The use of *pitsa* among Basotho pregnant women in Mafikeng, Roma

By

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DECLARATION

Name: Matsepiso Catherine Mosia

Degree: Master of Science in Health and Medical Sociology

I declare that the study entitled, “The use of *pitsa* among Basotho pregnant women in Mafikeng, Roma” is my own work and that all the sources that have been used or quoted have been indicated and acknowledged by means of complete references.

JULY, 2021

Signature **Date**

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ABSTRACT

The current study explored the views of Basotho women about the use of *pitsa* during pregnancy. Research globally shows the use of complementary and alternative medicine (CAM) as prevalent and influenced by factors including inadequate healthcare services in developing countries. In exploring the use of *pitsa* as a form of CAM, the current study adopted the Rational Choice Theory (RCT) as the lens through which to look at women's experiences. The RCT attributes the use of CAM to family and societal norms, an individual's accessibility to resources, their personal values and the competence to develop the right values.

The study adopted a qualitative research approach and used case study design to explain Basotho women's views within an interpretivist paradigm. Convenient sampling was used chose Roma Valley as the site for data collecting while a combination of convenience and purposive sampling was used to select 11 women participants. Participants were women who had given birth. Semi-structured individual interviews were conducted with all 11 participants and thematic analysis was used to analyse data. Women in the study felt they had no other choice but to use *pitsa* during their pregnancies because some lived far from healthcare centres when they first gave birth, but most importantly the use of pitsa during pregnancy was a norm around them. Some state that they were young and did not know better but given that *pitsa* was suggested to them by elders who were close to them namely, a mother, a mother-in-law, or grandparents, it was easy to use it. As such, participants did not feel victims in their use of *pitsa*, they found it to be a beneficial practice inherited from their trusted elders. Thus, the closeness of the people who introduced *pitsa* to them made them to adopt it without resistance. Further, participants did not share any known dangers and threats to the use of *pitsa* except human misuse such as witchcraft which is intentional. Some were superstitious and referred to *pitsa* as a form of fortification to themselves and their babies during pregnancy. The study concludes that *pitsa* seems a trusted medication for the participants and its use must be studied further to improve it.

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CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Alternative medicine is defined by World Health Organisation (WHO) as a variety of health practises, approaches, knowledge and beliefs including plants, animals, and mineral based medicines, spiritual therapies, manual techniques and exercises applied in particular or in grouping to maintaining wellbeing as well as to treat, establish or avoid illnesses (Peltzer, 2009). The National Centre for Complementary and Alternative Medicine (NCCAM) in the United States of America (2007) adds that complementary and alternative medicine (CAM) comprises movement therapies, that is, a broad range of Eastern and Western movement-based methods used to stimulate physical, mental, emotional, and spiritual well-being.

Basically, Coulter and Willis (2004) observe that it is difficult to understand CAM because it does not have constant definition. A definition that is used by the NCCAM (2007) in the United States healthcare practices does not really describe what conventional medicine is fundamentally. Therefore, Onyiapat, Okafor, Okoronkwo, Anarado, Chukwukelu, Nwaneri and Okpala (2017) state that different ethnic groups have different belief system and practices common to each in relation to CAM therapies and their practices. Peltzer (2009) adds that ethnicity is another demographic characteristic that has been examined in conjunction with CAM.

According to Pal (2002), CAM is an expansive traditional health care practice used globally but many of the practices have not been tested or studied to give an indication of which experimented practice is right and which one is not. It is therefore believed that traditional medicine (TM) describes a group of healthcare practices and products with a long history of use (Pal, 2002). Research finds that CAM therapies include five major domains namely, alternative medical system, body mind intervention, biological- based treatments, manipulative and body-based methods and energy therapies (Coulter and Willis, 2004). It can be stated that the definition of CAM supports indigenous knowledge. For instance, Abbott (2014) affirms that CAM commonly refers to medical knowledge

developed by indigenous cultures that combine plants, animal and mineral-based medicines, spiritual therapies and manual techniques designed to treat illness or maintain wellbeing. Possa and Khotso (2015) state that CAM is referred to as medical because the medicinal plants, herbs, and drugs are adopted for the therapies that have healing properties.

Complementary and alternative medicine therefore refers to all sorts of healing systems that are aimed at bringing health and wellness into the life of a person who resorts to its use (Peltzer, 2009). Kennedy et al. (2016) found that CAM therapies are so good that some of their healing alternatives are recommended by medical doctors and other healthcare practitioners. On the other hand, the NCCAM (2007) does describe CAM as a group of diverse medical and health systems, practices and products that are not part of conventional medicines and therefore not taught in medical schools or generally used in hospitals. So, they are not covered by medical insurance companies and are used by patients willing to pay for the services out of their pockets.

Abou-Rizk, Alameddine and Naja (2016) note that CAM is a group of various medical and health care systems, therapies, and products like nutritional, supplements, herbal remedies, acupuncture, and meditation that are not currently part of medical training or practice in the countries where allopathic medicine forms the basis of national health care system. NCCAM (2007) indicates that people of all backgrounds use CAM and the most commonly reported forms of CAM use are vitamins, followed by prayer, meditation and spiritual healing. It seems that CAM is trusted for majority of health ailments because World Health Organisation (WHO) (2013) states that traditional, complementary, or alternative medicine has many positive features, and that traditional medicines and its practitioners play an important role in treating chronic illnesses, and improving the quality of life of those suffering from minor illness or from certain incurable diseases. Abou-Rizk et al (2016) indicate that CAM use has always been dominant among many patients living with life threatening illness and chronic diseases.

Generally, the CAM is a broad domain of healing resources that encompasses all health systems, modalities, practices and their accompanying theories and beliefs, other than those inherent to the politically dominant health system of a particular society or culture in a given historical period (Pal, 2002). Some research holds that the most common CAM practices in America are herbal treatment, relaxation techniques, chiropractic treatment, yoga, massages, and special diet (Uysal, Karvel & Vigit, 2019). They also add that CAM, especially yoga, is frequently used by people with cardiovascular diseases to make them relax. Peltzer (2009) notes a closely related term used namely traditional medicine, which is an inclusive term for traditional medical systems including traditional Chinese medicine, Indian Ayurveda and Arabic Chiari medicine and different forms of indigenous medicine. The World Health Organisation (2013) explains traditional, complementary, and integrative medicine as those medical herbs which are botanical drugs, teas, dietary, supplements or native formulation containing herbs which have been recognised medicinally for the past 20 years (Illamola et al., 2020).

Alternative medicine is a broad set of healthcare practices available to the public but are not readily included in the dominant health care model because alternative medicine is said to pose challenges to various societal believes and practices that includes cultural, economic, scientific, medical, and educational (Eskinazi & Mindes, 2001). As Abbott (2014) understands, CAM is a group of health care systems with practices and products not presently considered to be part of allopathic medicine. He maintains that traditional medicine, as part of CAM, tends to be practiced outside of allopathic medicine, also known as biomedicine, conventional or western medicine, which is the dominant system of medicine in the developed world.

Several views have been raised about the usefulness of CAM resulting in its labelling with a variety of words such as unproven, unorthodox, fraudulent, dubious, integrative, questionable, quackery, irregular, unscientifically, and naturopathic, propaganda-based medicine and opinion-based medicine (Pal, 2002). However, Pal (2002) sees the labels as signifying judgemental attitudes, conditioned by cultural beliefs and views CAM as a

broad range of healing philosophies, approaches and therapies that exist largely outside the institutions where conventional health care is taught and provided. He insists that some of these CAM therapies are not institutionalised but contain such practices and ideas defined by their users as inhibiting or treating illness or safeguarding health and well-being.

Fontanarosa and Lundberg (2009) are of the view that there is no alternative medicine per say, rather there is only scientifically proven, evidence-based, medicine supported by concrete data or unproven medicine, for which data is lacking. A study done in Lesotho by Possa and Khotso (2015) defines CAM including *pitsa* for Sesotho, which is one of traditional medicines classified by the World Health organisation (WHO) (2005) to be a sum total of the knowledge, skills and practices grounded on the theories, beliefs and experiences original to different cultures, whether rational or not, and used in the upkeep of people's lives.

Thus, traditional medicine results from practices that are based on health as well as in the inhibition, diagnosis, enhancement, or treatment of physical and mental health (WHO, 2005). In the context of Lesotho, a country in Southern Africa, Basotho who experience the healing system of *pitsa* are, in most cases a rural population, with knowledge being passed on by traditional healers and herbalist (Shale, Stirk & van Staden, 1999). In this study *pitsa* refers to alternative medicine prepared traditionally to be used by Basotho women during pregnancy. *Pitsa* is a Sesotho mixture of traditional herbs for use by Basotho pregnant women as a supplementary or alternative medicine to the one prescribed by their antenatal care giver during pregnancy.

Abbott (2014) indicates that CAM includes traditional medicine as well as modern practices developed out of indigenous communities. He adds that sometimes these two terms; CAM and traditional medicine (TM), are used interchangeably. However, the label CAM from complementary and alternative medicine is commonly used in the studies from

Western countries whereas Traditional medicine (TM) is a label used for developing regions such as Africa (Shewamena, Dune & Smith, 2017). Shewamena, Dune and Smith (2017) add that in African countries, Western medicine is not the main health care system. The NCCAM (2007) also states that complementary medicine is also used together with conventional medicine but can also be used in place of conventional medicine. Therefore, the NCCAM (2007) indicates that an integrative medicine combines both conventional and CAM treatment and is approved to be safe.

The integrative approach is illustrated by Sanchez (2014) to be a combination of conventional and alternative medicine, where there could be the use of anti-anxiety medicine and massage therapy to treat stress. However, Peltzer (2009) and WHO (2002) indicate that in the countries where the dominant health care system is based on allopathic medicine, or where TM is not being incorporated into national health care system, it is termed complementary and alternative or non-conventional medicine. The World Health Organisation (2000) states that other terms used to describe these health care practices under CAM include natural medicine, non- conventional medicine and holistic medicine. It is therefore wise not to confuse the readers of this study, and use CAM and TM interchangeably.

1.2 STATEMENT OF THE PROBLEM

Herbal medicine is known to have many harmful effects to pregnant women and their unborn children. Lawen et al (2017) point out that harmful effects of traditional medicine include causing abortion (Kennedy and Lupattelli et al., 2016), increased morbidity and mortality of mothers (Illamola and Amaeze, 2020) and the risk of congenital malformation of the foetal eyes (Ying Lau, 2012). In the context of Lesotho, Moteetee and Van Wyk (2011) link the use of traditional medicines to culture. The use is sustained despite knowledge of the side effects (Mothibe and Tshabalala, 2018). There is need to explore the reasons for Basotho women's use of conventional medicine concurrently with the traditional one given that the public health facilities are accessible and cheap. Thus, the

current study seeks to find out why pregnant women use *pitsa* despite accessibility to a health facility.

1.3 AIM OF THE STUDY

The general objective of the study was to explore Basotho women's reasons regarding the use of alternative medicine during pregnancy.

1.3.1 Specific objectives

The specific objectives of this study are:

i. To explore Basotho women's perceptions about the use of alternative medicine' during pregnancy.
ii. To explain women's reasons for using alternative medicine concurrently with pitsa during pregnancy.
iii. To find out women's sources of alternative medicine during pregnancy.

1.4 JUSTIFICATION OF THE STUDY

The study sets out to explain reasons pregnant women use alternative medicine while still attending their routine antenatal care treatment. The use of CAM among pregnant mothers is said to be more popular in developing countries with a significant number of pregnant English women (at around 57%) using CAM and globally the use of CAM ranges from 55 percent to 96 percent (Onyiapat, Okafor, Okoronkwo, Anarado, Chukwukelu, Nwaneri & Okpala, 2017). These findings were to clarify that CAM is used among majority of people all over the world. Therefore, there is a need to find out what is it that conventional medicine is not addressing, that compels the women to go and seek help from their indigenous healing including Lesotho. In the case of Mafikeng, the hospital is very near, and women are advised to use conventional medicine but they still prefer to use traditional medicines during pregnancy.

Generally, Frawley, MClinSc, Adams, Steel, Broom, Gallois and Sibbritt (2015) posit that the disclosure of CAM use among pregnant women is very low, as 76 percent of women do not reveal their CAM use to their Midwifes or doctors. This study is intended to find out their reason for not using conventional medicine more during pregnancy. at the same time the study will contribute to literature and give more knowledge.

According to Balogun, Tshabalala and Ashafa (2016) in South Africa the herb Kapokbos is translated as snowbush in Afrikaans and rosemary in English and is widely distributed in the mountain areas of Free State and Western Cape Province and in Namibia. Traditionally the plant is used as diaphoretic and diuretic agents for the treatment of cold and many other ailments (Balogun et al., 2016). In the same manner, Possa and Khotso (2015) make a list of some herbs in Lesotho used for a variety of purposes. For example, there is a list of medicinal plants that are associated with good luck like, *molomo- monate* in Sesotho, and translate as 'sweet mouth' in English, scientifically known as lotononis eriantha, another is called *lemanamana* in Sesotho, that translates as 'sticky' in English and scientifically known as tida congesta and many others. The acceptable use of a variety of medicines make a huge influence to pregnant women to use plants named *phakisane* that is said to 'speed up labour process' in the hope that it will work for them during their pregnancy (Possa & Khotso, 2015). It has been noted that the list for herbs used by women at various stages of pregnancy is long; every stage of pregnancy has a medical plant for use (Moteetee & Seleteng-Kose, 2016).

It is therefore important to instil knowledge among Basotho women regarding the use of these herbal or traditional medicine during their pregnancies. As such the current study explored opinions of Basotho women about the reason they used alternative medicine so as to establish the gaps in knowledge and empower women with more knowledge about the use of alternative medicine during pregnancy. In this regard, Sanchez (2014) reveals that knowledge is always a major barrier to CAM use. However, Chang et al (2019) shows that the reason for nurses as an example not talking about CAM use is because their nursing scope is not clear of practice regarding CAM. Therefore, this study will argue that

there must be awareness of a need for CAM education and interdisciplinary teamwork for CAM practice and establishment of an organisation standard for CAM practices to allow for an open knowledge transfer and support from medical professionals. This study also will like to great awareness to CAM use so that even the nurses and pregnant women will know the importance and disadvantages if they are there.

In echoing Fontanarosa and Lundberg's (2009) assertion that there is scientifically proven and unproven medicine, Masupha, Thamae and Phaqane (2013) reveal that in Lesotho about 56% of traditional healers have gone beyond primary education level. Their knowledge of herbs is acquired from initiation school and their elders while still attending to livestock. This casts doubt on whether these herbs can be argued to be doing what is alleged they do, which is positive in the eyes of their users. For enhancement of traditional healer's skills and knowledge, training has been provided to traditional healers to realise the symptoms of certain illnesses like tuberculosis so that they use their experience in herbal and mystical remedies to support their trade of treating the community (Masupha et al., 2013).

1.5 RESEARCH QUESTIONS

i. What was women's views regarding their use of alternative medicines during pregnancy?
ii. Why do women use alternative medicines concurrently with pitsa during pregnancy?
iii. How do women procure alternative medicine?

1.6 DEFINITION OF TERMS

Each term was defined operationally.

- Alternative medicines: This is the medication that people use on their own without consulting the doctor or professional health care practitioner. In this

study alternative medicines meant a general term for all concoctions that pregnant women decided to use as a supplementary to prescribed antenatal care medications during their pregnancy.

- *Pitsa*: This is a Sesotho mixture of traditional plants prepared in a pot over heat that Basotho pregnant women use as a supplementary alternative medicine rather than the one prescribed by their antenatal care giver during pregnancy.
- Herbal material or medicine: Is a medicine extracted from raw herbs. In this study herbal medicine was a raw herbal material that were not tested.

1.7 LIMITATIONS OF THE STUDY

Given that it was a qualitative study, it was not covering many participants so, its findings were limited to a small number which cannot be generalised to the population in Lesotho. Furthermore, these study truths cannot be logically proven. It might not work out logically by following a step-by-step way of analysing the problem but rather focus on understanding the context of the problem.

1.8 SUMMARY OF THE CHAPTER

This chapter describes the background to the study by first defining Complementary and alternative medicine (CAM). What alternative medicines are, and their preference by pregnant women. Next, it describes the problem statement, the research aim and objectives, justification of the study as well as research questions. Then the terms key to the study will be defined followed by a description of the limitation of the study.

CHAPTER TWO: REVIEW OF LITERATURE

2.1 INTRODUCTION

Human beliefs are an organised system behaviour shared by a group but having a reciprocal causal effect from individuals to broad social networks of people in a community. Thus, this chapter starts by explaining the rational choice theory (RCT) as the lens to explain women's choice of traditional and alternative medicine amidst abundance of Western medical science. The RCT helps the study put into perspective literature across the world, including locally, on women choice and use of alternative medicine during pregnancy. The literature points to several causal factors such as socio-economic, and cultural influences.

2.2 THEORETICAL FRAMEWORK

This study has adopted the rational choice theory as the lens through which to view and explain human behaviour as it relates to the use of complementary and alternative medicine. The theory deals with how individuals' contexts such as family environment, socioeconomic resources and personal values individually and collectively contribute to behaviour development. The theory is the most appropriate for the study because it explains human diversity. That is, while it could be said that western medicine is viewed as the panacea for human ailments globally, there are people who fall back on traditional medicine that may be perceived as unscientific.

2.2.1 Basic Assumptions of the Rational Choice Theory

According to Ogu (2013) Rational Choice Theory (RCT) is credited to the work of political economists such as Adam Smith, John Locke and Thomas Hobbes. However, Gary Becker's publication of 1968 entitled '*Crime and Punishment'* is noted as one of the most well-known and influential work on the modern view of RCT (Mehlkop and Graeff, 2010). The rational choice or action theory explains social and economic influences on human behaviour. Ogu (2013) states that the theory starts from the vantage point of an individual,

as opposed to looking at the collective behaviour of a group. While theorist inspired by this theory may be interested in explaining behaviour of large social groups, each must first “make different assumptions about the individual and proceed to larger social groups and systems, each theorist begins with the individual as the foundation unit of the theory” (Ogu, 2013, p. 92). The theory indicates that while tradition may be explained belonging to a group of people and shared over generations, "it is only individuals who ultimately take actions and social actions” (Abell, 2000, p. 8). Ogu (2013, p. 92) concludes that the basic assumptions of the theory give a picture of what he terms ‘the methodological individualism of the theory’ where individuals first prioritise their individual needs and welfare before considering the social concern.

Wittek (2013) opines that rational choice theory is the umbrella term for a range of models explaining social occurrences as outcomes of individual action that can in some way be interpreted as rational. On the other hand, Hetcher and Kanazawa (1997) argue that the theory is concerned with social instead of individual outcomes but conclude that individual values and contextual factors interact to influence human behaviour. Abell (2000, pp. 8-9) identifies the following basic assumptions about rational choice theory:

1. Individualism – it is only individuals who ultimately take actions and social actions and it is, thus, social actions, which cause the macro social outcomes or events, we wish to explain. Further, it is through the "causal" impact of macro social phenomena upon individual (social) actions that macro connections are established

2. Optimality – Individual actions and social actions are optimally chosen (i.e. they are the best that can be achieved) given the individual's transitive preferences (utilities, i.e. beliefs and affects) across the opportunities he or she faces.
3. Self-Regarding – Individuals’ actions and social actions are entirely concerned with their own welfare.

Ogu (2013) observes that in RCT, the emphasis is on the individual and his or her interests as the point of departure. Then, she or he takes individual and social actions

which are the ultimate source of larger social outcomes. Wittek (2013) adds to the assumptions of rational choice theory by indicating that individuals have self-preferences, they maximize their own utility and act independently based on full information. Ogu (2013) further states that individuals balance costs against benefits to arrive at action that maximises personal advantage. Applied to the study of CAM, this theory explains why individuals who use traditional medicine go against advice from conventional practitioners. Basically, they make choices given available resources and the choice are meaningful to their contexts. Friedman and Hechter (1988) state that human actions are purposive and intentional and align with individuals' ultimate values. That is, human actions show expression of purpose of achieving ends that are consistent with their hierarchy of preferences.

2.2.2 Application of Rational Choice Theory

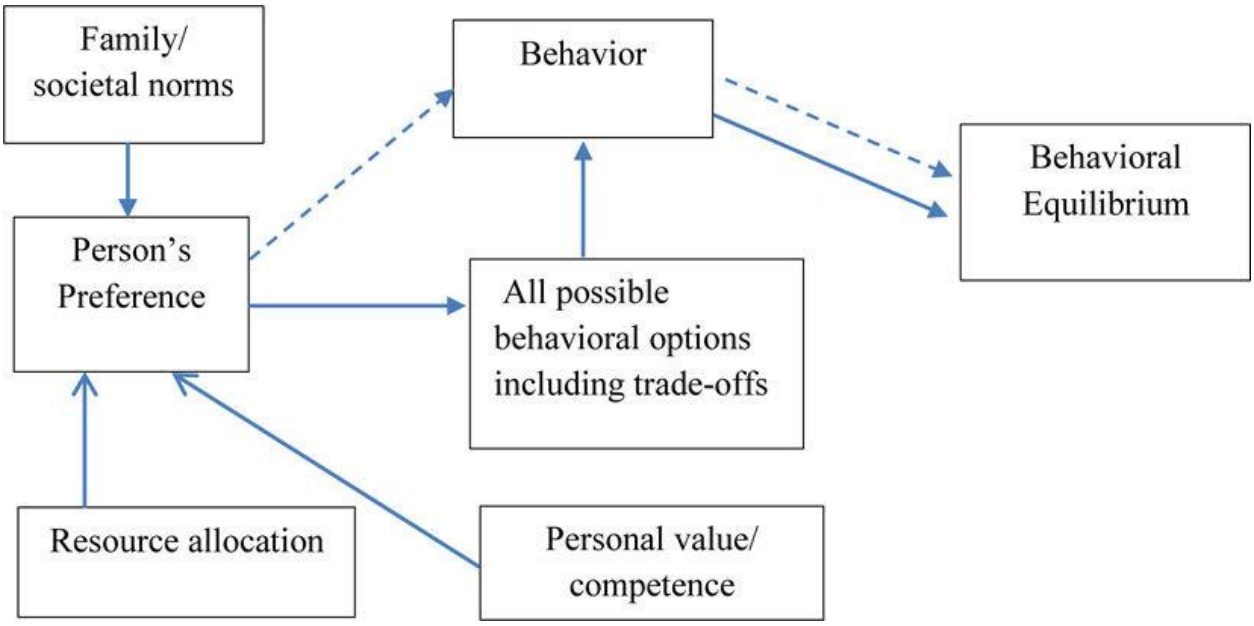
Friedman and Hechter (1988) identify one of the starting points from which it is possible to generate explanations as the micro-macro level links of the theory. This means, individuals are influenced at personal level in their interaction with family member, friends to the overall influence of values from society. Wittek (2013, p. 688) clarifies that preferences have many roots, "ranging from culturally transmitted tastes of food to other items such as personal habits and commitments.'" Frietman and Hechter (1988) indicate that, overall the rational choice theory is silent about what these preferences might be and where they come from. But Wittek (2013) indicates that preference denotes the positive or negative appraisals individuals assign to the possible outcomes of their actions. Ogu (2013) further notes that structure and norms that dictate a single cause of action are simply special cases of rational choices. At the same time, structures may not be optimal from the viewpoint of an individual with insufficient resources. Nevertheless, Ogu (2013) explains how a situation arises and is sustained through rational choice because people do the best they can, given circumstances at hand.

In their research, Frietman and Hechter (1988) explain preference-formation and argue that to a certain extend individual action is not only the product of intention but it is also

subject to limitations that arise from at least two independent sources. First being scarcity of resources; differential possession of and access to resources make some more difficult and prevent the achievement of others altogether. In the same manner, Ogu (2013) finds that from assumptions of rational choice theory such as optimality, people choose actions that are more suitable, depending on their preferences as well as opportunities or restrictions with which an individual face. Ogu (2013) makes reference to the theory's application to five areas namely, gaming, party politics, legislation, public good and coalition building. In each scenario, people may be seen as making collective decisions, but closer scrutiny reveals individual ends for each act taken; people may use others to achieve their personal benefit.

Figure 1 illustrates Cha et al.'s (2016) view of rational choice theory, which looks at three fundamental elements namely, the family/societal norms, person's preferences and resources. They argue that people's choices are influenced by resource allocations, that is, if a person comes from a family or society where traditional medicine was the major form of healing, their view towards the use of traditional or conventional medicine will be affected. The resources that a family provides for a child in their upbringing affect their choices of medications. In the case of African society, Masupha et al. (2013) state that Basotho, like other communities, raise their children exposed to unique traditional knowledge, beliefs and behaviour.

Figure 1 A conceptual framework based on the Rational Choice Theory



Adapted from Cha, Crowe, Braxter & Jennings (2016)

A family and society influence people's personal preferences in the sense that the knowledge they get from the two sources instil how they will behave towards the use of medicine. A child raised in a family which has enough money to be introduced, to conventional medicine, will affect that child's knowledge, values and behaviour towards medicine preferred. Family resources can influence one to prefer and use conventional medicine even if most in that society use traditional medicine. In this case, Sanchez's (2014) study state that majority of young people use traditional medicine because they get knowledge of that medicine from their families and community. He also explains that most CAM users are those with low financial resources.

Several conclusions can be drawn from the diagram and research above: an individual's values and competence are built in relation to their upbringing and knowledge inherited from the family and society. In addition, an individual's family resources provide opportunity and expose one to behave in a certain way towards the choice of medicine. That is, the interaction between one's knowledge through socialisation and resources influence preference or choice of habits related to health and the expected consequences of the choice. Hechter (1994) says that rational people try to set up their lives so as to

decrease their exposure to these tough choices and use certain medicine with intentions to get personal benefit. Human choices are attempts at achieving behavioural equilibrium, the need to fulfil personal needs and attain social cohesion.

From the rational choice theory, pregnant women would use complementary and alternative medicine as a reflection of the influence of their community on their individual choices. It is the instrumental rationality of people in their choices of medicine, either conventional or alternative medicines (Cha et al., 2016). The study on rational choice theory talks about the design of behavioural interventions that include improvement in health literacy, enabling adults to accurately calculate benefits and risks of certain behaviours, thereby enhancing self-efficacy, and helping to modify behaviours and establishing new equilibrium. Furnham and Lovett (2006) asserts that rational choice theory views human beings, and in the case of the current study, pregnant women, as always making choices that they intentionally and thoughtfully believe are the best for their situation. This therefore means that pregnant women would choose *pitsa* in the hope that they are best for their health.

Green (2002) states that once individual behaviour is established, the analysis generally moves on to observe how individual choices manifest into outcomes that may be good for their health. In addition, Furnham and Lovett (2006) says that psychology of individual actor sees humans as having particular distinctive character that shape and influence their acts. Individuals act on what they have, which is an informed position given their background resources. In this regard, Cha et al. (2016) observe that a study about the use of complementary and alternative medicine can help equip users with knowledge to estimate how likely different groups of alternative medicines are suitable in achieving the health outcome they value.

Furnham and Lovett (2006), on the other hand, clarifies that when people make choices, rationality is not enough, their behaviours are shaped by ideas that are not inherent within individuals but come from people who communicate them in common language. Therefore, Furnham and Lovett (2006) insist that human nature is not totally fixed by

human biology, rather, it is shaped through learning and education and must be regarded as both open and flexible. Hence one makes choices depending on their resources and values instilled by their family or society as Cha et al (2016) insist that knowledge may modify one's behaviour as explained by changes in their choice.

RCT, therefore, describes people as probably motivated by both inherent as well as external values (Hechter 1994). Cha et al (2016) see the theory explaining that the motives that inform human actions to be culturally formed and may differ considerably through history and from one place to another. Hechter (1994) affirms that people are to a certain extent individually motivated. However, Green (2002) understands that rational choice generally begins with consideration of the choice of behaviour for one or more individual decision-making units. He indicates that choice theory considers that individual decision making represent the larger group hence pregnant women would use complementary medicines familiar to them or the one their society and family members are also using or have experienced.

In their rational choice model, Friedman and Hechter (1988) outline that individuals do not act alone from their intentions but rather their actions are subject to limitations that arise from at least two independent sources. These are scarcity of resources which can limit the actor from achieving their end goal and social construction which qualifies all life sectors surrounding one's life and restraints in their social norms (Friedman & Hechter, 1988). Generally, it can be concluded that RCT is a theory inspired by both individual and social contexts in terms of spheres of influences on human development. An individual's social context socialises him or her as one gets exposed to social norms and values, and well as availability of resources for medical services. Once an individual matures into his culture, he or she exercises choices that serve personal needs, and the choices collectively influence a community's culture.

2.3 INTERNATIONAL PERSPECTIVE ON THE USE OF ALTERNATIVE MEDICINE

Studies on the use of CAM in international countries found that in European countries CAM use is more of a medical choice and not a necessity (Lawan et al, 2017). According

to Mishra, Neupane and Kallestrup (2014), CAM has been linked inseparably to human existence since the beginning of time. At least 158 million of adult population in the United States use complementary medicine, according to USA commission for alternative and complementary medicines (WHO, 2002). In European countries CAM use also depend on their seasons for chosen herbal plants (Lawan et al, 2017). It has been documented that in Europe, North America and other industrialised region over half of the population used CAM at least once (Peltzer, 2009). Jelly, Yadaw, and Dey (2018) affirms that in a study of data from 2007, National Health Interview Survey (NHIS), Harrigan reported that of 2.673 women who interact with any obstetrician /gynaecologist for medical care 31,8% reported CAM use, while only half of these women disclose CAM use to a physician, they continue to use CAM during pregnancy.

2.3.1 Cultural influences on the use of CAM

Lawen et al (2017) contributes that at least 65% and 80% of the world's population use herbal medicine as their primary form of health care. Kemppainen, Kemppainen, Reippainen, Salmenniemi and Vuolanto (2017) add that CAM has become more popular than conventional medicine and accepted in European countries, culture and history has been realised as the main influencer in the use of traditional or herbal medicines among Africans and majority of Western countries, as their alternative or supplementary medicine (Lawan et al 2017).

In Eastern European countries, herbal medicine use was more among younger pregnant women less than 20 years (Illamola & Amaeze 2020). According to Birdeen, Kemper, Rothman and Gardiner (2014), CAM use among pregnant and postnatal women would be higher among individuals who were young, white and had higher income or education 11.7% vs, 17.6% or 18.7% respectively are reported to use CAM during pregnancy. Moreover, Johnson and Blanchard (2006) add that 51% of 1.754 students sampled at Rutgers University in 2004 were using herbals, mainly for relief of physical symptoms, prevention of illness, and general wellbeing. They belief that CAM practices could become so widespread that it may not be accurate to continue to consider them as alternative

medicine in the near future, for college students move into their adulthood and take their preference for CAM with them (Johnson & Blanchard 2006).

Illamola and Amaeze (2020) enhances that there is a difference in the social influence around the use of herbal medicines as a form CAM around the world. However, National centre for Complementary and Alternative Medicine (NCCAM) argues that people of all background use CAM. It is more common among adults, especially women using it during pregnancy. There is emphasis that in different countries women are more likely to use CAM than men (Kemppainen & Kemppainen et al 2017). They add that in international worlds and some of developed nations media was one of the supporting basis in the decision about the herbal medicines use during pregnancy (Abdullahi et al 2017). Mar and Sugathan (2019) indicates that among their study population, the prevalent CAM use during pregnancy and postnatal period was 81.3%. Highest proportion of 59% used CAM during the postpartum period. 31% used during pregnancy and 10% used in both periods.

Eardly, Bishop and Prescott et al (2012) tells that CAM use has increased greatly, in 4862 adults surveyed in Europe, UK, 766(16%) had seen a CAM practitioner, for the last 25 years. Pregnant women from the eastern European countries often made their choices to use CAM grounded on advice of a treating physician. CAM therapy in the global regions is not cultured as biomedical treatment rather is seen as impersonal and too technologically oriented (Abdullahi et al,2017). According to Robles, Gomez, Delgado, Merales, and Iglesias (2018), 67.74% of health professionals insists that they recommended the use of CAM therapies sometimes. CAM is considered culturally as a provider for spiritual care, to satisfy people's spiritual needs and is a major issue for health care providers to understand that. They also belief that CAM consumers are using it because of their underlying cultural values, beliefs and philosophical orientation towards health and life (Dodds, Bulmer & Murphy, 2014)

Childbearing women have different reasons for using alternative medicine or herbs during pregnancy, some of the reasons are discussed next. Abdullahi, Khani and Charati (2017) found that women chose herbs during their pregnancies and their normal routine

according to their cultural beliefs and season in different regions and other international countries. They found that most common herbs were used during harvesting in Middle East and Iran used sour orange, peppermint and borage, peppermint. Ginger anise and thyme are commonly used herbs among women from China, Ethiopia, Palestine and Kazeron of Iran (Abdullahi, Khani, & Charati 2017).

In Chinese culture there are some limitations to protect the child from 'malign' effect and avoid the problems related to pregnancy and birth such as miscarriage, still born, death of the mother and some imperfection in a new born (Lau 2012). However, Peltzer (2009) indicates that, in China, traditional medicine (TM) account for around 40% of all health care delivery, while in Asia and Latin American people continue to use TM as a results of historical circumstances and cultural belief. Therefore, Lau (2012) found that among Chinese population, older members of family still likely hold traditional beliefs about antenatal care, and pregnant women may struggle in silence, control their frustration and lack of decision-making power.

Birdee and Kemper (2014) on the other hand reveals that studies grounded on the Australian longitudinal studies on women's health from 1996 to 2006 reported that both pregnant and non- pregnant women used CAM equally. However, pregnant women use CAM specifically to relieve back pain, tiredness, and dysuria and half of these women are seeing CAM practitioner for pregnancy related conditions like neck pain and sciatica. Abbott (2014) highlights that traditional knowledge or indigenous knowledge covers a wide-ranging matter areas from art to agriculture as well as medical uses of plants and traditional systems of medical diagnosis. They also apply that traditional knowledge is a difficult theory to explain because it covers such diversity. On the other hand, Uzoba and Abasiekong (2019) contribute that the Health Belief Model (HBM) believe that people engagement in health behaviour depend on their cultural beliefs about health problems and perceived benefits of action.

A report from a multi-national study, excluding Asians suggested that herbal use in pregnancy was higher in Russia with 69%, Eastern Europe 51.8% and Australia with

43.8%, than the other regions and was associated with non-smokers, folic acid or alcohol consumption in pregnancy, being students and having education other than a high school degree (Mar & Sugathan, 2019). However, Abbott (2014) emphasis that the use of CAM may delay the use of effective allopathic treatments and it can directly cause opposing effects.

According to Jelly, Yadaw and Dey (2018), a 2010 systematic review on CAM use during pregnancy mentioned a broad incidence ranging from 1% to 87%. They argue that pregnant women tend to use CAM to relieve specific pregnancy related conditions, including back pain, tiredness, and dysuria. He implies that half of women in their study reported seeing CAM practitioner for pregnancy related conditions like, neck pain and sciatica. Sanchez (2014) finds that most of women who participated in his study 53.9% of them get information about CAM from their family and friend and 20.7% got information from physician, due to the traditional beliefs and culture surrounding the use of CAM among pregnant women. Sanchez (2014) said most participants in his study (48%), did not believe they had enough education about alternative medicine to use it.

Jelly et al (2018), insist that the commonness of CAM use is the same during pregnancy but less during the postpartum period as compared with non-pregnant women, particularly in relation to biologically based, manipulation, and body-based therapies. He said one out of four women reported using mind-body practices regardless of being pregnant or postpartum. However, Mar and Sugathan (2019) depict that although general CAM use was high among Chinese women with 86% incidence of traditional Chinese medicine (TCM) use in pregnancy was relatively low. But, majority of participants reported that they had plans to use CAM in the future pregnancies and would recommend CAM to others.

According to Jelly et al (2018) There are recent studies on complementary and alternative therapies in perinatal period, which discover that homeopathy in pregnancy states the following homeopathic remedies that are often required, both during pregnancy and after labour:

Meditation: Randomized Controlled Trial (RCT) was done to inspect the effect of mindfulness meditation on stress among Indian pregnant mothers with 12 weeks of pregnancy to reduce stress and blood pressure. Their study advocates that mindfulness meditation moderates' sympathetic nervous system and also improves parasympathetic functions during pregnancy and hence reducing the perceived stress among the pregnant women.

Mind-body interventions are the interconnectedness of mind and body and their potential to affect each other. The study shows that the various mind-body interventions for chronic illnesses but are proven to be beneficial in acute delivery situations. They reduce maternal stress that may cause complication like hypertensive disorders during pregnancy and its more serious for eclampsia.

Incorporating *Yoga* during pregnancy is safe. It said to improves birth weight, decreases preterm labour, and decreases IUGR either in separation or connected with PIH, with no increased complications. The integrated yoga is an efficacious means of improving the quality of life of pregnant women and enhancing certain aspects of their interpersonal relationships.

Acupuncture increase degree of cervical ripening but does not reduce the amount of oxytocin or epidural analgesia administration, also does not shorten length of induced labour. Acupressure may reduce labour pain and labour period, but acupressure has not been found to increase cervical ripening or induce labour. Use of ice massage of the acupressure energy peak point large intestine is located on the median midpoint of the first metacarpal within 3 to 4mm of the web to the skin between the thumb and forefinger to reduce labour pain during contractions is a safe, non-invasive, non-pharmacological method of reducing labour pain.

Reflexology is found to reduce the duration of first stage by hours and second stage by 21 minutes as compared to situation where reflexology was not received. It also reduces pain during labour. It quickens labour and reduce pain in the process. Arnica is a

necessary remedy that can be given from time to time during labour to help the muscle function properly, to relieve the over-exertion of labour and lessen the sore feeling after delivery to relieve pain, bruising and after-pains. Also helpful for babies who are bruised from a long labour or a forceps delivery.

Caullophyllum is used for a difficult labour, where the cervix is slow to open and the pains are strong but unproductive. Kati phos for simple exhaustion during labour, mental, emotional and physical. Pulsatilla speed healing for mother and baby, postnatal blues, especially when the milk comes in. Lastly, aconite is for shock following the fear of the intensity of birth.

Hypnosis brings a state of deep relaxation by reducing the awareness and it is a tested intervention for minimizing stress and anxiety. Women reported that it reduces stress during labour. It makes them feel calmer and more confident. The training of antenatal women for self-hypnosis was proven to be beneficial during the birthing process. This technique needs attention of health care providers to get applied in the maternal care.

Music therapy is said to distract anxiety from labour process. It reduces the pain from the first stage of labour. It has been recommended in antenatal wards and labour room along with the standard treatment.

Manipulation and Body-Based Practices includes massage therapy: Massage therapy is said to reduce labour period and increases APGAR scores at birth first and fifth minute after birth. Massage therapy is said to shorten the duration of labour women prefer for normal vaginal delivery. It reduces anxiety on pregnant women and the symptoms of depression, relieves muscle and joint pain and therefore improve outcomes of labour and health status of born. Many women are said to report reduction in sciatic nerve pain during pregnancy liked reduced bone, joint pain, improvement in circulation, relaxation to the tissues and improved quality of sleep. Jelly et al (2018) includes Biologically based practices that are used during pregnancy. Herbs, foods, vitamins, and dietary supplements.

2.3.2 Socio-economic issues on CAM.

National Centre for Complementary and Alternative Medicine (NCCAM) (2008) found that in the United States, CAM is mostly used by women, especially those with higher level of education and higher income. For instance, Illamola and Amaeze (2020) clarifies that most pregnant women who choose complementary or alternative medicine that contain herbal medicine in most of international countries were married women with secondary schooling or university degrees. They relate more that these herbal medicine users are normally non-smokers over 30 years old with higher incomes and previous history of the herbal medicine use.

Fred (2013) relates that CAM is cheap, locally available everywhere and can help a country save a lot of money used to purchase conventional medicine. However, Kennedy and Lupattelli et al (2013) apply that some reported motivations for a woman's use of CAM therapies in pregnancy includes the belief that it provides safety alternatives to pharmaceutical drugs. Mugomery et al (2015) clarifies that despite CAM being cheap and accessible, there is a need to incorporate information on potential dangers of using medicinal herbs during pregnancy into the training curriculum for traditional birth attendants and midwives. Illamola and Amaeze (2020) add that it has been recorded in the US and to some range in the UK and Germany that CAM use contribute well to economy and public health.

Shewamene et al (2017) finds that funds for accessing Western medicine among poor Africans is a major determining factor into the high use of TM, they uncover that majority of Africans turn to belief that TM is more effective than Western or conventional medicine because it is more accessible and much cheaper. In the same manner, EUROCAM (2014) includes that CAM therapies can play important role into delivery of primary health care which is facing a negotiating crisis as the demand increases at the same time as modern biomedicine becomes over costly to deliver, they believe that at these point CAM has much to offer.

2.4 AFRICAN PERSPECTIVE ON ALTERNATIVE MEDICINE

In developing countries traditional medicine as part of CAM can be seen as the support of health care delivery, especially in remote or rural areas (World Health Organisation (WHO) in 2008, 2013). Possa and Khotso (2015) agrees that in most African societies traditional medicine plays a significant part in the lives of many people who cannot access Western medicine and pregnant women for their pregnancy related issues and giving birth. These practices have been norm for so long in certain places (Gale, 2014). WHO (2002) finds that at least up to 80% of the population including pregnant women in Africa use traditional medicine. They also unfold that in Sub-Saharan Africa, the ratio of traditional healers to the population is roughly 1:500, while medical doctors have a 1:40 000 ratio to the rest of the population (Masupha, Thamae & Phaqane, 2013).

2.4.1 Cultural influences on the use of CAM

CAM therapies are striking in Africa because they are not seen as more compatible with patient's values, ethics, world view, spiritual philosophy or beliefs regarding the nature and meaning of health and illness (Lawan et al, 2017). They found that majority of African communities use CAM as their main source of healing. They are mostly guided by their culture and social systems into the use of herbal medicines (Lawan et al, 2017). However, Illamola and Amaeze (2020) finds that other vital referral sources mainly in Africa were traditional birth attendants, local herb sellers and herbalists (Illamola & Amaeze, 2020). They also indicate that it becomes normal for pregnant women to use herbal medicines that they sometimes use them subconsciously. Shewan et al, (2017) indicates that there are different forms of alternative medicines that includes all sorts of herbs in Africa that most women at least use one of them during their pregnancy.

It was found by Illamola and Amaeze (2020) that in African culture, herbal medicine use was dominant in the first and third trimester of pregnancy. They were usually used in the first trimester to prevent and treat early pregnancy problems like nausea, vomiting, and

gastrointestinal disorders. During the third trimester, they were normally used to prepare the uterus for childbirth and ease child delivery. World health organisation (WHO) (2012) estimates that in several African countries, traditional attendants assist in the majority of births, meanwhile in many developed counties CAM is becoming more and more popular. Mothibe and Tshabalala (2018) affirms that in Africa, up to 14% of the women agree that they use traditional medicine during their pregnancies, 88% of pregnant women agree that it works well for them. 48% of these women testified that they have declined recommendations from relatives and parents to use traditional medicines during pregnancy.

Amar et al (2017) shares that at least 65% and 80% of the world's population use herbal medicine as their primary form of health care. James and Wardle (2018) support that both urban and rural population use traditional, complementary, and alternative medicine (TCAM), from their findings among 324 residents of the Ashanti region of Ghana, they did not find any substantial difference between TCAM users residing in both rural and urban regions. Masupha et al (2013) agrees that traditional healers are playing an important and influential role in the lives of African people, and they have the potential to serve as a vital constituents of a complete health care strategy.

James and Wardle (2018), supports that traditional, complementary, and alternative medicine (TCAM) is said to be common among people aged 20 to 50 years, however they include their study was conducted in the rural areas that entails that TCAM users are likely to be older than 55 years. James and Wardle (2018) insist also that TCAM users have little or no formal education. They realise that majority of users are more married than unmarried. In their finding's most TCAM users are residing in rural areas more especially in South Africa. However, Masupha et al (2013) finds that in Southern Sudan, people who are visiting traditionally range between 21 and 40 years and mostly women and pregnant. These traditional medicine users are said to be less educated compared to the general population in the area. Uzobo, and Abasiekong (2019) emphasise that these phenomena of CAM use among pregnant women is yet to be explored in detail among the people of the South-South of Nigeria.

The holistic CAM model says health is not merely the absence of sickness or infirmity, but the ability of an individual to respond adaptively to a wide range of environmental challenges for instance physical, chemical, infectious psychological and many other (European Committee for Homeopathy (ECH), 2008). Shewamene et al (2017) highlight that in most African communities including Nigeria, especially in the northern parts of Nigeria, health awareness and utilization of health services are slow for pregnant women to trust them for their health. So, Khan, Khan and Khan, (2014) says CAM users might have trust in their healing methods because they believe that they are natural, and they might be healthy. On the other hand, Abbott (2014) contributes those traditional medicines are not really safe merely because they are natural and have been used for a long time.

2.4.2 Socio-economic influences on the use of CAM

Alternative medicine in Africa is more of essential or a normal practise because of the low-income state of living (Illamola & Amaeze 2020). They add on the issue of accessibility to health care facilities, that in Africa women who use herbal medicine during pregnancy were below 30 years old with no formal education, of low socio- economic status, and living in rural areas far from public health facilities. However, Mugomeri et al (2016) add that socio-economic factors such as poverty and lack of education contribute to high stillbirth rates in developing countries.

The world medicine situation 2011 report assessments that between 70% and 95% of the population in the developed countries use traditional medicine (TM) (Shewamena, Tinashe & Smith 2017). They realise that in Africa more than 80% of the population use TM for most of pregnant women and general population this is traditional healing is the only available primary health care option mainly for the rural African communities. According to Mugomeri et al (2016), socio-economic factors may contribute to major barrier in preventing negative pregnancy outcomes that might come with not consulting health professional or attending antenatal care. Tenashi and Smith (2017) says socio-

economic hardships plays a big role too in the use of TM in Africa because people are located deep in the rural areas far from the financial sources too, the job market. Therefore, Lawan, Takai, Abdullahi and Umar (2017) concludes that in Africa herbal and spiritual remedies are increasingly being used mostly by women in the management of perinatal conditions especially in the rural communities due to easy access and low costs.

According to Lawan et al (2017), pregnant women in Nigeria use traditional medicine throughout pregnancy, labor, and puerperium. They assume that that could be harmful to the pregnant women and their babies but according to Agyei-Baffour (2017) in their research in Ghana, on pregnant women visiting health facilities for anti-natal care, they report that they use herbal medicines over for treatment of abdominal pain, constipation, to protect their pregnancies and for smooth delivery. James and Wardle et al (2018) add that traditional, complementary, and alternative (TCAM) users were described in many studies to be usually individuals with a lower socioeconomic status and who are unemployed and unskilled. Therefore, Mar and Sugathan (2019) state that habitual users of CAM are at high risk of taking during pregnancy and face the unknown outcomes due to lack of scientific evidence in their CAM use.

Lawen et al (2017) clarifies that through their talk with the professional health workers they realised that majority of Nigerian resort to traditional medicines because it is easily accessible due to unimproved socio-economic status of average Nigerians. A study done in Nigeria reported that there is a huge increase in TM use among pregnant women aged 20-30, with no formal education, good income, those earning above 250 dollars per month and married (Shewamene et al, 2017). Hence, Dodds, Bulmer and Murphy (2014) belief that CAM consumers are using it because of their underlying values, beliefs and philosophical orientation towards health and life.

2.4.3 Issues of safety in Using CAM in African countries

Research by Mugomeri, Chatanga, Seliane and Malbvise (2015) highlights that the majority of Southern African countries have higher maternal mortality rate due to their lack of knowledge and lack of investigations around their use of alternative medicines

during pregnancy. Khan, Khan and Khan et al (2014) add that users of CAM self-medicate to deal with their ailments without proper diagnosis of that disease. According to Mugomeri et al (2016), these medical plants that are used as CAM contain non-nutritive, diversified plant chemicals known as phytochemicals, they can be harmful to pregnant women and their babies. They realise that in African countries information on herbal medicine is passed down family lines through oral traditional, therefore these passing of information increases the chance of wrong identification and misuse of some medical plants (Mugomeri et al, 2016).

According to Lawan et al, (2017), in African countries in particular, traditional medicines or herbs are used in their raw or cooked forms without testing them in laboratory, investigating their safety and efficacy for liability to side effects and interactions. The use of traditional medicine presents unique public health challenges. WHO (2002) notes that inappropriate use of traditional medicines or practices can also have a negative or dangerous effects, therefore they depict that further research is needed to establish the efficiency and safety of many traditional medical practices. Lawan et al (2017) add that in Africa herbal and spiritual remedies are increasingly being used in the management of perinatal conditions especially by women and if they are poorly managed may lead to death of foetus, mother of both.

EUROCAM (2014) clarifies that CAM doctors and practitioners need a significantly expanded range and scope of herbal medicinal products to practise effectively. Coulter and Willis, (2004) put forth that they are puzzled by their findings that in as much as there is high practise of alternative medicine or herbs the Westerns are agreeing that there is no scientific proof in to these overriding practices or medical practices. Saying that this enlargement of health care branches only claims to be scientific and therefore they are generally questioned.

Mwaka et al (2020) contributes that there is lack of knowledge among women and general population that use CAM and professional health care workers as well also contributes to majority of health risks. The cause being that majority of medical school do not teach

aspects of drug or herbal interactions. They explain that only a few medical schools teach aspect of traditional and complementary medicines (T&CMs). EUROCAM (2014) talk about CAMbrella reports that highlighted the lack of CAM integration into national public health systems and the inadequate research facilities available to CAM. However, European committee for Homeopathy (ECH) (2008) believes that CAM provide holistic approach to health, emphasising that it does not have toxics that might be found in conventional medications.

2.5 USE OF ALTERNATIVE MEDICINE AMONG BASOTHO

2.5.1 Cultural perspectives in the use of *pitsa*

Basotho have their unique traditional knowledge, beliefs and culture that help them raise their children, unite them as a nation, protect themselves, their life and that of their families and community (Masupha et al, 2013). Possa and Khotso (2015) applies that the indigenous knowledge of the Basotho makes it simple for this speech community to name their traditional medicinal plants in such a way that they are meaningful. Medicinal plants names seem to be idiomatic and express certain beliefs of the Basotho society. According to Moteetee and VanWyk (2011) medicinal plants are taken as decoctions in water, water infusions or in the form of powder snuff, while others forms includes smoke inhalation from burning medicinal herb and inhalation of vapour from freshly crushed medicinal herb.

There is easy access to medicinal plants for Basotho, lack of adequate health care facilities, shortage of human resource in health facilities and the truth that traditional healing is part of a strong cultural heritage in Lesotho. This is the main reason why the local inhabitants seek alternative medicinal remedies such as medicinal plants. (Seleteng-Kose, 2017). Mothibe and Tshabalala (2018) shows that there are 303 plants species in total that are taken by Basotho as a form of protection and used as medicines. There are abundance medical plants resources complements local public health prevention efforts and may lead to poverty reduction. Mugomeri et al (2015) shows that the herbs are sold in Maseru city and Mafeteng town as well as Maputsoe and Maseru boarder post, for

those herbs are entrusted to heal various ailments including those used for preparation of *pitsa* for pregnant women.

Mugomeri et al (2015) explain that Basotho women from other traditions take *pitsa,* translate to pot, and it is made of Basotho medicinal plants mixture and taken by pregnant women from the time the family knows about their pregnancy until the last trimester. Mugomeri, Chatanga, Raditladi, Makara and Tarirai (2016) agrees that in Lesotho plants are important sources of medicine. Around 9% of pregnant women in Lesotho do not attend antenatal care services but use traditional medicines called *pitsa* for their pregnancy related medical needs, and they find that some attend the services but use the medication simultaneously with pitsa (Mothibe & Tshabalala, 2018). Possa and Khotso (2015) applies that there is element of trust, affordability and accessibility for *pitsa* among Basotho pregnant women. There is a world medicine situation in 2011 that account guesses that between 70% and 95% of the population in developing countries including Lesotho use traditional medicine (TM).

Shenamene, Tinashe and Smith (2017) explain that in Lesotho and other African countries more than 80% of the population use TM because for most of them this is the only available primary health care option, especially for the rural communities. In Lesotho, there are places that are deep in the mountains because of its terrain, where traditional medicine is the main medical practices even for pregnant women. There is high usage of *pitsa* than in urban areas. According to Makoa (2002) in place of attending antenatal care in health facilities, pregnant women in rural area use pitsa to strengthen the mother and the baby during pregnancy and to make sure the mother and the baby are safe during delivery. In addition, Mothibe and Tshabalala (2018) add that traditional healers say pitsa helps in prevention of miscarriages and shorten labour.

They summarise that Basotho are very good at taking care of their pregnant women because they have their own way of counting the months of a pregnant woman and tell when it is time for the baby to be born (Possa & Khotso, 2015). Mothibe and tshabalala (2018) realised that *pitsa* was used all trimesters to satisfy all pregnancy natural stages

until the birth of the baby. According to Possa and Khotso (2015), the meaning of the concoction that are prepared by Basotho as *pitsa* is connected to the functions that medicinal plants are believed to perform.

Mothibe and Tshabalala (2018) explain that, in the first trimester, there is *pitsa* mixture called *seshapetso* is used to treat heartburn and to protect the baby from evil plots. *Khamane e kholo* is the plant that is boiled to make *pitsa* and taken orally to prevent nausea and vomiting. For the second trimester there is *pitsa* in a boiled plants and taken orally called *phethola* that is believed to turn the baby for right birth direction. It is named after the action of turning (Mothibe & Tshabalala, 2018). There are specific plants like *Morara o mofubelu* that Moteetee and Seleteng-Kose (2016) share that their roots are decoction to create *pitsa*. Taken orally by pregnant women in their latter stage of their pregnancy. Their purgative effects and *Selepe* roots are decoction and taken orally as *pitsa* for flatulency in pregnant women. *Monatja,* their roots are said to be toxic, they are decoction taken orally in low dosage to avoid adverse effect, pregnant women use them to prevent birthmark on their unborn children (Moteetee & Seleteng-Kose, 2016).

Mothibe and Tshabalala (2018) discovers that during labour process Basotho use *pitsa* called *phakisane*, which translates to quicken. They said that, that plant is named after the realisation that it can speed up labour process. Moteetee and Seleteng-Kose (2016) supports that *Phakisane* roots decoction are taken orally by pregnant women as *pitsa* for their hurrying effects. To ease labour Moteetee and Seleteng-kose (2016) finds that *Setima-mollo* roots and leaves are decoction, taken orally as *pitsa* for pregnant women to ease child labour and *mohlana oa pere* and *qobo*, is cooked together for *pitsa* that is taken on the 8th month of pregnancy. they are meant to shorten the labour process and help the baby come out fast and easy (Mothibi & Tshabalala 2018). *Motsitla*, given parturition their roots are decoction and taken orally as *pitsa* to ease labour and strengthen contractions (Moteetee & Seleteng-Kose 2016).

Lesotho said to have highest maternal mortality ratio in Southern Africa, and there is no hope that there will be reduction in maternal deaths in Lesotho because of unsafe use of

herbal medicines during pregnancy continues to be a thread to accomplishing that goal (Mugomeri, Chatanga, Seliane & Malbvise 2015). According World Health Organisation (WHO) (2005), the lifetime risk of dying from pregnancy-related causes in Lesotho is 1 in 45, lower than the average of 1 in 22 for sub-Saharan Africa but higher than the global average of 1 in 92.

In Lesotho, majority of women who use *pitsa* do not go through three stages of active labour, the average stage of labour is said to last for 6 to 8 hours, but for those who use *pitsa*, labour happen suddenly and in forceful close times (Mothibe & Tshabalala 2018). They exhibit that contractions and delivery among Basotho pregnant women who use *pitsa* occurs very soon after the labour pains began, at least in less than 5 hours or as little as 3 hours. In their observation, Mothibe and Tshabalala (2018) implies that, hurried labour may result in complications such as extensive tearing of birth canal leading to extensive bleeding after birth, failure of the artery to diminish back to normal size. They put that sometimes arterial rapture occurs and if not noticed early, the woman may bleed to death (Mothibe & Tshabalala 2018).

Mothibe and Tshabalala (2018) highlights that quick labour that normally occurs among Basotho women who use *pitsa* during pregnancy not only harm the mother but the baby as well, pointing out that the baby may experience difficulty in breathing, the heart activity of the baby as well may also be affected, leading to fatal distress. All these caused by rapid exit through the birth canal. For instance, Moteetee and Seleteng-Kose (2016) found that there are 48 plants species that are used for pregnancy and labour. On the other hand, there are complications that might arise due to the use of those plants. Mothibe and Tshabalala contributes that *pitsa* does not help if the baby is in the right position rather cause the baby to breech. In that case, caesarean delivery is recommended, but it get difficult if the patient is in precipitate labour because then there is no time to go to the theatre (Mothibe & Tshabalala, 2018). This finding relates to situation of Lesotho where there is no easy access to health facilities. On the other hand, some nurse midwives reported the positive effects of *pitsa* as its good work to shortening and inducing labour for some women (Mothibe & Tshabalala, 2018).

2.5.2 The safety issues in the use of traditional medicine in Lesotho

In the study conducted in Lesotho by Moteetee and Seleteng-Kose (2016), they did not show the measurement to concoction of plants that they believe can cure certain illnesses, majority of them are said to be used for pregnancy. Mothibe and Tshabalala (2018) advice that researchers supposed to recommend a laboratory-based analysis of the traditional medicines used during pregnancy, for the purpose of clinically ascertaining the effects of these medicines on mother and child. Mugomeri et al (2016) add that safety of herbal products is a major concern in Lesotho. Ingredients, dosage, side effects and competing signs of these traditional medicines sold in Lesotho are usually not listed or are wrongly labelled.

Mugomeri et al (2016) clarify that there are several indigenous plants that are used during pregnancy with all the question of whether they are appropriate or not. Eskinazi and Mindes (2001) agrees that the reference of CAM and their existence today derive from old age traditional systems of other cultures and today the public and scientific community wonder why their use increase so fast, for they are under-research. In his research, Abbott (2014) found that high profile cases of hazardous effects from herbal medicine supplements have demonstrated the possible dangers of poorly regulated traditional medicine.

Moreover, Mothibe and Tshabalala (2018) list traditional medicines that are used by Basotho for different ailments and during pregnancy, and majority of them are entrusted to induce labour without no dosage and supervision. Mugomeri et al. (2015) found out that Lesotho has the highest maternal mortality rate in Southern Africa, due to unsafe use of medical herbs during pregnancy.

2.6 SUMMARY OF THE CHAPTER

Studies from different parts of the world show that CAM has been there for a while as one of the indigenous methods of healing. CAM use has been observed and interpreted

differently from continents to continent; from the European, Asian, and the African continent including Lesotho. There seems to be different social influences as well into the use of CAM according to different cultures. It always been observed that CAM always play vital role into the lives of people who resort to it. People turn to use both conventional and CAM medicines that are available in their continents or their countries. In some countries like the European countries, there seems to be harmony in the use of both conventional and complementary medicines because conventional doctors are realizing the importance of CAM in the holistic healing of a human person, while on the other hand in African countries literature shows that there is reluctance for nurses and doctors to accommodate CAM in the healing system, therefore there is a lot unknown about CAM in Africa than in European countries.

CHAPTER THREE: RESEARCH METHODS AND METHODOLOGY

3.1 INTRODUCTION

The object of the current study is to explain women's belief, attitudes and practices. The study of people's views and beliefs is best conducted through qualitative research designs. Therefore, this chapter describes the model adopted for researching the subject matter of the study namely, an interpretive paradigm. Then it explains qualitative research approach and case study design. Thereafter, participant selection, data generation and analyses methods are discussed. The chapter concludes with a description of how the study ensured trustworthiness and adopted methods of generating data ethically.

3.2 RESEARCH PARADIGM

This study has adopted a combined constructivist/interpretivist paradigm which acknowledge that reality is socially constructed and takes many forms (Riyani, 2015). According to Morgan (2014) a constructivist/interpretivist paradigm is founded on the view that people have unique experiences and beliefs, and no one can explain their reality without invoking on their perception. Within this model, knowledge is relative to and best explored by engaging the people whose experiences we seek to understand. The paradigm does not seek to predict or manipulate the research environment but to allow a platform for narration of participants' reality (Lincoln & Lynham, 2011).

From this perspective, knowledge is socially constructed, hence the concept social constructivism and the researcher comes to explain meaning which already exists hence his or her interpretative role (Creswell & Creswell 2018). The current study seeks to explain individual stories of Basotho women on how they go through their pregnancies using pitsa and each participant would have a chance to give her personal meaning and these meanings will reflect lived reality for participants. Creswell and Creswell (2018) note that within this worldview, reality has multiple and varied meanings and that the researcher must listen carefully for meaning which reflects individual participants' reality,

and since a researcher has his or her background, she/he must acknowledge its potential influence on understanding participants.

Generally, a constructivist/interpretivist paradigm enables the researcher to explain multiple views of a research problem through the eyes of participants, which is the pursuit of a subjective epistemology that emphasises social context and human diversity (Rashid, Rashid, Warraich, Sabir & Waseem 2019).

3.3 QUALITATIVE RESEARCH APPROACH

A qualitative research approach relies on spoken and written text and does not emphasise data in numerical form (Wolgemuth, Erdil, Moody, Opsal, Cross, Kaanta, Dickmann & Colomer 2014). According to Leddy and Ormrod (2015), although qualitative studies cover a variety of methodologies that are distinct from each other, they have two features in common: they deal with issues that are happening or have previously happened in natural settings and their description seeks to capture reality in its diversity (Leedy & Ormrod 2015). As inspired by the constructivist/interpretivist approach this qualitative research tries to gain insight into the specific meanings and behaviours of women in their use of pitsa during pregnancy and explain this social phenomenon through their subjective experiences. It is designed to help the researcher understand the participants, the social and cultural context within which they live (Riyani 2015).

In this study, women shared their experiences regarding the use of '*pitsa*.' The qualitative research approach helped the study to gain in-depth, rich, and contextualised experiences of women who provided clarity on reasons behind their use of traditional medicine. According to Jackson, Drummond and Camara (2007), the focus of qualitative research is to understand human beings' richly textured experiences and reflections about their experiences. The researcher relies on the participants to offer in-depth responses to questions about how they have constructed or understand their experience. Qualitative research design was important in this study because in as much as all these

women went through the same experience of using *pitsa* in their pregnancies they had different stories to tell and different concepts to that.

3.4 CASE STUDY DESIGN

This study explains the case of Roma community which is a community unique from others given its resources. Roma is located about 35km on the southeast of Maseru, the capital city of Lesotho. It takes its name historically from being the first place in Lesotho where the Roma Catholic Church settled and established its mission. As such, the church established monasteries and seminaries as training colleges for its clergy. The country's only public university, National University of Lesotho, which started as a Roma Catholic College – Pius XII is located here. Among other institutions are, Roma Nursing College, attached to St Joseph's Hospital, three secondary and six primary schools. The community mainly an agricultural community depending on livestock rearing and crop farming.

Case study design is considered when the focus of the study is to answer how and why questions and one cannot manipulate the behaviour of those involved in a study (Baxter & Jack 2010). Leedy and Ormrod (2015) state that with case study design, a researcher gives contextual details to the case including the socioeconomic and historical background to the selected case to help readers and researchers draw conclusions about similar contexts. A case study design suits a study that explores a topic which is poorly understood and can help track changes in human behaviour over time (Leedy & Ormrod, 2015). Babbie (2013) opines that a case study deals with a single illustration of a social experience in a village, or a family to give insight into an issue under study. Case study researchers may seek a distinct explanation of a particular case under examination and in this study, women's use of *pitsa* during pregnancy in an effort to bring into light ideas about a belief system (Babbie, 2013).

Storman (2013) says case study design is appropriate for qualitative methodology, which seeks to make an in-depth examination of a particular case of some social phenomenon,

such as a village or a family. Roma valley is a densely populated community that has more than three primary and high schools, a theological college, has the only national university and also has a large public hospital. Given the accessibility of a public health facility which is cheap, the current study seeks to find why pregnant women use *pitsa* despite accessibility to a health facility.

3.5 PARTICIPANT SELECTION

Participant selection was done purposively by selecting women above 18 years, who had given birth to at least one child in the community of Mafikeng Roma. The study involved 11 women. Convenience sampling is a non-probability sampling in which a researcher uses the participants who meet certain practical criteria such as “easy accessibility, geographical proximity, availability at a given time, or the willingness to participate are included for the purpose of the study” (Etikan, Musa & Alkassim 2016, p. 2). On the other hand, participants are purposively selected when it is believed their participation would help the study address the problem it has identified (Leedy & Ormrod, 2015).

Selection of the participants was done until the point of theoretical saturation. That is, there was no fixed number of participants identified for the study, but interviews were continued for as long as the given information add further details. Thus, selection was continued until there was commonality to their stories (Fusch & Ness, 2015). Sanndors et al. (2017) add that theoretical saturation occurs when the complete series of ideas that make up the theory is fully shown by the data.

3.6 DATA COLLECTION TECHNIQUES

Through data collection a study systematically collects information about people or objects and can also gather information about the contexts in which the phenomena occur. Qualitative data collection techniques include, among others, observations, face-to-face interviews, focus group discussions (Chaleunvong, 2009). Data collection is an important aspect of the study because it is a process of gathering and measuring

information of interest in a systematic fashion so as to answer stated research questions (Kabir, 2016).

As a qualitative study, this subsection explains qualitative methods of collecting data that Grundmeyer (2012) says contribute to discovering the meaning that people give to events that they experience. This study used qualitative interviews where the researcher conducts face-to-face conversations with participants or telephone interviews, or conducts focus group discussions with six to eight people in each group (Creswell & Creswell, 2018). According to Creswell and Creswell (2018) interviews, which is the only data generation methods intended for this study, entail giving unstructured and open-ended questions that are few in number and intended to stimulate opinions from the participants.

As Babbie (2013) notes, being curious of the world around, asking questions and jotting down answers are natural human processes. In this study, the researcher wondered about in the village and inquired about women with at least one child, once ethical considerations were addressed, told stories about their lived experiences in relation to using pitsa while pregnant. Grundmeyer (2012, p. 58) affirms that qualitative interviewing is suitable when “studying people’s understanding of the meaning in their lives world”. As an interviewer, I used an interview schedule which had a set of standard questions to be covered and asked in an open-ended manner so that participants can be free to share their stories as if in a natural conversation (Babbie, 2013, p 346).

According to Harrell and Bradly (2009), semi-structured interview guide is used, with questions that must be covered in the same manner across participants. Interviewing is the best technique to find out things we cannot directly observe, for instance, feelings, thoughts and intentions, and therefore qualitative interview results in thick accounts of the subject matter being studied (Grundmeyer 2012). Semi-structured interview suits the study because it is often used when the researcher wants to dig deeply into a topic and to understand thoroughly the answer provided (Harrell & Bradly 2009). This study adopted

standardised open-ended interviews because this allowed asking participants the same questions, hence the increase in response comparability among interviewees (Johnson & Christensen 2014). The method was good for this study because it gave participants chance to answer liberally and gave me as the researcher opportunities to record participants' understanding of the topic (Morgan 2014). While interviews proceeded, as a researcher used an audio-recording device to record data.

3.7 DATA ANALYSIS TECHNIQUE

Data analysis is the process of bringing order, structure and meaning to the amount of collected data (Baxton & Jack 2010). Once data are collected, they were transcribed to produce textual information which were read several times for familiarisation for the purpose of analysis and interpretation. The study adopted thematic analysis approach to analyse data. According to Akinyode and Khan (2018) thematic analysis is an attempt to organise data into sets of similar messages. Castleberry and Nolen (2018) state that messages are given codes to mark differences between participants' perceptions about the concept. The analysis organises themes into matrices to arrange participants' roles, key themes and variables across them and data sources are identified into rows and columns to provide a broad visual representation (Castleberry & Nolen 2018).

Castleberry and Nolen (2018) explain that themes are patterns takes numerous pieces of related code to show a bigger picture of what is being depicted for themes can be further divided into sub-themes. Therefore, they depict that, two common ways qualitative researchers put the data back together within themes are by hierarchies and matrices because thematic hierarchies provide a visual tool with which to articulate how themes are subordinate or superordinate to each other. Hierarchies are constructed by clustering similar codes to produce higher-order codes.

In this study, the hierarchies and matrices clarified which one is a main theme and which one falls under. The broad themes were highlighted, and the subthemes were outlined

below them. The aim was to organise, interpret and present the collected data to bring light on the occurrences and settings of interest and to remain contextually grounded (Jason & Glen wick 2016). Maguire and Delahunt (2017) say the goal of thematic analysis is to identify themes, patterns in the data and the researcher is not looking for anything beyond what a participant has said or what has been written. The study organised data into common messages that respond to the objective of the study.

3.8 TRUSTWORTHINESS

In qualitative research trustworthiness helps explain what in quantitative research is called validity of results. Leedy and Ormrod (2015) explain trustworthiness of qualitative research results to examine the quality of the results. Trustworthiness is an assessment of research results to say they are valuable (Elio & Kaarlainem 2014). In explaining the trustworthiness, several procedures are assessed such as credibility, dependability, conformability, and transferability.

Trustworthiness offers power and guidance to develop thoroughness in a study. According to Yin (2011), the first objective for building trustworthiness and credibility is that qualitative research must be completed in a publicly accessible manner. Trustworthiness refers to the degree to which the data obtained in the study is plausible, credible, and trustworthy (McMillan & Schumacher, 2010). It stems from the co-construction and interpersonal connection with participants and the subsequent data (Guercini, Raich, Müller, & Abfalter, 2014). Yin (2011) designates that trustworthiness is guaranteed by giving comprehensive and thick description of accounts completed from the planning stages through to the reassembling of interviews. This allows other people to be able to evaluate authenticity of a study through the confirmation used to support its findings and conclusions.

3.8.1 Credibility

Credibility is one of the four marks for quality in qualitative research. Tracy (2013) states that a credible report is the one that a reader is happy to use findings to make decisions. One way in which credibility was attained in this study were to give thick descriptions of socioeconomic and cultural contexts of each participant so that readers can draw their conclusions on factors which influence participants' views and beliefs.

According to Daynes (2019), a report must reflect sincerity in its traditional sense and must be read as a truthful report showing genuine feelings of participants. To achieve this the researcher collected data, used a diary to record my thoughts and observation and once data were transcribed and they were sent back to participants for member check, so that they can affirm their views in the transcribed data to reduce chances of bias interpretation of the researcher (Creswell & Creswell 2018).

3.8.2 Transferability

Tracy (2013, p. 239) calls transferability a process through which readers "appreciate a study's findings and then intuitively apply them to their own situations". Transferability refers to the possibility of referral to findings because of its good value (Elio & Kaarlainem 2014). The current study explained how data were collected, confirmed and analysed to allow verification of findings by other researchers. Therefore, there was a good explanation of the way data were collected and analysed to give readers information to judge if there was "possible transferability of findings to other milieux" (Bryman 2012, p 392).

3.8.3 Dependability

Dependability refers to the stability of data over time and also how that data will still be reliable overtime (Elio & Kaarlaine, 2014). Riyami (2015) states that the study is supposed to be constant even after many years. According to Van de Riet & Durrheim (2006, p. 94) dependability can be achieved "through rich and detailed descriptions that show how certain actions and opinions are rooted in and develop out of contextual interaction". This

study provided description of the area of Roma community and explained the social and economic backgrounds of the participants.

3.8.4 Confirmability

Confirmability refers to the objectivity, that is, the potential for comparison between two or more independent people about the data's correctness importance or meaning (Elio & Kaarlainen 2014). Hays and Singh (2012) explain confirmability as whether results of a study show personal views of the research participants. It is also to find means that the participants provided the interpretation of the data not as conceived by the inquirer and ensuring data, interpreting and outcomes are rooted in the contexts and persons concerned (Riyami 2015). This is to say, the study is genuine, there is no bias in the research process and the findings. This principle is similar to objectivity or neutrality in quantitative research. In this study, the principle was addressed by quoting what participants said verbatim in the presentation of results to show their understanding of issues (Hays & Singh 2012). There was a clear difference between my analysis and real words research participants.

3.9 ETHICAL CONSIDERATION

The following ethical issues were considered in this study: the principle of do no harm, informed consent, confidentiality and anonymity. According to Neuman (2011), ethical issues are the concerns, dilemmas and conflicts that arise over the proper way to conduct research. Johnson and Christensen (2011) add that research ethics are a guiding set of principles that assist researchers in conducting ethical studies. As the researcher undertaking a qualitative study, I am responsible to consider the ethical issues to protect the participants from any kind of harm.

Babbie (2014) explains that social science research can lead to emotional and mental harm such as being angry, disturbed, guilty or afraid and makes researchers aware that they should avoid against such results in the participants. As a Social scientist, I tried to

be sensitive to the emotions of the participants so that I do not force them to share experiences they are not ready to. According to King (2010) ethics is conducting a study means that researchers must conduct studies in a way society views healthy and morally defensible (King 2010). This study explains two principles that were followed by the researcher once the university has approved the proposal and satisfied itself that the topic and questions were to do no harm to participants.

3.9.1 The principle of do no harm

According to Miles et al (2014, p. 66), all researchers must be guided by the classic principle of humane conduct: first, do no harm. Australian Council for International Development (2017) emphasizes that to fulfil this principle, research must be of value to participants, their community, country or development practice more broadly. It must be designed to minimise risks and participants must be duly informed of potential benefits and risks of the research. As a researcher and interviewer I had to make sure that participants understood clearly the purpose of the study and they are free to tell their stories and experiences of *pitsa* comfortably. There might be various aftermath to insensitive misconduct with the participant that might affect their self-esteem and future decision making. This research should be viewed as a platform to support and empower women to always to know more about what might be good for them and their health. I ensured participants study had no discomfort or embarrassment during the interviews by asking open-ended questions which required reflections of how they perceive themselves around their life experiences with no reference to educational knowledge that might make them feel interrogated about personal practices and their efficiency.

3.9.2 Informed consent

Fouka and Mantzorou (2011) state that the major ethical issues in conducting research is more about informed consent. They say that informed consent means that a person knowingly, voluntarily and intelligently and in a clear and unmistakeable way gives consent. Hays and Singh (2012) agree and add that a researcher should give participants

enough information about the purpose of the study so that participants can make the decision whether to take part willingly and without deception. In this study participants were made aware of their rights to participation and their information including the right to stop when they found the information that they must share are against their belief system and values. The researcher clearly highlighted that in taking part in the study, there will be no harm (Babbie, 2013) as the study is conducted with the sole purpose of acquiring a master's degree and information will be handled carefully to not share their identity as explain below under confidentiality.

Before collecting data, an authoring letter from the National University of Lesotho to the village chief and participants was made to ask for permission to conduct the interviews. The letter was written in native language Sesotho explain to the chief the purpose of the research (see Appendix A). An information note was read by the research to each participant using Sesotho before interviews were conducted so that they know what the study was about and their role (see Appendix B). Then a consent form was read before they could sign it as an indication that they agree and understand their role and they will participate (see Appendix C). They were informed that all the information collected was confidential and were assured that their experiences and perceptions would be treated anonymously.

3.9.2.1 Voluntary participation

According to Marshall, Adebamova, Adeyemo and Ogundirant (2006), voluntary participation is observed through the researcher informing the participants that their involvement in the study is voluntary and they can withdraw at any time at any time. Sigaud et al. (2009) state that research must affirm everyone's developmental process and individual characteristics in order to guarantee their voluntary participation considering their mental and ability to fully understand for their part in the study and decline on their own will by understanding fully what their rights are. Babbie and Mouton (2001) state voluntary participation among vulnerable people is hard to practice despite it being required for no harm principle, however, in this study informed consent will give

all required information to participants so that they can decide whether to participate or not.

3.9.3 Confidentiality

The idea of confidentiality closely relates to informed consent because participants can be open to share their experiences with a researcher if the researcher has explained the purpose of the study and also told them information they give will not be of harm to their lives (Hays & Singh 2012). Creswell and Creswell (2018) emphasise that researchers need to protect their research participants, develop a trust with them, promote the integrity of research, guard against misconduct and impropriety that might reflect on their organizations or institutions, and cope with new and challenging problems. To adhere to this, I ensured that the identity of the respondents remains anonymous in the research report by using pseudonyms instead of their real names, also that their participation in the study was voluntary and that they were free not to share information which made them uncomfortable.

The confidentiality criteria show respect for human rights such as the right to privacy and privileged communication (Hays & Singh 2012). Hays and Singh (2012) see a difference between anonymity and confidentiality as the say anonymity means the researcher record information in a way that she cannot link information with a person. However, because the researchers want to refer unclear data to participants and want them to confirm transcribed data through member check, confidentiality will be used instead of anonymity. Confidentiality means that the researcher can identify the person who contributed to a particular point but the public should not be able to do so (Babbie, 2013).

3.10 SUMMARY

This chapter has defined the research paradigm, research approach and design used in the study, including, participants' selection, data collection tools, analysis methods, and ethical consideration. It continued by designating numerous stages involved in the design

and development procedures of the research in this study. I have described the qualitative research approach and its methodologies for participant selection, data generation and analysis. The use of face-to-face interviews was thus perceived as suitable for this study as it permits for the generation of data through conversations. Lastly, the applicable of ethical considerations and trustworthiness of the research were chatted.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents and analyses results of the study which explored Basotho women's belief and perceptions about the use of *pitsa* during pregnancy. Data generation was guided by the four main objectives namely;

i. To explore Basotho women's perceptions about the use of alternative medicine during pregnancy.
ii. To explain women's reasons for using alternative medicine during pregnancy.
iii. To find out women's sources of alternative medicine during pregnancy.
iv. To find out if pregnant women are using conventional antenatal medication concurrently with *pitsa.*

Analysis of data brought about three broad themes namely, 1). Perceptions about *pitsa* 2) Mechanics of using *pitsa,* specifically source and availability 3). Reasons for using *pitsa*. Each theme is presented and analysed while highlighting the nuanced underlying meanings embedded in them.

4.2 PARTICIPANTS' BACKGROUND

Eleven participants were selected and interviewed for this study. Ten out of eleven participants were permanent residents of Roma while one participant had lived in Roma for only six months because it was her work of place. She was a domestic worker. All participants were married women who had two to eight children. The youngest participant was 30 years old while the oldest three participants were aged between 80 and 85 years. In talking about the age at which the participants got married, they indicated that they were married at the ages ranging from 15 to 26 years while the oldest three participants were uncertain. They estimated that they were not older than 18 years old.

None of the participants had a post-secondary qualification. First, the temporary resident of Roma had done twelve years of schooling, which is referred to locally as Form E. Three participants had done 10 years of school (Form C) and attained Junior Certificate. Another three participants had done nine years of schooling (Form B) while the rest of the six

participants did not go further than primary level education. They had less than seven years of schooling. Except for the temporary resident, 10 out of eleven participants were not working.

4.3 PERCEPTIONS OF PITSA

Findings of the study under this theme highlight women's knowledge, their sources of knowledge as well as views and reaction to *pitsa*. Presentation of each of the subthemes follows below.

4.3.1 Knowledge about pitsa

All eleven participants had a general knowledge about *pitsa*. The findings revealed that the use of *pitsa* is a normal practice among Basotho women. Asked if they knew about *pitsa*, the following were some of their utterances:

Mrs Makhi said,

> *'Yes, I know about pitsa even though I do not know that much about it'.*

Mrs Matla recounted,

> *'Yes, I know about pitsa, even though I really did not know the name, the mixture and where it came from when it was introduced to me. My elders would only encourage me to take it'*.

Although some gave answers right away, other participants were confused about what I meant by *pitsa* and sought clarity before answering. For example, Mrs Toba asked, 'What do you mean? Do you mean *pitsa* for pregnant woman?" Similarly, after some clarification Mrs Makoa finally said, 'Which pitsa, the Sesotho medicine? Yes, I know about *pitsa*'. Mrs Tsebo, referred to a herb and explained that she did not know the herb but had used it, she said,

> '*I cannot claim to know the plant (herb) but I know about pitsa because I used it when I was pregnant'.*

The findings about knowledge revealed that participants did not necessarily use the same terms. However, when asked if they used traditional medicine during their pregnancies, ten out of eleven participants declare that they used it. Some knew it was used during pregnancy and was generally referred to as Sesotho medicine for pregnant women. But

it became clear that there were some forms of misunderstanding about what *pitsa* as a word is. Given the mixed feedback about the knowledge, the researcher asked participants how they got to know about it.

4.3.2 Source of information about *pitsa*

It could be deduced that the knowledge came from their similar social environment and culture, but the main point was to find out how they were individually introduced to it. Nine out of eleven participants were encouraged to use *pitsa* by their mothers, mothers-in-law, or grandparents. The following are some of their views:

Mrs Fuma said,

'Pitsa was suggested to me by my mother but I did not use it. Later, I heard people talk about… They affirmed that they used it when they were pregnant so that their children could be born faster without much pain'.

Mrs Makhi said,

'I used pitsa when I was pregnant…. It was my mother-in law who introduced pitsa to me. I was living with my mother-in-law, you know how we are when we live with our in-laws, we always have to show that we are obedient and respectful. I had no choice but to do what they wish'.

Mrs Khau said,

'My mother-in-law introduced it to me when I was pregnant with my first child. It was in a form of roots, something that was shaped like carrots. I did not know the name. I have three children; with my other two children I am not sure if what I used can still be called pitsa because they were not root plants anymore.'

In her answer Mrs Ntoi who has four children said,

'I was young when I got married, I was about 15 years, and I did not stay long before falling pregnant with my first child'. My mother-in-law and my mother brought different kinds of pitsa for me.'

Mrs Matla said;

'When I got married, because I was 25 years old, one would not say at that age that I would struggle to fall pregnant, but it was difficult. The elders had to talk to me about

pitsa, they advised me to use it to open my veins to fall pregnant and I did not stop even after pregnancy. My mother-in-law always made sure that I had it'.

Mrs Toba, an 80-years-old lady, is one of the two participants who talked about the male figures in their lives that encouraged their use of *pitsa*. She recalled,

'When I arrived here my mother-in-law was no more. I heard some friends and other people talk about it, then I knew that there is pitsa that a pregnant woman had to take. I cannot really say I heard from my acquaintances only because my biological father knew more about traditional medicines. He used to collect them.

Mrs Tlali, an 85-year-old lady also said;

'Both my grandmother and my grandfather used to tell me about pitsa. I cannot really say they were traditional healers, but they knew a lot about traditional medicines. They used to provide Pitsa for me wherever they went either to the field for agricultural activities or when my grandfather looked after the animals. They usually collected herbs for different ailments'.

The findings show that participants were introduced to *pitsa* by a variety of persons, but it was mostly their elders such as parents or grandparents rather than peers. While most participants used *pitsa* because they were pregnant, one participant notes that when she seemed to have problems falling pregnant, *pitsa* was recommended as helpful. Generally, the findings reveal the use *pitsa* as a cultural practice that was transferred from older generations to the younger ones orally.

4.3.3 Women's views of *pitsa*

Participants were asked to give their evaluation of *pitsa* and the findings revealed neutral to positive views. The following are some of their views:

Mrs Fuma said,

'What I can only say is it that people have to put their trust in God because he is the creator of the universe. He is the one who is in control. These medicines might not work but God is always there. These medicines are sometimes being used to harm people. People might misuse those medicinal plants'.

Mrs Makhi said,

'I don't really know what I can say about pitsa. I just used it because I was confused and scared. Anyone who wants to use it can use it, it all depends on one's reasons'.

Mrs Makhi continued,

'I used pitsa out of confusion because my first child died immediately after birth…. I am not sure if I would have used pitsa if I was not young and confused. Hmm! [sighing] When I had my second child, they gave me pitsa… My Mother-in-law and other family members told me that before I had my second child, I had to go and see a traditional doctor or even a medical doctor to see if there was anything wrong with me. To see if everything is in place because they did not know under what conditions my first child died. But I did not go to any doctor because the pregnancy was unexpected … I delivered my second child without any complications, even though I passed my due date. I delivered normally like everyone else.

Mrs Khau reflected on using different types of *pitsa* with different pregnancies and thinks the one used in latter pregnancies worked better than what she used in her first pregnancy. She shared,

'I am not sure if pitsa worked for me when I was pregnant, or things happened because they were supposed to happen that way. What I know is that pitsa protects the child to be born at the right time. But my first child was born before his due date, even though I was using pitsa which was cooked plants roots… With my second and third child, I was using pitsa named 'khaketlana' (shell) or 'lehe la mche' (ostrich egg). The children were both born on their due date. I therefore think that the latter types of pitsa that I used in my pregnancies work differently'.

However, she shared some doubts as she also felt pitsa might be abused as noted,

'I later knew the traditional healer who gave women pitsa at my village, depending on those women's needs. Some asked for pitsa to help them conceive while others needed pitsa that would stop them from having children. He even knew how to manipulate their situation because he sometimes swapped pitsa. He swapped pitsa because he thought the women who did not want to have the child were too young or the woman who wanted the child were too old. At this point, I was scared that pitsa

can be misused, so much that I cannot be confident that pitsa work for what is meant for. Sometimes it might be one's belief that it worked while things happen the way they were meant to'.

Mrs Matla reported that *pitsa* was introduced to address a problem of not falling pregnant as she noted,

'I started using pitsa when I realised that it was difficult for me to be pregnant. It was nearly a year in my marriage without being pregnant. They started giving me pitsa and I fell pregnant…. Then my mother-in-law continued giving me pitsa so that the baby will stay at the right place, and for everything to be good. I was confused if both of my situations before and during pregnancy were to be addressed by the same kind of pitsa'.

The use of *pitsa* can be accompanied by some fears and superstitions as it is revealed in Mrs Matla's views,

'Like I said, as soon as I realised that I was pregnant I started using pitsa so that things would stay in their place, but with my third child I encountered some problems. I was bewitched so that I die with the baby. During my pregnancy, I had my menstrual circle, even though I was five to six months pregnant. In my seventh month of pregnancy, I got some labour pains, but nothing happened. My child was born after eleven months of pregnancy. I used pitsa at the beginning of my pregnancy. I think I used it when there was already something not right with my pregnancy. One is supposed to use pitsa as soon as they realized that they are pregnant'.

Mrs Ntoi seemed to show much interest and positive views about *pitsa*, she said,

'Nowadays these traditional plants we used as pitsa are no longer available as they used to be. They are also stunted unlike in the past. That discourages us to even introduce our children and daughters-in-law to use pitsa when they are pregnant or prepare for our grandchildren when they are sick'.

Mrs khetsi similarly shared positive views as she opined,

'It is my first time to talk to someone about these Sesotho medicines, especially pitsa. People might misunderstand them or misuse them. It is a private subject because others might misuse these plants and kill themselves or other people …. My first two children were delivered at the hospital I used pitsa at that time…. My third, fourth and fifth children were delivered at home, even though I did not use pitsa, pitsa does work.'

Mrs Toba, an 80-years-old lady shared,

'There were other pitsa that would be cooked, and I took it in a traditional cup called 'Mohope'. Nowadays those 'Mehope' are no longer available, one just uses a regular cup. There was pitsa that I used to take when labour pains started…. Pitsa does not have a name, it was called pitsa. You just differentiate them and their use according to pregnancy stage, for there were pitsa for every stage of pregnancy, and complications it entrusted to control, that is why others were called pitsa for sweat, because it helps to reduce body temperatures during pregnancy. The other one is called "phetola" named after the action of turning the baby, because it is used to turn the baby. There is also "phakisane" to speed up labour, and many others that I did not use myself'. There were pitsa for different stages, so they are named according to their help during those stages'.

Mrs Tsebo equally shared positive views,

'Anyone who wants to use pitsa can do that without a doubt because it will help them a lot. I do not find reasons why there are people against it because it has been used from generation to generation without fail and it has helped a lot…. In the past people were having many children than nowadays using pitsa and their children were healthy. So pitsa does work…. I will introduce pitsa to my child as well without a doubt. I will ask…. for it and find it because when I used it I was young, I did not ask where they got it. Now I have to find it for my child…. It was always cooked in a black tin and I used it and I will do that to my child'.

Except for a participant who seemed to rely much on prayer and indicated that she has never used *pitsa*, other participants had used it. The study shows that some participants used *pitsa* as a locally available remedy, but they have not developed any personal judgements on whether it is right or not. For some, the use of *pitsa* goes with superstitious fears of being bewitched and in that regard, they think it dispels any bad omen or spell cast of them while some participants are overly positive and want to continue the tradition.

4.4 MECHANICS OF USING PITSA

Participants were asked to share the ways in which *pitsa* is used including their sources and availability of *pitsa*, and the dosages. They also shared the stage at which *pitsa* was

introduced in their pregnancy and how they felt about using *pitsa* concurrently with modern medicine.

4.4.1 Source and availability of *pitsa*

Pitsa seemed to be found easily according to women who used it as they received it from mothers, mothers-in-law, and herbalists. Participants were asked to explain how the traditional medicine was accessed and the following were their responses:

Mrs Khau said,

'My mother-in-law always told me that she is going to fetch medicine from somebody, but I did not know that person and she would prepare and give it to me. Clearly it was not difficult for her to find it for me.

Mrs Ntoi shared,

'They were uprooted at the fields. Even though I did not know their names, they were abundant plants that we normally used for most of our health needs not only for pregnancy, even after the baby was born…. Other plants would be fetched from the mountain, but at that time they were everywhere. Other places were richer with traditional herbs than others, but that did not take way the truth that most of the plants at our homes were used as medicines and pitsa during and after pregnancy'.

Mrs Khotso, the 85-year-old lady recalled,

'It was normally our grandparents, or a traditional healer… My mother and grandmother picked the herbs for me, whenever one of them went out, either to attending her fields or going to fetch water they came with them, as if they were along the road and they just uprooted them'.

Mrs Khetsi said;

'My mother got it from one gentleman, he was a herbalist. He worked at one institution here at the science department, medicine section. He used to go and harvest medicines; it was their usual work to go and collect those herbs and medicinal botanic plants. But he died long time ago. I used pitsa during my first and second child pregnancies, *even though I have five children. I was 19 years old when I was pregnant with my first child. I was worried when I had to go through other three pregnancies and my mother had died and no one helped me with pitsa, but in God's grace, the children were fine.'*

Mrs Makoa stated,

'My mother used to fetch it for me, it was found here at our village, we are living on the hills. Those plants are found at the hills and mountains… "Qobo" is sold in many places. Even at our village taxi rank there, there were gentlemen who sold it. When my mother did not fetch it from the field, I used to buy it at the taxi rank, near the University main gate.

Mrs Toba on the other hand said;

'Like I said, I did not have mothers on both side of my family, so I found my ways to get it myself. I sourced it from people around here.'

Mrs Tlali, one of the 85-years-old ladies said,

'I cannot really say, but my grandparents used to get pitsa when they went to the fields or when they went to get firewood. It was found everywhere at that time. There were a lot of plants at that time that were used for most of illnesses… Even that peach tree was a headache medicine at that time. It was burned and one would inhale its smoke to cure a headache. So many things were used. We did not go to the doctors when were sick. I used 'Mohalakane' for stomach pains. Our elders were our doctors at that time'.

Mrs Tsebo in addition said,

'They are plants that people would uproot in the fields. Even here at Roma at the mountain one can find them depending on the season. People who know them always get them because they are basically everywhere'.

All participants except for Mrs Toba relied on their elders to source the medication for them at the time they needed it. Mrs Toba personally got it from people she knew, and indicated no challenges finding people to give her the medication. Participants also indicate that traditional medicine was not for pregnancies only, but families benefited from healing of ailments such as headache, stomach pains etc. using locally accessible plants. Notable is the fact that none of the participants says they are experts in finding and using *pitsa*, they seemed passive recipients at the time they used. Passiveness is displayed in Mrs Khetsi who used it for two pregnancies because her mother was alive and never used it with the three children born after her mother's passing. The proximity

of the community to the National University of Lesotho played a role as one participant mentioned her source as someone who worked for the botanic garden of the university, and another mentioned a taxi rank outside the university gate as the market for such medicine.

4.4.2 Preparation, dosage and pregnancy stage of taking *pitsa*

Participants were asked to explain the processes of preparing *pitsa*, dosage and timing of the dosage in the pregnancy. Most said they consumed what was already prepared for them, with only few explaining how it was prepared as noted below.

Given that the age of Mrs Khotso, 85 years old, and the fact that she had eight children, it could be concluded that she knew much about *pitsa* and its preparation, but she noted,

> *'I did not know how it was mixed, which plants were used but I used to take it, you know how our elders were, they always cared for us in terms of medicines, but they never showed us'.*

Mrs Makhi started a slightly active engagement,

> *"What I knew was that it was Sesotho medicine, some form of plants roots. I just started cooking and drinking it … I used pitsa with my second child, right from the first month as I lost the first child maybe from not taking it.'*

Mrs Khau said;

> *All the time there were those plants roots left on our window seal to dry in the sun. I realised that they were cooked when dry… I drank half a cup in the morning and in the evening, I did not use it during the day... I was about 17 years old, and pregnant with my first child and it was in the middle of my pregnancy, when I was about six or seven months into my pregnancy. At that stage where I came from there was a believe that one really had to use pitsa because it was at the end of the pregnancy. My mother-in-law always told me that my pelvic bones would not be ready for delivery unless they are tightened to make them ready for birth stage'*

Other participants mainly commented on the dosage and timing as noted below.

Similar to Mrs Khau, Mrs Makoa took it in the later months of pregnancy as she noted,

'I used to take half a cup once a day. I did that with all five of my pregnancies... I used to take it from five months of pregnancy until the day I had to deliver my child... After the baby was born I took another pitsa called 'qobo.' 'Qobo' worked very well so I did not hesitate to use it, who doesn't want to service after carrying blood clots for nine months?'

Mrs Ntoi said

'If not mistaken, I used to take either a full cup or half a cup three times a day: in the morning, during the day and in the afternoon. It all depended on how I was instructed to take it. I used pitsa in all of my four pregnancies from the first month I realised I was pregnant so that things stay on their places.

Mrs Toba said;

'I was taking half a cup three times a day. From two months of my pregnancy until I had a child, with all my pregnancies… Around my second month of pregnancy I took pitsa, because in the first month, one is not sure if she was pregnant or not. In all of my children's pregnancies, I used pitsa I realised that it worked very well for me. I was glowing but you never tell everyone that its pitsa that is doing that for you when people compliment your looks'.

Mrs Khotso said;

'*No, I did not have dosage instructions. I took it just randomly in my cup, because it was there and they told me to drink it'.*

Mrs Tlali said;

'There were no measurements, we only use a cup to drink it anytime one remembers. From the time I realised was pregnant?...I do not remember clearly but, what I know is as soon as I realised that I was pregnant, I started using pitsa until the child was born.'

Mrs Tsebo concurred, she said;

'No there were no measurements. Because it has no bitter taste you can drink it like water, anytime you want. You can drink more than a litre a day. *I used pitsa from seven months of my pregnancy until the baby was born. With both of my children, I knew that I did not want to suffer during my children's deliveries, hei, [she was laughing] I just went in and came back with a baby with all two of my children'.*

Similar to an earlier finding that the participants seemed passive in finding the sources of *pitsa* during the periods they used it, it is noted that they were not much involved in the preparation of it either. Sketchy information shows that it was roots that are normally dried before they are cooked. It is also shown that there is not uniform dosage or the stage of pregnancy at which to start the medication. Some participants note that there was no prescribed dosage.

4.4.3 Concurrent use of *pitsa* with conventional medicine

Given the proximity of the village communities to a large public hospital and clinics was within walking distance, participants were asked to comment if their use of *pitsa* was concurrent with modern medicine that seemed equally accessible. Majority of participants stated that they used *pitsa* and antenatal care medication from the clinic at the same time as noted in their responses below.

Mrs Khau said,

"Yes, I was using antenatal care treatment together with *pitsa*."

Mrs Makhi explained,

'Yes I used pitsa and medicines from the clinic, only with my second child... because the first born did not survive… With my third child, I did not use pitsa because we were not on good terms with my mother-in-law, I did not even know where she got pitsa. So I did not know where to get it myself. I only used medicine from the clinic'.

Mrs Ntoi, a 65-year-old lady with four children recounted her story even though none of her children were born in Roma.

'Yes, I used them both because there was nothing wrong with doing that. They were both helping me. Pitsa is very important, there is nothing wrong with it because it enhances the life of the baby'.

She continued,

'With my last born, the nurses told us that women who were above 30 years, who had at least one child, did not have to come to the nearby clinic for delivery. The clinic was not big enough to accommodate many people. Only younger women who had their first-born babies delivered their babies helped at the nearby clinic, a short walking

distance. So they said older women could handle labour pains on their way to the district hospital which was a bit far. When labour pains, started I knew nurses were not going to take it well, since they had all those rules. I prepared myself and I took my pitsa so that the baby would be born faster, so that the nurses would not get annoyed that I wasted their time, yet I knew I was not supposed to be there. On my way (to the nearby clinic), I stopped at my relative's place to prepare pitsa. When I arrived, the nurses went out to organise transport that will take me to the district hospital. At time when I was left alone in the room, I started drinking it and threw away the bottle through the window. As soon as the nurse entered the room the labour pains were strong, and it was not long before the baby was born'.

Some participants used only one form of medicine. Mrs Khotso, the 85-year-old lady, disagreed with the concurrent use of *pitsa* and antenatal care. She recounted,

'No, I did not go to the clinics. I only used pitsa and all my children were born at home, Hm! [she said with excitement, whispering and bending towards me] Ever since my elders introduced pitsa to me I was also drinking Sesotho beer so I did not think much about what that was [laughing]…I took both of them without any problems'.

Similar to Mrs Khotso, Mrs Matla recalls drinking beer as well, as she shares,

'Yes, [laughing] I used them both because there was no problem in doing that. They were both helping me'... 'pitsa is very important. There is nothing wrong with it. It enhanced the life of the baby... With my last born, I was craving Sesotho beer. So, I drank it with pitsa and medication from the clinic at the same time. My child's skin was very clean when she was born. She was very beautiful. She did not have blood that usually appear on a child skin during delivery'.

On the other hand, although Mrs Tsebo attended antenatal clinic, she made no concurrent use of the medication as she shared,

'No, not really, I used to go to the clinic to take the pills that they give us but I did not use them. I used pitsa instead of them. I put those pills aside'.

The findings reveal that some participants attended antenatal clinic but seemed to have no full reliance on its treatment as they continued to use *pitsa* to the last stages of their

pregnancies. On the other, two participants were very clear, their trust was with the *pitsa* and not modern medicine as one lady delivered her babies at home while the other went to the clinic for courtesy calls only but used *pitsa* exclusively. Two participants also mentioned using beer while using the two types of medicine concurrently.

4.5 REASONS FOR USING PITSA

In recounting their initial and continued use of *pitsa*, participants were asked to state reasons they used *pitsa* and whether using it was not life threatening. A few illustrative cases of the various justifications are stated below.

Mrs Makhi narrated,

> *'No, it did not frighten me when they first introduce me to pitsa because after my first child died for not using pitsa during that pregnancy. Later that year my sister-in-law came home because she was pregnant and according to the tradition she was supposed to have her first child at her birth home. I saw my mother-in-law preparing pitsa for the rest of her pregnancy, she came when she was around five months because she was supposed to stay alone when her husband was at work, in the mines in South Africa. On her due date, she gave birth to a healthy baby, and I was not surprised because I thought maybe when someone is pregnant she is supposed to take pitsa for protection, which was not the case with my first child… My fist child died because there was no Sesotho traditional medicine that I used to protect me during my pregnancy'.*

She continued,

> *'When I realised that I was pregnant I had to be smarter than before, difficult situations taught me lesson. I still had hope when I had my second child, hm (sighing) I never knew that children could just die like that, I always blame myself that maybe if I had used pitsa with my first child and did not hide my pregnancy things would have gone well, and the baby would still be alive. That is, why I always make sure that I do not make the mistake of not taking my pitsa every day from as early as possible in my pregnancy with my second child. With my first child, I came to my marriage already late in my pregnancy and the baby was born, may be my mother would give me pitsa on time if I did not hide my pregnancy'.*

Mrs Khau, a 46-year-old lady revealed,

'No, at that time I was young, I did not think much about many things. Even when some people tried to scare me about many terrifying and unexpected things that can happen during delivery, that passed. It was always difficult to find meaning in so many things when you were me, 17 years old and pregnant. What I also realise now is that I was too shy to ask my mother-in-law many questions. She would think I was disrespectful. So, when she talked about pitsa I was not nervous, all I wanted was to be safe since she told me it is for my safety'.

She continued,

'People can misuse or take advantage of other when they are pregnant to cast a spell on them so that they have complication or get difficulties during labour. Sometimes one end up having a caesarean section for no reason'. So pitsa was intended to protect the child so that it got delivered at the right time not prematurely or late, and also to protect the child to be healthy…. It protected me because both my second and third child were born at home not in hospital. With my second and third children I deliver at home and I was using 'khatetlana' that is also called 'lehe la mche' that is boiled to drink.

In the same manner, the 85-year-old Mrs Tlali confided,

'No, those things of being scared or surprised were not there at that time. Even a feeling that one can kill you with traditional medicine was at the back of our minds. I was young and stupid, again they were given to me by people I trusted with my life…. It was a norm and part of our culture to use pitsa, because we even had the belief that when one did not take pitsa during pregnancy they might encounter some problems…. There were different types of pitsa for different reasons during pregnancy. There was normal pitsa that one took for pregnancy, there was another pitsa that one took for sweat, also entrusted to prevent vaginal sores or vaginal rash'…. There was also pitsa that prevented vaginal sores and rash. It was a mixture of water from boiled sorghum and the pitsa liquid drank as one dose. This was pitsa for Sweat, 'Mofufutso'…. There was also pitsa one would take at the last stage of pregnancy to ease labour pains'.

She added,

'Pitsa was the only option that a pregnant woman used during that time. So, my grandparents told me to take it so that I could deliver my child without any complications. It was called pitsa, they gave me the roots so I had to prepare it myself…. I was not sick. They were giving me for the sake of the child in my belly, so that the child grows well, and I do not get miscarriage, ho phutsa as she said it in Sesotho.

The 63-year-old Mrs Ntoi, shared,

'At that time at my home in Thabana Morena, Mafeteng, it was normal to take pitsa when one was pregnant. Pitsa was taken to protect both the mother and the baby. There is pitsa that one has to take during their seventh to ninth month of pregnancy, that is called phetola. Phetola helps the baby to turn, so that the head of the baby face downward in preparation for birth'.

In sharing reasons for using *pitsa*, Mrs Matla, a 46-year-old lady said,

'I was not really sick, pitsa was introduced because I was close to a year in my marriage without falling pregnant. It was used to help me conceive…. I used it again after I fell pregnant so that the everything would stay at the right place and I do not miscarry. I used it to protect my pregnancy. It also cleansed me, because before I used pitsa I used to have virginal discharge that was a concern but as I used pitsa it stopped... When I was pregnant with my fist child I was staying at my husband's home in Ha Marakabei. It was far in the rural areas the clinic was a two days walking distance so I used pitsa because it was the only antenatal medicine at that moment'.

Mrs Khotso, the 85-year-old lady opines,

'During pregnancy it was a norm to use pitsa, those were my only source antenatal care...I never went to the clinic for antenatal care... All of my eight children were born at home without any problems, so pitsa was very important and effective. I had no complications when I was using it during my pregnancies'.

A 38 years old lady, Mrs Makoa, said;

'When one was pregnant, I had a feverish type of condition where my body's temperature was high and I also had vaginal discharge. I used pitsa to treat the two conditions. Even after pregnancy pitsa that was called qobo also helped me to cleanse

my system after birth and to get rid of blood clots and stomach pains that one experienced after giving birth'.

The study reveals that participants used *pitsa* for a variety of reasons. Most importantly for majority of the participants was the use of *pitsa* as a norm and with modern medicine coming secondary to antenatal treatment. It is also notable that participants were married young and knew no better than follow in the footsteps of persons who had tramped the road before. There was also an element of trust between advocates for *pitsa* namely, parents, grandparents and in-laws which made participants adopt its use without much questioning. Participants also cite efficacy in that some use it exclusively and delivered at home without complications while some talk about ailments that were cured after taking it.

4.6 SUMMARY OF THE CHAPTER

The study found that *pitsa* was commonly used by participants in the study except one who relied on faith to her healing. Participants viewed *pitsa* as a common practice in their community and they were initiated into it by trusted family elders such as parents and grandparents. For most participants, when they first used *pitsa*, they were young and did not know much except heed advice by elders. The use of *pitsa* results from participants' perception that it works as they have not narrated any case of a person becoming ill due to its use.

None of the participants seems hand on in terms knowing which plant is used and picking it for themselves, they depended on their elders to the extent that for one participant, when her mother died, she never used *pitsa* in her subsequent pregnancy. *Pitsa* is known by the participants because it was part of the traditional medicinal system that the community uses for its health in general. However, it was not always normal to talk about it freely for there seemed to be different understandings and perceptions about *pitsa* and other alternative medicines or traditional medicines among Basotho. There was more positive common believes about *pitsa* and it is easy for participants to get it due to Lesotho vegetation and weather also a lot of support from family, community and friends. In the

same manner there is a realization that there is no openness and harmony between Basotho about alternative medicines, the use of *pitsa* and conventional antenatal care or medications.

CHAPTER FIVE: DISCUSSION OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter ultimately presents a discussion of the findings, conclusions, recommendations and limitations of this study. The findings are discussed using the three research questions, previous literature and the theoretical framework as guides to explore Basotho women's perceptions about the use of alternative medicine during pregnancy, explain their reasons for using alternative medicine during pregnancy, find out these women's sources of alternative medicine during pregnancy and also to find out if pregnant women are using conventional antenatal concurrently with *pitsa*. Moreover, the conclusions for the study are drawn to make results about the findings and contribution of the study. Lastly, the limitations of the study are outlined.

5.2 RATIONAL CHOICE THEORY AS THE LENS

As noted earlier, the RCT explains social and economic influences on human behaviour. Cha et al, (2016) show human behaviour as affected by three main principles/influences namely, family and societal norms, personal value/competence, and resource allocation. Looked from this lens, this study concurs with Cha et al.'s assertions. First, participants reported using *pitsa* because of family and societal norms. Secondly, none of the participants were really forced to use *pitsa*, they adopted it because it was a common practice they observed, and they gradually made it part of their practices or personal values. One participant used it so that she would not appear disrespectful to her mother-in-law, but she did not reveal any dissentient while another participant used another CAM, reliance on prayer. Finally, the use of *pitsa* was found to be affected by participants' resources. For example, though participants live in an area that has a clinic and a hospital within a walking distance, in their initial pregnancies they lived far from such modern medical facilities and CAM dominated health practices. They continued such practice after moving to a semi-urban place with better resources.

Ogu (2013) says the theory starts from an individual and in this study it was found that none of the participants had post-secondary qualifications and only one was working.

Higher education may influence people to be sceptical of CAM or *pitsa*. This relates to the role of allocation of resources. Cha et al. (2016) argue that knowledge helps people calculate risks and benefits for using CAM. However, there were no reports of any harm caused by CAM in this study. On the other hand, Hetcher and Kanazawa (1997) say RCT focuses on social instead of individual outcomes but states that individual and contextual factors work together. The study found that all participants knew about *pitsa* including a participant who did not use it. This showed that it was a social practice influence by, as Wittek (2013) states, individual preferences. The participants who used it showed that it was done, as Friedman and Hechter (1988) note, purposively and as showing individuals' ultimate values. In looking at the inaccessibility of health centres in the initial pregnancies of some participants, Ogu (2013) says people do the best they can, given their circumstances and in this case, *pitsa* was known to have helped women to give birth without complications. Frietman and Hechter (1988) summarises the understanding of RCT as they argue that people and, in this study, pregnant women developed their preferences from their intentions and limitations that arise from at least two independent issues namely, scarcity of resources and the differential possession of and access to such resources.

5.3 PERCEPTIONS OF *PITSA*

Findings of the study under this theme highlight women's knowledge, their sources of knowledge as well as views and reaction to *pitsa*. Presentation of each of the subthemes follows below.

5.3.1 Knowledge about *pitsa*

All eleven participants had a general knowledge about *pitsa*. The findings revealed that the use of *pitsa* is a normal practice among Basotho women. The study indicates that Basotho women knew about *pitsa* during the time they were introduced to it, when they were pregnant. They had a common knowledge about it due to their social upbringing, culture and their individual beliefs. Even one participant who shared that she did not use *pitsa* when she was pregnant but knew about it. Onyiapat et al. (2017) agrees that people of different worlds have common traditional beliefs about herbs they use as their complementary medicines. This study confirmed that people's knowledge of CAM derives

from being part of a particular cultural group. The term *pitsa* was not common to all participant despite them knowing a form of medicine referred by various names as good to use during pregnancy, which aligns with Onyiapat et al.'s (2017) view that different social groups have different belief systems and practices. Abbott (2014) also opines that CAM commonly refers to medical knowledge developed by indigenous cultures. Thus, the study established that *pitsa* is known to all and was used by all but one participant.

5.3.2 Source of information about *pitsa*

The study revealed that participants' knowledge came from their similar social encounters and cultural background, but the main point was to find out how they individually got introduced to it. Nine out of eleven participants were encouraged to use *pitsa* by their mothers, mothers-in-law or grandparents. Some participants went as far as stopping the use of *pitsa* for some of their pregnancies when they were not staying with people who introduced *pitsa* to them. Similarly, Cha et al. (2016) state that European perspectives show the main sources of CAM knowledge as the family/societal norms, person's preferences, and resources. Pal (2002) equally argues that CAM is adopted as a traditional health practice and the findings in this study that it is transferred by elders to the younger generation. The study also confirms an argument by one study in Lesotho, which shows *pitsa* as easily accessible (Seleteng-Kose, 2017). Easy access means it is a common practice where people in communities know and share wisdom about local medicinal plants (Seleteng-Kose, 2017). Traditional herbalists or doctors are also the source as some members shared that their parents got *pitsa* from a local herbalist. Generally, the findings reveal the use *pitsa* as a cultural practice that was transferred from older generations to the younger ones orally.

5.3.3 Women's views of *pitsa*

Participants' views reflected two major evaluations namely, neutral and positive appraisal. Participants' neutrality comes mainly from using pitsa early when they were young and did not know any alternative to pitsa for their pregnancies. Mrs' Fuma's neutrality is almost to the negative side as she thinks pitsa may not work but does not compare it to conventional medicine either; she is just a Christian believer. Positive views come from

the participants' views that it helped people deliver without any complications. For example, the 85-year-old Mrs Khotso delivered eight children at home relying on *pitsa* only. Similarly, the World Health Organisation (WHO) (2013) research indicates that traditional, complementary, or alternative medicine has many encouraging features, which leads nurses and doctors to appraise health results in some patients using CAM. Additionally, Abou-Rizk et al. (2016) concurs that CAM use has always been important among many patients living with life threatening illness and chronic diseases.

Except for a participant who seemed to rely much on prayer and indicated that she has never used *pitsa,* other participants had used it. The study shows that some participants saw *pitsa* as a locally available remedy, but they have not developed any personal judgements on whether it is right or not. The results support Peltzer's (2009) findings, which states that many people (40%) in China still rely on traditional medicine while Asian and Latin American populations use traditional medicine because they hold cultural belief. Lau (2012) also states that among the Chinese population, older members of family still likely hold traditional beliefs about antenatal care and pregnant women may have struggle in silence. Similarly, the study found that eldest participants were overly positive and say there was no choice during their time and they still hold that belief in traditional ways of doing things.

Some participants were confused in their experience of using *pitsa* because they were young and did not know better. The findings from European countries by Dodds, Bulmer & Murphy (2014) concurs that participants who seemed to be confused and had mixed feeling about *pitsa* still did not put aside the idea of using *pitsa* because as CAM users they were basically using it because of their cultural values, beliefs and philosophical orientation towards health and life. Cha et al. (2016) state that knowledge helps one to make decisions about risks and benefits, and with knowledge, people change behaviour. However, in this study all participants do not have college education. So, as Cha et al. (2016) see, they may remain using *pitsa* because their knowledge is limited.

For some, the use of *pitsa* goes with superstitious fears of being bewitched and in that regard, they think it dispels any bad omen or spell cast of them while some participants are overly positive and want to continue the tradition. In this regard, Sanchez (2014) reveals that knowledge is always a major barrier to CAM use, which justified that some views whether positive or not that positive still have to be modified by more knowledge to verify them.

5.4 MECHANICS OF USING *PITSA*

In locating the source and accessibility of *pitsa* participants saw it as a local resource easy to find and seemed removed from active knowledge of the plants and methods of preparations as noted below.

5.4.1 Source and availability of *pitsa*

Pitsa is said to be made from locally available plants, in particular plant roots. Parents and other elders were trusted to find the plants or in some cases, a local herbalist provided the medicine. One participant also noted that due to drought, the plants were wearing off and limiting the supply. Ogu (2013) argues that CAM choices are made given the availability of the resources and their choices of using *pitsa* during their pregnancies. In agreement with finding is Seleteng-Kose's (2017) research emphasises that medicinal plants in Lesotho are easy accessible. Research done from other countries by Shewamena et al. (2017) insist that in African Countries, Western medicine is not the core health care system. Masupha et al. (2013) on the other hand make an example looking at Lesotho situation, they realised that the family or society where traditional medicine was always at their disposal subconsciously turn to it as the major form of healing.

5.4.2 Preparation, dosage and pregnancy stage of taking *pitsa*

The found that as most participants did not personally source the medicine, most of them also did not know how to prepare it. Similarly, dosage varied from person to person, and it was also used at different stages of pregnancy by different participants. The findings

support research that not much is known about the use of traditional medicine. For example, Coulter and Willis (2004) say that there is no know knowledge bases to understand CAM. Onyiapat et al. (2017) say the practices differ from one ethnicity to another while Pal (2002) says while CAM is used globally, many practices have not been tested to decide which practice is right for which medicine.

In Lesotho, Moteetee and Seleteng-Kose (2016) state that there is no clear dosage to the concoction of plants that they believe can cure certain illnesses and the majority of them are said to be used for pregnancy. Similarly, Mothibe and Tshabalala (2018) make an example of the long list of traditional medicines that are used by Basotho for different ailments and during pregnancy, and most of them as the current study revealed, are entrusted to induce labour even though they did not have stable or prescribed dosages. Thus, users and in this case participants in the current study came up with their own dosages, for there was no one who had clear knowledge about dosages. Mugomeri et al. (2015) were of the view that the cause of high mortality and maternal rate in Lesotho may be due to unsafe use of medical herbs during pregnancy. However, participants in this study had good stories about their own experiences. Masupha, Thamae and Phaqane (2013) revealed that in Lesotho about 56% of traditional healers have only gone beyond primary education level but knowledge about the medicines is acquired from initiation school and their elders while still attending to livestock.

5.4.3 Concurrent use of *pitsa* with conventional medicine

Although participants lived in communities with proximity to a large public hospital and clinics within walking distance, majority still used both *pitsa* and antenatal care medication from the clinic at the same time. The use means purposeful and not because there no access to conventional health centres. All the participants who used the medicines concurrently said they did not tell the nurses that they were using *pitsa* even though they still attended their regular antenatal check-ups. Pal (2002) labels CAM as unproven medicine while he says conventional medicine is proven medicine and the idea of proven and unproven is echoed by Fontana and Lundberg (2009), but the participants did not pass such evaluations about *pitsa*. They seemed to think these

medicines complemented each other. One Australian research by Frawley et al. (2015) indicates that the confession of CAM use among pregnant women is very low, 76 percent of women who use CAM concurrently do not tell their midwives or doctors.

Shenamene, Tinashe and Smith (2017) agreed as a comparison to their study that about 80 percent of participants and other TM users, use it as the only available primary health care option. However, this study revealed that three out of ten women who used *pitsa* during their pregnancies claimed to have used *pitsa* alone in some of their pregnancies, one of them was 85 years old, the other 46 years old and the last was 35 years old. The 35 years old said it was her choice to use *pitsa* alone, the other revealed that at the point of using only *pitsa*, the clinics were very far, and as Shenamene et al. (2017) note, *pitsa* becomes the immediate antenatal care when conventional medication is inaccessible. In line with rational choice theory, Masupha et al. (2013) view the use of traditional or conventional medicine as dependent on the resources that a family provides for people from their childhood or in their upbringing. This argument seems to apply to the current findings.

5.5 REASONS FOR USING PITSA

The study revealed that participants used *pitsa* for a variety of reasons. Most importantly, most participants use *pitsa* as a norm and with modern medicine coming secondary. It is also notable that participants were married young and knew no better than follow in the footsteps of persons who had tramped the road before. There was also an element of trust between advocates for *pitsa*, namely, parents, grandparents, and in-laws, which made participants adopt its use without much questioning. Participants also cite efficacy in that some use it exclusively and delivered at home without complications while some talk about ailments that were cured after taking it. The finding compares with Possa and Khotso (2015) results who explained that some of the reasons for Basotho pregnant women to use *pitsa* was trust, affordability, and accessibility, showing that a world medicine situation in 2011 predicted that between 70% and 95% of the population in developing countries including Lesotho use traditional medicine (TM).

Some participants said *pitsa* helped them conceive and they used it immediately after pregnancy to nurture their bodies. In other word, *pitsa* seems to be a cure for any day ailments. Comparatively, Mothibe and Tshabalala (2018) notes that Basotho would use *pitsa* because of the advertisement by traditional healers that *pitsa* helps in prevention of miscarriages and shortens labour thus making it popular among pregnant women. Shenamene, Tinashe and Smith (2017) explain that one of the main reasons Lesotho and other African countries have more than 80% of their population use TM is because for most of them it is the only available primary health care option, especially in the rural communities. This compares with the finding in the current study as one of the participants revealed that she used *pitsa* because she had no other options. Similarly, Seleteng-Kose (2017) say Basotho resort to their traditional healing of inadequate health care facilities and shortage of human resource in health facilities. This scarcity combines with the fact that the traditional healing has always been part of a strong cultural heritage in Lesotho. Therefore, it would not be difficult for Basotho to rely on traditional medicine.

5.6 CONCLUSIONS

The study concludes that most participants had positive views about *pitsa* and its health benefits during pregnancy. The study also concludes that among the reasons women use *pitsa* is because of the cultural and/or traditional heritage which accommodate the use of *pitsa*. Pitsa is used by trust others and these trusted people provide network of emotional support for women to use the medicine. The study also found that participants do not have a judgmental attitude about *pitsa*, which made them compare it with modern medicine. It can also be concluded that *pitsa* is likely to continue to be used many pregnant women because of its ease of access.

5.7 LIMITATIONS AND RECOMMENDATIONS

The study is a qualitative study and only involved 11 participants from one community. Therefore, the findings must be read as referring to these participants and cannot be generalised to Lesotho.

It is recommended that a national study be conducted to establish the number of women who rely on *pitsa* and what kinds of plants they use for the purpose of *pitsa*. This study

would inform whether there is a need to do tests on the safety or danger of the plants used for *pitsa*.

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APPENDICES

APPENDIX A: INTRODUCTION LETTER FROM NUL

THE NATIONALUNIVERSITY OF LESOTHO
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Motšeanong 7, 2021

Moreneng Mafikeng
Ha Motoko
Roma, 180

Monghali/Mofumahali,

Kopo ea ho lumelloa ho etsa boithuto

Kea lumelisa. Ke kopela 'Matšepiso Mosia, moithuti sekolong se seholo sa sechaba, The National University of Lesotho, ho etsa boithuto motseng oa Mafikeng, khoeling ea Motšeanong 2021. Moithuti enoa o lakatsa ho utloisisa ka botebo tšebeliso ea pitsa ho mafumahali eo ebang ba kile ba e sebelisa kapa ba tseba ka eona. Ke hona, o lakatsa ho botsa mafumahali motseng mona, lipotso mabapi le tšebeliso ea bona ka pitsa. Lipotso tsena li tla botsoa feela mafumahali a amohelang kopo ea ho botsoa lipotso.

Ke tebello ea sekolo hore baithuti ba etse boithuto bona hore ba tle ba qete lithuto tsa bona selomong sena sa 2021. Ke kopa ke hona hore o lumelle 'Matšepiso ho etsa boithuto bona motseng oa Mafikeng.

Ka boikokobetso,

Relebohile.

Relebohile Morojele
Mosuoe oa NUL
Department of Sociology and Social Work

APPENDIX B: INFORMATION SHEET TO PARTICIPANTS

Information Sheet

Dear Madam

My name is Matsepiso Mosia. I am a student at the National University of Lesotho (NUL). As a part of my study, I am doing a research about the use of traditional medicine (pitsa) by Basotho women during their pregnancy. Literature shows that pregnant women use some form of alternative medicines when they are pregnant, for this reason, I am asking for your permission to take part in this research.

With your permission, you will take part in interviews that will take at least 30 minutes. The interviews will be audio-recorded to make sure that your opinions are captured correctly. It is voluntary to take part in this research; there is no consequence for not taking part. You will not be in any danger due to your contribution to this study and you will not be pressured to answer questions that you are not intending to answer. However, your opinion is important for the study and other women with regard to the use of pitsa during pregnancy, and its importance to pregnant women.

All the information you share during the interview will be used specifically for study and possible publication and for no other reason. Thus, the findings will be used for study purposes, including conference proceedings and publications. Your name or anything that identifies you will not be shown to protect your identity. To make sure that your contribution is confidential, there will be pseudonyms used instead of real names in this research.

Your participation will be appreciated.

Yours sincerely

.....

Matsepiso Mosia

(Student at the National University of Lesotho (NUL))

APPENDIX C: CONSENT FORM

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), wish to state that Mrs Mosia asked for my consent to take part in this research and she has told me about everything I need to know about taking part in the study.

I have read (or she explained) and understood information provided in the sheet.

I had enough time to ask questions and I decided to take part in the study.

I understand that my participation is deliberate and that I am free to stop at any time without consequences.

She told me that the study will not use my name in the research report and she will delete the voice record once she has finished writing it down. I agree that she records the interview.

Name & Surname of participant (print)	Name & Surname of researcher (print)
Signature of participant	Signature of researcher

APPENDIX D: INTERVIEW GUIDE

Interview Guide

Personal information

1. What is your name?
2. How old are you?
3. Are you married?
4. Have you ever attended school?
    - What is the highest level of education attained?
5. Are you employed?
    - What do you do for a living?
        - What type of work do you do?
6. How many days in a week do you usually work?
7. Are you a permanent resident of Roma?
    - How long have you been living in Roma?

Perceptions of using pitsa

8. Do you have any children of your own?
    - How many children?
    - When was your last pregnancy?
    - How old is the child
9. What do you know about pitsa?
    - Have you ever used pitsa?
    - If you have ever used pitsa, at which pregnancy did you use pitsa?
    - How old were you when you used pitsa?
    - Did you use pitsa during your last pregnancy?
    - At what stage of your pregnancy did you start using pitsa?

Reasons for using Pitso

10. What were your reasons for using pitsa?
    - Do you think pitsa was effective? Please explain.

- What was the dosage?
- Pregnancy number?

11. Was there a point when you stopped using pitsa during your pregnancy?
    - If you did, at what stage of the pregnancy did you stop?
    - What were your reasons for stopping?

Sources of pitsa

12. Where do you get pitsa?

- Family member
- Neighbour/acquaintance
- Traditional healer

13. What were the reasons for your family member or neighbour for giving you pitsa?
14. If it is traditional healer, how did find out the healer?
    - Location of the healer
    - Did anyone suggest the use a healer?
15. How did you feel when you started taking pitsa?
    - Did you hesitate?

Health concerns and the use of pitsa

16. What can you say about your health during pregnancy?
    - Do you get sick more often?
17. Do you ever visit antenatal clinic when pregnant?
    - At what stage of your pregnancy do you start consulting?
18. Does your doctor or a nurse know that you use pitsa?
    - If yes, how did you tell them?
    - What did he or she say?
    - Did they encourage you to continue using them?

- If no, why did you not tell them about your use of pitsa?

19. Is there anything else you would like to tell me?