

**TEMPLATE ECOLOGICAL ANALYSIS OF THE NARRATIVES OF
PARTNER'S AND FAMILY MEMBER'S OF WOMEN WHO CONSUMED
ALCOHOL IN PREGNANCY**

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ABSTRACT

Although there is increasing research on alcohol in South Africa, most of this work has an epidemiological focus. Very little research has explored alcohol use during pregnancy specifically from the perspective of the woman's partner or family member or focused on contextual risk factors beyond the pregnant woman. This information is important to ensure that interventions are formulated based on the social contexts within which drinking in pregnancy takes place and in guiding interventions that aim to prevent prenatal alcohol use, thereby preventing the occurrence of FASDs. This study was guided by Bronfenbrenner's Ecological Systems Theory to understand partners' and family members' perspectives of prenatal exposure within the actual environments in which alcohol use takes place. According to this theory, an individual exists within layers of social relationships: the family, intimate partners, friendships, and healthcare workers (microsystems), interactions among these microsystems, for example, interaction between healthcare workers and intimate partner and family and social workers (mesosystem), accessibility of alcohol in the neighbourhoods (exosystems), religion, culture and society (macro-systems) and changes of the individual and socio-historical context (chronosystem). The data were collected using a biographic narrative interpretive method of interviewing. Thirteen narrative interviews were conducted with partners and family members in a disadvantaged community in Buffalo City, Eastern Cape Province. The interviews were analysed using Template Analysis within the Ecological Systems Theory to interrogate the stories of partners and family members. According to participants, some of the reasons women consumed alcohol in pregnancy are: drinking habits before pregnancy that were difficult to break in pregnancy; women drank during the first trimester of their pregnancy because of unplanned pregnancy; women continued drinking throughout their pregnancies to cope with the emotional upset caused by the trauma of rape and losing loved ones, stress, receiving HIV-diagnosis in pregnancy, intimate partner violence, infidelity, rejection and denial of pregnancy from partners. After birth, some women continued drinking. Consequently, their children were taken away from them by social workers and family members because the parents were unable to care for the child due to alcohol use. There was lack of compliance of shebeens with liquor regulations, heavy drinking, high rates of alcohol use in pregnancy, and easy accessibility of alcohol within this study community. Pregnant women used religious coping beliefs to cope with their circumstances such as changes in their health, relationships and finances. Drinking during pregnancy is a complex problem that stems from multiple social and structural issues and interventions should therefore not only focus on the individual, but also on social networks and communities.

Keywords: alcohol use, pregnancy, social context, ecological systems theory, biographic narrative interpretive method, template analysis.

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GLOSSARY OF TERMS

The <i>dop</i> system	<i>Dop</i> is named after the colloquial Afrikaans word which means an alcoholic drink; <i>dop</i> system, where farm workers were paid in drink, dates back to European colonialism
Yoh	Used in South Africa to express awe or surprise
Tyhini	Used in South Africa to express awe or surprise
Mmmh	An expression used to show thought or reflection
Ijelemani	German print dress
Ifaskoti	Apron
Ixakato	Small blanket
Ikhetshemiya	Black headgear with white line
Ubugqwirha	Witchcraft
Umshologu	Spirit madness
Ukuthwasa	Becoming a traditional healer
Ubizo	Calling
Inkenqe	Cultural madness
Imithi/umuthi	Traditional medication
Mos	An Afrikaans term used in various South African languages translatable to ‘at least’ or ‘indeed’
Ahhh	Realisation or understanding

LIST OF ACRONYMS

ARBDS	Alcohol Related Birth Defects
ARND	Alcohol Related Neurodevelopmental Disorder
ART	Antiretroviral Therapy
ADHD	Attention-deficit/hyperactivity disorder
AUDIT-C	Alcohol Use Disorders Identification Test-Consumption
AWL	Alcohol Warning Labels
BNIM	Biographic-Narrative-Interpretative Method
CNS	Central Nervous System
CSSR	Critical Studies in Sexualities and Reproduction
FAS	Foetus Alcohol Syndrome
FASD	Foetus Alcohol Spectrum Disorders
IPV	Intimate Partner Violence
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organisation
pFAS	Partial Fatal Alcohol Syndrome
PAE	Prenatal Alcohol Exposure
PIN	Particular Incident Narrative
SES	Socioeconomic Status
RPERC	Research Projects and Ethics Review Committee
RUESC	Rhodes University Ethical Standards Committee

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CHAPTER 1: INTRODUCTION

Although there is increasing research on alcohol in South Africa, most of this work has an epidemiological focus. Very little qualitative research has been conducted, particularly research that captures the nuances of the conditions within which drinking takes place and that can ensure that interventions are formulated according to local social dynamics. This dissertation aims to address this by exploring alcohol use in pregnancy from the perspective of partners and family members of women who drank alcohol in pregnancy. An in-depth look at how partners and family members report on the experiences of these women and their context can be used to inform the content and delivery of intervention initiatives (Kelly, & Ward, 2017).

FOETAL ALCOHOL SPECTRUM DISORDERS

The drinking of alcohol in pregnancy is the most common cause of births of mentally delayed children and the primary cause of foetus malformation in South Africa. Popova, Lange, Probst, Gmel, and Rehm (2017) state that alcohol is a teratogen that can readily cross the placenta, resulting in damage to the brain and other organs of the developing embryo and foetus. Exposure to alcohol during pregnancy places a child at risk for a range of negative impacts, including: premature delivery, neonatal death, low birth weight, birth defects, neurodevelopmental disorders (Watt et al., 2014), stillbirth, spontaneous abortion, intrauterine growth retardation, preterm birth and congenital malformations (Popova et al., 2016). In other words, alcohol use during pregnancy harms the developing foetus and the exposed child can suffer a variety of disorders. Together, the outcomes are known as foetal alcohol spectrum disorders (FASD) (Watt et al., 2014).

Gardner (2016) defined FASD as a collective term encompassing the various clinical diagnoses that can occur in a child who was exposed to alcohol prenatally. FASD is the umbrella term used to describe a number of effects a child may have as a result of alcohol use in pregnancy rather than a specific diagnosis itself. Because each of the individual abnormalities is often subtle, hard to detect, and non-specific, the diagnosis of FASD relies on the occurrence of a set of diagnostic criteria which have been prearranged into four categories: facial features, growth retardation, structural or functional dysfunction of the central nervous system (CNS), and history of prenatal alcohol exposure (PAE) (Dorrie, Focker, Freunscht, & Hebebrand, 2014).

Although the criteria for FASDs diagnoses have been described thoroughly in the guidelines put forth to date, the diagnosis of FASDs remains challenging, and the specific assessment techniques used to make the definitive diagnosis are still debated (Popova et al., 2016). There are still questions and

challenges regarding the four diagnostic categories within the continuum of FASD. The specific diagnosis from most severe to less severe include: Foetal Alcohol Syndrome (FAS), partial foetal alcohol syndrome (pFAS), alcohol-related neurodevelopmental disorders (ARND), and alcohol-related birth defects (ARBD) (Clarke, & Gibbard, 2003), each of these are described below.

The most severe form of FASD is foetal alcohol syndrome (FAS) (Watt et al., 2014). Williams, Smith, and Committee on Substance Abuse (2015) defined FAS as a clinical diagnosis based on a specific constellation of physical, behavioural and cognitive abnormalities resulting from prenatal alcohol exposure. FAS is associated with a wide range of effects including permanent brain damage, congenital anomalies, prenatal or postnatal growth restriction, and characteristic dysmorphic facial features, along with cognitive, behavioural, emotional, adaptive functioning deficits (Popova et al., 2017). The FAS diagnosis is made only when an individual meets all three diagnostic criteria: prenatal and/or postnatal growth deficiency, the cardinal facial features and any of a range of recognised structural, neurologic, and/or functional central nervous system (CNS) deficits. Confirmed prenatal alcohol exposure strengthens the evidence, but FAS can be diagnosed without this history when all the specific FAS diagnostic criteria have been met (Williams et al., 2015). Therefore, the presence of the three symptoms can confirm a FAS diagnosis with or without confirmed maternal drinking in pregnancy.

The term partial foetal alcohol syndrome (pFAS) is applied to the patient with a confirmed history of prenatal alcohol exposure who has some but not all the characteristics of FAS. The presence of the highly specific FAS facial features confirms a FAS diagnosis and distinguishes it from less severe conditions on the spectrum of FASD (Clarke, & Gibbard, 2003). Additionally, for a person to be diagnosed with partial FAS s/he must indicate some, but not all, facial features of FAS, CNS dysfunctions as in FAS and a confirmed Parental Alcohol Exposure (PAE) (Dorrie et al., 2014). This implies that other individuals whose features meet most but not all the diagnostic criteria for FAS are described as having partial fetal alcohol syndrome.

According to Dorrie et al. (2014), alcohol-related neurodevelopmental disorder (ARND) is characterised by pattern of CNS abnormalities without facial features and confirmed PAE. Similarly, Gardner (2016) states that children diagnosed with alcohol-related neurodevelopmental disorder display few or none of the FAS facial features and their growth and height may range from normal to slightly below normal, but they display significant CNS damage. In other words, children who show significant neurodevelopmental dysfunctions as a results of prenatal alcohol exposure with or without FAS facial features are diagnosed with alcohol-related neurodevelopment disorder.

Alcohol-related birth defects (ARBD) involves various birth defects without CNS deficits and confirmed PAE (Dorrie et al., 2014). An individual diagnosed with ARBD presents with a range of congenital abnormalities that are associated with prenatal alcohol exposure but does not have the key features of FASD (Gardner, 2016). This suggests that children with ARBD present a range of physical abnormalities from birth that are associated with prenatal alcohol exposure but have none of the other key features of FAS (Popova, Lange, Burd, & Rehm, 2015).

THE EFFECTS OF ALCOHOL USE ON THE AFFECTED CHILD

Physically

Alcohol is a known teratogen that can cause a spectrum of damage and disrupt foetus development in all three trimesters. According to Gardner (2016), during the first trimester, alcohol can change the way in which cells grow and organise themselves. This may result in abnormalities of the face, heart, brain, limbs and urogenital system. In the second trimester, it can lead to miscarriage, and in the third trimester, it can impair overall foetal growth. Likewise, Van Vuuren, and Learmonth (2013) state that in the first-trimester, exposure is associated with organ, facial and musculoskeletal anomalies, while second- and third trimester exposure is linked with growth and intellectual and behavioural deficits.

Thus, alcohol use in pregnancy is harmful to the developing foetus in all trimesters and there is no known safe level of alcohol consumption during pregnancy. Even tiny amounts of alcohol have been found to cause adverse neurobehavioral effects, many of which cause lifelong disabilities (Skagerstrom, Chang, & Nilsen, 2011). In contrast, Popova et al. (2017) argue that not every woman who drinks during pregnancy will deliver a child with FAS. There is a lack of evidence about the effects of small to moderate amounts of alcohol. Thus, given the uncertainty and lack of evidence surrounding the effects of low amounts of alcohol consumption during pregnancy, the latest guidelines recommend that for pregnant women or women planning a pregnancy, not drinking is the safest option (Crawford-Williams, Steen, Esterman, Fielder, & Mikocka-Walus, 2015).

Cognitively

The affected child may suffer a range of lifelong primary and secondary disabilities. Primary disabilities are the direct result of organic brain damage which creates problems with communication skills, memory, learning ability, visual and spatial skills, intelligence and motor skills (Gardner, 2016). In addition, alcohol-exposed children are delayed on executive function tasks, such as problem-solving, planning, concept formation and conceptual set shifting, verbal and nonverbal fluency, response inhibition, and working memory (Mattson, Crocker & Nguyen, 2011). These

functions are essential for self-regulation and decision making. Difficulties arise in domains such as school and work performance, social interaction and adaptive living skills (Dorrie et al., 2014).

Secondary disabilities are those that arise because of primary disabilities and include: mental health problems, disrupted schooling experience, trouble with the law, inappropriate sexual behaviour, alcohol and drug abuse, difficulty with independent living, difficulty with employment and problems with parenting and academic failure (Gardner, 2016). Both the primary and secondary effects have a significant effect on the mother, family and surrounding community (Whitehurst, 2011) and while the primary effects are congenital abnormalities which are irreversible, secondary results could be reduced or prevented if the diagnosis is known and appropriate interventions are put in place (Rutman, & van Ribber, 2010). This shows that prenatal alcohol exposure has lifelong implications and affected children may require permanent assistance.

Social and behavioural

According to Patra et al. (2011), excessive alcohol consumption during pregnancy is associated with adverse postnatal behavioural development such as displaying delinquent and impaired moral behaviour. Likewise, Mattson et al. (2011) argue that the behavioural difficulties and psychopathology of children with FASD persist into adulthood. This means that the affected child might behave in a socially unacceptable way and this might be challenging to teachers, carers, parents and friends. Also, many children with FASD are described as talkative, short-tempered, impulsive and intrusive with reduced social abilities. As they lack understanding for the play ideas of their peers, they are at considerable risk of marginalization (Dorrie et al., 2014).

Moreover, children with prenatal alcohol exposure are likely to have increasing difficulty adapting to the social demands in skills and communication function as they become teenagers and adults (Mattson et al., 2011). It may be difficult for them to make and maintain friendships. As a result, there is a high rate of depression and suicide in people with FAS. Lack of social support, which can result from awkward social behaviour, has been shown to be a major contributor to depression (Kelly, Day, & Streissguth, 2000).

PREVALENCE OF FASD AND ALCOHOL USE DURING PREGNANCY IN SOUTH AFRICA

South Africa (SA) has among the highest rates of FASD reported in the world (May et al., 2013). Although no single national study has been conducted to determine its prevalence, several localised studies found the prevalence of FAS to be particularly high (Urban et al., 2015). The highest documented prevalence of FASD has been reported among the general population in the Western

Cape Province (Popova et al., 2016), particularly among the mixed ancestry populations ¹(coloureds) who reside in rural areas and small towns (Urban et al., 2015). Similarly, OLusanya and Barry (2015) state that in the Western Cape Province, approximately 34% of women who reside in urban areas and 41%-51% of women who live in rural areas, consume alcohol during pregnancy. Additionally, various prevalence studies in SA have revealed FAS rates as high as 26 per 1 000 in Gauteng; 64, 74.7, and 119.4 per 1 000 in Upington, Kimberley and De Aar, Northern Cape, respectively; 6.7, 9.6 and 100 per 1 000 in the Saldanha Bay Municipality, the Witzenberg sub-district, and Aurora on the West Coast, respectively; and 290 per 1 000 in the Winelands area (Olivier, Viljoen, & Curfs, 2016). This demonstrates that studies conducted in areas of the Northern Cape and Gauteng provinces have also documented high rates. In contrast, alcohol use is highly stigmatized for women in the northern Limpopo Province and alcohol consumption is reported as relatively low (0.07% of pregnant women) (Morojele et al, 2010). Olivier et al. (2016) stated that one more evaluation is currently underway in an urban area in the Eastern Cape. Alcohol use during pregnancy in South Africa appears to differ by province. To set priorities for public health policy, funding for public health initiatives, and health-care planning, it is necessary to know the prevalence of FAS and its main causal risk factor alcohol use during pregnancy (Popova et al., 2017).

COSTS OF FASD IN SOUTH AFRICA

FASD is associated with high costs as reported from several different countries. According to Popova et al. (2015), FASD imparts a large burden on society through the health care system, mental health and substance abuse treatment services, foster care, the criminal justice system and the long-term care of individuals with intellectual and physical disabilities. The fact that FAS is complex and chronic means that both the individual and their family are affected, and in many cases, people with FAS require lifelong assistance (Popova et al., 2017).

Watt et al. (2014) state that the cost of alcohol-related harm in South Africa was recently estimated to be about R300 billion. Also, Eaton et al. (2012) found that FAS has had a devastating impact on the Western Cape economy and health care system. This tells us that FASD is a significant public health and social problem that consumes a large amount of resources, both economic and societal in South Africa. However, many of the costs associated with FASD can be reduced with the implementation of effective social policies and intervention programmes (Popova et al., 2015). To

¹The apartheid government divided South African population into four racial groups; Whites, Natives (Blacks), Indians and Coloured people (people of mixed race). Race was used for political, social and economic purposes. The apartheid construction of race segregation is used throughout this thesis to highlight the consequences of which are still experienced today.

address the FASD burden in South Africa, attention needs to be focused on how the community understands drinking during pregnancy (May, & Gossage, 2011), which this study takes up. FASD remains undiagnosed in South Africa, indicating a lack of awareness among communities and healthcare professionals (Urban et al., 2015).

RATIONALE

Research on alcohol use in pregnancy generally focusses on under-diagnosed FASD and how alcohol harms the development of foetus, and subsequently the child. There is a little research on the narratives of partners and family members of women who consumed alcohol in pregnancy. This information is important to ensure that interventions are formulated based on unique needs of communities. Also, as pregnancy is often considered as women's responsibility, interventions that aim to combat the prevalence of FASD frequently work with the pregnant women only, minimizing and ignoring the role of male partners and family members in pregnancy as well as the social context in which drinking during pregnancy takes place.

This study aims to explore how partners and family members of women who drank alcohol while pregnant make sense of alcohol use and the social context within which drinking during pregnancy takes place. Very little research has explored alcohol use specifically from the partner or family member perspective of women who consumed alcohol while pregnant or focused on contextual risk factors beyond the pregnant woman. An in-depth look at how partners and family members report on the experiences of these women and their context can be used to inform the content and delivery of intervention initiatives (Kelly, & Ward, 2017).

Furthermore, this study is part of a bigger project that aims to inform interventions aimed at preventing prenatal alcohol use and decreasing the incidence of FASDs. Other studies conducted in the project are: a baseline and end-term summative evaluation of the effects of an intervention on the drinking of women presenting at antenatal clinics; a formative evaluation of the intervention; and analysis of the stories of women who drank during pregnancy.

RESEARCH QUESTIONS

How do partner and family members of women who drank alcohol at harmful levels narrate the journey of pregnancy?

- What themes at the individual (history of alcohol abuse, attitudes, beliefs and knowledge) are evidenced in these stories?
- What themes at the microsystem (family, friends, intimate partner and clinic) are evidenced in these stories?
- What themes at the mesosystem (which includes the links of different systems together within microsystem such as clinic and partner, friends and partner etc.) are evidenced in these stories?
- What themes at the exosystem (which consists of settings that individual do not have direct contact with but still influence the individual e.g. the environment where people live) are evidenced in these stories?
- What themes at the macrosystem (which includes broader cultural beliefs, societal issues, policies and regulations) are evidenced in these stories?
- What themes at the chronosystem (which include changes in individual or socio-historical context) are evidenced in these stories?

OVERVIEW OF CHAPTERS

In this chapter 1, I offered an overview of this dissertation. Chapter 2 covers the empirical literature relevant to this study. It gives an overview of the literature on risk factors of alcohol use in pregnancy, families of children with FASD, partner involvement and current strategies to reduce the FASD burden and their limitations. In Chapter 3, the theoretical framework that informs this study (Bronfenbrenner's Ecological System Theory) is introduced. Ecological Systems Theory argues that behaviours (in this case alcohol use in pregnancy) take place within a set of nested and changing environments and that complex relations within and between those nested environments shape behaviours (alcohol use). Chapter 4 provides the outline of the research methodology of the study, the aims, objectives, research questions and the research design. It also includes information on the study location, the participants of the study and the method of sampling used in the study. It outlines the data collection and analysis methods in detail, the reflexivity of the researcher, the trustworthiness of the study and the ethical considerations. In chapter 5 the findings of the study are analysed using thematic template analysis within the Ecological Systems framework to interrogate the stories of the partners and family members of women who consumed alcohol in pregnancy and this section focuses on the pregnant woman and their microsystem. In Chapter 6 the second section of findings, which focuses on larger systems namely, mesosystem, exosystem, macrosystem and chronosystem, is presented. Finally, Chapter 7 discusses the implications of the findings in terms of interventions and concludes the dissertation.

CHAPTER 2: LITERATURE REVIEW

According to Anderson, Hure, Kay-Lambkin, and Loxton (2014), several alcohol guidelines worldwide suggest that pregnant women should abstain from alcohol. Despite health guidelines advising women to abstain from drinking alcohol during pregnancy, numerous South African women drink alcohol during their pregnancy. This raises questions about how and why women make the choices they do about their alcohol consumption during pregnancy. It indicates a need to understand factors that influence alcohol consumption during pregnancy. This section will discuss some of risk factors that contribute to use alcohol in pregnancy, in order to identify further opportunities for intervention and prevention.

PREGNANCY

Pregnancy may be associated with increased motivation to reduce unhealthy behaviours, because of the desire to have a healthy baby and healthy pregnancy (Skagerstrom et al., 2011). Positive health practices include: abstaining from tobacco, alcohol, and other harmful substances; obtaining regular prenatal care; maintaining a good diet; obtaining adequate rest and sleep; engaging in regular exercise; and learning about pregnancy and childbirth (Alhusen, Gross, Hayat, & Sharps, 2012). Thus, most women limit or stop alcohol consumption when they learn they are pregnant (Gearing, McNeill, & Lozier, 2005). But some women continue to drink even after pregnancy recognition (Zelner, & Koren, 2013). This suggests that there are many influences at play: knowledge that one is pregnant is not necessarily sufficient to prevent drinking.

Research conducted in Western Cape suggests that a key predictor of drinking during pregnancy is a woman's pre-pregnancy drinking patterns. A woman who drinks heavily is more likely to continue to drink during her pregnancy, perhaps due to habit and/or alcohol dependence (Choi et al., 2014). Likewise, Onah, Field, Heyningen, and Honikman (2016) argue that higher alcohol consumption before pregnancy was found to predict drinking during pregnancy in all the studies that reported on this factor. Therefore, women who drink prior to conception may find it difficult to stop drinking during pregnancy.

Balachova et al. (2014) argue that the challenge in terms of FASD is that approximately half of pregnancies are unplanned and that many women consume alcohol at pre-pregnancy levels prior to knowledge of pregnancy. A potential reason as to why women drink during the first trimester of their pregnancy is that they may be unaware that they are pregnant, particularly if their pregnancy is unplanned. However, a study conducted by Watt et al. (2014) in the Western Cape province showed that even when an unplanned pregnancy is discovered and despite the knowledge of the negative re-

percussions of maternal drinking, most women continued to drink at hazardous levels throughout pregnancy.

Gardner (2016) argues that most pregnant women who plan to carry a foetus to term act in ways that foster the welfare of their future children. With the intent to deliver a normal, healthy birth baby, a pregnant woman will alter her lifestyle accordingly. However, some pregnant women behave in ways that are not conducive to the birth of healthy children. For example, in a study conducted by Watt et al. (2014), two women in the sample stated that they drank substantial amounts of liquor in the early stage of their pregnancies as an effort to abort the pregnancy. As one woman recounts, she was not successful in aborting the pregnancy, and went on to drink heavily throughout the pregnancy period. This demonstrates that when pregnancy is unplanned and unwanted and when women have no connection to the foetus, they are less likely to be willing or able to make any lifestyle changes to accommodate their new situation. As one woman said: “I didn't want the child. I didn't want to be bound by something I didn't want” (Watt et al., 2014, p.123). Therefore, pregnancy does not stimulate all women to decrease or stop drinking while pregnant.

LACK OF KNOWLEDGE

Balachova et al. (2014) argue that the most influential factor in a woman's decision regarding alcohol consumption during pregnancy is her knowledge. Women who lack knowledge of the effects of alcohol have been identified as at risk for drinking while pregnant (Peadon et al., 2011). Also, Eaton et al. (2014) found that a substantial number of men believed that a woman could consume alcohol safely during her pregnancy. Because of a lack of education, women could be unaware that prenatal alcohol use is harmful to the foetus (Eaton et al, 2014). This provides evidence supporting the need for public education efforts to reduce alcohol use in South Africa.

Peadon et al. (2011) argue that women who hold the belief that any amount of alcohol is safe during pregnancy have been identified at risk for drinking in pregnancy. Women have held numerous misconceptions about alcohol use in pregnancy, including that some types of alcohol pose less risk than others, that drinking only causes problems early in pregnancy and that women need to consume large amounts of alcohol to cause harm (Elek et al., 2013). These misconceptions may be because of the uncertainty and lack of evidence surrounding the effects of low amounts of alcohol consumption during pregnancy (Crawford-Williams, Steen, Esterman, Fielder, & Mikocka-Walus, 2015). Guidelines that condone light drinking in later pregnancy recommend abstinence in the first trimester, yet the teratogenic effects of alcohol can occur at any time, though there is an increased risk during the first trimester (Anderson et al., 2014). Healthcare providers particularly midwives may encourage

the use of wine not only for stress relief, but as a benefit to the developing foetus (Crawford-Williams et al., 2015). However, healthcare authorities currently recommend abstaining from alcohol use throughout pregnancy, because there is no known safe amount, no safe time and no safe type of alcohol to drink in pregnancy (Elek et al., 2013).

Social norms are sometimes conflicted with knowledge about maternal drinking that women receive from the antenatal clinics. In a study conducted by Watt et al. (2014), pregnant women in South Africa were found to be influenced by certain peer networks that encouraged prenatal alcohol use, both because social groups may encourage pregnant women to attend bar sites and because these groups can create social environments where alcohol use is promoted. For example, several women spoke about how their friends would encourage and support their drinking behaviour, even though the friends were knowledgeable of the pregnancy. One participant expressed intentions to drink less, but said that her friends would encourage her drink, often up to six beers in a single evening. Having peers who do not see anything harmful with alcohol use in pregnancy encourages the pregnant woman to continue drinking despite healthcare professionals' recommendations to reduce or abstain from alcohol use in pregnancy.

HIV DIAGNOSIS IN PREGNANCY

Watt et al. (2014) state that pregnancy in South Africa may introduce further social and contextual stressors including human immunodeficiency virus (HIV) testing and diagnosis, possible relationship dissolution, depression, and regret around unintended pregnancies. Also, pregnancy can have emotional, physical and economical complications for the mother. If pregnancy is accompanied by negative events such as a diagnosis of HIV infection, it is likely that mothers may experience their pregnancy as distressing and struggle to come to terms with it (Netshimbupfe, 2017). An HIV diagnosis together with the initiation of antiretroviral therapy (ART) may have an emotional effect on pregnant women that influences how they will cope with the pregnancy as well as their adherence to a treatment plan (Fords, Crowley, & van der Merwe, 2017). Alcohol abuse and other drugs has also been identified as a means for 'coping with everyday life' for pregnant (Onah et al., 2016). It is not surprising that women may rely even more heavily on previously established maladaptive coping strategies such as drinking.

SOCIOECONOMIC STATUS

A woman's socioeconomic status (SES) may play a role in the association between her intention to become pregnant and her alcohol consumption. Although women of any socioeconomic status can bear children with FASD, the more severe forms of FAS and pFAS most frequently have been found in the lower SES categories in various countries (May, & Gossage, 2011). A key determinant to preconception health is socioeconomic status with education, income, and access to health care as important indicators of socioeconomic status. Positive health-promoting behaviours during pregnancy can be inhibited by socioeconomic difficulties, especially during unintended pregnancies. These unintended pregnancies contribute to delayed pregnancy recognition, which allows for longer periods to engage in risky behaviours (Lepper, 2016). The SES of mothers of children with FASD is consistently lower than control subjects in epidemiologic studies as well. For example, in most population-based studies, women with FASD children have lower levels of education and more frequently are unemployed or underemployed (May, & Gossage, 2011). The higher the education level, the more likely that binge drinking will be reduced among women intending to become pregnant. Women who are more educated tend to make informed choices about their pregnancy planning, are aware of the recommendation to not drink during pregnancy, and engaged in healthy behaviours (Lepper, 2016).

In contrast to the above-mentioned research, McCormack et al. (2017) reported that women who consume alcohol during pregnancy tend to be older, more highly educated, and earn higher incomes, than those who do not. In addition, a longer history of alcohol consumption and more confidence to manage social situations predicted heavier drinking among pregnant women. Skagerström et al. (2011) argue that previous research has shown that higher alcohol consumption among people with high socioeconomic status is primarily because of frequent light social drinking rather than heavier binge drinking. Therefore, FASD is more common among children of low-income families compared with women of higher SES status, as low SES is an increased risk factor for women binge-drinking during pregnancy (Baxter, Hirokawa, Lowe, Nathan, & Pearce, 2004).

Rural populations tend to be lower in income than urban residents, and FAS appears to be negatively related to socioeconomic status. As a result, rates of heavy alcohol use tend to be slightly higher among rural as opposed to urban residents (Baxter et al., 2004). It is important to note some of the differences in alcohol consumption in urban areas vs rural communities (Jacobs, & Steyn, 2016). All population-based studies of FASD in South Africa have indicated that the highest rates are found among women who live on the poorest rural farms where living conditions and nutrition are poor, and weekend binge drinking is a regular practice (May, & Gossage, 2011). Also, one of the reasons

could be homebrews are more popular in rural areas where ancestral rituals and ceremonies are undertaken. Yet, in urban areas, alcohol is more accessible and affordable (Jacobs, & Steyn, 2016). It is critical, therefore, to acknowledge and address the underlying factors which contribute to women's use of alcohol in pregnancy (Gearing et al., 2005).

Popova et al. (2016) argue that the high prevalence of FASD in Western Cape can be partially attributed to the historical roots of heavy alcohol consumption among the working class in that area. It is widely believed that heavy drinking among poorer South Africans, particularly Coloureds, is deeply-rooted in the legacy of the *dop* system. The *dop* system, named after the colloquial Afrikaans word which means an alcoholic drink, has a long history dating back to European colonialism. In the Western Cape Province (where some of the highest rates of FAS have been recorded worldwide), the agricultural economy centred on grape and wine production (Russell, Eaton & Petersen-Williams, 2013). Historically, these workers were given wine as partial payment for their labour. Although this practice was outlawed in the 1960s, high levels of drinking and alcohol dependence continued. This demonstrates that the *dop* system encouraged and sustained a culture of alcohol consumption that not only ensured that local communities remained impoverished, but also promoted alcohol use in pregnancy.

Patterns of hazardous alcohol use in the Western Cape are, in part, the results of social norms that emerged in response to the *dop* system and apartheid (Watt et al., 2016). Women who became pregnant continued to drink at harmful levels during their pregnancies (Eaton et al., 2012). For example, according to research conducted by Watt et al. (2014) in the Western Cape, women spoke about how drinking during pregnancy was normative in their communities and in their social circles. Coloured women spoke about this as a universal truth (i.e., "all" pregnant women drank), while Black women were more likely to talk about it selectively (i.e., "some" pregnant women drank). None of the women in the sample talked about hiding their drinking behaviours from others, implying that their behaviour was either accepted or endorsed in their immediate networks and social norm in their communities. Therefore, maternal drinking cannot be separated from the persuasive culture that accepts and supports the use of alcohol in communities (Coons, 2013).

FAMILIES OF CHILDREN WITH FASD AND PARTNER INVOLVEMENT

According to Hanson and Jensen (2015), social support is defined as the availability of helping relationships, the quality of those relationships, and functional interactions where individuals provide aid, assistance, and comfort to others. There are several types of social support, including emotional (provision of empathy, love, and trust), instrumental (provision of tangible aid and services), and

informational (provision of advice, suggestions, and information). This section of literature review discusses how family members' and partners' support may reduce alcohol use in pregnancy. Also, how lack of support may exacerbate alcohol use in pregnancy harming the wellbeing of foetus and the pregnant woman.

FAMILY MEMBERS OF CHILDREN WITH FASD

Gearing et al. (2005) argues that most young women who quit or reduce their drinking during pregnancy were encouraged by others, specifically family members, to avoid alcohol use during their pregnancies. Women who had good social support were more likely to abstain from alcohol consumption during pregnancy. This suggests that the availability of people on whom pregnant women can rely may help in reducing prenatal alcohol use (Abadi, Ghazinour, Nojomi, & Richter, 2012). Therefore, social support can both reduce and increase drinking, depending on the behaviours and support of family members.

According to May and Gossage (2011), women who have borne children with FASD are likely to have heavy drinking in their families of origin. These households and families tend to be less stable and more chaotic. These features may also enhance the negative behaviour traits that are often associated with children who have FASD. Likewise, Hanson and Jensen (2015) argue that many women who continue drinking during pregnancy reported frequently drinking with family members as well as substance abuse problems amongst siblings.

Parents of children with FASD experience emotional reactions to the diagnosis and blame themselves for drinking during pregnancy. Childrearing a child with FAS is associated with feelings of guilt and shame, financial strain and frustration (Olson, Oti, Gelo, & Beck, 2009). Sanders and Buck (2010) argued that parents expressed difficulty: preventing the child's behaviour problems; making time for themselves; keeping plans for themselves and their families; collaborating with the school; keeping the FASD child involved in community activities; gaining support from professionals; keeping their child involved with peers; and coping with the child's learning and behaviour problems.

Additionally, higher levels of stress may be experienced in families of FASD children (Sanders, & Buck, 2010). Increased parenting stress has commonly been attributed to the child's behavioural problems rather than his/her developmental delay. In addition, there are the increased demands placed upon family members for the child's support needs (Coons, 2013). This suggests that when the diagnosis is more severe, families of children with FASD experience higher levels of stress.

According to Coons (2013), parents frequently report frustrations with being unable to receive a diagnosis of FASD for their child, because it prevents them from accessing appropriate services and supports. Medical and mental health professionals may diagnose disorders based on behavioural symptomatology without considering prenatal alcohol exposure (PAE). For example, children with FASD and children with Attention-deficit/hyperactivity disorder (ADHD) may present quite similar behaviours, and as such, children with FASD are often diagnosed with ADHD (Baskin, Delja, Mogil, Gorospe, & Paley, 2016). Therefore, lack of knowledge of FASD by health professionals and service providers appear to be particularly challenging for families and could lead to misdiagnosis of patients and poor-quality service to affected individuals.

²PARTNER INVOLVEMENT IN PREGNANCY

One fundamentally important, but frequently minimised and ignored factor, is the role of fathers in FASD. Gearing et al. (2008) defined partner involvement in pregnancy as a combination or sole contribution of four overall dimensions: emotional support, financial contributions, amount of time spent with children and the family; and quality of this time. Likewise, Kaye et al. (2014) states that the ideal supportive partner that women desire in pregnancy is accessible (present, available, a team player) and responsible (is concerned, maintains connection with the woman carrying the child regardless of the partnership status, and is a caregiver, provider or protector). In addition, Cohen et al. (2016) found that pregnant women desired male partner involvement during pregnancy, labour and delivery.

However, pregnancy and childbirth have primarily been considered a mother's responsibility, whereas the role of the father has mainly been that of the provider and breadwinner (Bond, 2010). Consequently, lack of paternal involvement is associated with decreased birth weight, decreased prenatal care, younger gestational age at birth, and increased complications in pregnancy (Cohen et al., 2016). Also, pregnant women revealed that the absence of the man in the pregnancy and delivery processes generated feelings of loneliness, neglect and emptiness (Silva et al., 2016). This demonstrates that lack of partner involvement is harmful to the development of foetus and well-being of pregnant women. Aktas and Calik (2015) argue that insufficient support from partners during pregnancy deteriorates the psychological health of the pregnant woman and has a poor effect on eating habits and leads to an increase in the use of alcohol, smoking, and substance use. Thus, when the

² This study reviewed literature that focussed on heterosexual couples and sample was heterosexual partnership, thus it does not box families into one structure.

pregnant women support needs from their male partners are unmet, they adopt unhealthy habits to cope with the absence of the partner.

Additionally, the focus on the role of the pregnant female in the health of the foetus has tended to minimise concern for possible male-mediated effects (Gearing et al., 2005). Phiri (2015) argues that dissatisfaction with partner support among pregnant women is associated with depressive symptoms, worries, and general emotional distress. Perceived lack of partner support has negative consequences for maternal, infant and child health. As a result, single women have a greater likelihood of drinking than do married women (Gearing et al., 2005). This suggests that when a male partner is not involved nor supportive in pregnancy, the pregnant women suffers from depressive symptoms, general emotional distress and this may contribute to drinking in pregnancy.

Anxiety and depression during pregnancy have been associated with poor pregnancy outcomes, such as preterm delivery, low infant birth weight, small-for-gestational-age infants and alcohol use (Rosand, Slinning, Eberhard-Gran, Roysamb, & Tambs, 2011). Also, Vythilingum, Roos, Faure, Geerts and Stein (2012) found that depression and anxiety in pregnancy consistently predict women who continued to use alcohol and those who were substantial risk drinkers antenatally. Similar, Hartley et al. (2011) state that women with higher levels of depression often continue to use alcohol despite knowing they are pregnant and clinician advice against such use. Therefore, depression may serve as both an initiating and a maintaining factor for alcohol use in pregnancy. Women self-medicate, that is to use alcohol as a means of coping with the emotional pain caused by lack of support/male partner involvement (Skagerstrom et al., 2011).

Furthermore, some research has highlighted alcohol use among pregnant women as a factor that is associated with greater likelihood of experiencing intimate partner violence (IPV) and that alcohol use among expectant fathers is associated with a greater likelihood of perpetrating intimate partner violence against pregnant women (Eaton et al., 2012). Abused pregnant women may develop symptoms like low weight gain during pregnancy, infections, high blood pressure, and vaginal bleeding; they may suffer from post-traumatic stress syndrome, anxiety disorders including panic attacks, depression, sleeping or eating disturbances, tobacco, alcohol, or drug abuse or suicidal syndromes (Abadi et al., 2012). For women during a pregnancy period, IPV has serious implications because their pregnancy may have been a consequence of violence itself (Teixeira et al., 2015). Women experiencing domestic or intimate partner violence may feel caught in a vicious circle due to societal norms. They may stigmatise themselves and consequently do not ask for support when they are in need and because they are afraid of additional violence by their husbands/partners if they become aware of their disclosure. They may even be stigmatized by other family members or societal officials for violating societal norms by disclosing the abuse (Abadi et al., 2012). Consequently,

women may use alcohol in pregnancy as a way of coping with the trauma and fear that comes from intimate partner violence or domestic violence happening at home.

The stability of the couple relationship is associated with a decreasing risk factor in women who consume alcohol while pregnant (Gearing et al., 2005). Likewise, Van der Wulp, Hoving and Vries (2013) argue that pregnant women in their third trimester found that social support was significantly related to the reduction of alcohol use in pregnancy. This suggests that women are more likely to avoid alcohol during pregnancy when their partners support the pregnancy and find it more difficult to stop or reduce their drinking when they lack support and experience intimate partner violence.

ABSENCE OF CLEAR ROLES OF MALE PARTNER IN PREGNANCY

Men have not played a significant role in family planning, pregnancy, and childbirth nor have they had a place in reproductive health initiatives. According to Kaye et al. (2014), contemporary societal expectations in Uganda encourage male participation in childbirth but the cultural and societal values are unclear regarding this expectation. Also, Adeniran et al. (2015) reported that many men in low resource countries do not accompany their partners to the health facility during pregnancy unless there is a complication. Others wait outside at the clinic while the women participate in health talk and consultation with the health worker. Consequently, men often felt distanced from their partners during pregnancy, childbirth and the postpartum period. As they approached birth, some mothers moved from the men's home to stay with the women's relatives who would support them during the labour process. If the men accompanied their partners to the antenatal clinics, they generally stayed outside the clinic, as there was no space or seat for them. The men reported that on several occasions, they were not given any attention (Kaye et al., 2014). This demonstrates a need to educate men how they can support their partner in pregnancy and healthcare services must include men in antenatal clinics and allow them to be involved in the wellbeing of the pregnant women and developing foetus.

Moreover, Nesane, Maputle and Shilubane (2016) state that culture is perceived as a factor that affects male partners' involvement in maternal healthcare services. For example, participants from a study conducted in Venda, South Africa indicated that their culture, Tshivenda, does not allow them to participate in maternal healthcare services (Nesane et al., 2016). Similarly, Lewis, Lee and Simkhada (2015) identified factors that discourage husband involvement such as the prevailing traditional beliefs, culturally-determined gender roles around pregnancy and childbirth (with the mother-in-law upholding a significant role), discouragement by the medical system for men to enter the delivery room, and women's shyness, especially during delivery, of involving their partners. This implies that

certain cultures and healthcare professionals restrict men from participating in maternal healthcare services.

HOW CAN PARTNERS BE MORE INVOLVED IN PREGNANCY?

Adeniran et al. (2015) argue that men can provide emotional support and empathy, participate in preparation for the baby's arrival, and provide company during antenatal hospital visits, consultation and delivery. Also, van der Wulp, Hoving and de Vries (2015) state that men can support their partners in pregnancy in three ways: partner norms (i.e. the partner's belief regarding acceptability of prenatal alcohol use), partner modelling (i.e. the partner's own alcohol use during the woman's pregnancy) and partner support (i.e. the partner's help in abstaining from alcohol during pregnancy). In other words, men need to clearly communicate their views of alcohol use in pregnancy, need to decrease their own alcohol use and need to support their partner's decision to decrease alcohol use in pregnancy. The social pressure for expectant fathers to abstain from drinking is obviously not as strong as for pregnant women. However, to encourage mothers to follow health instructions and abstain from alcohol during pregnancy, it has been argued that fathers ought to reduce their alcohol consumption as well (Mellingen, Torsheim, & Thuen, 2013).

According to Vermeulen et al. (2016), men in the majority of low-and middle-income countries, maintain a significant role in decision making in private life. Their role is highly influential in women's choice for health care seeking behaviour. Therefore, men can encourage health facility visits, support good nutrition, reduce workload during pregnancy, assist in birth preparedness and provide emotional support. Mutually supportive family planning involving male partners mitigates the risk of conceiving an unplanned pregnancy and the possible use of alcohol use before the pregnancy is known (Gearing et al., 2005).

Furthermore, men tend to be decision-makers within families; they may control the use of contraceptives, the availability of nutritious food, women's workload, and the allocation of money, transport and time for women to attend health services (Nesane et al., 2016). Therefore, men's behaviour influences the reproductive health of both men and women and the health of their children. Yet men are often unable to make informed choices because they have not been included in reproductive, maternal health care services and education. The failure to incorporate men in maternal health promotion, prevention and care programmes by policy makers, programme planners and implementers of maternal health services has had a serious impact on the health of women and the success of these programmes (Nesane et al., 2016). Greater male involvement in maternal health

programmes may help to reduce unintended, unwanted pregnancies and the transmission of sexually transmitted infections as well as reduce alcohol use in pregnancy.

INTERVENTIONS

Given the health risks to infants who were prenatally exposed to alcohol, some interventions aimed at prevention have been undertaken. The United States Institute of Medicine recommended comprehensive prevention of FASD at three levels: universal, selected, and indicated. Universal methods such as public education and public policy are appropriate for entire populations (May et al., 2013). For example, Alcohol Warning Labels (AWLs) have been used by many countries as a way of trying to prevent FASD by encouraging women to abstain from alcohol consumption during pregnancy. The United States, France, Russia, South Africa, and the Yukon and Northwest Territories in Canada have regulations requiring warning labels related to drinking during pregnancy and/or other risks. AWLs are associated with many positive behaviour changes, although not necessarily with decreases in alcohol consumption (Thomas, Gonneau, Poole, & Cook, 2014).

Scholes-Balog, Heerde and Hemphill (2012) suggest that alcohol warning labels may improve knowledge and attitudes regarding the harmful consequences of alcohol use among adults, but there is little evidence to suggest that warning labels have any effect on people drinking at harmful levels or specific alcohol-related risky behaviours such as drink-driving. It has been suggested that alcohol warning labels have the potential to positively contribute to reducing harmful levels of alcohol consumption when implemented in conjunction with a variety of other policies (e.g. public and school-based education campaigns and legislation governing alcohol service and provision), AWLs should be varied and occupy a large section of the alcohol package. Universal prevention efforts, including AWLs, may lead to increased public knowledge about the risks of alcohol consumption during pregnancy, but additional strategies are required to achieve goals for prevention of FASD (Thomas et al., 2014).

Several public health strategies to prevent FASD have been developed and implemented in Western countries, including public awareness campaigns, screenings and brief interventions in primary care, community interventions, and other approaches. These efforts have shown some efficacy in reducing rates of alcohol use among pregnant women (Balachova et al., 2014). This indicates that Western countries use a variety of public health strategies to prevent and reduce alcohol use in pregnancy and FASD. However, in South Africa, typically interventions to reduce FASD have been in prenatal clinics and have focused on increasing women's knowledge about the detrimental impact of alcohol on the developing foetus (Watt et al., 2014).

South African prevention efforts are selective because they miss women whose attendance to prenatal care is late or irregular, a phenomenon that is much more common among heavy drinkers (Watt et al., 2014). Thomas et al. (2014) argue that selective prevention reaches women of reproductive age who drink alcohol. It may involve health professionals talking to pregnant women about alcohol use and providing women who drink with assistance in reducing or quitting alcohol and in making related improvements in their health. In many cases, selective prevention uses brief interventions. FASD prevention efforts have focused solely on maternal alcohol use. It has been suggested that this approach may have limited impact for women whose alcohol use co-exists with other conditions (Gearing et al, 2008), e.g. depression as mentioned above. These prevention efforts are problematic because they may fall short in preventing FASD as they may fail to address the complex psychosocial and contextual factors that motivate women to drink during the pregnancy period (Watt et al., 2014).

Indicated prevention of FASD is where women of childbearing age who drink are provided birth control to prevent a pregnancy when they are drinking. But if pregnant, or about to become pregnant, case management can be utilised to educate, coach, and support women through a healthy pregnancy (May et al., 2013). Selective and indicated prevention initiatives support reduction in maternal alcohol use and thereby improve health outcomes for both mothers and children.

Indicated interventions to prevent FASD have focused mostly on pregnant women. Recent research concludes that prevention of FASD should begin pre-conceptionally, by either reducing alcohol consumption in women at-risk or planning pregnancy or preventing pregnancy in women drinking at risky levels (Hanson & Jensen, 2015). But, for these interventions to be effective, men should be involved in the treatment, education, and prevention of FASD (Gearing et al., 2005). This suggests that prevention of FASD must start before a woman becomes pregnant by encouraging women to make use of contraception if they are not planning to have children and healthcare workers and policy makers must also encourage men to support and participate in reproductive health of their partners and the prevention of FASD.

Therefore, interventions should prioritise the social context of drinking, include a component that works with both pregnant women and their partners'/family members and use supportive and non-judgemental approach to supporting pregnant women (Kelly & Ward, 2017). Hanson and Jensen (2015) found that a brief intervention with a general population of pregnant women and their partners using goal selection and social support was successful in encouraging pregnant women to abstain from drinking alcohol. This suggests that social support may help the pregnant women not to go through pregnancy alone and may play a significant role in reducing alcohol use in pregnancy. Additionally, there is evidence for the need to address alcohol use in pregnancy from a social-contextual perspective that focusses on how one's environment shapes behaviour (Watt et al., 2016).

This means that it is important to understand circumstances that bring some women to use alcohol and make it difficult for them to stop or decrease during pregnancy. The social context of drinking helps in understanding the roots of the problem, as well as in informing the content and delivery of intervention strategies. Also, there is a great need for context-sensitive and location-specific national alcohol prevention and intervention programs (Morojele et al., 2010), especially for those pregnant women who reside in the most vulnerable and high-risk populations (Russell et al., 2013).

CONCLUSION

The above chapter discussed some of the risk factors that may contribute to alcohol use in pregnancy such as pregnancy itself, HIV-diagnosis, lack of accurate knowledge about harms of prenatal alcohol exposure and socioeconomic status. How social support from family members and partners may increase or reduce alcohol use in pregnancy was outlined. And lastly, I discussed existing interventions proposed by The United States Institute of Medicine to reduce alcohol use in pregnancy at three levels: universal, selected and indicated. The limitations of these interventions were also outlined.

CHAPTER 3: THEORY

There has been an increase in interest in, and application of, ecological models in research and practice, due in part to their promise in guiding wide-ranging approaches to changing behaviours that will reduce serious health problems (Sallis, Owen, & Fisher, 2015). Ecological models are a formalised conceptualisation of the individual and environmental determinants of health behaviours and public health outcomes (Richard, Gauvin, & Raine, 2011). The basic principle of ecological models marks a shift away from purely individually-oriented thinking about behaviour to include interpersonal and environmental influences in understanding health behaviour. Various theories use ecological principles to explain human behaviour (Duncan, Bowman, Naidoo, Pillay, & Roos, 2007). This study utilized Bronfenbrenner's Ecological Systems Theory, which suggests that alcohol use in pregnancy is shaped by the interaction between pregnant women, the contexts within which alcohol use in pregnancy develops and the types of exchanges that take place in the interaction between pregnant women and her context (Shaffer, & Kipp, 2013). The purpose of this research study is to understand alcohol use in pregnancy as expressed by partners and family members from an ecological perspective hoping to inform and guide interventions to prevent prenatal alcohol use and decrease the incidence of FASDs.

BRONFENBRENNER'S ECOLOGICAL SYSTEMS THEORY

Bronfenbrenner (1979) developed an Ecological of Human Development Theory, also known as Ecological Systems Theory, a multilevel systems approach for understanding child outcomes and behaviour. Bronfenbrenner defined human development as changes during the life course in enduring patterns of behaviour or perceptions resulting from the interplay of biological characteristics of the person and the environment; He stressed the role of environment on individual development (Mizokawa, & Komiya, 2014). Bronfenbrenner (1979) assumed that natural environments are the major source of influence on the developing persons; this is often overlooked by researchers who choose to study development in the highly artificial context of the laboratory (Shaffer, 2008). Bronfenbrenner challenged the conventional study of human development by describing developmental research as "the study of the strange behaviour of children in strange situations for the briefest possible period of time" (Ferguson, & Lee, 2013, p.71). He argued that development should be studied in its ecological context or, in other words, within the actual environments human live (Ferguson, & Lee, 2013). This theory stresses the importance of the interaction between people and their changing environments and asserts that the main effects on human development stem from that interaction (Senefeld, & Perrin, 2014).

The central precepts of the ecology of human development are that human development takes place within a set of nested and changing environments and that complex relations within and between those nested environments shapes behaviour (Ennett et al., 2008). Similarly, the ecology of human development contains the scientific study of the progressive, reciprocated space between active growing human beings and the changing properties of the immediate setting in which the developing person lives as this progression is affected by relationships between settings and by the larger contexts in which settings are embedded (Bronfenbrenner, 1979). In other words, the developing person is said to be at the centre of and embedded in several environments, ranging from the immediate settings such as family and peer groups to more remote contexts such as broader culture. Bronfenbrenner (1979) identified four basic environmental systems that are important in understanding individual behaviour namely microsystems, mesosystems, exosystems and macrosystems (Duncan et al., 2007). He later added chronosystem in 1986 to expand the theory (Rankin, & Stallings, 2005). Each of these systems is assumed to interact with others and with the individual to influence development in important ways (Shaffer, 2008). These systems begin with one closest to the developing person, and moving outward:

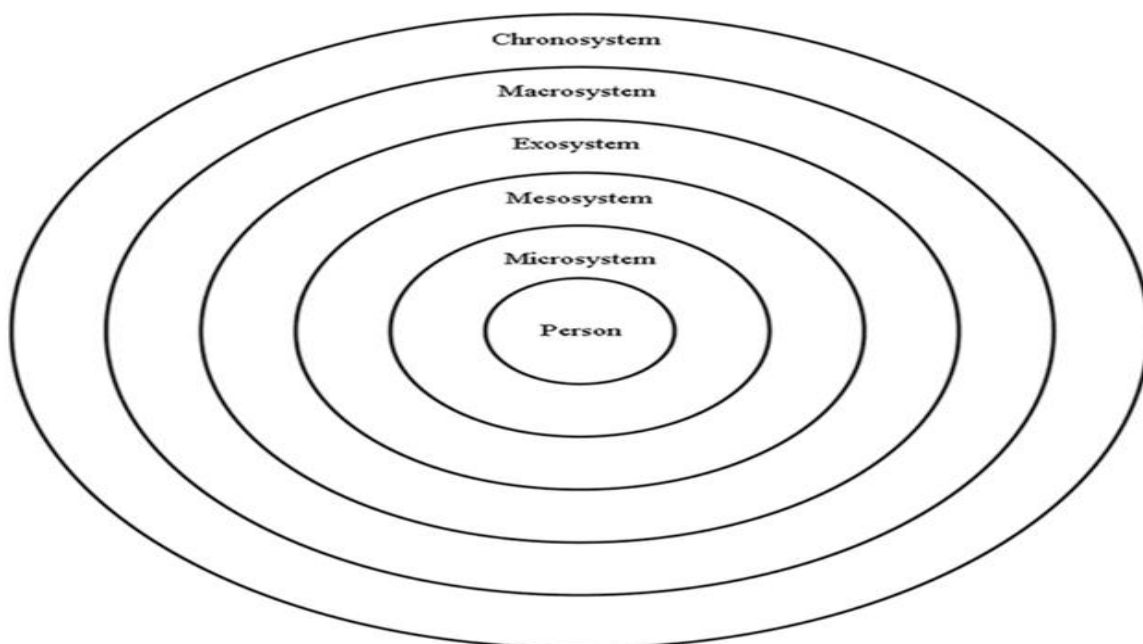


Figure 1. Bronfenbrenner's Ecological Systems Theory, (adapted from Graves, & Sheldon, 2017).

Microsystem

Bronfenbrenner defined the microsystem as the most proximal setting, in which a person is situated, such as the home, child care, playground, and in which the developing person can interact in a face-to-face way with others (Rosa, & Tudge, 2013). In other words, the microsystem consists of

relationships and interactions with which the individual has frequent and direct contact. Additionally, as this layer forms a set of structures with which a person has direct contact, the influences between the developing person and these structures are bi-directional. The person influences and is influenced by the microsystem (Johnson, 2008). The microsystem of the pregnant women would include parents, peers, partners, school or workplace.

Mesosystem

A mesosystem comprises the interrelations among two or more settings in which the developing person actively participates such as, for a child, the relations among home, school, neighbourhood and peer group, and for an adult among family, work and social life (Shaffer, & Kipp, 2013). This means that the mesosystem consists of the links or connections between settings within the microsystem. Just as the influences within the microsystem are bi-directional, the mesosystem involves bi-directional influences between these various structures (Johnson, 2008), for example, the interaction between the mother of a developing person and school teacher. Thus, a mesosystem is a system of microsystems. It is formed or extended whenever the person moves into a new setting (Shaffer, & Kipp, 2013).

Exosystem

An exosystem refers to one or more settings that do not involve the developing person as an active participant, but in which events occur that affect the settings containing the developing person (Shaffer, & Kipp, 2013). In other words, this involves links between a social setting in which individuals do not have an active role and individuals' immediate contexts. The exosystem represents the larger social system and encompasses events, actions, decisions, and policies over which the developing person has no influence. The exosystem thus exerts a unidirectional influence. This influence directly or indirectly impacts the developing person. For example, state regulations concerning schooling is an exosystem that has unidirectional impact on the micro-system of a school within which an individual may be located (Johnson, 2008).

Macrosystem

According to Johnson (2008), the macrosystem can be thought of as the social blueprint of a given culture, subculture, or broad social context. The overarching pattern of values, beliefs, lifestyles, opportunities, customs, and resources of a particular context constitutes the macrosystem. The macrosystem differs from the other levels of context, embracing the institutional systems such as the economic, education, legal, and political systems (Rosa, & Tudge, 2013). This system is generally

considered to exert a unidirectional influence upon not only the person but the micro-, meso-, and exosystems as well. The macrosystem of an individual includes the cultural, political, social, and economic climate of the local community, but also that of the nation as a whole (Johnson, 2008).

Chronosystem

Chronosystem refers to changes in the individual or the environment that occur over time and influence the direction development takes (Shaffer, & Kipp, 2013). In other words, changes in the child or any of the ecological contexts of development can affect the direction that development is likely to take. The chronosystem can refer to both short- and long-term time dimensions of the individual over the course of a lifespan, as well as the socio-historical time dimension of the macrosystem in which the individual lives (Johnson, 2008). The chronosystem also known as the dimension of time, was added by Bronfenbrenner (1986) so the effects of change and continuities on developing person would be better understood (Rankin, & Stallings, 2005).

APPLICATION OF BRONFENBRENNER'S ECOLOGICAL SYSTEM THEORY

Bronfenbrenner originally conceptualised his ecological systems theory model as a framework for studying development within the actual environments people live in (Freudenberg, Klitzman, & Saegert, 2009). However, it has been very influential and frequently utilised in public health and by health psychologists to understand the social and structural issues in health promotion. It has been important in community health psychology for understanding the person-in-context (Rohleder, 2012). Therefore, this framework lends itself well to the study of health within context, which necessarily emphasizes the interaction between characteristics of the person and characteristics of the environment in determining specific health outcomes (Freudenberg et al., 2009).

In this study, this theory is used as a framework to understand prenatal alcohol exposure within the actual environments in which alcohol use in pregnancy takes place. Research conducted on alcohol use in pregnancy in the Western Cape Province indicates that there is evidence for the need to address alcohol use in pregnancy from a social-contextual perspective that addresses how one's environment shapes this behaviour (Kelly, 2017). Ecological Systems Theory may provide a useful theoretical framework for understanding the role of social context in drinking during pregnancy. Also, it enables researcher to consider the broader social and environmental influences on health and health behaviour and social, structural factors that facilitate or prohibit health behaviours in community (Rohleder, 2012).

Ecological Systems Theory argues that alcohol use in pregnancy takes place within a set of nested and changing environments and that complex relations within and between those nested environments shape alcohol use (Ennett et al., 2008). This suggests that the fundamental assumption is that alcohol use in pregnancy is the result of the interaction between the pregnant women and the contexts to which they are exposed. Moreover, an individual exists within layers of social relationships: the family, intimate partners, friendships, school, the workplace (microsystems), interactions among these microsystems, e.g. communication in the family may influence peer group interaction or interaction at clinic (mesosystem), organisations, neighbourhoods (exosystems), culture and society (macrosystems) and change of the individual, changes in family structure or socioeconomic status (chronosystem). Each layer has an impact on the other layers in an interdependent way (Duncan et al., 2007). This theory is useful for this study because it shows the wide range of contexts that may shape alcohol use in pregnancy and these will be discussed below.

The pregnant woman

The pregnant woman represents the individual's beliefs, knowledge and attitudes that contribute to their behaviour. This also includes demographic factors such as age, education, income and geographic location that contribute to an individual's approach to alcohol use in pregnancy (Coleman, & Alonso, 2016). A study conducted in Canada showed numerous individual risk factors related to maternal alcohol consumption during pregnancy and these include: maternal age, whether the pregnancy was planned, substance use, marital status, a history of physical and emotional abuse, mental health, self-esteem, prenatal care nutrition, and socioeconomic status (Zelner, & Koren, 2013). Likewise, Morojele et al. (2010) indicate that maternal risk factors for FAS have been investigated in Western Cape and Northern Cape Provinces. The individual risk factors identified include demographic characteristics (e.g. education, employment and marital status) and alcohol consumption patterns (e.g. current drinking). Additionally, in a study conducted by Watt et al. (2014) in Delft Township, Western Cape province, women reported that the pregnancy itself was a stressor, with women talking about their sense of disappointment or shame about being pregnant. They spoke to the stress of poverty, unemployment, food insecurity, and the difficulties of their economic situation. This shows that pregnancy may be a psychologically stressful life transition for women that may interact with previous stressors to influence drinking trajectories.

Microsystem

The microsystems are contexts in which face-to-face interactions occur with the people closest to the pregnant woman such as family, partner, friends and healthcare workers. A woman's partner, family

and friends all could act either as supporters of the woman's efforts not to drink or as negative influences by pressuring them to drink (Elek et al., 2017). For example, a study conducted in the Western Cape by Watt et al. (2016) found that some women received explicit encouragement from friends to continue drinking, as exemplified by one woman who had decided to abstain from alcohol while pregnant to protect the health of her baby, but received backlash from her friends: "my friend said she was drinking while she was pregnant but her baby was fine, so there is nothing wrong with drinking while pregnant" (p.5). Additionally, Morojele et al. (2010) indicate that partners' and family members' characteristics (e.g., partner drinking, heavy drinking by family members) were identified as maternal risk factors for FAS in the Western Cape and Northern Cape provinces. This suggests that social networks may influence a woman to drink during pregnancy such as socialising with people who drink regularly, attitudes of their social group, pressure to drink from friends, as well as their partner's use of alcohol or other drugs (Crawford-Williams et al., 2015). Therefore, the interaction between the pregnant women and their social networks can either reduce or increase drinking, depending on the behaviours and support of friends, partners and family members.

Mesosystem

Mesosystems consists of connections between microsystems, for example, the interaction between the pregnant woman's partner and antenatal clinic. In low resource countries many men do not accompany their partners to the health facility during pregnancy unless there is a complication (Adeniran et al., 2015). Nevertheless, a study conducted in Limpopo, South Africa found that most men were willing to learn about their expected roles during childbirth and were eager to support their partners, but they found the health system unwelcoming, intimidating and unsupportive (Nesane et al., 2016). In a study by Kaye et al. (2014) in Uganda on experiences of male involvement in their partners' healthcare during pregnancy and childbirth, men reported that when they accompanied their partners to the antenatal clinics, they generally stayed outside the clinic while the woman participated in health talk and consultation with healthcare worker, as there was no space or seat for them and they were not given any attention. As result, men often felt distanced from their partners during pregnancy, childbirth and the postpartum period. Healthcare providers in a study conducted in KZN, South Africa reported that if a person was accompanied by her partner to the clinic, they would make the partner stand outside and let the woman go in alone (Mullick, Kunene, & Wanjiru, 2005). The lack of interaction may result in the partner not understanding the health and support requirements of the pregnant women, information that he could obtain if attending the antenatal clinic with his partner. Also, participation in prenatal consultation is an opportunity for fathers to feel closer to the child to be born. Without this experience they will only have subjective perceptions through information

obtained from mothers (Silva Ferreira et al., 2016). Therefore, researchers argue that special efforts should be made to highlight men's shared responsibility and to promote their active involvement in maternity care (Sokoya, Farotimi, & Ojewole, 2014).

Exosystem

The pregnant woman's exosystem consists of systems that influence individuals, but the individual is not able to influence because they do not have direct access to the system (Brakenhoff, & Slesnick, 2015). An exosystem comprises more remote social environments, such as neighbourhoods, in which microsystems are embedded (Ennett et al., 2008). In other words, the exosystem contains larger contexts that have a profound influence on alcohol use in pregnancy, even though the pregnant women are not directly involved with them. This includes where people live, their neighbourhoods or living conditions within a prescribed geographical area (Vantamy, 2009). For example, alcohol use in pregnancy is common in impoverished communities of the Western Cape and the Northern Cape provinces of South Africa (Olivier et al., 2013). In an FASD case-control study in the Western Cape, approximately 24 % of the control women (children without FASD) reported that they drank during pregnancy, with an average of six drinks consumed per week, demonstrating how common drinking during pregnancy is in this setting. Almost all women reported that it was common for pregnant women in the community to drink, and several stated that most of their friends drank while pregnant (Watt et al., 2016). Also, in the Western Cape specifically, alcohol remains the most frequently abused substance, with the highest prevalence rates for lifetime alcohol use, and risky drinking (Puljević, & Learmonth, 2014). This demonstrate that aspects of the contextual environment (i.e., neighborhood or community) influence pregnant women attitudes and behaviours regarding substance use. Also, high rates of substance use, and the ready availability of substances within their community is a risk factor for engaging in substance use (Connell, Gilreath, Aklin, & Brex, 2010).

Macrosystem

The macrosystem differs from the other systems of context, embracing the institutional systems of a culture or subculture, such as the economic, social, education, legal, and political systems (Rosa, & Tudge, 2013). Likewise, the macro-system includes large-scale societal factors that have an impact on people's lives, such as governmental policies (Duncan et al., 2007). For example, public health specialists agree that moderate consumption of alcohol can have some health benefits, but frequent and heavy consumption of alcohol is linked to ill-health and negative social behaviour. As a result, government bodies almost always try to restrict access to alcohol, through regulating where and when it can be sold (Smith, 2014), because of the association between alcohol availability, rates of alcohol

consumption, and drinking-related problems (Bowers et al., 2014). Therefore, the Eastern Cape Liquor Act of 2003 prohibits the sale or serving of alcohol to those under 18 years old. It clearly states that only people registered in terms of this Act may sell liquor. Such registered people may sell liquor on any day of the week but only during the hours determined by the municipality in which the premises are situated.

Chronosystem

The chronosystem is the final aspect of environment within ecological systems theory and focuses on aspects of individuals and their environment that remain constant or that change over time (Brakenhoff, & Slesnick, 2015). In other words, chronosystems are the changes in the pregnant women or any of the ecological contexts that can affect the direction that pregnancy is likely to take. For example, pregnancy and childbirth are particularly vulnerable periods for a woman, especially first pregnancies as these involve changes to her body image, her identity as a woman, concepts of motherhood, and changed intimate relationship variables (Kathree, Selohilwe, Bhana, & Petersen, 2014). Research conducted in a community health centre in the North West Province reported that women experience rejection by the partner, lack of material and/or emotional support, disinterest in the child and denial of paternity, physical abuse, and infidelity in pregnancy (Kathree et al., 2014). A study conducted by Mmusi-Phetoe (2016) in KZN indicated that pregnant women being neglected and abandoned by male partners was a determinant of poor health outcomes for these women. Also, abandonment by a partner, especially when pregnant, was narrated as a degrading and humiliating experience for women, causing serious ill health. Postnatal depression is evident in the context of unwanted pregnancies, rejection of the pregnancy by the partner, and lack of support for the woman and child from the partner's family (Kathree et al., 2014). This demonstrates that changes in the pregnant woman and romantic relationships (microsystem) which may affect the direction pregnancy is likely to take by causing serious ill-health and maternal alcohol use.

Moreover, in the Western Cape province of South Africa, the historic *dop* system left communities with a legacy of heavy drinking. Patterns of hazardous alcohol use in the Western Cape are, in part, the result of social norms that emerged in response to the *dop* system and Apartheid. Under the now illegal *dop* system, farm workers were paid for their labour with alcohol, a model that contributed to an environment where excessive alcohol use was normalised (Watt et al., 2016). Women who became pregnant continued to drink heavily throughout their pregnancies (Eaton et al., 2012). Although this practice was outlawed in the 1960s, elevated levels of drinking have continued (Watt et al., 2014). This shows that the *dop* system encouraged and sustained a culture of alcohol consumption, impoverishing local communities and promoting maternal drinking during pregnancy. Therefore,

maternal drinking during pregnancy cannot be separated from the history (chronosystem) and pervasive culture (macrosystem) that accepts and supports harmful or hazardous use of alcohol in communities (exosystem) (Coons, 2013).

LIMITATIONS OF ECOLOGICAL MODELS

The application of this model to alcohol use in pregnancy allows for examination of how these systems contribute to an individual's use of alcohol and creates a framework to develop interventions that prevent alcohol use in pregnancy and decrease high FASD rates. The ecological perspective provides a description of environment and environmental influences in alcohol use in pregnancy. Each person functions in microsystems that are linked by mesosystems and embedded in larger contexts of an exosystem, a macrosystem, and chronosystem. It makes little sense to an ecological theory to study environmental influences in laboratory contexts. Instead they argue that only by observing transactions between pregnant women and their dynamic natural settings will we understand how individuals influence and influenced by their environments (Shaffer, & Kipp, 2013).

A limitation, however, of Ecological Systems Theory is that alcohol use may be treated as though it were solely dependent on environmental factors. In addition, the theory does not reveal the processes by which the environment influences the pregnant women. In other words, the personal characteristics implicated in alcohol use may be down played (Shaffer, & Kipp, 2013). Proponents of this model may assume that all individuals living in a particular context are equally affected by it, regardless to their biological and psychological characteristics (Rosa, & Tudge, 2013). This implies that, despite its strengths, the Ecological System Theory may not be a complete account of alcohol use in pregnancy, as it does not investigate specific biological contributors to alcohol use in pregnancy. Thus, the emphasis on transactions between pregnant women and their environments is both a strength and weakness of Ecological System Theory (Shaffer, & Kipp, 2013).

The second limitation is the complexity of the Ecological System Theory. With so many interacting systems, it is difficult to pin down where the causal chain leading to health behaviour lies (Edberg, 2015). Influencing all aspects of the environment and characteristics of an individual may be impractical because multilevel interventions pose considerable operational challenges. Such interventions require larger financial resources than single-level efforts (Golden, & Earp, 2012). Chiphamba et al. (2012) recommend that interventions should focus at least on two systems of influence. Changes made in one system or environment will impact on and lead to changes to other systems (Rohleder, 2012). However, expecting any single intervention to focus on three or more ecological levels may also be unrealistic (Golden, & Earp, 2012). This shows that Ecological System

Theory reflects certain practical limitations in terms of formulating interventions to address alcohol use in pregnancy. Nevertheless, the Ecological System Theory may be useful as a tool to help understand alcohol use within a set of interconnected individual and contextual factors rather than as a prescription for intervention.

CONCLUSION

In conclusion, the Ecological Systems Theory provides a framework for understanding how different relationships and environmental factors interact to influence alcohol use in pregnancy. Bronfenbrenner's Ecological Systems Theory is useful in explaining the complexity of interaction between pregnant women and their environment. The ecological approach to alcohol use in pregnancy would help people who are either directly or indirectly engaged in addressing alcohol use in pregnancy (e.g., healthcare workers, partners, family members, friends and policy makers) to better understand alcohol use in pregnancy from multifaceted perspectives, and ultimately provide solutions and support pregnant women to reduce the high prevalence of FASD in South Africa.

CHAPTER 4: METHODOLOGY

Research methodology is a systematic way to solve a problem. Essentially, the procedures by which researchers go about their work of describing, explaining and predicting phenomena are called research methodology (Rajasekar, Philominathan, & Chinnathambi, 2013). In this chapter, I explain the aims, research questions and the research design in detail. Also, I include information on the method of sampling, recruitment of participants, the study location, the participants of the study, the data collation and analysis methods, ethical considerations and validation of the study. The aim of this chapter is to discuss how I arrived at my findings, what methods I used and why they are trustworthy and how they answer my research questions.

RESEARCH AIMS

This study aims to explore how partners and family members of women who drank alcohol while pregnant make sense of alcohol use and the social context within which drinking during pregnancy takes place. Very little research has explored alcohol use specifically from the partner or family member perspective of women who consumed alcohol while pregnant or focused on contextual risk factors beyond the individual woman. An in-depth look at how partners and family members report on the experiences of these women and their context could possibly, despite the criticisms noted in the last chapter, be used to inform the content and delivery of intervention initiatives (Kelly, & Ward, 2017). Additionally, this study is part of a bigger project that proposes informing interventions aimed at preventing prenatal alcohol use and decreasing the incidence of FASDs.

RESEARCH QUESTIONS

How do partner and family members of women who drank alcohol at harmful levels narrate the journey of pregnancy?

- What themes at the individual (history of alcohol abuse, attitudes, beliefs and knowledge) are evidenced in these stories?
- What themes at the microsystem (family, friends, intimate partner and clinic) are evidenced in these stories?
- What themes at the mesosystem (which includes the links of different systems together within microsystem such as clinic and partner, friends and partner etc.) are evidenced in these stories?

- What themes at the exosystem (which consists of settings that individual do not have direct contact with but still influence the individual e.g. the environment where people live) are evidenced in these stories?
- What themes at the macrosystem (which includes broader cultural beliefs, societal issues, policies and regulations) are evidenced in these stories?
- What themes at the chronosystem (which include changes in individual or socio-historical context) are evidenced in these stories?

INTERPRETIVE PARADIGM

To explore understandings of participants, this research study is located within the interpretivist paradigm. Interpretive social science can be traced to the German sociologist Max Weber (1864–1920) and German philosopher Wilhelm Dilthey (1833–1911). Weber argued that social science should study social action with a purpose. He embraced what in German is known as “verstehen” (empathic understanding of human behaviour) and felt that researchers should study the personal reasons or motives that shape a person’s internal feelings and that guide decisions to act in particular ways (Neuman, 2013). Most research on alcohol use in pregnancy focuses on how alcohol harms the developing foetus. This study instead focusses on a family member’s or partner’s narrative about an event (pregnancy) and the social conditions that underpin the consumption of alcohol in pregnancy. The interpretive approach is suitable for this study, because it explains the subjective reasons and meanings that lie behind social action (alcohol use in pregnancy) (Neuman, 2013).

QUALITATIVE APPROACH

Qualitative research uses a naturalistic approach that seeks to understand phenomena in context-specific settings (Golafshani, 2003). Denzin, and Lincoln (1994) describe qualitative research as multi-method in focus, involving an interpretive, naturalistic approach to its subject matters. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (Hammersley, 2012). Qualitative research aims at an in-depth understanding of an issue, including an exploration of the reasons and context for participants' beliefs and actions, so is often designed to be probing in nature (Richards, & Schwartz, 2002). Therefore, this method is suitable for generating an in-depth understanding of alcohol use from partners’ and family members’ perspectives of women who drank alcohol while pregnant.

Moreover, I used a qualitative approach because qualitative research usually attempts to describe and understand human action and experience from the perspective of the participants (Fisher, 2005). In this study, partners and family members of women who drank alcohol while pregnant described the journey of pregnancy and the immediate physical, cultural and social setting in which pregnant women who consume alcohol live and the people and institutions with whom they interact. This makes this a descriptive research study, which starts with a well-defined issue and tries to describe it accurately. The study's outcome is a detailed picture of the issue and answer to the research question (Neuman, 2013). Therefore, descriptive research presents a picture of the specific details of a situation, social setting and relationships. Qualitative description is a suitable approach when the goal of the research study is a straight description of a phenomenon and when the information is sought to develop and refine interventions (Kim, Sefcik, & Bradway, 2017).

RESEARCH DESIGN

Hammersley (2012) argues that qualitative research involves collection of a variety of empirical materials such as case studies, personal experiences, introspection, narratives, interviews, observational, historical, interactional and visual texts. For example, this study used narratives to elicit data about how participants make sense of alcohol use in pregnancy. According to narrative theory, we are born into a storied world, and we live our lives through the creation and exchange of narratives (Smith, & Sparkes, 2008). A narrative is a story that tells a sequence of events that are significant for the narrator and his or her audience. A narrative has a plot, a beginning, a middle and an end. It has an internal logic that makes sense to the narrator. A narrative relates events in a temporal and a causal sequence. Every narrative describes events that have happened (McCance, McKenna, & Boore, 2001). Therefore, a narrative can be defined as an organized interpretation of a sequence of events (Smith, & Sparkes, 2008). I used narrative because narratives are gaining the attention of researchers in health professions as a primary way of making sense of an experience (McCance et al., 2001).

DATA COLLECTION

As I mentioned before, this study is part of a bigger project. Thus, data were collected by two student researchers; my co-researcher focussed on women's narratives who drank at harmful levels in pregnancy and I focussed on narratives of partners and family members of women who drank at harmful levels in pregnancy. This part of the methodology chapter describes the method of sampling

and recruitment used in the study, the participants of the study, description of the study location, method used to collect data, and analysis methods.

Sampling

In this study, participants were selected through purposive sampling. The purposive sampling technique, also called judgment sampling, involves the deliberate choice of an informant due to the qualities the informant possesses (Tongco, 2007). Also, it involves identifying and selecting individuals who have experience with a phenomenon of interest (Palinkas et al., 2013). In other words, the researcher sets out to find people who can and are willing to provide the information pertinent to the study by knowledge or experience. Purposeful sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest. For example, the researcher wanted to know the journey of women who drank alcohol in pregnancy from their partner's and family member's perspectives.

It is important to be clear on informant qualifications when using purposive sampling (Tongco, 2007). The participants were selected based on pre-determined criteria namely: partner/family member of women who were recently pregnant and who had used alcohol at any time during their pregnancies; the partner/family member were more than 18 years old (for reasons related to consent); the partner/family member obtained consent from the woman prior to participation because the participants were talking about the woman; and the women must be known to have used alcohol during pregnancy as measured by the Alcohol Use Disorders Identification Test—Consumption (AUDIT-C) which is a brief validated screen for risky drinking and alcohol abuse and dependence (Frank, DeBenedetti, Williams, Kivlahan, & Bradley, 2008); the partner/family member were willing to narrate the journey of pregnancy from before pregnancy to birth.

Recruitment

Gatekeepers are individuals who have the power or influence to grant or refuse access to a field or research setting (McFadyen, & Rankin, 2017). The gatekeeper was a Non-Governmental Organisation (NGO) that aims to educate the public on the effects of alcohol consumption during pregnancy, as well as decrease alcohol consumption during pregnancy. Gatekeepers support builds trust and credibility with participants and may facilitate recruitment (Namageyo-Funa et al., 2014). I and my co-researcher worked with the social worker from the NGO, who, with the Company Executive Officer, made the final decision to allow the researchers access to undertake the research and helped with recruiting potential participants.

Recruiting participants involved the following steps: I and my co-researcher presented the research study to gatekeepers with the purpose of clarifying the study, the gatekeeper roles and our expectations; the social worker from the identified NGO and the mentors who work closely with her showed willingness to help with recruitment. The partners and family members were approached by the mentors who gave all potential participants an information sheet about the research (see Appendix 1). Following this, pregnant women, their partners and family members indicated their willingness to participate by giving the mentors permission to provide the researchers with their names and numbers to contact them and provide more information about the proposed research. The researchers contacted potential participants to arrange an information session.

The information sessions aimed to provide potential participants with more information about the research, the purpose of the study, what it entails to participate in the study, informing the participants about their rights and the potential risks and benefits of participation. Participants who showed up for information sessions were previous pregnant women who drank in pregnancy and their family members or partners. Family members/partners obtained consent to participate after having spoken to the woman and having asked for consent to narrate the woman's journey of pregnancy from the family member's/partner's perspective. The participants signed an informed consent (see Appendix 2) after the information session to indicate willingness to participate in the study. Only two family members signed a consent form at the first information session. The targeted sample size was ten participants preferably 5 partners and 5 family members. The researchers asked the sample who came to information session (who were recruited for my co-researcher's study) to refer others (their family members and partners if they were comfortable with that) who met the eligibility criteria. This sampling method is called snowball sampling, a technique in which the researcher initially samples a small group of people relevant to the research questions and these sampled participants propose other participants who had the experience or characteristics relevant to the research (Bryman, & Bell, 2015). Women came with their partners and family members who were interested in participating to the initial interviews. This sampling method was useful and is often used to recruit people with specific traits who might be difficult to identify by ordinary means (Profetto-McGrath, Polit, & Beck, 2010).

Participants

In total 13 participants were recruited, eight family members and five male partners. The tables below contain information on participants' demographic information. The tables have been organised according to partners and family members.

Table 1: Demographic information of male partners

Pseudonym and relationship with previously pregnant women	Age	Racial identity	Relationship status	Language	Level of education	Employment status	No. of people you live with	No. of children
Luvo (Husband)	57	Black	Married	IsiXhosa	Primary school	Unemployed	5	3
Khaya (husband)	45	Black	Married	IsiXhosa	High school	Unemployed	5	3
Jonga (Husband)	37	Black	Married	IsiXhosa	Matric	Employed	8	2
Sizwe (Husband)	33	Black	Married	IsiXhosa	High school	Employed	3	1
Lunga (Husband)	48	Black	Separated	IsiXhosa	High School	unemployed	1	5

Table 2: Demographic information of family members

Pseudonym and relationship with previous pregnant women	Age	Racial identity	Relationship status	Language	Level of education	Employment status	No. of people you live with	No. of children
Nazo (Family member)	48	Black	Widowed	IsiXhosa	Primary School	Employed	3	2

Linda (Mother)	45	Black	Married	IsiXhosa	High School	Unemployed	3	4
Lisa (Niece)	32	Black	In a relationship	IsiXhosa	None	Unemployed	6	3
Lumka (Mother)	48	Black	Married	IsiXhosa	High school	Unemployed	6	3
Lulu (Sibling)	23	Black	In a relationship	IsiXhosa	High School	Unemployed	2	1
Liso (Aunt)	32	Black	Married	IsiXhosa	Matric	Unemployed	5	3
Kuhle (Mother)	57	Black	Married	IsiXhosa	Primary school	Unemployed	6	4
Jade (Daughter)	38	Black	Married	IsiXhosa	High School	Unemployed	4	3

Description of the location of the study

The location of the study was a township in Buffalo City, Eastern Cape province. The term “township” has no formal definition. However, it usually refers to the underdeveloped, urban, residential areas that were reserved during Apartheid for non-whites (Africans, Coloureds and Indians) (Pernegger, & Godehart, 2007). This segregation, which persists post-Apartheid, is evident in this area. The broad area is divided into two: the formerly white area where few blacks can afford to stay (near shopping centres and other amenities) and the previously black only area with mostly of IsiXhosa speaking residents. I and my co-researcher conducted our studies in the previously black only area (see the below tables). Tables 3 and 4 outline the racial composition and languages spoken of the population of this area.

Table 3: Racial groups in study area

Group	Percentage
Black African	99,1%
Coloured	0,2%
Indian/Asian	0,1%
White	0,1%
Other	0,4 %
Total population 8, 338	

Sources: Statistics South Africa (2011)

Table 4: Language spoken in the study area

Language	Percentage
Afrikaans	0,5%
IsiNdebele	0,3%
IsiXhosa	95,1%
IsiZulu	0,1%
Sepedi	0,1%
Sesotho	0,1%
Setswana	0,2%
Sign Language	0,6%
Other	0,7%

Sources: Statistics South Africa (2011)

The township is divided into two areas as well. There are Reconstruction and Development Programme (RDP) houses in one area with few shacks behind the houses, and informal settlements in another area. Informal settlements are living conditions (shacks, squatter camps and slums) which lack at least one of the basic conditions of housing – adequate sanitation, water supply, durable housing or adequate living space (Marutlulle, 2017). Govender, Barnes and Pieper (2011) argue that living in urban areas potentially offers improved access to health care, education, better housing and improved economic opportunities compared to rural areas. However, the growth of urban informal settlements in South Africa has brought about an increase in poverty as many unemployed and often unskilled people leave rural areas to try and find employment in cities (see the tables below).

Table 5: Education level in the study area

Group	Percentage
No Schooling	6,6%
Some Primary	15,9%
Completed Primary	7,8%
Some Secondary	49%
Matric	19,4%

³ Reconstruction and Development Programme (RDP) house are houses that have been built by government and are given to low income families.

Higher Education	1,3%
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Sources: *Statistics South Africa (2011)*

Table 6: Average household income of the study area

Income	Percentage
No income	20, 2%
R1 - R4,800	11, 8%
R4,801 - R9,600	24, 8%
R9,601 - R19,600	21,1%
R19,601 - R38,200	8,7%
R38,201 - R76,400	1,5%
R76,401 - R153,800	0,5%
R153,801 - R307,600	0,4%

Sources: *Statistics South Africa (2011)*

Increasing unemployment is one of the causes of informal settlements. Unemployment rates are higher in informal settlements with informal settlements acting as ‘arrival cities’ accommodating those seeking an entry point into the labour market (Marutlulle, 2017). People who live in informal settlements tend to have a low level of education and income.

NARRATIVE INTERVIEW

The narrative approach is a way through which lived experience can be understood; it seeks to study the lives of people by collecting their stories and then interpreting those stories in context (Peta, Wengraf, & McKenzie, 2018). The data were collected through the biographic narrative interpretive method (BNIM) interviewing method. A biographic narrative means that a person comes up with a story concerning a particular issue of his or her own life and experiences. This method allows the participant to shape their own story and its structure, and is a powerful way of facilitating the voice of those who are located at the margins of society. It empowers participants (in this case partners and family members of women who drank at harmful levels in pregnancy) to contribute towards the creation of knowledge in academic circles (Peta et al., 2018). Also, interviews are the commonest qualitative method in health services research, and are particularly well suited to the collection of data on sensitive topics such as alcohol use in pregnancy (Richards, & Schwartz, 2002). The interviews were conducted in isiXhosa; I and my co-researcher used an audio recording device to capture the words of the participants in interviews. Participants signed a use of tape-recording consent form to

give us permission to record their stories (see Appendix 3). With a recording, the interviewer can concentrate on listening and responding to the participant, without being distracted by needing to write extensive notes (Stuckey, 2013). The researcher generated data using the three sub-sessions of the BNIM interviewing techniques as explained in detail below.

Biographic- narrative- interpretive method (BNIM)

Elmir, Schmied, Jackson and Wilkes (2011) believe that the way to develop good research rapport involves giving as well as receiving information in a two-way process between participant and researcher. From the start of the interviews I was honest as possible with participants, regarding the topic of the study and the study's purpose and explained to them that I was willing to answer any questions that the participants had. I took time to build rapport with the partners and family members of the women who drank in pregnancy because one of the most important elements of data collection during in-depth interviewing on a sensitive topic is the ability for the researcher to develop rapport with participants. Developing rapport with participants in qualitative interviews enhanced the researcher's access to the interviewees' lives (Elmir et al., 2011).

In using the BNIM technique, I started sub-session 1 by asking a single question designed to elicit the story of the participant as he or she chooses to tell it (Wengraf, 2001). The initial narrative question was: "Please tell me the story of your partner's or family member's pregnancy, from before she was pregnant through to when (name of the child) was born; tell me all the events and experiences that were important to her and you". This question proved to be very useful in unlocking the elicitation of data through enabling participants to control the framing, sequencing, content and duration of the interview. Consequently, family members touched on their own stories of drinking during pregnancy and difficulties they faced during their pregnancy as well. This is in contrast to other more structured interview techniques that may direct participants to talk about what interviewers wanted to hear.

I listened without interruptions while the co-researcher took some notes for her and me to discuss afterwards. As the participant began telling their story, I used non-verbal encouragement, for example smiles, saying hmmm and so on to encourage the participants to talk freely (Anderson, & Kirkpatrick, 2016). The aim was to help the participant continue their story telling for as long as they wish. The first sub-sessions lasted between 3 to 25 minutes. I avoided interrupting until there were obvious signs that the participant had finished telling their story (Anderson, & Kirkpatrick, 2016). Sub-session one characteristically ended with the participant's own closure, such as "*that's where my story ends*" (Lisa, Family member) and "*I think I am done*" (Sizwe, Partner). After sub-session one ended, I and

my co-researcher spent about 15 minutes composing questions that arose for us from the participant's story to explore further in sub-session 2.

The principle in sub-session 2 is to only ask questions about issues that were raised in sub-session 1, in the order in which they were raised and using the words that were used by the narrator. No other topics in which the researcher may be interested are raised (Peta et al., 2018). In other words, the participants continue to direct the interview. I gradually learned to use the material provided in sub-session 1 for the sub-session 2, excavating additional stories through asking Particular Incident Narrative (PIN)-seeking questions. PIN-seeking questions are questions that pursue incidents raised by the participant in sub-session 1 (Peta et al., 2018). This basically meant that I started my question with what the participant mentioned and asked for more details of the story. An example of a question during this sub-session would be, "you mentioned that *it was not your agreement for her to get pregnant*. Please tell us more about this" (Jonga, Partner). This is when my active listening became useful as I was able to use the participant's own language to fill in any gaps (Anderson, & Kirkpatrick, 2016). This part of the interview allowed for deeper questioning about incidents brought up during sub-session 1. Once we completed sub-sessions 1 and 2, alcohol use of the woman during her pregnancy was assessed using a questionnaire AUDIT-C (see Appendix 4). The questionnaire contained three questions about the frequency of drinking, amount consumed when drinking, and frequency of binge drinking and took between 3 and 5 minutes to complete. Partners and family members completed AUDIT-C, which means that we measured the partner's and family member's perception of women's alcohol use in pregnancy using AUDIT-C. If the previously pregnant woman had more than one pregnancy, family members and partners were instructed to answer the questions based on the pregnancy in which she drank.

Table 6. Drinking patterns of women during past pregnancy

Participants	Pregnant women score	All questions answered
Nazo	7	Yes
Lumka	3	No
Lisa	6	No
Liso	12	Yes
Jade	12	Yes
Linda	11	Yes
Jonga	10	Yes
Khaya	3	Yes
Sizwe	6	Yes
Lunga	9	Yes
Luvo	8	No
Lulu	11	Yes
Khuhle	6	No

The AUDIT-C consists of the three consumption questions from the AUDIT and scores range from 0 to 12 points (Rubinsky, Kivlahan, Volk, Maynard, & Bradley, 2009). A score of 0-3 (females) indicates a low risk of drinking under usual circumstances (Phelps, & Hased, 2012). In this study, there is one pregnant woman who scored 3 based on a fully completed AUDIT-C. Another scored 3 because her husband could not answer all the three consumption questions as she usually drank at taverns or shebeens with friends. A score of 4-7 (females) indicates a risky pattern of drinking (Phelps, & Hased, 2012). Participants indicated that 4 women had risky patterns of drinking in pregnancy. Additionally, a score of 8+ (both females and males) indicates a high-risk pattern of drinking (Phelps, & Hased, 2012). According to partners and family members 6 women had a high-risk drinking pattern. This means that most women, according to partners and family members, had either a risky or high-risk pattern of drinking in pregnancy. The AUDIT-C has been widely validated and is being used increasingly to screen for alcohol misuse in large health care systems (Rubinsky et al., 2009).

Finally, sub-session 3 took place a couple of weeks later after I had transcribed the data of sub-sessions 1 and 2 and conducted an initial reading of the material (Wengraf, 2001). This enabled me to meet with each participant again, after about four weeks, to ask direct and pre-prepared questions that are associated with the research questions and to clarify ambiguous points (Peta et al., 2018). For example, most participants talked about the pregnant women in sub-sessions 1 and 2, and I wanted to know more about the interactions between the pregnant woman and microsystem, mesosystem, exosystem, macrosystems and chronosystem.

Reflections on data collection interview

The appropriateness of the narrative interview empowered the participants to structure their own narrative and to talk about what they are comfortable to share. For example, one of the participants said that *“I love what you guys are doing; it’s interesting. I feel alright; it pushes me and gives me power”* (Lumka, Family member). This was key considering the sensitive nature of the topic of alcohol use in pregnancy. Sensitive topics are those that elicit powerful emotional responses such as anger, sadness, embarrassment, fear and anxiety (Elmir et al., 2011). Also, this narrative interview made participants feel like they have a contribution to make in knowledge creation. For example, one of the participants said, *“I feel right because in things like this you learn, and you can teach others”* (Nazo, Family member). Participants, therefore, challenged the myth that those who are located at the periphery of society are unable to take part in the creation of knowledge in academic circles (Peta et al., 2018).

Moreover, this narrative interview created a comfortable and trusting atmosphere. When there is trust, participants might share information that they may not otherwise have chosen to reveal (Elmir et al., 2011). For example, one of the participants reported that *“After sharing my story, I was happy because when you speak about it, you release some of the things and your heart heals through speaking. Talking about it to people that I know won’t share it with anyone, made it easy. Because I am not a person who usually opens up. When you asked me to share my story, I felt like now I can talk”* (Lulu, Family member). Trust can create potential threats associated with unstructured interactive interviews (e.g., later regretting revealing certain things), but they can also be beneficial (Corbin, & Morse, 2003). Orb, Eisenhauer and Wynaden, (2001) identified the benefits of narrative interviews as catharsis, self-acknowledgement, sense of purpose, self-awareness, empowerment, healing and providing a voice for the disenfranchised. This is evident in this study; participants described the opportunity to share their experiences as a benefit, and that taking part in the study empowered them. This shows that although interviewing participants about sensitive topics has the potential to cause a degree of discomfort, talking about an experience in a safe and respectful environment can be useful (Elmir et al., 2011).

ANALYSIS METHODS

A qualitative approach to analysing data means systematically organising, integrating, and examining the data and searching for patterns and relationships. To analyse, data are connected to concepts, and broad trends or themes identified. This section describes how data were transcribed and translated from isiXhosa to English and how they were analysed.

Transcribing and translation

Regmi, Naidoo, and Pilkington (2010) defined translation as a process where the meaning and expression in one language (source) is tuned with the meaning of another (target) whether the medium is spoken, written or signed. The researchers, who are both bilingual, translated the data from isiXhosa to English and validated each other’s translations to ensure accuracy. This was done to gain access to a wider range of reading audiences and also because the medium of instruction in the University is English. Maintaining accuracy when representing people's views and perspectives when using qualitative approaches is important but challenging, particularly when the research project is conducted in one language and then analysed in another (Regmi et al., 2010). Language differences may have consequences, because concepts in one language may be understood differently in another language (van Nes, Abma, Jonsson, & Deeg, 2010). It is important, therefore, that when translating,

the research team be aware of and understand the linguistic or social context within which utterances are made (Regmi et al., 2010).

Halai (2007) argues that converting spoken word into text is much more than simple writing down what is said. He defines transcription as a technique for fixing (e.g., on paper, on a computer screen) fleeting events (e.g., utterances, gestures). Transcription for this study involved two stages: firstly, I roughly transcribed and translated the data of sub-sessions 1 and 2. The first rough transcription was done by listening to data and writing out the verbal content of interactions, without any specific symbols (Moore, & Llompert, 2017). After completing an initial, rough transcription, my co-researcher and I went back to the field for follow-up interviews (sub-session 3). To transcribe all the data after all sessions, Humble's transcription conventions (see Appendix 5) were used. When all the data were collected, I conducted a fine-tuned transcription with symbols added to best represent the features of the data to be analysed (Moore, & Llompert, 2017). Additionally, I gave my co-researcher verbatim transcripts of the interviews and the audio recordings for her to listen and verify the accuracy of the simultaneous translation and transcription, correcting errors or inaccuracies and providing clarifications. We discussed the verbatim transcripts of interviews and when we had different opinions, I consulted a master's student from the isiXhosa department for external assistance.

Template Analysis

Template Analysis is a method of thematically organising and analysing qualitative data which has been applied in a broad range of research areas in the social sciences (King, 2012). Central to Template Analysis is the development of a coding template, which summarises themes identified by the researcher as important in a data set and organises them in a meaningful and useful manner. Themes are recurrent features of participant's accounts characterising perceptions and/or experiences that the researcher sees as relevant to their research question (Brooks, & King, 2014). This research project utilised template analysis to analyse the narrative interview transcripts. The main procedural steps of this analytic process are described below.

King (2012) argues that before beginning preliminary coding, it is essential to read through the transcripts for familiarisation and to check for any possible errors in transcriptions. In other words, it is always important to become familiar as possible with the data. For example, the first step I took was to familiarise myself with the raw data to be analysed through reading all the narrative interview transcripts several times before I began any further work on the data. Also, listening to the audio-

recordings of the interviews while transcribing was helpful in terms of familiarising myself with the data.

The next step was to carry out preliminary coding of the data. This is essentially the same process used in most thematic approaches where the researcher highlights anything in the textual data that is relevant and potentially contributes to understanding the research question (Brooks, & King, 2014). However, in Template Analysis, it is permissible (though not obligatory) to start with some *a priori* themes, identified in advance as likely to be helpful and relevant to the analysis (Brooks, McCluskey, Turley, & King, 2015). Before commencing preliminary coding, I identified six *a priori* themes to use based on Bronfenbrenner's Ecological Systems Theory.

The *a priori* themes were: the individual (which looks at talk about individual's knowledge, attitudes, beliefs, history of alcohol use and psychological well-being), the microsystem (which consists of relationships and interactions that the individual has frequent and direct contact with, such as with family, intimate partner, friends and clinic), the mesosystem (which includes the links of different systems together such as clinic and intimate partner), the exosystem (which consists of settings that individuals do not have direct contact with, but still influence the individual), the macrosystem (which includes the broader cultural beliefs, policies and values systems that exert influence on the meso- and microsystems of the individual) and chronosystem (which includes changes in relation to the individual or ecological context, major life transitions and historical events). The *a priori* themes are usually identified because a research project has started out with the assumption that certain aspects of the research question being investigated should be focused on. The *a priori* themes provide a logical starting point for analysis, but important additional new codes/themes, which emerged through data analysis were identified and incorporated into the final template structure. They can be re-defined or removed if they do not prove to be relevant, useful or appropriate (Brooks, & King, 2014).

After I identified codes in the narrative interview transcripts, and organized the themes into meaningful clusters, and I began to define how they relate to each other within and between these groupings (Brooks et al., 2015). The template was organised so that it usefully and meaningfully represented the relationship between different themes and codes. I ensured that the data selected for this purpose included varied accounts which capture a good cross section of the issues and experiences presented in the data overall (Brooks, & King, 2014). This included hierarchical relationships, with broader themes encompassing one or more narrowly focused themes (King, & Brooks, 2014). For example, within the individual (pregnant woman) theme, the narrower themes "drinking habits, pregnancy, trauma and stress etc" were identified.

The clusters of themes served as the basis for producing an initial version of the coding template (Brooks, & King, 2014). Brooks et al. (2015) state that it is normal in template analysis to develop an initial version of the coding template based on a subset of the data rather than carrying out preliminary coding and clustering on all accounts before defining the thematic structure. I produced the initial template using the clusters of themes and a diagram showing hierarchical organisation of themes within each cluster and links across the clusters. Consequently, modification of the template was necessary, where new themes were inserted, and existing themes redefined or deleted when they seemed redundant.

At this stage, I examined additional data and where material of potential relevance to the study was identified (Brooks et al., 2015). In other words, the template was amended where weaknesses were found in its ability to capture what is relevant. This iterative process of refining successive versions of the template, modifying and testing it again continued for five times to allow a rich and comprehensive representation of the data (Brooks, & King, 2014).

Once there were no more significant changes needed to ensure that all data of relevance were covered, the full data set was coded in relation to the final version of the template (Brooks, & King, 2014). However, according to Brooks et al. (2015), it should be said that there is never a “final” version of the template, in that continued engagement with the data can always suggest further refinements to coding. I used the template as the basis for interpretation of the data set, as well as a useful guide to the writing-up of research findings (see figure 1).

Figure 2: Final version of the template (Analysis of Bronfenbrenner’s Ecological Systems Theory)

1. The pregnant woman	1.1 Drinking habits
	1.2 Pregnancy
	1.3 Trauma and stress
	1.4 HIV-diagnosis
	1.5 Woman’s knowledge
	1.6 Behaviour when drunk
	1.7 Being untrustworthy
2. Micro-system	2.1 Support from family members
	2.2 Support from partners

	2.3 Support from healthcare providers
	2.4 Church
	2.5 Traditional healers
	2.6 Rejection and denial of pregnancy
	2.7 Intimate partner violence
	2.8 Infidelity
	2.9 Drinking habits of partners
	2.10 Drinking habits of friends
	2. 11 Drinking habits of family members
	2. 12 Drinking establishments
	2.13 Criminal Justice System
3. Meso-system	3. 1 Family members and School
	3. 2 Family members and Social Workers
	3.3 Family members and Drinking establishments
	3.4 Partners and Friends
	3.5 Partners and 'Other men'
	3.6 Partners and Criminal Justice System
	3.7 Partners and Antenatal Clinic
	3. 8 Partners and Church
	3.9 Police and Drinking establishments
4. Exo-system	4.1 Incompliance of Shebeens with liquor regulations
5. Macro-system	5. 1 Religious Beliefs
	5.2 Cultural Beliefs
	5.3 Gender norms
	5.4 The social phenomenon of crime

	5.5 The social phenomenon of child-headed household
	5.6 The social phenomenon of transitional sex
	5.7 Socio-economic status
6. Chrono-system	6. 1 Changes in health
	6.2 Changes in family structure
	6.3 Changes in relationships
	6.4 Changes in finances
	6.5 Legacy of apartheid

ETHICAL CONSIDERATIONS

Codes of ethics are formulated to regulate the relations of researchers to the people and fields they intend to study (Flick, 2014). Ethics pertains to doing good and avoiding harm. Harm can be prevented or reduced through the application of appropriate ethical principles (Orb et al., 2001). These codes of ethics require that research should be based on informed consent, including not invading participants' privacy and not deceiving them about the aims of the research. Research should avoid harming the participants and produce some positive and identifiable benefit rather than simply be carried out for its own sake. All people should be treated equally. Thus, the protection of participants in any research study is imperative (Orb et al., 2001). This part of research methodology discusses the above-mentioned ethical considerations in relation to the present study.

Gate-keeping and recruitment

Before approaching the social workers (gate-keepers) from Non-Governmental Organisations, it was necessary to receive ethics clearance from several bodies. This study was granted ethical approval by the Psychology Department's Research Projects and Ethics Review Committee (RPERC), and the Rhodes University Ethical Standards Committee (RUESC) (see Appendix 6). After receiving ethical clearance, gate-keepers needed to be approached to recruit women (co-researcher's study) and partners and family members to participate in the study. The researchers sent letters to relevant NGOs requesting assistance in recruiting participants. Several NGOs refused to assist us because of the sensitivity of the topic and anxiety in relation to the women who drank in pregnancy, their partners and family members not taking up their programmes. However, we eventually found an NGO that assisted us in recruitment and a confirmation letter from the NGO was sent to RUESC (see appendix 7).

Respect for the autonomy of persons

Autonomy has been defined as the capacity to think, decide, and act based on a freely made decision (Townsend, Cox, & Li, 2010). Respect for the autonomy of people is the recognition of a participant's rights, including the right to be informed about the study, the right to freely decide whether to participate in the study, and the right to withdraw at any time without penalty (Orb et al., 2001). The researchers held an information session before interviews aimed at informing participants about the purpose of the research study, the procedure and potential consequences of the research, that their participation was voluntary and that they could withdraw from the research at any point up to write-up and participants will receive token of appreciation (R200 food voucher) even if they decide to

withdraw from the study. Also, participants were informed that the narrative interviews would be tape recorded (with their consent), and that all the information collected from them would remain strictly confidential. This principle was honoured by informed consent forms, which is an explicit agreement by participants to participate in the research after receiving and comprehending information regarding the nature of the research (Townsend et al., 2010). Consent was obtained from the pregnant women for partners and family members to talk about their pregnancy. And, signed consent forms were obtained from the partners and family members before the narrative interviews began for participation and tape recording.

However, current ethical and regulatory framework regard the provision of vouchers or cash payments to participants in human subject research as potentially problematic. Incentives for research participation may undermine the autonomy of partaking choice (London, Borasky, & Bhan, 2012). For example, when the incentive is enough to persuade potential participants who otherwise would not take part to the study in which there might be momentous risks. In this study, incentives for participating to this research were high enough to show respect for family member's and partner's time and expertise but not so high that might coerce participants into participating when they would rather not (Head, 2009). Consequently, there were participants who came to the information session and met the pre-determined criteria to participate but chose not to participate. Thus, incentives did not compromise the autonomy of participants by undermine their integrity of their decision-making process (London et al., 2012).

The concern for the impact on freely given consent is the concern that providing incentives to participants might mean they "tell us what he or she feels we want to know rather than giving an authentic account of their experiences, views and attitudes (Head, 2009, p. 342). For example, as previously stated, in this study mentors and previously pregnant women (who took part in my co-researcher's study) were relied upon to introduce the research being conducted in their communities and to recruit participants. Community members heard from participants and mentors that participants will receive vouchers (token of appreciation). As a result, several community members came to enquire how to get one. This indicates that incentives do help with encouraging participation in research, but this was not the motivation of researchers. The token of appreciation was to recognise their effort and time for participation. My co-researcher and I clarified this by explaining who we were, where we were from, the research we were conducting, its aims and the participants we were looking for. Consequently, it was difficult for me to decide whom I should select to participate because I wanted participants to participate out of their interest in the research rather than to get the voucher. This may shape the nature of researcher-researched relationship, which, in turn, affects the

information that participants are willing to share (Berger, 2015). There were participants whom I felt were giving us what we wanted to get the voucher, for example, those who produced very short initial narratives. Most, however, made use of the space to tell their stories and benefited emotionally from telling their stories. Also, participants showed up for follow-up interviews even though researchers did not provide incentives for this session and participants were aware of this. Therefore, one can argue that participants took part in this study because of their interest in contributing to academic knowledge not just to receive vouchers. In contrast, incentives may have contributed to continue their participation until the study is completed (London et al., 2012).

Furthermore, anonymity of participants was maintained throughout the study by applying pseudonyms to each participant at the point of data collection. Identifying data such as specific location, dates, and names of pregnant women and their partners and family members were changed to ensure anonymity of the participants. Regarding confidentiality of data, during the transcription process the only person beside myself who had access to the audio files was my co-researcher. She focused on narratives of women and understood the importance of maintaining participants' confidentiality by not sharing their stories with others. She accessed the audio files for the purpose of validating the Xhosa-English translation I conducted while transcribing the data. Also, concerning access to the interview transcripts, researchers involved in the Critical Studies in Sexualities and Reproduction (CSSR) research programme, of which this research is part, will have access to the transcriptions under the same conditions of confidentiality; this was agreed to by participants. The transcripts will be stored for a maximum period of five years in password protected files on the CSSR admin computer and hard copies will be locked away in the same building. The audio files were deleted from the recording device when they were no longer being used.

Beneficence and non-maleficence

The principles of beneficence and non-maleficence involve an obligation to provide benefits for the participants and to balance such benefits against risks and require that the researcher should do the participants no harm and should prevent harm and remove existing sources of harm arising from the research (Townsend et al., 2010). For example, a risk of participating in this study was the triggering of painful experiences. Three participants cried during the interviews particularly given the sensitive nature of this research. When this happened, I recognised the vulnerability of participants and reminded them of their right to withdraw at any time if they felt uncomfortable. I asked the participants if they want to continue with the interview or to stop the interview; they indicated that they wanted to continue with the interview.

When obtaining consent for an interview study, it is never possible to accurately estimate the risk, in terms of emotional upset. Nevertheless, researchers can anticipate its potential and take appropriate measures to prevent harm (Townsend et al., 2010). In this study, the participants were made aware of a Non-Profit Organisation referred to as the Family and Marriage Society of South Africa (FAMSA) that offers a range of psychological services, free of charge, to the public so that any participant experiencing undue distress could be supported, with counselling available if necessary. When it was necessary, the researchers helped the participants with appointment booking and I referred three participants from the study.

Justice

The principle of justice refers to equal share and fairness. An important feature of this principle is avoiding exploitation and abuse of participants. The researcher's understanding and application of the principle of justice in qualitative research studies is demonstrated by recognising the vulnerability of the participants and their contributions to the study (Orb et al., 2001). The narratives of family members and partners contributed to the need to understand and address alcohol use in pregnancy from a social-contextual perspective that addresses how one's environment shapes this behaviour (Watt et al. 2016). Their narratives can be used to inform the content and delivery of intervention initiatives (Kelly, & Ward, 2017). For example, one of the participants stated that taking part in this research made her feel "*right because in things like this you learn, and you teach others*" (Nazo). This indicates that the researcher made the participants aware of the contribution they are making by taking part in this research. Consequently, participants felt like they could learn from participating and teach others including the researcher.

Additionally, another way of implementing the principle of justice is listening to the voices of the disadvantaged groups as well as protecting those who are most vulnerable, such as children, prisoners, the mentally ill, and the elderly (Orb et al., 2001). The narrative form of interviewing does exactly this by giving participants a voice and empowering people to be heard who might otherwise remain silent because of their disadvantaged background. A voice is the right and the ability to make oneself heard and to have one's experiences and perspectives available to others (Ashby, 2011).

REFLEXIVITY

Reflexivity is the term used to refer to the recognition of the need to incorporate the subjective value of the researcher's feelings and attitudes into consideration of the findings (Long, & Johnson, 2000). This suggests that the researcher is considered an important part of the research: her values and beliefs

play a role in both the type of research that is performed as well as the results found. In this process researchers focus on self-knowledge, sensitivity, the role of the self in the creation of knowledge, their biases, beliefs, and personal experiences on their research (Berger, 2015). Therefore, researchers are encouraged to reflect on their own beliefs in the same manner as they examine those of their participants. These beliefs and values are made explicit and considered so that rather than engaging in futile attempts to eliminate the effects of the researcher, reflexive researchers try to understand them (Long, & Johnson, 2000). In this study, the subjectivity of the researcher was acknowledged throughout the research process by keeping a research journal, where I wrote my thoughts and experiences. Some of the thoughts and experiences are discussed below.

Positioning the researchers

Relevant researcher positioning includes personal characteristics, such as gender, race, affiliation, age, sexual orientation, immigration status, personal experiences, linguistic tradition, beliefs, biases, preferences, theoretical, political and ideological stances, and emotional responses to participants (Berger, 2015). In terms of personal characteristics applicable here, I am a Xhosa-speaking young woman coming from disadvantaged community which is similar with my participants. But, of course, there were also differences in terms of gender, age and level of education. I am Master's student at Rhodes University. My academic and disadvantaged background would have influenced how I related to the participants of this study and how they related to me. This would have influenced the way in which I perceived the participants and the way in which I talked and related to them.

These positions of the researcher may impact the research in two major ways. First, they can affect access to the 'field' because respondents may be more willing to share their experiences with a researcher whom they perceive as sympathetic to their situation and the researcher may be more knowledgeable about potentially helpful and informative resources (Berger, 2015). For example, one of the participants said that "*when I heard about the research, I told myself I should come maybe I will get advice on what to do with my child [weeping]*" (Linda, Family member). This demonstrates that she perceived me as being in a position of authority perhaps because I was a Master's student in the field of psychology or she felt I would be able to give her advice and empathically. These positions could have affected what stories she chose to tell me and how she chose to tell them (Berger, 2015).

Secondly, the way in which I selected whom to participate and the theoretical framework of this research had an impact on the research process. My selection was based on the proposed sample: I came to the field hoping to hear the stories of 5 partners and 5 family members. There were many

family members who were keen to participate but not so many partners. Thus, my first preference was to select male partners. I contacted additional family members after meeting the target of 5 partners and 5 family members. Also, I chose Bronfenbrenner's Ecological Systems Theory because the basic principle of the ecological models marks a shift away from purely individually-oriented thinking about behaviour to include interpersonal and environmental influences in understanding health behaviour and of my own interest in community-based interventions and hope that this research project could make a valuable contribution in this regard. This study, therefore, offers one possible framing of research questions, theoretical framework, participant selection, collection and analysis of data. Other researchers may have conducted and interpreted the study differently and emphasised different aspects of it (Willig, 2008).

Researcher and participant

Guillemin and Gillam (2004) argue that ethics and reflexivity are closely connected: the way in which the relationship between the researcher and the participant is managed by the researcher should be reflected upon. For example, I had a participant who was referred by his wife (pregnant woman). Before the narrative interview I informed him what the research was about, and the aims and the procedure of narrative interviews, and that the research is part of the requirements for a Master's degree at Rhodes University. I encouraged him to ask questions if something was not clear. He did not have any questions at the time, so I asked if he was interested in taking part in the research. He was interested and signed all the necessary documents. Towards the end of follow up interview, I asked him how it was like taking part in this research. He said "*when my wife told me about this research, I was keen. But I had questions about where it's going, and I could not answer myself?*" (Jonga, Partner). Because I encouraged all participants to ask questions and created a space where participants are comfortable to ask questions, I was surprised when he asked where this research is going. This shows that without being aware the researcher enjoyed a privileged position in that the 'expert role' is one which protects the researcher from being questioned (Macleod, 2012). Also, this highlighted an aspect left out in the consent form: what you are going to do with the findings of this study over and above producing a thesis? I did not explain that this project is part of a bigger project that aims to inform interventions aimed at preventing prenatal alcohol use and decreasing the incidences of FASD's on the consent form.

Between researcher and co-researcher

This project is part of a bigger project. I was working with a co-researcher who was interested in narratives of women who drank during pregnancy. We used the same methodology in collecting our

data. I was helped by previously pregnant women who took part in her study, to recruit partners and family members of women who drank in pregnancy because my participants were hard to reach compared to her participants. The role of my co-researcher was assisting me with the narrative interview process by listening to the participant's narrative in sub-session 1 and making notes on what the participant had said, being careful to use the participant's own words. The notes were very helpful in creating questions to ask in sub-session 2 of the narrative interviews. After each narrative interview, we would reflect on our thoughts and feelings about the interviews. Also, our participants shared painful stories and there were times where we held our tears during sessions and cried during the 15 minutes break we took to formulate questions to ask during second sub-session. This was helpful in regulating our emotions and ensuring that we follow the BNIM.

Between researcher and supervisor

To conduct a study, we follow a sequence of steps; however, the exact sequence and specific steps vary according to whether we follow a quantitative or qualitative approach and the type of social research study we are conducting (Neuman, 2013). It is common knowledge that the role of a supervisor is to guide a student in following a sequence of steps when conducting a research. These include, for instance, the research topic and aims of the research, the participants (who to study), how participants will be recruited, how data will be collected, theoretical framework used to guide the research process and data analysis. In this study, all decisions were made after discussion between my supervisor and me. For example, as I previously mentioned, this study is part of bigger project and that means the aims and questions of this study, and the approach to data collection was developed by my supervisor. Even though there was a structured plan of how I should conduct the study, I reformed a few things such as changing the research questions a bit, the theory underpinning the study and how data would be analysed (with the guidance of my supervisor). This illustrates that my supervisor conducted our relationship in a way that encouraged me to take charge of study and to have an input in the decision-making processes. However, whenever I got stuck or was unclear about anything, I always consulted my supervisor.

VALIDATION

Qualitative research is frequently criticised for lacking scientific rigour with poor justification of the methods adopted, lack of transparency in the analytical procedures and the findings being merely a collection of personal opinions subject to researcher bias (Noble, & Smith, 2015). Therefore, it is crucial for researchers to make judgements about the 'soundness' of the research in relation to the application and appropriateness of the methods undertaken and the integrity of the final conclusions.

However, there are ongoing debates about whether terms such as validity, reliability and generalisability are appropriate to evaluate qualitative research (Noble, & Smith, 2015). Golafshani (2003) states that the quality of a study in each paradigm should be judged by its own paradigm's terms. For example, while the terms reliability and validity are essential criteria for quality in quantitative paradigms, in qualitative paradigms the terms Credibility, Consistency and Applicability are to be the essential criteria for quality.

Credibility

Credibility is defined as the confidence that can be placed in the truth of the research findings. Credibility establishes whether the research findings represent information drawn from the participants' original data and is a correct interpretation of the participants' original view (Anney, 2014). One of credibility strategies is peer-debriefing. As part of a bigger project under the Critical Studies in Sexualities and Reproduction (CSSR) research programme, we made good use of peer-debriefing which gave us the opportunity to test our insights and to expose ourselves to questions from our colleagues. Also, a qualitative researcher should seek support from other professionals willing to provide scholarly guidance, such members of academic staff, and the department (Anney, 2014). For example, the academic support from other researchers in the programme has been very useful from writing a research proposal to final writing up of this thesis. Throughout the process I presented updates on the research in colloquia and received constructive feedback from other scholars.

Another strategy for improving the quality of qualitative data is allowing member checks. Member checks mean that the data and interpretations are continuously tested amongst various audiences and groups from which data were solicited (Anney, 2014). After sub-sessions 1 and 2 of the narrative interviews, I listened to the voice recording and transcribed and translated the data. My co-researcher and I went for follow-up sessions where I checked with my participants if I understood their narratives correctly and they confirmed my understanding and clarified where I did not understand well. After all the sessions, I transcribed and translated the remaining data, checked errors and sent all the transcripts and recordings to my co-researcher to check if I transcribed everything correctly and accurately captured meaning especially in relation to translated data from isiXhosa to English. This was to ensure accuracy of the voices of respondents in the analysis and interpretation of the data. The purpose of doing member checks is to eliminate researcher bias when analysing and interpreting the results (Anney, 2014).

Consistency

The criterion of trustworthiness considers the consistency of the data, that is, whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context (Krefting, 1991). For example, I provided a clear description of the research process from initial outline, through the development of the methods and reporting of findings. Also, I kept a research diary documenting challenges and the issues that assisted in maintaining cohesion between the study aims, design and methods. This shows that the researcher's decisions are transparent. Ultimately an independent researcher using the same methodology in the same setting should be able arrive at similar findings.

Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents. It is the interpretive equivalent of generalisability. The researcher facilitates the judgment of transferability through 'thick description' and purposeful sampling. To ensure transferability of qualitative inquiry the researcher must collect in-depth data which allows comparison of this context to other possible contexts (Anney, 2014). In this study, I recruited my participants using purposeful sampling which ensured that participants were selected based on characteristics of particular people and the aims of the study. Also, I included rich and thick descriptions of the participants and the context, and translated from isiXhosa to English verbatim descriptions of participants' accounts to support findings.

CONCLUSION

In summary, the above chapter explained how I arrived at my findings, what methods I used and why they were suitable and credible and how they answered my research questions. I have done this by providing detailed information on methods of sampling, recruitment of participants, the study location, the participants of the study. Five partners and eight family members of women who drank while pregnant were interviewed individually using the biographic- narrative- interpretive method. The data from these interviews were analysed using thematic template analysis. Lastly, appropriate ethical principles were applied to do good and avoid harm, and the quality for qualitative research was assessed in terms of credibility, consistency and transferability. In the following chapters, I will report and discuss the findings of this study.

CHAPTER 5: ANALYSIS OF PREGNANT WOMAN AND MICROSYSTEM THEMES

This chapter presents an analysis and discussion of the data collected. This study has *a priori* themes that emerged from Bronfenbrenner's Ecological Systems Theory. The Ecological Systems Theory places the pregnant person in her environment and observes the interaction with other systems influencing health behaviour. Additionally, under each *a priori* theme, there are sub-themes that emerged from the data collected. The themes are explained in detail below, together with excerpts from the narrative interviews; insights from the literature are used to demonstrate the themes. This chapter focusses on the pregnant woman and the microsystem themes.

A PRIORI THEME: THE PREGNANT WOMAN

The pregnant woman refers to an individual's knowledge, beliefs, attitudes, health, history of alcohol use and demographic factors such as age, education, income and geographic location that contribute to an individual's alcohol use in pregnancy (Coleman, & Alonso, 2016). This *a priori* theme has sub-themes which are family member's and partner's renditions of the pregnant woman's drinking habits, pregnancy, trauma and stress, HIV diagnosis, knowledge, behaviour when drunk and being untrustworthy.

Sub-theme: Drinking habits

All participants stated that pregnant women who drank before pregnancy did not stop drinking nor change their alcohol consumption after learning they were pregnant:

Extract 1

She got pregnant to our first born in 2009____ (name of the child). At that time, she was not listening and used to drink (Luvo, Partner).

Extract 2

I think she knew that she was pregnant when she was 3 months. She was drinking, she drinks a lot and loves alcohol. She was a problem to me because people would wake me up (at night) saying she is drunk, she does not want to go to sleep and she needs to be fetched. When her tummy was big, she continued drinking; she was not listening, and she would do everything (drinking, partying and fighting). She drank until she gave birth (Liso, Family member).

In the above extracts, family members and partners described women who consumed alcohol after recognising their pregnancy and throughout their pregnancies as not listening and a problem. This

suggests that family members and partners might have tried reprimanding the pregnant women concerning drinking during pregnancy, but the women continued drinking.

In the extracts below, family members and partners described the drinking habits of the pregnant women as personal characteristics:

Extract 3

She drinks, she goes out, she likes clubbing and dancing. She is not a rebellious child, but she loves alcohol (Lumka, Family member).

Extract 4

I asked her to stop walking at night while pregnant. She must move in with me because she is pregnant, and she must stop drinking alcohol. She said, she won't stop drinking because alcohol is in her blood (meaning it's a habit) (Linda, Family member).

Extract 5

When you are pregnant you have things, you crave things such as an apple, cabbage or orange or alcohol. It was not like going out to drink. She would ask me to get her a cider and she would not even finish it (Lunga, Partner).

In Extract 3, Lumka indicates that the pregnant woman liked going out, clubbing, dancing and loved alcohol. Alcohol use is viewed as part of the woman's personal characteristics. In Extract 4, the participant stated that the pregnant woman refused abstaining from drinking because alcohol is in "her blood", implying that it's a personal habit that is difficult if not impossible to break. In contrast, in Extract 5, the participant indicated that the drinking habits of the pregnant woman were not heavy: she would crave a cider and not even finish it and he compared her drinking habits with any other pregnancy cravings.

According to family members some women did not drink before pregnancy but started drinking and continued drinking throughout their pregnancies:

Extract 6

She started drinking wine and she was not a person that would drink wine. It was her first time, she is not a person who drinks (Lisa, Family member).

Extract 7

Her tummy got bigger; we stayed. After this, she started drinking. I sat down with her and told her not drink because the father of her child rejected her. Because rejection does not mean I am not here, and your father is not here. Fine... she seemed like she heard me, but she continued drinking while pregnant, she continued (Kuhle, Family member).

This suggests that it's not only women who drink frequently before pregnancy who are at risk of alcohol consumption in pregnancy. For example, in Extract 6, the participant said that the woman was "not a person that would drink wine". Drinking thus was not seen as a personal characteristic, but a response to a situation like the male partner rejecting the woman in pregnancy as seen in Extract 7.

Some family members and partners reported that pregnant women continued drinking up until birth:

Extract 8

She continued drinking up till birth (Kuhle, Family member).

Extract 9

She got pregnant again our second born. She did not want to stop drinking. Even when her tummy was big, she did not stop (Luvo, Partner).

Extract 10

She stopped (drinking) when she was about to give birth (Lumka, Family member).

Family members and partners indicated that pregnant women who drank alcohol before pregnancy were likely to drink during and throughout their pregnancies. Also, in Extract 9, the participant reported that the pregnant women continued drinking even in her second pregnancy.

According to a study conducted by Watt et al. (2014), patterns of drinking prior to conception are a strong predictor of drinking during the pregnancy period. Likewise, Onah et al. (2016) said that higher alcohol consumption before pregnancy was found to predict drinking during pregnancy in all the studies that reported on this factor. This implies that women who are at higher risk of alcohol consumption in pregnancy include women who currently drink frequently.

In addition, frequency of drinking plays an important part in establishing habits that might be difficult to break. Habits have been described as a milder form of dependence, being learned sequences of acts that have been repeated until they become more or less automatic responses to contextual cues (Skagerstrom et al., 2011). This means that a certain degree of repetition or practice is required for a habit to develop. For example, frequency of alcohol use before pregnancy may develop a habit of alcohol consumption that might be difficult to break in pregnancy. Nevertheless, prior drinking is not necessary is not a predictor of drinking during pregnancy and, as seen above, women may start drinking during pregnancy.

Sub-theme: Pregnancy

Almost all family members and partners indicated that the pregnancies of the women were unintended but wanted. An unintended pregnancy is conventionally defined as a pregnancy that is either unwanted, mistimed, or unplanned. An unwanted pregnancy is a pregnancy that occurs when no children or no more children are desired, whereas a mistimed pregnancy is a pregnancy that occurs earlier than intended. In addition, an unplanned pregnancy is a pregnancy that occurs when a woman does not desire to become pregnant but is not using contraception or her method of contraception failed (Ernstoff, 2016). This means that unplanned pregnancy is basically pregnancy that occurred without advanced planning and it could be wanted or unwanted:

Extract 11

She told me she was going to the clinic. That was not an issue. She came back telling me she was pregnant. We agreed it was good. That's not a problem. I was happy about the pregnancy. It was going to be my first time having a child with her (Sizwe, Partner).

Extract 12

It was not our agreement for her to get pregnant. It was not an issue. I was not shocked because of most of the time she was next to me, even missing clinic sometimes. She would tell me that it was her dates [appointments for contraceptives] and she did not go. I would not take it seriously because I don't know much about contraceptives. But what made her pregnant, it was because she was competing with the other woman (Jonga, Partner)

Extract 13

I stay with my sister's child too, that's how I heard about this (pregnancy). I was telling her I don't know what's wrong with___ (name of her daughter) and she told me, "She is pregnant, and she told you". I said, "I don't know about this; she did not tell me". And she explained that the book she placed on my sidelight was a note for me so see that she is pregnant. She could not tell me by herself. I asked if it is true. I was scared, and I cursed. Then, she came, and we sat down and talked, and she cried. She told me she was 4 months pregnant. I told her, "Hey but it's not an issue" (Lumka, Family member).

Family members and partners indicated that even though pregnancy was unplanned or not the agreement, they did not have an issue with it, meaning that it was wanted. In Extract 11, the participant stated that he was happy about the pregnancy even though it was not planned. In Extract 12, the participant further states that the pregnancy did not shock him because he knew that his partner would miss her contraception dates now and then. In Extract 13, the mother of the pregnant woman was not so happy about the pregnancy. We can see this when she says, "I was scared, and I cursed" even though she eventually said that the pregnancy "was not an issue".

Balachova et al. (2014) argue that the challenge in terms of FASD is that approximately half of pregnancies are unplanned and that many women consume alcohol at pre-pregnancy levels prior to knowledge of pregnancy. A potential reason as to why women drink during the first trimester of their pregnancy is that they may be unaware that they are pregnant particularly if their pregnancy is unplanned. A study conducted by Choi et al. (2014) among South African women showed that participants significantly decreased their drinking after pregnancy recognition.

Sub-theme: Trauma and stress

Family members and partners reported that an unplanned pregnancy together with trauma was a risk factor for alcohol use in pregnancy and alcohol was used to cope with distressing intrusive memories of the trauma:

Extract 14

She was raped by someone we know, who stays in our area. He raped her and ran. She was raped, and we decided to go to police station because we did not know what to do and when we got there to report. After reporting, ___ (name of policeman) who was a police officer there said to my sister "she must follow him". When they got to his office, he asked to see where she got raped. Only to find out he raped her as well. He was working as a Detective at the police station and he said if she tells anyone that he raped her, he will do something about her. It seemed like he was going to help us, and my sister did not tell me that ___ (the policeman) raped her on our way home. When we got home, she told me what the policeman said and did when they got into his office. So, she fell pregnant like that, while she was still at school (Lulu, Family member).

In this extract 14, Lulu indicated that the pregnancy occurred through the traumatic event of being raped by someone in the neighbourhood and the police officer. Also, she was a child, meaning that she was under the age of 18 and still at school.

Family members reported that pregnant women experienced the trauma of losing loved ones during their pregnancies through tragic events such as murder:

Extract 15

The last thing that happened, in the same year she was pregnant, four people died. Two were murdered and two got sick. Her sister was in Cape Town, not coming back. She left in 90 (1990) and got back very sick and did not make it. She died. We had a brother who was in the (ward) committee. He was not drinking but the day he passed away, he was murdered for his position, we saw a bottle with alcohol. He was drinking that with milk [weeping]. That's where my story ends (Lisa, Family member).

Extract 16

I opened, and the person said, “Come, your husband is injured”. My husband was drinking recently... My neighbour got there before me and when he got there, he was down. When I got there, he was severely stabbed here [pointing at her head]. He was making sounds. I did not see how ____ (name of her daughter) got out of the house. She was there and saw his father, this affected her. She was supposed to give birth in December. Her father died on the 11th of November, and she gave birth on the 18 of November. She did not give birth in December because of the shock of her father’s death. And I did not have a husband since then. I took care of my children. That’s my story. But, ____ (name of her daughter) continued with drinking. She was worse after her father’s death (Kuhle, Family member).

These deaths may have resulted in psychological trauma for the pregnant women. Psychological trauma is considered as being present at an event which involves death, injury, or a threat to the physical integrity of another person; or to become aware of the unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or another person with whom you are closely related (Malizia, 2016). In Extract 16, Kuhle stated that the shock and trauma of losing a loved one resulted in giving birth before the due date and worsened drinking in pregnancy.

Watt et al.’s (2014) study in South Africa has found that women with lifetime trauma histories are indeed more likely to increase consumption or sustain hazardous levels of drinking during pregnancy, compared with women without such traumas. This is likely explained through an effort to cope with the psychological sequelae of traumatic experiences which may be exacerbated during the pregnancy period. Similarly, Choi et al. (2014) said that following pregnancy recognition, pregnant women with prior experiences of intimate partner violence or childhood abuse tended to drink at elevated levels. This suggests that pregnant women may be less likely to decrease their drinking during their transition to pregnancy if they have a history of trauma.

Moreover, family members stated that pregnant women consumed alcohol in pregnancy because of stress. Stress is any uncomfortable emotional experience accompanied by predictable biochemical, physiological and behavioural changes (Nargund, 2015).

Extract 17

She (my mother) was drinking, I think maybe she was drinking because of stress because she fought with her husband (my father) and left him. We stayed with my mother's family suffering (Jade, Family member).

Extract 18

Her tummy got big and she did not know she was pregnant. She drank alcohol because all of this was stressing her out (Lulu, Family member).

Extract 19

When I asked her why she is drinking while pregnant, she would say she drank because she was stressed (Sizwe, Partner).

Family members and partners interpreted the drinking of pregnant women as being caused by stress. In Extract 19, the partner said that he asked the pregnant woman why she was drinking, and she said, she was drinking because of stress. This shows that women self-reported drinking in pregnancy as a way of coping with stress. Therefore, the recognition of pregnancy does not always reduce alcohol use in pregnancy even when the pregnancy is wanted. This may be because recognition of pregnancy may act as an additional stressor that interacts with the woman's trauma history to increase distress and related drinking behaviour. History of trauma exposure may make some women more likely to continue or even increase hazardous drinking behaviour upon recognition of their pregnancy (Choi et al., 2014). In other words, after recognition of pregnancy women may start drinking, increase their alcohol consumption or not change their drinking behaviour even though the pregnancy is wanted.

Sub-theme: HIV diagnosis

Many women only discover their HIV-positive status once they are pregnant and make the use of antenatal services. One participant reported that her family member started drinking alcohol after discovering she was HIV positive in pregnancy. Also, a family member touched on her own experience of being diagnosed with HIV in pregnancy. She spoke about how she tried to commit suicide after receiving the HIV-diagnosis:

Extract 20

It was my aunt... she was pregnant, and she used to drink too much. She started drinking wine and she was not a person that would drink wine. It was her first time; she is not a person who drinks. What bothered her and made her drink, she got tested while pregnant. She found out she was HIV positive and that made her drink too much alcohol (Lisa, family member).

Extract 21

It (HIV positive diagnosis) affected me so much because I ate [took] poison, but it did not kill me (Lulu, family member).

In Extract 20, the participant stated that the pregnant woman was not a drinker, but she started drinking after receiving an HIV+ diagnosis. In Extract 21 Lulu demonstrates that receiving an HIV+ positive diagnosis during pregnancy is particularly traumatic. Women who receive a HIV+ diagnosis face many challenges as they adjust to life with this chronic illness. Problems such as substance abuse,

stigma and depression are common (Netshimbupfe, 2017). An HIV+ diagnosis during pregnancy is distressing for the newly diagnosed woman, as it increases concern about her own and her child's wellbeing. The diagnosis of HIV in pregnant women may leave a woman particularly vulnerable to suicidal thoughts and feelings of depression, denial and condemnation (Netshimbupfe, 2017).

Moreover, participants reported that pregnant women who drank prior to the pregnancy drank more heavily after receiving an HIV+ diagnosis and engaged in unprotected sex:

Extract 22

It affected her in this way, after this she did not know how to take care of herself. She became worse and worse (drinking behaviour became worse). She told herself that she is HIV positive now, so she will die anyway. I should allow her to eat (enjoy) life. When I asked her if she does use condoms with the people she sleeps with, she said she doesn't have time for that, she will die anyway. And her child is affected too, what is she living for? (Lulu, Family member).

Extract 23

I tried stopping her from drinking while she was pregnant, but she did not listen because of stress. I sat down with her and told her that HIV is everyone's disease and it does not kill (Lisa, Family member).

Lulu and Lisa indicated that after their relatives received the diagnosis, they (the relatives) lost hope in life. In Extract 22, Lulu described how after diagnosis, her sister did not know how to take care of herself. She drank heavily, she engaged in unprotected sex and she did not see a reason for living nor taking care of herself. In Extract 23, the participant said that she tried encouraging her relative to stop drinking but she did not listen because of the stress that comes with receiving an HIV+ diagnosis in pregnancy.

A study conducted in low and middle income countries, including South Africa, shows that there is the concern that pregnancy might be a time of heightened mental health vulnerability for HIV+ women due to adverse contextual factors that commonly co-occur with HIV infection among women, such as intimate partner violence, post-traumatic stress disorder and substance abuse (Kapetanovic, Dass-Brailsford, Nora, & Talisman, 2014). This implies that being diagnosed with HIV in pregnancy may result mental health problems for the women leading to feelings of despair, destructive behaviour (drinking alcohol at harmful levels) and engaging in unprotected sex.

Family members and partners indicated that healthcare providers instruct pregnant women or partners to tell someone about their HIV status and to encourage their sexual partners to get tested too. However, individuals diagnosed with HIV often have difficulty disclosing their status to others and testing may only occur when illness sets in:

Extract 24

When you look at her, she looked like she accepted it, but I saw from the way she drank alcohol that she had not accepted it. Because, when you get tested, they (healthcare providers) explain about the harms of alcohol and what you should do and not do and instruct you to tell someone. She did not tell anyone that she was HIV positive (Lisa, Family member).

Extract 25

I got sick and I was hospitalized. When I got there, they found out I have AIDS... HIV. After prison, I never slept with anyone beside her. I told her to go and get tested and we found out that she has also. But I did not blame her for it. I just took it as any other disease. So, now it's been years living with it. I take my treatment. She gave birth to our children with HIV (Luvo, Partner).

In this Extract 24, Lisa interpreted the pregnant woman's decision not to tell anyone about her HIV status, despite being encouraged to do so, and her alcohol use as lack of acceptance of her HIV status. In Extract 25, the partner said that he found out that he was HIV positive only when he got sick and was hospitalized. HIV testing only took place at this stage.

Walcott, Hatcher, Kwena and Turan (2013) argue that disclosure may be particularly crucial for pregnant women. During pregnancy, women are at considerably increased risk for HIV acquisition (male-to-female) and transmission (female-to-male). Without partner support, it is often difficult for women to adhere to recommended HIV treatment and breastfeeding regimens, behaviours that are necessary to reduce transmission of HIV to their infants, protect their own health, and ensure the health of their partner. This is particularly relevant for women in middle countries such as South Africa, where they are often economically, culturally and socially disadvantaged and may fear abuse or abandonment once their diagnosis is known (Visser, Neufeld, de Villiers, Makin, & Forsyth, 2008).

A family member who was diagnosed with HIV in pregnancy herself shared her own fears of disclosing her HIV status to her intimate partner:

Extract 26

He will see that I have this (HIV) and he would say I infected him. There is a high number of men killing women here at ____ (name of the township). Maybe he will end up killing me. What will happen to my unborn child and I don't know if I infected my child already because I booked late (started going to antenatal clinic late). But she (neighbour) would try guiding me and telling me that everything will be okay, I must continue eating (taking) my pills, because she is also married and living with HIV. But with her, she is married and has parents. To her it seems easy. She accepted easily and it's not easy for me because I have no one to guide me. It's better with her: she stays with her husband; she has a place to stay now. And I

have no place to stay. She said, “Look, I will keep your pills, the person you are dating (cohabitating with) will not find out” (Lulu, Family member).

In Extract 26, Lulu mentioned her fears of disclosing her HIV status to her intimate partner with whom she was cohabiting. She feared being accused of infecting him, and she feared for her life because in her community there is a high number of partners killing women who disclosed their HIV status to them. She was worried about her unborn child. Also, she was worried about where she would go because she had no place to stay. These circumstances meant that she needed to keep her HIV status confidential and that someone else had to keep her treatment so that her partner did not find out. Additionally, her statement that her neighbour’s circumstances were easier than hers justified non-disclosure.

This shows the complexity of the decisions HIV-positive pregnant women need to make in the short time between diagnosis and the birth of their babies, with little or no psychological support to them in dealing with the diagnosis itself, fear of disclosure, pressure to protect of their partners and their babies (Visser et al., 2008). Yet, during pregnancy there is an urgency for a woman to make choices that may impact on her own well-being and possible HIV transmission to her partner and baby. A study conducted in South Africa indicated that many women need more time to come to terms with the diagnosis before being willing to disclose (Visser et al., 2008). Also, a study conducted in Kenya showed that after testing for HIV, many women do not feel safe and comfortable disclosing their HIV status to partners due to fears of partner reactions to an HIV-positive test result (Walcott et al., 2013).

Sub-theme: Women’s knowledge

Most of the family members and partners indicated that the pregnant woman had some level of awareness about the dangers of drinking alcohol during pregnancy, but were not necessarily aware specifically of the term FASD, even though they could describe what it entails. However, some participants reported that pregnant women knew that they should not drink in pregnancy but did not know why. A few of them reported having personal experiences with children affected by alcohol use during pregnancy, either knowing about them from their relatives or having children affected by alcohol in pregnancy themselves:

Extract 27

She does know that there could be a problem when you drink in pregnancy, and at the clinic they are taught about the effects of alcohol in pregnancy. For example, it affects the brain and the child could be delayed in certain things. She did have knowledge and understanding of this. Also, when I told her not to drink, I knew that alcohol might cause disability in children

for example, in the eyes, confusion, problems with learning and child feeling lonely. I did understand that alcohol in pregnancy could have effects... she seemed like she heard me when I told her not to drink, but she did not stop. People say that, even though pregnant women know what to eat and not to eat, sometimes what they should not eat they craved and like it because of pregnancy. When you say “No”, they steal it because of pregnancy. But I said, she should not crave alcohol. However, the child looks okay and she looks okay too. I did not notice any abnormality. Everything is alright (Lumka, Family member).

Extract 28

I knew that women are not supposed to drink in pregnancy and I am certain that she also did have this knowledge. Because it’s always been there that when you pregnant you must not drink. Even in the clinic, there are talks around this and HIV/ AIDs. When a child is exposed to alcohol, it does not come out right. Alcohol affects the brain, body parts and might result in disability. So, these things happen if you do things the clinic instructs you not to do (Khaya, Partner).

In Extract 27, Lumka stated that the pregnant woman did have knowledge about the possible harms of alcohol use to the developing foetus. The pregnant woman received information about the effects of alcohol in pregnancy from clinic as well as from her. She explained why the pregnant woman continued drinking, despite this knowledge: she had cravings just like cravings for food that come with pregnancy. Also, in Extract 28, Khanya indicated that knowledge about the harms of alcohol use in pregnancy has “always been there”, meaning it is transmitted through social messaging as well as through the official medium of the clinic. This implies that awareness alone is not enough to change or decrease alcohol use in pregnancy because many pregnant women continue to drink alcohol despite social injunctions against alcohol usage, clinical recommendations to abstain from alcohol in pregnancy and being told by their family members about the risks associated with prenatal alcohol use.

In contrast, some family members indicated that pregnant women lacked knowledge about dangers of alcohol use:

Extract 29

I don’t think she knew the dangers of drinking in pregnancy but growing up when you are pregnant you were not allowed to drink, smoke or use any drugs. She would drink over weekends. For example, when I am drinking over the weekend, she would have a few glasses. She was not drinking to get drunk (Jonga, Partner).

Extract 30

Yho, it was 1992. I don't think she knew. Because awareness about alcohol use in pregnancy it's something new. I don't think she knew about the effects or harms of alcohol use in pregnancy (Jade, Family member).

In Extract 29, the partner differentiates between knowing that women should not drink during pregnancy from a social perspective and knowing the effects of alcohol use on the foetus. In Extract 30, the family member recognises the possibility of the pregnant woman not knowing about the dangers of alcohol in pregnancy, but she excuses the behaviour because there was no public awareness at the time (prior to the democratic elections in South Africa). This indicates that some women do not know the dangers of alcohol use in pregnancy, but they are aware that they should not drink in pregnancy because of social messages. Also, in Extract 30, the partner justified the pregnant woman's drinking by saying that she would have few glasses of drinks containing alcohol when he is also drinking over the weekend and that she was not drinking to get drunk.

The most influential factor on a woman's decision regarding alcohol consumption during pregnancy is her own knowledge (Balachova et al., 2014). Women who hold the belief that any amount of alcohol is safe during pregnancy, as well as women who lack the knowledge of the effects of alcohol on the foetus, have been identified as at risk for drinking while pregnant (Peadon et al., 2011). Also, Eaton et al. (2014) found that a substantial number of men believed that a woman could consume alcohol safely during her pregnancy. Because of a lack of education, women could be unaware that prenatal alcohol use is harmful to the foetus, or they may hold misconceptions with regards to the risks associated with drinking while pregnant (Eaton et al, 2014). This provides evidence supporting the need for public education efforts to reduce alcohol use in South Africa.

Additionally, participants reported on the misconception that women need to consume large amounts of alcohol to cause harm and that some types of alcohol pose less risk than others:

Extract 31

There are a lot of people who drink in pregnancy. For example, we sit with them at the Tavern, and we will tell them, they not supposed to be there. But they will say we should leave them alone; they are there to relieve their stress. There is a belief among them that when you drink Smirnoff, it helps somehow with pregnancy. I don't know how (Jonga, Partner).

Extract 32

She knows the harms of alcohol use in pregnancy. I told her not to drink in pregnancy, but she would say "No mama, I do not drink too much". I told her when you drink in pregnancy, people say there will be issues or difficulties. Even with her child, I have not seen any issue. The child eats, plays and goes to pre-school. What I know is, even us when we were pregnant, we were told not to drink. When you drink in pregnancy, there will be problems. For example,

one of my relatives was drinking in pregnancy and her child was not okay. The doctor said the child has heart disease. You see, the child is a big man now and has no issues (Kuhle, Family member).

In Extract 31, Jonga drew on his experience of visiting taverns to indicate that pregnant women believed that drinking Smirnoff was not harmful to the developing foetus and helped with pregnancy. These kinds of understanding lead to some confusion among pregnant women and the public about the accepted level of alcohol use and types of alcohol to drink during pregnancy. In Extract 32, Kuhle indicated that the pregnant woman was knowledgeable about the harms of alcohol use in pregnancy but believed that she was not drinking too much. Also, the family member corroborates this by indicating that despite people saying that there will be issues or difficulties with the child, the child is fine. Again, one of her relatives who was drinking in pregnancy was told that her child had heart disease but now he is a big man with no issues. These exceptions reinforce the idea that it is heavy drinking that is the problem contrary to social and official messages.

In contrast, some participants believed that every woman who drinks in pregnancy will have a child with FASD:

Extract 33

Yoh! The dangers of using alcohol in pregnancy is what I am currently seeing. If you drink alcohol in pregnancy, your child does not come out normal, like a child of a person who did not drink in pregnancy. Doctors say your child is a failure, s/he will be delayed, all because of alcohol use in pregnancy. When you drink alcohol, your child does not get vitamins which will make your child healthy. You do not use what you need to use when you are pregnant when you are drinking. When you are drinking, you do not follow the treatment you should follow. This damages your child. It is the same as when doctors say you must stop smoking and drinking. The doctors know these things are harmful to your child, and this is the truth. I saw the harms with my two children. And this is true, my children are experiencing the consequences of drinking and smoking in pregnancy. For example, I have four children. Out of four there is one who's affected because with the other three I did not drink nor smoke. And my grandchild whose mother was drinking, they even said he was disabled. But he is not disabled. It's because of alcohol use in pregnancy. Also, my sister's child they said at school, they will do a referral letter for a specialist to check her/his brain because he/she ⁴was slow at school and ended up dropping out in standard 4 (Nazo, Family member).

In Extract 33, Nazo indicated knowledge of the effects of alcohol use during pregnancy from her experiences, seeing her relatives' children suffering from some of the symptoms of FASD, and being

⁴ The IsiXhosa language does not have pronouns.

informed by Doctors. On the basis of this, she was convinced that all women who drink in pregnancy will have children with disabilities.

According to Cloete and Ramugondo (2015), not all women who drink alcohol during pregnancy will have a child with FAS. Similarly, Popova et al. (2017) said that although research has not been able to delineate the exact pattern, amount, or critical period of prenatal alcohol exposure necessary for problems, it is known that not every woman who drinks during pregnancy will deliver a child with FAS. As indicated above, a study conducted in Western Cape, South Africa, showed that women have knowledge about instances where women drink in pregnancy and give birth to a child without any FASD. Participants described knowing women who consumed large quantities of alcohol throughout their pregnancies, but their babies are fine. They were thus convinced there is nothing wrong with drinking while pregnant (Watt et al., 2016).

Sub-theme: Behaviour when drunk

Family members and partners reported that pregnant women misbehaved when they are drunk by initiating fights, shouting and being aggressive:

Extract 34

When she was drunk, we would fight, and I would report to her mother that she was misbehaving (and it was) worse when she drank alcohol. Her mother called us. We were about to divorce, but we called her father from another town. He came, then we talked and fixed things. We are getting along, and we are still together (Sizwe, Partner).

Extract 35

She loves shouting when she is drunk. When she comes back, she will shout at us about why we did not fetch water etc. (Jade, Family member).

Extract 36

When I started asking (about her behaviour), she threw a vase at me that was on top of the table. It's clear that alcohol makes her aggressive (Linda, Family member).

Family members and partners indicated that when pregnant women are drunk, they misbehave. In Extract 34, the partner did not specify what exactly the pregnant woman did but he interpreted it as misbehaving which caused fights and almost divorce. Giancola et al. (2009) argues that alcohol is more likely to facilitate verbal aggression in women whereas it is more likely to produce physical aggression in men. For example, in Extract 35, the participant said that she loved shouting at her children. Similarly, in Extract 36, the participant highlighted aggressive behaviour when the pregnant

woman was drunk. According to Giancola et al. (2009), intoxicated women almost always exhibit somewhat higher levels of aggression than sober women.

Sub-theme: Being Untrustworthy

The family members highlighted that pregnant women were not trustworthy as manifested by failure to attend school or fulfilling major role obligations:

Extract 37

I heard that she was bunking school and I was going to go Cape Town to follow up on this, but I didn't have money yet (Linda, Mother).

Extract 38

But with her she wants to take something from the house to sell when she does not have money to drink. I asked her if she is on drugs, but she said she was only drinking... she likes brandy, that's what she drinks. I asked her what is going to happen with the child (Linda, Mother).

Extract 39

When she was about to give birth, she stayed in hospital because the child was at risk. Also, she was physically abused by her boyfriend and she was not eating well. They said the child drinks alcohol only and does not eat. She did not know that the child was affected by what she was doing. They made her stay in hospital until birth, and after birth she stayed with the child there (Linda, Mother).

In Extract 37, Linda reported that her daughter was not attending school, and in Extract 38, she stated that she did not trust her with items in the house. In Extract 39, she further explains that her daughter had to be hospitalized because she could not be trusted to eat properly. These are signs of alcohol dependence where the pregnant woman neglects activities, spends an inordinate amount of time drinking and continues despite alcohol related physical harm (Shenton, & Turetsky, 2010). People who are alcohol dependents use whatever means necessary to maintain alcohol use, hence the stealing of house items. Also, they do not eat well but drink alcohol heavily. This does not help the developing foetus because poor nutrition compromises the body's ability to effectively metabolise and clear alcohol, thus leading to greater levels of toxicity. It is believed that a nutritionally rich diets can act as a buffer to protect foetal development among alcohol using pregnant women (Eaton et al., 2014).

Moreover, family members and partners reported that women who drank in pregnancy are likely to neglect their children after birth:

Extract 40

We did not have money at home and food. You would find out that we also did not have things school needs, for example, uniform. We did have, but when your mother is drinking, she does not see if there is something we need. We wash ourselves to go to school. If our uniform was torn, she will notice only after some time (Jade, Family member).

Extract 41

There are challenges. One of them is the mother of my children (wife) leaving my children alone for fun in shebeens with her friends. My kids must cook for themselves. When I asked... she said, "They can cook for themselves". But they are not at the age where they can cook for themselves. What if something happens and they burn themselves. If they get burnt, I will become angry because I don't want to lose my children due to negligence (Lunga, Partner).

Extract 42

After birth we stayed and stayed, and things seemed to be okay, but she started where she left off and drank. Look at her child... she got burned, she was with her. If you can ask her now, who burned her she will tell you. I took the child from her because she goes out and drinks. I think she left a cigarette or whatever because there is no way that a pillow can get burned while a child is sleeping. A neighbour heard a baby crying and she went and checked. If the neighbour was not there, she was going burn to ashes... that's how it is, our children and alcohol (Linda, Family member).

In Extract 40, the participant spoke about how they did not have basic needs such as food, money and school uniform because her mother was a drinker and did not pay much attention. In Extract 41, the participant mentioned that his wife leaves children alone to have fun in shebeens without cooking for them and as result the children cook for themselves. Likewise, in Extract 42, the participant stated that the previously pregnant woman left her child sleeping alone and went out to drink and the child was found by her neighbour burning. This demonstrates that family members are concerned that the children of drinking mothers are at risk of child neglect after birth.

According to Freisthler, Johnson-Motoyama, and Kepple (2014), opportunities for socialising outside the home (such as areas with higher densities of bars or restaurants) may increase the likelihood that parents spend time away from home. This means that child care cannot be secured: a child may be left at home or in unsafe situations without supervision. Parents who consume alcohol neglect their children by disregarding children's safety in and out of their home that expose them to dangerous situations. Also, they may physically neglect their children by failing to exercise a minimum degree of care in meeting the child's physical needs such as food and medical care (Freisthler, Wolf, & Johnson-Motoyama, 2015).

A PRIORI THEME: MICROSYSTEM

Bronfenbrenner (1979) argued that microsystems consist of relationships and interactions with which a person (in this case the pregnant woman) has frequent and direct contact such as the pregnant woman's family, friends, partners, clinic, and church. Under the microsystem, there are sub-themes that, according to the partners and family members, support the pregnant woman in abstaining or reducing alcohol use namely support from partners, family members, healthcare workers, church and traditional healers. There were also sub-themes about exacerbating the pregnant woman's alcohol use, namely rejection and denial of pregnancy by male partners, intimate partner violence, infidelity, the drinking habits of partners, family members and friends, drinking establishments and a poor criminal justice system.

Sub-theme: Support from family members

According to Edmonds, Paul, and Sibley (2011), pregnant women need the support of family members, partners and health professionals. Family members reported on providing various types of social support namely emotional and instrumental support to pregnant women:

Extract 1

She told me because I also got tested and I am HIV positive; that's why I have the strength to encourage her. Because I don't have a child who died because of HIV. I got tested and ate (took) the treatment accordingly. All my children were not affected. I had the strength to encourage her (Lisa, Family member).

Extract 2

After the passing of the child, she never drank alcohol again. And now she is in good health, she is taking her treatment and eating [taking] it well. Because I showed her my treatment and told her to look at me when I am taking my treatment, see. And when my family found out that I was HIV positive, they did not get hurt because they can see that I am not sick (Lisa, Family member).

In Extract 1, Lisa stated that the pregnant woman disclosed her HIV status to her because she (Lisa) was living with HIV and had experience and strength to encourage her. In Extract 2, Lisa reported that her relative is taking her treatment now because she encouraged her to take her treatment by showing how well she was doing on hers. This indicates that family members living with HIV were able to understand the feelings of being diagnosed with HIV since they shared the same experience at one point in their life and talking with someone with experience can help people newly diagnosed with HIV to deal with their feelings. Effective social support is usually provided by individuals who

are socially similar to the support recipients and who have experienced similar stressors or situations (Hanson & Jensen, 2015).

Moreover, family members stated that they provided overt statements of support:

Extract 3

I sat down with her and told her, she must not drink because the father of her child rejected her. Because rejection does not mean I am not here, and her father is not here. Fine...she seemed like she heard me, but she continued drinking while pregnant, she continued (Kuhle, Family member).

Extract 4

When someone is pregnant... even if your man impregnated you and left you does not mean that we at home or as your family we will not reject you and we will support your child (Liso, Family member).

In Extract 3, Kuhle implied that the drinking of the pregnant woman was caused by the stress of rejection from her intimate partner. The family member offered support by assuring the pregnant woman that rejection from her partner does not mean she does not have support from her parents. Likewise, in Extract 4, the participant stated that she offered support to the pregnant woman because she is family and family will not reject you, but it will support you throughout. This demonstrates provision of emotional support from family members to pregnant women.

Furthermore, family members said that they voluntarily supported the pregnant women with acts of service, and after birth, with childcare and the provision of money for basic needs of the new-born:

Extract 5

She was a problem to me because people would wake me up (at night) saying she is drunk, she does not want to go to sleep and she needs to be fetched. Our area is dangerous: people get raped, murdered etc. My husband would wake up because he was always around. He would go and fetch her (Liso, Family member).

Extract 6

She does not listen, and when she wants to go out, I will tell her to leave her child. I will take care of her because she won't be able to go with a child. She would leave the child and I would fight with my husband because this child must eat, and I would take from my child's food (Liso, Family member).

Extract 7

I have not seen a thing (financial support from her partner). Yesterday I bought the big tin of baby milk for R290 and nappies for R250. I started with buying the bottles and other things. because I saw her situation, because when she gave birth, her breasts were not milking. She

went to the clinic, but they did not see anything wrong. When she gave birth, she breastfed with the other one, but it also became hard, painful and bloated. I told her to stop breastfeeding and she went to the clinic and was told to pull her breasts and wash them and breastfeed the child. But I told her to stop breastfeeding because she needs to be cleansed to stop whatever is making her breast hard and painful. There are many Xhosa explanations: maybe she jumped over something or something is sucking her breasts while she is breastfeeding the child. Then, she stopped breastfeeding. So, I buy everything (bottles, clothes, nappies, milk, etc.) for the child (Lumka, Family member).

Family members indicated that they offered instrumental support to the pregnant woman. Instrumental support includes activities that help the recipient satisfy personal needs, such as offering help with childcare, act of services, money, and time (Sriyasak, Almqvist, Sridawruang, & Haggstrom-Nordin, 2018). For example, in Extract 5, Liso stated that her husband would wake up at night to fetch the pregnant woman from shebeens because their neighbourhood is dangerous. In Extract 6, the participant said that she offered to help with babysitting when the previously pregnant woman wanted to go out and she shared her child's food with this child. In Extract 7, Lumka stated that she offered financial support to the woman by buying the basic needs of her child such as bottles, clothes, nappies and milk etc. This was necessary as she disagreed, drawing on "Xhosa understandings" with the advice from clinic nurses. It is thought that instrumental support may be the most effective in alleviating stress as it reduces situational demands and conveys the message that one matters to others and is valued (Reid, & Taylor, 2015).

Sub-theme: Support from partners

Partners mentioned that they offered support to their pregnant women by spending time with them, doing everything together, helping each other, encouraging them to decrease their alcohol use and stopping their own alcohol use:

Extract 8

I took a decision that there must be one person who stops drinking between the two of us and I stopped. She continued drinking and she is still drinking even now (Lunga, Partner)

Extract 9

Even though I was troublesome, I was not drinking. I tried encouraging her to stop drinking but it was difficult, because she is younger than me. But I tried and there was improvement (Luvo, Partner).

Extract 10

Mmmh, I don't want to lie because most of the time we were always together when she was pregnant. However, I am a person who loves going out so much, so when she was pregnant, I

adjusted to the situation. Because I did not want to upset her... Maybe that could affect the child, you see (Jonga, Partner).

Extract 11

Mmmh, we helped each other in everything. We were not staying together. She stayed at her home. She would come to visit, and I would feel the pain that she is pregnant and it's my baby and I love this baby too. After all, I know it's my baby, so in everything we were together. She would ask me to go with her to the clinic, so on and so on. I was always next to her most of the time (Jonga, Partner).

In Extract 8, the partner stated that he stopped drinking because he thought one of them should stop. But the woman continued drinking. In contrast, in Extract 9 Luvo said that although it was difficult to encourage her to stop drinking, there was improvement. In Extract 10, the partner reported that he spent most his time with the pregnant woman; although he loves going out, when his partner was pregnant, he reduced this to spend time with her because he did not want to upset her. Also, in Extract 11, the partner mentioned helping each other, doing everything together and accompanying the woman to the clinic. In a study conducted in Soweto, South Africa, women reported a need to have their partner show care by providing for them. They also emphasised their desire for emotional care, for their partner to show his affection for them including his involvement in and implied commitment to the pregnancy, through his physical presence as much as his financial support. Women with more sources of support, including a reliable and loving partner, reported less stress than those with less support (Mlotshwa, Manderson, & Merten, 2017).

Sub- theme: Support from healthcare providers

Family members and partners indicated that pregnant women received informational support related to alcohol use and pregnancy, living with HIV and nutrition from health professionals:

Extract 12

They tell us at the clinic that we must protect our babies. When we get tested there, we don't get forced. They sit down and talk to you to ensure that the baby is safe (Lisa, Family member).

Extract 13

She used to go all the time to the clinic; she never missed her dates. At the clinic... her first experience... her nurses used to like her because she would not wear jeans when she goes to clinic. She would not wear jeans; she would wear a maternity dress. Secondly, she would wash her breasts and make them clean. The nurses noticed how neat she was. I would ask her what they did or were taught at the clinic that is special beside alcohol use. She would say "What is important is that I do not miss my dates for check-ups because I don't know how I

would give birth to this child, I never gave birth before, so I want to know everything we are told at the clinic. But what they say I am good at is that I don't suffocate my child. I wear a full dress because some people wear jeans and belts while they pregnant that causes back pains and the child might not stay well to the womb, so I wear a dress and flat shoes". She did not mention anything unjust about the nurses. There is a nurse who was good at the clinic who used to do check-ups with her. She did not get a bad service (Lumka, Family member).

Extract 14

Sisters (Registered Nurses) do tell us do not drink and smoke in pregnancy. And to rest, eat healthy food and they give us pills. But we throw them away (Nazo, family member).

Extract 15

They create a folder for you and start your treatment. I started eating [taking] my treatment in June so every year in June a blood sample is taken to check if I am taking the pills right or at the right times. They tell you to eat fruit, green stuff and drink water. So, I keep their instructions. Also, when you go out for a drink, they encourage us not to drink the pills because they are drugs (Lulu, Family member).

The family member in Extract 12 stated that healthcare providers are encouraging: they do not force pregnant women to get tested but they sat down and talk with pregnant women. This is in line with pre-test counselling guidelines: to explain the HIV testing process, give individuals relevant HIV information by assessing HIV knowledge, correcting misconceptions and assessing the client's risk reduction options (Mohlabaane et al., 2015). Additionally, in Extract 13, the participant described healthcare providers as supportive in terms of preparing the pregnant woman for childbirth, creating a supportive space which encourages women to not miss their clinic visits, paying attention and praising the pregnant woman for being neat and wearing a maternity dress. Contrary to some reports, in Extract 14, Nazo spoke about how pregnant women do not follow the instructions they receive at the antenatal clinic about drinking and smoking, and about resting, eating healthy food and taking the pills they receive from the healthcare workers. In contrast, in Extract 15, the participant mentioned that healthcare providers created a folder for her, checked if she was on the right treatment and instructed her concerning what to eat and not to drink alcohol with treatment. Also, the participant mentioned that she followed the healthcare provider's instructions. Therefore, some women do follow the advice and instructions of healthcare providers.

Family members and partners indicated that in clinical settings healthcare providers mostly offered informational support related to living with HIV/AIDS, abstaining from alcohol use and smoking, and nutrition. They did not speak much of emotional support that enables better processing of the diagnosis and reducing alcohol use in pregnancy. According to Cook, Candidate, Ennis, and Cook (2018), healthcare providers' response to the poor return rate of patients is to convey as much

information as possible to the person at the time of diagnosis or antenatal visit. This may be too much information for newly HIV diagnosed women as they still need to process the diagnose and emotional trauma.

Sub-theme: Church

Family members and partners reported that the interaction pregnant women had with church helped in reducing and abstaining from alcohol use:

Extract 16

On the third week I asked them (the church) to visit my house at night. She was revived, and she stopped drinking. After three months I got promoted at church as a preacher. In prison there was church, so I knew Bible verses. I was a preacher and we both went to church for a while, but she went back to alcohol again (Luvo, Husband).

Extract 17

[You mentioned that your family member stopped drinking and she goes to church now; do you think church played a role in helping her to stop drinking?]. Yes, it played a huge role because you smoke or drink or fight when you are drunk but when you go to church, there are changes that happen because they tell you what you must do and not do. Also, they pray for you. So, whatever problem you have God can help you or if you cannot get out of a situation, God makes a plan. You see many things. If you were wrong, you see yourself. When it's dark, you see light (Nazo, Family member).

In Extract 16, the partner reported that he asked his church to visit his house for whole night service with the hope of helping his wife stop drinking. After she was revived, she stopped drinking for a while and they would go together to church. However, she went back to drinking again. Also, a family member in Extract 17 stated that church played a huge part in helping the pregnant woman to stop drinking by guiding the pregnant woman, offering prayer support, and reassuring the pregnant woman.

Sub-theme: Traditional healers

One partner reported that the pregnant woman consulted a traditional healer to get help for her drinking problem and that her drinking behaviour changed after she was given traditional medication to use:

Extract 18

She changed after we prayed for her and even went to consult a traditional healer. He (traditional healer) told us someone poisoned her to never stop drinking alcohol. But even

under the circumstances, I tried to help, and we used traditional medicine. But I was worried because people say you cannot mix western medicine with traditional. So, the healer gave her some medicine and she was cleaned. He gave her something to vomit with and things like millipedes and lizards came out from her tummy. And she stopped complaining about things going up and down in her body. So that's what we got from the healer (Luvo, Partner).

In this Extract 18, the participant said that the pregnant woman consulted a traditional healer and prayed for her drinking problem. A traditional health practitioner is defined by the World Health Organisation as 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. The approach of traditional health practitioners to health care is based on indigenous knowledge and belief systems. Traditional healing consists of a combination of healing practices such as divining, herbalism and spiritualism (Zuma, Wight, Rochat, & Moshabela, 2016). The participant said that after they consulted a traditional healer, the drinking behaviour of the pregnant women changed, and the healer explained that she has a drinking problem because she was poisoned to never stop drinking.

Interestingly, the partner stated that he was worried about mixing HIV treatment with traditional medicine because people say you cannot use them both at the same time which may limit effectiveness of either system. Zuma et al. (2016) pointed out that eight in ten black South Africans are believed to utilise traditional health practitioners alone or along with Western medicine. The partner said that the pregnant woman was cleansed, meaning that herbal mixtures were added to bath water to purify the pregnant woman. She was given traditional medication with which to vomit; this consists of large volume (up to 2 litres) of lukewarm herbal infusion which is drunk; a process of self-induced vomiting occurs to cleanse and to take the poison out her system. According to the partner, she stopped complaining about other health-related issues she used to experience.

SUB-THEMES THAT EXACERBATE THE PREGNANT WOMAN'S ALCOHOL USE

Family members and partners pointed out that a lack of support or the total lack of participation in pregnancy from partners, infidelity and intimate partner violence may have resulted in pregnancy being an unpleasant experience as well as in drinking while pregnant. Also, the drinking habits of partners, friends and family members, the interaction between the pregnant women and drinking establishments, and the interaction between the pregnant woman and criminal justice system may have exacerbated alcohol use in pregnancy.

Sub-theme: Rejection and denial of pregnancy

Family members and partners themselves described how intimate partners of the pregnant woman did not offer support and rejected or denied the pregnancy:

Extract 19

When ___ (name of the pregnant woman) was pregnant, she continued with the pregnancy. I remember I was checking my phone mos, the phone is mine. ___ (name of the pregnant woman) does not have a phone; she lost it. I saw a message, she sent a message to her boyfriend telling him she was pregnant. I saw a response message saying, "I did not get you pregnant" (from her boyfriend). I saw this message, but I told myself I will pretend like I have not seen it. Her tummy got bigger. We stayed. After this, ___ (name of the pregnant woman) started drinking. (Kuhle, Family member).

Extract 20

She loved going to his (boyfriend's) place, I would tell her not to go to his place because he did not want her. When he walks around with his friend and she calls him, he would say nasty things like she is old for him. But she insisted on going and found out she was pregnant, and her boyfriend did not want her. Her tummy was big, and she continued drinking (Liso, Family member).

In Extract 19, Kuhle stated that she saw a message from the pregnant woman's partner stating that he did not get her pregnant. After this message, the pregnant woman started drinking. Similarly, in Extract 20, Liso reported that she told the pregnant woman to stop visiting her boyfriend because he did not want her. The implication is that pregnant women drank alcohol to cope with the rejection and denied paternity of their partners. Denied paternal responsibility is described in characteristics of women with low post-natal social support and negative maternal mental health (Nduna & Jewkes, 2012). A study conducted by Mmusi-Phetoe (2016) in KwaZulu Natal indicated neglect and abandonment by male partners is a determinant of poor health outcomes for women in South Africa. Also, abandonment by a partner, especially when pregnant, was narrated in the above study as a deeply degrading and humiliating experience for women, causing serious ill health. Sometimes they felt lonely and helpless by the lack of support from their partners which may have resulted in events that harmed their health (Cremonese et al., 2017).

Partners rationalised their rejection through reference to woman's bad behaviour and rumours:

Extract 21

In our first born, *in our first born* I did not believe that it was my child because of how she carried herself. She would go out and visit her family. When she was there, she would have

fun (drink) with friends. When I went there, I would see that they are having fun with friends and other men. I would have to leave, but I would pretend to leave and not leave. I would see her with other men outside. I denied the pregnancy and kicked her out but when the child is denied he comes out looking like you. I don't know how this happens. So, I told her I will see by the looks of the child if it's mine or not. He (child) looked like me. Even at home they agreed it was my child, but I could not believe it even when I saw him (Khaya, Partner).

Extract 22

I heard rumours that it was not my child, and this bothered me. Because most of the time I work at night, I am not around. I come back in the morning, sleep and leave late for work. I reported this to our parents, that there are such rumours and I asked how that makes them feel. They said they will call the people who were spreading such rumours. They came, and they did not have evidence of what they said. When the child was born, it was mine. There was no problem (Sizwe, Partner).

The partners reported that fathers often deny paternity when they have uncertainties about the child's paternity. In Extract 21, the partner concluded that he had not impregnated his wife because he saw her with other men. Similarly, in Extract 22, the partner reported that he heard rumours that it's not he who impregnated his wife. This seemed possible because of his night shift work. In both cases, the situation was resolved. Men's doubts, denial or disputes of pregnancy are generally based on the credibility of the woman, questioning her moral or drinking behaviour, infidelity and spiteful intentions. In the event of denial by the man, the families wait for the birth of the baby, when the man's family may scan the infant for family resemblance (Nduna, & Jewkes, 2012).

Sub-theme: Intimate partner violence

A study conducted by Eaton et al. (2012) in impoverished townships in the Western Cape reported that pregnant women live in environments where alcohol intake during pregnancy has become normalised and intimate partner violence (IPV) is reported at high rates. This is similar to the research findings of this study which was conducted in an impoverished township in the Eastern Cape. Almost all participants reported that pregnant women who consumed alcohol at harmful levels experienced intimate partner violence:

Extract 23

She found out that she was pregnant. Her man was beating her up. They will fight, and people will call us (Liso, Family member).

Extract 24

At that time, she was not listening and used to drink. She got pregnant again, our second born. She did not want to stop drinking. Even when her tummy was big, she did not stop. She would

fall in the streets drunken. Sometimes I would be so angry and end up beating her unintentionally. This was hurting me, and she became worse after birth (Luvo, Partner).

Extract 25

My father was still around at that time. They loved fighting. Those were the things we would experience when they are drunk, they will shout at each other and fight. You see... my father was beating her while pregnant, but nothing happened to the pregnancy. But she would drink, drink, drink although she was pregnant. You see (Jade, Family member).

In Extract 23, Liso reported that the partner of the pregnant woman was beating her, and people would call the pregnant woman's family to resolve the fights. In Extract 24, the partner self-reported that he would be so angry that he would end up beating his wife unintentionally because she was not listening and drinking in pregnancy. Additionally, in Extract 25, Jade stated that when her parents were drunk, they loved fighting. Her statements suggest mutual intimate partner violence.

Shneyderman and Kiely's (2013) study conducted in Washington found that when one or both partners abused alcohol, there were significantly higher rates of IPV experienced by women. Also, a study conducted in South Africa highlighted that alcohol use among expectant fathers is a factor that is associated with a greater likelihood of perpetrating IPV against pregnant women, and that alcohol use among pregnant women is associated with greater likelihood of experiencing IPV (Eaton et al., 2012). Thus, it is clear from the study that alcohol use by partners or pregnant women is a risk factor for experiencing intimate partner violence.

Family members and partners reported that intimate partner violence against pregnant women was caused by jealousy:

Extract 26

I am a jealous person. That must be clear. A man must not say something that does not sit well with me to my wife. So, it was those challenges that made me raise my hand to her (beat or hit her). She applied for a protection order. I accepted it, but I took it lightly when I was drunk (Lunga, husband).

Extract 27

She would drink brandy, beer and wine. And she was always fighting with her husband. They would argue and fight. She is a violent person; she will take everything seriously more especially when she is drunk. [What were the fights about?], She would fight because of jealousy, her husband loved women and they would fight about that (Nazo, Family member).

Extract 28

I was suspicious. When she was away from home, we would fight about that. We would fight because maybe I would also be drunk. When we are not drunk, I would be free but once I

drank, I become angry about what I saw (his wife drinking with other men). We stayed together. We would beat each other, and we were still living in the village then (Khaya, Partner).

In Extract 26, Lunga stated that he is a jealous person, he gets triggered, he beat his wife to the extent that his wife applied for a protection order against him. Similarly, in Extract 27, Nazo described the pregnant woman as someone who was violent especially when she is drunk. Also, she reported that she would fight with her husband because of jealousy. Additionally, in Extract 28, the partner stated that they will fight because of his suspicions, when he is drunk, and because of he saw his wife drinking with other men.

The above extracts demonstrated that episodes of intimate partner violence are often triggered by jealousy and suspected sexual infidelity. Likcani, Stith, Spencer, Webb and Peterson (2017) defined jealousy is a form of emotional fusion. At its most severe, jealousy illustrates intolerance for boundaries and separateness from loved ones. Jealousy occurs when one or both partners feel that their relationship has been threatened. This threat often revolves around concerns of partner infidelity and unavailability. Whether the infidelity is real, suspected, or just feared, men and women might use violence to dissuade their partners from being unfaithful or from leaving the relationship and to retain control over reproductive activity (Kaufman-Parks, Longmore, Giordano, & Manning, 2018).

Sub-theme: Infidelity

Family members and partners indicated that men cheated on the pregnant woman in pregnancy and that pregnant women were rejected for another woman:

Extract 29

Ahhhhh firstly, what happened was... when I was in a relationship with her... I impregnated someone else, but we were not married then. So, what happened is she found out about that. This affected my partner and pushed her to get pregnant as well. That was not our agreement for her to get pregnant. So, as time goes, she told me she was pregnant, and I understood maybe the reason it's because of the other child. I stopped seeing the other lady, but the child grew. So, we have a child together and I think this situation is one of the reasons that she drank too much alcohol in pregnancy. Because she was stressed most of the time. This was one of the many reasons she drank too much (Jonga, Partner).

Extract 30

[You mentioned that after finding out she was pregnant; her boyfriend would beat her up. How did that affect her?] It affected her... because the boyfriend did not want her, and she was forcing herself onto him. She took time to realize that her boyfriend did not want her. When she found out he was cheating, she would go and fight with the other woman. Even

though she saw that her boyfriend did not want her, people would call us to come and stop the fight. And people would insult her and laugh at her (Liso, Family member).

In Extract 29, the partner mentioned that he impregnated someone else while he was in a relationship with the pregnant woman. He said that his partner got pregnant too to compete with the other woman. He interpreted this situation as one of the reasons the pregnant woman drank too much in pregnancy because this was stressful for her. In Extract 30, the family member said that the pregnant woman was affected by the infidelity and rejection from her partner. She was in denial at first and it took time for her to accept that her boyfriend did not want her. Infidelity is defined as a sexual and/or emotional act by a person who is in an intimate relationship, with this act occurring outside the primary relationship. There is a breach of trust and/or violation of the rules agreed by the couple (Scheeren, Apellániz, & Wagner, 2018).

Sub-theme: Drinking habits of partners

A factor concerning alcohol intake among pregnant women is the drinking patterns among expectant fathers. Although alcohol intake among expectant fathers is not routinely assessed, their alcohol use patterns may influence that of their partners (Eaton et al., 2012). Partners stated that they used to drink with their pregnant women even though women did not drink as much as they did:

Extract 31

She would drink over weekends. For example, when I am drinking over the weekend, she would have few glasses. She was not drinking to get drunk (Jonga, Partner).

Extract 32

She used to drink at that time, but it was me who drank most of the time (Khaya, Partner).

Extract 33

We used to drink together before she was pregnant until marriage. We got our first born. In our first born there was no issue because we recently got married and she was still staying with my family then. But, for the second born she drank so much. As a result, the unborn child died in her tummy. Then, we had our third born, she was drinking but we had no issue. Also, with our forth born and last born she was drinking while pregnant. She drank alcohol in all pregnancies. Then, we had issues in our marriage, I took a decision that there must be one person who stops drinking between the two of us and I stopped. She continued drinking and she is still drinking even now (Lunga, Partner).

In Extract 31, Jonga defends his partner by indicating she would drink over weekends when he was drinking, but she would not get drunk. In Extract 32, Khaya similarly problematised his drinking

compared to hers. However, in Extract 33, the participant said that although they used to drink together before marriage he eventually decided to stop. Van der Wulp, Hoving, and de Vries (2015) called this partner modelling, referring to the partner's own alcohol use during the woman's pregnancy. This implies that the partner's alcohol use may have an influence on the pregnant woman's alcohol use in pregnancy, more especially when the partner drinks in the home environment.

Sub-theme: Friends' drinking habits

Family members and partners indicated that pregnant women's friends' drinking habits appeared to play a pivotal role in drinking during pregnancy:

Extract 34

My sister's friends, they pushed her to go out and drink alcohol and I noticed that she was also smoking dagga (Lulu, Family member).

Extract 35

She would go out with her friends and drink. When she was drunk her friends would take her home (Kuhle, Family member).

Extract 36

Her friend drinks so much. Even when she works, she works for alcohol. She said that I don't want her, and she would bad mouth me. But I chose not to care because I know where I come from (Luvo, Partner).

Extract 37

Yes, she used to go out with her friends and they were all pregnant... *they were all pregnant*. One of her friends gave birth to a premature (baby) and the rest of the babies are okay. They used to all go out together (Lumka, Family member).

Extract 38

After she decided to leave me, she moved to her home. When she got there, her friends interfered, the ones who influence her to drink. After she was back to drinking with no one controlling her, she applied for a protection order against me (Lunga, Partner).

Family members and partners believed that friends had influence in the drinking of pregnant women. In Extract 34, the participant said that friends pushed the pregnant woman to go out, drink alcohol and smoke dagga. In Extract 35, Kuhle did not see friends as a bad influence specifically. Instead, she mentioned that the pregnant woman would go out with friends to drink but, positively, when she was drunk, her friends would bring her home. In extract 36, the partner said that the pregnant woman had a friend who drinks a lot implying a bad influence that led to bad behaviour. In Extract 37, the

family member said that the pregnant woman used to go out with her friends to drink and they were all pregnant. In Extract 38, Lunga reported that after his wife left him, her friends influenced her to drink. She went back to drinking as no one was controlling her drinking behaviour, implying that he used to control it when they were together.

Van der Wulp, Hoving, and de Vries (2015) refer to partner norms in relation to drinking but in this case, I will refer to friends' norms: pregnant women are more likely to use alcohol during pregnancy when they think that their friends agree with this decision. Family members and partners indicated that friends encouraged and supported the drinking behaviour of pregnant women even though the friends were knowledgeable of the pregnancy. Likewise, a study conducted in Cape Town showed the influence of peer networks on encouraging prenatal alcohol use. Participants reported that their friends encouraged the pregnant women to attend bar sites and created social environments where alcohol use is promoted (Watt et al., 2014). This implies that having friends that see nothing harmful with alcohol use in pregnancy encourages women to continue drinking despite healthcare professional recommendations to reduce or abstain from alcohol use in pregnancy.

Two participants, however, believed that, despite peer influence it was the decision of the pregnant women to drink or not to drink in pregnancy:

Extract 39

Yes, friends had an influence, but it was her decision entirely. She wanted to drink while pregnant. In most cases, people do not drink alone, they drink with friends. Even when someone buy drinks to drink at home, she would still want to go out to be with people. When she has alcohol, she invites her friends. Also, her friends invite her when they have drinks. It's like that (Jade, Family).

Extract 40

It's her decision, she is the one who goes to her drinks and drinks. It's not her friends that come to her. I used to hate her friends and fight with them, but I decided to stop because it's her who goes after them (Luvo, Partner).

This family member and partner implied that even though there was peer influence, it was fundamentally the pregnant woman's decision. In Extract 39, the participant recognised that friends did have an influence because most people want to drink with other people. However, it was the pregnant woman's decision, she drank in pregnancy because she wanted to. Likewise, in Extract 40, the participant said that it was the pregnant woman who went out to drink with her friends. It was not her friends that come over to her. Therefore, it is her who took the decision to drink in pregnancy.

Sub-theme: Drinking habits of family members

According to the participants, most family members' interaction with the pregnant women revealed support of abstinence from alcohol during pregnancy. However, two participants mentioned that when the pregnant woman visits her family, she would come back drunk:

Extract 41

When she goes to visit her home, she starts drinking because they all drink at their house. She would come back drunk. Even this year when she went, she came back drunk and broke some windows (Luvo, Partner).

Extract 42

She would go out and visit her home. When she was there, she would have fun (drink) with friends. When I went to her home, I would see that they are having fun with her friends and other men (Khaya, Partner).

These two partners indicated that the women were from families where it was the norm to drink while pregnant. In Extract 41, Luvo mentioned that sometimes his partner reduced her alcohol use but when she visited her family she started from where she left off. A study conducted in Washington found that family members who drank while pregnant and did not see it as harmful to their children, and saw their personal experiences as evidence that drinking does not harm to the foetus. They, therefore, thought it was acceptable to drink while pregnant (Elek et al., 2017).

Sub-theme: Drinking establishments

Family members and partners indicated that the high number of shebeens exacerbated alcohol use in pregnancy, especially those that operate without licences because everyone is allowed entrance including pregnant women:

Extract 42

Many women drink in pregnancy. There are many shebeens (Nazo, family member).

Extract 43

There are so many of them (shebeens). The ones with licenses, they don't allow you in if you are pregnant because they have people at the door. If they don't notice that you are pregnant, they do allow you. If they notice, they take you out. They did not notice me because I am big, and my tummy was not showing. But the ones with no licenses, everyone is allowed even children. Age does not matter. If you have money you can go into the tavern (Lulu, family member).

Extract 44

There are a lot of people who drink in pregnancy. For example, we sit with them at the Tavern, and we will tell them, they not supposed to be there. But they will say we should leave them alone; they are there to relieve their stress. There is a belief among them that when you drink Smirnoff, it helps somehow with pregnancy. I don't know how (Jonga, Partner).

In Extract 42, Nazo claimed that majority of women drink in pregnancy because there are number of shebeens. In Extract 43, Lulu (who also drank in pregnancy) refers to the lack of control in informal shebeens. In Extract 44, Jonga describes how community members attempt to regulate pregnant women's drinking in these entablements but with no success. Therefore, a plausible explanation for drinking trends lies in access (Ramsoomar, & Morojele, 2012).

Sub-theme: Criminal Justice System

Rape is one of the most devastating of personal traumas. And, just when they most need support, many rape survivors feel alone and let down by the institutions that supposedly exist to protect them (Naidoo, 2013). A family member indicated that the failure of criminal justice system exacerbated alcohol use in pregnancy:

Extract 45

She was raped by someone we know, who stays in our area. He raped her and ran. When we arrived... because he knew, we will not know what to do because our big brother is a person who smokes drugs, he does not care about anything. As the older sister I had to be the one who comes up with a plan when we are in trouble at home. She was raped, and we decided to go to police station because we did not know what to do and when we got there to report. After reporting, ___ (name of policeman) who was a police officer there said to my sister "she must follow him". When they got to his office, he asked to see where she got raped. Only to find out he raped her as well. He was working as a Detective at the police station and he said if she tells anyone that he raped her, he will do something about her (Lulu, Family member).

In this extract, the participant reported on how the criminal justice system failed her sister when she went to report her rape case. She was raped again by someone she trusted to help her to get justice. Watson (2015) argues that in the South African context, the police's ability to deal effectively with sexual offences must be located within the broader context of low public confidence in the police. In 2013, the police disclosed that an internal audit had revealed that 1 448 serving police officers were convicted criminals. Sexual offences victims need to be treated with sensitivity and empathy. The police are often the victim's first point of contact with the criminal justice system, which sets the tone for the rest of the engagement with the system. Failure to provide the services victims need produces secondary trauma.

CONCLUSION

In this chapter, I discussed the partners' and family members' renditions of alcohol use in pregnancy at the individual, pregnant woman level. Also, I discussed the direct interaction pregnant women had with the people closest and how these interactions supported and encouraged abstinence and reduction of alcohol use in pregnancy, as outlined by partners and family members. Lastly, I outlined how these interactions with microsystem were reported as worsening alcohol use in pregnancy. The following chapter will discuss larger contexts *a priori* themes namely mesosystems, exosystems, macrosystems and chronosystems and under each *a priori* theme there are sub-themes that emerged from data collected.

CHAPTER 6: LARGER CONTEXTS

This chapter will provide a description of findings based on larger contexts *a priori* themes that emerged Ecological Systems Theory namely mesosystem, exosystem, macrosystem and chronosystem. I will do this by discussing sub-themes under each *a priori* theme that emerged from the data collected. The main aim is to report on findings and explain the implications of the excerpts from narrative interviews using literature to demonstrate the themes.

A PRIORI THEME: MESOSYSTEM

The mesosystem refers to relations between microsystems or connections between these contexts (Christensen, 2016). Sub-themes under the mesosystems are: family and teachers, family and social workers, family and drinking establishments, partners and friends, partners and “other men”, partners and the criminal justice system, partners and the antenatal clinic, partners and church, and police and drinking establishments.

Sub-theme: Family members and School

Pregnancy can result in a detour in the education of young women with some deciding to stop their schooling while others are interrupted and later decide to return to school to complete their studies (Matshotyana, 2010). Family members of women who got pregnant at school reported that these women dropped out of school and did not return:

Extract 1

This is what happened when she was pregnant... she was all over the place, she did not want school. I decided to change her from a black school to a coloured school. Then, I transferred her to coloured school and I paid school fees but still she was not attending school. I had to call and ask if she did come to school. I went to school to check for her on the register. When I checked the register, in one month she went to school for 8 days. So, I worked together with the teachers to ensure that she goes to school. But she stopped going to school, she disappeared (Lumka, Family member).

Extract 2

I called my husband, he is not their father but loves them. I called him, and I told him that I will stay for a while because I want to see what's wrong with this child because she is drinking and dropped out of school. When I went to the school, the principal said, he does not know that she does not stay at home. He gave her a letter to give to her parents because they found her and her friends in the school toilets with a bottle containing alcohol. Then I called a meeting for their parents to find out why their children are behaving like this (Linda, Family member).

In Extract 1, Lumka speaks about her interactions with school. She transferred her daughter to a different school. She went to the school to check on the register and worked together with teachers to ensure that her daughter attended school. But she (the daughter) stopped going and disappeared. Also, in Extract 2, Linda reported that she went to the principal to discover that her daughter was suspended from school because she brought alcohol on to school premises. A failure in communication occurred when the pregnant woman did not pass on a letter from the principal. The interruption of schooling that may accompany pregnancy is seen as problematic in South Africa as it may limit the young mother's future career prospects, thereby contributing to a lower socio-economic status for her and her child (Ramulumo, 2014). Thus, interactions between the school and parents are important to ensure continued attendance.

Sub-theme: Family and Social Workers

Family members indicated that after birth previously pregnant women continued to drink. As a result, they would leave their children alone to drink at drinking establishments. This resulted in family members asking for the assistance of social workers:

Extract 3

After birth we stayed and stayed, and things seemed to be okay, but she started where she left off and drank. Look at her child... she got burned, she was with her. If you can ask her now, who burned her she will tell you. I took the child from her because she went out and drank. I stay with the child. Last week I went to social workers to tell them that ____ (name of her daughter) left with the [social] grant card and she went back to Cape Town. I asked social workers for help because she will not get the child again (Linda, Family member).

Extract 4

I found out the mother of the child was drinking. We took the child from her because she would leave the child alone to drink. The child came to me with social workers, so we can see the problem of this child comes from the mother drinking in pregnancy (Nazo, Family member).

These family members indicated that children were taken away from their natural parents because the parents are unable to care for the child due to alcohol use. Consequently, in Extract 3, the child got burned because the woman went out to drink and left the child alone. Linda went to social workers to seek help so that she could become the caregiver. Similarly, in Extract 4, Nazo reported that she found out that the previously pregnant woman was drinking. As result, social workers organised for her to care for the child. The law can declare a person unfit (legally unsuitable) to look after a child.

A social worker must supervise the relationship, and check that the child is being given enough care. If the parent does not care for the child, the child may be removed from the parent (“The Rights of Children”, 2010).

Sub-theme: Family and Drinking establishments

One family member reported that drinking establishment owners sold alcohol on credit to her child who are still at school. She then intervened:

Extract 5

I asked her (woman who sells alcohol) for her phone. I asked her, how can she give a school child alcohol and expect her to pay? What will she pay with? Because she is not working (Linda, Family member).

In Extract 5, Linda reported that she asked for her daughter’s phone from drinking establishment owner who took it because her daughter could not pay for alcohol. She questioned why the owner would give a child who is still at school alcohol on credit. The minimum drinking age is 18 in South Africa, which is in line with international practice (Marara, Rath, Sharma, Bosman, & Srinivas, 2016). Yet, Linda indicated that the law on no selling of alcohol to children under 18 is not fully enforced. This means that family members have to intervene.

Sub-theme: Partners and Friends

Partners indicated that pregnant women’s friends influenced them to drink and go out with to have fun with other men:

Extract 6

She went back to Joburg. Then when she got there, she changed her clothing. She did not dress like a (Xhosa) married woman and she started going clubbing. She came back, and we forgave each other. Then, her friend that was with her in Joburg came. I arrived while they were talking about things, they did in Joburg. I asked why they are changing the topic when I arrive, but they were talking about Joburg... I told her friend that she does not belong in our house and she is not married. If they wanted to meet and talk why she (his partner) did not go to her friend's place instead. Her friend and I argued. They were drunk, and I slapped her (Lunga, Partner).

In Extract 6, Lunga reported that his wife moved to Johannesburg, (where she behaved inappropriately and dressed and behaved not like a Xhosa married woman). He told her friend that

there is no place for her in their house and she is not married implying that she should not be friends with his wife. A study conducted among South African women attending drinking establishments reported that most women drank with their friends (Watt et al., 2014). Here we see conflict between two microsystems (partner and friend).

Sub-theme: Partners and “Other Men”

Partners reported on conflict resulting from the women’s interactions with other men. One partner reported that he felt suspicious when the pregnant woman drank with other men:

Extract 7

When I went to her home, I would see that they are having fun with her friends and other men. I would see her with other men outside. She not with just girls, she was with other man and that made me suspicious that they could be something going on (Khaya, Partner).

In Extract 7, Khaya indicated that he felt that his relationship with the pregnant woman was threatened when she drank with other men. This made him suspicious, which had implications for how he interacted with his partner. As indicated by other researchers whether such concerns are anticipated, the resulting jealousy may lead to further distress, conflict and aggression within the relationship (Kaufuman-Parks et al., 2018).

Also, one partner reported that when his wife slapped him in front of “other men”, which challenged him to fight back:

Extract 8

The last time we fought I was arrested. When I got there (shebeen), she was there sitting on a table with her friends and men. I went to her and asked her what she is doing? I called her aside. We went outside, and her friends followed and asked, “Where she is going? They are drinking” and then a man from the table asked, “Where is she going”. So, she said, I am drawing attention to her and slapped me. I left her but what made me fight back is that people laughed at me. After, one of the guys she was sitting with there said “Tyhini!! his wife is beating him”. That challenged me so hard and I fought back. And the next thing I was at the police station. I was arrested. When I was arrested, the magistrate sentenced me for five years or one year in prison. So, I was sentenced last of last year. Till today, I chose to stay away from her, stop drinking and go to church (Lunga, Partner).

Lunga reported on using violence against his partner when he was questioned by other men. He had already stopped going to her house because he was on a protection order but on that day, he heard a child crying loudly and it was his child. He found his wife drinking with her friends and other men at

a shebeen. He reported that he did not fight back at first when his wife slapped him, but when people laughed and the man from the table remarked on his wife beating him, his masculinity was challenged. Next thing he was arrested. Intimate partner violence has been framed in terms of men's need to maintain power and control in society and at home, a power system in which men are dominant and women are subordinate (Hines, & Douglas, 2010). Those who step out of line (e.g. allowing a wife to beat him) are called out by others.

Sub-theme: Partner and Criminal Justice System

Partners indicated that prison disciplined them, and they do not want to go back. Sometimes partners do get tempted to beat their pregnant women, but they try not:

Extract 9

After prison I was scared of breaking the law, even now when she is drunk. Even if I am tempted to beat her (Khaya, Partner).

Extract 10

I lived under the circumstances and I always remembered that I am from prison, I don't want to go back because prison disciplined me, and I became a preacher. So, I lead a church and I tried bettering her (Luvo, Partner).

Extract 11

I would like to teach others that alcohol, dagga, drugs and being a thug does not build you. It holds your future and pauses your life. Even though they say you learn in prison, yes you do, and I also did, but it hits you that you are in prison. I schooled there up to standard 8. I left here with standard 5 (Khaya, Partner).

In Extract 9, the partner indicated he was tempted to beat his wife but after prison he is scared to break the law again. In Extract 10, Luvo said he lives under circumstances of having a wife who drinks, but his memory of prison led to his trying to better his wife by encouraging her to stop drinking. In Extract 11, the participant said that prison bettered him: he would like to teach others that alcohol, dagga and other drugs and being a thug does not build you. This resonates with the argument of the effectiveness of rehabilitation interventions that target specific behaviour with the purpose of reducing the likelihood of the offender reoffending and achieving the goal of reintegration of offenders into society (McAree, 2011).

Sub-theme: Partners and Antenatal clinic

Healthcare provider focus often rests solely on a pregnant woman, while a woman's partner may prove to be an ally in a pregnant woman's health behaviours (Cohen et al., 2016). One participant reported that he accompanied his partner to the antenatal clinic and he waited in the waiting room while the pregnant woman participated in health talk and consultation with the healthcare provider:

Extract 12

[You mentioned you would go to clinic with her? How was the experience for her and you? What are her thoughts about clinic visits and healthcare providers?]. At the clinic, I would wait for her in the waiting room. I would not go to nurses with her and hear how things are going. But I would hear from her afterwards (Jonga, Partner).

In Extract 12, the partner indicated that he was not included nor encouraged to participate in the health talk and consultation with the healthcare provider and the pregnant woman. He waited in the waiting room and heard from the pregnant woman how the developing foetus is afterwards. This indicates how childbirth and child-care are still regarded as exclusively women's affairs as in many other patriarchal societies. Men generally do not accompany their wives for antenatal care, neither are they expected nor encouraged to be in the labour room during delivery (Sokoya, Farotimi, & Ojewole, 2014). This implies that health professionals do not facilitate this participation.

Sub-theme: Partners and Church

Partners described church as a supportive space that helped them to stop physically abusing pregnant women. It helped them to stop drinking and encouraged their pregnant women to reduce alcohol use:

Extract 13

I stopped drinking and I am going to church. Some things I have moved away from. Yes, it's helping me 100% because it keeps me busy. Before I was busy partying on weekends, but now I am busy with church. During the week, I am busy looking for greener pastures, where can I live, and I play golf. I play golf from Wednesday to Saturday, Sunday I got to church. After church, I chat with people I go to church with. Like today, I was chatting with one of the ladies I go to church with about what happened Sunday. So, she could not go because she helps people with their problems. Church is helping me 100% but I don't want to take people to church. I want people to see change in me and decide to go to church. I do not rush my change, and I don't force my beliefs on people. There are steps at church, for example you move from this position to another up to a pastoral position so there is nothing that can pull me back (Lunga, Partner).

Extract 14

This was hurting me, and she became worse after birth. So, I thought she would change if I go to church. I joined Zion because it was a church I would dream about now and then. When I got there, it did not have many people. On the third week I asked them to visit my house at night. She was revived, and she stopped drinking. After three months I got promoted at church as a preacher. In prison there was church, so I knew Bible verses. I was a preacher and we both went to church for a while, but she went back to alcohol again (Luvo, Partner).

Extract 15

But when I was not a church going person, I used to shout at her and swear at her and beat her when she comes home drunk. But I stopped, I told myself that she is my wife and God sees. I stopped beating her (Luvo, Partner).

Extract 16

What I love about my church is they tell you something and give you things that could help you. You buy them yourself... candle, water, Vaseline. Your candle is your protector, friend and neighbour. You tell your problems to the candle (light a candle and pray). As I am here, I know what happened to my marriage and who ruined it (Lunga, Partner).

Two partners indicated that religiosity, church attendance and religious commitment helped in reducing and abstaining from alcohol use. In Extract 13, Lunga indicated that church helped him to stop drinking alcohol. Instead of going out to party on weekends he goes to church. He keeps busy with church, golf and job hunting. Likewise, in Extract 14, Luvo stated that when he asked his church to visit his house, his wife was revived, she stopped drinking. Additionally, in Extract 15, the participant stated that before he started going to church, he used to physically and verbally abuse his wife when she came home drunk. But he stopped, when he started going to church. This suggests that religious messages that discourage alcohol use might help pregnant women and their partners to stop drinking. In Extract 16, Lunga described church as a supportive space where they do not just preach but give you solutions to your problems. Kim (2018) states that frequency of religious service attendance is a protective factor of alcohol use disorders and intimate partner violence. Most religious beliefs' doctrines emphasize harmonious marriages and family relationships and they also encourage refraining from certain behaviours that might cause conflicts between intimate partners, such as drinking alcohol. Thus, religion can play a positive role in preventing intimate partner violence and reducing alcohol use.

Sub-theme: Police and Drinking establishment

Participants reported that there are many shebeens in their community, the majority of which are illegal. When police conduct inspections, they do not reach illegal shebeens that are situated in informal settlements. And those they are able to reach and close down reopen:

Extract 17

Yoh!! people drink so much here because we have MANY shebeens. You see the shacks behind these houses (points in the direction of houses). In one area we have about 4 shebeens and police do not go there to close them down. So, people here drink. Most shebeens are illegal. Those are the ones police do not go to. The shebeens do not close and everyone can buy alcohol from them, even pregnant woman (Jade, Family member).

Extract 18

There are many shebeens that operate 24/7. Police come and close them, and they open again. There are too many shebeens here, they don't close, our kids dance until the morning. This area is worse: it's like there are no police and schools. Other places are better, but this is worse. it's like we are under earth. Even crime that happens, it happens in the shebeens. Our kids are young but live on the streets, even under 18 children drink and have access to alcohol (Nazo, Family member).

The South African Police Service has in recent years made concerted efforts to increase its focus on the enforcement of liquor related legislation (Faull, 2013). Yet, in extract 17, Jade reported that there was many shebeens in their area, most of which sell alcohol illegally. When police do inspection, they do not go there to close them down. In Extract 18, Nazo reported that police do come and close shebeens, but they open again.

A PRIORI THEME: EXOSYSTEM

The exosystem contains systems that have a profound influence on alcohol use, even though pregnant women are not directly involved in them (Christensen, 2016). The one sub-theme under exosystem is the lack of compliance of shebeens with liquor regulations, and the lack of enforcement of these regulations.

Sub-theme: Lack of compliance of shebeens with liquor regulations

All participants reported that the lack of compliance of shebeens with liquor regulations influenced alcohol use in pregnancy:

Extract 1

People use alcohol beyond measures, I can count the shebeens I have been with women who are pregnant or still breastfeeding. There are so many shebeens here, they sell to children. I could send a child now to go and buy alcohol and you will see if they don't come with it. Young children at the age of 9-10 years can buy alcohol. I can count shebeens that have licenses but most they don't have licenses (Lunga, Partner).

Extract 2

What I see is... There are children at the age of 10-11 years who can go and buy alcohol. People here care about money; they don't care if you young. There are just few big ones that do not allow children but majority of shebeens they allow children. Majority of shebeens operate without licenses and the number of shebeens without licenses is higher than the ones with licenses (Luvo, Partner).

Participants in Extracts 1 and 2 indicate that there are many shebeens in one area, mostly operating without licence, and selling alcohol to everyone including children and pregnant women which is not in line with Eastern Cape Liquor Act 10 of 2003. The Eastern Cape Liquor Act 10 of 2003 limit alcohol availability through laws and regulations that proscribe sales to underage youth; distribution, or sales of alcohol; and reduce physical access to alcohol by reducing numbers of outlets or limiting hours and days of sale (Gruenewald, 2011). When liquor distributors or shebeen owners do not comply with these regulations, it affects community members who do not have direct influence on policies and decisions, or on the regulation and compliance with these policies. Without regulation and compliance, these restrictions on availability may not be effective for reducing alcohol abuse and related problems such as alcohol use in pregnancy.

A PRIORI THEME: MACROSYSTEM

The macrosystem differs fundamentally from the other levels of context, embracing the institutional systems of a culture or subculture such as the economic, social, education, legal and political systems (Rosa, & Tudge, 2013). In other words, the macro-system describes the overall societal culture in which pregnant women live. Under the macrosystem there are following sub-themes: religious beliefs, cultural beliefs, gender norms, crime, child-headed households, transitional sex and socioeconomic status.

Sub-theme: Religious Beliefs

Participants stated that they found comfort and strength in telling themselves that God knows, and He sees their circumstances:

Extract 1

I am someone who quickly comforts herself and tell myself it's God who knows I am not okay (Lumka, Family member).

Extract 2

I am thankful that this (alcohol use) did not send him to where it sent me (prison). So, I am thankful that God made him successful. I am thankful for God's strength in everything (Khaya, Partner).

Extract 3

I used to shout at her and swear at her and beat her when she comes home drunk. But I stopped, I told myself that she is my wife and God sees. I stopped beating her (Luvo, Partner).

Extract 4

But I took it as I am not sick. Its God who knows. I gave my everything to God (Luvo, Partner).

Family members and partners indicated that they used religious coping as a way of dealing with negative life events. Adam and Ward (2016) argue that religious coping refers to the use of cognitive-behavioural techniques to manage stressful situations in light of one's spirituality or religious beliefs. For example, in Extract 1, Lumka indicated that she quickly comforts herself by reminding herself that God is all knowing. In Extract 2, Khaya spoke about how thankful he is to God for not sending his son to where alcohol sent him (prison) and for the strength God gave his son to be successful. In Extract 3, the partner described religious beliefs as helpful in coping with the drinking habits of his wife and stopping him from emotionally and physically abusing his wife. In Extract 4, the Luvo indicated that he used religion to cope with being diagnosed with HIV. This demonstrates positive religious coping strategies, which are based on macrosystemic religious beliefs, such as reinterpreting a stressor as salutary, treating God as the partner, seeking and appreciating God's love and care (Xu, 2015).

Sub-theme: Cultural Beliefs

Family members and partners explained how they understand the events that were important to them and pregnant women during pregnancy and the drinking behaviour of pregnant women in terms of culture:

Extract 5

She came this side. Then she was married to me. After she changed, and we fought, she went back to Joburg. Then when she got there, she changed her clothing. She did not dress like a (Xhosa) married woman and she started going clubbing (Lunga, Partner).

Bongela (2001) argued that every member of the African society is living under a set of rules which govern conduct, behaviours, morality and teach him or her the cultural norms of society. For example, the partner in Extract 5 suggested that changing your cultural clothing as a Xhosa married woman is an indication of changed behaviour. Hence, the pregnant woman started clubbing. A Xhosa woman wears a dress made of German print known as *ijelemani*. She wears a kind of apron known as *ifaskoti*

on top of the dress. She ties a towel around her waist and she covers her shoulders with *ixakato* (small blanket). Lastly, she covers her head with black headgear with white line; this is known as *ikheshemiya* (Bongela, 2001). However, Xhosa women no longer stick to this attire. They wear dresses, headgear of their own colour and make use of the fashionable clothes of the modern times to the extent that there is little difference between married and unmarried women who go bare headed, with short dresses, pants and other fashionable clothing (Bongela, 2001).

Mlisa (2009) argues that belief in the witchcraft is an aspect in the African cosmology of illness. Historically, the amaXhosa believed in *ubugqwirha* (witchcraft) as one of the main causes of illness and misfortunes. These beliefs are seen in the extracts below:

Extract 6

So, I don't believe what black people say that the baby was killed by someone. She was drinking, I will not believe that it's witchcraft and jealousy etc. You are going to say it is witchcraft but what about alcohol? It takes its place too. Because they (Doctors) said that the heart of the baby was beating slowly (Lunga, Partner).

Extract 7

She got pregnant again, but her pregnancy failed. We discovered that the child was taken (meaning there was witchcraft involved hence stillborn). She fell on something hard and she had seizures. That's how she lost the baby. That's how the child was attacked. The fights happened in daylight and the child was taken at night by an evil spirit. People who are looking will say it's me who harmed her. They wanted that chance. She did not even go to hospital, after you have seizures you normally lose your consciousness. I used to have seizures before, you don't know what happened or how you got where you are. But with her, she remembered everything. We talked about what happened and her mother was there too. she asked her why she is talking with people who are not married, what if they are jealous of her position (marriage). She listened. After a person has seizures, it takes time to get back to normal but with her it did not take time. This proves that what happened had to happen. When she went for check-ups, the child did not have any injuries and was healthy. The child died healthy and they don't know how it happened. We went to traditional healers. They told us the child was taken by one of the people she goes out with (Lunga, Partner).

In Extract 6, the participant reported that people said that his wife had a stillbirth because someone bewitched her. But he refused to believe that. However, in Extract 7, the participant contradicts himself by stating that they discovered that the child was taken through witchcraft and that's why his wife had a stillbirth because someone was jealous of their marriage. In Extract 7, he furthered stated that people will say that it's him who harmed her. The explanation of witchcraft, confirmed by traditional healers, provides a counter to this accusation.

Moreover, Lumka spoke of conflictual space created by a possible calling to become a traditional healer:

Extract 8

I stopped talking about school because she does not want to hear that. My parents said maybe she is sick with *umshologu* (spiritual madness). But I told them, she cannot be sick at school. *Umshologu* is a Xhosa thing, school is western, what does *umshologu* have to do with school (Lumka, Family member).

Extract 9

A person with *umshologu* (spiritual madness) is someone who has a calling to be a traditional healer. Her grandmother said it could be *umshologu* because when you are about to become a traditional healer your behaviour drastically changes, and you don't listen. For example, I send her to school and she bunks school, she is not married and gets pregnant. These things sometimes when they happen in the Xhosa culture they lead to the calling. My mother said her behaviour is leading to this calling, but I said to her. I rebuke this. Her grandmother said these are the signs of a road leading to be a traditional healer: she will walk barefoot and beat the drums and do traditional Xhosa dance. She is going somewhere. I said may God help me because if she gets there, I will have to be responsible for that and I have no cows. That will require cows and goats to be slaughtered for her to accept her calling. Let's take it as if it's something of this generation [her age group] and it will pass, and she will be fine (Lumka, Family member).

In Extract 8, Lumka's parents explained the pregnant woman's behaviour of bunking school as her being sick with *umshologu* (spiritual madness). *Umshologu* is a description of a person's behaviour before they undergo the process of *ukuthwasa* (becoming a traditional healer). *Ukuthwasa* is a spiritual journey that is specifically designed by ancestors for those who are endowed with the gift of healing by their ancestors (Mlisa, 2009). In Extract 9, the participant explained *umshologu* as a drastic change in behaviour, for example, suddenly someone does not listen, bunks school and gets pregnant outside marriage. This is because amaXhosa define *ukuthwasa* as an inborn gift that manifests in afflictions and crises as a person grows. In turn, afflictions and crises are viewed as normal processes to force a person to accept *ubizo* (the calling) as well as to train the person how to deal with the hardships of the others. Sometimes *ukuthwasa* involves signs that resemble madness, such as hallucinations and illusions. Due to these characteristics it is known as *inkenqe* (cultural madness), or *umshologu* (spiritual madness) (Mlisa, 2009). Lumka, however, wishes to distance herself from this explanation owing to the cost involved.

According to Bhat (2014), the Xhosa speaking people use wide range of remedies to treat diseases and illness. In the following extracts, Lumka refers to this:

Extract 10

There are many Xhosa things. Maybe she jumped over something or something is sucking her breasts while she is breastfeeding the child. Then she stopped breastfeeding. So, I buy everything (bottles, clothes, nappies, milk, etc) for the child (Lumka, Family member).

Extract 11

[You said you used to stop her from going out at night because she might jump over something that is unsafe or unclean that may cause complications. Can you tell us more about that?] I used to... from walking at night. Because there are people who use traditional medicine for luck, people who do not wish others good. People get wrong traditional medicine. There are things like that, you walk and step on those things. Your child changes colour to green because of stepping on things you should not. When you are pregnant, you must stay at home and take care of yourself. People use medicine to vomit and when you walk around and come across that, it might negatively affect your unborn child (Lumka, Family member).

In Extract 10, the participant stated that there are Xhosa things (Xhosa remedies) that women should be careful of while pregnant such as when your breasts are not milking, it could be that some evil spirit is sucking your breasts, or you jumped over something. In Extract 11, the participant further explained that when you walk at night you might jump over or step on something unclean and unsafe that might complicate the pregnancy, for example, the traditional medication that people use to for luck or to vomit with. This traditional medication is known as *imithi* or *umuthi* (singular) and include remedies derived from trees, shrubs, herbs, leaves, barks, bulbs and roots. The elderly people, herbalists and traditional healers have much knowledge about medical plants (Bhat, 2014).

Sub-theme: Gender norms

Gender norms are interpreted as social and cultural constructions of the ways that women and men are expected to behave (Fladseth, Gafos, Newell, & McGrath, 2015). Participants spoke about how they did not like doing certain things because it is not what society defines as their role. Certain behaviours of a woman when she is drunk and alcohol use were seen as masculine. Men leaving their partners in pregnancy was also normalised:

Extract 15

It does not sit well to me to be the one doing groceries, withdrawing grant money while I am a man and be the one keeping the grant card while she is around (Luvo, Partner).

Extract 16

She fights, she loves fighting because she is masculine (Liso, Aunt).

Elements of masculinity and femininity are commonly set up as binary opposites, and many behaviours have clear gender stereotypes (De Visser, & McDonnell, 2012). In Extract 15, the participant expressed that it does not sit well with him to do groceries and handle finances because he is a man. Because his wife drinks heavily he must take what he considers as the role of his wife. This demonstrates the traditional gender role ideology which normalises the idea that specific roles are limited to specific genders (Kruger, 2015). Moreover, the family member in Extract 16 perceived fighting as masculine and not feminine. Masculinity is often stereotyped with men exhibiting characteristics such as independence, physical strength, aggressiveness, competitiveness, objectivity, rationality and showing less emotion than women. By comparison, women are considered to be more co-operative, physically weak, affectionate, attractive, emotional, neat, dependent, gentle, religious, quiet, strong irrational, passive, and more communicative than men. Violence is therefore more strongly associated with men or masculinity compared to women or femininity (Bozkurt, Tartanoglu, & Dawes, 2015).

Some participants used gender norms to try trigger change in behaviour or acceptance of current circumstances:

Extract 17

I sat down with her and I told her a woman must never drink while a man does not drink. Don't you see what that says about you when you drink and get drunk while your boyfriend does not? What does that say? It's better for him to get drunk, not you. She did not respond. She stopped (drinking) when she was about to give birth (Lumka, Family member).

Extract 18

Even if your man impregnated you and left you does not mean that we at home or as your family will reject you and we will support your child. Leave the man because that's how men are. If he does not want you, it does not matter if he impregnated you (Liso, Family member).

In Extract 17, the participant implied that it is acceptable for men to drink but for women to drink says something about character of the woman. This demonstrates that drinking is not condoned as acceptable feminine behaviour, as it is linked to unwomanly behaviour such as sexual disinhibition, and is believed to impair nurturing, maternal behaviour (De Visser, & McDonnell, 2012). In Extract 18, Liso stated that "it is how men are" thereby normalising the behaviour of men running away from responsibility when they have impregnated someone. A recent South African literature review demonstrated that women's relative disempowerment in relationships with men reinforce unequal positions in families, societies and public domains (Fladseth et al., 2015).

Sub-theme: the social phenomenon of crime

According to Kruger and Landman (2008) crime in South Africa remains a serious challenge and there is a general feeling in the country that the situation is worsening. Family members and partners described their community as dangerous and with high rate of crime such as rape and murder:

Extract 19

Anyone can get in to their house. She might open the door thinking it is one of her brother's friends and be in danger (Lunga, Partner).

Extract 20

Our area is dangerous. People get raped, murdered etc (Liso, Family member).

Extract 21

One day, my little sister came back from school and we were not there, a man came and raped her. When we got back from school, we saw that she had locked herself (inside the house). She was raped by someone we know, who stays in our area (Lulu, Family member).

Extract 22

The situation is bad. You can die at any time, but I cannot leave because my children go to school here. Crime is very high here, and this is one of the reasons I started boxing. I want to reduce crime (Khaya, Partner).

Family members and partners described their community as dangerous where people get raped and murdered. This requires vigilance, as seen in Extract 19. In Extract 21, the participant stated that her sister was raped by someone they know, meaning that vigilance has to extend to known people. In Extract 22, the participant described living in their community as preparing to die at any time which requires actions (e.g taking up boxing). The poor in South Africa are more exposed to interpersonal crimes such as assault, murder and rape (Kruger, & Landman, 2008).

Sub-theme: The social phenomenon of child-headed households

Mturi (2012) defined child-headed households as when the parent or primary caregiver of the household is terminally ill or has died, no adult family member is available to provide care and support and where a child has assumed the role of primary caregiver in respect of a child or children in the household in terms of providing food, clothing, and psycho-social support. In this study, a family member described the difficulties of growing up without having parents around – how that makes one vulnerable to abuse and doing anything to get the next meal:

Extract 23

I was born in 1995 and my sister in 1996. Our mother passed away in 2012. My mother passed away, we were left alone at home (Lulu, Family member).

Extract 24

We did not know what to do because (name of policeman) knew where we stayed. He would come to our house and pretend like he will help us. He told my sister not to tell anyone about what he did. He would come to our house and buy us food. We enjoyed that because we did not have hope where we will get our next meal and we hid what he did (kept it a secret). Her tummy got big and she did not know she was pregnant. She drank alcohol because all of this was stressing her out. If someone came and showed us what to drink, we will drink because when we get drunk things seems easy. It's easy because if we were going to get money for doing something, we would do whatever we were asked to do (Lulu, Family member).

Extract 25

It affected us so much. My prayer now that we have children, is for our children not to grow up the way we did, not be abused like we were. It was painful because it's not nice growing up without parents and when you grow up without your parents, it seems like everything is harder for you even though it gets hard too when you have parents. Because if mama was around, things would be better because when your parents are around, you will never sleep with an empty stomach (Lulu, Family member).

In Extract 24, Lulu spoke about the vulnerability of not having parents and a police officer taking advantage of her and her sister. Economic hardship resulted silence about the abuse to obtain food. Also, in Extract 25, the participant spoke about the difficulties of not having parents around such as being abused and not knowing where the next meal will come from. In Extract 24, the participant stated that her sister was drinking in pregnancy because all of this was stressing her, and things seems easier when they got drunk. Mturi (2012) recognised this by stating that child-headed households face: serious threats to education because of poverty; difficulties in obtaining food and shelter; a high risk of being sexually abused by relatives and neighbours; the threat of child prostitution and child labour; difficulties in getting birth registration which is a prerequisite in procuring healthcare and social security benefits; and experiencing property grabbing by families and communities.

Sub- theme: The social phenomenon of transactional sex

A family member stated that she and her sister had to hustle for their next meal through sleeping with men for the exchange of money and stealing money from men:

Extract 26

When we did not have food, each person had to leave and hustle for something to eat or what we going to do for us to eat before we sleep. There was no way we could work, we had to hustle through men, maybe get a boyfriend and your boyfriend would maybe help you (Lulu, Family member).

Extract 27

We would go out to have fun. We would go without having money. We would look for someone who could love you, and we would watch to see when he orders alcohol, how much does he use to buy alcohol? Does he have money? So when he buys often it indicates he has money so if he likes me, I will say yes because he has money. We would go to sleep at his place and search for money when he falls asleep. Through everything we did I got sick. I had a headache and it did not stop. I went to clinic I was advised to get tested and I found out I was HIV positive (Lulu, Family member).

Lulu (who also spoke of being in a child-headed household) indicated that she and her sister had sex with men in exchange for money for them to have food. In Extract 26, she said that they had to get boyfriends as they could not work. Similarly, in Extract 27, she mentioned that she and her sister would target men with money at drinking establishments. Ranganathan et al. (2017) argue that transactional sex is primarily motivated by basic survival or subsistence needs. There is also recent evidence that indicates that young women whose opportunities are limited may also use transactional sex to elevate their status, particularly in youth cultures that prioritise sexual success and conspicuous consumption. Additionally, in Extract 27, the participant mentioned that she was infected with HIV. Transactional sex or sex that is exchanged for money and/or gifts is considered to be an important contributing factor to the prevalence of HIV/ AIDS among young women (Ranganathan et al., 2017)

Sub-theme: Socio-economic status

Family members and partners indicated that most pregnant women did not have a source income and for those who did have, it was mostly social grants and part-time jobs:

Extract 28

What's worse is we are both not working. She does a part-time job when she comes back the money will go to debts and it will be finished. She depends on me (Lunga, Family member).

Extract 29

We did not come together because of the distance (between the families). I told her there must be something placed on the table. It does not matter the amount so that your family/home can take care of your child. Your boy[friend] needs to hustle so he can keep money, in case our family decides to go to him. It does not matter the amount, but they must not come back empty

handed. You must talk to your boyfriend. It's not okay to raise a child and when s/he is old grow wings like a bird. Because once we have raised the child, the father of the baby will show himself. She said it's okay, the family can go. Maybe they will go, and the boy does not show up. We don't know (Lumka, Family member).

Family members and partners indicated that pregnant women were unemployed and had low socioeconomic status. In Extract 28, the partner stated that he was unemployed, and his wife had a part-time job, but she was drowning in debts and she mostly depended on him financially. In Extract 29, the family member indicated that the pregnant woman was not working, and her boyfriend was not supportive financially. And the participant suggested that the boyfriend must hustle so that he can pay for *intlawulo* (damages) if the family decides to go to his family. Shishehgar, Dolatian, Majd and Bakhtiary (2014) argue that socioeconomic status plays a crucial role in the stress perceived by pregnant women. This means that pregnant women with low socioeconomic status can experience greater stress during pregnancy and after pregnancy compared to those with higher socioeconomic status. Stressors related to poverty and socioeconomic status may contribute greatly to drinking during pregnancy period (Watt et al., 2014).

A PRIORI THEME: CHRONOSYSTEM

The chronosystem represents changes in the individual or environment that occur over time and influence the direction pregnancy takes (Shaffer, & Kipp, 2013). Chronosystem refers to both short- and long-term time changes over the course of a lifespan, as well as the socio-historical time in which individuals live (Johnson, 2008). Under chronosystem there are sub-themes namely: changes in health, changes in family structure, changes in relationships, changes financially, and legacy of apartheid.

Sub-theme: Changes in health

According to Fords et al. (2017), an increasing number of pregnant women in low- and middle-income countries are being tested for human immunodeficiency virus (HIV) during pregnancy. In this study, participants reported on alcohol use as a result on receiving HIV diagnosis in pregnancy:

Extract 1

She is not a person who drinks. What bothered her and made her drink, she got tested while pregnant. She found out she was HIV positive and her HIV status made her drink too much alcohol (Lisa, Family member).

In Extract 1, Lisa stated that the pregnant woman found out she was HIV positive in pregnancy and that this change led her to drinking. In South Africa, prevention of mother-to-child transmission (PMTCT) guidelines recommend HIV testing in the antenatal period and, more recently, initiating lifelong triple ART as soon as the diagnosis has been made. An HIV diagnosis together with the initiation of ART may have an emotional effect on pregnant women that influences how they will cope with the pregnancy as well as their adherence to a treatment plan (Fords et al., 2017).

Sub-theme: Changes in family structure

When a loved one is murdered, the life of surviving family member is forever altered, and the perception of the world they inhabit is reshaped (Aldrich, & Kallivayalil, 2016). Participants reported that women lost loved ones through murder during pregnancy:

Extract 2

“I spoke with her and told her that drinking will not help, but she did not listen. She continued drinking and more once her father died because her father loved them” (Kuhle, Family member).

The family member in Extract 2 reported that women experienced the trauma of losing some of their family members during their pregnancy. Aldrich and Kallivayalil (2016) argue that trauma and loss caused by humans, in this case murder, is the most harmful and cause severe and enduring reactions in survivors. This may explain why pregnant women increased their alcohol use during this period.

Sub-theme: Changes in relationships

According to Kathree et al. (2014) pregnancy and childbirth are particularly vulnerable periods for a woman, particularly first pregnancies as these involve changes in her body image, her identity as a woman, concepts of motherhood and changes in intimate relationships. In this study, participants reported denial of pregnancy by the partner and relationship dissolutions as a result of pregnancy.

Extract 3

I denied the pregnancy and kicked her out but when the child is denied he comes out looking like with his father (Khaya, Partner).

In Extract 3, the partner reported that when he found out about the pregnancy, he denied paternity and ended the relationship. Research conducted in a community health centre in the North West Province reported that women experienced similar rejection by the partner (Kathree et al., 2014).

These changes (pregnant women being neglected and abandoned by male partners) were a determinant of poor health outcomes for women in South Africa (Mmusi-Phetoe, 2016).

Sub-theme: Changes financially

The pregnant woman and their families come from socioeconomically disadvantaged backgrounds. Participants reported that the pregnancy exacerbated the economic disadvantage of already poor families:

Extract 4

Boys are not like the olden days where if a boy got someone pregnant, he would marry the girl without the parents finding out that she is pregnant. So nowadays, she will have to be our responsibility. Now I will compromise my monthly doctor check-ups because we will have to use the money to take care of the new-born. My health won't be okay. That's what her father said (Lumka, Family member).

In Extract 4, the participant spoke of social changes: previously, boys used to take responsibility if they impregnated someone, but nowadays it is the parent's responsibility. This means having to make financial sacrifices to take care of the new-born. The socio-economic conditions of households in poverty can, and do, impose major constraints on the pregnant woman's ability to provide and sustain childcare, and this places an excessive burden on the home and the family (Nkani, & Bhana, 2016).

Sub-theme: Legacy of Apartheid

Family members and partners reported on persistent of segregation in schools based on race, the distance of townships and rural areas from resources that could create jobs for them, and informal shebeens, which arose initially during Apartheid, as a place of socialising:

Extract 5

I decided to change her from a black school to a coloured school. Then, I transferred her to coloured school and I paid the school fees but still she was not attending school (Lumka, Family member).

Extract 6

If I was able to leave this place I would but in rural areas job opportunities are rare, its far. Here we are close to white people (Khaya, Partner).

In Extract 7, Lumka referred to the segregation of schools based on race that still exists in South Africa. During Apartheid Whites were entitled the first-class citizenship while Coloureds and Indians

were the second-class citizens. Indigenous Africans were regarded as the third-class citizens. This led to the formation of the Bantu Education Act in 1953, which put into place an inferior education system specifically for the majority Black population. Blacks were denied access to an educational system that would enable them to compete with their White counterparts (Thobejane, 2013). This explains why in Extract 8, the participant stated that if he had a choice, he would to leave the Township but there are no job opportunities in rural areas. Townships he asserted are close to White people who create job opportunities. This can be traced back to race-based legislation under South African's Apartheid system which created densely populated Townships (designated for black Africans) and rural areas with little opportunities for employment (Smit, 2014).

As see in previous extracts family members and partners reported that there are many shebeens in their community and the majority of them operate without licences. Consequently, they sell alcohol to everyone including children under the age and operate for 24 hours. This implies that informal shebeens are acting similarly to “dop system” facilitating easy access to alcohol; they continue to play a significant role in a cycle of poverty and alcohol dependence from which escape is very difficult (Bowers et al., 2014). Also, Watt et al. (2014) argue that the densely populated townships created during apartheid provide little opportunities for employment and recreation. In these settings, shebeens remain among the only social outlets for residents. The popularity of shebeens as social gathering places has laid the foundation for elevated use of alcohol, including alcohol use during pregnancy.

CONCLUSION

In conclusion, this chapter has discussed the following themes; family and teachers, family and social workers, family and drinking establishments, partners and friends, partners and “other men”, partners and the criminal justice system, partners and the antenatal clinic, partners and church, and police and drinking establishments under connections between microsystems namely mesosystem. Also, a theme under the exosystem which involves links between social settings in which pregnant women do not have active role, shows how lack of compliance and regulation of alcohol legislation influences their alcohol use in pregnancy. Moreover, themes that describe the overall culture in which pregnant women live and their social conditions have been discussed, including religious beliefs, cultural beliefs, gender norms, the social phenomenon of crime, child-headed households and transactional sex, and socio-economic status. Lastly, this chapter discussed themes about changes that took place in pregnancy and influence the direction pregnancy takes such as changes in health, family structure, relationships and finances. Additionally, socio historical context such as legacy of apartheid in facilitating easy access to alcohol.

CHAPTER 7: RECOMMENDATIONS AND CONCLUSION

Alcohol use in pregnancy is the most common cause of births of mentally delayed children and the primary cause of foetal malformations in South Africa. Popova et al. (2017) state that alcohol is a teratogen that can readily cross the placenta, resulting in damage to the brain and other organs of the developing embryo and foetus. Also, it has been linked to many adverse health consequences for the foetus including but not limited to stillbirth, spontaneous abortion, intrauterine growth retardation, low birthweight, preterm birth, congenital malformations and FASD (Popova et al., 2016). Therefore, alcohol use in pregnancy harms the developing foetus and the exposed child can suffer from a variety of disorders.

Most research on alcohol use in pregnancy generally focuses on what FASD is and how alcohol harms the development of the foetus. Very little research has explored alcohol use specifically from partner or family members' perspectives of women who consumed alcohol in pregnancy or focused on contextual risk factors beyond the pregnant woman. Also, pregnancy is considered as solely women's responsibility. Interventions that aim to combat the prevalence of FASD tend to work with the pregnant women only, minimizing the role of male partner, family members and social context in which drinking takes place. Understanding the interpersonal and social contexts within which drinking during pregnancy occurs is essential in terms of formulating effective interventions.

The aim of this research study was to fill this gap by exploring how partners and family members of women who drank alcohol while pregnant make sense of alcohol use and the social context within which drinking during pregnancy takes place. The main research question of this study was how partners do and family members of women who drank at harmful levels narrate the journey of pregnancy. The sub-question was: what themes at the individual (history of alcohol abuse, attitudes, beliefs and knowledge), microsystem (family, friends, intimate partner and clinic), mesosystem (which includes the links of different systems together within microsystem such as clinic and partner, friends and partner etc.), exosystem (which consists of settings that an individual does not have direct contact with but still influence the individual e.g. the environment where people live), macrosystem (which includes broader cultural beliefs, societal issues, policies and regulations) and chronosystem (which include changes in individual or socio-historical context) are evidenced in these stories.

I used Bronfenbrenner's Ecological Systems Theory as a framework to understand prenatal alcohol exposure within the actual environments in which alcohol use in pregnancy takes place. The fundamental assumption is that alcohol use in pregnancy is the result of the interaction between the pregnant women and the contexts to which they are exposed. I collected data using narrative interviews from five male partners and eight family members of women who consumed alcohol in

pregnancy and analysed it using the template analysis method. The findings of this study highlighted why some women drank in pregnancy and continued drinking throughout their pregnancies and how the interaction between the pregnant woman and her context shaped this behaviour. The following chapter will summarise these findings, discuss the practical implications of the findings, and explore the limitations of this study as well as suggestions for future research.

SUMMARY OF FINDINGS

Women consumed alcohol in pregnancy despite some level of awareness about the dangers of alcohol use. According to their partners and family members, they drank for several reasons: frequency of drinking before pregnancy established habits that were difficult to break in pregnancy; women drank during the first trimester of their pregnancy because they were unaware of being pregnant; they continued drinking throughout their pregnancies even after learning they were pregnant in order to self-medicate, that is, use alcohol as a means of coping with the emotional upset caused by trauma of rape and losing loved ones, stress, and receiving HIV-diagnosis in pregnancy. Despite knowing about not drinking during pregnancy, women may lack accurate knowledge about harms of alcohol use in pregnancy. This is exacerbated by women knowing people in their communities who drank at harmful levels, but their children turn out fine.

Pregnant women received emotional, instrumental and informational support from family members, partners and healthcare providers to reduce or abstain from alcohol use in pregnancy. Also, the direct interaction between pregnant women and church or traditional healer helped in reducing alcohol use in pregnancy. However, the social network of the pregnant woman played a pivotal role in their individual drinking. For example, the alcohol use of family members, partners and friends influenced women's drinking by exposing them to alcohol, modelling alcohol use and encouraging the pregnant woman to attend shebeens. Additionally, the emotional effect of lack of support, rejection and denial of pregnancy from partners, infidelity and intimate partner violence may have resulted in pregnancy being unpleasant and worsening the drinking behaviour of women.

The connections within microsystems, as alluded to by the partners or family members include the following. Family members interact with the school to ensure that pregnant women continue with school attendance (however, women who got pregnant at school eventually dropped out and did not return). After birth, some women continued drinking which resulted in family members asking social workers to intervene because the parents are unable to care for the child due to alcohol use. Drinking establishments operate without licence, distributing alcohol to everyone including school children despite the age limit – as result family members have to intervene by reprimanding shebeens owners

because when police conduct inspections, they do not reach illegal shebeens that are situated in informal settlements. Conflict between partners and friends of the pregnant woman was reported because partners perceived the friends as 'bad influencers' who contributed to pregnant women's alcohol use; in addition, there was conflict between partners and 'other men' because pregnant women drink with other men in drinking establishments and this made their partners suspicious and challenged their masculinity. The interaction between partners and the criminal justice system showed that prison disciplined partners and they try not to break the law again. Partners described their interaction with antenatal clinic when they accompany their pregnant partners as not inclusive and encouraging of the male partner participating in the health talk and consultation with the healthcare providers and the pregnant woman. Lastly, partners described their interaction with church as a supportive space that helped them to stop physically abusing pregnant women, stopped drinking and enabled them to encourage the pregnant woman to reduce alcohol use.

The lack of compliance of shebeens with liquor regulations created heavy drinking within this study community as high rates of alcohol use in pregnancy were connected to the accessibility of alcohol within the community. There were many shebeens that created easy access to alcohol in their community, and these establishments sell alcohol to everyone including children below the age limit and pregnant women. This normalises and legitimates drinking in a community setting, which may lead heavy drinkers to believe that their alcohol use is not problematic or dysfunctional, as others in their community are engaging in the same drinking behaviour. Also, the culture of alcohol abuse and weekend drinking, and the difficulties women have in coping with problematic social conditions, influenced their individual alcohol use. Therefore, drinking during pregnancy is a complex problem that stems from multiple social and structural issues and interventions should therefore not only focus on the individual, but also on social networks and communities (Rosenthal, Christianson, & Cordero, 2005).

Participants and pregnant women used religious beliefs to cope with their circumstances. Participants explained how they understand the events that were important to them and pregnant women during pregnancy and the drinking behaviour of women in terms of culture. Also, they explained certain behaviour of women in terms of gender norms. For example, aggressive behaviour of women when drunk and alcohol use were seen as masculine. Drinking was not condoned as acceptable feminine behaviour. Women consumed alcohol in pregnancy to cope with difficulties of growing up without parents around which made them vulnerable to abuse and doing anything to get the next meal. For example, hustling for their next meal through sleeping with men for the exchange of money and stealing money from men. Most pregnant women did not have a source of income and those who did

have, it was social grants and part-time jobs. Socio-economic status played a crucial role in the stress perceived by pregnant women, according to participants.

Women during their pregnancy experienced changes in their health that influenced the direction pregnancy, such as receiving HIV diagnosis in pregnancy which may have emotional effect that influences how they will cope with the pregnancy as well as their adherence to treatment plan. Some women experienced changes in family structure through the trauma of losing loved ones due to murder, while some experienced changes in their romantic relationships such as denial of paternity and relationship dissolutions. Changes in finances and the pregnancy exacerbated the economic disadvantage of already poor families. Lastly, alcohol use in this community is the legacy of apartheid. For example, informal shebeens in the community are acting similar to the '*dop* system' facilitating easy access to alcohol and continue to play a significant role in a cycle of poverty and alcohol dependence from which escape is very difficult.

RECOMMENDATIONS FOR INTERVENTIONS

Interventions to prevent FASD have focused on pregnant women. Recent research concludes that prevention of FASD must begin before a woman becomes pregnant by either reducing alcohol consumption in women likely to become pregnant or preventing pregnancy in women drinking at risky levels (Hanson, & Jensen, 2015). Knowledge is an important potential influence of behaviour but information of the effects of alcohol in pregnancy alone is not enough to change women's behaviour, as seen in this research. Participants also indicated that some women knew they should not drink but they did not why. Accurate knowledge about harms of alcohol use in pregnancy should only be seen as a starting point in helping to reduce maternal alcohol consumption (Elek et al., 2017). Additionally, partners and family members indicated that the pregnancy of the women were unintended. This may explain why women drink during their first trimester of their pregnancy; it could be because they may be unaware that they are pregnant. Interventions, thus, should include education and counselling that promote safe sex behaviours, planned pregnancies, and changes in alcohol consumption behaviour (Rosenthal et al., 2005).

Traditional public health approaches have concentrated on increasing public knowledge through awareness campaigns. However, approaches to the prevention of FASD must encompass more than education to be effective (Peadon et al., 2010). The findings of this study indicated that women drink throughout their pregnancies to self-medicate, that is, use alcohol as a means of coping with the emotional upset caused by various forms of trauma. There should be available psychosocial services for women facing difficulties during their pregnancy to help them develop effective coping strategies

so that they do not feel they need to turn to alcohol in order to cope with their problems (Watt et al., 2014).

Elek et al. (2017) argue that other strategies may prove more beneficial than increasing knowledge alone, such as encouraging support from partners, family and others for a pregnant woman's decision to abstain. In this study, participants indicated that pregnant women who reduced their alcohol use were encouraged by their partners, family members and church. Also, pregnant women who continued drinking had friends who encouraged them to attend shebeens and partners and family members who supported their drinking behaviour. Therefore, prevention interventions should involve family, friends, partners and church to change social norms about alcohol use among pregnant women, providing education programmes about the dangers of alcohol (Vantamay, 2009). These interventions should use an emphatic and non-judgemental approach that focus on supporting pregnant women.

For example, a brief intervention with a general population of pregnant women and their partners and families concluded that goal selection and social support were successful in encouraging pregnant women to abstain from drinking alcohol (Hanson & Jensen, 2015). This suggests that interventions to reduce FASD must include the pregnant women, their partners and family members in raising awareness of the negative consequences of drinking during pregnancy, support for the pregnant women with drinking reduction goals and contraceptives. Hanson and Jensen (2015) state that women garner the opinions of family, friends, sexual partners, and healthcare professionals regarding contraception, and a significant factor in deciding to use contraceptives is the perception of social networks

Moreover, intervention strategies should also be implemented on a community level. The findings of this study showed that lack of compliance of shebeens with liquor regulations increased access to alcohol and shaped the social behaviour of harmful drinking. Community-based prevention to restrict accessibility to alcohol should be addressed, such as limiting the number and concentration of alcohol outlets in community, eliminating irresponsible alcohol distributors in community, limiting the days or hours of alcohol sales in community, and encouraging the participation of community members to report shebeens that do not comply with laws and regulations (Vantamay, 2009). Therefore, to effectively enforce this policy, the focus should be on sellers, who could be made to face closure for noncompliance (Marara et al, 2016).

In addition, using mass media, education campaigns beverage warning to raise awareness about harms of alcohol use in pregnancy has been associated with an increase in awareness about the consequences of drinking during pregnancy (Barry et al., 2009). Participants reported on the misconception that women need to consume large amounts of alcohol to cause harm and that some types of alcohol pose less risk than others. There is clearly a need for the delivery of accurate and culturally relevant information about the risks of alcohol-exposed pregnancies, in order to increase knowledge of FASD. It is important that such public health campaigns not only target antenatal clinics but also reach the broader community, including family and social networks, where norms are established and reproduced. In particular, settings where individuals purchase and consume alcohol are important targets. (Watt et al., 2016). South Africa needs to invest more in education campaigns because there are still misconceptions particularly in disadvantaged communities about the harms of alcohol use in pregnancy.

Furthermore, participants reported that when male partners accompanied their partners to antenatal clinics, they waited in the waiting room while the pregnant woman participated in health talk and consultation with healthcare providers. Healthcare system policies should include men in antenatal clinics and allow them to be involved in the wellbeing of the pregnant women and developing foetus. This will not only improve birth outcomes but also have a positive influence on the relationship that a woman has with her partner and can be regarded both as emotional and instrumental support which improves the mother's feelings about her pregnancy (Phiri, 2015). Participation in prenatal consultation is an opportunity for fathers to feel closer, experiencing the gestation of the baby, so that the materialization of the child can happen, because without this experience they will only have a subjective perception through information obtained from mothers (Silva Ferreira et al., 2016). It is essential that men have easier access to these services, feel welcomed and encouraged to participate in the consultations and educational groups, and present concrete reasons to encourage other parents to also participate. Therefore, special efforts should be made to emphasize men's shared responsibility and promote their active involvement in maternity care (Sokoya et al., 2014).

LIMITATIONS OF THE STUDY AND RECOMMENDATIONS FOR FUTURE RESEARCH

While this study has contributed in exploring why women drink and the social context within which drinking during pregnancy takes place, it is not without its limitations. One of the limitations of this study is that it was conducted in a disadvantaged community which is characterised by poverty, unemployment, crime, low levels of education, lack of provision for basic needs etc. Thus, the findings are not applicable to every community in South Africa. An obvious limitation of qualitative

research is that it usually works with small sample sizes and as a result, findings of qualitative work are not necessarily generalizable to the wider population (Willig, 2008). Future research would benefit from not only studying alcohol use during pregnancy with larger samples but also with individuals who come from different backgrounds. Moreover, the interviews were conducted with partners and family members meaning that the findings are not from the perspective of women who drank in pregnancy. The pregnant woman is seen in a network of context, not as an independent factor. Therefore, future research needs to include women as well to understand the intrapersonal influences of alcohol use in pregnancy from their perspective.

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