



GUIDELINES FOR PROVISION OF MATERNAL MENTAL HEALTH CARE SERVICES BY TRADITIONAL HEALERS IN VHEMBE DISTRICT OF LIMPOPO PROVINCE

by

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DECLARATION

I, **Musiwa Ivy Rambau**, hereby declare that the dissertation titled “**Guidelines for Provision of Maternal Mental Health Care Services by Traditional Healers in Vhembe District of Limpopo Province**” tendered by me for the degree **Doctor of Psychology**, has not been submitted previously at this or any other university, that is my own work in design and in execution, and that all reference materials contained herein have been duly acknowledged (Appendix 6).

Signature: 

Date: 09 August 2025

DEDICATION

I dedicate this work to my family and friends for giving me support to complete my study.

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First and foremost, I would like to thank God Almighty, the covenant keeping immortal and only wise one, for giving me this opportunity, courage, hope and strength to complete this project. Without His favour upon my life, I would not have done it. Thank You Lord, for seeing me through all this.

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ABSTRACT

Background: Women have an increased risk of mental health disorders during pregnancy, especially after giving birth, and these disorders are associated with increased maternal morbidity and mortality, and adverse child health outcomes. Traditional healers (THs) are an important source of psychiatric support to pregnant women in many parts of the world. The aim of this study was to develop guidelines to be used by THs in the provision of maternal mental health care services at Vhembe District in Limpopo Province. The study consists of two phases, namely, the Empirical Phase (Phase 1) and the Guidelines Development Phase (Phase 2). In Phase 1, a qualitative approach was used to conduct the study.

Purpose: The purpose of the study was two-fold:

Phase 1 (Empirical Phase): Phase 1a focused on exploring THs' knowledge on maternal mental health care, to identify maternal mental health care needs, to describe maternal mental health care services provided by THs, to discuss the possibility of referral by THs. Phase 1b focused on exploring the experiences of pregnant mothers in the provision of mental health care services by THs.

Phase 2 (Profiling the Guidelines): The purpose of this phase was to use the findings of Phase 1 to profile the guidelines for provision of maternal mental health care services by THs at selected villages of Vhembe District of Limpopo Province, South Africa.

Methods: The design of the study was guided by the WHO Model of Guideline Development (2012). The model focuses on the contextual factors - enabling factors, predisposing factors and needs factors - that influence the individual's utilization of health care services. Seven selected villages of Vhembe District of Limpopo Province, South Africa, were selected for the study. The qualitative research method was used to conduct Phases 1a and 1b of the study. A qualitative study was used to explore the objectives of the study.

Results: Following in-depth analysis of interview data, several main themes were identified from study participants, viz., THs and pregnant women who accessed maternal mental health care services provided. The study utilized an explorative-descriptive research design. Purposive and snowball sampling techniques were used

to draw 14 participants from the selected villages of Vhembe District in Limpopo Province. Data were collected from participants using semi-structured and unstructured interview methods of the qualitative approach. Data collected were analyzed using thematic content analysis. To ensure trustworthiness of the study, the researcher applied the following criteria: credibility and dependability. Internal and external ethics protocols were taken into consideration when the study was conducted. Phase 2 concentrated on developing guidelines for provision of maternal mental health care services by THs. The researcher adopted Steps 2 to 9 stipulated in the WHO (2012) Handbook for Guideline Development.

The main themes raised by the THs who provided mental health care were financial support, accessibility to resources, safety and security needs, non-adherence by patients on mental health care services, and combination of Western and Traditional mental health care services. The pregnant women in this study identified lack of respect, discrimination, accessibility challenges, gaps in available maternal mental health care services, diagnosis methods utilized, decentralized maternal mental health care services, lack of information, affordability, long waiting period in hospital and effectiveness of maternal mental health treatment utilized as challenges associated with poor maternal mental health care services delivery and outcomes.

The quality of maternal mental health care services in Western intervention models was perceived as poor by both the pregnant women seeking care and THs providing maternal mental health care. The main concerns raised by pregnant women were lack of respect, lack of privacy, and difficulty to receive mental health care services in hospital. The results confirmed that guidelines were needed for the effectiveness in the provision of maternal mental health care services by THs.

The findings from the qualitative study were used by an expert group to develop guidelines to enhance effectiveness in the provision of maternal mental health care services by THs. The profiling of the guidelines was validated by group experts. The researcher adopted Steps 2 to 9 stipulated in WHO (2012) Handbook for Guideline Development. The selected Guidelines Development Group (GDG) assisted in validating the guidelines profiled. The validated guidelines were useful to the researcher to verify whether the guidelines developed were congruent with the practice of THs in the provision of maternal mental health care services.

Conclusion: This study concludes that access to comprehensive quality maternal mental health care services must be rendered to all women in times of need. Quality

maternal mental health care services should be rendered by skilled THs who underwent training and are well-equipped to be functional in the provision of maternal mental health care services and the researcher updated the guidelines accordingly.

Keywords: care, maternal, mental health services, pregnant women, traditional healers

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CM	Conventional Medicine
CMPs	Conventional Medicine Practitioners
CPMD	Common Perinatal Mental Disorders
DSM-IV	The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
GDG	Guidelines Development Group
HICs	High-Income Countries
IKS	Indigenous Knowledge Systems
IPs	Indigenous Practitioners
LMICs	Low- and Middle-Income Countries
MDGs	Millennium Development Goals
MHCA	Mental Health Care Act
NRF	National Research Foundation
NDoH	National Department of Health
SASH	South African Stress and Health
SDGs	Sustainable Developmental Goals
TAC	Limpopo State of Health Report
TBAs	Traditional Birth Attendants
T&CM	Traditional and Complementary Medicine
THs	Traditional Healers
THPs	Traditional Health Practitioners
TM	Traditional Medicine
UVHDC	University of Venda Higher Degrees Committee
WHO	World Health Organization

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

Traditional and Complementary Medicine (T&CM) is an important and often underestimated issue of health care. T&CM is found in almost all countries of the world and the demand for such services is increasing. Traditional Medicine (TM) of proven quality, safety, and efficacy contributes to achieving the goal of ensuring that all people have access to care (WHO, 2014-2023). Very few studies have addressed the holistic scenario of traditional healing practices in Bangladesh, although these serve around 80% of the ailing people (WHO, 2013).

The aforementioned study which explored distinctive forms of traditional healing practices in rural Bangladesh found that the majority of the community members, especially people of low socioeconomic status, first approached the traditional healers with their medical problems. Only after failure of such treatment did they move to qualified physicians for modern treatment. Interestingly, if this failed, they returned to the traditional healers. Both religious and non-religious healing practices do exist (Haque, Chowdhury, Shahjahan & Harun, 2018).

Assam and Arunachal Pradesh have very rich tradition of herbal medicines used in the treatment of various ailments. Tribal communities practice different types of traditional healing practices. Enough documentation is available on the healing practices in other tribal communities, except Mishing community of Assam and the foothills of East Siang district of Arunachal Pradesh, hence, the attempt was made for the same. A survey on folk medicinal plants and folk healers of the Mishing tribe was conducted in few places of Lakhimpur and Dhemaji district of Assam and East Siang district of Arunachal Pradesh, where this ethnic group is living since time immemorial (Shankar, Lavekar, Deb & Sharma, 2012).

Traditional healing practices sought by Muslim psychiatric patients treated at public hospitals of Lahore City, Pakistan, encompassed patients self-reporting on the Case History Interview Schedule that they had sought diverse traditional healing methods, including Homeopathy, Naturopathy (Tibb), Islamic Faith Healing, and Sorcery, for their psychiatric disorders prior to their current treatment from licensed psychiatrists, with the majority indicating they had sought more than one of these traditional healing practices. Proportionately more male than female patients used multiple traditional healing practices. The male patients showed a higher number of visits per week to traditional healers than their female counterparts. These different help-seeking practices may be attributed to gender discrimination in mobility and taboos attached to women's consultation of male traditional healers (Farooqi, 2006).

Over the past two decades, India's economic development has coincided with critical improvements in lifespan, literacy, and income (Central Intelligence Agency. World Factbook; South Asia: India, 2013). Despite these advances, and with a population that is still largely rural, significant challenges remain in infrastructure and access to services, including quality medical care. As in other countries, both developing and wealthy, India's mental health problems cause a significant effect on the well-being of many individuals, leading to emotional distress, family tension, and economic loss (Thirunavukarasu & Thirunavukarasu, 2010). Meanwhile, resources for patients often are scarce. The latest data from 2011 shows that the prevalence of psychiatrists in India is approximately 5 per 1 million people; by comparison, in 2012 in the United States, there were 24,210 psychiatrists for a population of 318 million, or 76 per 1 million (World Health Organization, 2002-present; Bureau of Labor Statistics, 2014; Royal College of Psychiatrists, 2014). Even if mental health resources are available to a given community, they may prove financially burdensome for patients and their families. Additionally, although many villages (home to 70% of India's population) have health clinics, knowledge of psychiatry among local providers often is limited. Visiting a hospital may involve a long journey resulting in financial and lost-opportunity costs (Thirunavukarasu & Thirunavukarasu, 2010).

Traditional Healers (THs) play a vital role in the health care of most of the South African population and elsewhere on the African continent (Mokgobi, 2014). Mental health issues are a worldwide phenomenon and impacts every single society and contributes greatly to the global burden of disease. Mental illness has been identified by the WHO as one of the leading causes of disability worldwide (Strümpher, van Rooyen, Topper, Andersson & Schierenback, 2014). Like the rest of the world, the burden of mental

illness in Africa is substantial, and it is predicted to increase with the epidemiological transition to chronic and non-communicable diseases - a trend that is widespread in many low- and middle-income countries (LMICs) (Lund, Kleintjes, Petersen & Bhana, 2012).

In many African belief systems, attitudes and perceptions about mental health include stigmas that perpetuate discrimination that potentially influence the health-seeking behaviours and the adherence to treatment for many individuals with mental health disorders. High levels of stigma and discrimination make individuals with mental health conditions vulnerable to abuse, violence, and neglect by their families and from the whole of society (Strümpher et al., 2014). Many of these attitudes, perceptions and stigmas are rooted in the traditional belief systems that govern societies. Exploring and understanding how these variables interact are important to confidently integrate the use of traditional healing methods and primary health care models. According to Khan, Fahad, Naushad & Faisal (2020), over the years the stigma and discrimination attached to certain illnesses have remained perpetual public health concerns. Lee & Waters (2021) reported on a study conducted in many African countries that revealed stigma and the misconception of the cause of mental illness as being one of many major barriers to seeking treatment. This was found to occur in many poorly-resourced contexts where local traditions and religions had a dominant impact on people's lives.

Traditional healing among Africans is considered holistic in approach (Bojuwoye & Moletsane-Kekae, 2018). African culture is characterized by belief in supernatural forces; faith in magic of symbols; expectations of supernatural punishment; orally preserved tribal legends and mythological concepts with emphasis on animism; full play of affective activity in daily life; complete identification with the group; lowering of ego boundaries and thought processes; ancestor worship; beliefs in the existence of idealized good objects; a tendency to regard dream life as objective reality; a simple restricted ill-defined and rudimentary usage of symbols; and strong religious belief (Lambo, 1959) as cited by Ebigbo, Elekwachi, Eze, Nweze & Innocent (2013). Studies on the origin of illnesses in Africa are viewed from both natural and supernatural perspectives (Lightner, Heckelsmiller & Hagen, 2023). In a related study, Ventevogel, Jordans, Reis & De Jong, (2013) reported similarities in three main areas of what constitutes mental illness among different ethnic groups in Africa: firstly, the widespread belief in spirit; secondly, both physical and mental illness are attributed to various external causes; and thirdly, there is a strong bond to group.

African indigenous psychotherapy is embedded in African cultural beliefs that diseases

and ill-fortune relate to the mind, body and spirit; thus, when an individual is ill (psychopathologic or somatic), there is a disharmony (Olutope, 2020) between the individual and his environment; hence, the healing process must seek to restore balance or harmony first within the individual and between the individual and the environment. Desire for traditional psychotherapy is embedded in a cultural model of cure seeking, therefore, the appeal for traditional healing is also based on the holistic nature of traditional approaches which seek to restore harmony and balance within the individual and between the individual and his/her environment. The traditional healing process is holistic, engaging the mind, body, and soul of individuals, as well as their families and communities. This form of mind-body-spirit integration of traditional healing practices, according to Hamim, Alyami, Shurayyan, Alyami, Alyami & Alyami, (2023), is a major component of the healing process.

Western originated psychotherapies and African indigenous psychotherapeutic practices are seen to be “worlds apart” because of the different models of illness and health, different cultural perspectives and worldviews. Also, African traditional healing methods have been accused as lacking systematic and scientific procedures which can be replicated by others, poor documentation of methods and generally not properly researched. In this thesis, we consider the challenges faced by the African traditional healing system, and the implications these challenges portend for the development of African indigenous psychotherapy.

1.2 Background to the Study

The potential impact of the COVID-19 pandemic on mental health should not be neglected, especially in vulnerable populations. The study findings of Thapa, Mainali & Schwank (2020) and Pierce, Hope & Ford (2020) revealed that pregnant and breastfeeding women are facing numerous life changes that make them particularly vulnerable to mental health disorders. According to the WHO (2020), about 10% of pregnant women and 13% of (recent) mothers experience a mental disorder, primarily depression. The WHO further indicated that a large multinational study on perinatal mental health conducted before the COVID-19 era showed that between 4% and 8% of women have moderate-to-very-severe depressive symptoms during pregnancy and in the postnatal period.

In the context of the COVID-19 pandemic, maternal distress might be compounded by concerns and fears regarding the risk of infection or hospitalization due to COVID-19, especially as perinatal morbidity and mortality associated with COVID-19 have been

described. Allotey, Stallings & Bonet (2019), Westgren, Pettersson, Hagberg & Acharya (2020) and Favre, Pomar & Baud (2020) revealed that maternal depressive symptoms, anxiety, and stress have been associated with adverse pregnancy, foetal, and (long-term) infant outcomes. Jarde, Morais & Kingston (2016), Grigoriadis, Graves & Peer (2018) and Witt, Litzelman, Cheng, Wakeel & Barker (2014) concluded that it is critical that mental health disorders are detected and addressed in clinical practice.

In high-income countries (HICs), 10% of pregnant women and 13% of those who have given birth experience some type of mental disorder, most commonly depression or anxiety (Groenewald et al., 2014; World Development Indicators, 2015). In Brazil, the prevalence rate of mental health problems among pregnant women is estimated to be 60%, and the rate for depressive symptoms was about 20% (Faisal-Cury & Rossi, 2015). Furthermore, in Bangladesh the prevalence rate of depressive symptoms among pregnant women is estimated to be 33% (Oosthuizen 2013) and 42.7% in Pakistan (Imran & Haider, 2014). The systematic review on prevalence and determinants of common perinatal mental disorders in women conducted by Oats (2015) revealed that in HICs, maternal suicide is the leading cause of death during the perinatal period.

Fisher, Mello, Patel, Rahman & Tran (2012) revealed that maternal mental health problems are approximately three times more prevalent in LMICs than in HICs. Provision of maternal mental health care services is a global challenge. The literature shows that funding allocation to mental health care services is inadequate. Global statistics illustrate that the expenditure on mental health is less than US\$2 per year per capita across all countries and less than 25% in low-income countries (LIC).

Maternal mental health problems in sub-Saharan countries are higher as compared to HICs. In developing countries, 15.6% of pregnant women and 19.8% of women who have given birth experience mental health problems, most commonly depression or anxiety (Hara, Swain & Rates, 2014; World Development Indicators, 2015). In severe cases, mothers' suffering might be so serious that they may even commit suicide. In addition, the affected mothers cannot function properly. Walker, Wachs, Gardner, Lozoff & Wasserman (2016) indicated that untreated mental health problems during pregnancy render mothers unable to provide quality care to their children which lead to a compromised childhood development. THs have provided mental health care services to communities for decades and are viewed as an important source of psychiatric support in many parts of the world, including Africa. They offer a parallel

system of belief to conventional medicine regarding the origins, and, hence, the appropriate treatment of mental health problems.

THs play roles of physician, counsellor, psychiatrist and priest, and pregnant women visit THs for problems ranging from social dilemmas to major medical illnesses (Hewson, 1998). Many LMIC, including 15 of 19 African countries, allocate less than 1% of their health budgets to addressing mental health care services challenges (WHO, 2015). There is a demand for effective mental health care services which will raise the standard of mental health promoting policies and practices worldwide (WHO, 2002, 2004b, 2015; Murray & Lopez, 2014). Some HICs, such as the United States, have developed mental health systems that are very expensive, fragmented, and not focused on outcomes relevant for the service users (Rathod, Persaud & Naeem, 2016). Traditional interventions are commonly used to treat or prevent disease and chronic illness and to improve quality of life. In China, traditional medicine accounts for around 40% of all health care delivered. In Chile, 71% of the population, and in Colombia 40% of the population, have used such medicine. In India, 65% of the population in rural areas use *Ayurveda* and medicinal plants to help meet their primary health care needs. In developed countries, traditional intervention is becoming more popular. For example, the percentage of the population that have used traditional medicines at least once is 48% in Australia, 31% in Belgium, 70% in Canada, 49% in France and 42% in the United States of America (WHO, 2014).

Some have argued that in resource-constrained countries women are protected from experiencing maternal mental health problems through the influence of social and traditional cultural practices during pregnancy and in the postpartum period (Hara, Swain & Rates, 2014). The widespread use of THs could also be attributed to the accessibility of THs relative to medical professionals; across sub-Saharan Africa, there is a traditional healer for every 500 people, compared to a doctor:population ratio of 1:40,000 (Abdullahi, 2014).

Studies conducted in South Africa show even higher prevalence rates (Figure 1.1), with depression found in an estimated 22% (diagnosed) to 39% (screened) (Heyning, Myer, Onah, Tomlinson, Field & Honikman, 2016) of pregnant women and 34.7% (screened) of postpartum women in Cape Town (Cooper, Tomlinson, Swartz, Woolgar, Murray & Molteno, 2016), 47% (Rochat, Tomlinson, Bärnighausen, Newell & Stein, 2011) (diagnosed) of pregnant women in rural South Africa, and 21% (screened) in the Western Cape. A recent South African study conducted at Hanover Park in Cape

Town, found that there is a 33% prevalence of diagnosed common perinatal mental disorders (CPMD). Several reports indicated prevalence of suicidal ideation and behaviour of 18% (Van Heyningen, Honikman, Myer, Onah, Field & Tomlinson, 2017; Onah, Field, Bantjes & Honikman, 2017).

Maternal mental disorders are linked to adverse outcomes in children such as poor cognitive development and performance in school, emotional and social behaviour problems, significant psychological difficulties, decreased growth, incomplete immunizations, and higher rates of diarrhoea, stunting, infectious illness and hospital admission (Austin & Verkuil, 2014; Richter, Norris, Stein, Avan & Ramchandani, 2014).

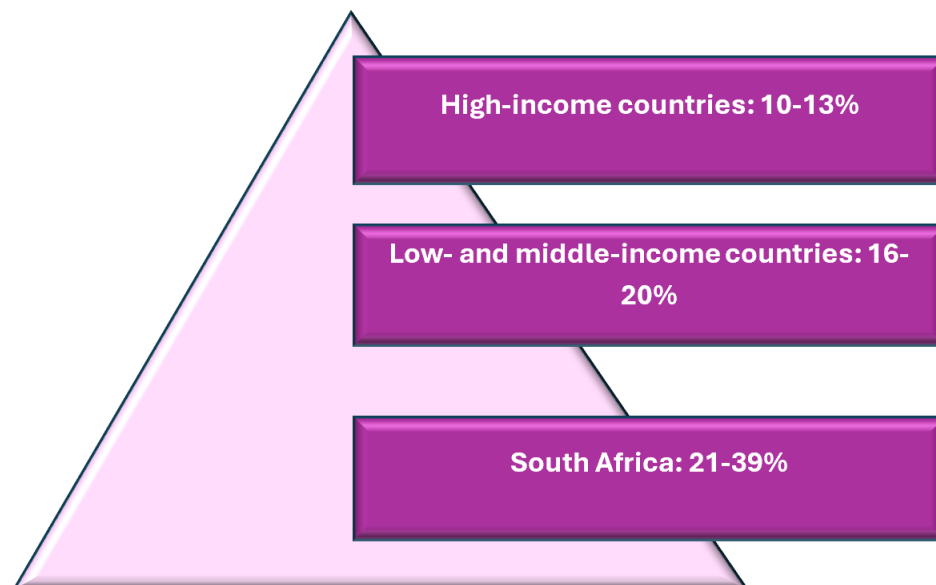


Figure 1.1: Prevalence of maternal mental health problems

Leis, Heron, Stuart, Mendelson Leis, Heron, Stuart & Mendelson (2014) observed that increased children's emotional and behavioural problems are linked to maternal depression after controlling for later maternal mental health problems. In South Africa, there is a notable pattern of using the traditional healing system, comprising both indigenous and religious sectors. There are different types of THs in South Africa, which are diviners, herbalists, faith healers, traditional birth attendants (TBAs) and traditional surgeons (Gqaleni, Moodley, Kruger, Ntuli & McLeod, 2007; Moshabela, Pronyk, Williams, Schneider & Lurie, 2015).

This study focused on herbalists, diviners and faith healers. The National Department of Health (NDoH) in South Africa has taken firm steps towards the official recognition and institutionalization of Traditional Healing (South African National Department of Health, 2015). The steps include establishments of the Interim Traditional Health Practitioners Council of South Africa to provide for a regulatory framework to ensure that there is efficacy, safety and quality of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession; and to provide for matters connected therewith (Government Gazette, 2013).

Daniels (2018) observed that the provision of mental health care services in South Africa is fragmented, limited or non-existent, particularly in remote or rural areas (Vergunst, 2018). This was based on narrative reports of Mental Health Societies from different parts of the country (Nicholson, 2018). Vergunst (2018) emphasized issues surrounding staffing, transport, the need to shift or share tasks and formal vs informal medicine (i.e., African culture vs Western medicine). Most South Africans, especially in rural areas, have limited access to psychiatric care and psychosocial care. According to Statistics South Africa (2012), South Africa has a population of approximately 51.8 million people. Thwala & Edwards (2014) observed that currently there are about 6,000 psychologists, 10,000 social workers, 30,000 medical doctors and 125,000 nurses to care for nearly 50 million people in South Africa. Effectively, this means that other community aiding resources like THs do most of the work in the provision of maternal mental health care services (Thwala & Edwards, 2010).

In Limpopo Province there is a shortage of mental health care services and health specialists, including psychologists to enable proper mental health care services as compared to other provinces. Shortage of well-trained personnel lead to poor mental health care services offered in hospitals, increased pressure on staff and some staff members developing negative attitudes (TAC Limpopo State of Health Report, 2018). Other shortcomings in modern health care settings such as shortage of medication, poor infrastructure, long waiting times and bad services provided make those experiencing maternal mental health problems to be reluctant to seek help in hospitals. Some of them resort to THs for health care services, including maternal mental health care.

The literature highlights key organizational barriers that lead to poor mental health care

services in LMICs, including organizational barriers such as difficulties in accessing mental health services, the competing public health priorities, low investment in mental health services, a paucity of specialist human resources, and resistance to decentralization (Breuer, De Silva & Shidaye, 2016). The availability of geographically spread practical facilities influences access and outcomes in the mental health of pregnant women. Providing treatments in wide expanses of rural areas or where transport links are difficult, especially when resources are concentrated in one central, usually urban base, is a difficult practical issue common in many developing countries. It might be difficult, indeed impossible, for some pregnant women to return to a health facility for interventions on a regular basis (Breuer, De Silva & Shidaye, 2016).

In South Africa, 27.1% of the population live in rural areas. In Vhembe, which is the area of interest in this study, 74.4% of the district's population are living in rural areas (Statistics South Africa, 2012). Peltzer, Mqondaniso & Petros (2014) showed that indigenous healers are widely dispersed throughout South Africa and are more knowledgeable about the cultural norms in the communities where they operate. Consequently, their advice and interventions are often sought and acted upon by their patients.

The current study focused on the provision of maternal mental health care services provided by THs. Mbwayo, Ndeti, Mutiso & Khasakhala (2013) revealed that mental health care procedures followed by THs involve diagnosing the illnesses by examining the patient, observing his/her behaviour and mode of talking and getting the history of the patient. They further indicated that some THs use the mirror to arrive at a diagnosis (spiritual 'imaging'), others pray to get revelations from spirits (divination) and some beat a drum to get revelation.

THs use different methods to provide mental health care services. The methods used for treatment depended on the severity of the disease, the cause of the illness, the age of the patient, the gender and the weight. Counselling was the most popular method of treatment; use of various types of herbs which are used differently, for example, taken orally or some used for washing by the patient, while others are inhaled; combining herbal treatment with counselling; consulting the spirit world, including the ancestors who then gave instructions on how the patient should be treated.

Other THs moved to the patient's home to help him/her remove certain items which the traditional healer claimed had been used to bewitch the patient. Furthermore, it

was revealed that THs refer their patients to other more experienced healers (Mbwayo, Ndetei, Mutiso & Khasakhala, 2013). It has been documented in different studies that depression, anxiety and psychological stress are common maternal mental health problems and some women experiencing maternal mental health develop suicidal thoughts or try to kill themselves (Heyningen et al., 2016) due to shortage or lack of proper mental health care services. In this study, the terms pregnant women and maternal will be used interchangeably when referring to a maternal mental health problem.

1.3 Problem Statement

Sustainable Developmental Goal 3 (SDG 3), also known as Good Health and Well-being, aims to ensure healthy lives and promote well-being for all at all ages. Many people, especially the elderly and those with chronic conditions, struggle to access quality health care services. Sustainable Development Goals (SDGs) are viewed as extensions of Millennium Development Goals (MDGs) and a post-2015 agenda to fight against poverty and hunger, while protecting human rights of people and ensuring inclusive and sustainable development and healthy lives. It sounds simple, but there are very complex international dynamics involved with evolution of MDGs and then SDGs.

In Vhembe District there is a shortage of mental health care services and health specialists, including psychologists to offer mental health care services as compared to other provinces. Shortcomings in the modern health care landscape such as shortage of well-trained personnel, shortage of medication, poor infrastructure, long waiting times and bad services provided cause pregnant women to experience challenges of receiving maternal mental health care services. The increased pressure on staff makes some of them to develop negative attitudes towards patients (TAC Limpopo State of Health Report, 14 June 2018). Therefore, pregnant women experience challenges in accessing mental health care services and resort to THs. The reports revealed that in hospitals like Tshilidzini and Elim patients waited for files for around five hours. That occurs because of shortage of staff (TAC Limpopo State of Health Report, 14 June 2018). Shortcomings in Western interventions compromise the quality of mental health care services and the majority of pregnant women resort to THs such as faith healers, diviners, traditional birth attendants and herbalists for mental health care services.

Vhembe, which is the area of interest in this study, has a 74.4% of population living in rural areas (Statistics South Africa, 2012). Peltzer, Mnqundaniso & Petros (2006) underscored that indigenous healers are widely dispersed throughout South Africa and are more knowledgeable about the cultural norms in the communities where they operate. The cultural beliefs influence rural and urban pregnant women's decisions for seeking help from THs as they believe that some illnesses such as mental health problems are caused by evil spirits or exposure to polluting sources, possession by a demon, or the evil eye, ghost possession and sorcerers (James, Wardle & Steel, 2018). The study conducted herein explored the knowledge of THs in the provision of maternal mental health care services and aided on profiling how THs provide maternal mental health care services.

1.4 Aim of the Study

The aim of the study was to develop guidelines for provision of maternal mental health care services by THs in Vhembe District of Limpopo Province.

1.5 Objectives of the Study

The study was guided by the following objectives, organized according to phases.

Phase 1a: Traditional Healers

- [1] To explore traditional healers' knowledge on maternal mental health care.
- [2] To identify maternal mental health care needs.
- [3] To describe maternal mental health care services provided by traditional healers.
- [4] To discuss the possibility of referral by traditional healers.

Phase 1b: Pregnant Women

- [5] To explore the experiences of the provision of maternal mental health care by traditional healers.

Phase 2

- [6] To develop guidelines for use by traditional healers in the provision of mental health services to pregnant women.

1.6 Research Questions

The study was guided by the following research questions:

Phase 1a: Traditional Healers

- [1] What are the roles played by traditional healers in the provision of mental health services to pregnant women?
- [2] What are maternal mental health care needs?
- [3] What kind of maternal mental health care services are provided by traditional healers?
- [4] What is the possibility for referral?

Phase 1b: Pregnant Women

- [5] What are your experiences of the provision of mental health care services by traditional healers?

1.7 Significance of the Study

The study is of great importance because it may contribute to and bolster the existing body of knowledge as well as encourage future research. The study was aimed at providing a great depth of information that may assist in adding value to an existing knowledge about the provision of maternal mental health care services by THs. The documented information in this study aided the preservation of ancestral knowledge of THs used in the past and which may be on the brink of disappearance for future generations. The knowledge can provide a new starting point that may benefit present and future generations as it is useful to address Sustainable Development Goals (SDGs) that focus on maternal challenges.

The study may help the community to understand the role THs play in the provision of maternal mental health care services. The study provided insights to the community and society to change their attitude towards THs. The study aided the Department of Arts and Culture to evaluate the role of THs on improving maternal mental health and

neonatal health. Knowledge to be gained from this study may help the Department of Arts and Culture to protect, support and promote the role of THs. The findings of the study may also be used by the Department of Arts and Culture to enhance social transformation regarding the provision of maternal mental health care services by THs. The study provided the Department of Health with the information about the guidelines for provision of maternal mental health care services, especially in rural areas where there is a dire lack of clinics and hospitals.

The study may help the professional midwives to perceive THs as co-workers providing mental health to pregnant women. By understanding the role of THs in the provision of maternal mental health services to pregnant women, the researcher hoped to develop opportunities for new interventions and collaborations involving THs, the medical community, and patients who seek support for maternal mental health problems. The findings can be used as guidelines to build linkages between formal scientific institutions and informal knowledge systems. Furthermore, the study may promote the development of effective evidence-based strategies and policies that could be used by THs to improve the provision of maternal mental health care services to pregnant women. The results of the study may also influence the review of certain laws and policies, particularly those that are perceived as disadvantageous to and in violation of the rights of THs in South Africa. The results may also provide guidance to THs in the provision of maternal mental health care services.

The study may benefit pregnant women as it provided the information about the alternative ways they may use to receive mental health care services that promote mental health during pregnancy. It may also help pregnant women to understand the risks associated with pregnancy. For the THs, the findings of the study provided information on how they may conduct maternal mental health services, how they refer pregnant women, the challenges they experience providing maternal mental health care services and explore strategies they may use to address those challenges. The study sought to develop comprehensive and effective guidelines that may provide THs with an approach that assist in reducing the challenge of maternal mental health problems. The findings of this study may help to develop effective evidence-based guidelines that could be used to control maternal mental health problems.

1.8 Rationale of the Study

Some pregnant women experience good mental health during their pregnancy.

However, it is common for other pregnant women to experience mental health problems such as stress, anxiety and depression brought on by low socio-economic status, unplanned or unwanted pregnancy, and stressful life events such as relationship breakdown or divorce, losing a job, incarceration, housing insecurity; history of physical or sexual abuse during childhood or adulthood, grief related to miscarriage, substance use and intimate partner violence (Registered Nurses Association of Ontario, 2018). Intimate partner violence also contributes to maternal mental health problems (Satyanarayana, Lukose & Srinivasan, 2018). The outcomes such as low birth weight, neglecting children, abandoning children and child adoption occur as a result of poor maternal mental health problems. Some women who experience maternal mental health develop suicidal thoughts or try to kill themselves (Heyning et al., 2016).

The increased risk of mental health disorders during pregnancy are associated with increased maternal morbidity and mortality, and adverse child health outcomes (Groenewald, Evans, Morden, Zinyakatira, Neethling & Msemburi, 2014; Prince, Patel, Saxena, Maj, Maselk & Phillips, 2017). Common mental disorders such as anxiety, stress and depression are among the leading causes of disease burden globally for women between 14 and 44 years of age (Mayosi, Flisher, Lalloo, Sitas & Tollman, 2016). Sawyer, Ayers & Smith (2010) revealed that depression is a constant maternal mental health problem. By 2030, these risk factors are expected to rise. Therefore, there is a need of mental health care services for the provision of maternal mental health care.

There are few population-level insights into the use of THs and other forms of alternative care for the treatment of common mental disorders in sub-Saharan Africa. Research examined the extent to which alternative practitioners are consulted, and predictors of traditional healer visits. A national survey was conducted with 3,651 adults in South African between 2002 and 2004 using the WHO Composite International Diagnostic Interview (CIDI) to generate diagnoses. A minority of participants with a lifetime DSM-IV diagnosis obtained treatment from Western (29%) or alternative (20%) practitioners. THs were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor. Use of THs in the full sample was predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder. Alternative practitioners, including THs and religious advisors, appear to play an important role in the delivery of mental health care services in South Africa.

The main purpose for conducting this study was the gap identified in the literature and many studies conducted thus far focused on the role of TBAs in helping pregnant women with pregnancy care, during childbirth and with postnatal care, which are not focusing on the developing guidelines for provision of maternal mental health care services.

The study conducted by Campbell & Graham (2006) focused on the strategies for reducing maternal mortality: getting on with what works. According to the researcher's observation, few studies looked at the provision of maternal mental health care services. The evidence-based intervention will help the maternal mental health care provider to be aware of the importance of THs in the provision of maternal mental health care services. Even though health services are free for pregnant women and children under six years of age in South Africa, pregnant women continue to seek help from THs because they are geographically accessible as compared to Western intervention. It seems as if the community has trust in them as they have been providing health services to the community for decades. Hence, this study unearthed the experiences of pregnant women on mental health care services provided by THs. Maternal mental health is of great importance as it has an impact on obstetric and neonatal outcomes such as low birth weight, delayed developmental milestones, proneness to disease, mental retardation, etc.

A study conducted in Pakistan, compared 147 physically healthy mothers with 147 mothers diagnosed with depression of similar gestational age and found that infants of depressed mothers had lower birth weights than infants of non-depressed mothers (Satyanarayana, Lukose & Srinivasan, 2018). Therefore, it was important for this study to be conducted as the guidelines developed will be used to promote best practices in the provision of maternal mental health care services by THs.

1.9 Delimitation of the Study

Phase 1a focused on THs who have been providing maternal mental health services for the past ten years in Limpopo Province, South Africa. Phase 1b was conducted among pregnant women receiving and those who received mental health care services from THs.

1.10 Operational Definitions of Key Concepts

The following section provides a brief explanation of the terms which are significant in

the conceptualization of this study.

1.10.1 Mental Health

Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society (Galderisi, Heinz, Marianne, Kastrup, Beezhold & Sartorius, 2015). In this study, mental health refers to the psychological well-being of pregnant mothers experiencing mental health problems such as anxiety, depression and stress.

1.10.2 Pregnant Woman/Maternal

The terms 'pregnant women' and 'maternal' will be used interchangeably when referring to maternal mental health. It is the time during which one or more offspring develops inside a woman (Kristen, 2003). In this study, pregnant women/maternal refers to a woman who have received or is receiving maternal mental health care services from THs.

1.10.3 Traditional Healers

A traditional healer is defined (based on the Traditional Health Practitioners Act No. 22 of 2007) as a person who engages in traditional health practice and is registered under this Act (Department of Health, 2004). For this study, THs refer to herbalists, diviners, faith healers and Inyangas providing maternal mental health care services.

1.11 Structure of the Thesis

The thesis is structured as shown in Table 1.1.

Table 1.1: Structure of the thesis

Chapter 1	Overview of the Study This chapter presents an overview of the study, the problem statement, and significance. It also describes the aim and the objectives, and the research questions that guided the study.
Chapter 2	Literature Review This chapter provides an extensive review of literature about maternal mental health from different parts of the world and gives an overview

	of all the objectives being measured. It also highlights the guidelines that were developed in previous studies to promote proper use of traditional mental health services from different parts of the world.
Chapter 3	Theoretical Framework This chapter explains the use of three different theoretical frameworks, namely, WHO Model for Guideline Development and Afro-Sensed Theory that supported the study objectives.
Chapter 4	Research Methodology This chapter presents the research approaches, research design, setting, target population, sampling, and data collection methods. Moreover, the chapter discusses how trustworthiness was ensured. It also outlines data analysis methods and ethical considerations, as well as highlights on how concept analysis was done and how the guidelines were developed. This chapter presents Phase 2 of the guidelines development process.
Chapter 5	Presentation and Discussion of the Findings This chapter presents the Findings and Discussion of the study, as relating to the participants' responses.
Chapter 6	Development of the Guidelines The chapter presents the developed guidelines using the findings of the study. This chapter describes the process followed during the development of the guidelines for effectively promoting the proper use of maternal mental health care services by traditional healers. The Traditional Healers Act defined traditional healers' guidelines as systematically developed statements which assist clinicians and people living with maternal mental health problem in making decisions about appropriate treatment for specific conditions.
Chapter 7	Evaluation, Justification, Limitations, Conclusions and Recommendations This chapter evaluates the study to check whether it has met all its objectives outlined in Chapter 1. The justification of the study together with its limitations, conclusions and recommendations are provided in terms of guidelines for provision of maternal mental health care

services in Vhembe District of Limpopo Province.

1.12 Conclusion

This chapter presented an overview of the study. The background of the study discusses the global aspects of maternal mental health care services. The researcher provided the statistics on maternal mental health care services which indicated the variations in different countries, including South Africa. The aim of the study was to develop guidelines to be used by THs in the provision of maternal mental health care services at Vhembe District of Limpopo Province. This section also presented the problem statement of the study, the aims and objectives of the study, research questions, significance and rationale of the study, delimitation of the study, and operational definitions of key concepts.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Indigenous mental health care has deep roots in traditional healing practices that have been passed down through generations. Elders, healers, and community leaders play a central role in guiding individuals through emotional and mental struggles, often using ceremonies, rituals, herbal remedies, and spiritual practices (Noh & Lee, 2020). Historically, mental health was seen not as an individual issue, but as something interconnected with the entire community's health. These practices focus on the connection between mind, body, and spirit, emphasizing holistic well-being and balance (Esterwood & Saeed, 2020). With the arrival of colonialism and Western medical practices, Indigenous healing systems were often marginalized or suppressed (Jones, 2023). In modern times, there has been a resurgence of interest in blending traditional knowledge with contemporary mental health practices, aiming to create more culturally relevant and effective care for Indigenous peoples. This has led to efforts to integrate traditional Indigenous practices with Western approaches to address mental health in ways that honour both cultural heritage and modern understanding (Cameron, Joyce, Delaquis, Reynolds, Protudjer & Roos, 2020).

2.2 Traditional Healers' Knowledge on Maternal Mental Health Care

Traditional healers often possess valuable knowledge about mental health, passed down through generations. They approach mental well-being by considering the balance of mind, body, and spirit, and use holistic methods to restore harmony. This can include spiritual rituals, herbal remedies, and guidance through talking therapies. They emphasize the importance of community support, lifestyle balance, and emotional expression as essential components for mental health care. Their approach tends to focus on the individual as a whole, rather than just treating symptoms.

In many parts of Africa, mental health problems are understood to be present when an individual shows behavioural signs and symptoms that are perceived to deviate from social norms (Koen, Niehaus, Muller & Laurent, 2003; Mufamadi, 2014; Mzimkulu & Simbayi, 2006). For example, a study by Mufamadi (2014) found that symptoms often associated with mental illness were aggression, talking incoherently, isolation, shouting loudly, confusion and strange behaviour and reported perceived causes such as heredity, witchcraft, sorcery, disregard of cultural norms and spirit possession.

The Dagon people of Malawi recognize someone to be mentally ill when s/he talks loudly even when speaking to elders; is always alone; and refuses to be with others of his/her own age group (Benduce, 2016). According to Chavunduka (1978), in Zimbabwe a person is considered mentally ill if s/he performs foolish acts without realizing what s/he is doing. Mental illness can therefore be explained in mystical terms by indigenous healers to fit the belief systems of their clientele, as ancestral spirits are not a relic of the past, but archetypes of the collective unconscious individuals (Bodibe, 2011; Mabetoa, 2002; Mabunda, 2001). Musara, Maramba & Fuyane (2015) and Mutebirwa (2013) in Zimbabwe found that psychosis was believed to be caused by supernatural powers.

Similarly, a study conducted in Malaysia by Razali, Khan & Hasanah (2016) found that 70% of Malaysian indigenous healers attributed mental problems to supernatural causes such as witchcraft and angered ancestors. According to Aina (2008), Srinivasan & Thara (2012), and Kadri, Manondi, Berrada & Moussaoni (2004), THs in developing countries attribute mental problems to stressful life events, supernatural phenomena, and heredity. According to Vontress (2011), indigenous knowledge systems (IKS) regarding health care, or indigenous health care approaches and methods have been in existence since time immemorial. They have been playing significant roles in improving mental health problems, or elevating the quality of life, promoting health, curing disease, preventing illness, facilitating personal empowerment and social transformation.

African history is a widespread custom that ancestors choose someone within the family, which depends on the powers that the previous ancestors had (Kale, 2014). Mufamadi & Sodi (2014) noted that many traditionally orientated Africans who are called to be indigenous healers are believed to be chosen by supernatural agents like deities, ancestors and the Supreme Being. These “chosen” people to become indigenous healers may display signs like aggression, social withdrawal, or bizarre

behaviours before they accept the calling and undergo training (Mufamadi & Sodi, 2002). These people become mediators between the ancestors, and the community also takes up the position as a leader in the community. Indigenous healers believe that if one fails to adhere to the calling, the person is doomed with bad luck and with illness that is incurable (Kale, 1995). Zanemvula (2008) also illustrated that if the “chosen” person continues to decline the calling they will continue to be sick for some time until they finally accept. The most mystical point about the resistance of the calling is that they will have chronic illness that Western medicine is unable to diagnose.

2.3 Maternal Mental Health Care Needs

2.3.1 Mental Health Facilities

Availability of mental health services that offer psychological services to pregnant women experiencing mental health problems during the perinatal period is important for mental well-being of pregnant women. The 1994 Action Plan of the International Conference on Population and Development emphasized the need to improve health services, including mental health services. However, the study conducted by Nkwanyana (2011) in Mandini, iLembe District in KwaZulu-Natal, highlighted that the villagers’ pregnant women encountered difficulties regarding transportation, thus leading to their inability to access mental health facilities and clinics. In many LMICs, access to and use of formal mental health services is limited for various reasons, including shortage of trained professionals, limited resources and perceived high cost of care (Rathod, Pinninti & Irfan, 2017; Peltzer & Pengpid, 2015; Durie, 2009). As a result of these and other factors, alternative and complementary health care methods such as traditional and faith healing have become popular avenues for receiving care in many LMICs, including many African countries (Galabuzi, Agea & Fungo, 2010).

The studies conducted by Van Deventer, Couper, Wright & Tumbo (2008), and Thompson, Neighbors & Munday (2003) revealed that concerns such as overcrowding in mental health facilities, lack of specialized psychiatric units in the primary health care, the absence of specialists, rapid discharge from the referral hospitals which leads to relapse, ignorance of the Mental Health Care Act and the possibility of patient abuse at home by relatives led to poor mental health among pregnant women. Those factors also led to re-admission of mental health patients.

Although the South African Mental Health Care Act (MHCA) mandates the integration of mental health services into primary health care, barriers mentioned below make

pregnant women to seek help from THs:

- ✱ The high burden of disease.
- ✱ Pressured primary health care services where staff have multiple tasks, high patient loads, limited supervision and poor referral networks.
- ✱ The lack of political will, particularly the absence of mental health on the public health priority agenda.
- ✱ The lack of public mental health leadership.
- ✱ The stigma of mental illness, viewed as a sign of weakness and disgrace.
- ✱ Lack of knowledge regarding the prevalence and nature of mental illnesses.
- ✱ Under-resourced health facilities with regard to staff, infrastructure, and medication.
- ✱ Poorly trained nursing staff.
- ✱ Lack of appropriate screening tools.
- ✱ Insufficient skilled counsellors, psychologists and psychiatrists to provide effective treatment (Meintjes, Field, Van Heyningen & Honikman, 2015; Lund, Tomlinson, De Silva, Fekadu, Shidhaye & Jordans, 2012).

2.3.2 Empowerment

Empowerment is a multi-dimensional social process that helps people gain control over their own lives. Psychoeducation and self-management education can be employed as the strategies that can assist in reducing the re-admission rate of mental health care users. Psychoeducation provides disease-specific information, and self-management education which teaches problem-solving skills that allow patients to take appropriate actions to improve their health (Vreeland, Minsky & Yanos, 2006). Mental health care users can be educated on the following tactics as outlined by Schizophrenia (2010) and Robinson (2005):

- ✱ Do not use street drugs and moderate any use of alcohol.
- ✱ Make an ongoing effort to develop your social skills as much as you can.
- ✱ Avoid social isolation.
- ✱ Make an ongoing effort to maintain friendships with adults.
- ✱ Make an extra effort to learn positive perspectives on the world.
- ✱ Make extra effort to learn how to deal with stress and anxiety.

2.3.3 Social Support

Family meetings and collateral contact with patients' family/friends have been useful in understanding the role that families may play in contributing to mental health problems as well as identifying what supportive measures the family can offer. Outcome studies have indicated benefits of family involvement in hospital treatment, although at times patients themselves may be hesitant to involve family due to embarrassment and privacy issues. The use of family meetings and collateral contacts can be useful (Perreault, Tardif, Provencher, Paquin, Desmarais & Pawliuk, 2005). Smith, Saisan & Segal (2014) reiterated that having a strong support system speeds up recovery. Isolation fuels depression, so the patient should reach out to others, even if s/he feels like rather being alone or does not want to feel like a burden to others. The truth is that most people would be happy that they chose to confide in them; they will be flattered that someone trusts them enough to open up.

So, mental health care users should let their family and friends know what they are going through and how they can support them. If support from family and friends, positive lifestyle changes, and emotional skills building are not enough, they should seek help from a mental health professional. There are many effective remedies for depression, including therapy, medication, and alternative treatments. Families with social adversities and with parental mental health problems should be supported to secure their children's development (Paananen et al., 2013).

2.3.4 Family Support

In most indigenous communities, pregnant women have important roles, ranging from

performing domestic chores and managing household resources to working as wage earners or discharging duties and exercising authority of assigned jobs, in the public sphere. Despite their valuable contributions, indigenous pregnant women still face inequality in several areas, such as capital markets and other economic resources, educational and employment opportunities and health care services, access to information, freedom of choice, freedom of association and lack of access to decision-making processes and institutions.

In addition, the adverse life conditions of indigenous peoples, in general, have left most indigenous women politically disenfranchised, more insecure economically, physically more vulnerable, and emotionally more strained, which pose further challenges to their mental well-being (Singh, 2004). Kissman (2010) also pointed out that pregnant women need various types of support, including emotional, information, task support and financial assistance. Extended family members should provide support to pregnant women to relieve the burden of performing different roles.

2.4 Referral of Patients to Other Health Workers

The study conducted by Mbwaiyo, Ndeti, Mutiso & Khasakhala (2013) revealed that THs refer their patients to other more experienced healers. They only refer the patient to hospital if the patient is not getting better. They said that though they refer their patients to the hospitals, the doctors do not reciprocate. Sorsdahl (2010) stated that there are few advantages of referring patients with mental health problems to Western-trained practitioners focused on treatments that were not always specific to psychiatry. THs reported that some pregnant women experiencing mental health problems are often violent, aggressive, and destructive. This was believed to hinder the ability of the patient to take medication prescribed by the THs. According to indigenous healers, Western-trained practitioners are in a possession of an injection that calms the patient down, allowing for the THs to administer “muti” which has the capability of healing mental health problems. (Sorsdahl et al., 2010). Melato (2000) believed that Indigenous healing systems and Western healing systems working side by side seems to be the only form of integration which could benefit all the citizens in the country. In case of maternal mental health crisis, the appropriate person (the pregnant woman) or family member/carer) should contact THs without delay and agree on the next steps to be provided in the woman’s care and support. THs are encouraged to refer all pregnant women to a health care facility for care by a skilled birth attendant (Ministry of Health/MoH, 2007). This should be done in line with national guidance such as the

Urgent and Emergency Liaison Mental Health Care Pathway Guidance. However, the health system is not coping. Anecdotal reports indicate that there is congestion at the facility for waiting mothers.

2.5 The Experiences of Pregnant Women on Traditional Healing

According to Popper & Ventura (2009), some traditional healing practices are an attractive field for female patients. The literature shows that women represent the majority of those utilizing traditional healing practices as patients. In their analysis of traditional healing practices among Moslem Arabs, Popper & Ventura (2009) noted that in many cases, a Muslim woman prefers to turn to a female healer. Indeed, Yocom (1985), who in her fieldwork interviewed women as well as men, identified that the practice of traditional healing by men and women takes place in different spaces and that female healers and patients often choose to meet somewhere private and intimate. According to her, the meeting space expresses not only a 'feminine touch', but also feminine influence and control; hence the kitchen or the dining room is often chosen as a feminine meeting space. On the other hand, male healers' meeting places are dark and scary, and they often wear animal skins and use intimidating voices reflecting their patriarchal outlook. Referring to Kenyon's work titled, 'Five Women of Sennar: Culture and Change in Central Sudan' (1991), Popper & Ventura (2009) observed that female healers operate in the domestic or private sphere and male healers in the public sphere. This is because women's work is held in the domestic sphere as part of the 'shadow economy that provides women, even in a traditional society, with some economic and personal independence.

In her opinion, women deal with opposition to their 'invasion' in the public sphere by working from home. They do not enter the public sphere, but rather bring it inside through the many patients who come to their homes. By doing so, they neither compete with men nor threaten them, but simply work in an independent manner. This private space allows women to open to each other as companions and enables them to mingle and receive their counterparts' support. This is the basic reason why more women than men turn to female healers. This scenario breaks the social hindrances that prevent women from integrating the many little fragments of their lives even though the patriarchal culture continues to question the value of such integration (Yocom, 1985).

The services offered by women healers are cheaper than those of male healers. The smaller fee may explain why women pursue certain traditional healing practices. That

male healers' services are often very expensive further portrays the gendered dimensions in a society connected with money and asset acquisition. Most women must raise the necessary funds for treatment themselves; using allowances or other monetary resources they succeeded in hiding from their husbands, and thus, often choose divination as a response to their misery - a one-time inexpensive solution (Anubha, 2008). According to Popper & Ventura (2009), women's access to traditional healing practices depends mainly on relational aspects. In Arab society in Israel, for example, the social and economic status of women and their personal welfare depends upon their relationships with men. This is especially so where women have no traditional supportive networks. In Uganda, Mubiru (2004) discerned that women are the largest group visiting THs precisely because of the reproductive roles that society has conferred upon them. She argued that women have the responsibility in the home for the provision of health care.

Therefore, they often go to seek antenatal and postnatal care and seek treatment for their children, which may sometimes be such a major burden that they cannot afford to travel to health centres or even pay the bills. She also stated that women are never comfortable in such patriarchal societies and hence some visit THs to seek favour over their co-wives, to have children of a particular sex, mostly boys, as well as to find love. Additional tensions underlying the decision to turn to traditional healing are also drawn from the transition to a modern lifestyle. In contrast to the past, where decisions about relational, economic, and professional issues were decided upon by the extended family, today's women are required to confront such issues themselves. These tensions, enveloped by feelings of uncertainty, frustration, and helplessness, are 'modern' by nature, and the prevailing institutions cannot offer solutions for them.

Therefore, more and more women turn to women healers for answers (Popper & Ventura, 2009). Women consider female healers to understand them, and they also position themselves within their surroundings. Female healers have similar experiences with their female clients. These include marriage and relationship challenges as well as social exclusion in society based on their gender. Consequently, the ability of a female healer to not only understand, but also heal these challenges from the angle of experience endears many female clients to them. This also makes both the female healer and her female clients to rediscover their identity as the excluded, which is the first step towards their own liberation. With adequate knowledge of the challenges that women face leading them to healers, female healers' service, through their traditional counselling techniques and from their own individual

experiences, become a foundation upon which female clients' conditions will improve as better wives and mothers, in both their homes and the wider community.

Furthermore, THs are in places to which the community has easy access. This makes them popular and readily relied upon (Abdool et al., 1994). Similarly, TBAs are popular with women for whom access to health care facilities is beyond their financial capacity (Hausmann et al., 2003:26). A female healer acts not only as a link between the patient, her family and community, but also as a socializing agent. For example, Kissman (1990) regarded fortune-telling as one of the ways through which older women connect younger women to their roles as wives, mothers and housewives, and through which they initiate them into the world of romantic relationships, child rearing and economic survival.

Similarly, the female healer, usually much older than her patient and proficient in cultural values and community customs, serves as a mentor. The socializing role of the female healer, therefore, replaces traditional institutions such as the extended family. Some traditional healing practices serve as tools that help women's socialization and fortify their status in the domestic sphere. As a result, they relieve the anxiety arising from changes in lifestyle, family structure and gender roles (Heather, 2007). Some traditional healing practices therefore respond to feminine challenges and opportunities. Some are occupation distinctive mainly to female healers, and primarily attract female patients and in many cases, focus on issues commonly identified as feminine. One lure of female healers for female patients revolves around the fact that the healer herself is a woman who relies upon the recommendations of other women: mothers, sisters or friends. Women often accompany each other when turning to a female healer, and the healing takes place as part of women's activity in the domestic, feminine sphere (Popper & Ventura, 2009). Tabuti (2003) complemented this view, asserting that traditional healing practitioners are consulted not only because they are closer and more affordable than their Western-trained counterparts, but also because they are embedded, extensively and firmly, within Ugandan culture.

2.6 Conclusion

In this section, the researcher focused on the literature review related to the provision of maternal mental health care services. The literature review shows the path of prior research and how the current project is linked to the former (De Vos, Strydom, Fouche & Delport, 2011). A literature review is defined as both a summary and an explanation

of the complete and current state of knowledge on a limited topic as found in academic books and journal articles (De Vos, 2014). A literature review is an excellent source for focusing on a topic, as it reduces the chances of focusing on irrelevant and outdated information. Finally, it provides the framework of the research and identifies the area of knowledge that tends to expand. The method of reviewing literature in qualitative research have been utilized in this study, and involved analyzing a variety of published documents. The theoretical orientation of the study will be discussed in Chapter 3. The search engines utilized to search relevant literature included Google Scholar, Sabinet, EBSCOhost, Science Direct and Ajol.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

To develop guidelines for use by traditional healers in the provision of mental health services to pregnant women, the researcher adopted the WHO (2012) Guideline Development Methodology and Afro-Sense Theory to ensure a clear path through the process and that the resulting guidelines have credibility and meet the WHO's criteria for content, methods and presentation, while remaining accessible and useful. A WHO guideline refers to any document containing recommendations about health interventions, whether these are clinical, public health or policy recommendations. A recommendation provides information about what policymakers, health care providers or patients should do. It implies a choice between different interventions that have an impact on health and that have implications for the use of resources. Guideline recommendations are intended to assist providers and recipients of health care and other stakeholders to make informed decisions. WHO has adopted internationally recognized standards and methods for guidelines development to ensure that the guidelines are free from bias, meet public health needs and are consistent with the following principles:

- ✳ Recommendations should be based on a comprehensive and objective assessment of the available evidence.
- ✳ The process used to develop the recommendations should be clear, that is, the reader must be able to see how a recommendation has been developed, by whom, and on what basis.

3.2 WHO Model Theory

3.2.1 Types of Guidelines to Be Developed

The World Health Organization model aided the researcher to develop full guidelines.

Applying the development of maternal mental health care services by traditional healers involves integrating indigenous knowledge systems and cultural practices into maternal mental health care, especially in communities where traditional healers are the first point of contact for health concerns. This can be a culturally appropriate and accessible complement to formal health services, particularly in low-resource or rural areas.

Below follows a structured approach on how traditional healers can contribute to the development of maternal mental health care services:

1. Capacity Building and Training

Goal: Equip traditional healers with basic knowledge of maternal mental health.

- ✦ **Mental Health Literacy:** Train traditional healers to recognize symptoms of perinatal mental health issues (e.g., postpartum depression, anxiety, psychosis).
- ✦ **Referral Training:** Teach them when and how to refer severe cases to medical professionals.
- ✦ **Confidentiality and Ethics:** Educate on patient confidentiality and respectful care.

2. Collaborative Frameworks

Goal: Build mutual trust between biomedical and traditional systems.

- ✦ **Community Health Integration:** Create partnerships between traditional healers and community health workers or mental health professionals.
- ✦ **Joint Clinics:** Organize community health days where traditional and modern practitioners work together.
- ✦ **Dialogue Platforms:** Set up forums for ongoing cultural exchange between the two systems.

3. Culturally Grounded Interventions

Goal: Provide maternal mental health care that aligns with cultural beliefs.

- ✦ **Rituals and Support Systems:** Utilize traditional rituals, storytelling, or herbal remedies that are considered healing in the local culture.
- ✦ **Social Healing:** Use communal and family-based healing approaches that emphasize social reintegration and support.
- ✦ **Spiritual Care:** Recognize the spiritual aspect of mental health where applicable, while maintaining scientific safeguards.

4. Community Awareness and Education

Goal: Reduce stigma and promote early help-seeking behaviour.

- ✦ **Use Local Media and Language:** Traditional healers can spread awareness through storytelling, community meetings, and radio programs.
- ✦ **Myth-Busting:** Correct harmful beliefs about mental illness, especially those blaming mothers for mental distress.
- ✦ **Men and Family Engagement:** Encourage involvement of spouses and elders to support maternal well-being.

5. Monitoring and Evaluation

Goal: Ensure effectiveness, safety, and continuous improvement.

- ✦ **Case Documentation:** Help traditional healers maintain records (possibly with assistance from community health workers).
- ✦ **Feedback Mechanisms:** Collect feedback from mothers on their care experience.
- ✦ **Periodic Evaluation:** Partner with local health institutions to assess the impact of the healer-based mental health support.

Benefits of Including Traditional Healers

- High trust in the community
- Accessibility in rural/underserved areas
- Cultural sensitivity
- Cost-effectiveness

Risks to Address

- Potential delays in referring severe cases
- Use of harmful practices or stigmatizing language
- Inconsistent treatment quality without standardization

The development of maternal mental health care services through traditional healers is a promising strategy, especially in areas with limited access to formal mental health care. A collaborative, respectful approach that blends cultural relevance with evidence-based practices can improve maternal mental health outcomes and bridge the gap between communities and formal health systems.

The researcher ensured that complete coverage of a health topic under study is provided. It is expected to include recommendations in relation to all aspects of the topic (e.g., diagnosis, maternal mental health care provision and clinical interventions) and to be fully based on systematic reviews of the evidence for each aspect. These are likely to take 2-3 years to complete and will require several meetings of a Guidelines Development Group (GDG). Given the time and expense of producing a full guideline, the requisite for doing these in WHO specifications needs to be carefully justified.

3.2.2 Overview of Guideline Development Process

Phases 1 and 2 of the study were channelled by the structure of guidelines development process outlined by WHO (2012). The WHO Guideline Development Process is summarized in Figure 3.1.

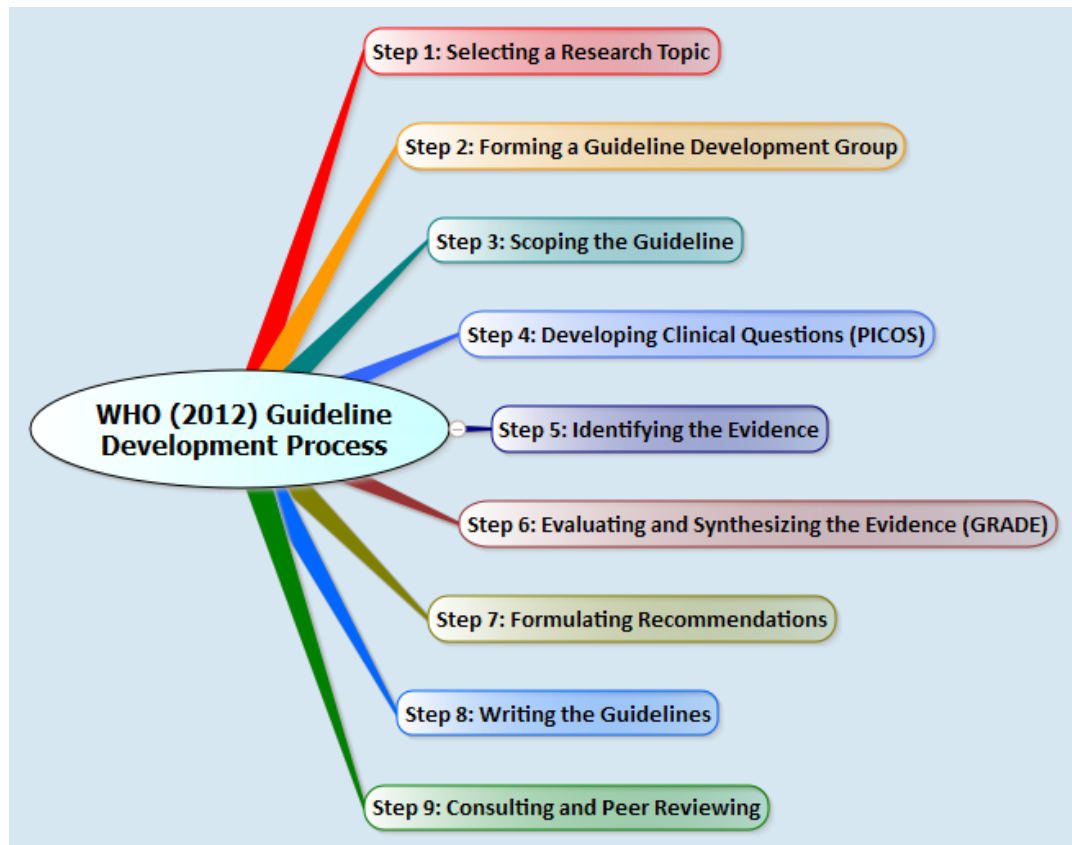


Figure 3.1: WHO (2012) guideline development process

The study consists of two phases:

Phase 1: Empirical Phase

Step 1: Selecting a Research Topic

Phase 1 of the study concentrated on the empirical phase, namely, the research methods the researcher used to conduct the study. Phase 1 was informed by Step 1 of the WHO Guideline Development Process which concentrated on selecting a research topic. The research topic selected involves developing guidelines for provision of maternal mental health care by THs in the selected rural communities of Vhembe District in Limpopo Province. Step 1 provided the researcher with the opportunity to explore THs' knowledge on maternal mental health care, identifying maternal mental health care needs, describing maternal mental health care services provided by THs, discussing the possibility of referral by THs, and exploring the experiences of the provision of maternal mental health care services by THs.

Phase 2

Guidelines developed were based upon data collected in Phase 1. Phase 2 focused on developing the guidelines to be used by THs in the provision of maternal mental health care services. The WHO (2012) Guideline Development Process was used to guide the researcher to achieve Phase 2 that focused on developing guidelines. Phase 2 was informed by Steps 2 to 9 of the WHO Guideline Development Process to develop the guidelines.

Step 2: Forming a Guidelines Development Group (GDG)

The researcher was guided by the Delphi Technique's step-by-step guide to establish a GDG that ensured trustworthiness in validating the guidelines to be developed. The Delphi technique indicated the communication process/methods to be followed in order to achieve a consensus associated with a specific topic (Figure 3.2).

Step 2A: Composition and Panel Size of Experts

According to the WHO (2012) Handbook for Guideline Development, the group should be small enough for effective group interaction, but sufficiently large to ensure adequate representation of relevant views. WHO stipulates that a group of 8 to 20 are usually feasible and affordable. It further highlights that the GDG should be balanced.

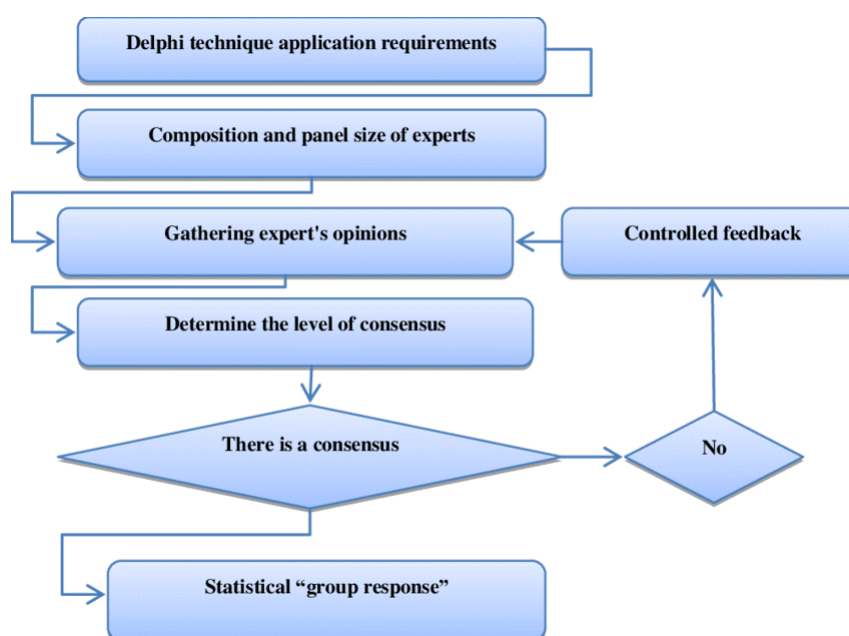


Figure 3.2: Delphi Technique: A step-by-step guide

Therefore, the researcher considered gender and geographically balanced group members from different areas of Vhembe District in Limpopo Province that were likely to provide maternal mental health care services using traditional interventions. The researcher selected a group of experts involved in the problem who are THs and pregnant women in the last five years. The GDG comprised:

- ✳ **The recipient** - Two pregnant women received mental health care services from traditional healers.
- ✳ **Implementors** of the guidelines - one male traditional healer provided maternal mental health care service for past five years.
- ✳ **Traditional Healer** - One female provided maternal mental health care service for the past five years.
- ✳ **Promoters** - Three supervisors (1 Promoter and 2 Co-Promoters).
- ✳ **Research Assistant** - One Scriber

The GDG was selected from different villages in Vhembe District in Limpopo Province. The researcher selected Venda-speaking THs and pregnant women. The researcher had face-to-face and online meetings with the GDG and introduced the guidelines.

✳ **Step 2B: Gathering of the Experts' Opinions**

The GDG developed predicated on the rationale that more heads were better than one and that inputs generated by experts based on their logical reasoning were superior to simply guessing - the technique engages a group of identified experts in detailed examinations and discussions on a particular issue for the purpose of policy investigation, goal setting, and forecasting future situations and outcomes. The Delphi technique attempts to assess what could or should be (Hsu & Sanford, 2007). The researcher had face-to-face and online meetings with the GDG and presented the guidelines to be developed. The research assistant aided in recording the suggestions.

✳ **Step 2C: Determination of Level of Consensus**

The central task of the external experts was to come up with evidence-based recommendations. The data collected and suggestions noted during the meeting were analyzed to determine the level of consensus achieved. The researcher planned to

have a maximum of three meetings with the GDG.

Step 2D: Consensus

There were consensus and the researcher did not arrange face-to-face meeting with the GDG to give feedback or collect data that may be needed to address gaps identified from the previous meeting.

Step 2E: Group Response

There was consensus in group responses and the researcher finalized the Guidelines. After finalizing the draft of the guidelines to be developed, the researcher arranged a meeting with the GDG to present the final draft of the Guidelines to be developed.

Step 3: Scoping the Guidelines

Scoping the guidelines is the process of defining what the guidelines included or not. The scope described the area of practice to which the guidelines apply, those whom the recommendations are intended to affect, the actions and interventions of interest and the outcomes that may result. The outcomes may be both positive and negative. This step assisted the researcher to ensure that the scope yielded questions that governed the data search and helped frame likely recommendations. It also ensured that the guidelines were of manageable size and adequately focused. The supervisors acted as external advisors. The researcher developed the objectives because these were crucial key issues that determined the breadth and depth of the work, identified the participants who were THs and who had provided maternal mental health care services in the past ten years. The researcher surveyed the literature to check the availability of other guidelines and thereafter produced a draft version of the scope. Developed potential recommendations facilitated the researcher to formulate draft PICO questions. The supervisors played the role of external advisors.

Step 4: Developing Clinical Questions (PICOS)

The researcher developed the clinical questions using the PICOS model (Figure 3.3).

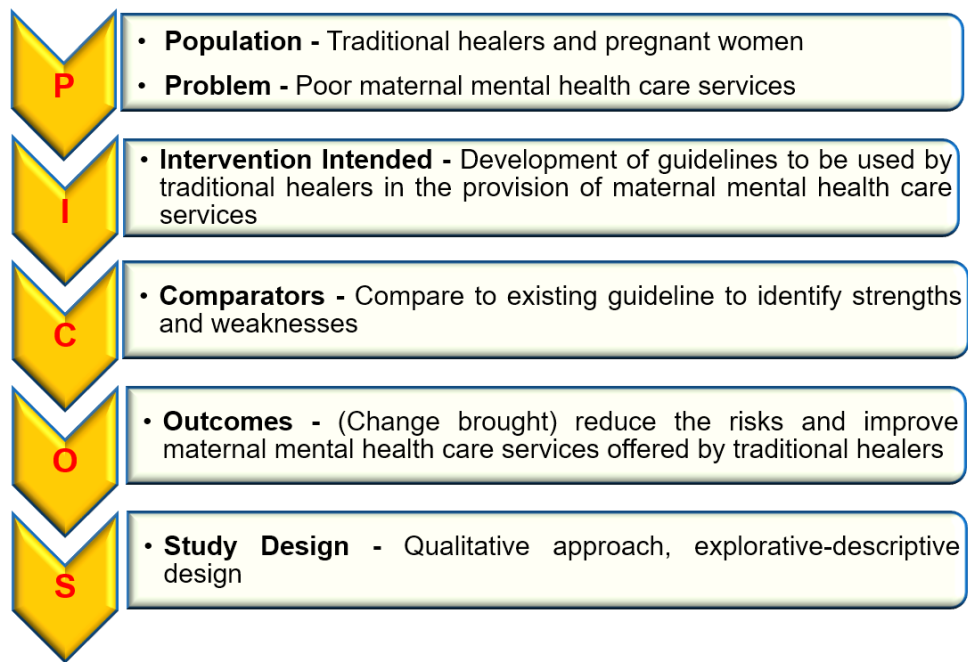


Figure 3.3: Developing clinical questions (PICOS)

✚ Step 5: Identifying the Evidence

This step informed Chapter 2 that focused on the literature review. The researcher did a thorough literature search for evidence-based or systematic reviews to support and identify already existing guidelines. The literature review encompassed the following aspects:

- ✳ To explore traditional healers' knowledge on maternal mental health care.
- ✳ To identify maternal mental health care needs.
- ✳ To describe maternal mental health care services provided by traditional healers.
- ✳ To discuss the possibility of referral by traditional healers.
- ✳ To explore the experiences of the provision of maternal mental health care services by traditional healers.

Step 6: Evaluating and Synthesizing the Evidence (GRADE)

This step assisted the researcher to develop full WHO guidelines by ensuring that the systematic search for evidence was completed before developing the recommendations. The researcher reviewed the literature to synthesize or develop the title and the abstract of the study. That aided in the introduction and outlining its relevance. The researcher employed one-to-one interviews and the independent coder to decipher the data to ensure trustworthiness of the study. Recommendations considered were used to develop the guidelines.

Step 7: Formulating Recommendations

According to the WHO (2012) Guideline Development Process, this step benefits the researcher to ensure that the guidelines address poor practice or to try to change clinical programme approaches, or health policies. That was the focus of the guidelines, and it is what differentiates the guidelines from textbooks or reference works. Research further puts emphasis on addressing gaps identified.

Step 8: Writing the Guideline

This step was considered to ascertain that the guidelines were written in concrete, unambiguous and specific terms. The key recommendations and audit criteria of the guidelines were thus delivered.

Step 9: Consulting and Peer Reviewing

This step assumed that experts' advice was objective and free from bias. The guidelines were subjected to extensive peer review prior to widespread dissemination and implementation for comment on the content, validity, clarity and applicability of the guidelines. The researcher considered feedback from different stakeholders and changes made to the document before final publication (Quality Assurance). The external reviewers of the guidelines were: potential users of the guidelines, supervisors and clinical experts in the topic area of the guidelines. That attested as proof that the clinical guidelines were validated to establish the potential consequences of their implementation. The researcher specified a date for updating the evidence base underpinning the guidelines recommendations (as time changes, people and ways of doing things change which make interventions ineffective or knowledge redundant). The review may be done if new evidence that would likely influence the recommendations become available, i.e., new study recommendations.

The researcher believed that the WHO (2012) Model of Guideline Development services the researcher to conduct Phase 1: Empirical Phase as guided by Step 1 of the WHO (2012) Guideline Development Process. Phase 2 was informed by Step 2 of the WHO process and aided the researcher to develop guidelines for THs in the provision of maternal mental health care services.

3.3 Afro-Sensed Theory

In the context of understanding the provision of maternal mental health care services by the THs in rural areas of South Africa, the researcher adopted an Afro-sensed approach to serve as the theoretical underpinning of this study which integrates a developmental and an intervention approach. The Afro-sensed theory was developed by Masoga in 2017 with the intention of guiding THs to help them to intervene efficiently by developing IKS in a local, culturally appropriate and sensitive manner.

Furthermore, Masoga & Shokane (2018) emphasized previously that the term “Afro-sensed” differs from “Afrocentric”, as it refers to one’s innate awareness, a “sense” of one’s identity, which is, being African; without making it “centric”. According to Masoga (2017), at the exclusion of all else, “centric” is akin to linking oneself in another classified organization structure, where one is better than another. The Afro-sensed theory encompasses using indigenous knowledge and cultural approaches to discover uniqueness and indigenous ways of healing (Masoga & Shokane, 2018).

This theory aided the researcher to move away from models that rely on Western frameworks and philosophies, towards Afrocentric models that are based on Indigenous (Ethnic) Knowledge Systems (IKS), community-based interventions and local values and practices (Magoro, 2008:35). Furthermore, the development of a health guideline approach was selected for its pro-poor approach, which promotes people-centred development and the quality of indigenous mental health services. This approach advocates for traditional mental health being equally important components of the development process (Patel, 2005).

3.4 Conclusion

In this chapter, the researcher discussed the theoretical framework used to guide the research process. The study was guided by the WHO (2012) Guideline Development Process. The researcher adopted the WHO (2012) methodology and Afro-sensed theory to explore the provision of maternal mental health care services by THs and

developed the guidelines to be used by THs in the provision of maternal mental health care services in Vhembe District of Limpopo Province. The researcher further advanced descriptive information on how the theoretical framework adopted facilitated the realization of the purpose of the study.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

Research methodology is defined as ‘the general approach the researcher uses in carrying out a research project’ (Merriam, 2014). The goal of this chapter is to describe the methodological process of the study, including a discussion on the research design, research context, sampling, data collection methods and procedures, data analysis, trustworthiness and ethics statement. The study sought to understand how pregnant women and new mothers experienced mental health services provided by THs. This section thus outlines how the research study was conducted. The researcher discusses the different methods the researcher utilized to conduct the study to address the problem. This chapter also indicated how the theoretical framework chosen guided the study.

4.2 Research Process

This study consisted of two phases (Figure 4.1 and Table 4.1). Phase 1 focused on the empirical aspects of the study and Phase 2 on guidelines development. The empirical Phase outlines all the research processes followed to conduct the study. It aided the researcher to conduct Phase 1a and Phase 1b. Phase 1a focused on exploring THs’ knowledge on maternal mental health care, identifying maternal mental health care needs, describing maternal mental health care services provided by THs and discussed the possibility of referral by THs. Phase 1b centred on exploring the experiences of the provision of maternal mental health care by THs. Phase 1 was informed by Step 1 of the WHO (2012) Guidelines Development Process. In Step 1, the research topic was selected. The objective explored in Phase 1 aided the researcher with the opportunity to collect data that were useful to develop the guidelines for provision of maternal mental health care services by THs in Vhembe District of Limpopo Province.

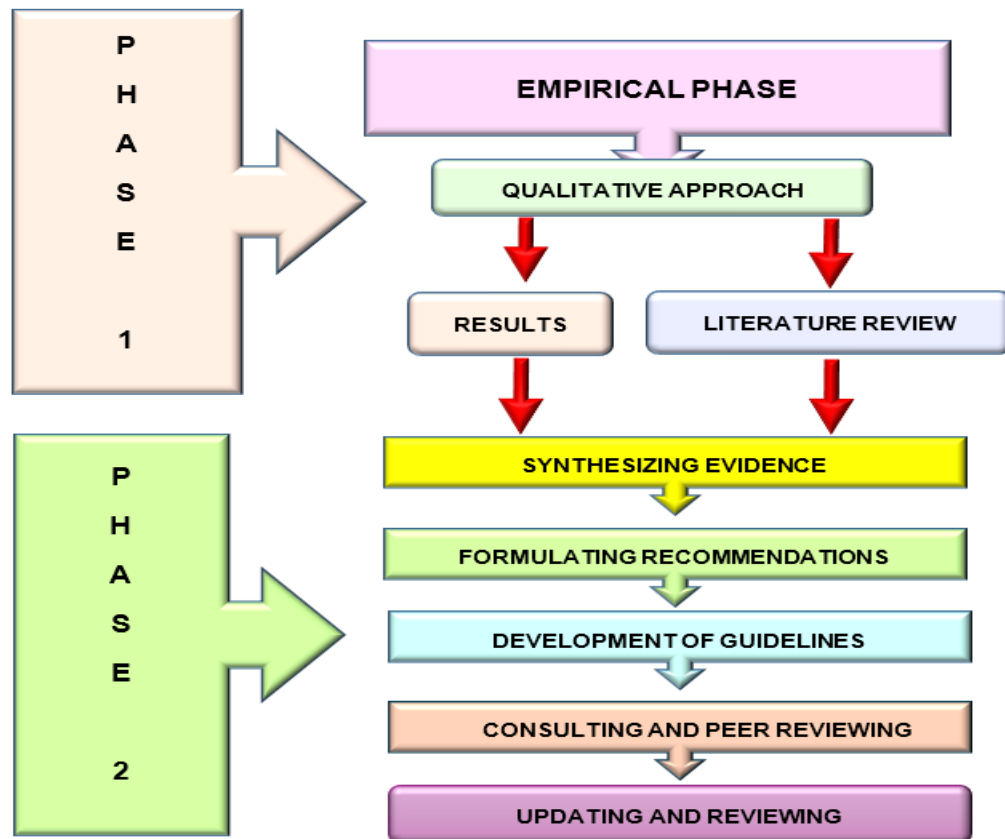


Figure 4.1: Phases of the study

Phase 2 assisted the researcher to achieve Objective 6 concentrating on the development of guidelines to be used by THs in the provision of mental health care services to pregnant women. Guidelines were developed based upon data collected in the empirical phase. Phase 2 was informed by Steps 2 to 9 of the WHO (2012) Guideline Development Process to develop the guidelines.

4.3 Phase 1: Empirical Phase

4.3.1 Phase 1a: Traditional Healers

4.3.1.1 Research Approach

The researcher adopted qualitative approach to explore the guidelines for provision of maternal mental health care services by THs. Qualitative approach is the research approach that was used systematically to describe the life experiences and situations to give them meaning Alvi (2016).

Table 4.1: Phases of the study

Phases	Approach	Objective	Design	Population	Sampling	Data Collection	Data Analysis	Trustworthiness
Phase 1 Empirical Phase	Qualitative approach	1	Explorative-descriptive research design	Traditional healers	Purposive & snowball sampling	Semi-structured interview	Thematic content analysis	Trustworthiness
	Qualitative approach	2	Explorative-descriptive research design	Traditional healers	Purposive and snowball sampling	Semi-structured interview	Thematic content analysis	Trustworthiness
	Qualitative approach	3	Explorative-descriptive research design	Traditional healers	Purposive & snowball sampling	Semi-structured interview	Thematic content analysis	Trustworthiness
	Qualitative approach	4	Explorative-descriptive research design	Traditional healers	Purposive & snowball sampling	Semi-structured interview	Thematic content analysis	Trustworthiness
	Qualitative approach	5	Explorative contextual and the phenomenological research design	Pregnant women	Purposive sampling	Unstructured interview	phenomenological explication	Trustworthiness
Phase 2 Guideline development	Develop the guidelines	4	WHO (2012) model of guidelines development					

The qualitative approach attempts to collect rich descriptive data of a phenomenon with the intention of developing and understanding the topic studied (Maree, 2016). This approach was of assistance to the researcher as it created a platform to provide complex textual descriptions of the provision of maternal mental health care services by THs in Vhembe District of Limpopo Province. Another advantage of the qualitative approach is that the researcher was able to obtain a more realistic feeling of the world that cannot be experienced in the numerical data and statistical analysis used in quantitative approach (Merriam, 2014). The current study utilized a qualitative research design which focused on how people make sense of their experiences to gain a better understanding of their social reality (Mohajan, 2018). As a result, this design was fitting as it allowed for an in-depth understanding of the unique meaning that mothers in the study have attached to their mental health. A similar study conducted by Davhana-Maselele, Lebese & Mothiba (2015) focusing on the assessment of indigenous knowledge and practices during pregnancy, labour and delivery in selected villages of the Limpopo Province used the qualitative approach. The quantitative approach was not utilized because there were no existing guidelines for provision of maternal mental health care services by THs.

4.3.1.2 Research Design

Research design is a plan of the research methodology that researchers use to conduct research (Becon-Shone, 2015). Peniel (2005) defined research design as a plan, structure, and strategy of exploring with the purpose of answering research questions. The researcher selected the explorative-descriptive research design to explore the guidelines provisions of maternal mental health care services by THs. Exploratory-descriptive research is defined as a large proportion of social research conducted to explore a topic or to provide basic familiarity of the topic (Maree, 2016). The explorative-descriptive research design was useful to conduct research on a new area being investigated or when little is known about an area of interest and used to investigate the full nature of phenomenon (Gibson, 2017). Exploratory-descriptive research design was identified to be relevant for the study since the researcher required to explore THs' knowledge on maternal mental health care services, identify maternal mental health care needs and explore the experiences of pregnant women in the provision of mental health care services by THs. The design aided the researcher to gain insight into the THs' situation (Blaikie, 2013). The researcher sought basic information on the area of interest, which focused on developing guidelines for THs in the provision of maternal mental health care services, to get acquainted with their

situation. The identified research design further assisted the researcher to gain a deeper and broader understanding about the guidelines in the provision of maternal mental health care services. Descriptive study is defined as a type of research which involves either identifying the characteristics of an observed phenomenon or exploring possible association amount of two or more phenomena (Kim & Boyd, 2017). Kowakzyke (2016) defined a descriptive study as a strategy to depict the respondents in an accurate way. The researcher provided the THs with an opportunity to describe maternal mental health care services they provide and discuss the possibility of referring pregnant women in Vhembe District.

4.3.1.3 Location of the Study

The study was conducted in the selected villages of Vhembe District located in the Limpopo Province, South Africa (Figure 4.2). Vhembe District consists of four local municipalities (Makhado, Musina, Collins Chabane, and Thulamela) (Figure 4.3). Therefore, the study was conducted in the selected villages located in the above-mentioned municipal areas. Vhembe District lies in the northern part of the Limpopo Province, and it is bordered in the east by the Kruger National Park; northeast by Botswana; north by Zimbabwe and west by Mozambique.



Figure 4.2: Vhembe District Municipality located in the Limpopo Province; Source: <https://images.mapsofworld.com/south-africa/limpopo-map.jpg>



Figure 4.3: Local municipalities in the Vhembe District, Limpopo Province. Source: <https://municipalities.co.za/map/129/vhembe-district-municipality>

There is an influx of people from Zimbabwe and Mozambique, and they depend on the health facilities of Vhembe District, thus increasing the burden on health facilities. The Vhembe District has a total population of 1 302 113 of which 81% resides in rural areas (Statistics South Africa, 2012). The main languages spoken in the Vhembe District are Tshivenda and Xitsonga with 69% of the population speaking Tshivenda, 27% Xitsonga and the remainder Northern Sotho, Afrikaans and other languages (Statistics South Africa, 2012). The traditional councils that are found in the Vhembe District are those of the Vhavenda and the Vatsonga tribes. Therefore, the study focused on Vhavenda speaking ethnic group.

Vhembe District is regarded as a semi-rural municipality because it has different locations, such as villages and townships. Most people who reside in the townships are literate unlike those in rural areas, although there is a high rate of unemployment. Some pregnant women located in the rural areas of Vhembe District rely on mobile clinics which visit their villages periodically. Therefore, a maternal mental health care service becomes a distant reality to those who live in rural areas as they cannot afford to travel to hospital on a regular basis due to the high rate of unemployment. The researcher observed that in some villages of Vhembe District, there is an influx of people visiting THs for mental health problems. Rituals and ceremonies for different events and practices are still conducted. Two TH Organizations are registered with the

Traditional Health Practitioners Council of South Africa, namely, the Vhembe Traditional Health Practitioner; and Vhangona Indigenous Health Practitioner (Traditional Health Practitioner Regulations, 2015). THs can either register as THs in one of the two local Traditional Healers Organizations.

4.3.1.4 Population

A study population consists of the entire set of individuals having some common characteristics (De Vos, 2015). The target population of this study comprised THs who provided maternal mental health care services in Vhembe District of Limpopo Province. The population chosen was among the Vhavenda ethnic group who are found in the Northern part of the Limpopo Province. The Vhavenda ethnic group reside in Vhembe District in the Limpopo Province and still honour their traditional cultural practices, including consultation with THs such as faith healers, herbalist and diviners. There are two Traditional Healers Organizations registered with the Traditional Health Practitioners Council of South Africa, namely, the Vhembe Traditional Health Practitioner; and Vhangona Indigenous Health Practitioner (Traditional health Practitioner Regulations, 2015).

4.3.1.5 Sampling and Sample Size

Sampling is defined as a procedure that the researcher follows to sample the participants of the study from the population chosen (Alvi, 2016). For this study, the researcher used non-probability sampling methods that originate in the qualitative research approach. Non-probability sampling is defined by Cresswell (2013) as any kind of sampling where the selection of elements is not determined by the principle of randomness. The researcher identified that purposive and snowball sampling types of non-probability sampling methods were relevant to select the participants (THs and pregnant women) of the study. Purposive sampling was done with a particular purpose in mind of selecting the participants that possessed the characteristics that the researcher required ((Etikan & Alkassim, 2016). This type of sampling is typically used in exploratory-descriptive research that allowed the researcher to use her own judgement in selecting cases or selecting participants with a particular purpose in mind (Neuman, 2018). Hence, the researcher used purposive sampling and snowballing to select 7 THs who provided maternal mental health care services for five past years. The researcher created space for gender balance in the number of participants selected.

The participants of the study were arranged in two categories of THs, namely, faith healers and herbalists. Gender consideration during sampling assisted the researcher to achieve gender balance in Step 3 of the process of guidelines development. The researcher requested the identified THs to assist in identifying other THs in the selected villages of Vhembe District in Limpopo Province. Snowball sampling was particularly useful for finding participants who met unusual criteria and were typically hard to locate (Groove, 2018). The advantage of snowball sampling was that it gave the researcher opportunity to find more participants for studies than would be possible by other types on non-probability sampling methods. The number of participants (THs) of the study was determined by data saturation. However, the researcher anticipates collecting data from seven THs (faith healers and herbalist) in Vhembe District of Limpopo Province.

4.3.1.6 Inclusion and Exclusion Criteria

Inclusion Criteria

Inclusion criteria specify population characteristics, and it must be present for participants or elements to be regarded as part of the study (Grove & Burns, 2019). For this study, the researcher selected both female and male THs who provided maternal mental health care services in the past five years; and who were above the age of 30 because they are categorized as professionals. The researcher has taken into consideration THs who were enthusiastic to participate in the study voluntarily and registered with the Traditional Health Organization Act. The THs participated in the study were faith healers and herbalist.

Exclusion Criteria

THs below the age of 25 did not form part of the study and those who did not provide maternal mental health care services such were not allowed to form part of the study. The study excluded THs who have not been practicing for the past five years and those who were not licensed/registered with the Traditional Health Council of South Africa.

4.3.1.7 Entry Negotiation

Prior to the commencement of the study, entry negotiation was done. The researcher asked for permission from the Traditional Healers Organization to interview their members. After permission had been granted, the researcher also went to THs to

request for their permission. After they had agreed to participate in the study, the researcher made appropriate arrangements regarding the schedule and venue for interviews.

4.3.1.8 Research Instrument

The researcher utilized a semi-structured interview guide to gather in-depth rich information from the participants (Kruger, Mitchel & Welman, 2015). Semi-structured interviews are types of interviews where a researcher has a set of predetermined questions on an interview schedule, but the interview is guided rather than dictated to by the schedule (Grove & Burns, 2019). Semi-structured interviews allowed the researcher to gain a detailed picture of participants' beliefs, perceptions or accounts about the topic being studied. Additionally, this method allowed the researcher and participants to be flexible and if participants mentioned something interesting, the researcher was able to follow-up on the information even though it was not part of the scheduled interview questions.

The research instrument contained four sections of questions asked to participants of the study. The first section focused on the socio-demographic information of THs, for example, gender, age, occupational status and marital status, number of children, level of education, etc. Socio-demographic information served the purpose of helping the researcher to determine whether the researcher was reaching the target participants as it provided information about the participants of the study. The second section comprised questions eliciting information on THs' knowledge of maternal mental health care services issues. The third section was limited to questions eliciting information on maternal mental health care needs. The fourth section covered questions eliciting information on maternal mental health care services provided by THs.

The last section delimited on questions eliciting information on THs' referral system. The researcher asked open-ended questions that provided the researcher with an opportunity to probe for more information, clarity and accurate answers when seeking information about the provision of maternal mental health care services by THs. The questions were asked in the participants' first language which they understood, thus giving all participants an equal opportunity to respond to their full potential. Data collection took place over a period of one month. The availability of participants was determined by the date and time for the interviews conducted. The interview session conducted persisted for a maximum of one hour and thirty minutes, per participant. To

maintain confidentiality of the data collected, the researcher ensured that the data were properly stored in safe place.

4.3.1.9 Pre-Testing

Pre-testing involved collecting data from a small subsample to test whether the data collection instrument for the main study was appropriate (Shaughnessy, Zechmeister & Zechmeister, 2012). The researcher administered the interview guide to a small sample of participants under conditions like those anticipated in the final administration of the study. The researcher ensured that the participants were typical of those to be included in the sample of main study. A pre-test was done with two Venda-speaking THs who provided maternal mental health care services in Vhembe District of Limpopo Province prior to conducting the main study. By conducting a pre-test, the researcher was able to identify gaps in the instrument and detect whether the questions in the interview guide would really generate comprehensive narratives and allow for probing and follow-up questions to emerge. Pre-testing helped the researcher to restructure the interview guide if the required information was not elicited. Consequently, the researcher was able to elicit requisite information from the participants by asking appropriate questions by during the pre-test.

4.3.1.10 Data Collection

Data collection involved the gathering of information from participants by the researcher using a relevant technique. For data collection in this study, the researcher used semi-structured interviews to gain a detailed picture of the participants' beliefs, perceptions and experiences about the provision of maternal mental health care services by THs (Durrheim & TerreBlanche, 2018). Semi-structured interviews provided reliable, comparable qualitative data (Breakwell, 2017). Accurate data collection was essential for maintaining the integrity of the research study (Bless, Higson-Smith & Kagee, 2015). Throughout data collection, the researcher considered the culture of the participants and the context in which they live (Cresswell, 2010; Kruger, Mitchel & Welman, 2015). Permission to use an audio recorder to record the interviews were asked from participants' prior commencement of the interviews. The researcher recorded the data and jotted down non-verbal cues during data collection.

The interviews conducted lasted a maximum of one hour and thirty minutes per participant. The questions asked by the researcher were open-ended question and the researcher used their first language which the participants understood better; in this

case, Tshivenda was the language used by the researcher during interviews with the participants. The interviews were conducted in a private room and no unauthorized persons were allowed to enter the room. The researcher followed measures for Covid-19 regulation such as social distancing, sanitizing, frequent washing of hands with water and wearing face masks. The participants were interviewed individually to safeguard their integrity (Cresswell, 2008). Data collection took place over a period of two months. Data collected analysed using forward translation because data were taken from the source language to target language (from Venda to English. Data will be stored for five years and will be accessible to supervisor and locked in a cabinet.

4.3.1.11 Data Analysis

Data analysis elaborates a process of systematically organizing, integrating, examining and searching for patterns and relationship among specific details (Neuman, 2013). During the process, researchers connect data to concepts, advance generalizations and identify broad trends or themes. The descriptive data to be collected will be analyzed using thematic content data analysis methods. Thematic data analysis involves the compilation of all the relevant notes, identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006). The task of the researcher was to identify a limited number of themes which adequately reflect textual data (Howitt & Cramer, 2011). It goes beyond simply counting phrases or words in a text and moves on to identifying implication and explicit ideas within the data. Thematic content analysis was performed through the process of coding in six phases to create established, meaningful patterns. These phases were familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining, and naming themes.

The researcher was able to catalogue the emerging codes and look for patterns in the codes. These patterns were called the main themes and sub-themes emerged from the data collected and analyzed. Some themes are grouped under much broader themes called super-ordinate themes. The final set of themes are summarized and placed into a table or similar structure where evidence from the text given to back up the themes produced by a quote from the text transcribed from participants' responses (Smith, 2011).

The researcher considered the following steps during the process of data analysis (Krueger, 2018):

Step 1

Read the text several times to acquire the overall understanding of it. Reading the text several times supported the researcher to be familiar with the data gathered from participants during interview sessions.

Step 2

The researcher went through the text again, underlying or highlighting words, phrases or sentences which were relevant to the research questions and aided the researcher to identify the emerging themes from the data analysis.

Step 3

The researcher created groups of different units of the same meaning into themes of meaning from transcriptions.

Step 4

The appropriate titles were provided by the researcher to name the themes according to the content of each theme that emerged.

Step 5

The researcher discussed the relationship of themes, thereby presenting what the whole text portrayed.

Step 6

After the final themes have been reviewed, the researchers embarked on the process of writing the final report.

4.3.2 Phase 1b: Pregnant Women

4.3.2.1 Research Approach

The researcher adopted a qualitative research methodological approach to explore the experiences of pregnant women who received mental health from THs in Vhembe District of Limpopo Province. Qualitative research refers to an approach that concentrates on qualities of human behaviour. The qualitative research takes place within the natural setting (Creswell, 2009). The qualitative approach is seen as a semi-

structured, exploratory research methodology based on small samples that provide insight and understanding of the problem setting (Agarwal & Marouf, 2016). To gain insight, the researcher needed to explore the depth, richness, and complexity inherent in the phenomenon on which the researcher aims to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour. The researcher believed that this type of method was best for the study because it gave the researcher a chance to understand the meaning and the experiences on maternal mental health care services provided by THs. The researcher was able to understand the pregnant women and gain an in-depth understanding on how pregnant women adjusted and felt about their experiences when their illnesses are being managed by THs. The main focus of this approach was to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values and experience of groups of people.

4.3.2.2 Research Design

The researcher used an explorative contextual and phenomenological research design to conduct the study. Explorative studies aid researchers to explore the topic or to provide basic familiarity of the topic (Marree, 2016). Explorative studies are undertaken when a new area is being explored or when little is known about an area of interest used to study the full nature of the phenomenon and other factors related to it (Gibson, 2017). Contextual studies are significant in qualitative research. Khair (2013) defined contextual study as carrying out research that aids the researcher to understand and explain where, how and why ideas fit into practice. The research design allowed the researcher to explore the experiences of pregnant women who received mental health care services from THs to find out the meaning, formal structure and essence of the lived experience of the phenomenon or group of people (pregnant women) with the same experiences. The researcher gave special consideration to how individual participants subjected themselves to reality. This method was applied to make the experiences meaningful (Creswell, 2010).

The phenomenological research design aided the researcher to understand phenomena on their own terms and to provide a description of human experiences as felt by the subjects, thus following their essence to emerge (De Vos, 2011). Brink & Rensburg (2012) stated that phenomenology examines human experience through the descriptions that were provided by the people involved, and it answers the “what is it like to experience this or that”. Phenomenology also focuses on aspects such as the meaning, structure, and essence of the lived experience of this phenomenon by an

individual or by many individuals (Babbie & Mouton, 2008). Phenomenology empowered the researcher to gather research information through a close analysis of the individual's lived experience. A phenomenological inquiry was appropriate for addressing meanings and perspectives of the research participants in this study. Phenomenology thus provided the researcher with an opportunity to understand how meaning is created, it was done through the description of the individual's lived experiences (Starks & Trinidad, 2007). The design was important in helping the researcher to gain access in the lived experiences of pregnant women who received mental health care services from THs in Vhembe District of Limpopo Province.

4.3.2.3 Location of the Study

A location, according to Hawkins (2018), is a place where something is situated. This study was carried out in two of the five districts of South Africa's Limpopo Province, namely, Vhembe District and Mopani District. Vhembe District Municipality is the country's northernmost district. It is a Category C municipality in the Limpopo Province's northernmost region. Through the Kruger National Park, it shares borders with Zimbabwe and Botswana in the northwest and Mozambique in the southeast. The Limpopo River valley forms the border between the district and its international neighbours. The Mopani District Municipality is a Category C municipality located within the northeastern quadrant of the Limpopo Province. It is bordered in the north by Zimbabwe and Vhembe District Municipality, in the south by the Mpumalanga Province through Ehlanzeni District Municipality, in the southwest by Sekhukhune District Municipality, in the east by Mozambique, and in the west by the Capricorn and Vhembe District Municipalities.

In Vhembe District, 10 pregnant women formed part of the study. Vhembe District is regarded as a semi-rural municipality because it has different locations, such as villages and townships. Most people who reside in the townships are literate unlike those in rural areas, although there is a high rate of unemployment. Some of the pregnant women located in rural areas of Vhembe District rely on mobile clinics which visit their villages periodically. Therefore, a maternal mental health care service becomes a faint reality to those who live in rural areas as they cannot afford to travel to hospital on a regular basis due to high rate of unemployment. The researcher observed that some pregnant women in Vhembe District consulted THs for different health problems including mental health problems.

4.3.2.4 Population

A population is made up of individuals, groups, organizations, human products, and events, as well as the conditions to which they are subjected (Welman, Kruger & Mitchell, 2005). This study's population consisted of pregnant mothers, new mothers, and general key informants. Ranjit (2011) specified that research includes human subjects of a specific population from which information to answer the research questions are obtained. There is a clear distinction between a target population and an accessible population. Botma, Mulaudzi & Wright (2015) defined a target population as the entire set or aggregation of objects, persons, behaviour or events, or any other single unit of a study sometimes called element of single unit that meet a sampling criterion. Accessible population is a portion of a target population to which the researcher has reasonable access (Grove & Burns, 2019).

In this study, the accessible target population included two groups:

The first group: Pregnant women are women in prenatal stage who received maternal mental health care services from THs.

The second group: New mothers who received maternal mental health care services from THs.

4.3.2.5 Sampling and Sample Size

Sampling is defined as a procedure that the researcher follows to sample the participants of the study from the population (Alvi, 2016). For this study, the researcher considered non-probability sampling methods used in the qualitative approach as appropriate for the study. Non-probability sampling, defined by Cresswell (2013) as any kind of sampling where the selection of elements is not determined by the principle of randomness. The researcher selected purposive and snowball sampling methods to select the participants (pregnant women) of the study. Purposive sampling was done with a particular purpose in mind of selecting the participants that possessed the characteristics that the researcher wants (Howitt & Cramer, 2011). This type of sampling is generally used in exploratory research and the researcher uses own judgement in selecting cases, or selecting participants with purpose in mind (Neuman, 2013). The researcher selected purposive and snowball sampling methods to select the participants (pregnant women) of the study. Purposive sampling was done with a particular purpose in mind of selecting the participants that possessed the

characteristics that the researcher wants (Howitt & Cramer, 2011). This type of sampling is generally used in exploratory research and the researcher uses own judgement in selecting cases, or selecting participants with purpose in mind (Neuman, 2013).

The researcher used purposive and snowball sampling to select pregnant women who received mental health care services from THs at the selected villages of Vhembe District in Limpopo Province. The study focused on pregnant women above the age of 22 and who had received mental health care from THs. The researcher requested the participants identified in Phase 1a (THs) to assist in identifying pregnant women who had received or were receiving mental health care services from them. Snowball sampling was particularly useful for finding participants who met unusual criteria and were typically hard to locate (Groove, 2011). The advantage of snowball sampling is that it helped the researcher to find more participants for the study than would be possible by other methods.

The number of participants (pregnant women) in the study was determined by data saturation. However, the researcher anticipated collecting data from seven pregnant women who received mental health care services from THs at the selected villages of Vhembe District according to criteria-specified population characteristics (Grove & Burns, 2019). For this study, the researcher selected pregnant women currently receiving or who had received mental health care services from THs; and who were above the age of 22. The researcher only considered Venda-speaking women who were residing in the Vhembe District municipality and willing to participate in the study.

4.3.2.6 Inclusion and Exclusion Criteria

Inclusion Criteria

Women who experienced conception and had given birth formed part of the study. The study considered woman residing in the Vhembe District who had received mental health from THs.

Exclusion Criteria

The researcher did not consider pregnant women below the age of 22 and who did not receive mental health care services from THs to form part of the study. Women who did not have children did not form part of the study.

4.3.2.7 Entry Negotiation

Prior to the commencement of the study, entry negotiation was done with the traditional authority to allow the researcher permission to conduct the study in the selected villages where the participants lived. After permission has been granted, the researcher arranged a meeting with the participants willing to form part of the study.

4.3.2.8 Research Instrument

The researcher utilized a semi-structured interview technique to gather data on the experiences of pregnant women/new mothers at Vhembe District of Limpopo Province. It is a type of interview which is commonly used in qualitative studies (Kruger, Mitchel & Welman, 2005). The research instrument consisted- of two sections. The first section included the socio-demographic information of pregnant women, for example, gender, age, occupational status and marital status, number of children, level of education, etc. Socio-demographic information assisted the researcher to determine whether the researcher was reaching the targeted participants as it provided personal information about the participants of the study. The last section contained questions that concentrated on obtaining information on the experiences of pregnant women in the provision of mental health care services by THs in Vhembe District of Limpopo Province. The questions used by the researcher to elicit information from the participants allowed for more questions to emerge in relation to the study objective to drive, lead and guide the discussions.

The researcher impersonated open-ended questions using the language the participants understood best to give all participants an equal opportunity to respond to their full potential. In this case, Tshivenda was the language used to facilitate the interview process with the participants. Open-ended questions provided the researcher with an opportunity to probe for more information, clarity and accurate answers when seeking information about the provision of maternal mental health care services by THs. Data collection took place over a period of one month. The availability of participants determined the time and dates for interview sessions. The interview sessions conducted with the participants continued for a maximum of one hour and thirty minutes per participant. To maintain confidentiality of the data collected, the researcher ensured that the data were properly stored in safe place.

4.3.2.9 Pre-Testing

Pre-testing involves collecting data from a small subsample to test whether the data collection instrument for the main study is appropriate (Shaughnessy, Zechmeister & Zechmeister, 2012). The researcher administered the interview guide to a small sample of participants under conditions like those anticipated in the final administration of the study. The researcher ensured appropriateness of the participants were typical of those to be included in the sample of main study. A pre-test was conducted with two Venda-speaking pregnant women who received mental health care services from THs prior to conducting the main study. By conducting a pre-test, the researcher was able to identify gaps in the instrument and detect whether the questions in the interview guide really engendered ample narratives and allowed for probing and follow-up questions to emerge. Pre-test was made with the intention of helping the researcher to restructure the interview guide if it did not elicit the required information. In this study, the outcome of the pre-test showed that the research instrument used during data collection was sufficient to produce appropriate required information related to achieving the objectives of the study and no question was modified because of ambiguity or confusion.

4.3.2.10 Data Collection

Data collection involved the gathering of information from the female THs by the researcher using a technique which is relevant to the study. For data collection in this study, the researcher used unstructured interviews (Durrheim, 2014). This method was less formal as it gave the researcher an opportunity to get to know the participants closely and gain insight into how they felt and thought (Durrheim & TerreBlanche, 2018). When implementing unstructured interviews, the researcher considered each participant's individuality (Durrheim, 2014). The interview questions focused on the experiences of pregnant women in the provision of mental health care services by THs, using an interview guide with a set of questions to guide the interview process (Appendix 4A).

The researcher asked one open-ended question using the language the participants understood best. In this case, Tshivenda was the language used by researcher to elicit information from the participants. The researcher also asked other follow-up questions to probe for more information where necessary when exploring the experiences of pregnant women who received mental health care from THs. The researcher recorded

the interviews using an audio recorder and noted non-verbal cues. Data collection took place over a period of two months. Availability of the participants determined the time and dates to conduct the interview sessions with the participants. Data saturation was determined by the number of participants to be interviewed and that occurred when the data collected were no different from the data already collected. The interview session was expected to last for one hour and thirty minutes per participant.

4.3.2.11 Data Analysis

The researcher used the phenomenological explication method of data analysis to analyze the data gathered from participants. The term explication is rooted in the verb to illuminate which concerns the process is unfolding and making clear the meaning of things. The expression explication is used in both analytic philosophy and literacy theory (Cresswell, 2009). Phenomenological data analysis methods involve the researcher reading and re-reading the data collected from participants to become familiar with the data gathered. This enabled the researcher to code data. By coding the data, a researcher was able to develop the themes and sub-themes from the data. This was of great importance for the interpretation of the results (Creswell, 2010).

The following steps adapted from Ranjit (2011) were considered by researcher when analyzing the data manually:

Step 1: Identify the Main Themes

The researcher carefully went through the descriptive responses to each question given by the participants to understand the meaning they were communicating. From those responses, the researcher developed broad themes that reflected those meanings. According to Ranjit (2011), the researcher must notice the different words and language that were used by participants to express themselves. It was important for researcher when selecting the wording of the themes in a way that accurately represented the meaning of the responses that were categorized by the emerging themes.

Those themes became the basis for analysis of the text of the interviews. Similarly, the researcher has also gone through the field notes to identify the main themes.

Step 2: Assign Codes to the Main Themes

Ranjit (2011) stated that whether the researcher assigns a code to a main theme is dependent upon whether the researcher wanted to count the number of times a theme has occurred in an interview. If the researcher decided to count themes, then the researcher should, at random, select a few responses to an open-ended question or from the researcher's observational or discussion notes and identify the main themes. In this study, the researcher read through the data and continued with the identification of themes from the same questions until the researcher reached a saturation point. The researcher assigned a code to each written theme, using keywords.

Step 3: Classify Responses Under the Main Themes

After the researcher had identified the themes, the next step involved going through the transcripts of all the interviews and notes and classifying the contents under the different themes. In this case, the researcher was able to do data analysis of the collected data manually.

Step 4: Integrate Themes and Responses into the Text of the Researcher's Report

After identifying the responses that fall within different themes, the next step involved integrating them into the text of the report. It was the researcher's choice to decide on how to integrate them. The researcher identified quotations from the responses of the participants to support the main themes identified during analysis and gave a feeling of the participant's responses.

4.4 Trustworthiness

Trustworthiness of a qualitative study can be increased by maintaining high credibility and objectivity. A research definition of trustworthiness might be: "Demonstration that the evidence for the results reported was sound and when the argument made based on the results was strong." To enhance trustworthiness of the study, the strategies defined by Lincoln & Guba (2012) were followed by the researcher. A qualitative study cannot be called transferable unless it is credible, and it cannot be deemed credible unless it is dependable. Trustworthiness was established by ensuring credibility and dependability.

4.4.1 Credibility

Credibility in qualitative research means the results of a qualitative study are believable

and trustworthy from the perspective of a participant or subject in the research itself (Brink, 2012). The researcher did member checks by probing and asking follow-up questions to the main questions after the responses of the participants. It helped the researcher to seek clarity and more detailed explanation to exclude any inconsistencies in the answers which would signify falseness. The researcher ensured member checking by going back to each participant and read to them the transcripts of their own interview to confirm the responses. Peer scrutiny of the research project by the colleagues, peers and academics was also welcomed and the feedback offered to the researcher at presentations during the duration of the study was taken into consideration for the quality of the findings of the study.

4.4.2 Dependability

The researcher ensured dependability by showing that the findings were consistent and could be repeated. Dependability was determined by checking the consistency of the study process (Lincoln & Guba, 2012). Detailed information of the methodology was provided to allow future researchers to adopt or repeat the work. The detailed information also allowed the readers of the research report to develop a thorough understanding of the methods used and their effectiveness. Supervisors of this research played a role of helping the researcher to ensure dependability by providing guidance on how to conduct the study through feedback from supervision. An auditor (expert supervisor) examined documentation of critical incidents (documents and interview notes) and products such as research findings, interpretations and recommendations and confirmed that all these products were supported by data.

4.4.3 Transferability

Transferability relates to how results or to what extent they can be generalized to other settings to show that the findings have applicability in other contexts; it is also usually equated to external validity in a quantitative study. The researcher believed that transferability can be achieved through a portrayal of the methods used to gather data. In this study, transferability was achieved by the researcher outlining the context and setting in which the research took place so that the reader can decide looking at the context if the experiences of THs can apply to them.

4.4.4 Confirmability

Confirmability refers to the degree to which the results could be confirmed or

corroborated by others. Confirmability is also similar to reliability in quantitative research. It is only possible for the result to be compared if other researchers follow the process in an identical manner. To address the confirmability issue, the researcher made sure that the findings of the research were indeed representing the reality of the impact faced by THs and pregnant women, and not the experiences or own views of the researcher.

4.5 Ethical Considerations

According to Bless & Higson (2008), ethical issues are concerned with whether the researcher's behaviour conforms to a code or a set of principles. Ethical requirements assisted the researcher to minimize the possibility of exploitation by ensuring that participants were treated with respect during and after research. The researcher observed ethics from two angles: institutional and external.

4.5.1 Institutional Ethical Consideration

The research proposal observed the following institutional ethical issues: the proposal was presented in the Department of Psychology, and it was recommended for approval, then presented before the School of Health Sciences' Higher Degrees Committee for quality assurance. It was submitted to University's Higher Degrees Committee (UHDC) for approval. Finally, it was submitted to the University of Venda Research Ethics Committee (UVREC) for ethical clearance (Appendix 1).

4.5.2 External Ethical Institution Consideration

Permission to conduct the study was sought from the relevant authorities in the selected villages of Vhembe District and THs agreed to participate in the study before commencement. The researcher was guided by the following ethics: informed consent, confidentiality and anonymity, voluntary participation and respect to ensure that the study was ethically conducted.

4.5.3 Informed Consent

The researcher obtained permission from the participants after the purpose of study had been thoroughly and truthfully explained them. The information was contained in the consent letter (Appendix 2 and Appendix 3). Participants signed the consent forms prior to starting with the interviews. Participants were told that they could withdraw from

participating in the study anytime they want to (Ranjit, 2011).

4.5.4 Voluntary Participation

Voluntarism is an approach to human agency and causality that assumes human actions are based on the subjective choices and reason of individuals (Neuman, 2011). The study only enrolled participants who were voluntary willing to be part of the study. No-one was forced to participate in the study.

4.5.5 Respect

The researcher assured respect to each participant in the research study. The researcher also showed respect through ensuring that each participant has received a full disclosure of the nature of the study, the risk, benefits, and alternatives, with an extended opportunity to ask question (Barbie, 2019).

4.5.6 Confidentiality

Confidentiality is the protection of information gathered from the participants and not made available to anyone other than the researcher (Bless et al., 2008). It implies that the data collected from the participants are kept confidential until it is published to the public through lawful ways. It is important to note that semi-structured interviews remained anonymous. The names and addresses of participants were not published in any document. Participants were informed about the duration the findings of the study may be published.

4.5.7 Anonymity

Anonymity means that people remain anonymous or nameless. The researcher did not indicate names of participants to maintain anonymity. According to Neuman (2006), researchers protect privacy by not disclosing participants' identity after the information has been gathered or obtained. Alphabets were used to represent the actual names of participants in the study.

4.5.8 Avoidance of Harm

According to Barbie & Mouton (2013), social research never injures the people being studied, regardless of whether they volunteer for the study or not. An ethical obligation rests with the researcher to protect subjects against any form of physical discomfort

that may emerge, within reasonable limits from the research project. Participants were thoroughly informed beforehand about the study's objectives.

4.6 Conclusion

In this section the researcher discussed the qualitative research approach used to conduct the study with pregnant women who received mental health care services from THs for the five past years. The researcher explained in detail the research approach, design, location of the study, population, sampling and sample size, inclusion and exclusion criteria, entry negotiation, research instrument, pre-testing, data collection, data analysis, trustworthiness and ethical considerations.

CHAPTER 5

PRESENTATION AND DISCUSSION OF THE FINDINGS

5.1 Introduction

The previous chapter presented and discussed research methods utilized to conduct the study, including measures to ensure trustworthiness and ethical considerations. This chapter presents the qualitative outcomes for Phase 1 of the study. The study focused on profiling guidelines for provision of maternal mental health care by THs in the selected villages of Vhembe District of Limpopo Province. The findings for Phase 1 emerged from THs who provided maternal mental health care services; and for Phase 2 emerged from pregnant women received mental health care services from THs. The researcher interviewed 12 THs who provided maternal mental health and 11 women who received maternal mental health care services from THs. In this chapter, the researcher expounds various themes that emerged from the data. The data collection was guided by the following objectives:



Phase 1a: Traditional Healers

- ✳ To explore traditional healers' knowledge on maternal mental health care.
- ✳ To identify maternal mental health care needs.
- ✳ To describe maternal mental health care services provided by traditional healers.
- ✳ To discuss the possibility of referral by traditional healers.



Phase 1b: Pregnant Women

- ✳ To explore the experiences of the provision of maternal mental health care by traditional healers.

The researcher collected data from THs (Phase 1a) and pregnant women (Phase 1b). The objectives in Phase 1a and Phase 1b were achieved by making use of the qualitative research approach to explore THs knowledge on maternal mental health care, identify maternal mental health care needs, describe maternal mental health care services provided by THs, discuss the possibility of referral by THs, and to explore the experiences of the provision of maternal mental health care by THs in selected villages of Vhembe District in Limpopo Province, South Africa.

5.2 Overview of Fieldwork Activities in the Qualitative Approach

The researcher used the qualitative method of data collection to gather in-depth data from participants. Semi-structured data collection in qualitative approach was used to explore THs' knowledge on maternal mental health care, identify maternal mental health care needs, describe maternal mental health care services provided by THs, discuss the possibility of referral by THs. In Phase 1a, 4 questions were used by the researcher to gather in-depth data from 7 THs using a semi-structured interview guide. The interview sessions were conducted in Tshivenda as the participants were not comfortable in speaking English due to their level of education, therefore, the researcher translated questions to ensure that participants were comfortable with the language used to collect data. Translation of questions aided the researcher to promote quality in the process of obtaining data from the participants. The data were conducted in 8 villages of Vhembe District, namely, Maangani, Mudimeli, Mukula, Tswinga, Tshikuwi, Makushu, Mangondi and Rabali.

The following questions directed the study:

Phase 1a: Traditional Healers

- ✱ What are the roles played by traditional healers in the provision of mental health to pregnant women?
- ✱ What are maternal mental health care needs?
- ✱ What kind of maternal mental health care services are provided by traditional healers?
- ✱ What are the referral systems considered?

Phase 1b: Pregnant Women

- ✳ What are your experiences of the provision of mental health care services by traditional healers?

5.3 Findings for Phase 1a (Traditional Healers)

The data collection process was divided into two categories, namely, Phase 1a: traditional healers and Phase 1b: pregnant women. The themes listed below emerged from the data collected from THs in the Vhembe District of Limpopo Province who provided maternal mental health care services:

- ✳ Traditional healers' knowledge on the provision of maternal mental health care.
- ✳ The need for traditional healers in the provision of maternal mental health care services.
- ✳ Indigenous maternal mental health care services provided by traditional healers.
- ✳ Referral systems on maternal mental health care services by traditional healers.

5.3.1 Demographic Information of the Traditional Healers

In this section, the views of the THs who provided maternal mental health care services are presented. Table 5.1 provides demographic information about the participants of the study for Phase 1a, namely, THs. The researcher sampled 12 participants using two types of non-probability sampling, namely, purposive and snowball sampling. Two of the participants were self-employed, 2 were educators and the other 8 were unemployed. The participants' areas of specialization were herbalist and faith healers. All the participants have been practicing their intervention for providing maternal mental health care services to the community for more than five years. Two of the educators had achieved tertiary level education, viz., degrees and the majority were educated up to secondary level. The researcher interviewed both female and male participants.

Table 5.1: Distribution of the traditional healers according to their demographic characteristics (Phase 1a)

Participants	Age	Occupational Status	Marital Status	Area of Specialization	Number of Years in Practice	Educational Level	Number of children
A	53	Educator	Married	Herbalist	15 years	Degree	Male
B	66	Self-employed	Married	Herbalist	28 Years	Grade 12	Male
C	43	Unemployed	Married	Faith healers	10 Years	Grade 10	Male
D	45	Educator	Married	Herbalist	14 Years	Degree	Male
E	54	Self-employed	Married	Herbalist	13 years	Grade 9	Male
F	38	Unemployed	Married	Herbalist	10 years	Grade 12	Female
G	67	Unemployed	Married	Faith healer	16 years	Grade 6	Male
H	46	Unemployed	Single	Faith healer	10 Years	Grade 7	Female
I	51	Unemployed	Single	Herbalist	11 Years	Grade 10	Female
J	47	Unemployed	Married	Faith healer	10 Years	Grade 10	Female
K	60	Unemployed	Single	Faith healer	13 Years	Grade 11	Female
L	58	Unemployed	Married	Herbalist	9 Years	Grade 12	Male

The ages of the THs providing maternal mental health care services in Vhembe District of Limpopo Province ranged from 38- over 60 years. Therefore, maternal mental health care services were provided mostly by participants who were above the age of 30 years old. This provides strong evidence that herbalists and faith healers play a significant role in restoring maternal mental health that promote a good state of optimal mental health functioning as they invest their resources, knowledge, and expertise in the provision of maternal mental health care services.

This study found that all THs providing maternal mental health care services were married and some were single parents. THs revealed that they received emotional support, love, help, and care from their family members. Furthermore, they indicated that having a spouse that supports and understand their duty as THs minimizes conflict within the family and makes them feel comfortable with their work. Therefore, the researcher found that all THs provided maternal mental health care services to the community at large in case of the women presenting to them with mental health complications.

5.3.2 Summary of the Themes and Sub-Themes (Traditional Healers)

The researcher used the qualitative phenomenological explication method to analyze the data gathered from Phase 1 participants (THs) who provided maternal mental health care services. The term explication is grounded in the verb to explicate which concerns the process of folding and making clear the meaning of things, to make explicit. The expression explication is used in both analytic philosophy and literacy theory (Cresswell, 2009). The use of the qualitative phenomenological explication data analysis method gave the researcher the opportunity to read and re-read the data collected from participants to become familiar with the data gathered. This enabled the researcher to code data by identifying main themes and sub-themes from the data analyzed (Table 5.2). Therefore, the researcher found the approach useful during the interpretation of the results.

5.3.2.1 Main Theme 1: Traditional Healers' Knowledge on the Provision of Maternal Mental Health Care Services

The WHO (2012) model to the provision of maternal mental health care services by traditional healers emphasizes the importance of integrating traditional knowledge into the health system. This integration could help improve access to maternal mental health care, ensure culturally sensitive services, and foster collaboration between

traditional and modern medical practitioners to provide comprehensive, effective care.

The main theme that emerged from the data analysis was the THs' knowledge in the provision of maternal mental health care services. When the researcher asked participants about their knowledge in the provision of maternal mental health care services, their answers were very specific.

Table 5.2: Main themes and sub-themes (traditional healers)

Main Themes	Sub-Themes
1. Traditional healers' knowledge on the provision of maternal mental health care services	1.1. Strategies to detect maternal mental health disorders 1.2. Knowledge acquisition by traditional healers in the provision maternal mental health care services
2. The needs of traditional healers in the provision of maternal mental health care services	2.1. Socio-economic support 2.2. Support systems on maternal mental health care services 2.3. Settlement of the amount on maternal mental health care services 2.4. Equipment for maintaining healthy maternal mental health care service delivery 2.5. Accessibility to natural healing resources 2.6. Collaboration with Western health professionals 2.7. Safety and security needs 2.8. Adherence of patients to mental health care services 2.9. Combination of Western and Traditional mental health care services 2.10. Deceitful traditional healers 2.11. Fsormal system to protect their knowledge
3. Indigenous maternal mental health care services provided by traditional healers	3.1. Facilities and context for indigenous maternal mental health care services 3.2. Payment for indigenous maternal mental health care services 3.3. Quality assurance for indigenous maternal mental health care services

			3.4.	Treatment utilized to eliminate maternal mental health disorder
			3.5.	Types of indigenous maternal mental health care services provided by indigenous healers
			3.6.	Prevention of child mortality
			3.7.	Provision of indigenous prenatal care
			3.8.	Provision of indigenous post-delivery care
			3.9.	Provision of indigenous paediatric care
			3.10.	Provision of indigenous birth control
4.	Referral systems on maternal mental health care services by traditional healers	4.1.	The possibility for referral to enhance quality maternal mental health care services by traditional healers	
		4.2.	Referral structures considered by traditional healers for provision of quality maternal mental health care services	
		4.3.	Motives for consideration of different referral systems	
		4.4.	Limitations associated with referrals on maternal mental health care provided by traditional healers	

For the researcher to gather rich in-depth information, probing questions were asked for clarity. Although some responses were not clear, the researcher probed further to obtain accurate answers.

Sustainable Development Goal 3 (SDG 3) aims to improve maternal health because it is regarded as critical to saving the lives of hundreds of thousands of indigenous women who die due to complications from pregnancy and childbirth each year. The WHO (2012) Guideline Development theoretical framework stipulates that the health intervention strategy should identify potential benefits and minimize harm to enhance quality health care among services users. Consequently, inadequate technical services lead to continuation of poor-quality care in traditionally modified health care interventions (Hospital and Clinic) as borne out by scientific research and knowledge integration conducted by different indigenous studies (Sofowora, 1982; Bloom, Retbi, Dahan & Jonsson, 2002; MINSANTE, 2007).

The indigenous hospital and clinic treatment only addresses a patient's biological

manifestation of the illness and does not attempt to heal spiritual aspects of illness. Place the role for indigenous medical practitioners, in contrast to indigenous modified health care intervention (Western medicine), which is technically and analytically based (Tuley, 1997; Sam & Gopalakrishnakone, 2008). The indigenous maternal mental health intervention evidenced by local populations continue to bridge the gap of poor maternal mental health care services in hospitals and clinics.

Indigenous healers utilize indigenous assessment tools/techniques as guidelines to facilitate the trustworthiness/reliability and validity to gather data for assessment criteria outcomes found in patients to be able to render quality indigenous maternal mental health care services. Therefore, the indigenous healers do not have standardized assessment criteria upfront to guide the assessment's measurable goals as compared to indigenous modified health care intervention (Western medicine). The indigenous assessment tools/techniques direct the process for provision of quality indigenous maternal mental health care services.

Therefore, lack of healing power associated with the spiritual world on indigenous modified health care intervention (Western medicine) makes most of the Vhembe population continue to consult indigenous healers. On the other hand, poor services rendered by indigenous modified health care intervention (Western medicine) practitioners with budget allocation of 40% to serve about 84% of the South African population rely on public health systems. However, a smaller percentage of 16% depend on the private sector for quality indigenous modern health care intervention (Western medicine) which serves the affluent minority (Department of Health, 2002, 2013, 2017).

Research showed that in some Asian and African countries, traditional medicine forms the primary mode of health care for 80% of the population. Edwards (2011) deliberated that research estimates that approximately 70% to 80% of the indigenous human population make use of indigenous medicine before they consult with a primary health care practitioner. Given this finding, it is important that indigenous belief systems be carefully considered when attempting to understand mental health and health-seeking behaviours in culturally diverse societies. Mashabela (2017:12) noted that with regard to healing in a diversified cultural context, there is a need for reflection on indigenous practices that pay attention to all indigenous individuals' knowledge and voices from an indigenous perspective. The innate gift among diversified indigenous healers

enables the utilization of indigenous assessment tools/techniques that reveals the unknown/revelation about the patients and evidence-based output that were observable that influence the Vhembe citizen in Limpopo Province to be able to use visual, hearing and textile dynamics of learning to identify the observable competency about indigenous healing practice. Brain (1973:120) confirmed distinct terms for ancestors as dead in contrast to living forebears. Brain observed further that gifts made to elders were not as equivalent to sacrifices made to ancestors.

THs Arts (innate gift) for the provision of the quality of indigenous maternal mental health care utilize a holistic discipline involving the use of indigenous herbalism, combined with aspects of indigenous spirituality. The studies conducted by Lebaka (2018) and Berliner (1981) noted that the belief of ancestors as an influence to have the potential power to affect the living, both for good, if they were respectfully and properly venerated, and for evil, if their veneration is neglected. These ancestors were not worshipped in the true sense of the word, but rather venerated. Imasogie (1985:) agreed with Mbiti (1970) and Willoughby (1928:89) in that 'the ancestral spirits are also the guardians of morality in the family circle'.

Lebaka (2018) implied that rituals performed by indigenous healers were not confined to the spiritual and physical healing of both the indigenous healers and their trainees during the process of dance only but also served as a resource that enhance power on the utilization of indigenous assessment tools/techniques and healing power among indigenous maternal mental health care services. Therefore, the study purpose explores the indigenous assessment tools utilized by indigenous healers to ensure trustworthiness to enhance quality indigenous maternal mental health care services delivery informed by holistic approaches founded on indigenous healing systems at Vhembe District of Limpopo Province, South Africa. The following section focuses on the sub-themes that underpin this main theme.

5.3.2.1.1 Sub-Theme 1.1: Strategies to Detect Maternal Mental Health Disorders

This sub-theme focuses on the indigenous assessment tools to promote the trustworthiness for the provision of indigenous maternal mental health care services. The findings of the study revealed that most the participants used different indigenous assessment tools/techniques to understand the underlying problem that led to stress and depression among pregnant women and new mothers were dominant on

supernatural world of the ancestors, Spirit and God that provide wisdom and guidance to facilitate the process of healing. Moreover, some of the participants articulated that referral to different stakeholders such as Clinic and Hospital, and well experienced indigenous healers were considered to ensure the trustworthiness of the indigenous assessment tools/techniques used to detect the aetiology, treatment, prevention, and effectiveness of the output among stressed and depressed pregnant mothers and new mothers.

When I assess the patient observation at the patient clothes to see if it is clean occur prior the starting a conversation like greeting and later the mother will explain further the reasons for the visit. If she came to consult, I will ask her to enter to my traditional consultation room and there are all necessities for consultation. I will start throwing bones to diagnose the causes of the problem, and treatment needed. Traditional bones (Thangu) also aided me to understand the severity of the problem with the help from my ancestors. (K)

I pray for help from supernatural powers to guide me by revealing the nature of the problem and explain the prophecy to the patient. I refer the complicated cases to hospital to make the patients understand with the evidence to be obtained from the health professionals. (H)

The findings of the study are in line with Thabede (2008) who noted that the indigenous healing and spirituality, religion, philosophy, culture, and society are interconnected as aspects of being, where all of life is a unitary field and wherein the spiritual and physical worlds are one. Merriam (1982) supported the purposeful use of music to improve our lives and asserted that 'indigenous music is functional in almost all aspects of life'. The relationship between music and dance in healing has been researched by several scholars (Berliner, 1981; Boddy, 1994; Comaroff, 1985; Gouk, 2000; Gray, 1991; Hindley, 1982; Kongo, 1999; Nzewi, 1991; 2003; Omibiyi- Obidike, 1998). Hindley (1982), Kongo (1997), Nzewi (2003) and Omibiyi-Obidike (1998) reported music and dance in indigenous healing as an accompaniment to healing rites in different parts of the African continent. Scholars of indigenous healing such as Berliner (1981), Comaroff (1985), Gray (1991), Boddy (1994) and Gouk (2000) confirmed the relative

importance of music in healing. Gouk (2000:171) confidently claimed that ‘music plays a significant role as a symbol of the priest-practitioner’s power, particularly his control of spirits and deities’. Attesting to the observations above, Madikedike Simon Sete (personal communication, 24 July 1998), senior indigenous traditional healer confirmed that the ritual is not just for entertainment purposes, but also acts as a cohesive force a healing link between the population and the ancestral realm.

5.3.2.1.2 Sub-Theme 1.2: Knowledge Acquisition by Traditional Healers in the Provision Maternal Mental Health Care Services

This sub-theme encompasses knowledge and guidance for administration of indigenous assessment tools/techniques on indigenous maternal mental health care services, purpose for implementing indigenous assessment tools/techniques among traditional maternal mental health care services provider, different types of indigenous assessment tools/techniques applied on indigenous maternal mental health intervention, minimum requirements for purchasing and administering the required indigenous assessment tools/techniques among indigenous healers and barriers for indigenous assessment tools/techniques on traditional maternal mental health care services. The findings of the study revealed five types of indigenous assessment tools/techniques useful to conduct maternal mental assessment to detect the aetiology, treatment, prevention and outcome verification among stressed and depressed pregnant women and new mothers utilizing indigenous maternal mental health intervention implemented by the participants under study. Maclellan (2001) emphasized that the goal of assessment is thus to determine strengths as well as weaknesses, so that service providers can improve instruction and provide more opportunities for achieving the expected outcomes to enhance positive output and increase self-esteem/trust during service delivery. Assessment, according to Adams (2001), involves the collection of information on what the service providers do and do not know, and their ability to apply this knowledge to enhance positive outcome.

5.3.2.2 Main Theme 2: The Needs of Traditional Healers in the Provision of Maternal Mental Health Care Services

By applying the WHO (2012) framework, the integration of traditional healers into maternal health care services can improve the accessibility, quality, and cultural appropriateness of maternal care, particularly in underserved communities. A collaborative approach that blends modern health care with traditional practices can enhance the overall maternal health experience, leading to better health outcomes and

reducing maternal mortality and morbidity.

This main theme that emerged from the data analyzed focused on the needs of THs in the provision of maternal mental health care services in the selected villages of Vhembe District Limpopo Province. In lower-resourced countries such as South Africa, the provision of maternal mental health care services is still limited by various factors such as low socioeconomic status, culture of patients, late detection of mental disorders and limited access to mental health (Lund, 2015). Consequently, THs continue to serve the community by providing maternal mental health care services with limited resources to improve maternal mental health (Gyamfi, Hegadoren & Park, 2018). Traditional health practitioners were widely used for provision of maternal mental health South Africa, but traditional mental intervention was merely tolerated and were yet formally institutionalized. South Africa had developed legislation on IKS, for example, the Traditional Health Practitioners Act No. 22 of 2007. The Act, however, still had to be implemented. There is a need to consider strengthening traditional mental health care services to protect consumers and to add value to African Traditional mental intervention.

Thornton (2009) explained concisely that human psychopathology is also caused ‘by ancestors who are the source of both misfortune and disease, but also the source of power to heal these, because the ancestors have suffered violence and death and therefore can transcend it.’ Thus, in many African cultures, a fundamental belief exists that psychopathology is due to a violation of cultural taboos or can be attributed to witchcraft (Mufamadi & Sodi, 2010; Urbasch, 2002). Furthermore, it is argued that African traditional healing involves a holistic integration of mental and spiritual guidance, herbs, nutrition, and physical therapy and is linked to African cosmology (Mufamadi & Sodi, 2010).

Many women in South Africa, and in other LMIC countries, utilize traditional mental health care services to improve their mental and physical well-being. Professional health care exposed many challenges for developing countries, such as shortage of staff, lack of accessibility, unaffordability, and perceived lack of cultural relevance (Kahissay et al., 2020). As a result, most women experience maternal mental health care challenges in South Africa, and in other LMIC countries, continue to consider THs’ services for a variety of mental health disorders and biological illness (Mokgobi, 2014; Thornton, 2009; World Health Organization, 2004). Africans existed with different

forms of traditional mental health intervention that are captured under the broad concept of traditional health intervention.

A traditional healer is 'a person who is known by the community where s/he lives as someone competent to provide health care services by using plant, animal and mineral substances and other methods based on social, cultural and religious practices' (WHO, 2000a). Traditional health intervention that has been accepted by other populations (outside its indigenous culture) is often termed alternative or complementary health intervention. Herbal treatment used include herbs, herbal materials, herbal preparations, and finished herbal products that contain parts of plants or other plant materials as active ingredients (WHO, 2008).

African traditional health intervention has been accused as lacking systematic and scientific procedures which can be replicated by others, poor documentation of methods and generally not properly researched. This research considers the challenges faced by THs in the provision of maternal mental health care services, and the implications these challenges signify for the enhancement of African indigenous mental health intervention.

The sub-themes that underpin the main theme are as follows: Socio-economic challenge, lack of support on maternal mental health care services, settlement of the amount on maternal mental health care services, equipment for maintaining healthy maternal care service delivery, accessibility to natural healing resources, working relationship with Western health professionals, fraudulent THs, and lack of formal systems to protect their knowledge.

5.3.2.2.1 Sub-Theme 2.1: Socio-Economic Support

The participants highlighted a need for financial support as a common challenge experienced by THs when rendering maternal mental health care services to patients. The participants further indicated that maternal mental health care services become a source of income that aids them to have all the required remedies to assist patients and rely on the income received from patients for survival in their families. The income generated from maternal mental care services is inadequate to meet all the needs required. The participants do not provide their services to patients for free as in the public professional health system wherein a patient receives treatment for free.

The participants indicated that they do not receive financial support to relieve the burden of purchasing the required medicine for treatment, and any form of reward in the form of salary which makes them to rely only on the income paid by patient for consultation and treatment. The findings are consistent to Maluleka & Ngoepe (2018) who noted that THs are less supported by the government despite their playing a major role in the health of the people in the country. They are exposed to different health hazards because they deal with different illnesses at times and sometimes without being paid. Because of little protection from the government, healers are exploited by some government officials who demand bribes when they find them in possession of herbs or when they try to cross the border to collect herbs or to check on their clients.

I ... require help in finance as majority of people visits us do not work and sometimes, I provide maternal mental health care services without full payment. The patient who fails to pay makes me to experience financial challenge. (L)

My family depend on my duty, and I cannot perform other job because I was chosen in my family to be a healer. Inability to pay by patients after received help make me to experience financial challenge because I do not have other source of income. (C)

Thus, the researcher asserts that the participants experience socio-economic challenges due to inadequate amounts received from patients. The maternal mental health care services require the participants to have a reliable source of income for purchasing resources needed for helping patients and at the same time become dependent on the income generated from the services rendered to community for survival. As a result, the participants disclosed concern about not having any organization or Department that compensate them for services they render to the community.

5.3.2.2.2 Sub-Theme 2.2: Support Systems on Maternal Mental Health Care Services

The participants revealed that recognition by government has not benefited them as they do not receive any funding in the form of financial support for serving the community as front-line mental health care service providers. Generating income by charging patients for consultation and treatment needed affords participants to have

some source of income. The findings are in line with Maluleka & Ngoepe (2018) who revealed that THs depended on the money they make from healing people to put food on the table. They mostly heal people and never receive payment in return. They end up finding themselves in a difficult situation because their ancestors do not allow them to turn the sick people away if they come to them without money. Consequently, they treat the people, but their families go hungry, and they end up with no money to buy herbs.

I do not understand why government legalize us because we are not funded to provide the services to the community. Those ... those people complicate our system ... they expect us to follow their route and I did not go to school. I am blessed by my ancestors to have the basic needs in my family. (A)

Excellence services provided to patients bring rewards. I have transport company that I started using money earned from traditional healing. My family depend on such income for survival. (D)

Consequently, the researcher concludes that participants do not receive any salary from Government to compensate them for their practices in provision of maternal mental health care services. Participants felt neglected by Government structures because they were only recognized and allowed to serve the community without putting mechanisms in place to compensate them.

5.3.2.2.3 Sub-Theme 2.3: Settlement of the Amount on Maternal Mental Health Care Services

This sub-theme emerged from the data analysis and focused on consultation fees for diagnosis (Thangu/prophesy) and pricing for treatment. The participants showed that all patients paid similar amounts for consultation which ranged from ZAR 100.00 to ZAR 200.00 and the measure of treatment depended on the nature of illnesses and severity. The participants further articulated that price determination was informed by ancestors and THs may not change the price. The participants narrated that sometimes they helped patients without payment and allowed them to pay later. In most such cases, the patient did not return to settle their payment after they have received help from THs. This study's findings concerning payment are corroborated by Thornton (2009), who reported that a 'sangoma is not a poor man's doctor; they

generally charge as much as a registered medical practitioner would.’ Our own research observations were that there was no formal record-keeping, and follow-ups following oral and memory patterns of managing the affairs of the healing shrine. The literature indicated that traditional healing is the most relevant route to addressing health issues for most of the population, because most people live in rural areas.

Sometimes I have zeal to patients consult with inadequate amount of money and allow them to pay late. The challenge arises when the healed patients no longer return to settle the payment. (D)

Sometimes my ancestors require me to first assist patient and pay later after having a baby. It is an instruction from ancestors that the patient pay after giving birth, but some do not return immediately or at all which negatively affect my service delivery. (F)

Therefore, the researcher concludes that the participants provided maternal mental health care services rooted in socio-cultural principles of respect and reciprocity and healers receive respect and gratitude in return for their services. However, sometimes the recipient does not return to settle the payment and THs are often rewarded with small gifts or modest amounts of money by patients.

5.3.2.2.4 Sub-Theme 2.4: Equipment for Maintaining Healthy Maternal Mental Health Care Service Delivery

The participants articulated that they experienced challenges of meeting the needs for purchasing equipment necessary for maintaining healthy maternal mental health care services. The participants showed the need for specialized traditional infrastructure for their practices, containers for storage for medication and gloves. Storage also presented a challenge as few bottles and boxes were available. Furthermore, the participants stated they did not have gloves, soap, or clean cloth and all the required equipment were scarce. The participants tried to avoid blood exposure by making use of bread bags, shopping bags and smooth sticks to apply the herbs. Usage of small sticks to apply the medicines on the cuts to ensure that do not touch the blood with bare hands was done for protection. The findings of the study are consistent with Audet, Ngoben, Mkansi, Wafawanaka, Aliyu, Kahn & Wagner (2018) who reported that healers’ exposure to patient blood have an adjusted 2.4-fold higher odds of being HIV-positive than those with no exposure and the majority expressed a willingness to

use gloves, believed they were at high risk of infection through blood exchange, and indicated fairly good relations with the local Department of Health as a potential source of gloves.

Audet, Blevins, Moon, shepherd, Pires, Vergara & Vermund (2012), and AnoAudet, Salato, Blevins, Silva, Gonzalez-Calvo, Vermund & Gaspar (2016) on the other hand showed that the potential option would be for healers to require patients to come with their own razor blades for the procedure. Healers already employ this successful strategy with the razor blades used in THs are an understudied group of health care providers that are largely unregulated, independent providers who perform health care services in the community. In sub-Saharan Africa, THs are frequently exposed to different viruses through the widespread practice of traditional injections, in which the healer performs dozens of subcutaneous incisions using a razor blade to rub herbs directly into bloodied tissue. After a long campaign by the Government, THs were encouraged to use new blades for each procedure (Ayisi, 2006).

I purchase gloves using my own money to protect myself from infections during body cutting made to protect the patient from sorcerers ... (E)

I need bottles for storage of medicine, and other equipment for processing the medication prior the provision to the patient ... (I)

Consequently, the researcher concludes that the participants were generally aware of the risks associated with blood exposure and accordingly adopted various strategies to protect themselves from infection. The participants considered healthy storage of medication to avoid contamination by making use of clean empty bottles and boxes. The also encouraged patients to bring new razor blades, wear gloves and adhere to safety storage of traditional medicines.

5.3.2.2.5 Sub-Theme 2.5: Accessibility to Natural Healing Resources

Participants conveyed that access to healing resources is a challenge as they were required to travel to other villages to gather herbs essential to treat maternal mental health challenges. The participants showed that accessibility to resources have changed over the past few years, and the legislative rules provided by the Department of Environmental Affairs, protected areas hindered THs from cultivating herbs.

Participants recently relied on purchasing herbs using their own money as they could not access areas visited to cultivate herbs and permission to access remedies involves paying traditional leaders to allow them in cultivating herbs. WHO-AFRO (2010) confirmed that none of the Africa member nations have national policies for conservation of medicinal plants and engagement in large-scale cultivation of medicinal plants in botanical gardens.

Knowledge and sustainability on herbal materials for products are collected from wild plant populations and cultivated medicinal plants. The expanding herbal product market could drive over-harvesting of plants and threaten biodiversity. Poorly managed collection and cultivation practices could lead to the extinction of endangered plant species and the destruction of natural resources. Efforts to preserve both plant populations and knowledge on how to use them for medicinal purposes are thus needed to sustain traditional medicine. Natural resources include animals, plants, air, water, soil, minerals, geographic features, and associated processes. As individual components, and as part of ecosystems, they are essential for the economy, health, and well-being of biodiversity. The Environment Act (2016) requires the 'sustainable management of natural resources to contribute to an objective 'to maintain and enhance the resilience of ecosystems and the benefits they provide'. The Act provides an iterative framework that ensures that managing natural resources sustainably will be a core consideration in decision-making.

Walking alone to bushes is scary and as a female traditional healer I cannot go to the bushes alone. I am afraid of criminals and wild animals. I rely on purchasing ingredients for healing because I cannot work without remedies. I ... only go to harvest herbs with other traditional healers. (L)

My traditional leader requires me to pay for cultivating of herbs. I was told that the nature may not be harvested for free without paying the landowners ... I ... live in his village and I must obey his instruction...(B)

Participants indicated that the money they received in the form of thanksgiving by patients helped them in purchasing remedies required in assisting patients. Participants emphasized that maternal mental health care services make them to

receive rewards from patients in the form of payment and token. Most of the time the participants do receive more than they have charged the patient. The findings are consistent with Akinawo & Akpunne (2018) who noted inadequate allocation of sufficient financial resources for implementation of traditional medicine activities; the establishment of mechanisms for the official recognition of traditional health practitioners; lack of national policies in some countries and limited national strategic plans for policy implementation; and lack of mechanisms of collaboration between practitioners of conventional and traditional medicine.

My patient pays for diagnosis and treatment ... Cash paid by my client I use to buy food and buy all resources such as wood, water, remedies needed to render the maternal mental health care services. (A)

I travel to town and other villages around to get the required herbs needed to help my patient. The payment of cash helps me to pay fuel for travelling and I also travel with other healers to minimize travelling expenses. Other healers feel happier about the provision of transport because travelling as a group is much cheaper than travelling alone to the bushes. (H)

Therefore, the researcher concludes that the quality of services provided contribute to outcome of financial resources of the THs' family as they received extra income for achieving quality output in the mental health care of patients.

5.3.2.2.6 Sub-Theme 2.6: Collaboration with Western Health Professionals

The sub-theme on collaboration with professional health workers emerged from the findings of the study. The participants revealed that they did not have a collaborative working relationship with professional health workers. The maternal mental health care services provided by THs serve independently without engaging professional health workers formally and resulted as an outcome of negative attitude of professional health workers towards traditional mental intervention. The participants complained about disrespect of the services by professional health workers. Summerton (2006) argued that Western health practitioners' critical view of traditional medicine is based on notions that perceive traditional health practitioners as posing a danger to the health of their patients. This mindset must change; interviews revealed that THs demanded

respect from their Western counterparts as well as the Government.

According to Summerton (2006), Western practitioners lack the knowledge about traditional theories of disease and health. This causes tension and stands in the way of collaboration. Mathibela et al. (2015), however, cautioned that the South African Government's health care system has had a negative impact on the practice of traditional healing, as patients consult Government health care centres before turning to THs. During such visits, some doctors in hospitals discourage patients from consulting THs for health reasons. According to Summerton (2006), Western health practitioners' critical view of traditional medicine is influenced by their lack of knowledge about traditional theories of disease and health, and this causes mistrust between the two sides. Akinnawo & Akpunne (2018) noted that there was some consensus amongst participants that the well-being of patients was of greater importance and that, like their Western counterparts, they had the best interest of their patients at heart; however, healers felt less respected by the Western doctors. They complained that some Western doctors called them witches and thought that what they did was better than what THs did.

I am not concerned about not given opportunity to share my knowledge with health workers. I ... I am also provided a training by Department of Health, but they condemn my services because they are not ready to work with traditional healers. (K)

We do not communicate effectively when referring the patient because of poor relationship we have resulted from differences in rendering the services... (J)

5.3.2.2.7 Sub-Theme 2.7: Safety and Security Needs

The participants articulated that the wealth generated from traditional intervention makes other people to be envious and they start stigmatising the participants as robust. Participants further articulated that they are viewed as thieves, witches, and false prophets. The stigma attached to participants were also experienced by their children. The findings of the study showed that participants felt that their rights were violated by some members of the community because they experienced verbal abuse and sometimes their property is destroyed. The participants have a safety challenge, especially female healers who mentioned that they become afraid to open their gates

at night for clients because they fear robbers.

The findings are consistent with Maluleka & Ngoepe (2018) who noted that, at times, criminals consult them for muti (herbs) to use for criminal activities and they found themselves in a difficult position. Furthermore, it is strenuous to work long hours at night, especially if they have a day job and are expected to report for duty the next morning. THs further indicated that they are exposed to different kinds of illnesses with limited resources and, therefore, they require the public services structure to intervene to protect THs from such illnesses and ensure the sick are treated under good conditions (Maluleka & Ngoepe, 2008). The laws passed by government on traditional healing need to be implemented and enforced. Traditional healing is harbouring criminals who continue to do their criminal activities hiding behind traditional healing. WHO-AFRO (2010) argued about the safety, effectiveness, and quality of traditional health intervention. It was revealed that there are limited research data on the safety, efficacy, and quality of traditional health intervention. The scientific evidence from tests done to evaluate the safety and effectiveness of traditional health treatment and used products and practices is limited.

My children do not want to play with other kids around the village because their father is a traditional healer. She performs well at school, at the same time other labelled her as using herbs at school to perform well. He becomes angry and beat them (angry). (G)

I am reluctant to attend funerals and weddings because I must attend wearing my traditional beads and traditional bracelets. It becomes visible to others that I am a traditional healer, and they will start moving away from me. Most of the time I remain alone and to be allowed in preparing the meals at the funerals ... (H)

Therefore, the researcher concludes that THs do not feel welcomed by some community members. They stigmatize THs by calling them different names and some do not feel safe in their homes during the night.

5.3.2.2.8 Sub-Theme 2.8: Adherence of Patients to Mental Health Care Services

Participants revealed that adherence to medication play a significant role in improving

maternal mental and physical health. The participants articulated that adherence to treatment involves following the instructions provided on how to take the prescribed medication. However, some patients failed to follow the given instruction which led to non-adherence. The findings of the study are consistent with Oxford English Dictionary (2016) that defined adherence as a steadfast commitment to a belief or practice, fidelity, devotion and strict or faithful observance of a rule or promise. The term adherence refers to a patient being committed to the recommended treatment. Rutebemberwa et al. (2013) emphasized that knowledge about proper treatment and the danger of not taking the treatment as prescribed need to be sensitized.

Ummm ... patients sometimes do not consider following my instruction and as a result their mental health do not improve because they are not adhering to medication as required. Some complain about health professionals that discourage them to take traditional medicine whereas they are not making improvement on their health. (B)

The participants showed concern of being labelled as incompetent in their work for provision of maternal mental health care services because some patients failed to adhere to medication prescribed by professional health workers without informing the TH. When patients consult with THs for help it makes the participants to be viewed as discouraging the patient from adhering to Western medication. The participants revealed that patients do not adhere to traditional treatment intervention as well and some end up disappearing without paying for the services rendered to them. Participants emphasized the desire of the patient to get treatment playing significant role to produce quality output on their maternal mental health. According to the study by Hughes, Aboyade, Beauclair, Mbamalu & Puoane (2015), that the use of traditional herbal medicines is common in Africa, and it is used to treat different illnesses. The use of treatment by patients is often unsupervised and self-managed. There can be a risk using traditional medicine to treat the illnesses due to drug interactions with other medicines. The health carer is not always informed about the patient's use of herbal medicines, and the interactions have not yet been investigated. Hughes et al. (2015) argued that it is important to inform the patients about the usage of treatment and to give the appropriate advice regarding the use of traditional treatment.

Umm ... I experience challenge with patients moving from one

traditional healer to another because they do not wait to complete the treatment, I provide to them and because of no-adherence do not improve on their maternal mental health. (E)

Hai ... if patient has desire to improve mental health is very important to adhere to all services provided without directing the service provider. Some adolescent unemployed mother loves money and think adherence will make them to be given more money by their husband and do not come to us with realistic expectations, some it becomes very difficult for such women to adhere to treatment. (L)

5.3.2.2.9 Sub-Theme 2.9: Combination of Western and Traditional Mental Health Care Services

The participants revealed that they allowed combination of treatments and patients visited them after Western intervention failed them. Participants specified that patients who visited them showed dissatisfaction with Western health intervention because it failed to deliver the services proficiently to meet the patients' needs/expectations. Although participants have trust in their health intervention, they emphasized usage of prescribed medication by Western health care providers. The findings reported above are consistent with research conducted by Watermeyer & Penn (2019) who found that patients in rural settings of South Africa often access both traditional and scientific approaches to healing: their dual belief systems correspond with their treatment seeking paths. Brandt & Rozin (2013) claimed that 'the way a society responds to disease reveals its deepest cultural, social and moral values'. Puckree et al. (2002) and Truter (2007) estimated that between 60% and 80% of South Africans exercise dual treatment belief systems; however, Indigenous healers are consulted more frequently than their Western-trained counterparts. These findings are corroborated by Thornton (2009) who reported that the traditional healer 'offers a wide range of counselling, divination/diagnostic, medical and other services'.

Ummm ... after conception sent to clinic for pregnancy test and encourage to attend antenatal care. Women go to clinic, also consult with me for treatment for protection of the pregnancy and prevention of miscarriage. (F)

I encourage women to go to clinic regularly for antenatal care. Usage of special treatment for pregnant women is available and other treatment women are advised to return for consultation after birth.

(A)

Therefore, the researcher concludes that combination of Western and Traditional mental health interventions was common among maternal mental health care users. Subsequently, the researcher deduced that both Western and Traditional mental intervention experience adulteration on traditional and Western mental health care services they provide. The researcher also assumed that patients consulted mental health care intervention concurrently.

5.3.2.2.10 Sub-Theme 2.10: Deceitful Traditional Healers

The participants revealed that some community members do not respect their practice. The participants were concerned about bogus community members claiming to be a THs with the intention to take people's money. And on the other hand, some painted competent THs as evil because of making false promises of healing the patients. The participants indicated that there is no mechanism to regulate or eliminate such kind of healers. The findings are consistent with (Maluleka & Ngoepe, 2018) who revealed that there is a serious concern amongst healers about bogus healers practising in the province. Many of these bogus healers are not even South Africans and they find it very easy to practise as healers in the country. The interviews have revealed that it was easy to obtain a certificate from the non-statutory bodies offering certificates to healers, which makes it easy for these bogus healers to operate. This makes the job of genuine healers very difficult as they are painted with the same brush when something bad that was done by a bogus healer is reported. Ebomoyi (2009) contended that fake and untrained healers is another fundamental challenge to traditional health intervention and that the widespread reported cases of fake healers and healing, though, is not limited to traditional medicine practice only.

I am not happy about people who claim to be traditional healers with intention to make money. Some people consult with us for different problems and illness. But ... some community members claiming to be a healer take their money without helping them. (K)

5.3.2.2.11 Sub-Theme 2.11: Formal System to Protect Their Knowledge

The participants revealed that fails to provide evidence by producing written document indicating how maternal mental health services were provided and their duties is not documented due to the reason that there is no formality in rendering the maternal mental health services because they receive guidance from different ancestors. Akinnowo & Akpunne (2018), reasoned in 'Poor Protection of Knowledge and Intellectual Property Rights' that there are inadequate regimes for adequate protection of traditional medicine knowledge and intellectual property rights. (WHO-AFRO, 2010) noted that there is insufficient allocation of adequate financial resources for implementation of traditional health intervention activities; the establishment of mechanisms for the official recognition of traditional health practitioners; lack of national policies in some countries and limited national strategic plans for policy implementation; and lack of mechanisms of collaboration between practitioners of conventional and traditional medicine.

I rely on the guidance received from my ancestors to help patients and to practice traditional healing effectively requires traditional knowledge and the experienced traditional healer is the one that trained me. (G)

Consequently, the researcher concludes that participants did not receive any salary on their practices for provision of maternal mental health care services. Participants only generated income by charging patients for consultation and payment for entire treatment.

5.3.2.3 Main Theme 3: Indigenous Maternal Mental Health Care Services Provided by Traditional Healers

The WHO (2012) model for Indigenous maternal mental health care services provided by traditional healers allows for a culturally sensitive, community-based, and rights-focused approach. It bridges the gap between traditional and modern care, ensuring that Indigenous women receive holistic, accessible, and effective mental health support during the critical maternal period. This main theme centres on indigenous maternal mental health care services provided by THs that emerged from the data analysis. Different types of participants utilized different assessment tools to facilitate the healing process among the stressed and depressed pregnant women and new

mothers at Vhembe District of Limpopo Province. The sub-themes that underpinned the main theme were as follows: The facilities and context for indigenous maternal mental health care services, payment for indigenous maternal mental health care services, quality assurance for indigenous maternal mental health care services, treatment utilized to eliminate maternal mental health disorder, types of indigenous maternal mental health care services provided by indigenous healers, prevention of child mortality, provision of indigenous prenatal care, provision of indigenous post-delivery care, provision of indigenous paediatric care, and provision of indigenous birth control.

5.3.2.3.1 Sub-Theme 3.1: Facilities and Context for Indigenous Maternal Mental Health Care Services

The study findings revealed that most of the participants centralized maternal mental health care services by using special indigenous rooms that served as traditional clinics for consultation and is also regarded as the dwelling for supernatural powers/spirits. Some of the participants needed more than one context such as patients' homes for rituals ceremonies and prayer services; hospital and clinics for referrals; indigenous church contexts for consultation and healing sessions to facilitate a quality healing process. The participants of the study declared that patients were not concerned about the traditional facility because it was accessible and useful to provide proper care to rural pregnant women and new mothers.

I have a specialized room for consultation ... is a special room because no one should just enter as I keep all the items such as fabric, animal leather and remedies to treat maternal mental health problem and other diseases. That is the room for my ancestors and is a special context to communicate with them. (L)

Complicated patients I refer them to hospital so that they may get drugs to calm them down and those who are very sick I recommend hospitalization because I do not hospitalize patients. I only have two rooms for consultation and a waiting room. (A)

The study conducted by Tweed (2006) revealed that the dwellings and crossings involved in excursion flows across landscapes to places and sacred objects by reflecting on his own positionality and engagement with religion. The kinetic ritual

where people engage with a landscape's inherent features and atmosphere led to an analysis of how mobile practices helped to construct apparently sacredly charged places, the power of place, and the role of landscape aesthetics in the spiritual magnetism of excursion sites (Maddrell et al., 2015; O'Brien, 2008; Mantsinen, 2020). According to Yamin (2003), health services should not only be accessible, but should include physical accessibility, as substantiated by the United Nations (2000): health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS.

5.3.2.3.2 Sub-Theme 3.2: Payment for Indigenous Maternal Mental Health Care Services

Most participants revealed that patients were charged for consultation and treatment. The participants indicated that they required upfront full payment for consultation and deposit for treatment to have the necessary resources for treatment. Some of the participants revealed that the patients paid for or purchased the necessities for treatment and were not charged for maternal mental health care services because the gift for healing was rendered for free. The study findings discovered that the participants' expenses for services were paid by clients and the participants also benefited through tokens and gifts or rewards received from patients. Thus, the participants allowed the patients to pay in instalments if they could not afford to make immediate payments. The payment was also deferred until delivery/recovery.

The findings on payment are consistent with the Traditional Health Practitioners Act No. 22 of 2007 which requires THs to be registered in order for them to be considered for payment for traditional health services prior to obtaining informed consent for the maintenance of such persons (Government Gazette, 2010). The study results concerning payment were corroborated by Thornton (2009), who reported that an indigenous healer was not viewed as a poor man's practitioner because they generally charge as much as a registered medical practitioner would. The study findings conducted by Mbwaiyo, Ndeti, Mutiso & Khasakhala (2013) revealed that the THs were expensive, the fact that they got well meant that the cost did not matter. The patients who felt that the THs were expensive said that they could pay in instalments.

5.3.2.3.3 Sub-Theme 3.3: Quality Assurance for Indigenous Maternal Mental Health Care Services

The study results revealed that the participants should have a calling, trained by well-experienced THs that serve mentors after completion of training and register with the licencing board of THs Act to enhance effective functionality for provision of quality maternal mental health care services.

I am a member of Vhembe traditional healers' association ... my grandfather discovered my calling during adolescence, and he was a traditional healer. I stayed with him until I passed Grade 12 and by that time, I was learning from him a lot of traditional healing ... I did not want to be a traditional healer, but difficulties I was experiencing required me to start with training after getting married ... it was difficult for my wife to understand... (J)

The study findings were inconsistent with those of Thornton (2009) who argued that the estimated number of THs were approximately 200,000 in South Africa and there were unregistered THs which indicated that the estimated figure of practicing THs might be an underestimation. The study conducted by Shilton, Howat, James & Lower (2001) and Farley & Clewley (2005) revealed that the traditional training make provision for a combination of attributes such as knowledge, abilities, skills and attitudes which enable an individual to perform a set of tasks to an appropriate standard. Regulation and quality assurance issues are addressed in South Africa by the Traditional Health Practitioners Act 2003, which aims to ensure the quality of the health services provided by this group. A national body has been established to set training standards and regulate entry into the profession. Professional associations of THs have been established and have been encouraged to develop practice guidelines and a code of ethics.

5.3.2.3.4 Sub-Theme 3.4: Treatment Utilized to Eliminate Maternal Mental Health Disorder

Most of the participants articulated that they utilized bone throwing, observation, and communication to understand the underlying problem that led to stress and depression among patients. The findings of the study further discovered that the participants used traditional assessment tools and the supernatural powers from the ancestors to aid with the mechanisms of supplying wisdom to detect proper herbs for healing.

I am not like church pastors ... those one uses their own things. I throw bones to be able to see and understand the way I should assist the patient and also determine if I will be able to heal the patient because some chronic illness like HIV is difficult ... Some mothers do not want to go to clinic and hospital ... (L)

The findings of the study are in line with Thabede (2008) who noted that the indigenous healing and spirituality, religion, philosophy, culture, and society are interconnected as aspects of being, where all of life is a unitary field and wherein the spiritual and physical worlds are one. The study findings are in agreement with Imasogie (1985), Mbiti (1970) and Willoughby (1928) who pointed out that 'the ancestral spirits are also the guardians of morality in the family circle', thus confirming that ancestors see to it that there is no permanent feud between earthly members of the family.

Some of the participants said that they utilized prayer and prophecy, communication, and observation to detect the underlying problem that caused the maladaptive behaviour of stress and depression among pregnant patients. The study findings discovered that the participants used prayer and traditional bath salt, water, tea, steaming, etc., to eliminate the maladaptive behaviour of stress and depression using a holistic approach influenced by culture. Consequently, traditional maternal mental health care systems treat patients holistically and do not have treatment specifically for mental health.

My patients come and join me during Sunday services and receive prophecy about their illness some report ... others I may I see on my own during prayer session and inform them ... Most of the patients come during the week for help ... the prayer helps me to get revelation of their problems and things needed to assist with healing ... (E)

Norliza (2010) noted that relationships with others determine the quality of someone's life and that failure in building good communication usually happens when people do not want to understand each other's thoughts/ideas, feel annoyed when getting a message, create further distance when communicating with others, always fail to encourage others to act. Morine's (1985) research findings showed that nonverbal communication became one of the most culturally influenced by behaviour. Thus,

taking note of nonverbal communication should be taken into consideration during the process of conducting assessment as the difference between a significant cultural role when members of one of the other language cultures learn it. Myrvoll (2010) in her study conducted in a small Sami area in Nordland stated that the healers' abilities can be regarded as heritage or a gift of grace. When conducting the healing prayer, the healer often applies prayer in combination with prophetic words. Various words were used for different diseases.

5.3.2.3.5 Sub-Theme 3.5: Types of Indigenous Maternal Mental Health Care Services Provided by Indigenous Healers

The inclusion of mental health in the Sustainable Development Goals represents a global commitment to improve maternal mental health among the highest health and development priorities for investment. LMICS such as South Africa, contemplating mental health systems scale-up are embedded in wider-universal health coverage-related health system transformations that require detailed and locally derived estimates on existing mental health system resources and constraints. Indigenous healers that utilize indigenous approaches to healing are based on the intimate connection of spirit, mind, and body. Western approaches have separate disciplines for physical maladies, mental disorders, and spiritual crises, reflecting the longstanding pattern of separating body, mind, and spirit. Physicians, psychiatrists, psychologists, and ministers have different training regimens, licensing bodies, are governed by different standards of care, and rarely collaborate in patient care. Western research is focused on the identification of laws of behaviour and functioning that are global and applicable to all cultures. Indigenous psychology challenges the biomedical foundations of Western medicine and psychiatry, asserting that variations in cosmology and socio-cultural diversity make it impossible to apply universal psychological theory to non-Western populations. (Adamopoulos & Lonner, 2001; Mercer, 2007; Suzack, 2010).

The impact of Indigenous Traditional Healing practices on the health and well-being of Indigenous People has been widely reported and recognized (Mapping the Healing Journey, 2020, Correctional Service Canada. Report 5, 2020). It is 'widely believed [Indigenous Traditional Healing] [is] the most efficacious way to assist distressed Indigenous individuals due to the inherent potency of these traditions achieved through long pre-contact histories of therapeutic refinement' (Mapping the Healing Journey, 2020:98). However, support for Indigenous Traditional Healing practices within

Western health care systems has been lacking, due in part to the history of colonization and differences in worldviews, despite various policy recommendations that have been made. The Western Biomedical Model has been prioritized over an Indigenous Holistic Model of Health and used as the main system of health care delivery to both non-Indigenous and Indigenous people in many countries, including Canada, Australia, and New Zealand. While Indigenous worldviews have embraced a holistic model of health, only recently have Western Biomedical worldviews incorporated a holistic definition (Oliver, 2013).

However, the Western biomedical Model focuses explicitly on disease and healing through scientific models, using a rational and highly mechanistic emphasis on the physical domain (Struthers Eschiti, 2005). Within the Western Biomedical Model, the rest of the whole, such as social determinants of health, are often dealt with outside of the mainstream health care system. Indigenous Peoples' holistic worldview, on the other hand, focuses on the concept of 'well-being,' which contends that the social, emotional, cultural, and spiritual aspects of an individual's health must be addressed within the health care delivery system (McLennan, Khavarpour, Koithan & Farrell, 2010). The Indigenous holistic model of health often employs Traditional Healing practices such as rituals and traditions that may be viewed as non-scientific to the Western Biomedical approach (Waldram, 2013; Nelson, 2012; Marks, 2006). Within the Western biomedical worldview, what constitutes 'scientific' is measurable therapeutic potency and outcomes of therapy, in that 'if we cannot measure it, it is not real'. However, Indigenous Traditional Healing's epistemology, philosophy, and logic have long been a system of knowledge and pedagogy understood only by Indigenous peoples. Indigenous healers are frequently hesitant to share this information for fear of exploitation (Marks, 2006). With little knowledge on how these Traditional Healing practices work within the evidence-based Western Biomedical model, the full support of these practices becomes even more challenging in mainstream health care systems (Struthers & Eschiti, 2004).

One of the strategies identified as being crucial for saving the lives of pregnant women and as an indicator for progress in the reduction of maternal mortality is the utilization of skilled birth care (Adatara, Afaya, Baku, Salia & Asempah, 2018). The current health care system is fragmented, and the pluralistic systems are operating in silos. Studies indicate that approximately 50% of pregnant women in the rural communities (LMICs) consult and prefer indigenous healers' practices over the modified scientific medicine;

however, 68% of women across developing regions receive skilled health attendant care (Amutah-Onukagha, Rodriguez & Opara, 2017; Haruna, Kansanga & Bagah, 2019; Musie, Peu & Bhana-Pema, 2019; Lane & Garrod, 2016). The poor services rendered in hospital and the lack of collaboration between the system seems to undermine the country's ability to progress in terms of the fight against the maternal mortality as indicated by SDG 5 which indicates a global need for maternal mortality rates to be reduced to less than 70 per 100,000 live births by 2030.

However, the existence of humankind is attributed to the services of indigenous healers. Indigenous healers have been rendering indigenous maternal mental health care services for decades and in many communities in developing countries, including South Africa (Adatara, Afaya, Baku, Salia & Asempah, 2018) with limited resources harvested on their own. Indigenous healers have played a fundamental role in indigenous maternal health care, long before the formalization and the recognition of midwifery as a distinct area of practice (Hernandez, Oliveira & Shirazian, 2017). Traditional midwifery is another category of indigenous healer regarded as an expert who assists the mother throughout the stages of pregnancy and facilitates the childbirth processes. This study aimed to explore functionality for indigenous maternal mental health care services provided by indigenous healers at Vhembe District of Limpopo Province, South Africa.

5.3.2.3.6 Sub-Theme 3.6: Prevention of Child Mortality

The study results discovered that the male participants were limited to fully offer pregnancy related health care services. In most cases, referrals were made to female THs. The male participants articulated that they were limited on giving advice as treating female private organs were not in line with the norms and values of society. The female participants revealed that they incorporated prevention measures for maternal and child mortality by providing treatment for mental and physical illness. Most of the participants said that traditional illnesses such as Gokhonya to avoid miscarriage, infertility, and conflict and child mortality were known to be treated by female participants.

I specialize with women ... but I also help male patients ... Many women do not know about the Gokhonya illness that make it difficult to conceive and if conception happen causes miscarriages and child mortality ... Most of women I help them ... but usually come with

stresses about the inability to have children.... some are brought by their husband or parents because many young people are not familiar with the diseases. (H)

On the other hand, Western medical practitioners never refer patients to them even when they are sitting with illnesses that they do not understand or those that require traditional healing. For example, the results of the study by Bopape, Mothiba & Malema (2013) suggested that illnesses such as hlogwana, themo/lekone, makgoma, sekgalaka and sephateare are known to be cured by THs in the Limpopo Province. Nevertheless, hospitals never consider sending patients with such illnesses to traditional healers and, as a result, healers have indicated that collaboration is one-sided because they are the ones referring patients whilst hospitals never reciprocate referrals.

5.3.2.3.7 Sub-Theme 3.7: Provision of Indigenous Prenatal Care

Several participants indicated that some women experience unplanned pregnancy, and as such, become stressed and confused. Furthermore, most of the participants articulated that prenatal care provided involves provision of emotional support, preventing complications during pregnancy and enhancing physical well-being of the pregnant mother and her unborn baby. The study findings showed that most of the participants always encouraged pregnant women to use both modern and indigenous prenatal care. Therefore, the researcher concludes that the participants value needs for collaboration between indigenous and modern health care services to complement each other for effective maternal mental health care service delivery.

She entered the traditional consultation room because I cannot talk to patients present of other people ... The traditional diagnostic tool (Thangu) helps me to examine the health of the pregnant mother and the unborn baby to get revelation on how to remove the causes/ treat the causes of poor health ... mothers require good health during prenatal. (D)

I ... I start with prayer as a way of giving comfort to the patients ... other instruction and treatment needed to eliminate the illnesses that causes poor health will appear in spirit and noted down through writing ... pregnancy special treatment are provided and some

treatment are procrastinated to be used after birth ... pregnant women are not allowed to drink some of treatment ... (L)

I am not happy about women who neglect antenatal care because of the reason that nurses do not treat them with respect ... some patients do not want to think for themselves (not happy) ... nurses they will think I am the one that influence mothers not to attend antenatal care. They ... they must go to clinic as well ... (C)

Several authors showed that some indigenous healers are also herbalists, and they administer herbs to both the mother and the newborn (Byrne et al., 2016; Mahiti et al., 2015). Another study conducted in Kenya indicated that the majority of the indigenous healers managed pregnancy complications using herbs (Kaingu et al., 2011). Hence, the role of the indigenous healers varies according to local needs and customs. The study conducted by Sang (2009) revealed that the families, TBAs and herbalists attend church. The church has women's groups that give support to the pregnant mothers; as well, the TBAs usually connect vulnerable pregnant women to these groups in the church. The women's groups also advise pregnant mothers and women on the benefits of utilizing the formal health care services. The TBAs usually refer their clients to the herbalist and formal health care providers.

5.3.2.3.8 Sub-Theme 3.8: Provision of Indigenous Post-Delivery Care

The findings of the study discovered that most of the participants educate new mothers with skills required during the postnatal period. Most of the participants indicated that they advised mothers to eat warm food to have milk for breastfeeding, taking care of newborn, indigenous newborn exercises, prepare special settings for the newborn, special items specifically for the newborn, and the use of indigenous nutritious food for feeding during infancy.

Uhmhhh ... new mothers and teenage mothers do not know how to take care of themselves and newborn babies. On the other hand, multiple roles encountered by a new mother is stressful and the mother needs assistance for handling the baby. (J)

The study findings were supported by Gilbert (2011) who stated that mothers are

encouraged to eat a well-balanced diet and increase fluid intake to improve skin integrity, gastrointestinal activity and the absorption of iron and minerals, as well as to reduce the potential for constipation and feelings of fatigue. Furthermore, the well-balanced diet encourages the flow of breast milk, which is essential to infant feeding. Nolte (2011) also stressed that to regain strength and energy, a breastfeeding mother needs a diet high in protein and carbohydrates for milk production. However, there is a need to advise the TBAs that cold food can also be a well-balanced and nutritious diet and does not stop milk production.

5.3.2.3.9 Sub-Theme 3.9: Provision of Indigenous Paediatric Care

The study results revealed that most of the participants offered indigenous paediatric care by performing traditional incisions for Gokhonya illness that inhibit child mortality. The participants said that the traditional assessment of the illnesses was done after birth and the treatment engaged both the mother and the newborn. The participants articulated that mothers with such kind of culturally related illness were also treated prior to conception to avoid infertility and miscarriage. Some of the participants conducted indigenous ceremonies to welcome the newborn baby.

I ... I take care of newborn babies' health because some illnesses may not be treated in hospital in such a way that the hospital does. Therefore, the mothers bring themselves and their babies for help to eradicate the illness such as Gokhonya as it takes the life of newborn babies. (G)

The study findings are consistent with other researchers' observations that patients still believe in THs, with the latter playing an important role in the community (Yoder, 1957; Slikkerveer, 1972; Griffiths & Cheetham, 1982; EllisUk & ufa KwaBantu, 1996). Consultation with a traditional healer and a medical doctor for the same illness is common in many cultures. Haran (1991), Azevedo, Prater & Lentum (1991), Edward (1986) and Gort (1989) revealed that the indigenous treatment provided depended on the healer. Some indigenous healers give an enema and ointment, others oral medicines and ointment, and yet others ointment only to treat culturally related illness among newborn babies. Furthermore, most of these treatments are also used in other countries and problems may occur due to an overdose of oral medicine or an enema. Ointments provided only likely to harm children when applied on fresh scarification. The findings of the study asserted that the participants considered the precaution for

not exposing the newborn babies to oral medication as it may be harmful.

5.3.2.3.10 Sub-Theme 3.10: Provision for Indigenous Birth Control

The findings of the study discovered that the participants educate mothers on indigenous ways for birth control. The participants articulated that indigenous family planning minimizes complications for failure to conceive. Consequently, the participants teach the pregnant mothers and new mother indigenous birth control methods to be able to conceive without difficulty. Some of the participants articulated that the indigenous birth control education was also educated to the spouse of pregnant mothers and new mothers. According to the Department of Health (2012:35), postnatal women are advised to use contraceptive methods immediately after delivery in order to have a chance to regain their health and give them a chance to feed their children adequately. Ngunyulu, Mulaudzi & Peu (2015) noted that THs encouraged postnatal women to delay resumption of sexual relations until the baby is at least two years of age. Delayed resumption of sexual relations serves as the most suitable and reliable method of child spacing.

Umm ... I ... I advise mothers who have difficulty to have conception with traditional ways of doing family planning. So that they will not experience difficulty with conception if they want to fall pregnant. (F)

Bleeding after birth is a challenge of many women resulted from Western family planning. I advise husband and wife indigenous ways for healthy traditional prevention method. (B)

Therefore, the researcher asserts that participants play a significant role in uniting families of married couples by performing rituals. In this case, mental health care services involve relatives of patients to form part of family rituals.

5.3.2.4 Main Theme 4: Referral Systems on Maternal Mental Health Care Services by Traditional Healers

The WHO (2012) model to maternal mental health care services by traditional healers involves creating a well-structured referral system that ensures women receive appropriate care, with clear protocols for when and how to refer, while respecting cultural practices. The system should foster communication, quality care, systematic

follow-ups, and patient-centered approaches, ensuring a holistic and integrated model of care for maternal mental health. This main theme that emerged from the data analyzed showed that the participants were attentive to referrals in their practice. The reliable referral system were other THs and professional health workers. The sub-themes that underpin the main theme are discussed below.

5.3.2.4.1 Sub-Theme 4.1: The Possibility for Referral to Enhance Quality Maternal Mental Health Care Services by Traditional Healers

The WHO (2012) Handbook for Guideline Development put emphasis on formulating recommendations from the identified gaps in health intervention as useful to ensuring that the intended guidelines strategies address poor practice or to try to change clinical programme approaches or enhance quality mental health care services that benefit the recipients. Therefore, the study conducted identified a need for referrals to overcome the barriers on traditional maternal mental health care intervention by engaging different stakeholders through referrals to provide quality maternal mental health care services. Data analyzed revealed the strengths and weaknesses of maternal mental health care services provided by THs and it was useful for them to consider referrals in their practice to enhance quality maternal mental health care services.

The gaps identified that may hinder quality maternal mental health care services were addressed by making referrals to different stakeholders. According to Zhang et al. (2017), different choices of referral systems were based on the different choices of evidence-based values and preferences when full understanding of the purpose of referral ensued. The results were merged and built up the strength of evidence that the participants were able to provide high quality maternal mental health care services through referrals. The suggestions and recommendations were valued and were designated to be used in the development of the guidelines.

5.3.2.4.2 Sub-Theme 4.2: Referral Structures Considered by Traditional Healers for Provision of Quality Maternal Mental Health Care Services

The participants explained referral as the process or steps taken by a service provider to get extra assistance for a patient with whom they directly worked. In traditional mental health intervention, there are three distinct types of referrals: referrals for rituals, special female treatment, and for biomedical treatment (surgery). The participants

indicated that the key for making referrals was to ensure that all maternal mental health patients have access to the highest possible standard of mental health care services, irrespective of where they access care in the traditional health system. Referrals benefit the maternal mental health care service provider to deliver quality care that holistically addresses the needs of patients, for example, evidence for diagnosis of HIV. In many urban and rural areas of Africa, people used to consult a traditional healer before they sought a conventional medicine practitioner (Abdullahi, 2011; WHO, 2013). According to the WHO (2013), the ratio of THs to population is 1:500 while the ratio for conventional medicine doctors is 1:40,000 in Africa (WHO, 2013). The emphasis for collaboration between THs and Western health practitioners is regarded as important since THs may improve accessibility to a health system. The Ministry of Health (MoH, 2011) revealed that effective referral also contributes to reduction of health care access inequity and better serves the needs of health services for remote rural communities. A systematic review conducted by Kok (2015) found that at the time of the review there was no evidence that functional referral affects performance, and he was not aware of papers that have come out since to demonstrate this direct link. Instead, this is likely to be an effect mediated through other factors such as supervision, capacity development through feedback and improved communication and coordination with the health system.

I refer patients for different reason that is beyond my control. I usually refer patients with complication to Traditional Birth Attendants that specialize with women who are pregnant, those who want to conceive and given birth. More experience traditional healers and modern health workers I consider them as important on helping patients that I may not be able to assist. (L)

The male participants further indicated that pregnant mothers were referred to TBAs who are regarded to have more expertise the provision of maternal mental health care services. The male participants indicated that the culture does not allow them to perform treatment that engage female private parts, such as removing Magokhonya (cells that develop on female private parts) and screening pregnancy. Female THs confirmed that they referred complicated cases viewed as beyond their control for further help.

Haja (2019) emphasized that there is a need to move from a consideration of gender

as something that can be easily patched upon existing health systems, towards a recognition that gender inequality fundamentally predetermines and shapes health systems and outcomes in ways that require essential changes. Gender inequalities and biases rooted in restrictive gender norms are also reflected in health systems. Left unaddressed, gender inequalities can weaken or even incapacitate a health system's functioning, as seen in Taliban-controlled Afghanistan in the 1990s, where female health providers were denied the right to practice, compromising health-care access and quality (Sarah, 2019).

I refer patient to hospital if do not feel better because I am not allowed to stay with patient at my home because if she dies, I am going to be in trouble ... (D)

I refer complicated cases of patient to my mentor who trained me to be traditional healer because some patient consulted with me do have major health challenges that need well experienced healer. Umm ... Yes, it is true that some kind of illnesses are difficult to treat if are not on my area of expertise. (L)

5.3.2.4.3 Sub-Theme 4.3: Motives for Consideration of Different Referral Systems

The participants indicated that the holistic approach used in the provision for treatment makes the referral process a consideration in their practices because the traditional health system lacks some of the skills, the facilities, or both, to manage complicated cases that require the biomedical perspective. Consequently, the participants do referrals to get assistance from various health providers who are better equipped or specifically trained to guide them in managing or to take over responsibility for a particular episode of a clinical condition in a patient. Therefore, the participants asserted that they implement referrals of patients to hospitals and clinics to compensate weaknesses associated with low level of education and inability to perform the scientific tests and generate reports to be able to provide quality maternal mental health care services.

A study in Zanzibar in 2012 that looked at the possibility of collaboration in the general health sector demonstrated that THs are prepared to collaborate with doctors, and doctors acknowledged that patients' mental health could benefit through the holistic

approach from THs, who often provide counselling. This holistic approach has been shown to be particularly appreciated by patients with mental health problems. THs could also offer a more culturally acceptable, less stigmatized, and more varied approach to treatment which is consistent with patient beliefs about the causes of mental illness.

I do not have some treatment that are found in modern health intervention, for example patients who are HIV-positive referred to hospital and clinic as a way of encouraging them to take their medication regularly. I ... I lack some modern health knowledge on medicine. (K)

Eee ... I have a desire to work with modern health worker to cover the lack of modern health remedies needed to assist patients. Most of patients I help referred to hospital for some checkup that require modern approach. (A)

The participants further highlighted that the referral enables them to overcome barriers during maternal mental health care service delivery by making referral to health professional that provide patient with drugs for calming down the complicated patients; provide hospitalization of weak patients that may need biomedical treatment to gain strength, and Caesarean section services in case were the patients delayed seeking help from the traditional intervention. The prescription of pathological tests in private diagnostic centres where doctors may have personal interests, is an example of this, even when 90% of pathological tests and other investigations are available in public sector hospitals (Adams, Ahmed, Shuvo, Yusuf, Akhter & Anwar, 2019; Mackintosh, Channon, Karan, Selvaraj, Zhao & Cavagnero, 2016). These practices fall within the remit of the concern for more evidence-informed referral practices, but require further specific study and policy attention. The importance of recognizing the value of THs is emphasized in The Joint United Nations Programme on HIV/AIDS (UNAIDS) recommendations for collaborating with THs on HIV, which is relevant to potential collaboration on mental health in Zanzibar (UNAIDS, 2012). The recommendations include acknowledging the status and power of THs and recognizing that traditional medicine can be more holistic. They suggest discussing openly differences, and what the strengths and failures of each group entail.

Eee ... many mothers with complicated cases were referred to hospital in order to find drugs to stabilize mood ... Afterwards the patients return back with family member and continue with traditional treatment. (J)

Furthermore, gender roles in traditional healing contexts inhibit male participants from treating female and newborn babies' illnesses and, in such cases, male participants refer patients to TBAs. The female participants revealed that traditional rules do not allow them to help patients if they are pregnant, postnatal stage and during the time of their menstrual cycle which makes them to consider referral of patients to other healers.

As the above analysis demonstrates, gender power relations play a key role in maternal health care access and utilization. Despite this, demand-side interventions and strategies fail to adequately consider and incorporate gender into intervention design, implementation, or evaluation (Elmusharaf, 2015). Understanding how gender intersects with other social stratifications can help us understand how gendered power relations shape differential needs, experiences, and outcomes both within and beyond the health system (Morgan, 2016).

I ... I ... do have co-workers who are Traditional Birth Attendants that specialize with mothers and newborn babies. I am not allowed to assist mothers with pregnancy, I ... refer most of mothers to Traditional Birth Attendants because they are competent in helping mothers and their area of expertise. (G)

The participants indicated that they facilitated the process of referral of patients to quality assure and make improvement on maternal mental health care services because the participants required the quality health intervention that meets the needs of patients. The participants expressed the key mechanism through which the setting of standards for treatment enabled them to detect possible benefits and harm. Therefore, the participants were able to show the evidence of effectiveness and cost-effectiveness applicable to the traditional maternal mental health care services to determine the possibility for referral and amend treatment protocols.

The findings are similar to Van Lerberghe (2008) and Kok (2015) who showed that the

effective referral systems from the community to the health care facility are essential to save lives and ensure both the continuum and quality of care and can influence performance in mental health care services. McCollum, Gomez, Theobald & Taegtmeyer (2016) and Munguambe (2016) in their studies revealed that when key factors to promote referral and health facility use are in place, mental health intervention can play an important role in reducing barriers to accessing health care that stem from socio-economic status, language barriers, transportation, and socio-cultural norms.

Most of HIV-positive patients deny the symptoms for HIV and prefer to be aided with the treatment of symptoms. I refer most of them to modern health care services. Second opinion gathered through referral makes me to agree with patient on the causes of illness and treatment needed. (H)

Therefore, the researcher concludes that referrals enabled the participants to create the path of maintaining appropriate balance in the provision of maternal mental health care services between resources available and those available to be able to provide adequate and effective maternal mental health care services in traditional contexts.

5.3.2.4.4 Sub-Theme 4.4: Limitations Associated with Referrals on Maternal Mental Health Care Provided by Traditional Healers

Some participants expressed a concern of negative attitudes among professional health workers that label the traditional mental health intervention as evil and unprofessional. The participants said that they felt unhappy, isolated, undermined, and discriminated against by some of the professional mental health providers. As a result, it became difficult for them to work transparently with some of the professional mental health care providers. However, the participants continued with referrals of patients to professional mental health workers to enhance quality maternal mental health care services delivery to an extent that satisfied the needs of the recipients. Another important field where an effective reciprocal referral can be seen or expected between these two kinds of care is the management of malaria as well as mental and neurological disorders (Graz et al., 2011; Flint, 2015; Bitta et al., 2019). In line with the objective of being licensed, the THs had to collaborate with nurses. For most of them it was a first time they (both practitioners) have this kind of collaboration. Both practitioners were willing to cooperate, and they had positively acknowledged the

collaboration as they learned from each from other.

These findings corroborate other studies (Peltzer & Khoza, 2002; Kaboru, 2013; Gyasi, 2018). Nurses were satisfied with the experience, especially the reciprocal referral to assess the ethnomedical evidence. Both female and male THs are faced to the same challenges, e.g., low levels of literacy, little recognition and notoriety, lack of good information, low interactions with conventional medicine practitioners (CMPs), little or no access to financial resources. However, women are more likely to encounter some of these issues compared to the men as described elsewhere (Adebo & Alfred, 2011). In this report, we noticed that regarding to their position within their association, women were somewhat under-represented in the governing body of the association. This situation may be related to the lack of self-confidence and the fact that contrary to their male counterparts, women need the support/authorization of their husbands before integrating groups or associations. Indeed, some selected women at the starting of the project later gave up since their husbands refused.

I am not happy about modern health intervention that do not accept traditional healers. I refer patient to modern health worker, but health workers critique traditional healer as if are not competent in healing patient. E ... ee ... to be labelled in a negative way condemn me because traditional healing is my calling. (I)

The participants further said that the referral to Western health care services considered on a temporary measure or a last resort. Most participants shown that the allopathic physicians do not treat them with the respect and view the traditional mental intervention as incompetent in the provision of maternal mental health care services delivery because of different views on mental health disorders. Furthermore, some of the participants received the support from professional health in the form of training on maternal mental health risks and the training provided by health professional acknowledged by some of the participants as useful on making improvement on their practice. Consequently, most of the participants had trouble on engaging health professionals formally during referrals. Two studies in Kenya found that most practitioners (including THs, faith healers and formal health care workers) were willing to collaborate, and showed recognition of the benefits of collaboration (Mbwayo, Ndeti, Mutiso, Khasakhala, 2013 & Musyimi, Mutiso, Nandoya, Ndeti, 2016).

On the other hand, Western medical practitioners never refer patients to them even when they are sitting with illnesses that they do not understand or those that require traditional healing. For example, the results of the study by Bopape, Mothiba and Malema (2013) suggest that illnesses such as hlogwana, themo/lekone, makgoma, sekgalaka and sephate are known to be cured by THs in the Limpopo Province. Nevertheless, hospitals never consider sending patients with such illnesses to healers and, as a result, healers have indicated that collaboration is one-sided because they are the ones referring patients whilst hospitals never do any referrals.

Health workers do now show respect to me as traditional healers and it becomes difficult to work with them. After referring my patient to hospital, I do not want my patient to disclose to health workers because will discourage them to take remedies from traditional healers. (E)

Most of the participants highlighted that there is a lack of collaboration between two different spheres that provide maternal mental health care services delivery as a challenge because do not complement each other. Rather, the health professional put more emphasis on transforming the traditional intervention to adopt western strategy that is not applicable to the participants intervention because of spiritual domain encountered by healers during the process of maternal mental health care services delivery. In many urban and rural areas of Africa, people used to consult a traditional healer before they seek for a CMP (Abdullahi, 2011; WHO, 2013). According to the WHO, the ratio of THs to population is 1:500 while the ratio for conventional medicine doctors is 1:40,000 in Africa (WHO, 2013).

Therefore, there is a critical need for a collaboration between traditional medicine (TM) and conventional medicine (CM) since THs may improve accessibility to a basic health care in the rural areas of sub-Saharan Africa (van den Geest, 1997; Moshabela et al., 2017). The collaboration of CM and TM healers has been noticed and acknowledged throughout Africa with the role of the latter in the management of HIV/AIDS pandemic, especially the opportunistic infections related to AIDS (Mbwambo et al., 2007; Innocent, 2016; Moshabela et al., 2017). Conventional medicine practitioners and THs are also willing to cooperate about bone setting, a traditional medical knowledge related to a traditional orthopedic practice (Amzat & Razum, 2018; & Krah et al., 2018).

I do not work in partnership with health workers because I cannot go to them formally and discuss the patient problem. The problem with health workers always warrant themselves more competent than traditional healers. (L)

5.4 Findings for Phase 1b (Pregnant Mothers)

This section focuses on the presentation of findings for Phase 1b (Pregnant Mothers).

5.4.1 Demographic Information of the Pregnant Mothers

Table 5.3 summarizes the demographic information of the participants (pregnant mothers). The researcher conducted unstructured interviews with 12 participants who received maternal mental health care services from THs for the past five years in the Vhembe District of Limpopo Province. The participants were aged between 25 and 50 years. Eight participants were unemployed and three were employed.

Table 5.3: Demographic information of the participants (pregnant mothers)

Participants	Age	Employment Status	Gender	Educational Level	Marital Status
A	43	Unemployed	Female	11	Married
B	36	Unemployed	Female	9	Married
C	34	Employed	Female	12	Married
D	38	Employed	Female	10	Married
E	31	Unemployed	Female	Diploma	Married
F	41	Unemployed	Female	10	Married
G	34	Unemployed	Female	9	Married
H	51	Employed	Female	12	Married
I	48	Self-employed	Female	Degree	Married
J	42	Self-employed	Female	12	Single
K	28	Self-employed	Female	11	Single

All the participants were married with children. Six participants interviewed showed a low level of academic literacy which resulted from school dropout, and only one participant achieved a higher education qualification. All the participants received

maternal mental health care services from THs. Regular traditional intervention users in most of the studies were women with no formal education and low income. This may be caused by the fact that most women living in rural villages in Africa have less opportunity for education and employment (Park, 2013). This may, in turn, limit women's knowledge about available health care options outside of traditional and cultural health practices. Additionally, some African women experience limited autonomy as compared to their male counterparts who may be responsible for making decisions concerning the women's health care choices and well-being (Adams, Sibbritt & Lui, 2011; Shabaya & Konadu-Agyemang, 2004).

African women may also embrace traditional beliefs and practices that influence their use of TM as a maternity health care choice. For instance, they trust the knowledge of TBAs, and prefer their care and expertise to the treatment that they receive from midwives in hospitals and clinics (Princewill, Jegede, Nordström, Lanre-Abass & Elger, 2016).

5.4.2 Summary of the Themes and Sub-Themes (Pregnant Mothers)

The researcher used the qualitative phenomenological explication method of data analysis to analyze the information gathered from pregnant women who for the past five years received maternal mental health care services from THs. The term explication is grounded in the verb to explicate which concerns the process of folding and making clear the meaning of things, to make explicit. The expression explication is used in both analytic philosophy and literacy theory (Cresswell, 2009). By making use of qualitative phenomenological explication data analysis methods, gave the researcher opportunity of reading and re-reading the data collected from participants 'as to become familiar with the data gathered. This enabled the researcher to code data by identifying main themes. By coding the data, the researcher developed the themes and sub-themes from the data analyzed. Therefore, the researcher found it useful during the interpretation of the results. The objective of Phase 1b was to explore the experiences of pregnant mothers in the provision of maternal mental health care by THs. The researcher asked open-ended question to participants and responses emerged focused on negative and positive experiences on maternal mental health care services provided by traditional mental health care providers. One main theme and 8 sub-themes emerged from the findings of the study (Table 5.4). The main theme concentrated on experiences by pregnant women in the provision of maternal mental health care services, benefits for quality maternal mental health care services received

by mothers from THs, and strategies used to eliminate maternal mental health challenges by THs.

Table 5.4: Main theme and sub-themes (pregnant mothers)

Main Theme	Sub-Themes
1. Experiences of pregnant women in the provision of maternal mental health care services, benefits for quality maternal mental health care services received by mothers from THs, and strategies used to eliminate maternal mental health challenges by THs	1.1 Fear of evil spirits 1.2 Socio-economic challenges 1.3 Accessibility 1.4 Obedient to adult instructions 1.5 Enhance prenatal and neonatal well-being 1.6 Learn restriction on consumable food 1.7 Waiting period in hospital 1.8 Source of emotional support

5.4.2.1 Main Theme 1: Experiences on Maternal Mental Health Care Services Provided by Traditional Healers

The main theme emerged from the study focuses on experiences of maternal mental health care services. The sub-themes mentioned below underpin the main theme.

5.4.2.1.1 Sub-Theme 1.1: Fear of Evil Spirits

The participants indicated that they feared being attacked by evil spirits during pregnancy because the supernatural evil spirits are believed to cause serious pregnancy-related complications such as miscarriage, abnormal appearance of the baby in the uterus, deformed baby, death of a baby, and the death of the mother. Similarly, in other studies, it was indicated that the culture and beliefs of the communities influenced and underpinned the traditional health-seeking behaviour of a woman during pregnancy (Aworinde, Olufemi-Aworinde, Awotunde & Adeniji, 2019; Zerfu, Umeta & Baye, 2016).

It was also discovered that when indigenous practices were used by the people of the former Transkei, pregnant women in this rural area depended on the natural plant resources of their environment for medicine; food; and pastoral, cultural, and religious care, during pregnancy (Bhat, 2013). Other authors confirmed that indigenous traditional healing medicinal plants contribute significantly to a large portion of the

South African population that lack easy access to health care services, and that these medicinal plants are found in the informal marketplaces (Makunga, Philander & Smith, 2008).

Eee ... I am afraid of sorcerers. Sometimes during pregnancy, I consult with traditional healers because I am afraid of being possessed by evil spirits. In hospital, nurses do not talk about traditional illnesses caused by evil spirits. It is my own responsibility to consult with a traditional healer ... I ... want safety during pregnancy. (B)

5.4.2.1.2 Sub-Theme 1.2: Socio-Economic Challenges

Most of the participants indicated that they did not earn a salary and the salary of the husband is low so they frequently did not have money for consultation. Consequently, most mothers resorted to THs because the price was affordable. Some participants articulated that clinics and hospitals focused on modern related illness. Contradictory to the findings of this study, other researchers found that the users of traditional medicinal plant products are more likely to be of low socio-economic and educational status because they can afford to pay for them. This is in contrast to Western medicinal products, which are expensive (James, Wardle, Steel & Adams, 2018). These researchers further stated that the formal natural products benefited those people with better socio-economic standing, more so than the informal products, which benefit people of low socio-economic status.

I benefit from traditional healers because I can afford, although I am earning low income unlike with modern health care wherein to get their services, I have to first pay a lot of money that I do not have because I am unemployed and every time when I consult with modern health care I have to pay for better services. With traditional healers I do not pay for checkup as all the money paid at the initial stage covers everything. (K)

5.4.2.1.3 Sub-Theme 1.3: Accessibility

Most of the participants said that they found it difficult to access maternal mental health care services and they were not referred for counselling. The maternal mental health

care services became a distant reality to them because they did not know the process to be followed to access the mental health care provider in clinics and hospital. Participants further revealed that maternal mental health care services rendered by THs were located around villages and they were not required to travel to access the services. The traditional maternal mental health care service providers were always readily available to provide care and support to patients. Participants revealed that they did not make appointments to be able to access maternal mental health care services provided by THs. Other authors also confirmed that indigenous intervention contributed significantly to a large portion of the South African population that lacked easy access to health care services, and that these remedies were found in the informal marketplaces (Makunga, Philander & Smith, 2008). This study has shown that traditional intervention was used during pregnancy regardless of pregnant women's general awareness, knowledge, and perceptions, as well as their ages, gravidity, level of education, and employment. These findings were consistent with previous research, which found that pregnant women with low education, low income, and who lived far from health facilities were much more aware of traditional interventions used during pregnancy than those with a high level of education and income (Gaede & Versteeg, 2011).

I know her and I stay with her in my village. She always helps me with different problems I experience, and I never had anyone talking about my challenges. (A)

I leave the house as if I am going to church. I do not tell anyone for consultation with my pastor for maternal mental health care services. I walk for thirty minutes to reach the destiny. (F)

I am staying far from hospital, and I must pay transport for consultation. It is difficult for me because I am not working, and I arrive late at hospital due to transport problem. (G)

5.4.2.1.4 Sub-Theme 1.4: Obedient to Adult Instructions

Some of the participants revealed that health workers do not treat them with respect and emotions of patients were not taken into consideration because they shouted and laughed at pregnant women during antenatal care visits in clinics and hospital. Seeking

emotional support was a challenge for the participants because of negative attitudes of health workers at the clinics and hospitals. Therefore, mothers consulted with THs as an instruction from elderly people from home that guided them on what to do during pregnancy. New mothers who were pregnant for the first time knew about the same traditional intervention products, and this was confirmed by another study that yielded similar findings: the use of traditional medicinal products by pregnant Zimbabwe women was not significantly associated with null parity and null gravidity (Mureyi, Monera & Maponga, 2012). This resulted in pregnant women having to rely on advice from elderly women in the community as well as from traditional health practitioners about the health products used during their pregnancy.

I do not like it when a health worker discloses my age to other women who attended antenatal clinic and it is true that I conceived my first child at the age of 14 ... umm ... I felt I cannot discuss my problem with health workers because always call me names. (E)

I went to hospital for pregnancy-related illness, and I was above the age of 40. I was not happy when health workers discussed and laughed at me Asking questions that are not related to the purpose of the visit. My mother-in-law identified the traditional healer that I should consult with if I encounter challenges during pregnancy. (H)

I am not comfortable about the disclosure of my illnesses in front of another patient. I felt disrespected when talking among themselves as health workers about the nature of my illness. (J)

I became pregnant at earlier stage, and I was treated like a useless person, not respected because I was adolescent at that time. I did not enjoy attending antenatal clinic and for other challenges. (G)

5.4.2.1.5 Sub-Theme 1.5: Enhance Prenatal and Neonatal Well-Being

Most of the participants used traditional health medicines to protect the mother and the baby from any perceived causes of ill-health that could affect them physically, psychologically, spiritually, or socially. Such products included holy water, cord prayed

for, herbal decoctions, traditional illness treatments (diarrhoea). According to Peltzer & Khoza (2002), an egg of a slaughtered hen would be broken on the head of a pregnant woman so as to release the woman from any magic and evil spirits that were attacking her and the baby. All pregnant women have the same desires and concerns for a healthy and safe pregnancy. The researchers also discovered that pregnant women avoided eating rodents, snakes, and snails for fear of the baby crawling on their chests, as well as avoiding stealing when pregnant to avoid the infant being kidnapped (Aworinde, Olufemi-Aworinde, Awotunde & Adeniji, 2019). Similar observations were made in Ghana where there were prohibitions such as not strolling near graveyards, not going out at specified times of the day, and not mingling with people who were considered to be wicked (M'Soka, Mabuza & Pretorius, 2015). Also reported regarding maternal health practices, beliefs, and customs in Southeast Madagascar was the fact that pregnant women did not consume anything bitter, to prevent the baby from having stomach cramps and the pregnant women from experiencing heartburn (Morris, Short, Robson & Andriatsihosena, 2014). Religious beliefs and practices, as indicated in this study, were reported to be playing an important role among pregnant women in Ghana, who did not believe in traditional herbs; instead, they consulted faith-based healers who gave them 'some stuff' and prayed for it to be used during pregnancy (Aziato, Odai & Omenyo, 2016).

Nurses do not consider traditional disease that I was concerned about and as such I went to a traditional healer for help to promote good health for me and my unborn baby. Traditional intervention referred me to traditional birth attendants if she cannot assist. At clinic, nurses just keep quiet about indigenous illnesses. Consequently, I consult with traditional healers, although they discourage that at clinics to benefit myself. (I)

5.4.2.1.6 Sub-Theme 1.6: Learn Restriction on Consumable Food

Most of the participants reported that during pregnancy, there were restrictions on food, water, and clannish rituals. They used the Holy Bible, anointed oil, blessed water and stickers during their pregnancy. To be present in within the same community that observed its culture and custom did not make everyone within that community obey the culture and tradition. There were also mothers, as much as they existed within the same community of the study, who were not clear about the traditional practices used during pregnancy. This lack of knowledge was due to different belief systems that

people had; those who were inclined in Western medicinal practice would disregard traditional practice and vice versa. Participants reported restrictions on fatty food, fizzy drinks because they cause heartburn, and giving birth to a baby with discharging eyes. The same observation was made in Zambia, where pregnant women believed having a balanced diet such as eggs, okra, bones, offal, sugar cane, and salt was associated with giving birth to healthy babies.

In faith healing, I steam, bath and smear oil to chase away evil spirits. I was given a traditional product that is different to those who were not pregnant to protect myself and the unborn baby. In faith healing at church, those who are pregnant selects to be given anointing oil, pen, bath water and other prayed products to use at home. I am prohibited to eat eggs and other food during pregnancy. (I)

5.4.2.1.7 Sub-Theme 1.7: Waiting Period in Hospital

The current study discovered that some participants preferred traditional maternal mental health care providers because they did not have to wait for assistance for a longer period as compared to a hospital waiting periods are prolonged in different sections prior the consultation with the health workers. Some of the participants indicated that they sometimes left the hospital without having been assisted because they resided in rural areas and transport to return back was difficult to find during late hours. The participants from rural villages resorted to traditional maternal health care services.

I do not have to spend the whole day to receive help form a traditional healer unlike in clinics and hospital where there is a lot of patients. (H)

I make appointment that suit my schedule for consultation and different from hospital because employees will not assist me if I arrived late because of long que of patient looking for help. Within thirty minutes of my arrival for consultation, I can receive maternal mental health care services immediately without long waiting period because he assists patient with respect. (E)

I prefer a traditional healer's intervention because she does not leave me unattended, going for tea and lunch time like in clinic. Sometimes nurses do not pay attention to patients during consultation, and I can spend five hours to receive help which makes me to resort to traditional healers for help. (G)

Thus, the researcher concludes that the participants did not experience long waiting periods during their consultations with THs to get maternal mental health care services. The THs' services were scattered around villages and readily available to serve the participants. Hence, the participants received care immediately, unlike in hospitals and clinics where they can spend the whole day and return for consultation after making appointment.

5.4.2.1.8 Sub-Theme 1.8: Source of Emotional Support

The current study findings showed that THs gave pregnant mothers emotional support in times of distress; feeling low, isolated, lonely, fatigued; and having suicidal thoughts. The participants articulated that THs provide emotional support that gives comfort and treatment to overcome the barrier of poor maternal mental health.

I talk to my traditional healer in time of distress ... he comforts and encourages me all the time during consultation. (A)

Prior the consultation with my traditional healer, I was always thinking of killing myself because of the challenges I was experiencing ... she gave me support I needed to feel better... (K)

He encouraged me not to give up in trying to make a baby and I am happy now because I have two children. (F)

I used to feel low, isolated, and angry ... After consultation with my traditional healer, my problems got resolved ... If I encounter a problem, I consult with him for help. (G)

Thus, the researcher asserts that the participants relied on THs for quality emotional support in times of distress and it helped the participants to achieve optimal mental

health to cope in their daily functioning.

5.5 Conclusion

This chapter highlighted the findings of the study that emerged from the data analyzed. The study focused on profiling the guidelines for provision of maternal mental health care services by THs at the selected villages of Vhembe District in Limpopo Province. The data collection consists of two phases. Phase 1a represented data collected from THs and Phase 1b data collected from pregnant mothers. Data collected from both phases were analyzed and presented separately.

CHAPTER 6

DEVELOPMENT OF THE GUIDELINES

6.1 WHO Guideline and Qualitative Approach

The researcher applied the globally accepted WHO Guideline Development Process to develop effective clinical guidelines (WHO 2012).

6.2 Objective

The objective of Phase 2 of this study was to develop guidelines for provision of maternal mental health care services by THs in Vhembe District of Limpopo Province.

6.3 Introduction

The findings of the study on the provision of maternal mental health care services in that were reported in Chapter 5 revealed the need for the development of guidelines for such services in Vhembe District of Limpopo Province. This need became apparent from the findings that emerged from the qualitative data collected through semi-structured interviews with THs and unstructured interviews with pregnant and new mothers at the selected villages of Vhembe District. Participants were women who had accessed mental health care services provided by THs. The results of Phase 1a revealed four main themes related to the above, namely, THs' knowledge on maternal mental health care, maternal mental health care needs, maternal mental health care services provided by THs and the possibility of referral by THs when rendering maternal mental health care services. Phase 1b focused on the experiences of pregnant and new mothers who received maternal mental health care services by THs. An important finding was the poor modern maternal mental health care services available which led to consultation with THs. Thus, the objective of the work described in this chapter was to profile the guidelines for provision of maternal mental health care services by THs.

The researcher decided to develop the guidelines based on the four main themes identified, and the thematic facets that led pregnant and new mothers to seek help from THs, as evidenced by high maternal mental health problem rates. The development of the guidelines was in accordance with the principles set out in the “WHO Guideline Development Process” (2012:4). The approach uses 10 steps to profile the guidelines for provision of maternal mental health care services by THs to provide quality maternal mental health care services associated with positive maternal mental health outcomes. It also used WHO’s PICO model (Population, Intervention, Comparator and Outcomes). A systematic literature search was conducted, and a review of the evidence undertaken. The certainty of the evidence on safety, effectiveness and satisfaction was assessed using the Grading of Recommendations, Trustworthiness, Development and Evaluation (GRADE) approach (WHO, 2014). This chapter has two main parts. The focus of the first part is to describe the process of the profiling the guidelines, as well present the results. The focus of the second part is on the study that was carried out to ensure trustworthiness of the developed guidelines.

6.4 The WHO Guidelines Development Model

6.4.1 Overview of the Guidelines Development Process

Phase 1 and Phase 2 of the study were channelled by the structure of the Guidelines Development Process outlined by WHO (2012). The guidelines development process used in this study is summarized in Figure 6.1.

6.4.1.1 Selecting the Topic

Phase 1 of the study was the empirical phase that focused on the research methods the researcher used to conduct the study. Phase 1 of the study was informed by Step 1 of the WHO Guideline Development Process which focused on selecting a research topic. The research topic selected concentrated on developing guidelines for provision of maternal mental health care services by THs in the selected rural communities of Vhembe District in Limpopo Province. Step 1 provided the researcher with the opportunity to explore THs’ knowledge on maternal mental health care services, identifying maternal mental health care needs, describing maternal mental health care services provided by THs, discussing the possibility of referral by THs, and exploring the experiences of pregnant and new mothers on the provision of mental health care services by THs.

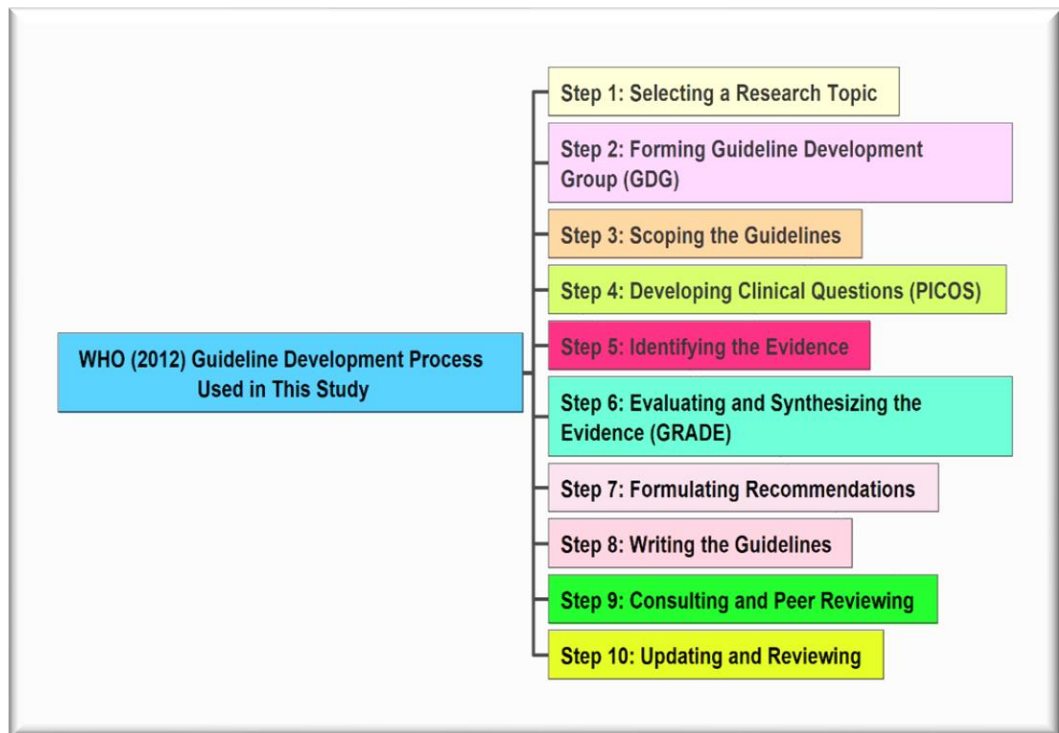


Figure 6.1: WHO (2012) guideline development process used in this study

The researcher selected the study topic under the supervision of three National Research Foundation (NRF)-rated researchers. The topic was ‘Guidelines for Provision of Maternal Mental Health Care Services by Traditional Healers in Vhembe District of Limpopo Province’. It is anticipated that the profiled guidelines may be used as a basis for the development of local protocols and guidelines which consider maternal mental health care provision and the need to improve quality of care to pregnant and new mothers accessing maternal mental health care services provided by THs.

6.4.1.2 Forming a Guidelines Development Group (GDG)

The Guidelines Development Group (GDG) is a small group of multidisciplinary experts of Indigenous Knowledge Systems (IKS) that have sufficient knowledge and experience to explore the topic. The group comprised 8 experts to facilitate interaction; 3 supervisors; 2 pregnant women; 2 THs; and 1 social worker. The Vhembe District was selected because of the high rate of pregnant and new mothers experiencing maternal mental health challenges and consulting THs for mental health care services. The experts selected using purposive sampling in the selected villages of Vhembe

District, Limpopo Province. Emails, telephone calls and meetings were also considered to increase the efficiency in profiling the guidelines. In this study, the outstanding team of THs and pregnant/new mothers participated in the working group that produced the final version and ensured trustworthiness of the guidelines. The process of integrating values and preference guidelines development is shown in Figure 6.1. The guideline recommendations were formulated based on the evidence from literature, study results and preferences, e.g., evidence on the balance between benefits, harms and cost (Zhang et al., 2017:138).

The researcher used the Delphi Technique's step-by-step guide to come up with the GDG to ensure trustworthiness of the guidelines to be profiled (Figure 6.2). The Delphi technique abetted the researcher to indicate the communication process and methods to be followed to achieve a consensus associated with the specified topic.

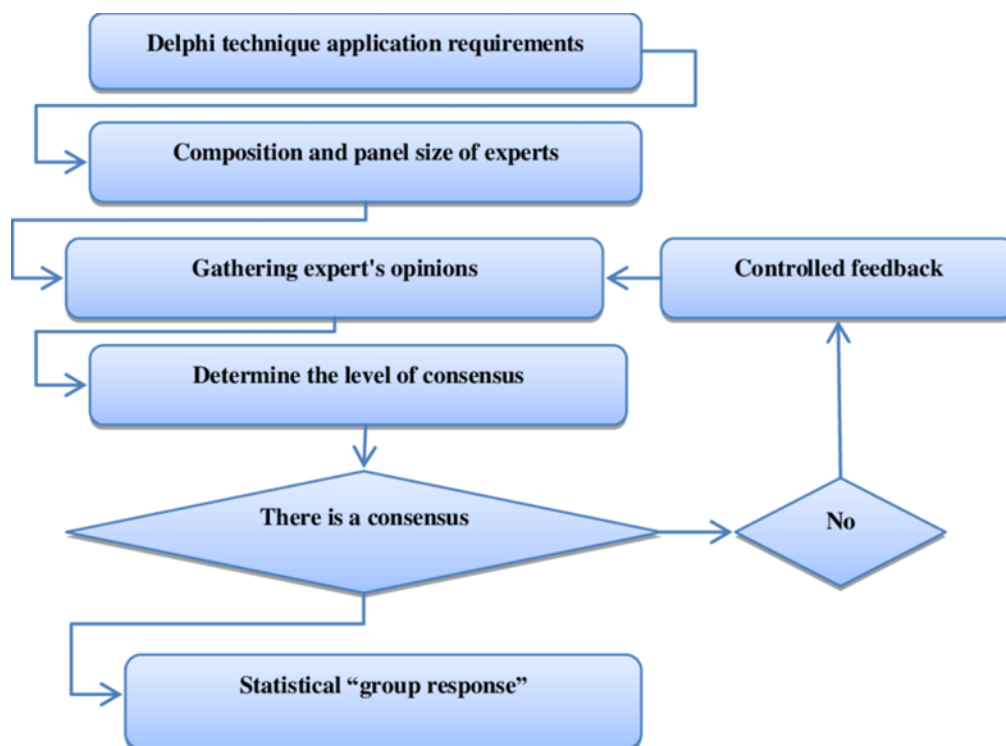


Figure 6.2: The Delphi Technique: A step-by-step guide

⊕ **Step A: Composition and Panel Size of Experts**

According to WHO (2012) model, the group should be small enough for effective group interaction, but large enough to ensure adequate representation of relevant views.

WHO stipulates that a group of 8 to 20 is usually feasible and affordable. Its further highlights that the GDG should be balanced. The researcher considered gender and geographically balanced group members from different regions that are likely to use the guidelines. The researcher gathered the group of experts involved in the problem. The GDG were constituted as follows:

The recipient	Two pregnant/new mothers who received mental health care services from traditional healers.
Implementers of the guidelines	One male traditional healer who provided maternal mental health care services. One female traditional healer who provided maternal mental health care services.
Promoters	Three supervisors (One promoter and two co-promoters)
Research Assistant	One (Scriber)

The GDG were selected from different municipalities of Vhembe District in Limpopo Province. The researcher selected Venda-speaking THs and pregnant/new mothers. The researcher conducted face-to-face and online meetings with the GDG to present the guidelines with intention to collect requisite guideline propositions.

✚ **Step B: Gathering of the Expert's Opinion**

The GDG has been established on the rationale that more heads are better than one and that inputs generated by experts based on their logical reasoning are superior to simply guessing. The technique engages a group of identified experts in detailed examinations and discussions on a particular issue for the purpose of policy investigation, goal setting, and forecasting future situations and outcomes. The Delphi technique attempts to ensure trustworthiness on what could or should be (Hsu & Sandford, 2007). The researcher had face-to-face and online meetings with the GDG and presented the profiled guidelines to determine consensus. The researcher assistant aided in recording the recommendations.

Step C: Determination of the Level of Consensus

The researcher selected experts whose central task was to come up with evidence-based recommendations. The feedback from the supervisors and data collected/suggestion noted during the meeting were analyzed to determine the level of consensus achieved. The researcher planned to conduct a maximum of two meetings with the GDG to achieve consensus.

Step D: Consensus

In case where consensus was not achieved, the researcher arranged face-to-face meetings with GDG to give feedback and collected data that benefited addressing gaps identified from the previous meeting.

Step E: Group Response

After achieving consensus in group response, the researcher concluded the guidelines. After finalizing the draft of the guidelines profiled, the researcher submitted the guidelines to the supervisors for approval.

Step 3: Scoping the Guidelines

Scoping the guidelines involved the process of defining what the guidelines were included and what were not covered. The scope described the area of practice to which the guidelines apply, those whom the recommendations are intended to affect, the actions and interventions of interest and the outcomes that may result. The outcome may be both positive and negative. This step directed the researcher to ensure that the scope yielded questions that governed the data search and helped frame likely recommendations. It also facilitated to ensure that the guidelines were of manageable size and adequately focused. The supervisors acted as external advisors. The researcher developed the objectives because there were crucial key issues that determined the breadth and depth of the work. The objectives were as follows:

-  Traditional healers' knowledge on maternal mental health care.
-  Identify maternal mental health care needs.
-  Describe maternal mental health care services provided by traditional healers.

- ✦ Discuss the possibility of referral by traditional healers.
- ✦ Experiences on the provision of maternal mental health care services by traditional healers.

The researcher conducted the literature search to check the availability of any other guideline and thereafter produced the draft version of the scope. The developed potential recommendation(s) assisted the researcher to formulate draft PICO (Population, Intervention, Comparator and Outcomes) questions.

The GDG was formed with THs, pregnant/new mothers, and social workers. The group looked at the data and realized that there was a shortage of and poor maternal mental health care services in Vhembe District of Limpopo Province which had a high rate of maternal mental health challenges. There were no current guidelines for the provision of maternal mental health care services by THs in the province and nationally.

The group then came up with recommendations profiling the guidelines on the provision of maternal mental health care services by THs, recognizing the need to meet the objective of preventing lack and poor maternal mental health care services. The group hoped that implementation of the guidelines by THs will promote future sustainable standard quality maternal mental health care services, regardless of the areas in which the woman is accomplished.

The guidelines recommended prevention, lack and poor maternal mental health care services and make improvement on strategies in the provision of maternal mental health care services provided by THs to ensure that the services reflect and meet community expectations and needs. The importance of the THs to discuss counselling to assist mothers to deal with emotional needs, physical health needs, treatment and other reproductive health services was included in the guidelines.

✦ **Step 4: Developing Clinical Questions (PICOS)**

6.4.1.3 WHO (PICOS and GRADE) Model

Figure 6.3 depicts the WHO (PICOS and GRADE) model adapted for this study.

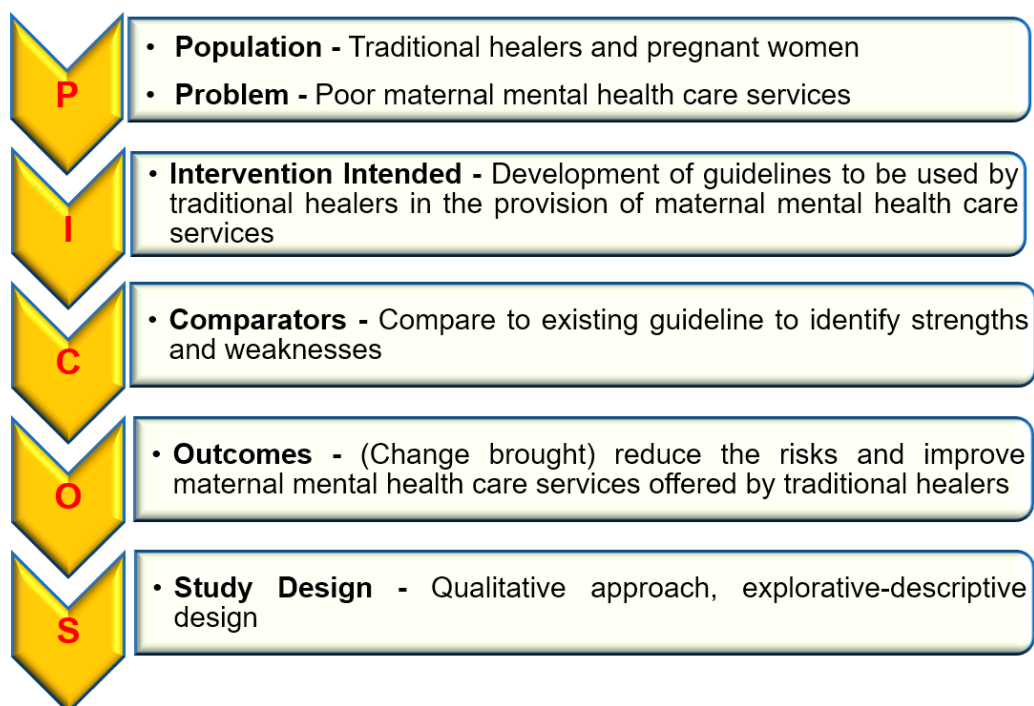


Figure 6.3: The WHO (PICOS and GRADE) model adapted for this study

✚ **P = Identifying the Problem**

During the process of problem identification, the GDG identified the current problems and any other problems that could emerge in the future. The responsibility of the group was also to come up with the actions and the recommendations that will ensure that the goals and the objectives are met. When identifying the problem, the researcher collected data to shed light on and determine the evidence-based problems, extent, their causes and effects, and their associated economic, social, and health impacts. The letter P also represents the population that the recommendations are meant to apply on traditional maternal mental health care services. After data analysis in Phase 1a and Phase 1b, the researcher contacted THs and pregnant/new mothers for permission to conduct a meeting, which was granted. The letter P represents the population which comprises the THs and pregnant/new mothers as the participants of the study. The researcher purposively selected one pregnant/new mother received mental health care services from THs, one pregnant woman receiving mental health care services from THs, one male TH and one female TH.

✚ **I = Intervention**

Intervention comprises the accomplishment to be considered, treatment, procedure, or the intended intervention. In this study, there was no treatment given, nevertheless, the intervention included recommendations for maternal mental health care activities that must be adhered to when maternal mental health care services are to be rendered by THs. The intention of the intervention was to improve and reduce complications that will lead to poor maternal health care services in Vhembe District of Limpopo Province.

✚ C = Comparison

The researcher experienced lack of available alternative choices of action such as frameworks, guidelines, interventions, or standards to make baseline comparisons. In this study, the researcher did not find existing baseline standards as laid down in the provision of maternal mental health care services by THs to compare with the current situation as revealed in the findings of this study. Therefore, the researcher concludes that there was no existing framework for provision of maternal mental health care services by THs to be useful for comparison. Table 6.1 summarizes the available mental health care services and the challenges faced by THs when providing such services.

Table 6.1: Summary of available mental health care services and the challenges faced by traditional healers when providing such services

Maternal challenges faced when accessing mental health care services	Challenges faced by traditional healers when providing maternal mental health care services
✚ Lack of respect and privacy from the modern health care workers	✚ Discrimination by community members and modern health care workers
✚ Poor sub-standard care	✚ Lack of relationship between indigenous and modern trained health care workers
✚ Lack of transport to and between the modern facilities	✚ Transport problems from rural areas to modern health centers.
✚ Centralized service on maternal mental health care facilities.	✚ Limited availability of registered trained indigenous mental health care workers where the service is available

The findings indicated that there was a lack of maternal mental health care services management guidelines. From the literature review, no guidelines could be found on maternal mental health care services available in South Africa or Limpopo Province. The gap identified from the literature review, together with the research findings, were used to profile the guidelines for the provision of maternal mental health care services

in all villages of Vhembe District, Limpopo Province. After the guidelines were profiled, trustworthiness was ensured and then implemented in Vhembe District of Limpopo Province.

✚ **O = Outcome**

The outcome focuses on the health outcomes and includes what was achieved and what harms the outcome could lead to. The outcome of this study focused on the results of implementing the profiled guidelines. The outcome was evaluated by experts in the field of study to check the benefits, potential harm, and financial cost incurred during the process of guidelines implementation.

✚ **S = Study Methodology**

To develop the guidelines, the WHO (2012) methodology was utilized wherein a group of 8 members were formed with the purpose of profiling maternal mental health care provision guidelines to promote effective maternal mental health care services by THs that led to improved traditional maternal mental health care service delivery.

6.4.1.4 Evaluating and Completing the Evidence for a Decision Framework for Each Recommendation (GRADE)

Table 6.2 shows how the GRADE model had been applied in this study. Original and updated literature searches were undertaken, focusing on examination of full primary papers, titles and abstracts relevant to the topic. Data were collected from relevant experts in the field. The study selection and data extractions that were not related to the topic in question were rejected, with the assistance of the supervisors.

Table 6.2: The GRADE model

GRADE Evaluate and complete GRADE evidence to decision framework for each recommendation	✚ Evidence on balance between benefits or harms
	✚ Evidence on cost and cost-effectiveness
	✚ Values and preferences
	✚ Evidence on acceptability, implementation, and other issues

Coding of collected data was done by the independent coder who was employed. Appraisal tools and data extraction forms were used to ensure the literature was appraised systematically and consistently using the same standards. Evidence tables

were used to help collate and summarize the data to identify similarities and differences between studies. Then recommendations that met criteria were used to develop the guidelines. The researcher was guided by the PICOS and GRADE models to ensure that the information that was used to develop the guidelines were from the studies with low risk of bias (Table 6.2). The researcher used the qualitative approach with two groups of participants to reduce the risk of bias. This was also ensured by making use of the multiple data sources (THs and pregnant women), as well as various data collection instruments (semi-structured and unstructured interviews). To build up the strength of evidence, synthesis and the reporting of results were ensured by merging of the results (WHO, 2012).

6.4.1.5 Determining the Recommendations and Their Strengths

Once the evidence was retrieved, synthesized, and assessed, this evidence was used to develop recommendations. According to WHO (2012), the strength of a recommendation reflects the extent to which the end user of the guidelines can then individually or collectively willingly decide to act within the specific situation to achieve the maximum positive outcomes and reduce the negative health effect (WHO, 2012:114). A recommendation is not only subject to the extent of an intervention outcome, but should comprise other deliberations and standards that govern the direction and strength of recommendations, such as the importance or weight of the health outcomes. Recommendations are the invention of inclusively considered impacts by a group of respondents in a research study through an organized process. The experts in the committee who were developing guidelines included the researchers and stakeholders who might select different treatment choices when the same evidence is presented. According to Zhang et al. (2017), different choices of recommendations are based on the different preferences of evidence-based values when full understanding of the information is ensured. In the development of the guidelines, the qualitative approach, different data sources (THs and pregnant women), as well as different data collection instruments (semi-structured and unstructured interviews), WHO (PICO and GRADE) models were used to produce high quality results. The results were merged and advanced the strength of evidence. The suggestions and recommendations were valued and designated to be used in the development of the guidelines (Figure 6.4).

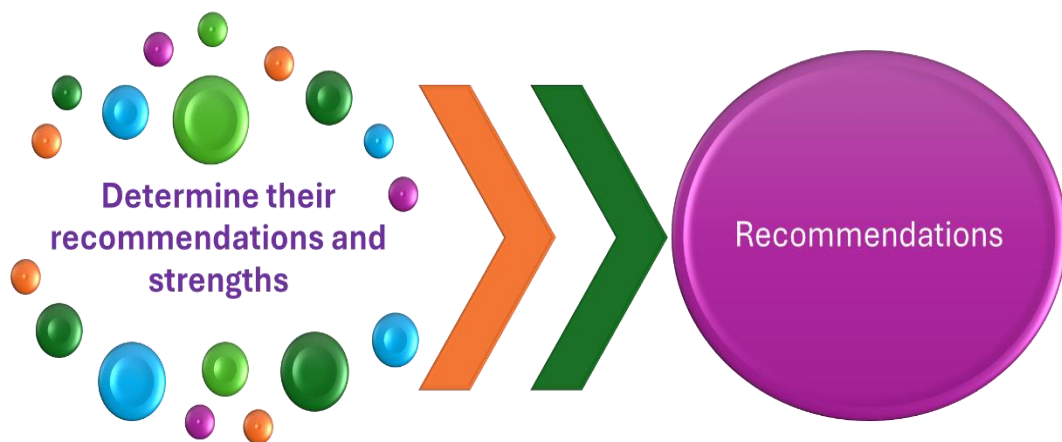


Figure 6.4: The WHO (PICO and GRADE) process implemented in determining the recommendations and their strengths

The qualitative results showed that there was a lack of effective maternal mental health care service delivery in Vhembe District of Limpopo Province, leading to increased consultation with THs for such services. The mental health care users of recommended interventions in hospital indicated that their choices of maternal mental health care services were limited due to various challenges experienced and they resorted to THs who provided mental health care services. The recommendations were assessed and graded using the guide as summarized in Table 6.2. High quality results with limited bias and few limitations were revealed after using the WHO (PICOS and GRADE) model (WHO, 2012).

6.4.1.6 Writing up of the Guidelines

The researcher profiled the guidelines based on the findings, participants' recommendations, literature review and input from the stakeholders. Table 6.3 presents the scope, purpose, and stakeholders for the guidelines. Tables 6.4 to 6.11 present the main recommendations for Guidelines based on the empirical evidence of the researcher's findings. Each of these recommendations is supported by detailed guidelines for fulfilling the goals of the recommendations.

Table 6.3: Scope, purpose and stakeholders

Title of the guidelines	Guideline of maternal mental health care services at Vhembe District, Limpopo Province.
Principal authors	PhD Candidate Promoter Co-Promoter x2
Guidelines Development Group (DGD)	Managers 1. X2 Traditional healers 2. X2 Pregnant women 3. X1 Scribe 4. X3 IKS experts (Supervisors)
Duration	July 2022
Purpose of the guidelines	The main purpose of the guidelines was to provide the Clinical Practice Guidelines that are consistent with maternal mental health care, philosophy and model of care, and to encourage quality provision that will enhance benefits of effective maternal mental health care services in Vhembe District of Limpopo Province.
Clinical problem	Lack of effectiveness in the provision of maternal mental health care services that leads to poor mental health, seeking mental health care.
Care providers	Traditional healers in Vhembe District of Limpopo Province
Consumers	Pregnant/new mothers accessing mental health care service
Review date	Three years or when new WHO or National recommendations are made available.
Setting for the guidelines implementation	All traditional healers providing maternal mental health care services in Vhembe District of Limpopo Province.

Table 6.4: Recommended guidelines to promote quality provision for maternal mental health care services in the selected Villages of Vhembe District of the Limpopo Province

Ways traditional mental health care service providers support quality provision to promote effectiveness on their service delivery.	
1.	Traditional healers to provide an enabling and safe environment to ensure availability, equitable access and appropriate delivery of quality maternal mental health care services.
2.	Traditional healers to provide adequate resources to meet the demand for maternal mental health care services such as budget, human and traditional medicine.
3.	Traditional healers to develop maternal mental health care baseline information and implementation plan for operational references purposes.

4.	Traditional healers to receive clinical training programmes to equip maternal mental health care service delivery skills.
5.	Traditional healers must create demand for maternal mental health care services through conducting community awareness programmes.
6.	Traditional healers must ensure provision of customer care quality maternal mental health care services and adhere to traditional standards of code of conduct.
7.	Traditional healers to set up referral system from one traditional healer and hospital for further management
8.	Traditional healers to provide follow up care after provision of maternal mental health care.

Table 6.5: Guideline 1

Traditional healers to provide an enabling and safe environment to ensure availability, equitable access and appropriate delivery of quality maternal mental health care services.	
Creating enabling, supportive environment is only possible when resources and traditional healers are successfully managed. Encouraging pregnant/new mothers to take control of their mental health.	
<i>The following should take place to ensure: Optimal Maternal Mental Health Care Service Delivery</i>	
1.	Guideline 1
1.1	Traditional healers should attend training to increase knowledge on maternal mental health care to produce more trained traditional health care workers.
1.2	Develop policy appropriately designated, functional facilities, in compliance with Traditional Healers' Act, 2007, with quality services.
1.3	The hospitalization of patient occurs in hospital through referral by traditional healers.
1.4	Improve information management systems and the mechanism of decision-making.
1.5	Mechanisms for efficient referral services and adequate backup at all levels need to be put in place.
1.6	Untrained traditional maternal mental health care providers have to be supported and used optimally.
1.7	Traditional healers need ongoing capacity building.
1.8	Good maternal mental health care practices, in accordance with policy and protocols, should be promoted.

Table 6.6: Guideline 2

Traditional healers to provide adequate resources to meet the demand for maternal mental health care services such as budget, human and traditional medicine.	
Adequate support with resources is critical to give access to safe traditional maternal mental health care, an accessible option for all mothers in Vhembe District of Limpopo Province.	
<i>The following should take place to ensure: Adequate Resources</i>	

2.	Guideline 2
2.1	Provision of budget to traditional healers to meet additional requirements.
2.2	Use the available resources for baseline information.
2.3	Engage stakeholders to achieve quality resource use.

Table 6.7: Guideline 3

Traditional healers perform hospitalization of patient in hospital through referral. To have a progressive traditional maternal mental health care services in place, gains made for mothers' mental health rights have to be vigilantly guarded. <i>For optimal functioning the following must take place on mental health care services guideline:</i> Guideline 3 Develop an effective legal guideline policy to strengthen maternal mental health care service delivery and implementation on an ongoing basis. Availability of administration to manage according to the Act and Guideline stipulations. Promote pro-choice traditional healers' initiatives. Promote optimal mental health choices as a fundamental human right.

Table 6.8: Guideline 4

Traditional healers receive clinical training programmes to equip maternal mental health care service. Additional numbers of traditional healers need to be trained to meet demand for maternal mental health care services. The process of complimenting mainstreaming will remove stigma attached to traditional maternal mental health care provision and contribute to alleviate pressure on the present relatively small number of maternal mental health care service providers. <i>To mainstream traditional maternal mental health care training, the following must take place:</i>
3. Guideline 4
3.1 Encourage traditional healing management buy-in to provide support for the importance of improving the access to maternal mental health care services.
3.2 Involve traditional mental health care service provider leaders to ensure sustainability, functionality and achievement in maternal mental health care services.
3.3 Prioritize registered traditional healers to provide mental health care services.
3.4 Maintain home infrastructure to allow more efficient flow and increase privacy and user satisfaction

Table 6.9: Guideline 5

Mechanism for efficient referral services and adequate back up at all levels need to be put in place.	
Prioritize the mental health of pregnant and new mothers by enabling them to take a greater control of their mental health by making responsible and independent choices for the future.	
<i>The following need to take place to create demand:</i>	
4.	Guideline 5
4.1	Increase pregnant and new mothers' awareness of their rights and mental health.
4.2	Increase traditional maternal mental health care service prevalence amongst pregnant and new mothers.
4.3	Provide good customer care on traditional maternal mental health care services treating pregnant and new mothers with respect.
4.4	Enhance community member empathy and support for pregnant and new mothers' rights.

Table 6.10: Guideline 6

Traditional healers must ensure provision of customer care of quality maternal mental health care services and adhere to traditional standards of code of conduct.	
Pregnant/new mothers' experiences of the health system significantly determine their use of resources and services. When a mother seeks mental health care service, the system has already failed her. At this stage, she lacks mutual trust. How she experiences her maternal mental health complications will now help or hinder her in taking control of her mental health in future. If the need for traditional healers is ever to be decreased, it is absolutely essential to make maternal mental health care service experience enabling encounters.	
<i>The following need to take place to provide: Client-Friendly, Quality Services</i>	
5.	Guideline 6
5.1	Enhance strength on behaviour towards maternal mental health care services provision.
5.2	Always provide few wider choices on maternal mental health knowledge.
5.3	Create a platform on service delivery which will allow respect and dignity.
5.4	Support providers in enhancing good customer services.

Table 6.11: Guideline 7

Traditional healers to provide follow up care after provision of maternal mental health care.	
All mothers going through mental health care services should routinely be offered support without delay upon request. All mothers, regardless of their risk of mental health problem, should receive appropriate mental health care. Mental health information and services are an essential part of maternal mental health services as they help the mothers to avoid unwanted stressors in the future and reduce the need for poor mental health.	
<i>The following must take place to ensure that clinical care take place:</i>	

6. Guideline 7	
6.1	Promote mental health education and outreach programs in the community.
6.2	Promote health education at own home and consultation room.
6.3	Refer patient to hospital to utilize outreach teams, war rooms, and traditional healers to give health education mental health.

6.5 Updating and Reviewing the Guideline

The researcher recommends reviewing the guidelines on a three-year basis from the date of implementation or when new recommendations for the guidelines are brought up. The specific date of updating the guidelines is set to be three years from implementation.

6.6 Trustworthiness of the Developed Guidelines

6.6.1 Aims/Objectives to Ensure Trustworthiness of the Guidelines

The aim of trustworthiness was to collect, evaluate data and explore authenticity, importance and usefulness of the guidelines.

- ★ To demonstrate understanding of the constructed guidelines through interpretation of the phases in relation to the sub-themes.
- ★ To check if the developed guidelines can be used to address the identified gaps in management of maternal mental health care services.

6.6.2 Guideline Trustworthiness Methodology

Intervention design was used by the researcher. Trustworthiness was done after two quarterly meetings that took place during the period of 12 months where the researcher and the GDG conducted a literature review and came up with the recommendations for guidelines development. The researcher invited 8 respondents who developed the guidelines from the districts to meet at Dzata ruins. The researcher met with the GDG for two days during which the meetings lasted 2 hours each day. To ensure credibility on the first day of the meeting, the researcher presented the draft to the GDG. The respondents formulated one group, and the group was allocated a group leader who presented the outcome of the discussion from the group. The researcher called the

group together to discuss the findings as one group. Trustworthiness of a qualitative study can be increased by maintaining high credibility and objectivity. A research definition of trustworthiness might be: 'Demonstration that the evidence for the results reported was sound and when the argument made based on the results was strong.' To enhance trustworthiness of the study, the strategies defined by Lincoln & Guba (1985) were followed by the researcher. A qualitative study cannot be called transferable unless it is credible, and it cannot be deemed credible unless it is dependable. Trustworthiness was established by ensuring credibility and dependability. The two terms of establishing trustworthiness will be discussed next.

6.6.2.1 Credibility

Credibility in qualitative research means the results of a qualitative study are believable and trustworthy from the perspective of a participant or subject in the research itself (Brink, 2012). The researcher did member checks by probing and asking follow-up questions to the main questions after the responses of the participants. It helped the researcher to seek clarity and more detailed explanations to exclude any inconsistencies in the answers which would signify falseness. The researcher ensured member checks by going back to each participant and read to them the transcripts of their own interview to confirm the responses. Peer scrutiny of the research project by colleagues, peers and academics was also welcomed and the feedback at presentations that the researcher received during the duration of the study was taken into consideration for the quality of the findings of the study.

6.6.2.2 Dependability

The researcher ensured dependability by showing that the findings were consistent and could be repeated. Dependability was determined by checking the consistency of the study processes (Lincoln & Guba, 1985). The detailed information of the methodology was provided to allow future researchers to adopt or repeat the work. The detailed information also allowed the readers of the research report to develop a thorough understanding of the methods used and their effectiveness. The expert supervisors of this research played roles of helping the researcher to ensure dependability by providing guidance on how to conduct the study through feedback from supervision. An auditor (expert supervisor) examined the documentation of critical incidents (documents and interview notes) and products such as research findings, interpretations and recommendations and confirm that all these products were

supported by data.

6.6.3 Data Collection Method

A checklist with five questions was used as outlined by Chin & Kramer (2008). To determine the quality and applicability of the guidelines, the appraisal of guidelines research and trustworthiness was used (Brouwers et al., 2016).

6.6.4 Data Analysis

The descriptive data collected were analyzed using thematic content data analysis methods. Thematic data analysis involves the compilation of all the relevant notes, identifying, analyzing and reporting patterns within data (Braun & Clarke, 2006). The task of the researcher was to identify a limited number of themes which adequately reflected textual data (Howitt & Cramer, 2011). It goes beyond simply counting phrases or words in a text and moves on to identifying implication and explicit idea within data. The thematic content analysis is performed through the process of coding in six phases to create established, meaningful patterns. Findings also supported the notion that the guidelines can be used as the basis of maternal mental health. The literature review was done to support the guidelines.

6.7 Consultation of Peer Review of the Guidelines

The THs in Vhembe District were asked to provide an extensive review and comment on the content, clarity and applicability of the draft guidelines prior to widespread dissemination and implementation thereof. After the health care workers appraised the content, clarity and applicability of the guidelines, the GDG deliberated on the comments from these experts and essential changes were made to the document before final publication. The external reviewers were included, i.e., methodological experts in the topic area. These included Prof M.T. Mulaudzi, Dr FJ Takalani and Dr. M.D. Mushwana.

CHAPTER 7

EVALUATION, JUSTIFICATION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The previous chapter discussed the validation of the guidelines. This chapter evaluates the study in order to check whether it has met all its objectives outlined in Chapter 1. The justification of the study will be outlined concerning the originality in contributing to the body of knowledge. Attention is also given to the limitations of the study, conclusion and the recommendations of the study in relation to the guidelines for provision of maternal mental health care services by THs. The purpose of this study was to develop guidelines for provision of maternal mental health care services in Vhembe District of Limpopo Province. The study used the qualitative exploratory and phenomenological approach. Ten THs were purposefully selected, and this was reached through data saturation. The study data were analyzed using Interpretive Phenomenological Analysis (IPA). The study findings revealed that pregnant women felt comfortable in seeking mental help from THs. Some complained about discrimination and stigma in the community that affected their mental state. This situation compromised the mental health of patients and increased chances of recidivism when patients were subsequently released from THs' households. The development of the guidelines was done according to WHO (2014b).

7.2 Evaluation of the Study

The evaluation of the study was ranged against the rationale, purpose and objectives as described in Chapter 1.

7.3 Rationale of the Study

Some pregnant women experienced good mental health during their pregnancy.

However, it is believed that other pregnant women experienced mental health problems such as stress, anxiety and depression brought by low socio-economic status, unplanned or unwanted pregnancy, and stressful life events such as relationship breakdown or divorce, losing a job, incarceration, housing insecurity; history of physical or sexual abuse during childhood or adulthood, grief related to miscarriage, substance use and intimate partner violence (Registered Nurses' Association of Ontario, 2018). Intimate partner violence also contributes to maternal mental health problem (Satyanarayana, Lukose & Srinivasan, 2018). Outcomes such as low birth weight, neglecting children, abandoning children and child adoption occur as a result of poor maternal mental health services. Some of the women who experienced maternal mental health developed suicidal thoughts or try to kill themselves (Heyningen et al., 2016).

The increased risk of mental health disorders during pregnancy are associated with increased maternal morbidity and mortality, and adverse child health outcomes (Groenewald, Evans, Morden, Zinyakatira, Neethling & Msemburi, 2014; Prince, Patel, Saxena, Maj, Maselk & Phillips, 2017). Common mental disorders such as anxiety, stress and depression are the third leading cause of disease burden globally for women between 14 and 44 years of age (Mayosi, Flisher, Lalloo, Sitas & Tollman, 2016). Sawyer, Ayers & Smith (2010) revealed that depression is a common maternal mental health problem. By 2030, these disorders are expected to rise. Therefore, there is an urgent need for maternal mental health care services.

There are few population-level insights into the use of THs and other forms of alternative care for the treatment of common mental disorders in sub-Saharan Africa. Research examined the extent to which alternative practitioners were consulted, and predictors of traditional healer visits. A national survey was conducted with 3,651 adults South African between 2002 and 2004 using the WHO Composite International Diagnostic Interview (CIDI) to generate diagnoses. A minority of participants with a lifetime DSM-IV diagnosis obtained treatment from Western (29%) or alternative (20%) practitioners. THs were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor. Use of THs in the full sample was predicted by older age, black race, unemployment, lower education and having an anxiety or a substance use disorder. Alternative practitioners, including THs and religious advisors, appeared to play an important role in the delivery of mental health care in South Africa.

The main purpose for conducting this study was the gap identified in the literature and many studies conducted focus on the role of TBAs on helping pregnant women with pregnancy care, during childbirth and with postnatal care, which are not focusing on developing guidelines for provision of maternal mental health care services. In a study conducted by Campbell & Graham (2006) which focused on the strategies for reducing maternal mortality: getting on with what works. According to the researcher's observations few studies looked at the provision of maternal mental health care services. Evidence-based intervention will help the maternal mental health care provider to be aware of the importance of THs in the provision of maternal mental health care services. Even though health services were free among pregnant women and children under six years of age in South Africa, pregnant women continued to seek help from THs because they were geographically accessible as compared to Western intervention services. It seemed as if the community had trust in them as they have been providing their health services to the community for decades.

Hence, the study unearthed the experiences of pregnant women on mental health care services provided by THs. Maternal mental health is of great importance as it has an impact on obstetric/neonatal outcomes such as lower birth weight, delayed developmental milestones, proneness to disease, mental retardation, etc. A study conducted in Pakistan, compared 147 physically healthy mothers with 147 mothers diagnosed with depression of similar gestational age and found that infants of depressed mothers had lower birth weights than infants of non-depressed mothers (Satyanarayana, Lukose & Srinivasan, 2018). Therefore, it was important for this study to be conducted as the guidelines that had been developed will promote best practices in the provision of maternal mental health care services by THs.

7.4 Purpose of the Study

The purpose of the study was to develop guidelines for maternal mental health care services in Vhembe District of Limpopo Province. The WHO (2012; 2014) framework was used to conceptualize the guidelines.

7.5 The Objectives of the Study

All the objectives of the study were met. The objectives focused on the provision of maternal mental health care services by THs. Objectives of the study were to:

7.5.1 Phase 1a: Traditional Healers

- ✳ To explore traditional healers' knowledge on maternal mental health care.
- ✳ To identify maternal mental health care needs
- ✳ To describe maternal mental health care services provided by traditional healers.
- ✳ To discuss the possibility of referral by traditional healers

7.5.2 Phase 1b: Pregnant Women

- ✳ To explore the experiences of the provision of maternal mental health care by traditional healers.

7.5.3 Phase 2

- ✳ To develop guidelines to be used by traditional healers in the provision of maternal mental health care services in Vhembe District.

7.6 Original Contribution of the Study to the Body of Knowledge

Focus was placed on maternal mental health and their rights, receiving mental health treatment from THs, followed by the issue of many patients at the healers' households and then ending up not receiving nutritional food whilst at the healer's home. However, the development of guidelines on how to provide traditional maternal mental health treatment among pregnant women is the original contribution of this study to the body of knowledge. No guideline has ever been developed in the Vhembe District that focused specifically on the provision for maternal mental health care services in pregnant women. The study revealed that for effective maternal intervention to take place, there must be a mutual trust between the healer and the patient. A needs analysis must be conducted prior to the development and the implementation of the treatment. The developed guidelines will contribute to the body of knowledge by helping pregnant women in Vhembe District. Furthermore, they could be extended to other provinces. As has been noted, this is the first time that the guidelines were developed in Vhembe Districts which deals with pregnant women.

7.7 Significance of the Study

This study sought to develop comprehensive and effective guidelines that may equip pregnant women to understand the morbidities associated with maternal mental health and challenges that pregnant women face when seeking help. Furthermore, it may also assist THs to teach pregnant women the proper use of mental health intervention. Most importantly, the study may help to develop effective evidence-based strategies and policies that could be used by THs to control maternal mental health. The study is of great importance because it may contribute to the pool of knowledge that may lead to future research. Prospective researchers may use the developed guidelines as a theoretical framework. Guidelines could be aimed at providing information that may assist in developing pregnant women's cognitive behavioural programmes, which will gain international recognition for being the most effective programmes for reducing maternal mental health.

In addition, there is no evidence of guidelines that have been developed to promote maternal mental health care services by THs in selected districts in Limpopo Province. Therefore, this study developed guidelines to promote maternal mental health care services by THs in selected districts of Limpopo Province. In carrying out this study, individuals and organizations or Government may benefit. Stakeholders that may benefit from this study include policymakers who may want to refine existing guidelines to protect the public from dangerous and possibly opportunistic practices by both THs and pregnant women, as well as to promote acceptable standards of the traditional healing system in South Africa, thereby making THs a significant resource which could be used by the national health system.

The recommendations and guidelines that have been developed by this study will enlighten communities on the adverse effects of maternal mental health, and thus persuade them to refrain from practices that involve mental treatment of THs. THs may benefit by having a platform to share their understanding of the causes and effects of mental health and, by doing this, they may assist the quick recovery of maternal mental health patients by adherence to a specific treatment. Pregnant women may benefit by altering the mindset that mental health treatment adulteration of THs is good because patients believe that mixing traditional medicine is the fastest way to get healed, not realizing that some pregnant women end up dying as the result of this behaviour. The developed guidelines in the study will help and encourage pregnant women to stick to one traditional healer. This is the contribution that the study is going to bring to the

body of knowledge in this field. Therefore, the assessment of the quality of traditional health providers' skills should be taken into consideration (Shaikh, 2016:241). Research on the challenges of the users of traditional healer services on quality of service is of importance in Vhembe. This can aid in providing the input in policy making and addressing the challenges in using the service. THs play an important role in the provision of mental health care services in Vhembe. Therefore, it is important to understand their challenges in provision of mental health care services. Providers' challenges may impact on health-seeking behaviour of the health care users. Providers with poor skills or inadequate knowledge related to mental health care services may cause pregnant women to receiving poor quality services, delay care seeking that again may lead to complications (Melkamu et al., 2010:241). The study findings should add to the existing body of knowledge on maternal mental health care services provided by THs. In addition, it is hoped that the study may provide the following:

Guidance to promote proper use of African traditional medicine in pregnant women with poor mental health in selected districts of Limpopo Province should include:

- ✱ Expansion of emergency mental health care, in other words increasing safety of people living with poor mental health in seeking early treatment service.
- ✱ Closing the gap between health system capacity and services needed.
- ✱ Improvement of the full continuum of care required to treat and manage the range of complications which may result from poor mental health.
- ✱ Guidance for traditional healers to teach pregnant women various ways to cope with African traditional medicine.
- ✱ Improvement of standards of care for pregnant women through developing guidelines which aim to promote maternal mental health care services by THs in selected districts of Limpopo Province.
- ✱ Offer guidance for policymakers when formulating health policies for traditional healers in treating maternal mental health. The guidelines developed for provision of maternal mental health may promote healthy mental health in selected districts of Limpopo Province and could be

applied by traditional healers across the country and by those of other developing countries with modification to suit each organizational setting.

7.8 Limitations of the Study

- ✳ One of the biggest challenges that the study encountered during data collection was that the research assistants were not allowed to enter the healers' households because of the Covid-19 pandemic. The healers only allowed the principal investigator. This made the data collection difficult since the researcher could not speak other languages like Xitsonga.
- ✳ The developed guidelines were not reviewed by all participants to ascertain whether the recommendations presented in the guidelines represented their experiences of living with mental health.
- ✳ Some healers had contracted Covid-19 by the time appointments were made and the researcher had to wait until their full recovery from the illness.
- ✳ Some patients had to withdraw from participating because they were afraid to be labelled or stigmatized.

7.9 Recommendations

The following recommendations are based on the research findings. These are coupled with the commendations made during the stage of guidelines development which was discussed in Chapter 6.

7.9.1 Recommendations for Future Research

- ✳ Research should be conducted on negative attitudes towards maternal mental health care services.
- ✳ Similar research should also be conducted in other districts and provinces within South Africa to check its feasibility and reliability.
- ✳ Further research can be initiated to evaluate the guidelines promotion and to make the necessary adjustments.

7.9.2 Recommendations for Traditional Healers

- ✳ A formal policy development process should be followed.
- ✳ Awareness and policies that will increase the ability of patients to cope with their challenges should be put in place.
- ✳ Traditional healers should provide and improve necessary treatment protocols in their households. This is crucial to help patients to cope with the challenges of their illness.
- ✳ The traditional healer should provide treatment to all patients, irrespective of the length of their illness.
- ✳ The traditional healer should appoint or refer patients to the next healer that will help improve the outcome of treatment of the illness.
- ✳ There should always be services that are rendered and implemented within the traditional healers' households in order to assist patients to cope with their illness.

7.10 Conclusion

This concluding chapter focused on what the study intended to do and what it actually achieved. Towards this end, the objectives of the study were reviewed to show that they had been achieved. The justification of the study was also revisited. The limitations of the study were fully discussed. Finally, recommendations for future research and the guidelines for provision of maternal mental health care by THs were made. In conclusion, it was very enlightening to learn that most of the interviewed THs indicated that they were learning a lot from the disease, and they were ready to change their treatment patterns so that pregnant women are not put at risk. Among the significant findings were the hardships encountered by THs in terms of finance, the transport needed to collect medicinal plants, the shortage of medicinal plants, the lack of cooperation from the formal health care sector and the discrimination and abuse suffered at the hands of members of the community.

REFERENCES

- Abdol Karim, S.S., Arendse, R. & Ziqubu-Page, T.T. (2003). Bridging the gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa. Project report prepared for the South African Medical Research Council. *South African Medical Journal*, 84, 1-16.
- Adamopoulos, J. & Lonner, W.J. (2001). Culture and psychology at a crossroad: Historical perspective and theoretical analysis. In: D. Matsumoto (Ed.), *The Handbook of Culture and Psychology*, 11-34. Oxford, UK: Oxford University Press.
- Adatara, P., Afaya, A., Baku, E.A., Salia, S.M. & Asempah, A. (2018). Perspective of traditional birth attendants on their experiences and roles in maternal health care in rural areas of northern Ghana. *International Journal of Reproductive Medicine*, Article ID 2165627.
- Akinnawo, E.O. & Akpunne, B.C. (2018). Challenges of African Traditional Healing System: Implication for the Development of Indigenous Psychotherapy, *International Journal for Psychotherapy in Africa*, 3(1), 51-65.
- Ahmed, O.A., Akinwale, O.P. & Odunukwe, N.N. (2005). Knowledge and Practices of Traditional Birth Attendants in Prenatal Services in Lagos State. *African Journal of Medical Science*, 34, 55-58.
- Aletor, A.L. (2007). Traditional birth attendants in Mexico: advantages and inadequacies of care for normal deliveries. *Social Science Medical Journal*, 43(2), 199-207.
- Alvi, M. (2016). A manual of selecting techniques in research. *The Qualitative Report*, 6, 22.
- Asante, M.K. (2003). Afrocentricity: The theory of social change (revised and expanded) Chicago: *African American Images*.
- Audet, C.M., Blevins, M., Moon, T.D., Shepherd, B.E., Pires, P, Vergara, A.E. & Vermund, S. H. (2012). HIV/AIDS-related attitudes and practices among traditional healers in Zambezia Province, Mozambique. *Journal of Alternative and Complementary Medicine*, 18(12), 1-9.
- Audet, C.M, Salato, J., Blevins, M., Silva, W., Gonzalez-Calvo, L., Vermund SH & Gaspar F. (2016). Occupational hazards of traditional healers: repeated unprotected blood exposures risk infectious disease transmission. *Tropical Medicine & International*

- Health*, 21(11),1476-80.
- Audet, C.M., Ngobeni, S., Mkansi, M., Wafawanaka, F., Aliyu, M.H., Kahn, K. & Wagner R. (2018). Occupational hazards of traditional healers in rural South Africa: Bloodborne pathogen exposures and risk of HIV transmission. In: 22nd *International AIDS Conference*, Amsterdam: Netherlands.
- Ayisi, R. (2006). Traditional healers' practices under AIDS spotlight. *Mail and Gardian Online*: Johannesburg.
- Aziato, L., Odai, P.N. & Omenyo, C.N.(2016). Religious beliefs and practices in pregnancy and labour: An inductive qualitative study among post-partum women in Ghana. *BMC Pregnancy Childbirth*, 16:138.
- Babbie, E. (2010.) The process of social research. (12th ed.). California: Wadsworth.
- Barclay, L. & Kruske, S. (2004) Effect of shifting policies on traditional birth attendant training. *Journal of Midwifery and Women's Health*, 49 (4), 306-311.
- Becker, M.H., Rosenstock, I.M. & Strecher, V.J. (1988). Social learning theory and the health belief model. *Journal of Health Education and Behaviour*, 15 (2), 175-183.
- Bless, C. & Higson, S. (2008). Fundamentals of social research methods. (4th ed.). Cape Town: Juta.
- Bojuwoye, O., Moletsane-Kekae, M. (2018). African Indigenous Knowledge Systems and Healing Traditions. In: Fernando, S., Moodley, R. (eds) *Global Psychologies*. Palgrave Macmillan, London. https://doi.org/10.1057/978-1-349-95816-0_5.
- Bulte, L.M. (2011). Traditional birth attendants in South Africa: Professional midwives' beliefs and myths. *Curations*, 21, 59-66.
- Burns, N & Grove, S.K. (2012). The practice of nursing research: Conduct, critique and utilization. (8th ed.). Philadelphia: W. B. Saunders Company.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in Psychology. *Qualitative Research in Psychology*, 3 (2), 77-101.
- Campbell-Hall, V., Petersen, I. and Bhana, A. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Journal of Transcultural Psychiatry*, 47(4), 610-28.
- Central Intelligence Agency. World factbook; South Asia: India 2013. Available at:

- <https://www.cia.gov/library/publications/the-world-factbook/geos/in.html>. Accessed May 13, 2014.
- Correctional Services Canada. (2020). Report 5—Preparing women offenders for release—Correctional Service Canada [Internet]; 2020 Aug 1 [cited]. Available from: http://www.oag-bvg.gc.ca/internet/English/parl_oag_201711_05_e_42670.html.
- Correctional Service Canada. (2020). Strategic plan for Aboriginal corrections - chapter one: Aboriginal Healing Lodges [Internet]; Aug 1 [cited]. Available from: <https://www.csc-scc.gc.ca/005/007/005007-2005-eng.shtml>.
- Carpenter, C.J. (2010). A meta-analysis of the effectiveness of health belief model variables in predicting behaviour. *Health Communication*, 25 (8), 661-669.
- Chalmers, O I. (2003). Assessing the role of traditional birth attendants (TBAs) in health care *African Journal of Reproductive Health*, 6(2), 94-100.
- Chipfakacha, V. (1994). The role of culture in primary health care. *African Medical Journal*, 84(12), 860-861.
- Costello, A, Crowe, S., Pagel, C & Utley, M. (2012). How many births in sub-Saharan Africa and South Asia will not be attended by a skilled birth attendant between 2011 and 2015? *British Medical Journal of Pregnancy and Childbirth*, 12 (4), 2-12.
- Cotter, K., Hawken, M. & Temmerman, M. (2006). Low use of skilled attendants' delivery services in Rural Kenya. *Journal of Health Population and Nutrition*, 24(4), 467-471.
- Cresswell, J.W. (2010). First steps in research. (5th ed.). Pretoria: Van Schaik.
- Cyert, R. & March, J. (1992). Behavioural Theory of the firm. New York: Armonk.
- Davidhizar, R.E. & Giger, J.N. (1998). Transcultural nursing assessment and intervention. St Louis: Mosby.
- Department of Health. (2004). Traditional Health Practitioners Act. Pretoria: Republic of South Africa.
- Descombe, M. (2003). The good research guide. (2nd ed.). Philadelphia: Open University Press.
- De Vos, A.S. (2002). Scientific theory and professional research. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. (2nd ed). Research at grass roots for the social sciences and human service professions. Pretoria: Van Schaik.

- Dommeruth, A.M. & Salihu, H.M. (2014). The impact of maternal mortality interventions using traditional birth attendants and village midwives. *Journal of Obstetric Gynaecology*, 24, 5-11.
- Donnelly, J.P. & Trochim, W.M.K. (2007). The research methods knowledge base. London: Sage.
- Durie, M. & Maori, J. (2009). knowledge and medical science: the interface between psychiatry and traditional healing in New Zealand. In Cayawar, M., Wintrob, R & Bouchard, L. editors. *Psychiatrists and traditional healers: unwitting partners in global mental health*. Chichester: Wiley & Sons, 237-249.
- Durrheim, K. (2014). *Research in Practice: Applied Methods for the social Sciences*. Cape Town: University of Cape Town Press.
- Faisal-Cury, A. & Rossi-Menezes, P. (2007). Prevalence of anxiety and depression during pregnancy in a private setting sample. *Arch Womens Mental Health*, 10, 25-32.
- Farooqi, Y.N. (2006). Traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. *International Journal of Disability, Development and Education*, 53(4), 401-415.
- Gaede, B. & Versteeg, M. (2011). The state of the right to health in rural South Africa. *South African health review*, 2011(1), 99-106.
- Galabuzi, C., Agea, J.G. & Fungo, B.L. Traditional medicine as an alternative form of health care system: a preliminary case study of Nangabo sub-county, central Uganda. *African Journal of Traditional Complementary Alternative Medicine*, 7, 11-16.
- Gausia, K., Fisher, C., Ali, M. & Oosthuizen, J. (2009). Antenatal depression and suicidal ideation among rural Bangladeshi women: a *community-based study*. *Arch Womens Mental Health*, 12, 351-358.
- Gqaleni, N., Moodley, I., Kruger, H., Ntuli, A. & McLeod, H. (2007). Traditional and complementary medicine: health care delivery. In: Harrison S, Bhana R, Ntuli A, editors. *South African Health Review*. Durban: *Health Systems Trust*, 175-88.
- Gibson, N. (2017). *Step by Step guide to qualitative data analysis*. Cape Town: Juta.
- Gorman, C.J. (2010). *Research in psychology methods and design*. (4th ed.). New York: John Wiley and Sons.
- Gureje, O. & Lasebikan, V.O. (2006). Use of mental health services in a developing country: results from the Nigerian survey of mental health and well-being. *Social Psychiatry*

- Epidemiology*, 41, 44-49.
- Gyamfi, S., Hegadoren, K. & Park, T. (2018). Individual factors that influence experiences and perceptions of stigma and discrimination towards people with mental illness in Ghana. *International Journal of Mental Health Nursing*, 27(1), 368–377.
- Hald, F.F. (2010). Living with HIV: Experiences and perspectives of HIV-infected sexually transmitted disease clinic patients after post-test counselling. *Sexually Transmitted Diseases*, 25, 28-37.
- Hamim, M.M.A.B., Alyami, M.G.M., Shurayyan, F.D.M.A., Alyami, M.R.A., Alyami, A.M.S & Alyami, S.M. (2023). Evaluating The Harmony: A Critical Review of Natural Therapy in Balancing Mind, Body, and Spirit. *Journal of Survey in Fisheries Sciences*, 10(5), 26-32.
- Hartley, M., Tomlinson, M., Greco, E., Comulada, W.S., Stewart, J. & Le Roux, I. (2011). Depressed mood in pregnancy: prevalence and correlates in two Cape Town peri-urban settlements. *Reproductive Health*, 8(9), 4755-4758.
- Haque, M.I., Chowdhury, A.A., Shahjahan, M & Harun, M.G.D. (2018). Traditional healing practices in rural Bangladesh: a qualitative investigation. *BMC Complementary and Alternative Medicine*, 18(1), 62.
- Hernandez, S., Oliveira, J.B. and Shirazian, T. (2017). How a training program is transforming the role of traditional birth attendants from cultural practitioners to unique health-care providers: a community case study in rural Guatemala. *Frontiers in Public Health*, (5) 111.
- Hewson, M. (1998). Traditional healers in Southern Africa. *Annals of Internal Medicine*, 128 (12), 1029-1034.
- Howitt, D. & Cramer, D. (2011). Introduction to Research Methods in Psychology. (3rd Ed.). Prentice Hall.
- Incayawar, M., Wintrob, R., Bouchard, L. & Bartocci, G. (Eds.). (2009). Psychiatrists and traditional healers: Unwitting partners in global mental health. London: John Wiley & Sons.
- Imran, N. & Haider, I.I. (2010). Screening of antenatal depression in Pakistan: risk factors and effects on obstetric and neonatal outcomes. *Asia-Pacific Psychiatry*, 2, 26-32.
- Israel, E. & Kroeger, M. (2003). Integrating prevention of mother-to-child HIV transmission into existing maternal, child, and reproductive health programs. Pathfinder International Technical Guidance Series 3, January 2003.

- Karen, G., Rimer, B.K. & Viswanath, K. (2008). Health behaviour and health education: theory, research, and practice. (4th ed.). San Francisco: Jossey-Bass.
- Kim, C. and Boyd, A. (2017). Research methodology: CSC426 research methods and practice. Prezi.
- Khan, N., Fahad, S., Naushad, M. & Faisal, S. (2020). Effects of Social Stigma on the Sick People of Covid-2019 in the Community of the World. Available at SSRN 3600579.
- Koithan M. & Farrell C. (2010). Indigenous Native American healing traditions. *Journal of Nurse Practical* [Internet]. 6(6). <https://doi.org/10.1016/2Fj.nurpra.2010.03.016>.
- Kowakzyke, D. (2016). Overview of exploratory, descriptive and casual research in marketing. USA.
- Kumar, D. (2011). Research methodology: A step guide for beginners. (3rd ed.). Washington DC: Sage.
- Kruger, F., Mitchel, B. & Welman, C. (2015). Research Methodology (3rd ed). Cape Town: Oxford University Press.
- Lane, K. & Garrod, J. (2016). The return of the traditional birth attendant," *Journal of Global Health*, 6 (2).
- Lee, S. & Waters, S.F. (2021). Asians and Asian Americans' experiences of racial discrimination during the COVID-19 pandemic: Impacts on health outcomes and the buffering role of social support. *Stigma and Health*, 6(1), 70.
- Lightner, A.D., Heckelsmiller, C. & Hagen, E.H. (2023). Ethnomedical specialists and their supernatural theories of disease. *Review of Philosophy and Psychology*, 14(2), 611-646.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Enquiry*. Beverly Hills, CA: Sage Publications.
- Lund, C., Tomlinson, M., De Silva, M., Fekadu, A., Shidhaye, R. & Jordans, M. (2012). PRIME: a programme to reduce the treatment gap for mental disorders in five low-and middle- income countries. *PLoS Medicine*, 9(12), e1001359.
- Lund, C., Petersen, I., Kleintjes, S. & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry*, 15(6), 402-405.
- Mabunda, M.M. (2001). Perceptions of disease, illness, and healing among selected black communities in the Northern Province, South Africa. *South Africa Journal of Ethnology*, 24(1), 11-16.

- McLennan, V., Khavarpour, F. (2004). Culturally appropriate health promotion: its meaning and application in Aboriginal communities. *Health Promotion Journal Australia* [Internet]. 15(3),237-239. <https://doi.org/10.1071/HE04237>.
- Makanjuola, A.B., Adelekan, M.L. & Morakinyo, O.O. (2000). Current status of mental health practice in Ilorin Emirate Council area of Kwara State, Nigeria. *West African Journal of Medicine*, 19, 43-49.
- Makunga, N.P., Philander, L.E. & Smith, M. (2008). Current perspectives on an emerging formal natural products sector in South Africa. *Journal of Ethnopharmacology*, 119(3), 365-375.
- Mapping the healing journey [Internet]. (2020) Jul 31 [cited]. Available from: <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/mppng-hlng/index-en.aspx>.
- Marks, L. (2006). Global health crisis: can Indigenous healing practices offer a valuable resource? *International Journal Disability Development Education* [Internet]. 53(4):471-478. <https://doi.org/10.1080/10349120601008688>.
- Mathole, T. (2004). A qualitative study on women's perspectives of antenatal care in a rural area of Zimbabwe. *Midwifery*, 20(2), 122-132.
- Mercer, J.A. (2007). A universally particular psychology? A feminist practical theological exploration of indigenous and cultural psychology. *Pastoral Psychology*, 56, 81-94. doi: 10.1007/s11089-007-0091-0.
- Maree, K. (2016). First steps in research. (2nd Eds.). Van Schaik; Pretoria.
- Merriam, S.B. (2009). Qualitative research. Pretoria: Van Schaik.
- Meintjes, I., Field, S., Van Heyningen, T. & Honikman, S. (2015). Creating Capabilities through Maternal Mental Health Interventions: A Case Study at Hanover Park, Cape Town. *Journal of International Development*, 27(2), 234-250.
- Minnie, K., Mulaudzi, F.M., Nyangena, E., Otieno-Ayayo, Z.N. & Serony, G.C. (2012). Knowledge and attitudes and practices of trained traditional birth attendants on HIV/AIDS, Kenya. *Baraton Interdisciplinary Research Journal*, 2(1), 8-16.
- Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation and Dance*, 20(sup-2), 24-34.
- Mosala, T., Nqeteko, A., Peltzer, K. & Shisana, O. (2006). Utilization of delivery services in the context of prevention of HIV from mother-to-child (PMTCT) in a rural South African community. *Currations*, 29(1), 54-61.

- Moshabela, M., Pronyk, P., Williams, N., Schneider, H. & Lurie, M. (2011). Patterns and implications of medical pluralism among HIV and AIDS patients in rural South Africa. *Journal of AIDS Behaviour*, 15(4), 842-52.
- Morris, J.L., Short, S., Robson, L. & Andriatsihosena, M.S. (2014). Maternal health practices, beliefs and traditions in southeast Madagascar. *African Journal of Reproductive Health*, 18(3), 101-117.
- Mureyi, D.D., Monera, T.G. & Maponga, C.C. (2012). Prevalence and patterns of prenatal use of traditional medicine among women at selected harare clinics: a cross-sectional study. *BMC Complementary and Alternative Medicine*, 12(1), 164.
- M'soka, N.C., Mabuza, L.H. & Pretorius, D. (2015). Cultural and health beliefs of pregnant women in Zambia regarding pregnancy and child birth. *Curationis*, 38(1), 1-7.
- Ngoma, M.C., Mann, A. & Prince, M. (2003). Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. *British Journal of Psychiatry*, 183(4), 349-55.
- Nortje, G., Oladeji, B., Gureje, O. & Seedat, S. (2016). Effectiveness of traditional healers in treating mental disorders: a systematic review. *The Lancet Psychiatry*, 3(2), 154-170.
- Olutope, A.E. (2020). Challenges of African traditional healing system: implication for the development of indigenous psychotherapy. *International Journal for Psychotherapy in Africa*, 3(1).
- Paniel, B. (2015). Research design. United theological seminar: ResearchGate publication.
- Park, C. (2013). Mind-body CAM interventions: Current status and considerations for integration into clinical health psychology. *Journal of Clinical Psychology*, 69(1), 45-63.
- Pearse, S.M. (2010). Characteristics of traditional birth attendants and their belief and practices. *Bulletin of the World Health Organization*, 75(6), 537-538.
- Peltzer, K. & Pengpid, S. (2015). Utilization and practice of traditional/complementary/alternative medicine (T/CAM) in South East Asian nations (ASEAN) member states. *Study of Ethno-Medicine*, 9, 209-218.
- Peltzer, K., Phaswana-Mafuya, N. & Treger, L. (2009). Use of traditional and complementary health practices in prenatal, delivery and postnatal care in the context of HIV transmission from mother to child (PMTCT) in the Eastern Cape, South Africa.

- African Journal of Traditional, Complementary and Alternative Medicines*, 6(2), 155-162.
- Princewill, C.W., Jegede, A.S., Nordström, K., Lanre-Abass, B. & Elger, B. S. (2017). Factors affecting women's autonomous decision making in research participation amongst Yoruba women of Western Nigeria. *Developing World Bioethics*, 17(1), 40-49.
- Rathod, S., Pinninti, N. & Irfan, M. (2017). Mental health service provision in low and middle income countries. *Health Services Insights*, 10, 1-7.
- Registered Nurses' Association of Ontario. Assessment and interventions for perinatal depression. (2018). (2nd Ed.). Toronto, ON: Registered Nurses' Association of Ontario.
- Richter, M.L. (2004). Traditional healing and human rights in South Africa. *British Medical Council of Pregnancy Childbirth*, 10, 10-43.
- Royal College of Psychiatrists. Overseas Blogs, India. One psychiatrist for 200,000 people. Available at: <http://www.rcpsych.ac.uk/discoverpsychiatry/overseasblogs/india/onepsychiatristper200,000.aspx>. Accessed May 13, 2014.
- Rudasa. South African Rural Mental Health Campaign report: A call to action. 2015 [cited 2017, Apr 25].
- Schaffnit, S.B. & Sear, R. (2014). Wealth modifies relationships between kin and women's fertility in high-income countries. *Behavioural Ecology*, 25(4), 834-842. doi:10.1093/beheco/aru059.ISSN045-2249.
- Shabaya, J. & Konadu-Agyemang, K. (2004). Unequal access, unequal participation: some spatial and socio-economic dimensions of the gender gap in education in Africa with special reference to Ghana, Zimbabwe and Kenya. *Compare: A Journal of Comparative and International Education*, 34(4), 395-424.
- Shangase, M., Pengpid, S. & Peltzer, L. (2010). Traditional Birth Attendants and HIV/AIDS in South Africa: A Trainers' Manual. Pretoria:Department of Health.
- Shankar, R., Lavekar, G.S., Deb, S. & Sharma, B. K. (2012). Traditional healing practice and folk medicines used by Mishning community of North East India. *Journal of Ayurveda and Integrative Medicine*, 3(3), 124.
- Sorsdahl, K., Stein, D.J. & Grimsrud A (2009). Traditional healers in the treatment of common mental disorders in South Africa. *Journal of Nervous Mental Disorder*, 197(6), 434.
- South African National Department of Health. (2014). Efforts to Strengthen and Promote

- Traditional Medicine. Pretoria: Department of Health. [Internet]. [cited 4 March 2016].
- Statistics South Africa. (2012). Census. Pretoria: Statistics South Africa
- Statistics South Africa (Stats SA). (2011). Mid-year population estimates. Statistical Release P0302: Pretoria.
- Thapa, S.B., Mainali, A., Schwank, S.E. & Acharya, G. (2020). Maternal mental health in the time of the COVID-19 pandemic. *Acta Obstetricia et Gynecologica Scandinavica*, 99(7), 817.
- Tomlinson, M., O'Connor, M.J., le Roux, I.M., Stewart, J., Mbewu, N. & Harwood, J. (2014). Multiple risk factors during pregnancy in South Africa: the need for a horizontal approach to perinatal care. *Prevention Science*, 15(3), 277-282.
- UNAIDS. (2016). Review of data from People Living with HIV Stigma Index surveys conducted in more than 65 countries.
- Ventevogel, P., Jordans, M., Reis, R. & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health*, 7(1), 3.
- Westgren, M., Pettersson, K., Hagberg, H. & Acharya, G. (2020). Severe maternal morbidity and mortality associated with COVID-19: the risk should not be downplayed. *Acta Obstetricia et Gynecologica Scandinavica*, 99(7), 815-816.
- White, P. (2015). The concept of diseases and health care in African traditional religion in Ghana. *Theologisches Studien/Theology Studies*, 71, 2762.
- Witt, W.P., Litzelman, K., Cheng, E.R., Wakeel, F. & Barker, E.S. (2014). Measuring stress before and during pregnancy: a review of population-based studies of obstetric outcomes. *Maternal and Child Health Journal*, 18(1), 52-63.
- WHO Traditional Medicine Strategy: 2014–2023; 2013: 7–15; Available at: http://apps.who.int/iris/bitstream/10665/92455/1/9789241506090_eng.pdf?ua=1 [Accessed 20 Feb 2016].
- World Health Organization (2014). Promoting mental health: concepts, emerging evidence, practice (Summary Report). WHO, Geneva, 2004.
- World Health Organization Western Pacific Region (2015). Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific: Towards a social movement for action on mental health and well-being. Manila.

World Health Organization. (2008). Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in the African Region. WHO African Region: Brazzaville.

World Health Organization. Mental Health ATLAS (2011). World Health Organization.

World Health Organization. Scaling up care for mental, neurological, and substance use disorders. Available: http://www.who.int/mental_health/mhgap_final_english.pdf. Accessed 28 April 2014.

World Health Organization. (2012). WHO Handbook for Guideline Development. https://iris.who.int/bitstream/10665/75146/1/9789241548441_eng.

World Health Organization. (2014). WHO Handbook for Guideline Development. https://iris.who.int/bitstream/10665/75146/1/9789241548441_eng.

APPENDIX 1

UNIVERSITY OF VENDA RESEARCH ETHICS COMMITTEE (UVREC) CLEARANCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms IM Rambau

Student No:
9800405

PROJECT TITLE: **Guidelines for provision of
Maternal Health Care Services by
traditional healers in Vhembe District
of Limpopo Province.**

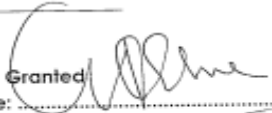
PROJECT NO: **SHS/19/PSYCH/06/2410**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof T Mulaudzi	University of Venda	Promoter
Dr FJ Takalani	University of Venda	Co - Promoter
Dr D Mushwana	University of Venda	Co - Promoter
Ms IM Rambau	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: October 2019
Decision by Ethical Clearance Committee: **Granted**

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: **Senior Prof. G.E. Ekosse**



University of Venda
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DIRECTOR
RESEARCH AND INNOVATION
2019 -10- 28
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APPENDIX 2A

INFORMATION LETTER (ENGLISH)

My name is..... I am a PhD student at the University of Venda. I am currently conducting a research study titled “Guideline for provision of maternal mental health care services by traditional healers in Vhembe District of Limpopo Province”. The aim of the study is to develop guidelines for provision of maternal mental health care services in Vhembe District of Limpopo Province.

The information you provide will help us to develop the guidelines to be used by TBAs in the provision of mental health to pregnant women. During the interview session the researcher will use audio recorder to record data and also take notes on nonverbal cues to help with data analysis. I assure you that your personal information/identity will be kept confidential, and it will not be revealed in any written data or in reports resulting from the study. All the information you provide will be kept confidential. The interview will last for a maximum of one hour and thirty minutes. If the participant interested to participate in this study, we will need her consent. Note that your participation is strictly voluntary, and that you are allowed to withdraw at any time during the study.

When it comes to responding questions, there are no rights or wrong answers. I assure that all the information provided by you will be used only for the purpose of the study. Everything that you say when answering the questions will be treated with confidentiality. This means that apart from the person who asks you the questions, no one will know how you answered. All information provided will be kept in a locked cabinet.

Furthermore, you also have a right not to answer any question that makes you feel uncomfortable. Should you be willing to agree to participate in this study, we would like to thank you for your time and for the information you are willing to share with us. Please note the information sheet is for you to keep. Kindly note that participants will not be paid for taking part in the study.

APPENDIX 2B

INFORMATION LETTER (TSHIVENDA)

Dzina langa ndi pfi Lufuno Mashamba. Ndi mutshudeni wa PhD university ya Venda, Thohoyandou. Ndi takalela u tshimbidza mushumo uyu wa toduluso kha PhD yanga kha nyaluwo ya tsumbandila kha vho maine vha tshirema nga ndila ya u tandulula thaidzo kha na u khwinisa mashumisele a mishonga ya tshirema kha tshitiriki tsha Vhembe kha Vundu la Limpopo. Zwi tshi kwama vhalwadze vhare Hiv. Muhumbulo muhulwane wa ngudo ndi wau khwinisa tsumbandila ine ya do gonyisa mashumele avhudi a mishonga ya vho maine vha tshirema kha vhlwadze ha HIV. Nga ndila yeneyo ndi humbela thendelo ya u tshimbila ndi tshi kuvhanganya ndilo kha vho maine vha tshirema, tshivhangalelwa hu u toda u l shumisa kha thoduluso yanga. Fulufhelo langa ndi la u shumisa lushaka lwa nyambedzano l sina ndugiselo, kha maitele a u kuvhanganya mafhungo kha vho maine vha tshirema. Othe mafhungo ane nda do a kuvhanganya u bva kha vho maine vha tshirema a do vhlungwa lwa ndeme na tshiphiri. U sa divhea zwi do vha zwa mathakheni kha vhothe vhataleli na hone vha do tendelwa u di bvisa kha ngudo tshifhinga tshinwe na tshinwe arali vhe na lutamo sa izwi uvha kha nyambedzano hu songo vha ha khombe khombe. Phedziseloni ya thonduluso yanga, ndi do kovhekana mawanwa navho hu u itela u nekedza mafhungo a ndeme ane a do thusa kha mashumisele kha vhlwadze. Ndi a fhulufhedzisa u di vhotha nga mulayo wa matshimbidzele ane a tewa u shumiswa nga nne tshifhingani tsha nyambedzano na vho maine vha tshirema.

Ndivhuwo yavhudi

Lutamo lwavhudi

Ivy Rambau (Mutshudeni)

Prof M.T. Mulaudzi (Mututuwedzi)

D. F.J. Takalani (Muthusa Mututuwedzi)

Dr M.D. Mushwana (Muthusa Mututuwedzi)

APPENDIX 3A

INFORMED CONSENT FORM (ENGLISH)

I _____ hereby agree to voluntarily participate in the data collection process done by _____ for a study topic on “Guideline for provision of maternal mental health care services by traditional healers in Vhembe District of Limpopo Province”. I understand that my choice to participate in this interview or not will not have any implications as to how I provide services to pregnant women now or in the future and that I am not obliged to complete the interview if at one point I change my mind not to complete the activity. I understand that my name will not be mentioned in the study findings and the report and that any information given by me in this study will be treated in confidentiality.

Signed _____

Witness _____

Date _____

APPENDIX 3B

INFORMED CONSENT FORM (TSHIVENDA)

Nne..... heneffa ndi di netshedzela u dzhenelela kha ngundo ya toduluso yo rinwaho 'Nyaluwo ya tsumbandila ya vho maine vha tshirema kha ha u shumisa mishonga ya tshirema kha vhalwadze vhare HIV+ kha tshitiriki tsha Limpopo. Ndi pfesesa uri ndi khou dzhenelela ndo vhofoholowa hu sina u kombetshedza nga dzi ndila dzifhio uri ndi ite ngauralo. Nahone ndi pfesesa uri ndi nga litsha nyambedzano musu ndi sa sa tsha toda u isa phanda. Maitele a ngundo ino u vha na thaluso yo fhelelaho kha ne nahone ndi dovha nda vha na u pfesesa ho ho fhelelaho nga nyimele ya u dzhenelela hanga.

Tsaino ya mudzheneleli duvha

Tsaino ya mutodulusi duvha

APPENDIX 4A

INTERVIEW GUIDE (ENGLISH)

Section A: Demographic Information

1. How old are you?
2. What is your highest qualification?
3. Are you presently employed?
4. How many children do you have?
5. What is your present marital status?

Section B: Role of Traditional Healers in the Provision of Maternal Mental Health Care Services

1. What are the roles played by traditional healers in the provision of maternal mental health care services?

Section C: Maternal Mental Health Care Needs

1. What are maternal mental health care needs?

Section D: Maternal Mental Health Care Services Provided by Traditional Healers

1. What kind of maternal mental health care services provided by traditional healers?

Section E: Referral Made by Traditional Healers to Other Health Workers

1. Do you refer pregnant women to other mental health care workers?

APPENDIX 4B

INTERVIEW GUIDE (TSHIVENDA)

Tshipida A: Fhungo la tshanduko ya lushaka

1. U wa vhukale vhungafhani
2. Vhuimo ha vhutholiwa
3. Tshivhalo tsha vhana vhane nga muthihi vha dzhenelela afha
4. Vhuimo hanu ha vhudzekani
5. Tshikale/ ndalukanyo yanu kha pfunzo

Tshipida B:

Ndi ifhio ndivho ine vhavha nayo malugana na thusa vhafumakadzi vho di hwalahohat are the roles played by traditional healers in the provision of maternal mental health care services?

Tshipida C:

Ndi dzi fhio thodea dza u lafha vhulwadze ha muhumbulo kha vhaimanas?

Tshipida D:

Ndi ifhio thuso ya vhulwadze ha muhumbulo ine vho maine vha nea vhafumakadzi vho di hwalaho.

Tshipida E:

Vha a rumela vhalwadze kha vhanwe vhaongi?

Phase 1b

Ndiifhio tshenzhemo ya u lafhiwa nga vho maine sa vha fumakadzi vho di hwalaho?

APPENDIX 5

CONFIRMATION BY LANGUAGE EDITOR



Prof Donavon C. Hiss

Cell: 072 200 1086 | E-mail: hissdc@gmail.com

28 July 2024

To Whom It May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the **Doctor of Psychology** dissertation by **Musiwa Ivy Rambau**, titled: “**Guideline for Provision of Maternal Mental Health Care Services by Traditional Healers of Vhembe District of Limpopo Province**” The manuscript was also professionally typeset by me.

Sincerely Yours



Cert. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD (Medicine)

APPENDIX 6

TURNITIN REPORT

GUIDELINES FOR PROVISION OF MATERNAL MENTAL HEALTH CARE SERVICES BY TRADITIONAL HEALERS IN VHEMBE DISTRICT OF LIMPOPO PROVINCE.

by Ivy Rambau

Submission date: 18-Jul-2024 08:37PM (UTC+0200)

Submission ID: 2418783883

File name: Ivy_Rambau.docx (1.07M)

Word count: 50156

Character count: 287470

GUIDELINES FOR PROVISION OF MATERNAL MENTAL HEALTH CARE SERVICES BY TRADITIONAL HEALERS IN VHEMBE DISTRICT OF LIMPOPO PROVINCE.

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