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Navigating Diverse Understandings of Childbirth Complications: Experiences of Traditional Healers Working as Professional Nurses in Johannesburg Hospitals

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February 2025

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ABSTRACT

As biomedicine is the primary health strategy used in hospital settings, understanding and managing childbirth complications are primarily biomedically oriented. However, many black South Africans consult traditional healers before, during, or after receiving biomedical therapy for health disorders that they believe are better addressed traditionally. Traditional healers are thus critical in the health-seeking of such community members. The study aimed to investigate how professional nurses who are also traditional healers understand and navigate childbirth complications in hospitals around Johannesburg. The theoretical lens/framework the study used was hermeneutical phenomenology to explore the lived experiences of traditional healers working as professional nurses. It also used the social identity theory to understand how professional nurses' identities as traditional healers navigate their roles when dealing with childbirth complications. The study was qualitative and used a phenomenological design. Snowball sampling was used to target this hard-to-find group. Data was generated through semi-structured interviews with healthcare providers with dual identities as traditional healers working as professional nurses. Interpretive phenomenological analysis was used to analyse the generated data. The study shows that traditional healers who serve as professional nurses have a distinct viewpoint on delivery difficulties that differs from nurses who are not traditional healers or vice versa. The findings show that their cultural and medical expertise may transform how delivery is managed, reducing the use of caesarean sections and opting for a more holistic approach to managing childbirth complications. This approach, in turn, contributes to developing health programs that bring access to good-quality health services and holistic healing within the hospital space. Thus, it is recommended that the perspectives and approaches conceived by such a category of nurses be critically considered for developing policies that give room for collaborative and holistic approaches to maternal care and childbirth.

Keywords: Childbirth complications; traditional healers; nurses; hospital; caesarean; South Africa.

DEDICATION

To my baby girl, UNOKUHLE KUKHANYA TENZE,

who God whispered as

'Too good for this world.'

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Before all else, I give thanks to God for everything, good and bad. I thank him for the opportunity to write this thesis. The strength he gave me throughout the research process, his protection and for continuously reminding me that I am fearfully and wonderfully made, which means whatever I put my mind to, I can do, regardless of the obstacles that may come before me.

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ACRONYMS AND ABBREVIATIONS

ASNA - Anthropology Southern Africa

CIOMS - The Council for International Organizations of Medical Sciences

CMJAH - Charlotte Maxeke Johannesburg Academic Hospital

CPD - Cephalopelvic disproportion

CS - Caesarean section / C-section

FH - Foetal Heart

IPA - Interpretative Phenomenological Analysis

ICU – Intensive Care Unit

NVD - Normal Vaginal Delivery

PAR - Participatory Action Research

PPH - Postpartum haemorrhage

PROM - Prelabour Rupture of Membranes

RHT - Refusal of Hospital Treatment

TBAs - Traditional Birth Attendants

THM - Traditional Health Medicine

(THPs) - Traditional Health Practitioners

TM - Traditional Medicine

UCP - Umbilical Cord Prolapse

UNFPA – United Nations Population Fund

WHO - The World Health Organization

“Native” Word Definitions:

Abantwana abaza bambethe - Children who birthed while in the amniotic fluid sac.

Akashiswelanga imphepho - Lighting incense.

Amadlozi – Ancestors.

Azange wabika - Letting the ancestors know.

Umchamo wemfene – This folk treatment is a herbal concoction containing herbs like swart sewe or swart sowe rather than actual baboon urine to help induce labour for pregnant women.

Bafuthe - The act of using umuthi to steam.

Ba sedulwanga - Women who massage your stomach.

Dikgaba – A term for injury or suffering, frequently connected to supernatural forces and occasionally connected to unfavourable pregnancy conditions like difficult delivery or stillbirth.

Endumbeni – A holy healing area, or hut, where traditional healers, especially in South Africa, confer with clients and ancestors and perform rituals.

Gobela – An instructor or guide in traditional African spirituality, namely in the sangoma practice.

Hosedula – Massaging.

Ibhayi – Ancestral spiritual cloths that have deep symbolic meaning in African religion.

Idlozi lomndawo - Water Spirits.

Idumane - Red hair because of traditional reasons in a way to bring your ancestors closer so communication lines are strong.

Imbeleko - The process of introducing the child to the ancestors.

Imbiza yegazi - Muthi for blood.

Imbiza – Is a traditional South African herbal tonic that is used to heal ailments like kidney infections and stress, as well as to detoxify and strengthen immunity.

Imihlola – Abominations.

Imimoya – Spirits.

Intambo – Strings.

Intambo yokubamba umoya/uLinda – A string that holds in life.

Ischitho – A spiritual curse that stems from jealousy or hatred and prevents someone from succeeding and forming connections by making them seem ugly or bothersome to others.

Isihlambezo – A decoction drink that helps promote a healthy pregnancy, assist childbirth, and protect the baby.

Isithunzi – Refers to a person's dignity

Isithunywa – Refers to a spiritual messenger that is frequently referred to as a "prayer spirit" or "messenger."

Isiwasho – An African traditional cleansing concoction, usually a herbal blend or blessed water, is believed to defend against bad spirits and negative energy, bring good fortune, and purify the body and soul.

Izinyamazane - Which is an African root used to remove evil.

Mkhulu – Refers to a male senior who is highly respected for his wisdom and closeness to the ancestors, in addition to his advanced age/It is a term used to call a traditional healer who is possessed by a male elder during initiation.

Moroto wa tswene - Baboon pee.

Muthi – A herb.

Ntho yahokotha - Something to lick.

Sangomas - By definition, sangomas/traditional healers are fate tellers who study patterns of thrown bones, while a traditional birth attendant provides an extra qualification and greater credibility, allowing them to aid and alleviate labour-related issues and concerns.

Thokoza – To respect and honour the ancestors, it is most used as a spiritual greeting.

Thwasa/Intwaso – The process of becoming a traditional healer in Southern Africa involving spiritual emerging and initiation.

Tse sa bonwing - Unseen things.

Ubungoma – An important spiritual practice that explains the natural ancestral calling to be a traditional healer in Southern African traditions, especially among the Zulu.

Ukuboshwa isisu - Stomach tied.

Ukugchaba – To strengthen or introduce.

Ukuphahla – Prayer, offerings, and certain ceremonial activities as a means of interacting with ancestors.

Ukuphalaza - The act of drinking something that will help you vomit.

Ukushweleza – The process of making a ritual to ask the ancestors to do something for you to appease them or infuriate them.

Umphefumulo – The soul.

Umoya – The wind.

Umthandazeli – Is a conventional faith healer or prophetic healer who functions under a paradigm of Christianity and indigenous spiritual beliefs.

Umthetho Weshobo – Laws, directives, or spiritual precepts that control traditional healing methods**.**

Umtungu – A traditional herb used for pregnant women.

Umudlisile - the process of being fed something traditionally that hinders you from carrying your child or from doing your everyday acts.

Usithegile umntwana – a child hiding in Zulu.

Uyocinisa isisu - Protecting your pregnancy.

Yahotsasa - Something to soothe your pregnancy with.

LIST OF TABLES

Table 1: Summary of participants' demographics	31

LIST OF FIGURES

Figure 1: Conceptual Framework on Childbirth Complications	16
Figure 2: The Map of the City of Johannesburg with its respective sub-districts	29

TABLE OF CONTENTS

DECLARATION ON PLAGIARISM ii
ABSTRACT iii
DEDICATION iv
ACKNOWLEDGEMENTS v
ACRONYMS AND ABBREVIATIONS vi
LIST OF TABLES x
LIST OF FIGURES xi
TABLE OF CONTENTS xii
CHAPTER ONE 1
1. INTRODUCTION AND LITERATURE REVIEW 1
1.1 Introduction and Background 1
1.2 Literature Review 4
1.3 Significance of the Study 10
1.4 Structure of Thesis 11
1.5 Summary of Chapter 14
CHAPTER TWO 15
2. THEORETICAL AND CONCEPTUAL FRAMEWORKS 15
2.1 Introduction 15
2.2 Conceptual Framework 15
2.3 Theoretical Framework 19
2.2.1 Social Identity Theory 19
2.2.2 Hermeneutical Phenomenology Theory 21
2.4 Research Aim, Objectives, and Key Questions 22
2.4.1 Research Aim 22
2.4.2 Research Objectives 22
2.4.3 Key Questions 23
2.5 Summary of Chapter 23
CHAPTER THREE 24
3. RESEARCH METHODOLOGY 24
3.1 Introduction 24
3.2 Study Approach 24
3.3 Research Design 25

3.4 Study Setting 27
3.5 Study Population and Sample Size 30
3.6 Sampling Approach 32
3.7 Data Generation 33
3.8 Data Analysis 35
3.9 Ethical Considerations 36
3.10 Summary of Chapter 40
CHAPTER FOUR 41
4. SPIRITUALITY OF PREGNANCY 41
4.1 Introduction 41
4.2 “Pregnancy is a Spiritual Process” 41
4.3 Miscarriages as attacks 44
4.4 Secrecy to Protect Pregnancies and Childbirth 47
4.5 Summary of Chapter 51
CHAPTER FIVE 52
5. BIOMEDICAL MODELS TO CHILDBIRTH COMPLICATIONS 52
5.1 Introduction 52
5.2 Negligence as a cause of childbirth complications 52
5.3 Forms of Childbirth Complications 56
5.4 Summary of Chapter 66
CHAPTER SIX 67
6. TRADITIONAL MODELS TO CHILDBIRTH COMPLICATIONS 67
6.1 Introduction 67
6.2 Protection from evil 67
6.3 Methods of Protection 75
6.3.1 “Whatever is done through witchcraft can be fixed.” 75
6.3.2 Drinking Herbs: “Isihlambezo, umchamo we nfene and isiwasho.” 79
6.3.3 String around the waist to avoid miscarriages 87
6.3.4 Prayer as a preventive approach to miscarriages 89
6.4 Summary of Chapter 91
CHAPTER SEVEN 92
7. INCORPORATING TRADITIONAL HEALING IN HOSPITALS: BENEFITS AND BARRIERS 92
7.1 Introduction 92
7.2 For traditional healing, the space matters 92
7.3 Avoidance of confusion when in a trance 96
7.4 Non-conformity to “standardised” treatment practices 97

7.5 Value of nurses with dual roles of nursing and traditional healing in hospital spaces 105
7.6 Dualism is seeking and promoting safety 116
7.7 Summary of Chapter 120
CHAPTER EIGHT 122
8. CONCLUSION AND RECOMMENDATIONS 122
8.1 Conclusion of findings 122
8.2 Study Limitations 124
8.3 Recommendations 125
BIBLIOGRAPHY 127
APPENDIX 1: ETHICS APPROVAL 140
APPENDIX 2.1: INVITATION LETTER - ENGLISH 142
APPENDIX 2.2: INVITATION LETTER - ISIZULU 145
APPENDIX 2.3: INVITATION LETTER - SESOTHO 148
APPENDIX 3.1: INFORMED CONSENT FORM – ENGLISH 151
APPENDIX 3.2: INFORMED CONSENT FORM - ISIZULU 154
APPENDIX 3.3: INFORMED CONSENT FORM - SESOTHO 158
APPENDIX 4: INTERVIEW GUIDE OF THE RESEARCHER 161

CHAPTER ONE

1. INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction and Background

Women have been delivering babies since the dawn of time, but delivery was then medicalised in the early twentieth century, and physicians began to deliver babies (Williams, 1997). Women no longer had to stay at home to give birth but could instead go to a hospital for “increased safety” in delivery. With the emergence of various medical treatments, including induction and pain management, such as an epidural or a caesarean section delivery (CS), women were given additional options for how to deliver their babies. Therefore, the medicalisation of labour was established to aid in the delivery of a healthy infant. Because of technological advancements, particularly in the last 20 years, any anomalies of the foetus or pregnancy difficulties may be detected extremely early on through using systems such as ultrasounds for hearing the baby’s heartbeat and even seeing the baby’s movements (Sherr, 1995; Haws et al., 2009). Globally, it has been argued that childbirth complications have increased with a high rate of maternal mortality (Musie et al., 2022: 1).

In dealing with illnesses in society, several ways may be used. South Africa presently benefits from a diversified healthcare system (Wreford, 2005), which makes the healthcare system pluralistic. Medical pluralism is the use of more than one healthcare system for both well-being and sickness (Moshabela et al., 2016). According to research by Wreford (2005), the most prominent approaches are the traditional, biomedical, and spiritual approaches. Each of these tactics has some influence on individuals. However, the influence of each depends on the dominant ideology that enlightens and directs the behaviour of individuals who use it. Traditional medicine and healers are the most visible and well-liked of these three systems (Wreford, 2005).

When looking at childbirth complications, medical pluralism enhances the treatment obtained to meet additional healthcare demands, such as other psychosocial and spiritual needs met by the mix of healthcare systems (Moshabela et al., 2016). South Africa's pluralistic healthcare system comprises an institutionalised biomedical system based on scientific methods and various non-conventional treatments. Non-traditional treatments are frequently based on

indigenous knowledge systems, beliefs, and African traditional practices (Pemunta and Tabenyang, 2020). Despite this fact, South Africa is a multicultural nation in which healthcare delivery is predominantly Westernised, neglecting the reality that healthcare patients are denied access to both contemporary and traditional healthcare systems. However, the African National Congress (1994a) argues that if the current healthcare system does not embrace the old system, which is the system that takes into consideration traditional healing, we will be unable to meet the demands of most patients.

Within the African context, where existence and daily occurrences can be seen and interpreted spiritually, specific ailments have cultural connotations and are commonly known as culture-bound syndromes. Some foetal anomalies and pregnancy difficulties can also be understood through a traditional lens. Traditional healers existed before the Dutch colonisation of South Africa in the 17th century. Despite competition from biomedicine, they have thrived. In South Africa, around 250,000 traditional healers' practice, compared to 23,000 modern medicine physicians. This makes traditional healthcare providers more accessible and reasonably priced. They are acquainted with the neighbourhood's customs and beliefs. This prevalence of traditional healers and understanding of health and illness from a traditional perspective thus contributes to the estimated 80 per cent of South Africans using a traditional health remedy at some point in their lives (Grant et al., 2013), demonstrating the extent of engagement of South African traditional healers in health care provision (Keetan, 2004). Traditional healers are revered and respected in their communities and are frequently opinion leaders (Kale, 1995).

Traditional birth attendants (TBAs) have a long history as delivery attendants across the world, as well as in many communities in developing nations such as South Africa. Long before the formalisation and acknowledgement of midwifery as a distinct practice area, traditional delivery attendants performed a crucial role in maternal health care (Musie et al., 2022). Even so, the interaction between biomedical and indigenous forms of treatment has historically been strained, with the notion that the two systems would be unable to collaborate owing to starkly opposed perspectives on illnesses and healthcare (Green and Colucci, 2020). Traditional medicine employs spiritual healing procedures instead of the lab-tested methods employed by biomedicine, which explains why the two systems sometimes function at arm's length or in parallel positions. However, such a condition of systems functioning at arm's length of health approach presents difficulties and hinders attempts to promote a healthy society (Green and

Colucci, 2020). According to experts such as Coovadia (2009), this reflects the dysfunction of South Africa's healthcare system.

Biomedicine and its health systems, brought during the colonial era, did not replace well-established systems of traditional medicine (TM), and many Africans learned to employ both health systems based on the availability of medication or the type of ailment (Van der Kooi and Theobald, 2006). However, Traditional healing is not incorporated into healthcare policy, legislation, or education, raising significant worries about its uncontrolled nature (Green and Colucci, 2020: 102). Most traditional healers have little official education; some learned from family, while others were trained through apprenticeship (Ohaja, Murphy-Lawless and Dunlea, 2019). Therefore, concerns about the authenticity of the medicine are raised. Despite this, Mngqundaniso and Peltzer (2008) argue that the claim that traditional healers' practices are not empirically supported is incorrect.

The primary distinction between African TM and Western biomedicine is how health and sickness are conceptualised. In TM, illness denotes a cultural, spiritual, and bodily imbalance that demands a natural solution (Van der Kooi and Theobald, 2006). Traditional healers and delivery attendants commonly use herbs. Traditional medicine encompasses a diverse range of items and techniques that may include herbal remedies, animal products (which include snake, fats, oils, and skin), acupuncture, beliefs, and meditations, as well as mysterious activities such as spiritual treatment (Pemunta and Tabenyang, 2020). On the other hand, biomedical health practitioners have received government-approved formal education and are thus regarded as genuine practitioners (Ohaja, Murphy-Lawless, and Dunlea, 2019).

To increase access to treatment, the WHO has proposed collaborating more closely with alternative healthcare providers, especially traditional healers, to establish services within local frameworks (WHO, 2015). The World Health Organisation has suggested cooperation between healthcare professionals and TBAs to increase women's access to maternal health care. However, in South Africa, TBAs are not officially incorporated into the mainstream healthcare system. The Traditional Health Practitioners Act was officially promulgated in 2007 to acknowledge the practice of traditional medicine. However, not much has been done, particularly in an urban setting, to create official venues for conventional therapeutic modalities (Chinsamy, 2017). Most healers still work out of their homes, where patients have little privacy and can interact with other sick individuals and their families. Some utilise more exclusive

back rooms at their home. One of the issues that frequently arises in disputes regarding traditional healing is the failure to distinguish traditional healing methods from other types of medical care, including witchcraft. It is impossible to ascribe a single description to the diverse traits and aspects of traditional medicine and healers (Pemunta and Tabenyang, 2020).

This thesis unravels traditional healers' clinical decision-making as professional nurses in understanding childbirth complications. In doing so, *sangomas*, traditional health practitioners, traditional healers, and traditional birth attendants will be used interchangeably. However, this thesis does not imply a distinction between these; all these terms will refer to the same person, disregarding the slight difference between a traditional healer and a traditional birth attendant. Furthermore, according to Selepe and Thomas (2000), a traditional healer can be a traditional birth attendant or childbirth care provider. A traditional birth attendant, however, is not automatically a traditional healer. By definition, sangomas/traditional healers are fate tellers who study thrown bone patterns. In contrast, a traditional birth attendant provides an extra qualification and greater credibility, allowing them to aid and alleviate labour-related issues and concerns (Selepe and Thomas, 2000). A traditional birth attendant is a lay midwife, community midwife, or traditional midwife, and a healthcare professional assisting with pregnancy and childbirth (Sibley and Sipe, 2004). Due to this research explicitly focusing on traditional healers who are professional nurses who have dealt with childbirth complications, the definitions above will serve as the working definition of a traditional birth attendant in this study.

1.2 Literature Review

According to Ngomane and Mulaudzi (2012), pregnancy symbolises a highly structured social reality intended for women to comply with and culminates in childbirth. Childbirth is unavoidably uncomfortable and risky and requires numerous measures to ensure its safety (Westergren 2021: ix). Childbirth is a complicated set of events that takes place over a long period. It is seldom the result of nine months of development but a lifetime's worth of learning, planning, and socialisation (Sherr, 1995). Childbirth has long been a contentious subject in society. It arouses stronger emotions today than ever. All these emotions must be considered when determining who has responsibility for childbirth and how labour might be adequately cared for (Robson, 2001). In addition, it is a culturally characterised emotional, personal, and

private experience, as well as a socio-cultural event in and of itself. Therefore, many culturally established rituals are related to pregnancy and childbirth, a time when both mother and child are vulnerable and perceived to be in danger (Dunsworth and Eccleston, 2015). To deal with the potential risks and fundamental uncertainty associated with birth, people tend to develop a set of privately standardised and mutually reliant practices and beliefs designed to manage the physiologically and socially problematic aspects of childbirth in a way that makes sense in that specific environment of culture (Dunsworth and Eccleston, 2015).

The conclusion of a pregnancy is the delivery of a child (Sherr, 1995). However, maternal labour is exhausting, challenging, and painful, and it comes with a significant chance that the mother or the baby may suffer harm or die throughout the process (Dunsworth and Eccleston, 2015). Any issue that arises during delivery that poses a risk to the mother's or baby's health is referred to as a birth complication (Lincetto et al., 2006). The issues that arise after pregnancy and during childbirth are the cause of death for women, which is termed maternal mortality. Some of the most common biomedically explained complications are foetal arrhythmia/dysrhythmia, shoulder dystocia, non-progressive labour, prelabour rupture of membranes (PROM), which is the early water breaking, continence tears, umbilical cord compression/umbilical cord prolapse, perinatal asphyxia, and excessive bleeding (Chadwick and Foster, 2014). Others include malposition, antepartum haemorrhage, and retained placenta (Mills and Bertrand, 2005).

Global estimations show that about 20 million women experience childbirth complications annually, with three million stillborn babies and three million neonatal fatalities occurring each year (Koblinsky et al., 2012: 124). Induced labour and caesareans have been primarily used to solve most complications within biomedical spaces (Robson et al., 2015). Because some of these complications are unexpected, expectant mothers may worry when approaching childbirth. Due to this worry of giving birth and childbirth complications, more women request caesarean deliveries (Melender, 2002: 101; Olieman et al., 2017; Stoll et al., 2015). In a 2018 study conducted in the United States (Hehir et al. 2018), where 27,044 217 deliveries from 2005 - 2014 were monitored, it was found that 31.6% had a caesarean delivery. Of these, 31.4% were primiparous (birthing for the first time or having had one previous birth). The study also found that "almost 90% of women with a previous caesarean underwent repeat caesarean delivery. For breech presentation among nulliparous (birthing for the first time) and multiparous (birthed more than once) women, 95.9% and 92.8%, respectively, underwent

caesarean" (Hehir et al., 2018). A similar increase, which Robson (2001) stated began in the early 90s in the United Kingdom, is due to two significant reports: the Changing Childbirth Report (Department of Health 1993), which empowered women to make birthing decisions, and the Audit Commission Report (Audit Commission 1997), which promoted women-centred approaches to maternity services.

According to the South African Department of Health, more than 4,300 expectant mothers die each year because of pregnancy and childbirth complications. Women die from avoidable causes associated with pregnancy and delivery, with haemorrhage being the primary cause of maternal mortality in areas such as Limpopo in South Africa (Marabele et al., 2020: 691). Before the entrance of Western medicine, African societies considered Western procedures to be the sole acceptable way of treating ailments, whilst children were born in families utilising their own Indigenous Knowledge Systems. Despite this, it was discovered that traditional health practitioners (THPs) are the first to be contacted before a patient may be admitted to a hospital and that after the patient returns from the hospital, they go to the THPs to provide input on what happened at the hospital (Mothiba, Davhana-Maselesele and Lebese, 2015). This then portrays how people have diverse perspectives on healthcare services right now. Those who choose traditional healing may be labelled superstitious at times, regardless of the rationale or conclusion of the consulting process. At the same time, no labels are attached to being solely biomedical in one’s healing perspective.

Feminists have considered the medicalisation of childbirth as the seizure of power, choice, and control over women's reproduction by biomedical authority, forcing women to seek the advice of biomedical professionals for what has traditionally and naturally been women's territory (Brubaker and Dillaway, 2009). According to Foucault (1978), this power reveals itself in the instruments, strategies, and processes used to affect the behaviour of others (Hindess, 1996). Pregnant women have been viewed as sick and in need of medical treatment rather than as healthy women bearing new life, which feminists claim has taught women that their instincts and genetic knowledge in childbirth are incorrect (Stewart, 2004). In Foucault's words, the more information one knows, the more authority one has to alter other people's lives (Foucault, 1980). The power of the medical practitioner in the medical context is established because their expertise is seen as reliable and respectable, therefore closing the knowledge that traditional healers bring to the table.

As biomedicine is the primary health approach utilised in hospital spaces, including South Africa, where it is assumed that most women, regardless of their medical assistance, will give birth at a hospital, understanding and managing childbirth complications are primarily biomedically aligned. Biomedicine frequently exclusively links medical issues to biological causes, such as bacteria and infections, when describing health issues (Sikkink, 2009: 3). Biomedicine has significantly contributed to diagnostic technology and illness management systems for health promotion. However, it has dominated how healthcare is understood and utilised in most societies globally (Chinsamy, 2017: 10). Brubaker and Dillaway (2009) assert that such an effort is regarded as medicalisation when attempting to define, describe, understand, and treat a health condition through biomedicine.

Healthcare concepts and procedures, however, are intricate, and as a result, childbirth complications can be explained and even understood in many ways other than biomedically. Quinlan (2015: 383) asserts that every illness has several plausible causes and explanations, which tend to be influenced by people's sociocultural backgrounds, experiences, and perceptions of their symptoms. Stekelenburg (2005) states that traditional healers in Zambia are consulted by pregnant women for birthing processes, with or without complications. Similarly, Tabi et al. (2006) show that traditional healers consult for childbirth complications in Ghana. In South Africa, however, not much is written about traditional healers being part of the birthing process; however, traditional birth attendants, some of whom are also traditional healers, are an integral part of birthing in the country (Troskie 1997).

In South Africa, health care is provided within a multi-ethnic framework, with cultural ideas and values playing a significant role in health care perspectives. Daily exposure to and expectation of overcoming cultural barriers are faced by biomedical healthcare professionals, especially nurses, who often lack the necessary training (Grant et al., 2013). It is a diverse nation with different traditions and beliefs and a threefold cultural legacy from Africa, Asia, and Europe (Chinsamy, 2017: 4). This composition, therefore, opens multiple ways into how people understand and approach health and illness (Chinsamy, 2017: 4). The country's healthcare, however, is not diverse (Moshabela, Zuma, and Gaede, 2016: 83). Despite this lack of diversity, a more accepting and, in some cases, a reconciliatory discourse of a healing paradigm is currently protected by the Traditional Health Practitioners Act (22 of 2007). This is a transition from a pejorative witchcraft paradigm maintained by the Witchcraft Suppression Act (3 of 1957) (Moshabela, Zuma and Gaede, 2016). Nonetheless, Wreford (2005: 68) states

that many Black South Africans utilise traditional healers before, during, or after getting biomedical therapy for health conditions that they feel are best managed traditionally, whether culture-bound syndrome or not. Therefore, a traditional healer may understand childbirth complications linked to certain traditional practices. In contrast, a non-traditional healer may only understand the complication as solely explainable biomedically. Therefore, understanding how traditional healers who are professional nurses manage childbirth complications within the hospital is critical because of their dual identity. This could bring light to the way forward in decreasing the maternal mortality rate and the rising number of complications of childbirth within South Africa.

Cultural factors of pregnancy are sometimes overlooked, as portrayed above, even though indigenous beliefs and practices are shaped by cultural qualities that are passed down from generation to generation, which makes pregnancy more spiritual than it is physical (Kaido et al., 1996). TBAs engage in spiritual practices because they believe that pregnant women are vulnerable to spiritual attacks that might harm the pregnancy, but can be avoided by providing spiritual care (Ohaja, Murphy-Lawless and Dunlea, 2019). Many black South African women utilise traditional herbal medicines as prenatal drugs for inducing or augmenting labour, to evacuate the placenta, and possibly to avoid post-partum haemorrhage (Kaido et al., 1996). 'Isihlambezo,' 'Imbelikisane,' and 'Inembe' are the most prevalent herbal treatments utilised during pregnancy and labour. These are often made by boiling the herbal components in water as a mixture (Kaido et al., 1996).

Although studies have shown that traditional and biomedical health care coexist, little is known about how traditional healers working as professional nurses manage and understand childbirth complications. It is thought that about 1% of Black nurses in South Africa are also traditional healers. However, this is difficult to quantify because nurses in hospitals and clinics are unwilling to declare themselves fulfilling both professions (Tessendorf and Cunningham, 1997). This dual identity that traditional healers working as professional nurses hold solidifies the widely held view among traditional health practitioners that certain illnesses are natural and should be treated by doctors. In contrast, other illnesses are supernatural and should be treated by traditional healers. Regardless of the cause of the sickness, patients are guaranteed a cure when they are encouraged to do both therapies (Galvin, Chiwaye and Moolla, 2023).

According to Galvin, Chiwaye and Moolla (2023), researchers who conducted a study on medical pluralism among South African nurses who are traditional healers discovered that the nurses were part of pluralistic systems that drew from both Western and African cultural contexts. Still, they did not fully align with either. Because they are given more status in their communities than in hospitals, there is tension between the two roles as they work there. Because of their dual roles, they enjoy tremendous respect from their neighbours and friends, and the care they give is seen as having cultural significance (Tessendorf and Cunningham, 1997). Therefore, nurses and traditional healers desire greater acknowledgement and parity with Western medical staff.

Traditional Health Practitioners function in African civilisations, where they not only treat the illness's symptoms but also explain them. This is a point of differentiation for THPs working as professional nurses and nurses in general (Galvin, Chiwaye and Moolla, 2023). Specific experts contend that this could account for the persistence of THP's appeal even in areas where access to biomedical care is comparatively accessible (Galvin, Chiwaye and Moolla, 2023). However, it is indeed that while traditional healers who do not have the dual identity of a professional nurse utilise powerful medication that is deemed harmful by Western medicine, nurses who have the dual identity of a traditional healer and a professional nurse are significantly more cautious about this (Tessendorf and Cunningham, 1997: 60). For example, it is against the standard medical practice to give enemas to children who have diarrhoea because it increases the risk of dehydration. The treatment of this illness may reflect the influence of both Western and traditional medicine (Tessendorf and Cunningham, 1997).

Despite the many challenges of having the dual identity of being a traditional healer working as a professional nurse, according to Galvin, Chiwaye and Moolla (2023), traditional healers who are nurses typically limit their practice to nursing while a patient is in the hospital. Even so, they occasionally must care for patients who they believe would receive better treatment from a traditional healer than a nurse, and they sometimes must refer patients to traditional healers even though this is not recognised by the official system (Tessendorf and Cunningham, 1997). They frequently comment that traditional healers treat patients physically, socially, and psychologically holistically. They believe that, given the opportunity, they could be helpful in hospitals as traditional healers (Tessendorf and Cunningham, 1997). Furthermore, in a much more recent study by Naidu and Darong (2015), it is demonstrated that nurses with the dual identity of being a traditional healer and a professional nurse fear being reprimanded and losing

their jobs, which puts them in a difficult position of assisting their patients in hospitals even though some of their illnesses are much more traditional rather than medical. Traditional healers working as professional nurses are forced to maintain that they cannot demonstrate their skills and share their traditional gifts where they want or where it is critical due to rules and other circumstances, such as the 'oath' that limits them (Naidu and Darong, 2015).

According to Kruske and Barclay (2004), policymakers risk disregarding the vital cultural and social responsibilities that TBAs play in their communities and failing to acknowledge the challenges of providing expert care that traditional birth attendants may bring to the health system. The supply of professional attendants for all birthing mothers cannot occur in isolation from TBAs, who are also highly skilled. Tessendorf and Cunningham (1997) argue that more thought should be given to how doctors and traditional healers might work together in the best interests of their patients. Now, the two responsibilities of the traditional healer nurse occasionally clash. Still, there is an opportunity in the newly forming healthcare system (a system that accommodates both traditional and biomedical care) for them to become more complementary, mutually enriching, and supportive. Even though this system is gradually forming, it can be said, according to Tessendorf and Cunningham (1997), that with the many conspiracies and judgements surrounding being a traditional healer, there is a long way to go to accept the much more advanced healthcare that considers the traditional and biomedical care. Musie et al. (2022) argue for recognising the contributions of traditional healers within the hospital space and the need for relevant mechanisms and laws to be developed to control their activity, since we cannot ignore the fact that women consult them for childbirth complications. With literature that explains the need for collaboration and recognition of traditional healers who are nurses, no literature intensively shows the clinical decision-making of traditional healers and how they manage childbirth complications within the hospital space and their private rooms for traditional healing at home.

1.3 Significance of the Study

Some studies on childbirth complications, such as Hoban's (2007) article on *'Celebrating childbirth'* and Ashford's (2002), primarily focus on how many people experience such complications and the causes, often said to be biomedical. Others focus on the mental health of people who go through these complications (López-Morales et al., 2021). While such studies are relevant, it is also significant to understand the clinical decision-making process of nurses

who are traditional healers working in maternity wards. Based on their dual identity, which is critical to how they understand and approach health, traditional healers working as professional nurses have a unique perspective on childbirth complications, which is different from that of nurses who are not traditional healers, or vice versa. Exploring this experience will aid in understanding how medical pluralism, often practised in secret within hospital spaces, can be formalised. It is especially significant to give a voice to people who have been largely silenced due to the nature of their jobs, who must pick a side when having to deal with illnesses and diseases. The experiences of traditional healers working as professional nurses dealing with birthing difficulties have not been extensively recorded in literature. Hence, this study aims to understand how traditional healers working as professional nurses in Johannesburg hospitals understand and navigate childbirth complications.

1.4 Structure of Thesis

This dissertation is divided into eight chapters, each with a significant and interrelated subject of discourse.

CHAPTER ONE: Introduction and Literature Review

The first section of this chapter examined the understanding of childbirth complications, the usage of the notion of medical pluralism, and the role of traditional healers working as professional nurses in understanding the complications of childbirth and health in general. This chapter illustrated the need for a comprehensive approach to healing within a country. The chapter highlighted some of the ways the dual identity of being a traditional healer working as a professional nurse has benefited and will continue to benefit when people with this dual identity are allowed to practice loudly, as well as how traditional healers have made a significant contribution to health since the introduction of midwifery, yielding partial findings and conclusions. Literature, as illustrated in the chapter, demonstrates how being a traditional healer working as a professional nurse is complex and frequently fraught with conflicts, particularly between the many health methods employed by multiple health users, but also within the traditional healers working as professional nurses in determining when to utilise which system.

CHAPTER TWO: Theoretical and Conceptual Frameworks

The chapter begins with a map to assist one in comprehending how things impact one another, making sense of how the work is conceived, and illustrating possible linkages between ideas. This conceptual framework demonstrates a better delivery experience. The chapter then employs a theoretical framework to arrange or organise the concepts, laying the groundwork for data processing and interpretation. As a result, the chapter focuses on social identity theory and hermeneutic phenomenology theory to analyse the study results. Furthermore, the chapter examines the study's purpose and objectives and the main questions employed to draw the research's conclusions.

CHAPTER THREE: Research Methodology

This thesis methodology chapter acts as a study map, outlining all the methods used in the preparation, execution, and analysis of this thesis. This chapter discusses the methodology and procedures employed in the study. The study took an ethnographic and qualitative approach, with participants recruited using a non-probability sampling strategy known as purposive sampling and data collected using semi-structured interviews. Thematic analysis was used to analyse the collected data, and the ideas discovered in the data were analysed to better understand the clinical decision process of nurses who are traditional healers. The chapter demonstrates the strategies and methodologies employed and the rationale for their usage. It provides an organised method to explain how participants were recruited and how data was gathered and analysed. In investigating the methods and approaches employed in this study, space was made available to describe the rationale for using each method and its potential influence on the study's conclusion. Considering the methodology utilised, this provides a clear interpretation and comprehension of the study's conclusions.

CHAPTER FOUR: Spirituality of Pregnancy

This chapter speaks to how pregnancy is linked to spirituality in understanding how pregnancy is tempered by people, leading to a pregnant woman having a miscarriage. In explaining this, the chapter highlights the sacredness that comes with pregnancy through the understanding of secrecy and avoiding the need to announce their pregnancy without people seeing it, leading to one meeting unforeseen misfortunes.

CHAPTER FIVE: Biomedical Models of Childbirth Complications

In this chapter, the introduction of the complications of childbirth through the traditional healers working as nurses is explained, using their training and experience to help one understand the complications of childbirth. This chapter uncovers how negligence by those in authority during childbirth is the reason for the complications and maternal death. In explaining those mentioned above, the chapter also considers complications such as PROM, Breech, PPH, FH, CPD and other childbirth complications while portraying how they can be handled within the hospital space.

CHAPTER SIX: Traditional Models of Childbirth Complications

This chapter develops an understanding of traditional healers' role as nurses and their traditional identity. This chapter looks at ways traditional healers protect pregnant women from evil through the understanding that there are always negative energies targeting the baby. In explaining this, the chapter looks at methods of protection, such as strings, *isihlambezo*, prayer, *isiwasho* and so forth, as ways for pregnant women to have their babies in their arms after childbirth.

CHAPTER SEVEN: Incorporating Traditional Healing in Hospitals: Benefits and Barriers

In this chapter, traditional healers working as professional nurses are seen to voice out the challenges and successes they face because of having this dual identity. In doing this, the chapter illustrates the convergence of the health systems and policies restricting traditional healers from working as professional nurses in their identities. The dual identity of traditional healers working as professional nurses is seen to rise, where traditional healers act out of their nursing scope or out of the scope of *umthetho weshobo* for the patient's benefit. In this, the clinical decision-making of the traditional healers working as nurses is seen to rise while illustrating how the people with this dual identity benefit from it and separate it in spaces where the dual identity is not allowed to act.

CHAPTER EIGHT: Conclusion and Recommendations

The traditional healers working as professional nurses in this study believe that, even though pregnant women have the benefit of mainstream healthcare, some continue to use traditional medicine for reasons such as witchcraft that biomedicine cannot handle. These factors include avoiding evil spirits during pregnancy and preparing for labour and delivery. Herbal medications are used from conception until delivery to ensure a healthy pregnancy without complications. This chapter concludes the thesis by summarising all the study findings. This includes making recommendations for further study and determining the study's limitations.

1.5 Summary of Chapter

According to Wreford (2005), in undeveloped nations, women continue to seek care from traditional healers during pregnancy even when there are sophisticated health systems available. It is clear according to many studies, such as Kale's (1995) article on *South Africa's Health: Traditional healers in South Africa: A Parallel Health Care System* and Galvin, Chiwaye and Moolla's (2023) article on *Religious and Medical Pluralism Among Traditional Healers in Johannesburg, South Africa* that accessibility is of great significance in getting the proper healthcare needed. With patients getting both traditional and biomedical therapy within the hospital, childbirth complications could be treated in many ways and that can help patients get the help that they need. Despite this case, traditional healers are still not trusted by biomedical practitioners. This can be seen in how traditional healers frequently complain that they have sent referrals to biomedical practitioners but have not received any back; patients explain that they got a referral from biomedical practitioners (Solera-Deuchar et al., 2020).

CHAPTER TWO

2. THEORETICAL AND CONCEPTUAL FRAMEWORKS

2.1 Introduction

Eisenhart (1991: 202) defines a framework as a skeleton structure meant to support or surround anything, which researchers describe as supporting or enclosing their findings. A framework for this study gave a clear and cohesive structure for this research endeavour, which assisted in minimising misunderstanding, inconsistency, and bias (Eisenhart, 1991: 203). The frameworks (conceptual and theoretical) employed for this study gradually refined and narrowed the issue of childbirth complications to a discernible gap in what is unknown about the topic, in this case, how people with dual identities of being professional nurses and traditional healers handle and understand childbirth complications. Following the introduction and literature review discussion, I have presented the study's conceptual and theoretical frameworks, emphasised the research aims and objectives, and presented the study's key questions in this chapter.

2.2 Conceptual Framework

According to Maxwell (2012), a conceptual framework is "a collection of ideas, presumptions, expectations, beliefs, and theories that support and inform research" through concepts that bring the research together. This framework aims to identify and characterise concepts pertinent to the research and draw links between them (Rocco and Plakhotnik, 2009: 122). Furthermore, it explains why a study is pertinent and significant and how the study design, including other methods used within the study, adequately and objectively answers the research question(s) (Ravitch and Riggan, 2016). The framework also situates a study within various settings and how a researcher is located concerning the research (Ravitch and Riggan, 2016). It serves as a link between the context, theory, and the way the study is structured. It assists in integrating one's understanding of all the influences and aspects of a particular study to create a more deliberate and methodical process of connecting the various parts of the study. The conceptual framework below depicts the significant factors the researcher found regarding childbirth complications. It portrays the researcher's presumption and comprehension of childbirth complications.

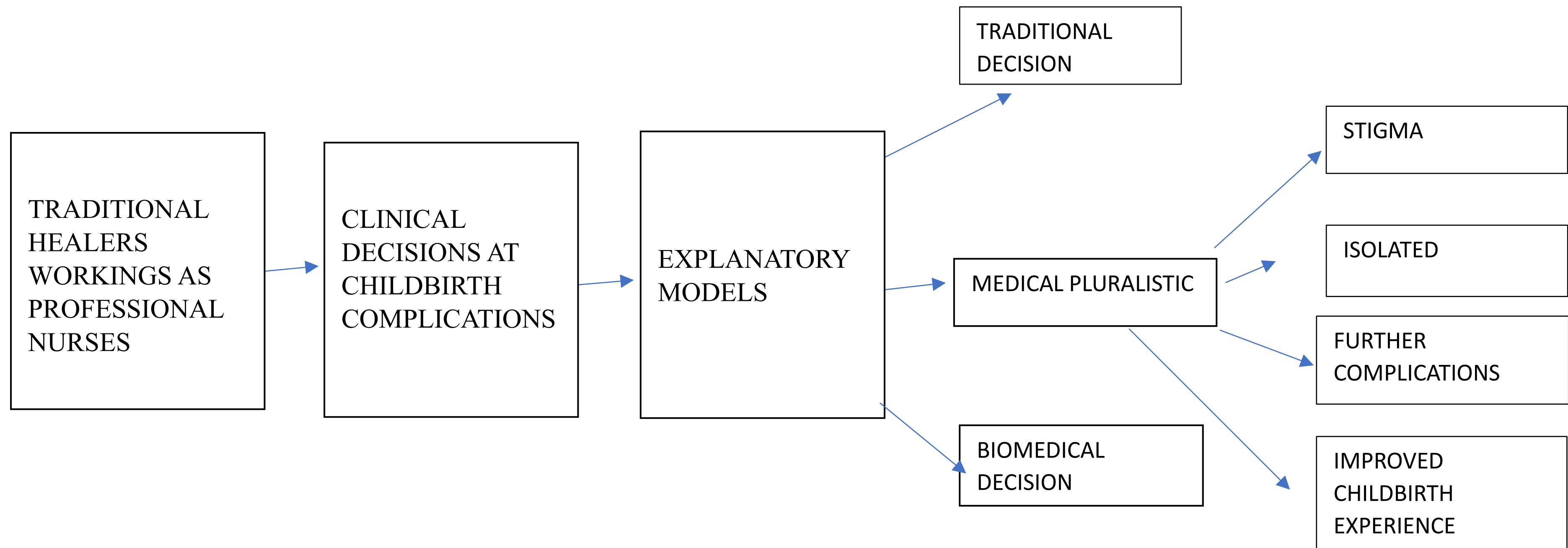

Figure 1: Conceptual Framework on Childbirth Complications (Developed by the researcher)

The conceptual framework functions as an encompassing ecological system that helps researchers deliberately bring all aspects of a study together by clarifying their connections, overlaps, tensions, and the contexts shaping the research setting and the study of phenomena within that place (Ravitch and Riggan, 2016). Above is a framework on childbirth complications developed by the researcher. The above arrows of this specific framework illustrate what contributes to what.

Figure 1 depicts notions of traditional healers working as professional nurses and numerous ideas that can lead to a cohesive conceptual framework and a comprehensive knowledge of the topic under investigation. The above depicts clinical judgments about childbirth complications as a phenomenon of interest. Traditional healing is one component of a professional nurse's identity that influences their viewpoints. In addition, biomedical viewpoints are the predominant approach in hospitals, which may differ from conventional ideas. Furthermore, medical pluralism within the conceptual framework exemplifies medical plurality as the presence of diverse medical systems. In this conceptual framework, the traditional healers are professional nurses who bridge the gap between systems. Identity negotiation appears to be the most crucial aspect of this study, mainly focusing on how traditional healers working as nurses manage their traditional healer and nursing identities.

Following the diagram, explanatory models influence the agent, traditional healers working as nurses. According to Dinos et al. (2017), explanatory models are people’s perceptions, interpretations, and responses to sickness and illness. These are influenced not just by sickness and illness but also by the cultural and social environment. Traditional healers who are working as professional nurses understand the complications of childbirth in various ways. Traditional healers working as professional nurses have experience and training in both biomedicine and traditional medicine. In understanding the complications of childbirth in various ways, the traditional healers working as professional nurses are forced to decide whether they heal the complications of childbirth biomedically, traditionally, or even in a medical pluralistic way. Decision-making is the process that leads to choosing a course of action from a set of alternatives (Ofstad et al., 2016). As illustrated above, traditional healers working as professional nurses decide to act within a biomedical sphere, which focuses on the patient's pathophysiology, or act within the traditional domain, which considers the spiritual aspect of childbirth complications. Regardless, they are also faced with the decision to treat the patients in a medical pluralistic manner. According to Amzat and Razum (2014), medical pluralism

refers to the coexistence of several medical traditions in a community founded on diverse concepts or worldviews. In the case of this study, traditional and modern healthcare treatments are compared.

Traditional healers working as professional nurses face the stigma that mostly surrounds them as traditional healers. Most literature mentions this stigma arising from traditional medicine being perceived as illogical and lacking scientific rigour (Sobiecki, 2014). This, unfortunately, is not the only reason, but also still falling victim to the Witchcraft Suppression Act (3 of 1957), which criminalised traditional healers and labelled them as witchdoctors (Moshabela et al., 2016). Although South Africa has a pluralistic healthcare system, this continues. This is the other way around for medicine, since it overpowers the understanding and knowledge of traditional healing. This illustrates the power of biomedicine within South African countries. Nonetheless, traditional healers working as professional nurses because of their medically pluralistic nature are forced into isolation because, according to Green and Colucci (2020), traditional healing is not incorporated into healthcare policy, legislation, or education, raising significant worries about its uncontrolled nature. They have little official education; some learned from family, while others were trained through an apprenticeship system (Ohaja, Murphy-Lawless and Dunlea, 2019). Traditional healers working as nurses are forced to hide their dual identity within the hospital space, which leads to them being isolated in terms of identity and practice.

Being a traditional healer who is a nurse, one is subjected to making clinical decisions that consider medical pluralism and, therefore, lead to further complications, especially since, as will be shown within this study, traditional healers working as nurses are limited in how they act within the hospital space. Nonetheless, they are seen practising secretly to work for the better health of their patients. This further complicates the mother and child, especially in how traditional healers work, as professional healers decide to act. One can depict from this research that this specific dual identity improves the childbirth experience, especially since they look at it from both a traditional and medical perspective, resulting in holistic healing.

The above conceptual framework can bring together hypothesised links between ideas. Traditional Healer Professional Nurses' understanding of birthing issues may differ from biological ones. Their multiple identities require them to navigate medical diversity at hospitals and negotiate their identities when treating difficulties. The study uses phenomenological approaches to investigate the lived experiences of professional nurses who work as traditional

healers in understanding and treating delivery difficulties. The findings shed light on how traditional healers, acting as professional nurses, apply traditional and biomedical expertise to manage the challenges.

2.3 Theoretical Framework

The theoretical framework is a structure that organises concepts and theories generated from previously tested and published knowledge, which is synthesised to provide a theoretical foundation or the foundation for data processing and interpretation of research data (Kivunja, 2018). It entails presenting a specific theory, such as systems theory or self-efficacy, and empirical data (Rocco and Plakhotnik, 2009). This then helps give meaning to the written data within the study by employing theories. Theories are critical because, while anthropologists acquire data through fieldwork, data alone is worthless (McGee and Warms, 2004). Theories offer well-supported explanations for occurrences, enabling researchers to make predictions and link their research topics to existing knowledge. The two theories utilised in this study are the Social Identity Theory and Hermeneutical Phenomenology Theory.

2.2.1 Social Identity Theory

Regarding identity, it is argued that it is vital for one to "belong" because belonging helps with social connection, shared beliefs, experiences, and values. After all, with this, one can know who they are (Day, 2011). Tajfel and Turner's social identity theory, presented in 1986, proposes that people experience collective identity depending on how they identify in a group, such as racial/ethnic and gender identity (Ramasubramanian and Murphy, 2014). Individuals' social identities cause them to divide themselves and other significant groups into "us" and "them"(Ramasubramanian and Murphy, 2014).

Henri Tajfel's scholarly work, like that of many other social psychologists of his period, was influenced by his encounters involving prejudice and group disputes. He argues in his early publications that he was compelled to understand how people who had lived together as neighbours, colleagues, and friends might come to consider each other dangerous foes even when there were no reasonable or objective reasons to do so (Ellemers and Haslam, 2012). In contrast to a field research approach, he attempted to understand these issues by using scientific

rigour to study groups in the laboratory and by investigating basic social cognitive processes that were important in some of his previous studies on objective grouping.

Social identity is described as that component of an individual's self-image that originates from his knowledge of his participation in a social group and the emotional meaning associated with that membership (Ellemers and Haslam, 2012). In addition to developing the idea of the social identity, Henri Tajfel (in cooperation with his PhD student John Turner) suggested that human connection may vary from entirely interpersonal to purely intergroup (Hornsey, 2008). An entirely interpersonal relationship, which Tajfel and Turner (2014) considered uncommon, includes people interacting just as individuals without knowledge of social categories (Hornsey, 2008). In a strictly intergroup interaction, individuals engage solely as representatives of their groups, with group memberships taking precedence over individual characteristics. Shifting from interpersonal to intergroup affects how individuals perceive themselves and others (Hornsey, 2008).

According to the theory, social identity supports intergroup behaviour, fundamentally different from interpersonal behaviour. It defines the conditions under which social identities will likely become sufficiently significant to become dominant predictors of social perceptions and behaviours (Ellemers and Haslam, 2012).

Social Identity Theory examines how group membership is absorbed into our self-concept and impacts our opinions of other members and non-members of our groups and members of opposing organisations (Neighbours, Foster and Fossos, 2013). In understanding where social psychological theory and research have brought us, there was a lot of controversy in the late 1960s and early 1970s, when the "crisis of confidence" was introduced in social psychology (Hornsey, 2008). This crisis was most apparent in discussions of group dynamics and intergroup connections. Many reviewers chastised the discipline for focusing on intrapsychic and interpersonal processes rather than 'big picture' components like language, history, and culture. The social identity approach, including identity theory and self-categorisation theory, emerged during a crisis (Hornsey, 2008). An ambitious and far-reaching set of concepts arose as an alternative to existing conceptions of intergroup relations that are unduly individualistic and reductionist.

The application of this Social Identity Theory in this study assisted me in understanding how professional nurses who are traditional healers navigate their roles when dealing with the complications of childbirth. Also, it helped me understand how their dual identities shape how people see them and how the biomedical ethical guidelines restrict their ability to provide traditionally aligned care to mothers experiencing childbirth complications. Moreover, this theory portrays how traditional healers working as professional nurses' identities must be adapted, negotiated, and revised when managing childbirth complications within the hospital space.

2.2.2 Hermeneutical Phenomenology Theory

Researchers have employed hermeneutic phenomenology extensively to explore lived experiences. People are as distinctive as their life stories (Miles et al., 2013: 409). Therefore, this theory is regarded as an interpretation theory that sheds light on and gives meaning to things worldwide, such as childbirth complications. Its purpose is to express human experience in its entirety. Phenomenologists strive to give a knowledge of the internal meanings or essences of a person's experience in the lived world by a thorough description of that experience, aiming to explain rather than provide a causal explanation for that experience (Van Derder Zalmzalm and Bergumbergum, 2000: 212).

According to Van Derder Zalmzalm and Bergumbergum (2000: 212), this theory respects a nurse and patient relationship and one that accepts the holistic approach to an individual, therefore showing that there is more than one way to understand disease and illness, much as there is more than one way to heal that specific disease and illness. Hermeneutic phenomenological thinking is founded on the notion of being in the world, which encompasses humans connecting to and with the entire context of their environment through rituals, symbols, and languages that comprise their shared meanings (Miles et al., 2013: 410).

Applying this theory in this study portrayed that there is more to childbirth than just complications; there are aspirations and needs in social, emotional, physical, spiritual, and cultural areas. It showed that when one is going to give birth, there are a lot of cultural rituals that need to be done, and some spiritual rituals need to be done for the baby to come out healthy. Ultimately, this theory has helped me understand how nurses who are traditional healers experience managing childbirth complications.

As seen above, choosing the proper framework is essential for researchers because, as Asghar (2013: 3121) points out, a paradigm offers a universe of perspectives that defines the world's character and the range of possibilities for its bearers in connection to reality. This study operates within a critical paradigm because it seeks human emancipation to free humans from the circumstances that imprison them (Asghar, 2013: 3121). The critical paradigm opposes the existing status quo and seeks a balanced and democratic society. It is primarily concerned with the question of power relations within society, as well as the interplay of race, class, gender, education, the economy, religion, and other social structures that contribute to the functioning of a social system (Asghar, 2013: 3121). This research, therefore, focuses on countering the status quo of biomedicine being mainstream in healing by exploring how traditional healers can work hand in hand with biomedical practitioners in giving a more holistic approach to managing childbirth complications. For that reason, with different paradigms that exist, this specific paradigm fits better with this study because the study moves past what is seen as the norm, in this case, professional nurses acting within their profession but, in this instance, using their dual identity of being an experienced nurse and traditional healer to help with the complications of childbirth, showing the need for people with such a dual identity within the hospital space.

2.4 Research Aim, Objectives, and Key Questions

2.4.1 Research Aim

The study aimed to investigate how professional nurses who are also traditional healers understand and navigate childbirth complications in hospitals around Johannesburg.

2.4.2 Research Objectives

1. To explore how traditional healers working as professional nurses understand complications during childbirth in hospitals around Johannesburg.
2. To explore explanatory models used by traditional healers working as professional nurses in navigating childbirth complications in hospitals around Johannesburg.

3. To understand how traditional healers working as professional nurses negotiate their traditional/professional identities in navigating the complications in childbirth that they observe in hospitals around Johannesburg.

2.4.3 Key Questions

1. How do nurses, who are also traditional healers, understand childbirth complications?
2. What explanatory models do nurses, who are also traditional healers, use in navigating childbirth complications?
3. How do nurses, who are also traditional healers, negotiate their professional/traditional identities in navigating childbirth complications?

2.5 Summary of Chapter

The theoretical framework serves as the basis upon which all information for a research project is built symbolically and practically (Grant and Osanloo, 2014). It provides structure and support for the study's rationale, problem description, purpose, importance, and research questions (Grant and Osanloo, 2014). Thus, according to Grant and Osanloo (2014), the theoretical framework serves as a "blueprint" for the thesis investigation. As illustrated above, the blueprint is seen in how the work is linked to give meaning and sense through understanding the social identity theory and the hermeneutical phenomenological theory. Therefore, providing a structure for the thesis. The conceptual framework allows for the specification and definition of issue concepts, creating an organised framework and visual representation of how ideas relate to one another (Rocco and Plakhotnik, 2009). The research aim of the study was to investigate how professional nurses who are also traditional healers understand and navigate childbirth complications in hospitals around Johannesburg.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 Introduction

A research technique gives a study legitimacy and yields conclusions supported by science (Sandelowski, 1986; Oun and Bach, 2014). It is methodical since some straightforward steps and procedures must be followed throughout the research process to gather the most accurate results and identify the answers the researcher seeks at the end of the study (Oun and Bach, 2014). Therefore, putting together the necessary facts to help conclude the study is impossible without a methodical approach (Sandelowski, 1986). Thus, the availability of a methodological approach to understanding how nurses who are traditional healers working in Johannesburg hospitals understand and navigate the complications of childbirth is crucial. This chapter reinforces this by revealing how the research design, the study population, the sample size, the sampling approach, data generation, and data analysis were employed to obtain the study's results.

3.2 Study Approach

This study was qualitative ethnographic research from June to October 2023. This choice of ethnographic research is because it permits one to understand and describe people's lived experiences that are hard to put in numbers as it locates the observer in the world (Neumann, 2014: 275; Creswell, 2007: 36). What qualitative research uniquely provides to professional knowledge is a phenomenological awareness of the lived experiences of the study participants, and that viewpoint may be critical in tackling societal challenges and problems more equitably and effectively (Koch, Niesz and McCarthy, 2014). Participants assist in making public their understandings and experiences in ways that can lead to substantial transformations in their worlds through a broader or professional knowledge of their lives and, possibly, via their own greater human understandings (Koch, Niesz, and McCarthy, 2014). It is a formal, impartial, and methodical approach to gathering data about the world (Burns and Grove, 2015).

According to Hammersley (2018), the question of ethnography is complex and tricky to define. However, it can be defined as the activity of probing the private lives of others. Moreover, it systematically studies individuals in natural environments or fields using techniques that capture their social meanings and everyday activities (Hammersley, 2018). Despite being from Johannesburg, the study participants are not from one neighbourhood or medical facility in Johannesburg; hence, this research employed anthropologist George Marcus's (1995) multi-sited ethnographic technique. Multi-sited ethnographic research provides for a more intricate and in-depth circulation of cultural meanings, artefacts, and identities in diffuse time-space (Marcus, 1995: 96). This strategy enables the examination of themes and relationships between multiple sites that give a variety of data. This links strongly with my study because it investigates how traditional healers working as professional nurses in different health facilities in Johannesburg understand and approach health while exploring how medical pluralism, often practised in secret within hospital spaces, can be formalised.

3.3 Research Design

Burns and Grove (2015) state that a researcher's choices on conducting a study ultimately determine the study’s design. The plan for carrying out the study is guided by the design, which is intimately related to its framework. Therefore, this study employed a phenomenological research design. According to Vagle (2014), phenomenology is an interaction and way of life. Phenomenology is both a philosophy and a research methodology. Rather than investigating objectively agreed-upon concepts, phenomenology emphasises isolating reality as it is experienced by individuals and explaining occurrences through emerging core themes anchored on qualitative research methodologies (Vagle, 2014). Phenomenology is particularly well-suited to research that focuses on the uniqueness of a person's experiences, how those experiences are rendered meaningful, and how such meanings manifest themselves within the context of the person as an individual and in their many roles (Shaw, 2001). Sloan and Bowe (2014) claim that experience, as opposed to an objective, physically stated reality outside of the individual, determines human action, making this theoretical point of view an advocate for studying individual experiences. When looking at this as a design, it conveys the importance of a phenomenon or reality via the lived experiences of many individuals (Creswell, 2007). Once participants encounter a phenomenon, the design focuses on expressing what they share (Creswell, 2007).

The type of phenomenological design that this study has used is hermeneutical phenomenology. Creswell (2007: 59) defines hermeneutical phenomenology as being focused on the lived experience that captures participants' and researchers' ongoing concerns and childbirth complications. Kafle (2011: 186) also explains hermeneutic phenomenology as concerned with the subjective experiences of people and organisations. The hermeneutic shift in phenomenology arose from the belief that our experiences are best understood through the stories we make about them. To comprehend the world, we must investigate the tales that individuals tell about their experiences, typically with the assistance of a hermeneutic or style of interpretation (Kafle, 2011: 191). The focus is on illuminating details and seemingly trivial aspects within the experience that may be taken for granted to create meaning and achieve a sense of understanding. It attempts to convey the world as the subject experiences it via their life tales.

Hermeneutic phenomenology requires the researcher to think thoroughly about what the participants say. Apart from this, the researcher is invited to experiment with the participants to become caught in a profound discourse with them. This form of study allows the reader to enter the world that the participants will reveal and open in front of them (Kafle, 2011: 192). Hermeneutic Phenomenology offers methods that advise the researcher to understand the meanings associated with events (Sloan and Bowe, 2014). To uncover these meanings and permit interpretation, these methods frequently lead to text analysis. The focus of this design is on comprehending the meaning of experience through the identification of themes and interpretive engagement with the data. Furthermore, hermeneutic phenomenology seeks to leave the data analysis up to the context of the experience itself without formalising any analytic procedure (Sloan and Bowe, 2014). In understanding hermeneutic phenomenology, one embraces that there may be several viewpoints on a phenomenon, like how one section gets concealed when we spin a prism. Another part opens (Kafle, 2011: 192). Concerning this study, one can point out that the way of understanding and dealing with childbirth complications among the study participants differs, even though they share this dual identity. Therefore, by 'dual identity,' this study emphasises the identity of a traditional healer working as a professional nurse. Furthermore, the cultural differences among the participants impact their shared dual identity. As a result, each participant has a distinct understanding of how to address a particular complication of childbirth. Moreover, their education also has a significant impact because, despite the widespread belief that biomedicine is universal, one's approach to the field depends on what they learned at school. These numerous variables are kept open-

ended, including the participants' upbringing, current living situation, and surroundings, among other things. These all demonstrate the diversity and help better understand the participants' dual identities.

3.4 Study Setting

According to Given (2008), a research setting refers to the physical, social, and cultural environment in which a study is conducted. Johannesburg, with a population of little more than 4,4 million, is home to a diverse population (Vearey et al., 2017). It is primarily made up of indigenous and foreign migrant black Africans. A patriarchal culture generally believes in witchcraft (Kadenge and Ndlovu, 2012). Furthermore, Johannesburg is a hybrid city with individuals from many countries, cultural origins, religious views, and educational levels. People in this metropolis are cut off from immediate contact with their relatives and native communities because of the life that comes with living in this specific metropolis. People in this city have come to achieve personal achievement in various ways, but for a variety of reasons, including poverty, immigration status, and religious convictions, as well as to receive health care, which they do not usually get from their homelands (Kadenge and Ndlovu, 2012). It is famously known as 'Egoli' in IsiZulu and/or 'City of Gold' (Vearey et al., 2017).

The study was conducted in Johannesburg. Johannesburg lies in Gauteng, South Africa's smallest province, yet the country's economic hub. The province was established in 1994 as part of the democratic regime (Abrahams and Everatt, 2019). Gauteng, along with KwaZulu-Natal, has the most significant number of births in South Africa, with Gauteng having 254,952 birth registrations and KwaZulu-Natal having 219,290 birth registrations, all in the year 2021 (Guidozzi, Branch and Chauke, 2019; Statistics South Africa, 2021). Therefore, this area was chosen as it is one of the country's three provinces with the highest caesarean rates (with Nelson Mandela Bay at 40.1%, eThekwini at 37.0%, and Johannesburg at 32.6%) (Salonki et al. 2020), a common way of dealing with most childbirth complications. Also, its multicultural nature allowed me to get traditional healers working as professional nurses from various cultures.

According to Joburg City Services (2018), Johannesburg has 19 hospitals and nearly 100 clinics, of which 81 are public. Unfortunately, not all clinics provide childbirth services, but all hospitals do. Charlotte Maxeke Johannesburg Academic Hospital (CMJAH), a former 'white' hospital with 2,000 beds that opened on Parktown Ridge in 1978, is the best-equipped of all hospitals in Johannesburg (Ominode, 2011). The sprawling Baragwanath complex, located on the Northern edge of Soweto, is the largest hospital in Johannesburg and Africa. It provides care to more than 5,000 patients daily (Findley and Ogbu, 2014: 131). On the other hand, this study was conducted with nurses from two hospitals and two clinics that allow births and deal with delivery complications. For ethical reasons, hospital number one will be called Midway, hospital number two, Bhekani, clinic number one, Chase, and clinic number two, Kholo. These health facilities were not selected as the focus of the study. Instead, the nurses, regardless of their place of work, were selected and were afterwards discovered to be working in these facilities. Due to the location of the facilities, most of its patients are from the adjacent black neighbourhoods, and the hospitals or clinics allowed for birthing as well as the handling of the complications of delivery, factors which meant the nurses recruited had rich expermorein childbirth, childbirth complications, but also in dealing with black African mothers, who may have traditional understandings of childbirth complications.

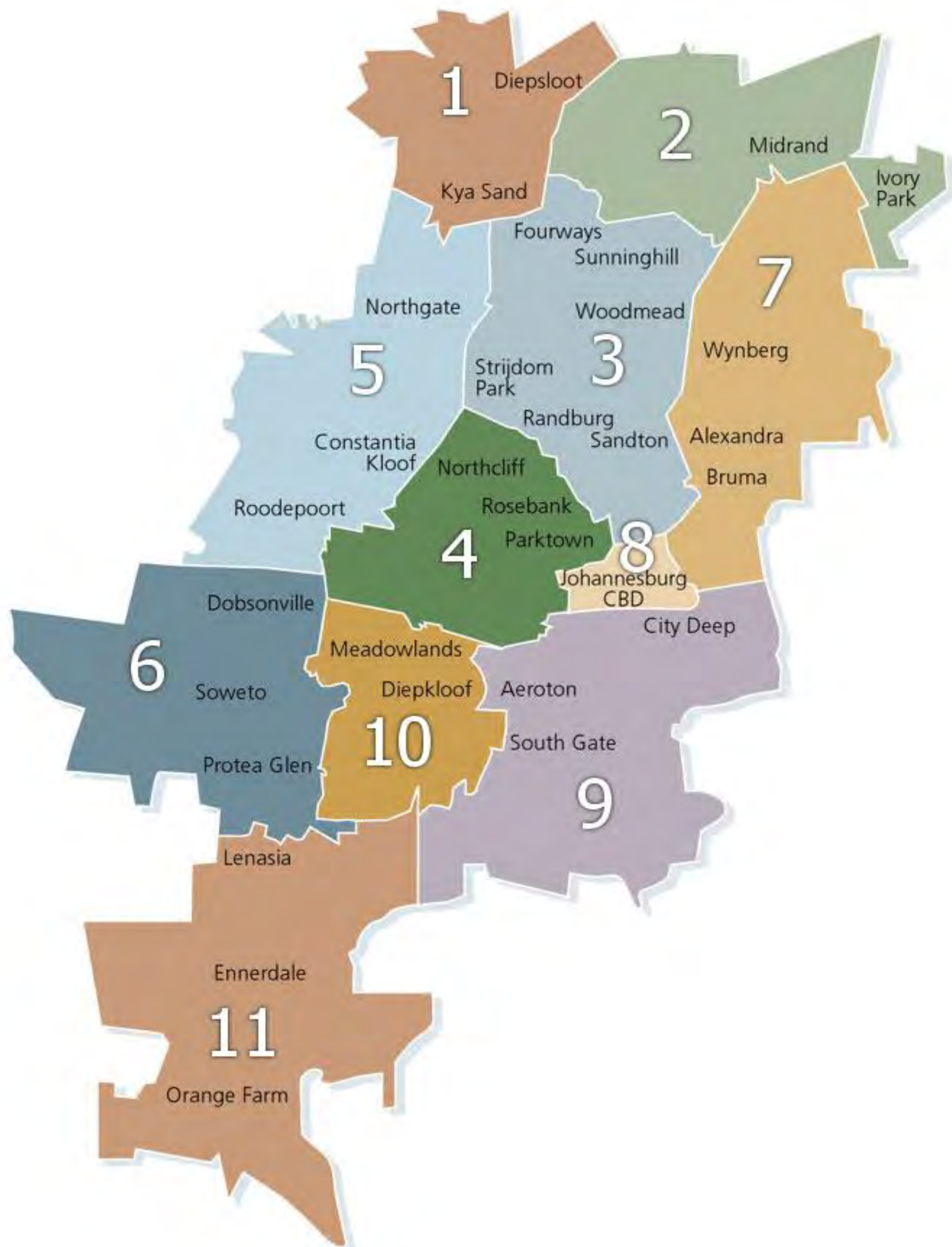

Figure 2: The Map of The City of Johannesburg with its respective sub-districts (de-academic.com, 2016)

3.5 Study Population and Sample Size

This study gathered in-depth data on experiences from traditional healers working as professional nurses in Johannesburg who have had experience managing childbirth complications within their hospitals. The 12 nurses recruited for this stage occur when no more new data is discovered from which a researcher can construct attributes (Saunders et al., 2017). As the researcher observes comparable situations, the researcher gains empirical confidence that a category is saturated (Saunders et al., 2017). Saturation occurs when the same topics emerge frequently during interviews and observation. The study was not focused on gender, even though the 12 people recruited in this study were females.

The research participants in this study have various work experiences and different age groups. I chose these specific people because they better understood my research question by giving biomedical and traditional perspectives on their understanding of childbirth complications, since they are traditional healers working as professional nurses who work in maternity wards and have had experience managing childbirth complications. They were thus more knowledgeable in biomedicine and traditional medicine because they had received training in both. In contrast to a professional nurse who does not have the dual identity of a traditional healer and vice versa, they would have been involved in labour and dealt with birthing complications. As a result, they confront more everyday problems, choices, and clinical judgments regarding each patient, putting their dual identities as traditional healers and professional nurses to the test. A key criterion, however, was that they must have observed a childbirth complication case in the hospital setting.

Participants were aged 25 to 54. This age group allowed for intergenerational perspectives on the research topic, which was the understanding and navigation both biomedical and traditional perspectives of childbirth complications. People with these dual identities had many comparable perspectives and understandings of childbirth complications. This common characteristic was crucial for this research study because the study mainly focused on traditional healers working as professional nurses' understanding and navigation of childbirth complications. Although the participants had diverse viewpoints, this resulted in significantly richer data than I anticipated, which proved helpful in this study.

Table 1: Summary of participants' demographics

S/N	NAME (pseudonym)	AGE	MEDICAL TITLE	NURSING YEARS	TRADITIONAL HEALING YEARS	HEALTH FACILITY
1.	Portia	40	Midwife	16	3	Hospital
2.	Mkhulu Mkhontowamanzi	30	Midwife	8	4	Hospital
3.	Lethu	27	Midwife	4	1	Clinic
4.	Thuli	27	Midwife	4	12	Hospital
5.	Keneilwe	26	Nurse	4	5	Hospital
6.	Nkgono Modiehi	33	Midwife	9	5	Clinic
7.	Busisiwe	32	Nurse	9	2	Hospital
8.	Lizzy	54	Advanced Nurse	13	8	Hospital
9.	Tsholo	31	Midwife	7	1	Clinic
10.	Gogo Noma	33	Nurse	8	15	Hospital
11.	Lesego	36	Midwife	7	15	Clinic
12.	Nomathemba	63	Midwife	22	25	Hospital

NOTE: Participants are arranged in order of interview schedule

3.6 Sampling Approach

Sampling is the process of picking an appropriate portion of a population. The sampling procedure decides how generalisable the study findings are (Showkat and Parveen, 2017). It is the process of selecting a subset of a population to research. Therefore, this study has used non-probability sampling, which, as opposed to probability sampling, draws the sample using non-randomised techniques. According to Neumann (2014: 274), the researcher intentionally identifies and chooses a specific population through non-probability sampling. Therefore, the population selected for this study was traditional healers working as professional nurses in maternity wards of biomedical health facilities in Johannesburg.

The non-probability method used is purposive snowball sampling. Purposive sampling is a method where the researcher selects participants based on their discernment, bearing in mind the study's goal (Showkat and Parveen, 2017). I used opportunistic purposive sampling to initially enrol participants since I had previously identified and approached a traditional healer who is a nurse with a thorough grasp of the complications of childbirth, both traditionally and biomedically. Opportunistic or accidental samples are unexpected sources of knowledge that fall into your lap (Neumann, 2011). I later used snowball sampling, a chain referral technique that builds a network of connected individuals with related experiences (Neumann, 2011: 274). This aided me by having the first participant recommend a possible person who had comparable experiences and was willing to engage in this study, and then having that potential participant do the same, and so on. I identified new participants on social media as I spent more time looking for them and continued to seek references. As a result, obtaining permission from the participants was not difficult because most of the participants were friends. In contrast, others were coworkers who became interested in the study through their colleagues, who then introduced me to them. I was able to attract the number of people I did because of their friendly welcome, assistance, and support. I could work seamlessly with the traditional healers, who were also expert nurses, and I was continually supported with whatever answers I needed whenever I had a question.

According to Showkat and Parveen (2017), Snowball sampling is employed when a specific population is challenging to discover. As a result, I feel this selection strategy aided me immensely in the study since locating traditional healers working as professional nurses was difficult, especially those who are open about their practice and are not frightened of being judged.

3.7 Data Generation

According to Goldkuhl (2019), ' data generation' refers to how researchers get empirical data or the researcher's ability to create settings that yield abundant and valuable data for future study. Focusing on capturing data, extracting, noting, and searching are examples of data-generating activities. It is also the circumstance that researchers set up to generate data that they believe will be relevant for subsequent data analysis, given the declared study objective (Goldkuhl, 2019). The behaviours of researchers in a data-generation setting are determined by their research interests and problems. Qualitative data is culturally distinctive and contextually rich (Bernard 2006). It contributed to this study because data involving health, especially the complications of anything related to health, is crucial in constructing complete solutions to public health problems in underdeveloped nations. Therefore, this study makes it easy to provide knowledge about other cures. Moreover, data was gathered in the first person to comprehend and investigate an individual's awareness and experiences concerning a specific occurrence, in this case, childbirth complications (Bernard, 2006).

De Fina (2019) states that an interview is a qualitative researcher's preferred methodological technique. Due to this, the data collection approach used for this study is semi-structured interviews. Semi-structured interviews are talks in which a researcher with a general idea of what they want to learn then asks questions to study participants (Fylan, 2005: 65). This type of interview provides for exploration as well as the freedom to follow topical trajectories as the interview progresses, allows the interviewees to oversee the conversation, elaborate, and develop their ideas on the topic being explored during the interview (Marcus, 1995: 100; Magaldi and Berler, 2020). The semi-structured interview method was used to examine the understanding and navigation of the traditional healers working as professional nurses and their experiences of childbirth complications. A semi-structured interview guide was used as a tool during the interviews. An interview guide is a series of questions that steer the conversation throughout the interview towards the study topic (Kallio et al., 2016). The quality of the

interview guide influences both the implementation of the interview and the interpretation of the acquired data. Therefore, the semi-structured interview guide had well-formulated, participant-oriented, non-leading, and open-ended questions to obtain the most comprehensive data possible. While using the guide, the responses mirrored the participant's thoughts and allowed new concepts to arise. This method enabled in-depth discussions that helped me fully grasp the participants' understanding of the topic. Furthermore, I used a phone recorder for these semi-structured interviews, and I transcribed all interviews entirely. The authorisation to use it was contained in the participant consent form and invitation letter, and I also verified its use with each participant before the commencement of each interview. Diverse data collection methods, such as ethnographic data from interviews and literature, aided me in using corroboration for data analysis.

Although qualitative research often involves observation and participation, I could not fully participate and observe the participants when handling childbirth complications because this study was conducted in the participants' spare time rather than via the hospital. The participants determined the venue of the interviews. Some invited me to their house, others asked me to come to their place of work during their lunch hour, and others requested that we meet at a mall. Visiting the participants at their homes and work areas allowed me to become acquainted with their professional and personal lives. This allowed me to see how people treat them, how their coworkers treat them, and how they handle their dual identities, which are forms of observation, although not of them handling childbirth complications. Each interview lasted around two hours due to both my and the participant's engagement in the interview. Each participant could make the interview longer or shorter, depending on their schedule.

The participants' reactions influenced how my study came out, especially my openness about my views (Christian beliefs) and how my grandmother is a traditional healer, making it easier for them to open up to me. This gave them confidence in supporting me since they realised it was due to an intellectual hunger for information. Some participants, however, found it challenging to inform me about the problems of childbirth because they feared it would prevent me from choosing to have children.

3.8 Data Analysis

According to Naidu and Darong (2015), a researcher must eventually act with the information they have obtained while conducting their study. By ‘acting’, the researcher needs to make sense of the data by processing and analysing it. Therefore, this study has utilised interpretive phenomenological analysis to make sense of the data. The deep evaluation of personal lived experience is the focus of interpretative phenomenological analysis (IPA). IPA declares a phenomenological commitment to exploring an issue in its terms to the greatest extent feasible (Eatough and Smith, 2017). In the case of this study, it means allowing the traditional healers working as professional nurses to speak of their experiences of childbirth complications through how they handle them traditionally and biomedically. IPA is concerned with carefully investigating particulars, beginning with an in-depth assessment of each instance before seeking patterns of convergence and divergence amongst cases (Eatough and Smith, 2017). Due to this, the thematic analysis was employed as a tool for this study.

Thematic analysis is a versatile strategy that enables the researcher to focus on the data in a variety of ways by enabling the researcher to spot multiple cross-references between the data and the study’s developing themes (Alhojailan, 2012: 39; Braun and Clarke, 2012: 2). This analysis helps by identifying, evaluating, and reporting patterns (themes) within the data, therefore assisting in the interpretation of raw data (Castleberry and Nolen, 2018). It offers flexibility for using inductive and deductive approaches to research patterns (Alhojailan, 2012). According to several studies (Bradley et al., 2007; Miles and Huberman, 1994; Burnard et al., 2008), the deductive approach codes use a theme-based organising framework. The framework, sometimes called a start list, is used in the analysis with the expectation that the data will contain some fundamental ideas. Conversely, the inductive approach bases its analysis only on the participants' experiences, which are the primary source of information (Azungah, 2018). It describes methods that rely on in-depth readings of unprocessed data to identify concepts and themes. As thoughts emerge, it involves carefully reviewing each data line and allocating codes to paragraphs or text segments pertinent to the research objectives (Azungah, 2018). Therefore, this study used these approaches to identify the study's most theoretically and empirically intriguing elements. This was most suitable for this study because the goal of this study was to generate information by comparing various sets of evidence that are relevant to various situations within the same study, in this case, understanding how traditional healers heal the

complications of childbirth, how nurses manage the complications of childbirth and understanding where they clash and where they align.

Using the Interpretive Phenomenological Analysis (IPA) technique to do this study allowed me to participate in reflexive and introspective thinking, which has been incredibly helpful throughout the research process. It allowed the study to take a conscious note of the possible effects of dwelling too much on my interpretation, therefore guaranteeing the fact that my personal experience does not influence my impressions and that the interviews and the study itself are very much on the meanings attached to any phenomenon by the research participants rather than mine. Furthermore, all electronic recordings were transcribed and categorised based on the interviews and participants' identities to make the data analysis practicable. I manually analysed the acquired data because the coded information existed in my field notes and recorded data. The data was then organised into themes that emerged during the ethnographic and data generation processes.

3.9 Ethical Considerations

The Rhodes University Ethics Committee authorised this research investigation (2023-7224-7600). Anthropology Southern Africa (ASNA) Ethical Guidelines were observed, and my conduct during the project was regulated by ASNA norms of conduct for anthropologists (Anthropology Southern Africa, 2008). The ethical guidelines observed and norms of conduct regulated in this study were:

- *Protecting respondents and anticipating harm*

When researching humans, it is crucial to prioritise avoiding injury to individuals. According to Burns and Grove (2015), these injuries are identified as potential hazards of psychological and emotional injury. Anthropologists should foresee potential harm and intervene to preserve and protect participants' dignity. In the event of a conflict of interest, the rights of the study participants take precedence. Therefore, providing proper protection for participants may necessitate the use of safeguards. Giving pseudonyms to both people and locations or providing anonymity. Moreover, it is a researcher's job to tell participants that, while every attempt will be taken to maintain anonymity, unintended disclosure is possible.

- *Informed Consent form*

Brink et al. (2014) state that an informed consent form is a legal prerequisite before participating in a study. It is the researcher's job to inform participants about the study's goal and, if possible and viable, to incorporate their concerns into the study design and accommodate them in the research technique and output. Researchers are responsible for ensuring that participants have given their permission to participate in their study. This may necessitate the use of signed consent forms at times. Nonetheless, researchers must confirm that participants understand the research and consent.

- *Vulnerable persons/groups*

People's vulnerabilities may be revealed or exacerbated because of research. As researchers, we are responsible for guaranteeing that our study or its outputs do not make individuals more vulnerable. We should withhold publishing our materials if either of these scenarios appears likely. Furthermore, the susceptibility of specific persons and groups must be acknowledged and addressed.

- *Information dissemination, intellectual property, and returns from research*

Research findings should be shared with participants as widely as feasible. It is our responsibility to ensure that the findings are correctly understood. Findings, publications, and, when possible, raw data should be made available to participants in national and local languages after careful evaluation of the potential harm of disclosing raw or processed data. Moreover, interpretation conflicts should be addressed, and appropriate action should be taken. When intellectual property rights are created because of research processes, it is the researcher's responsibility to protect the rights and interests of other study participants. Wherever possible, the researcher is responsible for channelling the benefits of research back into the communities engaged in the research. The protocols suggested by the Council for International Organisations of Medical Sciences (CIOMS) (2009) were also adhered to in this research. Taking into consideration beneficence, autonomy, nonmaleficence, and justice.

- *Beneficence*

Doing well is known as beneficence. It refers to the ethical imperative to maximise advantages and minimise damages. The principle gives rise to norms requiring that the risks of research be justified given the projected benefits, that the research design be good, and that the researchers be competent both to perform the research and to protect the welfare of the research

participants. Second and third parties review this ethical aspect, which is considered when seeking permission to conduct the study.

- *Autonomy*

It arises when a person can make and commit to decisions. Honouring this means that a person has the right and permission to participate in a study (Polit and Beck, 2015). This permission is provided, written or verbally, and should be straightforward with enough information about the study. Therefore, Polit and Beck (2015) suggest providing relevant information to encourage participation, allowing individuals to choose to engage. Moreover, informed consent embraces and respects the individual's freedom of choice. Regarding human autonomy and informed consent, cultural values must be considered while adhering strictly to ethical standards.

- *Nonmaleficence*

To not harm participants. According to Polit and Beck (2015), this considers how a study could potentially hurt a participant and what mitigation measures should be adopted. This is typical in studies of complex themes since traumatic experiences may be unrevealed during the participant-researcher interview.

- *Justice*

refers to the ethical need to treat everyone according to what is morally proper and to give everyone what is due to them. The principle pertains primarily to distributive justice in the ethics of human subjects in research, which necessitates the equitable allocation of the obligations and benefits of participating in research (Brink et al., 2014). Differences in the distribution of responsibilities and benefits are only permissible if they are founded on morally meaningful distinctions between people; vulnerability is one such distinction. Justice aims to determine who gains from research and who endures the burdens (Polit and Beck, 2015). This is to achieve a sense of fairness. It is, however, recommended that participants benefit more.

This was done to secure and protect the participants' human rights and adhere to the ethical guidelines. Participants were initially given an invitation letter outlining the study's purpose, the participant's involvement in the study, and a disclaimer that participants would not benefit directly from their participation. This declaration was included as a safeguard to avoid creating unrealistic expectations about their probability of benefiting from the study; thus, participants

took part free of unfounded optimism. At the outset of each interview, participants signed an informed consent form with permission to record the interview. Moreover, this was done individually and discreetly with each participant. The informed consent and invitation letters were written in English, IsiZulu, and Sesotho. Despite this, none of the participants opted to be provided with an informed consent form and invitation letter in any language other than English. The interviews were conducted in Zulu, English, and Sesotho (depending on the interviewees), and no translator was present or required due to my proficiency in these languages. Participants were informed that they may skip questions that they did not feel like answering and may withdraw at any time throughout the interview to guarantee that no compulsion occurred. After explaining the research requirements and the role they would play, each participant and I signed the approved consent forms, of which each person retained a copy, and I kept one from each participant.

There was the ease of response when I asked the participants about their experiences with birthing issues, because the nature of their employment does not enable them to be sensitive to the topic, as they witness these complications regularly. Despite this, I was aware of the possible traumatic emotions the interview could have aroused in them. As such, I recommended participants seek any mental support needed from a hospital near them, where they could visit a psychologist who might help them deal with mental discomfort and trauma aroused by the interviews. There was, however, no specific case where a participant felt they could not continue with an interview or participate in the study or stated that they were traumatised by the interviews.

People increasingly appear to have varying viewpoints on healthcare services. Traditional healers may sometimes be labelled superstitious, regardless of the reason for and/or outcome of the consultation process. This is due to the perversion and disdain of African traditional healing approaches (Dauskardt et al., 1990: 76). As a result, most persons who operate as both a traditional healer and a professional nurse are cautious to declare themselves as fulfilling both responsibilities (Tessendorf and Cunningham, 1997). Given what has been said, the anonymity and confidentiality of all participants were upheld throughout this study. To ensure confidentiality, I informed participants that their identities would be protected during the writing of my thesis or in any case in which the gathered material would be published or communicated audibly using pseudonyms. The study data has been saved in a cloud-based

folder, protected by passwords that only the researcher and I can access. The data of this study will be available for five years from the submission of this thesis.

3.10 Summary of Chapter

While this study employed a qualitative approach to explore the dual identities of traditional healers practising as professional nurses, several limitations must be acknowledged. First, the interpretive nature of qualitative research carries the potential for researcher bias, as the researcher's perspectives and positionality shape the analysis. To minimise this, reflexivity and careful documentation of the research process were applied, though subjectivity cannot be eliminated. Second, the sensitive and complex nature of negotiating dual identities may have influenced how participants represented their experiences. Given the possible stigma associated with practising traditional and biomedical healing forms, participants have withheld or modified aspects of their narratives. Finally, interpreting the dual identities of participants presents challenges, as identities are fluid, context-dependent, and deeply personal. Capturing the full depth of these experiences within a single study is inherently constrained, and findings should be understood as situated rather than universally generalizable.

Nonetheless, according to the World Health Organisation, ethical standards are essential for protecting study participants' dignity, rights, and well-being (Sivasubramaniam et al, 2021). Therefore, having a research methodology chapter assists researchers in planning, organising, and carrying out their study methodically and consistently. It also assists researchers in justifying and explaining their study design, methodologies, and strategies (Sivasubramaniam et al., 2021). This then gives life to the thesis and portrays the ethical guidelines observed and norms of conduct regulated in the study by showing that the research did adhere to protecting respondents and anticipating harm, Justice, Beneficence, Autonomy, Nonmaleficence, Vulnerable persons/groups, Information dissemination, intellectual property, and returns from research.

CHAPTER FOUR

4. SPIRITUALITY OF PREGNANCY

4.1 Introduction

Birth tales shed light on the relationship between childbirth and spirituality, providing valuable insights (Callister and Khalaf, 2010). Therefore, ignoring the topic of spirituality during labour ignores a vital part of humankind and healthcare practice (Wojtkowiak, 2020). While not all women in this study had a comparable spiritual attitude, most agreed that childbirth and pregnancy promote spirituality.

In understanding spirituality, Wojtkowiak (2020) defines spirituality as a component of our lives that provides meaning, a sense of purpose, unifies our life story, emotions of interconnectedness, and the opportunity to strengthen connections with ourselves and others. Tanyi (2006) argues that a woman's spirituality is crucial when evaluating her ability to have children. It may be related to religion and a belief in a characteristic of the divine, but not always. Spirituality is an element of our well-being and comprises psychological, emotional, and cultural dimensions of being and growing (Wojtkowiak, 2020).

4.2 "Pregnancy is a Spiritual Process"

A spiritual experience is a phenomenon we cannot comprehend beyond the scope of intellectual, scientific explanations (Wojtkowiak, 2020) and sometimes beyond traditional explanations. It can be seen through reading what the participants have said that spirituality is vast. Wojtkowiak (2020) defines spirituality as a moral component regarding what individuals perceive as good and right or wrong. It is a practice that adheres to laws, is based on tradition, and mimics the past while also opening the door to future opportunities for personal growth and connectedness (Wuthnow, 2001). Spirituality is something you are, and it is an experience. Thus, according to Carver and Ward (2007), many women consider pregnancy to be a spiritual experience. Gogo Noma, a new mother who is a traditional healer working as a professional nurse, spoke of how she understood her pregnancy, which she explained as being more spiritual than physical, looking back at when she was in the initiation and all the things that happened to her. She said:

I believe it is even more like someone going through traditional initiation, the first three months. You go through a lot of things such as vomiting, crying and not being yourself, feeling hot, feeling angry, and no one sees that; when you walk about, they then say you look so good, you glowing, you look beautiful, and that is the gift when you are going through all the dreams, your life is changing, and you do not know what is happening to you. You are then told you have a gift, but nobody knows it because you are still walking up and down. The second trimester is the time when you are now accepting the gift, and you are getting to go into initiation because this is the time when people around you start seeing that something is different about you and start telling the people around you about what is happening to you. Even in the spirit calling, that is what happens; when you have accepted, that is when you start telling people around you, and that is when you even begin telling of your intentions of going through the initiation. The third trimester is when you are in the initiation, and everyone can now see that you have a gift because in the third trimester, the stomach is out there, and everybody can see that you are expecting. The time for delivery then is when you are now leaving the initiation. Now, you are going to the real world to become this healer that you were trained to be, and that is motherhood……

One can take from the above tale by the participant that there are parallels between giving birth and being a traditional healer because the road to being a traditional healer is more of being reborn and taking on the knowledge of spirituality. In the 1970s, research outlined Thwasa/Intwaso as a 'turmoil in living and an innovative disease' as a first step to becoming a Xhosa Traditional Healer. This may present as a period of breakdown where the person no longer perceives themselves as a whole and experiences some form of connection with their ancestors. Visions or dreams are often accompanied by unique physical signs and symptoms (van der Wat et al., 2021). This, according to medical doctors, is seen as a mental disorder, while in the traditional sense, it is seen as a gift (Aborigo, Allotey and Reidpath, 2015). In accepting this gift, people live with their gobela (who helps them in their traditional journey until they learn everything they need for their specific gift. When leaving the gobela's house, a ceremony is done where their family and friends are invited to celebrate the journey the traditional healer took (Aborigo, Allotey and Reidpath, 2015). Even though this is the case,

pregnancy shares the same faith as the traditional healing route, as mentioned by Gogo Noma. According to Tranter (2022), pregnant women are faced with the tragedy of having to vomit, eat a lot and always sleep because of the life they are bringing to the world. Nonetheless, this life brings smiles to their faces once the gestation period has been completed and the baby is in the mother's arms. As illustrated by Gogo Noma, pregnancy and traditional healing go hand in hand in how both journeys are filled with pain in the beginning and joy at the end.

> *Pregnancy is a spiritual process, and this spiritual being you are carrying, when the child is six weeks or 12 weeks or so, they are still in a fragile state; they are still between the physical and spiritual, and it is still not confirmed. That is why, after the first trimester, doctors tell you that you are out of the danger zone; they know this is a danger zone. Spiritually, when a woman conceives, it is a family thing because it is still connecting to the ancestors of this person to understand who is being reincarnated. Is this body ready to handle all this? This is when a woman starts having dreams. In many traditions, a woman will not tell her husband she is pregnant; when you miss your period, you go to the aunts and grannies, not even your mother-in-law. Some traditions, it will be the sister to the father of your husband that you inform who is then the granny; before she goes to the in-laws and your husband, she will go phahla to tell the ancestors that the daughter-in-law has caught can she be protected, barely two weeks after you have told her she will say to your in-laws who will also go phahla before telling your husband. Pregnancy in an African house has never been a physical thing; it has always been spiritual. The reason people share names in families is because of this process; the granny is then told who is reincarnated, even before the birth of the baby. It is spiritual because it is even given to the ancestors before the whole family, and even the father of the child ….*

Gogo Noma's above sheds light on the importance of "hierarchy." She uses hierarchy as a cultural way to help one understand the spirituality of pregnancy. She uses this to show that pregnancy is protected in different ways, and the way it is done and announced to the family members is more of an intimate way to shield the pregnant woman from any people who might try to harm her. Not only that, but also how names help reincarnate a loved one in the family. Much has been discussed about spirituality at the end of life, but spirituality at the beginning of life has received less attention or perception (Crowther and Hall, 2015). This can be seen in

how the preceding demonstrates how most spiritual worldviews are supported by traditions, cultures and pregnancy-related actions that introduce the pregnancy to spirituality rather than the aftermath of miscarriages, abortions and other ailments that have spirituality taking place. This then helps bring meaning to the women's pregnancy experience. This is due to participants' understanding of what happens when pregnancy is announced and not just seen. Even though this is the case, Roper (1991) argues that, unlike practically any other contemporary source, witch cases provide a glimpse into the imaginative, psychological experience of early modern people. Understanding what Roper meant is that even though there is a practical explanation for reasons why one is faced with a complication of childbirth, the idea of being African and understanding of witchcraft forces us to blame every misfortune on the unknown that is unexplainable or rather witches (which are humans acting in a manner that harms other humans using muthi) (Nwakaeze-Ogugua and Oduah, 2017). This understanding made me probe deeper into the reasons why people would choose to target one's pregnancy and not just the person before the person conceives or brings life into the world.

4.3 Miscarriages as attacks

Pregnancy is scary because it comes with a lot of attractions from the universe, and you find a lot of people who go before your pregnancy because they know you are not carrying a normal child…(Tsholo)

Tsholo uses the concept of "attractions" to explain the fragility of pregnancy and what it brings into one's life. She explains that people go before one pregnancy, while she explained this as people tampering with your pregnancy; witches and bad spirits are thought to be capable of stealing or interfering with the pregnancy. As a result, the pregnant lady is not allowed to socialise with the neighbourhood's notorious witches or have outsiders stroke her tummy (Echezona-Johnson, 2014).

During my time with the traditional healers who work as nurses, they shared different views of pregnancy, which are interconnected with spirituality, showing that pregnancy is not merely a bump but rather what ancestors give to a person and that people are seen to tamper with readily. The notion and connection of spirituality emerged strongly in a conversation with Gogo Noma, where she said:

Pregnancy is spiritual because not every woman can be pregnant, not every woman can give birth; many can be pregnant, but many also have miscarriages that are unexplained. For us to say it is spiritual endumbeni, you then see a child who was aborted, whether three weeks, whether six weeks, that spirit always fights back, because if that spirit were not alive, then we would not do a reading on you and see that you have had an abortion. It is spiritual in the sense that the minute the spirit leaves the spiritual realm and enters the physical realm, no matter how long it was in the physical realm, I am in the physical realm as a mother. The moment my egg catches the sperm and fertilisation happens, that is life. That is why life will scream. This is even the case for miscarriages; the spirit speaks and experiences things in the spiritual realm. No matter what science says.

As much as one can see that pregnancy is a blessing, and it is a duty to protect it, before one is seen as physical, they are spiritual and acknowledged spiritually. Therefore, it is more than just a biological phenomenon. During pregnancy and birth, the infant transforms into an organism in the outside world. It is also surrounded by a wide range of social and cultural implications, for example, giving a baby a name, which is a social recognition of that new life thing as a human being (Wojtkowiak, 2020).

This process of naming the child emerged in how the understanding of spirituality works in pregnancy by Mkhulu Mkhontowamanzi, who also used the naming of a child as a spiritual factor that is strong enough to even lead to dangers such as miscarriages if not done after the first miscarriage. Mkhulu Mkhontowamanzi said:

I have had a patient who has been having countless miscarriages; the message I got for her from my ancestors is that her mother is umudlisile (the process of being fed something traditionally that hinders you from carrying your child). I told her that her condition was not medical, and she then mentioned that she knew and asked if I could help her. I then had a child recognition ceremony where we recognised the spirit of the child by making a birthday for the child and even naming the child.

Even though a baby dies traditionally, it must be given a name, so this shows that spiritually, a baby is born when fertilisation happens and not really during childbirth. Before the baby is seen in its physical form, it has already lived out its spiritual form and is prone to many things that need to be tackled before birth. This is seen in Lethu explaining that *"You are spirit before you are human"*.

This was also how Gogo Noma understood spirituality as being more with us in the physical domain, or rather, being us. Crowther and Hall (2015) support this by mentioning that, as humans, we are not only mental and social beings but also fundamentally spiritual beings. A growing scientific exploration of how the body, mind, and spirit interact is evolving, yet spirituality remains a poorly understood part of the human experience. Therefore, spirituality is fundamental to human survival (Lowe and Struthers, 2001). This shows that a lot more happens that "we" with human eyes cannot see, but traditional healers can because of their spiritual understanding. Gogo Noma further explains her knowledge of what she meant by that pregnancy is spiritual by noting a personal event in her life. She said:

> *I was six weeks pregnant when I went to the doctor to check, and already, I could hear the heartbeat because now there is a vaginal sonar………. So, I heard the heartbeat of my child at six weeks, and then you are told that at six weeks, pregnancy is not viable medically, and you can still have an abortion because, according to medicine, that is not a person yet. So, spiritually, my baby's spirit had already reported that I am leaving the spiritual realm and coming into the physical realm. Science cannot prove it, but we cannot argue that endumbeni.*

Crowther and Hall (2015) asserted that Spirituality is increasingly recognised as a fundamental component of our humanity, providing access to self-fulfilment, tranquillity, and the ability to handle healthcare issues. This goes a long way in understanding pregnancy, childbirth complications and their correlation to spirituality, and this can be seen in these words by Lethu:

> *We have patients who have lost babies with no apparent cause because pregnancy is spiritual more than it is physical. A lot of people treat it as a physicality and not a spiritual, and that is when we encounter a lot of problems during pregnancy.*

This view captures the similarity in positions as shared by other participants in the study, acknowledging the spiritual dimension of pregnancies and how miscarriages can occur when the spiritual dimension of the pregnancy is not respected, thus leaving one vulnerable to spiritual attacks.

4.4 Secrecy to Protect Pregnancies and Childbirth

According to Wojtkowiak (2020), spirituality can be discovered in the unknown, in experiences we cannot understand. This is portrayed in how a pregnant woman's condition may change when they are in theatre without nurses, doctors or even midwives being able to explain it or even foresee it coming. This can be close to the doctors' eyes and even the traditional healer's eyes who are helping you. This was made clear to me during a conversation with Gogo Modiehi, who explained how spirituality works in a way that is incumbent because of people going before your pregnancy and trying to harm you or the baby. Gogo Modiehi said:

Spiritually, a pregnancy can be hidden; you go to the clinic and get a confirmation that you are pregnant, but when you come to get a reading on the pregnancy, you cannot see the baby. This happens because her ancestors are hiding her, or it is because of witchcraft. Usithegile umntwana (translated to the child hiding in Zulu). I once had a client whose ancestors were protecting the baby from enemies; when she was busy doing everything, people could not tell she was pregnant. She had to say, "Yes, she is pregnant." Because when she was checked in the clinic, they could hear the heartbeat of the baby, but her physiology did not change at all. The baby is there, but hidden from our eyes.

Thus, understanding some of the ways spirituality affects pregnancy is very important in how traditional healers working as nurses navigate their dual identity and understand the complications of childbirth. As seen above, they start from a spiritual standpoint of pregnancy and, from then on, lead to physical childbirth complications that take place in hospitals. These similar views of the traditional healers working as nurses became crucial for this study in introducing childbirth complications from traditional healers working as professional nurses.

People do not always like it when you achieve because, to some, pregnancy is an achievement; in most cases, it's either the mother coming back alive or

the baby. Cases like she went to the theatre and never came back. It makes you wonder, especially if they did not even have any complications… (Lethu).

One can see the advantage of keeping one's pregnancy a secret. Pregnancy is often seen as a situation that makes a woman and her unborn child more susceptible to sorcery, spirit possession, sickness, and obstetric difficulties (Haws et al., 2010). Therefore, it must be hidden at the beginning stages due to fear of witchcraft (Mogawane, Mothiba and Malema, 2015). This was also mentioned by Gogo Noma, who said:

We need to start understanding that pregnancy is a life-and-death situation. It goes back to us culturally; we are told that women should not go around announcing their pregnancy, people must see you are pregnant, and you should not be telling people that you are pregnant. Hence, you will find that many people only announce their pregnancy after the first trimester, around 4-5 months; for me personally, I did not even have a baby shower. I am not very traditional, but I understand the sacredness of how the pregnancy journey works.

According to Mulondo (2020), the first few months of pregnancy are vital and vulnerable; bad people are thought to damage the newborn through miscarriage or deformity. Most African societies believe in the witchcraft system, as indicated by the belief that an evil eye may be cast on pregnant women. As a result, pregnancy is seen as a sensitive matter in African communities, with pregnant women and their unborn children considered vulnerable during this time, according to Roberts et al. (2016). Medically, in the first trimester, the baby is weak, even spiritually, because the child is prone to disasters. Hence, women keep their pregnancy and labour a secret out of fear (Roberts et al., 2016). Gogo Noma continued:

Pregnancy is a spiritual process, and the spiritual being you are caring for, when the child is six weeks or 12 weeks or so, they are still in a fragile state; they are still between the physical and spiritual, and it is still not confirmed. That is why, after the first trimester, doctors tell you that you are out of the danger zone; they know this is a danger zone.

These were words of Gogo Noma, which correlated with Lizzy's words:

You go out and tell everybody you are pregnant. You are four months old. Why must you tell everybody? You do not owe them anything.

Pregnancy is not something that people should talk about because of its sacredness. There is a perceived awareness of not informing others about the pregnancy before a specific period, and if one does notify people, or if people eventually learn that one is pregnant, the gestation is not revealed; people will observe that the pregnancy is now apparent (Roberts et al., 2016). The secrecy surrounding pregnancy and childbirth also indicates that discussing pregnancy-related information with others may be dangerous. Women utilise secrecy to shield themselves from evil or spells performed by those who may intend to harm them. Individuals internalise the conventions of secrecy by avoiding sharing information or knowledge regarding pregnancy and delivery (Roberts et al., 2016). As a result, most mothers-in-law warn their pregnant daughter-in-law not to divulge the pregnancy too soon because of the risks that may arise if others learn about it (Maluka et al., 2020). While sitting with Portia as she nursed her baby, she mentioned that:

Most miscarriages are not really miscarriages because somebody did something for the baby to die; hence, after you find out you are pregnant, you keep quiet and wait for the 3rd trimester for people to see the pregnancy. You do not just go around talking about it. Women these days are cruel; they do not fight to leave my man. They just go to a traditional healer and fight using muthi. So, immediately when you find out you are pregnant, you wait until the pregnancy is viable. You do something that protects your pregnancy to protect the baby.

According to Crowther and Hall (2015), pregnancy is seen as something vulnerable that needs to be protected so that it may continue to exist. These protection standards are upheld by not disclosing any information or knowledge regarding pregnancy and delivery (Lori and Boyle, 2011). This can be seen in Lethu's understanding of secrecy. She said that:

With how the world is set up in the 21st century, we quickly announce that you do not do that because not everyone is happy for you. I have a lot of clients. I would casually ask where their church is because I believe you protect a pregnancy. Because someone can curse the baby while it is in the stomach. Nightcrawlers can see way deeper into you than you can see into yourself; they know when a particular child will be born who will possibly

uplift your family, and they would do anything possible to stop that from happening. Be it you pray, they make you strings, but a pregnancy is supposed to be protected.

It can be seen from Lethu and Gogo Noma, as well as Portia, that pregnancy is a state when every woman is prone to disasters, and the more people know, the more "in danger" the mother and unborn child are. The participants demonstrated that sharing pregnancy-related information with others could be dangerous. Hence, women use secrecy to protect themselves. The concealment safeguards pregnant women from spiteful, infertile ladies and malicious individuals who may curse them and cause their pregnancy to terminate (Haws et al., 2010). Therefore, the family, friends, and neighbours are not notified early because they may perform witchcraft, and the baby may disappear out of nowhere or, more seriously, result in a miscarriage (Mgata and Maluka, 2019). Hence, practices are implemented to protect the mother and unborn child (Kotoh and Boah, 2019). This then goes back to Gogo Noma's hierarchy of who needs to be informed first and who should know about the pregnancy.

According to Withers, Kharazmi and Lim (2018), pregnant women must be steady and avoid moving around, as well as scary encounters and unpleasant things that may stress the unborn child; this then reduces the chances of meeting people who practice witchcraft. This is more widespread in the Pedi community, where there is a belief that persons who practise witchcraft draw lines on the road to harm others unless there is a compelling reason not to or when seeking medical attention (Withers, Kharazmi and Lim, 2018). Considering this and how pregnancy works, I asked one of my participants what happens when one goes around with their pregnancy. Lizzy said:

We love it when you are pregnant to stand anywhere and everywhere. Others put things in the street like water; you do not even know why; you step and pass, not knowing that binds your pregnancy. The next time you come to me to help with this bind. We tell you to sit at home when you are pregnant, but you do not listen. Respect your pregnancy because there is a lot of witchcraft. It is not good.

This portrays that remaining at home protects against evil spirits during pregnancy, especially since spiritual encounters occur during childbirth (Crowther and Hall, 2015). Pregnant women are restricted in their ability to move; they are banned from moving frequently because they may walk on evil traps and lose the fetus. Wandering around outdoors is associated with the complications of childbirth; the mother will face danger and evil eyes because of the evil eyes disturbing her. This, therefore, shows the importance of secrecy in pregnancy because 'staying at home' is a massive part of secrecy.

4.5 Summary of Chapter

According to a study made by Callister and Khalaf (2010), it was found that several women described delivery as a profound and spiritually altering event. A Finnish woman felt that having her first kid was a rebirth, allowing her to embrace her new position as a mother (Callister and Khalaf, 2010). This illustrates the significance of spirituality in childbirth not only in South Africa but also in other countries where birth is seen to spiritually alter one's life, making one take up a new role. As portrayed by the participants, the new role is filled with a lot of misfortune because people choose to go before one's pregnancy. Thus, pregnancy and childbirth in this chapter are recognised but not celebrated because of the sacredness that comes with it (Echezona-Johnson, 2014).

CHAPTER FIVE

5. BIOMEDICAL MODELS TO CHILDBIRTH COMPLICATIONS

5.1 Introduction

The dominant biomedical model of health and sickness prioritises biological variables and allopathic treatments over psychological, environmental, and societal considerations (Clancy, Boardman, and Rees, 2022). Based on this understanding, this chapter explores the nurses' understanding of childbirth complications from their biomedical knowledge. Nurses are approved qualified professionals with the knowledge and abilities required to offer high-quality healthcare to individuals, families, and communities, and they are classed according to their university degree level (Mboineki et al., 2019). These include certificates, diplomas, advanced diplomas, bachelor's, master's, and doctoral degrees. The nursing education curriculum includes educational material and clinical skills (Mboineki et al., 2019). Nurses are also taught how to work as part of a multidisciplinary team to safeguard their customers' interests. Without a medical doctor, nurses can distribute medications, perform minor surgeries, and perform other advanced tasks if they have the appropriate training (Mboineki et al., 2019).

5.2 Negligence as a cause of childbirth complications

According to the bible, childbirth is between life and death (Portia).

When asked what she understood by childbirth, one of my participants responded with these words. She saw it as being between life and death, demonstrating the possibility of dying and surviving during delivery. According to UNFPA (2023), the experience of giving birth is linked to sickness and death. This is demonstrated in Portia's explanation of why maternal mortality occurs. Portia said:

> *In the hospital, we are not expecting mothers to die because they are not sick; they are pregnant. The government has launched the saving mothers saving babies campaign for this reason. We are expecting a healthy mother and healthy baby post-delivery. It does not matter how the mother got in the hospital. For any complication, a nurse is supposed to see in the antenatal ward (care before birth), labour ward or even the postnatal ward.*

There are so many wards for someone to not see that the mother is going to die, and if not seen, then the nurse will get arrested.

Portia emphasises that giving birth has many risks, including death. Even if the delivery technique is performed perfectly, there is a 50% probability of survival and a 50% chance of death. No matter how sick the mother is or any complication that happens during childbirth, post-delivery, both the mother and baby are supposed to be healthy. If this is not the case, Keneilwe argues that this is due to neglect because nurses and physicians are trained in how to handle childbirth without causing the child or mother to die. Keneilwe said:

Due to the health system having good policies and procedures concerning maternal deaths, maternal deaths are not encountered a lot, especially since there are drills and courses that teach you what to do when that happens so maternal deaths do happen, but most of the time it is never the nurse's fault because as a nurse you need to report to a senior person who in this case will be the doctor or nursing service manager and nurses do their part, whenever there is a maternal death nurse are usually not at fault for example in our hospital maternal deaths happen because a doctor did not arrive on time because nurses work is limited they can do something until a certain time and then at some point, a doctor is now needed to come to do other things.

Nurses continue to be an oppressed group in comparison to other professions in the healthcare system, controlled by those considered more powerful, such as doctors, who continue to interfere in nursing affairs, influencing nurses' lives positively or negatively (Daiski, 2004). In as much as nurses have authority within the hospital, their authority is far lesser than doctors because they cannot act in the best interest of the patient without a doctor present. She further explains that:

A lot of mothers and babies die in theatre because of negligence because there is an estimated time of the c-section; if a lot of time is spent, then there is a risk; if things are not done right, there is a risk, if the child is taken out without examination that is a risk, if the equipment is not checked correctly swamps can be forgotten inside the person, if the number of stitches is no calculated properly and stitch wrong. People die not because of big things, just small things. For example, a doctor and

nurse can be busy cutting and end up cutting a person's intestines, which creates another problem. This is why people are given consent forms agreeing that this can work and this cannot work, therefore selling their lives away. The first thing is that they will always try to save the baby before the mother (Keneilwe).

Childbirth is a traumatic and unpredictable event (Nakano, 2012). This can be seen in how doctors can make mistakes such as stitching someone wrongly or even cutting the specific person where they should not. This, in turn, creates more childbirth complications that lead to more c-sections. This can be seen in Portia's words as she elucidates on what Keneilwe said, she said:

There are instances where a c-section is done where the doctor is supposed to cut your uterus, and then he or she cuts your bladder; I do not know whether to say it is because of fatigue or because they are not vigilant, but your bladder can be injured which is called bladder injury which would lead to you living with a cathode for a while……the other is when doctors leave the instruments in your abdomen. An instant where I have encountered such was before I went for my maternity leave, when the doctor was stitching the patient, and half of the needle broke into the abdomen. The doctor could not find it, but he closed-up and as a nurse you then told this and you wonder if you should book the patient for relook which becomes denied most of the time because doctors feel the stitching is still fresh (Portia).

Although a firm believer in biomedicine, Portia, a traditional healer working as a professional nurse, expressed her distrust in the specific health system, stating unequivocally that in her years of working in both the private and public medical sectors, she would prefer the private or not use either at all if possible. This instils a lot of suspicion in those who hear it because if a professional nurse expresses her distrust of the biological health system, what little faith does a person not in this field have in that specific health system? This specific distrust is especially visible in an event she shared close to her heart. Portia mentioned:

My cousin went for an elective caesarean when she was pregnant; the first day, her pulse was high. The doctor was told that she had tachycardia (high pulse rate); the doctor prescribed medicine that was

then given to my cousin, which was antibiotics and so forth. The following day, her temperature went up, so now it was both tachycardia and temperature (which indicates sepsis). So the doctor then booked her for a relook so as to clean the wound. Post relook, she was then sent to the ICU. 2-4 days, her condition was still the same, but then her BP was going down, which was now generalised sepsis, which means whatever the doctor did in the relook did not work. The doctor re-booked for a relook, which then led to my cousin dying on the table. She died 2 months before her wedding, but the baby survived because of the C-section. There are a lot of complications that come with C-sections.

This narrative demonstrates that no matter what stages Portia's cousin went through, she was not treated in the way Portia would have expected. This demonstrates the shortcomings of the biological health system, which mostly emphasizes neglect. This demonstrates that a lot may happen during childbirth that might leave one permanently injured because of just giving birth by c-section, which is sometimes necessary to have a safe and healthy kid. Mkhulu Mkhontowamanzi provided an example of when a c-section is of enormous relevance to back up my point. Mkhontowamanzi said:

We have encountered a person who has water breaking, meaning we must deliver the baby, only to find out that you can see the child crowning, but the child is not coming out, meaning the patient is macrosomic. This person needs to go for an emergency c-section or a transverse opening because the child has already engaged in the pelvis but, unfortunately, is stuck.

This creates long-term issues for the mother that can even impact her subsequent pregnancy because, from Portia's experience, where exactly does the needle then stay in the woman's body, and why are such problems not addressed or rather fixed from the onset as they happen? Despite this, Gogo Noma claims the body can support two persons, even if the experience is unpleasant. Gogo Noma said:

Pregnancy is a highly complex condition, we always hear the phrase 'When you are pregnant, you are not sick,' but as a midwife and somebody who has been pregnant, I tend to not agree with the statement, yes, you are not sick because sick people mean that there is a disease with you but you are

also not well because, one, as a woman the one body that is supposed to supply whatever it needs to supply for you has to supply for two people. Secondly, things are shifting in your body; your internal organs are shifting; hence, pregnant women have heartburn and so forth. Your bladder is being pressed, your liver is pushed up, and your heart is pushed to the side. Yes, you are not sick, but you are not well.

This demonstrates her awe of the human body's possibilities despite the knowledge she brings from her career. She shows how pregnancy could be made less stressful if pregnancies were viewed as the woman's illness rather than simply being pregnant.

5.3 Forms of Childbirth Complications

Most of the complications encountered are cord around the neck, breech misrepresentation and unresponsive child (Keneilwe)

The first complication the participants spoke of is breech representation. Breech presentation, according to Zsirai et al. (2015), has been connected to adverse pregnancy outcomes. Nevertheless, the cause of this relationship remains uncertain. When defining this concept of breech presentation, Keneilwe said:

Medical complications that we encounter are children that are breech, which is the most common one, breech presentation; the child will come out with the feet first instead of the head because the normal presentation would be that the child needs to come out with the head first……

Even though literature suggests that various maternal and foetal anomalies are related to an increased likelihood of breech presentation. It is indeed unclear if breech presentation per se has the potential to influence the outcome of pregnancy (Zsirai et al., 2015). When Gogo Noma explained this complication, she was able to make me understand that a lot of unexpected things may happen when it comes to childbirth that are not taught when one is getting educated in the nursing profession. Gogo Noma used one of her experiences in explaining this. She said:

………this is when the baby comes with the buttocks. She knew her baby was breech and she was booked to come in 2 days, but unfortunately nature, there is a saying that my midwifery teacher used to say: midwifery

is a closed book; we learn what could happen in a normal delivery, but honest, nothing ever happens as the book says, we are only taught what is the normal and how it goes but every woman, every pregnancy is different. They experience it differently because every delivery is different. Her contraction started, which she did not think much about, just until her water broke. She was 7 metres dilated. We tried to call the theatre to prepare, but unfortunately, there were a lot of emergencies. She was an emergency, but the baby was not that big. I delivered the child well, but then the child had the cord around the neck, which meant the baby had two complications in one. The cord was 2-3 times; luckily, it was not tight, so I just pulled it out of the baby.

When it pertains to pregnancy and labour, the pregnant mother is at risk of numerous issues because pregnancy is not obvious and straightforward due to all the complications that come with it. Looking at the difficulty from a medical standpoint, Keneilwe then discussed the organisational structure of what happens when a person has a breech baby, including who is notified first and who does what. She mentioned:

In instances of breech delivery, we call the doctor to come and assist with the delivery, call an advanced midwife, call paediatrics', call the whole multi-disciplinary team that deals with children so that you know before you attend if the baby is coming out you know you have proper support and everyone around you to help you because the child can go into shock at any time. The child can get sinuse, so you need to immediately when the child gets out if they do, that is if they do; if you are able to deliver normally the breech presentation, then you will need to make sure that you have doctors around that can write statements, check the health of the baby, to make sure the baby is not compromised in any way (Keneilwe).

Childbirth complications such as breech are given high priority in being solved by the way healthcare is seen to act through notifying the first person to the last person for both the mother and child to survive. In as much as this is the case, breech presentation is seen to be a high-rated complication. It is also very dangerous if identified late, as the complication is not sorted out. It creates many more complications on top of the initial one, such as the head of the baby being stuck; this can be seen through Keneilwe's explanation. Keneilwe said:

If the breech presentation was diagnosed late, then you will have to deliver; let's say the person is in labour now then you will have to try and deliver; there are specific manoeuvres that you use to try and deliver, and that is why you will call everybody to be there so that you assist each other if it is seen before labour time then you book for a caesarean section because it is risky to deliver a breech presentation, the baby can get stuck, the head can get stuck inside.

The second complication the participants mentioned is the cord around the neck. According to Chase (2011), a nuchal cord occurs when the umbilical cord becomes 'coiled' around the newborn's neck. These nuchal cords are single coils and loose, while tight, double, and multiple coils are less prevalent. In explaining what this childbirth complication is, Keneilwe said:

………….or it would be a complication of the cord around the neck, which would mean the child would have turned several times, then they would have a cord around the neck, maybe two times or three times, so you need to be careful with that because if you force delivery or do specific manoeuvres you need to be careful that you do not strangle the child……….When the cord is around the neck during labour, you need to perform an episiotomy to make space for the baby. If it is a natural birth, you cut the vagina to make space for the baby by inserting your finger and cutting the cord. Still, you need to cut and clip because if you do not, there will be heavy bleeding by the mother and the child, which you have to be very careful with, as it is a complication on its own, but manageable.

The complications of childbirth, if not clearly observed early and attended to early, lead to more complications. Even when taking note of the time frame, one needs to be very careful. According to Peesay (2012), some autopsy reports on stillbirths reveal that most deaths are due to the tight cord around the neck. The alarm of this specific complication arises when the mother is told of this even though a baby having the cord around the neck is easy to manoeuvre when the cord is not tight, but when it is, it leads to a c-section taking place because a baby cannot be pushed out with the cord because of the possibility of the baby being strangled by the cord. In explaining this, Nkgono Modiehi said:

Cord around the neck: this shows in the scan, but you do not tell the client because it can make them panic. The first thing is that when the head

comes out, we check the neck by putting our finger. If there is a cord around the neck, we grab on to it; if it is loose, we pull it over the neck, and it's done. If it is tight around the neck, some twice, some thrice around the neck, it depends on how tight it is, but if it is too tight, we just clamp, clamp and cut the cord because sometimes it gets so tight that the baby cannot be pushed out.

In further explaining the complications of childbirth, Nkgono Modiehi mentions PROM, she said:

Premature Rupture of Membranes (PROM) is when labour has not started, but the water comes out, which protects the baby from accidents, STIs and other infections. So, when the water comes out first, there is an opening, and the baby is exposed to infections because it lives in that water and survives in that water. So, when this happens, this is an emergency; patients are not even allowed to wait for pain.

It is known that when a woman is about to give birth, the water breaks when the contractions or the baby puts pressure on it (Khatun et al, 2021). No one knows what happens when the water breaks and the contractions do not happen. Nkgono Modiehi highlights this complication by using the complication PROM to explain that infants die because the water breaks without the contractions, which creates further risks on top of that specific risk, because the baby is now prone to a lot of things since the water that breaks protects the baby throughout pregnancy. This then leads to another complication being dealt with by a C-section. Therefore, most people are forced to go through the theatre for the well-being of their babies and themselves. In highlighting this matter of most emergencies needing c-sections, Keneilwe said:

C-section is a choice. People choose that they want a normal vaginal delivery. People know their pain tolerance, and if you have a gynae or nurse that you go to, they will explain how it feels, and when you are in labour, you can feel that you can do it or cannot do it. If you tell yourself you are in pain, but you will be able to do it, then you will do it. But if you feel that when you booked, you said normal vaginal delivery, but now you want something different, it can also be changed on the spot. It is an easy choice for people in private hospitals, but not for those who go to government hospitals.

The problem of class comes even in the context of childbirth and how it is carried out. As Keneilwe noted, individuals may select how their infants are born, especially if they are in a private institute rather than a government one. One can only assume which of the two hospitals has the most difficulties during labour and how those issues are treated. However, many people die because of complications. Even though c-sections are a choice, Portia views them differently, believing that they should not even be a topic of conversation but rather an option presented to a newborn for them to survive. Portia said:

> *A c-section is done if the baby is in a stomach, post-dates, which is above 40 weeks. To prevent death, C-sections are done, and babies are put first.*

Portia went on to further explain another complication known as Postpartum Haemorrhage, she said:

> *There are a lot of childbirth complications. There are people who deliver normally and people who deliver through C-section. Normally (NVD) – Normal Vaginal Delivery, the most common complication is PPH - Postpartum haemorrhage, whereby you are heavily bleeding in your vaginal area, your blood pressures drop, you become dizzy and weak, and you can collapse and die. In those instances, after birth, we check the umbilical line, which will have a sort of ball which will be rubbed within the uterus, to make sure that there is nothing related to birth that is left and check your vagina through rubbing and pushing to check if there is nothing left. If the body has small pieces of membranes or placenta that are left after birth, it will cause one to bleed, so they will have to be removed. Secondly, if there is a tear, which depends on the size of the head of the baby and the size of the vagina, people may tear. So, if a person stitches the top layer, there will be bleeding underneath.*

When looking at how childbirth happens, it is safe to mention it as a near-death experience because, no matter how delivery is done, whether normally or through a C-section, there are still complications that may occur. One may only wonder if such a thing as a pregnancy without complications exists. Childbirth is constantly supposed to be done in a way that considers the chances of one coming back to deliver another baby. Despite this knowledge, there are still more complications that come with giving birth. Mkhulu Mkhontowamanzi mentions shoulder dystocia; she said:

Shoulder dystocia is where the head of the baby is out, but the shoulders are unable to go out; this then leads to certain bones being broken, where their hands cannot work, and they are disabled or dysfunctional.

Shoulder dystocia is a significant medical problem for babies; this specific complication causes mortality and brain damage (Menticoglou, 2018). As illustrated above, childbirth is indeed a scary process where a mother should expect anything regarding her baby because childbirth is an unexplainable event that comes with a lot of unexpected traumas, such as shoulder dystocia. Nonetheless, the medical complications do not end there. Portia mentions cord prolapse, which she explained as:

Cord prolapse is when the water breaks, and then the baby's cord comes out while the baby is still in the stomach; the baby then does not get any supply of anything, which can lead to the death of the baby.

The presence of aberrant foetal heart (FH) tracings and the palpation of the prolapsed cord are used to diagnose overt umbilical cord prolapse (UCP). It is simple because the UC is seen coming out of the vagina or palpable as a soft pulsation mass during vaginal examination (Wong et al., 2021). When explaining cord prolapse, Portia mentioned it as a complication that closes off the pregnancy, meaning that it stops the process of the pregnancy because the baby stops getting the food supply, which leads to the baby dying. Keneilwe then further explained this complication, she said:

The placenta comes out before the child; it ruptures, and that is an immediate death. There is placenta abruption and placenta previa; if you see the child is coming, you put the placenta back inside and rush the person to the theatre. Unfortunately, the person will have to keep their hand inside until the c-section is done to avoid the placenta being sinuses- since it is not warm, and there is no blood flowing, therefore making it dry, and all life will stop (Keneilwe).

Keneilwe took a different angle in explaining cord prolapse by explaining that the placenta, too, sometimes comes out rather than the umbilical cord. The difference with this is that the placenta is far more prone to rupturing and can, therefore, kill the mother or the child. It also easily dries up when it comes out before the child; hence, the person who checks the pregnancy needs to hold it in, therefore, call for an emergency C-section. This is not the only complication

that Keneilwe mentioned, but also the complication of the child not responding right after birth. Keneilwe said:

> *………..when the child is born, and they do not respond, that would be a result of maybe the mother was given too much analgesics, which are pain medications, that weakens the child; there is a medication to counter react that then sometimes the child just does not want to respond because the labour could have been prolonged, the child could have fought for too long so then after delivery you asses the child and take him or her to ICU for further investigation of which part of the body was affected the most because it could be the lungs, it could be the heart, so most children die because of this because you can see maybe the nurse was late or the child began to respond but then a few hours was then too tired but if given close monitoring they sometimes survive.*

This goes back to the part that there is a huge possibility that nurses and doctors cannot measure the level of medication needed for the mother during delivery, despite their educational background. It is indeed unfortunate that most women are met with such misfortune that it leads to their baby being born dead. When talking to some of my participants, I was able to learn that most medication given to help the mother go into labour or ease the pain of labour goes directly to the child, making the child fight and the contractions sometimes stronger. Unfortunately, this then leads to the child being exhausted. Because of shortages of staff and the rise of people electing for c-sections as well as getting emergency c-sections, most of these women, when they get to the theatre, get there with their babies dead already. Despite having such complications, complications keep arising, or new complications are always learnt as women deliver their babies. Gogo Noma mentions another complication, which is known as Cephalopelvic disproportion (CPD). Gogo Noma said:

> *A CPD is when the baby's head is bigger than normal. A colleague of mine was the one delivering the baby, and I witnessed it. The pelvic area was smaller than the head, which is a complication because you find the baby stuck and the mother is taken to the theatre, which is a dangerous place when the baby is already stuck because the baby cannot breathe at times because as the contraction happens, the mother will be squeezing the baby's head leading to the baby having brain damage and so forth. With*

research that has been done, you are asked about your size so they can place you on NVD or caesarean, the same for one's height. The lady, in this case, had to go for a C-section, which was rushed. The baby came out, but it had asphyxia, where the baby could not breathe, which meant there was a lack of oxygen for some time. The baby was taken to the neonatal ICU for a good 6 weeks. The mother was also kept in the ICU because she went into shock.

Cephalopelvic disproportion is a pregnancy complication wherein the foetal head is too big to pass through the maternal pelvis and represents a major indicator for caesarean section (Althaus et al., 2006). As indicated by Gogo Noma, the biomedical health system, even though it brings negligence and a lot of mistrust even by its staff, tries to bring many more advancements and ways to better solve childbirth complications without creating far more complications, like the one Gogo Noma mentions of a baby being stuck and not being able to breathe. These methods bring better ways to handle these complications by checking stuff like one's shoe sizes to know whether they will have a c-section or normal birth, even before the person prepares for childbirth. When sitting with Nkgono Modiehi, trying to understand these complications, she was able to mention foetal distress. She said:

Foetal distress is when the heartbeat of the baby drops; in layperson's terms, the baby is not coping with the labour. So, it can be for several reasons; we then see this with the heartbeat, and in some instances, the heartbeat will be very accelerated, above 160, or drop and sound like an adult heartbeat, leading to death.

Yentis (2003) states that foetal distress is characterised simply as an ill-defined c-section, which is the protracted, deep foetal bradycardia that chills the most hardened obstetric anaesthetic heart. This is another issue that leads to emergency c-sections, which can sometimes result in mortality if one is not aware of the situation during the pregnancy. As a result, it is critical for pregnant women to get prenatal checkups. This can also be seen in one of Nkgono Modiehi's experiences. She said this:

I had a case where a client came in 2 minutes before; I knocked off; I had even changed from my work clothes because I was going to a party. When she came, I was in the bathroom, but something said I should go check on her; my boss always says if it is late, I do not want you to do it because

you will be rushing to finish. But I then said, It's fine, I will check her; while holding her file, I went straight to the scan, even though usually we start with taking the urine, scans and so forth. Something just pushed me; when I checked, the baby was quiet, and the heartbeat was gone, so that sometimes happens early, and the mom does not know, so she can sit with a baby that has passed on and then starts rotting inside; this is known as macerated stillbirth. When those babies come out, their skins have changed colour, and the water is smelling. You can never know what causes this because sometimes there is no reason the mother's blood pressure is fine, the sugar is perfect, and the mother did not have an accident.

Many people are unable to get prenatal check-ups due to financial constraints, such as transportation or scans. As a result, many individuals turn to traditional healers in their communities. One can only wonder how such macerated stillbirths may be averted without the woman needing to attend prenatal check-ups due to financial constraints. Despite these worries, Nkgono Modiehi noted that when a macerated stillbirth occurs, the woman is compelled to go through the delivery process to give birth to a baby who, regrettably, cannot hear or carry. According to Parle (2003), Western biological paradigms of handling sickness have inherited an understanding, and nurses have been educated in this manner. According to Capra (1982), biomedicine does not make practical attempts to treat the psychological and social dimensions of sickness but rather focuses on the physical body. Then, it demonstrates that biological medicine concentrates solely on the birth of this unique baby, the mother's physical health, and not the mother's mental health because of this specific trauma. The participants then shared their experiences to demonstrate that birthing is not open-ended and straightforward. Gogo Noma stated that:

A 16 year old who came in who was already dilating, we do suspect she took something like imbiza at home that accelerated the contractions because the baby was already passing meconium in the womb which is the stool of which the baby is not supposed to pass the stool because if they pass stool they aspirate because they are learning how to swallow and drink from the uterus so the meconium becomes part of the amniotic fluid and the baby starts gasping on it especially when its contracting and it goes to the babies lungs as soon as they breath when they come out which

is very dangerous because meconium is very acidic, it will burn those little lungs—leading to even not breathing well. It is also very sticky, so it also blocks the alveoli in the lungs, the little sacs that help with the gaseous exchange for the oxygen to come in and the carbon dioxide to come out. This is an emergency, but she could not go to the theatre because she had already dilated; unfortunately, she had to deliver the baby. We had to put a tube in the baby's stomach to remove the meconium, and this led the baby to go to the neonatal ICU. Luckily, they both survived, but it was traumatic because everything was rushed. This happened in 30-40 minutes. The contractions were too heavy for her, and that is a danger for uterine rupture; if it ruptures, that means she could bleed to death. This complication is known as meconium aspiration.

It is, therefore, clear that doctors and nurses are not always the reason the complications arise, but rather the decisions pregnant women make when they are ready to give birth. Some of these decisions, just like the one above, unfortunately, led to the baby going into the neonatal ICU, and sometimes such complications are not easily manoeuvred around because the baby dies when passing stages such as the meconium, which is acidic, as Gogo Noma mentions. These are certain instances that may lead to babies even being deformed for life, just because childbirth did not go the way it was supposed to. When talking of complications that could lead to deformity for life, Thuli went deeper into this; she said:

I have delivered a baby in a hospital. The head was attached to the placenta, and I have delivered a baby that was properly deformed, lifeless, and also complications related to what I do in the hospital. The baby could not come out, and in such, we opt for surgery, and then there are cultures that do not allow their people to have surgery or be given blood in case of bleeding; we are not supposed to make choices for a patient unless the superintended who is the owner of the hospital decides on behalf of the patient if the family is not there or if the patient is unconscious if the patient is conscious we tell them the risks, and they then make a decision, in most cases, they die because they decide, no in our church, the Wash Towers do not want us receiving any human blood into our systems so we have seen people die from such while delivering a baby because you tend to bleed sometimes due to shock.

Caesarean sections may be the result of a curse or psychic attack, necessitating the employment of traditional healers, as illustrated throughout the thesis. Patronising religious establishments is another approach to avoid CS because it may be regarded as a demonstration of faith, which sometimes leads to death for most pregnant women (Ugwu and De Kok, 2015). It is stated that emphasising your faith in God will avoid CS; divine intervention will make vaginal birth feasible. A CS, on the other hand, may raise doubts about a person's religious upbringing. CS may be required due to supernatural factors, but a woman may be able to escape this intervention by divine intervention or by accepting the need for a caesarean section (Ugwu and De Kok, 2015). According to both schools of thought, expressing one's religion can help expedite vaginal birth. Religious leaders may discourage women from CS by stating that a new strategy centred on faith and prayer can result in vaginal delivery, which can be seen in Thuli's words about women deciding not to have a CS because of religion, which is sometimes not a good move to make, as it results in death (Ugwu and De Kok, 2015).

5.4 Summary of Chapter

As mentioned above, it is sometimes not the nurses and doctors who are responsible for our ill health, but rather our religions and cultures, because of the rules put in place. When faced with a childbirth complication which needs a C-section, doctors are now forced to handle this complication with a normal delivery, even though that may lead to many complications, but because of culture and religion, the need for a C-section is swayed away. According to Naidu and Darong (2015), biomedicine has sought to ignore the possible influence of cultural beliefs on patients' and nurses' health values and beliefs to correct the health beliefs that this study considers while dealing with the complications of childbirth.

CHAPTER SIX

6. TRADITIONAL MODELS TO CHILDBIRTH COMPLICATIONS

6.1 Introduction

The plural health world is multifaceted, influencing how multiple individuals and groups seek treatment. Considering the presence of other health systems in the research community, all the participants used the biomedical and traditional health approaches. Participants used these approaches to handle childbirth complications and navigate their dual identities within the hospital. The participants' understanding of these health systems demonstrated their knowledge of childbirth and how they handle childbirth complications.

According to Bogopa (2010), one cannot discuss health in South Africa without recognising the existence of ancestral beliefs. The World Health Organization (WHO) refers to traditional medicine as a combination of knowledge, skills, and practices based on ideas, opinions, and personal experiences (Vawda, 2019). Therefore, being endemic to many cultures, whether explicable or not, is employed in health maintenance and preventing, detecting, enhancing, or ameliorating physical and mental diseases. According to the World Health Organization (WHO), 65-80% of the worldwide population considers traditional medicine the essential underpinning of health care (Vawda, 2019). Nonetheless, this research investigates how traditional healers working as professional nurses navigate childbirth complications in Johannesburg hospitals.

6.2 Protection from evil

According to Kiguli, Namusoko, and Waisa (2015), pregnant women who had premature labour and stillbirths sought protection from sangomas, or witchdoctors, to escape the impacts of evil spirits and witchcraft, as well as subsequent stillbirths. When I spoke with my participants, I discovered that most of the pregnancy and childbirth complications are caused by humans rather than nature. This may be observed in what Gogo Noma said:

Some people open your womb every time you are pregnant, which leads to countless miscarriages.

Gogo uses the notion of "opening your womb" to explain the process of one tempering with one's pregnancy, therefore leading to the pregnant woman having a miscarriage. According to Putu (2017), by following traditional traditions and ceremonies, it is thought that the pregnant woman will have serenity, a healthy pregnancy, and a healthy child. This goes back to the understanding of Gogo Noma's words of "opening up" one's womb, which illustrates the importance of having ceremonies and practices to prevent all these from happening. Pregnant mothers visit hospitals for check-ups to monitor their child's progress. Nonetheless, many people face the terrible reality of no longer having children. Even though it is technically defined as your uterus's inability to carry a baby, this reveals how spiritual a pregnancy is. Tsholo elaborated on Gogo Noma's statement, stating:

You are able to pick up certain events that have occurred and are a blockage; for example, a person with repeated miscarriages has a high chance of miscarrying again because the person did not cleanse for those children, as much as you can die as a tiny baby, you grow up spiritually and this baby growing can block your blessings if the spirit feels abandoned or feels unrecognized. It is very important for a person who has undergone miscarriages or abortions to cleanse and even give the child a name so the child can be a great spirit and be able to grow...without that cleansing, you will continuously have blockages. You would ask them for a child, but you would be pregnant every three months, and you would probably have a miscarriage. Moreover, the thought that when you are pregnant, your family loves you or your husband's family loves you, or being over-excited and announcing your pregnancy, not knowing your child is destined for greatness, people go and work that pregnancy, announce at a point where you have passed the first trimester, because miscarriages happen around the first trimester. Also, you do not tell people when you are supposed to give birth because people are willing to plan because those things are your things (Tsholo).

Traditional medicine and health practitioners acknowledge the spiritual aspect of certain health disorders and the role of ancestors in both causing and treating them. This is indeed seen in Tsholo's words that ancestors can block you from getting children just because you did not appease them with a cleansing that is meant to be done when one loses a child. She further

touches on the announcement of pregnancy, which is highlighted in the 'spirituality of pregnancy' chapter, where this is seen to bring witchdoctors and other sorcerers closer to you to harm your baby. Nomathemba then continued from where Tsholo had left; she said:

You are not supposed to post about your pregnancy because not all of us when we see you pregnant, are happy for you, can be friends, can be family; they can close you so that you do not get the baby or lead to you getting the baby after complications or you lose your life or the baby grows up with complications or even the baby dies. Naturally, things can happen, but sometimes it is done by people (Nomathemba)

Due to the difference in healing approaches between biomedicine and traditional medicine, specific symptoms are sometimes linked to biomedical health conditions. In contrast, they manifest traditional conditions that can only be treated traditionally. In the case of miscarriages, Tsholo was able to make clear that no matter how you lose your child, a spiritual ceremony needs to be done, which biomedicine does not cater for, to help one start on a new slate and be able to get pregnant again. Without this ceremony, one moves backwards in pregnancy and is continuously met with the loss of their child.

If I know you have been losing babies, I protect your pregnancy twice as much (Mkhulu Mkhontowamanzi).

These were the comments of one of my participants as she revealed what she does when her clients continue to lose their infants, whether due to biomedicine or tradition. She protects the pregnancy twice as much by employing traditional remedies, which will be discussed more in this chapter. Belief in ancestors and their influence on people's everyday lives is essential to many African cultures. As a result, according to Kale (1995), all daily events, including health, are viewed not merely from a natural standpoint but principally from a supernatural one. It can be seen from Thuli's words that for pregnancy complications to exist, it is because witchcraft has taken place, which is sometimes unexplainable by humans who do not have the traditional healing gift.

I encounter a lot of pregnancy complications endumbeni but they get to be solved there because they are mostly related to witchcraft, where a pregnancy is being tempered with in the sense that the baby is supposed to die or mother is supposed to die then they close the functioning of the placenta or the tube transferring food from the mother to the child so they can close that using medicine of black magic,

they use such to block the functioning of anything that would bring life to either or, at the end of the day we unlock that, everything in traditional healing has an antidote, if you do something it can be reversable still, I work in the reversing department, they come here with complications and we create medications to use externally, I do not use any internal ingestions, they do not drink anything, I do not make bottles, I do not know how they function, a pregnant woman is not supposed to take imbiza, we use anything externally, there's oils to rub the pregnancy so it goes according to term, the child has to turn so they can temper with the turning which leads to a breech delivery, the baby sitting sideways or the bum coming out first, it means the turn did not happen and it means something was tempered with and it would affect the child. With breech, there is a temper; it is a spiritual issue; in Western medicine, we try to make things normal; we call it breech now, suddenly, but it is spiritual. Sometimes, these happen through touch or through using your picture; it is not explainable; it is witchcraft (Thuli).

Thuli makes one comprehend that pregnancy complications are extensive and that they are typically medically explained in a way that does not make sense conventionally. As a result, according to research done in Nigeria among the Yoruba people, people seek herbal medicine from traditional healers because they think witches and sorcerers are responsible for all illnesses owing to their magical skills (Borkini & Lawal, 2014). There is no reason why some people should have normal births while others are compelled to have C-sections. Thuli discusses the supernatural nature of difficulties leading to varied delivery, using a simple example of someone touching your pregnancy. As we were in my car discussing it, she highlighted how we do not know what others have in their hands when they come to touch our pregnancies and how a little touch might convert your kid into a breech or even die unexpectedly. She says that traditional healers may cure these issues. Indeed, traditional healers cannot reverse these complications if one does not consult with them and instead seeks medical advice. For this reason, according to Wreford (2005), many Black South Africans seek explanations before, during, or after getting biomedical therapy for health conditions that they feel are best managed traditionally, whether culture-bound syndrome or not. When asking Keneilwe what all these complications mean traditionally, she said:

Most things traditionally do not have a name or meaning but are rather easily called imihlola (abominations) or tse sa bonwing (unseen things) (Keneilwe).

With so much pain that witchcraft brings, the understanding of why people do these things, how they are done and what they are done for is unknown. These are just things Keneilwe calls abominations, which should not be happening. Gogo Noma further explained Keneilwe's statement by mentioning that some complications show what kind of child you will have; therefore, sometimes one must have those complications.

Breech can be done by somebody, but it can also be an indication of the kind of child you are going to have. For example, children who come in the amniotic fluid sac (abantwana abaza bambethe). This is then seen as a gifted child, according to the elders. You understand from Endumbeni that if a child is gifted, they will never come in a normal way. I, for one, remember my mom telling me that her stomach used to shine like a mirror, and she was even afraid to look at it. My mother used to say maybe she was too thin, and her stomach was stretching. What made her mother start wondering what was wrong with her was that she craved traditional beer throughout her pregnancy, and she had a glass of it every single day until she delivered it. When I was born, I had a red spot on my forehead that people now call being kissed by an angel. I used to be told by elders when I was walking around the street that I had a gift because there was a star always shining on my forehead. The red spot lasted for three months, and then, when I was ready to be seen by the world, it disappeared, but those who had the third eye always saw it, and even today, some still say your star shines bright, and I understand what they mean. Yes, it is a complication in medicine, but for us, in a traditional sense, we know it tells us something about the child (Noma).

She cites issues confirmed as complications in the hospital context to show their advantages in the conventional sense. Traditional healing through Noma's eyes has a cause for things happening, unlike in a medical context, where a kid is said to be going out breech with their bottom first and being described as the baby not turning, which traditionally explains something. She explains that the "red spot" on her forehead represents her being someone who will help the community by healing people traditionally; this is even seen in her mother drinking traditional beer while pregnant, indicating the ancestors, her child, and the gift she will bring. Keneilwe agreed with this point by saying that:

Bleeding throughout the pregnancy and not understanding why, only to find out it is spiritually linked and not that it needs the hospital or Western interventions (Keneilwe).

She emphasises that we often try to heal spiritually related things biomedically when they do not require that. Thuli mentioned above that biomedicine always finds a way to normalise all these spiritual difficulties, treat them better physically, and understand them in the Western sense. Tsholo makes it apparent that while biomedicine can help with these challenges, it can also generate spiritual problems for the person because the person must first address the source of the problem. Handle a spiritual problem spiritually and a biomedical problem biomedically. According to Tsholo's remark, without spiritual purification, women continue to lose their children even after having a miscarriage and cleaning from the hospital. In helping one understand all these points, Lethu introduced the concept of dikgaba; she said:

At times, they would say that the baby is too big for the pelvis, and then a C-section is done. They then come back with a baby with a size of a phone and you wonder which pelvis. If the baby is the size of a phone, then they can pass through that pelvis, but because there is the concept of dikgaba, when people count your months, then when you are supposed to give birth, you cannot, because now nothing is happening. So this leads to prolonged pregnancy; this is why a lot of people die while giving birth (Lethu).

She uses the concept of dikgaba to explain how far the treatment of spirituality goes and how biomedicine handles those problems. Indeed, biomedicine finds a way to solve spiritual matters biomedically. Nonetheless, there are far more people who are seen to encounter childbirth complications than through dikgaba. Nkgono Modiehi mentioned ischitho. According to Gibson (2013), there are different types of isichitho. There is an isorhythm isichitho, which is sent to disrupt the home. People in such a household will constantly be at odds, resulting in fighting. Sometimes, people mistakenly plant isichitho plants or shrubs. These weeds are incredibly harmful and have the potential to tear up families.

You can get isichitho (a curse) sent to the pregnant mother, which leads to the death of the baby; it can complicate their birth; you are supposed to give birth normally, then the baby poops, so now the baby is in meconium, now there is poop everywhere, even in the lungs and what not. This is an emergency that leads to recitation because there is water everywhere, and we need to get the baby

breathing on their own again. It can even cause foetal distress and harm the baby, complicate your delivery and sometimes even kill the mother (Nkgono Modiehi).

Nkgono Modiehi explained isichitho as being vast, and the one she spoke of is the isichitho that is sent to complicate or kill the mother or the baby. She uses an example to illustrate this specific point. This portrays that many things can happen when pregnant; they are prone to many unexplained disasters. On the note of disasters, Mkhulu Mkhonowamanzi said:

There are also dolls people use where they put needles; you then make the child work for you. This closes a person from giving birth significantly if you do not strengthen your pregnancy; you will even die while pregnant, or your babies after nine months will die stillborn.

Witches and evil spirits are said to be able to steal or interfere with a pregnancy (Echezona, 2016). When speaking with Mkhulu Mkhonowamanzi about childbirth and pregnancy, she stated that being pregnant is not simple; you may be pregnant, but the kid would be someone else's. She described this in such a manner that it was evident that because your kid is someone else's and is performing every wicked behaviour for that specific person, you may endure an extended pregnancy. Because of the exhaustion of being pregnant for so long, it occasionally results in death, or you discover that your baby is not breathing in the stomach. This instils fear about what pregnancy is and how it works. You may assume that everything is going fine, but spiritually, it is not.

According to Edwards et al. (2009), there is a close bond between the living and the deceased, evidenced by the reverence given to ideas such as umphefumulo, umoya, and isithunzi. In this research, ukuthwasa, ubungoma, isithunzi, and isithunywa are seen to arise to illustrate this bond between the living and the dead. All these are seen to have an impact on pregnancy and childbirth. Keneilwe said:

Traditional healers focus mainly on people who are already here than the child inside unless you have a speciality of dealing with pregnant women because you can be able to see because it is a specific gift on its own that traditional healers would be able to look at the pregnancy and say no there is something wrong even when the pregnant woman says the child is okay, it is a separate gift on its own just like speciality. It is the same as when you are a traditional healer; you will be like a general nurse, specialising in kids, will be like you specialising in midwifery, and when you are a gobela, you specialise in ukuthwasisa (initiating).

It is just like specialising in the medical ward and the psych ward. There is a general Bungoma and specialities within ubuNgoma. If you are good at protecting people's houses, ukubhethela or isithunzi and so forth, then that would be your speciality. If you are good at isithunywa (praying for people), you will be good at that. You cannot be an isangoma or umthandazeli and do everything; you will see that you are gifted in this or more inclined in this.

According to Keneilwe, the methods used in traditional medicine and biomedicine are comparable; nevertheless, they do not focus on healing similarly. Keneilwe describes the notion of specialisation and how it affects one's recovery. You might go to a traditional healer with a pregnancy issue, only to be told that you are fine, but this is just because the traditional healer is not trained in that area. Some sangomas pray for water, some administer muthi, and some specialise in educating people about ancient healing practices. In addition, Keneilwe makes it clear that most traditional healers only focus on helping the baby when he or she is already here and not when the baby is still in the stomach. In Keneilwe's explanation of where traditional healers dominate and how they go about doing that, Nkgono Modiehi explained the importance of what traditional healers do and why they do it. She said:

The whole point of us as traditional healers putting people in baths, putting strings around their abdomen, and massaging them is because we are protecting them from witchcraft. Because some clients come here, and when they get in, you tell them you see a child, and if they do not know, they are pregnant and other stuff around them in their lives. Some you see right then and there, and some you are protecting just in case, for somebody, some you just see they have enemies just by getting in (Nkgono Modiehi).

According to traditional healers working as professional nurses, pregnant women are washed as part of their job, and the bath water is infused with traditional medicine and herbs that are supposed to protect both the mother and the unborn child. Following washing, which is supposed to ward off evil spirits, the lady is treated with sacred oils (Ozioma & Chiwe, 2019).

6.3 Methods of Protection

Unlike biomedicine, traditional medicine is said to function deeper and without the use of technology, relying instead on intuition. When a pregnant lady interacts with a traditional healer, she is exposed to treatments such as bathing, stringing, and massages to ensure a smooth pregnancy. These methods used by traditional healers provide a glimpse of what is going on in the mother's and baby's lives, allowing the traditional healer to spot any complications as early as possible.

6.3.1 "Whatever is done through witchcraft can be fixed."

These were Nomathemba's words, making it clear that no matter what witchcraft does, it can be reversed or fixed. This helped with the following theme, which shows how these traditional healers, working as professional nurses, traditionally handle childbirth complications. Gogo Noma then uses the explanation of prolonged pregnancy to explain what Nomathemba meant; she said:

> *In prolonged pregnancy, people use their own clothing to prevent them from delivering, and we need that specific attire to destroy it so you may give birth. Sometimes, they bury that something for you not to deliver, so we need to do something that represents us digging it out and burying something else to release (Noma).*

In this presentation, Gogo Noma demonstrated how anything as basic as a person's attire might affect their pregnancy. As a result, she explained how if someone is bewitched using their clothing or anything else, a process is performed in which their clothing is buried, or something else is buried in its place. The traditional healer must travel to the mountains and do something that represents the digging of the clothing by burying something else in its place, allowing the woman to give birth. Nomathemba follows a similar approach to assist pregnant women in giving birth. Nomathemba said:

> *When a woman has been pregnant for too long, I give them isihlambezo or umuthi in a plastic cup to drink. When she is done drinking, she must throw the cup on the floor so that it breaks; this then takes her straight into labour.*

She says that if a mother is unable to give birth and has crossed the 40-week mark without going into labour, there are manoeuvres available to help the baby come out. She created the notion of isihlambezo, which will be explained more below, which is a sort of muthi administered to pregnant women by traditional healers. The glass shattering is particularly significant because it demonstrates the importance of both drinking the isihlambezo and ensuring that the glass breaks, which aids delivery. For example, glass shattering might be interpreted as depicting the process of water breaking or the process that initiates contractions. Lizzy approached the issue of prolonged labour and how people deal with it uniquely by using an example of when her daughter was pregnant. Lizzy said:

> *My daughter took time to give birth. I gave her an ostrich egg and gave her remedies for her to give birth, such as the LP that had existed from long ago. Then she got labour pains, but she drank black forest tea to give birth; she was already tired. Her ex-boyfriend had bound her pregnancy; she was in labour and only gave birth after two days (Lizzy).*

In comprehending what Lizzy stated, it depicted that when a traditional healer gives you muthi, you should not use anything else since it can potentially prevent or postpone the muthi's effectiveness. In the same way that an ostrich egg and an LP can help one go into labour, black forest tea can do the same, demonstrating that there are many traditional ways to deal with pregnancy complications without having a c-section or using any biomedicines.

According to Naidu and Darong (2015), some diseases are viewed as a misfortune from the ancestors owing to their inability to carry out a ceremony, while others appear to arrive as a sign to signify that a particular individual has been uniquely chosen to pursue the traditional path into becoming a healer.

> *You can have prolonged labour because azange wabika (letting the ancestors know) that you are going to the hospital, and a specific ritual was not done for you. You can have a child that cries non-stop because the child akashiswelanga imphepho (lighting incense) to say we will receive this child, and imbeleko (the process of introducing the child to the ancestors) will be done; therefore, if not done, the child will be irritable (Keneilwe).*

> *There are instances where it is hard to block a pregnancy complication because the ancestors could be showing you that you are getting twins or you have had an operation before that requires you to have another operation (Nkgono Modiehi).*

We communicate with the ancestors at the door when you are pregnant because ancestors can bind your pregnancy, so after this communication, others can give birth. They bind your pregnancy because you do not listen to the rules. The child is not from you but from the ancestors (Lizzy).

Phantom pregnancies could also be labelled as complications; this could be caused by ancestors, just because a person does not want to initiate. This happens especially when a person really wants a child; amadlozi (ancestors) can use this to make you believe you are pregnant while you are not. When consulting, they will tell you idlozi lomndawo (water spirits) is what is bothering you because these are the ancestors focused on your reproductive system, because they stay by your sacral region, because water flows everywhere. Water is made for reproduction and whatnot (Keneilwe).

These were responses from the participants as they tried to explain how ancestors can influence one's pregnancy, just because the person is not following their ancestral rituals, or if someone has done something that does not go hand in hand with what their ancestors stand for. A belief in any supernatural or metaphysical being has been shown to impact people's lifestyles and attitudes about life significantly. Many participants in this study expressed their beliefs on how their ancestors contributed to people's suffering, in this case, the complication of childbirth. Such infliction is seen as a type of punishment from the ancestors for failing to show proper regard to the ancestors, either through customary rites or rituals or as a warning of what may happen to the person. Nonetheless, Nkgono Modiehi explains that problems might indicate that your ancestors are trying to tell you something rather than that you have done anything that does not please them. She explains that childbirth complications are managed through C-sections and that having a C-section may sometimes be a godsend since you may be having twins, which is not a complication. Even so, Keneilwe emphasises that to have a good pregnancy or give birth, one must acknowledge the presence of one's ancestors, understand their existence, and provide them with what they require so that they do not discriminate against you. She gives the example of phantom pregnancies, stating that most occur because the ancestors want you to acknowledge and honour them. This is especially shown in how one must tell the ancestors to complete the delivery safely before going to a hospital. Lizzy appears to agree with Keneilwe that before doing anything, such as giving birth, ancestors should be told to avert any tragedy that may occur.

A woman's experience with childbirth is heavily influenced by culture and tradition. Lowe and Struthers (2001) believe this is vital in nursing. They adhere to various values, religious and traditional beliefs, and rituals, even during childbirth. Understanding these beliefs helps traditional healers better understand how to heal or help them with childbirth complications.

When you are pregnant, it is essential to know your roots, know that you are Zulu, Sesotho, and so forth, and to take proper interventions, go to uyocinisa isisu (protecting your pregnancy). These days, people are pregnant and flaunting their pregnancies like celebrities. We are black people; we cannot walk around wearing tight stuff when pregnant but relatively comfortable; one needs to make sure they are protected because any little thing, such as people touching your belly or imimoya (spirits) around, can affect the pregnancy, because when you are pregnant you are fragile, it is as if you are the baby you are carrying. Therefore, you need to take care of yourself and take proper measures. Find someone who will help you, whether it is a sangoma, umthandazi, or whatever, and find someone who resonates with you. This can even be your grandmother if they know this type of stuff, because the coming generation of grandmothers is only TikTokers. People these days are wearing tight stuff, suffocating the children, and going everywhere; these things are hazardous to the baby and the mother (Keneilwe).

There are different clothes for different things; some clothes are because of culture. I have had a woman whom I had to make a certain red cloth for that she was going to wrap around when she goes to work because, in the place she was working, enemies were trying to. She has had a few miscarriages before, and it was sort of a position fight; they were fighting her for the position she was holding as a HOD in the company, but whatever muthi they were using was affecting her ability to hold a baby because it was meant to be isichitho which means everything you hold will spill hence all her pregnancy would spill (miscarriage) so that certain cloth with muthis had to be done so that the baby can be protected and the mother can be protected (Gogo Noma).

In understanding the reasons for childbirth complications, the participants noted the importance of knowing their roots, performing the rituals needed, or preventing complications from happening beforehand. Failure to perform this ceremony brings numerous disasters to the

mother and the infant (Pauw, 1994). Keneilwe explained the importance of protecting a pregnancy by using what the person has learned at home to avoid misfortunes. She notes that, as Black people, we hold pregnancy sacred, which is indeed true because, as Black people, pregnancy is not announced before three months to avoid miscarriages. However, now people are seen taking pictures of the pregnancy's progress and posting those pictures right up to the time of childbirth. One may even question when, as Black people did, we lose our cultural roots. Nonetheless, Gogo Noma uses Keneilwe's concept of roots to show how this works within the traditional space. She showed how people within the number are seen to be given different remedies for the same thing; one may get a red cloth to protect her pregnancy from miscarriages, while another wears a white one for the same reason, just because of culture. While sitting with Gogo Noma as she washed her baby's clothes, she mentioned that when a person gets in her ndumba, she allows the person's ancestors to guide the process; she allows the person's ancestors to show her how to heal the person.

6.3.2 Drinking Herbs: "Isihlambezo, umchamo we nfene and isiwasho."

According to Roberts et al. (2016), pregnant women believe traditional healers are better able to care for them during pregnancy than Western practitioners. Meanwhile, Gumede (1987) emphasises that belief in spiritual and traditional healers extends beyond pain alleviation and encompasses comfort. In helping one understand this, Nkgono Modiehi said:

> *Isiwasho is water-based, depending on person by person and type of client, because some are more comfortable since they have come to me even before conceiving. Some clients are given blessed water, and it becomes isiwasho to them.*

Pregnant women are considered to believe in holy water, and traditional birth attendants pray for it to be given to them to sustain their pregnancy and protect the unborn infant from evil eyes (Mudonhi, 2020). Nkgono Modiehi introduced the concept of isiwasho, which she mentioned is a way to help strengthen and deliver a healthy baby. She further explained this, she said:

> *Inside the ndumba, when I check for complications, it is a spiritual x-ray. I get them and let them know your child is a breach, and then you confirm. I have not had a case where the mother goes into labour, and anything bad goes on because, in my practice, I also use a foetal doppler; I check the heartbeat as well when I*

am done with the massages, and then I also have the machine where we can both listen to the heartbeat in my ndumba. I include my nursing profession in there as well, so even when I give them isiwasho, I reassure them that it is safe for pregnancy because some clients come in. They are not apostolic because apostolics are more comfortable with isiwasho and amaZion, too, unlike people in mainstream churches like Raima and Universal, who are uncomfortable and continuously ask what is in there and what it will do. So, I mention that I give them this as a midwife, and it is safe (Nkgono Modiehi).

According to a study conducted in Zimbabwe, pregnant women consume various church concoctions (Mudonhi, 2020). Pregnant ladies visit with pastors, who prepare water for them to bathe in every day for the safety of their unborn child. This is a ritual deeply rooted in the Zulu culture. Understanding what Nkgono Modiehi means by isiwasho reveals that it is a light muthi that is not considered muthi by most religious groups. She makes it clear that this is a way she can help the mother and the child throughout the pregnancy; if the mother drinks, then Nkgono Modiehi can detect where the problem is, which then shows that isiwasho does something to the body that then helps Nkgono Modiehi to help the pregnant woman further. For church people, this is then seen as holy water. Mogawane, Mothiba, and Malema (2015) state that the sort of herbal medicine a person receives might vary depending on their culture. Others may get religious items such as tea (which can even be given to you by church members), Vaseline, and coffee. In addition to this, pregnant women believe that using holy water will fight off evil powers and avoid tragedies like miscarriages (Mudonhi et al., 2021). This was substantiated by a study conducted by Mogawane, Mothiba and Malema (2015), which indicated that pregnant women are given special water containing certain chemicals that have been prayed for and can be consumed at any time following pregnancy confirmation.

Lethu then mentioned imbiza, which has the same impact as isiwasho. She said:

Imbiza strengthens the pregnancy, and imbiza that protects the pregnancy (Lethu).

She clarifies that medication can be called in the same traditional way, but plays different roles. She explained imbiza as being split into two, therefore playing different effects, which, in this case, imbiza for strengthening the pregnancy and another imbiza that protects the pregnancy from witchdoctors. In explaining this, Keneilwe explains how imbiza should be with the statement:

You have to be very careful with a pregnant person; a pregnant person cannot be given medication, and a doctor gives out panado or a light dose, with stuff like Ibiza for a pregnant lady; one needs to be very careful because things such as panado go through processing, there are labs for that, that make sure they are at a right schedule, that is why they have doses and ingredients, with traditional healers we dig medication from the source so you are giving a person the source a very strong one at that so one needs to be careful on what they give and when. You cannot just go to a sangoma and get that mbiza; it needs to be very light, needs to serve a certain purpose, and it must be a mbiza for a pregnant person; you cannot take imbiza yegazi (muthi for blood) because that is very strong and can even make one miscarry. A pregnant woman is, therefore, managed differently. Imbiza is a last resort after being given something to soothe your pregnancy with (yahotsasa) through massaging the pregnancy or ntho yahokotha (something to lick), but not imbiza. Usually, older women understand these things and have been there for a long time (Keneilwe).

Keneilwe explains that there is a lot of unreliability and mistrust in muthi given to pregnant women since traditional healers who are not nurses do not know how much muthi is appropriate for a pregnant person. It is understood that pregnant women are treated differently from other people who visit a traditional healer; thus, one may question the effectiveness of the specific muthis of traditional healers and whether they are the sole cause of women experiencing childbirth complications. Keneilwe, like Nkgono Modiehi, acknowledges that there are several mbizas and that each of the current mbizas must fulfil a role in the lives of pregnant women. Gogo Noma explained how strong an mbiza is and when it should be used.

When a woman is pregnant, you do not give them imbiza because you do not want to hurt the child. You can give it towards the end of the pregnancy, but many healers use it religiously so that women can deliver (Noma).

Gogo Noma demonstrated how traditional healers employ imbiza and how this ultimately leads to the mother's death. This relates to how a traditional healer working as a professional nurse understands and handles muthi differently than traditional healers who do not have a traditional identity. Traditional healers use imbiza regularly to help women give birth, which often results in c-sections since the baby fights to come out and the contractions grow severe.

Treatments before childbirth include massaging, bathing, and swallowing (Mogawane et al., 2015). In some churches, elders oversee and take care of the pregnancy by massaging it, giving pregnant women tea, and providing holy water (Mudonhi, 2020). Portia explained that:

> *There are women ba sedulwanga (women who massage your stomach) and women who put you in bathtubs as a means of protecting the pregnancy. You make sure that your friends do not even touch your pregnancy because someone can have muthi in their hands, and you would not see it just by touch, then you have a miscarriage.*

Portia stated that traditional healers treat delivery problems through various methods, including baths and massages. She emphasised that individuals should not conceal their pregnancy because there are several ways pregnant mothers can lose their infants. In stating this, she demonstrates how anybody, including a friend or family member, may go before your pregnancy because not everyone wants the best for you. In mentioning all this, she explained the sacredness of this procedure. She said:

> *The process of hosedula is so sacred that you would not see any of my age mates doing it; it was done by grannies years ago; it is not very popular unless there is an ancestor in you that gave you this gift (Portia).*

While nursing her baby in the dining room, she stated that a hosedula is essential since it facilitates birth. Not only that, but it is done by the elderly, who no longer engage in sexual intercourse and are pure. She emphasises the importance of being 'selected' for something rather than just doing it because you can. Lethu agreed with what Portia said. She said:

> *…… In some ndumbas, they offer massages where the pregnant woman is told what to buy. It is a practice done by old sangomas who no longer engage in sexual activities or grannies who are gifted as traditional midwives. This also helps with turning the baby by using something as simple as Vaseline because of the power bestowed on your hands and your tongue. Sometimes, all you need to do is touch a person or pray for the person, and things just happen (Lethu).*

Nomathemba goes on to give an example of how and when hosedula takes place, she stated:

> *We are given a hosedula to position the child in the right way. If it is a pregnancy from 7-8 months without the baby turning, we call it breech. We also perform hosedula so that the baby can turn so that they can come with their*

head and not legs. Your ancestors gave me Hosedula; as I said, I have been given the knowledge for pregnant women, but when the baby is born, then I have no job anymore because I was not given that by my ancestors. Not everyone can do it. I have two people who are pregnant; this other one was having a problem. She is seven months pregnant, and she could not walk because she could feel that the baby was sitting on the cervix already, in the position for labour. With the process of hosedula (massaging), she is good; even when she goes to the clinic for a checkup, they do mention that the baby is now fine. She does not have pain any more; she does not feel like her baby is pressed down anymore, which is why the movement was difficult for her; after massaging, she felt good. When my patients come, I always advise them to go to the medical doctors; I think that is why no one has ever lost their baby while they are coming to consult. I believe we work hand in hand with doctors because there are some things that I can do within the ndumba, but still need medical treatment (Nomathemba)

Nkgono Modiehi explained what she uses for the process of hosedula. She said:

I use Vaseline and Harmanes hosedula and the holy oil I make…. I use my own home-made holy oil hosedula using olive oil, herbs, baptismal oils, and other oils, but my basis is pure virgin olive oil. I only use things I have made with my own hands (Nkgono Modiehi).

Hosedula, I use holy ash and new Vaseline. When a person comes pregnant, all I want from them is a brand-new huge towel to make her sleep on as I perform the hosedula process and washing cloth. When she comes to consult always, she will always sleep on the towel until she gives birth and original Vaseline not perfumed, holy ash. This then helps the baby sit in a good position because sometimes a baby can come here in a crossed direction, so I do the hosedula process to put them back into their supposed direction. I start with isihlambezo, not the one that has muthi. I take this holy ash and lukewarm water, mix them, pray, and then give the pregnant person a drink. After that, I give them a muthi cooked up isihlambezo. You do not perform things such as ukuphalaza (the act of drinking something that will help you vomit). If a person has complications, instead of

ukubaphalazisa, you can make them bafuthe (the act of using umuthi to steam) (Nomathemba).

According to the participants, traditional healers and church leaders utilise massages to monitor the growth of the foetus in gestation (Mesele, 2018). Additionally, the massaging of the pregnant woman is done using curative herbal oils, including Vaseline, because they are considered holy. These specific massages are done to offer alleviation from some pregnancy complications, such as breech, because some women do not attend antenatal check-ups (Mesele, 2018). Nonetheless, these messages can jeopardise the mother if there is an ectopic pregnancy, especially in the first trimester (Levi, 2016). According to the participants' comments, the hosedula is a vital component of pregnancy since it allows the baby to be positioned in a way that helps relieve minor delivery difficulties. This demonstrates the value of traditional healers since they may prevent a problem from progressing; as a result, a lady no longer requires a C-section but rather an expected delivery because the massage helped flip the baby. Just as there are diverse cultures and traditions, several traditional healers practice their healing methods. For example, Nkgono Modiehi employs Vaseline and other herbs and oils, but other traditional healers use various materials. Unlike Nkgono Modiehi, who makes her oils, Nomathemba uses simple things such as Vaseline, a brand-new towel, holy ash, and a washing cloth that has never been used to massage pregnant women. One might say that the use of all brand-new items is to portray a pure new life. Nonetheless, Lethu shows the power that one has when they are handling a pregnant woman; it is in their prayer and in their hands where the pregnant women are then healed or when the complication is then relieved. This demonstrates the participants' different levels of understanding of childbirth complications and their approach to healing.

According to Siveregi and Ngene (2019), herbal drugs like isihlambezo are used throughout the pregnancy, from conception to delivery, to guarantee a healthy pregnancy free of difficulties. Isihlambezo is an herbal combination that pregnant women use to prepare their uterus for pregnancy, keep the uterus inactive during pregnancy, and induce cervical maturation at term. This was one of the ingested muthis my participants mentioned is suitable for pregnant women.

In early pregnancy, no one gets muthi. For the baby to grow well in the womb, there is what we call isihlambezo, which is good but also not good, even if you do not know the measurements, because some people use their minds to measure. When someone drinks isihlambezo, her way to open up with no complications, they need to drink isihlambezo with a plastic glass with whatever measurement you might have given her; she lets the glass fall; it opens the baby path because sometimes you can go to the clinic with all the signs for childbirth but get to the clinic and the child does not come out and the doctors do not see anything then the person has labour pains for a week or so. It goes hand in hand with witchcraft because you cannot have your water breaking and have signs of childbirth, but when you get there, everything just stops. You are supposed to know in a 2L how to measure isihlambezo. Imbiza is not good for someone who is pregnant; it is meant to clean the blood. Imbiza for pregnant people isihlambezo. Isihlambezo has a set time for it to be taken, unlike imbiza; you can take imbiza anytime and any day. Isihlambezo does not interfere with the baby's formation within the womb. Imbiza is dangerous; it is strong and breaks clots; you cannot drink it while pregnant; it is done with so much strong muthi; it is given to people who are not doing well on their periods, and so forth. Isihlambezo is not done with strong muthi, which is why it can be given to pregnant women. Prolonged pregnancy is also helped by isihlambezo because sometimes prolonged pregnancy is witchcraft. I do not believe that medical doctors can handle this, but traditional healers can because this was done by someone. By medical terms, you are given when you will give birth. If you do not give birth, then it is straight to c-section, but with us as traditional healers, even after the expected date of delivery has passed, we can help you to get a normal delivery if you do come on time by giving you muthi for the baby to come out, because this is because of a person, it is black magic. If someone comes against you, it is possible for them to hinder the development of your child by just holding your belly while you are pregnant. As traditional healers, we are trying to prevent such things so that people do not encounter pregnancy complications. (Nomathemba)

A baby of isihlambezo is very beautiful. When you drink isihlambezo at seven months, you can give birth at eight months. I make people drink it for seven months, and then I let nature take its course. You can have labour pains but not deliver even after drinking isihlambezo; this can also be because of God. Isihlambezo is good, but it forces the baby (Lizzy).

I do not like using isihlambezo that traditional healers use since I practice both. There is isihlambezo that has muthi and umchamo wemfene included; it has a lot of things in it that I do not like using. There are different types of isihlambezo because culturally, I am sure even Xhosa-speaking people have their own; Sesotho-speaking people have their own because I have learnt that each culture uses things for different things (Nkgono Modiehi).

You can also drink umchamo wemfene, which works much like isihlambezo (Nomathemba)

When discussing how isihlambezo works, Nomathemba emphasises that it is the sole mbiza that pregnant women receive. According to her, Isihlambezo makes it easier for the pregnant mother to go into labour without any complications. It, therefore, halts any intentions by witch doctors who may be attempting to bind one's pregnancy since it causes birth. She wonders why sangomas use imbiza for pregnant women because it is very powerful for them, mainly because drinking it dissolves blood clots in the body. She also discusses the limitations of biomedicine, stating that with isihlambezo, everything is conceivable, even after medical professionals affirm the baby's due date has passed. Nonetheless, Lizzy goes on to describe how the infant is after the mother had used isihlambezo throughout her pregnancy. While sitting with her, she summoned her grandson to show me how attractive he is, illustrating her thesis that infants are beautiful when their moms utilise isihlambezo. When approached by Nkgono Modiehi about what she perceived to be the use of isihlambezo, she stated that it is a cultural barrier for her because she does not use it, but has heard of it. She also stated that if what she gives pregnant women is known as isihlambezo, it does not contain any heavy herbs such as umchamo wemfene, which is seen to arise as another muthi used for pregnant women by traditional healers. The above demonstrates that most spiritual worldviews are based on traditions and behaviours connected with reducing pain during childbirth and helping with childbirth, such as the use of traditional medicines and treatments, like massages with oils, which are thought to alleviate pain and make birth simpler. As a result, while the medicalised hospital environment

may rely heavily on pharmaceutical-based medication, traditional healers are seen to use their private space to help women more traditionally.

6.3.3 String around the waist to avoid miscarriages

According to a study of Zulu women, pregnant women are given strings to tie around their waists to safeguard their pregnancy and prevent premature labour (Drigo et al., 2020).

> *With Intambo (strings), when we use it mostly with pregnant women, with the womb, we need to keep it closed, so if you bind it, it means we are keeping it closed (Gogo Noma).*

When Gogo Noma explained the importance of the string around the waist, she said strings guard your pregnancy from miscarriages and other things witches could wish to do to your baby. The string maintains the baby's life in your tummy. According to Scina (2017), in specific households, when married, the in-laws expect the bride to bear children so that the family may grow. The string around the waist becomes monitored once the woman is pregnant to see if it becomes too tight, indicating foetal growth. If this does not happen, the elders will notice this and take steps to resolve this with the belief that traditional medicine is intended to support the pregnancy through the taking of traditional herbs until childbirth (Scina, 2017). According to Buana, Adjie and Harinyato (2017), pregnant women wrap seven-coloured strings around their waists at six, seven, eight, and nine months to protect themselves and the foetus from harm until childbirth. These specific strings are prevalent among pregnant women because they believe they prevent premature labour and miscarriage; this practice, according to Buana, Adijie and Harinyato (2017), is not dangerous and works for those who believe it. In explaining how the strings work, Nomathemba said:

> *After performing the massaging process, you then put uLinda, which can also be called intambo yokubamba umoya (a string that holds in life), around their waist, not in the early months, maybe around six months. I only do this if the person comes early because other people come when they already have complications and when they are close to their expected delivery date. The Linda I made has 7 knots. On your birth month or in case of prolonged pregnancy, every day, the pregnant woman must pray with a candle. After praying with the candle, she needs to switch it off and use it another day to pray with it for seven days. While doing this for seven days, you untie one knot every day. On the sixth or seventh*

knot, the pregnant woman is guaranteed to give birth. In case of bleeding during pregnancy, I give the pregnant woman umtungu, I cook it and give it to the woman; this will stop the bleeding, then the pregnancy will progress well, but the problem is she needs to consult until birth. In such cases, I then do the string immediately to hold the pregnancy to not lead to miscarriage.

Nomathemba explains how the strings operate and their significance. She demonstrates that each knot in the string is significant and contributes to a smooth delivery. Using the Linda string, which means wait, allows the infant to develop properly and even prepare for delivery without the mother having to worry about being targeted by witches and wizards. Keneilwe explained the string around the waist as follows:

Protecting yourself does not mean having a lot of izintambo (strings) or dirty, but rather one clean one that is tight enough but not too tight because it might close the child from coming. Before going to the hospital, you take a bath and take it off because, in the hospital, you will be opening your legs and so forth; you cut it off, then uyayiphahlela (talk to the ancestors) that now is the time to put the strand in a plastic or a bag safely. A family member can also do this because a traditional healer is there to only facilitate and not rule. It could also be possible that the traditional healer, when called to come cut the strand, does not want you to have the child no more by doing particular voodoo…(Keneilwe).

Keneilwe describes how this string might cause problems for the mother since it may be overly tight, preventing the baby from coming out. Furthermore, when women have extended labour, it is not always due to someone preventing them from giving birth or a medical emergency, but rather because the pregnant woman did not cut the string. Because the thread is designed to retain everything inside, childbirth is impossible. Thuli agrees with what Keneilwe said by stating that:

You give me your expected delivery date, and then I cut it when you are about to deliver (Thuli).

This then portrays the importance of having the string and cutting it off when you deliver so that you may come back with your child. Nomathemba further explains the concept of using strings for pregnancy by saying:

> *Protection of the pregnancy is done with strings; you are avoiding miscarriages; there is a string called Linda, which means waiting. My Linda string is blue and white, but people can make different ones for the same reason: when the pregnant lady is going to give birth, that is when they take it out. Wherever they are, they are getting pain, they cut it out or destroy it and then go to the hospital. If someone comes with the mind of not wanting you to carry your child or anything that has to do with witchcraft, the string then protects from that. Other people use ukugchaba for pregnant women, which I do not do. This makes them strong; it works hand in hand with the strings. (Nomathemba)*

In understanding what Nomathemba said, even with strings, culture, tradition, and the person's ancestors play a role in how the string is to be. Nkgono Modiehi then supports Nomathemba's statement by stating that:

> *The treatment goes hand in hand with the type of pregnancy because some have lousy luck, which needs to be removed. It depends on the cases because I have had uncomplicated clients who just required a simple white string, other clients who required a different type of string, and others who required certain clothes. So, extra things to protect the child from witchcraft because there are people who target the baby (Nkgono Modiehi).*

It can be seen in Nkgono Modiehi's words that protection is vast and different. When a person wants to protect their child, it is then essential that they see a traditional healer who will help them with this string and make life easier for them so that they do not worry about witch doctors targeting their pregnancy.

6.3.4 Prayer as a preventive approach to miscarriages

> *You will find that a person would have a situation of the breach, which can be classified as a traditional thing because you did not go through the steps your family used to go through when pregnant; for example, some families go to prayer women for massaging their pregnancy, therefore, turning the baby because these are the people trained for this, they will turn and protect the baby (Keneilwe).*

It is clear, according to Keneilwe, that not only traditional healers massage a pregnancy but also pastors. In understanding what Keneilwe said, one is meant to understand that if one does not follow the procedures of childbirth that her family follows, she is followed with complications. Throughout pregnancy, women strengthen their prayers to God for protection, safety, safe delivery, and benefits (Aziato, Odai and Omeyo, 2016). Nonetheless, it is shown in this study that most of the traditional healers utilise prayer while they offer protection to their clients. When sitting in the dining room with Nomathemba, trying to understand how she handles the complications of childbirth within the ndumba, she then told an experience she had; she said:

> *Ukuboshwa isisu (Stomach tied) from 10 months to 11 months; she came on her 10th month, and we prayed with different coloured candles before I gave her the massage. I gave her isihlambezo, then gave her the string; she was able to give birth after three days. I have had a patient who was six months pregnant with so many complications; the pregnancy was even heavy, and she was even walking in a terrible manner. It was done by the boyfriend's girlfriend. The boyfriend had to come to join the consultation, and isihlambezo was then made. I then prayed for her and put her in izinyamazane, which is an African root used to remove evil, and she was able to give birth naturally and well. (Nomathemba)*

As Nomathemba explained this, I could further understand that there are different traditional healers, and they specialise in different things. It is shown how Nomathemba uses isithunywa, which is her praying, to help her clients during prolonged labour. She mentions how she uses different candles to pray. In praying, she mentioned that she does not touch any of the muthis she uses without prayer, signifying the importance of prayer within her speciality. Before she is seen giving the pregnant women strings, isihlambezo and so forth, she prays for those. This then illustrates the convergence of religion and tradition and how both help a person regain their health. Nomathemba is not the only traditional healer who mentioned prayer as being a vital need for her in helping pregnant women. Gogo Noma said:

> *The uterus is a muscle, and this muscle expands during pregnancy, so the rubbing helps with the positioning of the baby; hence, when you are rubbing, there is a certain technique and a certain technique for each trimester they are to make sure that the placenta is also intact. When we go to the hospital, they use sonas, but the only way I can connect to the spirit of your child or your child and see what is*

happening and whatever is touching as a healer. As I am rubbing, that is communication with the life within you; we just do not massage. As we massage, we are praying and trying to see if there are any complications that are coming your way and if we can prevent them, to prevent them if so or prepare you for them.

According to the study's findings, praying and asking for divine intervention from above can safeguard pregnant women from bad spirits. Gogo Noma explains how vital prayer is and how it can help her pinpoint any complications a pregnant mother might have. She uses the process of massaging a pregnancy to explain this. It is evident in her words that the massage builds a bond between the mother, the traditional healer and God because, without prayer, the massage is considered useless and irrelevant. To position the baby and know what is wrong with the baby, the massage and prayer are meant to go hand in hand so that the traditional healer may be able to prepare the mother for complications or even pray for the child so God protects the child from any complications that may arise. According to a study conducted in Malawi, most pregnant women strongly believe in the supernatural; thus, they frequently visit religious leaders to safeguard themselves against evil spirits (Roberts et al., 2016). The author went on to say that a pregnant woman should always pray for protection and safety and be guarded and at peace. This prayer is then said to keep the evil eye away.

6.4 Summary of Chapter

The chapter discusses the research findings. The literature supports the conclusion reached thus far based on a comprehension of the literature. This chapter highlighted that pregnant women's cultural customs varied in several ways, including procedures to confirm pregnancy, methods to avoid preterm labour, practices to nourish pregnancy while guarding it against bad spirits, and finally, to treat difficulties. These include drinking holy water, bathing in holy water, consuming isihlambezo, and simply remaining at home. This demonstrates the significance of having some type of pregnancy protection due to all the unfavourable aspects of pregnancy described by the participants in this chapter. This chapter demonstrates the significance of understanding how different cultures function and the value of practices.

CHAPTER SEVEN

7. INCORPORATING TRADITIONAL HEALING IN HOSPITALS: BENEFITS AND BARRIERS

7.1 Introduction

Integrating traditional and alternative medicine into healthcare systems is a growing trend worldwide, including in Africa (Lampiao, Chisaka and Clements, 2019). Despite this, the challenges and advantages of integrating traditional identities are at their pinnacle. According to Tessendorf and Cunningham (1997), traditional healing nurses may use methods that biomedical practitioners deem harmful. Giving enemas to children with diarrhoea is not recommended as it can lead to dehydration. The barriers to having the traditional healer identity are visible in how this ailment is treated (Tessendorf and Cunningham, 1997). Therefore, collaborating with traditional healers may be perceived as legitimizing unethical behaviours by Western-trained healthcare practitioners (Mokgobi, 2013). Even though this is the case, authors such as Mokgobi (2013) believe that integrating traditional healing practices into mainstream health care can alleviate the pressure on Western healing systems.

7.2 For traditional healing, the space matters

Traditional healers working as professional nurses make several judgments in the hospital setting in response to childbirth complications. This section describes their personal experiences in the hospital and within their ndumbas, including how they are seen, how their dual identity has benefited them, and how they separate these identities because their dual identities affect how they handle childbirth complications. Hence, Bautista-Valarezo et al. (2021) argue that the traditional concept of health and sickness emphasises the significance of balancing four bodies: physical, mental, social, and spiritual, which is the opposite of the biomedical concept of health. Traditional ancestral medicine is a treatment practice used to promote or maintain the health of people and communities—traditional healers practice by applying their inherited knowledge and abilities (Bautista-Valarezo et al., 2021).

People come to the ndumba in secrecy, so the inclusion of traditional healers in the hospital space will break this. You are defeating the purpose. It could help, but no. We are also very loud, so we cannot even be in a clinic setting for this (Nkgono Modiehi)

When asked how she thinks the traditional healing identity can benefit the hospital space, these were the words of one of my participants. The British and then the apartheid authorities banned African traditional medicine and rituals in South Africa under the guise of witchcraft. This resulted in secrecy in the practice (Molebatsi et al., 2020). Therefore, patients of traditional healers may value what they consider nonjudgemental, private and unrecorded consultation (Chateau et al., 2023). Nkgono Modiehi was not the only one who found the inclusion of the traditional healing identity in the hospital space to be a problem that takes away privacy, the unrecorded consultation and what the identity is about. Busisiwe said:

I cannot say that nurses who are sangomas within the hospital space should practice our traditional healing because we already have our place to practice which is indumba. So, if someone wants to consult, it is a matter of choice; if someone will go endumbeni or the hospital, I can refer the person to the hospital if I see that this person is above me and needs the hospital, and it will be the person's choice if she/he is going to the hospital or see another traditional healer, so I believe the way things are, are fine.

Both participants, therefore, did not see a need for traditional healers to assist within the hospital, the main reason being to keep the sacredness of the identity. Not only does this traditional healing identity within the hospital take away what traditional healing is about, but also what nursing is. It takes one out of the professional identity they have signed for to who they are when they should be home in their ndumbas.

According to Mwaka, Achan and Orach (2023), most traditional health practitioners indicated that people become healers through ancestor recurrence, dreams, studying healing skills from other healers, and having spirits follow them after becoming ill with certain illnesses. Similar methods were used to achieve healing powers and the recognition of effective medications. This illustrates that one cannot be a traditional healer without having passed all these stages. Nonetheless, without wanting this for themselves, but acquiring it from their ancestors, participants in this study are met with many hurdles.

We are privileged to work in a black community hospital. When I do my overtime in a private hospital, I remove my beads because we try to make people comfortable. In the private sector, a patient is first. If the patient is not comfortable with you, like can that sister no hold me, then you will not be able to hold the person (Portia).

When attempting to understand how the participants perceived themselves inside the hospital setting and community, it became evident that this only works if the people in the community and hospital see them. Portia made an essential point about how being Black and working in a hospital full of Black people makes it easy to carry the traditional healer and nursing identity because everyone knows that being a traditional healer is African and being part of the "chosen" that will help heal and protect the community from misfortunes and illnesses. She highlighted the limits that come with being a private hospital. Many white individuals in South Africa indeed choose to receive healthcare in private hospitals, whilst many black people utilise public hospitals due to a lack of financial resources. Portia states that one can wear their beads in public hospitals. However, it is difficult in private since patients are not taught about this vocation, making them uncomfortable having and seeing such persons treat them.

I have never really cared how people view me as a traditional healer and nurse, but I do have people who are distant now because of my gift, and it is their right because we all have different belief systems. At work, it was not always pleasant, but it gets better; there was a part where I almost resigned because they do not believe in African spirituality; it was said that I was scaring patients away because I had to have idumane (red hair because of traditional reasons in a way to bring your ancestors closer so communication lines are strong) there was no way to be in work uniform with red hair. This created a lot of factions and a lot of hate; I got to see who was in my corner and who was not because my argument was if you can allow a Muslim lady to cover herself, then why can you not allow me to cover my head because it did not make sense to me how they wanted to force me out of work of something I did not ask for but was born into and had no control over….. There are people who will never walk in this room if I am in this room. There are those who will not sit in my chair because, apparently, I am a witch, so when they get here, they bring a special chair.

(Lethu).

Lethu's statements show that the nursing council's regulations ignore traditional healers and their beliefs while tolerating others. Because of her initiation, Lethu became different, and being different meant that others no longer wanted to be near her. She discusses how being in each place might be an issue for many people, even if she has only sat in a specific chair since accepting the calling. Nonetheless, Portia agreed with what Lethu said; she stated:

Having this identity, people will be distant from you, people will fear you, and some will cut ties with you (Portia).

She demonstrates how accepting the calling causes others to distance themselves from you and become afraid of you since you are now more informed in more areas. Even more respectable. Thuli elaborates by stating:

The community take me very highly; people think the incorporation or integration of the two, being a traditional healer and professional midwife, brings out proper outcome; they feel more comfortable being with somebody that would know both sides than one. That's how my community views me (Thuli)

Thuli believes having this dual personality is extremely important to her patients because they think in holistic therapy. Because a traditional healer is a nurse, they may heal a patient spiritually, intellectually, and physically, which is why Thuli's community regards her highly. However, Noma says:

People have their beliefs and do not act differently. However, there are no boundaries in conversations, and this is because there is a misconception that as traditional healers, we do not know God and we do not pray; that is when the conversations change from let us pray about it and even when there are morning prayers, and they would think you would stop. In the community of nursing interaction wise, nothing changed with my colleagues when they found out I am a traditional healer. However, when it came to other things, especially patients who were not okay, it was the thing of everybody looking at me to sort of hope that I would tell them something else about the patient or other times if they saw I was in a patient's room. I had the curtains closed for about 15-20 minutes, and everybody would look at me in the sense that I shared what I was saying to the patient. In nursing, we talk about confidentiality and even endumbeni there is still that confidentiality. I cannot go around and tell my colleagues that, do not see that

patient like that she needs to go thwasa (the process of being a traditional healer). So, there was a shift in treatment (Noma).

Gogo Noma exemplifies the high expectations that come with this dual identity; it is no longer a case of being unable to achieve anything because you are competent in both domains. She demonstrates how individuals not educated about traditional healing have assumptions about it, such as not praying. In addition, she discusses her experiences with aiding patients in a closed room, citing her colleagues' disregard for nursing ethics and their need for her to speak out about what is wrong with patients, whether conventional or medically.

7.3 Avoidance of confusion when in a trance

Busisiwe, when explaining this, said:

I have only had a trance once or twice within the workspace; luckily enough, it was around 1-2 lunchtime, and the patients were not around; the person who saw me was my colleague, who is a sangoma. I was hiding it from coming out, but it was not stopping, so they then had to make a ritual for me there, such as ukushweleza

Traditional healers can enter a trance, interact with spirits, and determine the source of disease or bad luck (Podolecka, 2023). When placed in a hospital setting to accomplish their function as professional nurses, they commonly encounter trances that they cannot control and require rituals to end. One can only imagine how hospitals with only one traditional healer would manage any trances that a specific traditional healer may experience. This creates a barrier inside the medical setting with the traditional healing identity because these are two distinct professions. When trying to understand this, Portia said:

I cannot take up the ancestors wearing a uniform and throw them at work, in the hospital, because when you go on a trance at work, it is a problem; who will put you on the side, full-on trance at work and then what? People will run around, not knowing what to do and fetch snuff. I walk with the elderly, a mkhulu, and he does not smoke snuff but rather a cigarette. They will be running around doing thokoza thokoza, doing things they do not know yet. You provoked the ancestors at work, so these are some of the challenges for now, but I am good at handling them.

People with this dual identity are forced to hide their traditional identity because of how they come out at work and the problems it brings for the people around them. Not only this, but according to Mokgobi (2014), traditional healers are seen as people who perform witchcraft and are the reason for most causes of diseases and illnesses. Tsholo explains this by showing how people treat her because of this traditional healing identity in the workspace. She says:

The community and workplace are very judgmental towards me being a traditional healer, especially when I wear my regalia or beads. Since they did not know me before, they started asking a lot of questions about initiation, what was going on and so forth. At work when I started working, I did not have any beads, I did not have anything that showed that I am a spiritual person, so when they saw my first beads, questions came flooding in, which in turn I addressed as if they got letters from my gobela about me going to the initiation, and that they should mind their own business, this has led to people being scared of me at work because I can obviously see all their evil stuff, so they start isolating themselves and not associating themselves with me. Still, I do not have a problem with that (Tsholo).

This goes back to how people understand traditional healing. Therefore, most African societies believe in the witchcraft system (Mulondo, 2020), and this brings a lot of preconceived notions about traditional healers. This is seen in how people start avoiding a person because the person is a traditional healer or are uncomfortable because of a specific person's traditional identity. This shows that people still regard traditional healing as a form of witchcraft and not purely as people who are following a calling that can help society with any ailments.

7.4 Non-conformity to "standardised" treatment practices

According to Mngqundaniso and Peltzer (2008), nurses are worried about traditional healers' misconduct, hygiene, infection control, and lack of record keeping. In addition, the dosage suggested by traditional healers to patients is not always adequate because the traditional healers' medicine is not always adequately prepared. This can be seen in Thuli's words, she said:

……..there has been a case where I told this lady that I am also a traditional healer, but I think this is very harmful to you because you are taking huge volumes of the muthi; I feel it should have been prepared in a certain way or do not bring it to the hospital because now you are complicating, it might harm the brain and

the functioning of the baby and everything like that because I know for sure that this is very strong. I do not think you should have used it in the first place, and they would tell me I cannot tell them that I will have this baby my own way because it is mine.

This is viewed as both a barrier and a benefit to the medical space because the nurse now knows what to fix and where to fix it; however, as previously stated, it removes the nurse's professional identity because they are now making the patient uncomfortable, especially since the patient was seeking medical help rather than traditional help. Keneilwe goes on to discuss the dose and type of muthi that traditional healers give patients, which can be harmful to them and their newborns. She said:

As traditional healers, we dig medication from the source, so you are giving a person the source, a very strong one at that, so one needs to be careful about what they give and when. You cannot just go to a sangoma and get that mbiza; it needs to be very light, needs to serve a certain purpose, and it must be a mbiza for a pregnant person; you cannot take imbiza yegazi (muthi used to clean the blood) because that is very strong and can even make one miscarry. (Keneilwe)

This, therefore, demonstrates the benefits of having a dual identity as a traditional healer and a nurse because a traditional healer without a nursing identity does not know what is considered safe and what is not, or even what dosage to give the patient because nurses are qualified professionals with the expertise and abilities to give high-quality healthcare to patients (Mboineki et al., 2019). Noma then uses the concept of infection to show the blurry lines that the traditional identity brings within that hospital space, which can affect patients' health. She says:

This is a matter of how you were socialised into the profession and how you stand for your rights. You can wear beads on your neck, but on your hands, it is questionable, especially in the workplace. We are taught professional etiquette because patients can sometimes be psychotic. People do not read their contracts. They just sign and come back and fight. It is not about being difficult, but as a nurse, you have made a pledge to act in the patient's best interest. Yes, you can disinfect your beads, but will they be 100% disinfected? (Noma)

Nurses are often overlooked in decision-making due to a lack of power and are viewed as just pawns to carry out medical doctors' directives (Mboineki et al., 2019). However, the nursing council reveals that nurses are heroes for individual patients, families, and the community to ensure safe care delivery (Mboineki et al., 2019).

Traditional medicine is often practised outside of the established healthcare system. Even though this is the case, traditional healers work to augment the healthcare system.

The thing about medicine is that it is about pathophysiology; it is concerned with how the disease happens, the process of it going wrong, and how we make it better, but it is not really a cure. But when you come to the spirit realm, we are concerned about the why, the root cause of the problem; we do not care about the problem; it is there. It has happened, it has occurred; we are more concerned about why it happened, why there is a dis-ease, because everything should be at ease in life, everything should be balanced, there should be equilibrium. So, when a woman goes to give birth and there is a complication, we then need to come back and ask why the complication happened, and then find out the root problem of the complication. But in medicine, they will say Okay, there is a cord around the neck; the cord was too low; how do we solve this? Let us cut. We look at why it went around the baby's neck; it is not supposed to be there. That is the difference between medicine and traditional healing; medicine is about the how, and indumba is about the why and making sure this does not happen again. For example, I had a C-section, and the next time I give birth, I will be getting a C-section. I will never have a normal delivery again. I already have a problem, and it exists; it will never go away. So yes, they solved the problem then, but it is not long-term because I will be dealing with the same thing again……….As traditional healers, we try to prevent complications; hence, we focus on what needs to go right; we are optimistic in our nature, in our calling and how we do things, and when it comes to birth because of the regulations that are regulating us as a nation and the world we are living in right now, it is scarce to find someone giving birth endumbeni unless they are in the rural areas. Legally, you need sonas and so forth. You cannot deliver a baby and put cow dung on the umbilical cord, so even when one gives birth endumbeni, they still need to go to the hospital for the birth to be registered with Home Affairs. So, the system does not allow us to have these births unless there are the necessary papers and

resources. It is not that we are not concerned about it, but the life we are living does not allow we would be in trouble (Gogo Noma).

When I spoke with Gogo Noma, I discovered that traditional healers not only focus on curing complications but also on preventing them from occurring in the first place, which is why pregnant women are given strings around their waists to protect them from witchcraft. Gogo Noma labels the differences of traditional healing and biomedicine making it clear that these are two health systems that can coexist because they do not focus on the same things. She explains biomedicine as something that continuously comes back to bite the person, while using the idea of having a C-section. The moment one gets a C-section for their first baby, automatically, all the babies that follow are C-section delivered. While explaining this, she made it obvious that traditional healers being there at birth is illegal. She described their limitations, even though traditional healing is an independent profession, like medicine. She mentions how a traditional healer cannot make you deliver your baby because that is a crime. The chances of going wrong are very high because traditional healers do not have the equipment that biomedicine has, even though they are well-equipped for this, as Gogo Noma mentioned. Nonetheless, the legal framework under which both parties operate is not generally understood, and it has changed dramatically in recent years. When healers must act, bureaucratic barriers cause fear and anxiety (Bautista-Valarezo et al., 2021). In explaining this, Portia said:

In hospitals, you are guided by a scope of practice for nurses; there are things you cannot do, and there are things you can do. So, I was telling my Gobela that at work, you become confused because now you do not know what you need to do…There is something called umthetho weshoba, which is a scope of practice in nursing. Being a sangoma, we work under umthetho weshoba. There are things that I cannot just tell you, things that are not urgent or that are life-threatening to you.

Understanding what Portia stated reveals that being a traditional healer, like being a nurse, entails a significant amount of legality. To be considered proper, one must behave within one's discipline. Gogo Noma expands on Portia's arguments by providing an example of one of the regulations nurses observe as outlined within the scope of practice. She said:

There are policies in the hospital, such as the infection controls, for which we cannot wear our beads. There are traditional healers who wear these beads even though the policy mentions that they are bare below the elbows, which means there should not be anything below your elbows, nothing, not even watches. This then also goes back to Indians who put their red ropes; they are not being reprimanded; Jewish people who come to the hospital with whatever…You cannot act accordingly if you do not have the knowledge to act accordingly. You do what you know. If I did not have the knowledge I have of Western knowledge, I would not be able to accommodate the Western treatment endumbeni; I would be against it because that is what happens in most cases where you find traditional healers and Western healers fighting each other when we do not understand that the end goal is to make the patient better. I know the benefits, and it is not all bad for both. We no longer exist in the 18th century, there is space for western medicine because of the medicine they provide and the wide-scale diseases that exist now (Gogo Noma).

She utilises the notion of infection control to emphasise that, as a traditional healer and nurse, you must follow what you are taught since not doing so is damaging to the patients you help. She discusses how the present nursing scope of practice benefits other cultures while forcing other cultures and customs to follow the standards. In doing so, she emphasises that biomedicine is a significant aid at this period since it advances with time. In contrast, traditional healers opt to hold back and create bureaucratic hurdles, as Bautista-Valarezo et al. (2021) have highlighted. Nonetheless, Keneilwe shares her own experience with how she balances her identities as a traditional healer and a nurse, saying:

You do not just put a pregnant woman in your number. You ask about the health of the child first, like when you last felt your baby kicking, and whether you have been eating well. If you see the pregnancy is above 26 weeks. The woman tells you the baby last kicked last week since during this time the baby is supposed to quick frequently, you must not even consult the person, the person must go because it is an emergency, tell the person to go to the nearest hospital or take the person to the nearest hospital to check that because as a traditional healer you cannot check the heart rate of the child because that needs machines, to be able to detect if the child is okay, you need the machines which the hospital has, you cannot use the bones to check that, the mother needs to tell you how the child is before they

walk into your ndumba, unless if as a traditional healer, you see something is wrong. You are able to fix it, then that is when you can fix it, and if not, the woman has to go. As a traditional healer, it is okay to say no; you are not always supposed to say yes. You know what you can manage and what could get you into trouble, because anything that happens could be in the tabloids and go viral. Your practice as a traditional healer will be taken away from you, just like the nursing practice. Traditional healers, too, are registered under organisations, and they will take you to court, and you will have to explain what you were doing, and you will get banned for that (Keneilwe).

Keneilwe describes how she considers the fact that traditional healers cannot always tackle the same problems that biomedicine can. They all have a location they cannot reach; she cites the example of checking the child's heart rate. Traditional healers cannot accomplish this unless they have the machinery installed in their ndumbas, something traditional healers who are not nurses are unfamiliar with. This demonstrates the limits of conventional healing. Despite this, Keneilwe portrays both nursing and traditional healing as having stringent standards that prioritise the patient's health over the nurse or traditional healer. Regardless, traditional healer nurses would want to see more recognition and regulations for traditional healing among modern medical practitioners (Tessendorf & Cunningham, 1997).

I am not allowed to practise at work, and I see it mostly as a matter of approach. I see myself as Sr Noma at work, who is working in the scope of the South African Nursing Council as a professional nurse, so I must act within the scope, and that scope in medicine is about pathophysiology, which means I cannot tell someone they have a problem that cannot be scientifically or medically proven. I am not allowed, but yes, I have secretly practised because I do ask patients for consent if there is a message for them from the ancestors. In this, I am tapping out of Sr Noma, which proves that I have practised as a traditional healer in the workplace. Showing them that the tests the doctors are doing are not wrong, but that there is an alternative way of doing things, while being careful what you say, because people can quickly record you; everyone has a phone these days. We are not allowed to practise honest facts, which is disturbing because you find pastors coming into the ward praying for patients. But it also depends on the patient because patients have the right to call their traditional healers to come through. For us, a professional needs to remember that we signed a contract, and the

contract said that you are coming in as Sr Noma, which means practice as Sr Noma (Gogo Noma).

Traditional healers who work as nurses in hospitals have limited abilities and mostly focus on nursing. Nonetheless, they are regularly required to care for patients who they believe would be better served by a traditional healer rather than a nurse. While they may provide references and ideas or urge clients to see a traditional healer, this is not formally permitted (Bautista-Valarezo et al., 2021). When attempting to understand what Gogo Noma meant, it becomes clear that, despite specific laws prohibiting traditional healers from acting in a hospital setting, nurses are forced to act outside their scope of practice because they believe other diseases and illnesses are better treated traditionally rather than medically. Gogo Noma uses the concept of pastors being able to come to hospitals to pray for patients as an example of how traditional healers are marginalised and ignored; yes, some bring their traditional healers with them, but the traditional healers are then forced to conform to biomedical rules and not do anything unrelated to medicine. Despite this, Gogo Noma is observed to follow the restrictions in place, pointing out that when they learn about their duty as nurses, they are educated about these specific constraints. Keneilwe then goes on to describe how she manages to have these two identities, saying:

Suppose I feel there is an emergency, and I have to explain to the patient. In that case, there is something that I am seeing, it is not on the western side of things, and I understand that you are in the hospital. However, if it is something spiritual that is bothering you, there is something spiritual that you need to fix; this is so that you get consent first from the patient before you say it; you cannot just blurt things out to the patient without getting consent from them on whether or not they believe or whether they want to hear what that is about or they are not interested (Keneilwe).

The participants are shown providing the patients with the opportunity to express their traditional side without pushing their views on them, but also acknowledging that not all of them would want to hear this because they went to the hospital for medical treatment, not traditional support. Nonetheless, Lesego describes how she navigates her responsibilities as a traditional healer and professional nurse inside the hospital, stating:

We have not been told not to practice at work. There are instances when a patient comes in, and I see that the person's issue is not a medical problem but a spiritual one; I ask the patient if they are a believer and give them my number to call me after work and talk regarding what I see while I treat the patient medically. We are not supposed to be consulting people haphazardly, but sometimes, it just comes, and there is nothing you can do. I go into a trance when I am busy helping you medically, just because your granny wants to talk to you. I come back to my senses later, especially if I keep trying to suppress the trance by disobeying the ancestors by not consulting at work. I have learnt not to consult people at work because it is unprofessional, but if it comes and I consult you, then it happens. I omit a lot of things unless it is something very serious. I tell you, I am a traditional healer and would like to speak to you in a traditional healer capacity and not a medical capacity, so if you agree, it is fine, and if you do not, it is fine (Lesego)

Lesego outlines her approach to patients when she feels they might benefit from standard therapy. She describes the sorrow she feels from having to suppress her identity as a traditional healer to follow the rules and be professional in the workplace. Despite this, she always proclaims her talents as a traditional healer to patients who require it when they allow her to. Portia agrees with Lesego and says that:

Sometimes, this dual identity at work becomes one. However, sometimes, I need to separate these two because the image of the hospital will not accommodate me as a traditional healer, but when the ancestors come, they come (Portia).

Many of these women operate as traditional healers in prenatal care for pregnant women. However, their role is limited since medical professionals do not acknowledge them (Ebey-Tessendorf & Cunningham, 1997: 21). Portia depicts how the regulations limit their ability to work as traditional healers in the workplace. However, following these rules may be difficult for them when they cannot control their trance. According to Bautista-Valarezo et al. (2021), different healing paradigms should coexist for the patient's benefit.

7.5 Value of nurses with dual roles of nursing and traditional healing in hospital spaces

While some participants felt that it would not be appropriate to practice traditional healing within the hospital and patients need to visit them at their own number, others were different. When asked if doctors can work hand in hand with nurses who are traditional healers to make patients' lives easier, Noma said:

> *There is a need for traditional healers in hospitals, but not for them to be working under Western doctors, but rather working with them. We need to have this as an independent profession, but the problem is traditional healing; you cannot prove with dreams, while medicine requires you to prove. Medical practitioners want to steal the knowledge and not work with us. A lot of traditional healers who are doctors or nurses are now opening their practices that provide dual health*
>
> *(Noma)*

The prescription and use of traditional medicine in South Africa is not regulated. Therefore, there is always the danger of misadministration, particularly with lethal herbs (Sobiecki, 2014). Because traditional healing exists on its own, as do physicians, comprehending traditional practice within the hospital becomes difficult, especially given that traditional healers and modern doctors have distinct perspectives on health. The fact that traditional healers have a distinct approach to assisting patients and a different method of administering medication distinguishes the two professions in East and West lengths, demonstrating that there are several challenges to being a traditional healer inside the hospital setting. Even though this is the case, according to Pretorius (1999), their approach is holistic, addressing both the physical, emotional, and psychosocial aspects of disease and illness. This then portrays what traditional healers working as professional nurses bring to the table. When talking to Thuli about what she believes traditional healers working as professional nurses bring to the table, she said:

> *We want sangomas to work with the hospitals, even if I was not a traditional healer; I would wish for that because what we see as traditional healers and what the doctors and we as nurses have learnt at school is totally different, because I am seeing this placenta is blocked. You are seeing a patient outside feeling pain; those things are two different things that could be solved independently if we could work together. honestly, we would have a better South Africa because the birth mortality rate in hospitals is due to witchcraft in most cases and due to*

preventable things that could simply be solved if we worked together; why can't we work with this doctor, gynae, this patient has this issue, I can bring the oils, and then this issue is solved (Thuli).

With so many differences between traditional healing and medical healing, helping a person from both a medical and traditional point of view can heal them holistically, solving certain illnesses without any major surgeries. Agreeing with Thuli, Keneilwe said:

Being a traditional healer and professional healer has helped me in the sense that I now understand healing differently; you understand it both medically and traditionally, and you can see that not everything needs the hospital or Western doctors; not everything is what it seems, for example, someone can be presenting with these symptoms but there is a deeper and larger thing that they need to solve, not everything can be healed by western doctors, some other things need you to go back to your roots to fix from there because someone can be having a recurrent infection or disease only to find that no, one of that person's ancestors had that thing, their leg was rotting, and now it is coming to you and now you are going to doctors and they are not seeing anything or doctors just giving you antibiotics that are not even helping. But when you get to a traditional healer, you are diagnosed and given traditional medicine and healed because you have attended to the source; other things need you to go directly to the source and not look superficially on and think that Western medicine is the only way to go.

Like many other developing countries, South Africa values medical pluralism or the presence of numerous unique therapeutic systems in a single cultural milieu (Haque et al., 2018). Having medical doctors or, instead, hospitals existing without traditional healing proves to kill a person further. Traditional healers provide what medical doctors cannot, which is very significant in people being healed from diseases and illnesses. Therefore, traditional healing procedures include natural medical compounds and objects like sorcery enhancements, incantations, religious passages, spiritual approaches, ceremonies and so forth (Haque et al., 2018). As much as traditional healing focuses more on a person's spirituality, biomedicine focuses on physicality. When asking Nomathemba to differentiate these two, she said:

Having traditional healers in the hospital can help with traditional medicine because sometimes people go with dark shadows that Western medicine cannot fix. It is about time for traditional healers to show their capabilities within the

hospital space because we can. We are just looked down upon by people because of fly-by-night sangomas. There are a lot of things that we can do that medical doctors cannot; with us being involved, there will be no c-section. Everybody will have a standard delivery because all this is done by people (Nomathemba)

This portrays the impact traditional healers can have on our lives. Instead of increasing the risks of childbirth complications through having a C-section, people will know of ways in which they could have natural births, therefore reducing the complications of childbirth using traditional medicine. Not only that, it also illuminates the bad energies that come with witches and wizards, often referred to as people with bad intentions towards you who can do anything to see you down. Moreover, the understanding of traditional healing within the hospital could lead to many people being healed from unexplained illnesses such as schizophrenia and the like because most of these are rather spiritual instead of physical. This can be seen in what Tsholo said, she said:

It would be perfect to have a place where we could practice our traditional healing in the hospital space because I deal well with people who are mentally unstable. You can sit with mentally ill people, and at some point, you would see they are not crazy but rather just running away from the calling; it would be nice in the hospital to have traditional doctors so that there is a second opinion and patients are not misdiagnosed, being given anti-depressants, and all those things only to find out what the person needs is just snuff or complete his initiation things so that he can perform. (Tsholo).

There are many things that doctors can do that they have learnt from school and skills that they acquire along the way, but that does not make them qualified in both traditional healing and medicine, which is very crucial in holistic healing, as traditional healers working as professional nurses bring. This was also mentioned by Lethu, who said:

I can nurse my patients holistically because I can tackle the spiritual aspect of you, the mental health aspect, and every other issue in your life without you even realising what we are dealing with just by talking. You ask one question in the right direction, and everything will bring itself.

People with this dual identity can help you in ways you never thought you would need. According to Sobiecki (2014), in this manner, the traditional healer seeks to correct physical, spiritual, or interpersonal discrepancies to understand all aspects of the individual. This then gives the nurse, a traditional healer, direction on how to help you and what to do to take you back to your good state. When talking to one of my participants, I had to understand that because of the different knowledge and skills that come with being a traditional healer who works as a nurse, things are much more open on a wider scale and even though that helps, it affects them at work because they might lose their jobs if found exercising their traditional healing identity in the workplace. Thuli said:

> *Being a traditional healer and nurse has made things diverse; it has allowed me to learn how to incorporate the two, and I get to explore further onto a situation or problem and solve it better with more insight and knowledge because if I am in the hospital and see that this has something fishy around it I check, I check anything and everything but it does not mean it gets out there because in most cases because I am protecting my job because the policy hinders me from saying anything.*

Traditional healing practices are holistic in nature, with the goal of improving the person's entire well-being. It places the body, self, and society in a state of dynamic equilibrium. The holistic approach considers a person's values, desires, beliefs, social relationships, and spiritual perspective (Haque et al., 2018). It can be seen from the participants' responses that although they all share this dual identity, they all experience it differently. Some find it to be much more of a barrier. In contrast, others find it to bring benefits because it provides holistic care that biomedicine and traditional medicine alone cannot provide, even when dealing with the complications of childbirth.

Tessendorf and Cunningham (1997) found that traditional healers who are also nurses have several advantages in their private practice. Specifically because traditional healing in South Africa has centred on detecting and treating ailments related to witchcraft or disrespect for ancestors. Nonetheless, according to Wreford (2005), South Africa has a diverse approach to healthcare delivery. The country prioritises traditional, biological, and spiritual approaches to healthcare, and it is important to note how all these are maintained by people who carry the dual identity of being a traditional healer and working as a professional nurse.

You are getting everything in totality with this dual identity, holistic healing, and comprehensive healing. When you get out of the incumbent, you do not have any worries. You know that you have been covered, including all aspects of you, the spiritual, the physical, the financial, and everything. I am an educator at heart, and I believe that plays a huge role in both roles; I do not believe that as a nurse, I have given a patient a pill without telling them what the pills are doing to them, or even admitting them without telling them what their diagnosis means. Doctors come and tell you that you have pneumonia, and when you ask people what it is, they say it is a lung infection; they need to understand what is happening to their lungs for them to get them here, because, for others, it is a lifestyle, and we can give you as much medicine as we can. Still, if you are going to go back to the very same lifestyle, then it is pointless. I even do the same thing, endumbeni. I take things one step at a time, and I equip you to stand alone in my absence. I believe in independence. If you educate a person and show them why things are going wrong, then you have given the cure and not the medicine (Gogo Noma).

Being a traditional healer and nurse has made things diverse; it has given me the opportunity to learn how to incorporate the two, and I get to explore further a situation or problem and solve it better with more insight and knowledge because if I am in hospital and see that this has something fishy around it I check, I check anything and everything but it does not mean it gets out there because in most cases because I am protecting my job because the policy hinders me from saying anything (Thuli).

Being a traditional healer and midwife has helped in my use of herbs, umuthi, and iziwasho because I am not conscious of what I use because I know if I cannot use specific medication for certain things when a client walks in with problems, it is not about the problems, they could be hypertensive now I know that there are certain herbs I cannot use on them. For example, when I make their bath salts, I do not use salt; instead, I use Epsom salt. You now combine the two. You can now tell the difference between things; you know which one is medical and which one is not. I offer confidentiality that you would get from the clinic endumbeni with my patients, no matter what anyone says. In every area, you combine the two (Nkgono Modiehi).

As a traditional healer and nurse, I have professional secrecy when I help someone as a traditional healer. At work, people come to me for help as a traditional healer, and that, for me, is an advantage in itself (Lizzy).

When trying to understand how the participants had benefited from having a dual identity, the comments listed above were received. Gogo Noma emphasised that it is spiritual growth that allows her to help everyone in ways she never thought were possible with just her medical knowledge. She added that having this dual personality allows her to serve everyone. The participants' comments indicate that they feel that being a hospital member might benefit their patients' health since they treat their patients not just medically but also socially and mentally, in other words, holistically. It is well known that traditional healers are not vocal about the muthi's they use, but because of her professional background, Gogo Noma is seen educating her patients, whether in the hospital or endumbeni, about what is wrong with them, what they can do to find healing and how they can protect themselves from this happening again. Thuli agrees with Gogo Noma, noting how having this dual identity broadens their knowledge; they are no longer limited to comprehending a person's physiology but also the mental, spiritual, and physical aspects of a person, which are critical for recovery. Nkgono Modiehi takes a different approach to interpreting the benefits of this identity, stating that being a nurse allows one to know what is beneficial for a pregnant woman and what is not. One can measure the drug so that it heals rather than harms the patient. She even demonstrates how having this identity adds ethical value to everything she does. Because nurses are instructed not to inform other people about others' ailments and illnesses, incumbent no one teaches them this. However, because of having a dual identity, traditional healers working as professional nurses recognise its importance. Lizzy agreed with Nkgono Modiehi that most ethical principles within the scope of nursing are becoming increasingly crucial inside endumbeni, utilising the notion of secrecy to explain this.

Traditional healers exploited specific individuals' vulnerabilities for financial gain. There was also an understanding that these deceptive activities hampered access to proper care, potentially resulting in poor care, potentially resulting in poor health outcomes due to delays, disruptions, and not being sure of what is wrong with the patient (Moshabela et al., 2017). Lizzy mentions that this dual identity allows them to target patients and coworkers who require assistance. This may be seen as going against the scope of nursing. It is widely known that many South Africans

avoid traditional healers because it is believed that they target people for money, so having patients in need of assistance may be interpreted as traditional healers working as professional nurses, exploiting these patients. Participants agreed that having this dual identity is highly beneficial to patients since it considers all aspects of their health, including the spiritual, instead of biomedicine. Therefore, having them within the hospital practice will take this into consideration, leading to holistic healing.

> *Having these two identities within the hospital space brings comfort to the clients who need the service; they can be comfortable enough to do it at the hospital because they know we will not do it for them at the hospital. It will also benefit nurses who are traditional healers because we will be comfortable to know that we can now come as we are and we will not need to separate the two beings; we are coming to work knowing that okay, fine, if a patient has a spiritual problem, we can tend to it right there and then, that there is a room specifically designed for that so they try this way because the western way is not working (Keneilwe).*

According to Adams (1999), comprehending traditional healing requires acknowledging that the izangoma cannot solve problems on their own. A sangoma receives direction from ancestor spirits and communicates the message to the client. Taking this into consideration, mental health concerns in Africa are often misunderstood and poorly addressed due to a lack of study on the subject (Anjorin & Wada, 2022). Traditional healers are essential in providing treatment and offering a complementary belief system to people's cultural beliefs. They identify the root causes of mental health issues and tailor therapy accordingly (Anjorin & Wada, 2022). Traditional healers play an essential role in mental health care because of their availability and cultural beliefs, making them a vital community component. When discussing how the participants have benefited from having a dual identity, Portia discussed mental health diagnosis and therapy via her expertise in childbirth, saying:

> *I once had a patient who usually delivered; when they dropped her off at the ward, she had to give birth and leave. I had a trance at the same time just by looking at her; I ran out and then came back to people praying; in your medical eye, you see her as a person hallucinating because she was like, "Take me out of here otherwise I will die," that message was an emergency, and usually I dodge my ancestors trying to communicate with me during work hours. The nurses were*

making noise and praying, so I asked for a bible after going out to smoke outside a lot of times; the ancestors were still trying to send this message through me. I asked the husband for consent, explaining that whatever I was seeing was not medically related and that I could perform a reading on her. Because of the beads that I was wearing, it was clear that I was a traditional healer. Because of trauma or whatnot, the husband agreed that I perform the reading, and I used the bible to see what was going on with her. The mother-in-law sent an isilwane (translated to animal). She was waiting for the child to be born because she had this mentality that the lady was eating her son's money because he was no longer sending money like before. So, she sent the animal to make her crazy, which eventually should have led to her death. I went on constant trances on that day, which led me to approach the doctors and tell them it is not psychosis but witchcraft. My unit manager and everybody else above me were called to be told that I asked for a mentally disturbed woman to be discharged because she would die. It was a huge case where they let her stay in the hospital for 3 days without getting better; this is after I told them. I then advised the husband to sign the RHT (Refusal of Hospital Treatment) to take the woman somewhere because she needs a traditional healer, not a hospital, because she will die. That guy listened but was hurt because to believe that your mother could bewitch your wife. He did not come back to me, but I hope they are fine (Portia).

The use of Traditional Health Medicine (THM) is congruent with the indigenous belief systems of the majority of South Africans, primarily Black South Africans, in which there is a linear causal relationship (Vawda, 2019). The individual strives not only to understand the occurrence. If I were not a midwife, I would give the patients because if there is a way to speed up the process, why not? (2019). When talking to Portia and recounting her experience, she expressed sadness that she did not pick this road, but it chose her. She regarded it as a negative. However, I saw it as a positive because if she had not spoken out, the patient might have died. She said that without the traditional healer persona, one would be unable to recognise this, since one would continuously be treating a patient medically when their illness is witchcraft related. As previously said, biomedicine disregards this feature of the human (the spiritual). Portia could use her knowledge and expertise as a traditional healer and nurse to determine the most appropriate therapy for the patient. Her viewpoint was rejected because traditional healers lack confirmed knowledge, whereas biomedicine requires testing before it can be considered

fact. They utilised her conventional wisdom to reject what the patient said despite their ineffective treatment. Therefore, this can be seen as a limitation of biomedicine, which leads to people refusing to be treated by biomedical practitioners. South Africa's healthcare system is marked by a significant divide, creating two distinct tiers contributing to widespread inequality in access and quality of care (South African Human Rights Commission, 2003). The public and private healthcare systems create a divide in which one healthcare system best suits one. Traditional medicine is perceived as efficacious, culturally relevant, and affordable for specific ailments. Traditional medicine is frequently preferred over or used in conjunction with biomedicine due to its cost-effectiveness, cultural significance, and perceived efficacy for specific ailments, even though biomedicine is the first step for most people (Ahmed et al., 2023). Thuli relayed a similar experience, stating:

> *I do not have active trances in public but I have been shown within the hospital space that this baby will die if we do not take any measures which could have been any measures, medically, or anything but because we have this issue with our government and not having enough equipment's to work, that patient, yes they tempered with her pregnancy, she came to hospital on time and we could have just done the cesarean section but the effect of the muthi that they used was to then either kill the mother or the baby, the baby survived and the mother died, I was shown that and I told them that something is not right with this woman if only we could push her first because the others are just there to deliver via caesarean section because they have been cut before, but this was not seen as an emergency because she was not a complication but you could tell her health was deteriorating, they did not listen to me because the doctor gives the final decision so the only time she started gasping that is when they realized that no something is wrong, personally, I did my part. I was hurt, and it was painful, but I did not get to make decisions; I wish we were given room to make proper decisions in the faculty (Thuli).*

Thuli, like Portia, shared her experience with me, demonstrating the inferiority of their position inside the medical setting. Even though her forefathers taught her what to do, medicine cannot explain ancient healing methods. The Western healing system looks overwhelmed and inadequate in treating many ailments due to a shortage of healthcare professionals and medical resources (Mokgobi, 2013). One may blame the lack of medical equipment, as Thuli noted,

because if there had been, the mother and infant would have been treated on time, rendering the muthi ineffectual. Regardless, the benefits of having dual identities are depicted in this tale, demonstrating that traditional healers who work as professional nurses may spot a problem before it leads to death. They perceive things that biomedicine cannot, despite their voices being silenced. Even though this is the case, nurses act out in both their identities, acting in the best interest of their patients.

> *I do not take traditional medicine to work, but I do, my prayers and ukuphahla, I always have ibhayi, I just do an emergency phahling by using water. I pray for the water, take ibhayi, the patient was in pain and we are not allowed to give any medication besides panado unless if the doctor wants to give any other thing, because if we give anything the patient's condition might be worsened. I realized she is from Mozambique, just like I am; I spoke to her in our language and asked if she believes in traditional medicine and African spirituality, and she said yes and said she believes it could be related to that because she has four kids and this has never happened, I took my cloth, wrapped it around her waist, I said cover it up, I mentioned how this could get me fired and that honestly that is what she needed and she delivered in the next 10minutes (Thuli).*

The scope of nursing requires one to act in the best interests of the patient. The aim of pursuing this medical approach is to assist people in returning to good health. Thuli demonstrates how she was able to treat a patient by surreptitiously practising her traditional identity and acting in the best interests of the patient, ignoring all the laws associated with practising any other kind of healing outside medicine inside the hospital setting. She could assist the patient because her dual identity enabled her to do so. It is possible that the patient or the baby would have died if the cloth procedure had not occurred. However, because Thuli could see this from a different perspective, she could attend to it without informing her superiors. Inevitably, traditional healers and nurses occasionally use medicines that Western medical practitioners consider harmful (Tessendorf & Cunningham, 1997). The participants unravelled the consumption issues when continuing the conversation about the benefits of their dual identity.

> *Medically speaking, you are not supposed to give a pregnant person something to drink, but traditionally, we do give them …When we work in the labour ward, we tell them not to drink isihlambezo because their private parts become red because of it. The baby does not come out (Lizzy).*

Isihlambezo can be a hazard. It causes the child to be macerated…. The use of strings around the pregnancy prevents blood circulation because they are not measured and they are tight (Nomathemba).

The most complications I get are those of people who drink isihlambezo because the progression of their labour is abnormal, there are a lot of abnormalities, the baby might be stillborn, the mother might bleed profusely…. Drinking isihlambezo, I do not give them. I feel like if I was not a midwife, I would give the patients because if there is a way to speed up the process why not but now that I understand that labour should happen like this, speeding up the process only harms the baby…Pregnant women drink moroto wa tswene (baboon pee), and it has high doses of oxytocin. The patient progresses rapidly, but that then affects the baby. With every contraction there is a purpose for it, one helps for the baby to go down and the other further more down, but when you drink something to speed up that process you end up with the baby with autism at birth. They bleed profusely because they need medical interventions because the oxytocin is too much, where nurse would give you 0.5 and you then you have drunk 1litre of it (Lesego).

The participants clarified that most of the things traditional healers give patients are unsafe for them. Even though this is the case, the participants are still giving patients strings to put around their waists and even giving them muthi to help with delivery. According to Lizzy, pregnant women are not supposed to be given anything for consumption because during their gestation period, they are fragile, and anything can happen to their babies. In explaining this, she even mentions how isihlambezo negatively affects the mother, leading to her not being able to give birth. Even with this knowledge, medically speaking, she is seen giving her daughter isihlambezo and other traditional medicines to help with her delivery. In addition to this, Nomathemba mentions how isihlambezo leads to a macerated child and how strings lead to blood circulation because most of these strings given to pregnant women by traditional healers are very tight. One can note hypocrisy in the words of the participants because they mention another and do another, act their role as purely a traditional healer and their role as purely professional nurses, without changing anything. They know the after-effects of the music and strings and still give them to patients for protection and delivery in their private spaces. Moreover, Lesego makes clear the negative side of muthi given to pregnant women by traditional healers. She mentions moroto wa tswene, which, like isihlambezo, helps with delivery. She mentions how both, even though helpful in birthing, can affect the child, leading

to death. In doing this, she mentions the importance of having the dual identity of a traditional healer working as a professional nurse. If this were not the case, she would continuously give her patients the music, not knowing their side effects. In saying this, it can be noted that the other participants with this knowledge still give their patients these hazardous muthis, therefore not considering their adverse effects. Regardless, Traditional healers who work as professional nurses argue for the recognition and clarification of the usefulness of certain traditional medicines in preventing birthing difficulties and their incorporation into mainstream medicine (Siveregi & Ngene, 2019).

7.6 Dualism is seeking and promoting safety

People continually define themselves by reflecting on and connecting with many locations and situations, including family, traditional, religious, and cultural groups, and recreational activities (Adams & Crafford, 2012). Therefore, people focus on the roles they feel are indicative of themselves. This can be seen in how the traditional healers working as nurses separate their identities.

I have not had any complaints about my identity as a traditional healer; even at work, everyone does not treat me differently because I wear my beads at work. My boss has not even had any problems with my beads because she knows I separate the two. At work, they have no problems. They actually come with their dreams and advice that are traditional, so it is bringing them closer to this other side of me…We use a herb in the delivery room, which is more accepted in herb practice, but I do not use it secretly; these are raspberry leaves. This is because Western clients are more accepting of it. Culturally, we use ostrich egg shells, so I combine ostrich egg shells and raspberry leaves; when I make them tea, they know I am making them raspberry leaf tea, but I also add ostrich egg shells. I do this in the delivery setting. They buy it from home and start using it from there. Ostrich eggs are a tonic, and some know that I add these, but some do not (Nkgono Modiehi)

I always separate the two for ethical reasons. I am forced to respect the policy, but I would not if it were not for me. I would work both ways, and I know I would achieve much better results; this is because I see things in the hospital space that

could have been prevented; people have died with me, seeing that I could solve this right now (Thuli).

Yes, I do feel the need to separate the two, especially at work, because you need to respect that you are at work; you cannot always join these things together. You only join the two when there is a need to do so; you cannot if every time there is a client you want to consult, you are at work, so focus on that, and at home, you focus on your dlozi's, so you must tell your ancestors that you are going to work. You are working, and if there are clients your ancestors want to bring to you, they may bring them in a certain way. For example, they can book if a person needs help over and above the hospital setting. You can refer them if you do not specialise in that thing, or you can build a relationship outside the hospital setting. Still, you cannot control where you meet your clients, but you can control how you separate your identity, or you will go around consulting people in the streets, but I do not do that. If you want my help, I will tell you to book a consultation because I do not consult in the streets or at work (Keneilwe).

Being a professional nurse is my identity, and being a traditional healer is my identity; now you need to split the two because the two cannot work in the same space, but then comes a person who is pregnant and has spirits, or there is a granny who wants a message for us to tell you. You need to find a corner because now you do not want to find yourself being questioned about whether you are practising traditional healing at work or are you a sangoma at work or a nurse, but there are some situations where you go into a trance, or someone gets in onesicitho or onesiliwane or uhambiswa ngani, then I must tell you the message. I pull the person to the side. That the person takes the message is up to them (Portia).

Endumbeni, when you come for a reading, I automatically do both medically and traditionally because that is me. There is no way I can separate the two. Endumbeni is more relaxed and happens naturally because I do not have to look over my shoulder while in the ward. I need to be careful in my approach when I step into Gogo Noma's advisory, but the two can never be separated. If I were to separate these two, then I would not be able to pick out spiritual things about

patients in the hospital space because Gogo Noma would be at home (Gogo Noma).

I phahla (communicate with the ancestors) every day so that my ancestors know I am a sangoma. I have told my ancestors that I have always been passionate about helping people, and nursing is also about helping people, so they need to separate their ndumba and work because they cannot just come and appear here; this is my speciality, and they understand because I do not wear beads at work. I do not want it when I come out. Now, everyone is saying "thokoza gogo," which exposes you as a person. People need to come to you, not the beads, because people start becoming uncomfortable with you because they think you can see everything about them when they see this, especially at work. People now say I am uncomfortable with this traditional healer, and I am supposed to help that person (Mkhulu Mkhontowamanzi).

It is rare; it is not easy to say I am separating myself because it can happen. I get into a trance at work, so I cannot say I am separating the two; I would ask them, yes, I am going to work; please watch over me and wait for me, but if it happens, they come, they can come at any time, so I cannot separate the two (Busisiwe).

There is no separation of the two because both are your callings and are intertwined. The first thing you see when a person walks in is their spiritual aspect, which is the beauty of having two gifts practising in the same space, because the minute you walk in and tell me you have a headache, I already know your problem is down there. I probe by asking how the headache started, what prompted it, whether you fought with anyone, and what triggered it, until we get to a point where you are free and open. My spirit is welcoming, and it is easy for people to open up, even though some other people are evasive, because some people are afraid of us as professionals, so you need to make a way for them (Lethu).

When I spoke with my participants about how they negotiate their identities as traditional healers and professional nurses in the hospital setting, it became clear that they occasionally split their identities. When I spoke with Nkgono Modiehi, I discovered that her traditional healer persona has no bearing on her but attracts individuals who may want her assistance. She discusses how she may prepare tonics for patients in the hospital that do not diminish her

traditional healing identity but strengthen it because these tonics allow her to assist patients using traditional herbs in a Western context. She is depicted respecting the borders of her identities and understanding where she should not go over as a traditional healer. Furthermore, Thuli notes that her identity as a traditional healer within the hospital environment is always hushed owing to ethical considerations since she follows the Nursing Council's standards, which restrict her from acting outside her nursing scope. In clarifying this constraint, she emphasises that if the regulations did not exist, she would operate in a way that accommodated both of her identities for the sake of patients. Nonetheless, when asked about the same issue, Keneilwe answered that it is essential to separate the two identities until they come together due to a "need." She is shown informing patients that the hospital situation does not allow for what they may require traditionally because there are no muthi, bones, and so on within the hospital, just medical technology. She explains that if a patient comes to a hospital and asks for her assistance, she refers the patient or assists her while she is not on the hospital grounds. Furthermore, Portia discusses the negative aspects of having a dual identity regarding the hospital's rules. She illustrates this with the example of being in an uncontrollable trance at work. In discussing this, she emphasises the need for traditional healers as part of the medical health system, assisting where medicine cannot, which is spiritual. Furthermore, Gogo Noma demonstrates the benefits of having both identities and the impossibility of having them separated because, no matter how hard she tries not to see people's problems in the traditional sense within the hospital space, she still does.

On the other hand, unlike Gogo Noma, Mkhulu Mkhontowamanzi is seen as differentiating her dual identity with the thought that the aura of a traditional healer should speak for her, not that she must act in such a manner that others now recognise her as such. She avoids having to act out her traditional identity in the hospital setting by first talking with her ancestors before leaving for work and working in a job that deals with people's healing, which she also performs as a traditional healer. Busisiwe, on the other hand, is debating whether it is feasible to separate these two identities since they are traditional healers and would have trances at any point, which agrees with Portia's statement. Nonetheless, Lethu expands on what the other participants have said, stating that the identities of a traditional healer and a professional nurse are inextricably linked and cannot be separated. She goes on to say that having a dual identity requires observing the person's spiritual state before touching them and then doing any physical examinations as a nurse, since that is who you are. Even if a person enters without knowing what is wrong with them, the dual identity allows the participants to provide holistic therapy

without their realising it. All the participants' answers to identity separation demonstrate the importance of identity negotiation, particularly in sociocultural and intergroup circumstances. As demonstrated by the participants, identity negotiation establishes interpersonal relationships and promotes interpersonal harmony (Swann & Bosson, 2008).

7.7 Summary of Chapter

The proposed unification of the two healthcare systems faces various difficulties. Some objections to the two's unification are based solely on religious reasons, image, and economic competitiveness. Some of the criticisms appear to be valid, such as the question of unsanitary practices of traditional healers, which pose serious foetal risks to patients, and, most notably, the issue of both health systems being worlds apart in their approach to childbirth complications and their methods of mitigating them. Nevertheless, according to Mokgobi (2013), a collaboration between traditional and Western medicine is showing promise in several African countries. Healthcare workers in these nations have positive opinions regarding traditional healing, which could soon serve as an opportunity for South Africa to collaborate with these two healthcare systems.

According to the traditional healers working as professional nurses, pregnant women are given traditional herbs and roots to eat, steam with and even drink throughout their pregnancy. This is so that the pregnant woman may be protected from evil spirits and evil people to ensure the foetus's growth and development. The traditional healers working as professional nurses in this study believe that even though pregnant women have access to mainstream medical assistance, some continue to use traditional medicine for reasons such as indicators that Western medicine does not meet all their healthcare demands throughout pregnancy (Bautista-Valarezo et al., 2021). These reasons include avoiding evil spirits throughout pregnancy and preparing for labour and delivery. Herbal drugs are utilised throughout the pregnancy, from conception to delivery, to ensure a healthy pregnancy without complications. It can be seen above that all the participants in this study handle their identity differently and are mostly faced with the need to hide their identity or behave in ways that hinder their calling, just because of policies in place by the nursing board that make them act in that manner. Nonetheless, traditional healers working as nurses benefit from their identity, especially as holistic healthcare professionals who can help spiritually, physically, and mentally.

While the study highlights the potential benefits of integrating traditional healing practices with professional nursing in managing childbirth complications, this emphasis may overshadow critical risks. Ethical concerns – such as conflicts with biomedical protocols, patient safety, and consent -were not fully explored within the scope of this research but rather touched on. Similarly, practical and logistical barriers and resource constraints may limit the feasibility of such integration in real-world clinical settings.

This limitation suggests that while the study provides valuable insights into how dual practitioners navigate childbirth complications, future research should also engage critically with the challenges and possible unintended consequences of integration, to ensure a balanced understanding of both opportunities and risks.

CHAPTER EIGHT

8. CONCLUSION AND RECOMMENDATIONS

8.1 Conclusion of findings

This thesis has successfully given meat to the skeletal bones of the objectives by exploring how traditional healers working as professional nurses understand complications during childbirth in hospitals around Johannesburg. This can be seen in chapters 5 and 6, where chapter 5 explains childbirth complications through a biomedical lens and how they are handled biomedically. In contrast, it can be seen in Chapter 6 that childbirth complications can also be explained traditionally, disregarding the fact that specific complications have names. Traditionally, complications are handled but are not given names. Even with this in mind, both chapters portray the understanding of childbirth complications by traditional healers working as professional nurses.

Secondly, the objective of the explanatory models used by traditional healers working as professional nurses in navigating the complications of childbirth in hospitals around Johannesburg can be seen in that the traditional healers working as nurses trying to understand these complications biomedically when dealing with their patients in hospital and even when dealing with patients at home before they can even explore how this can be handled traditionally. Since explanatory models are defined as people's perceptions, interpretations, and responses to sickness and illness (Dinos et al., 2017), the traditional healers working as professional nurses consider where these patients come to ask for help, either in the participant's home or their workplace, to help the patient the best way the patient wants to be helped. An example is when the participants ask if the patients believe in the specific treatment method that the participants feel or see is the problem at that specific time (p115 of this thesis as an example). '…*I spoke to her in our language and asked if she believes in traditional medicine and African spirituality. She said yes and that she believes it could be related to that because she has four kids, and this has never happened. I wrapped my cloth around her waist; I said to cover it up….' (Thuli).*

Lastly, I will understand how traditional healers working as professional nurses negotiate their traditional/professional identities in navigating the complications in childbirth that they observe in hospitals around Johannesburg. This objective can be seen as being fed by the participants, who explain how they behave in the hospital with their dual identity. Throughout the thesis, the participants portray that their identity as a traditional healer is not neglected when in the hospital space; they still fall into trances and help patients they feel could be better cared for by a traditional healer. The traditional healers also show that their help is limited to things like water, prayer, and ukuphahla, which are quick ways they have found to help patients who are not deemed unsafe by law or rather harmful to patients within the hospital space. Their knowledge of medicine has been seen to help within their ndumbas in the sense that they can now have foetal dopplers and other things that traditional healers without the biomedical knowledge do not have to check and see if the baby is okay before they can assist the client (This can be seen in p78 of this thesis). *'.....because in my practise I also use a foetal doppler; I check the heartbeat as well when I am done with the massages, and then I also have the machine where we can both listen to the heartbeat in my ndumba….'(Nkgono Modiehi)*

Furthermore, the thesis's rich tales depict some of the problems that traditional healers who work as nurses encounter while making therapeutic judgments. While some nurses believe that having a dual identity benefits the hospital setting, others, such as Busisiwe, do not. Regardless, nurses are perceived as compelled to conceal their traditional identity within the hospital setting, disguising that they have a second identity for fear of behaving and losing their employment. This may limit participants' ability to communicate their opinions in the hospital setting. According to Kwame (2021), biomedical practitioners sometimes view traditional practitioners' activity as unlawful and do not send patients to them, creating a perceptual difficulty. Some clinicians may harass or mistreat patients who practice traditional medicine before obtaining biomedicine in the hospital. This argument implies that many traditional medicine practitioners outside research institutions go unnoticed (Kwame, 2021). This gives biomedicine considerable power, even though it takes the easy way out, which results in considerably greater patient issues, as illustrated in the data and analysis chapter.

The cultural knowledge embedded within traditional healers working as professional nurses may have assisted the participants in contributing to the medical pluralistic nature of health in South Africa due to the uniqueness of their cultural character and, particularly, their dual identity. Thus, without a knowledge of the variety that participants might bring to health practice, it is possible to claim that no system will be fully capable of utilising the techniques

to achieve the holistic healing that comes with this identity. Traditional healers working as nurses have been observed discreetly practising their traditional identity in cases where they believe a pregnant lady would benefit from the care of a traditional healer rather than a nurse. They practice secretly since deciding what to do in such situations is challenging. Despite this, some nurses, such as Nkgono Modiehi, Lizzy, and Mkhulu Mkhontowamanzi, are allowed the ability to express themselves and act per their cultural identities due to the power granted to them by their superiors. This demonstrates the relevance of their dual identities within the institution. As a result, nurses may be caught between two worlds: the world of technological medicine, which represents modernism, and the realities of a developing country, where patients and doctors have a traditional and popular understanding of illness and disease that necessitates simple technologies to treat the most common diseases (Finkler, 2004).

Culturally created diagnoses have little or no place in understanding and treating patients' labour problems under the biomedical approach. According to Roberts et al. (2016), pregnancy is a delicate issue in which African communities are expected to protect the mother and infant since they are regarded as vulnerable during this time. Throughout this thesis, it is evident that being African requires acknowledging the relevance of ancestors and traditional healing procedures. Most childbirth complications are seen from a spiritual rather than a clinical perspective. Overall, the participants' narratives show how their understanding of diseases and health influences their attitude toward patients and patient care in the hospital. Clinical judgment requires applying critical thinking, as seen by how they handle birthing problems and their dual identities. The paper demonstrated how traditional healers working as professional nurses rely not only on their essential biomedical training in dealing with childbirth complications but also on their extensive nursing experience and their traditional healing experience and understanding of childbirth complications.

8.2 Study Limitations

The findings of this study are drawn from the experiences of traditional healers working as professional nurses within hospitals in Johannesburg. As such, they are shaped by the cultural, institutional, and policy environment unique to this context. The insights generated may not fully capture the experiences of these dual practitioners in rural areas, private healthcare settings, or other provinces where attitudes, resources, and regulations may differ significantly. While the study offers valuable depth of understanding, its broader applicability is limited.

Future research could expand on these findings by including diverse geographical settings for greater transferability across the South African healthcare system and beyond.
The main strength of this study is that it conveys the clinical decision-making of traditional healers working as professional nurses and how they handle the complications of childbirth within the hospital spaces using their dual identity of being a traditional healer who works as a nurse. Nonetheless, the limitations encountered in this study were that participants expressed reservations in fully disclosing some of the traditional medicines or practices they engage with when dealing with some of the childbirth complications they managed within the hospital space or at home. This, according to Thipanyane et al. (2022), serves to protect the traditional healer's therapeutic knowledge and identity as a healer in terms of what they can do and what they cannot do, not limited to reluctance by traditional healers to trust researchers or biomedical specialists because of the fear of biomedicine using the traditional knowledge as their own.

To mitigate this limitation, I let the participants give me the name of the process or explain it to me without giving me the names of the specific muthis they use. This ensured this research had relevant data in that it answered the thesis's objective and aim, giving the rich data this thesis has.

8.3 Recommendations

Women, particularly those in their adolescent years, must be educbe enactedancy, risk signs of pregnancy, potential complications, and what they mean so that they can seek medical attention as soon as possible, as well as be taught how traditional healers can assist with childbirth complications—in addition to this, integrating cultural ideas, myths, and behaviours into care delivery to reduce its negative impact on women's reproductive health. Moreover, it builds community understanding and attitudes about the causes of maternal fatalities, which will impact their decision to seek care in an emergency. Furthermore, traditional healing must be understood, recognised, and included in the medical care system. According to Tessendorf and Cunningham (1997), South Africa's healthcare system is expected to become increasingly community-driven. Therefore, integrating traditional and modern medical systems is one requirement. Nurses who are traditional healers may substantially improve mutual understanding and collaboration by participating in both systems if hospital laws limiting their practice are eased. Especially since we cannot ignore the reality that women in rural areas consult traditional healers. Therefore, the required mechanisms and rules to oversee their use

must be implemented, especially in conventional healers working as professional nurses; hospital policies should be modified to accommodate them. Moreover, these recommendations can come into effect through coordinated action at the policy, advocacy, and community levels. Policymakers, particularly within the Department of Health, are best placed to integrate these measures by formalising collaboration between traditional healers and modern healthcare providers, while revising restrictive hospital laws and creating regulatory frameworks to guide their involvement. Advocacy and lobbying should be driven by professional nursing associations, NGOs, and women's health organisations, who can highlight the importance of culturally sensitive, community-driven maternal care and adolescent education on pregnancy risks. At the community level, nurses, traditional healers, and local leaders would play a crucial role in direct implementation by working collaboratively, fostering mutual understanding, and ensuring that women are encouraged to seek medical help early. Together, these stakeholders can transform the recommendations into practice, thereby reducing maternal fatalities, addressing reproductive health challenges, and improving trust between modern and traditional systems.

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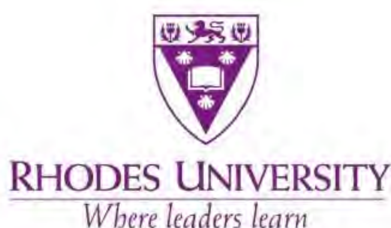
APPENDIX 1: ETHICS APPROVAL



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https://www.ru.ac.za/researchgateway/ethics/

5 May 2023

Bongiwe TENZE

Email: g19t9197@campus.ru.ac.za

Review Reference: 2023-7224-7600

Dear Ms TENZE

Title: NAVIGATING DIVERSE UNDERSTANDINGS OF CHILDBIRTH COMPLICATIONS: EXPERIENCES OF TRADITIONAL HEALERS WORKING AS PROFESSIONAL NURSES IN JOHANNESBURG HOSPITALS

Researcher: Bongiwe TENZE

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Humanities Faculty Research Ethics Committee (HF-REC). Your Approval number is: 2023-7224-7600

Approval has been granted for 1 year. An annual progress report will be required to renew approval for an additional period. You will receive an email notifying you when the annual report is due.

Please ensure that the Humanities Faculty REC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the Humanities Faculty REC should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

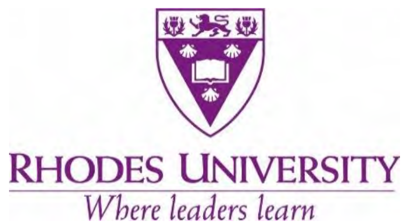
Sincerely,

Dr Priscilla Boshoff

Chair: Humanities Faculty Research Ethics Committee

AUTHORITY TO GRANT GATEKEEPER'S PERMISSION TO CONDUCT LOW AND MEDIUM-RISK RESEARCH IN RELATION TO STUDENTS AT RHODES UNIVERSITY HAS
BEEN DELEGATED FROM THE REGISTRAR TO THE RELEVANT RESEARCH ETHICS COMMITTEE CHAIRS AS APPROVED BY RHODES UNIVERSITY
SENATE ON 19 AUGUST
2022

APPENDIX 2.1: INVITATION LETTER - ENGLISH



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TO WHOM IT MAY CONCERN

RE: LETTER OF INVITATION TO PARTICIPATE IN RESEARCH

Dear Resident of Johannesburg,

This letter serves as an invitation to participate in a research project titled: Navigating diverse understandings of childbirth complications: Experiences of traditional healers working as professional nurses in Johannesburg Hospitals. This research is part of a Master's requirement in the Department of Anthropology which forms part of my exam, test and learning experience.

1. The research specific intended objectives are:

- To explore how professional nurses, who are also traditional healers, understand complications during childbirth in hospitals around Johannesburg.
- To explore the explanatory models that nurses, who are traditional healers, use to navigate complications of childbirth in hospitals around Johannesburg.
- To understand how nurses, who are also traditional healers, negotiate their traditional/professional identities in navigating the complications in childbirth that they observe in hospitals.

2. This research study has received ethical clearance from Rhodes University (Ethics Approval Number: **7224**). You can request to examine the clearance certificate by emailing the ethics coordinator at ethics-committee@ru.ac.za.

3. By taking part in this study endeavour, you will be contributing towards educating the society on the different ways of healing by providing a dual understanding of health through unravelling the issue of complications of childbirth

4. You will take part in the study by answering the questions which I will ask to help me understand the complications of childbirth traditionally and medically during one-on-one interviews.

5. You participation is entirely voluntary and should you at any stage wish to withdraw from participating further, you may do so without any negative consequences.

6. You will not be compensated for participating in the research, but your out-of-pocket expenses will be reimbursed.

7. The only harm which may arise in this research is that of you telling the researcher of activities which you do which are traditional or not allowed in the hospital space. If you become emotionally triggered by discussing the difficult decisions you have had to make pertaining childbirth, you will be reminded that you can choose to not respond to the question and the interview will be stopped. You will further be encouraged to seek some psychological counselling from either a social worker or a psychologist in a hospital closest to you, preferably not one that you work at, to reduce any further harm by having colleagues being aware of your possible conflicting decisions.

8. I have plans to submit this as research for a journal article. Nonetheless, records will be kept personal and anonymous, and unless you specify otherwise or make that information publicly available, no one who was not a part of the research will learn your name or identify.

9. You have the right, in accordance with the Protection of Personal Information Act (No. 4, 2013), to ask me to provide you a thorough justification of how confidentiality and anonymity will be maintained. You have the right to ask how and for how long your personal information will be kept securely. Your shared data will be kept in a password-protected cloud-based folder that is only accessible by me and any research assistants who will help with translations as needed.

10. You will be notified in writing and asked for your written consent once again if I decide to use any of the information acquired about you for this study project in any other project. If such additional research conflicts with the preliminary information provided for this study, you are not required to grant consent (POPIA, s15(3)). You can just simply decline the request. In these circumstances, I must submit a written request through the Ethics Coordinator (ethics-committee@ru.ac.za).

11. In terms of the POPI Act, you possess the right to receive feedback about this research. This will take the form of a hard copy delivered to you or digital copy sent through your email unless you elect not to receive this feedback.

12. Any further questions that you might have regarding the research, or your participation will be answered by me (the researcher), Bongiwe Tenze – Bongiwetenze50@gmail.com or the supervisor, Dr Gabriel Gyang Darong – g.darong@ru.ac.za

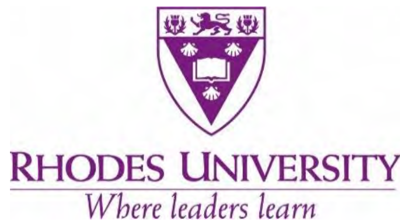
13. No photographs and/or videos of you will be taken for this research project.

14. During interviews, voice recordings of your thoughts and opinions will be created. During the visit, I will take notes and record all conversations using audio equipment. You are permitted to ask for a copy of the notes to ensure that your input was appropriately documented.

Yours Sincerely,

Bongiwe Tenze
The Researcher
Rhodes University

APPENDIX 2.2: INVITATION LETTER - ISIZULU



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OTHINTEKAYO

RE: INCWADI YESIMEMO SOKUBAMBA IQHAZA OCWANINGO

Mhlali waseGoli othandekayo,

Le ncwadi isebenza njengesimemo sokubamba iqhaza kuphrojekthi yocwaningo enesihloko esithi: Ukuzulazula ekuqondeni okuhlukahlukene kwezinkinga zokubeletha: Okuhlangenwe nakho kwabelaphi bendabuko abasebenza njengabahlengikazi abaqeqeshiwe ezibhedlela zaseGoli. Lolu cwaningo luyingxenye yemfuneko ye-Master eMnyangweni Wezifundo Zomuntu oyingxenye yokuhlolwa kwami, ukuhlolwa kanye nolwazi lokufunda.

1. Izinhloso ezihlosiwe zocwaningo yilezi:

- Ukuhlola ukuthi abahlengikazi abaqeqeshiwe, nabo abangabelaphi bendabuko, baziqonda kanjani izinkinga ngesikhathi sokubeletha ezibhedlela eziseGoli.
- Ukuhlola izibonelo ezichazayo abahlengikazi, abangabelaphi bendabuko, abazisebenzisayo ukuze babhekane nezinkinga zokubeletha ezibhedlela eziseGoli.
- Ukuze uqonde ukuthi abahlengikazi, abangabelaphi bendabuko, baxoxisana kanjani ngobunikazi babo bendabuko ukuze babhekane nezinkinga zokubeletha abazibona ezibhedlela.

2. Lolu cwaningo luthole imvume yokuziphatha eNyuvesi yaseRhodes (Inombolo Yokuvunyelwa Kwezimiso Zokuziphatha: **7224**). Ungacela ukuhlola isitifiketi

sokugunyazwa ngokuthumela i-imeyili kumxhumanisi wezimiso zokuziphatha kokuthi ethics-committee@ru.ac.za .

3. Ngokubamba iqhaza kulo mzamo wocwaningo, uzobe ubamba iqhaza ekufundiseni umphakathi ngezindlela ezahlukene zokwelapha ngokunikeza ukuqonda okubili kwezempilo ngokudalula udaba lwezinkinga zokubeletha.

4. Uzobamba iqhaza ocwaningweni ngokuphendula imibuzo engizoyibuza ukuze ungisize ngiqonde izinkinga zokubeletha ngokwesiko nangokwezokwelapha phakathi nezingxoxo zomuntu oyedwa

5. Ukubamba iqhaza kwakho kungokokuzithandela futhi uma kwenzeka ufisa ukuhoxa ekubambeni iqhaza, ungakwenza lokho ngaphandle kwemiphumela engemihle.

6. Ngeke unxeshezelwe ngokubamba iqhaza ocwaningweni, kodwa izindleko zakho eziphuma ephaketheni zizobuyiselwa.

7. Ukulimala okungase kuvele kulolu cwaningo ukuthi utshele umcwaningi ngezinto ozenzayo ezendabuko noma ezingavunyelwe endaweni yasesibhedlela. Uma uvukwa imizwa ngokuxoxa ngezinqumo ezinzima obekumele uzithathe mayelana nokubeletha, uzokhunjuzwa ukuthi ungakhetha ukungawuphenduli umbuzo futhi inhlolokhono izomiswa. Uzophinde ugqugquzelwe ukuthi ufune ukwelulekwa ngokwengqondo kusonhlalakahle noma isazi sokusebenza kwengqondo esibhedlela esiseduze nawe, okungcono hhayi leso osebenza kuso, ukuze unciphise noma ikuphi ukulimaza ngokuba nozakwenu bazi ngezinqumo zakho ezingase zingqubuzane.

8. Nginezinhlelo zokuhambisa lokhu njengocwaningo lwendatshana yejenali. Noma kunjalo, amarekhodi azogcinwa engumuntu siqu futhi engaziwa, futhi ngaphandle uma usho okuhlukile noma wenza lolo lwazi lutholakale esidlangalaleni, akekho obengeyona ingxenye yocwaningo ozofunda igama lakho noma ukukhomba.

9. Unelungelo, ngokuhambisana noMthetho Wokuvikelwa Kolwazi Lomuntu Siqu (No. 4, 2013), lokungicela ukuthi ngikunikeze izizathu ezigcwele zokuthi ukugcinwa kuyimfihlo nokungaziwa kuzogcinwa kanjani. Unelungelo lokubuza ukuthi ulwazi lwakho lomuntu siqu luzogcinwa kanjani futhi isikhathi esingakanani. Idatha yakho eyabiwe izogcinwa kufolda esekelwe efwini evikelwe ngephasiwedi efinyelelwa yimina kuphela nanoma ibaphi abasizi bocwaningo abazosiza ngokuhumusha njengoba kudingeka.

10. Uzokwaziswa ngokubhala futhi ucele imvume yakho ebhaliwe futhi uma nginquma ukusebenzisa noma yiluphi ulwazi olutholwe ngawe kule phrojekthi yocwaningo kunoma iyiphi enye iphrojekthi. Uma lolo cwaningo olwengeziwe lungqubuzana nolwazi lokuqala olunikeziwe kulolu cwaningo, akudingekile ukuthi unikeze imvume (POPIA, s15(3)). Ungamane usenqabe isicelo. Kulezi zimo, kufanele ngithumele isicelo esibhaliwe ngoMxhumanisi Wezimiso Zokuziphatha (ethics-committee@ru.ac.za).

11. NgokoMthetho we-POPI, unelungelo lokuthola impendulo mayelana nalolu cwaningo. Lokhu kuzothatha uhlobo lwekhophi eliqinile elilethwe kuwe noma ikhophi yedijithali ethunyelwe nge-imeyili yakho ngaphandle uma ukhetha ukungatholi le mpendulo.

12. Noma yimiphi eminye imibuzo ongase ube nayo mayelana nocwaningo, noma ukubamba kwakho iqhaza kuzophendulwa yimina (umcwaningi), Bongiwe Tenze - Bongiwetenze50@gmail.com noma umphathi, uDkt Gabriel Gyang Darong - g.darong@ru.ac.za

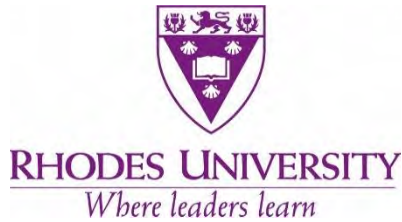
13. Azikho izithombe kanye/noma amavidiyo akho azothathwa ngalo msebenzi wocwaningo.

14. Phakathi nezingxoxo, kuzokwenziwa ukuqoshwa kwezwi kwemicabango nemibono yakho. Phakathi nokuvakasha, ngizothatha amanothi futhi ngirekhode zonke izingxoxo ngisebenzisa okokusebenza okulalelwayo. Uvunyelwe ukucela ikhophi yamanothi ukuze uqinisekise ukuthi okufakile kubhalwe ngokufanelekile.

Ozithobayo,

Bongiwe Tenze
Umcwaningi
Rhodes University

APPENDIX 2.3: INVITATION LETTER - SESOTHO



Lefapha la Anthropology
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e: Bongiwetenze50@gmail.com

HO EO E MO AMANG

RE: LENGOLO LA MEMO EA HO KENYA KA PELO PATLISISO

Moahi ya ratehang wa Johannesburg,

Lengolo lena le sebetsa e le memo ea ho kenya letsoho morerong oa ho etsa lipatlisiso o bitsoang: Ho tsamaea ka kutloisiso e fapaneng ea mathata a pelehi: Liphihlelo tsa lingaka tsa setso tse sebetsang e le baoki ba litsebi lipetleleng tsa Johannesburg. Patlisiso ena ke karolo ea tlhokahalo ea Master Lefapheng la Anthropology leo e leng karolo ea tlhahlobo ea ka, tlhahlobo le boiphihlelo ba ho ithuta.

1. Lipheo tse ikhethileng tsa lipatlisiso ke:

- Ho hlahloba hore na baoki ba litsebi, bao hape e leng lingaka tsa setso, ba utloisisang mathata nakong ea pelehi lipetleleng tsa Johannesburg.
- Ho hlahloba mehlala e hlalosang eo baoki, bao e leng lingaka tsa setso, ba e sebelisang ho rarolla mathata a pelehi lipetleleng tsa Johannesburg.
- Ho utloisisa hore na baoki, bao hape e leng lingaka tsa setso, ba buisanang ka boitsebahatso ba bona ba setso/litsebo ho rarolla mathata a pelehi ao ba a bonang lipetlele.

2. Phuputso ena ea lipatlisiso e fumane tumello ea boitšoaro ho tsoa Univesithing ea Rhodes (Nomoro ea Tumello ea Boitšoaro: **7224**). O ka kopa ho hlahloba setifikeiti sa tumello ka ho romella lengolo-tsoibila ho mohokahanyi oa melao ea boitšoaro ho ethics-committee@ru.ac.za .

3. Ka ho nka karolo boitekong bona ba boithuto, o tla be o kenya letsoho ho ruteng sechaba ka mekhoa e fapaneng ea pholiso ka ho fana ka kutloisiso e 'meli ea bophelo bo botle ka ho manolla taba ea mathata a pelehi.

2. O tla nka karolo phuputsong ena ka ho araba dipotso tseo ke tla di botsa ho nthusa ho utlwisisa mathata a ho beleha ka tlwaelo le ka tsa bongaka nakong ya dipuisano tsa motho ka mong.

3. Ho nka karolo ha hao ke ha boithaopo, 'me ha nako efe kapa efe u ka lakatsa ho ikhula ho ea pele, u ka etsa joalo ntle le litlamorao tse mpe.

4. U ke ke ua lefshoa ka ho kenya letsoho lipatlisisong, empa litšenyehelo tsa hau tse tsoang ka pokothong li tla buseletsoa.

5. Ha ho na likotsi tse amanang le ho nka karolo ha hau lipatlisisong tsena.

.

6. Ke na le merero ea ho fana ka sena e le lipatlisiso bakeng sa sengoloa sa koranta. Leha ho le joalo, litlaleho li tla bolokoa e le tsa botho le tse sa tsejoeng, 'me ntle le haeba u bolela ka tsela e fapaneng kapa u etsa hore tlhahisoleseding eo e fumanehe phatlalatsa, ha ho motho eo e neng e se karolo ea lipatlisiso ea tla ithuta lebitso la hau kapa lebitso la hau.

7. U na le tokelo, ho latela Molao oa Tšireletso ea Boitsebiso ba Botho (No. 4, 2013), ho nkōpa hore ke u fe mabaka a utloahalang a hore na ho tla bolokoa lekunutu le ho se tsejoe joang. U na le tokelo ea ho botsa hore na tlhahisoleseling ea hau e tla bolokoa neng le nako e kae. Lintlha tsa hau tse arolelanoang li tla bolokoa ka har'a foldara e sirelelitsoeng ka har'a maru e sirelelitsoeng ke 'na feela le bathusi leha e le bafe ba lipatlisiso ba tla u thusa ka liphetolelo ha ho hlokahala.

8. O tla tsebiswa ka lengolo mme o kopa tumello ya hao e ngotsweng hape haeba ke nka qeto ya ho sebedisa tlhahisoleseding efe kapa efe eo ke e fumaneng ka wena bakeng sa projeke ena ya thuto morerong ofe kapa ofe o mong. Haeba lipatlisiso tse joalo tsa tlatsetso li hanana le lintlha tsa selelekela tse fanoeng bakeng sa phuputso ena, ha ho hlokahale hore u fane ka tumello (POPIA, s15(3)). U ka hana kopo feela. Maemong ana, ke tlameha ho kenya kopo e ngotsoeng ka Mohokahanyi oa Melao ea Boitšoaro (ethics-committee@ru.ac.za).

9. Ho latela Molao oa POPI, o na le tokelo ea ho amohela maikutlo mabapi le lipatlisiso tsena. Sena se tla nka sebopeho sa kopi e thata e rometsoeng ho uena kapa kopi ea dijithale e rometsoeng ka lengolo-tsoibila la hau ntle le haeba u khetha ho se fumane maikutlo ana.

10. Lipotso life kapa life tse ling tseo u ka bang le tsona mabapi le lipatlisiso, kapa ho nka karolo ha hao ho tla arajoa ke 'na (mofuputsi), Bongiwe Tenze - Bongiwetenze50@gmail.com kapa mookamedi, Ngaka Gabriel Gyang Darong - g.darong@ru.ac.za

11. Ha ho linepe le/kapa livideo tsa hau tse tla nkuoa bakeng sa projeke ena ea lipatlisiso.

12. Nakong ea lipuisano, ho tla etsoa lirekoto tsa lentsoe tsa mehopolo le maikutlo a hau. Nakong ea ketelo, ke tla ngola lintlha le ho hatisa lipuisano tsohle ke sebelisa thepa ea molumo. U lumelloa ho kopa kopi ea lintlha ho netefatsa hore tlhahiso ea hau e ngotsoe ka nepo.

Oa hau ka hlompho,

Bongiwe Tenze
Mofuputsi
Univesithi ea Rhodes

APPENDIX 3.1: INFORMED CONSENT FORM – ENGLISH

PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participant/s)

Project Title: Navigating diverse understandings of childbirth complications: Experiences of traditional healers working as professional nurses in Johannesburg Hospitals

Bongiwe Tenze from the Department of Anthropology, Rhodes University has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to:

   - To explore how professional nurses, who are also traditional healers, understand complications during childbirth in hospitals around Johannesburg.
   - To explore explanatory models used by nurses, who are traditional healers, in navigating complications of childbirth in hospitals around Johannesburg.
   - To understand how nurses, who are also traditional healers, negotiate their traditional/professional identities in navigating the complications in childbirth that they observe in hospitals.

2. Rhodes University has given ethical clearance to this research project **7224** and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za)

3. By participating in this research project, I will be contributing towards educating the society on the different ways of healing by providing a dual understanding of health through unravelling the issue of complications of childbirth.

4. I will participate in the project by answering the questions asked by the researcher to help her understand the complications of childbirth traditionally and medically during one-on-one interviews.

5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.

6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed.

7. The only harm that may arise in my participation is that of me telling the researcher of activities which I do which are traditional or not allowed in the hospital space. If I become emotionally triggered by discussing the difficult decisions, I have had to make pertaining childbirth, the researcher will remind me of that voluntary nature of this research, so I can choose to not answer or stop the interview.

8. The Researcher intends to publish the research results in the form of a journal article.

However, confidentiality and anonymity of records will be maintained and my name and identity will not be revealed to anyone who has not been involved in the conducting of the research, ***unless I indicate to the contrary/recognize that as a public figure my identity will inevitably be/become known, in which case I agree to accept the loss of anonymity.***

9. In terms of the Protection of Personal Information Act (No. 4 of 2013) it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity of the data I provide will be achieved. I may also request to know exactly how my personal information will be stored securely, for how long it will be stored.

10. If any data collected from me for this research project is to be used by the Researcher for any further study, I am to be informed in writing and my written consent requested again. I need not give consent for the new research if it is incompatible with the initial purpose of the present study (POPIA, s15(3)). Equally, I can simply reject the request. In such cases, a formal request needs to be made to me by the researcher via the Ethics Coordinator (ethics-committee@ru.ac.za).

11. In terms of the POPI Act, I possess the right to receive feedback about this research. This will take the form of a hard copy delivered to me or digital copy sent through my email unless ***I elect not to receive this feedback.***

12. Any further questions that I might have regarding the nature of the research and/or my participation in it will be answered by the researcher, Bongiwe Tenze: Bongiwetenze50@gmail.com or the supervisor, Dr Gabriel Gyang Darong: g.darong@ru.ac.za

13. By signing this informed consent declaration, I am not waiving any legal claims, rights, or remedies. A copy of this informed consent declaration will be given to me, and the original will be kept on record by the Researcher.

14. I ***agree/disagree*** to the Researcher's request to take photographs, or videoing me as part of this research project, recognizing that agreement here is likely to raise the risk of compromising my anonymity and that steps will be taken to ensure this will not happen it my consent is given.

15. I ***agree/disagree*** to the Researcher's use of voice recording of my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views/responses. Furthermore, I have the right to request a copy of the interview transcriptions to confirm that my opinions are accurately recorded.

I, ………………………………………………………………………., have read the above information / confirm that the above information has been explained to me in a language that I understand and I am aware of this document's contents. I have asked all questions that I wished to ask, and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

…………………………………. ………………………… ……………………………

Participants signature **Witness** **Date**

APPENDIX 3.2: INFORMED CONSENT FORM - ISIZULU

UMHLANGANISI WAZISE NGEMVUME

(Izosayinwa abahlanganyeli/abahlanganyeli)

Project Title: Ukuzulazula ekuqondeni okuhlukahlukene kwezinkinga zokubeletha: Okuhlangenwe nakho kwabelaphi bendabuko abasebenza njengabahlengikazi abaqeqeshiwe ezibhedlela zaseGoli

Bongiwe Tenze eMnyangweni we-Anthropology, iNyuvesi yaseRhodes icele imvume yami yokubamba iqhaza kuphrojekthi yocwaningo eshiwo ngenhla.

Ubunjalo nenjongo yephrojekthi yocwaningo kanye nalesi simemezelo semvume enolwazi ngichazelwe ngolimi engiluqondayo.

Ngiyazi ukuthi:

1. Inhloso yephrojekthi yocwaningo ukuthi:

- Ukuhlola ukuthi abahlengikazi abaqeqeshiwe, nabo abangabelaphi bendabuko, baziqonda kanjani izinkinga ngesikhathi sokubeletha ezibhedlela eziseGoli.
- Ukuhlola izibonelo ezichazayo ezisetshenziswa abahlengikazi, abangabelaphi bendabuko, ekubhekaneni nezinkinga zokubeletha ezibhedlela eziseGoli.
- Ukuqonda ukuthi abahlengikazi, abangabelaphi bendabuko, baxoxisana kanjani ngobunikazi babo bendabuko ukuze babhekane nezinkinga zokubeletha abazibona ezibhedlela.

2. I-Rhodes University inikeze imvume yokuziphatha kulo msebenzi wocwaningo **7224** futhi ngibonile/ngingase ngicele ukubona isitifiketi sokugunyazwa ngokuthinta Umxhumanisi Wezimiso Zokuziphatha (ethics-committee@ru.ac.za)

3. Ngokubamba iqhaza kulo msebenzi wocwaningo, ngizobe ngifaka isandla ekufundiseni umphakathi ngezindlela ezahlukene zokwelapha ngokunikeza ukuqonda okukabili ngezempilo ngokudalula udaba lwezinkinga zokubeletha.

4. Ngizobamba iqhaza kuphrojekthi ngokuphendula imibuzo ebuzwa umcwaningi ukuze ngimsize aqonde izinkinga zokubeletha ngokwesiko nangokwezokwelapha phakathi nezingxoxo zomuntu oyedwa.

5. Ukubamba kwami iqhaza kungokokuzithandela ngokuphelele futhi uma kunoma yisiphi isigaba ngifisa ukuhoxa ekubambeni iqhaza ngokuqhubekayo, ngingenza kanjalo ngaphandle kwemiphumela engemihle.

6. Ngeke nginxeshezelwe ngokubamba iqhaza ocwaningweni, kodwa izindleko zami eziphuma ephaketheni zizobuyiselwa.

7. Ukulimala okungase kuvele ekubambeni kwami iqhaza ukuthi ngitshele umcwaningi ngezinto engizenzayo ezendabuko noma ezingavunyelwe endaweni yasesibhedlela. Uma ngivukwa imizwa ngokuxoxa ngezinqumo ezinzima, kuye kwadingeka ngenze eziphathelene nokubeletha, umcwaningi uzongikhumbuza lolo cwaningo lokuzithandela, ngakho ngingakhetha ukungaphenduli noma ukuyimisa inhlolokhono.

8. Umcwaningi uhlose ukushicilela imiphumela yocwaningo ngendlela ye-athikili yejenali.

Kodwa-ke, ukugcinwa kuyimfihlo nokungaziwa kwamarekhodi kuzogcinwa futhi igama lami kanye nomazisi ngeke kudalulwe kunoma ubani ongazange abambe iqhaza ekuqhutshweni kocwaningo, ngaphandle uma ngibonisa okuphambene/ngibona ukuthi njengomuntu osobala ubunikazi ***bami buyoba khona nakanjani. ukwaziwa/ukwaziwa, lapho ngivuma ukwamukela ukulahlekelwa kokungaziwa.***

9. NgokoMthetho Wokuvikelwa Kolwazi Lomuntu Siqu (No. 4 ka-2013) kuseyilungelo lami ukucela Umcwaningi ukuthi anginikeze incazelo enemininingwane yokuthi ukugcinwa kuyimfihlo nokungaziwa kwedatha engikunikezayo kuzofinyelelwa kanjani. Ngingase futhi ngicele ukwazi kahle ukuthi ulwazi lwami lomuntu siqu luzogcinwa kanjani ngokuphephile, ukuthi luzogcinwa isikhathi esingakanani.

10. Uma noma yimiphi imininingwane eqoqwe kimi yale phrojekthi yocwaningo izosetshenziswa Umcwaningi kunoma yiluphi olunye ucwaningo, ngizokwaziswa ngokubhala bese ngicelwa imvume ebhaliwe futhi. Akudingekile ukuthi nginikeze imvume yocwaningo olusha uma ingahambisani nenjongo yokuqala yocwaningo lwamanje (POPIA, s15(3)). Ngokulinganayo, ngingamane nje ngenqabe isicelo. Ezimweni ezinjalo, isicelo esisemthethweni sidinga ukwenziwa kimina umcwaningi ngoMxhumanisi Wezimiso Zokuziphatha (ethics-committee@ru.ac.za).

11. NgokoMthetho we-POPI, nginelungelo lokuthola impendulo mayelana nalolu cwaningo. Lokhu kuzothatha uhlobo lwekhophi eliqinile elilethwe kimi noma ikhophi yedijithali ethunyelwe nge-imeyili yami ngaphandle kwalapho ***ngikhetha ukungayitholi le mpendulo.***

12. Noma yimiphi eminye imibuzo engingase ngibe nayo mayelana nohlobo locwaningo kanye/noma ukubamba kwami iqhaza kulo izophendulwa umcwaningi, u-Bongiwe Tenze: Bongiwetenze50@gmail.com noma umqondisi, uDkt Gabriel Gyang Darong : g.darong@ru. ac.za

13. Ngokusayina lesi simemezelo semvume enolwazi, angideli noma yiziphi izimangalo ezingokomthetho, amalungelo, noma amakhambi. Ikhophi yalesi simemezelo semvume enolwazi ngizonikezwa mina, futhi eyokuqala izogcinwa kwirekhodi ngumcwaningi.

14. Ngiyasivuma ***/a angivumelani*** nesicelo somcwaningi sokuthatha izithombe, noma ukungithwebula ngevidiyo njengengxenye yale phrojekthi yocwaningo, ngiyabona ukuthi isivumelwano lapha singase sinyuse ubungozi bokwenza igama lami lingaziwa nokuthi kuzothathwa izinyathelo zokuqinisekisa ukuthi lokhu ngeke kwenzeke kimi. imvume inikiwe.

15. Ngiyavuma ***/angivumelani*** nokusetshenziswa komcwaningi kokuqopha izwi lokuphawula kwami nemibono phakathi nezingxoxo, inhloso yakho okuwukuqinisekisa ukurekhodwa okunembile kwemibono/izimpendulo zami. Ngaphezu kwalokho, nginelungelo lokucela ikhophi yokulotshiwe kwenhlolokhono ukuze ngiqinisekise ukuthi imibono yami iqoshwe ngokunembile

Mina, ……………………………………………………………………………………., ngilufundile ulwazi olungenhla / ngiqinisekisa ukuthi imininingwane engenhla ngichazelwe yona encwadini ulimi engiluqondayo futhi ngiyakwazi okuqukethwe yile dokhumenti.

Ngiyibuze yonke imibuzo ebengifisa ukuyibuza, futhi iphendulekile ngendlela egculisayo. Ngikuqonda ngokugcwele okulindeleke kimi ngesikhathi socwaningo.

Angikaze ngicindezelwe nganoma iyiphi indlela futhi ngivuma ngokuzithandela ukuhlanganyela kuphrojekthi eshiwo ngenhla.

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

Isiginesha yabahlanganyeli **Usuku** **Lokufakaza**

APPENDIX 3.3: INFORMED CONSENT FORM - SESOTHO

SEBAKA7OA TSEBISA POLELO EA TUMELO

(E tla saenoa ke bankakarolo ba lipatlisiso)

Project Title: Ho shebana le kutloisiso e fapaneng ea mathata a pelehi: Liphihlelo tsa lingaka tsa setso tse sebetsang e le baoki ba litsebi lipetleleng tsa Johannesburg.

Bongiwe Tenze ho tsoa Lefapheng la Anthropology, Univesithi ea Rhodes e nkopile tumello ea ho nka karolo morerong oa lipatlisiso o boletsoeng ka holimo.

Mofuta le morero oa morero oa lipatlisiso le phatlalatso ena ea tumello e nang le tsebo ke hlalositsoe ka puo eo ke e utloisisang.

Kea tseba hore:

1. Sepheo sa morero oa lipatlisiso ke ho:

- Ho hlahloba hore na baoki ba litsebi, bao hape e leng lingaka tsa setso, ba utloisisang mathata nakong ea pelehi lipetleleng tsa Johannesburg.
- Ho hlahloba mekhoa e hlalosang e sebelisoang ke baoki, bao e leng lingaka tsa setso, ho rarolla mathata a pelehi lipetleleng tsa Johannesburg.
- Ho utloisisa hore na baoki, bao hape e leng lingaka tsa setso, ba buisanang ka boitsebahatso ba bona ba setso / litsebi ho rarolla mathata a pelehi ao ba a bonang lipetlele.

2. Univesithi ea Rhodes e fane ka tumello ea boitšoaro morerong ona oa lipatlisiso **7224** mme ke bone/nka kopa ho bona setifikeiti sa tumello ka ho ikopanya le Mohokahanyi wa Melao ya Boitshwaro (ethics-committee@ru.ac.za)

3. Ka ho kenya letsoho morerong ona oa lipatlisiso, ke tla be ke kenya letsoho ho ruteng sechaba ka mekhoa e fapaneng ea pholiso ka ho fana ka kutloisiso e 'meli ea bophelo bo botle ka ho manolla taba ea mathata a pelehi.

4. Ke tla kenya letsoho morerong ona ka ho araba lipotso tse botsoang ke mofuputsi ho mo thusa ho utloisisa mathata a ho pepa ka tloaelo le meriana nakong ea lipuisano tsa motho ka mong.

5. Ho nka karolo ha ka ke ka boithaopo 'me haeba nako efe kapa efe nka lakatsa ho ikhula ho ea pele, nka etsa joalo ntle le litlamorao tse mpe.

6. Nke ke ka lefshoa ka ho kenya letsoho liphuputsong, empa litšenyehelo tsa ka tse tsoang ka pokothong li tla buseletsoa.

7. Kotsi e le 'ngoe feela e ka 'nang ea hlaha tabeng ea ho kenya letsoho ha ka ke ea hore ke bolelle mofuputsi ka mesebetsi eo ke e etsang e leng ea setso kapa e sa lumelloeng sebakeng sa sepetlele. Haeba ke ameha maikutlong ka ho buisana ka liqeto tse boima, ke tlameha ho etsa qeto mabapi le pelehi, mofuputsi o tla nkhopotsa ka boithaopo ba lipatlisiso tsena, kahoo nka khetha ho se arabe kapa ho emisa lipuisano.

8. Mofuputsi o ikemiselitse ho phatlalatsa liphetho tsa lipatlisiso ka mokhoa oa sengoloa sa koranta.

Leha ho le joalo, makunutu le ho se tsejoe ha lirekoto li tla bolokoa 'me lebitso la ka le boitsebiso ba ka li ke ke tsa senoleloa mang kapa mang ea so kang a kenya letsoho ho etsoeng ha lipatlisiso, ntle le haeba ke bontša ho fapana le hoo/ke hlokomela hore ha ke le motho oa sechaba, boitsebahatso ba ka bo tla ba teng ***. tseba/ho tsebahala, moo ke dumelang ho amohela tahlehelo ya ho se tsejwe.***

9. Ho ea ka Molao oa Tšireletso ea Boitsebiso ba Botho (Nomoro ea 4 ea 2013) e ntse e le tokelo ea ka ea ho kopa Mofuputsi hore a fane ka tlhaloso e qaqileng ea hore na hantle-ntle ho boloka lekunutu le ho se tsejoe ha lintlha tseo ke fanang ka tsona li tla finyelloa joang. Hape nka kopa ho tseba hantle hore na lintlha tsa ka tsa botho li tla bolokoa joang ka mokhoa o sireletsehileng, hore na li tla bolokoa nako e kae.

10. Haeba lintlha tse bokeletsoeng ho 'na bakeng sa morero ona oa lipatlisiso li tla sebelisoa ke Mofuputsi bakeng sa boithuto bo bong hape, ke tla tsebisoa ka lengolo mme tumello ea ka e ngotsoeng e kopuoe hape. Ha ke hloke ho fana ka tumello bakeng sa lipatlisiso tse ncha haeba e sa lumellane le sepheo

sa pele sa thuto ea hajoale (POPIA, s15(3)). Ka mokhoa o ts'oanang, nka hana kopo feela. Maemong a joalo, kopo e hlophisitsoeng e hloka ho etsoa ho 'na ke mofuputsi ka Mohokahanyi oa Boitšoaro (ethics-committee@ru.ac.za).

11. Ho latela Molao oa POPI, ke na le tokelo ea ho fumana maikutlo mabapi le lipatlisiso tsena. Sena se tla nka sebopeho sa kopi e thata e rometsoeng ho 'na kapa kopi ea dijithale e rometsoeng ka lengolo-tsoibila la ka ntle le haeba ***ke khetha ho se fumane maikutlo ana.***

12. Lipotso life kapa life tse ling tseo nka bang le tsona mabapi le mofuta oa lipatlisiso le/kapa ho nka karolo ha ka ho eona li tla arajoa ke mofuputsi, Bongiwe Tenze: Bongiwetenze50@gmail.com kapa mookameli, Dr Gabriel Gyang Darong : g.darong@ru. ac.za

13. Ka ho saena phatlalatso ena ea tumello e nang le tsebo, ha ke tlohele likopo tsa molao, litokelo kapa litokiso. Ke tla fuoa kopi ea phatlalatso ena ea tumello e nang le tsebo, 'me ea mantlha e tla bolokoa tlalehong ke Mofuputsi.

14. Ke ***lumellana/ha ke lumellane*** le kopo ea Mofuputsi ea ho nka linepe, kapa ho nketsetsa video ke le karolo ea morero ona oa lipatlisiso, ke hlokomela hore tumellano mona e ka hlahisa kotsi ea ho senya lebitso la ka le hore ho tla nkoa mehato ea ho netefatsa hore sena se ke ke sa etsahala. tumello e fanoe.

15. Kea ***lumellana/ha ke lumellane*** le tšebeliso ea Mofuputsi ea ho rekota maikutlo le maikutlo a ka ka lentsoe nakong ea lipuisano, sepheo sa eona e leng ho netefatsa hore maikutlo a ka / likarabelo tsa ka li rekota ka nepo. Ho feta moo, ke na le tokelo ea ho kopa kopi ea lingoliloeng tsa lipuisano ho netefatsa hore maikutlo a ka a tlalehiloe ka nepo.

Nna, ………………………………………………………………………………., ke balile lintlha tse ka holimo / ke tiisa hore ke hlaloselitsoe lintlha tse ka holimo puo eo ke e utloisisang 'me ke tseba litaba tsa tokomane ena. Ke botsitse lipotso tsohle tseo ke neng ke lakatsa ho li botsa, 'me li arabetsoe ka tsela e nkhotsofatsang. Ke utloisisa ka botlalo se lebelletsoeng ho nna nakong ea lipatlisiso.

Ha kea hatelloa ka tsela leha e le efe 'me ke lumela ka boithatelo ho kenya letsoho morerong o boletsoeng ka holimo.

……………………..………………………………………………………………………

Barupeluoa ba saena **Letsatsi** **la Paki**

APPENDIX 4: INTERVIEW GUIDE OF THE RESEARCHER

1. What are the complications of childbirth that you have encountered as a nurse in the hospital?
2. What do you think are the causes of such childbirth complications?
3. How did you handle those complications medically?
4. What are the complications of childbirth that you have encountered outside the hospital as a traditional healer?
5. What do you think are the causes of such childbirth complications?
6. How did you handle those complications traditionally?
7. What childbirth complications have you encountered at the maternity ward that you think could have been handled effectively traditionally?
8. How were you able to respond to such childbirth complications?
9. What will you consider as the advantages of your dual identity within the hospital space?
10. What will you consider as some of the disadvantages of your dual identity in the hospital space?
11. How do you negotiate and navigate your dual identities as a traditional healer and as a nurse within the hospital setting?
12. How best can these dual identities contribute to a better understanding and approach to childbirth complications within the hospital space?

NB: These questions served merely as a guide for the interviewer throughout interviews.