

**THE INDIGENOUS PERSPECTIVE OF THE MEANING AND
TREATMENT MODALITIES OF DYSMENORRHOEA AMONG
THE BATLOKWA WOMEN OF LIMPOPO PROVINCE.**

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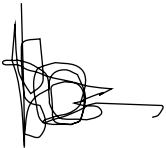
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DECLARATION

Student Number: 11370272

I, Melitah Molatelo Rasweswe hereby declare that “**THE INDIGENOUS PERSPECTIVE OF THE MEANING AND TREATMENT MODALITIES OF DYSMENORRHOEA AMONG THE BATLOKWA WOMEN OF LIMPOPO PROVINCE**” is my own work. This work has not been submitted before for any other degree at any other higher education institution. Information derived from the published and unpublished work of others has been acknowledged in the text and a list of references is given.



13 October 2020

Signed: MM Rasweswe

Date

Melitah Molatelo Motlalepula Rasweswe

DEDICATION

It is with great gratitude that I dedicate this work to the memory of my beloved parents. Thank you, for providing me with a wonderful example of kindness, compassion and integrity. My mother you passed on while I'm collecting data for phase 1, your motivation and encouragement for me to work even harder to wear a colorful graduation gown is largely the reason I pushed through and completed PhD. I wish you could have seen me finish this, but I know I have made both parents proud.

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ABSTRACT

The world, including developing countries such as South Africa, is burdened with deeply rooted women sexual health challenges such as dysmenorrhea. Dysmenorrhoea, also known as, "period pains", while not life-threatening, has been troubling many women of childbearing age since ancient times. Many interventions and drugs are available and approved for use in the treatment of dysmenorrhea. However, dysmenorrhea remains least understood, many cultures and religions of the African countries still regard it as a "taboo" subject because it is a sexual and reproductive issue, and means of coping are considered indigenously "women's knowledge", as such increasingly, women negotiate with cultural beliefs and practices in the management of dysmenorrhea. South Africa, as a multicultural society, allows the practice of different types of health care systems such as dysmenorrhea management. Extensive efforts are being made by the government and the healthcare sector to understand and document the indigenous health knowledge for safe practices in improving the overall health of South Africans. Moreover, this study was conducted.

This study aimed to understand the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. Purposive and snowball sampling was used to select participants. The findings were used to develop strategies to empower Batlokwa women with dysmenorrhea knowledge. This study was premised on a conviction that Batlokwa women have a unique perspective on dysmenorrhea meaning and treatment modalities based on their ethnicity background.

The study was conducted in two phases. Phase 1 was the empirical phase which was qualitative and was divided into two parts to address the first two objectives of the study. The population for Phase 1 constituted of the Batlokwa Traditional Health Practitioners (THPs) and Indigenous Knowledge Holders (IKHs). In part one modified photovoice approach was used to collect data in four different stages:

- Stage 1 – brainstorming and photograph taking training
- Stage 2 – taking photographs
- Stage 3 – Individual interviews

- Stage 4 – modified Lekgotla discussion

Data analysis for part one followed steps of photovoice data analysis guided by questioning the acronym “PHOTO” (Hussey 2006). The process involved photograph selection, contextualising and codifying. Photovoice enabled Batlokwa women (Traditional Health Practitioners and Indigenous Knowledge Holders) to share indigenous dysmenorrhea knowledge. Photographs taken by the participants were used to understand their perspectives regarding the meaning and treatment modalities of dysmenorrhea.

Part two used in-depth interviews to collect data from women. In-depth interviews were conducted with different women to enhance the knowledge gained from the photovoice study. It was also to capture additional information that should have been missed during the photovoice study. Content data analysis was used in part two to provide detailed guidance for the coding process and analysis.

The Africana Womanism theory was used as a framework to guide the study process and discussion of the findings and was grounded within critical realism worldview. This provided means to follow a systematic structure of understanding how the indigenous dysmenorrhea knowledge surfaced and maintained within the Batlokwa ethnicity. Five major themes were identified: holistic understanding of dysmenorrhea meaning; self-naming and definition of dysmenorrhea; diagnostic processes in indigenous health care practices; treatment modalities of dysmenorrhea; roles of THPs and IKHs in treatment and prevention of dysmenorrhea.

Phase 2 addressed the third objective, which developed strategies to empower Batlokwa women with dysmenorrhea knowledge. Experts from indigenous knowledge holders, traditional health practitioners, health and education sectors. To reach consensus, a modified Lekgotla discussion utilising an expert panel reviewed items for importance, clarity, applicability, validity and reliability, with items subsequently amended or removed as such clear strategies which apply to the demographic group was developed to empower Batlokwa women with dysmenorrhea knowledge.

Keywords: Dysmenorrhea; Indigenous knowledge; Indigenous Knowledge Holders; Lekgotla; Traditional Health Practitioners; Treatment modalities

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ANNEXURE K	Transcript individual interview
ANNEXURE L	Language editor's certificate

LIST OF ABBREVIATIONS / ACRONYMS

ABBREVIATION / ACRONYM	MEANING
COMETSA	COMETSA
CINAHL	Cumulative Index of Nursing and Allied Health Literature
DoH	Department of Health
IKH	Indigenous Knowledge Holders
ITM	Iranian Traditional medicine
NDoH	National Department of Health
NGT	Nominal Group Technique
NHS	National Health Services
PA	Percentage agreement
PBL	Problem-based learning
POPI	Protection of Personal Information
SASAS	South African Social Attitudes Survey
SHARE	Sanitation and Hygiene Applied Research for Equity
SIGN	Scottish Intercollegiate Guideline Network
SONA	State of the Nation Address
SOWETO	South Western Township
STI	Sexual Transmitted Infections
T&CM	Traditional and Complementary Medicine
THP	Traditional Health Practitioners
UNICEF	United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1

OVERVIEW OF THE STUDY

“IT IS IMPORTANT TO REMEMBER THAT ACKNOWLEDGING A PRACTICE DOES NOT NECESSARILY MEAN YOU ENDORSING IT!” ADOLF D. WOOLF (2003)

1.1 INTRODUCTION

There is a high prevalence of dysmenorrhea or “period pains” reported globally. According to a systematic review conducted by the World Health Organization (WHO), the prevalence of dysmenorrhea in the world was up to 94% based on reported cases (Latthe, Latthe, Say, Gülmezoglu & Khan 2006). Many countries, including South Africa, are faced with a challenge of controlling this burden. Literature shows that there are many strategies and methods in place to deal with dysmenorrhea (Acheampong, Baffour-Awuah, Ganu, Appiah, Pan, Kaminga and Liu 2019; Bezuidenhout, Mahlaba, Nxumalo, Meyer & Chukwu 2018:20; Lindeque 2015:32-34). However, in light of this overwhelming information, the prevalence of dysmenorrhea remains escalating and reoccurring to many women including adolescent girls (Acheampong et al. 2019; De Sanctis, Soliman, Elsedfy, Soliman, Elalaily & El Kholy 2017:242). Some of the women find the information limited and fragmented. Whilst other women indicated that the available information on dysmenorrhea is least understood (Chandra-Mouli & Patel 2017:2). Increasingly, these women prefer to negotiate with cultural beliefs and practices, to understand the meaning and treatment modalities of dysmenorrhea (Behmanesh, Delavar, Kamalinejad, Khafri, Shirafkan & Mozaffarpur 2019:228; Wong, IP & Lam 2016:262; deWet & Ngubane 2014:130; Hina, Wajeeha, Farzana & Humyra 2013:89; Wong 2011; Smith & Carmady 2010:53). However, women’s voices and choices on using cultural beliefs and practices for the management of dysmenorrhea are rarely promoted. It was, therefore, important to understand the indigenous health from the perspectives of its originators, believers and practitioners.

The research reported in this thesis engaged the Batlokwa Traditional Health Practitioners (THPs) and Indigenous Knowledge Holder (IKH) women of Limpopo Province, South Africa. This study

used modified photovoice, in-depth interviews and a modified Lekgotla discussion to explore and highlight their knowledge of indigenous meaning and treatment modalities and development of strategies to empower the Batlokwa women with dysmenorrhea knowledge. The study also highlighted the roles that THP and IKH women play within the community in the prevention and treatment of dysmenorrhea through their perspectives and stories. I had chosen to focus the study on women of Limpopo Province in South Africa because of my interest in the rich cultural diversity and traditions of its rural people, who comprise the largest share of ethnic or clan groups.

The study focused on the Batlokwa village community because from the literature, it has been the most ignored and under-researched group of people compared to other ethnic groups in South Africa. In addition, indigenous information on the health status, illness experiences and indigenous health care and healing of Batlokwa people are scarce. Specifically, this study was premised on a conviction that the Batlokwa women have a unique perspective on dysmenorrhea meaning and treatment modalities based on their ethnicity background. The study began to take shape when the principal researcher wanted to address, acknowledge and document a significant gap of indigenous dysmenorrhea care that she recognised while growing up in Botlokwa Limpopo Province in South Africa, through the voices of rural women. The study was guided by the Africana Womanism theory, modified photovoice and modified Lekgotla discussion to position and empower the women as co-researchers.

Chapter one outlines the synopsis of the entire research, putting more emphasis on the background and rationale, problem statement, aim and objectives, key terms, paradigm, theoretical framework, research design and ethical considerations, and how the study is organised.

1.2 BACKGROUND AND RATIONALE

Many South African women experience health issues associated with menstruation; these can include menstrual pain also referred to as dysmenorrhea (Bezuidenhout et al. 2018:19; Lacovides, Avidon & Baker 2015:272; Oni & Tshitangano 2015:214). It is well documented that these women regard sexual and reproductive issues such as dysmenorrhea as a private subject, with coping strategies indigenously considered “women’s knowledge” rather than medically or scientifically valid practice (Hennegan, Shannon, Rubli, Schwab & Melendez-Torres 2019; Ahuja, Sharma & Singh 2016:1; Lacovides et al. 2015: 274). While many drugs are available and approved for the treatment of dysmenorrhea, in many countries, women tend not to utilise them because they prefer

to rely on self-management with indigenous practices known to their communities (Behmanesh et al. 2019:233; Hennegan et al. 2019; Wong et al. 2016:272).

According to Hina et al. (2013:88), dysmenorrhea existed since ancient times, and it had been treated differently based on the indigenous knowledge, cultural beliefs and practices of the women. In support, the World Health Organization (2019) estimates that 80 per cent of the population in developing countries relies on indigenous health care systems as their primary source of care. Consequently, they give an undertaking for it to be considered in the health care system. In South Africa, the National Department of Health (NDoH) has taken firm steps in transforming and recognising indigenous health since the end of apartheid (South African National Department of Health 2015). Moreover, the existence of indigenous health in South Africa has been adequately demonstrated in the literature, especially HIV/AIDS health services (Nemutandani, Hendricks & Mulaudzi 2018; Burman 2018:166; Zuma, Wight, Rochat & Moshabela 2017).

Despite the above, indigenous health care is still poorly understood compared to Western health care. The poor understanding of indigenous health care feeds to confusion and frustrations in integrating it into the national healthcare system. This knowledge also faces the challenge of extinction (Hina et al. 2013:88, Reddish 2006:842). The evolution of indigenous primary health care services arose from mainstream health services being unable to meet the needs of indigenous communities adequately. It was also observed that indigenous health care is marginalised, whereas, in South Africa, most citizens use indigenous knowledge as the first entry to health services (Rikhotso 2017; Mulaudzi 2007:32). The reason is that indigenous health care services are part of their cultural beliefs and are offered and underpinned by the values and principles of their communities.

The indigenous health care system involves health promotion, prevention of illness, treatment and rehabilitation, however, differs from the Western health system in its integral and holistic approach. Moreover, Wilson, Oliver, Flicker, Prentice, Jackson, Larkin, Restoule and Mitchell (2016:81) concur with Flicker, O'Campo, Monchalin, Thistle, Worthington, Masching and Thomas (2015:1151) that the indigenous health care system is complex and shaped by indigenous peoples' historical experiences and worldviews. In South Africa, a rich cultural diversity of various ethnic groups influences the health of its population (Pillay & Teleki 2018:46). It can be argued that the multicultural influences make it necessary to explore and understand their health perspectives, in particular, dysmenorrhea as they might be able to offer insights that have been neglected by the Western health care system.

The efforts are towards the official recognition and use of dysmenorrhea indigenous knowledge in primary health care. Enhancing awareness of how rural women view, prevent and treat dysmenorrhea is increasingly important based upon the issue of decolonising health care (Olowokere, Oginni, Olajubu, William & Ironoye 2014:4040). However, this issue has received little attention and remains in a highly difficult space. Often, the documented beliefs and practices of indigenous health are faced with criticisms and negativity (Kahissay, Fenta & Boon 2017:1; Mulaudzi, Chinouya & Ngunyulu 2015:21). These do not reflect the truth about indigenous health. According to Chittabrata (2017:170), it is linked to historical colonialism in Africa.

The success of indigenous primary health care services is partly understood, because it often provide comprehensive programmes that incorporate treatment and management, prevention and health promotion, as well as addressing the social determinants of health (Percival, McCalman, Armit, O'Donoghue, Bainbridge, Rowley, Doyle & Tsey 2018:93). However, there are gaps in understanding the indigenous perspectives of meanings and treatment modalities. Nonetheless, the gap in knowledge about the indigenous meaning and treatment modalities of dysmenorrhea was partially corrected by gathering first-hand information from the Batlokwa women. This study addressed the identified gap; part of the solution was to recognise indigenous meaning and treatment modalities of dysmenorrhea. Modified photovoice assisted by modified Lekgotla discussion, and Africana Womanism theory principles drew the attention of the marginalisation in using indigenous knowledge for dysmenorrhea and empowered the Batlokwa women in developing strategies to empower other Batlokwa women with dysmenorrhea.

1.3 PROBLEM STATEMENT

In this age of increasing globalisation and demand of decolonisation, South Africa as a country with a cultural diversity needs to position itself to be able to provide health care to its citizens based on their indigenous knowledge. This will assist the country to guide and meet the needs and expectations of the diverse societies it serves. Indigenous knowledge formed an integral part of the health care history in South Africa (Rankoana, Nel, Mothibi, Mothiba, Mamogobo & Setwaba 2015). In addition, the NDoH in South Africa had put some strategies and methods in place to recognise indigenous knowledge in the health care system. The principal researcher, as a practising nurse and nurse educator, recognised the failure of the current strategies and methods to meet the varying dysmenorrhea needs of the indigenous women, because women have different perspectives about dysmenorrhea meanings and treatment modalities. In the same vein, Subasinghe, Happo, Ayasinghe, Garland, Gorelik and Wark (2016:829) and Armour, Dahlen and

Smith (2016) assert that globally women's choice of seeking help and managing dysmenorrhea are shaped by local knowledge and taboos relating to menstruation, as well as by personal preferences and available resources. Therefore, this study explored and described the Batlokwa women indigenous perspectives of the meaning and treatment modalities of dysmenorrhea using modified photovoice, in-depth interviews and a modified Lekgotla discussion. This was after recognising the failure of the currently available strategies and methods to meet the varying dysmenorrhea needs of the indigenous women,

The Batlokwa ethnicity, like many other South African Black tribes, preserved their indigenous health knowledge, such as dysmenorrhea despite the impacts of colonisation. As mentioned in the introduction, the principal researcher grew up in Botlokwa and learnt that the Batlokwa women and adolescent girls are knowledgeable about the meaning and treatment modalities of dysmenorrhea according to their cultural beliefs. She realised that most women in this particular community use indigenous knowledge successfully for dysmenorrhea care. However, the success of their knowledge in managing and treating dysmenorrhea is not known to the fellow South Africans and the world at large. It is because the knowledge is not documented but buried in the memories of indigenous practitioners. The other reason is that the use and value of indigenous knowledge for health care are negatively criticised and ignored in South Africa (Nemutandani et al. 2018; Rikhotso 2017). As such, its success in treating illnesses is not openly communicated.

In view of the abovementioned statement, it was, therefore, important for this research to also set out the platform to fill up the gap by developing and documenting the strategies to empower the Batlokwa women with dysmenorrhea knowledge.

1.4 SIGNIFICANCE OF THE STUDY

The study adds to the body of literature on the subject of women's empowerment because it provided an opportunity for the Batlokwa THPs and ICHs to voice out their indigenous perspectives on the meaning and treatment modalities of dysmenorrhea. By giving these women a voice, the study provided a general description of dysmenorrhea knowledge and treatment modalities from the Batlokwa women where customs. Cultures concerning women and dysmenorrhea have hardly been explored and documented.

The provided knowledge assisted in developing strategies to empower the Batlokwa women with dysmenorrhea knowledge. The health care providers, including Indigenous Knowledge Holders

(IKHs), can use the materials to educate patients and clients suffering from dysmenorrhea. Therefore, local women who are aware of the available indigenous health care and prefer indigenous treatment modalities than biomedical treatment are more likely to use this method. In future, the constructed strategies to empower the Batlokwa women with dysmenorrhea knowledge will be of value to the education, health and training for integrating indigenous and Western health. The findings of this study contribute to the literature through knowledge that informs greater comprehension and awareness of indigenous women’s health issues, as well as the complexity of culture, obstacles they face, and the specific healthcare services needed. Furthermore, the study contributed to the knowledge in the areas of feminism and gender studies, which seek to understand how women view and make decisions about their bodies. Finally, this study added to the current literature in assisting those who are in the academic and professional women’s health and Indigenous Knowledge Systems field. This is to grasp the complexity of the issue of dysmenorrhea from the perspective of women and research this issue further.

1.5 AIM OF THE STUDY

The study aimed to understand the Batlokwa women’s indigenous perspective on the meaning and treatment modalities of dysmenorrhea and to use findings to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

1.6 OBJECTIVES OF THE STUDY

Table 1.1 Research objectives

Phase 1 Part 1 and part 2	
Objective 1	To explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province.
Objective 2	To explore the roles of Batlokwa women in Limpopo Province as knowledge holders for the management of dysmenorrhea in their community.
Phase 2	
Objective 3	To develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

1.7 RESEARCH PARADIGM AND ASSUMPTIONS OF THE STUDY

1.7.1 Research paradigm

A paradigm or the researcher's philosophical worldview guide the research activity. According to Kaushik and Walsh (2019:1), a research paradigm is composed of certain belief categories and principalities to understand the nature of reality (ontology), the nature of knowledge (epistemology), and the philosophy of the research process (methodology) which includes the assumptions and values that serve as a rationale for the research. Further, Polit and Beck (2017) and Creswell (2014:6) refer to a research paradigm as a worldview or the lens through which people see the world. A paradigm guides action to encompass their values, customs, and beliefs developed through socialisation in the community. According to Creswell and Poth (2018:325), a paradigm defines the nature of the world to its holder, and the place of the individual within it, as well as the diverse possible relationships in that world. Each of the paradigms is organised around concepts, theories, assumptions, beliefs, and principles that form the manner in which a discipline interprets the subject matter (Creswell 2014:6). Therefore, paradigms are sets of beliefs and practices that are shared by communities of researchers and that regulate inquiry within disciplines (Lincoln, Lynham & Guba 2011). In order to understand why researchers choose certain paradigms for research over others, it is important to be cognizant of the underlying paradigms or philosophical worldviews and their contributions towards disciplinary knowledge construction.

The philosophical point of departure for this research study originates in the ideology of critical realism. Critical realism is most notable in the work of Bhaskar (2007). The decision to use critical realism paradigm in this study was based on its suitability for this particular research process. According to Botma, Greeff, Mulaudzi and Wright (2010:43), followers of critical realism do not just generate knowledge but seek to understand, explain and effect social change. In order to understand indigenous dysmenorrhea reality, this study used modified photovoice, in-depth interviews and modified Lekgotla discussion, guided by the Africana Womanism theory to position the Batlokwa women at the centre and as co-researchers rather than subjects. Photovoice was used because it fosters participation through capturing of photographs and attaching meanings to the captured photographs (Wang & Burries 1994). These were done to achieve the philosophy of critical realism, because at the core of critical realism lies a belief that individuals have a capacity for action, and continually appraise the world around them to gauge the need for response and action to bring social change (Bhaskar 1989). Through critical realism, pertinent and complex issues addressing indigenous knowledge of dysmenorrhea were illuminated. The Batlokwa women

(THPs and IKHs) explained their perspectives on the meaning and treatment modalities of dysmenorrhea to uncover the complicated multi-layered dimension of indigenous dysmenorrhea. Considering the report of Bunt (2018:176) that critical realists search external reality to construct social meanings associated with that particular reality, critical realism paradigm was appropriate and relevant to discover the truth from social, political, cultural, economic, ethnic and gender factors that Batlokwa ethnicity developed into reality over some time (Botma et al. 2010:44). The discovered reality, in turn, was used to effect social change through direct involvement. The women developed strategies to empower the Batlokwa women with dysmenorrhea knowledge. These were achieved by exploring the relationships between the Batlokwa ethnicity cultural beliefs on dysmenorrhea and aligning them to the power and benefits that their indigenous dysmenorrhea knowledge holds.

1.7.2 Philosophical assumptions

The three major dimensions of philosophical assumptions relevant to the critical realism paradigm and theoretical framework of Africana Womanism theory are discussed. These assumptions include: ontological (beliefs about the nature of reality and humanity), epistemological (the nature of knowledge that informs the research), and methodological (how to access that knowledge).

1.7.2.1 Ontological assumptions

Ontology is the branch of philosophy dealing with the nature of reality, which needs to unearth how the reality is formed and why it is in existence and what can be known and learned from it (Botma et al. 2010:40). The critical realism believes that the world is layered into three domains of reality. Sorrel (2018:1271) defines these different domains as 1) *actual*, meaning events which take place, 2) *empirical*, referring to the experiences of those events, and 3) *non-actual or real* referring to the structures, mechanisms, powers and tendencies which govern the events taking place in the actual world.

The application of critical realism in this study viewed the social reality of dysmenorrhea from Batlokwa THPs and IKHs as empirical (what is known as experienced within their ethnicity regarding dysmenorrhea), actual (what they practice successfully to prevent and treat dysmenorrhea) and real (what exists socially and naturally in their community to be used as objects to treat dysmenorrhea). Reality was derived from the captured photographs that THPs and IKHs presented to describe the indigenous meaning and treatment modalities of dysmenorrhea as

believed and practised in their community. Following the presentation and discussion of captured photographs through the individual interviews, the co-researchers participated in a modified Lekgotla discussion, to further deliberate the issue of indigenous dysmenorrhea until they realised the importance of their knowledge and positioned it as a health care system. Through the modified Lekgotla discussion, THPs and IKHs constructed meaningful statements of reality that were used to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

The Africana Womanism theory assisted in finding and positioning the Batlokwa indigenous dysmenorrhea as empirical, actual and real. It also liberated the Batlokwa women's knowledge from social and cultural oppression based on their cultural beliefs and practices (Chilisa 2012). On the same vein, Africana Womanism principles gave central focus on the situatedness of the co-researchers and the idea that meaning is generated in historical processes of collective experience over time. Noteworthy, the tradition of Africana Womanism principles enabled the study to investigate and succeeded in identifying and understanding insights into local knowledge on dysmenorrhea.

These were rooted in gender, social, and ethnic history, cultural beliefs on disease conception (naming), causation, signs and symptoms, prevention, progression and treatment modalities. Women indigenous THPs and IKHs, especially those who reside in rural areas, may accept and embrace such evidence to use in managing dysmenorrhea. The current study served as a step in such a direction.

1.7.2.2 Epistemological assumptions

Epistemology is a branch of philosophy that deals with the nature of the theory of knowledge (Botma et al. 2010:40). Critical realism accepts and posits that the nature of knowledge is relative to local understanding, and it emerged from social structures and history (Isaksen 2016:248). As such, all viewpoints must be equally valid and considered real. Accordingly, the indigenous knowledge generated in this study was based on the THPs and IKHs' perspectives and understanding of the meaning and treatment modalities of dysmenorrhea as known in their ethnicity. The focus of this study was to uncover the beliefs and powers that participants have to underpin their indigenous practice and use the findings to develop a plan of action for change. Moreover, the researcher used the power of indigenous knowledge within the social structures of Batlokwa ethnicity to initiate action. This positioned them as the knowers of the phenomenon under study.

Adopting critical realism provided a means to follow a systematic structure of understanding how the indigenous dysmenorrhea knowledge surfaced and maintained within the Batlokwa ethnicity.

1.7.2.3 Methodological assumptions

According to Botma, Greef, Mulaudzi and Wright (2010:41), methodological assumptions consist of rules and procedures specifying how the researcher must investigate the phenomenon. Critical realism paradigm advocates and supports for the methodology that will recognise and use different types and stages to construct knowledge (Isaksen 2016:248). This study employed modified photovoice, in-depth interviews and modified Lekgotla discussion to uncover indigenous dysmenorrhea knowledge. Photovoice has been identified as ideally suited to this study as it uses different methods to collect data. Additionally, it shares the focus of empowering participants with critical realism and Africana Womanism theory. In-depth interviews were employed to capture additional information from THPs and IKHs that were not part of the photovoice study. The other reason was to ensure that data saturation was reached. A modified Lekgotla discussion was used as a social forum in which ideas and perspectives were shared and would not be easily achieved through the use of photovoice and in-depth interviews. The modified photovoice, in-depth interviews and modified Lekgotla discussion are discussed further in Table 1.2 and Chapter 3.

1.7.3 Theoretical framework

The theoretical framework is the theory informing the methodology and providing criteria and logic that the research process should follow (Polit & Beck, 2017:119). During the research proposal development stage, the researcher scrutinised various theories and models to gain insight regarding this type of the research study and to find the appropriate theory or model to guide the study process. Therefore, this included the consideration of the purpose and objectives of the study and influenced the Batlokwa women to participate in the study actively. In this thesis, the Africana Womanism theory was used. Africana Womanism theory has an Afrocentric perspective to deal with African women's issues. Clenora Hudson-Weems developed the concept of Africana Womanism in 1987 out of the realisation of the total inadequacy of feminism to differentiate African women's life experiences from their Western counterparts (Hudson-Weems 1993:8, 22). The theory raises awareness that African women positioned themselves within "womanhood" ideology than feminists. The ideology of "womanhood" or "bosadi" as known in Botlokwa positions women at the heart of the discussion (Masenya 2004:120). The researcher centralised women to revive and

elevate the status of women within the African culture, not forgetting to critique the oppressive cultural elements (Masenya 2004:121).

The use of this theory was borne out of the need to delineate a platform for African women to have a standpoint regarding their indigenous knowledge. It was also to facilitate empowerment paying attention to the local cultural beliefs and practices (Chilisa 2012:161). The application of Africana Womanism in this study asserts that one needs to understand African culture and history (Afrocentric perspectives) in order to thoroughly understand the nature of the knowledge they possess and relationships between what they know and how the knowledge was constructed. Moreover, Hudson-Weems (1993:48) and Masenya (2004:120) concur that Africana Womanism differs from feminism theory because it deals with African women and their exclusive experiences and practices. It was clear that African women base their dysmenorrhea knowledge on cultural and ethnicity background. Chapter 2 further discusses how Africana Womanism was applied in this study.

1.8 OPERATIONAL DEFINITION OF TERMS

1.8.1 Dysmenorrhea

Lacovides et al. (2015:273) define dysmenorrhoea as painful, spasmodic cramping in the lower abdomen, just before and during menstruation, in the absence of any discernible macroscopic pelvic pathology, and lasts 8 -72 hours. The dysmenorrhoea pain may be accompanied by nausea, vomiting, diarrhoea, fatigue and insomnia. In this study, it is a pain accompanied by any unpleasant symptoms such as headache, nausea, fatigue, and more experienced by women during menstruation.

1.8.2 Indigenous knowledge

According to the South African Department of Science and Technology, notice 243 (2015:57) indigenous knowledge is tangible or intangible aspects of the whole body of knowledge that has been held, used, refined and transmitted by the indigenous communities collectively or as individual custodians to express their cultural identity. In this study, it is the knowledge that reflects the dynamic ways in which the women understand their natural environment, beliefs and practices regarding dysmenorrhea to enhance their lives, which is passed orally from one generation to another.

1.8.3 Treatment modalities

A method of application of, or the employment of, any therapeutic agent, usually limited to physical agents (Medical Dictionary for the Health Professions and Nursing 2012). In the current study, it is any practicing-activities that individuals or groups initiate and perform to relieve the symptoms of dysmenorrhea, which involves physical or spiritual agents.

1.8.4 Indigenous Knowledge Holders

According to Rikhotso (2017:9), Indigenous Knowledge Holders (IKHs) are community members who possess indigenous knowledge that has been developed within the indigenous community's cultural practices. The Indigenous Knowledge Holders did not undergo any training; they gained knowledge through observation; some was passed on orally by their elders. This study involved only women IKHs.

1.8.5 Lekgotla

Lekgotla is the African methodology used by the indigenous community to discuss community issues (Mphuthi 2015:31-32). In this study, Lekgotla is a gathering in which participants engaged in a discussion to construct the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. It was used as a method of data collection and analysis in Phase 1.

In Phase 2, it was used as an approach to facilitate deep thinking, creativity, consultation and verification of the decisions during the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge.

1.9 OVERVIEW OF THE RESEARCH DESIGN AND METHODS

This study was conducted in two phases.

- Phase 1 was conducted in two parts:
 - Part 1: Empirical or preliminary research, which gathered basic indigenous perspectives of the meaning and treatment modalities of dysmenorrhea from Batlokwa THPs and IKHs using photovoice.

- Part 2: Empirical or preliminary research, which gathered basic indigenous perspectives of the meaning and treatment modalities of dysmenorrhea from Batlokwa THPs and IKHs using in-depth interviews, in order to verify if Part 1 had reached data saturation.
- Phase 2: Focused on the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge.

Table 1.2 provides a summary of the research design and methods for both phases. The full description is in Chapter 3.

Table 1.2 Summary of the research design and methods

RESEARCH DESIGN AND METHODS	BRIEF DESCRIPTION		
	PHASE 1		PHASE 2
	PART 1	PART 2	
METHODOLOGY	Modified photovoice	In-depth interviews	Modified Lekgotla discussion
SETTING	Botlokwa village in Limpopo Province, South Africa		
STUDY POPULATION	<ul style="list-style-type: none"> • Women Traditional Health Practitioners and Indigenous Knowledge Holders • Women only • Residing in Botlokwa village, Limpopo Province, South Africa 	<ul style="list-style-type: none"> • Women Traditional Health Practitioners and Indigenous Knowledge Holders • Women only • Residing in Botlokwa Village, Limpopo Province, South Africa 	<ul style="list-style-type: none"> • Batlokwa women • Local stakeholders, including THPs, IKHs, Nurses, Teachers, local authority representatives, leaders from the community groups.
SAMPLING METHOD	<ul style="list-style-type: none"> • Purposive sampling technique first, then snowball sampling 		
SAMPLE SIZE	<ul style="list-style-type: none"> • Eight women in total • Three THPs and five IKHs 	<ul style="list-style-type: none"> • Seven women in total • Four THPs and three IKHs 	<ul style="list-style-type: none"> • 22 participants • Six THPs, ten IKHs, two registered nurses, three schoolteachers, one representative from local tribal authority
RESEARCH DESIGN AND METHODS	BRIEF DESCRIPTION		
	PHASE 1		PHASE 2
	PART 1	PART 2	
DATA COLLECTION	<ul style="list-style-type: none"> • Capturing of photographs (216 photographs) • Individual interview • Modified Lekgotla discussion 	<ul style="list-style-type: none"> • In-depth interviews 	<ul style="list-style-type: none"> • Dialogues • Debates
DATA ANALYSIS	<ul style="list-style-type: none"> • Photovoice data analysis steps • Analysed 24 photographs 	<ul style="list-style-type: none"> • Content data analysis 	<ul style="list-style-type: none"> • Qualitatively. Qualitatively it followed thematic analysis

1.10 ETHICAL CONSIDERATIONS

Ethical approval was granted through the Human Research Ethics Board at the University of Pretoria prior to data collection (Cresswell & Poth 2018:55). The research proposal was also reviewed and approved by the institutional review committees, including the Department of Nursing Science and the School of Health Sciences. To ensure scientific integrity of the current research, the researcher consulted supervisors to review her work throughout the study process. The supervisors provided feedback from the development of the proposal until the finalisation of the thesis. This allowed refinement of the research problem, research questions and objectives, theory and methodology to guide the research process, data collection and analysis as well as presentation of the results. In sum, the refinement of the research protocol was conducted. During the proposal development and write-up of the research findings, the researcher used only reviewed and evidence-based articles and acknowledged authors.

The researcher informed and explained the purpose of the study to the Batlokwa local authorities and participants. Approval to conduct the study prior to data collection was also obtained from the local authority after several meetings with the representatives and headmen. In the meetings, the researcher enquired about cultural, religious and other differences that needed to be respected, to avoid cultural beliefs and practices' violations. She emphasised and assured each participant that participation was voluntary, and they could withdraw their involvement at any time with no negative consequences. All the participants signed consent forms in order to be involved in the study (Cresswell & Poth 2018:55). Both verbal and photographic results were conveyed in a manner that ensured indigenous knowledge holder anonymity, and no names were linked to quotes or pictures when results were shared.

1.10.1 The Declaration of Helsinki principles

The researcher ensured that the Ethical Principles namely "Respect for persons, Beneficence and Justice" were maintained throughout the study, to protect the participants from harm and discomfort (Polit & Beck 2017:139).

1.10.1.1 Principle of beneficence and non-maleficence

This principle encompasses freedom to benefit from the research without harm and exploitation (Polit & Beck 2017:139), because research should make a positive contribution towards the

welfare of people. No physical harm resulted from participating in this study. Instead, this research acknowledged the indigenous perspectives of dysmenorrhea and treatment modalities of Batlokwa ethnicity. The researcher and assistant researcher were physically present during the first, third and fourth stages of photovoice to observe and assist any participant who needed to deal with discomfort. They also provided their telephone numbers so that any participant who experienced problems later in the absence of the researchers may have an opportunity to discuss any aspect of the study after the meeting.

1.10.1.2 Principle of respect for human dignity

This principle includes the right to self-determination and to full disclosure (Polit & Beck 2017:140). Participants' rights to self-determination were honoured as participation was voluntary; no one was forced to participate or threatened if they decided not to participate even after signing the consent form. The participants were informed not to answer any questions that caused discomfort; to disclose or not to disclose personal information and to ask for clarification about any aspect that caused some uncertainty.

1.10.1.3 Principle of justice

According to Polit and Beck (2017:141) this principle involves the right to fair treatment and the right to privacy and confidentiality. The selection of participants in this study was according to the study inclusion criteria not vulnerability. The researcher did not mistreat or threaten the participants who declined to take part in the study. All information from this study was treated as confidential and the information was only for the purpose of the research study. Participants remained unidentifiable throughout the research process including during the publication and presentation of results. Pseudo names were used during data collection and results' presentation.

1.10.2 Photovoice ethics

A set of ethical considerations specific to researchers employing photo voice methods was strictly adhered to throughout the process (Liebenberg 2018). Participants were trained on how to use the cameras during the recruitment process, training time and any time when they needed help. As a condition of the research ethics approval, participants were not permitted to take any photos of people showing their faces. This message was relayed to women when they received their

cameras. After being developed, the researcher reviewed all photos and removed any pictures of people prior to returning the photos to the women.

Ethics and consent during a photo voice project are an ongoing process. Participant researchers decided on which photographs ought to be part of the research project and which to exclude. During the study process, the researcher made verbal requests to take photographs, videos and audios. All participants were provided with written information and signed a written consent form at the start of the initial meeting. Multiple consent forms were used, including (i) the participants' consent to take part in the study, (ii) acknowledgment and release forms – for people who appeared in any photograph, and (iii) a form for release of the photographs asking permission to use participants' photographs in the dissemination of results.

Since there was uncertainty in how familiar participants were in taking photographs, the researcher selected simple disposable cameras with large, clear controls and default automatic operations. All participants were shown how to use the cameras during the recruitment process and during training time. Participants were also provided with written instructions and a reminder of the photography mission. Photo voice ethics should include considerations of research project agendas and power dynamics (Wang & Redwood-Jones 2001). For example, in this study, the researcher allowed each participant to choose their own photographs to be discussed, and the Lekgotla discussion facilitator allowed all participants to generate knowledge without influence from the research team members.

1.10.3 Protection of Personal Information (POPI) Act

The researcher followed the guidelines of POPI Act suitable for healthcare professionals, as suggested by Buys (2017).

1.10.3.1 Lawful information processing

- **Minimality:** Only the information relevant to answer the research objectives was collected from the co-researchers. The co-researchers were informed to take the photographs of objects and symbols related to the indigenous meaning and treatment modalities of dysmenorrhea. They were informed not to show the faces of the people when taking their photographs.

- Informed consent from the people who are photographed: This includes the principles of competence (mental and legal capacity), voluntariness (which includes autonomy, non-coercion and the right of objection) and disclosure of pertinent information (alternatives and risks). This was ensured by signing an agreement for taking and releasing a photograph (see annexure A)
- Data collection by participants themselves: The researcher opted for the photovoice method of data collection. This method involves the participants taking photographs, explaining why they are taking the photographs and be involved in analysing the data collected through those photographs.

1.10.3.2 The rights of the participants

The co-researchers were informed that the collected personal information would be published and accessed by others. However, it would not be traceable to them as individuals but as the Batlokwa women. They were also informed to withdraw from the participation any time they felt the need to do so, and that they were not obliged to share the information that they felt was sacred.

1.10.3.3 Personal information

The participants gave a voluntary consent for the release of personal knowledge, including photographs of their objects and symbols. The researcher ensured that the personal information regarding names and addresses was not used in the study. Only information regarding race, gender, marital status, ethnic origin, age, culture, language, education and employment are published but not traceable to the owner.

1.10.3.4 Recording of personal information

This entails any written, drawings, photographs, film negatives of personal information. In this study, the mentioned information was put in the safe possession of the principal researcher.

1.11 STRUCTURE OF THE THESIS

Table 1.3. Summary of the study structure:

CHAPTERS	SUMMARY
Chapter 1	Overview of the study
Chapter 2	Literature review and theoretical framework
Chapter 3	Research design and methods
Chapter 4	Interpretation and presentation of empirical findings
Chapter 5	Discussion of findings and literature control
Chapter 6	Discussion of the findings in alignment to the Africana Womanism theory
Chapter 7	Development of strategies to empower Batlokwa women with dysmenorrhea knowledge
Chapter 8	Summary of the study findings, recommendations, implications, limitations, researcher's self-reflection, and conclusions

1.12 SUMMARY OF THE CHAPTER

This chapter provided an overview of the phenomenon under discussion, namely the indigenous perspective of the meaning and treatment modalities of dysmenorrhea among the Batlokwa women of Limpopo Province. The chapter introduced the study, stated the problem, questions and objectives under study, highlighted the study's background, as well as the significance and relevance to this research study. It provided the rationale for undertaking the current research study, and summary of the study structure.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

A literature review is conducted to lay the foundation for the study (Polit & Beck, 2017). Neuman (2011: 125) opines that a literature review is an essential step in doing a study because reviewing the accumulated knowledge about a question or questions being investigated is very important during the research process. Moreover, Creswell (2013) alludes that a literature review assists the researcher in establishing research ideas and connecting concepts to form research questions and bound the study. In return, it provides a logical starting point for determining an appropriate methodology and theoretical framework to guide the study.

Considering that this study was aimed at understanding the indigenous perspectives of the meaning of dysmenorrhea and treatment modalities among Batlokwa women, to empower them with dysmenorrhea knowledge. It was worth reviewing existing literature related to indigenous health and healing. The review started with a history of indigenous health and healing, factors shaping perceptions of dysmenorrhea by indigenous health care systems, cultural beliefs and management practices of dysmenorrhea, discussion on practitioners of the indigenous health system and the roles of indigenous health practitioners in the communities. This was followed by the use and prevalence of indigenous health and healing systems in South Africa. In this chapter, the Africana Womanism theory centering the concepts relevant to this study was also described and grounded based on scholarly literature.

The primary purpose of the literature review is to explore what other scholars have contributed to the indigenous health care system and to sharpen and deepen the theoretical framework guiding this study (Leedy & Ormrod 2010:66).

2.2 SOURCES OF INFORMATION

The primary sources of information for the current study were journal articles, books and websites. Books were mostly used for definitions, background information and theoretical information that may not be available in some of the journal articles. Furthermore, the principal researcher attended seminars, participated in conferences and other training interventions that were relevant to the study to gain more understanding on indigenous knowledge. Journal articles were mostly consulted and referred to because of their frequency in publication and were found to have the most current and relevant information for this study.

2.2.1 Search strategy

Several libraries and electronic databases, including search engines, were utilised to obtain information relevant for review. Considering the scarcity of literature on this topic, the search engine was extended to scholarly and peer-reviewed journals, articles, papers, documents, websites, theses, and dissertations. The principal electronic databases that were utilised for the review included WorldCat.org, MEDLINE/PubMed database, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Taylor and Francis Journals database, Biomed Central database and Wiley Online Library database. Publishers' databases such as Springer, Elsevier JSTOR and ISSN were also launched. An internet search using Google and Google Scholar databases was also carried out. All these searches were maintained from the University of Pretoria database.

Keywords such as indigenous health care, indigenous dysmenorrhea, perceptions on indigenous dysmenorrhea, cultural management of dysmenorrhea and Africana Womanism were utilised in searching databases. Salient concepts that evolved throughout the literature search initiated further searches and cycles of reading, in which indigenous health care was replaced with indigenous knowledge; traditional knowledge; and cultural knowledge.

Throughout the search process, the databases were searched from inception through 2019 to scan relevant and latent peer-reviewed published citations, but more specifically, the focus was for 2015 through 2019. These were done to ensure the analysis of recent articles, which are less than five years old to meet the requirements for the dissertation as accentuated by the

University of Pretoria. The search list was refined manually to include studies conducted globally, Sub-Saharan Africa and South Africa.

2.2.2 Inclusion and exclusion criteria

The included articles were:

- Published in English
- Quantitative, qualitative or mixed methods
- From inception to 2019
- Focusing on indigenous health care
- Discussing dysmenorrhea globally, Sub-Saharan Africa and South Africa

2.2.3 Data extraction and analytic approach

For each study, I extracted information manually on the author(s), title, and year to assess the growth of the literature on indigenous and health over time. Content analysis was also employed to identify common themes across studies and integrated for a clear understanding of what is already known about indigenous health care and dysmenorrhea. These assisted with identifying gaps in the literature and making recommendations. However, some of the articles in this literature review are briefly referred to as they only provide supportive information for this study.

2.3 DISCUSSION OF RESULTS FROM LITERATURE.

This section discusses the results of the literature review in addition to an analysis of African Womanism theory to ground the importance of the current research.

2.3.1 What is known about dysmenorrhea: Western health perspective?

Dysmenorrhea, also known as “period pains”, is described as painful cramping of the lower abdomen because of menstruation (Lacovides et al. 2015:273). In addition to lower abdominal pains, many women with dysmenorrhea experience back and thigh pain, headaches, diarrhoea, nausea and vomiting (Lacovides et al. 2015:773). Dysmenorrhea may be primary without pathology or secondary to pelvic pathology (Bezuidenhout et al. 2018:19). However, Lindeque

(2015:32) suggests that a third type should be considered, i.e. once off, at the time of passing an endometrial cast (membranous dysmenorrhea). The pathophysiology of primary dysmenorrhea is related to the secretion of potent prostaglandins (especially PGF2 alpha) from the endometrium in the premenstrual and menstrual phases. This leads to vasoconstriction and uterine contractions (Lindeque 2015:33). The author further alludes that it becomes evident during ovulatory cycles, where the luteal phase is present and prominent. Some persons experience this very severely, and the description of primary dysmenorrhea should be reserved for such women. According to Lindeque (2015:32), primary dysmenorrhea is diagnosed based on symptoms. Bezuidenhout et al. (2018:22) list symptoms of primary dysmenorrhea as back and thigh pain, headache, diarrhoea, nausea and vomiting, of secondary dysmenorrhea as dyspareunia and menorrhagia.

Management of dysmenorrhea includes both pharmacological and non-pharmacological management (Bezuidenhout et al. 2018:20-24). However, treatment is based on the pathophysiology, aiming at symptomatic relief and the suppression of ovulation (Lindeque 2015:33). The choice of treatment is combined with oral contraceptives and nonsteroidal anti-inflammatory drugs (NSAIDs). It is believed that $\geq 90\%$ of women experience relief from pain when NSAIDs are taken during the bleeding phase of the menstrual cycle (Lindeque 2015:33). However, the burden of dysmenorrhea in women of all ages and ethnicity is more significant than any other gynaecological complaints despite progress in understanding the pathophysiology of dysmenorrhea and the availability of effective treatments (De Sanctis et al. 2017:242).

2.3.2 Prevalence and impact of dysmenorrhea

Hina et al. (2013:88) indicates that dysmenorrhea is a global sexual and reproductive health challenge that has been in existence since ancient times, with cases being reported in every country. De Sanctis et al. (2017:242), in a systematic review of 50 studies, found that the prevalence of dysmenorrhea is high, ranging between 0.9% to 94%. De Sanctis et al. (2017) study further, showed that there are different prevalence rates among females in different countries and different associated factors with dysmenorrhea or severity of pain. As such, it is considered a major gynaecological complaint; however, many do not seek medical care. Oni and Tshitangano (2015) conducted a study in rural South Africa on the prevalence of menstrual

disorders and its academic impact among TshiVenda speaking teenagers. The findings revealed a high prevalence of undiagnosed dysmenorrhea. According to Egenti, Onuorah, Ebenebe, Adogu and Egwuatu (2016), the true prevalence of dysmenorrhea is not known because women perceive menstrual pain differently, while some do not consult medical health care providers, moreover many cases are not documented.

Oni and Tshitangano (2015:217) link dysmenorrhea to a variety of harmful effects, affecting women physically, socially, psychologically, academically and economically. These, in turn, decrease women's quality of life, cause women's chronic absenteeism from work and changes in productivity or absence from school and classroom concentration in school-age women, which affects their overall grades, reducing their participation in sport and other social activities (Oni & Tshitangano 2015:216).

To add on the impact of dysmenorrhea, many studies indicate that dysmenorrhea has the potential to create significant chronic health problems. This is so because in some women, the pain is accompanied by excessive sweating, headaches, nausea, vomiting, diarrhoea, anxiety, mood swings and alter their sleeping patterns and pain perception (Nooh, Abdul-Hady & El-Attar 2016:138; Shewte & Sirpurkar 2016:475; Aboushady & El-Saidy 2016:53; Lacovides et al. 2015:773). One of the many burdens is the cost involved in treating the symptoms of dysmenorrhea on a long-term basis and finding a way to treat the complications as well. According to Yeh, Hung, Chen, Lin & Wang (2013), 38% of women regularly use medical therapy to treat their dysmenorrheal symptoms; and this burdens the health system.

2.3.3 History of indigenous health and healing

Indigenous healing had existed for many years before the arrival of Christian missionaries and the development of modern medicine in South Africa (Zuma et al. 2016). According to Setswe (1999:57), indigenous health and healing refer to the ancient system of understanding, managing and treating illnesses, which are culturally-orientated and used before the discovery of Western healing systems. In support of the above statement, Mothibe and Sibanda (2019) state that indigenous healing is one of the oldest healing systems, although it is poorly recorded.

Furthermore, the authors alluded that humankind has been using an indigenous healing system for the treatment of various diseases long before Western medicine. This suggests that it becomes more meaningful if understood from a socio-cultural point of view. Indigenous healing is not a homogenous healing system; it varies from region to region and culture to culture.

Lichtenstein, Berger and Cheng (2017:248) point that these healing systems have something in common, and every healing system is an integral part of a culture. That is, illness is culturally defined; therefore, in every culture, different symptoms are accepted as indicators that someone is ill; this might be the case with dysmenorrhea. This will determine the healing methods and health practices, which are dynamic and are continually influenced by internal creativity and experimentation. Mothibe and Sibanda (2019) note that it is because illness and different health care systems in any society are in one way or another closely connected to the culture or worldviews of that particular society. Nonetheless, it is well accepted that for centuries, indigenous health and healing was the only health care system available for the prevention and treatment of illnesses in different societies (Mulaudzi 2007:32).

In addition, Ozioma and Chinwe (2019:209) allude that every society develops its cultural way of dealing with illnesses. For example, the Māori in New Zealand, Australian Aborigines, Indians, Chinese, native Hawaiians, Native Americans, and more use different treatment methods. However, in some countries, indigenous health and healing are well rooted compared to others. For example, it is well established in countries such as China compared to South Africa. Meanwhile in South Africa, indigenous healing is well utilised mostly in the Black population (Mothibe & Sibanda 2019). Hence, De Sanctis et al. (2017) believe that perspectives of the meaning and treatment of dysmenorrhea differ from country to country. The populations that are using indigenous healing consider it as the best alternative treatment because of its intrinsic quality, unique and holistic approach as well as its accessibility and affordability (Nemutandani et al. 2018). According to the report of the World Health Organization, it shows that in 2012 indigenous healing was increasingly popular to treat many health problems (WHO 2019).

Further information on the report regarding indigenous health and healing shows that there was an increase in the number of Member States reporting the sale of herbal medicines with claims. Medical claims remained the most popular type of claim used for herbal medicines (WHO, 2019). The report suggests that globally, there is growing interest in advancing research for accommodating indigenous ways of knowing in many fields, including health. Moreover,

Moshabela, Bukenya, Darong Wamoyi, McLean, Skovdal, Ddaaki, Ondeng'e, Bonnington, Seeley, Hosegood and Wringe (2017) agree that African indigenous health and healing should be understood through the recognition of autonomy, beliefs and traditions of users and practitioners.

Although it is very challenging to define indigenous health and healing, it is possible to relate the history of ideas about health and illness to different populations, from generation to generation. The World Health Organization (2003) defines indigenous healing as “health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercise, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain wellbeing”. This definition qualifies the practice of indigenous healing to be holistic and embodies collective wisdom of indigenous knowledge, generated and shared among generations (Mokgobi 2014:27).

2.3.3.1 Indigenous prevention of illnesses

Indigenous health and healing have to do with maintaining a sound body, mind, and spirit in order to prevent illnesses (Lichtenstein et al. 2017:250). In order to prevent the occurrence and re-occurrence of illnesses, van Wyk and Wink (2004) identify that African indigenous health has different cleansing methods. Harfield, Davy, McArthur, Munn, Brown and Brown (2018) discovered that these prevention methods include: performance of purification rituals, abstaining from certain activities, and wearing protective materials. Nene (2014) states that, among others, these methods include therapeutic vomiting or emesis, steaming to inhibit sweating, enema, elimination of toxins through the nose (sneezing), animal sacrifices and bloodletting. It was identified that purification rituals play a role in preventing illness and fostering healing. According to Lichtenstein et al. (2017:250) toxins that build up in the body should be purified in order to prevent some form of illnesses. O'Connor (2007) alludes that purification in Māori healing practices involves applying pressure to various parts of the body to release and remove toxic build-up and waste. Native American purification rituals involve sweating, which purifies the body and soul (Lichtenstein et al. 2017:250). In South Africa, purification involves taking herbal remedies orally or through the skin, incisions to cleanse the blood; steaming with a mixture of hot water and herbs, whereby the vapour enhances relaxation and washes off bad luck (Campbell 2008).

Diet was also found to play an essential role in the prevention of disease by indigenous people because nutrition is considered the first line of defence in health matters (Cosio & Lin 2016). In agreement, the participants in a study conducted on the use of indigenous knowledge in primary health care: A case study of Makanye community in Limpopo Province, South Africa, reported that traditional subsistence crops, vegetables and fruits are nutritious foods and primary sources of body strength that reduces susceptibility to illness or disease (Rankoana et al. 2015:276). Indigenous healing believes that combining foods with specific properties at different seasons may ensure good digestion. According to Rahmatullah, Noman, Hossan, Rashid, Rahman and Chowdhury (2009) cited in Kasole, Martin and Kimiywe (2019), some foods provide health benefits beyond their nutritional value and are effective in the prevention and treatment of various diseases. Diets are typically focused on organic fruits, flowers, vegetables, seeds, spices and grains; hence the indigenous health practitioners recommend uncontaminated products and least processed food for their patients (Cosio & Lin 2016). In addition, Frimpoung and Nlooto (2019) reveal that Tswana THPs recommend the elimination of caffeine, salt, sugar, and other toxins to prevent chronic illnesses. Overall, a healthy lifestyle is key to the prevention of disease.

In addition, to diet as a means of preventing illnesses, literature revealed that physical activity is a protective factor against illnesses (Bustan, Seweng & Ernawati O'Donovan, Lee, Hamer & Stamatakis 2017; Sadarangani, Hamer, Mindell, Coombs & Stamatakis 2014; Warburton, Nicol & Bredin 2006). It is believed that keeping active promotes and maintains a good body, mind and spirit. According to these studies, it is widely recognised that physical activity has numerous health benefits related to physiological and psychological health. The different activities such as walking, dancing, yoga, and aerobics were listed as beneficial in promoting health. This led to WHO choosing physical activity as the theme of World Health Day in 2002, and most delegates adopted the resolution. Since then, each year, physical activity is observed as an essential strategy for health and wellbeing. Hence, Global health observatory (2016) and WHO global guidelines (2018) consistently call for a minimum of 60 minutes per day of moderate-to-vigorous physical activity by school-age children.

Many traditional healing systems emphasise body and spirit in disease prevention. Lichtenstein et al. (2017:154) found meditation, yoga and creative therapies such as art and music beneficial in the prevention of illnesses. According to Ayurvedic Medicine, regular massage with body oils,

yoga, and pranayama, also known as breathing techniques for maintaining balance prevent pain. Qigong is a traditional Chinese mind-body exercise that is also based on movement, breathing and meditation. In practising meditation and exercise regularly, the body can maintain homeostasis and prevent the onset of disease (Dong & Zhang 2001:17). Moreover, in 2017, the draft of the WHO global action plan on physical activity 2018 - 2030 was crafted and opened for the large process of commentary to promote health through physical activity. On the other side, if the practitioner perceives the cause of the disease to be an attack from evil spirits, the person would be protected using protective elements such as amulets, body marks, and spiritual bath to drive the evil spirits away (Ozioma & Chinwe 2019:199). These are rites aimed at driving off evil and dangerous powers, spirits or elements. Their function is to eliminate the evils or dangers that may have already taken root in a family or community.

2.3.3.2 Indigenous treatment of illnesses

Indigenous communities started their effective way of dealing with illnesses, whether physical or spiritual long before the arrival of Western health (Mulaudzi 2007:32; Shenefelt & Shenefelt 2014). Usually, this indigenous treatment of illness is holistic, where the physical and spiritual world are incorporated (Ukoma, Ogechukhu & Oji 2016:23). Treatment modalities include the use of herbs, cleansing, performing rituals and ceremonies to appease spirits, gods and ancestors. Treatment choice depends on the kind of illness as symptoms are related to the practitioner and the assumed cause of the illness.

Herbal remedies are found to be the most prevalent in use throughout indigenous healing systems to cure the illnesses despite the existence of Western medicine (White 2015). Herbal remedies are the oldest and still the most widely used system of medicine in the world today. Most societies and cultures use herbs to prevent and treat illnesses (Kpobi, Swartz & Omenyo, 2019:252). According to WHO (2019), herbal remedies are made of plant kingdoms such as leaves, flowers, barks and roots of trees, vegetables and fruits. Herbs may be used fresh or dry. A finished herbal product may contain whole plants, parts of plants, or a combination of other plant materials, as active ingredients intended for human therapeutic use or other benefits in humans and sometimes animals (Ozioma & Chinwe 2019:204).

In South Africa, remarkable discoveries have also been made in the knowledge of therapeutic plants, methods of preparing and administering of herbal remedies in some illnesses (Rankoana 2016:47). This knowledge resides with the specified practitioners (White 2015). To that effect, Maluleke and Ngulube (2018:126) highlight that practitioners hand the knowledge to the trusted family members or initiates. Moreover, secrecy and competition surround the use of indigenous medications. These herbs are used as preventative and healing medicines and during rituals. They come with specific instructions of preparation, dose and timeframes (Kpobi et al. 2019:258). Although the use of herbal medicines appears to be universal in different cultures, Ozioma and Chinwe (2019:193) realised that the plants used for the same ailments and the modes of treatment might vary from place to place. According to WHO (2018:85), the knowledge of properties of the herbs are essential, as well as their taste and toxicity. The herbs are combined for modifying effects, such as to make them less toxic or to have synergistic effects (WHO 2018:86).

Moreover, expert practitioners teach and train others on how to combine herbal medications (Nemutandani, Hendricks & Mulaudzi 2016). Herbal medicines are combined in such a way that the delivery of the primary treatment herb is aided by the associate, adjuvant, and messenger herbs. Herbs are usually boiled in water or mixed with food.

Herbs can also be burnt and applied directly to the bloodstream or inhaled through the nose (Ozioma & Chinwe 2019:196). Chanting and praying is another form of treating illnesses (White, 2015). Ceremonies are held wherein the patient, family and community members participate in singing and dancing to facilitate healing power (Monteiro & Wall 2011:235:238). According to Lebaka (2018), among the South African tribes, sacrifices are sometimes offered at the request of the spirits, gods, and ancestors. In a study conducted in Ghana, the concept of diseases and health care in African traditional religion showed that sometimes animals are slaughtered as a sacrifice to appease spirits, gods and ancestors (White 2015). Hence, Mokgobi (2014) states that appeasing spirits, gods, and ancestors is to calm them in case the illness or curse are caused by an invocation of a curse or violation of taboos. The author further indicates that appeasing will then be according to the severity of the case and ritual elements, and the spirit, gods and ancestors will instruct the process (ibid). A ritual element is offered and presented to the invoked spirits, gods and ancestors as a supplication or act on behalf of the patient, family and community for mercy (Lebaka 2019).

2.3.4 Factors shaping perspectives of dysmenorrhea by an indigenous health care system

The indigenous healing system conceptualises some illnesses such as dysmenorrhea differently from the other healing systems (Kpobi & Swartz 2019). For many people in African countries, various factors contribute to the conceptualisation of illness, including dysmenorrhea sufferings (Mokgobi 2014). The indigenous health systems often include components such as cultural norms and beliefs that have formed part of the everyday lives of people within communities when conceptualising illnesses. This pluralistic nature of illness conceptualisation and treatment modalities influence health-seeking behaviours.

White (2015) points out that there are several ways the indigenous health system explains or understands the causes of illness. For example, the findings from the study conducted in Ethiopia on beliefs and perceptions of ill-health causation revealed that several factors might cause illness (Kahissay et al. 2017). Furthermore, the participants listed supernatural (Almighty God/ Allah, natural spirits, and witchcraft), natural (environmental sanitation and personal hygiene, poverty, biological and psychological factors) and societal causes (social trust, experiences of family support and harmony; and violation of social taboos) to be the causes of illnesses. White (2015) adds that indigenously, illnesses revolve around witchcraft/sorcery, breaking of cultural taboos, the anger of gods or ancestors, natural, as well as inherited. Thus, illness is believed to be of natural/supernatural, cultural, or social origin. Cultural or social illness is thought to be related to supernatural causes such as angered spirits, breaking of cultural taboos, witchcraft, or alien/evil spirits, even for conditions now known to be well understood in modern medicine such as dysmenorrhea, diabetes and hypertension.

According to Moshabela et al. (2017), human beings are made up of physical, spiritual, moral, and social dimensions. On the other vein, once there is no harmony in these aspects, the illness will occur. As such, the treatment of illness includes both physical, spiritual, moral and social components of being (White 2015). Moreover, Nmutandani et al. (2018) and Moshabela et al. (2017) emphasise that the understanding of causes of illnesses according to indigenous health differs from the Western health systems, as articulated in this study.

Similar to cases in other African countries, South Africans have their understanding of dysmenorrhea aetiology and ways of managing and treating dysmenorrhea (Mothibe & Sibanda 2019). Many women depend on indigenous health care systems and make use of indigenous, faith and allopathic healing systems to manage their health needs (Mathibela, Egan, Du Plessis & Potgieter 2015). In support, Reid, Steel, Wardle and Adams (2019:203) report that many women use indigenous health and healing for the management of dysmenorrhea. De Wet and Ngubane (2014:129) reported that there are various indigenous treatment modalities used by South African women to manage women's reproductive health, including dysmenorrhea. The use of indigenous treatment modalities may be attributable to socio-cultural perspectives within the community. Moreover, Mulaudzi et al. (2015), find it essential to understand beliefs about the causes of illnesses, for the proper diagnosis and choice of treatment.

The following sub-sections discuss how indigenous healing system deals with the aetiology and conceptualisation of illness, such as dysmenorrhea. Much emphasis is placed on the indigenous understanding of dysmenorrhea.

- **Taboos**

The concept of taboo is challenging to define. Holden (2000) refers to taboos as things, or a way of life restricting particular practices. Taboos (Setlokwa) are called "diila" and are seen as actions and behavioural rules that community members should observe. A community or a group of people (Kahissay et al. 2017) usually forbids these practices. Taboos (diila) within Batlokwa ethnicity carry sociological, health, educational and religious elements aimed at encouraging and maintaining the state of norms, customs, values and beliefs. Ndlovu and Ngwenya (2010) realised that there are several taboos in many Africans societies that affect women in their reproductive years, such as menstruation, menstrual problems such as dysmenorrhea, pregnancy, and more. According to Kahissay et al. (2017), disobeying taboos is one of the ways people could become sick. For Scanlan (2003), breaking of taboos can lead to punishment from the ancestors or spirits in the form of disease and misfortune. Misfortunes from taboos can only be relieved whenever possible, by a ceremony of purification" (Barre, Grant & Draper 2009:31). The breaking of taboos in African societies is blamed for a variety of illnesses, including dysmenorrhea.

Taboos vary from community to community, but generally, it is thought that illnesses are caused when taboos are not adequately observed or are disregarded. Menstruation-associated myths and taboos still exist in many African countries (Umeora & Egwuatu, 2008:110). For example, many women believe that it is taboo to speak about menstruation (Ssewanyana & Bitanhirwe 2019). In addition, Chandra-Mouli and Patel (2017:2) highlight that many cultures and religions of the African countries still regard it as a “taboo” subject because it is a sexual and reproductive issue. They consider it a women’s problem. This, in turn, may impact how women perceive and manage menstrual pain or dysmenorrhea due to their beliefs and attitudes and a lack of accurate information (Hawkey, Ussher, Perz & Metusela 2017:1481).

A qualitative case study on traditional menstrual practices and contextual factors in the rural communities of far-Western Nepal revealed that the taboos attached to menstruation influence family members to overlook health problems of the women such as dysmenorrhea and heavy bleeding (Thapa, Bhattarai & Aro 2019:7). Armour, Parry, Al-Dabbas., Curry, Holmes, MacMillan, Ferfolja and Smith (2019) realised that this perception had led women not to seek medical advice for dysmenorrhea, instead rely on self-care, which includes exercises, analgesics, herbs and meditation. Moreover, Morowatisharifabad, Vaezi, Bokaie, Askarishahi and Mohammadinia (2018) recommend that when preparing teenage girls for menstruation including dysmenorrhea knowledge and management, socio-cultural and economic issues of the society should be considered to resolve taboos related to women’s issues. It is, therefore, essential for the health care practitioners to acquire knowledge of local communities and cultural perceptions about the causes of this disease. People in some communities, in for example Iran, understand dysmenorrhea as caused by the breaking of taboos (Morowatisharifabad et al. 2018). Hence, it is essential to establish the patient’s social and cultural background as well as their understanding of the conditions that they present with, to offer culturally sensitive care that enhance healing. These include *Ubuntu* when handling and treating patients.

- **Witchcraft or evil spirit**

Witchcrafts are practised by witches or sorcerers, wherein Africans believe in having power and the forces of nature to harm other people. Thabede (2008:241) refers to a witch as someone who harms others utilizing a psychic force. Some Africans strongly believe that they have health problems because someone is bewitching them (Rankoana et al. 2015:275). For example, in

2008 a study was conducted on traditional healing in South Africa. The participants indicated that illness is seen as a form of punishment from ancestors or curses from witches (Ross 2010). In most developing countries, such as in South Africa, the indigenous healing system is commonly used for women's health problems (Mulaudzi et al. 2015:22). In agreement, Ozioma and Chinwe (2019) indicate that most indigenous African people believe that certain illnesses which defy Western health systems are caused by witchcraft or evil spirits. These include women's health such as dysmenorrhea, infertility and repeated miscarriages. For those who think that dysmenorrhea is caused by witchcraft or evil spirits when seeking medical attention, they would first seek indigenous healing.

2.3.5 Cultural beliefs and management practices of dysmenorrhea

Chandra-Mouli and Patel (2017:2) argue that dysmenorrhea is a least understood women's menstrual problem. Armour et al. (2016) argue that this is because women perceive pain during menstruation based on their cultural beliefs and practices. In comparison, some women believe that menstrual discomfort should be endured and not talked about (Lacovides et al. 2015:762). In reviewing the research that provides a global overview of how women in different cultures perceive and treat dysmenorrhea naturally, one notices that in many countries, indigenous healing is an ancient and common practice used effectively (Hina et al. 2013:89). This practice continues today as the effectiveness of some proven treatment modalities, many even influence current herbal approaches (Jo & Lee 2018). Some plant materials are believed to reduce pain. Therefore, some women with dysmenorrhea also use them to manage pain during menstruation. An example of these is cinnamon, turmeric, ginger, parsley, Chamomile, and more (Kashani, Mohammadi, Heidari & Akhondzadeh 2015). For example, a study conducted in Indonesia showed that giving turmeric acid therapy (non-pharmacologic) proves to be more effective against the decrease of dysmenorrhea in female students at the Academy of Midwifery (Sembiring, Suryani & Suswati 2018:22). Moreover, Chen, Tang, Guo, Kaminga and Xu (2019) allude that herbal products are becoming a significant alternative for the reduction of dysmenorrhea pain without side effects, in young women. To affirm, deWet and Ngubane (2014:130) noticed that women in South Africa use traditional herbs to manage symptoms of dysmenorrhea.

In China, different treatment modalities, including herbs and acupuncture, are used to treat dysmenorrhea according to the believed cause. The indigenous treatment of dysmenorrhea is based on the following perspectives a). Dysmenorrhea is the result of chronic imbalances in the flow of qi and blood, b). Liver qi deficiency, excess, or stagnation, which result in a significant effect on menstrual flow and are a source for painful periods, c). Spleen qi imbalance: reflective in digestive disturbances and sugar cravings, and d). Kidney qi imbalance, tends to be responsible for ovulation (Smith, Crowther, Petrucco, Beilby & Dent 2011:2).

2.3.6 Practitioners of an indigenous health system

There are different types of indigenous health practitioners, depending on countries of origin. As previously indicated, every society has established its indigenous healing systems conforming to its culture, beliefs, norms, indigenous knowledge and practices. Various types of practitioners of indigenous health and healing are recognised in South Africa (Zuma et al. 2016). Although practitioners with specific specialisations exist, for the sake of this study, we refer to the categories of practitioners whose work includes, but is not necessarily limited to, women's health. These practitioners use different methods in their work, based mostly on their knowledge acquired during training and orientation (Zuma et al. 2016). The different practitioners of indigenous healing in South Africa include IKHs (untrained healers) and THPs, trained according to the area of speciality and play different roles in their practice (Zuma et al. 2016). According to Zuma et al. (ibid), THPs and IKHs are widely viewed as cultural experts, and thus have elements of indigenous knowledge, cultural values and societal expectations of conduct in their work.

2.3.6.1 The roles of indigenous health practitioners in the communities

Globally, THPs and IKHs play an essential role in many spheres of people's lives. In South Africa, THPs and IKHs are increasingly acknowledged as essential providers of health care. Therefore, the National Department of Health (NDoH) takes firm steps towards the formal regulation of THPs (Moshabela, Zuma & Gaede 2016:83). It is important to note that THPs and IKHs can hold a multiple number of roles (Purkree, Mkhize, Mgobhozi & Lin 2002). Historically speaking, indigenous health practitioners have accumulated extensive knowledge of natural materials for healing purposes over some time. They play a large role in the management of

health, holistically, and in either a preventative, curative and palliative nature (White 2015). Thus, the leading role of indigenous health practitioners is to diagnose, prevent, promote and rehabilitate physical, mental and emotional illness as well as address issues within the family and society. They offer health care services to those who believe and use their services, educate people about culture and how it originated (Kahissay et al. 2017). According to Kbopi (2019), indigenous health practitioners manage ranges of illnesses and diseases, from those presenting with physical symptoms to those manifesting psychologically.

Indigenous health practitioners' roles include understanding the socio-cultural basis of illnesses, to clarify to the patients why they are suffering from certain illnesses (Kahissay et al. 2017). They also recognise, activate, or utilise resources and support systems necessary to treat those illnesses. On the other hand, the indigenous health practitioners serve as counsellors, psycho-cultural educators, social advisors, storytellers, dream interpreters and custodians of indigenous knowledge systems in all spheres (White 2015). Thus, they advise their clients in all aspects of life, including physical, psychological, spiritual, moral, and sometimes legal matters. Stefanski, Valli & Jacobson (2016) allude that this is because they are familiar with what is happening in families and communities. Furthermore, the indigenous health practitioners on the other side are recognised by others as mediators between the living and the dead (Mokgobi 2014). According to van Dyk (2001), the living and dead are ancestors who continue to show interest in the daily lives of the relatives who are still alive.

2.3.7 The use and prevalence of indigenous health and healing systems in South Africa

The age of indigenous health and healing systems is quite difficult to determine, especially in Africa, where previously it was undocumented. According to Sofowora (1982), records of indigenous health systems date as far back as between 2730 and 3000 B.C. Nonetheless, the use of indigenous health system and healing in South Africa has recently increased, since the 1990s (Nemutandani et al. 2016; Mokgobi 2013:48). These include a variety of indigenous systems based on traditional practices and beliefs. The practice of indigenous health and healing among the Batlokwa is probably as old as their culture. Their history clearly illustrates that it has been an important method of health promotion through prevention and treatment. The continued existence and survival of the Batlokwa as an ethnicity is seen to be dependant on the active and loyal role of indigenous knowledge.

This health system continues to be used for many ailments and conditions including pain, mental disorders, hypertension, gynaecological disorders and HIV. (Zuma, Wight, Rochat & Moshabela 2018). A 2009 national survey conducted in South Africa (South African Social Attitudes Survey [SASAS]), was aimed at obtaining baseline data on perceptions and attitudes towards various IKS and related issues. Seventy-four per cent of the respondents agreed that indigenous health and plants could lead to medicinal discoveries (Moos 2009).

2.4 AFRICANA WOMANISM THEORY

In this thesis, I used the Africana Womanism theory that carries an idea and a perspective that advocate for the African women to see, study, interpret and interact with people, life, and reality informed by African culture.

2.4.1 Description

The Africana Womanism theory was developed following the understanding that African women have different life experiences from those of their Western counterparts (Hudson-Weems 1993; 2004).

According to the author, the name Africana Womanism came out after a lengthy public debate on the importance of self-naming for Africana women (Hudson-Weems 1998). The name Africana Womanism is one in two, just like a coin (Hudson-Weems 2004). The one side of the coinage, Africana, represents the ethnicity of the Black woman and establishing her cultural identity about her land Africa. The other side of the coin, Womanism, stands for a woman who battles with the dominant alienating forces in her life and questioning the accepted idea of womanhood. The term Womanism was also found more appropriate than feminism because animals and plants are also referred to as female.

Overall, the definition of Africana Womanism rose out of the need to demarcate a space for Black women to theorise their existence, formulating a specific approach that focuses on Black women's identity (Arndt 2000:711). As such, Africana Womanism strongly makes the point that the experiences, realities, struggles and needs of African women are unique and should be studied according to their cultural beliefs and practices (Ntiri 2001; Mangena 2014).

According to Alexander-Floyd & Simien (2006:70), the application of the Africana Womanism concepts incorporates and encourages the inclusion of eighteen (18) characteristics, proposed as viable means for addressing the uniqueness of Africans (refer to Figure 2.1). The 18 characteristics are; self-naming; self-definition; genuine sisterhood; family centredness; in concert with men in struggles; wholeness; flexible role-playing; adaptability; authenticity; male compatibility; recognition; ambition; nurturer; strength; respect; respectful of elders; mothering and spirituality, which are the essential pillars for its survival as summarised in Table 2.1. Each of the characteristics has a specific meaning that collectively establishes a basis for Africana Womanism as a vehicle of empowerment and influence. These 18 characteristics are interrelated and grouped according to their emphasis. The first group includes self-naming and self-definition. The second groupings of characteristics are family centredness, wholeness, authenticity, role flexibility, adaptability, in concert with men in struggles, and genuine sisterhood. The third and last clustering of the characteristics is strength, male compatibility, respect, recognition, respect for elders, ambition, mothering, nurturing, and spirituality.

2.4.2 The Africana Womanism approach to indigenous health and healing

For this study, it is imperative to discuss the Africana Womanism approach to indigenous health and healing. Africana Womanism recognises indigenous knowledge as a distinct and whole knowledge system that exists on its own (Owusu-Ansah & Mji 2013). In South Africa, the experience of colonisation, and the long-term effects of being colonised, has caused inequalities in indigenous health practices. Africans have historically faced the denial of rights to practice their indigenous knowledge, which is now facing the destruction if not resuscitated (Nemutandani et al. 2018).

There are still those who possess cultural knowledge, values, customs and traditions to form the basis of the cultural heritage of indigenous healing and share it with others (Nkwanyana 2018). In traditional South African culture, women have many avenues through which they participate in the creation of indigenous knowledge and management of health. They were never at the periphery of isolation in society regarding providing health care to others.

The application of Africana Womanism in this study focused on the right to health and healing system of choice, bearing in mind the close links between health and illness. A human rights-

based approach demanded state accountability and transparency, as well as participation and non-discrimination. It focuses on entitlements in concrete terms and identifies who is responsible for ensuring access to these entitlements.

The Africana Womanism approach exposes the roots of vulnerability and marginalisation and expands the range of responses by empowering the oppressed to improve their conditions (Alexander-Floyd & Simien 2006:68).

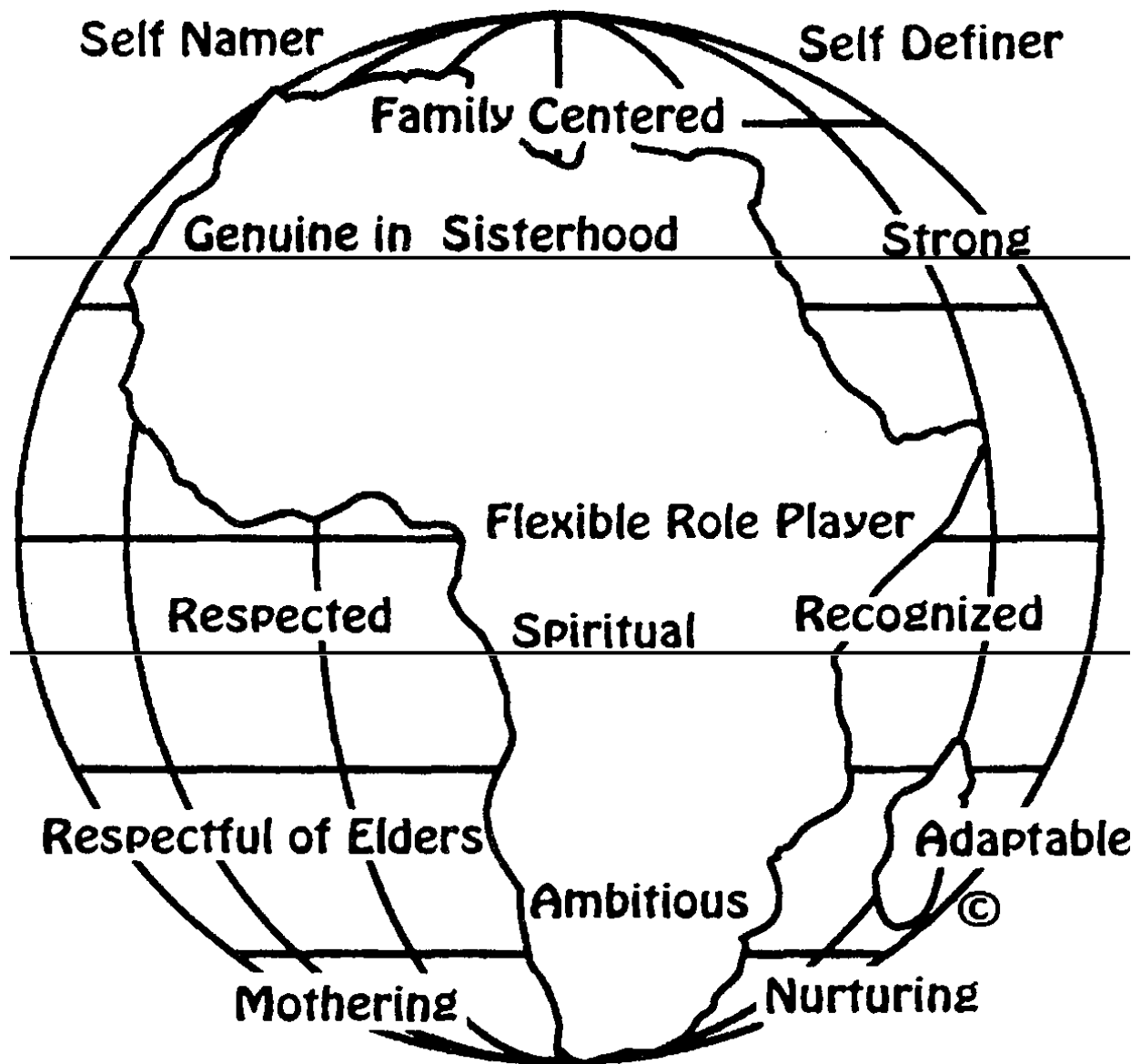


Figure 2.1 From Africana Womanism by Clenora Hudson-Weems, PhD

Table 2.1. Summary of Africana Womanism theory

CHARACTERISTIC	DESCRIPTION
Self-naming	This characteristic discusses the importance of proper naming for self-identifying by African women in society.
Self-definer	Entails own description and definition of realities that African women face, with no particular allegiance to existing ideals.
Genuine sisterhood	Its emphasis is on the strong reciprocal relationship that African women have. The relationship is genuine because a Black woman goes through the same experience of oppression and can therefore empathise with one another.
Family centredness	It describes the interests of an African woman within families and community. It is also about the success of a black community as a whole and maintains a sense of wholeness.
In concert with men in struggles	In concert with men is the African woman's push to develop strong relationships with like-minded men in the struggle for overarching the Black person's liberation and eventually Black women's liberation.
Wholeness	The characteristic of wholeness describes the importance of self-sufficiency (Wholistic) that an African woman must have in order to upkeep her household and Black nation as a whole. It represents that the African woman needs to connect to her culture.
Flexible role-playing	It acknowledges and discusses the fact that the Black woman has never been subjugated.
Adaptability	The characteristic of adaptable presents how the African woman adapts to different environments, without demanding a separate place for nourishing her individual needs and goals.
Authenticity	This characteristic is embedded within wholeness, since the African woman's sense of wholeness is compatible with her cultural consciousness and authentic existence.
Male compatibility	The characteristic of male compatibility is based upon mutually beneficial relationships between a well-respected African woman and a supportive, like-minded, man. The African woman desires positive male companionship, in which there is mutual support.

CHARACTERISTIC	DESCRIPTION
Recognition	The characteristic of recognition refers to the acknowledgement of humanity, capability, and power of Black women.
Ambition	The characteristic of ambition is based on the responsibilities that the African woman fulfils for herself, family and Black nation.
Nurturing	Nurturing is the caring aspect that goes hand in hand with the characteristic of mothering.
Strength	The characteristic of strength presents how the African woman has preserved centuries of physical and emotional struggles for herself, family, community and African people at large.
Respect	Respect refers to the reverence an African woman has for her self-esteem and self-worth that enables her to have complete and positive respected relationships with people.
Respectful of elders	Describes the value and benefits of respecting and appreciating elders in the African communities.
Mothering	This characteristic position an African woman to play an active role in the rearing and caring of the community activities.
Spirituality	This characteristic of spirituality is based on the belief system of the African woman in higher power that transcends rational ideals, and it is an ever-present part of the Africana culture.

2.4.3 Characteristics that are relevant to the study

Out of the 18 characteristics, the researcher identified 13 characteristics that fit within this study and included them in the discussion. These are self-naming, self-definition, genuine sisterhood, family centredness, strength, adaptability, respect, recognised, respectful of elders, mothering, nurture, wholeness and spirituality. Hudson-Weems (2004) argues that these characteristics are all derived from African culture.

- **Self-naming**

“Self-naming” is one of the prominent attributes of Africana Womanism (Alexander-Floyd & Simien 2006:67) because it is through a name that anything can be defined. When one self-names, she challenges the labels given by namers or definers or labellers. Hudson-Weems (2004) emphasises that those who name or define something hold the standpoint power.

Dysmenorrhea is a Greek word, in which Dys means “difficult” or “abnormal”; meno is “month”; and rhea is “flow” (Ou, Hsu, Lai, Lin & Lin 2012:817). This study proposed the application of Africana Womanism theory to Batlokwa women’s indigenous perspectives of the meaning and treatment modalities of dysmenorrhea as a means of analysing the process through which “self-naming” confers identity upon Black women in South Africa. In our study, naming holds a significant role in African culture since “the proper naming of a thing gives it essence” (Hudson-Weems 2004:18).

According to Niles Goins (2011:531), African women affiliate with each other through communication discourse because it is laden with idiosyncratic socio-cultural and historical properties as well as linguistic codes and practices. Thus, with African women, there is a need to name dysmenorrhea according to history and culture, in order to reveal the truths of their indigenous knowledge existence. The point here is that there is an urgency to remove the terms and words that do not have a meaning to African women through self-naming and self-definition, such as dysmenorrhea.

Likewise, in the work of Scott (1995) called *Black women’s talk*, some young Black college undergraduates switched to Black vernacular when they were around other Black women so they could effectively and efficiently connect. Most women cross over the cultural border into the territory of their ethnicity to preserve identity and culture (Niles Goins 2011:539). Therefore, the appropriate naming of dysmenorrhea should concern the way the dysmenorrhea condition is perceived and in a language that is well understood by the participating women. In Africana Womanism, it is a prerequisite for the survival of African women. They have the need to “self-name”, rather than wait for others to do so on their behalf. According to Clarke (1992:21), naming cannot be left in the hands of the oppressors, whose abusive power has repressed Blacks in various predicaments.

To be appropriate, the Batlokwa women's naming of dysmenorrhea should be according to the identity of cultural reality (Hudson- Weems 1993:57). In doing that, they will be liberated from the false and distorting labelling of Africana women and men, which was once "left in the hands of the dominant group" (Hudson- Weems 1993:2). Through the process of understanding the women's perspectives of indigenous dysmenorrhea, women were empowered, as they became the agents of their health identification. By "self-naming" dysmenorrhea according to their cultural perspectives, Batlokwa women proclaimed their identity as Black and African women.

- **Self-definer**

Regarding "self-definition", According Hudson-Weems (1993; 1998; 2004), it is interwoven with self-naming. It explains that with an African woman, there is always a real reason for the existence of any practice. This implies that an African woman should have the opportunity to present and explain the reality of beliefs and practices without being stigmatised. African women as "self-definers" need to define themselves, not by the standards of the dominant culture, but out of what Hudson-Weems notes as the "authenticity of their activity" (Hudson-Weems 2004:56). Moreover, the Batlokwa women reflected their life experiences, beliefs and practices for meaning and treatment modalities of dysmenorrhea. Through "self-defining", African women are removed from the realms of fantasy and stereotype that previously the definer attached to them. By mere "self-defining" the Batlokwa women declared their voices for the reality of their daily existence, in opposition to that of the dominant culture.

- **Genuine sisterhood**

Africana Womanism seeks to define African womanhood from an African centred perspective. According to Hudson-Weems (1993:65), to show "genuine sisterhood" African women recognise a need to connect with others and look out for one another. In light of "genuine sisterhood", women position themselves to reach out in support of each other. For the Batlokwa women, the Africana Womanism characteristic "genuine sisterhood" played a significant role in the social support process of caring for other women experiencing dysmenorrhea. They did this taking into consideration their cultural norms, values and beliefs of their families and society (womanhood). Jones (2009) opines that family life responsibilities that African women undertake compound their "sisterhood" role. In this study, Africana Womanism explicates how Batlokwa women

collectively (sisterhood character) counterattacked oppression by re-appropriating the strength of indigenous health knowledge of dysmenorrhea. By reifying the strength of indigenous health knowledge of dysmenorrhea, Batlokwa women celebrated their “sisterhood” unapologetically.

- **Family centredness**

The characteristics of “family centredness” focus on doing things collectively (Hudson-Weems 2004:44). The family has always been a fundamental unit of the African community. Hudson-Weems (2004:60) argues that African women do not focus on themselves as individuals but that their focus is on “the family and its needs”. Thus, there is no individualism, the entire Black family unit and community get involved in building-up each other. In this sense, African Womanism is family and community orientated. Like any other Africans, the Batlokwa ethnicity group are family-centred and are orientated to the health of other members. Individuals within families recognise that people have unique needs. It also believes that no individual can be empowered when others are oppressed. The researcher in this study believes that for the success of the centering family, the whole Black community uses *Ubuntu* to maintain a sense of wholeness. Additionally, Black African women use *Ubuntu* to share an understanding of tribal, national and family issues (Mulaudzi, Mogale & Masoga 2018).

Looking into the South African history, it is permeated with discrimination based on race and gender, despite the claims of freedom since 1994. In this study, African Womanism was applied to investigate women’s oppression within the African society. It was also utilised to identify the elements of gender-based indigenous healing. This was to further assist in analysing Black African women centred attitudes to dysmenorrhea meaning and treatment. Moreover, Owusu-Ansah and Mji (2013) attest that African Womanism seeks to find sources within the traditions, heritage and cultural experiences of the African people to empower them. This is the case with the Batlokwa THPs and IKHs and all other indigenous women who participated in sharing indigenous perspectives of the meaning and treatment modalities of dysmenorrhea.

To improve the quality of health of indigenous people, it makes sense to improve access to indigenous local health and illness understanding and increase indigenous health education. Indigenous communities’ attention to their health may be increased if interventions are based on communities’ knowledge bases, especially if there is limited use of Western health services. For

the characteristic of recognition, indigenous communities face widespread disparities with the broader societies in which they live, in all countries where threats to land, culture and linguistic heritage destabilise identity and self-determination. These circumstances generate health challenges that are specific to a particular group. Moreover, Africana Womanism focuses on recognising and respecting local indigenous cultural values, customs and beliefs (Nwanosike & Onyije, 2011:628). These include indigenous healing and practices, respecting women's and men's cultural needs, such as women only discussing women's health business with other women or gender-specific services and programmes. As well as ensuring the local communities are engaged and in control of indigenous health services.

- **Respect**

The element or characteristic of respect in Africana Womanism promotes the avenue of self-worth and self-esteem. For the indigenous community, respect includes respect for self, others, and one's knowledge. Respect encompasses a broader view that honours every living being as part of the entire living family. Respect as an essence of indigenous health and healing philosophy was described as reciprocal. This is so because it is given and received between practitioners of indigenous health and their clients, as well as the community at large (Moemeka 1989:4). Thus, the way respect manifests in indigenous communities encompasses how community members treat each other, treat their elders, treat their environment, resources and indigenous knowledge. According to the Africana Womanism theory, respect refers to reverence an African woman has for herself, before respecting others and her elders (Hudson-Weems 2004).

- **Recognition**

The pillar of recognition refers to the acknowledgement of humanity, capability, and power of Black women. It is interwoven with respect. In African people, recognition plays a large role in keeping peace within clans and families. According to Gilliam (2013), in Black communities, women are recognised and considered critical in the struggle for equality. Getting to know the indigenous knowledge of dysmenorrhea from Batlokwa women recognised and offered respect for their existence and wisdom.

- **Respect for elders**

Respect for elders is considered as one of the principles that outlines the caring nature of the African woman (Alexander-Floyd & Simien 2006). Respecting elders in Africa does not only mean respecting age; it includes respecting leadership, indigenous knowledge holders and others. For it is believed that elders have served as role models, and paved ways for younger generations.

Respect for elders is also an extension of the African historical tradition of ancestral reverence. Ancestral reverence is the habitual act of caring for elders, and eventually ancestors, within a community or society with the belief that once they die, the ancestors will provide wisdom and guidance to the living (Hudson-Weems 2001).

- **Strength**

Strength is one of the unique characteristics of Africana Womanism (Alexander-Floyd & Simien 2006:70). The strength idea is internalised as an integral aspect of Black women's identity, which she preserved from the struggles she endured in slavery. According to Watson and Hunter (2015), behaviours associated with strength are to maintain power and control, be self-sufficient, appear self-assured, be opinionated, value honesty and authenticity. In contrast, Donovan and West (2015) and Woods-Giscombe (2010) consider that internalisation of strength promotes a host of negative mental, emotional and physical effects in African women.

In this study, despite destructive functions of strength, the characteristic was used as a resource for solidarity and resistance, since Black women always had emotional and physical strength from what happened in slavery. Batlokwa women used the strength of their indigenous dysmenorrhea knowledge to speak of their existence. Dennis and Wood (2012) agree that respecting other's socio-cultural knowledge enables the oppressed group to challenge conventional knowledge. For example, if oppressed individuals share their knowledge in a group discussion, they can identify patterns in their knowledge and recognise how those patterns connect to their oppression. Moreover, Neal-Barnett, Stadulis, Payne, Crosby, Mitchell, Williams and Williams-Costa (2011) opine that African women can extract strength from relationships with other Black women in times of trouble (sisterhood).

The traditional health practitioners and indigenous knowledge holders believe that their strength has been transmitted culturally, or passed on to them through a superpower, listening to, observing, and modelling the behaviours of their ancestors. According to them, this type of strength requires diligence, commitment, drive, and purpose to provide healing.

- **Mothering**

The nurturer and motherer are both described as a call for all community members to play an active role in the rearing of the community and propaganda of the race through care. An African woman must not only care and nourish her family but also provide the care and nourishment for her race as a whole. Fostering and guiding fellow women, advances the Africana Movement. The initiative taken to further the public's appreciation and education about the Africana Movement exemplifies the principle of Ambition (Hudson-Weems 2001).

- **Nurturing**

According to Hudson-Weems (2001), Africana woman shows her mothering characteristic through nurturing. She offers caring attitudes to herself, family, community and Black nation. Usually, this is identified when she is active and takes part in community issues.

- **Wholeness**

The interest in the success of the Black community as a whole maintains a sense of wholeness. Wholeness stresses physical, mental/emotional, spiritual, cultural connectivity and working in harmony with other people. The principle of wholeness describes the importance of self-sufficiency that an African woman must have in order to upkeep her household. Wholeness also stresses the required self-esteem that emanates from within an African woman who must be strong for not only herself but also her family and community as a whole. Alexander-Floyd & Simien (2006) state that the success of the group and collective outcomes maintain a sense of wholeness. This was identified during the Lekgotla discussion, in which the Batlokwa women chose in order to be successful in maintaining a sense of wholeness as a community.

- **Spirituality**

The spirituality character stresses the importance of the reverence for traditional African spiritual systems. These spiritual systems call for recognition of invisible beings that live within a person and environment. From a spiritual perspective, Momoh (1998:40) states that African philosophy is about African doctrines or theories on reality (being) and the universe that is made up of things such as God and gods.

- **Empowerment**

Interestingly, the concept of empowerment emanated from the literature related to Africana Womanism. The empowerment concept is interlaced with the characteristics of strength. Africana Womanism is centred on the fact that African women should be set free, valued and empowered rather than being gender conscious (Owusu-Ansah & Mji 2013). The study used photovoice to collect data. Its application in this study led to meeting some of the important precedents necessary for meaningful empowerment of Batlokwa women. Incorporating indigenous knowledge into health programmes can contribute to local empowerment and development, increasing self-sufficiency and strengthening self-determination. Applying this knowledge during the planning, implementation and evaluation of programmes legitimised local people as knowers and increased cultural pride.

- **Culture**

It also became evident through the process of analysing Africana Womanism, that culture played a central role and was embedded throughout the discussion. The Africana Womanism is a theory grounded in African culture. Although the theory did not define culture in the context of indigenous health, it demonstrated how aspects of culture were embedded within Africans' perspectives of life, how to maintain wholeness and how culture is respected. According to Hudson-Weems (2004), African women should be recognised and appreciated within their cultural context. Africana Womanism emphasises that African communities have a unique way of doing things that relies on cultural experiences (Chilisa 2012). It seeks to define those unique perspectives in deliberating women in particular. Africana Womanism exists because Black African women exist and have pressing issues to deal with in their families and communities. As

such, the critical role of culture in healthcare delivery should be identified and recognised (Ngunyulu, Mulaudzi & Peu 2015). This is because individuals bring in different modes and ways of communication, religion, health beliefs and practices to the healthcare sector.

- **Ubuntu**

Out of culture, a principle of *Ubuntu* also came out strongly as discussed below. *Ubuntu* emanates from the different roles that women play in the society or community. *Ubuntu* is an African concept that is not easy to define in foreign languages. *Ubuntu* is a Zulu word which means humanity in English and “botho” in Setswana. According to Mulaudzi et al. (2018), *Ubuntu* is an ethical element that embodies characteristics that promote mutual social responsibility, humanness, unity or togetherness and caring for one another. Within Africana Womanism theory and this study, *Ubuntu* prescribes a culture of shared meaning with patterns of beliefs and practices acceptable to the African communities. African women humanity is based on *Ubuntu* philosophy to maintain the human relationship with others, especially when dealing with indigenous health and healing (Mulaudzi et al. 2018). In addition, Ramose (1999) argues that the link between *Ubuntu*, local language and indigenous knowledge systems, is central to an understanding of African existence and being. As such, indigenous knowledge in the hands of African women must be used to affirm humanity as well. To avoid similar and worse circumstances driven by poor access to indigenous resources and culture to exist continuously, the social practice should be recognised as a driving force in health and healing. As such, there is a need for new, innovative and transformative intervention strategies and policies that use *Ubuntu* principles to make long-term improvements in the health of indigenous people.

In addition, Ndlovu (2015) and Cornell and van Marle (2015) allude that *Ubuntu* forms part of Africana Womanism, but the focus falls on women’s roles in a society that focuses on interconnectivity, community and respect of culture. This is applicable within the South African context. Moreover, Mulaudzi et al. (2018) argue that *Ubuntu* is an ideology and ethical system of being that cannot be equated in European terms. For the sake of this study, *Ubuntu* was used to focus on the woman within the group rather than individually. The IKHs and THPs women within the Batlokwa ethnicity took part as knowers of dysmenorrhea and treatment modalities, rather than as mere members providing information. *Ubuntu* within Africana Womanism further allowed IKHs and THPs women in Botlokwa to take leadership roles in naming and treating without

shame. Hence, Ebuloluwa (2009) believes that Africana Womanism provides an alternative for a Black African woman to focus on their own identity and gender issues, as well as on how to address them.

2.4.4 Reasons for choosing Africana Womanism in this study

As indicated in Chapter 1 (refer Section 1.7.3), the Africana Womanism (Hudson-Weems 1993; 2004) is a reliable source to have guided the study process. Africana Womanism was used to guide the collection and analyses of data in this study. Africana Womanism was also applied in the process of developing strategies to empower the Batlokwa women with dysmenorrhea knowledge.

Africana Womanism is a viable framework to use in this study because it places African women at the centre of the analysis. It also allowed the researchers to explore the variables of health and healing from Africans' unique socio-cultural-spiritual perspectives. Dove (1998:516) considers Africana Womanism as an Afrocentric theory because it sees African culture as a tool to understand the nature of African women's experiences. Africana Womanism, therefore, is a theory that identifies the ethnicity of the African woman, and her cultural identity relating her to African practices and history (Hudson-Weems, 1993: 22). For Hudson-Weems, Africana Womanism also provides space for Black women to view their agency and empowerment as it is centred around African values, defining their agenda in a way that is reflective of their experiences within African culture (ibid).

Moreover, Mangena (2013:8) argues that Womanism allows specific discussions of the African woman's real existence, and in imagined existence. Ntiri (2001) and Mangena (2014) concur that Africana Womanism represents an ideology that focuses on the experiences, realities, struggles and needs of African women. Therefore, this study considered Africana Womanism to understanding the African culture of women's experiences in the management of dysmenorrhea.

In applying the definitions of Africana Womanism by Ntiri (2001), one might hypothesise that it provides unique and powerful perspectives in conceptualising indigenous dysmenorrhea by Batlokwa women through modified photovoice and modified Lekgotla discussion. Thus, it challenged the dominant discourse and brought women's issues and cultural knowledge onto

the public sphere. The main reason for using Africana Womanism theory was for Batlokwa women to create their criteria for assessing realities, both in thought and in action. One distinct feature of Africana Womanism theory, relevant to this study, is that it argues for women's rights and empowerment from the premise of African cultural values (Hudson-Weems 2004). Therefore, Africana Womanism theory was borne out of the need to delineate a space for African women in facilitating their empowerment while sensitive to their socio-cultural context.

2.4.5 Criticism of Africana Womanism

Charles (1997:362) asserts that although Africana Womanism aims to voice Black women's standpoint, it does not fully consider the diverse histories, experiences, and cultures of women of African descent. Thus, it fails to meet the heterogeneity of African women.

Hudson-Weems is of African American descent. As such, she cannot claim to understand the dynamism of the African culture fully. This is especially important since there are differences between the conduct of African Americans and Africans on the African continent. However, this study acknowledges that Africana Womanism has limitations but is a relevant theory given its articulations about the importance of using African cultural perspectives to examine African life without relying on popular Eurocentric theories.

2.5 GAPS IN LITERATURE

The state of indigenous health and healing systems is well documented in the literature (Lebaka 2019; Kasole et al. 2019; Mathibela et al. 2015). It is also indicated how important it is to be aware, understand and acknowledge cultural behaviours on diagnosing and treating illnesses. However, in South Africa, there is limited access and engagement in indigenous health services that aim to prevent, manage and treat dysmenorrhea for indigenous communities. The health system of South Africa lacks services that meet the specific cultural needs of indigenous people (Nemutandani et al. 2018). According to the reviewed dysmenorrhea literature, South African health systems tend to rely heavily on printed Western health education material to convey dysmenorrhea information. This may not be appropriate and act as a deterrent to some people of the indigenous community who have limited literacy skills and do not believe in the Western health system. This may further heighten feelings of 'shame' and resulting in disengagement

with the health services. Indigenous health education materials, on the other hand, incorporate real-life beliefs and practices and are developed through interactive and participation of the community members, rather than relying on the passive transfer of information.

Given their experience and central role in the delivery of indigenous healing and patient education, THPs and IKHs health could provide useful knowledge and insight into potential solutions to current dysmenorrhea health care and education practices and address potential barriers required for the uptake of indigenous healing. Further, a successful understanding of strategies to empower the Batlokwa women with dysmenorrhea knowledge in clinical practise requires the support and acceptance from other health professionals. This study was conducted to address the abovementioned gaps. The primary aim was to explore indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women, in order to develop strategies to inform the development of indigenous health education materials of dysmenorrhea. Strategies to empower women with dysmenorrhea knowledge are not a new concept and are increasingly documented as powerful and important factors in the delivery of culturally sensitive healthcare (Ebijuwa & Mabawonku 2015). Despite being a decisive and an essential factor to base cultural health care, it remains one of the least understood and neglected factors. It is important to note that a thorough review of the literature did not identify any examples of the indigenous health education materials of dysmenorrhea, indicating a critical gap in both practice and research. As such, this research sought to understand and develop strategies to inform the development of indigenous health education materials of dysmenorrhea.

2.5.1 Moving forward towards bridging the knowledge gap

The use of indigenous health and healing in South Africa is existent. However, more work is needed to unpack and understand the uses of this health care system and to regulate it. A firm step in bridging the knowledge gap is to conduct more studies that aim to explore indigenous health and healing of women's health and how they are managed within cultural understandings of health and illness in different communities. The emphasis should be on asserting the standard of indigenous health and healing based on cultural values and beliefs rather than opposing or comparing it to the Western health care system.

2.6 SUMMARY OF THE CHAPTER

This chapter focused on the indigenous knowledge and theoretical framework for the research. The theoretical framework of Africana Womanism theory was embraced throughout the research process. This enabled me to understand the indigenous perspectives of dysmenorrhea and treatment modalities among Batlokwa women. Although it became clear that producing knowledge using Africana Womanism theory requires more time, needed indigenous knowledge of dysmenorrhea and treatment modalities were successfully generated from the participants guided by this theory.

Within the broader framework of Africana Womanism theory, it could be seen that women's living conditions differ due to their racial and socioeconomic backgrounds, as well as the contexts within which they find themselves across the world. In this vein, it was necessary to bring in Africana Womanism theory in order to advocate for the different struggles experienced by women of Africa and the fact that they have been oppressed through not only patriarchy and race but through belief systems as well (Rafapa, Nengome & Tshamano 2011).

From the recruitment of the participants, it was apparent that experiencing oppression does not give one a standpoint to produce knowledge (Harding 1991). However, it takes time, courage, action and practice to claim the social position as a knower of situated knowledge. In the current study, Africana Womanism theory showed us the necessity of confronting different issues in order to move from experience to knowledge. Furthermore, providing an invaluable basis from which to commence research about women's perspectives. I also addressed some of the ethical issues when researching an indigenous setting. I discussed my position as a researcher.

I argue that the way one decides to use a theory to guide research is fundamental because it determines how knowledge will be produced. Africana Womanism was the most suitable theory to situate the representations of Batlokwa women's perspectives of dysmenorrhea and treatment modalities since Africana Womanism theory draws from the notion that knowledge is socially situated. Whilst on the other vein, it challenges the invisibility and distortion of indigenous knowledge about dysmenorrhea and treatment modalities.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

The preceding chapter discussed the reviewed literature relevant to our study. Chapter 3 focuses on presenting and justifying the research design and methods used to generate the answers to the research questions. The study was conducted in two phases. Phase 1 was an empirical study that gathered necessary indigenous information on the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province.

Phase 1 was conducted in two parts. Part 1 used modified photovoice process, whilst part 2 engaged more Batlokwa women who did not participate in the photovoice study (part 1), using in-depth interviews to reach data saturation that might have been impossible to measure with a photovoice study. Phase 2 was a modified Lekgotla discussion based on the results of Phase 1. Phase 2 developed strategies to empower the Batlokwa women with dysmenorrhea knowledge.

3.2 THE RESEARCH AIM AND OBJECTIVES

The overall aim of this study was to understand the Batlokwa women's indigenous perspective on the meaning and treatment modalities of dysmenorrhea and to use findings to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. The research objectives were to:

- explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province.
- explore the roles of Batlokwa women in Limpopo Province as knowledge holders for the management of dysmenorrhea in their community.
- develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

3.3 RESEARCH PARADIGM

In this study, critical realism was considered to be the best and suitable worldview to generate indigenous knowledge on the meaning and treatment modalities of dysmenorrhea and to justify the use of the generated knowledge to develop strategies that will effect social change within the Batlokwa ethnicity. Refer to chapter 1 for detailed discussion of critical realism.

3.4 RESEARCH DESIGN AND METHODS

The main aim of this study was to explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. Therefore, I sought to use a research methodology where I could analyse participants' meaning making. This research used qualitative methodologies because I wanted to incorporate a range of different qualitative tools into the research design. This was so as to anticipate that women's indigenous perspectives of dysmenorrhea are contextual and fluid and that the same research participants may choose to represent different aspects of their life-world in separate settings (for example photographs, different types of interviews, and group discussion). Therefore, it was important not to restrict participants, or myself, to the collection of data through one method.

Each phase had its appropriate and suitable methods to answer the phenomena under study. Triangulation of methods was used as advocated by critical realism (Oliver 2012). Therefore, each phase and research methods used are described separately as follows below. However, the common elements such as research setting, and trustworthiness are discussed collectively in this chapter.

3.4.1 Phase 1: Part 1 (Photovoice)

The intention of part 1 was to directly engage participants through action in understanding their knowledge by reflecting upon the available resources in their community. To achieve action, it was necessary to use the methodology that has elements of participatory. Considering the above and nature of research, the researcher used a modified photovoice methodology for part 1. Although the photovoice research approach follows a given framework, its process is flexible and does not require a high level of technology to modify it to suit any group under study. The

modified photovoice approach was found necessary to align with the Africana Womanism theory and type of the participants for this study. Wang (1999) is of the support that the photovoice approach can be modified to suit the targeted community and situation.

It is important to note that this research initially grew from the idea of using photovoice methods only. However, from the advice of my study co-supervisor, it was found necessary to conduct in-depth interviews with additional participants in part 2 to ensure that data saturation was reached.

3.4.1.1 Photovoice research approach

Photovoice is a research process that can be applied in a research study as a theory, methodology or data collection tool (Polit & Beck 2017:512). In this study, it was used as both methodology and data collection tool. Photovoice was developed as a reaction to more traditional approaches failing to involve the participants as co-researchers (Wang 1994). Photovoice research approach involves acquiring information through photographs captured by the participants. The captured photographs are used to promote critical group dialogue that addresses the issue under study. The collective information that emerged from the group dialogue is then used as a catalyst for social change. This process automatically positions participants to be co-researchers in creating and defining images that shape public knowledge (Wang 1999:191). It is mostly applicable when dealing with silenced or marginalised individuals to fully immerse them in using the available strengths of their community to resolve issues under study and to empower them in turn (Wang & Burris 1994). These position them in control of how they represent themselves and their ideas to the world (Polit & Beck, 2017:482). In its nature, photovoice is based on participation, self-documentation, and empowerment. Therefore, it was a suitable methodology, which could assist with the attainment of the objectives of the study. It was also found relevant to be applied in this study because it is a culturally appropriate method for conducting rural and remote health research (Moffitt & Vollma 2004:189).

3.4.1.2 Origins of photovoice research approach

Photovoice was originally termed Photo Novella (Wang & Burris 1994). Photo Novella was used in assessing women's health needs in rural China. It was later utilised to engage projects that

empower others. The name photovoice was derived after photographs failed to create a full understanding of individual perspectives, in one of the women projects. Narratives used to explain the photographs were found necessary to create understanding. In addition, photovoice was initially developed to explore the voice of rural Chinese village women who work laboriously but had no voice in personal or policy decisions, believing that power comes from those who have a voice (Wang & Burris 1997; Wang, Burris & Ping 1996). Therefore, its nature is flexible and can be adapted to a variety of settings such as health (Wang 2005; 1999:187; 1994).

3.4.1.3 Situating photovoice to the philosophical and theoretical framework of this study

On the note that critical realist researchers have long recognised the need for local participation to generate knowledge and strengthen research outcomes. Using photovoice in conjunction with critical realism and Africana Womanism theory was appropriate for this study. The key assumptions that underlie the three were found to be similar in many ways. Photovoice approach is firmly situated within the version of the critical realism thought of grounding understanding and recognising perspectives, local knowledge, cultural beliefs, skills, and resources (Wang 1999:187). This thought is also seen in Africana Womanism framework specifically through questioning common understandings of power, representation and voices and using methods that allow participants to construct their knowledge in ways that empower them (Wang & Burris, 1994). The photovoice draws on Africana Womanism theory thoughts such as attempts to take back authority, power and dignity, to the historically oppressed groups such as women and ethnic minority groups. The participatory value of photovoice approach is aligned to Africana Womanism theory and purports that no individual can be empowered when others are oppressed (Hudson-Weems 1993). The photovoice approach is situated within both critical realism philosophy and Africana Womanism theory advocacy to involve and position the marginalised at the centre of research, to empower them.

Owing to the critical realism philosophy, acknowledging that there are different domains of reality and that below the layers of those realities are other structures and mechanisms that cannot be seen, the photovoice approach was used as assistance to uncover structures and mechanism powers from the Batlokwa women THPs and IKHs. In turn, the reality of indigenous dysmenorrhea knowledge was shared with the public. In sum, photovoice integrated the

elements or characteristics of critical realism and Africana Womanism to empower the participants.

3.4.1.4 Justifying the use of photovoice approach in this study

The Africana Womanism framework is based on the understanding that knowledge is produced according to what is experienced within the environment based on cultural beliefs and practices (Hudson-Weems 1993). As such, it was essential to understand the participants' perspectives of constructing such knowledge in their localised and personalised context through active involvement. To understand the perspectives of the participants, it was essential to select a research approach that is well situated in the framework of Africana Womanism. The selected approach was supposed to provide an opportunity for Batlokwa women in Limpopo Province to express and represent their indigenous knowledge of dysmenorrhea and treatment modalities in a creative, effective and meaningful way. The modified photovoice approach was appropriate as it involved the participants of this study actively because according to Booth and Booth (2003), photovoice is an empowering research approach based on its participatory nature.

However, according to Liebenberg (2018) for the empowerment to happen, the participants should assume the role of co-researchers, as it is seen in the photovoice approach. Balomenou and Garrod (2016:372) allude that photovoice empowers participants because it facilitates the inaccessible social and behavioural settings unavailable when using traditional forms of data collection. In sum, for the participants to be actively involved as co-researchers and empowered in the process, the research approach and process should have the potential to involve and empower participants.

On the other vein, photovoice research approach was considered relevant in this study because it has been used successfully in other health research that involved rural women (Wang 2005; 1999:187; 1994). Furthermore, the author successfully used photovoice to a broader range of social issues with culturally diverse groups whilst exploring and addressing community needs. In addition, Moffitt and Vollma (2004:189) argue that photovoice is a culturally appropriate method for conducting rural and remote health research because it has a unique capacity to engage hard-to-reach groups. It is also easy to elicit open and honest conversation not ordinarily heard by those in positions of power when using photovoice. Catalani and Minkler (2010) used

photovoice research to highlight the experiences and perspectives of the marginalised group. Therefore, photovoice research is uniquely suited for use in low-income minority communities such as Botlokwa in Limpopo Province.

The main objectives of using photovoice approach in this study were to actively involve THPs and IKHs 1) In identifying, recording and reflecting on community strengths of making meaning and treating dysmenorrhea, 2) To promote critical dialogue and debates between the participants to deliberate on the indigenous knowledge of dysmenorrhea, 3).To effect social change regarding the use of indigenous knowledge to prevent and treat dysmenorrhea. Importantly in this study, photovoice was used to give participants the opportunity to co-construct indigenous knowledge of dysmenorrhea. As well as sharing experiences through synergy with fellow participants to develop strategies for empowering the Batlokwa women with dysmenorrhea knowledge.

3.4.1.5 Disadvantages of photovoice as a methodology and overcoming them

According to Castleden (2008:1402), photovoice is limited to what is observable, and it denies access and discussion to what was not photographed. Although the interviews in this study were based on the selected photographs, at the end of every interview, the researcher asked the participants to discuss anything that was not discussed but related to the indigenous dysmenorrhea and treatment modalities. In the Lekgotla discussion, participants were asked to list all that they thought was important to know and use when one experiences dysmenorrhea as a focal question. The researcher discovered that it was challenging to reach data saturation when collecting data using the photovoice method. In order to reach data saturation, in-depth interviews were employed in part 2 of the study.

During the research process, I discovered that the photovoice process is costly. The cost of cameras, film developing, training and discussion workshops, transportation allowances, travelling between my province of work to reach participants in the other province, facilitators and interpreters impacted on the funds allocated for my study. The photovoice process is also time-consuming; it requires a great deal of time commitment and thorough follow up of the participants, from recruitment, training, and discussions.

It was also risky to give someone a camera to take photos of others, environment, objects or anything, due to uncertainty and unpredictability of what may occur when taking photos. This could have led to unintentional consequences such as broken or stolen cameras. Hence, participants were advised, during the training session, to contact the researcher at any time if experiencing problems related to the study, for support and replacement of tools.

Participants were also taught to take precautionary measures such as safety when taking photos. Further, they were provided with guiding questions and advised to take photos that would provide relevant knowledge to the phenomenon under study. Wang and Burris (1997) emphasised the ethical considerations of documenting community issues through photography. The participants in the current study were orientated and trained on the photovoice process and provided with ethical issues related to the method, and on how to protect themselves and others during the process. A package with consent forms for taking and releasing photographs was provided.

Wang et al. (1996) warn that photovoice enables individuals to communicate their perspective to influential community advocates, but it does not shift the power to them to decide on policy. Participant researchers were aware that the information they gave might influence policy, not meaning that they were the ones to do the actual policy amendments. There was also the chance that participants who are motivated to making changes in the community could feel a sense of cynicism, despair or powerlessness when the results of their efforts did not match the results they had hoped for (Wang, Yi, Tao & Carovano 1998). Some researchers feel that it is wrong to give control of the research process to the participants because the integrity of the research is compromised and becomes unscientific. However, Wang et al. (1998) argue that it is inherently political and value-driven, and that participatory approaches give priority to the community's needs as opposed to the researcher's agenda. On a positive note, the choice of the approach, however, favoured women's preferred ways of sharing knowledge (Liebenberg 2018).

3.4.1.6 Benefits of using photovoice research approach in this study

The modified photovoice approach allowed the Batlokwa women THPs and IKHs to direct the research process (Wang 1999). Using photovoice approach, the participants used captured

photographs and descriptions to address questions related to the indigenous knowledge of dysmenorrhea in the context of health care. The version of the modified photovoice approach provided Batlokwa women with the tools that captured and understood their marginalised voices better (Wang & Burris 1997). The Batlokwa women took photos, explained dysmenorrhea meanings, and treatment modalities relating to the selected photos. The photographs they took, which represented their voices and privileged their perspectives, not just the researcher, guided interviews and discussions.

The photographs provided a concrete representation of each of the participant's whole reality (Freire 1970:105). These photos acted as "codes" that represented the participants' perspective descriptions of dysmenorrhea and treatment modalities. When analysing photographs, they used words to explain further and effectively communicate their thoughts, and to stimulate discussion among themselves and the researcher, opposed to traditional styles of data collection, such as a survey, which tends to draw out prescribed responses (Balomenou & Garrod 2016:372). This format of inquiry provided women with the freedom to express their issues and concerns in a way that is relevant to them. The process revealed "seldom-heard ideas, images, conversations, and voices into the public forum regarding dysmenorrhea and indigenous treatment modalities" (Balomenou & Garrod 2016:372), which is unique and had been hidden or ignored by the health care sector in South Africa.

Photovoice empowered Batlokwa women on a technical and social level. Women were trained on how to take photographs; a technical skill not held by everyone. Additionally, they became more aware of their surroundings, developed social skills through interactions with fellow participants and the social world. Being given opportunities to discuss their indigenous perspectives of the meaning and treatment modalities of dysmenorrhea, they began to identify the social realities and strengths of health care available in their community. They gained the power to voice out their rich knowledge on dysmenorrhea. The multiple roles they played as photographers, knowers of indigenous meaning and treatment modalities of dysmenorrhea and constructors of knowledge for the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge as highly appreciated.

3.4.2 Population

The population is the totality of all objects or events that conform to a set of specifications from which a sample can be drawn (Marshall & Rossman 2014:323). Burns and Groove (2009:343) describe a population as of particular individuals or elements who are the focus of the research and could form the target and accessible populations of the study. Neuman (2011:241) defines a population as the abstract idea of a large group of many from which a researcher draws a sample and to which results from a sample are generalised. According to Cresswell and Poth (2018:157), the researcher must decide on what is to be studied and who is supposed to participate in the study. The target population in this study included the Batlokwa women residing in Limpopo Province, South Africa. Three neighbourhood sections were selected within Ga-Ramokgopa village for the project, namely: Mekomene, Eisleben and Ga-Phasha.

3.4.2.1 Sampling

Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Beck 2017:743). Neuman (2006) notes that researchers usually do sampling to save time, costs, and produce accurate results. Participants were selected using purposive and snowball sampling. According to Sarantakos (2013), purposive and snowball sampling are some of the main nonprobability sampling techniques that can be used in the research studies.

The first step in the sampling was to purposively select the women who contacted the researcher and agreed to participate in the study. The current study decided to include only the women participants because of the multiple burdens of inequality they face, often impeding their empowerment (Bambra, Pope, Swami, Stanistreet, Roskam, Kunst & Scott-Samuel. 2009:41). Purposive sampling involves the researcher selecting specific participants based on their understanding and knowledge relating to the study (Cresswell & Poth 2018:158:326). Traditional health practitioners and indigenous knowledge holders were purposively selected to take part in the study. The idea behind purposive sampling was to concentrate on the women who have indigenous knowledge of dysmenorrhea and treatment modalities to provide relevant information for the study and to maximise information rather than to facilitate generalisation (Polit & Beck 2017:741). Furthermore, it was assumed that the selected participants could provide necessary data to meet the focus of the study (Cresswell & Poth 2018:158:326; Polit & Beck 2017:493). However, in purposive sampling, participants are rarely a representative of the population and the choice is based on the judgement of the researcher. Therefore, different

comparison groups were chosen to allow similarities and differences to emerge during data analyses.

According to Glaser and Strauss (1967), the usefulness of the themes found during analysis could also be verified in order to establish a clear relationship and confirm the truth of the findings. The women who were eligible to participate in this study met the following criteria: (a) woman; (b) over 18 years of age; (c) IKHs of dysmenorrhea and treatment modalities or THPs; (c) Batlokwa ethnicity group. All the participants were inhabitants of Botlokwa Ga-Ramokgopa Village in Limpopo Province, above the age of 18 years, and willingly consented to participate in the research study.

A brief meeting was held with each woman referred and volunteered to participate. This was done to re-emphasise the aims and the process of the study, and to discuss the roles of participants. The researcher also wanted to identify and verify if the volunteered women suited the purpose of the study. The women who met the study's inclusion criteria were provided with an information letter and consent form outlining: (a) the study aims, (b) its potential benefits and harms, (c) that participation was entirely voluntary and if they withdrew at any time during the study process they would not be victimised. Additionally, (d) that participants can choose not to answer questions without penalty. Informed consent of the participants was sought for (a) their participation in a photovoice study and taking photographs, (b) participation in an interview, (c) their participation in a Lekgotla discussion, (d) the audio-recording of interviews and the Lekgotla discussion to aid in the transcription of data. Lastly, (e) permission for the researcher to collect field notes throughout the research study to provide context to the data.

The snowball technique was used to further identify potential participants through the informed network and recommendation of the women who were already recruited by the researcher (Cresswell & Poth 2018:159). They directed the researcher to others whom they knew and trusted as genuine IKHs of dysmenorrhea and treatment modalities. This referral process continued until the researcher had relevant participants that fit the study's inclusion criteria. The main reason for using purposive and snowball sampling was that the number of IKHs in South Africa is not known. In addition, to gain access to their knowledge one has to rely on those who consented to assure others that the study meant no harm to their knowledge.

3.4.2.2. Sample size

Sampling size is essential in the data collection process. However, in qualitative research, it is not about the numbers but about collecting rich, relevant information for the study phenomenon and opportunity to identify themes (Cresswell & Poth 2018:158: 160). According to Wang (1999), 07 to 10 people are an ideal group size for any photovoice research to allow practical ease and in-depth discussion. In the current study, the size of the study sample was estimated based on Wang (1999). A total of 15 women showed interest in the study. Out of 15, three did not come for the photovoice training session.

Therefore, twelve women signed the consent forms, attended and completed the photovoice training sessions. The 12 were given disposable cameras and informed to take photographs for four weeks. Only five women handed their cameras to the researcher four weeks after taking photographs. One participant wanted to hand her camera with captured photographs after two weeks, but the researcher was not available to pick it up. Consequently, arrangements were made that she hands it with others after four weeks as agreed in their last meeting because the researcher was in a different province.

Seven participants asked for two weeks' extension, and only two participants handed precisely after two weeks of extension, one participant handed hers after an extra five weeks of extension. Several follow-ups were made for the remaining four participants, and they never handed their cameras after the extension. The researcher kept phoning them to remind and check how far they were with capturing of the photos, whilst also concurrently conducting the individual interviews. The researcher eventually gave up on them, when she was done with individual interviews of describing narratives attached to the provided photographs with those who had handed their cameras and needed to start with the Lekgotla discussion. Hence, only eight participants (3 THPs and 5 IKHs as indicated in Table 1.2) contributed to the findings of phase 1, part 1.

3.4.2.3 Gaining entry to the research setting

The researcher gained access through the local tribal authorities of the Botlokwa village to get permission from the clan leaders in February 2018. Meetings between the researcher and representative members of the local authorities' team continued until May 2018 when approval was granted. Gaining access to the study sites and individuals involved several steps (Cresswell & Poth 2018:154). Continuous consultation with tribal authority representatives was to affirm the relevance of the current research and to ensure that the research was conducted in ways appropriate to local customs.

Immediately after obtaining approval, the researcher commenced with invitations and recruitment (Latz 2017). Multiple methods and strategies of recruitment were implemented over one month (May 2018). The first recruitment strategy involved the introduction of the researcher to a group of clan leaders who were regarded as gatekeepers. This is in line with Cresswell and Poth (2018:156) that it is essential to have gatekeepers for easy access of marginalised groups. The researcher was allowed to explain the intentions of the study to the group of clan leaders. Recruitment letters explaining the study intentions were given to the clan leaders to read in the clan gatherings held on Sundays. The researcher was also given the opportunity to present the intentions of the study to the women in social clubs known as "Lekgotla la basadi". These were done to reach the wider population and to gain a greater audience. Another approach of recruitment was a flyer that described the research study, its purpose, objectives, and eligibility requirements. The researcher's phone number was included on the flyer so that potential participants could contact her. Study flyers inviting potential participants were distributed and placed in various public places and venues in Botlokwa including shopping malls, local churches, clinics and schools

The interested women contacted the researcher, who then scheduled a meeting for a brief orientation about the purpose and nature of the study, the researcher's interest in the topic, and participants' role in the research. The researcher obtained informed consent during the first meeting with the interested participants, followed by a training session on the process of photovoice, including taking of photographs. Time requirements and timelines for completing all activities of the study, and methods of data collection were also discussed in the first meeting. After two weeks of recruitment, the researcher started receiving an influx of calls from women who wanted to participate. The researcher conducted a group photovoice training with the first group of women after two weeks of recruitment, after that, she conducted individual photovoice

training as potential women started showing interest in the study instead of waiting for a group of potential participants, and as the need for training arose.

3.4.2.4 Data collection

Data collection is the process of gathering information from the selected participants in order to address a research problem (Polit & Beck 2017:725). The research used a modified photovoice method of data collection that best suited the design of the study. The following techniques were used to engage with the participants: brainstorming and photovoice training, taking photographs, individual interviews and modified Lekgotla discussion.

- **Stages of data collection**

Data collection involved four stages, as outlined in Figure 3.1. Data collection for Part 1 took place from May to November 2018.

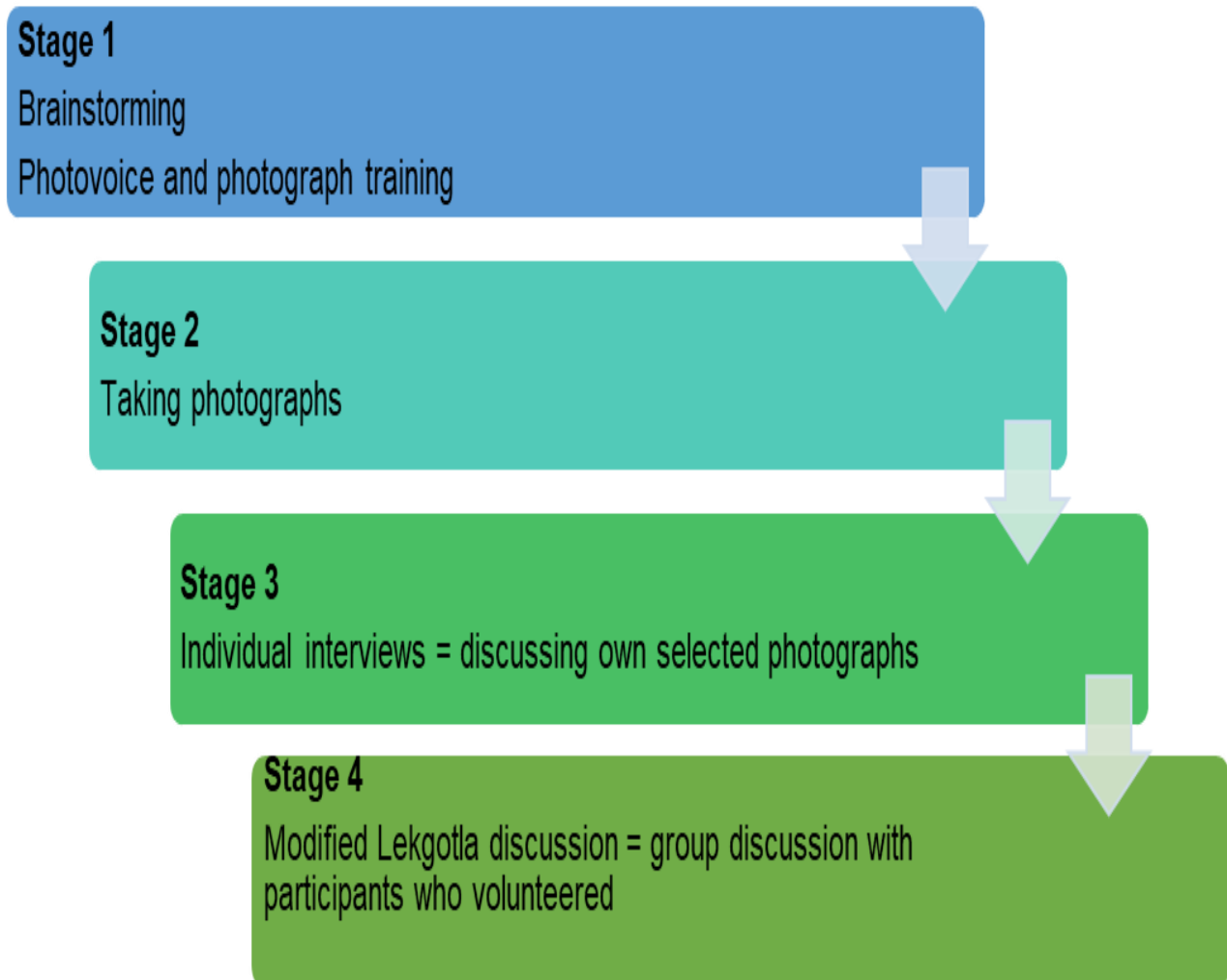


Figure 3.1: Data collection process in Part 1

Stage 1: Brainstorming and photograph taking training

The first stage of data collection involved obtaining the informed consent forms, informal brainstorming session, photovoice and photograph training with participants in their homes. The purpose of this session was to familiarise the participants with the research topic and photograph taking technique. Participants were allowed to ask questions about anything related to the study. They were also allowed to take photographs with a test camera. It was also stressed that participants should not take photos of people, including themselves if there was a need to do so, they should hide the face on the photograph. In the first part of the brainstorming, the researcher gave a brief overview of the photovoice method, as an action to make their silenced voices on dysmenorrhea and treatment modalities a possibility. The researcher then outlined that she was interested in their indigenous perspectives on dysmenorrhea and treatment modalities.

Stage 2: Taking photographs

Once the researcher verified that the participant had signed an informed consent form, was orientated and trained about the photovoice process, they were handed a demo camera to practice taking photographs. When the researcher was satisfied that the participant could use and was able to take photographs, they were handed a 27-exposure disposal camera. Thereafter, the researcher reviewed the usage instructions of the camera with the participant. The women were directed to take pictures of anything, not necessarily the apparent subject matter, that they felt related to indigenous perspectives of dysmenorrhea and treatment modalities. These could have been the environment, objects, symbols, plants, people that reflect indigenous perspectives of dysmenorrhea and treatment modalities within the community. They were advised to refer to the guiding questions when choosing things to photograph. The participant researcher was taught to avoid taking photos of people without their consent, and to avoid and hide people's faces. The participants were advised to take many photographs as the camera may allow and choose a maximum of three for inclusion in the interview session. A time limit of four weeks was given to ensure that photographs were taken while there was still enthusiasm in the study, and to allow sufficient time to take interesting photographs to address the research questions and objectives.

After four weeks, the researcher arranged a time and a convenient place to pick up the camera. Women who finished taking photos related to indigenous perspectives of the meaning and treatment modalities of dysmenorrhea were contacted after four weeks to hand in cameras. The researcher developed and duplicated the photographs within four weeks after receiving the camera. This was done using a photo development service so that the pictures were available in time for the interviews. Then, the researcher scheduled a meeting for individual interview sessions with the participants. This took almost three weeks, preferably at a place convenient to the participants.

Stage 3: Individual interviews

According to Wang and Burris (1997), it is imperative to interpret the photographs taken when using the photovoice approach. This helps to elicit the participants' understanding of their photographs. Immediately after processing the photos, the researcher contacted all 08 participants and scheduled individual interviews to attach meanings to their photographs rather than a focus group, which is usually used in photovoice studies. This was to offer a confidential and secure close and deep conversation between the interviewer and participants. Moreover, it was not difficult to schedule time in which all participants gathered for the Lekgotla discussion. All 08 interviews were conducted at different venues, as preferred by the participants. Each participant chose a private, quiet place to discuss photographs. Most participants preferred their own homes. The participants were reminded of the research question and then asked to choose three photos that they felt were the most significant. As well as those they wished to refer to regarding dysmenorrhea and treatment modalities.

Each interview was guided by questioning acronym "PHOTO" (Hussey 2006) and lasted approximately 45 minutes to an hour-long, or until there was nothing to tell about the three photos selected (Pies & Parthasarathy 2008:7). Individual interviews eliminated any potential for participant discomfort in sharing their photographs and stories within a larger group. At the interview session, the researcher obtained permission to audiotape the interview. Additionally, the researcher took detailed field notes, maintained a log, and completed contact summary forms after each interview. These forms allowed the researcher to reflect on key themes from the interviews, summarise information that might not have been collected during the interviews (but could be collected at another time), prepare for the next interview or point of contact with the participant, and reconnect the subject when preparing the write-up. The contact summary

forms proved to be beneficial as the researcher moved from one interview to the next. They also served as building blocks, helping the researcher to focus on emerging themes, highlighting key points and impressions from the interview, and helping rephrase unclear questions. The process is further explained under data analysis. After the interviews, the participants were recruited to take part in the Lekgotla discussion.

Stage 4: Lekgotla discussion

Photovoice approach typically includes a group discussion, because it should advocate and facilitate community action. This study used a modified Lekgotla discussion rather than a usual group discussion as suggested by the participants. Lekgotla discussion is an open forum in which indigenous community members in Sub-Saharan Africa use to debate and reach agreements on raised issues (Pienaar 2004:25 cited in Mphuthi 2015:56). Some ethnicity groups in South Africa refer to it as Kgoro (informed by the participant). During Lekgotla or Kgoro, the selected facilitator leads a discussion and allows every member to deliberate the issue under discussion to her expertise.

Lekgotla discussion differs from focus group discussion because the Lekgotla discussion involves elements of *Ubuntu* that view each member as equal and each member's opinion as necessary (informed by the participant). In South Africa, different ethnic groups practice Lekgotla or Kgoro discussions according to their traditional beliefs. The researcher modified the process of Lekgotla, whereby one close to the chief or elected member from the chieftaincy led the process. One of the participants was elected to be a leader and facilitated the process. The process allowed the participants to voice opinions about indigenous dysmenorrhea and treatment modalities in a respectable manner and without fear. In addition, the Lekgotla discussion stimulated critical thinking; participants discussed indigenous dysmenorrhea and treatment modalities among themselves, they exchanged ideas until a consensus was achieved. The Lekgotla discussion is discussed fully in point **3.4.1**.

- **Lekgotla discussion process (Phase 1: part 1)**

This session was optional, once all eight women were individually interviewed, the participants were contacted telephonically and some in person to participate in the Lekgotla discussion. Only

seven of them agreed to participate. A date was set and agreed upon, then only five confirmed their availability for attendance. The meeting took place under a tree shade in one of the participant's yard. Women gathered in a Lekgotla to share and discuss photographs with other participants. The process allowed individuals to reflect upon and analyse parts of their knowledge that they might not have paid attention to in their photos. The Lekgotla discussion emphasised the interaction among indigenous knowledge holders. The leader or facilitator of the Lekgotla discussion had facilitation skills acquired over years of observing its application by the elders in many gathering structures in the community. The participants selected a Lekgotla facilitator among themselves to conduct the meeting and plan another session of Lekgotla discussion to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. The Lekgotla facilitator was given a list of standard questions developed from the photographs and findings of the individual interviews by the researcher in order to guide the process. However, the researcher had the flexibility to probe and ask additional questions in between the discussion. In photovoice, discussion sessions centre on participant-generated photographs as a way of member checking.

The researcher reviewed all the photos and transcripts of each interview in order to identify the preliminary themes. Each woman was given a folder with her typed biography to edit, change or approve. The researcher and facilitator took it upon themselves to read and interpret for those who could not read and write. Their responses were indicated on their folders. A folder included a list of themes from photographs that emerged during individual interviews to provide feedback. The participants were also encouraged to provide verbal feedback and suggestions regarding the findings. The IKHs and THPs were informed that their input would be integrated into the final results that would inform the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge. The discussion lasted approximately five hours and was audio-taped and transcribed.

Participants codified issues about dysmenorrhea and treatment modalities, through identifying themes arising from photographs and modified Lekgotla discussion. Participants collaboratively synthesised emerging themes. Member checking of broad themes identified from the interviews was also done during the Lekgotla discussion. The discussion continued until consensus was achieved; this means that both emergent themes developed and continued until no additional information was derived from the provided photographs (Brink, Van der Walt & Van Rensburg

2012:141). They also provided feedback about the process of photovoice. They also discussed publication dialogue; interest of the women and possibilities for writing newspaper articles, internet blogs, poems, songs and academic articles, presenting at the local radio station and exhibiting their photographs for the public.

- **The following questions guided the Lekgotla discussion (Phase 1: Part 1):**

1. Are there any photos and themes that you would like to share with other participants in this study on indigenous knowledge and treatment modalities regarding dysmenorrhea?
2. What have you been thinking about since the individual interview regarding things you said or new things you would like to talk about concerning dysmenorrhea and treatment modalities?
3. What recommendations do you have to promote dysmenorrheal indigenous knowledge and treatment modalities in Botlokwa?
4. If you have the opportunity to present to HCPs, politicians, policymakers, educators, social workers, community members, friends and neighbours, what would you say to them about dysmenorrheal indigenous knowledge and treatment modalities in Botlokwa?
5. What has this process of photovoice been like for you, in illustrating and reflecting your indigenous knowledge and treatment modalities regarding dysmenorrhea?
6. How would you like to disseminate the information you provided?
7. Would you like to exhibit all the photos you have taken for the public to learn about dysmenorrhea and indigenous treatment modalities.

3.4.2.5 Data analysis

According to Polit and Beck (2017:725), data analysis is the systematic organisation and synthesis of the research data. In the photovoice approach, data collection and analysis do not occur in isolation. Participant observation and interviewing take place concurrently, as these methods are integrated into the participatory design. Latz (2017) indicates that photovoice data analysis typically includes traditional qualitative analysis methods such as inductive thematic analysis. Cresswell and Poth (2018:181) argue that qualitative researchers should equate data analysis with approaches for analysing text and images.

Twenty-four photographs (three photographs from each participant), interviews and modified Lekgotla discussion transcripts were analysed. Interviews and modified Lekgotla discussion were conducted in both Setswana and English. Data analysis in this study was ongoing guided by questioning the acronym “PHOTO” (Hussey 2006). During the individual interviews, data analysis involved reviewing each of the three selected photographs and its description as provided by the participant to answer the research questions and was concerned with trying to understand the Setswana women’s indigenous perspectives of the meaning of dysmenorrhea and treatment modalities. Common themes were identified for each participant based on her dialogue session. The researcher created a table to organise data, thereafter, compared and synthesised all of the participants’ themes. The analysis process engaged participants in the analysis of their photos and assisted moving them from a naïve consciousness to the reality of dysmenorrhea and available treatment modalities (Freire 1970:113). The process involved the following steps:

3.4.2.5.1 Photographs’ selection:

Participants selected three photographs from the captured photographs, also known as the “*preview*” session and ascribed meanings to each photograph. Thereafter, each participant engaged in a dialogue with the researcher about the photos to understand the participants’ intended representations and to situate the participant within the context of her photograph until there was nothing more to say (Pies & Parthasarathy 2008:7), using acronym “PHOTO” (Hussey 2006)

- What is in this **photo** related to dysmenorrhea and indigenous treatment modalities/ describe the activities on dysmenorrhea and indigenous treatment modalities in this **photo**?
- What is **happening** in this photo related to dysmenorrhea or indigenous treatment modalities knowledge?
- How does a photo **of** this object link to dysmenorrhea or indigenous treatment modalities knowledge?
- What does this photo **tell** us about dysmenorrhea or indigenous treatment modalities?
- How does this photo provide **opportunities** to improve knowledge of dysmenorrhea and indigenous treatment modalities?

The interview guide assisted with analysing the photos alongside stories. There were also questions as to why the particular photograph was taken depending on the photo and participant's sense-making. The interviewer asked her to elaborate on dysmenorrhea and treatment modalities. Once all the photos had been discussed, the participant was asked to sequence the photos in the order that made sense to her, using the titles given by the participant in response to the interview question as captions. This provided a sense of closure for the interview. Afterwards, each participant was given the option to write her biography or verbally provide what information she wanted the researcher to include in her folder of photos. The researcher labelled and numbered each photo according to the description provided by the participant. This process assisted with the identification and clustering of themes.

Holding individual dialogue sessions with each woman was deemed more helpful in this study, due to the possibly sensitive nature of some photographs and private nature of some reflections. Meanwhile, photos and stories or narratives about each photograph, which were recorded alongside the notetaking were grouped and categorised. The remaining photos were put aside to be included in the exhibition later as per participants' request. Notably, these are not part of this dissertation.

3.4.2.5.2 Contextualising

After taking the time to view photographs on her own, each participant chose the order in which to talk about her photographs, followed by "review". The researcher and participants reviewed photographs and stories to assess the congruency between the two and contextualise selected photographs by providing details and meaning of the photographs alongside their stories during the individual interviews in relation to the Batlokwa cultural beliefs and practices. The researcher encouraged participants to be free and creative when discussing their photographs so that it became easy to contextualise the meaning of the photographs related to indigenous dysmenorrhea and treatment modalities to their environment. This process allowed the participants to identify gaps from the photographs (visual) that may not be clear to the other person. Thereafter, it was discussed how these photographs may contribute to the knowledge of indigenous dysmenorrhea and treatment modalities among the Batlokwa ethnicity.

Each participant shared her insights with other participants and acknowledged each other's view and outlook during the modified Lekgotla discussion (Wang 1999:185-192). The significant statements identified regarding dysmenorrhea and treatment modalities were listed and grouped according to similarities in patterns of ideas and associations. This process provided a voice to the individual as well as group experiences. The researcher clustered all the selected photographs (24) into various groups, according to what was seen on the photograph, such as plants, animals, environment, person, and other objects. This exercise formed unique clusters with overlapping groups of associations that helped the researcher to develop, connect and discuss themes from the photographs to form the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women.

3.4.2.5.3 Codifying

During codifying, we followed an inductive classification system to reduce and organise the data set. The inductive classification assumed a knowable world of the IKHs and THPs, who gave a "voice" to meanings of dysmenorrhea and treatment modalities as reported in the data. Wang (2005) suggests that the researcher conducting photovoice research should facilitate dialogue, storytelling, and reflection on photos taken by the participants, and then attempt to codify the emergent themes that are generated through collective discussions. The researchers classified IKHs and THPs photos and context according to concepts identified in the individual interviews and modified Lekgotla discussion.

During the modified Lekgotla discussion, the principal researcher presented overarching themes that developed throughout the individual interviews. The participants then identified and discussed common issues or themes that emerged. Audio recordings and field notes assisted in identifying keywords and phrases related to indigenous perspectives of dysmenorrhea meanings and treatment modalities (Krippendorff 2004). The identification of common themes led the participants to develop main ideas and messages to be included in empowering other women with dysmenorrhea knowledge. Codes and themes generated during interviews and modified Lekgotla discussion expanded on how IKHs and THPs view dysmenorrhea and how they act towards treating it (Freire 1970:106). The coding stage provided an opportunity for the IKHs and THPs to classify their photographs based on qualitative study analysis' strategies. The process of codifying involved content analysis through identifying, sorting, comparing,

categorisation, and building themes that are reflected in the entire photograph collection selected for discussion and engagement with the text and its interpretation. This was to understand the complexity of indigenous dysmenorrhea and treatment modalities. The researcher was able to identify similarities and differences of the information provided by the participants in order to develop meanings and themes.

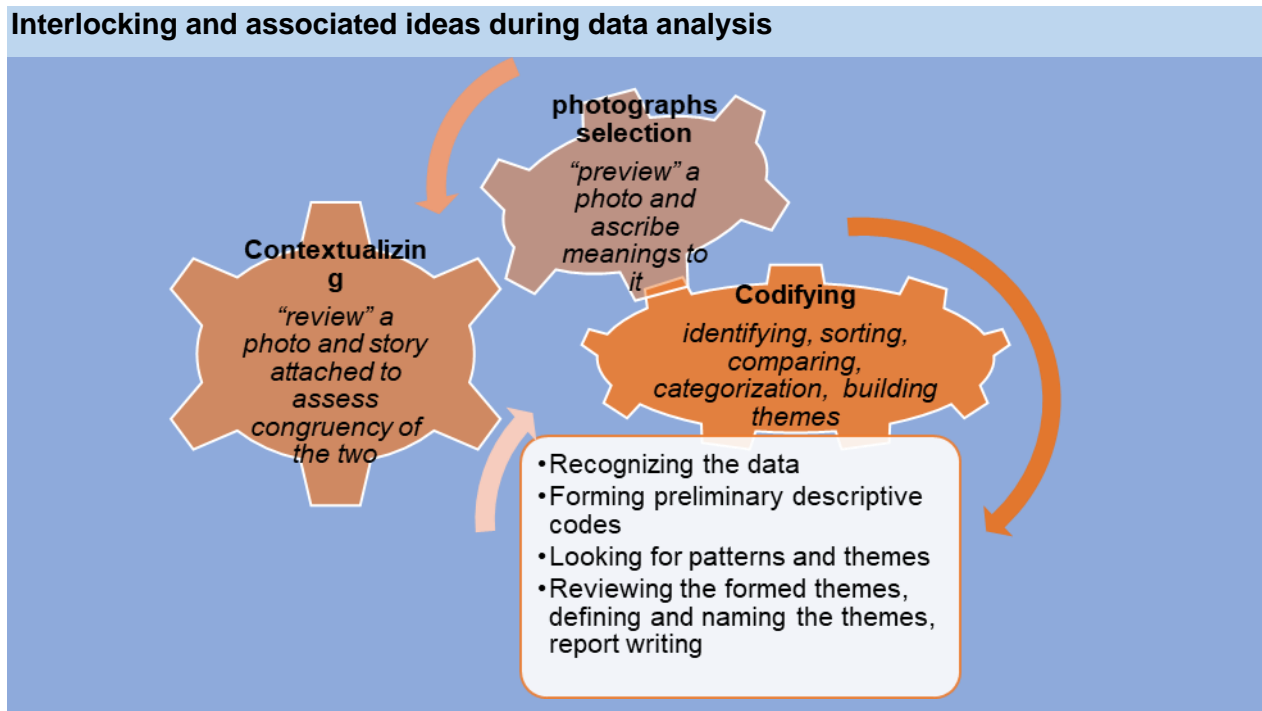


Figure 3.2: Part 1 data analysis process

3.5 PHASE 1: PART 2 RESEARCH DESIGN AND METHODS

3.5.1 Research design: Part 2

In this part, indigenous perspectives of the meaning and treatment modalities of dysmenorrhea were explored and described. A qualitative exploratory and descriptive design was used as this approach attempts to explore the social reality from the perspective of participants until saturation is reached.

Exploratory and descriptive studies are essential when breaking new ground because they afford space for reflection about events and facilitate the probability of yielding new insight and

an understanding of the area in the research process (Polit & Beck 2017). In this study, the indigenous dysmenorrhea knowledge carried by Batlokwa women (THPs and IKHs) is described and presented through the voices of Batlokwa women.

3.5.1.1 Exploratory design

According to Polit and Beck (2017), exploratory research is research that investigates a problem that is not clearly defined, in order to have a better understanding, as such exploratory research explores an unknown area to obtain new insights and becoming familiar with unknown situations (Polkinghorne 2005:137). An exploratory approach was used to explore and obtain an in-depth understanding of the participants' indigenous perspectives of dysmenorrhea. Such exploration was particularly useful given that my topic included examining aspects of culture, beliefs and values related to dysmenorrhea.

3.5.1.2 Descriptive design

In descriptive design, a profile of described relevant aspects of the situation under study is offered from a participant-orientated perspective (Sileyew 2019). A qualitative descriptive approach, therefore, offers the opportunity to gather rich descriptions about a phenomenon in which little is known.

The intent of descriptive design in this part was to describe the actual social reality as presented by the participants. In this study, the descriptive design enabled the researcher to discover the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea as offered by the Batlokwa THPs and IKHs. The THPs and IKHs also described their roles as perceived within their ethnicity group. After exploring and gaining insight into indigenous dysmenorrhea from THPs and IKHs, the researcher developed an understanding of the situation to the extent of developing strategies to empower the Batlokwa women with dysmenorrhea knowledge from the findings.

3.5.2 Research methods: Part 2

In this section, the study population, sampling, data collection and data analysis are discussed.

3.5.2.1 Study population

The study population in part 2 consisted of all female THPs and IKHs in Botlokwa village who did not participate in Part1 (Photovoice study).

3.5.2.2 Sampling method and sample size

The researcher combined purposive sampling with snowballing for recruiting women who are known to be THPs and IKHs in the community. The initial selection of THPs and IKHs using purposive sampling was complemented by snowball sampling until the amount of new information from participants was filled. These sampling methods helped to identify the most suitable THPs and IKHs. The participants with the relevant characteristics were identified and included in the study.

- **Inclusion and exclusion criteria**

All women that participated were THPs and IKHs. They were all residing in Botlokwa, Ga-Ramogopa Limpopo Province, South Africa. They had not participated in Part 1 (Photovoice study).

- **Sample size**

The study included seven women THPs and IKHs (4 THPs and 3 IKHs, as indicated on Table 1.2). This sample size was decided through the principle of saturation as outlined by Creswell, that after reaching saturation, the same number of participants should be interviewed until absolute saturation (Creswell 2014). Data saturation occurred when no new or relevant data emerges when all avenues or leads have been followed and do not provide further insight into the study (Cresswell & Poth 2018:203: 318). It was also based on the belief that it is sufficient to have a few participants who provide high-quality data that provide a full insight into the research problem (Holloway & Wheeler 2010:146). The point of data saturation was reached after the third interview in comparison to the information obtained in Part 1. However, four more participants were interviewed until the researcher was certain that there was no more new information emerging.

3.5.2.3 Data collection

Data were collected from seven participants through in-depth interviews. Data collection for Part 2 occurred over three months during 2019 (March to June). It is important to note that the decision to leave the field is dependent on data saturation

3.5.2.3.1 In-depth Interview method

According to Kumar (2011:144), an interview is a verbal communication between the researcher and participant, while Polit and Beck (2008:124) advise that it is essential to note non-verbal communication and seek clarification when unsure of any information. An in-depth interview is a qualitative data collection method. It allows freedom for both the interviewer and the interviewee to explore additional points and change direction, if necessary. In-depth interviews are typically carried out face-to-face so that a rapport can be created with participants (Kumar 2011:244). In addition, using face-to-face interviews enabled the researcher to observe and monitor body language or non-verbal communication.

3.5.2.3.2 Interviews with THPs and IKHs

The seven selected THPs and IKHs were located and recruited, and the intentions and nature of the study were discussed in detail with each of them. The informed consent form was issued to those who showed interest in partaking. After signing the informed consent form, appointments were made for the interviews. In order to understand the women's indigenous perspectives of the meaning and treatment modalities of dysmenorrhea, all the interviews were conducted face-to-face in the women's homes. The choice of a location for the interviews was discussed with each participant when making an appointment.

The unstructured in-depth interviews were used to gather information in Setsitlaka, the home language of the participants. Unstructured interviews are one of the primary qualitative data collection methods in which there is no specific set of predetermined questions because usually, the interviewer has specific topics in mind for the interview (Guest, Namey & Mitchell 2013). It also can enable participants to use a descriptive mode in providing details, feelings and views on the issue being investigated.

In this regard, the objectives of the study became the topic and questions that the researcher used. The interview was more of a guided conversation than a question and answer session, which facilitated the flushing out of the participant's views through open-ended questioning. The researcher was guided by the information given to ask more questions. Moreover, various communication techniques such as paraphrasing, clarification, probing, exploration and reflecting were used as needed to facilitate the interview. Visual signs like nods, frowns and smiles were noted. The researcher preferred unstructured interviews because it allowed the researcher to ask follow up questions and obtained richer and more valid data on the phenomenon under study. The duration of interviews varied from one participant to another; interviews lasted between 40 minutes and two hours. Five of the interviewees were tape-recorded, whilst two participants refused the use of a tape recorder. However, the research assistant took notes on permission.

There were many disappointments during data collection. Some of the women kept on postponing their appointments due to urgent calls to assist clients. Some eventually were interviewed, but others were never interviewed. This affected the data collection period but not the data.

3.5.2.4 Data analysis

The content data analysis method was followed. In this study, interviews were conducted and transcribed in Setswana. Although data collection and analysis proceeded concurrently from the first interview, the researcher and female transcriber transcribed the recorded interviews verbatim. In order to maintain confidentiality, I used pseudonyms.

The initial analysis of data was done in Setswana the original language because Koponen Salmi and Nikulin (2019) suggest that analysing the data in the original language is faster and more accurate than in the translated data. Furthermore, it improves the quality of analysis. However, for reporting findings, I translated from Setswana to English; thereafter, a research assistant verified and adjusted where necessary. The notes taken by the research assistant during interviews were compared to the data obtained from tapes, additional information and changes were made where necessary.

Because Setlokwa is my first language, I thoroughly reviewed all of the interview transcripts by listening to the audio recordings and comparing them to the transcripts, in order to verify the accuracy of the transcription and to correct any transcription errors. Then notes were written on critical concepts and insights emerging out of the data. In order to assist in content analysis, the next step was to describe, classify and interpret data into codes and themes as originated from the participants' responses. Thereafter, codes and themes were put into meaningful context based on the researcher's interpretation, at times referring to Africana Womanism theory characteristics. Thereafter, data were grouped according to each theme emanating from the objectives of the study. This means that all responses addressing a particular objective were grouped. The last step presented themes and sub-themes and their relationships. The researcher drafted a set of preliminary statements to inform the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge based on the findings of the empirical data collected in Phase 1 of the study. In Phase 2, questions with guiding criteria were used to collect data from the panel of experts who were involved in the rounds to generate their opinions until consensus was reached.

3.6 PHASE 2: DEVELOPMENT OF STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHEA KNOWLEDGE

Phase 2 focused on the development of the strategies to empower Batlokwa women with dysmenorrhea knowledge. Empirical data collected in Phase 1, supported by literature and Africana Womanism theory, assisted the development of strategies to empower Batlokwa women with dysmenorrhea knowledge (Refer to Chapter 6, Table 6.2 and Figure 6.1). To confirm the study findings and reach consensus on the set draft, a one-day Lekgotla meeting with participants and experts was conducted.

3.6.1 Research design

This study used Lekgotla discussion as a research process (Rau, du Toit, Mavhungu & Kabeta 2009; Tsima 2018).

3.6.1.1 The Lekgotla methodology

The Lekgotla methodology is a structured process that indigenous South African communities use to gather information and reach a consensus from a group through discussion (Tsimba 2018). The Lekgotla methodology was used to reach consensus on the draft strategies to empower Batlokwa women with dysmenorrhea knowledge. Pienaar (2015:59 cited in Nare, Pienaar & Mphuthi 2018) alluded that Lekgotla is the data collection method to be used in order to obtain more information from the participants.

Lekgotla originates from the word '*Kgotla*' (meaning gathering or meeting). Originally, the technique was introduced to be used by the Kings or Chiefs as a way of generating knowledge to deal with the communities' issues, including the traditional court (Tsimba 2018). Hence, it is essential to have a pre-meeting with the King/Chief, or headman or any local tribal authority representatives to clarify reasons and to obtain permission to call the meeting, establishing a team and recruiting participants, role clarification, planning, budgeting and other logistics (Pienaar 2004:25 cited in Mphuthi 2015:56).

In South Africa, it is used widely and successfully by many ethnic groups who adopted it to suit their cultural and environmental setup for solving and taking decisions. For example, the ruling party, African National Congress (ANC), calls Lekgotla gatherings when conducting meetings to take decisions on the matters that are for the community benefit. Within the field of health, Lekgotla discussions are used to collect data on how the Campbell and Melesi community prepares, administers and stores *wildeals* and *wynruit* decoctions (Mphuthi 2015). Nare et al. (2018) used Lekgotla discussion to engage participation in the construction of African primary health within mental health care. The results of their Lekgotla discussion showed that all the groups were able to debate and dialogue until reaching consensus effectively. It also showed that Lekgotla discussion was culturally and community sensitive. The technique has since become a widely used standard to conduct research studies in the indigenous communities (Nare et al. 2018; Mphuthi 2015; Pienaar 2004). The Lekgotla methodology is effective for generating large numbers of creative new ideas and for group priority settings.

Tsimba of COMETSA use Lekgotla to facilitate workshops for coaching managers. It is even used by the government of South Africa to guide several gatherings and meetings, as a

mechanism of bringing the government closer to the people. The Lekgotla outcomes are then used as an input to the Cabinet Lekgotla. Lekgotla processes also assist the state in preparation for the State of the Nation Address (SONA). Most researchers have used the Lekgotla process simply to collect data. This implies that the Lekgotla process can be adapted in any setting and modified depending on its use. The data produced by this methodology can be both qualitative and quantitative, depending on the way it is used.

The Lekgotla methodology requires direct participants involved in a non-hierarchical way and non-intimidation (Tsimma 2018). The sitting arrangement during the Lekgotla process creates the environment for the participants to listen actively, participate without fear, respect each other, and fully engage with the matters of the day. The facilitator will know his/her role and offer solutions. This ensures that outcomes are from all the participants. The Lekgotla process is well organised as it tackles one issue at a given time. If other issues arise from the discussion, they are noted and put aside to be discussed later if there is still time or relegated to a separate Lekgotla (Tsimma 2018). The technique includes some formal steps to be followed to maintain order during the process. These steps include time for greetings and finding out how the other feels, so as their family's wellbeing. The issue of anonymity is difficult in Lekgotla discussions since they are open discussion forums.

Once the facilitator or leader is convinced that all is well with the Lekgotla participants, she welcomes all present. Then the rules are laid in a free and respectful manner to make sure that there are no objections to the agenda. Thereafter, the facilitator introduces and gives the background of the issue to be discussed. Then the facilitator engages participants in dialogues and debates. Once all the participants have raised their issues and have been fully heard, the facilitator summarises the inputs and resolutions are taken.

Although the use and application of Lekgotla are different in the previous studies, findings demonstrated many essential points about the success of the Lekgotla discussion method. As such, the Lekgotla was found to be complementary with Africana Womanism, which demonstrates that it was useful in our study. The actual steps followed in this phase are discussed in Chapter 7.

3.6.1.1.1 Advantages of Lekgotla methodology

The advantages of using Lekgotla methodology is that it allows participation of the whole cohorts or representative groups of participants without limitations. It can generate greater and creative ideas from various participants (Tsimba 2018). The author further indicated that Lekgotla discussion offers a fair and valid representation of group views since all participants have an equal voice, and all responses to the posed question have equal validity. It facilitates deep thinking, creativity, listening, flowing dialogue, consultation before decisions are made. The verification of the decisions taken, and discussions are made until everybody is satisfied that they made their input.

Additionally, the Lekgotla methodology promotes meaningful, interpersonal disclosures among participants by gathering equally weighted responses. When Lekgotla methodology guides the research process, results are produced immediately, since ideas are generated, debated and evaluated at the session (Nare et al. 2018). Although Lekgotla methodology shares some similar elements with Nominal Group Technique (NGT), the following differences are noted: Lekgotla methodology does not limit the number of participants, it allows as many participants as the community (Tsimba 2018), whilst NGT uses a structured variation of a small-group discussion to reach consensus (Manera, Hanson, Gutman & Tong 2019). The sitting arrangement in a Lekgotla process is a circle, implying that all participants' ideas are equal including the facilitator and promoting togetherness as a principle of *Ubuntu* (motho ke motho ka batho). In NGT, they usually sit in a U-shape. Unlike NGT, the participants of Lekgotla proceedings arrive at the venue earlier than the scheduled time, for greetings and knowing each other as the Lekgotla methodology is embedded in the culture of *Ubuntu*.

3.6.1.1.2 The nature of the Lekgotla methodology in this phase

As indicated above, the concept of the Lekgotla has been used by the Kings or Chiefs in South Africa for long, to tackle the issues of concern in their communities. It is essential to bear in mind as mentioned in Chapter 1 that Batlokwa ethnicity group still adhere to their cultural background in many ways; the focus was to use the ways that bring out their cultural uniqueness. The participants suggested the idea of using Lekgotla methodology for this phase after it was used successfully in Phase 1 as a data collection method. The main idea was to

actively gather information while providing a space for the experts to share their knowledge and experiences of dysmenorrhea (Tsimba 2018). The process was also used to generate more ideas and reach consensus on strategies to empower the Batlokwa women with the generated knowledge on dysmenorrhea.

The Lekgotla methodology can be compared to NGT; however, with Batlokwa ethnicity, Lekgotla carried more weight than NGT, because it is the methodology that they are familiar with when conducting group discussions. The researcher intended to use the process of NGT in this phase. However, participants suggested the use of Lekgotla. The researcher finds Lekgotla an appropriate forum for engaging Batlokwa THPs and IKHs women when developing strategies to empower the Batlokwa women with dysmenorrhea knowledge.

The underlying premise of the modified Lekgotla methodology was the unmediated engagement of the Batlokwa women, including THPs and IKHs and other categories of women. The process did not impose restrictions and normative measures compromising participants' freedom of knowledge. Hence, all women could attend. The procedures of the modified Lekgotla methodology in this phase revolved around liberating Batlokwa women to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge from the results of Phase 1. The facilitator was chosen by the participants based on the understanding that she was knowledgeable and experienced on the process, as she facilitated the modified Lekgotla discussion in Phase 1.

3.6.2 Population

The population in this phase comprises of all Batlokwa women, including THPs, IKHs, Nurses, Teachers, local authority representatives, and leaders from the community groups.

3.6.2.1 Sample size and sampling technique

No sample size was drawn since Lekgotla methodology does not require any numbers for participation. Purposive sampling technique was used to recruit the participants from local schools, clinics, THPs' associations, leaders from local authority and women's groups. Snowball sampling was also used as the researcher asked the participants to recruit other women to

attend based on their knowledge of indigenous dysmenorrhea. Among the participating women in this phase were 10 IKHs, six THPs, two professional/registered nurses from the local clinics, three schoolteachers from the local schools, one representative from the local authority, and a retired schoolteacher. All in all, 22 women participated.

Table 3.1: Profile of participants for modified Lekgotla discussion in Phase 2

POPULATION	NUMBER OF PARTICIPANTS
THPs	6
IKHs	10
Professional/registered nurses	2
School teachers	3
Local authority representative	1
Total	22

3.6.3 Data collection

The development of strategies to empower the Batlokwa women with dysmenorrhea knowledge was based on the empirical data collected in Phase 1. The data collection method for this phase was a modified Lekgotla discussion in a form of dialogue and debates among the participating women (Pienaar 2015:59 cited in Nare et al. 2018). Although there was existing information from Phase 1 that guided dialogues and debates. The participants were requested to freely add information considered appropriate for inclusion in the envisaged strategies to empower women with dysmenorrhea knowledge. After the researcher presented the findings of the study and formulated preliminary statements, the focal question was posed to initiate modified Lekgotla discussions with the participants and to reach an agreement on the useful items of indigenous dysmenorrhea. The focus of the discussion was on what is suitable to be considered a strategy, purpose, objective, rationale and key performance indicator to empower Batlokwa women with dysmenorrhea knowledge. The data collection in this phase was in the form of a workshop discussed in Chapter 7.

3.6.4 Data analysis

In this phase, data analysis was conducted as follows: the researcher and co-researchers calculated the frequencies of responses manually. Weighing of each statement was determined

through ranking by the participants according to their priority. Each participant assigned each statement a number of weights. The researcher assisted in how weights should be done. The score of 1 to 5 was used to select the weight of each statement. Number 1 reflecting less weight, whilst 5 reflected a higher weight. The list was then re-ordered to reflect the order of priority. See chapter 7.

3.7 ROLE OF THE RESEARCHER DURING DATA COLLECTION (ALL PHASES)

The researcher's role was to direct the data collection process to ensure that all the ethical issues as required by the research and photovoice methodology were applied. In addition, it was to maintain a high level of trust, not to take any sides should any controversial issue arise among the participant researchers but cautiously guiding them to solve it. Furthermore, it was to guard against emotional involvement with participants during interviews in order to avoid compromising collected data; to tape record the conversation in order to capture all the information that could have been missed when writing notes. Lastly, it was to observe the non-verbal communication during the interview and modified Lekgotla discussion, so that it was used to probe and later translated into spoken words.

3.8 CONTEXTUALISING THE RESEARCH

The study was conducted in Botlokwa, Ga-Ramokgopa village, which falls under Molemole Municipality, Capricorn District of Limpopo Province, South Africa. This study provides a brief overview of the setting, because according to Botma et al. (2010:95), it is essential to include a research setting in the study because the geographical setting of every society determines the health outcomes in its vicinity.

Limpopo Province is the fifth largest of the nine provinces in South Africa pointing to the north of the country. Limpopo Province borders Botswana to the west, Zimbabwe to the north and Mozambique to the east. According to Statistics South Africa Community Survey (2016), the population of Limpopo Province is estimated at 5.8 million from 5.4 million in 2011. The province is divided into five districts, namely Capricorn, Mopani, Vhembe, Waterberg and Sekhukhune. Capricorn district is the second largest of the five districts. The district is named after the Tropic of Capricorn which runs through it. The Capricorn District Municipality is situated in the centre of

the Limpopo Province, sharing its borders with all four district municipalities (Community survey 2016). The Capricorn district consists of four municipalities, namely Molemole, Blouberg, Polokwane and Lepelle Nkumpi. The total population for Capricorn district is 1 330 436, the majority being Black African, staying in rural tribal villages (Community survey 2016). Molemole Local Municipality is located in the central-eastern region. Molemole municipality population is estimated at 108 645 (Statistics South Africa community survey 2016). This municipality is predominantly rural and mainly comprises of agricultural activities. The municipality has four traditional authorities, namely Manthata, Makgato, Ramokgopa, and Machaka Traditional Authority (Integrated Development Plan 2020/21). Significantly, the N1-Trans Limpopo Corridor traverses Molemole from the south-west to the north-east, through Botlokwa village. Botlokwa, Ga-Ramokgopa is a rural area located about 60 km north of Polokwane (capital of Limpopo) in Capricorn District, Molemole municipality.

The Tropic of Capricorn line runs through this village in South Africa. Batlokwa is part of the Northern Sotho grouping. Botlokwa is the natural environment of the participants (Polit & Beck 2017:524, Creswell 2014:185).

Primary health care in Botlokwa is obtained in the clinics, hospitals, private doctors and Traditional Health Practitioners (THPs). The lives of this rural community are governed by cultural beliefs and practices that are unique from other North Sotho groupings in Limpopo Province and their decisions to use or seek health care is influenced by the individual, family or group indigenous perceptions of the illness. The Batlokwa ethnicity, just like other Northern Sotho of Limpopo Province, prefers self-medication through the administration of indigenous plant medicine to prevent illness and maintain good health and wellbeing, treat minor ailments, self-diagnose or as a family tradition (Rankoana 2014). The health sector in Botlokwa is controlled centrally by the Ministry of Health, which supervises the Department of Health (DoH) in the Limpopo Province.

This site was chosen to understand the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province. The Batlokwa women, as a group, are not discriminated on the ground of gender for they have an equal status in matters of education, remarriage, managing the household, right to property, freedom of expression, giving sound opinions and intellectual pursuit, and participation in public debate.

They even played a significant role in the struggle against apartheid. Women are encouraged and promoted to participate in decision-making positions at all levels and sectors by specific strategies and quotas, especially in politics. Nonetheless, men still dominate in decision making, including in the health care sector despite women HCPs outnumbering man HCPs (Czabanowska, Domagała, Kalaitzi, Krogulec, Burazeri & Babich 2017:280). However, women experience a form of oppression due to the silencing of their voices and rejection of their cultural context within the health care system. The indigenous perspectives of the meaning of dysmenorrhea and treatment modalities among Batlokwa women in Limpopo Province have not been heard. See Figure 3.3; the attached map for locating the study setting.

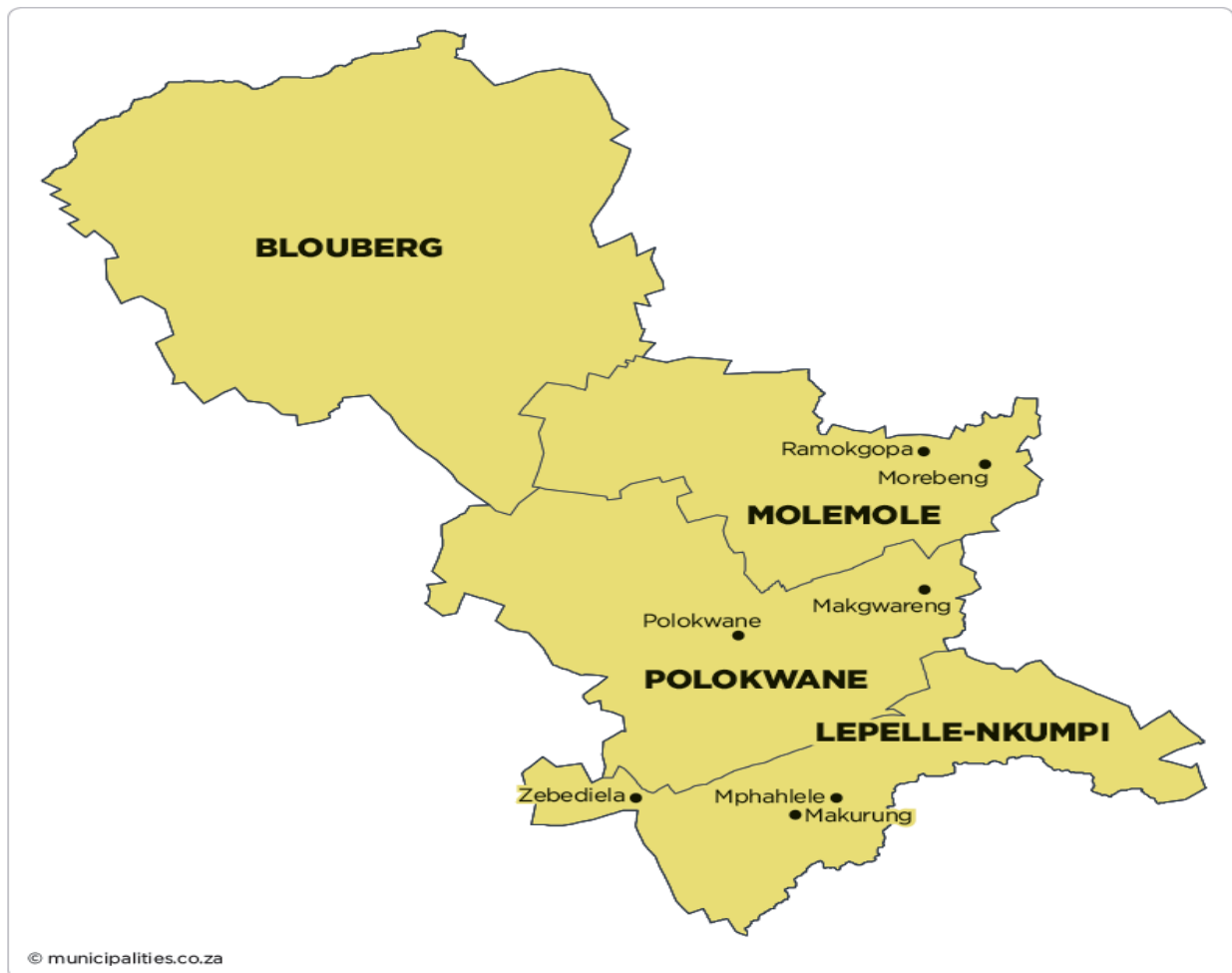


Figure 3.3: Map of Capricorn District municipality: Capricorn district municipality (DC35)
municipalities.co.za

3.9 TRUSTWORTHINESS

Polit and Beck (2017:747) define trustworthy as the degree of confidence qualitative researchers have in their data and analysis. The aim of trustworthiness in qualitative research is to support the argument that the inquiry's findings are valid and worthy. According to Polit and Beck (2017:559), the quality criteria most often described by qualitative researchers are those proposed by Lincoln and Guba (1985). Lincoln and Guba (1985:290) suggest credibility, transferability, dependability and confirmability as criteria for developing the trustworthiness in qualitative research (Polit & Beck 2017:559-560). These criteria represent parallels to the internal, external validity, reliability and objectivity in quantitative research (Polit & Beck 2017:559). Authenticity was added as the fifth criterion following criticism (ibid). Trustworthiness is illustrated in Table 3.2:

Table 3.2: Measures of trustworthiness

STRATEGIES	ACTIVITIES	APPLICATION
Credibility	Prolonged engagement with the field	<ul style="list-style-type: none"> - The researcher spent time negotiating with traditional leaders to gain access to the research field, this helped in understanding the proper procedure to recruit the relevant participants - The researchers spent more time with participants during data collection (8 months) and interviews until reaching the data saturation level - Built rapport and creating context of trust with participants - During both interviews, the researcher periodically observed and noted down any gestures from the participants - Many hours were spent scrutinising collected data to generate themes and sub-themes - The formal and informal discussion of the findings were done with participants
	Member checking	<ul style="list-style-type: none"> - The researcher deliberated probing during interviews and clarifying meanings of participants' comments - Throughout data collection, the researcher constantly checked the correctness of the information with the participants - Took back preliminary findings to the

		<p>participants for clarity and verification of some specific descriptions in thematic summaries.</p> <ul style="list-style-type: none"> - Participants were involved in data analysis and translation of data from local language to English
	Peer debriefing	<ul style="list-style-type: none"> - This research involved discussions with independent colleague and supervisors from proposal development to the finalisation of the thesis - The researcher reached consensus discussion with the independent coder - Presenting research design and findings at research forums and doctoral seminars,
	Reflexivity	<ul style="list-style-type: none"> - Writing of field notes during interviews reflecting researcher's feelings, thoughts, experiences and observations
	Data and method triangulation	<ul style="list-style-type: none"> - The study used semi-structured questions and multiple methods when collecting data (Photographs, individual interviews and modified Lekgotla discussion) - The interview questions were consistent in meaning across all the participants in all the sample - The study used two different data sources (trained THPs and untrained Indigenous Knowledge Holders)
Transferability	Realisation of the sample	<ul style="list-style-type: none"> - The researcher ensured that the participants are purposively selected/sampled as individuals who have indigenous knowledge of dysmenorrhoea and treatment modalities and willingly referred others who wanted to share their knowledge
	Theoretical framework	<ul style="list-style-type: none"> - Theoretical parameters and framework illustrated how this study ties into a body of theory
	Dense description of study context, participants and findings	<ul style="list-style-type: none"> - The researcher contextualised the study, participants gave rich, thorough and vivid descriptions of fieldwork, findings have verbatim quotes of participants, and detailed log of decisions

Dependability	Dense description of methodology	- The study described research process, design and methods in details, including changes and modifications that occurred and how the changes affected the study
	Realisation of the sample	- Selecting participants using purposive and snowball sampling
	Data and method triangulation	- The study used different data collection methods
	Code recode procedure	- The participants were involved with data analysis, including development of themes and sub-themes. - The participants were presented with the first draft of the strategies to empower Batlokwa women with dysmenorrhea knowledge
	Dependability audit	- Supervisors assisted throughout the research process and in reaching consensus during discussions - All material and documentation used in the field, gives a detailed log of decisions made during the research process - Scrutiny of data reporting and supporting documents by the supervisors and participants
	Peer debriefing and reflexivity	- Discussions with independent colleague and supervisors - The researcher positioned herself in the study
Conformability	Conformability audit	- The researcher will keep the record of research process (audit trail), i.e. raw data: audio tapes of interviews, and field notes safe for a period of 5 years after publication of the thesis
	Peer debriefing	-Discussions with independent colleague and supervisors
Authenticity	Bracketing and reflexivity	- The researcher acknowledged her relationship to the study and participants, reflected own actions, feelings and conflicts experienced during the research process - and avoided to portray personal and professional opinions as findings emerge - Keeping reflective journal of the researcher's personal biases, values and thoughts helped not

		to make judgement about observations and remaining open to data as it reveals themes
	Fair and faithful realities	<ul style="list-style-type: none"> - The researchers respected the participants' views about dysmenorrhoea, and perspectives were not changed to suit the researcher's own perspective - During data analysis, the direct words of the participants were quoted as evidence for the findings
	Thick and contextualised descriptions	- Lucid and textured descriptions including verbatim quotes from study participants were included

(Polit & Beck 2017:559-560, Lincoln & Guba 1985:290)

3.10 SUMMARY OF THE CHAPTER

This chapter presented and discussed the research design and methodology used to conduct this study. Photovoice and Lekgotla methodology was explained in detail. Data collection instruments and data analysis plan were also discussed and motivated. The population and sampling strategies used were clearly explained with justifications. The process of modified Lekgotla discussion and findings of Phase 2, which was the development of the strategies to empower the Batlokwa women with dysmenorrhoea knowledge are discussed in Chapter 6. The chapter also looked at issues of trustworthiness and ethical considerations and on how they were controlled. In the next chapter, the findings of Phase 1 are interpreted and presented.

CHAPTER 4

INTERPRETATION AND PRESENTATION OF EMPIRICAL FINDINGS

4.1 INTRODUCTION

The previous chapter discussed the research design and methodology. In this chapter, the findings from both Phase 1 (part 1 and 2) are addressed. The two parts were consolidated and presented as empirical findings. The chapter includes a collective analysis that presents the themes as they emerged. The findings are on the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. The findings also outlined the roles of THPs and IKHs in their community as informed by Africana Womanism. The objectives were to explore and describe the:

- Indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province.
- Roles of Batlokwa women in Limpopo Province as knowledge holders in the management of dysmenorrhea in their community.

The findings presented in this chapter were gathered from THPs and IKHs (women), using modified photovoice approach conducted in four stages and face-to-face in-depth interviews with different participants. Throughout data collection and analysis, the characteristics of Africana Womanism were considered. All the women who participated made meaning of dysmenorrhea and treatment modalities in several ways related to their understanding and involvement in treating dysmenorrhea. An intricate understanding of dysmenorrhea emerged from the participants' photographs and words. The descriptions illustrated increased an understanding of the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. The findings were numerous and encompassed several recurring themes and sub-themes based on general insights from the data and common threads among participants. All emerged themes and sub-themes are connected and presented in accordance with

objectives and guiding research questions that were clear and well understood by the participants.

The chapter unfolds with a brief transcribed description of selected participants' photographs and quotes from interviews and modified Lekgotla discussion. This is to support the key themes and sub-themes captured by the participants. The words in italics and inverted commas are direct quotes from the participants. The researcher's comments are presented in a normal font.

4.2 PHASE 1 FINDINGS: INCORPORATED PART 1 AND PART 2

The presentation begins with demographic findings. To protect the anonymity of participants, where names are used, unique pseudonyms were assigned. This was followed by the presentation and interpretation of the Botlokwa women's indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. Figure 4.1 represents the main themes and sub-themes of the study.

4.2.1 Participants

Women were the central participants in this study. All women in this study were of African origin and identified as Blacks from Botlokwa Limpopo Province as guided by the term Africana Womanism. They all have indigenous knowledge in treating dysmenorrhea at Botlokwa village, Limpopo Province. Seven of the women were trained THPs, and eight of them acquired indigenous knowledge through oral translation and observation either from the elders in the community or when they were treated for dysmenorrhea. While participants may have discussed topics related to dysmenorrhea before, this was the first time any of them was involved and participated in a photovoice research and in-depth interview. Initially, 15 women were recruited to participate in the photovoice study, and only 12 participants signed consent forms. 08 participants presented photographs and were interviewed individually. Out of 08 participants, 05 attended a Lekgotla discussion. The women who participated in the photovoice study were between the ages of 28 and 89 years old. Thereafter, seven more women between the ages of 25 and 79 were recruited and participated in the in-depth interviews only. Their educational status varied from diploma certificates, to university graduates. Some of them had primary or high school level qualifications, and others had no formal education. Their years of

experience as IKHs ranged from eight months to 53 years. This showed that many of the participants had managed dysmenorrhea for a long time. Demographic data of photovoice participants are detailed in Table 4.1

Table 4.1 Demographical data of Phase 1 participants (N=15)

NO	AGE	PRACTICE TYPE	YEARS OF PRACTICE	EDUCATIONAL STATUS	DATA COLLECTION APPROACH
1.	25 years	THP	4 years	Matric	In-depth interview
2.	28 years	THP	6 years	Teachers diploma	Photovoice
3.	33 years	IKH (Learnt from the late father)	21 years	Teachers diploma	Photovoice
4.	40 years	THP	9 years	High school level	In-depth interview
5.	47 years	IKH	30 years	Administration certificate	Photovoice
6.	47 years	IKH	Unsure (Teenage years)	Social worker	Photovoice
7.	52 years	THP	8 months	Teachers diploma	In-depth interview
8.	53 years	IKH	33 years	Anthropology degree	In-depth interview
9.	54 years	THP	12 years	High school level	In-depth interview
10.	55 years	IKH	20 years	High school level	Photovoice
11.	61 years	IKH	Unsure (Teenage years)	Primary education	In-depth interview
12.	63 years	THP	27 years	Retired nurse	Photovoice
13.	67 years	IKH	Unsure (Teenage years)	High school level	Photovoice
14.	77 years	IKH	62 years	Retired teacher	In-depth interview
15.	89 years	THP	53 years	Never schooled	Photovoice

4.3 FRAMEWORK OF THEMES AND SUB-THEMES

The findings of the study revealed that the Batlokwa ethnicity, like any other ethnical group, have their point of view towards the meaning and treatment of dysmenorrhea, which is

influenced by their cultural orientation. The photovoice participants took pictures of the environment such as rivers and land, symbols, objects, plants and people (not showing faces) that reflected their standing or position about dysmenorrhea within the community. This was for the researchers to understand their ethnicity point of view. Analysis of the data, as illustrated in Figure 4.1, surfaced five recurring themes with subsequent sub-themes. Themes and sub-themes are in relation to indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. Although each participant had their knowledge to share, common themes emerged. Africana Womanism theory was referred to during the organisation of themes and sub-themes. As such, they produced a relatively mixed bag of responses, but several participants made similar comments. These themes represent and speak to the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. The findings of the study revealed that the Batlokwa THPs and IKHs' views of dysmenorrhea are embedded and understood in their own beliefs and practices of naming, diagnosing, treating and preventing dysmenorrhea. The emerged themes are 1). A holistic understanding of dysmenorrhea meaning, and one subtheme was identified. 2) Self-naming and definition of dysmenorrhea, and one subtheme emerged. 3) Diagnostic processes in indigenous health care practices and three sub-themes. 4) Treatment modalities of dysmenorrhea, and two sub-themes. 5) Roles of THPs and IKHs in the treatment and prevention of dysmenorrhea.

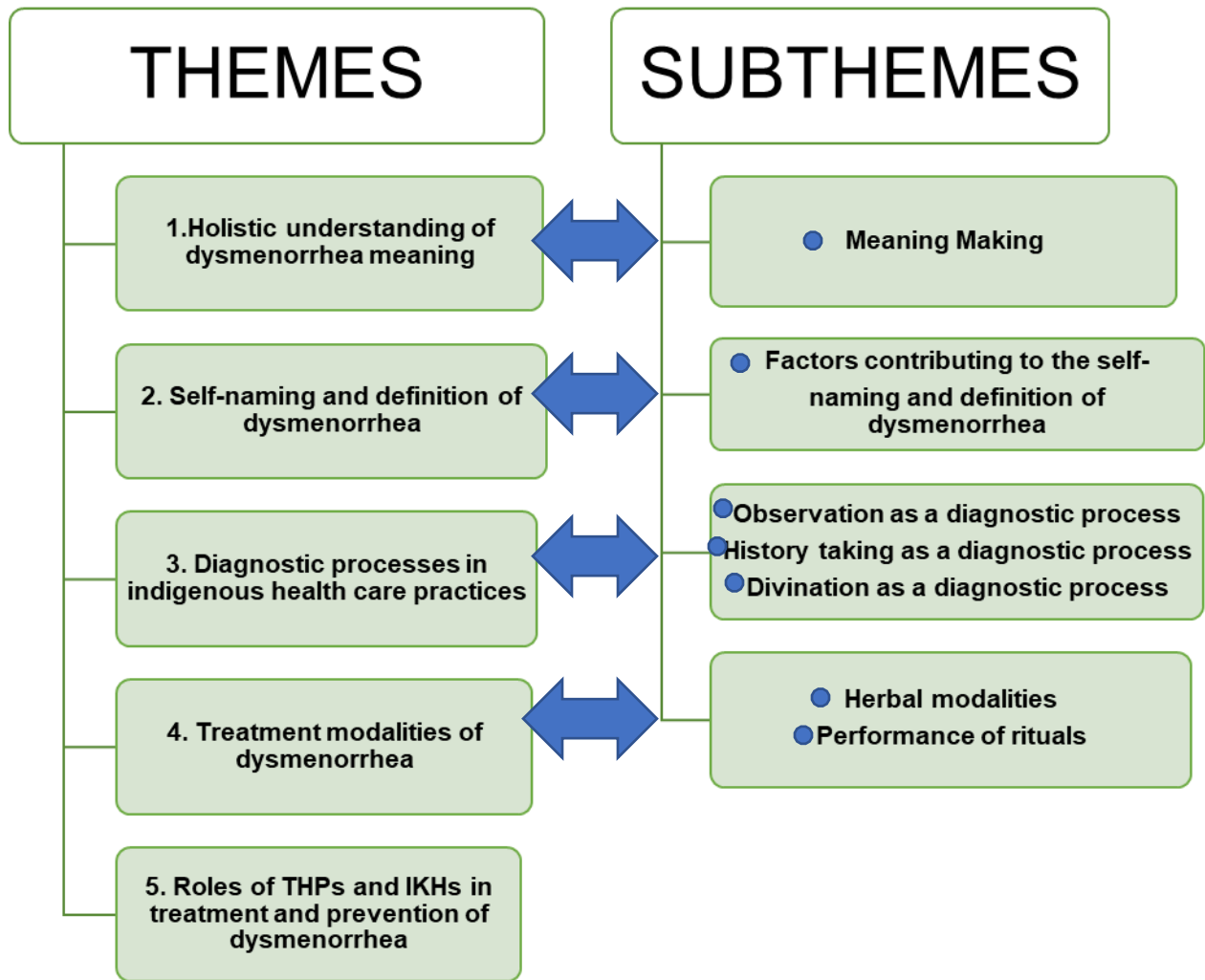


Figure 4.1 Themes and sub-themes

4.3.1 Theme 1: Holistic understanding of dysmenorrhea meaning

In this study, dysmenorrhea was better understood in a broad and integrated trend of illness that occurs periodically during menstruation. The central theme that emerged during data analysis was the holistic understanding of dysmenorrhea. The participants felt that the meaning of dysmenorrhea should be understood holistically because it is a problem of menstruation, which may vary from one cycle to another. According to Africana Womanism theory, the interest of a Black community as a whole maintains the sense of wholeness through cultural connectivity.

The voices of the participants affirmed a holistic meaning of dysmenorrhea. The presented photographs and meanings attached to them affirmed that dysmenorrhea is not only a physical illness, but also one interdependent with mental, emotional, spiritual, social, economic and environmental aspects. It was also clear that the women experiencing dysmenorrhea are connected to their families, community and cultural health beliefs and practices. The following quotes rest upon this finding:

“selumi” (dysmenorrhea) means that there is a disharmony with woman holistically, that is, the mind, body, emotion, spirit and environment are not balancing. Participant # 13

Participant # 6 said: *“Dysmenorrhea is addressed within a holistic approach, we consider the emotional, mental, spiritual aspects, including the environment in which the woman comes from”*.

Participant # 8 echoed that: *“Traditionally dysmenorrhea is understood as a women reproductive system illness that affects the body, mind and spirit, because our ways of healing looks holistically at the body, mind and spirit”*

In support of the statement from participant # 4: *“We all face the consequences and impact of dysmenorrhea as a community, as we associate the physical impacts of dysmenorrhea to emotions, spiritual, and socio-cultural disharmony”*

On the other vein, how participants viewed dysmenorrhea was heavily influenced by their relationships with other women in the society at large. For example, one of the uttered statements from participant #14 was: *“Dysmenorrhea is a holistic condition, it can only be understood and managed by women themselves”*. Implying that women experiencing dysmenorrhea view it as inclusive to all other reproductive health issues and turn to discuss and accept advice from women only. Recurring presentation of the photographs taken and the discussions throughout interviews showed how the women connected critical components of their definitions of dysmenorrhea to make sense of their perspectives. The findings revealed that, often the participants made meaning of dysmenorrhea through a collective social perspective inherent in the Batlokwa culture, which is holistic. The understanding of a more

holistic form of care extends to the environment. The provided photographs were mostly of the natural resources.

4.3.1.1 Subtheme 1: Meaning making

This subtheme was identified when participants were explaining the holistic understanding of dysmenorrhea. Therefore, it was considered essential to understanding the way the Batlokwa ethnicity perceive dysmenorrhea holistically. The aim of the meaning-making process was therefore to generate the experiences and reasoning behind the participants' beliefs, perceptions and attitudes as they pertain to constructions of dysmenorrhea in Botlokwa. Meaning making was defined in terms of dysmenorrhea as a process or journey connected to women's health and grouping of women's health issues.

4.3.1.1.1 Dysmenorrhea as a process and journey connected to women's health

In terms of dysmenorrhea as a process or journey, a photograph of a woman walking and carrying luggage on the head was presented (refer to Figure 4.2). This woman was referred to as embarking on the health journey, which is interrupted and distracted by physical and emotional pain. Dysmenorrhea was highlighted and connected to this photograph as a journey. Dysmenorrhea was described as a journey in which women embark throughout their reproductive age or as a process that occurs over some time in the women's' lives. Being a journey means that other reproductive system structures are affected. Participant # 6 said: *"dysmenorrhea starts very little, it builds up with time, when it shows up, already other parts of the women reproductive system are affected"*. In addition, participant # 2 echoed that *"when a woman complains of dysmenorrhea, we think of how long the person has being in this journey because symptoms starts mild and increase with time"*

However according to the participants in this study, the women who undergo this process or journey of dysmenorrhea have varying experiences. This may be the reason why some of the participants understood dysmenorrhea as a natural and normal process that affects some of the women during childbearing age. Participant # 4 said: *"some of the women in our community thinks it is normal to experience dysmenorrhea as a preparation for childbearing"*.

Participant # 11 echoed that *“In some women it is normal to experience dysmenorrhea, because they inherited it from their mothers, grandmothers, sisters and aunts”*.

However, others associated it with infertility that could have been caused by different factors. The quotes below back their understanding:

Participant # 15 indicated that dysmenorrhea might be natural or human-made as an indication that there is something wrong with the reproductive system. However, some of the participants argued that dysmenorrhea would never be expected; it is a pathology that needs attention before it complicates. The quotes below were noted during the debate and dialogue.

Participant # 6 said: *“Once the woman experiences dysmenorrhea, it means somehow the reproductive system is affected”*. Participant # 8 shared the same sentiments and elaborated on the point *“pain that comes with menstruation is not normal, it is an illness, it must be treated as soon as possible to prevent complications that may affect women”*. Nonetheless, through debates and dialogues, participants agreed that sometimes cramps are normal during menstruation. The discussions around their indigenous perspectives of dysmenorrhea encapsulated a holistic understanding that is rooted in the cultural practices. The in-depth interview participants spoke of a great array of more specific information that has been grouped into these general understandings. Participants highlighted how the onset of dysmenorrhea disrupts the womanhood in some of their clients. Some of the quotes echoed below reflected the cruelty of the process that women endure when experiencing dysmenorrhea physically and emotionally:

Participant # 5 referring to a photograph in Figure 4.7 said: *“ke a tseba, selumi se setlhogo kudu, ke selumi because o ya lomiwa ka mo popelong”* (I know, dysmenorrhea is very cruel, it literally bites your uterus inside).

Drawing from a photograph in Figure 4.2 another participant # 1 echoed: *“selumi ke leeto le bohloko!!!”* (dysmenorrhea is a painful journey!!!), *“poor woman is looking forward for the menstruation every month in preparation for falling pregnant, then what supposed to be a pleasant journey turn out to be a suffering”*.

Another woman during the in-depth interview echoed similar sentiments as the above: *“Some of the women walk this road every month, taking a very painful journey for the sake of womanhood”* Participant # 7.

Dysmenorrhea was referred to as a process or journey because it happens every month, it only ends with pregnancy or if treated successfully. Participants in the modified Lekgotla discussion debated on how the process or journey of dysmenorrhea affects women emotionally. Quotes like these were common in their discussion: *“being unable to perform house chores because of “selumi” is depressing”*. participant # 7.

“thinking of the stigma attached to “selumi”, been labelled with names such as “moopa” (the infertile woman) really affects women emotionally”. participant # 3.

“because “selumi” can also be transmitted sexually, in our culture we conclude that the woman was promiscuous or having STIs, it is so depressing to hear that”. participant # 8

On the other side, women talked about the process of dysmenorrhea in terms of having different levels, stages, or different degrees of pain during menstruation. This implies that each woman experiences and perceives dysmenorrhea differently. This means dysmenorrhea is a subjective matter, understood better by the sufferer. This is reflected in the following statement by participant # 2: *“period pains are not the same, everyone experiences it differently and endures it differently. I kept it a secret for a long period, I was ashamed to talk about it. My mother noticed and asked me, that’s how I was sent to a traditional healer”*. She was trying to clarify that every woman experiencing dysmenorrhea has their story to tell, which differs from the other.

Another woman elaborated and said: *“Well, there are a lot of women suffering “selumi” who believe it will be better with the next menstruation, forgetting that “selumi” is a process, it reoccurs if not treated well. if “selumi” is not treated, it will remain a monthly journey”*. Participant # 8.

The participant # 5 had same sentiments and echoed that: *“If not treated or not properly treated it will jump to the next level, hence we saying it is a journey, where it becomes very stubborn and painful”*

The above quotes indicate the meaning of dysmenorrhea as understood by the Batlokwa THPs and IKHs. The participants saw dysmenorrhea as a sexual and reproductive journey. These reported sexual and reproductive journeys varied based on the pain felt. Some of the women viewed dysmenorrhea as a necessity in preparation for reproduction. For example, this particular participant mentioned that mild dysmenorrhea happens as the process of cleaning and preparing for the pregnancy to take place. Additionally, some participants believed that dysmenorrhea is not a big deal to all women, because some pain is mild. Dysmenorrhea has been a process or journey, meaning that it continues throughout the reproductive age. However, it can change its form or pattern whenever it occurs. The provided descriptions imply that in this journey women are confronted with a pain threat during their monthly menstruation and can only be holistically treated through the traditional health system. Batlokwa women believe that women's health issues should be grouped together for better understanding and effective holistic treatment.



Figure 4.2. A picture of a woman carrying luggage

4.3.1.1.2 Grouping of women's health issues

Figure 4.3, a chain, conveys a strong sense of why and how dysmenorrhea is connected to other reproductive organs and connected to other women's health issues. At the same time, it is a metaphor of how the women experiencing dysmenorrhea are exposed to other gynaecological problems. The participating women seemed to group all women's health issues and approach them holistically. Grouping of women's health issues suggests that the presence of dysmenorrhea provides a platform to deal with all other reproductive health problems a woman might have. Such platforms appear to be rooted in cultural beliefs and practices.

The quote by participant #15 illustrates this point: *"When I consult and treat a woman presenting with dysmenorrhea, I check the whole reproductive system to identify the root of dysmenorrhea. In the treatment I include correction of infertility"*.

Interestingly, most of the participants seemed to make meaning about dysmenorrhea through the lens of women's reproductive health approach. This approach seemed beneficial and meaningful in understanding how the THPs and IKHs make sense of the process of categorising and defining causes of dysmenorrhea. Often, the women also made the meaning of dysmenorrhea through the women in their lives who had experienced some type of reproductive health problems. For example, in the modified Lekgotla discussion, THPs and IKHs used their client's reproductive problems as a vehicle for understanding dysmenorrhea as echoed here by participant # 13: *"I think "selumi" eats up the lining of the uterus. Then it affects the whole reproductive system because the whole abdomen and back will be painful"*

Participant # 15 added: *"I connected "selumi" to women's reproductive problems, because it only affects women, there is no single man that suffers this, it is coupled with menstruation, women are the one menstruating"*.

One participant pointed out that her perceptions stemmed from her grouping of all women's health issues together because dysmenorrhea is associated with menstruation and one of the causes of dysmenorrhea is a sexually transmitted infection that might block the reproductive system.

In understanding the quotes of the women, the findings revealed that the Batlokwa THPs and IKHs know the reproductive system and women's health. Their knowledge cannot be underestimated. Moreover, focus on women's health ought to move towards using their knowledge in determining the factors that may benefit their primary health care.

Other participants agreed during the modified Lekgotla discussion that "*dysmenorrhea is not just a pain, it's far more than that*". Participant # 13, # 2, # 5. This broad statement was constructed after a thoughtful debate among the participants in elaborating on the impact that dysmenorrhea has on the lives of the women. The contributors explained the meaning of the above statement differently. The constructed statement is understood as:



Figure 4.3. A picture of a chain

(i) Bridge

During individual interviews and group discussion, a photograph of a bridge was used as a metaphor explaining how dysmenorrhea is linked to other gynaecological problems (Figure 4.4). The provided data and quotes from the participating women somehow link dysmenorrhea to other women's reproductive health problems. According to the THPs and IKHs, dysmenorrhea is not just a pain; it is also seen as the bridge linking the sufferer to other chronic pain conditions associated with women reproductive system problems. The women mentioned quotes like this one.

"Dysmenorrheal pain is not only from menstruation; it is linked to other women illnesses. For example, it is like come closer, there is "sekgalaka" this side" Participant # 1.

“Sekgalaka” also known as “sebabo” are small sores that appear outside the womb and can be in the vaginal canal as well. The THPs and IKHs believe that “*sekgalaka*” is like a parasite that waits patiently for the menstrual period in order to manifest. Another participant concurred and said: *“dysmenorrhea co-occurs with other chronic pain conditions. Moreover, our treatment approach for dysmenorrhea is holistic; it treats other symptoms associated with other reproductive health problems such as “sekgalaka”, sexually transmitted illnesses and infertility”*.

The above quote emphasized the connection between dysmenorrhea and other women’s health issues to orient clients and practitioners and motivate holistic treatment. The symbol of a bridge, therefore, influences moving further and not concentrating on dysmenorrhea only, but on other elements such as culture and environment.



Figure 4.4. A picture of a bridge

(ii) Messenger

The THPs and IKHs believe that pain of dysmenorrhea is a message that there is something wrong with the women reproductive system and type of treatment modalities to be used. Most of the explanations related to a message that the woman will be infertile in the future or is already infertile. It was interesting to note that the women provided photographs that illustrated infertility clearly. The logic here was that dysmenorrhea sends the message to the woman and family to seek help and correct complications of infertility early. Infertility is a grave issue among

Batlokwa people as in other communities in Africa. For it is believed that bearing children is the core women's duty so that they can inherit and carry the family's legacy further when the parents have passed on. Summarised quotes to refer to infertility were "*inability to have children*", "*unable to fall pregnant*", "*will not have children*", "*childless*", "*moopa*" meaning barren, were extracted from the discussions. Participant # 9, # 3, # 10, # 7, # 11, # 12, # 14, # 15.

The participants' expressions of dysmenorrhea as a messenger for infertility were based on the following arguments: "*Indigenously when we treat women for dysmenorrhea, within a month or so the woman will fall pregnant, that's how we discovered that dysmenorrhea was just a sign for infertility*". Participant # 15.

In agreement, the other participant pointed out that her perception of inability to have children stemmed from her grouping of all women's reproductive issues together and realised that one way or another they are related and influence the other. "*People do not understand that been infertile as a woman starts from somewhere...I mean...eeerrh!!! Look...a woman will present with pain during menstruation, but when you do divination check (consulting ancestors), you find many reproductive health problems that are linked and related to what she is complaining about...and all will complicate to infertility*". Participant # 4

A couple of women talked about "*selumi*" being related to blocked fallopian tubes (eggs will be unable to pass through for fertilisation), sores in the womb (disturbing implantation), and untreated sexually transmitted infections. They believed that if all of these are not adequately treated, a sufferer would not fall pregnant. For instance, a photograph of a chained and locked padlock was presented and analysed as a message that a woman is blocked from conceiving a baby (see fig 4.5). A robe with a knot was also presented as blocked tubes, referred to as "*noga e bofile*" (see fig 4.6).

Some of the participating THPs and IKHs believed that the message from the pain of dysmenorrhea might be a sacred dimension. They saw it as a hint or rehearsal of labour pains as mentioned below by participant # 13: "*dysmenorrhea is sacred, it is not every woman who can taste labour pains without been pregnant, if one is able to endure the pain of dysmenorrhea, she will not be surprised by labour pains when giving birth*". This might have also been influenced by the belief that dysmenorrhea is endurable; it must only be treated if the woman is

ready to start a family because the nature of the treatment is to correct infertility. Considering this belief and explanation, it is understandable why other women endure the symptoms of dysmenorrhea or likely seek relief from it.



Figure 4.5. A picture of a padlock



Figure 4.6. A picture of a rope

4.3.2 Theme 2: Self-naming and self-definition of dysmenorrhea

The importance of self-naming and self-definition was identified through many statements made by the participants. As noted in the Africana Womanism theory characteristics or elements, self-naming and description are essential to Africans. The concept of dysmenorrhea appeared to be well understood by the participants in their names and description. Most of the participants equated dysmenorrhea with period pains or menstrual pain. However, they have their own cultural words and terms used when referring to dysmenorrhea. The issue of self-naming and defining was crucial and relevant in the context of understanding indigenous perspectives of the meaning of dysmenorrhea from Batlokwa women. Seeking a better understanding of how women name and define dysmenorrhea provided insight into their perspectives of the meaning.

Self-naming was a theme that was pervasive throughout the data related to meaning making. Self-definition emerged as participating women were trying to clarify the words and phrases used in naming the condition in their language. Based on the suggestion by the participants, self-naming and self-definition cannot be separated because they are interwoven, and therefore are discussed simultaneously.

Participants spoke of the importance of naming and defining or describing dysmenorrhea in their understanding and language. Naming a condition carries a significant meaning for the participants. Participants largely identified the name of dysmenorrhea in a way that is easily understood and acceptable in their ethnicity. The participants indicated that naming and defining dysmenorrhea was done according to the description of the character, causes and symptoms of the condition. For example, a name given and used to describe dysmenorrhea was “selumi” (something that bites). To make sense of the word “selumi”, most participants in the in-depth interviews stated that it is understood by splitting the word into two parts: the “se” in “selumi” means something that is alive and can move, whilst “lumi” simply means to bite Participant # 4, #7, # 9, # 14.

How the THPs and IKHs offered the details in the description of “selumi”, points out to some of the issues and symptoms that women experience because of dysmenorrhea. The African THPs and IKHs, when naming a condition, usually offer insight into the meaning, either through signs and symptoms or causes of that particular condition. The terms or words used appear to be

primarily easily understood and adaptive. The quotes that participants mentioned in naming dysmenorrhea correspond directly with the articulation and meaning of the word. Note the following quotes: “*ohoo, we call it “selumi”*”. Participant # 15

“Di period pains rena re di bitsa selumi, ba bangwe ba di bitsa mahlaba a letlhapo”, meaning that in their culture period pains are known as “selumi” or pains that accompanies menstruation. Participant # 1 and # 11.

“Ka Setlokwa gabotse ke “selumi” participant # 7 (In Setlokwa the truth is we call it “selumi”).

“when you have pains during menstruation, we diagnose you with “selumi”. Participant # 6

Other names referring to dysmenorrhea were also identified from all the participants in the form of phrases. Phrases such as “*letlhapo hloko*” (painful menstruation), “*tshilwana or kgwele*” (lower abdominal cramps occurring immediately after giving birth), “*bohloko ba o ya kgwedding*” (painful menstruation), and “*noga ya o loma*”, all referring to dysmenorrhea. The other prominent phrase used was “*letlhapo la o loma or tshoga* (cleansing that bites or cuts). When making meaning out of these phrases participant # 10 said: “*letlhapo. Errr, letlhapologo, I refer to menstruation. Bangwe bare ke o ya matsatsing or kgwedding*” (Others say it is going to the moon: direct translation). This means menstruation but it is related to the periodical event which is measured by the moon because it comes once a month like the revolving of the moon. In the modified Lekgotla discussion, other participants elaborated on it and spoke of why it is called “*letlhapo*”. *Why “letlhapologo”, it’s like the womb is cleaning itself, removing unwanted layers, that comes out with blood, this is happening periodically*”. Participant # 12. “*Ke ge motho a eya letlhapong ka Setlokwa, when a person menstruate monthly*”. Participant # 7.

The word “*mahlaba*” and “*bohloko*” in English refer to pain. The Batlokwa combine it with the word menstruation in their language to have a phrase that explains dysmenorrhea. For example, some participants, instead of using “*selumi*”, would say “*bohloko ba o ya kgwedding*” or *letlhapo hloko* or “*mahlaba a letlhapo*” (all these refer to menstrual pain). In Setlokwa culture, names are not mere labels of identity, they are cultural symbols and carry a lot of meaning. This means dysmenorrhea may also be understood in terms of its character, according to Batlokwa beliefs related to the language and use of the words.

The used names, phrases and quotes also verify that dysmenorrhea is not new to the Batlokwa ethnicity. It is, however, named differently from Western knowledge. A woman explained the confirmation of the long existence of dysmenorrhea knowledge during the modified Lekgotla discussion:

“Selumi” has been known to exist in our community long time ago, before the evolution of Western knowledge, hence our elders developed a way of understanding and managing it”.

Participant # 12.

In the background (picked up by audiotape), some participants agreed in a shallow pitch (maybe this was not to disturb or disrupt the speaker), saying “ee”, “ee” (meaning yes, yes). Elaborating on the statement of the long existence of dysmenorrhea, another woman said: *“according to my knowledge, in our community “selumi” was well controlled through indigenous healing and observing the idioms and taboos”* Participant # 15. The other woman (participant # 14) said: *“some of the names and treatment we are using were constructed by our great, great, great parents after making the meaning of this condition”.*

One of the IKHs (participant #11) during the in-depth interview said: *“nna ka selumi, ke tseba fela tseo ke rutilego ke bo rakgolo, ke somisa tsona fela, gape nna ga kena mpho ya bongaka”.* It means that when it comes to dysmenorrhea, I only know what my grandfather taught me, I only use that, because I do not have a gift to be a traditional health practitioner.

The quotes highlighted that the participating women have some actual indigenous knowledge of dysmenorrhea as it was practised in the olden days (cultural beliefs and practices). The responses from participants indicated that the Batlokwa women knew the words, terms, concepts and phrases used in their community to refer to dysmenorrhea. The fact that all participants were aware of the meaning of dysmenorrhea stimulated their desire to engage in discussing the factors that contributed to the decisions of naming dysmenorrhea according to their cultural understanding.

4.3.2.1 Subtheme 1: Factors contributing to the self-naming and definition of dysmenorrhea

Based on self-naming and definition, various factors that portray a picture contributing to the choice of words, terms and phrases emerged. Then, it was thought worthwhile to understand the factors that influence THPs and IKHs' decisions on the choice of words, terms, concepts and phrases. Participants considered the naming of dysmenorrhea to be influenced by the intersection of three factors: (i) Indigenous understanding of signs and symptoms of dysmenorrhea, (ii) Finding reasons for the cause of dysmenorrhea, and (iii) Constructing and connecting categories of dysmenorrhea. The recognition of these factors was viewed as an additional means towards understanding the use of the name "selumi" and phrases "bohloko ba o ya kgweding" or letlhapo hloko or "mahlaba a letlhapo". The responses we got were summarised and presented in Table 4.2.

Table 4.2. Summary of factors contributing to the self-naming and definition of dysmenorrhea

Factor	Contribution/meaning	Example of quote
Indigenous understanding of signs and symptoms of dysmenorrhea	The contributing influence of signs and symptoms towards self-naming and self-definition came in various forms, both objectivity and subjectivity. Identifying signs and symptoms of dysmenorrhea, assist in describing or defining the condition and giving it a name related to its character.	“Most of the time they complain of lower abdominal pain during menstruation”
		“A person affected appeared to have a very severe abdominal pain accompanied by many other symptoms including psychological (isolation)”
		“Menstrual flow is accompanied by abdominal pains, and the blood flow is mixed with thick clots”
Finding reasons for a cause of dysmenorrhea	Afrocentric approach to healing is holistic, therefore there is a need to make a meaning on what caused the illness, to select a proper treatment for holistic healing. Having a cause of the condition enables the practitioners to name and construct categories.	“People will tell you about witchcraft or bad luck from disregarding taboos, these are some of the causal components that they attach to dysmenorrhea”.
		“witchcraft happened to my client; she was inflicted with dysmenorrhea to cause infertility. She consulted I treated her and reversed the spell successfully”
		“If selumi is experienced by a young girl who is still a virgin, we know that it is due to heredity”.
		“In some women dysmenorrhea results from untreated sexual related infections”
Constructing and connecting categories of dysmenorrhea	In examining, identified names and definitions of dysmenorrhea, several broad patterns to distinguish them	“There are different types and patterns of dysmenorrhea, it depends on name or label given”

	are discerned.	“The other kind of dysmenorrhea is identified by the cause of symptoms”.
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4.3.2.1.1 Indigenous understanding of signs and symptoms of dysmenorrhea

An element that helps women formulate the understanding out of signs and symptoms of dysmenorrhea served as an indication for proper naming, according to cultural beliefs and practices. This factor is one of those that emerged as women were naming and defining the meaning and use of “selumi” when referring to dysmenorrhea. The participant described signs and symptoms of dysmenorrhea in a variety of ways. Many of the photographs taken by THPs and IKHs depicted images of knotted robes and women squeezing their waists and abdomens. Participants discussed how the idea of knots and squeezes represented the signs and symptoms of dysmenorrhea (Refer to Figure 4.6 and Figure 4.7).

Findings from discussions stimulated by these photographs showed that indigenous dysmenorrhea knowledge levels of the Batlokwa women were specific to some physical symptoms with some psychological impact. The physical symptoms that they presented with are beneficial in diagnosing and choosing a treatment option. For example, more participants than any other symptoms mentioned lower abdominal pains. In both the photovoice study and in-depth interviews, the pain reported by participants was predominantly physical. There was little said about the emotional, mental, or spiritual dimensions of their pain.

Some of the perspectives for abdominal pains were expressed as follows:

“O bonagala ge di period, ge di tswa ditswa ka go mo kwesa bohloko mo dimpeng”. Participant # 7 (It is seen when abdominal pains accompany menstrual flow) *“selumi” present itself by causing abdominal pains”*

“most women will have abdominal pains during menstrual period”. Participant # 3.

Participant # 10 elaborated by showing a photograph, *“When a person has “selumi”, you will see a woman pressing herself on lower abdomen like this during her monthly periods”.*

One participant in elaboration, said, *“most of them experience pain on the abdomen or around the waist at times the abdominal pain makes difficult to walk because it affects the thighs, but the pain can radiate anywhere accompanied by many other things”*. Participant # 3.

She was backed by another participant # 5, *“some press their waist, even back, yes sometimes it gives them a severe backache, then you must start suspecting “selumi”*

“Listen, you can just see it from facial expression as well, you will see a woman doing this” participant # 2, she demonstrated the expression. Others laughed. The laughing was because of the way she paused to make others understand the sign that can assist in diagnosing dysmenorrhea by mere observation.

Many participants described several ways in which dysmenorrhea symptoms may unfold, such as nausea and vomiting. They also indicated that even though some women have same symptoms, the time and severity may differ. *“Some women experience symptoms of dysmenorrhea some days before menstruation, it can even take a week, whilst others might just be few hours before menstruation”*. Participant # 4.

“Severity of the pain is not the same, with others it is mild, moderate or severe...you know peoples’ bodies react differently ...Other clients will even tell you that their pains persist throughout the bleeding days and few hours after bleeding, with others will just be the first day prior or of bleeding”. Participant 10.

The women shared different reasons to make sense of the pain. According to them, pain originates from the inflammation of the uterus, when it swells as a reaction to biting or an infection trying to be emitted with the menstruation. Some believed that the pain is from the hard pushing out of accumulated blood, clots and some dirt from infections, as naturally, the uterus cleans itself every month. Swelling of the uterus was also believed to press on the other organs of the abdomen and the pressure results in pain, hence sometimes pain radiates and affects the thighs.



Figure 4.7 A picture of a women illustrating abdominal pain: Collate

It was also noted that signs and symptoms such as blood with thick clots (“madi ale a tswang ka go kgahla le go bopana”), *dizziness* (“ka sedikwane o gona go tseya ke ledigwane wa dikelela”), *headache* (“Nako e ngwe wa khumana tlhogo e rema bohloko”, batho ba rema ke ditlhogo, backache (“nako engwe le mokokotlo o bohloko”), nausea and vomiting (“letlhatso ga o le khumane ge wena o tshetswe ke matsatsi feela le selumi se a kgona”), fatigue (“o khumana o sa gone o dia selo, o lapile ke mahlaba”), were also mentioned by some participants. More often, they were mentioned as accompanying symptoms of lower abdominal pains.

Thick clots were related to internal bleeding from the biting, headaches to psychological impact, such as overthinking the pain and suffering. Dizziness and fatigue were related to exhaustion from enduring severe pain. Nausea and vomiting were paralleled to the swelling of the uterus, pushing the abdominal contents up thus irritating the digestive system.

Some of the participants reported that dysmenorrhea might also have a social and psychological impact. They believe that the psychological factors are caused by stress from overthinking because of the pain or limitations in carrying out other activities. Participants expressed the following transcribed perspectives:

“through observing the behaviour of young girls during the menstrual period, those experiencing dysmenorrhea, lose interest of doing familiar activities, such as unable to engage in daily life activities”. Participant # 15.

“some will refuse to do house chores; they will want to sleep throughout their menstrual period”. Participant # 11.

“women who suffer dysmenorrhea isolate themselves during their periods, it’s a stigma because it associated with STI and infertility”. Participant # 1.

In closing the discussion on signs and symptoms, one participant commented that: when you see all these signs, then you know it is “selumi”. In this study, it was apparent that experiencing dysmenorrhea itself or being closely affiliated with a person with dysmenorrhea enhances the ability to recognise the signs and symptoms. This also helps with the understanding and contextualising experiences of a woman with dysmenorrhea. Comprehensive knowledge of other signs and symptoms of dysmenorrhea may be due to the interaction they had with clients who may have presented what they felt during menstrual periods and the investigations of the process and patterns. Some knowledge might have been acquired during preparation to becoming traditional health practitioners. The indigenous holders would have learnt this through oral transmission of knowledge and observing others. The characteristics of strength and adaptability as identified by Africana Womanism were noted when signs and symptoms of dysmenorrhea were explained.

4.3.2.1.2 Finding reasons for the cause of dysmenorrhea

Another common factor to assist in the naming and defining of dysmenorrhea was recognised as finding reasons for the cause of dysmenorrhea. Finding reasons for the cause of dysmenorrhea is understood as a means to answer the existential question: *“Why it is happening to her in particular”*. Finding a reason for the cause of dysmenorrhea was also perceived as a factor that contributes to holistic meaning-making. The reason for the question entails looking for a definite cause in order to name, diagnose, treat and prevent complications of dysmenorrhea early. This embraced the element of Ubuntu. In this study, the factor emanated from the fact that the participants wanted to know how and why certain women experience dysmenorrhea in order to appropriate the term to the cultural viewpoint.

This factor ran through the data of participants when they were explaining the holistic aspect of indigenous dysmenorrhea knowledge. The participants expressed understanding of the causes of dysmenorrhea from two perspectives: the invisible cause of dysmenorrhea resulting from witchcraft and the natural causes resulting from heredity and infections

The belief in witchcraft dominated participants' beliefs regarding the causes of dysmenorrhea. Most participants expressed that the clients that they are exposed to believe dysmenorrhea is caused by factors such as witchcraft and or punishment from crossing the set taboos about dysmenorrhea. With regard to witchcraft, one THP during in-depth interviews echoed "*Bangwe selumi se ba fiwa ke baloi, go ba tibela pelegi*". Participant # 14 (some are bewitched so that they end up infertile).

It was a common perception among the study participants that dysmenorrhea can be intentionally inflicted upon someone through an act of witchcraft. For example, the THP participant explained that some people with special knowledge, which can be Black magic or some other means, can cast spells on targeted individuals. One participant # 9 echoed that: "*Ke boloi, ke mona fela, batho ba kgahlega ge o mongwe a le bohlokong*" (Its witchcraft, its jealous only, people are happy to see others in pain).

In another statement, a THP participant # 4 re-counted her personal experience with a woman who had dysmenorrhea relating to witchcraft. "*witchcraft happened to my client; she was inflicted with dysmenorrhea to cause infertility. She consulted I treated her and reversed the spell successfully*"

The above quotes summarised the different dimensions of belief in the invisible cause of dysmenorrhea, which is a common belief in Africa about the origins and causes of illness. Participants' beliefs regarding the causes of dysmenorrhea included the beliefs in natural sources such as hereditary and infections. A couple of women talked about "selumi" being related to blocked fallopian tubes (eggs are unable to pass through for fertilisation), sores in the womb (disturbing implantation), and Sexually Transmitted Infections (STIs). Participant # 11 experienced dysmenorrhea before and said: "*ka nako engwe le ka no khumana gore nna maybe ke tseeletse bo mma ba be ba lomiwa*" (sometimes you can find that, maybe I inherited it from my mother). Other participants with the same sentiments spoke of children inheriting

dysmenorrhea from their mothers. The transcribed quotes are self-explaining to the logic of why it is inherited:

“Sometimes it can be something that runs in the family”. Participant # 2. *“Transmitted from the mother to girl child, when it happens like that it is natural”*. Participant # 6. *“The mother would have transmitted it to the child whilst still in utero, or just by passing through the delivery canal, “selumi” will be recessive until when menses starts, because it will want to come out with menstruation”*. Participant # 5.

Participant # 1 echoed that *“others get it from their parents, in particular a mother”*.

“If a woman was never sexually active and have dysmenorrhea, it is obvious, she has inherited it from uhh the mother or sister”. Participant # 11.

Participant # 15 said: *“Selumi se a fetela gape, ka go adimisana dikobo, o apara seaparo sa motho wa o ba le selumi sesala go wena”* (Dysmenorrhoea can be transmitted through contact, by wearing clothes of a person suffering from dysmenorrhea).

Another cause of dysmenorrhea was mentioned as a result of untreated sexually related infections, such as “drop”, candidiasis and “sekgalaka”. This factor represents the typical beliefs that are held by most of the study participants about the causes of dysmenorrhea. Given that THPs and IKHs are typically positioned within cultural orientation, the socio-cultural attributes were applied when making meaning about the causes of dysmenorrhea. Although participants held multiple names on the causes, it was evident that the ideas, labelling and names are interconnected and have almost similar meanings that reflect cultural concepts. For this reason, the Batlokwa culture has created more room to identify and understand the causal factors of dysmenorrhea as presented below:

4.3.2.1.3 Constructing and connecting categories of dysmenorrhea

The beliefs of how dysmenorrhea is caused, greatly influenced the women’s constructing and connecting processes of categorising dysmenorrhea. In a modified Lekgotla discussion, women debated on the names and phrases they use instead of dysmenorrhea. From the discussion, it

was clear that THPs and IKHs categorised dysmenorrhea using either symptoms or causes, at times a combination of both methods. Their local names identified the labels of categories used. This factor emanated from the belief that through examining names and definitions of dysmenorrhea, several broad patterns to distinguish them can be discerned and used as diagnosis.

Regarding categorising using symptoms, the THPs and IKHs distinguished dysmenorrhea according to the related symptoms that the clients or family explained (History taking). From the provided information, they are able to attach a label or name as described below:

“Rena le selumi sa o tla le letlhapo, se bonagala fela ge o bona kgwedi, ke sona re se bitsang letlhapo hloko”, “bohloko ba o ya kgweding” or “*mahlaba a letlhapo*”. *Participant # 15*.

(There is dysmenorrhea that is identified only when you menstruate, it is the one we call pains that accompany menstruation).

The second category of dysmenorrhea is identified by the cause of symptoms and the manner it is treated. In this study, the THPs and IKHs named it “tshilwana”. The quotes below explain how the THPs and IKHs labelled it “tshilwana”. *Participant # 15, # 11, # 9*.

Participant # 15 explained: “Tshilwana” occurs immediately after you have given birth, we believe that somehow, the afterbirths are not completely out, that’s the cause”.

The other participant # 11 elaborated that, “in some women the tshilwana is caused by the sores known as “sekgalaka” or “sebabo”. The participant further explained: “The name “tshilwana” comes from an object that we use to apply and rub the abdomen with during treatment”, pointing at the presented picture. “This is tshilwana, you see”, referring to Figure 4.8.

Several participants connected signs and symptoms, causes and categories or types of dysmenorrhea according to their traditional practices (situated knowledge), prior to naming and defining. This implied that in order to have a meaning, it was essential to understand the factors that will make a name more meaningful.



Figure 4.8. Picture of “tshilwana”

4.3.3 Theme 3: Diagnostic processes in indigenous dysmenorrhea practice

Diagnostic processes in this regard refer to the acts and methods that Batlokwa THPs and IKHs use to determine the causes and treatment of dysmenorrhea. Diagnosis in indigenous healing is an essential aspect before starting treatment because according to Batlokwa, diagnosis is better understood as related to the causes of illness rather than the classification of the symptoms. Throughout data analysis, it was becoming clear that the diagnostic process does not only seek answers to the question of how the dysmenorrhea originated but who or what caused it was necessary, as well as why it has affected this particular woman. The diagnostic processes described by the participants could be subdivided into three categories (sub-themes): observation, history taking and divination. The use of these methods varied widely among THPs and IKHs. Some admitted to a combination of the two or three diagnostic methods.

4.3.3.1 Subtheme 1: Observation as a diagnostic process

The first diagnostic process extracted from data was an observation. The participating THPs and IKHs indicated that one process to determine that the patient is experiencing dysmenorrhea is to observe her behaviour during the menstrual period. Through actions or non-verbal communication behaviours, it is easy to notice a woman who is enduring dysmenorrhea. After noticing the behaviour, they then link the observed behaviour to symptoms of dysmenorrhea.

This method may be relevant because usually when a woman is experiencing dysmenorrhea pain, she will try to squeeze it out of the abdomen and pelvis area. These quotes were noted, *“we observe them during menstrual time, the action they make to react to the symptoms, confirms that definitely there is a problem”*. Participant # 12.

“Some of them they have difficult in walking, they can’t move, because of the knots inside”. Participant # 4.

Based on the above, it can be suggested that observation also serves as a critical diagnostic role in the management of dysmenorrhea. Nonetheless, participants agreed that the process of observation usually needs confirmation from other methods such as divination and history taking.

4.3.3.2 Subtheme 2: History taking as a diagnostic process

The second diagnostic process is history taking. The IKHs ask questions or interview the client and family on the history of the onset and behaviour of the client during the pain episode. The information gathered is linked with what was observed to conclude that the client is suffering from dysmenorrhea. According to the IKHs in their practice, the information gathered from history can be used without any other diagnostic process. This understanding comes from IKHs only. The reason may be that some of them do not have the spiritual gift to confirm the diagnosis. The history-taking as a diagnostic process was seen from the following quotes:

“You can tell that she is really suffering from dysmenorrhea, depending on how she explains her experiences, or from what the family is saying. You can also know through their life history and the happenings in their past life”. Participant # 5.

“You can make a diagnosis of dysmenorrhea depending on how the behaviour is explained”. Participant # 2.

Participant # 13 said: *“I’m able to know that she is suffering from dysmenorrhea through talking and discussing with the woman or her family”*

At times it was noticed that the process of diagnosing seems to be different between THPs and IKHs. With IKHs, assistance from divination was not always mentioned, although IKHs mentioned the dreaming aspect. This may be from the saying of the IKHs that they learnt about

dysmenorrhea from family members; they are not trained to use other means such as divination. IKH participant # 3 echoed: *“My diagnostic processes end here with history taking, divination is not my size”*

Participant # 8 said: *“I do not throw any bones or analyses dreams about causes and treatment of dysmenorrhea, I either diagnose through observation and history taking”*

The THPs differed with IKHs on this process; THPs pointed out that clients and families are not supposed to reveal their problems to the healer. Instead as healers, they reveal what the client's problem is, as reflected in this extract:

From participant # 1: *“I will be waiting for them because I saw the whole scenario in my dream, I will be ready to tell them what they are here for, whilst still entering”*

Participant # 15 echoed that: *“I tell them not to say anything, and wait for the interpretation of the bones, after throwing and interpreting the bones, they will agree with the history, then we start the treatment”*

4.3.3.3 Subtheme 3: Divination as a diagnostic process

The diagnostic process of divination in this study differed from practitioner to practitioner and it is better presented under two headings. *“Throwing of bones”* (ditaola) and *“dreams analysis”*.

4.3.3.3.1 Throwing of bones

Data for this process came from the THPs only, as a method used to predict diagnosis for the women with dysmenorrhea. Traditional health practitioners spoke of bone throwing as the best diagnostic process because it covers all appearances of the physical and spiritual cause of dysmenorrhea, including treatment and prevention. They mentioned that it is in their practice to throw bones, in order to seek guidance from the spirits when it comes to diagnosing and for the individualised selection of treatment. It is understood that most of the THPs could not operate without traditional bones. They mentioned that because at times dysmenorrhea may have a sacred dimension, it is essential to throw bones, to hear what the ancestral spirits are saying. Throwing of bones can be done despite the use of observation and history taking. This is done

to confirm what is observed and said about the woman and dysmenorrhea. Some of the supporting quotes of bone throwing as a means of diagnosing and treating dysmenorrhea are: *“I use bones to communicate with my ancestral spirits to guide and confirm the diagnosis, more especially to select treatment that will totally cure dysmenorrhea”*. Participant # 4.

Participant # 7 indicated that: *“I throw bones on the floor; they talk to me on what must I do regarding treatment and prevention of dysmenorrhea”*

According to participant # 9: *“There are different kinds of methods that are used to diagnose dysmenorrhea, but I only use bones, I do not take history, communicating with bones provide all the information that is necessary from the personal details of the clients to treatment and prevention”*.

Based on the above quotes, throwing bones appears to precede the observation and taking of history by the THPs. This is owed to the fact that proper analysis of the bones provides holistic information, including the one that can be observed or obtained through history. This also implies that the spiritual dimension is also catered for in indigenous health and healing. It also means that the THPs and some of the IKHs continuously communicate with ancestral spirits throughout their practice. From the above extracts, it appears that ancestral spirits are regarded as very important in the diagnostic activities by the THPs. This may be due to the fact that they went through training that enables them to communicate with the ancestral spirits by interpreting the bones' (ditaola) language to the understandable language of the client.

4.3.3.3.2 Dream analysis

Analyses of dreams were mentioned other ways of communicating with the spirits for diagnostic and treatment purposes. Some of the THPs and IKHs alluded that most of the time, spirits will communicate with them regarding the client who will consult. In the dream, they will know how to diagnose and treat that client. As much as there is bone throwing for diagnoses, some rely only on the dreams they experience to diagnose. For example, this quote explains how analysis of dreams can be efficient in diagnosing dysmenorrhea. *“Most of the time I will have visions before the arrival of a client, I will see everything, the face of the woman, her name, know her*

reproductive health problems, what caused it and the solution". Participant # 12. In this regard, there will be no need for throwing the bones.

As mentioned previously, some of THPs use a combination of dreams and bones as mentioned below by participant # 1. *"My ancestors talk to me through dreams and bones. So I use both diagnostics methods "*

The understanding of the diagnostic process requires an understanding of the THPs and IKHs women as the healers of dysmenorrhea. The broad overview of this theme revealed the variety of diagnostic methods that were used by the Batlokwa THPs and IKHs in making meaning of dysmenorrhea. There were differences and inconsistencies among Batlokwa women regarding diagnostic processes. The reasons for differences might be caused by interviewing both THPs and IKHs. Alternatively, stemmed from the properties such as knowledge and experience each practitioner possesses. Usually, all these properties influence and guide the process of diagnosing and treating patients in general.

4.3.4 Theme 4: Treatment modalities

The Batlokwa treatment modalities of dysmenorrhea are determined by the perception of the cause or causes as predicted during the diagnostic processes, as treating a client always comes after diagnosis. Moreover, the participating THPs and IKHs believe that a good diagnosis aids them to give an appropriate treatment. The THPs and IKHs view dysmenorrhea as a curable condition but emphasised that other types can re-occur depending on the cause. Some of the most defined treatment modalities were seen in the provided photographs (Refer to Figure 4.9 and 4.10).

The participating THPs and IKHs described that after establishing a diagnosis, they would carry out the treatment that they deemed appropriate. There was some consistency in treating dysmenorrhea despite being a THP or IKH. According to the participating THPs and IKHs, the choice of treatment depends on the signs and symptoms, causes and type of dysmenorrhea. They all emphasised on the knowledge and experience of the healer to administer the right medication. The traditional treatment aim is holistic cure. It is holistic because the body, emotions, spirit, culture and environment are attended to during treatment.

It was found that there are two major treatment modalities that the indigenous healers use in the treatment of patients presenting with dysmenorrhea. These treatment modalities are the use of herbal modalities and performance of rituals.

4.3.4.1 Subtheme 1: Herbal modalities

Herbs are products from specific plants and shrubs with healing properties that are used by THPs and IKHs to treat illnesses. Photographs of herbs and plants stood out as an important driver for the treatment and prevention of dysmenorrhea. According to the participants, herbs are collected wet and dried or can be collected dry to make herbal medicines. These herbal medicines are thoroughly prepared to be administered to the clients. The traditional health practitioners emphasised that most of the time they are guided by the ancestral spirits on how to prepare and administer the herbs, especially if divination was used for diagnosis.

They use different modes of administering herbal medicine for dysmenorrhea. Herbal medicines can be taken orally, inhaled as smoke and sniffed, applied on the incised skin, induced by vomiting, bathing, steaming and smearing. It is believed that the herbs will force out the illness from the body and emit the spirits causing dysmenorrhea. Herbs are stored wet or dry and the wet herbs can be chewed, and dry ones can be swallowed in powder form. The herbs are either mixed with something to eat or drink. Some of those herbs are mixed with boiled water to be used for steaming and bathing. Some are burnt and inhaled or smeared on the incised skin. The following quotes illustrate how herbs are used in the treatment of dysmenorrhea:

Participant # 15 indicated that: *“I prepare a soft porridge for her, then pour a mixture of different herbs as instructed by the ancestors on top, then use a knife to divide the porridge into four quadrants. She then uses her bare hands to eat soft porridge”.*

Participant # 7 said: *“sometimes the toxins and bad luck are pushed out of the blood stream by making an incision on the targeted areas of the body, then smear the herbal medicines”.*

“First thing I will steam her using boiled water and stones mixed with herbs known as “makgonatshohle” (medicine that cures all diseases) the client will be covered with a blanket so that he/she should inhale the herbs that are mixed in hot water. Participant # 6.

Steaming is believed to detox the body from any bad luck or accumulation of toxins. This method is used in aggregation with other methods such as taking of herbal medicines for a certain period. There are other herbal medicines that are used such as “sekgopha”, scientifically known as aloe vera, leaves of a guava tree, known scientifically as *Psidium guajava*, moringa oleifera leaves and “modu wa mokgalo” (Buffalo thorn root). The scientific name for buffalo thorn tree is *Ziziphus mucronate*. It was very hard for the participants to mention their herbs, because they felt that it is sacred as such it must be kept a secret. The few that are mentioned are believed to be the common herbs in treating dysmenorrhea.

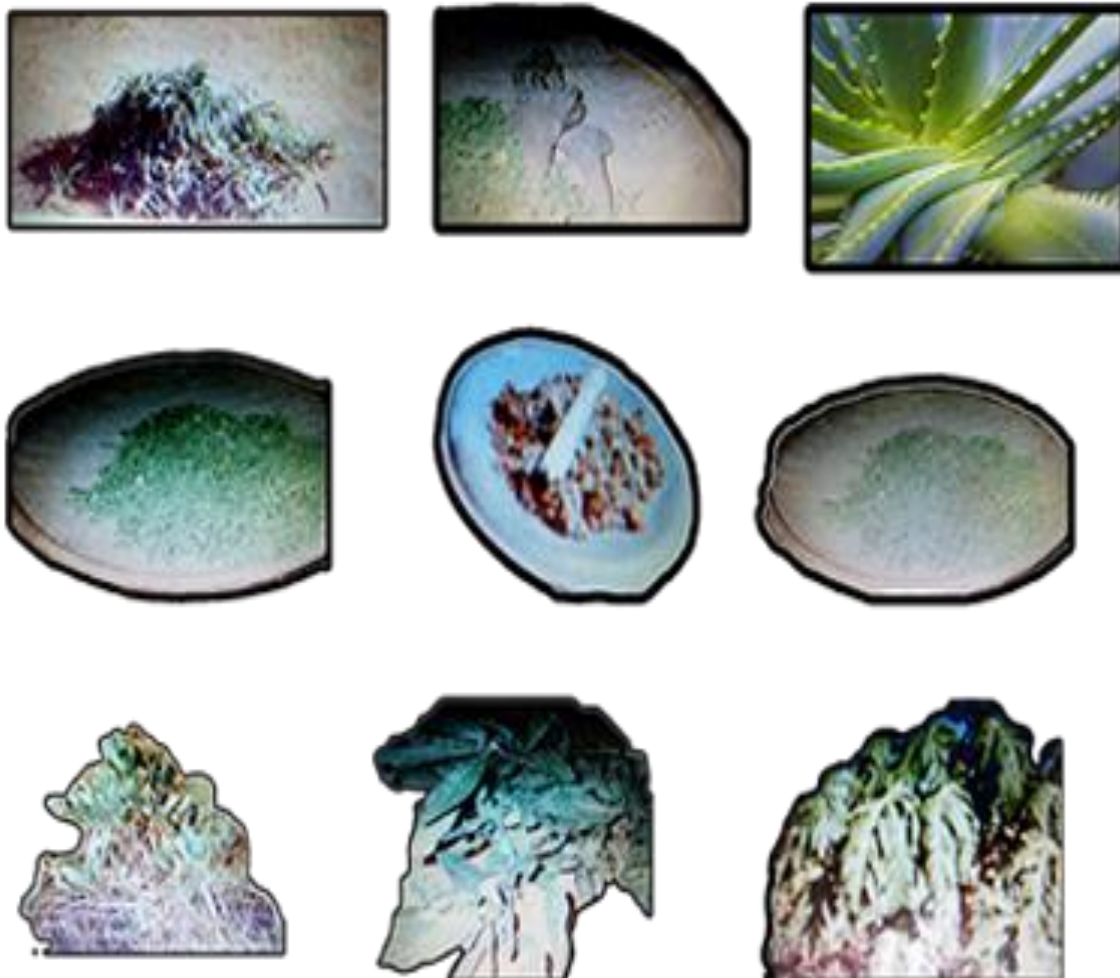


Figure 4.9 A pictures of herbs: Collate

4.3.4.2 Subtheme 2: Performance of rituals

The second treatment modality identified is performance of rituals. Within the Batlokwa ethnicity, rituals are performed as a means of treatment or prevention (protection). Usually, family members and communities are invited to dance and share the meat from the animal slaughtered to cleanse the patient. In case of dysmenorrhea treatment, rituals were found to be sacred, because the healer and the patient attend it.

Data showed that performance of rituals for dysmenorrhea was spiritual and physical, conducted in a sacred place. The participants indicated that depending on the healer, the rituals are divided into sessions. The type of the ritual mentioned was to “*o kgaola noga*” (simply meaning that they are cutting the menstruation). They cut the menstruation so that the woman must fall pregnant because her periods are painful; hence it is only performed on women that are ready to start a family. The following extracts illustrate the points above:

“I perform some rituals that I will not mention for research at “Ndumba” (ancestral hut) before heading to the “lediba” (natural water pool) to end menstruations with performance of another ritual. The woman should be menstruating because I’m going to cleanse her thereafter”. Some instead of natural water pool, they use “*mariba*” (caves) or “*dithaba*” (mountains). Participant # 15.

“I take the menstruating woman who suffers from dysmenorrhea to the veld under the “mokgalo” (buffalo thorn tree). I dig a hole to access roots, I then perform some rituals. The woman should be the one closing that hole, after she must go back to my place, without looking back. I will follow her”. “*On arrival at my home I perform another ritual. I will give her some herbal medicines to take continue taking at home for five days”.* Participant # 4.

From the above extracts, it was evident that the said rituals are also performed as part of making the woman fertile. Moreover, they view dysmenorrhea as a sign of infertility. It was also evident the treatment and healing of dysmenorrhea take place at the common area of the healer and sacred places such as at the forest under the buffalo thorn tree or natural water pools or caves, or mountains. All the participants refused to explain the whole ritual procedure during dysmenorrhea healing.



Figure 4.10. A picture of sacred places: Collate

4.3.5 Theme 5: Roles of THPs and IKHs in the treatment and prevention of dysmenorrhea

Another objective that was explored in some capacity in photovoice and in-depth interviews was the roles of THPs and IKHs in preventing and treating dysmenorrhea. The participating THPs and IKHs indicated that they manage dysmenorrhea by diagnosing and treating women experiencing dysmenorrhea, the transmission of indigenous knowledge to others and mentoring.

The participating THPs and IKHs echoed that they diagnose and treat dysmenorrhea in the community according to their specialities. One participant echoed on how she fulfils the role of diagnosis and treatment. *“I administer remedies and know which plants can cure dysmenorrhea”*. Participant # 2.

The role of diagnosis and treatment include supporting women in their healing journey for a proper healing process.

Traditional health practitioners and indigenous knowledge holders play a crucial role in the transmission of indigenous knowledge of dysmenorrhea. The transmitted knowledge will help the community to understand indigenous beliefs better. The oral transmission of knowledge has been passed down through generations, and the practice is still in use. The extracts below reflect this particular view regarding the transmission of indigenous knowledge.

Participant # 1 said: *“we share indigenous dysmenorrhea knowledge with the community members”*

“It is important for the young generations to have knowledge about indigenous dysmenorrhea. It is upon as healers to convey this knowledge”. Participant # 12.

Some of the participants reported that they mentor other THPs and IKHs about indigenous dysmenorrhea. This extract emphasizes on the said role:

“I’m the mentor to other healers, I guide them on indigenous healing including dysmenorrhea”. Participant # 15. This suggests that experienced healers teach and transfer their knowledge to trainees to understand indigenous healing and prevention, including dysmenorrhea. This in turn preserves the indigenous health knowledge.

The THPs and IKHs indicated that they play many other roles apart from diagnosing and treating.

Other prominent roles that were alluded by the participants were of an encourager, role model, psychologist, counsellor, social worker and doctor to the women experiencing dysmenorrhea and their families. The findings suggest that THPs and IKHs fulfil the role of social service and maintain social order through counselling. This implies that the THPs and IKHs deal with the complete person aside providing treatment for physical, psychological, spiritual and social symptoms.

4.4 SUMMARY OF THE CHAPTER

Chapter 4 presented and interpreted the empirical findings of the study. The chapter discussed five themes and its sub-themes. The discussed themes and sub-themes achieved the objectives of phase 1. It was essential to get to know indigenous meaning and treatment modalities of dysmenorrhea, as well as the roles that IKHs and THPs play to prevent and treat dysmenorrhea in their community. Chapter 5 presents the discussion of themes and sub-themes with literature support. The literature looks at how these findings compare and contrast to the findings of another research.

CHAPTER 5

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

5.1 INTRODUCTION

The previous chapter interpreted and presented the study's empirical findings. Through the presentation of the empirical findings, indigenous knowledge and perspectives of dysmenorrhea and treatment modalities by the participating women is clearly understood and confirmed. The current chapter moved from interpretation to the discussions of the themes that emerged and are presented in the previous chapter. The themes are supported by literature. The discussion will follow the same format used for the presentation and interpretation of themes and sub-themes in Chapter 4.

5.2 DISCUSSION OF FINDINGS

This study process brought together the Batlokwa THPs and IKHs. The main aim was to explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women using photovoice methodology. Content analysis of the photographs explored similarities and differences between objects or people portrayed by the participants and aimed to complement the thematic analysis (Rose, 2012). Several key themes emerged from the analysis of the photographs and discussions of Batlokwa THPs and IKHs women indicating the significance of cultural and social influences on the understanding of dysmenorrhea. The diversity of knowledge constructed on the meaning and treatment modalities of dysmenorrhea identified in this study reflects a critical social reality from the Batlokwa THPs and IKHs. The critical point here, however, was not on the reality as such, but rather on the relation THPs and IKHs' standpoint in understanding dysmenorrhea and its power. The power to dominate or impose dysmenorrhea knowledge on others and have it recognised as accurate (Seidman 1991). The role of critical social theory in this case, therefore, was to render society knowlegable in such a way that this knowledge can contribute to the transformation and recognition of knowledge in the society (Bhaskar 1989). Critical social theory perspectives are concerned with empowering human beings to transcend the constraints placed on them by race, class, and gender (Fay, 1987).

From the present study, it emerged that the THPs and IKHs understand dysmenorrhea as a holistic illness. During meaning-making, the Batlokwa THPs and IKHs used metaphors of process and journey to conceptualise dysmenorrhea as an illness that results from a normal process of menstruation in women of reproductive age. They related and grouped dysmenorrhea with other gynaecological problems such as; the importance of self-naming and self-defining dysmenorrhea deduced from the data. The factors that contributed to self-naming and self-defining were (i) indigenous understanding of signs and symptoms of dysmenorrhea, (ii) finding reasons for the causes of dysmenorrhea, and (iii) constructing and connecting categories of dysmenorrhea. It was also evident that the Batlokwa THPs and IKHs have their ways of assessing and diagnosing dysmenorrhea, which includes, among others, observation, history taking and divination. Among the three diagnostic processes, divination was found to be the most common process used by the THPs. The divination as a process of diagnosing dysmenorrhea according to Batlokwa THPs includes (i) throwing of bones and (ii) dream analysis. The findings revealed during the assessment and diagnosing dysmenorrhea the Batlokwa THPs and IKHs can establish different types of treatment modalities. In this case, herbal modalities and spiritual modalities were identified. Furthermore, the findings suggested roles that THPs and IKHs play in the management of dysmenorrhea. These findings are discussed below according to the emerging themes and sub-themes as identified in Chapter 4, Figure 4.1.

5.2.1 Theme 1: Holistic understanding of dysmenorrhea meaning

The findings revealed that the Batlokwa women view dysmenorrhea as an illness that women suffer from during menstruation. They indicated that menstruation is a normal process that every woman of reproductive age is expected to experience without any pains or with minimal pain, that occurs less often. According to the participants, the menstrual process is related to natural changes, which may vary from one cycle to another. However, it was indicated that if a woman experiences symptom frequently with menstruations or once-off severe symptoms that interfere significantly with their ability to lead an everyday life, it should be considered abnormal.

In agreement with this finding Chen, Kwekkeboom, and Ward (2016:368) revealed that 71.5% of participants believed that dysmenorrhea was a normal part of women's life, and on average, reported that their menstrual symptoms moderately affected their daily lives. In addition, majority of rural-living girls in Malaysia considered dysmenorrhea a normal aspect of menstruation (Wong 2011)

Dysmenorrhea was understood and described holistically among Batlokwa THPs and IKHs. Holistic understanding according to the Batlokwa THPs and IKHs means that dysmenorrhea does not affect the physical being only, but also affects the emotional, spiritual, cultural wellbeing of the whole community as well as the environment (Mji 2013). The photographs taken were of women acting as if they are experiencing dysmenorrhea, natural settings such as lakes and plants, spiritual healing items and the environment. These photographs were to serve as visual descriptions, to back up the discussion of dysmenorrhea by the THPs and IKHs. Connection of all these photographs and discussions were found essential to creating a relationship when making meaning of dysmenorrhea as a holistic illness.

The understanding of the relationship between photographs and discussion of physic, emotions, spirit, culture and environment show a holistic understanding of wellbeing (Mathibela et al. 2015). The traditional health practitioners and indigenous knowledge holders' understandings of their environment, their connection to physical, emotional, spiritual beings, culture, and the relationships they have with the plants and animals of their land are centred on their belief that there should be harmony between physic, emotions, spirit, culture and environment (Mothibe & Sibanda 2019). Notably, disharmony between the five elements was understood as the cause of illness. Moreover, the Batlokwa THPs and IKHs argue that when one aspect is affected, care should be extended to the other elements (holistic) to re-establish harmony between the elements that have been broken. In many Sub-Saharan Africa communities, illness takes into account the physical, psychological, spiritual, social and cultural factors (Sodi, Mudhovozi, Mashamba, Radzilani-Makatu, Takalani & Mabunda 2011). The findings further, showed that although symptoms of dysmenorrhea are predominantly physical, Batlokwa is not content with the physical illness of the body only. It is because, in their view, health goes beyond the physical wellbeing of the body. According to the participating THPs and IKHs, the affective state of emotions, spirit being, environment and cultural behaviour or some combination of both form part of wellbeing. This implies that Batlokwa THPs and IKHs understood that humans are made up of three attributes; the physical body, emotions and spirit. The relationship, therefore, between physic, emotions and spirit can be determined to nurture and benefit each other within the cultural environment (Mothibe & Sibanda 2019; Mji 2013). In most African countries, the desire to achieve a more holistic form of care may be a motivating factor as to why patients choose traditional medicine than Western medicine (Prescott & Logan 2018:99).

The traditional health practitioners and indigenous knowledge holders echoed that the available Western medical facility in their community does not address the holistic care when women seek

dysmenorrhea care. Therefore, the women seek the services of the THPs and IKHs for this kind of health. Wikman, Marklund & Alexanderson (2015) in agreement argues that it is too simple to consider illness as only physical, because the illness is caused by things we see, and we do not see, which attacks the body. He further postulated that many of the things we do not see are included in African belief systems, cultural and social values, philosophies and expressions. The same view is shared by Thomas, Mitchell, Rich and Best (2018) when referring to holistic understanding as recognising and considering physical, emotional, spiritual and economical aspects of the person and their context and integrates these aspects as whole than as fragments. In the discussions, it was evident that dysmenorrhea is not just a physical symptom of the women experiencing dysmenorrhea; it affects women emotionally, spiritually and economically.

Most often, participants indicated that women experiencing symptoms of dysmenorrhea do not only experience physical suffering. They also experience emotional and spiritual sufferings that occur because of the pain that limits them to carry daily activities. In the discussions, it was evident that family and community are also affected both emotionally and spiritually when there is a woman experiencing dysmenorrhea. They explained that negative impact on the physical, emotional and spiritual aspects that a woman is experiencing disrupt the social lifestyle of the family when supporting this woman. This implies that Batlokwa THPs and IKHs, see dysmenorrhea as an affliction that affects women's body, emotions and spirit, they also see it as a social and cultural problem causing disruptions in the family and community at large. Therefore, a holistic understanding of illness is familiar in Africa because African traditional medicine approaches health care holistically (Mothibe & Sibanda 2019). Mathibela et al. (2015) attest that indigenous people often view illnesses from a holistic perspective that includes spiritual, mental, emotional, and physical health.

Culture as an additional aspect of holism in understanding dysmenorrhea heightens the likelihood of success in integrating personal and community understanding of illness and healing to develop a cultural meaning. Indigenous communities have long argued this that it is impossible to separate cultural understanding of illnesses and healing (Krusz, Hall, Barrington, Creamer, Anders, King, Martin & Hennegan 2019; Nmutandani et al. 2016; Coombes, Lukaszuk, Sherrington, Keay, Tiedemann, Moore & Ivers 2018:364). Our findings point to the fact that indigenous health and healing fits within the worldview of the Africans. The reason is that the practice of indigenous health and healing within African culture generally, was never seen as solely a physical problem, rather the illnesses of an individual directly linked to the problems of the community as a whole.

The Batlokwa's holistic understanding of dysmenorrhea has elements of primary health care as stipulated by WHO and United Nations Children's Fund (UNICEF) (2018). The Batlokwa THPs and IKHs' principles of understanding dysmenorrhea holistically provided practical guidance in the management of menstrual and gynaecological health problems in a holistic approach (de Wet & Ngubane 2014). This put THPs and IKHs in a unique position to understand and heal the illness of their patients because they have a thorough knowledge and understanding of the history of their patients and they also share similar customs and beliefs. A holistic understanding of dysmenorrhea can also assist health care practitioners in both indigenous and Western worldviews with an excellent conceptual base when diagnosing, treating and preventing dysmenorrhea and other women's health illnesses.

Therefore, this finding suggests that a holistic understanding of dysmenorrhea should be prevalent in efforts aimed at improving the health of individual women experiencing dysmenorrhea and preventing dysmenorrhea within the rural communities.

The sub-theme illuminating the theme of a holistic understanding of dysmenorrhea involved meaning making. The participants used the metaphor of process and journey to make meaning of dysmenorrhea; at the same time, they connected dysmenorrhea to other gynaecological problems to approach it holistically.

5.2.1.1 Subtheme 1: Meaning making

Through the individual interview and modified Lekgotla discussion collaborated through the photovoice process, the participants created spaces to make meaning of dysmenorrhea. Many of the THPs and IKHs' photographs caused the participants to function as critical resources and see that there were multiple perspectives about the meaning of dysmenorrhea. The findings showed that Batlokwa ethnicity possesses the meaning systems that provided them with consistency, predictability, and a lens through which to see and interpret dysmenorrhea.

The participants indicated that for them to recognise illness, they should first make meaning out of it according to their understanding. In this case, the understanding of the meaning of dysmenorrhea was based on the action and characteristics of the illness and symptoms presented by the women seeking health. The metaphors of journey and process were also used to make the meaning of dysmenorrhea and connecting dysmenorrhea to other gynaecological problems and grouping these problems as women's health (Landau 2018:68). The participants related

dysmenorrhea to a journey connected to the women's health as discussed in 5.2.1.1.1, whilst others associated, connected and compared it to other gynaecological problems as discussed in 5.2.1.1.2. The explanations and descriptions thereof reported a general acceptance of dysmenorrhea as an illness. The use of metaphors was found to assist in adding clarity and depth of illness meaning rather than presenting factual information of the illness, which means making through metaphors is seen as an easier task to convey specific facts to the patient using non-medical language, preferably a language that makes sense on a deeper level. Indigenous researchers in other domains have documented the use of metaphors as a familiar sense-making mechanism that allows everyone in the community to contribute to teaching and learning (Fredericks, Clapham, Bessarab, Dudgeon, Bainbridge, Ball, Andersen, Adams, Collard & Duthie 2015).

The use of meaning-making derives from existential philosophies. Existentialists believe that people can establish meaning in their lives, especially when confronted with adversity (Gustavsson 2020; Van der Spek & Verdonck-de Leeuw 2016; Ownsworth & Nash 2015; Park 2010; Redekopp 1990). Meaning making involves searching for a more favourable understanding of the situation and its implications (Gustavsson 2020:28). Bruner (1990) adds that in order to gain insight into an individual, one must first understand how her meaning-making governs her experiences and behaviour.

The cultural socialisation influenced the form in which meaning making took place in this study. In order to understand dysmenorrhea, the participants searched for meaningful concepts that carry cultural meaning. For example, more often, the participants interpreted and referred their understanding of concepts used for dysmenorrhea events as what is believed and practised in their community. In agreement with the above facts, Bruner (1990) attests that meaning making is a culturally mediated phenomenon, which depends upon the prior existence of a shared symbol system. In addition, Idang (2015:97) revealed that people sought knowledge by making meanings in relation to their circumstances, environment and culture. Participants added that during the process of meaning-making, they search for the originality of the illness so that they explain and describe it readily. The finding is in line with the suggestions of Sprangers (2015) and Van der Spek and Verdonck-de Leeuw (2016), who believe that the way people make meaning of the illness and other life events, influences their understanding of the illness, coping mechanisms and wellbeing. The argument tallies with the view that meaning making can be seen as the existential dimension underlying coping and adjustment (Park 2010). Zimmermann (2017) revealed that making meaning of health and illness is essential in order to close the communication gap between

the community and the healthcare providers who serve them. The author further postulated that the act of assigning meaning to specific events in an illness process improves coping and healing effects. According to Park and George (2013), meaning-making efforts requires individuals to adjust views of the event or revise their goals and beliefs about the world to accommodate new information and restore a sense of the world as meaningful and life as worthwhile. These include observing health-seeking behaviour, timing for the occurrence of symptoms, and comparing it to events and actions.

It was also found that although dysmenorrhea is a universal illness, Batlokwa women understood it differently from the Western perspective. More often, when the participants were making meaning of dysmenorrhea, they referred to their situation and context, cultural beliefs and practices. Jongen, McCalman & Bainbridge (2018) attests that people's understanding of health arises out of interaction with cultural systems, which is in support of our findings. Several studies, in addition, highlighted the need for cultural awareness and understanding to make meaning of illnesses (Prescott & Logan 2019:98; Brooks, Manias & Bloomer 2018; Matthews & van Wyk 2018). Czechmeister (1994) warns that it is difficult to interpret a situation which is personal and accurately based on the culture. Therefore, context is essential in the interpretation of understanding illnesses from indigenous communities as it cannot be presumed that every community has a similar understanding of the same illness.

The findings further revealed that it takes a good sense to focus on both individual, community and cultural awareness, as well as interconnecting body, emotions, spirit, and culture to make meaning. For example, the participants connected critical components of the symptoms, causes, actions, circumstances and cultural beliefs and practices to make sense of the dysmenorrhea. As such, the finding of holistic understanding provided a good vantage point to know how the Batlokwa women synthesised their culture with action, symptoms and causes of dysmenorrhea to develop an indigenous perspective of dysmenorrhea meaning. This provided an essential implication on women's access and decision making on health and practices. Understanding the process by which most individuals make meaning of illness may offer important insights to enhance the efficacy of interventions that facilitate the adjustment. For example, the participants in the study conducted in Australia, considered dysmenorrhea to be a holistic condition that can be understood and managed by women themselves according to their cultural practices (Armour et al. 2016). In support, Andrade, Espey, Hall and Bauer (2019) maintain that if we understand illnesses holistically, we should apply effective strategies built on the tribal practices so that the community becomes involved in the management.

Understanding the meaning given to the concept of health can only enhance our ability to provide culturally competent care to peoples of different racial/ethnic, age, socio-economic, and gender groups. These findings point to the need for the inclusion of existential, meaning information into a holistic and integrated clinical understanding of people's perceptions and explanations of illnesses. They also provided an excellent point to understand the differing views of health and treatments of illnesses, which has important implications on health-seeking behaviour, health practices, and decision making regarding when and whom to consult or when to switch between treatment alternatives.

5.2.1.1.1 Dysmenorrhea as a process and journey connected to women's health

The description of a photograph in Figure 4.2 revealed that the participants of this study made dysmenorrhea a meaningful concept using a metaphor of a process and journey. According to Taylor and Dewsbury (2018), the essence of a metaphor is to understand and experience one kind of thing in terms of another. Metaphors, therefore, are used cross-culturally as a tool that reflects on illness experience and may help people to express their perspectives of self, environment and control (Landau 2018:62). These can help people to describe and make sense of their situations, as well as a source of encouragement and motivation to accept situations at their exposure. Skott (2002:231) argues that metaphors play a crucial part in the process of reconstructing meaning and coherence in a situation of illness. Semino, Demjén, Hardie, Payne and Rayson (2018) suggest that journey metaphors are better to use as they give a sense of purpose and control for the patient.

Moreover, Sinnenberg, Mancheno, Barg, Asch, Rivard, Horst-Martz, Bутtenheim, Ungar and Merchant (2018) attest that the use of metaphors in health contributes to the public's understanding of health. For example, in this study, the participants when making meaning of dysmenorrhea related and compared it to the process and journey, so that it can be understood holistically. This does not mean that the contextual and basic meanings of dysmenorrhea are literally a journey in which women partake. It is merely a comparison.

According to Batlokwa women, dysmenorrhea is a process or journey that has been in existence for some time, before its symptoms. Kahissay et al. (2017) allude that illness processes can take time before showing through symptoms. Moreover, dysmenorrhea was referred to as a process or journey. *The participants also indicated that when living with dysmenorrhea, it feels like embarking on a journey by foot.* The participants indicated that a journey points out a road that one travels on,

while process times out and measures the period that one travels the road of the illness and the luggage (struggles or battles) that is carried through the journey. According to Semino, Demjén, Demmen, Koller, Payne, Hardie and Rayson (2017:626), battle and journey reflect and reinforce how an illness is experienced. It was also evident that women take this journey throughout their reproductive age and the journey only ends with pregnancy, menopause or if treated successfully. However, Reisfield and Wilson (2004:4025) argue that there is no winning or losing on a journey; the emphasis is instead on a more extensive process, since life itself is often compared to a journey. The metaphor of a journey, therefore, emerged as an apt description of this process, because that was how the participants spoke about their knowledge of dysmenorrhea.

The metaphor of the journey was also used to describe the process that women experience from being diagnosed with dysmenorrhea until being cured. The participants revealed that dysmenorrhea as a journey was not an isolated event that just happens at a particular point in time, instead it is a negative process taking place over an extended period during reproductive age. The journey in this regard meant that as women go through experiencing dysmenorrhea, they hope to go from being ill to becoming healthy. The participants find a metaphor of journey suitable for dysmenorrhea because they are already used to the concept of life and its problems as a journey. In addition, the journey metaphor was found to be the language frequently used by patients, family and health caregivers (Demmen, Semino, Demjén, Koller, Hardie, Rayson & Payne 2015; Semino et al. 2017:629; Semino et al. 2018).

According to the participants, associating dysmenorrhea to a journey means travelling a long distance and often in dangerous or challenging circumstances. Experiencing dysmenorrhea was quoted as embarking on a hard-long road journey through the reproductive age. According to the participants, women experiencing dysmenorrhea depart to a realm that is unknown to them, which is symptoms of illness and the impacts, thereof (Zimmermann 2017:75). They also felt that it is essential to find more understanding and compassion for those living through dysmenorrhea. Moreover, they thought of battling or struggling journey. The participants spoke of dysmenorrhea as a cruel journey, experienced by women. The reason for that was, women experiencing dysmenorrhea and indigenous healers are battling with the symptoms of dysmenorrhea, and the most common substitute for a battle was found to be a journey.

Nonetheless, Semino et al. (2018) demonstrate that the battle was not inherently bad, nor was the journey inherently good for everyone. Instead, different people used each of the metaphors in both empowering and disempowering ways. Hendricks, Demjén, Semino and Boroditsky (2018:277)

explored how people appraise an illness situation when associated with a battle or journey. The authors discovered that although the two metaphors have different sets of entailments, they were, however, used together where the illness is engaged in a battle or struggling journey.

In addition to speaking in general about the metaphor of a journey, participants spoke at length about what it takes to experience dysmenorrhea. They included the vigilance and sacrifice that is involved in this kind of journey. According to the participants, a journey may entail possibility for struggles, courage, hope, discovery, growth, strength and change. Lee and Schwarz (2014:61) shared the same sentiments as the findings of this study. The authors indicated that naturally, journeys have both positive and negative experiences. According to the participants of our study, dysmenorrhea symptoms impact on the physical, emotional and spiritual life of the woman experiencing dysmenorrhea and their families. Positives are ideas of hope, discoveries of new information and help, the strength of continuing with the journey and growing in determination to fight the battles, as well as changes that may result when embarking and returning on a journey of dysmenorrhea (Reisfield & Wilson 2004:4026). For example, a holistic understanding of dysmenorrhea makes room of attention for the whole reproductive system. According to Zimmermann (2017:75), taking this journey implies that the clients will come back from the journey cured or in remission to resume life accordingly. In this regard, positives were cure from other gynaecological problems.

As participants were describing the meaning of indigenous dysmenorrhea, they also indicated that a woman experiencing dysmenorrhea does not walk this journey alone. Family is affected by what the woman is going through because of its negative impact on the physical, emotional and spiritual aspects on the women disrupt the lifestyle of the family as well. The participants as healers find themselves accompanying a woman and family through this journey in order to reach the destination. The destination in this regard was referred to as a total cure. A journey was commonly used to remind the women that there is a destination at the end of the travelling, although at times the road is not easy. Other participants called themselves companions because according to them, it takes their full participation guiding clients and families through the journey of diagnosing and healing dysmenorrhea. According to Elran (2019), the main benefit of using a metaphor of journey for illness encompasses the idea of companions, of the people with earlier diagnoses', family, friends and health care practitioners acting as guides and support system.

The participants also referred to themselves as overcomers of this journey because they can cure dysmenorrhea. The participants indicated that when a woman consults with them about

dysmenorrhea, their lives are impacted as well; they walk the journey with their clients, and it may last days or months depending on the progression. This finding also discussed the relationship that participants had with their clients and how it provided the foundation of trust and mutual understanding, enabling clients to overcome dysmenorrhea. Once a woman is cured, THPs and IKHs regard themselves as overcomers because they have successfully practised the teachings received from the creator. In this regard, dysmenorrhea was looked at as a journey to test and overcome the knowledge imparted to the THPs and IKHs.

In this study, dysmenorrhea was also found to be a process which differs from woman to woman depending on the way the pain is experienced and rated. The participants indicated that the experience of dysmenorrhea is subjective because individuals experience it differently. They categorised dysmenorrhea as mild, moderate and severe. This is entirely consistent with the findings from the study of Chen, Tang, Guo, Kaminga and Xu (2018), in which the college girls reported a high prevalence of dysmenorrhea, in rates of mild, moderate and severe pain. According to the people in Lesotho, dysmenorrhea pain ranges from dull and annoying to severe and extreme (Possa & Khotso 2015:44). According to Bekele and Gileteu (2019:73) variations occur due to differences in defining dysmenorrhea, pain severity and socio demographical variables. Individual dysmenorrhea variations, such as the extent and rating of pain as a journey, influenced viewpoints and meaning making of dysmenorrhea by the participants.

The women in the current study echoed both positive and negative sentiments regarding dysmenorrhea as a process. The indigenous perspectives of dysmenorrhea were related to the good and bad existential world. This has been illustrated through how the metaphors were used in terms of positive and empowering and negative and disempowering ways. The descriptions were based on their cultural beliefs and understanding. This implies that the health-seeking behaviour among women experiencing dysmenorrhea may be harmful or positive depending on how it is perceived culturally, and on how individual women experience and rate it. Ristevski, Thompson, Kingaby, Nightingale and Iddawela (2020:128) allude that culture affects health-seeking actions of individuals. The positivity was recognised and reported by some THPs and IKHs as when women experiencing dysmenorrhea, they seek intervention to correct infertility. Other participants point out positivity as viewing dysmenorrhea as normal or natural. The participants explained that some of the women experiencing dysmenorrhea view it as a process that affirms womanhood and fertility. In this case, mild or once-off episode of dysmenorrhea was considered as the process of cleaning the womb in preparation for pregnancy, and as such, there is no need for intervention (Hennegan et al. 2019). This is in line with the sentiments of some participants in the study conducted on

women's and girls' experiences of menstruation in low- and middle-income countries, in which the women and girls viewed menstruation and its problems as a healthy bodily function. Additionally, the stress of management was tempered by pride in being a woman and the potential of the joy of motherhood (Hennegan et al. 2019). In addition, the study conducted in Australia revealed that women do not reveal or list dysmenorrhea as a symptom to their acupuncturists, because it is viewed as part of being a woman (Armour et al. 2016).

On the other vein, the participants in our study reported that monthly recurrence of dysmenorrhea represents a negative impact on the life of the women. Although the literature that supports dysmenorrhea as a process and the journey is rarely found, Conney, Kretchy, Asiedu-Danso and Allotey-Babington (2019) report that dysmenorrhea affects the social life of women negatively. Other studies revealed that dysmenorrhea also impacts negatively on the health, education and psychosocial outcomes (Oni & Tshitangano 2015; Egenti et al. 2016; Bekele & Giletew 2019:73).

In this sense, suffering is considered a holistic experience, which covers the process through which the person lives and experiences negativity of the illness. As such, how individual woman processes the journey of dysmenorrhea should be valued and respected. The provided intervention, therefore, should be culturally sensitive. What we can learn from this finding is that the use of metaphors is not just overstatements in communications, instead, foundations for thought processes and conceptual understandings that function to map meaning from one knowledge to another. The Batlokwa women carefully developed these metaphors to make sense of dysmenorrhea and communicate ideas to influence action on the perceived idea. The provided information within this metaphor speaks to physical, emotional, and social impairment, which highlights the holistic consequences of the dysmenorrhea impact. Moreover, the Batlokwa understand and address dysmenorrhea within a holistic approach. It was also apparent that metaphors provided a collaborative way of creating knowledge among knowledge holders (Rodríguez & Bélanger 2014).

5.2.1.1.2 Grouping of women's health issues

A photograph of a chain (see Figure 4.3) and a bridge (refer Figure 4.4) provoked a critical discussion on how women's health issues should be approached during modified Lekgotla discussion. The findings of the discussion showed that when making meaning of dysmenorrhea women's health issues were grouped to have a holistic understanding of dysmenorrhea. In this regard, the participants' understanding of dysmenorrhea was most often associated with other

gynaecological illnesses. The participants understood dysmenorrhea as a way of indicating that the whole female reproductive system was negatively affected by illness. The participants were often reinterpreting dysmenorrhea to be a holistic condition that affects other reproductive organs of the women rather than a specific gynaecological condition (Conney et al. 2019). An explanation offered for this perspective was that dysmenorrhea as a physical illness is the symptom of more significant illnesses of a holistic nature related to the female reproductive system. Good gynaecological health was understood as a balance between all female reproductive organs (physical body), emotions and spirit. The gynaecological illness was considered as a state of disequilibrium between all female reproductive organs (physical body), emotions and spirit. This means that the Batlokwa THPs and IKHs understand the science of human body that it is divided into systems and can identify the women's reproductive organs (Stallbaum, da Silva, Saccol & Braz 2018:79).

The holistic understanding of dysmenorrhea teaches us that we cannot compartmentalise or separate illnesses affecting women the reproductive system. This finding has the potential to direct a more holistic focus of illnesses that incorporates attention to physical and spiritual, as well as emotional and mental aspects. Thus, understanding a client as a whole being rather than only physical is important. According to White (2015), this implies that the health care practitioners will deal and provide attention for physical, psychological, spiritual and social symptoms. The importance of 'holistic' understanding is widely recognised, particularly with an increasing prevalence of chronic illnesses (Prescott & Logan 2018). According to Kirmayer and Brass (2016), indigenous understanding of health and illness is complex; as such, it is necessary to be holistic when making meaning of illnesses. Several studies suggest a holistic approach in understanding how people perceive illnesses (Corp, Jordan & Croft 2018; Sultana, Khan, Quwat Nawaz & Syed 2016; Armour & Dahlen 2015; Hu, Lorenc Kemper, Liu, Adams & Robinson 2015; Lundy 2010).

This point illustrates how THPs and IKHs use their treatment framework to view the body in a fundamentally different way to Western health care. The literature confirms that indigenous people have always had a way of looking and treating the sick using the holistic framework (Prescott & Logan 2018:99; Fan 2017:153; White 2015:2; Zamanzadeh, Jasemi, Valizadeh, Keogh and Taleghani:2015). Throughout data collection, it became clear that a holistic framework understanding incorporated several components that played a role in treating dysmenorrhea as it provided guidelines for all aspects of the treatment of dysmenorrhea. They gave the different meaning of dysmenorrhea concerning the women who have experienced other gynaecological health issues. In doing so, one might get a more comprehensive understanding of dysmenorrhea

and behaviour of people experiencing it. The participants used bridge and messenger to argue on grouping women's gynaecological issues in understanding dysmenorrhea holistically.

The term bridge emerged from a photograph of a bridge presented by some participants as one way of understanding the findings linking dysmenorrhea to other women's health issues. The discussion revealed that the use of a bridge was applied as a throughway to identify other women's health issues causing dysmenorrhea because the pain from dysmenorrhea was associated to other hidden illnesses that women might be suffering from such as infertility. Elran (2019) argues that health care practitioners should function as bridges in which patients use to reach the side of normality. According to Penson, Schapira, Daniels, Chabner and Lynch, (2004:713), the metaphor of the bridge closes a gap between the patient experiences of illness and the way the health care practitioners perceive it. When connecting dysmenorrhea to other gynaecological issues, some THPs and IKHs indicated that they suffered from dysmenorrhea themselves. This resulted with infertility which was treated indigenously and in turn corrected dysmenorrhea. This finding suggests that dysmenorrhea is related to some form of infertility in women and act as a messenger agent. The findings are aligned to the study conducted by Gad, Abdel-Gayed, Dawoud and Amer (2017:358), which revealed that dysmenorrhea is the most leading symptom indicating endometriosis which contributes to infertility. The number of studies confirmed that dysmenorrhea might be a sign of infertility owing to the link between dysmenorrhea and endometriosis, which confirmed to be a cause of infertility (Conney et al. 2019; Ajayi, Ajayi, Biobaku, Oyetunji, Aikhuele, Atiba and Afolabi 2016:157; Cochrane, Smith & Possamai-Inesedy 2011). Furthermore, the authors indicated that penetrating menstrual cramps can be caused by several diseases that impact on fertility. Moreover, all the participating women associated dysmenorrhea with infertility.

Additionally, the findings showed that the Batlokwa women believed that dysmenorrhea is a message indicating problems within the reproductive system of a woman. Armour et al. (2016) revealed that a metaphor of messenger create links between activities and behaviours to assist women to understand the signs and symptoms of dysmenorrhea that they experienced. Lazard, Bamgbade, Sontag and Brown (2016) add that messages of health have tremendous power to effect changes in the behaviours. This provided evidence that messages can increase the effectiveness in the promotion of health.

5.2.2 Theme 2: Self-naming and self-definition of dysmenorrhea

The photovoice processes encouraged the women's creative representations and critiques of many of the factors pushing them and their community to self-name dysmenorrhea in their cultural understanding. The findings showed that Batlokwa ethnicity had their names and definitions associated with dysmenorrhea. It is imperative to understand the local views of dysmenorrhea from Batlokwa women since explanations of it are based on the constructs of social situations as found in community notions. The names that described dysmenorrhea were according to their understanding and language. In naming and defining dysmenorrhea traditional health practitioners and indigenous knowledge holders gave a range of explanations for dysmenorrhea drawing on their past dysmenorrheal experiences and observations of women experiencing dysmenorrhea as well as knowledge orally handed down from generation to generation. Findings discovered that despite similar social and cultural background, THPs and IKHs named dysmenorrhea in different ways. However, the used constructs, words, terms and phrases were familiar in the community and were relevant and related to dysmenorrhea.

The descriptions of dysmenorrhea by Batlokwa THPs and IKHs were based on different aspects such as understanding of human existential conditions and assignment of names to symptoms and characteristics. The related wide range of names, terms, phrases, definition and descriptions were analogous to their cultural beliefs and understanding of dysmenorrhea. These words and terms used to name and define dysmenorrhea produced a meaningful understanding of dysmenorrhea based on Batlokwa perspectives. This implies that Batlokwa THPs and IKHs are conversant about the indigenous meaning of dysmenorrhea. Mojapelo (2009:185) alludes that descriptions, terminologies, and manifestations of illnesses vary across cultures. In elaboration, Awah, Unwin and Phillimore (2009) indicate that every culture has several words that are always used to identify and name an illness. Possa and Khotso (2015:37) added that naming as a process is very important to societies across the world, because it makes it easy to identify people and items. Authors further revealed that naming displays historical, cultural and social disciplines. The reason for this may be influenced by the fact that names have a connection with the society that uses them.

Names and descriptions showed that Batlokwa women were creative in constructing terms and phrases to understand dysmenorrhea based on their cultural beliefs. Although creativity was observed in naming dysmenorrhea, constructed names highlighted problems related to women's reproductive health. These provided a framework for understanding and explaining dysmenorrhea.

Piko and Braissai (2016), argue that the general meaning system that people use comprises the lenses through which individuals interpret, evaluate, and respond to their experiences and encounters in their location. Mojapelo (2009:185) attested that traditions and patterns of naming reflect the cultural beliefs and practices of the people. Culture is, therefore, a strong determinant of people's perceptions of illness.

Several names were provided and explained in 4.3.5. The most prominent names were "selumi" (something that bites) and "letlhapo hloko" (painful menstruation). The name "selumi" relates to the character and signs and symptoms of dysmenorrhea. Participants described "selumi" as something biting inside the womb. As the results of the biting, the woman experiences pain on the lower abdomen. According to the participants as the biting continues, other gynaecological problems may result. They mentioned the wounds from the biting causes a heavy menstrual flow. The issue of infertility as a complication of biting was also described. The participants indicated that the healing from monthly biting causes scars which may block the tubes or and disturbs the implantation during pregnancy. It was discovered that in Lesotho, they also use the name "selumi" referring to dysmenorrhea (Possa & Khotso 2015:44). "letlhapo hloko" is related to the action and symptom. "letlhapo" means to bath or wash (an action), whilst "hloko" is the pain (symptom). The Batlokwa ethnicity believes that every month the womb cleanses itself and blood coming out is related to dirt. Hence, they use the action of bathing to describe menstruation. Pain that comes with menstruation is from the biting. Other provided names such as "tshilwana or kgwele" (lower abdominal cramps, affecting thighs and occurring immediately after giving birth), "bohloko ba o ya kgwedding" (painful menstruation), and "noga ya o loma"(biting snake), "noka ya o tshega" (painful waist) are either related to the action, character, symptoms or combination. It can be deduced from the above statements that the participants understand dysmenorrhea as an illness that affects menstruation, womb and fallopian tubes. In other words, people experiencing dysmenorrhea are menstruating women. The descriptions gave the impression that used words, terms, and phrases match the descriptions of dysmenorrhea by Western health care. This implies that "*selumi*" coexist as dysmenorrhea.

The wide variation in participants' concepts of dysmenorrhea and interpretations depended on cultural values and social norms. Abu Helwa, Mitaeb, Al-Hamshri and Sweileh (2018) emphasised that different understanding of the meaning of dysmenorrhea may account for the different ways of managing dysmenorrhea. It was evident that whenever THPs and IKHs were asked to explain what they understood dysmenorrhea to be, it was the local terms and their connotations that were most readily called upon. In this regard, dysmenorrhea in Botlokwa was most commonly understood and

made sense of by reference to traditional or pre-existing ideas. According to Africana Womanism theory, much focus when naming should be on self-naming and self-defining, in order to recognise cultural practices and promote ownership (Hudson-Weems 2004). Feminists such as Brooks (2007), Hirschmann (1997) and Harding (1991), insist on the importance of situating knowledge, in order to understand the reality regarding health practices. This means that the name is much more than a collection of letters. It provides meanings and understandings based on culture.

While much of the focus in the discussion of self-naming was specifically on dysmenorrhea, participants spoke quite strongly about how the issue of a lack of opportunity to name conditions in their language affects their self-esteem, because they are forced to use other nations' languages and viewpoints. The findings from this study align with Africana Womanism theory, which advocates for consideration of cultural identity, beliefs, social relationships and past experiences whenever trying to understand Africans viewpoints (Hudson-Weems 1993). Hence, the researcher advocates for the Batlokwa women meaning of dysmenorrhea to be documented in order to empower women with dysmenorrhea knowledge.

5.2.2.1 Subtheme 1: Factors contributing to the self-naming and definition of dysmenorrhea

Through the discussions, three factors contributing to the naming and definition of dysmenorrhea by the Batlokwa women were identified as discussed below.

(i) Indigenous understanding of signs and symptoms of dysmenorrhea

Drawing from the names, words, phrases and definition of dysmenorrhea by Batlokwa women, it was easy to identify signs and symptoms of dysmenorrhea. The photographs of knotted robes and squeezing of waists and abdomens commonly spoke of signs and symptoms of dysmenorrhea (Refer Figure 4.6 and Figure 4.7). It was apparent that experiencing dysmenorrhea or being closely affiliated with any person experiencing dysmenorrhea enhances the ability to recognise the signs and symptoms. Drawing from a discussion based on these photographs, some participants made it clear that they need to know and understand the signs and symptoms of dysmenorrhea in order to treat and impart the knowledge to others. Adeoye, Arulogun, Dipeolu and Jidda (2019) affirmed that traditional health practitioners and indigenous knowledge holders recognise signs and symptoms of the illnesses for effective diagnosis and treatment. Evidence from the literature showed that signs and symptoms are the critical and central theme in naming, diagnosing and choosing treatment for dysmenorrhea (Firouzi, Zahedifard, Salari & Mazlom 2019; Chen et al.

2018; Anand, Akhtar & Bhuvana 2018:437; Bernardi, Lazzeri, Perelli, Reis & Petraglia 2017). Traditional health practitioners mentioned that during training, they are taught to identify signs and symptoms in order to diagnose and treat illnesses. According to Dalglish, Straubinger, Kavle, Gibson, Mbombeshayi, Anzolo, Scott and Pacqué (2019), sometimes signs and symptoms of modern and traditional illnesses can overlap.

The participants had a common understanding of the symptoms of dysmenorrhea. The traditional health practitioners and indigenous knowledge holders categorised signs and symptoms of dysmenorrhea into physical and psychological. This indicates that dysmenorrhea affects both physical and psychological being. A similar finding was seen in Nigeria, in which physical and psychological symptoms were significant among the girls that were experiencing dysmenorrhea (Titilayo, Agunbiade, Banjo & Lawani 2009). The reason for categorising may be influenced by the fact that THPs and IKHs provide physical, psychological and spiritual care (Farleya, Balaa, Lengletc, Mehtae, Abubakara, Samuela, de Jong, Bilc, Oluyidea, Fotsoa, Stringerf, Cuestag & Venables 2020:29).

Lower abdominal pain, nausea, vomiting, backache, menorrhagia, dizziness and fatigue were reported to be signs and symptoms of dysmenorrhea. Similarly, the study conducted in Nigeria by Titilayo et al. (2009) revealed that in a dysmenorrheal woman, lower abdominal pain might be accompanied by nausea, vomiting, backache, menorrhagia, dizziness and fatigue. In addition, several studies revealed that in addition to lower abdominal pain women who are experiencing dysmenorrhea may have any of the abovementioned symptoms, (Fernández-Martínez, Onieva-Zafra & Parra-Fernández 2019; Wong 2016; Armour et al. 2016).

The lower abdominal pain was discovered to be the most frequently perceived symptom of dysmenorrhea. The findings indicated that this lower abdominal pain in some cases radiates to the waist, lower backache and thighs. The participants revealed that the length and severity of the pain differ from person to person. They further, explained that in its severity stage, it makes it difficult to carry the usual daily activities. Duran, Atan, Kavlak and Sirin (2012:417) and Conney et al. (2019) are supportive of the above findings. In their studies, they revealed that women experiencing dysmenorrhea complain of lower abdominal pain. According to the THPs and IKHs, their clients interpret and describe the lower abdominal pain they experience differently. The following characteristics were identified as they explain: Localised lower abdominal pain; this pain can be dull, aching, burning, stinging, sharp or stiff, making it difficult to stand straight. Others experience

the pain that radiates to the waist, buttocks and thighs, usually accompanied by numbness, making it difficult to walk.

Photographers of the images presenting signs and symptoms commonly spoke of feeling like embarrassment, outcasts, stigma and taboos. The participants indicated that the pain expression of dysmenorrhea is usually hidden and not openly communicated to avoid being seen that one is menstruating. The participants indicated that it is a taboo for people to know that one is menstruating. This finding is in line with the study conducted in Nepal by Amatya, Ghimire, Callahan, Baral & Poudel (2018). Societal judgements on menstruation and its related problems as embarrassment can result in self-stigmatisation, where the individual internalises these judgements and results in a deterioration of self-esteem and self-worth (Chandra-Mouli & Patel 2017).

Moreover, many women find it difficult to talk about menstruation-related topics, such as dysmenorrhea, because they find it embarrassing (Wilson, Haver, Torondel, Rubli, Caruso 2018; Chen, Kwekkeboom, Ward 2016). Nonetheless, Chen, Doyle Groves, Miller and Carpenter (2018:1241) recommend engaging men in dysmenorrhea conversations, in order to improve dysmenorrhea awareness. In support, Krusz et al. (2019) advocate for initiatives addressing menstruation from individual, family, community and societal levels to deal with the identified stigma and taboos attached to menstruation.

More importantly, the THPs and IKHs explained their perceptions of how the pain of dysmenorrhea may have originated. Different understanding emerged from their explanations as discussed below. The traditional health practitioners and indigenous knowledge holders believe that the pain originates from the inflammation and the wounds of the womb during and after the biting by the “selumi” or swelling as a result of infection. Some believed that the pain is from the hard pushing of accumulated blood, clots and some dirt from infections, forcing to come out with menstruations because naturally, the womb cleans itself every month. Swelling of the uterus was also believed to press on the other organs of the abdomen, and the pressure results in pain, hence sometimes pain is radiating and affecting other parts of the body such as thighs. As outlined previously in this thesis, the perspectives of illnesses’ meaning differ from one group to another. As discussed in Chapter 2, Smith et al. (2011) reveal that Chinese strongly believe that dysmenorrhea occurs because of chronic imbalances in the flow of qi and blood, liver, spleen and kidney qi deficiency, excess, or stagnation.

The appearance of thick clots with menstruation was conceptualised and described as the bleeding from the biting. This is in consistence with the perspective of the Chinese medicine, in which Acupuncturist and Herbalist Jill Blakeway, the founder of the Yinova Centre, lists blood stagnation as another type of dysmenorrhea, identified by dark menstrual blood with clots (Blakeway 2019). Dizziness and fatigue are related to exhaustion because the pain from dysmenorrhea is associated with walking a journey. According to the participants, nausea and vomiting is caused by the swelling of the womb, which pushes up other abdominal contents out their position.

Although the traditional health practitioners and indigenous knowledge holders related dysmenorrhea pain to the specific anatomical structures such as lower abdomen, waist, and thighs, the dysmenorrhea pain was understood as a holistic issue. Therefore, the diagnosis and management of pain related to dysmenorrhea in traditional health is conceived from the holistic approach. In this case, Western health care was considered incomplete when dealing with dysmenorrhea, because their conceptualisation of dysmenorrhea pain is on anatomy and physiology.

Although headache is a physical symptom, the THPs and IKHs viewed it as a psychological complication. They explained that it resulted from overthinking when trying to find reasons for the cause of dysmenorrhea. Hence, the psychological effect was related to the coping mechanism. The psychological aspect reported to have a social impact on some of the women and their families. The findings revealed that women experiencing dysmenorrhea do not cope well from the pain and the stigma that is associated with dysmenorrhea as caused by sexually transmitted illnesses. The women experiencing dysmenorrhea were reported to isolate themselves, sometimes hiding from being seen that they are menstruating, so as not to be associated with infertility and infections. As indicated earlier in this discussion, Amatya et al. (2018) reveal that this is similar in Nepal, where it is a taboo to mention the term menstruation. Balagué, Mannion, Pellisé and Cedraschi (2012) allude that psychological factors may adversely affect an individual's ability to cope with an illness.

On the other note, for most, dysmenorrhea is a negative aspect of the menstrual cycle; the photographs taken points to a painful experience. However, instead of focusing on the negatives that are evident and emphasised in the photographs, some participants chose to extract and highlight the possibility of experiencing mild dysmenorrhea. Mild dysmenorrhea was found to be necessary as a sign of fertility. In this case, the participants were positive and expressed a sense of hope. What often framed as a symbol of hopelessness and despair became a symbol of

strength and resilience. This aligns closely with what Freire (1970) describes as critical consciousness and positive reflection.

(ii) Finding reasons for the cause of dysmenorrhea

This study showed that experiencing dysmenorrhea among Batlokwa women usually involves an extensive process of searching for viable, decisive causes of dysmenorrhea. According to the participants in this study, it was necessary for them to search for the causes of dysmenorrhea, so that they can name, define, treat and prevent it. It appeared evident from the findings that the worldviews of THPs and IKHs regarding the causes of dysmenorrhea are similar. Most of the THPs and IKHs who participated in this study were of the view that there are many causes of dysmenorrhea. Supernatural powers such as witchcraft inherited and genetic factors, as well as infections, were identified as causal factors of dysmenorrhea. The researcher, being in the medical field, realised that Western perceptions and knowledge of the cause of illnesses are different from the indigenous perceptions. The Western perceptions are based on scientific understanding of anatomy, physiology and pathophysiology. This finding suggests the two-health care system to work together in meeting the needs of the diverse nation (Gandugade, Nlooto & Naidoo 2017:157).

Witchcraft was stressed as one of the contributory factors to dysmenorrhea. The findings revealed that witchcraft comes in different forms. For example, participants believed that people with evil powers could cause other people to suffer dysmenorrhea through the spiritual spell. This may result in infertility as a means of jealousy. Others indicated that witches prepare poisonous medicines and put it in someone's food intending to cause dysmenorrhea. Some participants alluded that some witches steal underwear or used pads to cast a spell and cause dysmenorrhea. From the above, it is apparent that Batlokwa THPs and IKHs accounts causes of "*selumi*" (dysmenorrhea) go beyond the biological but include witchcraft. According to Petrus and Bogopa (2007:2), witchcraft may account for the presence of disease as it is believed that evil spirits may cause illness. White (2015:7) notes that traditional healers in many African countries associate illness with attacks of evil or bad spirits such as witchcraft. In Malawi, during every interview conducted, the girls discussed menstrual pain and expressed reasons why they believed they were experiencing it. Some girls believed their pain was due to witchcraft (Pillitteri 2012:11).

Findings also identified Sexually Transmitted Infections (STIs) to be a contributory factor to dysmenorrhea. They believed that inflammation caused by infections in the female reproductive tract is the cause of pain in menstrual women. They also mentioned the presence of "*sebabo*" or "*sekgalaka*" which are sores that spread through the vaginal canal to the other reproductive organs

as a cause of dysmenorrhea. These sores are believed to be transmitted sexually or from poor hygiene. Study of Bezuidenhout et al. (2018:20) support this notion, and Chen (2018) postulated that pelvic infections are a risk factor for dysmenorrhea. According to Subbarao and Akhilesh (2017:1), STIs also known as Pelvic Inflammatory Diseases (PIDs) are the infections that are mainly transmitted through sexual intercourse and quickly spread to the uterus, fallopian tubes, ovaries urethra, bladder and kidneys. Alvergne, Wheeler and Tabor (2018:142) in their study testing if some negative premenstrual symptoms may be exacerbated by the presence of chronic Sexually Transmitted Infections, found that negative premenstrual experience might be aggravated by the presence of undiagnosed STIs, which can cause infertility.

Traditional health practitioners and Indigenous knowledge holders in Botlokwa also viewed dysmenorrhea as something that could be caused by heredity. The view expressed by several THPs and IKHs was that dysmenorrhea tends to run in families. For example, a woman may inherit dysmenorrhea from her mother, sister, grandmother or aunts. They indicated that family history usually repeats itself when it comes to dysmenorrhea. Previous studies support the notion that dysmenorrhea runs in families and that the transmission of risk is due to heredity (Muluneh, Nigussie, Gebreslasie, Anteneh & Kassa 2018; Vlachou, Owens, Lavdaniti, Kalemikerakis, Evagelou, Margari, Faso, Evangelidou, Govina & Tsartsalis 2019). The study of Silberg, Martin and Heath (1987:263), conducted among 1200 pairs of Monozygotic and dizygotic twin sisters have also confirmed that genetic factors were responsible for primary dysmenorrhea. A study of Fernández-Martínez et al. (2018) results reported that more than 80% of the students with dysmenorrhea in Spain had a first-degree family member suffering from pain and discomfort during menses.

The indigenous perspectives of the causes of dysmenorrhea showed that African people have a common belief about the causes of illnesses. These beliefs should be specifically addressed to develop appropriate educational materials, including cultural friendly models of care, assessment, diagnosis and treatment approaches. This finding assisted in understanding the indigenous perspectives of dysmenorrhea. Understanding of the Botlokwa causation of dysmenorrhea will assist clinical interactions between Western and indigenous health professionals and support cultural security in health and healing (Park & Canaway 2019:25).

(iii) Constructing and connecting categories of dysmenorrhea

The traditional health practitioners and indigenous knowledge holders constructed categories of dysmenorrhea through the process of naming. They used local language to name categories of dysmenorrhea. Naming dysmenorrhea according to the ethnicity language and understanding is expected. Iranian Traditional medicine (ITM) considers dysmenorrhea as Osre- Tams (Shirooye & Abdolhosseini 2017:52). Whilst the traditional Chinese medicine interpretation of primary dysmenorrhea is stagnation of qi and blood (Luo, Huang, Liu, Wang & Xu 2019:20; Tong 2018:99). The practice of categorising is essential because it is used to label the different types of dysmenorrhea. The findings of this study showed that there are two types of dysmenorrhea. The first type of dysmenorrhea was referred to as “selumi” (something that bites).

According to the participants, “selumi” is a kind of dysmenorrhea that is experienced when someone is menstruating. “selumi” can occur a few hours or days before, during and few days after menstruation. The findings further revealed that this type of dysmenorrhea affects any woman, including virgins. The other type of dysmenorrhea was referred to as “tshilwana”. According to the participants, “tshilwana” occurs immediately after childbirth. The participants further, explained that if “tshilwana” treated well after birth, it would end up occurring during monthly menstruation because it complicates to infection. According to the THPs and IKHs in this study, the origin of “tshilwana” as dysmenorrhea is from the couple. According to the participants, this kind of dysmenorrhea is the one causing miscarriages. They elaborated that if “tshilwana” misses to cause a miscarriage, after giving birth the mother will experience lower abdominal pains, severe than labour pains, because the womb is trying to get to its standard shape at the same time getting rid of the accumulated dirt caused by infections before pregnancy. The naming of “tshilwana” is derived from the object that is used to massage a woman during treatment. Luo et al. (2019:23) support the categorising of illnesses. The Chinese medicine categorises dysmenorrhea into five types: the stagnation of qi and blood, stagnation of liver and dampness, stagnation of cold and dampness, deficiency of liver and kidney, and deficiency of qi and blood (Luo et al. 2019:23). This finding implies that it takes many forms, including culture, to construct a name for an illness. We found that culture and language connected to symptoms, character and event provided a vital link to construct a name of an illness.

As a result of connecting words, terms and phrases to the definitions, Batlokwa women were able to self-name and self-define dysmenorrhea based on their cultural significance and understanding of the symptoms and characteristics observed from women who are experiencing dysmenorrhea.

In general, knowledge of categorising dysmenorrhea fulfils an essential aspect of primary health care. This aspect is promoted by knowledge of naming and describing dysmenorrhea and causes of dysmenorrhea (Awah et al. 2009).

5.2.3 Theme 3: Diagnostic processes in indigenous dysmenorrhea practice

Diagnosing individuals before treating them was found to be significant with Batlokwa THPs and IKHs. According to the Batlokwa THPs and IKHs, the main objective of the diagnostic process was to seek and establish the nature of the problem that brought the patient for the service. The traditional health practitioners and indigenous knowledge holders indicated that most of the time, diagnosis is guided by the ancestors and an attempt to identify and diagnose the particular phenomenon experienced by the patient must link the individual experience with a culturally meaningful understanding (Musyimi, Mutiso, Loeffen, Krumeich and Ndetei 2018). This means that the diagnosis of dysmenorrhea is linked to the woman's culture and spirituality. In this regard, during the diagnostic process, the Batlokwa THPs and IKHs use various methods and processes to question who caused the illness and why the illness occurred; diagnosing found to assist THPs and IKHs in inquiring and confirming that the woman is experiencing dysmenorrhea.

This understanding is consistent with Ababio, Kquofi and Asante (2019:2) in which it discovered that the diagnosing procedures should be able to determine who and what caused the illness, and why it has affected this particular person at a pointing time. Truter (2007:28) indicated that THPs and IKHs recognise diagnosis as art and method of seeking to discover the origins of the illness. According to Atindanbila and Thompson (2011) cited in Musyimi et al. (2018), these processes resemble diagnostics that were described to be 'traditionally African' about three decades ago, when the main tools for diagnosis were categorised. The study conducted in Kenya by Musyimi et al. (2018), exploring mental health practice among traditional health practitioners also identified that the use of diagnostic methods varied widely among practitioners and some combined several diagnostic methods.

The diagnostic processes found to be effective in determining cause and reason for experiencing dysmenorrhea by the Batlokwa THPs and IKHs were observation, history taking and divination (dream analysis and bone throwing). It was identified that the Batlokwa THPs and IKHs might use the diagnostic processes differently depending on the practitioner preference and the nature of the training received. Despite the differences in diagnostics, both services provided by the THPs and IKHs were found practically diagnostic and curative. In general, THPs and IKHs differ from each

other in the methods they use in the diagnostic process (Ababio et al. 2019:2). Some THPs and IKHs alluded that they can inform their client of the visiting reason. They also inform them of the social cause of their illness without having being told anything by their client. The majority of THPs mentioned that the ancestral spirit guides them in diagnosing (Ozioma & Chinwe 2019; Mokgobi 2014).

Meanwhile, many IKHs alluded that they are guided by the woman's physical appearance or presenting symptoms, characteristics of the illness and health-seeking behaviour (Ozioma & Chinwe 2019). In the same vein, the study discovered that there are experts in diagnosing (diviners) in other words, she is a specialist at carrying out a diagnosis according to the African belief system, in this case throwing bones (*ditaola*) or dream analysis. After a diviner has defined illness and causes, a diviner advises the client on the appropriate procedures to be carried to cure the illness. The client will decide where to get the treatment and may use the services of IKHs. However, most of the time, the diviner treats the client after diagnosis. Van Dyk (2001) argues that the diagnosis of diseases in an African traditional healing system is a twofold event. The physical cause of the illness must be established by careful observation, assessment and questioning by the practitioner, and by divination of the spiritual realm in order to effect treatment (Musyimi et al. 2018).

The finding of diagnostic processes for dysmenorrhea by Batlokwa THPs and IKHs are linked to the client's culture. Attaching cultural-congruent labels to dysmenorrhea highlights the extensiveness that THPs and IKHs take to confirm dysmenorrhea diagnosis. An understanding of what, how and why dysmenorrhea occurs is vital to help ensure safe, effective and coordinated indigenous health care services that can lead to optimal women's health outcomes (Conney et al. 2019).

The identified diagnostic procedures that the Batlokwa THPs and IKHs have been using to diagnose dysmenorrhea are discussed as the following sub-themes:

5.2.3.1 Subtheme 1: Observation as a diagnostic process

According to the Batlokwa THPs and IKHs, observation is regarded as noting the physical symptoms of the woman experiencing dysmenorrhea. The process undertaken to diagnose indigenously involves various modes and levels of observation, as is the case in any scientific knowledge generation process. The ability to observe was considered very important because they

can see from actions and behaviour that a woman is displaying to predict what could be the problem. The IKHs indicated that they rely on observations and history taking to diagnose because they do not use divination. This finding is in line with the findings of the study conducted in Malaysia by Sharan and Mazanah (2011:446) on how modern-day traditional healers diagnose and treat cancer. They discovered that despite using intuition for diagnosing cancer, the THPs observed for symptoms to confirm the diagnosis. Furthermore, the THPs in Malaysia indicated that they diagnose cancer patients through observation before a patient can say the problem and their diagnosis is usually entirely accurate. Musyimi et al. (2018) revealed that THPs also obtain information about the presented symptoms.

Mufamadi (2001) presentation in a conference on traditional healers' perceptions of and approaches to the treatment of mental illness, alluded that observation is one of the popular ways that traditional healers employ to diagnose. In addition, Peltzer (1995) found that although Zimbabwean healers use divination to diagnose, they first examine the patient physically and psychologically before a diagnosis is made. The practice of observing and examining the patient before making a diagnosis is also noted in the Western health system. For example, Proctor and Farquhar (2006:1134) allude that a focused physical observation coupled with the examination is usually adequate to diagnose primary dysmenorrhea. Waldron (2010:50) has acknowledged that notion and added that when using observation as a diagnostic process, the practitioners should consider that every society embraces particular observations, understandings and interpretations of specific symptoms, the behaviour of people affected by illness to conclude on the diagnosis. Therefore, the ability of THPs and IKHs to diagnose dysmenorrhea through observing the physical appearance or presenting symptoms may be uniquely explained depending on their culture.

5.2.3.2 Subtheme 2: History taking as a diagnostic process

The other diagnostic process was identified as history taking. According to this study, history taking involves THPs and IKHs obtaining information from the client or family members to confirm what they have observed or predicted through divination. The findings discovered that sometimes family members of patients are questioned about their history regarding dysmenorrhea to establish if it is hereditary. According to Musyimi et al. (2018), this method reflects both the symptom-focused method and cause-focused method of categorisation because it distinguishes between illnesses and subsequently sets a diagnosis based on the provided information about symptoms and cause at hand.

The participants alluded that to obtain information, they ask the clients and accompanying people questions related to dysmenorrhea system. Proctor and Farquhar (2006:1134) identified that history taking is a vital component of patient assessment because from interviewing the patient or their family, one can link the obtained information with signs and symptoms to conclude on the diagnosis. Once a diagnosis is made, the practitioner can determine the appropriate treatment (Musyimi et al. 2018). In addition, the study conducted in Kumasi Ghana by White (2015), confirmed that THPs do sometimes interview their patients in order to find out the history behind the illness, where they have been for treatment, and how long the person has been in that situation. The authors reasoned that this approach informs them of how to diagnose and treat the client. If the client is unable to speak, other family members speak on behalf of the sick person.

The Indigenous knowledge holders insisted that one can make a diagnosis of a patient, depending on how they have explained their illness or how the people accompanying them have explained.

Hence, Proctor and Farquhar (2006:1137) suggest that information about the onset, location, duration, and characteristics of pain, plus any aggravating or relieving factors, should be sought from the client. Thus, the patient's family history should also be sought in order to differentiate secondary dysmenorrhea from primary dysmenorrhea. Traditional health practitioners and indigenous knowledge holders reported that history of the illness from clients and families gives them a unique position to understand and heal the illness because they have a thorough knowledge and understanding of the problem and share similar customs and beliefs. In this regard, our study revealed that history taking is a reliable tool to make a diagnosis in women experiencing dysmenorrhea.

5.2.3.3 Subtheme 3: Divination as a diagnostic process

The findings revealed that divination was the most form of the diagnostic process that was identified from THPs. Divination is a means in which THPs consult the spirit world for guidance to diagnose and treat illnesses (Ozioma & Chinwe 2019). Among the Batlokwa THPs, the ability to diagnose illness through divination was considered as a gift from God the Supreme Being. The study revealed that ancestors, gods and other spirits who are believed to be the messengers of God are considered to have invested powers into THPs to diagnose all kinds of illnesses. Their type of training and belief systems influenced these. Truter (2007:58) revealed that divination makes it easy to identify the cause of illnesses and how to treat them. According to van Dyk

(2001), divination is also used to determine who is responsible for the illness and why the illness has occurred.

The data revealed that divination is diverse. For example, the Batlokwa THPs and IKHs attested that while the majority diagnose guided by throwing bones, others are possessed by the ancestral spirits in their dreams, and some may use both as spirits may possess them during the reading of the bones. However, it was noted that the divining processes follow a set routine despite been diverse. This finding indicates that all forms of divination or combination are effective in diagnosing dysmenorrhea. The Batlokwa THPs diagnosis process through divination consisted of (i) throwing of bones and (ii) dream analysis.

(i) Throwing of bones

Throwing of bones is throwing tools or objects of divination, during the consultation with a client, in order to identify the signs that provide diagnosis and appropriate advice and instructions (Lebaka 2018). The bones represent all of the forces that affect any human being, anywhere, whatever their culture (Cumes 2013). The THPs indicated that they use bones (*ditaola*) given and taught during initiation to arrive at a diagnostic consensus. According to the THPs, the bones “ditaola” are thrown on the floor, then, the THP interprets and understands the problem from how the bones fall. The THPs indicated that despite been taught how to read the fallen bones by their teachers during the training, the reading of the bones on the floor at times is guided by the ancestral spirits. The ancestral spirits talk to the diviner through the way the bones lay. The THP regards the position in which the bones have fallen as being influenced by the ancestors who are seen as directly involved in the whole procedure. According to Cumes (2013:63), only trained sangomas or inyangas (THPs) can be able to read or interpret the divination bones, which may comprise of animal bones, shells, dice, or any other objects to represent certain polarities. In Botlokwa, the diagnostic process using bones (*ditaola*) is locally known as *golaola*: it can take place where it is convenient for the client, but usually takes place at the healer’s homestead inside the ancestor’s house called “ndhumba”, under a tree or a veranda. According to Ross (2010:46), throwing of the bones is sometimes referred to in common parlance as a ‘floor X-ray’, because they are only interpreted when thrown on the floor.

According to the THPs during bone throwing, they communicate with their ancestors, and the client’s ancestors to determine the illness, causes of the illness and the therapeutic actions that need to be taken. A woman experiencing dysmenorrhea usually visits the THPs for consultation

and treatment. The THP will throw the bones to determine what, how, who and why she is experiencing dysmenorrhea, as well as the treatment regimen. The client and family members become part during bones throwing as they are supposed to breathe into the container holding the bones. According to the THPs, the bones recognise and connect with the ancestors of the client as she breathes into the container. Along similar lines, Lebaka (2018) confirms that through the throwing of divination bones, THPs can communicate with the spirits and determine things that are in the spiritual realm and why the patient is consulting. Using the bones to access the advice of ancestors in diagnosing a patient is a common practice in many African countries (Ozioma & Chinwe 2019). In support, Ramose (1999) notes that from time immemorial, African people have associated bodily and spiritual healing to their relationship with the living dead. Hence communication between the living and the living dead has always been vital. Ngubane (1977) argues that unlike consulting THPs, in the Western health system, the patient informs the doctor the reason for consultation in order to be diagnosed. Ramose (1999) notes that the bones are African diviner's diagnostic tools, and the stethoscope is a Western medicine diagnostic tool. The author further argues that the two ensue from different and contending paradigms of healing, none of which has prior and unquestionable superiority over the other. Ozioma and Chinwe (2018) documented that African THPs employ bone throwing and dream analysis as common diagnostic methods and tools in diagnosing people. Dream analysis as divination to diagnose dysmenorrhea is discussed below.

(ii) Dream analysis

A dream known as "*toro*" by Batlokwa ethnicity and is a message coming from the unseen world as a means of divine intervention. The Batlokwa THPs and some of the IKHs in this study considered dreams to be an essential aspect in diagnosing dysmenorrhea. The THPs believe that their ancestors and guiding spirits communicate with them in their sleep about whatever they find essential such as diagnosing and treating dysmenorrhea. They indicated that they are equipped with spiritual power and wisdom to analyse, interpret and uncover the messages from dreams. This is entirely consistent with some literature. For example, Mtuze (1999) discovered that amaXhosa believe that the dream is one way of communication between the living and the living dead hence ancestors send messages through dreams to their family members, telling them what ritual to perform to ensure wellbeing or to address a particular situation.

In addition, the participants in the study of the art to establish and maintain the contact with ancestors in Bapedi tribe observed that communication between the traditional healers and their

ancestors happens through dreams (*ditoro*) and music (Lebaka 2018). According to Lebaka (2018), Africans THPs use dream description and interpretation as an approach of diagnosing and treating because they claim that dreams serve the goal of wholeness by connecting the living with their ancestors. Lamla (1975:81) described that in traditional health, dreams have long been recognised as holding potential meanings or containing important messages from the ancestors and spirits. In this case, dreams are prophesying and reflecting a deeper reality, which needs divine intervention for analysis. Moreover, the Batlokwa THPs mentioned interpreting dreams as part of divination.

5.2.4 Theme 4: Treatment modalities

The treatment modalities are the use of both pharmacological and non-pharmacological approaches employed to reduce or eliminate the symptoms and causes of the illness (Gureje, Nortje, Makanjuola, Oladeji, Seedat & Jenkins 2015:172). Regarding treatment modalities, most participants considered dysmenorrhea to be a condition that can be treated through indigenous remedies and practices. The data suggested that traditional healers believe that if traditional medicine is administered to a person with dysmenorrhea, the aim is to heal by ensuring that it ceases to exist. The Batlokwa THPs and IKHs indicated that traditional health healing interventions treat dysmenorrhea effectively. However, traditional health practitioners indicated that there is a need to consult the ancestors with every patient that comes for treatment in order to receive spiritual guidance in terms of appropriate diagnosis and treatment. In this regard, the study discovered that what was perceived to be the cause of the illness, in a way, determines the treatment modality to be executed. This finding implies that the beliefs about the causes of dysmenorrhea influence the choice of treatment and methods. Bogopa (2010) in support of the above reasoned that it is because traditional medicine involves a combination of information, expertise and practices based on the ideas, opinions and views inherent in various values that are used to preserve health as well as to identify or treat physical and emotional wellbeing. Mji (2013) alludes that the treatment modalities employed by traditional healers are often in line with the traditional beliefs of the client and situated knowledge about the causation of dysmenorrhea and their general aim is to produce or eliminate the cause of the illness.

Drawing from the above finding, it was discovered that during the diagnosis process, the treatment modalities are also identified, assisted by the signs and symptoms, causes and type of dysmenorrhea. In this case, THPs and IKHs identified herbal and ritual performance (spiritual) modalities for the treatment of dysmenorrhea. This implies that apart from using the divination to

diagnose dysmenorrhea, these diagnostic processes are also used to identify the particular treatment modality that is appropriate for the individual woman. For example, the herbs or rituals that the indigenous healer is expected to use to treat dysmenorrhea will be determined through the use of the divination. This finding shows that there are typical treatments which reflect the beliefs and perceptions of people and family being treated and that of the healer. Fernández-Martínez, Onieva-Zafra and Parra-Fernández (2019) and Akiyama, Goren, Basurto, Komori and Harada (2018:1635) indicate that the activities engaged in the treatment of dysmenorrhea vary from healer to healer and according to the cause of illness and are culturally specific.

The inclusion of indigenous medicine and ceremony in care is a recurring discussion in the literature (Buwa-Komoren, Mayekiso, Mhinana & Adeniran 2019; Asuzu, Akin-Odanye, Asuzu & Holland 2019; Kim, Nam, Kim, Lee & Kim 2017; Sultana, Lamatunoor, Begum & Qhuddsia 2017; Sultana et al. 2016; Sanogo 2011). In line with this, 90% of the participants in the study on complementary and alternative medicine use for primary dysmenorrhea among senior high school students conducted in the Western region of Ghana, perceived complementary and alternative medicine methods and products to be effective in relieving the pain and discomfort associated with dysmenorrhea (Conney et al. 2019).

Unique to Western health care, the treatment modalities of dysmenorrhea discovered in our study claim to cure and prevent dysmenorrhea. A critical element to be considered is the THPs and IKHs' beliefs surrounding the power of the treatment modality to heal or cure the woman experiencing symptoms of dysmenorrhea holistically. This notion positioned Batlokwa THPs and IKHs as possessing healing power that provides a cure of dysmenorrhea than a Western health system. This may influence women to seek health care from THPs and IKHs in curing dysmenorrhea (Krah, de Kruijf & Ragno 2018:159; Asante & Avornyo 2013). According to the study participants, their treatment modalities for dysmenorrhea include prevention. In agreement, Lichtenstein et al. (2017:250) and Harfield et al. (2018) reveal that indigenous health and healing expand to the prevention and treatment of illnesses. The findings of our study revealed that for both prevention and cure the treatment could include the use of herbs/shrubs and rituals performance, at times combination of the two. Subtheme 1 (herbal modalities) and subtheme 2 (ritual performance) describe treatment modalities further

5.2.4.1 Subtheme 1: Herbal modalities

The data indicated that just like in any other type of healing, the Batlokwa ethnicity group has its treatment modalities for dysmenorrhea. All of the participating THPs and IKHs reported the use of herbal medicine as another modality for treating dysmenorrhea. They indicated that the herbal medicine they use is from plants in the form of trees, vegetables and shrubs growing in their community. According to the THPs and IKHs, the use of herbs is an illustration of how nature and environment are connected for the health and wellbeing of the people. Plants/herbal medicines have been practised for thousands of years before pharmaceutical companies began. The use of herbal medicine for the treatment of dysmenorrhea is not a new practice in South Africa. Semanya, Maroyi, Potgieter & Erasmus (2013:332) found that in traditional healing herbal medicines are commonly used, however, the preparations and routes of administration differ among practitioners. Generally, the use of herbal medicine for the treatment of dysmenorrhea among THPs and IKHs were reported in different studies such as Kim et al. (2017); Akiyama et al. (2018). Steenkamp (2003:98) revealed that there are 156 plant species that THPs in South Africa are using to treat more than one gynaecological complaint, whilst 44 species were found to treat dysmenorrhea. These medicinal plants and herbs grow in various environments across South Africa such as forests, mountains, gardens and rivers. Therefore, medicines from plants to treat dysmenorrhea form part of the South African Black identity and heritage.

It is also known that many of the pharmaceutical preparations used around the world are based on plants (Inoue, Hayashi & Cracker 2019). In support, Renzaho, Halliday, Mellor & Green (2015) attests that about 80% of people are reported to use traditional medicine from plants for various ailments. Moreover, many studies revealed that women suffering from dysmenorrhea prefer herbal medication to treat dysmenorrhea (Gao, Xiao, Jia and Wang 2019; Kim et al. 2017; Kashani et al. 2015), because of being natural and having fewer side effects. Moreover, Mokgobi (2014:30) believes that indigenous plants should be studied for both medicinal and spiritual significance.

All the participating women produced photographs of plants or and herbs that are used to treat dysmenorrhea, such as buffalo tree leaves and roots (Figure 5.3), bitter aloe leaves (Figure 5.2), guava tree leaves (Figure 5.1). However, it was identified that each practitioner might have his/ her unique blend of plants and herbs which are combined to treat dysmenorrhea. The literature review and different ethnobotanical surveys conducted in South Africa show that a series of medicinal plants are well known and used differently in the treatment of dysmenorrhea (Buwa-Komoren et al. 2019; deWet & Ngubane 2014; Semanya et al. 2013; van Wyk & Wink 2004; Steenkamp 2003).

The literature further revealed that in many rural African communities, several medicinal plants, including *Psidium guajava* Linn (Family: Myrtaceae), are used traditionally for the management, control and treatment of primary dysmenorrhoea. The study conducted in South Africa, to examine the spasmolytic effect of *Psidium guajava* Linn (Myrtaceae) leaf aqueous extract on rat isolated uterine horns, showed pharmacological support to the traditional use of 'guava' leaves in the treatment of primary dysmenorrhoea (Chiwororo & Ojewole 2009). The pharmacological effect of guava as treatment of dysmenorrhea was also discovered in the study of Doubova, Morales, Hernández, Martínez-García, de Cossío Ortiz, Chávez Soto, Arce and Lozoya (2007) conducted in Mexico. In this study, a randomised clinical trial study to assess the effect of a *Psidium guajavae folium* (guava) extract in the treatment of primary dysmenorrhea was done. Their findings showed that *Psidium guajavae folium* extract reduced menstrual pain significantly compared with conventional treatment and placebo. Refer to 5.1 for the photograph of guava leaves.

Steenkamp (2003:99) has alluded that South African women use bitter aloe for treating dysmenorrhea and other gynaecological complaints. Van Wyk (2008) study on aloe ferox gel and its constituents revealed that it contains at least 130 medicinal agents with anti-inflammatory, analgesic, calming, antiseptic, germicidal, antiviral, antiparasitic, antitumour, and anticancer effects. The medicinal agents such as anti-inflammatory, analgesics and calming may be the reason for its use in dysmenorrheal clients. Refer to 5.2 for the photograph of bitter aloe leaves.

The "mokgalo" (buffalo horn) tree roots are believed to have magical curative powers that are used for dysmenorrhea and infertility by Batlokwa THPs and IKHs. Buffalo thorn tree was found to have other medicinal value than treating dysmenorrhea. The leaves of buffalo thorn tree are chewed to make a poultice that is used to treat pulsating fontanel. Sometimes a poultice is applied to septic swellings of the skin. An infusion of the root is taken orally for dysentery (Rankoana 2012:184). It can also be used as a remedy for pain, treatment of boils, swellings and other skin infections (Coates Palgrave, 1984; Van Wyk & Van Wyk 1997).

The data revealed that there are many ways they employ to prepare these herbal medicines when treating dealing dysmenorrhea. Mostly they spoke of the medicinal concoctions. The information that was shared by the participants included the appropriate use, indications for the usage, preparation process, way of measurement and methods of administration of medicinal plants. Herbal medicine could be prepared for eating mixed with soft porridge. Most of the participants preferred to mix dysmenorrhea treatment with soft porridge. The preparation method of mixing plants decoction in the form of soft porridge is not a new practice. Arnold and Gulumian (1984)

discovered that the Vhavenda THPs most often prepare the traditional gynaecological treatment with soft porridge.

The participating THPs and IKHs explained that they use herbs to bath women experiencing dysmenorrhea in order to cleanse the body symbolically. Sanctified water focused on symbolic cleansing and purification of the body to break any psychosocial and spiritual factors that might be connected to or a part of the client's illness. The current study discovered that both THPs and IKHs use standard procedures when administering herbs for dysmenorrhea. They both use fresh or dry herbs. They either immersed the herbs in cold or hot water or make decoctions by boiling woody pieces for a specified period and filtered so that the client can drink the liquid. The dried parts are incinerated to ash, then sieved and added as such to water or food. Mixtures are sometimes prepared with more than one plant to enhance the effects of the composite plants (Ozioma et al. 2019). The procedures include vaginal douching and steaming, bathing, inducing body sweating through steaming, inducing vomiting by ingesting herbs and sneezing by snuffing dried medicine. Ngobe (2015) found that instilling of herbal nasal, use of oral medicine, bathing or washing with herbal water, burning/inhabiting of herbs were interventions employed by traditional healers. This resonates well with the literature that documents the healing power in medicinal plants (Che & Zhang 2019; Czompa, Szoke, Prokisch, Gyongyosi, Bak, Balla, Tosaki & Lekli 2018; White 2015). Taking from the above discussions, it is evident that the Batlokwa tribe value of using medicinal plants in treating dysmenorrhea is in line with other tribes around the world.

To protect clients from being overdosed or poisoned during herbal treatment, the World Health Organization prescribed procedures to be used when preparing herbal medicine. These procedures include advanced cutting and comminution (fragmentation), ageing, sweating (fermentation), baking/roasting, boiling/steaming, stir-frying and primary distillation. Technical information on these primary processing procedures is applied during the post-harvest processing as elaborated on in the current GHPP guidelines (WHO 2018:84). This implies that the properties of the herbs, as well as their taste and toxicity, are essential because herbal medicine safety and efficacy depend on their quality. Moreover, the World Health Organization provides technical support to monitor and ensure the safety, quality and efficacy of herbal medicines. The finding affirms the Mulaudzi (2007) argument that traditional medicine is an important part of the everyday life of people in African communities. This is a valuable contribution to the field of African ethnobotany.



Figure 5.1. A picture of guava leaves



Figure 5.2. A picture of bitter aloe leaves

In addition to the use of plants/herbal modalities when treating dysmenorrhea, THPs and IKHs mentioned the use and benefits of rituals' performance as a treatment modality. The performance of rituals is discussed next as subtheme 2 for treatment modalities.

5.2.4.2 Subtheme 2: Performance of rituals

As was indicated earlier, the second treatment modality of dysmenorrhea by Batlokwa THPs and IKHs involves the performance of some rituals. According to the THPs, rituals are performed because the Batlokwa ethnicity believes that for the treatment to be effective, they should communicate and appease their ancestors. The traditional health practitioners and indigenous knowledge holders strongly believe that adherence to the cultural rituals is a strategy to cure dysmenorrhea. These rituals are performed in constant liaison with the ancestors and are believed to assist in bringing positive change on the part of the dysmenorrheal woman. This type of dysmenorrhea treatment is believed to be an assurance that it attracts good fortune; hence, a woman falls pregnant after a ritual performance. It was evident that during rituals performance, the client and family emotions are linked to the spirits and environment to enact the healing process (Rodriquez & Lopez 2019:56).

The study discovered that these rituals in healing dysmenorrhea might involve casting away the bad spirits that are causing dysmenorrhea. Whilst some are performed to amend impurity or uncleanliness that were missed in childhood, menarche, childbirth, miscarriage and after death as the THPs and IKHs believed that not observing these rituals might have attracted witchcraft and caused dysmenorrhea. As such, the rituals are neutralising the bad luck caused by witchcraft (White 2015). The traditional health practitioners and indigenous knowledge holders indicated that in the treatment of dysmenorrhea, Western health approach seldom satisfies the client's beliefs and expectations, THPs are usually consulted to perform the necessary rituals. Therefore, the Batlokwa women experiencing dysmenorrhea may regard Western health approach ineffective if not accompanied by rituals to deal with the causes of dysmenorrhea (Rodriquez & Lopez 2019:56).

According to White (2015), rituals are spiritual interventions that are usually performed in an attempt to appease the ancestors, to create peace and harmony between the living and the spiritual world. Mkhize (2008) believes that harmony can be restored utilizing rituals and other processes, leading to good health. Moreover, Rodriquez and Lopez (2019:56) suggest that patients' emotions must be linked to transactional symbols in the form of rituals to enact the healing process. Broom, Booth and Schubert (2012) reason that it is because there is a connection

between internal body dynamics and external interpretations given to illness, as such rituals should be performed following a particular pattern repeatedly to achieve healing. The study that explored the role of rituals in symbolic healing through a close examination of the speech patterns and actions performed by a healer in a Chol Maya aimed at curing a woman of *kisin*—the “embarrassment-sickness.” It was noted that the healer performed rituals to restructure the patient’s body, which has been unstructured by the disease (Rodriguez & Lopez 2019:42). White (2015) indicated that in Africa, divine and ancestral sanctions are considered necessary before and during the preparation and application of medicine. This means that sometimes rituals are performed in order to consecrate some herbs.

The presented photographs (Figure 4.10) identified sacred places such as ancestral hut, rivers, mountains, specific trees as places where rituals are performed. It is not surprising that many of the customs and ceremonies are performed in a sacred place. Frese and Gray (1995:32) cited in Dafni (2007:2) disclosed that there are rituals, ceremonies and customs that are performed under trees that are considered sacred. These trees and their meanings may be incorporated into rituals of curing, initiation, marriage and death. In Botlokwa “mokgalo” (buffalo thorn) tree was found to be sacred and honoured for performing rituals when treating dysmenorrhea. According to THPs and IKHs, the tree has a hook thorn on one side of the branch and a straight thorn facing forward, which resembles one’s past and future (see Figure 5.3). The participants believe that the hook thorn tells you to put the past behind you and the straight thorn tells you to move on and keep looking forward and never backwards, hence after the rituals the client is told to walk away and not to look back. Buffalo thorn tree was found to be very popular in various cultural rituals and beliefs (Long 2005). Zulus use branches of buffalo thorn tree to attract ancestral spirits to new dwelling sites or to place on the graves of chiefs and kraal heads after burial and fed to cattle to understand that the owner has departed (Hutchings 1996). Swazi people use branches from the buffalo thorn tree to protect their graves from wild animals (Tredgold 1986: 138). According to SANBI (2012), a buffalo thorn tree indicates the presence of water underground and has magical properties to repel evil and evil spirits. Trees used in any of these contexts stand for the divine and represent the sacred beliefs being honoured through the ritual (Dafni 2007:2).

Rituals spaces such as Ndumba, rivers (pools), forests, caves and mountains were recognised as sacred spaces by Botlokwa THPs and IKHs. The ritual ceremonies performed in Botlokwa for dysmenorrhea may differ from those that are practised in other regions. According to Mensele (2011), Basotho nationality often use caves and mountains to perform their most prominent rituals such as the initiation rite which is one of the most sacred ritual activities among the majority of

African Communities. This finding highlights the fact that curative care provided by THPs and IKHs is comprehensive and has curative and protective elements. This finding also confirms that there is a scientific basis for many African traditional medicine practices.

Meanwhile, participants' photographs and discussions directly addressed local connections to the environment and spiritual life. The modified Lekgotla discussion participants' responses to the photos very palpably illustrated the pride the photographers took in their local environment and connected it to the land on which they live. These demonstrated the utility of photovoice in facilitating THPs and IKHs to articulate what was most important in being knowers of dysmenorrhea.



Figure 5.3. A picture of buffalo thorn leaves and hooks

5.2.5 Theme 5: Roles of THPs and IKHs in the treatment and prevention of dysmenorrhea

The study discovered that the roles of Batlokwa THPs and IKHs were mostly seen in diagnosing and treating indigenous dysmenorrhea. The participating THPs and IKHs indicated that they offer indigenous health care to the community members. Data revealed that indigenous health care services were very comprehensive and include diagnosing, curative, preventative, prophylactic, health education, counselling and role modelling. According to THPs and IKHs, the curative role was provided through primary health care by understanding the human conditions and the type of treatment they offer to patients, which is holistic. In line with this finding Rankoana et al. (2015)

alluded that South Africans prefer to use indigenous treatment as primary health care. In support, Alexander, Provencher, Henri, Taylor and Cooke (2019) and Iloka (2016) echoed that IKHs hold valuable knowledge that can be used to eradicate some of the problems that the world is facing at primary level. Nemutandani et al. (2018) noted that people use THPs as their first line of health care. As such, the IKHs and THPs in Batlokwa ethnicity are considered an essential part of the health care system, understood as consultants and physicians to diagnose and treat illnesses.

The study established that the Batlokwa THPs and IKHs' roles were not only to treat dysmenorrhea and other illnesses. Their treatment involved protection and prevention from illnesses or reoccurrences and other fates of life such as witchcraft. In this case, the view expressed by many THPs and IKHs was that a girl child should receive preventative treatment immediately after birth and at menarche. Failure to do so was associated with the development of gynaecological problems such as dysmenorrhea later in life. The preventative factors echoed by THPs and IKHs were discovered to occupy a substantial part of the Batlokwa health practices and to be the most common reason for the women experiencing dysmenorrhea consulting THPs and IKHs to prevent the symptoms from recurring as the Western health system does not prevent the symptoms from recurring. Mokgobi (2014:32) alludes that THPs and IKHs are very resourceful and play a pivotal role in many spheres of the people's lives despite diagnosing and treating illnesses. In addition, Nemutandani et al. (2018) indicate that the roles of THPs and IKHs in the South African communities as knowers of indigenous illnesses, are comprehensive and long acknowledged by the population despite being colonised for many years.

The Batlokwa THPs and IKHs' responsibilities were mostly seen in diagnosing and treating dysmenorrhea. The data revealed that the roles of Batlokwa THPs and IKHs are found to go far beyond diagnosing and treating illnesses. They were found to be supportive and responsible towards the women who are experiencing dysmenorrhea in their healing journey so that the process becomes easy and for the treatment to function effectively. They offered support by giving advice, health education and monitoring the client's actions throughout the indigenous healing process. The health education given included the prevention and promotion of good health. This is entirely consistent with the study conducted among the British Columbia First Nations Elders (FNE).

Moreover, knowledge keepers in British Columbia, where the FNE and knowledge keepers were found, play a supportive caregiver's role in the health and wellness journey (Gallagher 2019). The traditional health practitioners and indigenous knowledge holders in our study highlighted that as role models, they are always responsible and accountable to behave well (Gallagher 2019:6). The

advice of the THPs and IKHs is integrated into the moral concepts and beliefs prevailing in the society. Therefore, they are considered effective in social control.

Many THPs alluded that they are skilled in interpersonal relations and counselling, and they assist individuals with personal problems. They give advice which endorses popular sentiments and inspires a sense of justice and security in the traditional way of thinking and living in the village. This finding is supported by Ahlberg (2017) who indicates that THPs are 'medical knowledge storehouses', offering treatment for dysmenorrhea, educating community members about traditional culture. Mills, Cooper and Kanfer (2005) outline that THPs do not just offer medicines and rituals; more often they serve as counsellors, psychologists and social workers.

The THPs and IKHs in this study referred to themselves as role models whom people can look to as reference points for different things. The women in our study modelled responsibility and accountability. They also spoke of their services within the communities and within the traditional world as being respected and trusted by the people they serve. This is similar to the study in rural Mozambique, in which traditional healers were found to be more respected and trusted by the patients diagnosed with HIV (Audet, Salato, Vermund & Amico 2017:7). In addition, Mufamadi and Sodi (2010) and Gallagher (2019:6) pointed out THPs and IKHs hold an esteemed and influential position in societies, as such are considered good role models to many people in their communities.

The roles of THPs and IKHs in our study included teaching and sharing indigenous knowledge of dysmenorrhea and other illnesses. The photographs that were discussed pointed to the need for the community to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. An overwhelming majority of THPs and IKHs identified educating the young girls and women on menstruation and other gynaecological issues as extremely important. Not only essential for each individual, but also the good of the greater community. In this regard, the Batlokwa THPs and IKHs were found to teach the women and family members about good menstrual management. Drawing from the data, the emphasis was found to be placed on primary health care to promote and prevent the occurrence of illness through community participation. Most THPs and IKHs indicated that previously there were traditional schools in their community, where the young girls were taught about menstruation, problems associated with menstruation and on how to manage both. The researcher believes that since this is no longer mandatory to be observed in the community, the elements of indigenous dysmenorrhea need to be integrated into the mainstream school syllabus. Clarity may be required from the Indigenous Knowledge System

where necessary. Nmutandani et al. (2018) believe that indigenous values and cultural practices can still be re-centralised because some patients still prefer indigenous health medicine and practices. Maluleka and Ngoepe (2018) attest that indigenous knowledge was shared through teaching and learning from one generation to another through oral tradition. Therefore, it is essential to share knowledge and maintain it for future generations. Laudon and Laudon (2016) see the sharing of knowledge as a cornerstone that assists in developing and managing problems. Hence, this study developed and documented the strategies to empower the Batlokwa women with dysmenorrhea knowledge. Documented indigenous dysmenorrhea materials will be useful to the Africans who did not wholly adopt the Westernized health care.

On the other side, the THPs and IKHs serve a positive role as patient health advocates, and in the process, patients gain greater control over decisions and actions affecting their health. The participating women discussed the role of empowering in terms of educating indigenous dysmenorrhea. In South Africa, THPs and IKHs trained to assist in the control of mental illness were found to have a significant increase in knowledge, management strategies and referral systems beneficial to the patients (Audet, Ngobeni, Graves & Wagner 2017).

What is unique and essential with this theme is that Batlokwa THPs and IKHs are equipped to treat and handle dysmenorrhea and other responsibilities that may arise during the management of dysmenorrhea. Examining these roles perceived power in the diagnosis, treatment and prevention of dysmenorrhea in Botlokwa. Therefore, developing strategies to empower the Batlokwa women with dysmenorrhea knowledge from the roles that are displayed in this study are culturally relevant.

5.3 SUMMARY OF THE CHAPTER

This chapter discussed the findings of Phase 1 concerning available literature. The discussion reflected the study's aim and objectives. All these discussions speak to the photographs that were produced by the participating women and from the in-depth interviews with the participating women. Despite the shortcomings of photovoice methodology, the use of photovoice in this study provided benefits that extend beyond the initial aim of the research. First, the method enhanced the quality and credibility of research findings by allowing the research to receive the first-hand discussion from the Batlokwa THPs and IKHs.

The study found that participants were willing to share their knowledge and perspectives regarding dysmenorrhea. Many of the participants expressed excitement to finally have their voices heard, as

they articulated frustrations with the health care system in South Africa. Furthermore, this study introduced both THPs and IKHs to photovoice and the potential it has to serve as a change agent, bringing awareness to issues, and a means of inquiry-based learning.

The discussed themes revealed the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among the Batlokwa women living in Limpopo Province, South Africa. The results demonstrated that the belief systems and practices of Africans play a crucial role in naming, defining, diagnosing and treating dysmenorrhea. The study adds substantially to a limited body of evidence on the management of dysmenorrhea in Batlokwa ethnicity. The evidence was used to highlight the need for empowering women with menstruation and the problems associated with menstruation knowledge, particularly dysmenorrhea. Generally, the discussion of the findings argued that dysmenorrhea is an illness that women suffer during menstruation and should be approached holistically based on the socio-cultural understanding of the community. The discussion further highlighted the importance of naming and defining dysmenorrhea in a local language that is well understood by the local people. Thus, considering how signs and symptoms are identified, named and defined. In addition, finding reasons for the cause of dysmenorrhea and connecting them to form categories or types of dysmenorrhea concerning the terms and phrases that are used by the community members. The discussion included how dysmenorrhea is indigenously diagnosed and treated. The discussion included the roles of THPs and IKHs in diagnosing and treating dysmenorrhea indigenously.

On completion of writing up this chapter, the researcher re-visited the participants to discuss the first level of findings after data analysis, prior to aligning and refining of the findings with Africana Womanism theory. The researcher described the process followed in linking the study findings to other studies. The researcher clearly described the similarities and differences between the current findings and literature. The intentions of aligning and discussing the study findings with Africana Womanism theory, prior to the development of strategies, were also discussed with the participants. The participants agreed to the presented findings and further intentions, although they requested the researcher to indicate that their treatment modalities go hand in hand with a preventative element. This point was then added to the discussion of theme 4.

The next chapter discusses the findings based on the Africana Womanism theory that guided the study and assisted in the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge.

CHAPTER 6
DISCUSSION OF THE FINDINGS IN ALIGNMENT TO THE AFRICANA
WOMANISM THEORY

6.1. INTRODUCTION

The previous chapter discussed the findings of Phase 1 in relation to relevant available literature in order to relate and embrace the gathered knowledge with what is already known. As the previous chapter indicated, there is a substantial amount of research literature that supports the findings of this study. There are also significant connections between the study findings and Africana Womanism theory that was used to support the study. This chapter discusses the empirical findings in relation to Africana Womanism theory. The theory was used in order to look at how themes and sub-themes from the study findings can be aligned to the characteristics of the theory. This theory acts as a framework for the drafting and developing strategies to empower the Batlokwa women with dysmenorrhea knowledge.

6.2. AN OVERVIEW OF AFRICANA WOMANISM THEORY

The empirical study used the Africana Womanism principles to explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. The Africana Womanism consists of 18 characteristics that stand out as pillars for this theory. These characteristics are interwoven and embedded with each other. Out of 18 characteristics of Africana Womanism, 13 were identified to assist with the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge (Refer to Chapter 2, for the description of Africana Womanism theory in detail). The decision to use Africana Womanism theory was drawn from these characteristics as summarised in Table 2.1 and explained in Section 2.4.3 (Chapter 2). Table 6.1 summarises the Africana Womanism characteristics that are relevant to the current study (Hudson-Weems 1993; 2001; 2004).

Thirteen characteristics of Africana Womanism that are relevant to this study were included in the discussion. These characteristics include – self-naming; self-definition; genuine sisterhood; family centredness; strength; respect; recognition; respectful to elders; adaptability; mothering; nurturing; wholeness and spirituality. While each of these characteristics was clearly identifiable as independent themes within the literature, the interdependence between characteristics was also evident.

Table 6.1. Summary of Africana Womanism characteristics that are relevant to the current study

CHARACTERISTIC	DESCRIPTION
Self-naming	This characteristic discusses the importance of proper naming for self-identifying by African women in a society.
Self-definer	Entails own description and definition of realities that African women face, with no particular allegiance to existing ideals.
Genuine sisterhood	Its emphasis is on the strong reciprocal relationship that African women have. The relationship is genuine because a Black woman goes through the same experience of oppression and can therefore empathise with the other.
Family centredness	It describes the interests of an African woman within families and community. It is also about the success of a black community as a whole and maintains a sense of wholeness.
Respect	Respect refers to reverence an African woman has for her self-esteem and self-worth that enables her to have a complete and positive respected relationship with people.
Recognition	The characteristic of recognition refers to the acknowledgement of humanity, capability, and power of Black women.
Respectful of elders	Describes the value and benefits of respecting and appreciating elders in the African communities.
Strength	The characteristic of strength present how the African woman has preserved centuries of physical and emotional struggles for herself, family, community and African people at large.
Adaptability	The characteristic of adaptability presents how African women adapt to different environments, without demanding a separate place for nourishing her individual needs and goals.
Mothering	This characteristic position an African woman to play an active role in the rearing and caring of the community activities.
Nurturing	Nurturing is the caring aspect that goes hand in hand with the characteristic of mothering.
Wholeness	The characteristic of wholeness describes the importance of self-sufficiency (Wholistic) that an African woman must have in order to upkeep her household and Black nation as a whole. It represents the African woman's needs to connect to her culture.
Spirituality	This characteristic of spirituality is based on the belief system of the African woman, which believes in higher power that transcends rational ideals, and it is an ever-present part of Africana culture.

Hudson-Weems 1993; 2001; 2004

6.3. RELEVANCE OF AFRICANA WOMANISM TO THIS STUDY

Africana Womanism rests on the potential it holds as a theoretical framework with multiple cultural perspectives and characteristics to support the marginalised African people through participation and involvement during the construction of knowledge (Gilliam 2013). Although an African American intellectual coined it, this study used the Africana Womanism theory to represent strengths and values that are carried by the indigenous knowledge. Africana Womanism is a relevant critical theory for this research as it is an African centred paradigm that locates Africa at the centre of analysis of issues that relate to Africana women (Hudson-Weems 2004). The use of this theory was key to my study as it allowed the projection of women's voices, often muted in the African racial society. Consequently, these women were empowered, especially THPs and IKHs (Ntiri 2012). Zuma et al. (2018) argue that it is vital that scholars make sure that the voices of rural community members who are in these groups are heard.

Looking into the characteristics (pillars) of Africana Womanism, South African, and other African women's voices are centralised in understanding how they perceive and treat illnesses indigenously (Hudson-Weems 2004). As this study was concerned with Batlokwa women's indigenous knowledge, the Africana Womanism theory was similarly able to act as a vehicle for the positive representation of their perspectives and treatment of dysmenorrhea. The theory assisted them in self-naming and defining (Hudson-Weems 1998). This enabled us to understand African women's reality, identity and dynamics of empowerment. Africana Womanism theory was a viable framework to use in this study because it placed South African women at the centre of the analysis and allows researchers to explore the variables of race, gender and culture from Batlokwa's unique socio-cultural indigenous health and healing perspectives (Moshabela et al. 2016). Therefore, understanding of the indigenous beliefs and practices of clients regarding health issues is essential in ensuring effective health promotion strategies.

What made Africana Womanism theory more relevant in this regard was that it looked at women in the context of African culture and worldview (Hudson-Weems 2001). Acquiring knowledge from cultural perspectives is important because culture gives people identity, purpose and direction to choose what to practice and exchange with the world (Karenga & Tembo 2012:35). Although still challenging, Masenya (2004) and Chilisa (2012) have taken on the critical yet

daunting task of making theories relevant to African reality. Harvey (2013:81) analysed the role of spirituality and Africana Womanism in the self-management of chronic conditions among older African Americans successfully, to develop the self-management intervention designs aimed at assisting older African Americans.

In this study, Africana Womanism theory offered platforms for Batlokwa women to generate indigenous knowledge of dysmenorrhea and the authority they have over health and healing. Knowledge was explored from the participants in Batlokwa culture. This fitted well into Freire's (1970) notion that the oppressed should be involved and participate in dialogues to improve their lives. Thus, only a theory by, about and for Africans can help explicate the room Batlokwa women have always had in generating knowledge for managing dysmenorrhea. Masenya (2004) argues that this knowledge is deeply rooted in cultural socialisation. This complements Karenga and Tembo (2012:40) viewpoint that the African woman is culturally grounded. Thus, she extracts lessons from knowledge and practices and uses them in enriching ways.

Furthermore, Africana Womanism validated Black women's interpretive capacities that are shared through women-to-women networks and acknowledged personal expressions to represent Black womanhood (Hudson-Weems 2001). In addition, Africana Womanism theory was also used because Ebunoluwa (2009:230) argues that this theory tends to offer a more far-reaching analysis by advocating for the inclusion of traditionally oppressed and marginalised Black women. Drawing from this idea, it was particularly relevant to analyse the specific perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women as portrayed in this study.

It was also noted from the literature that few types of research had studied the application of Africana Womanism theory in understanding the relationship between women and indigenous health care (Ntiri 2001; Masenya 2004; Makombe 2018:121). Thus, the contribution of this theory is critical not only to understanding experiences of oppression that affect Black women in general but projects women's interpretive capacities to communicate, represent and share their identities (Ntiri 2012). Furthermore, as Africana Womanism theory deals with the significance of women in the African community, it allowed Batlokwa THPs and IKHs women to demonstrate their indigenous health knowledge (Oyěwùmí 2016). Therefore, in the context of my study, I

used African Womanism theory in order to highlight particularly racial discourses surrounding South African women.

6.4. ALIGNMENT OF THE FINDINGS TO THE AFRICANA WOMANISM THEORY

According to Oyěwùmí (2016:220), the vision of Africana Womanism theory is to appropriate cultural beliefs and practices within African communities to other existing worldviews. The characteristics of Africana Womanism were developed to situate culture at the centre of discussion in Africans (Mkhwanazi & Ramose 2005:167). The Africana Womanism theory was used during the empirical study to assist with understanding and providing a unique insight into indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women.

Firstly, the researcher during data analysis kept on asking herself this question: Do Black South African women's indigenous health knowledge fit within the realm of Africana Womanism and health care? The emerged themes matched well with the characteristics of Africana Womanism theory that influence how African women see their world. The discussion of the themes in relation to Africana Womanism theory provoked the relationship between the two. The discussion showed interrelationships between the study findings and Africana Womanism characteristics, in which thick meanings emerged as themes. It is from these common units and meanings that strategies to empower the Batlokwa women with dysmenorrhea knowledge are presented in Chapter 7. It was clear that the Batlokwa ethnicity's point of view regarding dysmenorrhea concerns Africana Womanism theory. Refer to Table 6.2, for the summary alignment of 13 characteristics of Africana Womanism theory and five themes derived from the empirical study.

Below, the 13 characteristics of Africana Womanism are harmonised with the five themes of the empirical findings to clarify the relationship between the characteristics and findings. However, due to the nature of the Africana Womanism theory, the characteristics are interrelated, interwoven and nested into each other to identify and describe the relationship. Moreover, most of the characteristics were discussed in pairs. The following discussions illustrate the application of the Africana Womanism theory to the current study findings.

- **Self-naming and self-defining**

The power of self-naming and self-defining underline the central components of Africana Womanism (Hudson-Weems 1993). This was evident in theme 2, in which Batlokwa women correctly positioned themselves by giving dysmenorrhea a name that considered cultural beliefs and practices that are familiar in their community. For example, referring to dysmenorrhea as “selumi” considered their local language. When translating this word “selumi”, it means something that bites, which in this case is relevant, as “selumi” describes the stabbing cramps and excruciating pain inside the uterus during menstruation. It pointed to the character and signs and symptoms of dysmenorrhea. This is commensurate with a study conducted by Matsheta and Mulaudzi (2008:108) on cancer care where the participants named cancer sesepidi- something that moves. The movement denoted or resembled the malignant nature of the disease. The naming is self-defining according to their understanding and language that they are familiar with, rather than using foreign concepts that are difficult to understand (Hudson-Weems 2004).

The factors that contribute to self-naming and self-definition point out to the fact that the Batlokwa women can recognise a woman who is experiencing dysmenorrhea by observing signs and symptoms. Through connecting words, terms and phrases to the definitions, Batlokwa women were able to self-name and self-define dysmenorrhea based on their cultural understanding of the symptoms and characteristics observed from women experiencing dysmenorrhea.

It was also recognised through self-naming and self-definition that they find reasons for the cause of dysmenorrhea and seeing “*selumi*” (dysmenorrhea) beyond the biological dimension. Through self-naming and self-defining, they were able to construct and connect two types of dysmenorrhea. In this regard, self-naming and self-defining dysmenorrhea as “selumi” and connecting the names and descriptions assured Batlokwa women of their identity and ability to diagnose and manage dysmenorrhea. Hence, it was found imperative to empower the Batlokwa women with dysmenorrhea knowledge based on their local views of dysmenorrhea. Thus, it is essential to consider self-naming, types, signs and symptoms in developing effective health education of dysmenorrhea in Botlokwa, Limpopo Province and other rural areas (Matsheta & Mulaudzi 2008:112).

Closely related to this self-naming is the description of “selumi” as a self-definer. Hudson-Weems states that “the Africana womanist also presents herself as a *self-definer*; she alone defines her reality” (1993:57). Self-defining, as in theme 2 of our study, describes Black women’s ability to define the originality of dysmenorrhea in their own words and understanding. This implies differentiating self-knowledge from other similar health and healing activities that do not place her socio-cultural understanding at the centre of recognition. Therefore, the insistence on self-naming and self-definition is not only crucial for self-affirmation, but it also wrestles power away from those who have for a long time marginalised Black women through the use of terms and words that were difficult to understand (Hudson-Weems 2004).

When critically unpacking self-naming and self-definition of dysmenorrhea in this study, it was realised that to self-name corrects hierarchical perspectives that marginalise Black women. Although self-naming and self-definition represent different concepts in Africana Womanism, they interconnect ideas that are united to explore the African woman’s identity. Since self-naming involves defining self, based on cultural beliefs and practices, it promotes flexibility to modify, reshape and reclaim self, following the belief system. According to the study findings, self-naming and self-definition are intertwined, and neither ultimately determine the other, but local language use is a significant indicator of the two. Moloko-Phiri, Mulaudzi and Heyns (2016:245) indicate that language is at the core of the description and interpretation of reality to produce meanings and to understand people’s lives. Whalen, Moss and Baldwin (2016) maintain that language maintenance and revitalisation efforts have positive effects on physical and communal health among indigenous populations. In this regard, self-naming and self-defining respect and promote the local language in which the women will understand the dysmenorrhea information easily. Therefore, self-naming and self-defining in a local language endorse a vital step in the process of awakening and recovering community resources to be utilised at primary health care level, in particular dysmenorrhea knowledge.

- **Genuine sisterhood and family centredness**

Africana Womanism theory emphasizes the role of women in general, but it mainly focuses on the importance of the sisterhood among women (Hudson-Weems 1993). According to Hill (1998), Africana woman is a Black woman who is family orientated rather than individual, who

focuses on race and class empowerment before gender empowerment. Therefore, she prioritises sisterhood and the entire family (Hubbard 2010).

Africana Womanism theory advocates for sisterhood, which is much needed for the survival of women in a male-dominated society (Hudson-Weems, 2001). Worth noting is that Batlokwa women, likewise, support one another when experiencing dysmenorrhea. Evidence from the finding of using the metaphor of process and journey and connecting dysmenorrhea to other gynaecological problems indicated that when Batlokwa experiences dysmenorrhea, they seek counsel from other women, either in the family or with THPs and IKHs for treatment.

The findings of this study in theme 1, theme 3 and theme 5 connect to Africana Womanism through the recognition of genuine sisterhood and family centredness. Seeking counsel from other women has always been a practice carried by African women in support of each other (Hudson-Weems 2004). Ramathuba (2015) made reference by indicating that among Vha Venda in Limpopo Province, women elders, aunts (Vho-Makhadzi) and girl peers genuinely teach and support young girls with menstrual issues and womanhood through social activities such as khombani, domba, vusha and musevhetho. In this regard, it is crucial to involve families and other women in the community in respect to how dysmenorrhea is perceived and managed.

In African culture, the family is the basic unit of society. Just like any other African group, the Batlokwa are a family-centred people and central to the family is the sisterhood orientation. Since Batlokwa women are family-centred, they are concerned with the welfare of the entire family, which may extend to the community whenever there is a need. Theme 1, subtheme one that is meaning making using the metaphor of process and journey connected to women's health, cemented the idea that Africana Womanism is family orientated (Gilliam 2013). These were realised as participants were describing the meaning of indigenous dysmenorrhea. For example, the finding indicating that a woman experiencing dysmenorrhea does not walk the journey alone was used intentionally to define the characteristics of family and sisterhood. According to Alexander-Floyd & Simien (2006) sisterhood in Africana Womanism has to be genuine and is genuine through the fact that Black women go through the same experience of oppression and can therefore empathise with one another in any hardship. The characteristic of genuine sisterhood, therefore, was found to serve as a network that proposes relationships between African women, in order to offer emotional strength to the women experiencing

dysmenorrhea. The thrust of the finding's arguments is that illness and healing in African people are not concerned with the individualism but expand to the family and community at large (Hudson-Weems 2001). In this regard, family members, THPs and IKHs are therefore part of holism and accompanists in supporting a woman who experiences dysmenorrhea.

The characteristic of genuine sisterhood and family centredness was also realised in theme 3, subtheme 2, in which family members are part of the diagnostic processes. Family members are to accompany a client during the consultation and offer support throughout the treatment. Therefore, when developing strategies to empower Batlokwa women with dysmenorrhea knowledge, it is important to involve family and community members to support women who are experiencing dysmenorrhea. The roles that are played by the THPs and IKHs in theme 5 explain the sisterhood relationship that is practised within the community. The support that is offered to the women experiencing dysmenorrhea throughout the diagnosis and treatment processes caters for cultural values, norms, beliefs and practices (Karenga & Tembo 2015:43). Therefore, the notion of "genuine sisterhood" among Batlokwa women is demonstrated through the support that is offered during menstruation and the problems related to menstruation.

- **Respect, recognition and respectful of elders**

The findings in theme 5 reveal the importance of respect and obedience. Since respect for the elders and community is part of the heritage of Africa, especially women, respecting the roles that THPs and IKHs play in managing dysmenorrhea was found appropriately connected to the characteristics of respect and respectful of elders. According to Mokala (2020), respect assists the African woman to develop strength and adapt to demanding situations. Recognition plays a large role in keeping communal peace and ensuring Black women's effectiveness in the struggle for equality. This view concurs with that of Africana Womanism theory that the African woman is a role model in the struggle to regain respect, reconstruct recognition, and create cultural integrity (Hudson-Weems 2004). Ntiri (2012) also intimates that within the African woman's circle, respecting and recognising self is distinct in order to achieve uncompromised self-esteem, self-worth and self-love. In addition, theme 5 defines how the community members recognise and respect the roles and importance of THPs and IKHs, not only for the gynaecological issues but in general, including role modelling in many aspects.

Characteristics of respect, recognition and respectful to elders are also identified throughout theme three and its sub-themes. The various diagnostic processes that are carried out respect and recognise the belief system of the Batlokwa women regarding dysmenorrhea. Boot and Lowell (2019) and Davy, Harfield, McArthur, Munn and Brown (2016) maintain that people participate in healthy activities that reward them with respect and recognition. Moreover, respect, recognition and respectful to elders remain the underlying issues at the core of the Batlokwa women knowledge of dysmenorrhea, diagnosis, healing and management processes. Thus, for the Batlokwa women to be empowered with dysmenorrhea knowledge, their diagnosis, healing and management processes should be recognised and respected.

According to Zuma et al. (2018), recognition and respect are necessary to improve healthcare-seeking behaviour and decisions based on local knowledge. Theme 4, which discusses treatment modalities of dysmenorrhea, was found critical in ensuring recognition and respect for understanding the cultural practices of Batlokwa women (Mokala 2020). In addition, Zuma et al. (2018) indicate that recognising and respecting knowledge and practices of treatment modalities in the community positively impact on the local resources. It is, thus, essential to recognise and respect treatment modalities through identifying possible specific roles of treatment modalities of dysmenorrhea utilised in the care and treatment of Batlokwa women. This will assist in improving the quality of dysmenorrhea information to empower Batlokwa women.

- **Strength and adaptability**

As already mentioned in chapter two of this thesis, Alexander-Floyd & Simien (2006:70) emphasise that strength is one of the unique characteristics of the African Woman. Hudson-Weems (2001) states that the characteristic of strength is often the one that is attacked by non-Africana oppressors because their goal is to force submission upon the powerful group that is Africana women. The finding of using the metaphor of process and journey, connecting dysmenorrhea to other gynaecological problems in theme 1 embraces the strong character of an African woman. The explanation of this metaphor demonstrates the strength and adaptability that Batlokwa women embrace when they experience dysmenorrhea. This was identified when the Batlokwa women indicated that in some of the women, dysmenorrhea is a process that affirms womanhood and fertility. However, according to Karenga and Tembo (2015:42), mothering is an element of strength that guides African women in adapting and making

decisions and choices for their lives. In this study, it refers to the strength the Batlokwa women adapt to when dealing with dysmenorrhea.

Using the metaphor of the journey to empower Batlokwa women with the dysmenorrhea knowledge, may help them to describe and make sense of dysmenorrhea regarding signs and symptoms, types, diagnosis, treatment and management. This will contribute to better understanding, awareness and self-control regarding dysmenorrhea (Semino et al. 2018). According to Sinnenberg et al. (2018), metaphors are used in the health care system for the community to understand illnesses and diseases, so that they adapt quickly to the condition when diagnosed. On the other hand, the metaphor of a journey explains the experiences of dysmenorrhea, in which the women should be strong and adapt to those experiences.

Theme 2, subtheme 1 on the indigenous understanding of signs and symptoms of dysmenorrhea point out the severity of pains and discomfort caused by dysmenorrhea. Despite pains and discomfort, the finding highlights the strength and resilience both physically and emotionally. This confirms the lines from Africana Womanism theory that the African woman's physical and emotional strength ensure their safety as well as the survival of their families (Hudson-Weems 2004). The strength of Batlokwa women regarding dysmenorrhea was also evident when some of the women did not focus on the negativity of dysmenorrhea but considered it as a sign of fertility.

In this theme, the element of strength was also identified by the fact that the Batlokwa women experiencing dysmenorrhea must be strong so that no one sees that they are menstruating as this is considered as embarrassing (Wilson et al. 2018).

- **Mothering and nurturing**

According to Huff, Rudman, Magalhães and Lawson (2018:558), an African woman is a mother who nurtures her children and humankind in general by providing for and protecting them. In this regard, Batlokwa women displayed the character of mothering and nurturing by creating indigenous knowledge on how to manage a woman experiencing dysmenorrhea. Gilliam (2013) emphasised that the African woman is a leader in the struggle to regain, reconstruct and create cultural integrity for order, balance and harmony. Drawing from the finding of using the

metaphor of process and journey and connecting dysmenorrhea to other gynaecological problems in theme 1, participants spoke of the compassion they offer to the women experiencing dysmenorrhea, even to embark this journey with them. It is clear from this finding that the Batlokwa women experiencing dysmenorrhea are not alone, family members, THPs and IKHs take care of them. Since the journey of dysmenorrhea entails possibilities for struggles, courage, hope, discovery, growth, strength and change, family members, THPs and IKHs are there to nurture and support the women experiencing dysmenorrhea (Zimmermann 2017).

Theme 5, the role of THPs and IKHs speak to the characteristic of mothering and nurturing. Africana Womanism recognises the roles that are played by THPs and IKHs within the Batlokwa ethnicity regarding the management of dysmenorrhea, as active roles in the rearing of the community and propaganda of the ethnicity group. The dual roles as mothers and nurturers begin with their children and extend to all humanity. They emotionally and physically nurture and sustain genuine sisterhood within their families and communities. According to Hudson-Weems (2001), mothering and nurturing in traditional African communities is a way of gaining status and respect among the community members. As such, cultural traditions, values and customs within African women highlight caring for others as an integral part of their lives. Therefore, applying elements of mothering nurtures a holistic understanding of dysmenorrhea, and can widen and diversify management and treatment of other gynaecological problems (Arora, Kurji & Tennant 2013).

On the other hand, the philosophy of holism makes sense of societal domains concerning the whole, and consider the dimensions of gender, age, race, class, and ethnicity from a holistic viewpoint (Zahle 2014). Understanding dysmenorrhea holistically may facilitate the discipline to address a woman as a complete being.

- **Wholeness**

The interest of a Black community maintains a sense of wholeness through cultural connectivity. The findings point to knowledge as cultural consciousness and awareness. Cultural awareness was closely linked to the issues of norms, values, language and practices related to dysmenorrhea knowledge. According to Campinha-Bacote (1999:204), cultural awareness is “the deliberate, cognitive process in which health care providers become appreciative and

sensitive to the values, beliefs, lifeways, practices, and problem-solving strategies of clients' cultures".

As such, Batlokwa women feel whole as they connect with culture. Wholeness also stresses the required self-esteem that emanates from within an African woman who must be strong not only for herself but her family and the Black nation as a whole (Hudson-Weems 2004). In this regard, the holistic understanding of dysmenorrhea emanates from data, to complement the union of African women and wholeness. Theme 1 and theme 4 embrace the importance of wholeness. Approaching dysmenorrhea from the holistic perspective goes hand in hand with the characteristic of wholeness (Hudson-Weems 2004).

Theme 1: holistic understanding of dysmenorrhea meaning, offers a unique pin to delve into the complexities of womanhood and women's health. This includes diverse ways of being, becoming, doing and belonging to a sum of whole knowledge systems (Mothibe & Sibanda 2019). The Batlokwa ethnicity understands that dysmenorrhea affects the whole of the person; the physical, emotional, spiritual, social and the environment they live in. Thomas et al. (2018), share a similar view that illness should be approached holistically. Grouping dysmenorrhea with other women's health issues also highlights the element of wholeness because it indicates that when a woman experiences dysmenorrhea, the whole reproductive system is affected. In theme 2, wholeness was realised when the Batlokwa women mentioned that pain of dysmenorrhea is understood as a holistic issue because it affects the lower abdomen, waist and thighs. Therefore, it is necessary to include the physical, emotional, spiritual, social and environmental impact of dysmenorrhea when empowering Batlokwa women with dysmenorrhea knowledge.

The wholeness aspect is evident in theme three because of the dysmenorrhea diagnostic processes that are used in the Botlokwa village. They use various methods to confirm the diagnosis of dysmenorrhea because they believe in holistic care (Ababio et al. 2019). In theme 4, treatment modalities enable the African woman to conduct self, following the standards of their cultural heritage and personal beliefs (Hudson-Weems 2001). The perspectives of Batlokwa women regarding dysmenorrhea are shaped by the individual and societal values, concerning what they count as beneficial for managing and treating dysmenorrhea. For the fact that Batlokwa women's perspectives of dysmenorrhea include physical, emotional and spiritual aspects, explains wholeness in care and management (Thomas et al. 2018). Therefore, the

philosophy of holism can facilitate the understanding of dysmenorrhea health knowledge and the uptake of dysmenorrhea treatment (Zuma et al. 2018). In summary, approaching dysmenorrhea from a holistic perspective can facilitate a more holistic and relational understanding, and it is interlinked to culture (Harfield et al. 2018).

- **Spirituality**

One of the noteworthy findings related to Africana Womanism was to recognise spirituality. The Batlokwa women were found to be very spiritual and believe in a higher power, which is highly connected to relationships with others and the impact of the spirit in their health and healing. This is reinforced in theme 3 when the THPs and IKHs were finding reasons for the cause of dysmenorrhea. Supernatural powers such as witchcraft were identified as one of the factors that cause women to experience dysmenorrhea. As such, the finding suggests that causes of dysmenorrhea go beyond biological to spiritual. Many African indigenous authors note this belief (Bogopa 2007; Pillitteri 2012; White 2015).

In addition, utilising Africana Womanism framework, the research was able to identify the specific spiritual and cultural safeguards that Batlokwa women use to diagnose, prevent and manage dysmenorrhea indigenously. Hudson-Weems (1993) notes that spirituality is part of the wholeness that recognises, acknowledges and connects all living kind-humans, plants, animals and materials with the divine. The study findings in theme 1 revealed that Batlokwa THPs and IKHs approach health and healing holistically, which includes the spirit (Harvey 2013:81).

Theme 3 presents the processes that the women in this study follow to diagnose dysmenorrhea indigenously. Spirituality may mean holding on to cultural beliefs in order to give themselves hope and spiritual support. In this regard, African Womanism endorses a return to spirituality based on the beliefs of African ancestors (Hudson-Weems 2004). The findings indicated that during divination, the ancestral spirits assist with relevant diagnosis and treatment. The traditional health practitioners discussed how their experiential knowledge relates to their spirituality and what role spirituality plays in their health care and healing. In addition, this theme described the participants' belief in the power of spirits for both unpleasant and favourable outcomes. The theme also highlighted how spirituality plays a significant role in the diagnosis and treatment of both their physical, psychological and social health (Ababio et al. 2019).

This idea was also evident in theme 4, subtheme 2; the finding discusses the rituals that are performed during the treatment of dysmenorrhea. According to Rodriguez and Lopez (2019:56), the performance of these rituals connects the woman, family and environment to the ancestral spirits for healing to take place. This implies that spirituality promotes community healing and wellbeing through accessing knowledge and practices from the ancestors (Ababio et al. 2019). Spirituality is, therefore, according to the findings of the current study, an essential aspect of healing. As such, this belief of spiritual practice instils a power of determination and optimism, while maintaining personal dignity and cultural meaning among this group of women (Harvey 2013:87). Relations with spirituality are considered essential and an essential indicator for dysmenorrhea knowledge. Therefore, including the spiritual aspect to dysmenorrhea knowledge, confidently enhances and appropriates the belief system of THPs in the management of dysmenorrhea.

Interestingly, while organising my data to align it to Africana Womanism, I discovered that empowerment, culture and *Ubuntu* fit into this theory and support the participants' process of understanding dysmenorrhea. Moreover, I expanded the discussion on these aspects below to situate them with the characteristics of Africana Womanism theory and explore them with the study findings.

- **Empowerment**

A concept of empowerment emanated from the literature related to Africana Womanism. Cornwall (2016:343) refers to empowerment as an unfolding process of changes in consciousness and collective power. The meaning of empowerment can vary, depending on the socio-cultural context conceptualisation. Within the Batlokwa context, there were 18 essential characteristics found to be carrying the empowerment agenda to influence change (Hudson-Weems 2000). According to Alexander-Floyd & Simien (2006), each of the characteristics has a specific meaning that collectively establishes a basis for Africana Womanism as a vehicle of empowerment and influence. Mostly, the empowerment concept was found interlaced with the characteristics of strength. Wherein, the Africana Womanism theory believes that African women should be set free, valued and empowered (Owusu-Ansah & Mji 2013).

In theme two, the self-naming process empowered the participants in being the agents of their identification. This encouraged an approach that looked into dysmenorrhea knowledge in a more holistic way (Cornwall 2016:345). Women in these groups used Africana Womanism to self-empower and negotiate their positions in the health care system (Blackmon 2008). The activities carried out during mothering and nurturing empowered them to be able to perform the roles as mentioned in theme 5. Hence, Hudson-Weems (2001) emphasised that Africana Womanism gives Black women opportunities to strengthen their knowledge capacity and empower them in return. It is essential, therefore, to empower and build the capacity of Batlokwa women, to effectively organise strategies to improve dysmenorrhea knowledge. Thus, the dysmenorrhea knowledge provided to Batlokwa women should empower them to have a greater control of dysmenorrhea.

The study used photovoice to collect data. Its application in this study led to meeting some of the important precedents necessary for meaningful empowerment of Batlokwa women. Incorporating indigenous knowledge of dysmenorrhea into health programmes can contribute to local empowerment and development, increasing self-sufficiency and strengthening self-determination. Applying this knowledge during the drafting of strategies may legitimise local people as knowers and increase cultural pride.

- **Culture**

It also became evident through the process of analysing Africana Womanism theory, that culture played a central role and was embedded throughout the discussion. The Africana Womanism theory is a theory grounded in African culture. Although the theory did not define culture in the context of indigenous health, it demonstrated how aspects of culture were embedded within Africans' perspectives of life, how to maintain wholeness and how culture is respected. As such, African women should be recognised and appreciated within their cultural context (Hudson-Weems 2004). Chilisa (2012) emphasises that African communities have a unique way of doing things that relies on cultural experiences. Africana Womanism theory seeks to define those unique perspectives. Africana Womanism exists because Black African women exist and have pressing issues to deal with in their families and communities. As such, the critical role of culture in healthcare delivery should be identified and recognised (Ngunyulu, Mulaudzi & Peu 2015).

Because individuals bring in different modes and ways of communication, religious, health beliefs and practices to the healthcare sector and needs for the recognition.

One of the defining hallmarks of Africana Womanism lies in its usefulness to express the reality of the African woman within the context of the Africana community and cultural beliefs. Black women can use culture as a tool to understand their world. This study emphasises the idea that Batlokwa women use their socio-cultural beliefs and practices to understand and manage dysmenorrhea. These were evident in theme 1 about holistic understanding of dysmenorrhea meaning. This finding was presented from the perspective that illnesses in African communities take into account the physical, psychological, spiritual, social and cultural factors (Sodi et al. 2011). Thus, for effective healing, the approach should be holistic, including body, mind, emotions, spirit, culture and environment (Mothibe & Sibanda 2019). Culture as an additional aspect of holism in understanding dysmenorrhea heightens the likelihood of success in integrating personal and community understanding of illness and healing to develop a cultural meaning. Therefore, Zuma et al. (2018) allude that indigenous health and healing are based on the traditional beliefs and practices of the client.

- ***Ubuntu***

Out of culture, the principle of *Ubuntu* also came out strongly as discussed herein. *Ubuntu* emanates from the different roles that women play in the society or community. *Ubuntu* is an African concept that is not easy to define in foreign languages. *Ubuntu* is a Zulu word which means humanity in English and “botho” in Setlokwa. According to Mulaudzi et al. (2018), *Ubuntu* is an ethical element that embodies characteristics that promote mutual social responsibility, humanness, unity or togetherness and caring for one another. Within Africana Womanism theory and this study, *Ubuntu* prescribes a culture of shared meaning with patterns of beliefs and practices acceptable to the African communities. African women humanity is based on *Ubuntu* philosophy to maintain the human relationship with others, especially when dealing with indigenous health and healing (Mulaudzi et al. 2018). In addition, Ramose (1999) argues that the link between *Ubuntu*, local language and indigenous knowledge systems, is central to an understanding of African existence and being. As such, indigenous knowledge in the hands of African women must be used to affirm humanity as well. To avoid similar and worse circumstances driven by poor access to indigenous resources and culture to exist continuously,

the social practice should be recognised as a driving force in health and healing. As such, there is a need for new, innovative and transformative intervention strategies and policies that use *Ubuntu* principles to make long-term improvements in the health of indigenous people.

In addition, Ndlovu (2015) and Cornell and van Marle (2015) allude that *Ubuntu* forms part of Africana Womanism, but the focus falls on women's roles in a society that focuses on interconnectivity, community and respect of culture. This is applicable within the South African context. Moreover, Mulaudzi et al. (2018) argue that *Ubuntu* is an ideology and ethical system of being that cannot be equated in European terms. For the sake of this study, *Ubuntu* was used to focus on the woman within the group rather than the position of being a woman. The IKHs and THPs women within the Batlokwa ethnicity took part as knowers of dysmenorrhea and treatment modalities, rather than mere members for providing information. *Ubuntu* within Africana Womanism further allowed IKHs and THPs women in Botlokwa to take leadership roles in naming and treating without shame. Hence, Ebunoluwa (2009) believes that Africana Womanism provides an alternative for a Black African woman to focus on their identity and gender issues, as well as on how to address them.

Theme 1's finding on meaning-making using the metaphor of process and journey connected to women's health, is in line with the notion of Africana Womanism of centralising ethnicity and the concept of *Ubuntu*, which always emanates when culture is mentioned. According to Ramose (1999), *Ubuntu* principles should always be applied when understanding the existence and being of African knowledge because it is ethical. The finding of meaning-making using the metaphor of process and journey connected to women's health emphasised the principles of humanness, social responsibility, unity, kindness and caring by the Batlokwa women towards women experiencing dysmenorrhea in their community. This emphasises the ethical dimension attached to dysmenorrhea care and maintaining ethical principles throughout the diagnosis and treatment of dysmenorrhea. It is, therefore, necessary to identify the values, norms, skills, beliefs and practices of Batlokwa women regarding dysmenorrhea and link them to the philosophy of *Ubuntu* to empower Batlokwa women with dysmenorrhea knowledge.

This finding of using meaning-making as a metaphor showed that Batlokwa ethnicity possesses their meaning systems that provide consistency, predictability, and a lens through which to see and interpret dysmenorrhea ethically. This confirmed the belief of Africana Womanism that

people sought knowledge by making meanings in relation to their circumstances, environment and culture to enhance the ability to provide culturally competent care to different racial/ethnic groups (Chen et al. 2018). To add on *Ubuntu*, throughout theme 3, theme four and theme five the Batlokwa women demonstrated the ideas, values, morals, compassion and humanity in general in support of the women experiencing dysmenorrhea. Ubuntu heightened the likelihood of success in integrating personal and community understanding of illness and healing to develop a cultural meaning. Table 6.2 illustrates a summary aligning the findings (themes) to the characteristics of Africana Womanism theory.

Table 6.2 Aligning findings to the characteristics of Africana Womanism theory

CHARACTERISTICS OF AFRICANA WOMANISM THEORY	STUDY THEMES AND SUB-THEMES
Self-naming and self-definition	<p>Theme 2: Self-naming and definition of dysmenorrhea</p> <ul style="list-style-type: none"> • Endorse local language and communication skills • Promote the use of local language <p>Endorsing and using local language will enable the Batlokwa women to communicate and share their dysmenorrhea knowledge more effectively</p>
Genuine sisterhood and Family centredness	<p>Theme 1: Holistic understanding of dysmenorrhea meaning</p> <ul style="list-style-type: none"> • Recognition of indigenous holistic health <p>The thrust of the finding's arguments is that illness and healing in African people is not concerned with the individualism but expand to the family and community at large. In this regard, family and community care services delivered and managed by community members reflect holistic nature of services.</p> <p>Theme 3: Diagnostic processes in indigenous health care practices</p> <ul style="list-style-type: none"> • Recognise and involve family members and community in creation and sharing of dysmenorrhea knowledge <p>Family and community participation in creation of dysmenorrhea knowledge acknowledges the strengths of Batlokwa women.</p> <p>Theme 5: Roles of THPs and IKHs in treatment and prevention of dysmenorrhea.</p> <ul style="list-style-type: none"> • Partner and engage with THPs and IKHs to learn and sustain indigenous knowledge of dysmenorrhea • Consider to network with THPs and IKHs for social and health resources <p>It is a common practice among Batlokwa ethnicity that THPs and IKHs roles are to support and educate people about indigenous knowledge.</p>
Respect, Recognition and Respectful of elders	<p>Theme 3: Diagnostic processes in indigenous health care practices</p> <ul style="list-style-type: none"> • create an environment that allows respect <p>Creating an environment that is safe and respected provides a setting where women are free to share knowledge of</p>

	<p>dysmenorrhea</p> <p>Theme 4: Treatment modalities of dysmenorrhea</p> <ul style="list-style-type: none"> • Recognising and respecting treatment modalities of dysmenorrhea practised by Batlokwa women • Support indigenous health care systems <p>Herbal medicine and spiritually led care is a fundamental aspect of indigenous health which has been practised by Africans for long and is becoming increasingly recognised and promoted by the World Health Organization.</p> <p>Theme 5: Roles of THPs and IKHs in treatment and prevention of dysmenorrhea</p> <ul style="list-style-type: none"> • Create a respectful and safe environment for both Batlokwa women and THPs and IKHs to practice indigenous healing. <p>The THPs and IKHs are valued for their specialist expertise in the treatment and prevention of dysmenorrhea.</p>
Strength and Adaptability	<p>Theme 2: Self-naming and definition of dysmenorrhea</p> <ul style="list-style-type: none"> • Allow women to construct dysmenorrhea knowledge well known terms and phrases in their community <p>Inclusion of local terms and phrases can strengthen the understanding of dysmenorrhea information</p>
Mothering and Nurturing	<p>Theme 5: Roles of THPs and IKHs in treatment and prevention of dysmenorrhea</p> <ul style="list-style-type: none"> • Empower and equip all role players with knowledge and skills necessary for understanding dysmenorrhea <p>Empowering and nurturing role players with relevant skills to manage dysmenorrhea can potentially remove or bridge challenges of mismanagement.</p>
Wholeness	<p>Theme 1: Holistic understanding of dysmenorrhea meaning</p> <ul style="list-style-type: none"> • Address dysmenorrhea from a holistic perspective, considering the importance of social, emotional, cultural and spiritual health”. <p>The importance of a holistic approach to dysmenorrhea offer a unique pin to delve into the complexities of womanhood and women’s health</p> <p>Theme 3: Diagnostic processes in indigenous health care practices</p> <ul style="list-style-type: none"> • Use various methods to diagnose dysmenorrhea

	<p>Theme 4: Treatment modalities</p> <ul style="list-style-type: none"> Promote indigenous healing of dysmenorrhea, that include medicinal and spiritual practices
Spirituality	<p>Theme 1: Holistic understanding of dysmenorrhea meaning</p> <ul style="list-style-type: none"> The importance of a holistic approach in the meaning and treatment modalities of dysmenorrhea <p>Understanding of dysmenorrhea is aligned with aspects of physical, emotional, social and spiritual being.</p> <p>Theme 3: Diagnostic processes in indigenous health care practices.</p> <ul style="list-style-type: none"> The importance of spirituality <p>The participants perceive “spirituality” as an important resource in helping with the diagnosis and treatment of dysmenorrhea.</p> <p>Theme 4: Treatment modalities</p> <ul style="list-style-type: none"> Spirituality manages physical being <p>The participants hold strong spiritual beliefs upon which they often base their decisions for dysmenorrhea treatment and practices</p> <p>Theme 5: Roles of THPs and IKHs in treatment and prevention of dysmenorrhea</p> <p>The Batlokwa THPs and IKHs play a vital role in diagnosing, treating and preventing dysmenorrhea, physically influenced by spirituality.</p>

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Empowerment	<p>Theme 2: Self-naming and definition of dysmenorrhea</p> <ul style="list-style-type: none"> enable Batlokwa women to take control over the naming and definition of dysmenorrhea <p>From a critical perspective, the findings within this study suggest that empowerment may increase women’s control over the management of dysmenorrhea.</p>
Culture	<p>Theme 1: Holistic understanding of dysmenorrhea meaning</p> <p>Within Batlokwa’s cultural context, family and group beliefs and practices influence women’s choices for dysmenorrhea health decision making.</p>

Ubuntu	Theme 1: Holistic understanding of dysmenorrhea meaning Identify the values, norms, skills, beliefs and practices of Batlokwa women regarding dysmenorrhea and link them to the philosophy of Ubuntu to empower Batlokwa women with dysmenorrhea knowledge.
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6.5 CONCLUSIONS OF THE FINDINGS WITH REFERENCE TO THE AFRICANA WOMANISM THEORY

The merging of study findings with Africana Womanism theory discovered concepts and key variables influencing the relationship between theory and the Batlokwa women's ways of creating dysmenorrhea knowledge (CohenMiller & Pate 2019:1218). This facilitated an understanding and connected the researcher to the dysmenorrhea knowledge existence among Batlokwa women (MacMillan & Schumacher 2001; Ravitch & Riggan 2017). The discussion of the findings concerning literature in Chapter 5, reflected the underlying reality associated with dysmenorrhea knowledge among the Batlokwa women. The discussion showed that the Batlokwa women's perspectives of dysmenorrhea and treatment modalities fit within the characteristics of Africana Womanism theory.

The discussion clarifies who my participants are and how they connect, influence and contribute to the dysmenorrhea knowledge in their community. The central understanding started from the discussion in Chapter 5, in which their dysmenorrhea knowledge, treatment modalities and practices were discussed based on several factors as identified during the literature review in Chapter 2. Five themes revealed the rich knowledge of dysmenorrhea health services, opportunities to strengthen their knowledge and value of empowering other women with dysmenorrhea knowledge. In addition, discovering and building on the knowledge and experience of my participants in constructing the meaning of dysmenorrhea according to their beliefs and practices helped in developing strategies to empower the Batlokwa women with dysmenorrhea knowledge.

Throughout the discussion of the empirical findings with the Africana Womanism theory, new insights and meanings emerged in which motivations and recommendations were formulated to inform the development of the strategies to empower the Batlokwa women with dysmenorrhea knowledge. Since the study findings fitted so well into the characteristics of Africana Womanism

theory, I found it essential to organise and illustrate how Batlokwa women can be empowered with dysmenorrhea knowledge utilising the Africana Womanism theory. The Africana Womanism theory characteristics were applied during the development of strategies to empower Batlokwa women with dysmenorrhea knowledge.

Firstly, the discussion identified that the Batlokwa women, in general, recognised dysmenorrhea in a holistic way where physical, psychological, spiritual, social and environmental factors depend on each other to balance health and wellbeing. Dudgeon and Walker (2015) argue that these aspects are considered interrelated and require equal attention and care to sustain the health and wellbeing in the rural community. This approach requires that dysmenorrhea knowledge be understood in the context of the Batlokwa social-cultural position. The concept of dysmenorrhea care in Batlokwa ethnicity focuses on the wellbeing rather than on sickness. It focuses on moving the women experiencing dysmenorrhea towards wholeness and balance. It means that when empowering them with dysmenorrhea knowledge, the information provided should acknowledge, incorporate and promote holistic concepts of health and wellbeing in a way that makes sense and is easily understood by the women. According to Cargo, Potaka-Osborne, Cvitanovic, Warner, Clarke, Judd, Chakraborty and Boulton (2019), many cultures perceive health and wellbeing as an interactive holistic concept, because the concept of holistic health is relevant to many indigenous populations regardless of where they live. The characteristic of wholeness in this regard is related to providing dysmenorrhea knowledge that incorporates all the holistic concepts as understood by the Batlokwa women (Hudson-Weems 2004). It supports the importance of understanding and approaching dysmenorrhea as a women's health condition that has an impact on their spiritual and psychosocial aspects. In addition, wholeness facilitates and encourages the diagnosis and treatment modalities of dysmenorrhea to be approached holistically as well.

Secondly, self-naming, especially in own language confers identity and it gives a core understanding of what is under discussion (Hudson-Weems 2004:18). The characteristic of self-naming and self-definition contribute to the use of familiar words, terms and phrases related to dysmenorrhea, in which the women feel comfortable and relaxed to share information. The characteristic of self-naming and self-definition will assist in building on the women's knowledge and experience of dysmenorrhea, in which they can construct meaning and apply information in the management of dysmenorrhea. Self-naming and self-definition help the women to

understand and remember dysmenorrhea information or some important aspect of it. Oral language skills are essential as well. Batlokwa women need to articulate dysmenorrhea knowledge and describe it accurately.

Understanding dysmenorrhea information is essential because women will be able to comprehend the meaning, treatment modalities and management of dysmenorrhea. Knowing information about a topic helps in remembering its facts. In addition, being able to understand and explain that information empowers the women to make meaningful decisions towards wiser health choices. In comparison, experience allows discussion and problem-solving to be based on what has already happened and evidence (Bhattacharrya, Medhi, Pala, Sarkar, Kharmujai & Lynrah 2018). The value of empowering Batlokwa with dysmenorrhea knowledge from the experiences is to share both good and bad experiences in the diagnosis, treatment and management of dysmenorrhea symptoms. The Batlokwa ethnicity attaches a substantial value to self-identity, traditional culture and language, as being essential and integral to lifelong learning. It was reasonable and evident during data collection that self-naming, self-definition and language are very much a part of who Batlokwa women are. Sultana et al. (2017:285) indicate that naming illnesses in their own language is effective in increasing health literacy. Therefore, in order to empower and improve the Batlokwa's knowledge of dysmenorrhea, the characteristic of self-naming and self-definition ought to be considered. The characteristics of self-naming and self-definition, therefore, clarify the information through the use of local language.

Thirdly, the findings identified that the participants believe that supernatural or higher powers can cause dysmenorrhea. It means that the spiritual needs of women and families have a fundamental role in diagnosing, treating and recovering from dysmenorrhea symptoms. Musyimi et al. (2018)) argue that spiritual needs have significant implications for individuals, families and communities. Puchalski, Vitillo, Hull and Reller (2014:646) reveal that spirituality does not require any sort of religious belief; it is expressed through beliefs, values, traditions, and practices. The characteristic of spirituality in this study plays a significant role in the recovery of the physical, psychological and social symptoms and impact caused by dysmenorrhea to produce actual wellbeing. As such, spiritual self-reflect will bring awareness into a personal understanding of dysmenorrhea.

Fourthly, the findings showed that Batlokwa women support one another when experiencing dysmenorrhea. Social and family wellbeing was discovered to be a fundamental aspect of the participants' perspectives of dysmenorrhea health. According to Gallagher, Muldoon and Pettigrew (2015), social and family wellbeing as the fundamental aspect of health is becoming increasingly recognised and promoted within the context of holistic health concepts. However, the challenge with the Batlokwa women was that dysmenorrhea and other sexual and reproductive health-related information was infrequently shared and discussed within social networks. As such, the characteristic of genuine sisterhood and family centredness acknowledge and support the inclusion of families and social networks within the diagnosis, treatment, management and prevention of dysmenorrhea. This will facilitate the informal sharing of dysmenorrhea knowledge collectively. The informal sharing of dysmenorrhea knowledge may lead to an understanding of dysmenorrhea among Batlokwa women. Genuine sisterhood will connect families and communities to share and discuss dysmenorrhea related information within their social networks (Hudson-Weems 2004).

Fifthly, most of the participants in this study understand the character of mothers and its social role in nurturing the relationship towards empowering other women with dysmenorrhea knowledge. It means the characteristic of mothering and nurturing brings the feminine forward and cultivates compassion and liberates fear. Nurturing community knowledge and skills in diagnosing and treating dysmenorrhea (Eriksson, Lindblad, Möller & Gillsjö 2017), may potentially remove or bridge challenges of mismanaging dysmenorrhea. The characteristics were also found helpful for the participants to relate their social roles as THPs, IKHs and mothers in showing compassion in treating and managing dysmenorrhea.

Sixthly, strength informs and enhances available resources and knowledge in individuals (Gao, Kerr, Lindquist, Chi, Mathiason Austin & Monsen 2018). This builds on the adaptability of shared knowledge from others. The characteristic of strength reflects on the personal implications of the dysmenorrhea situation, and on how to manage the situation. According to the analysis of the findings, almost all women who participated in the study identified the characteristic of strength as applied when empowering the Batlokwa women with dysmenorrhea knowledge. It was based on the fact that the findings discovered the strengths of dysmenorrhea knowledge from the participants. Therefore, empowering women through a strength lens will improve the knowledge of dysmenorrhea.

Seventhly, the findings revealed that the culture of Batlokwa women is based on respect. Busher Betancourt (2016) concurs with this finding that cultural respect is a means of showing an understanding of how things are done and should abide by the prescribed ways to eliminate unnecessary stressors from the clients. The importance of knowing, understanding and respecting the dysmenorrhea knowledge according to Batlokwa ethnicity was also emphasised. Respect was connected to all the themes that emerged from the study findings. Respect promotes trust and contributes to a safe environment in which the women share dysmenorrhea knowledge. Feeling safe encourages the women to engage with each other through dialogue and discussion, at the same time learning from each other (Budig, Diez, Conde, Sastre, Hernán & Franco 2018). Recognising and respecting the belief system of Batlokwa women regarding dysmenorrhea allows them to connect to their culture. Information that is culturally connected and sensitive to a specific cultural group can be quickly adopted and applied in their homes and community. In this regard, the characteristic of respect builds trust, influences positive attitudes and encourages sharing of ideas and experiences regarding dysmenorrhea.

Additionally, the study findings discovered empowerment, culture, and *Ubuntu* to be aligned with the Africana Womanism theory. According to Cornwall (2016), *Ubuntu* is the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights. Empowering and nurturing role players with relevant skills to manage dysmenorrhea can potentially remove or bridge challenges of mismanagement. Liebenberg (2018) argues that empowerment will only take place when an individual is motivated and feels respected by the system and activities, she is participating in. The concept of empowerment increases people's control over their health, to make informed choices, reduce health risks and increase the quality of life. For Batlokwa women to become genuinely empowered with dysmenorrhea knowledge, they need to negotiate and determine what comprises cultural safety within *Ubuntu* practices.

Exposure to Batlokwa women's cultural beliefs and practices has helped me to recognise that the process of empowering women with dysmenorrhea knowledge is as essential as their cultural awareness, knowledge, values and ethical principles. Knowing their culture, therefore, has potential to empower them with dysmenorrhea knowledge. This is in agreement with the Colomeda and Wenzel (2000:245) wherein they indicate that indigenous communities consider practising cultural ceremonies, speaking the language, applying the wisdom of the elders, learning the songs, beliefs, healing practices, and values as good health that has been handed

down in the community from generation to generation (Ngomane & Mulaudzi 2010; Asante, Ababio & Boadu 2017). The principle of *Ubuntu* heightened the likelihood of success in integrating personal and community understanding of dysmenorrhea. In light of this, the strategies to empower Batlokwa women with dysmenorrhea knowledge are suggested and developed in Chapter 7. Figure 6.1 illustrates how Batlokwa women can be empowered with dysmenorrhea knowledge using the Africana Womanism theory.

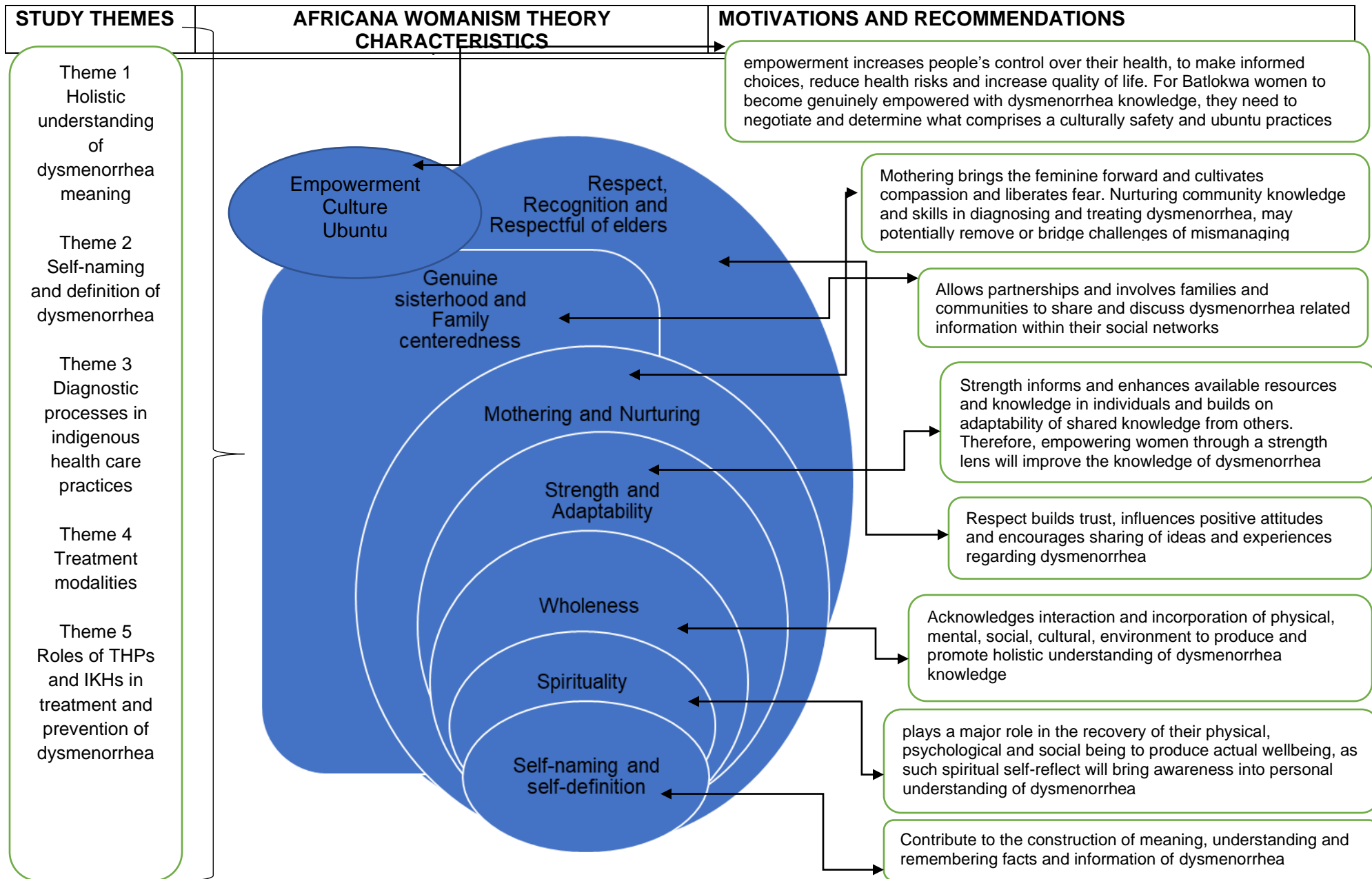


Figure 6.1: Illustrating how Batlokwa women can be empowered with dysmenorrhea knowledge using Africana Womanism theory

6.6. SUMMARY OF THE CHAPTER

This chapter presented the discussion of study findings in relation to the Africana Womanism theory. The findings were described to reflect the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province, South Africa. The relevant characteristics of Africana Womanism theory were aligned to themes and sub-themes of the study. Through aligning themes and characteristics of the theory, I gained a deeper understanding of the meanings to develop strategies for empowering the Batlokwa women with dysmenorrhea knowledge. Thus, the results of the discussion served as a basis for the development of strategies in the next chapter. This process ensured that the strategies were developed from the appropriate knowledge translation. Phase 2, Chapter 7, discusses how the strategies were developed.

CHAPTER 7
DEVELOPMENT OF STRATEGIES TO EMPOWER BATLOKWA
WOMEN WITH DYSMENORRHEA KNOWLEDGE

7.1. INTRODUCTION

Chapter 5 comprised a literature synthesis that integrated the five main themes of the empirical study. Chapter 6 merged and discussed the five main themes of the empirical study with Africana Womanism theory characteristics. This led to the formulation of a set of preliminary statements to inform the development of strategies to empower Batlokwa women with dysmenorrhea knowledge (Refer to Chapter 5 and Chapter 6, Section 6.4 and Table 6.2). Chapter 7 is Phase 2 of the study, and it focuses on the development of specific strategies that should empower Batlokwa women with dysmenorrhea knowledge.

The development of the strategies was based on the empirical findings obtained from the participants in Phase 1 and the literature related to the topic. In addition, the empirical findings were aligned with the characteristics of the Africana Womanism theory, which led to a deeper understanding of the meanings regarding dysmenorrhea to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. The researcher and experts drafted and formulated strategies by selecting appropriate statements from the more profound understanding after aligning empirical findings with the Africana Womanism theory. The findings were described to reflect the Batlokwa women's perspectives of the meaning and treatment modalities of dysmenorrhea.

The draft strategies were developed following (1) conclusions of the findings regarding Africana Womanism theory (see Section 6.5, Table 6.2 and Figure 6.1); (2) guiding principles in the strategy's development (see Section 7.2.3 and Table 7.1).

7.2. DEVELOPMENT AND VALIDATION OF THE STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHEA KNOWLEDGE

This study was conducted in two phases namely, empirical study and the development of the strategies to empower Batlokwa women with dysmenorrhea knowledge. The empirical study findings were discussed concerning literature and Africana Womanism theory characteristics. For details of the findings, there is a discussion in relation to the literature (see Chapter 5), for alignment with the Africana Womanism theory characteristics (see Chapter 6).

The alignment and discussion provided essential insights into indigenous knowledge of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. To be more specific, the study findings identified the unique and essential belief system and practices in the meaning and management of dysmenorrhea. The provided knowledge was noted, more importantly, to notify the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge.

Thereafter, the various elements of the discussed themes with literature and characteristics of the Africana Womanism theory were merged to form a framework for guiding the development of the strategies to empower Batlokwa women with dysmenorrhea knowledge (see Figure 6.1).

7.2.1. The rationale for the development of strategies to empower the Batlokwa women in Limpopo Province with dysmenorrhea knowledge

The initial plan to develop strategies to empower Batlokwa women with dysmenorrhea knowledge emanated from the new information and uniqueness of the study findings. The perspectives explored and described in Phase 1 and the new and unique knowledge identified by the participants included a range of suggestions and comments that were later transformed into themes that led to the scope and objectives of the strategies being developed, described and clarified. By analysing the indigenous dysmenorrhea knowledge from Batlokwa THPs and IKHs, it became clear that according to them dysmenorrhea symptoms can be managed without using pain medications, as there are other means such as vaginal steaming with natural herbs. The other new and unique knowledge in this study is that dysmenorrhea is curable and that the indigenous treatment of dysmenorrhea corrects infertility. Moreover, it was necessary to develop

strategies to be shared with the young and other women who might find indigenous knowledge an alternative method for managing dysmenorrhea.

On the other hand, having in mind that the long-term effects of colonisation impacted on the transmission of indigenous knowledge including menstruation and its problems, the Lekgotla discussion group took a resolution to use the findings of the study to develop strategies to empower the younger generation and other women with alternative methods of managing dysmenorrhea.

Strategies to empower Batlokwa women with dysmenorrhea knowledge were developed in order for the Batlokwa women, both the young and older women to be aware of the knowledge and utilise the information as alternative ways of managing dysmenorrhea. It was also directed towards increasing dysmenorrhea care resources and opportunities to educate women about indigenous knowledge. Furthermore, the strategies will assist in collaboration in public health problems-solving related to menstruation and women's health problems. Furthermore, the developed strategies can assist in the development and distribution of policies that will assure availability and access to dysmenorrhea indigenous knowledge services.

In formulating these strategies, we proposed an approach that focused on making health services, education and information systems more relevant to the study context. Given that women experiencing dysmenorrhea delay in seeking health care assistance, empowering women with dysmenorrhea knowledge can help in making an earlier diagnosis (Bernardi et al. 2017). For example, a woman who is fully informed about dysmenorrhea knowledge is likely to seek health interventions at an early stage. Therefore, the development of strategies is directed towards increasing knowledge, primary health care resources and opportunities regarding menstruation and dysmenorrhea. This, in return, can assist in the development and distribution of policies that will ensure the availability and accessibility of culturally-sensitive women's health care services.

The importance of developing health interventions from the strengths of the community derives from the Sustainable Development Goals (SDGs) number 3, 5 and 10; promotion of good health and wellbeing, gender equity and reducing inequality within and among countries (United Nations General Assembly 2015). The Sustainable Development Goals (SDGs) offer a timely and favourable opportunity for increased global attention and action on the promotion of health

at a primary level using the strengths of the community (United Nations General Assembly 2015). To achieve the 2030 agenda for sustainable development and to promote and maintain health across the life course, a renewed and sustained focus on improving indigenous women's health based on their cultural beliefs and practices is needed. In addition, some studies in the developed countries have demonstrated that strategies for health promotion led to a reduction in the burden of diseases in a relatively short time (Peu 2014; May & Aikman 2003). However, less attention has been given to this matter, which is a significant cause for concern. According to Peu (2014), relevant information regarding health promotion strategies should be included in health interventions.

In addition, the World Health Organization traditional medicine strategy 2014 – 2023, which was developed as a response to the World Health Assembly resolution on traditional medicine (WHA62.13) (World Health Organization 2009), calls out countries to develop a cohesive and integrative approach to health care. Health care that is safe (Traditional and Complementary Medicine [T&CM]) should be accessible to the users (World Health Organization 2013). Furthermore, the World Health Organization (2013) discovered that governments and consumers are interested in more than herbal medicines, they are also interested in the aspects of T&CM practices and practitioners and whether they should be integrated into health service deliveries. Therefore, to achieve the above, countries need to develop proactive strategies to educate on how to promote safety and respectable T&CM through health literacy.

7.2.2. Merging of adapted Africana Womanism theory characteristics and findings to inform the formulation and development of strategies to empower Batlokwa women with dysmenorrhea knowledge

Merging is a structured process in which various vital elements are combined to form a close union of whole, without complete loss of individual identities (Merriam-Webster 2019). In chapter 6, Table 6.2 and Figure 6.1, the five themes, seven sub-themes and 13 characteristics of Africana Womanism theory were merged with the study findings to apply the concepts to the practices of Batlokwa regarding dysmenorrhea knowledge (Ravitch & Riggan 2017). In return, the merging results underlined the relationship between the study findings and Africana Womanism theory. The Africana Womanism theory perspectives were found to be more in line with the local culture and customs. Drawing from the merging results, the framework to guide

the development and validation of strategies were formed and adapted. The adapted framework is ideal in the development of the strategies to empower the Batlokwa women with dysmenorrhea knowledge as it assisted the researcher to identify main related concepts and describe their effects concerning the strategies to be developed (CohenMiller & Pate 2019:1219). Figure 7.1 illustrates the adapted framework to inform the development of strategies to empower Batlokwa women with dysmenorrhea knowledge.

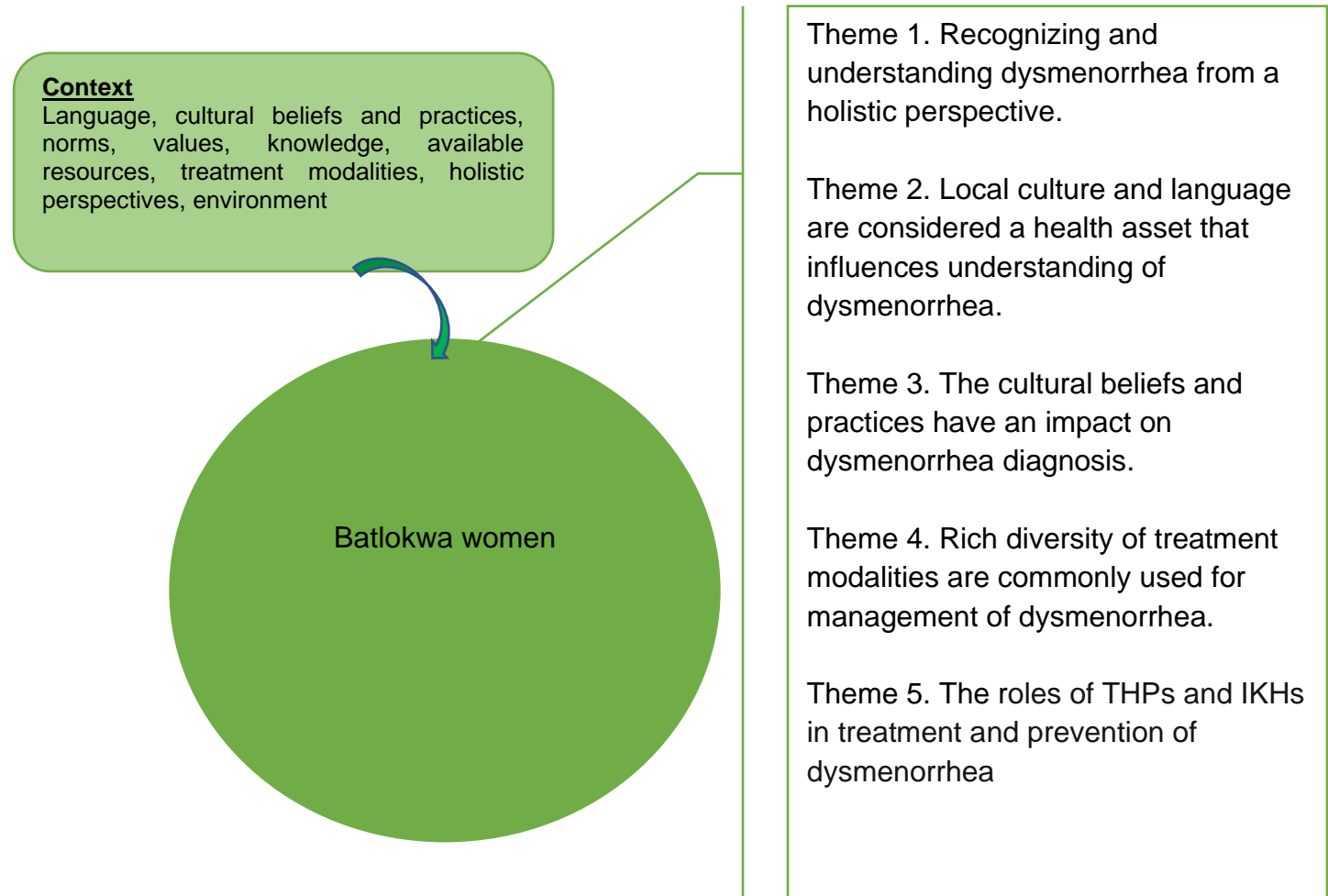


Figure 7.1: Rasweswe's framework that guided the drafted strategies

7.3. DEVELOPMENT AND VALIDATION OF THE STRATEGIES IN HEALTH CARE SYSTEM'S CONTEXT

A strategy is a plan, skill or method of action that directs how to deal with environmental activities to enable organisations to achieve goals over a specific time (Muller, Bezuidenhout & Jooste 2014:569). Sadler and Craig (2003) and Mefalopoulos and Kamlongera (2004:8) describe strategy as a systematic, long-duration action plan of activities, combining different methods, techniques and tools drafted to be logically adopted in achieving defined objectives. According to Mulenburg (2011), strategies assist in describing how the anticipated goals are going to be achieved. Thus, strategies force individuals to plan and describe how they are going to get activities done in achieving goals, rather than to wait passively until external forces compel. Thompson, Scott and Martin (2017) state that different types of strategies are developed to form part of the strategic management process.

Therefore, it is essential to formulate strategies in order to give direction on how to achieve outcomes and improve the performance of activities (O'Regan & Ghobadian 2002). In health care, the main aim of strategies is to guide how health services are supposed to be provided (El-Jardali & Fadlallah 2017). Moreover, this study developed strategies to empower the Batlokwa women with dysmenorrhea knowledge. In this study, the developed strategies are regarded as principles and recommendations to support the Batlokwa women in rendering relevant and appropriate holistic management of women experiencing dysmenorrhea within Batlokwa ethnicity in Limpopo Province, South Africa.

7.4. THE GUIDING PRINCIPLES USED FOR THE DEVELOPMENT OF STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHEA KNOWLEDGE

Principles are unique dimensions that define how the behaviour or action is guided to ensure that the community intervention process is ideally aligned with the goals for implementation (Kristjansson, Mann, Sigfusson, Thorisdottir, Allegrante & Sigfusdottir 2020). According to Walton (2012), principles articulate rules or beliefs that govern how, what and the approach that is correct in developing a character. This implies that it is necessary to establish a set of principles during the development of strategies, to which one can stand on or refer to when

evaluating the developed strategies. Therefore, principles can be consulted to identify and guide the quality of any strategy, for recognition and acceptance (Kristjansson et al. 2020).

During the development and validation, the researcher used various sources to identify the relevant and suitable principles to value and guide the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge (Scottish Intercollegiate Guideline Network 50 2019). Other principles derived from community-based decolonising indigenous approaches (Lekgotla) and Africana Womanism theory (refer chapter 6, Section 6.5), were used to embrace and gather indigenous knowledge of dysmenorrhea from the local community.

The community-based decolonising indigenous approach invited a multidisciplinary team, using a flattened hierarchy, to understand dysmenorrhea and develop strategies to empower the Batlokwa women. The decolonising and indigenous approaches are different from traditional Western scientific approaches (Elder & Odoyo 2018). Decolonising and indigenous approach look and aim to use indigenous beliefs and knowledge to guide the research to restore equity and balance to the local people throughout the research process (Lavallée 2009; Datta 2018:3). For instance, we used the modified Lekgotla discussion in both first and second phases of the study to guide conversations. Modified Lekgotla discussion process allowed us to observe appropriate community protocols during the meetings. Africana Womanism theory is grounded in African culture and emphasises the application of traditional African philosophy and values to create and sustain African cultural integrity. For a full description of how the decolonised indigenous approach was interrelated and applied to promote quality and cultural integrity, refer to Section 6.5.

The researcher used the Scottish Intercollegiate Guideline Network 50 (SIGN 50) criteria to measure quality during the development and validation of the strategies. SIGN is a collaborative network of clinicians and other health care professionals, funded by the National Health Services (NHS) Quality Improvement Scotland. It was established in Scotland as a means of grading and recommending the strength of evidence-based practice in healthcare. The SIGN 50 complies with the international standards of AGREE II Appraisal of Guidelines for Research and Evaluation. The researcher followed the steps, based on SIGN 50 (2019) guidelines for the development and validation of the strategies to ensure that the strategies would be of quality and recommended to be used in practice. Refer to Table 7.1 on how the principles from SIGN 50 were applied.

Table 7.1. GUIDING PRINCIPLES ACCORDING TO SIGN 50 (2019)

PRINCIPLE	FOCUS OF THE PRINCIPLE	APPLICATION OF THE PRINCIPLE TO THE STUDY
Scope and practice	This principle is concerned with the specific description of the overall aim or purpose, introducing and outlining the need for the strategy and the target population of whom the strategies are meant to apply	In this study, the aim of the strategies was to empower the Batlokwa women in Limpopo Province with dysmenorrhea knowledge. The scope or the target population would therefore be the Batlokwa women, including the local role players involved in the implementation of the strategies and programmes, i.e. THPs, IKHs, health care practitioners at primary level, school educators and indigenous knowledge educators parents and NGOs.
Stakeholder involvement	The principle is based on the participation and involvement of the intent users during the development and validation. It focuses on the views, opinions and preferences of the target group. It is also concerned with the propriety and acceptability of the outcomes	The appropriate stakeholders were involved through all phases of the study, including the development and validation of the strategies. The strategies development group included individuals from all the relevant professional groups The strategies were developed according to the cultural beliefs and practices of the ethnicity group. The community protocols were respected and observed. Ethical issues, rights and interests of the community members were considered.
Rigour of the development	Rigour of development focuses on the processes used to gather and synthesise the evidence, and link between the recommendation and the provided evidence. It is measured through validity and Reliability as well as appropriateness	In this study, the strategies are based on the findings, available literature related to the findings and Africana Womanism theory which guided the study. Thus, strategies are based on scientific evidence of analysed data, which was controlled with relevant literature as well as a relevant theory that was accepted by the community. The validity of the strategies was ensured through obtaining the inputs and recommendations from a panel of experts

		<p>during the modified Lekgotla discussion.</p> <p>Quality was also maintained through regular interaction with the participants in Phase 1 (using photovoice methodology, enabled regular interactive processes), and Phase 2 (modified Lekgotla discussion meeting allowed and facilitated interaction through debates and dialogues) to appropriate the strategies. Using Lekgotla discussion as a familiar methodology of the stakeholders in both Phase 1 and Phase 2, allowed participants to present their inputs openly, without fear and with confidence. This ensured the reliability and if the strategies are applied in the similar circumstances, using the same methods of development, the results would be the same.</p> <p>Therefore, the strategies will assist the health education material developers in formulating and implementing culturally relevant health programmes efficiently, and to empower the women with dysmenorrhea knowledge.</p>
<p>Clarity of presentation</p>	<p>The principle deals with specificity of the communicated variables and focuses on how easily it is identifiable and understood by the user. SIGN 50 recommends the layout structure of the content to clearly present the specific value of the strategy in improving the situation.</p> <p>Clarity of presentation includes the language use for the easy</p>	<p>The draft strategies are specific to empower the Batlokwa women in Limpopo Province with dysmenorrhea knowledge.</p> <p>The strategies are written in a simple and easy language that is easy to understand.</p>

	<p>understanding by the user.</p> <p>In general, the structure of the developed strategies should be easy to follow, practical and achievable</p>	
Applicability	<p>This domain focuses on describing the application of facilitators and barriers to the situation.</p> <p>It is concerned with how the recommended strategy provides advice in applying a theory to practice</p> <p>It pays more attention to the relevance, feasibility, flexibility, acceptability and sustainability.</p>	<p>The developed strategies should address the identified issues of concerns to improve the health practice. In this study, the strategies are relevant in terms of empowering the Batlokwa women in Limpopo Province with dysmenorrhea knowledge, as judged by the panel of experts. All efforts or interventions by the primary health care services should promote the indigenous health knowledge of Batlokwa women to ensure optimal women's wellbeing.</p> <p>The draft strategies are consistent with the literature and belief system of Batlokwa ethnicity regarding dysmenorrhea. The input of panel experts added value to the draft strategies.</p> <p>The current study was conducted in Botlokwa, Limpopo Province, South Africa, and the researcher did not aim to generalise the findings. However, the principles followed may be applied in similar settings, for example other villages in South Africa or any other African population.</p>

7.5. THE PROCESS OF DEVELOPING AND REFINING STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHEA KNOWLEDGE

The process of developing and refining strategies to empower Batlokwa women with dysmenorrhea knowledge entailed the following:

7.5.1. Research design

According to Dickoff, James and Wiedenbach (1968:425), designs are procedures, techniques, approaches, methods, principles that guide how activities are carried out. This study used a modified Lekgotla discussion as a research process (Rau et al. 2009). The word Lekgotla is a Sepedi word used to describe a meeting in a traditional court, a council meeting or a public meeting (Tsimba 2018). The King chairs the meeting, Chief or Headsman and decisions are arrived at by consensus of all present (Tsimba 2018). Therefore, Lekgotla discussion is a problem-solving consensus-seeking method commonly used in South African communities. The participants demonstrate the highest respect to fellow members of the Lekgotla. Lekgotla is fully described in Chapter 3, Section 3.4.1.

The idea was to actively gather information while providing a space for the experts to share their knowledge and experience of dysmenorrhea (Rau et al. 2009; Tsimba 2018). The Lekgotla was also used to reach consensus on the strategies to empower Batlokwa women with dysmenorrhea knowledge (Tsimba 2018). As with any rigorous research, this Lekgotla followed a carefully designed methodology, which is described herein.

7.5.2. Research methodology

A methodology for the development of strategies provides an outline of a planned process to be followed throughout the development of strategies (O'Regan & Ghobadian 2002). The research methodology followed in Phase 2 of this study is presented and discussed under population and sampling, data collection and analysis.

7.5.2.1. Population and sampling

A panel of experts who are qualified and knowledgeable about dysmenorrhea were recruited to participate in the study. These participants were not part of Phase 1. The experts were recruited through face-to-face conversations, telephonic conversations, face-to-face verbal discussions and word of mouth (referrals). Reminders were done telephonically and by word of mouth.

The researcher recruited experts from local schools, clinics, THP associations, leaders from the local authority and women's groups. A panel of experts met the requirements following the abovementioned inclusion criteria. The experts that participated in the empirical study were not included in Phase 2 of the study. All the selected experts were Batlokwa women. The experts were purposively selected based on their expertise. Snowballing was also used to select the experts. They came from different fields of specialty. The researcher included the THPs and IKHs to the panel of experts because the study was conducted within a critical realism paradigm. Since the followers of critical realism do not just generate knowledge but seek to understand, explain and effect social change, it was assumed that the THPs and IKHs' independent knowledge and practice would be acknowledged and influence a health care change (Botma et al. 2010:43).

The population, therefore, consisted of THPs, IKHs, nurses working in the local clinic, teachers from primary and high schools and representatives from local authorities and leaders from women's community groups. These were invited and attended (Refer to 3.4.2.1 sample size and sampling technique). Some of the participants were chosen because they have experience working within the Western health and education institutions such as clinics, primary and high schools, and universities. They also have experience in urban and rural cultural settings. The local tribal authority recommended others because they are recognised as experienced tribal knowledge keepers, facilitators and educators.

The total number of 22 women attended the meeting. Of the 22 women, six were THPs, ten IKHs, two registered nurses, three schoolteachers, one representative from the local tribal authority (See Table 1.2, Table 3.1 and Table 7.2). Among THPs and IKHs, some were teachers, lecturers, retired nurses, and women organisations' representatives. The anonymity of

the expert panel was not ensured due to the type of research design that requires the participants to be in a face-to-face meeting.

Table 7.2. Descriptive information of the experts' panel

SERIAL NO	POSITION	OCCUPATION	EXPERIENCE
1	THPs	Registered nurse	20 years
2	THPs	Registered nurse	10+ years
3	THPs	Housewife and THPs	13 years
4	THPs	Anthropologist	15 years
5	THPs	Former schoolteacher	20+ years
6	THPs	THPs	20+ years
7	IKHs	Politician	7 years
8	IKHs	Politician	15+ years
9	IKHs	Retired nurse	10+ years
10	IKHs	Community Health Worker	10+ years
11	IKHs	Housewife	5 years
12	IKHs	Housewife	15+ years
13	IKHs	Housewife	8 years
14	IKHs	Community leader	20+ years
15	IKHs	Nurse lecturer	20+ years
16	IKHs	FET lecturer	20+ years
17	Primary health care nurse	Registered nurse	20+ years
18	Primary health care nurse	Registered nurse	10 years
19	School teacher	Primary school teacher	15+ years
20	School teacher	Primary school teacher	15+ years
21	School teacher	High school teacher	11 years
22	Tribal authority representative	Community leader	20+ years

7.5.2.2. Data collection and analysis

In this phase, data were collected through modified Lekgotla discussion. The modified Lekgotla discussion meeting was held on the 17th December 2019 under a tree in one of the participant's yard at Botlokwa village where participants reside. The seating arrangement was a circle. In the middle of the circle was a small round table with some refreshments (dried vegetable seeds, nuts, dried fruits, chips and sweets), juice and water, in which each participant was free to eat as the meeting progressed. A flip chart was outside the circle and used only when the Lekgotla

facilitator was summarising a point. Otherwise, she remained in the circle with others and noting points on a small pocketbook. According to the participants, the use of a circle is viewed as a holistic way in which knowledge is shared among participants equally. Some participant indicated that it reflects a symbol of equity and that life goes around in a circle for everyone to have either negative or positive communication. The meeting process followed the proper steps as summarised below:

1. Arrival and Welcome
2. Engaging participants
3. Reaching consensus on the strategies to empower Batlokwa women with dysmenorrhea knowledge
4. Verification and refinement of the strategies to empower Batlokwa women with dysmenorrhea knowledge

Step 1: Arrival and welcome

The researcher welcomed all the participants as they were entering the venue individually or in groups. Interestingly, the participants greeted and introduced themselves to each other spontaneously as they entered. They were even asking about the welfare of each other's family members, although they did not know each other. As such, when all participants were present, and the meeting started, the introduction aspect was no longer necessary because they had already introduced themselves to each other. The researcher introduced herself as a PhD student and the reason she was conducting the meeting with them. She indicated that she saw all the participants networking and talking comfortably with each other. I asked the participants if they already know each other after networking. Some responded that they were meeting for the first time, but they already knew each other by family names. Verbal consent was obtained immediately after clarifying the purpose of the meeting. The participants were informed that their participation was voluntary. They were free to discuss dysmenorrhea related issues in the meeting and could withdraw from participation at any time (Polit & Beck 2017:140).

Participants were given information about the duration of the meeting and their role in the whole process. The researcher indicated that the meeting would follow some sessions that were outlined to them. The estimated time for each session was also provided.

Instead of setting rules for the modified Lekgotla discussion, the researcher and research assistant gave participants puzzle pieces to complete. This was done to observe respect, teamwork, commitment and participation among the group. Despite arguments and disagreements during the building of the puzzle, the researcher observed divisions into smaller groups, teamwork was also observed although the group was divided. Eventually, the puzzle was completed in harmony. The group started praising and laughing at the outcome. They also reflected on how they behaved during the process and laughed it out. After completing the puzzle, the researcher announced the intention of the exercise and the importance of arguing and debating to achieve better results. She also highlighted that during the formulation of strategies to empower the Batlokwa women with dysmenorrhea knowledge, the same behaviour might prevail. The researcher warned the participants not to be intimidated by the discussion. The whole exercise lasted for 45 minutes.

Step 2: Engaging participants

Data were collected by engaging participants in a discussion. This step consisted of two sessions, i) presentation of Phase 1 study findings, preliminary strategy statements and posing of the focal question, ii) debates and dialogues based on the presented information. The Lekgotla facilitator, research assistant and researcher took field notes during the discussion since the recording of the process was not allowed.

(i) Session 1: Presentation of Phase 1 findings and preliminary statements

The researcher presented the findings of Phase 1 bulleted on the flip chart, which consisted of themes and sub-themes. Relevant information from the literature was also shared in the study findings. The information was also tableted, where study findings, characteristics of Africana Womanism and preliminary strategy statements were grouped to show relationships. The findings showed that although there are some dysmenorrhea aspects that are similar between the Batlokwa ethnicity and Western perspectives, Batlokwa women understand dysmenorrhea differently from the Western perspectives. In support of this finding, De Sanctis et al. (2017) reveal that different countries understand dysmenorrhea differently. According to Mothibe and Sibanda (2019) cultural beliefs influence how societies view illnesses.

Moreover, Kpobi and Swartz (2019) realised that indigenous and Western perspectives conceptualise illnesses differently. Africana Womanism grants Africans to name, define and describe their knowledge based on their understanding (Hudson-Weems 1993; 2004). The session lasted for 20 minutes. Then the researcher posed a general question:

How can the study findings and Africana Womanism theory help to create strategies to empower the Batlokwa women with dysmenorrhea knowledge?

The participants went for a 15-minute comfort break. The main intention was for them to brainstorm on the presentation and the posed question.

(ii) Session 2: Debates and dialogues in relation to the presented information

After the comfort break, the facilitator took over to stimulate a debate and dialogue. She started by summarising the process of the meeting. She repeated the focal question, followed by a probing question to direct the debate and dialogue.

The participants were asked to consider the posed questions to provide opinions. Participants took turns presenting their opinions, through the facilitator's permission. This ensured that each member could contribute to the clarification of the opinion free from judgement and criticism. The facilitator summarised each participant's opinion after each presentation. The process created an opportunity for the participants to discuss and match similar opinions from the pool that was generated without spending too long on a single opinion.

The frame of the dialogue was more elaborating, including how the opinion can be framed as a strategy, purpose or goal to empower Batlokwa women with dysmenorrhea knowledge. This process assisted in grouping the opinions of similar meaning according to the themes of the empirical study. The flow of discussion provided an in-depth understanding of the development of statements to qualify as the strategies, goals and objectives. During this session, the domains of SIGN 50 were applied to make sense of the discussion. Refer to Table 7.1 and Step 3. The closure of this session was confirmed when there were no more emerging statements from the participants' opinions. This session lasted 75 minutes.

Step 3: Reaching consensus on the strategies to empower Batlokwa women with dysmenorrhea knowledge.

Muller et al. (2014:57) suggest a strategy development to be based on a process of trustworthy consultation by drafting the particular process and redefining it with the stakeholders involved. Moreover, to formulate the strategies to empower the Batlokwa women with dysmenorrhea, some tasks were performed collaboratively with a group of experts to evaluate and recommend the strategies. The experts discussed and compared the raised opinions to the preliminary strategy statements from Table 6.2 and Figure 7.1. When the opinions were compared with the preliminary strategy statements, relationships were established between the opinions and preliminary statements. Thereafter, the experts jointly selected the most appropriate statements found relevant and culturally acceptable to their context (Muller et al. 2014:57). The purpose was to include all the necessary information needed for the draft strategies. It was also to get cultural understandings of dysmenorrhea with the intent of transitioning the findings into various strategies. The researcher and research assistant worked together with the participants in overseeing the process.

After a joint effort by the experts to scrutinise and compare the opinions and preliminary statements, a mutual agreement was reached to summarise the available information into strategies deemed relevant to empower the Batlokwa women with dysmenorrhea knowledge. Whilst some of the information was considered, activities were required to achieve the strategies. The strategic goals and objectives emerged from the discussion and were checked if they addressed the themes and sub-themes of the empirical study, as well as the literature and Africana Womanism theory integration. Strategies to empower Batlokwa women were identified, as indicated in Table 7.4. This session lasted for 1 hour and 30 minutes.

Step 4: Verification and refinement of the strategies to empower Batlokwa women with dysmenorrhea knowledge

The proposed strategies were then presented to the experts to subject them to the final scrutiny. It was also to complement the proposed strategies with inputs from their respective perspectives and findings from the empirical study. The experts were asked to rate each of the developed strategies on perceived importance, clarity, applicability, validity and reliability. The researcher used a four Linkert scale as described under data collection tool and illustrated in Table 7.3. The Lekgotla discussion participants were also requested to reformulate, add or remove statements from the draft strategies. As such, discussion concepts were scrutinised, ideas and knowledge were constructed through the debate dialogue and shared freely to refine the strategies.

- **Data collection tool**

The researcher compiled closed-ended strategy statements that addressed the empirical data collected in Phase 1 of the study. The compiled strategy statements served as the evaluation criteria. The instructions to guide the ratings were: 1) How important are each of the strategies in the empowerment of Batlokwa women with dysmenorrhea knowledge; 2) how clear is the formulated strategy; 3) and how applicable it is to implement each of the strategies in empowering Batlokwa women with dysmenorrhea knowledge; 4) how valid will the strategy assist in empowering Batlokwa women; 5) how reliable is the strategy in producing similar results if applied in similar circumstances. Exact instructions on how to use the evaluation tool were given to the experts. The experts were requested to rate each strategy according to the Linkert scale privately and provide suggestions and recommendations where necessary for the reformulation of the strategy.

Each strategy statement was to be scored on one to four Likert point scale as stated herein: 1=irrelevant, totally not important, clear and applicable; 2=unclear, importance and applicability questionable; 3= important, clear and applicable but needs reformulation; and 4=extremely important, clear and highly applicable. The tool also had a space for comments and suggestions. The comments and suggestions were to be used to reformulate and refine the draft set of strategies. According to Grove, Burns and Gray (2013:430), the Likert scale is the most commonly used of the scaling techniques in nursing and health care studies. Table 7.3

below depicts the scores and evaluation criteria of developing strategies to empower Batlokwa women with dysmenorrhea knowledge.

Table 7.3. Scores and evaluation criteria for developing strategies to empower Batlokwa women with dysmenorrhea knowledge

SCORES	EVALUATION CRITERIA	COMMENTS/SUGGESTIONS
4	Extremely important, clear and highly applicable	
3	Important, clear and applicable, but needs reformulation	
2	Unclear, important and applicability questionable	
1	Irrelevant, totally not important, clear and applicable	

- **Data analysis**

Each participant was requested to share her scoring and suggestions whilst the facilitator was writing it on the flip chart. Thereafter, the facilitator and research assistant collected the evaluation tools from the experts for confirmation and further data analysis. The points against each response were indicated on a flip chart. Scores for each strategy were added up, and the final order of responses' scoring was grouped and calculated. Each participant knew immediate results in response to the evaluation of the strategies as the exercise was conducted openly.

Scores that registered 4's were accepted, the 3's and 2's were re-formulated, and the 1's were deleted. Most of the evaluators scored 4, and few strategies registering 3's were re-formulated based on the suggestions and comments, where there was a repetition of strategies, the repeated one was deleted. There were no 2's and 1's. The reformulated strategies were added to 4's and reflected in this chapter as the final refined strategies. To reach consensus, a summary sheet indicating the agreement was prepared with the refined and agreed upon strategies as a form of feedback, and put on a flip chart.

A statistical presentation determining the mean (M) and percentage agreement (PA) was also presented to the experts. After reaching the consensus, there were no shortcomings indicated. The experts commented that the proposed strategies are relevant and address the plan to

inform the Batlokwa women with dysmenorrhea knowledge (practicality). They all confirmed that the strategies are clear, specific and achievable as objectives. This step ensured the practicality and quality of the proposed strategies. Therefore, the result was a refined set of strategies to empower Batlokwa women with dysmenorrhea knowledge. This step lasted 45 minutes.

7.6. STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHOEA KNOWLEDGE, IN LIMPOPO PROVINCE, SOUTH AFRICA

This section presents the developed strategies, rationale, objectives and activities required to achieve the strategies. The presentation is composed of the following: name, aim, scope, structure, review and updating.

7.6.1. Name of the strategy

“Strategies to empower Batlokwa women with dysmenorrhea knowledge in Limpopo Province, South Africa”.

7.6.2. Aim of the strategies

The developed strategies are aimed at engaging and empowering women with dysmenorrhea knowledge. The knowledge gained from the strategies will increase the public education and awareness of the ways through which dysmenorrhea is diagnosed, treated and managed by the Batlokwa ethnicity. In turn, this will assist in meeting the dysmenorrheal needs of the indigenous women. Furthermore, the strategies will ensure that the activities carried out for dysmenorrhea are technically evidence-based and ethically bound.

7.6.3. Scope of the strategies

According to SIGN 50 (2019), any developmental material should cover the related practice area, policy and the people who will be affected by the recommendations of the study. The scope of the strategies will cover the Batlokwa women in general and any other investors intending to implement the strategies for the public benefit. The tribal authority house will be responsible for the developed strategies.

7.6.4. Description and structure of the strategies

The five key themes guided the strategies. This was done because the themes were complementary to the developed strategies, rather than exclusionary (Strategic Plan for Nursing Education, Training and Practice, NDoH 2012/13 - 2016/17:32). The specific rationale was developed for each theme to motivate the developed strategies. Developed strategies were based on the scope of each theme and guided by a broad goal. Each strategy has its objective. The details of the developed strategies are set out in Table 7.4 below.

Table 7.4. Guiding theme, goal, objectives, strategies and rationale

Guiding theme 1. Recognising and understanding dysmenorrhea from a holistic perspective	
Goal: To promote holistic understanding of dysmenorrhea that considers health care approach towards management of a person as a whole	
Objectives	Strategies
1.1. To recognise the belief of ‘wholeness’ or ‘completeness’ in the prevention and treatment of dysmenorrhea.	1.1. Integrate all aspects (physical, psychological, spiritual, psychological, social, environment), when providing dysmenorrhea care.
1.2. To appropriate and ensure that all treatment initiatives include other gynaecological problems that strengthen cultural and holistic understandings of dysmenorrhea during service delivery	1.2. Apply comprehensive approach in the assessment and treatment of women by incorporating indigenous dysmenorrhea knowledge(s) and holistic approach.
Rationale	
<p>According to Harfield et al. (2018), common characteristics of good strategies should give overall direction by pointing to an overall path without dictating a narrow approach. To apply their traditional knowledge for managing dysmenorrhea holistically, Batlokwa women have to strengthen their local knowledge capacity. For example, they respect and regard all beings as spiritual people. Therefore, they link dysmenorrhea with spirituality under the umbrella of wholeness. Dysmenorrhea and gynaecological problems are managed by the notion of this communal, spiritual relationship.</p> <p>For Batlokwa women, action to address dysmenorrhea will be more effective when undertaken systematically and holistically. Integration of physical, emotional, spiritual, social and environmental wellbeing is essential for Batlokwa women. It provides a foundation for effective</p>	

engagement with understanding the management of dysmenorrhea. The environment in which Batlokwa women live has an impact on their dysmenorrhea knowledge and practices. Additionally, good environmental health conditions are critical to support health care system that is known to the community. The Batlokwa women live with a traditional philosophy in harmony with understanding and managing dysmenorrhea holistically. Since the holistic paradigm recognises that wellbeing is influenced by mental, emotional, physical, spiritual, community, family, cultural, and country's wellbeing (Ventegodt, Kandel, Ervin & Merrick 2016). Additionally, Batlokwa have adopted principles that enable them to manage dysmenorrhea from physical, psychological, spiritual and social aspects. As such, when working with Batlokwa women and families, cultural beliefs and practices need to be included. For example, understanding dysmenorrhea from a holistic perspective. This can be through culturally based interventions such as programmes, through supervision, and through the ways one conducts assessments, diagnosis and treatment (Shrivastava, Couturier, Girard, Papineau & Emami 2020).

Guiding theme 2. Local culture and language are considered a health asset that influences understanding of dysmenorrhea

Goal: To preserve, promote and strengthen the local language in health care system in order to overcome and improve cross-cultural barriers related to communication.

Objectives	Strategies
2.1. To maximise understanding of concepts and engage women in dialogues to reason out the understanding and management of dysmenorrhea.	2.1. Adopt and use language, words, terms, phrases, metaphors that are familiar and acceptable to the women when providing dysmenorrhea services
2.2. To develop a clear appreciative conversation that constitutes excellent practice for dysmenorrhea information during care.	2.2. Apply good communication skills when providing information about dysmenorrhea and related activities

Rationale

As an oppressed people who have been denied the right to choose their own names or to define their own reality, Batlokwa women were extremely sensitive to names and labels, and the power, both symbolic and real, that comes from self-defining dysmenorrhea (Hudson-Weems, 2001). The Batlokwa ethnic people were found to be very conversant and took pride in their language (empirical study findings). de Moissac and Bowen (2019) indicate that words, phrases and languages used to construct, negotiate and maintain health meanings, are strongly embedded within the contextual and socio-cultural environment in which they take place. The preservation, promotion and strengthening of culture, cultural practices and language, through the delivery of health care and services, will enhance the protective factors of culture. It will also encourage greater access to culturally appropriate health services. Ignoring this, somehow can disempower community members and diminish their participation and involvement in the community activities.

Therefore, when empowering them one ought to consider how one can bring their language into the working space and explore if there are any phrases, words and terms that may be integrated into the information to be provided. The Batlokwa women and knowledge developers could be assisted to understand dysmenorrhea better by using the language, names and definitions that are familiar to them, rather than using many foreign concepts and examples (Fejzic & Barker 2019). When informing the women about dysmenorrhea, use concepts and examples that are familiar in the community, before drawing from outside their environment, for them to embrace and master the content.

It is, therefore, crucial to provide adequate strategies to guide and support identifying and empowering communities with appropriate communication and language aspects.

Guiding theme 3. The cultural beliefs and practices have an impact on dysmenorrhea diagnosis

Goal: To ensure that decisions and actions to treat and manage dysmenorrhea are grounded in evidence from diagnostic processes that are based on cultural beliefs and practices that are familiar in the community

Objectives	Strategies
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<p>3.1. (a) To create and ensure the environment that respects, utilises, strengthens and maintains local traditional diagnostic processes and practices that are accepted by the community to build evidence of dysmenorrhea diagnosis.</p> <p>(b). To endure values and beliefs embodied in the Batlokwa cultural beliefs and practices regarding originality of dysmenorrhea.</p>	<p>3.1. Prioritise and determine dysmenorrhea diagnosis actions in line with cultural beliefs and practices.</p>
<p>Rationale</p> <p>First, the study had collected sufficient evidence demonstrating that Batlokwa traditional diagnostic methods are an important influential factor in the diagnosis of dysmenorrhea. The relationship between these diagnostic methods is interactive and closely entwined (Mothibe & Sibanda 2019). These interdependent elements jointly influence the understanding and management of why and how dysmenorrhea occurs. Moreover, it is important to consider and integrate the culturally specific assessments and diagnostic processes in the health information of dysmenorrhea.</p>	
<p>Guiding theme 4. Rich diversity of treatment modalities are commonly used for management of dysmenorrhea.</p>	
<p>Goal: To create a system that supports individuals, families and communities to make informed choices in the type of dysmenorrhea care based on their belief system.</p>	
<p>Objectives</p>	<p>Strategies</p>
<p>4.1. To create a conducive therapeutic environment that</p>	<p>4.1. Prioritise and determine dysmenorrhea treatment actions to be taken</p>

<p>fosters respect, stimulates, preserves and maintains local traditional beliefs in relation to the knowledge of managing dysmenorrhea symptoms.</p>	<p>in line with care priorities and capabilities of the ethnic group</p>
<p>4.2. To ensure that the dysmenorrhea care provided is culturally sensitive and safe, to promote sustainable use of dysmenorrhea healing resources available in the community.</p>	<p>4.2. Build dysmenorrhea knowledge, prevention and treatment of the available resources and strengths of the family and community</p>
<p>Rationale</p> <p>Whereas woman see knowledge as accumulated information, they view wisdom as the ability to effectively apply knowledge in specific lived situations (Nkwanyana 2018). The Batlokwa women proposed an alternative world order where the wisdom of ordinary women is invited and valued; where there is never a top down delivery of information that bypasses the daily lives of the people (Mangena 2013). Drawing from the treatment modalities theme, it became evident that the Batlokwa women use traditional methods to treat, manage and prevent dysmenorrhea. These methods provide important information about their values, beliefs and practices. It is, therefore, important to assess the quality of treatment modalities as per preference and integrate it to the dysmenorrhea knowledge.</p> <p>In addition, fitting resources and opportunities, minimising resistance and barriers and taking advantage of current resources and assets by connecting interventions information with those whom it should benefit, is essential (Rowan, Poole, Shea, Gone, Mykota, Farag, Hopkins, Hall, Mushquash & Dell 2014).</p>	
<p>Guiding theme 5. The roles of THPs and IKHs in treatment and prevention of dysmenorrhea</p>	
<p>Goal: To facilitate partnership between traditional health system and local communities to harness participation and involvement in health</p>	

planning to produce broader dysmenorrhea knowledge that improves the delivery of women health services.	
Objectives	Strategies
<p>5.1. (a) To increase awareness, credibility and accessibility of indigenous dysmenorrhea health care services, and to recognise, acknowledge and appraise the role and support that THPs and IKHs play in managing dysmenorrhea.</p> <p>(b) For the consumers of indigenous dysmenorrhea health care services to gain an adequate understanding of the cultural activities performed during diagnosis and treatment of dysmenorrhea.</p>	<p>5.1. Provide information about the roles and contributions offered by THPs and IKHs in diagnosing, treating and preventing dysmenorrhea and implement all integral components of the dysmenorrhea care offered.</p>
<p>Rationale</p> <p>Experts and service providers who come with the knowledge contained in charts and numbers will not be able to reach most African women’s health knowledge. According to Mothibe and Sibanda (2019), Africans will only trust those who speak of their own struggles and bring personal wisdom rather than disembodied facts.</p> <p>The empirical study findings proved that THPs and IKHs have a major role in implementing indigenous diagnosis and treatment of dysmenorrhea successfully. The THPs and IKHs demonstrated more knowledge about local medicinal plants for dysmenorrhea and other valuable methods of curing dysmenorrhea. The Batlokwa THPs and IKHs have been practising health care for long and are respected in their communities. It is, therefore, crucial to identify and connect with the THPs and IKHs to bring out the dysmenorrhea knowledge and to support the dysmenorrhea literacy (Zuma et al. 2016).</p>	

7.6.5. The validity of the strategy

The strategies should have a particular focus on the opinions of the intended users who supplied information during data collection (Claassen, van den Ende, Meesters, Pellegrom, Kaarls-Ohms, Vooijs, Willemsen-de Mey & Vilet Vlieland 2018). The data collected from the participants were used to represent their opinions on the development of strategies. To enhance the credibility and acceptance of the strategies, the researcher had to ensure that the experts on the panel reflected the full range of stakeholders who had an interest in the results of the study. Their knowledge and expertise were used successfully to develop strategies to empower women with dysmenorrhea knowledge. The panel members were purposefully selected for participation in the Lekgotla discussion. In addition, they consisted of experts from various domains that had an interest in the results of the study. The participants were experts in the field of indigenous health knowledge, Western health knowledge, representing and sharing knowledge with others. Purposive sampling was used to select the experts to be part of the panellists in the study. This was done to obtain a full and thick description of the phenomenon under investigation as well as to obtain the real lived experiences of the participants in their own words (Polit & Beck 2017).

The nature of the methodology used during the empirical study (photovoice), involved participants through data collection, analysis and development of strategies. The components and information in support of the strategies were agreed upon by the Lekgotla discussion group based on the themes and sub-themes of Phase 1 findings supported with literature completed by the researcher. The process of developing strategies to empower the women with dysmenorrhea knowledge was guided and grounded on the pillars of Africana Womanism theory (Hudson-Weems 1993:2004). The purpose was to produce a creative and innovative strategy that would be sensitive to the needs and culture of the women experiencing dysmenorrhea.

In addition, the researcher presented the drafted strategies to the experts so that they could validate the content and suitability of the materials for the Batlokwa women. Feedback from the experts, therefore, approved and validated the accuracy of the developed strategies.

7.6.5.1. Cultural sensitivity and appropriateness

Callister (2016) states that when developing strategies for a specific group, one needs to be aware of customs, and values to create a culturally sensitive and useful tool. The culture was strengthened in many instances such as 1) Using photovoice approach which incorporates the

principles of participatory action research in collecting and analysing data. 2) The methodology and frameworks that guided the study and development of strategies acknowledged the voices of indigenous people, rather than Western theories. 3) We embraced the local community's indigenous beliefs and knowledge for the content of health education materials. 4) Ensuring that the local language was considered throughout the study and quoted within the report. 5) Respecting women's cultural needs by involving women only for discussion of women's health issues (gender-specific). 6) We respected the roles and status that traditional health practitioners and indigenous knowledge holders hold in their community. 7) The content and terms used in the construction of the strategies reflected needs, values and understanding of health and illness from traditional healing perspectives, through observing local protocols.

7.6.5.2. Community involvement and participation

Stakeholder involvement in developing strategies needs to form the basis of the design process in order to gain cooperation and ownership of the final product (Callister 2016). In this case, to facilitate community engagement and establishment of a strong relationship with the community, we consulted and introduced the intentions of the research to the local chieftaincy and authority (Piyasena, Zuurmond, Yip & Murthy 2019). The first steps in this study were to listen and learn from the traditional health practitioners and indigenous knowledge holders in order to understand their perspectives regarding dysmenorrhea. The shared information was used to draft strategies that are culturally appropriate, accessible and empowering. Local experts in health, education and governance were included in the panel during the formulation and validation of strategies to empower Batlokwa women with dysmenorrhea knowledge.

7.6.5.3. Applicability

Strategies for sharing health literacy should apply to its demographic group (Claassen et al. 2018). Applicability addresses the relevance, acceptability and adaptableness of strategies to the study setting. The developed strategies to empower Batlokwa women with dysmenorrhea knowledge were deemed to apply to the Batlokwa women. Moreover, they were involved in collecting information utilised to develop the strategies (Grabowski, Aagaard-Hansen, Willaing & Jensen 2017). The traditional health practitioners and indigenous knowledge holders showed interest in using the developed strategies to teach young girls and other women about dysmenorrhea. The school educators revealed that developed strategies are easy to follow and adopt in the life

orientation study. The nurses also showed interest in using the developed strategies to develop health education programmes to teach women about dysmenorrhea.

7.6.5.4. Clarity and presentation

According to SIGN 50 (2019), any developed material of information to be shared should be in a clear format. The language should also be straightforward, simple and easy to follow. The researcher used a table format, and there is a rationale for the formulation of strategies, objectives and activities were provided for easy understanding. The medical and biological terms were avoided; sentences used are short and in the active voice.

7.6.6. Implementation of the strategies

The principal researcher envisions implementing the developed strategies through workshops and seminars to the Batlokwa women, health care providers and local authorities' representatives to familiarize them with the strategies. The researcher intends to continue with this in her post-doctoral study and may identify a masters or PhD to implement and evaluate the developed strategies.

7.6.7. Review and updating of the strategies

According to Thompson et al. (2017) and Rodrigues et al. (2017: 1068) strategies are not permanent; they should be evaluated and reviewed periodically to establish their ability to achieve their intentions. The experts agreed that the strategies to empower the Batlokwa women with dysmenorrhea knowledge should be reviewed every three years, in order to update the information provided.

7.7. SUMMARY OF THE CHAPTER

This chapter presented the formulation and development of strategies to empower Batlokwa women with dysmenorrhea knowledge, in Limpopo Province, South Africa. The steps followed to develop and refine strategies were discussed. The experts were fully involved in refining and validating the strategies. The developed strategies are presented in this chapter. It is foreseen that the developed strategies would serve to empower women with dysmenorrhea knowledge and strengthen the implementation of health literacy of dysmenorrhea in Botlokwa Limpopo Province,

South Africa. The next and final chapter addresses the summary of the study findings, recommendations, implications, limitations, researcher's self-reflection and conclusions.

CHAPTER 8

SUMMARY OF THE STUDY FINDINGS, RECOMMENDATIONS, IMPLICATIONS, LIMITATIONS, RESEARCHER'S SELF- REFLECTION AND CONCLUSIONS

8.1. INTRODUCTION

Chapter 7 addressed the development and refinement of strategies to empower Batlokwa women with dysmenorrhea knowledge. This chapter addresses the summary of the study findings and its implications based on both phases' findings. Thereafter, the chapter draws conclusions based on the study's findings. Recommendations are suggested so that other researchers can have a point to probe into the different aspects that the study unearthed. The study limitations and researcher's self-reflection are acknowledged to enhance the validity and credibility of the study.

8.2. AN OVERVIEW OF THE STUDY AND SUMMARY OF THE FINDINGS

The main aim of the study was to understand the Batlokwa women's indigenous perspective of the meaning and treatment modalities of dysmenorrhea and to use findings to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. The study had three objectives, which were achieved in two phases. The objectives are highlighted under the summary of each phase.

A qualitative design was followed to comprehensively explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women of Limpopo Province. The findings yielded rich data to develop strategies to empower Batlokwa women with dysmenorrhea knowledge.

The researcher used the philosophical assumptions underlying the critical realism paradigm to understand, describe and interpret the perspectives of Batlokwa women regarding dysmenorrhea.

Therefore, interpreting, reconstructing and putting ideas and structures together to effect change were central to the reality of the participants (Botma et al. 2010:45). To further understand, strengthen the interpretation of the findings and develop the strategies, the researcher applied the characteristics of Africana Womanism theory, which were a guide throughout the study..

The study was conducted in two phases to address three research objectives, as mentioned in Chapter 1, Section 1.6. Phase 1 was an empirical study, and it was conducted in two parts to address two objectives. The findings from part 1 and part 2 were consolidated to form a single whole. Phase 2 addressed the third objective, which developed strategies to empower Batlokwa women with dysmenorrhea knowledge. Figure 8.1 outlines the research process. A summary of the two phases' findings is briefly discussed below.

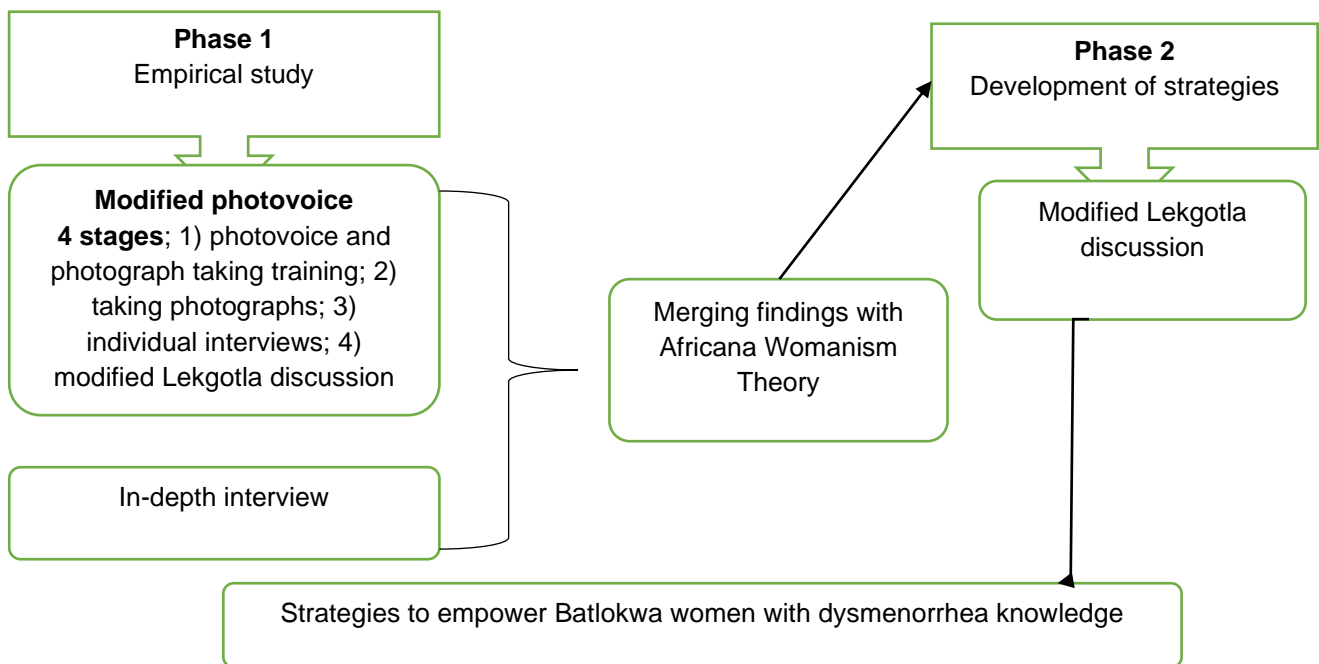


Figure 8.1. Outline of the research process

8.2.1. Phase 1 empirical study

The two objectives in Phase 1 focused on exploring and describing the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women of Limpopo Province. It also articulated the roles of THPs and IKHs in the management of dysmenorrhea using modified photovoice methodology and in-depth interviews. The findings of Phase 1 are briefly discussed according to the emerged themes. The emerged themes reflected the indigenous

perspectives of the meaning and treatment modalities of dysmenorrhea as understood by the Batlokwa THPs and IKHs, based on their cultural beliefs and practices.

8.2.1.1. Summary of Phase 1

Phase 1 of this study had two objectives, namely: To explore and describe the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in Limpopo Province. In addition, it was to explore the roles of Batlokwa women in Limpopo Province as knowledge holders for the management of dysmenorrhea in their community. A modified photovoice, Lekgotla discussion and in-depth interviews were used to achieve the two objectives. The process gave rise to five themes and seven sub-themes, see Figure 4.1. Themes and sub-themes were discussed in relation to literature and the Africana Womanism theory. The discussion was done to clarify and confirm the value and truthfulness of the findings to inform the development of strategies to empower Batlokwa women with dysmenorrhea knowledge. A summary of the five main themes is presented and discussed below.

8.2.1.1.1: Theme 1 Holistic understanding of dysmenorrhea meaning

The study discovered that the Batlokwa women's understanding of dysmenorrhea was based on a holistic perspective. These women viewed dysmenorrhea as an illness that does not affect the physical being only but affects the emotional, spiritual and social being as well. To obtain a holistic understanding of dysmenorrhea, the participating women made meaning through connecting critical components of the symptoms, causes, actions, circumstances and cultural beliefs and practices. The study realised that the cultural socialisation and practices influenced the form in which the participants made a meaning of dysmenorrhea. The meaning that came out of the interconnection was dysmenorrhea does not occur in a vacuum but is connected to the menstrual process and other gynaecological problems. This assisted them to approach dysmenorrhea as a women's reproductive illness.

The Batlokwa women's understanding of dysmenorrhea, as discussed by the participants, was compared to a journey and process. It was found that the use of journey and process metaphors assisted them in clarifying the depth of dysmenorrhea as an illness, rather than presenting factual information. According to the participants, journey and process were chosen because life is usually referred to as a journey. As such, it is to understand the implications that dysmenorrhea has on the woman experiencing dysmenorrhea and the family.

The indigenous perspectives of the meaning of dysmenorrhea in this study were found to be two-tongued. Some participants perceived them as a malicious process that takes place over an extended period during reproductive age. Other women perceived it as a positive process because it is associated with infertility. As such, women who experienced dysmenorrhea are identified early and get intervention for infertility. Another positive process was pointed out as an expected or natural sign to prepare a woman for reproduction. This implies that the experience of dysmenorrhea is subjective, and the uniqueness of individuals should be considered when it comes to the experiences of dysmenorrhea.

8.2.1.1.2: Theme 2 Self-naming and self-definition of dysmenorrhea

The study discovered that dysmenorrhea has Setswana names. The mentioned names are derived in several ways, as explained by the participants. They named dysmenorrhea based on the local significance of the meaning. The participants clarified that the names that they provided were according to their language and cultural understanding so that it is easy to understand and treat dysmenorrhea.

The study discovered that the names that participants mentioned were relative to actions, signs and symptoms and characteristics of dysmenorrhea. The names strictly reflected words and terms that define dysmenorrhea and are culturally sensitive and used by the community members, despite being related to female reproductive organs. It was apparent that some creativity was applied during naming.

As mentioned earlier in Chapter 4 and 5, the prominent names referring to dysmenorrhea were “selumi” (something that bites) and “lethapo hloko” (painful menstruation). However, this does not mean that every person uses the abovementioned names. Many more phrases and terms are used, see 4.3.5 and 5.2.2. The interpretations of the names depended on cultural values and social norms. The participants frequently spoke about using the standard terms and words that Setswana prefer when referring to dysmenorrhea. Nonetheless, most women preferred the word “selumi” instead of dysmenorrhea, and the preference was connected to the interpretation of the action from something that bites.

The study further discovered that the factors that influenced the self-naming of dysmenorrhea were, 1). Indigenous understanding of signs and symptoms of dysmenorrhea. In this case, the participants explained that through observing the way the women experience dysmenorrhea,

assisted them to note signs and symptoms and to treat the illness. 2). Finding reasons for the cause of dysmenorrhea, the participants mentioned that before naming dysmenorrhea, it was necessary to search for viable causes, then decide on the name. They revealed that most of the time, their ancestors guide them when naming. Some participants mentioned that the cause of dysmenorrhea is from the supernatural (witchcraft) or natural (heredity or infection), thus this impact on the word they use for dysmenorrhea.

The common understanding was of dysmenorrhea being caused by external forces to the human body such as witchcraft. 3). Constructing and connecting categories of dysmenorrhea, in this sense, participants revealed that self-naming of dysmenorrhea in their context includes categorising or coming up with types of dysmenorrhea. The findings revealed that there are two categories of dysmenorrhea. The first “selumi” (something that bites), is dysmenorrhea that is periodical and experienced when someone is menstruating. “Tshilwana” occurs immediately after childbirth; they elaborated that this kind of dysmenorrhea causes miscarriages. The word “tshilwana” is derived from the object that is used to massage a woman during treatment.

It was evident from the findings of this study that the THPs and IKHs have evolved a system that helps them to understand, classify, and label clusters of names that they use when referring to dysmenorrhea.

8.2.1.1.3: Theme 3 Diagnostic processes in indigenous dysmenorrhea practice

The study revealed that the Batlokwa THPs and IKHs do not merely treat dysmenorrhea; they follow some diagnostic processes to confirm that a woman is experiencing dysmenorrhea. The data that emerged from this study indicated that the diagnostic processes of dysmenorrhea by THPs and IKHs could be divided into three. Each of the processes has its valuable considerations to be utilised in diagnosing. The identified diagnostic processes were observation, history taking and divination (dream analysis and bone throwing). Observing the physical symptoms of a woman experiencing dysmenorrhea was found to be useful in noting the actions that lead to dysmenorrhea pain. The indigenous knowledge holders strongly indicated how effective this method is, mostly because they do not use divination to diagnose an illness.

According to the findings of this study, history taking was considered another method for diagnosing dysmenorrhea. History taking involves obtaining information related to dysmenorrhea from the client and accompanying person. The IKHs believe that linking the obtained information to

signs and symptoms observed assists in diagnosing dysmenorrhea. However, the THPs felt that history taking should only be used to confirm the diagnosis from divination as discussed next.

The study discovered that in addition to observation and history taking, THPs consult the spirit world for guidance to diagnose dysmenorrhea. According to the findings, divination was the most diagnostic process that was identified from THPs. It was mentioned that divination is a gift from God the Supreme Being. The study revealed that ancestors, gods and other spirits who are believed to be the messengers of God are considered to have invested powers into THPs to diagnose all kinds of illnesses. These were influenced by their type of training and belief systems. The study revealed that the diagnosis process through divination consisted of (i) throwing of bones (*ditaola*) and (ii) dream analysis (*ditoro*) as discussed below.

The traditional health practitioners indicated that during bone throwing, they communicate with their ancestors, and the client's ancestors to determine the causes of dysmenorrhea and the therapeutic actions that need to be taken. They believe in having a supernatural gift of interpreting through the bones (*ditaola*). Regarding dream analysis as a process of diagnosing dysmenorrhea, the Batlokwa THPs believe that their ancestors and guiding spirits communicate with them in their sleep about whatever they find essential such as diagnosing and treating dysmenorrhea. Based on these findings, diagnostic labels are communicated by the THPs and IKHs in a language that is understandable and consistent with the Batlokwa ethnicity group's cultural world view.

8.2.1.1.4: Theme 4 Treatment modalities

The traditional health practitioners and indigenous knowledge holders indicated that traditional healing interventions are used to treat dysmenorrhea effectively. The participants in this study believed that if traditional medicine is administered to a person with dysmenorrhea, the aim is to heal wholly. The data from traditional health practitioners and indigenous knowledge holders revealed that treatment of dysmenorrhea is identified during the diagnosis process.

The data from the IKHs revealed that treatment might be identified adequately through observation of signs and symptoms and from interviewing a client and family members regarding behavioural actions when experiencing dysmenorrhea (causes and type of dysmenorrhea). In comparison, traditional health practitioners believe that during divination, the treatment modalities are revealed. Nonetheless, both traditional health practitioners and IKHs identified herbal and ritual performance (spiritual) modalities for the treatment of dysmenorrhea.

The findings indicated that herbal modalities are an effective way of dealing with a variety of gynaecological disorders, including dysmenorrhea. All participants mentioned herbal medicine prepared from buffalo tree roots, bitter aloe, guava tree leaves, however, the preparations and routes of administration differed among practitioners. The participating THPs and IKHs explained that they use herbs to bath women experiencing dysmenorrhea in order to cleanse the body symbolically. The data indicated that some of the herbal treatment for dysmenorrhea is administered through vaginal douching and steaming with herbs, bathing, inducing body sweating through steaming, inducing vomiting by ingesting herbs and sneezing by snuffing dried medicine. As such, every indigenous practitioner holds some substantial knowledge on the herbal treatment effect and route of administration.

The performance of rituals is regarded as spiritual interventions usually performed in an attempt to appease the ancestors for peace and harmony between the living and the spiritual world. According to the data, rituals are not performed to all the clients as they do not experience dysmenorrhea in a similar manner. The type of the ritual mentioned was to “*o kgaola noga*” (simply meaning that they are cutting the menstruation). They cut the menstruation so that the woman must fall pregnant because her periods are painful; hence it is only performed on women who are ready to start a family. Sacred places such as ancestral hut, rivers, mountains, specific trees were identified as places where rituals are performed. The ritual ceremonies performed in Botlokwa for dysmenorrhea may differ from those that are practised in other regions.

8.2.1.1.5: Theme 5 Roles of THPs and IKHs in the treatment and prevention of dysmenorrhea

The findings of the study discovered that THPs and IKHs play various roles in the community, including the diagnosis and treatment of dysmenorrhea. According to the THPs and IKHs, other roles that they play in the community are consultants and physicians to diagnose and treat other illnesses; the transmission of indigenous knowledge to others and mentoring; general counselling and support and role modelling.

8.2.2 PHASE 2: DEVELOPMENT OF STRATEGIES TO EMPOWER BATLOKWA WOMEN WITH DYSMENORRHEA KNOWLEDGE

The objective of Phase 2 was to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge. For the findings articulated during the empirical study, refer to Chapter

4. Literature sources and Africana Womanism theory clarified, supported and confirmed the interpretation and organisation of the study findings, see Chapters 5 and 6. The study findings were further merged with the characteristics of Africana Womanism theory to prove and show the cultural relationship. The preliminary statements and recommendations that assisted with the development of strategies also emerged during the merging, refer to Table 6.2 and Figure 6.1. The experts were fully involved in the refinement and validation of the strategies during a Lekgotla discussion workshop. The process of development is discussed in detail in Chapters 6 and 7. The process of strategy development is summarised below.

8.2.2.1. Methodology

The researcher used the findings from Phase 1, information gained from an extensive literature review as well as the characteristics of Africana Womanism theory to draft the preliminary statements to influence the development of strategies. The strategies were developed to empower the Batlokwa women with dysmenorrhea knowledge. A set of eight preliminary statements and recommendations drawn from merging the findings of an empirical study with Africana Womanism theory were presented to the selected experts (see Table 6.2 and Figure 6.1). The experts debated the presented information to refine and validate strategies in a Lekgotla discussion workshop. After reaching consensus on the developed strategies, the verified and refined strategies were presented, refer to Table 7.3. A detailed description of the Lekgotla discussion and processes followed is provided in Chapter 7. For the easy flow of activities during the formulation of strategies, the researcher created a framework that guided and drafted the development of strategies based on the pillars of Africana Womanism theory (see Figure 7.1). As a structured process, the constructed framework utilised the generated ideas and opinions from the study findings and characteristics of Africana Womanism theory and illustrated how these key concepts are interrelated in developing the strategies (CohenMiller & Pate 2019:1218).

8.2.2.2. Population

The experts were purposefully selected. The population included THPs, IKHs, nurses working in the local clinic, teachers from primary and high schools and representatives from local authorities and leaders from women's community groups (Refer to 3.4.2.1).

8.2.2.3. Guiding principles

The strategy development was based on the best available evidence. The researcher used various sources to identify the relevant and suitable principles to value and guide the development of strategies to empower the Batlokwa women with dysmenorrhea knowledge (SIGN 50 2019). Other principles derived from community-based decolonising indigenous approaches (Lekgotla) and Africana Womanism, were used to embrace and gather indigenous knowledge of dysmenorrhea from the local community. The guiding principles are fully described in Chapter 7, Section 7.2.3 and Table 7.1.

8.2.2.4. Refinement and validation of the strategies

The strategies were formulated by the researcher and developed by the panel of experts who provided valuable and insightful contributions. The final strategies were developed. A multidisciplinary panel of experienced and highly acclaimed experts was used to measure the quality of the strategies during a Lekgotla discussion. To refine and validate the strategies, experts used the evaluation criteria in the form of a checklist with the ratings to confirm consensus (see Table 7.2). Each strategy statement was rated on a four-point Likert scale for importance, clarity, applicability, validity and reliability. The rating of the tool by the experts was done privately but shared openly among the experts as presented in Chapter 7, Section 7.5.2.2, Step 4. Twenty-two experts rated the strategies and reformulated the strategies that were rated 3. Table 8.1 below shows the final summary of the ratings of each strategy by experts.

Table 8.1. Final summary sheet of ratings for the strategy per evaluation criteria

STRATEGY	CRITERIA																			
	Importance: how important is the strategy in the selected community				Clarity: how clear, simple and logic is the strategy;				Applicability: how applicable it is to implement each of the strategy in empowering Batlokwa women with dysmenorrhea knowledge				Validity: the strategy will assist in empowering Batlokwa women with dysmenorrhea knowledge				Reliability: The strategy will produce similar results if applied in similar circumstances given the same evidence and methods for development			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Strategy 1.1				22				22				22				22				22
Strategy 1.2				22				22				22				22				22
Strategy 2.1				22				22				22				22				22
Strategy 2.2				22				22				22				22				22
Strategy 3.1				22				22				22				22				22
Strategy 4.1			1	21			1	21			1	21			1	21			1	21
Strategy 4.2				22			3	19			1	21				22				22
Strategy 5.1				22				22				22				22				22
Subtotal			1	175			4	171			1	175			1	175			1	175
Total	176				176				176				176							

8.3. DESCRIPTION OF THE FINAL STRATEGIES

The developed strategies were described under the following headings:

- Name of the strategies
- Aim of the strategies
- The scope of the strategies
- Description and structure of the strategies
- Validity of the strategies
- Review and updating of the strategies

8.3.1. Name of the strategies

“Strategies to empower Batlokwa women with dysmenorrhea knowledge in Limpopo Province, South Africa”. The name derived from the third objective of the study.

8.3.2. Aim of the strategies

The aim is to empower the Batlokwa women with dysmenorrhea knowledge. The knowledge gained from the strategies will increase public education and awareness regarding dysmenorrhea.

8.3.3. The scope of the strategies

The scope of the strategies will cover the Batlokwa women in general and any other investors intending to implement the strategies for the public benefit.

8.3.4. The structure of the strategies

The strategies were developed sequentially according to the guiding theme, goal, objective, strategy and rationale. The details of the developed strategies are set out in Table 7.2, see Table 8.2 for a summary of developed strategies.

Objectives	Strategies
1.1. To recognise the belief of 'wholeness' or 'completeness' in the prevention and treatment of dysmenorrhea.	1.1. Integrate all aspects (physical, psychological, spiritual, psychological, social, environment), when providing dysmenorrhea care.
1.2. To appropriate and ensure that all treatment initiatives include other gynaecological problems that strengthen cultural and holistic understandings of dysmenorrhea during service delivery.	1.2. Apply comprehensive approach in the assessment and treatment of women by incorporating indigenous dysmenorrhea knowledge(s) and holistic approach.
2.1. To maximise understanding of concepts and engage women in dialogues to reason out the understanding and management of dysmenorrhea.	2.1. Adopt and use language, words, terms, phrases, metaphors that are familiar and acceptable to the women when providing dysmenorrhea services
2.2. To develop a clear appreciative conversation that constitutes excellent practice for dysmenorrhea information during care.	2.2. Apply good communication skills when providing information about dysmenorrhea and related activities
3.1. (a) To create and ensure the environment that respects, utilises, strengthens and maintains local traditional diagnostic processes and practices that are accepted by the community to build evidence of dysmenorrhea diagnosis. (b). To ensure values and beliefs embodied in	3.1. Prioritise and determine dysmenorrhea diagnosis actions in line with cultural beliefs and practices.

the Batlokwa cultural beliefs and practices regarding originality of dysmenorrhea.	
4.1. To create a conducive therapeutic environment that fosters respect, stimulates, preserves and maintains local traditional beliefs in relation to the knowledge of managing dysmenorrhea symptoms.	4.1. Prioritise and determine dysmenorrhea treatment actions to be taken in line with care priorities and capabilities of the ethnic group
4.2. To ensure that the dysmenorrhea care provided is culturally sensitive and safe, to promote sustainable use of dysmenorrhea healing resources available in the community.	4.2. Build dysmenorrhea knowledge, prevention and treatment on the available resources and strengths of the family and community
5.1. (a) To increase awareness, credibility and accessibility of indigenous dysmenorrhea health care services, and to recognise, acknowledge and appraise the role and support that THPs and IKHs play in managing dysmenorrhea. (b) For the consumers of indigenous dysmenorrhea health care services to gain an adequate understanding of the cultural activities performed during diagnosis and treatment of dysmenorrhea.	5.1. Provide information about the roles and contributions offered by THPs and IKHs in diagnosing, treating and preventing dysmenorrhea and implement all integral components of the dysmenorrhea care offered.

8.3.5. Validity of the strategy

To ensure the validity of the strategies, the researchers applied different methods. The panel of experts reflected the full range of stakeholders who had an interest in the results of the study and were fully involved throughout the study. The methodology used in both phases of the study was culturally sensitive and appropriate to the participants. The developed strategies are clear and applicable to the demographic group intended to empower women. The detailed description of measures to ensure validity is presented in Chapter 7, Section 7.4.

8.3.6. Review and updating of the strategies

In order to update the knowledge on dysmenorrhea to empower the Batlokwa women, the strategies will be reviewed every three years as per the experts' agreement.

8.4 RECOMMENDATIONS

This study presented the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. The findings provided apparent evidence to empower the women with dysmenorrhea knowledge. The experts made relevant recommendations to use the gained knowledge of dysmenorrhea and develop strategies to empower the rest of the Batlokwa women. Further recommendations that emerged from the study were directed towards women's health services, Department of Health Services, nursing practice, nursing education, nursing research and mainstream education as discussed below:

8.4.1. Women's health services

The study discovered a need to empower women with dysmenorrhea knowledge. A well evidence-based information of dysmenorrhea will be shared with girls and women. Further, emphasis also needs to be given through workshops and seminars on menstruation and its challenges such as dysmenorrhea. The information should tap and emphasise on correcting misconceptions among adolescent girls, women, Western health care practitioners and the country at large.

8.4.2. Department of Health

Based on the evidence of this study, the Department of Health (DoH) needs to recognise, support and endorse the use of indigenous health and healing in health care facilities to enable health care practitioners and patients to have adequate knowledge and understanding of indigenous health in the management of illnesses. As well as to enable patients to have a choice of health care.

Given the complementary and unique role that THPs and IKHs play within the cultural context of South Africa, it is suggested that the current national efforts to recognise indigenous health knowledge be pursued. The Department of Health together with the government can put more efforts in obtaining and monitoring herbal medicinal knowledge from traditional health practitioners and indigenous knowledge holders to assist in meeting the health needs of women experiencing dysmenorrhea and other gynaecological illnesses in South Africa.

8.4.3. Nursing practice

Nurses as patients' advocates need to be knowledgeable of alternative management of dysmenorrhea and other related women's gynaecological problems. Therefore, regular workshops and training are suggested for the professional development of all nursing categories on indigenous dysmenorrhea knowledge. This will help nurses to keep abreast with other approaches in the management of dysmenorrhea and other women's health illnesses. In addition, nurses should keep and empower women with alternate dysmenorrhea knowledge to increase literacy on this matter. Since almost all local languages in South Africa can be written and studied just as the English language, I suggest intensive education in the local vernaculars.

8.4.4. Nursing education

The study provided evidence that traditional health practitioners and indigenous knowledge holders can provide care to women experiencing symptoms of dysmenorrhea. As such, the findings challenge nursing practice to include indigenous knowledge when teaching nursing students. It is, therefore, recommended that a short course on indigenous dysmenorrhea management be developed to orientate student nurses on indigenous dysmenorrhea as an entry into education programmes.

8.4.5. Nursing research

Based on the results of this research, there are multiple directions for future research in the area of health, indigenous knowledge and politics. Some potential directions include research methods, indigenous health and healing, and theoretical framework. The study discovered scanty literature on indigenous dysmenorrhea in South Africa. Therefore, the researcher recommends more nursing research in the area of indigenous dysmenorrhea in South Africa. Further studies in other South African communities can add more to the literature. Future research on dysmenorrhea could focus on a more extensive, more rigorous evaluation study in different urban and rural settings. Furthermore, including faith healers in exploring dysmenorrhea can add variety in the knowledge of management of dysmenorrhea. This would confirm the effectiveness of the indigenous management of dysmenorrhea.

This research study only developed strategies to empower the Batlokwa women with dysmenorrhea knowledge. Future research can share, implement and evaluate the developed

strategies. Furthermore, this study discovered the use of different plants and herbs in the treatment of dysmenorrhea by traditional health practitioners and indigenous knowledge holders.

Therefore, the researcher recommends the laboratory testing of pharmacological effects of the plants and herbs to document plants and their therapeutic properties for future generations. Additional knowledge about plants and herbal value will reveal additional opportunities for providing services and delivering them more efficiently. The need to conduct such studies is even more urgent in light of the current moves by the South African government to recognise indigenous health and healing officially.

8.4.6. Mainstream education

The issue of indigenous knowledge and management of dysmenorrhea should be incorporated into the schools' curriculum so that students know about other means of dealing with symptoms of dysmenorrhea. The government and department of education have neglected this important subject area.

8.5 IMPLICATIONS

8.5.1 Policy implication

This research has articulated indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women. Specifically, these results may be used to influence policy at the local level, by allocating resources and programmes specifically for the locals to learn about indigenous dysmenorrhea.

8.5.2. Body of literature implication

The study added to the body of literature on the subject of women's empowerment because it had provided an opportunity for the Batlokwa THPs and IKHs to voice out their indigenous perspectives on the meaning and treatment modalities of dysmenorrhea. By giving these women a voice, the study provided a general description of dysmenorrhea knowledge and treatment modalities from the Batlokwa women where customs and cultures, in relation to women and dysmenorrhea, have hardly been explored and documented previously.

The provided knowledge assisted in developing strategies to empower women with dysmenorrhea knowledge. The health care providers, including indigenous knowledge holders, can use the strategies to develop health education programmes of dysmenorrhea to educate patients and clients experiencing symptoms of dysmenorrhea. Therefore, local women who are aware of the available indigenous health care and prefer indigenous treatment modalities than biomedical treatment are more likely to use this method. In future, the developed strategies will be of value to the education, health and training to integrate indigenous and Western health.

8.6. UNIQUE CONTRIBUTIONS OF THIS STUDY

This research on Batlokwa THPs and IKHs women's perspectives and practices of dysmenorrhea are the first developed strategies to empower the Batlokwa women in Limpopo Province, South Africa. The knowledge generated from this study is useful in improving the development and implementation of culturally tailored nursing and public health interventions that include women's health.

Exploring and describing the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea contributes to understanding cultural practices and competence on the management of dysmenorrhea among THPs and IKHs. This encourages other health care professionals to embrace health care differences in a multicultural society towards possible incorporation into the national health system.

The findings of this study contribute to the literature through knowledge that informs greater comprehension and awareness of indigenous women's health issues and the complexity of culture regarding dysmenorrhea. Those who are in the academic, professional women's health and Indigenous Knowledge Systems field will grasp the complexity of the issue of dysmenorrhea and research further.

8.7. STRENGTHS AND LIMITATIONS OF THE STUDY

8.7.1. Strengths of this study

The strength of this study stems from theoretical underpinnings of the Africana Womanism, critical realism paradigm, photovoice and Lekgotla discussion, which positioned the participants as the 'experts' in the knowledge of dysmenorrhea. The theory, paradigm, and methodology were also deliberately empowering, because conversations started from the THPs and IKHs' understanding of dysmenorrhea without imposing other ideas of dysmenorrhea on them. The photovoice approach was well received by the participants, although they suggested the use of Lekgotla discussion method instead of a regular discussion.

Using photovoice methods allowed the weakness of individual data collection method to be offset by the strengths of the other. For example, this study collected photographs from THPs and IKHs; individual interviews were conducted, followed by a Lekgotla discussion. The methods informed each other. Thereafter, in-depth interviews were conducted with different THPs and IKHs to enhance the knowledge gained from the photovoice study.

8.7.2. Limitations of the study

Providing limitations for the study may assist in the use of future research designs and methods. The following limitations were identified:

8.7.2.1. Limitations concerning methodology

The photovoice approach was interesting to use, however, in this study, it incurred some limitations. A notable limitation with the photovoice method was the requirement for participants to adhere to the photovoice ethics. Participants commented that to avoid ethical issues, instead of asking permission to take some of the photographs, they opted not to take individual photographs. It is also important to note that instead of regular group discussions as practised with the photovoice methodology, participants in this study suggested a Lekgotla discussion, which is well known in their community.

In addition, during data collection, the process of photovoice proved to be long and required follow up interviews and a Lekgotla discussion. The Lekgotla discussion for developing strategies took

long, and some of the participants were not comfortable with the amount of time taken. Since the study used photovoice to collect data, it was difficult to reach saturation using this method because the researcher limited the number of discussed photographs. The researcher and supervisor opted to use in-depth interviews in addition to existing data collected through photovoice.

It was also noted that photovoice is an expensive method to use. The expenses included: a camera for each participant, processing of images/photographs, workshops for training participants on the use of the camera and ethics to be considered. It also required several methods of data collection.

The participants addressed some limitations of the photovoice method. Participants commented that disposable cameras limited each of them to capture 27 photographs, and some of the photographs were not clear. They also indicated that selecting only three photographs for discussion limited the information to be shared. They suggested that in future, digital cameras should be used so that they can delete unclear photographs and re-capture. This will increase the selection pool for interviews and discussions. Another advantage of using a digital camera is that participants could see the pictures that were taken, therefore perhaps be more comfortable with the photo-taking technique.

8.7.2.2. Limitations with regard to the sample group

The study was conducted as a prerequisite for a PhD programme and was therefore limited by human and financial resources. Upon reflection on the complex and activities involved throughout the process, the magnitude of this research required more human and financial resources as well as time to include more participants.

It was challenging to gain access to the study site. I had to travel considerably to sit in the meetings with tribal authority representatives. Regarding participants, it was complicated to access and recruit them because of the trust issues and sensitivity of the information. Some of them cancelled appointments when I was already at their homes because of other emergencies (to attend patients in other areas), or delays and interruptions by the clients that visit without appointments.

In addition, participants in the study were from Botlokwa, Molemole municipality. There are other municipalities in the district that could have contributed to literature. This was affected by the study's timing and spontaneous availability of participants.

Although some of the participating THPs and IKHs indicated that they experienced dysmenorrhea previously, non-involvement of the women experiencing dysmenorrhea in the sample is considered a limitation. The findings of this study were only from the THPs and IKHs' understanding. The participants were only from the Batlokwa ethnicity group.

8.7.2.3. Limitations with regard to the literature

This study explored the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among Batlokwa women in the Limpopo Province. There was limited literature on the Batlokwa ancestry and its dysmenorrhea perspectives and treatment. This made it difficult to compare the findings of the study to more previously researched work.

Previous studies would have assisted in locating whether there has been a shift in the conceptualisation of dysmenorrhea and to compare and confirm some of the findings from the study. This may have an impact on the validity of the responses by the participants. Nonetheless, studies from other South African cultural groups proved to be helpful in this regard.

8.7.2.4. Limitations relating to the ethnic background

South Africa, like many other countries in the continent, has many tribes and therefore many cultures, traditions and customs. Even within one tribe of Batlokwa, uniformity was not always possible as within the Botlokwa village there were other tribes such as Vendas, Tsongas and foreigners from neighbouring countries such as Zimbabwe, Mozambique, Lesotho, Botswana and Swaziland. These tribes might have brought their culture and incorporated it with the Batlokwas. It was challenging to identify this because these tribes have been leaving in Botlokwa for long, and they speak and call themselves Batlokwa.

The spoken language (Setlokwa) is challenging to put in writing because of the way words are pronounced in Setlokwa. The limitation may have resulted from having to translate some of the interviews and Lekgotla discussion data from Setlokwa into English. Therefore, several errors might have occurred during the translation, although the researcher and assistant researcher speak and write well in both languages. It is fair to acknowledge that it may always not have been possible to avoid some of the translation errors.

8.7.2.5. Limitations with regard to the context

The study was contextualised to a specific setting, which is a Botlokwa village in one municipality, Limpopo Province. The researcher was based in Gauteng province (place of work). She had to travel frequently between the two provinces, which are +350 kilometres apart. This caused delays in reaching participants; some appointments with participants were forfeited.

8.7.2.6. Some of the strengths and limitations are addressed through the researcher's self-reflection

8.7.2.6.1. Researcher's self-reflection

Researchers indirectly contribute in identifying the power dynamics that shape voices to be heard or silenced (Haraway 1988). As such, researchers should expose their perspectives to overcome power imbalances and how they influence the study. According to Absolon and Willett (2005:98), "locating the self in research brings forward one's reality"; who you are, where you come from, your intentions for conducting research, relationships to the land, language, spirituality, economy, environment and social elements in one's life. Consequently, the critical realism paradigm admits to bias being present in every action of a human being and expects the findings to support that bias (Okesina 2020). The researcher should continue to be as objective as possible throughout the research process. Researchers should also be aware that they influence the study findings; as such, they are required to position themselves so that bias does not affect the findings. Therefore, positioning myself meant to familiarise the reader with my understanding of self, my connections to the study and my motivations for this work.

- ***Self-reflexivity***

Reflexivity refers to the researcher's awareness of themselves as part of data collection; therefore, they should reflect on their behaviour and how their behaviour can affect data collection (Polit & Beck 2017:508). Therefore, researchers need to minimise possible biases that could affect the entire research process (Polit & Beck 2017:508, Cresswell & Poth 2018:228-229). In addition, Polit and Beck (2017:569) find researcher's qualifications and experiences essential and relevant in being reflected when conducting research, in order to establish confidence in the research findings. In those instances, I sought to minimise possible biases that could affect the current research, in a particular interpretation of results through ongoing reflexivity and acknowledging my intellectual

privilege and my location in the research process. I was also committed to seeing and analysing information from the participants' perspectives and avoiding academic and personal perspectives related to dysmenorrhea.

The act of self-reflexivity is also a critical part of participatory action research and essential to Africana Womanism theory and indigenous knowledge researchers in order to heighten awareness of the subjectivity and help to position the study (Cresswell & Poth 2018:44; 228-229). Hence, the Africana Womanism theory encourages researchers to adopt the practices of reflexivity when researching in order to overcome the methodological concern of objectivity. In support, Patton (2002 cited in Polit & Beck 2017:569) emphasised that the research report with the researchers' credentials and how he/she is connected to the community, participants, topic, methodology, theory, enhance trustworthiness. During the research process, I discovered that my background and perspectives as a researcher partially influenced the process. To overcome that challenge, I acknowledged my position as a researcher.

Conducting the current study in Botlokwa village was my decision directly related to my place as a Black, South African woman. I was born a Black woman and raised in a township called SOWETO and a rural village of Botlokwa, Ga-Ramokgopa, in Limpopo Province, South Africa. Growing up, I saw my parents struggling socially and politically against exclusion as Blacks. My mother, in particular, took care of my siblings and me when we were sick. She knew how to prevent certain illnesses and how to treat particular ailments using indigenous knowledge, and without consulting anyone. In Botlokwa we spoke the Setlokwa dialect of the Sepedi and TshiVenda language. My roots are in Botlokwa where I spent my primary and high school years. Back in Botlokwa, we had a Western clinic within walking distance. However, home remedies prepared by a family member were the first line of prevention and treatment of illnesses. Although I was born and raised in the post-independence era in South Africa and an insider to Botlokwa ethnicity, I was trained to think and act more as a nurse in Europe than in South Africa. As I progressed with my career, I realised that there are different types of health care systems; hence I developed an interest to understanding indigenous health knowledge.

During the conceptualisation and formulation of the research questions and methodology as well as during data collection, I was aware that my lived experiences as a Black woman from Botlokwa village and a Western-trained nurse shaped what I was studying and the approach I chose. Therefore, I could not avoid my subjectivity as a researcher because it was difficult to separate myself from the research. I used a photovoice methodology after discovering it for the very first time in my PhD journey because I am a visual learner and value creativity and unique approaches

that disrupt traditionally dominated research approaches. Furthermore, I wanted the lives and voices of Batlokwa women to be directors of this research through the participatory action approach.

- ***Outsider/Insider researcher***

This study was conducted as part of PhD requirements, not for any financial gain. In saying this, I conducted this study from a subjective position as a South African woman currently pursuing my post-graduate education. Although the study's focus was on feminism and Indigenous Knowledge System, I am a non-feminist and non-Indigenous knowledge holder. Therefore, I approached this study as a student. This positioned me as an outsider/insider researcher. According to Chhabra (2020), the role of the researcher, either as an insider or outsider within the fieldwork, is a significant issue when conducting qualitative research because it might affect the accuracy of the collected data and the subsequent analysis that unfolds. However, Hooks (1984) is of the opinion that it is an advantage for the researcher to hold both sides of the social divide when conducting research because one can develop a unique way of seeing and understanding reality from the outside in and inside out. During the whole process of research, I was both an outsider and an insider. This placed me in a unique position from which to understand how things are from the perspective of an outsider as a nurse academic who enjoys some degree of power and privilege both professionally and personally. Additionally, from the perspective of an insider as a Motlokwa woman who is marginalised as a result of gender and race.

I was an outsider on indigenous knowledge of dysmenorrhea and treatment modalities, which is only known by specific people within the Batlokwa clan. I began this research with an understanding of my outsider position to indigenous knowledge, aware of the benefits and disadvantages within it. The outsider advantaged my position because I was curious to obtain unfamiliar information from the IKHs. The other advantage I received was when IKHs gave detailed explanations because I was seen as a non-aligned group than as an insider who was assumed to know some of the information already. However, I was also aware that being an outsider to indigenous knowledge of dysmenorrhea and treatment modalities could be perceived negatively by the respective IKHs and THPs. They could not have wanted to discuss or share their knowledge with an outsider to their health practice. In addition, my position as an outsider to their knowledge might have been seen to prevent a true understanding of their practices. In addition, my research could have been perceived as having some other intentions since their knowledge was previously stolen and marginalised by others (Iloka 2016; Ocholla & Onyanacha 2005), despite my aim to

make their knowledge and practices known and recognised. These posed obstacles in terms of accessing the participants and understanding the dynamics inside the indigenous knowledge holders regarding dysmenorrhea and treatment modalities. Some of the information was considered sacred and only available to the insider. Some of these issues caused months of delays in collecting data.

My status as a Motlokwa woman positioned me as an insider as I share the same racial, gender, social class and cultural background as the participants. This position suited me well to uncover ideas and opinions about issues related to the indigenous meaning of dysmenorrhea and treatment modalities. There were no language barriers; the participants were in liberty to communicate in either Setswana or English. These enabled me to communicate with the indigenous knowledge holders and THPs using our mother tongue. Although it was not easy to build a smoother working relationship with the participants, in the beginning, because I am a graduate Western health care provider who is undoubtedly distanced and opposing their knowledge. However, sharing common gender bonds, ethnicity and culture, made them to accept and cooperate reasonably during the research process. Being a Motlokwa woman helped me to win their trust and connect easily with them. To win them, I became informal when talking to them. I shared childhood stories of menstruation and challenges and success stories of indigenous knowledge healing. However, during our conversations, I avoided sharing personal interests and particular experiences as a Black South African woman, Motlokwa, Western health care provider and student. My focus was on their knowledge and perspectives throughout the study. This positioned me neutrally and enabled me to acquire meaningful and honest data because participants felt comfortable to talk about their indigenous knowledge openly. The participants spoke very openly about menstruation and its challenges.

Being an insider somehow helped me to maintain a high standard of ethics and respect throughout the study process because I was familiar with the norms, customs, values and rules of the community. However, periodically I found myself floundering concerning the appropriate cultural rules and expectations of behaviour. I obtained permission to conduct the study from the local authority leadership and indunas, who shared my intentions with the councils (Lekgotla meetings). These made recruitment a little bit easier because the indigenous knowledge holders were informed in their Lekgotla gatherings about the research study. It was easy for me to recruit the indigenous knowledge holders and THPs because Setswana women were informed in their Lekgotla gatherings about the research study that would take place. However, to some extent perhaps, I may have underestimated the need for learning about a culture before going into the

field. For instance, when interviewing some THPs, I was expected to take off my shoes and sit on the floor. Some of the participants extended their friendship by phoning and asking about the progress of the study and my life in general. Some participants phoned to provide information about the history of Covid-19 and indigenous treatment. They expected me to share the information because of the pandemic, although it occurred long after I had collected data. I realised that the relationship between the researcher and the participants is essential and extended beyond the data collection process.

The dual position of outsider/insider posed very sensitive and challenging questions about the social and political reality that the Black women experience in their profession (when providing Western-based care to those who need indigenous based health care). I also in one way or another sympathised with the participants and other marginalised people who are victimised and undermined when using indigenous health care systems. However, through the whole research process, I could keep some sort of outsider status because I am not a victim of that system, so I was able to see “objectively” the victims’ perspectives. I used member checking after the interviews were transcribed to overcome the drawbacks that came with being both an outsider and insider. Member checking was also to check if I did not make assumptions from my outsider/insider status about what the participants told me and what I know.

8.8 FINAL CONCLUSION OF THE STUDY

This study explored and described the indigenous perspectives of the meaning and treatment modalities of dysmenorrhea among female THPs and IKHs in Botlokwa, Limpopo Province. The study discovered that THPs and IKHs play an essential role in the women’s health care system. They diagnose and treat dysmenorrhea and other women’s health challenges frequently.

The findings of the current study showed that indeed, indigenous health knowledge is widely used, and that traditional healing uses different modalities in treating dysmenorrhea. All the THPs and IKHs acknowledged that they all use the same modalities in diagnosis, treatment and prevention of dysmenorrhea. They highlighted different ways of diagnosing, treating and preventing dysmenorrhea. The study’s findings also reveal that diagnostic strategies and treatment modalities differ in the context of how the THPs have been taught by their ancestors. The traditional health practitioners seem to have the same understanding that dreams and bone analyses are the most useful methods in diagnosis and treating dysmenorrhea. There was evidence that indigenous

practitioners' perspectives of dysmenorrhea are influenced, to a large extent, by their cultural and spiritual practices and type of the practitioner.

Findings from the current study revealed that indigenous health knowledge was contrasted with the approach taken by Western health knowledge. The Western health knowledge views dysmenorrhea as fundamentally biological in origin and presenting with pathophysiology. To note is that indigenous health knowledge views dysmenorrhea from both biological and spiritual aspects. It regards dysmenorrhea as a holistic problem. Diagnosis and treatment aim at harmonising the women with the spirit through neutralising sorcery, appeasing ancestors by using practical experience and observation handed down from generation to generation. However, the study demonstrated that both indigenous and Western health care practitioners could collaborate in managing women experiencing dysmenorrhea to improve quality of life.

The study also developed and documented strategies to empower Batlokwa women with dysmenorrhea knowledge. The burden of dysmenorrhea is challenging physically, emotionally, socially and economically. It is hoped that the developed strategies will help in increasing the understanding of how to educate the women with dysmenorrhea. If the suggested recommendations are considered, there will be a decrease in the burden of biomedical management of dysmenorrhea. There will be economic relief as well. Respect for indigenous health knowledge will prevail, and more studies on indigenous health may be conducted.

There is no doubt that this thesis serves as a source of inspiration for other researchers to develop and implement the indigenous health education programmes from the knowledge gained from this study.

REFERENCES

Ababio, S., Kquofi, S., & Asante, E.A. (2019). The Indigenous Cultural Ways of Diagnosis in the Ashanti Region of Ghana. *Journal of Advances in Medicine and Medical Research*, Vol 31(4), pp 1-12.

Aboushady, R.M & El-Saidy T.M.K. (2016). Effect of Home-based Stretching Exercises and Menstrual Care on Primary Dysmenorrhea and Premenstrual Symptoms among Adolescent Girls. *IOSR Journal of Nursing and Health Science*, Vol 5(2), pp 47-57.

Abu Helwa. H.A., Mitaeb, A. A., Al-Hamshri, S. A., & Sweileh, W. M. (2018). Prevalence of dysmenorrhea and predictors of its pain intensity among Palestinian female university students. *BMC Women's Health*, Vol 18(18) DOI 10.1186/s12905-018-0516-1.

Acheampong, K., Baffour-Awuah, D., Ganu, D., Appiah, S., Pan, X., Kaminga, A & Liu, A. (2019). Prevalence and Predictors of Dysmenorrhea, Its Effect, and Coping Mechanisms among Adolescents in Shai Osudoku District, Ghana. *Hindawi Obstetrics and Gynecology International*. <https://doi.org/10.1155/2019/5834159>

Adeoye T.E, Arulogun O.S, Dipeolu I.O and Jidda K.A. (2019). *Journal of Medicine and Medical Sciences*. Vol. 10(1): 51-60. DOI: <http://dx.doi.org/10.14303/jmms.2019.1>

Ahlberg, B.M. (2017). Integrated Health Care Systems and Indigenous Medicine: Reflections from the Sub-Saharan African Region. *Front. Sociol*, Vol 2(12). doi: 10.3389/fsoc.2017.00012.

Ahuja, A, Sharma, M.K & Singh, A. (2016). Impact of dysmenorrhoea on quality of life of adolescent girls of Chandigarh. *Journal of child and adolescent behaviour*. Vol 4(3), pp 1-5

Ajayi, A.B., Ajayi, V.D., Biobaku, O., Oyetunji, I., Aikhuele, H., Atiba, A & Afolabi, B.M. (2016). A 10-year study of endometriosis in an indigenous Black African population. *Journal of Endometriosis and Pelvic Pain Disorders*, Vol 8(4), pp 157-166.

Akiyama, S., Goren, A., Basurto, E., Komori, T & Harada, T. (2018). Treatment preferences among Japanese women with dysmenorrhea: results from a discrete choice experiment study. *Dove press journal*, Vol 12, pp 1627-1640.

Alexander, S.M., Provencher, J.F., Henri, D.A., Taylor, J.J & Cooke, S.J. (2019). Bridging Indigenous and science-based knowledge in coastal-marine research, monitoring, and management in Canada: a systematic map protocol. *Environmental Evidence*, Vol 8(15). <https://doi.org/10.1186/s13750-019-0159-1>

Alexander-Floyd, Nikol G. & Evelyn M. Simien, E.M. (2006). "Revisiting 'What's in a name?': exploring the contours of Africana womanist thought." *A Journal of Women Studies*. Vol 27(1): 67–89

Alvergne, A., Wheeler, M.V & Tabor, V.H. (2018). Do Sexually Transmitted Infections exacerbate negative premenstrual symptoms? Insights from digital health. *Evolution, Medicine and Public Health*: 138–150. doi:10.1093/emph/eoy018

Amatya, P., Ghimire, S., Callahan, K.E., Baral, B.K & Poudel, K.C. (2018). Practice and lived experience of menstrual exiles (*Chhaupadi*) among adolescent girls in far-western Nepal. *PLoS ONE*, vol 13(12): e0208260. <https://doi.org/10.1371/journal.pone.0208260>

Anand, S., Akhtar, T & Bhuvana, K. (2018). A study of pattern of self-medication among students for dysmenorrhea. *Asian J Pharm Clin Res*, Vol 11(6), pp 436-438.

Andrade, N.S., Espey, D.K., Hall, M.E., & Bauer, U.E. (2019). A Holistic Approach to Chronic Disease Prevention: Good Health and Wellness in Indian Country. *Prev Chronic Dis*. doi:10.5888/pcd16.190081

Armour, M & Dahlen, H. (2015). A change of perspective: treatment for period pain using acupuncture alters how women view their menstrual cycle. *Integrative Medicine Research*. <http://dx.doi.org/10.1016/j.imr.2015.04.315>

Armour, M., Dahlen, H.G & Smith, C.H. (2016). More than needles: The importance of explanations and self-care advice in treating primary dysmenorrhea with acupuncture. *Evidence-Based Complementary and Alternative Medicine*. <http://dx.doi.org/10.1155/2016/3467067>

Armour, M., Parry, K., Al-Dabbas, M.A., Curry, C., Holmes, K., MacMillan, F., Ferfolja, T., Smith, C.A. (2019) Self-care strategies and sources of knowledge on menstruation in 12,526 young women with dysmenorrhea: A systematic review and metaanalysis. *PLoS ONE*, vol 14(7): e0220103. <https://doi.org/10.1371/journal.pone.0220103>

Arndt, S. (2000). "African gender trouble and African Womanism: an interview with Chikwenye Ogunyemi and Wanjira Muthoni." *Signs*, Vol 25(3), pp 709–726.

Arnold, H.J & Gulumian, M. (1984). Pharmacopoeia of traditional medicine in Venda. *Journal of Ethnopharmacology*, Vol 12, pp 35–74.

Arora, C., Sinha, B., Malhotra, A & Ranjan, P. (2017). Development and Validation of Health Education Tools and Evaluation Questionnaires for Improving Patient Care in Lifestyle Related Diseases. *Journal of Clinical and Diagnostic Research*, Vol 11(5), pp 6-9. DOI: 10.7860/JCDR/2017/28197.9946

Asante, E & Avornto, R. (2013). Enhancing healthcare system in Ghana through integration of traditional medicine. *Journal of Sociological Research*, 4(2), pp 256–272. doi:10.5296/jsr.v4i2.4224

Asante, E.A, Ababio, S & Boadu, K.B. (2017). The Use of Indigenous Cultural Practices by the Ashantis for the Conservation of Forests in Ghana. *SAGE Open*. doi:[10.1177/2158244016687611](https://doi.org/10.1177/2158244016687611)

Asuzu, C.C., Akin-Odanye, E.O., Asuzu, M.C & Holland, J. (2019). A socio-cultural study of traditional healers' role in African health care. *Infectious Agents and Cancer*, Vol 14(15)
<https://doi.org/10.1186/s13027-019-0232-y>

Atindanbila, S & Thompson, CE. (2011). The role of African traditional healers in the management of mental challenges in Africa. *J Emerg Trends Educ Res Policy Stud*, Vol 2, pp 457–464.

Audet, C.M., Ngobeni, S., Graves, E & Wagner, R.G. (2017) Mixed methods inquiry into traditional healers' treatment of mental, neurological and substance abuse disorders in rural South Africa. *PLoS ONE*, 12(12):e0188433.<https://doi.org/10.1371/journal.pone.0188433>

Audet, C.M., Salato, J., Vermund, S.H & Amico, K.R. (2017). Adapting an adherence support workers intervention: engaging traditional healers as adherence partners for persons enrolled in HIV care and treatment in rural Mozambique. *Implementation Science*, Vol 12(50). DOI 10.1186/s13012-017-0582-z Available at: <http://www2.unb.ca/parl/research.htm> [Accessed 28th of October 2018]

Awah, P.K., Unwin, N.C & Phillimore, P.R. (2009). Diabetes Mellitus: Indigenous naming, indigenous diagnosis and self-management in an African setting: the example from Cameroon. *BMC Endocrine Disorders*, Vol 9, pp 5.

Balagué, F., Mannion, A.F., Pellisé, F & Cedraschi, C. (2012). Non-specific low back pain. *The Lancet*, 379 (9814), pp 482-491.

Balomenou, N & Garrod, B. (2016). A Review of Participant-Generated Image Methods: in the Social Sciences. *Journal of Mixed Methods Research*. 2016;10(4):335-351.
doi:[10.1177/1558689815581561](https://doi.org/10.1177/1558689815581561)

Bambra, C., Pope, D., Swami, V., Stanistreet, D., Roskam, A., Kunst, A & Scott-Samuel, A. (2009). Gender, health inequalities and welfare state regimes: a cross-national study of 13 European countries. *Journal of Epidemiology and Community Health*, Vol 63(1), pp 38–44.

Barre, R.Y., Grant, M & Draper, D. (2009). The role of taboos in conservation of sacred groves in Ghana's Tallensi-Nabdam district. *Social & Cultural Geography*, Vol 10(1), pp 25-39.

Behmanesh, E., Delavar, MA., Kamalinejad, M., Khafri, S., Shirafkan, H & Mozaffarpur, SA. (2019). Effect of eryngo (*Eryngium caucasicum* Trautv) on primary dysmenorrhea: A randomized, double-blind, placebo-controlled study. *Taiwanese Journal of Obstetrics & Gynecology*, Vol 58, pp 227-233.

Bekele, W & Gilete, A. (2018). Prevalence and Associated Factors of Primary Dysmenorrhea Among Debre Tabor University Students, North Central Ethiopia. *American Journal of Health Research*, Vol 4(4), pp. 70-74. doi: 10.11648/j.ijbecs.20180404.11

Bernardi, M., Lazzeri, L., Perelli, F., Reis, F. M. & Petraglia, F. (2017). Dysmenorrhea and related disorders. *F1000 Research (F1000 Faculty Rev)*. doi: 10.12688/f1000research.11682

Bezuidenhout, S., Mahlaba, KJ., Nxumalo, G., Meyer, JC & Chukwu, B.O. (2018). Dysmenorrhoea: an overview. *S Afr Pharm J*, Vol 85(4), pp 19-25.

Bhaskar, R. (1989). "Critical Realism, Social Relations and Arguing for Socialism" in *Reclaiming Reality*. London: Verso. Pp 1-11.

Bhaskar, R. (2007). 'Theorising ontology'. In *Contributions to Social Ontology*. 192–204. Lawson C, Latsis J and Martins N (eds). Abingdon: Routledge.

Bhattacharya, H., Medhi, G.K., Pala, S., Sarkar, A., Kharmujai, O.M & Lynrah, W. (2018). Early community-based teaching of medical undergraduates for achieving better working skills in the community. *J Educ Health Promot*, vol 7(161). doi: 10.4103/jehp.jehp_153_18. PMID: 30693298; PMCID: PMC6332666.

Blackmon, J.L. (2008). *I am because we are: Africana Womanism as a vehicle of empowerment and influence* (Unpublished master's thesis). Virginia: Virginia Polytechnic Institute and State University, Blacksburg. Retrieved from <https://theses.lib.vt.edu/theses/available/etd-06302008182302/unrestricted/JBlackmonthesis.pdf>

- Blakeway, J. (2019). *Using Chinese medicine to treat menstrual cramps*. China: Yinova Center.
- Bogopa, D. (2010). Health and Ancestors: The Case of South Africa and Beyond. *Indo-Pacific Journal of Phenomenology*, Vol 10(1): 1-7. DOI: 10.2989/IPJP.2010.10.1.8.1080
- Boot, G.R & Lowell, A. (2019). Acknowledging and Promoting Indigenous Knowledges, Paradigms, and Practices Within Health Literacy-Related Policy and Practice Documents Across Australia, Canada, and New Zealand. *The International Indigenous Policy Journal*, Vol 10(3). Retrieved from: <https://ir.lib.uwo.ca/iipj/vol10/iss3/2> DOI: 10.18584/iipj.2019.10.3.8133
- Booth, T & Booth, W. (2003). In the frame: photovoice and mothers with learning difficulties. *Disability & Society*, Vol 18(4), pp 431-442.
- Botma, Y., Greef, M., Mulaudzi, F.M & Wright, SCD. (2010). *Research in Health Sciences*. 4th Ed. Cape Town, South Africa: Pearson Education.
- Brink, H., Van der Walt, C & Van Rensburg, G. (2012). *Fundamentals of research methodology for Health Care Professionals*. 3rd edition. Cape Town: Juta.
- Brooks, A. (2007). Feminist standpoint epistemology. In Hesse-Biber SN and Leavy PL. *Feminist Research Practice: A Primer*. Thousand Oaks CA: Sage Publications, pp 53-82.
- Brooks, L.A., Manias, E & Bloomer, M.J. (2018). Culturally sensitive communication in healthcare: A concept analysis. *Collegian*. <https://doi.org/10.1016/j.colegn.2018.09.007>
- Broom, B.C., Booth, R.J & Schubert, C. (2012). "Symbolic Diseases and 'Mindbody' Co-Emergence. A Challenge for Psychoneuroimmunology." *EXPLORE: The Journal of Science and Healing*, Vol 8(1), pp 16–25.
- Bruner, J. (1990). *Acts of meaning*. Cambridge: Harvard University.

Budig, K., Diez, J., Conde, P., Sastre, M., Hernán, M & Franco, M. (2018). Photovoice and empowerment: evaluating the transformative potential of a participatory action research project. *BMC Public Health*, vol 18(432). <https://doi.org/10.1186/s12889-018-5335-7>

Bunt, S. (2018). Critical realism and grounded theory: Analysing the adoption outcomes for disabled children using the retrodution framework. *Qualitative Social Work*, vol 17(2), pp 176–194.

Burman, C.J. (2018). An evaluation of the innovative potentials of a HIV pilot exploring medical pluralism in rural South Africa. *Journal of social aspects of HIV/AIDS*, Vol 15 (1), pp 164–178 <https://doi.org/10.1080/17290376.2018.1536560>

Burns, N & Grove, S.K. (2009). *The Practice of Nursing Research: appraisal, synthesis, and generation of evidence*. 6th Ed. St Louis: W B Saunders.

Busher Betancourt, D.A. (2016) Madeleine Leininger and the Transcultural Theory of Nursing. *The Downtown Review, Scientific research 2*.

Bustan, M.N., Seweng, A & Ernawati. (2018). Abdominal Stretching Exercise in Decreasing Pain of Dysmenorrhea Among Nursing Students. *Journal of Physics: Conf. Series* 1028 012103 doi:10.1088/1742-6596/1028/1/012103.

Buwa-Komoren, L.V., Mayekiso, B., Mhinana, Z., Adeniran, A.L. (2019). An ethnobotanical and ethnomedicinal survey of traditionally used medicinal plants in Seymour, South Africa: An attempt toward digitization and preservation of ethnic knowledge. *Phcog Mag*, Vol 15, pp 115-123.

Buys, M. (2017). Protecting personal information: Implications of the Protection of Personal Information (POPI) Act for healthcare professionals. *S Afr Med J*. Vol 107(11), pp 954-956. DOI:10.7196/SAMJ.2017.v107i11.12542

Callister, L.C. (2016). *Developing and assessing culturally appropriate health education for childbearing women*. March of Dimes Foundation.

Campbell, S.S. (2008). *Called to heal: traditional healing meets modern medicine in Southern Africa today*. Halfway House: Zebra Press.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, Vol 38(5), pp 204-207.

Cargo, M., Potaka-Osborne, G., Cvitanovic, L., Warner, L., Clarke, S., Judd, J., Chakraborty, A & Boulton, A. (2019). Strategies to support culturally safe health and wellbeing evaluations in Indigenous settings in Australia and New Zealand: a concept mapping study. *Int J Equity Health*, Vol 18. <https://doi.org/10.1186/s12939-019-1094-z>.

Castleden, H., Garvin, T & Huu-ay-aht. (2008). Modifying Photovoice for community-based participatory Indigenous research. *Social Science and Medicine*, Vol 66(6), pp 1393–1405. doi:10.1016/j.socscimed.2007.11.030

Catalani C & Minkler M. (2010). Photovoice: Review of the literature in health and public health. *Health education and behavior*. Vol 37(3): 424-451

Chandra-Mouli V & Patel S.V. (2017). Mapping the knowledge and understanding of menarche, menstrual health among adolescent girls in low-and middle-income countries. *Reproductive health*

Che, C.T & Zhang, H. (2019). Plant Natural Products for Human Health. *International Journal of Molecular Sciences*, Vol 20(830). doi:10.3390/ijms20040830

Chen, C.X., Doyle Groves, B.S., Miller, W.R. & Carpenter, J.S. (2018). Big Data and Dysmenorrhea: What Questions Do Women and Men Ask About Menstrual Pain? *Journal of women's health*, Vol 27(10). DOI: 10.1089/jwh.2017.6732

Chen, C.X., Kwekkeboom, K.L & Ward, S.E. (2016). Beliefs about dysmenorrhea and their relationship to self-management. *Res Nurs Health*, Vol 39, pp 263–276.

Chen, L., Tang, L., Guo, S., Kaminga, A.C & Xu, H. (2018). Primary dysmenorrhea and self-care strategies among Chinese college girls: a cross-sectional study. *BMJ Open* 2019;9:e026813. doi:10.1136/bmjopen-2018-026813

Chhabra, G. (2020). Insider, Outsider or an In-Betweener? Epistemological Reflections of a Legally Blind Researcher on Conducting Cross-National Disability Research. *Scandinavian Journal of Disability Research*, Vol 22(1), pp. 307–317. DOI: <https://doi.org/10.16993/sjdr.696>

Chilisa, B. (2012). *Indigenous research methodology*. Washington DC, United States of America: SAGE publications

Chittabrata, P. (2017). Medicine and Colonialism: Historical Perspectives in India and South Africa. *Indian historical review*, Vol 44(1), pp 170-172. Poonam Bala (ed.). <https://doi.org/10.1177/0376983617694711>

Claassen, A.A.O.M, van den Ende, C.H., Meesters, J.J.L, Pellegrom, S, Kaarls-Ohms, B.M., Vooijs, J., Willemsen-de Mey, G.E.M.P & Vilet Vlieland, T.P.M. (2018). How to best distribute written patient education materials among patients with rheumatoid arthritis: a randomized comparison of two strategies. *BMC Health Serv Res*. Vol 18(211). <https://doi.org/10.1186/s12913-018-3039-4>.

Clarke, J.H. (1992). To Name Ourselves. *The Voice holiday*. Vol 3(4). Austin: University of Texas.

Coates Palgrave, K. (1984). *Trees of Southern Africa*. Cape Town: *Struik*, pp 1–959.

Cochrane, S., Smith, C.A & Possamai-Inesedy, A. (2011). 'Development of a fertility acupuncture protocol: defining an acupuncture treatment protocol to support and treat women experiencing conception delays'. *Journal of Alternative and Complementary Medicine*, Vol. 17(4), pp 329-337. DOI 10.1089/acm.2010.0190.

CohenMiller, A & Pate, E. (2019). A Model for Developing Interdisciplinary Research Theoretical Frameworks. *The Qualitative Report*, Vol 24(6), pp 1211-1226. Retrieved from <https://nsuworks.nova.edu/tqr/vol24/iss6/2>.

Colomeda, L.A & Wenzel E. (2000). Medicine keepers: Issues in indigenous health. *Critical Public Health*, Vol 10, pp 243-256. DOI:[10.1080/713658247](https://doi.org/10.1080/713658247)

Conney, C.S., Kretchy, I.A., Asiedu-Danso, M & Allotey-Babington, G.L. (2019). Complementary and Alternative Medicine Use for Primary Dysmenorrhea among Senior High School Students in the Western Region of Ghana. *Obstetrics and Gynecology International*. <https://doi.org/10.1155/2019/8059471>.

Coombes, J., Lukaszyc, C., Sherrington, C., Keay, L., Tiedemann, A., Moore, R & Ivers, R. (2018). First Nation Elders' perspectives on healthy ageing in NSW, Australia. *Aust NZ J Public Health*, Vol 42(4), pp 361-364. doi: 10.1111/1753-6405.12796.

Cornell, D. & Van Marle, K. (2015). 'Ubuntu feminism: Tentative reflections'. *Verbum et Ecclesia*, Vol 36 (2), pp 1–8.

Cornwall, A. (2016). Women's empowerment: what works? *Journal of International Development*, Vol 28, pp 342–359. DOI: 10.1002/jid.3210.

Corp, N., Jordan, J.L & Croft, P.R. (2018). Justifications for using complementary and alternative medicine reported by persons with musculoskeletal conditions: A narrative literature synthesis. *PLoS ONE*, Vol 13(7). e0200879.<https://doi.org/10.1371/journal.pone.0200879>.

Cosio, D & Lin, E.H. (2016). Traditional Chinese medicine, especially acupuncture, is a popular form of therapy that pain patients have embraced. Pain clinicians should become familiar with these alternative therapies. *Traditional Chinese Medicine and Acupuncture*, Vol 15(7).

Creswell, J.W & Poth, C.N. (2018). Qualitative inquiry and research design: Choosing among five approaches. *International student edition*, 4th ed. Sage.

Creswell, J.W. (2013). Qualitative inquiry and research design: Choosing among five traditions. (3rd ed.). Thousand Oaks, CA: *Sage Publications*.

Creswell, J.W. (2014). Research design. 4th Ed. London: *Sage publications*.

- Cumes, D. (2013). South African indigenous healing: how it works. *Explore*, Vol 9, pp 58-65. Elsevier inc.
- Czabanowska, K., Domagała, A., Kalaitzi, S., Krogulec, A., Burazeri, G & Babich, S. (2017). *Exploring the Added Value of Women Health Care Managers in Poland. Mater Sociomed*, Vol 29(4), pp 280–285. doi:10.5455/msm.2017.29.280-285.
- Czompa, A., Szoke, K., Prokisch, J., Gyongyosi, A., Bak, I., Balla, G., Tosaki, A & Lekli, I. (2018). Aged (Black) versus Raw Garlic against Ischemia/Reperfusion-Induced Cardiac Complications. *International Journal of Molecular Sciences*, Vol 19, 1017. [CrossRef] [PubMed].
- Dafni, A. (2007). Rituals, ceremonies and customs related to sacred trees with a special reference to the Middle East. *Journal of Ethnobiology and Ethnomedicine*, Vol 3:28.
- DalGLISH, S.L., Straubinger, S., Kavle, J.A., Gibson, L., Mbombeshayi, E., Anzolo, J., Scott, K & Pacqué, M. (2019). Who are the real community health workers in Tshopo Province, Democratic Republic of the Congo?. *BMJ Global Health*. doi:10.1136/ bmjgh-2019-001529.
- Datta, R. (2018). Decolonizing both researcher and research and its effectiveness in Indigenous research. *Research Ethics*, Vol. 14(2), pp 1–24. s://doi.org/10.1177/1747016117733296.
- Davy, C., Harfield, S., McArthur, A., Munn, Z & Brown, A. (2016). Access to primary health care services for Indigenous peoples: A framework synthesis. *Int J Equity Health*, Vol 15(1):163. doi: 10.1186/s12939-016-0450-5. PMID: 27716235; PMCID: PMC5045584.
- De Sanctis, V., Soliman, A.T., Elsedfy, H., Soliman, N.A., Elalaily, R & El Kholy, M. (2017). Dysmenorrhea in adolescents and young adults: a review in different countries. *Acta Biomed*, Vol 87(3), pp 233-246.
- Demmen, J., Semino, E., Demjén, Z., Koller, V., Hardie, A., Rayson, P & Payne, S. (2015). A computer-assisted study of the use of violence metaphors for cancer and end of life by patients, family carers and health professionals. *International Journal of Corpus Linguistics*, Vol 22(2), pp 205–231. doi:10.1075/ijcl.20.2.03dem.

de Moissac, D & Bowen, S. (2019). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience*, Vol 6(1):24-32. doi:[10.1177/2374373518769008](https://doi.org/10.1177/2374373518769008).

Dennis, A.C & Wood, J.T. (2012). "We're not going to have this conversation, but you get it": Black mother–daughter communication about sexual relations. *Women's Studies in Communication*, Vol 35(2), pp 204-223. DOI: 10.1080/07491409.2012.724525.

De Wet, H & Ngubane, S.C. (2014). Traditional herbal remedies used by women in a rural community in northern Maputaland (South Africa) for the treatment of gynecology and obstetrics complaints. *South African Journal of Botany*, pp129–139.

Dickoff, J., James, P & Wiedenbach, E. (1968). Theory in a practice discipline. Part 1: *Practice-oriented theory Nursing Research*, Vol 17(5), pp 415–435.

Dong, H & Zhang, X. (2001). An overview of traditional Chinese medicine. In: RR Chaudhury UR, editor. *Traditional medicine in Asia*. New Delhi: World Health Organization, *SEARO Regional Publications*, pp 17-29.

Donovan, R & West, L.M. (2015). Stress and mental health moderating role of the strong Black woman stereotype. *Journal of Black Psychology*, 41(4), pp 384-396. DOI: 10.1177/0095798414543014.

Doubova, S.V., Morales, H.R., Hernández, S.F., Martínez-García M.C, de Cossío Ortiz M.G, Chávez Soto, M.A, Arce, E.R & Lozoya, X. (2007). Effect of a *Psidium guajavae* folium extract in the treatment of primary dysmenorrhea: A randomized clinical trial. *Journal of Ethnopharmacology*, Vol 110, pp 305–310.

Dove, N. (1998) *Africana Womanism: An Afrocentric Theory*. *Journal of Black Studies*, Vol 28(5), pp 515-539. *Sage Publications*. online: (<http://www.jstor.org.ezproxy.jyu.fi/stable/2784792>).

Draft WHO global action plan on physical activity 2018–2030, http://www.who.int/ncds/governance/gappa_version_4August2017.pdf?ua=1.

Dudgeon, P & Walker, R. (2015). "Decolonising Australian Psychology: Discourses, Strategies and Practice. *Journal of Social and Political Psychology*, Vol. 3(1), pp 276–297. doi:10.5964/jspp.v3i1.126.

Duran, E.T., Atan, S.U., Kavlak, O & Sirin, A. (2012). Traditional practices for Turkish women's Gynecologic complaints. *Indian Journal of Traditional Knowledge*, Vol 11(3): 414-419. Thousand Oaks, CA: SAGE Publications, Inc.

Ebijuwa, A.S & Mabawonku, I. (2015). Documentation and Use of Indigenous Knowledge by Practitioners of Alternative Healthcare in Oyo State, Nigeria. *Afr. J. Lib. Arch. & Inf. Sc*, Vol 25(1), pp 59-68.

Ebunoluwa, S.M. (2009). Feminism: The Quest for an African Variant. *The Journal of Pan African Studies*, Vol 3(1), pp 227-234.

Egenti, U.C., Onuorah, U.E., Ebenebe, P.O.U., Adogu, C & Egwuatu, C. (2016). Perception of Dysmenorrhea and Its Relationship to School Activities among Senior Secondary School Students in Nnewi, Nigeria. *ISRR*, Vol 4(2), pp 1-8.

Elder, B.C & Odoyo, K.O. (2018). Multiple methodologies: using community-based participatory research and decolonizing methodologies in Kenya. *International Journal of Qualitative Studies in Education*, Vol 31(4), pp 293-311, DOI: 10.1080/09518398.2017.1422290.

El-Jardali, F & Fadlallah, R. (2017). A review of national policies and strategies to improve quality of health care and patient safety: a case study from Lebanon and Jordan. *BMC Health Serv Res*, Vol 17(568). <https://doi.org/10.1186/s12913-017-2528-1>.

Elran, R.S. (2019). A Mind Trying to Right/Write Itself: Metaphors in Madness Narratives. *Humanities*, Vol 8(118). doi:10.3390/h8020118.

Eriksson, I., Lindblad, M., Möller, U & Gillsjö, C. (2017). Holistic health care: Patients' experiences of health care provided by an Advanced Practice Nurse. *Int J Nurs Pract*, Vol 24(1):e12603. doi: 10.1111/ijn.12603. Epub 2017 Oct 25. PMID: 29071766; PMCID: PMC5813192.

Fan, D. (2017). Holistic integrative medicine: toward a new era of medical advancement. *Front. Med*, Vol 11, pp 152–159. <https://doi.org/10.1007/s11684-017-0499-6>.

Farleya, E., Balaa, H.M., Lengletc, A., Mehtae, U., Abubakara, N., Samuela, J., de Jong, A., Bilc K, Oluyidea, B., Fotsoa, A., Stringerf, B., Cuestag, J.G & Venables, E. (2020). 'I treat it but I don't know what this disease is': a qualitative study on noma (cancrum oris) and traditional healing in northwest Nigeria. *Int Health*, Vol 12: 28–35. doi:10.1093/inthealth/ihz066.

Fay, B. (1987). *Critical social science*. Ithaca, NY: Cornell University Press.

Fejzic, J & Barker, M (2019) Pharmacy practitioners' lived experiences of culture in multicultural Australia: From perceptions to skilled practice. *PLoS ONE*, Vol 14(6): e0217673. <https://doi.org/10.1371/journal.pone.0217673>.

Fernández-Martínez, E., Onieva-Zafra, M.D & Parra-Fernández, M.L. (2019). The Impact of Dysmenorrhea on Quality of Life among Spanish Female University Students. *International Journal of Environmental Research and Public Health*, Vol 16(5), 713; <https://doi.org/10.3390/ijerph16050713>.

Firouzi, M, Zahedifard, T, Salari, P & Mazlom, S.R. (2019). Comparing the Pattern of Primary Dysmenorrhea Before and After Childbirth. *Journal of midwifery and reproductive health*, Vol 7(1): 1514-1521. DOI: 10.22038/jmrh.2018.8966.1081.

Flicker, S., O'Campo, P., Monchalín, R., Thistle, J., Worthington, C., Masching, R & Thomas, C. (2015). Research Done in "A Good Way": The Importance of Indigenous Elder Involvement in HIV Community-Based Research. *American Journal of Public Health*, Vol 105(6), pp 1149–1154. <http://doi.org/10.2105/AJPH.2014.302522>.

Fredericks, B., Clapham, K., Bessarab, D., Dudgeon, P., Bainbridge, R., Ball, R., Thompson (longbottom), M., Andersen, C., Adams, M., Collard, L., Duthie, D., & Daniel, C. (2015). Developing Pictorial Conceptual Metaphors as a means of understanding and changing the Australian Health System for Indigenous People. *Action Learning and Action Research Journal*, Vol 21, pp 77-107.

Freire, P. (1970). *Pedagogy of the oppressed*. (2008 30th anniversary edition ed.). MB Ramos, Trans. New York. NY: *The Continuum International Publishing Group*.

Frese, P.R & Gray, S.J.M. (1995). Trees. In *The Encyclopaedia of Religion* Volume 15. Edited by: Eliade M. New York: Macmillan Library Reference USA, *Simon and Schuster and Macmillan*, pp 26-33.

Frimpong, E & Nlooto, M. (2019). Tswana traditional health practitioners' perspectives on the management of diabetes and hypertension: a qualitative study using focus group discussions. *The Pan African Medical Journal*, 2019;34:93. doi:10.11604/pamj.2019.34.93.19112.

Gad, M., Abdel-Gayed, A.M.A, Dawoud, R.M & Amer, A.F. (2017). Prevalence of endometriosis in unexplained infertility and chronic pelvic pain in women attending Menoufia University Hospital. *Menoufia Medical Journal*, Vol 30(2), pp 356-360. DOI: 10.4103/mmj.mmj_415_16.

Gallagher, J. (2019). Indigenous approaches to health and wellness leadership: A BC First Nations perspective. *Healthcare Management Forum*, Vol. 32(1), pp 5-10.

Gandugade, P.V, Nlooto, M & Naidoo, P. (2017). Willingness and rationale of traditional health practitioners to collaborate with Allopathic doctors in the eThekweni Metro of Kwa Zulu Natal, South Africa. *PULA: Botswana Journal of African Studies*, Vol 31(1), pp 151-161, Supplement 1.

Gao, L., Xiao, Z., Jia, C & Wang, W. (2019). A comparison of the efficacy of Chinese herbal medicines in the treatment of primary dysmenorrhea A network meta-analysis protocol. *Medicine*, Vol 98(14).

Gilliam, D.W. (2013). "I Have to Know Who I Am: An Africana Womanist Analysis" (<https://diginole.lib.fsu.edu/islandora/object/fsu:183926/datastream/PDF/view>). *Florida State University Libraries*. Retrieved 12 October 2018.

Glaser, B.G & Strauss, A.L. (1967). *The discovery of grounded theory strategies for qualitative research*. New York: *Aldine Publishing Company*.

Global Health Observatory [database on the Internet]. *World Health Organization*. (2016). URL: <http://apps.who.int/gho/data/view.main.2485>.

Grabowski, D., Aagaard-Hansen, J., Willaing, I & Jensen, B.B. (2017). Principled Promotion of Health: Implementing Five Guiding Health Promotion Principles for Research-Based Prevention and Management of Diabetes. *Societies*, Vol 7(10). doi:10.3390/soc7020010.

Grove, S.K, Burns., N & Gray, J.R. (2013). *The practice of nursing research: Appraisal, synthesis and generation of evidence*. 7th edition. China: Elsevier.

Guest, G., Namey, E. & Mitchell, M. (2013). In-depth interviews. In Guest, G., Namey, E., & Mitchell, M. *Collecting qualitative data*, pp 113-171. 55 City Road, London: SAGE Publications, Ltd doi: 10.4135/9781506374680.

Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B., Seedat, S & Jenkins, R. (2015). The role of global traditional and complementary systems of medicine in treating mental health problems. *Lancet Psychiatry*, Vol 2(2): 168–177. doi:10.1016/S2215-0366(15)00013-9.

Gustavsson, C. (2020) Existential configurations: a way to conceptualise people's meaning-making. *British Journal of Religious Education*, Vol 42:1, pp 25-35. DOI: 10.1080/01416200.2018.1556598.

Haraway D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*. Vol 14: 575-599

Harding, S. (1991). *Whose Science? Whose Knowledge?* Milton Keynes: Open University Press.

Harfield, S.G., Davy, C., McArthur, A, Munn Z, Brown, A & Brown, N. (2018). Characteristics of Indigenous primary health care service delivery models: a systematic scoping review, *Global Health*. Vol 14(12) doi:10.1186/s12992-018-0332-2.

Harvey, I.S. (2013). The role of spirituality and Africana Womanism in the self-management of chronic conditions among older African Americans. *Journal of Nursing Education and Practice*, Vol. 3(12). DOI: 10.5430/jnep.v3n12p81.

Hawkey, A.J., Ussher, J.M., Perz, J & Metusela, C. (2017). Experiences and Constructions of Menarche and Menstruation Among Migrant and Refugee Women. *Qual Health Res*, Vol 27(10), pp 1473–1490. Epub 2016/10/16. <https://doi.org/10.1177/1049732316672639> PMID: 27742765.

Hendricks, R.K., Demjén, Z., Semino, E & Boroditsky, L. (2018). Emotional Implications of Metaphor: Consequences of Metaphor Framing for Mindset about Cancer. *Metaphor and Symbol*. Vol 33(4), pp 267-279. DOI: 10.1080/10926488.2018.1549835.

Hennegan, J., Shannon, A.K., Rubli, J., Schwab, K.J & Melendez-Torres, G.J. (2019) Women's and girls' experiences of menstruation in low- and middle-income countries: A systematic review and qualitative metasynthesis. *PLoS Med*, Vol 16(5). <https://doi.org/10.1371/journal>.

Hill, P.L. (1998). *Call and Response: The Riverside Anthology of the African American Literary Tradition*. Boston and New York: Houghton Mifflin Company.

Hina, R., Wajeeha, B., Farzana, A & Humyra, T. (2013). Approach to dysmenorrhoea in ancient ages and its current relevance. *International Journal of Herbal Medicine*, Vol 1(4), pp 88-91.

Hirschmann, N. (1997). Feminist standpoint as postmodern strategy, In S. Kenney and H. Kinsella (Eds.) *Politics and feminist standpoint theories*. New York: Haworth Press, pp 73-92.

Holden, L. (2000). *Encyclopedia of taboos*. Oxford: ABC-CLIO Oxford.

Holloway, I & Wheeler, S. 2010. *Qualitative Research in Nursing and Healthcare*. (3rd ed). UK: Wiley Blackwell.

Hooks, B. (1984). "Black Women: Shaping Feminist Theory," 1984. In *Let Nobody Turn Us Around: Voices of Resistance, Reform, and Renewal; An African American Anthology*, edited by

Manning Marable and Leith Mullings, 544-550. New York: Bowman & Littlefield Publishers, Inc., 2000.

Hu, X., Lorenc, A., Kemper, K., Liu, J., Adams, J & Robinson, N. (2015). Key elements of defining integrative medicine - a potential checklist for reporting. *Journal of Integrative Medicine*, Vol 7(1), pp 76-84.

Hubbard, L. (2010). Anna Julia Cooper and Africana Womanism: Some Early Conceptual Contributions. *Black Women, Gender and Families*, Vol 4(2), pp31-53. University of Illinois Press.

Hudson-Weems, C. (1993). *Africana Womanism: Reclaiming Ourselves*. Houghton Mifflin Company.

Hudson-Weems, C. (1998). "Self-Naming and Self-Definition: an Agenda for Survival." *Sisterhood, Feminisms and Power: From Africa to the Diaspora*. Ed. Obiama Nnaemeka. *Trenton: Africa World Press*, pp 449-452.

Hudson-Weems, C. (2000). "African Womanism: An Overview". In Aldridge, Delores P. (ed.). *Out of the Revolution: The Development of Africana Studies*. *Lexington Books*, pp 205–217.

Hudson-Weems, C. (2001). "Africana Womanism: The Flip Side of a Coin". *Western Journal of Black Studies*, Vol 25(3).

Hudson-Weems, C. 2004. *Africana womanist literary theory*. *Trenton: N.J Africa World Press*.

Huff, S, Rudman, D.L., Magalhães, L & Lawson, E. (2018) 'Africana Womanism': Implications for transformative scholarship in occupational science. *Journal of Occupational Science*, Vol 25(4), pp 554-565, DOI: 10.1080/14427591.2018.1493614.

Hussey, W. (2006). Slivers of the journey: The use of Photovoice and storytelling to examine female to male transsexuals' experience of health care access. *Journal of Homosexuality*, Vol 57(1): 129-158.

Hutchings, A. (1996). *Zulu Medicinal Plants: an inventory*. Scottsville: University of Natal Press.

Idang, G.E. (2015). African culture and values. *Phronimon*, Vol 16(2), pp 97-111.

Iloka, N.G. (2016). 'Indigenous knowledge for disaster risk reduction: An African perspective', *Jàmbá: Journal of Disaster Risk Studies*, Vol 8(1). <http://dx.doi.org/10.4102/jamba.v8i1.272>.

Inoue, M., Hayashi, S & Cracker, L.E. (2019). *Role of medicinal and aromatic plants: past, present and future*. Open access peer reviewed chapter – online first. Intechopen. DOI: 10.5772/intechopen.82497.

Integrated Development Plan 2020/21. Molemole municipality, Limpopo province, South Africa

Isaksen, K.R. (2016). Reclaiming Rational Theory Choice as Central: A Critique of Methodological Applications of Critical Realism. *Journal of Critical Realism*, Vol 15(3), pp 245-262, DOI: 10.1080/14767430.2016.1169369.

Jo, J & Lee, S.H. (2018). Heat therapy for primary dysmenorrhea: A systematic review and meta-analysis of its effects on pain relief and quality of life. *Scientific reports*, Vol 8. DOI:10.1038/s41598-018-34303-z.

Jones, J. (2009). *Labor of love, labor of sorrow: Black women, work, and the family, from slavery to the present*. New York, NY: Basic Books.

Jongen, C., McCalman, J & Bainbridge, R. (2018). Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research*, Vol 18(232).

Kahissay, M.H., Fenta, T.G & Boon, H. (2017). Beliefs and perceptions of ill-health causation: a socio-cultural qualitative study in rural North-Eastern Ethiopia. *BMC Public Health*, Vol 17, pp124, DOI 10.1186/s12889-017-4052-y.

Karenga, T & Tembo, C. (2012). "Kawaida Womanism: African ways of being woman in the world." *The Western Journal of Black Studies*, Vol 36(1), pp 33–47.

Kashani, L., Mohammadi, M., Heidari, M & Akhondzadeh, S. (2015). Herbal Medicine in the Treatment of Primary Dysmenorrhea. *Journal of Medicinal Plants*, Vol 14(53).

Kashani, L., Mohammadi, M., Heidari, M & Akhondzadeh, S. (2015). Herbal Medicine in the Treatment of Primary Dysmenorrhea. *Journal of Medicinal Plants*, Vol 14(53).

Kasole, R., Martin, H.D & Kimiywe, J. (2019). Traditional Medicine and Its Role in the Management of Diabetes Mellitus: “Patients’ and Herbalists’ Perspectives”. *Evidence-Based Complementary and Alternative Medicine*. <https://doi.org/10.1155/2019/2835691>.

Kaushik, V & Walsh, C.A. (2019). Pragmatism as a Research Paradigm and Its Implications for Social Work Research. *Soc. Sci*, Vol 8(255). doi:10.3390/socsci8090255

Kim, K., Nam, H. J., Kim, M., Lee, J & Kim, K. (2017). Effects of herbal medicine for dysmenorrhea treatment on accompanied acne vulgaris: a study protocol for a randomized controlled trial. *BMC Complementary and Alternative Medicine*, Vol 17:318 DOI 10.1186/s12906-017-1813-1.

Kirmayer, L.J & Brass, G. (2016). Addressing global health disparities among Indigenous peoples. *Lancet*, 388(10040), pp 105.

Koponen, M., Salmi, L & Nikulin, M. (2019). A product and process analysis of post-editor corrections on neural, statistical and rule-based machine translation output. *Machine Translation*. Vol 33:61-90. <https://doi.org/10.1007/s10590-019-09228-7>.

Kpobi, L & Swartz, L. (2019). Indigenous and faith healing in Ghana: A brief examination of the formalising process and collaborative efforts with the biomedical health system. *Afr J Prm Health Care Fam Med*. Vol 11(1), a2035. <https://doi.org/10.4102/phcfm.v11i1.2035>.

Kpobi, L.N.A., Swartz, L & Omenyo, C.N. (2019). Traditional herbalists’ methods of treating mental disorders in Ghana. *Transcultural Psychiatry*, Vol. 56(1), pp 250–266.

Krah, E., de Kruijf, J & Ragno, L. (2018). Integrating Traditional Healers into the Health Care System: Challenges and Opportunities in Rural Northern Ghana. *J Community Health*, Vol 43: 157–163. DOI 10.1007/s10900-017-0398-4.

Krippendorff, K. (2004). *Content analysis: an introduction to its methodology*. New York: Sage.

Kristjansso, A.L., Mann, M.J., Sigfusson, J., Thorisdottir, I.E., Allegrante, J.E & Sigfusdottir, I.D. (2020). Implementing the Icelandic model for preventing adolescent substance use. *Health Promotion Practice*, Vol 21: 70-79. doi:10.1177/1524839919849033.

Krusz, E., Hall, N., Barrington, D.J., Creamer, S., Anders, W., King, M., Martin, H & Hennegan, J. (2019). Menstrual health and hygiene among Indigenous Australian girls and women: barriers and opportunities. *BMC Women's Health*, Vol 19(146). <https://doi.org/10.1186/s12905-019-0846-7>.

Kumar, R. (2011). *Research Methodology: a step by step guide for beginners. (3rd ed.)* London: Sage.

Lacovides, S., Avidon, I & Baker, F.C. (2015). What we know about primary dysmenorrhoea today: a critical review. *Human Reproduction Update*, Vol 21(6), pp 762-778.

Lamla, C.M. (1975). *Present day diviners (ama-gqira) in the Transkei*. MA dissertation. Grahamstown: University of Fort Hare.

Landau, M.J. (2018). Using Metaphor to Find Meaning in Life. *American Psychological Association*, Vol 22(1), pp 62–72.

Latthe, P., Latthe, M., Say, L., Gülmezoglu, M & Khan, K.S. (2006). WHO systematic review of prevalence of chronic pelvic pain: a neglected reproductive health morbidity. *BMC Public Health*, Vol 6(177). doi:10.1186/1471-2458-6-177.

Latz, A.O. (2017). *Photovoice research in education and beyond: A practical guide from theory to exhibition*. New York: Routledge.

Laudon, K.C & Laudon, J.P. (2016). *Management information system*. Channai, India : Pearson Education India.

Lavallée, L. (2009). Practical application of an Indigenous research framework and Indigenous research methods: Sharing circles and Anishnaabe symbol-based reflection. *International Journal of Qualitative Methods* 8(1), pp 21–40. Available at: <http://ejournals.library.ualberta.ca/index.php/IJQM/article/view/943/5195> (accessed 28 April 2018).

Lazard, A.J., Bamgbade, B.A., Sontag, J.M & Brown, C. (2016). Using Visual Metaphors in Health Messages: A Strategy to Increase Effectiveness for Mental Illness Communication. *Journal of Health Communication*, Vol 21(12), pp 1260-1268.

Lebaka, M.E.K. (2018). 'The art of establishing and maintaining contact with ancestors: A study of Bapedi tradition', *HTS Teologiese Studies/Theological Studies*. Vol 74(1), pp 4871. <https://doi.org/10.4102/hts.v74i1.4871>.

Lebaka, M.E.K. (2019). 'Ancestral beliefs in modern cultural and religious practices–The case of the Bapedi tribe'. *HTS Teologiese Studies/Theological Studies* Vol 75(1), a5173. <https://doi.org/10.4102/hts.v75i1.5173>.

Lee, S.W & Schwarz, N. (2014). Framing love: When it hurts to think we were made for each other. *Journal of Experimental Social Psychology*, Vol 54:61–67. doi:10.1016/j.jesp.2014.04.007.

Leedy, P.D & Ormrod, J.E. (2010). *Practical research: planning and design*. 9th ed., New Jersey: Pearson education, Inc.

Lichtenstein, A.H., Berger, A & Cheng, M.J. (2017). Definitions of healing and healing interventions across different cultures. *Annals of Palliative Medicine*, Vol 6(3):248-252.

Liebenberg, L. (2018). Thinking Critically About Photovoice: Achieving Empowerment and Social Change. *International Journal of Qualitative Methods*. Vol 17: 1–9. DOI: 10.1177/1609406918757631.

Lincoln, Y.S & Guba, E.G. (1985). *Naturalistic inquiry*. London: Sage.

Lincoln, Y.S., Lynham, S.A., & Guba, E.G. (2011). *Paradigmatic controversies, contradictions, and emerging confluences, revisited*. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research*(4th ed). Thousand Oaks, CA: Sage Publications.

Lindeque, B.G. (2015). Dysmenorrhoea. *S Afr Pharm J*. Vol 82(8), pp 32-34.

Long, C. (2005). *Swaziland's Flora - siSwati Names and Uses*. <http://sntc.org.sz/>.

Lundy, T. (2010). A paradigm to guide health promotion into the 21st century: the integral idea whose time has come. *Global Health Promotion*, Vol 17(3), pp 44-53.

Luo, F., Huang, X., Liu, X., Wang, L & Xu, N. (2019). Comparative efficacy and safety of NSAIDs-controlled acupuncture in the treatment of patients with primary dysmenorrhea: a Bayesian network meta-analysis. *Journal of International Medical Research*, Vol 47(1): 19–30. DOI: 10.1177/0300060518800609.

MacMillan, J.H & Schumacher, S. (2001). *Research in Education. A Conceptual Introduction*. 5th Edition. Boston: Longman.

Makombe, R. (2018). Images of woman and her search for happiness in Cynthia Jele's Happiness is a four-letter word. *Tydskrif vir letterkunde*, Vol 55(1), pp 110-121. DOI: dx.doi.org/10.17159/2309-9070/tvl.v.55i1.

Maluleka, J.R & Ngoepe, M. (2018). 'Turning mirrors into windows: Knowledge transfer among indigenous healers in Limpopo province of South Africa'. *South African Journal of Information Management*, Vol 20(1), a918. <https://doi.org/10.4102/sajim.v20i1.918>

Maluleka, J.R & Ngulube, P. (2018). A framework for acquisition, transfer and preservation of knowledge of traditional healing in South Africa: a case of Limpopo Province. *ESARBICA Journal*, Vol 37, pp 111-137.

Manera, K., Hanson, C.S., Gutman, T & Tong, A. (2019). *Consensus Methods: Nominal Group Technique*. In: Liamputtong P. (eds) *Handbook of Research Methods in Health Social Sciences*. Singapore: Springer.

Mangena, T. (2013). "Theorising women existence: reflections on the relevance of the Africana womanist theory in the writing and analysis of literature by and about Zimbabwean women." *Journal of Arts, Science and Commerce*, Vol 1(1), pp 7–14.

Mangena, F. (2014). Can Africana women truly embrace ecological feminism?. *Filosofia Theoretica: Journal of African Philosophy, Culture and Religions*, Vol 3(2).

Marshall, C & Rossman, GB. (2014). *Designing qualitative research*. 6th Ed. Thousand Oaks, CA: Sage publications.

Masenya, M. (2004). *How worthy is the woman of worth? Re-reading the proverbs 31:10-31 in Africa-South African*. New York: Peter Lang publishers.

Mathibela, M.K., Egan, B.A., Du Plessis, H.J & Potgieter, M.J. (2015). Socio-cultural profile of Bapedi traditional healers as indigenous knowledge custodians and conservation partners in the Blouberg area, Limpopo Province, South Africa. *Journal of Ethnobiology and Ethnomedicine*. 11:49 DOI 10.1186/s13002-015-0025-3

Matsheta, M.S & Mulaudzi, F.M. (2008). The perceptions of traditional healers of cervical cancer care at Ga Mothapo Village in Limpopo Province. *Indilinga–African Journal of indigenous knowledge systems*, Vol 7(1), pp 103–116.

Matthews, M & Van Wyk, J. (2018). Towards a culturally competent health professional: a South African case study. *BMC Medical Education*, Vol 18(112). <https://doi.org/10.1186/s12909-018-1187-1>.

May, S & Aikman, S. (2003). Indigenous education: addressing current issues and developments. *Comparative Education*, Vol 39(2), pp 139-145.

Medical Dictionary for the Health Professions and Nursing © Farlex 2012

Mefalopulos, P & Kamlongera, C. (2004). *Participatory communication strategy design: A handbook*. Second Ed. Rome: Food and Agriculture Organization of the United Nations.

Mensele M.S. (2011). *A study of rituals performed at two sacred sites in the Eastern Free State*. Unpublished master's dissertation. University of Free State. South Africa

Merriam-Webster online dictionary for English word definitions, meanings, and pronunciation. #wordsmatter. (2019). Springfield, Massachusetts.

Mills, E., Cooper, C & Kanfer, I. (2005). *Traditional African medicine in the treatment of HIV*. *Lancet Infect Dis*. Vol 5(8): 465-467. doi:10.1016/S1473-3099(05)70172-9.

Mulenburg, G. (2011). *Managing by Henry Mintzberg*. *Journal of Product Innovation Management*. Prentice Hall. <https://doi.org/10.1111/j.1540-5885.2011.00855.x>

Mji, G. (2013). *Exploring the health knowledge carried by older Xhosa women in their home situation, with special focus on indigenous knowledge*. SUNScholar Research Repository. PhD Thesis. Stellenbosch University. South Africa.

Mkhize, N. (2008). *Ubuntu and Harmony: An African Approach to Morality and Ethics*. In Nicolson, R. (ed.): *Persons in Community: African Ethics in a Global Culture*. Pietermaritzburg: University of Natal Press.

Mkhwanazi, E.F & Ramose, M.B. (2005). Thought and practice in African philosophy. *Tydskrif Vir Letterkunde*, Vol 42(2), pp161-175.

Moemeka, A. (1989). *Communication and Africa Culture: A Sociological Analysis*. In S.K. Bofo (Ed.), *Communication and culture: African perspectives*. Africa Region: WACC.

Moffitt, P & Vollman, A.R. (2004). Photovoice: Picturing the health of Aboriginal women in a remote northern community. *Canadian Journal of Nursing Research*, Vol 36, pp 189-201.

Mojapelo, M.L. (2009). Morphology and Semantics of Proper Names in Northern Sotho. *South African Journal of African Languages*, Vol 29(2), pp 185–194.

Mokala, N.T. (2020). Understanding the Meanings Represented in Ditolobonya Songs: Basotho Women's Experiences and Realities. *International Journal of Linguistics, Literature and Translation (IJLLT)* ISSN: 2617-0299 (Online); ISSN: 2708-0099 (Print) DOI: 10.32996/ijllt.

Mokgobi, M.G. (2014). *Understanding traditional African healing. Afr J Phys Health Educ Recreat Dance*, Vol 20(Suppl 2), pp 24–34.

Moloko-Phiri, S.S., Mulaudzi, F.M & Heyns, T. (2016). Women Abuse under the Guise of Culture and Language Use: Women Narrate their Stories. *The Oriental Anthropologist*, Vol 16(2), pp 245-259.

Momoh, C.S. (1998). *African Philosophy: Nature Schools and Substance in Jim Unah Philosophy for all Disciplines Lagos: Joja Educational Research and Publications.*

Monteiro, N.M & Wall, D.J. (2011). African Dance as Healing Modality Throughout the Diaspora: The Use of Ritual and Movement to Work Through Trauma. *The Journal of Pan African Studies*, Vol.4(6), pp 234-252.

Moos, A. (2009). *Local is lekker: Indigenous knowledge should be encouraged: South African Social Attitudes Survey.* Preroria: HSRC review.

Morowatisharifabad, M.A., Vaezi, A, Bokaie, M., Askarishahi, M & Mohammadinia, N. (2018). Cultural Beliefs on Menstrual Health in Bam City: A Qualitative Study. *Int J Pediatr*, Vol 6(12), pp 8765-8778. DOI: 10.22038/ijp.2018.33206.2929

Moshabela, M., Bukenya, D., Darong, G., Wamoyi, J., McLean, E., Skovdal, M., Ddaaki, W., Ondeng'e, K., Bonnington, O., Seeley, J., Hosegood, V & Wringe, A. (2017). *Traditional healers, faith healers and medical practitioners: the contribution of medical pluralism to bottlenecks along the cascade of care for HIV/AIDS in Eastern and Southern Africa Sex Transm Infect.* 1-5. doi:10.1136/sextrans-2016-052974.

Moshabela, M., Zuma, T & Gaede, B. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. *SAHR*, 83-92.

Mothibe, M.E & Sibanda, M. (2019). African traditional medicine: South African perspective. *Traditional and Complementary Medicine*. DOI: <http://dx.doi.org/10.5772/intechopen.83790>.

Mphuti, D.D. (2015). *Anti-viral properties of wildeals (Artemisia afra) and wynruit (Ruta graveolens) as combination therapy and its effects on the renal system*. PhD thesis. North-West University: South Africa.

Mtuzze, P.T. (1999). *Hidden presences in the spirituality of the amaXhosa of the Eastern Cape and the impact of Christianity on them*. p.200. Available at: <http://books.google.co.za/books?id=KiSzXwAACAAJ>.

Mufamadi, J & Sodi, T. (2010). Notions of mental illness by Vhavenda traditional healers in Limpopo Province, South Africa. *Indilinga African Journal of Indigenous Knowledge Systems*, Vol 9, pp 253-264.

Mufamadl, J. (2001). *A group of traditional healers' perceptions of and approaches to the treatment of mental illness*. Indigenous Knowledge Conference 2001. 88-103.

Mulaudzi, F.M., Mogale, R.S & Masoga, A.M. (2018). Revisiting current nursing ethics: Can Ubuntu foster an environment for ethics of care? In (ed 2018). *Ubuntu and Personhood Africa World Press*. New Jersey: Trenton.

Mulaudzi, F.M. (2007). Indigenous health beliefs, attitudes and practices among Vha Venda: A challenge to the promotion of HIV & AIDS prevention strategies. *Curationis*, Vol 30 (3), pp 31-38.

Mulaudzi, F.M., Chinouya, M & Ngunyulu, R.N. (2015). Perceptions of the Vhavenda Regarding the Significance of IKS Rituals and Customs in Women's Health: "The Other Side of The Coin". *J Soc Sci*, Vol 44(1), pp 21-27.

Muller, M., Bezuidenhout, M & Jooste, K. (2014). *Health services management*. 3rd edition. Cape Town: Juta and company Ltd.

Muluneh, A.A., Nigussie, T.S., Gebreslasie, K.Z., Anteneh, K.T & Kassa, Z.Y. (2018). Prevalence and associated factors of dysmenorrhea among secondary and preparatory school students in Debremarkos town, North-West Ethiopia. *BMC Women's Health*, Vol 18(57). <https://doi.org/10.1186/s12905-018-0552-x>.

Musyimi, C.W., Mutiso, V.N., Loeffen, L., Krumeich, A & Ndetei, D.M. (2018). Exploring mental health practice among Traditional health practitioners: a qualitative study in rural Kenya. *BMC Complementary and Alternative Medicine*, Vol 18(334). <https://doi.org/10.1186/s12906-018-2393-4>.

Nare, N.E., Pienaar, A & Mphuthi, D.D. (2018). 'Conceptualisation of African primal health care within mental health care'. *Curationis*, Vol 41(1), a1753. <https://doi.org/10.4102/curationis.v41i1.1753>.

National Department of Health, South Africa. (2012). The National Strategic Plan for Nursing Education, Training and Practice. 2012/13 - 2016/17. Pretoria: Government printers

Ndlovu, P.M. (2015). *Discovering the spirit of ubuntu leadership: compassion, community, and respect*. Palgrave Macmillan.

Ndlovu, L & Ngwenya, T. (2010). Taboos and the Prenatal Period among the Ndebele: An Africana Womanist Approach. *NAWA: Journal of Language and communication*.

Neal-Barnett, A.M., Stadulis, R., Payne., M.R, Crosby, L., Mitchell, M., Williams, L & Williams-Costa, C. (2011). In the company of my sisters: Sister circles as an anxiety intervention for professional African American women. *Journal of Affective Disorders*, 129(1), pp 213-218. DOI: 10.1016/j.jad.2010.08.024.

Nemutandani, S.M., Hendricks, S.J & Mulaudzi, M.F. (2016). Perceptions and experiences of allopathic health practitioners on collaboration with traditional health practitioners in post-

apartheid South Africa. *Afr J Prm Health Care Fam Med*, Vol 8(2).
<http://dx.doi.org/10.4102/phcfm.v8i2.1007>.

Nemutandani, S.M., Hendricks, S.J & Mulaudzi, M.F. (2018). Decolonising the mindsets, attitudes and practices of the allopathic and indigenous health practitioners in postcolonial society: An exploratory approach in the management of patients. *Afr J Prm Health Care Fam Med*, Vol 10(1).
<https://doi.org/10.4102/phcfm.v10i1.1518>.

Nene, J.O. (2014). The concept of traditional healing and its role in African modern society. *International Journal of Social Science and Human Behavior Study*, vol 1(1), pp 1-15.

Neuman, W.L. (2006). *Social research methods: qualitative and quantitative approaches*. 6th ed. Boston: Allyn and Bacon.

Neuman, W.L. (2011). *Social research methods: qualitative and quantitative approaches*. 7th ed. Boston: Allyn and Bacon.

Ngobe, A.J. (2015). *Swati traditional healers' conceptualisation of causes and treatment of mental illness*. Unpublished master's dissertation. University of Limpopo. South Africa

Ngomane, S., Mulaudzi, F.M. (2010). *Indigenous beliefs and practices that influence the delayed attendance of antenatal clinics by women in the Bohlabele district in Limpopo, South Africa*. Midwifery. doi:10.1016/j.midw.2010.11.002

Ngubane, H. (1977). *Body and mind in Zulu medicine: an ethnography of health and disease in Nyuswa-Zulu thought and practice*. New York: Academic Press.

Ngunyulu, R.N., Mulaudzi, F.M & Peu, M.D. (2015). 'Comparison between indigenous and Western postnatal care practices in Mopani District, Limpopo Province, South Africa'. *Curationis*, Vol 38(1). <http://dx.doi.org/10.4102/curationis.v38i1.1252>

Niles Goins, M. (2011). Playing with dialectics: Black female friendship groups as a homeplace. *Communication Studies*, 62(5), 531-546. DOI:10.1080/10510974.2011.584934

Nkwanyana, M.O. (2018). Conserving cultural heritage and the usage of indigenous knowledge: A case study of the Zululand District Municipality, Kwazulu-Natal. *African Journal of Hospitality, Tourism and Leisure*, Vol 7(2). ISSN: 2223-814X

Nooh, A.M., Abdul-Hady, A & El-Attar, N. (2016). Nature and Prevalence of Menstrual Disorders among Teenage Female Students at Zagazig University, Egypt. *J Pediatr Adolesc Gynecol*, Vol 29 (2), pp 137-142.

Ntiri, D.W. (2001). "Reassessing Africana Womanism: Continuity and change". *Western Journal of Black Studies*, Vol 25, pp 163–167.

Ntiri, D.W. (2012). "Reassessing African Womanism: continuity and change." *The Journal of Western Black Studies*, Vol 25(3), pp163–167.

Nwanosike, O.F & Onyije, L.E. (2011). Colonialism and education. *Mediterranean Journal of Social Sciences*, Vol 2(4), pp 41-47.

Ocholla D.N and Onyancha B.O. (2005). The Marginalized Knowledge: An Info metric Analysis of Indigenous Knowledge Publications. *South African Journal of Libraries and Information Science*. Vol 71(3): 247-258.

O'Connor, T. (2007). *Governing bodies: A Māori healing tradition in a bicultural state* (Doctoral dissertation). University of Auckland, Australia.

O'Donovan, G., Lee, I.M., Hamer, M & Stamatakis, E. (2017). Association of "Weekend Warrior" and Other Leisure Time Physical Activity Patterns With Risks for All-Cause, Cardiovascular Disease, and Cancer Mortality. *JAMA Intern Med*. Vol 177: 335–342, <https://doi.org/10.1001/jamainternmed.2016.8014>.

Okesina, M. (2020). A Critical Review of the Relationship between Paradigm, Methodology, Design and Method in Research. *IOSR Journal of Research & Method in Education (IOSR-JRME)*. Vol 10(3), Pp, 57-68.

O'Regan, N & Ghobadian, A. (2002). Effective strategic planning in small and medium sized firms. *Management Decision*, Vol 40(7), pp 663-671.

Oliver, C. (2012). Critical Realist Grounded Theory: A New Approach for Social Work Research, *The British Journal of Social Work*, Vol 42(2): 371–387. <https://doi.org/10.1093/bjsw/bcr064>

Olowokere, A.E., Oginni, M.O., Olajubu, A.O., William, A.E & Irinoye, O.O. (2014). Menstrual disorders: the implications on health and academic activities of female undergraduates in a federal university in Nigeria. *Journal of Nursing Education and Practice*, Vol 4(5), pp 4040- 4059.

Oni, H.T & Tshitangano, T.G. (2015). Prevalence of menstrual disorders and its academic impact. *Kamla-raj, j hum ecol*. Vol 51(1 and 2), pp 214-219.

Ou, M.C., Hsu, T.F., Lai A.C., Lin, Y.T & Lin, C.C. (2012). Pain relief assessment by aromatic essential oil massage on outpatients with primary dysmenorrhoea: a randomized, double-blind clinical trial. *Journal of Obstet Gynaecol Res*, Vol 38, pp 817-822.

Ownsworth, T & Nash, K. (2015) *Existential wellbeing and meaning making in the context of primary brain tumor: conceptualization and implications for intervention*. *Front. Oncol*. 5:96. doi: 10.3389/fonc.2015.00096

Owusu-Ansah, F.E & Mji, G. (2013). African indigenous knowledge and research. *African Journal of Disability*, Vol 2(1): 30. doi: [10.4102/ajod.v2i1.30](https://doi.org/10.4102/ajod.v2i1.30).

Oyèwùmí, O. (2016). *What gender is motherhood: Changing Yorùbá Ideals of Power, Procreation and Identity in the Age of Modernity*. New York: Palgrave.

Ozioma, E.O J & Chinwe, O.A.N. (2019). Herbal Medicines in African Traditional Medicine. *Herbal Medicines in African Traditional Medicine* <http://dx.doi.org/10.5772/intechopen.80348> page 191-214.

Park, C & George, L. (2013). Assessing meaning and meaning making in the context of stressful life events: Measurement tools and approaches. *The Journal of Positive Psychology, Vol 8(6)*, pp 483-504. doi:10.1080/17439760.2013.830762.

Park, C.L (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136(2)*, pp 257–301.

Park, Y.L & Canaway, R. (2019). Integrating Traditional and Complementary Medicine with National Healthcare Systems for Universal Health Coverage in Asia and the Western Pacific. *Health Systems & Reform. Vo1 5 (1): 24-31. DOI: 10.1080/23288604.2018.1539058.*

Peltzer, K. (1995). *Psychology and health in African cultures: Examples of ethnopsychotherapeutic practice*. IKSO-Verlag fur interkulturelle kommunikation.

Penson, R.T., Schapira, L., Daniels, K.J., Chabner, B.A & Lynch T.J Jr. (2004). Cancer as metaphor. *Oncologist, 2004;9(6)*, pp 708-716. doi:10.1634/theoncologist.9-6-708.

Percival, N.A., McCalman, J., Armit, C., O'Donoghue, L., Bainbridge, R., Rowley, K., Doyle, J & Tsey, K. (2018). Implementing health promotion tools in Australian Indigenous primary health care. *Health Promotion International, Vol 33*, pp 92–106 doi: 10.1093/heapro/daw049.

Petrus, T.S & Bogopa, D.L. (2007). Natural and supernatural: intersections between the spiritual and natural worlds in African witchcraft and healing with reference to South Africa. *Indo-Pacific Journal of Phenomenology, Vol 7 (1)*, pp 1-10.

Peu, M.D. (2014). Health promotion strategies for families with adolescents orphaned by HIV and AIDS. *International Council of Nurses*.

Pies, C & Parthasarathy, P. (2008). Photovoice: Giving local health departments a new perspective on community health issues. *Contra Costa Health Services*. 1-8. Retrieved from <http://www.cchealth.org/topics/community/photovoice>.

Piko, B. F & Brassai, L. (2016). A reason to eat healthy: The role of meaning in life in maintaining homeostasis in modern society. *Health psychology open*. DOI: 10.1177/2055102916634360.

Pillay, P & Teleki, M. (2018). The Polemics of Gender Equality and Cultural Diversity in a Multicultural Setting: A South African Case Study. *African Journal of Public Affairs*, Vol 10(4), pp 41-56.

Pillitteri, S.P. (2012). *School menstrual hygiene management in Malawi: more than toilets*. Blantyre: WaterAid and SHARE (Sanitation and Hygiene Applied Research for Equity).

Piyasena, M.M.P.N., Zuurmond, M., Yip, J.L.Y & Murthy, G.V.S. (2019). Process of adaptation, development and assessment of acceptability of a health educational intervention to improve referral uptake by people with diabetes in Sri Lanka. *BMC Public Health*, Vol 19(614). <https://doi.org/10.1186/s12889-019-6880-4>

Polit, D.F & Beck, C.T. (2017). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 10th Ed. New York: Wolters Kluwer.

Polkinghorne, D. E. (2005). Language and Meaning: Data Collection in Qualitative Research *Journal of Counseling Psychology*, Vol 52, pp 137–145.

Possa, R & Khotso, P. (2015). Naming of Basotho medicinal plants: semantic connection to their remedies. *Southern African Journal for Folklore Studies*, Vol 25(1), pp 34–47.

Prescott, S.L & Logan, A.C. (2018). From the wellspring of holistic medicine to personal and public health imperative. *Planetary Health*, Vol 15 (2), pp 98-106. <https://doi.org/10.1016/j.explore.2018.09.002>.

Proctor, M & Farquhar, C. (2006). Diagnosis and management of dysmenorrhoea. *BMJ*, 332, pp 1134-1138.

Puchalski, C.M., Vitillo, R., Hull, S.K & Reller, N. (2014). *Journal of Palliative Medicine*, Vol 17(16), pp 642-656. <http://doi.org/10.1089/jpm.2014.9427>

Purkree, T., Mkhize, M., Mgobhozi, Z & Lin, J. (2002). African traditional healers: what health care professionals need to know. *International Journal of Rehabilitation Research*, Vol 25, pp 247-251.

Rafapa, L.J., Nengome, A.Z & Tshamano, H.S. (2011). Instances of Bessie Head's distinctive feminism, Womanism and Africanness in her novels. *Tydskrif Vir Letterkunde*, Vol 48(2).

Rahmatullah, M., Noman, A., Hossan, M.S., Rashid, M., Rahman, T & Chowdhury, M.H. (2009). "A survey of medicinal plants in two areas of Dinajpur district, Bangladesh including plants which can be used as functional foods," *American Eurasian Journal of Sustainable Agriculture*, Vol 3 (4), pp 862–876.

Ramathuba, D.U. (2015). 'Menstrual knowledge and practices of female adolescents in Vhembe district, Limpopo Province, South Africa'. *Curationis*, Vol 38(1). <http://dx.doi.org/10.4102/curationis.v38i1.1551>.

Ramose, M.B. (1999). *African Philosophy through Ubuntu*. Harare: Mond.

Rankoana, S.A. (2012). *The use of indigenous knowledge for primary health care among the Northern Sotho in the Limpopo Province*. Unpublished PhD Thesis. South Africa: University of Limpopo.

Rankoana, S.A. (2014). Self-medication through administration of indigenous plant medicine among the Northern Sotho people of Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, October (Supplement 1:2), pp 494-501.

Rankoana, S.A. (2016). Curative care through administration of plant-derived medicines in Sekhukhune district municipality of Limpopo Province, South Africa. *Afr J Tradit Complement Altern Med*, Vol 13(2): 47-51. <http://dx.doi.org/10.4314/ajtcam.v13i2.647>.

Rankoana, S.A., Nel, K., Mothibi, K., Mothiba, T.M., Mamogobo, P & Setwaba, M. (2015). The use of indigenous knowledge in primary health care: A case study of Makanye community in Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance, Supplement*. Vol 1(2), pp 272-278.

Rau, A., du Toit, P., Mavhungu, J & Kabeta, J. (2009). Media Leadership Strategies from Southern Africa. Sol Plaatje Institute for Media Leadership. Southern Africa Institute for Media Entrepreneurship Development.

Ravitch S.M. and Riggan M. (2017). Reason & Rigor: How Conceptual Frameworks Guide Research, 2nd Ed. Thousand Oaks, CA: SAGE Publications, Inc.

Reddish, S. (2006). Dysmenorrhea. *Australian Family Physician*, Vol 35(11), pp 842-849.

Redekopp, D.E.D. (1990). *A critical analysis of issues in the study of meaning in life*. Unpublished doctoral dissertation. Edmonton: University of Alberta.

Reid, R.N.D., Steel A., Wardle, J & Adams, J. (2019). Naturopathic Medicine for the Management of Endometriosis, Dysmenorrhea, and Menorrhagia: A Content Analysis. *The Journal of Alternative and Complementary Medicine*, Vol 25(2), pp 202–226.

Reisfield, G.M & Wilson, G R. (2004). Use of metaphor in the discourse on cancer. *Journal of Clinical Oncology*, Vol 22(19): 4024–4027. doi:10.1200/JCO.2004.03.136.

Renzaho, A.M.N., Halliday, J.A., Mellor, D & Green, J. (2015). The Healthy Migrant Families Initiative: development of a culturally competent obesity prevention intervention for African migrants. *BMC Public Health*, Vol 15(272). DOI 10.1186/s12889-015-1628-2.

Rikhotso, S.R. (2017). *Indigenous Knowledge of Traditional Practitioners in the management of Rigoni: Grounded Theory Approach*. Unpublished PhD Thesis. University of Pretoria: South Africa.

Ristevski, E., Thompson, S., Kingaby, S., Nightingale, C & Iddawela, M. (2020). Understanding Aboriginal Peoples' Cultural and Family Connections Can Help Inform the Development of Culturally Appropriate Cancer Survivorship Models of Care. *JCO Global Oncol*, Vol 6, pp124-132.

Rodrigues, T.C., Montibeller, G., Oliveira, M.D & Bana e Costa, C.A. (2017). "Modelling multicriteria value interactions with Reasoning Maps," *European Journal of Operational Research*, Elsevier. Vol 258(3), pp 1054-1071.

Rodríguez, C & Bélanger, E. (2014). Stories and metaphors in the sensemaking of multiple primary health care organizational identities. *BMC Fam Pract*, Vol 15(1). <https://doi.org/10.1186/1471-2296-15-41>.

Rodriquez, L & Lopez, S.D. (2019). Performing Healing: Repetition, Frequency, and Meaning Response in a Chol Maya Ritual. *Anthropology of consciousness*, Vol 30(1), pp 42–63. DOI: 10.1111/anoc.12107.

Rose, G. (2012). *Visual Methodologies: An introduction to researching with visual methods* (3rd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Ross, E. (2010). Inaugural lecture: *African spirituality, ethics and traditional healing – implications for indigenous South African social work education and practice*. Vol 3(1): 44-51.

Rowan, M., Poole, N., Shea, B., Gone, J.P., Mykota, D., Farag, M., Hopkins, C., Hall, L., Mushquash, C & Dell, C. (2014). Cultural interventions to treat addictions in indigenous populations: Findings from a scoping study. *Subst Abuse Treat Prev Policy*, vol 9:34 (ISSN: 1747-597X).

Sadarangani, K.P., Hamer M., Mindell, J.S., Coombs, N.A & Stamatakis, E. (2014). Physical activity and risk of all-cause and cardiovascular disease mortality in diabetic adults from Great Britain: pooled analysis of 10 population-based cohorts. *Diabetes Care*, Vol 37: 1016–1023, <https://doi.org/10.2337/dc13-1816>.

Sadler, P & Craig, J.C. (2003). *Strategic management*. 1st ed. London: Kogan Page publishers.

Sanogo, R. (2011). Medicinal plants traditionally used in Mali for dysmenorrhea. *Afr J Tradit Complement Altern Med*, Vol 8(S), pp 90-96.

Sarantakos, S. (2013). *Social research*. 4th ed. Palgrave: Macmillan.

Scanlan, R. (2003). "The concept of taboos in African society with reference to the Kikuyu of Kenya", in Getui, M (Ed). *MIASMU Research Integration Papers to African Culture: An overview. Jan-April semester.*

Scott, K. D. (1995). "When I'm with my girls": *Identity and ideology in Black women's talk about language and cultural borders.* Doctoral dissertation. Urbana-Champaign: University of Illinois.

Scottish Intercollegiate Guideline Network (SIGN). (2019). SIGN 50. *A guideline developer's handbook: SIGN Publication. 3rd ed no 50. Edinburgh.* Available at www.sign.ac.uk

Seidman, S. (1991). "The End of Sociological Theory: The Postmodern Hope". *Sociological Theory*, Vol 9(2), pp 131-145.

Sembiring, A.B.R & Suswati, S. (2018). Effectiveness of turmeric tamarind and warm compression in the dysmenorrhea degression: Non pharmacologic therapy. *International Journal of Multidisciplinary Research and Development*, Vol 5(2), pp 18-23.

Semenya, S.S., Maroyi, A., Potgieter, M.J & Erasmus, L.J.C. (2013). Herbal medicines used by Bapedi traditional healers to treat reproductive ailments in the Limpopo Province, South Africa. *Afr J Tradit Complement Altern Med*, Vol 10(2), pp 331-339.

<http://dx.doi.org/10.4314/ajtcam.v10i2.19>

Semino, E., Demjén, Z., Demmen, J., Koller, V., Payne, S., Hardie, H & Rayson, P. (2017). The online use of 'Violence' and 'Journey' metaphors by cancer patients, as compared with health professionals: A mixed methods study. *BMJ Supportive and Palliative Care*, Vol 7(1), pp 60–66. doi:10.1136/bmjspcare-2014-000785

Semino, E., Demjén, Z., Hardie, A., Payne, S & Rayson, P. (2018). *Metaphor, cancer and the end of life: A corpus-based study.* London, UK: Routledge.

Setswe, G. (1999). The Role of Traditional Healers and Primary Health Care in South Africa. *Health SA Gesondheid*, Vol 4(2), pp 56-60.

Sharan, M & Mazanah, M. (2011). "How Modern-Day Traditional Healers Diagnose and Treat Cancer: The Case of Malaysia1," *Adult Education Research Conference*. 444-450. <https://newprairiepress.org/aerc/2011/papers/66>

Shenefelt, P.D & Shenefelt, D.A. (2014). Spiritual and religious aspects of skin and skin disorders. *Psychol Res Behav Manag*, Vol 7, pp 201-212.

Shewte, M.K & Sirpurkar, M.S. (2016). Dysmenorrhoea and Quality of Life among Medical and Nursing Students: A Cross- Sectional Study. *Ntl J Community Med*, Vol 7(6), pp 474-479.

Shirooye, P & Abdolhosseini, S. (2017). Effect of Mentha Longifolia on 10 Patients with Primary Dysmenorrhea. *Asian J Clin Case Rep Trad Alt Med*, Vol 1(1), pp 51-56.

Shrivastava, R., Couturier, Y., Girard, F., Papineau, L & Emami, E. (2020). Two-eyed seeing of the integration of oral health in primary health care in Indigenous populations: a scoping review. *Int J Equity Health*, Vol 19(107). <https://doi.org/10.1186/s12939-020-01195-3>.

Silberg, J.L., Martin, N.G & Heath, A. (1987). Genetic and environmental factors in primary dysmenorrhea and its relationship to anxiety, depression, and neuroticism. *Behaviour Genetics*, Vol 17(4), pp 363–383.

Sileyew, K.J. (2019). *Research Design and Methodology* [Online First], IntechOpen, DOI: 10.5772/intechopen.85731. Available from: <https://www.intechopen.com/online-first/research-design-and-methodology>

Sinnenberg, L., Mancheno, C., Barg, FK., Asch, D.A., Rivard, C.L., Martz, E.H., Bottenheim, A., Ungar, L & Merchant, R. (2018). Content Analysis of Metaphors About Hypertension and Diabetes on Twitter: Exploratory Mixed-Methods Study. *JMIR Diabetes*, Vol 3(4). doi:10.2196/11177

Skott, C. (2002). Expressive metaphors in cancer narratives. *Cancer nursing*, Vol 25(3), pp 230-235.

Smith, C.A & Carmady, B. (2010). Acupuncture to treat common reproductive health complaints: An overview of the evidence. *Autonomic Neuroscience: Basic and Clinical*, pp 52-56.

Smith, C.A., Crowther, C.A., Petrucco, O., Beilby, J & Dent, H. (2011). *Acupuncture to Treat Primary Dysmenorrhea in Women: A Randomized Controlled Trial*. Evidence-Based Complementary and Alternative Medicine.

Sodi, T., Mudhovozi, P., Mashamba, T., Radzilani-Makatu, M., Takalani, J & Mabunda, J. (2011). Indigenous healing practices in Limpopo Province of South Africa: A qualitative study. *International Journal of Health Promotion and Education*, Vol 49:3, pp 101-110. DOI:10.1080/14635240.2011.10708216

Sofowora, A. (1982). *Medicinal plants and traditional medicine in Africa*. Chichester: John Wiley & Sons Ltd.

South African National Biodiversity Institute (SANBI). (2012). Plants of southern Africa. <http://plantzafrica.com/>

South African Department of science and technology. (2015). Protection, promotion, development and management of indigenous knowledge systems bill. *Government gazette, 20 March 2015. Notice 243 of 2015* www, gpwonline.co.za

South African National Department of Health. Efforts to Strengthen and Promote Traditional Medicine. Pretoria: *Department of Health*; 2015. URL: http://www.gov.za/sites/www.gov.za/files/gcis_documents/traditional-medicine.pdf

Sprangers, M.A (2015). How recent health-related life events affected my perspective on quality-of-life research. *Quality of Life Research*, 24(5), pp 1157–1162.

Ssewanyana, D., Bitanhirwe, B.K.Y. (2019). Menstrual hygiene management among adolescent girls in Sub-Saharan Africa. *Glob Health Promot*, Vol 26(1):105–108. Epub 2017/05/10. <https://doi.org/10.1177/1757975917694597> PMID: 28485220

Stallbaum, J.H., da Silva, F.S., Saccol, M.F & Braz M.M. (2018). Postural control of women with primary dysmenorrhea in different phases of the menstrual cycle. *Fisioter Pesqui*, Vol 25(1), pp 74-81. DOI: 10.1590/1809-2950/17243825012018

Statistics South Africa. (2016). Community survey. Pretoria: Government Printers.

Steenkamp, V. (2003). Traditional herbal remedies used by South African women for gynaecological complaints. *Journal of Ethnopharmacology*, Vol 86, pp 97–108.

Stefanski, A., Valli, L & Jacobson, R. (2016). Beyond Involvement and Engagement: The Role of the Family in School–Community Partnerships. *School Community Journal*, Vol. 26(2). <http://www.schoolcommunitynetwork.org/SCJ.aspx>

Subasinghe, A.K., Happo, L., Ayasinghe, Y.L., Garland, S.M., Gorelik, A & Wark, J.D. (2016). Prevalence and severity of dysmenorrhoea, and management options reported by young Australian women. *The Royal Australian College of General Practitioners*, Vol 45(11), pp 829-834.

Subbarao, N.T & Akhilesh, A. (2017). Knowledge and attitude about Sexually Transmitted Infections other than HIV among college students. *Indian journal of sexually transmitted diseases and AIDS*, Vol 38(1), pp 10–14. doi:10.4103/0253-7184.196888

Sultana, A., Khan, A., Quwat Nawaz, Q & Syed, L. (2016). Aetiopathogenesis and clinical features of dysmenorrhoea (*Usr-i-tamth*) in traditional Unani medicine and contemporary era: A literary research. *TANG [HUMANITAS MEDICINE]*, Vol 6(1). Association of genuine traditional medicine. doi:10.5667/tang.2015.0024

Sultana, A., Syed, L., Begum, M & Quwat Nawaz, Q. (2017). Management of Usr-i-Tamth (Menstrual Pain) in Unani (Greco-Islamic) Medicine. *Journal of Evidence-Based Complementary & Alternative Medicine*, Vol. 22(2), pp 284-293. DOI: 10.1177/2156587215623637

Taylor, C & Dewsbury, B.M. (2018). On the Problem and Promise of Metaphor Use in Science and Science Communication. *Journal of Microbiology & Biology Education*, Vol 19(1). DOI: <https://doi.org/10.1128/jmbe.v19i1.1538>

Thabede, D. (2008). The African worldview as the basis of practice in the helping professions. *Social Work/Maatskaplike Werk*: Vol 44(3): 233-244 <http://dx.doi.org/10.15270/44-3-237>

Thapa, S., Bhattarai, S & Aro, A.R. (2019). 'Menstrual blood is bad and should be cleaned': A qualitative case study on traditional menstrual practices and contextual factors in the rural communities of far-Western Nepal. *SAGE Open Medicine*, Vol 7, pp 1–9.

Thomas, H., Mitchell, G., Rich, J & Best, M. (2018). Definition of whole person care in general practice in the English language literature: a systematic review. *BMJ Open* 2018;8:e023758. doi:10.1136/bmjopen-2018-023758

Thompson, J., Scott, J & Martin, F. (2017). *Strategic Management*. Andover: Cengage.

Titilayo, A., Agunbiade, O.M., Banjo, O & Lawani, A. (2009). Menstrual discomfort and its influence on daily academic activities and psychosocial relationship among undergraduate female students in Nigeria. *Tanzania Journal of Health Research*, Vol 11(4), pp 181-188.

Tong, Z H. (2018). A Review for Integrating Western and Chinese Medicines in Primary Dysmenorrhea. *Advancements Bioequiv Availab*. Vol 2(1): 98-101. DOI: 10.31031/ABB.2018.02.000528.

Tredgold, M.H. (1986). *Food plants of Zimbabwe: with old and new ways of preparation*. Gweru: Mambo Press.

Truter, I. (2007). African traditional healers: cultural and religious beliefs intertwined in a holistic way. *SA Pharmaceutical Journal*. 56-60.

Tsima, P.S. (2018). *The Lekgotla Way Learning and Developmental Methodology*. COMETSA GoC International (Pty) Ltd. South Africa.

Ukoma, A.N., Ogechukhu, I.E.C & Oji A.E. (2016). African Heritage of Holistic Healing with Herbs. *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*. Vol 21(6): 21-28 e-ISSN: 2279-0837, p-ISSN: 2279-0845. www.iosrjournals.org

Umeora, O.U.J & Egwuatu, V.E. (2008). Menstruation in Rural Igbo Women of South East Nigeria: Attitudes, Beliefs and Practices. *African Journal of Reproductive Health*. Vol. 12(1), pp109-115.

United Nations General Assembly. (2015). *Transforming our world: the 2030 Agenda for Sustainable Development*. Geneva: UN.

Van der Spek, N & Verdonck-de Leeuw, I. (2016). Meaning-centered group psychotherapy for cancer survivors. In: Breitbart W (ed.) *Meaning-centered Psychotherapy in the Cancer Setting: Finding Meaning and Hope in the Face of Suffering*. Oxford: Oxford University Press. Pp 67–74.

Van Dyk, A.C. (2001). Traditional African beliefs and customs: Implications for AIDS education and prevention in Africa. *South African Journal of Psychology*, Vol 36(31).

Van Wyk, B & Van Wyk, P. (1997). *Field Guide to Trees of Southern Africa*. Cape Town, Struik Publishers. Pp 1–536.

Van Wyk, B.E & Wink, M. (2004). *Medicinal Plants of the World*. Pretoria: Briza Publications.

van Wyk, B.E. (2008). "A broad review of commercially important southern African medicinal plants". *Journal of Ethnopharmacology*, Vol 119(3), pp 342–355.

Ventegodt, S., Kandel, I., Ervin, D.A & Merrick, J. (2016) *Concepts of Holistic Care*. In: Rubin, I.L., Merrick, J., Greydanus, D.E., Pate, I D.R. (eds) *Health Care for People with Intellectual and Developmental Disabilities across the Lifespan*. Springer, Cham. https://doi.org/10.1007/978-3-319-18096-0_148.

Vlachou, E., Owens, D.A., Lavdaniti, M., Kalemikerakis, J., Evagelou, E., Margari, N., Fasoi, G., Evangelidou, E., Govina, O & Tsartsalis, A. N. (2019). Prevalence, Wellbeing, and Symptoms of

Dysmenorrhea among University Nursing Students in Greece. *Diseases* 2019, Vol 7(5). doi:10.3390/diseases7010005.

Waldron, I. (2010). The marginalization of African indigenous healing traditions within Western medicine: reconciling ideological tensions & contradictions along the epistemological terrain. *Women's Health and Urban Life*, Vol 9(1), pp 50-71.

Walton, S. (2012). *How to define principles, values and virtues. The positive parenting center.* https://www.the-positive-parenting-centre.com/define_principles.html.

Wang, C & Burris, M.A. (1994). Empowerment through photo novella: Portraits of participation. *Health Education and Behavior*, Vol 21(2): 171–186. doi:10.1177/109019819402100204.

Wang, C & Burris, M.A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education and Behavior*, Vol 24, pp 369-387.

Wang, C., Burris, M.A & Ping, X.Y. (1996). Chinese village women as visual anthropologists: a participatory approach to reaching policymakers. *Soc Sci Med*, Vol 42(10), pp 1391-1400. doi:10.1016/0277-9536(95)00287-1

Wang, C. (1999). Photovoice: a participatory action research strategy applied to women's health. *Journal of Women's Health*, Vol 8(2), pp 185-192.

Wang, C.C., Yi, W.K., Tao, Z.W & Carovano, K. (1998). Photovoice as participatory health promotion strategy. *Health Promotion International*, Vol 13(1).

Wang, C & Redwood-Jones, Y. (2001). Photovoice ethics: Perspective from Flint photovoice. *Health Education and Behavior*. Vol 28(5), pp 560-572. doi:10.1177/109019810102800504

Wang, C. (2005). Youth participation in photovoice as a strategy for community change. *Journal of Community Practice*. Vol 14, pp 147-161

Warburton, D.E., Nicol, C.W & Bredin, S.S. (2006). Health benefits of physical activity: the evidence. *CMAJ*. Vol 174: 801–809. <https://doi.org/10.1503/cmaj.051351>

- Watson, N & Hunter, C. (2015). "I had to be strong": Tensions in the strong Black woman schema. *Journal of Black Psychology*. 1-29. DOI: 10.1177/0095798415597093.
- WHA62.13. (2009). Traditional medicine. In: *Sixty-second World Health Assembly, Geneva, 18–22 May 2009. Resolutions and decisions, annexes*. Geneva, World Health Organization, 2009 (WHA62/2009/REC/1; http://apps.who.int/gb/ebwha/pdf_files/. 19–21.
- Whalen, D.H., Moss, M & Baldwin, D. (2016). Healing through language: Positive physical health effects of indigenous language use. *F1000Research*. Vol 5(852) (doi: 10.12688/f1000research.8656.1).
- White, P. (2015). The concept of diseases and health care in African traditional religion in Ghana', *HTS Teologiese Studies/Theological Studies*. Vol 71(3). <http://dx.doi.org/10.4102/hts.v71i3.2762>
- Wikman, A., Marklund, S & Alexanderson, K. (2005). Illness, disease, and sickness absence: an empirical test of differences between concepts of ill health. *J Epidemiol Community Health*, vol 59, pp 450–454. doi: 10.1136/jech.2004.025346.
- Wilson, C., Oliver, V., Flicker, S., Prentice, T., Jackson, R., Larkin, J., Restoule, J.P & Mitchell, C. (2016). 'Culture' as HIV prevention: Indigenous youth speak up!. *Gateways. International Journal of Community Research and Engagement*, Vol 9(1), pp 74-88.
- Wilson, E., Haver, J., Torondel, B., Rubli, J., Caruso B.A. (2018). Dismantling menstrual taboos to overcome gender inequality. *Lancet Child Adolesc Health*, Vol 2(8).
- Wong, L.P. (2011). "Premenstrual syndrome and dysmenorrhea: urban-rural and multiethnic differences in perception, impacts, and treatment seeking,". *Journal of Pediatric and Adolescent Gynecology*, Vol 24(5), pp 272–277. <https://doi.org/10.1016/j.jpag.2011.03.009> PMID: 21600811.
- Wong, C.L, IP, W.Y & Lam, L.W. (2016). Self-care strategies among Chinese adolescent girls with dysmenorrhea: A qualitative study. *Pain Management Nursing*. Vol 17(4), pp 262-271.

Woods-Giscombe, C L. (2010). Superwoman schema: African American women's views on stress, strength, and health. *Qualitative Health Research*, 20(5), 668-683. DOI:10.1177/1049732310361892.

World Health Organization and the United Nations Children's Fund (UNICEF). (2018). Primary health care: closing the gap between public health and primary care through integration. *Technical series on primary health care*. Geneva: UN.

World Health Organization. (2003). *Fact sheet no.134*. Traditional Medicine, Geneva, Switzerland; available at <http://www.who.int/mediacentre/factsheets/2003/fs134/en/>.

World Health Organization. (2013). Traditional medicine strategy 2014 – 2023. Geneva, Switzerland: UN.

World Health Organization. (2018). WHO Expert Committee on Specifications for Pharmaceutical Preparations Fifty-second report. WHO Technical Report Series, No. 1010, 2018. 81-152.

[World Health Organization global guidelines \(2018\) Global action plan on physical activity 2018-2030: more active people for a healthier world. Copenhagen.](#)

World Health Organization. (2019). global report on traditional and complementary medicine. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

Yeh, M., Hung, Y., Chen, H., Lin, J & Wang, Y. (2013). Auricular Acupressure Combined with an Internet Based Intervention or Alone for Primary Dysmenorrhea: A Control Study. *Evid Based Complement Altern*. doi: 10.1155/2013/316212PMCID: PMC3638620

Zahle, J. (2014) Holism, *Emergence, and the Crucial Distinction*. In: Zahle J., Collin F. (eds) *Rethinking the Individualism-Holism Debate. Synthese Library (Studies in Epistemology, Logic, Methodology, and Philosophy of Science)*, Vol 372. Springer, Cham. https://doi.org/10.1007/978-3-319-05344-8_10

Zamanzadeh, V., Jasemi, M., Valizadeh, L., Keogh, B & Taleghani, F. (2015). Effective factors in providing holistic care: a qualitative study. *Indian J Palliat.Care*, Vol 21(2), pp 214-224.

Zimmermann, M. (2017). Alzheimer's Disease Metaphors as Mirror and Lens to the Stigma of Dementia. *Literature and Medicine*, Vol 35(1), pp 71-97.

Zuma, T., Wight, D., Rochat, T & Moshabela, M. (2018). Navigating Multiple Sources of Healing in the Context of HIV/AIDS and Wide Availability of Antiretroviral Treatment: A Qualitative Study of Community Participants' Perceptions and Experiences in Rural South Africa. *Front. Public Health* Vol 6(73). doi: 10.3389/fpubh.2018.00073.

Zuma, T., Wight, D., Rochat, T & Moshabela, M. (2017). Traditional health practitioners' management of HIV/AIDS in rural South Africa in the era of widespread antiretroviral therapy. *Global Health Action*, Vol 10, 1352210 <https://doi.org/10.1080/16549716.2017.1352210>.

Zuma, T., Wight, D., Rochat, T and Moshabela, M., 2016. The role of traditional health practitioners in Rural KwaZulu-Natal, South Africa: generic or mode specific?. *BMC Complementary and Alternative Medicine*, Vol 16(304). DOI 10.1186/s12906-016-1293-8.

ANNEXURE A

**PARTICIPANT'S INFORMATION
AND INFORMED CONSENT
DOCUMENT**



Melitah Molatelo Motlalepula Rasweswe

PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT

Study title: The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

Dear Participant

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you decide to participate in the study. You must understand this fully, before you agree to take part. If you have any questions regarding this study, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved. If you have any questions concerning this study, you should contact Ms MM Rasweswe or her supervisors at University of Pretoria, Professor MD Peu and Professor FM Mulaudzi.

2) THE PURPOSE OF THE STUDY

To understand the Batlokwa women's indigenous perspective of the meaning and treatment modalities of dysmenorrhea, and to use findings to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

3) EXPLANATION OF THE PROCEDURES

The study will use modified photovoice methodology and lekgotla discussion. Participants must be eighteen years and above.

The minimum requirements for you as a participant include:

- Attending an initial training prior to research on issues related to this project, training on the project procedures, and informing of your responsibilities. The training is expected to last one to two hours.
- Taking pictures with a provided disposal camera of participant's community related to dysmenorrhea and treatment modalities and describe during individual interview. The

Melitah Molatelo Motlalepula Rasweswe

photovoice process may take up to 4 weeks and to take up to 8 pictures. If you take any photos of people, including yourself, please hide the faces and you will need to obtain a Photo Release Consent Form provided by the researcher.

- When you have completed the photo assignment before 4 weeks, you will contact the researcher to come and pick it up.
- Attending individual interview to discuss photos. The interview is expected to last one hour to one and half hour.

All interviews will be recorded using a digital voice recorder and a note taker will be present so as not to miss any pertinent information discussed. At any time, you may request that the recorder be turned off. You also have the right not to answer or give any information you feel not comfortable to. Each recording will be transcribed into a written form (transcript). Recordings and transcripts will be kept in a locked file cabinet, and your identity (if you choose not to be identified by name) will not be disclosed. In order to maintain confidentiality, no personally identifiable information such as name or phone number will be asked or associated with photos. Only the researcher and supervisors will have access to the files collected. All data files will be destroyed at the end of the study. The results of this project will be presented in conferences, seminars and workshops and may be presented in published articles.

Participation in the study is voluntary, and you may withdraw at any time without penalty, prejudice or loss of benefits.

4) BENEFITS

This study may include the valuable insights you may gain about the health strength of your community. You will be a participant researcher rather than been researched on. You may also enjoy the creative components of this study, giving you the opportunity to express yourself both visually, in the written form and verbally. Additionally, you may be allowed to keep the pictures and a gift will be issued at the end of individual interview to compensate for your participation and time during this study.

5) RISKS

This research study may include safety when taking pictures as well as the safety of the photo subjects. You will be instructed on safety and respect as described in the photovoice guidelines

Melitah Molatelo Motlalepula Rasweswe

that you will receive during the training at the initial meeting. Other inconveniences to you may be time to take the photos, submitting the camera to the researcher, and attending training, interviews and lekgotla discussions.

6) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read the above information or had read to me in a language that I understand before signing the consent form. The researcher explained the content and meaning of this information. I had an opportunity to ask questions and they were answered satisfactorily. I understand that my failure to participate in this study will not affect me negatively in any way.

I have received a signed copy of this informed consent agreement.

Participant's name _____ Signature _____ Date _____

Researcher's name _____ Signature _____ Date _____

Witness name and signature _____ Date _____

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ANNEXURE B

**APPLICATION FOR PERMISSION
TO CONDUCT A STUDY TRIBAL
AUTHORITY, BOTLOKWA
VILLAGE IN LIMPOPO**



Melitah Molatelo Motlalepula Rasweswe

**APPLICATION FOR PERMISSION TO CONDUCT A STUDY TRIBAL AUTHORITY, BOTLOKWA
VILLAGE IN LIMPOPO**

H27 Dikgomong Section
Ramokgopa
Botlokwa
2017

The Chairman
Botlokwa Tribal Authority
P.O Box 9302
Ramokgopa
0811

Madam /Sir

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN, BOTLOKWA
LOCAL AREA, LIMPOPO PROVINCE.

My name is Melitah Molatelo Rasweswe, a registered nurse and a PHD degree candidate at the University of Pretoria. I hereby apply for a permission to conduct a research study with the women in Botlokwa local area, Capricorn district, Molemole municipality. The study will be conducted in two phases.

The purpose of the study is to understand the Batlokwa women's indigenous perspective of the meaning and treatment modalities of dysmenorrhea, and to use findings to develop strategies to empower the Batlokwa women with dysmenorrhea knowledge.

The participation in this study is voluntary, no bribery, no coercion of any kind will be used. Privacy and confidentiality will be maintained throughout the study. Participants will not receive any remuneration, but they will be given money for transport and will be provided with lunch and thank you gifts.

Your consideration is highly appreciated. Thanking you in advance.

Yours faithfully
MM Rasweswe

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE C

**PARTICIPANT GUIDELINES FOR
PHOTOVOICE STUDY**



Melitah Molatelo Motlalepula Rasweswe

PARTICIPANT GUIDELINES FOR PHOTOVOICE STUDY

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

Getting Started: Photovoice study Steps

Step 1. Take a picture of anything that reflects indigenous perspectives of dysmenorrhea and treatment modalities within your community. Think about these guiding questions:

- What pictures best help women to recognize and perceive menstruation and its problems such as dysmenorrhea in my community?
- What factors contribute the way women in my community understand dysmenorrhea?
- What activities best assist women in my community to perceive constraints caused by dysmenorrhea?
- What pictures best describe the indigenous means of dysmenorrhea prevention, diagnosis, and remedial care in my community?
- What in my life or community has helped me and other women to be involved in sharing knowledge about dysmenorrhea and treatment modalities?
- What in my life or community has prevented me or other women for using available methods of relieving dysmenorrhea symptoms?
- What do I want to tell other people about dysmenorrhea and treatment modalities, and what might help me get there?

Step 2. Note the date, time and place of the photo you took and a description of the picture. You can note any additional reflections you may have about the photo.

Step 3. When you feel you have taken enough pictures that represent Batlokwa women's indigenous perspectives of dysmenorrhea and means of prevention and care (about 8 pictures), you may contact the researcher to pick up camera.

Step 4. After the researcher receives your photos, she will invite you for individual interview to discuss your photos and Lekgotla discussions to develop strategies to empower Batlokwa women with dysmenorrhea knowledge.

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE D

PICTURE TAKING TRAINING



Melitah Molatelo Motlalepula Rasweswe

PICTURE TAKING TRAINING

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

Photovoice Ethics and Respect

Photovoice is a visual research; consider legal implications at all times. Remember a picture is not worth taking if it will cause danger or harm to you or anybody else!

- Respect the lives and safety of others, think of people's safety, protection and rights first, and be respectful of their lives. Hide their faces even if they allowed it to be visible.
- Ask permission before taking people's photos for this study. Ask them to sign a photo consent form (provided in this packet).
- Respect feelings of people who do not want their photo taken, even if it is of value.
- Be prepared and ready to explain about the project to family, friends, or strangers, if they ask what you are doing.

Using Your Camera

- Your camera is ready for use after, you have run the wheel on the side clockwise
- The power button is located on the top of the camera (on/off). Press it once to turn the camera on. Your camera is now ready to take pictures!
- To take a picture, press the large round button (the shutter) on the top of the camera.
- To zoom in, press the slider surrounding the shutter to the right. To zoom out, press the slider back to the left.
- You will not be able to view pictures you have taken
- To return to picture-taking mode, press the button on the bottom right of the viewing screen again. Your camera should adjust to the surroundings. At night or indoors, it will automatically flash. Outdoors (during the day) or in well-lit areas, the flash will not go off.

If you need assistance operating the camera at any time, please phone, SMS or WhatsApp Ms MM Rasweswe on the provided number.

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE E

**PHOTOGRAPHY AND IMAGE
RELEASE CONSENT FORM**



Melitah Molatelo Motlalepula Rasweswe

ANNEXURE F

**TAPE RECORD RELEASE
FORM**



Melitah Molatelo Motlalepula Rasweswe

TAPE RECORD RELEASE FORM

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

I hereby agree that Melitah Molatelo Rasweswe, and all persons authorized by or claiming through or under it, shall be entitled to: Tape record my likeness and environment during training, interviews, discussions and workshops. Make copies of the tape recordings made, publish, play, transfer and otherwise use the recordings and any copies so made, or any part, therefore. Code name chosen by me, and use my likeness and environment, for the purposes of promotion and dissemination of research findings, recordings and any copies so made.

Name (print) _____

Signature _____ Date _____

Witnessed (print) _____ Signature _____

Date _____

Should you have any questions about the above, please contact the investigator Melitah Molatelo Rasweswe. You may also contact the research Supervisors at the University of Pretoria, Professor MD Peu and Professor FM Mulaudzi

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE G

INDIVIDUAL INTERVIEW GUIDE



Melitah Molatelo Motlalepula Rasweswe

INDIVIDUAL INTERVIEW GUIDE

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

The individual dialogue session will be around the participants' photographs. It will last approximately one hour to one and half hours.

Interview Script Prior to conducting interview

Thank you for your participation in this study. I would like to go over a couple of reminders before we get started. First, I want to reiterate for you that participating in this study is voluntary. If you feel uncomfortable answering a particular question, please let me know and we will move onto the next question. Also, you can request to stop the interview at any time for any reason. Identifying information shared during this interview will be removed from findings. The structure of the interview will start with questions.

Do you have any questions regarding your participation in this study before we start?. Next, I would like to ask your permission to sign an image, tape record release form, and to record this interview. Do you agree to be recorded?

Name: _____ Age: _____ Date: _____

Ethnicity _____

How long have you been staying in this community? _____

What is your position in this community? _____

Looking critically at photographs

Please choose three of some photographs that you would like to talk about and have to be included in the study. For each photograph, ask 1. Tell me about this photo photograph. (Including follow-up questions as needed: who, what, where, when, how) 2. What is happening in this photograph, and why? 3. What title would you like to give this photograph? Once all photographs have been discussed, sequence or place these photographs in the order that makes sense to you, from left to right.

Melitah Molatelo Motlalepula Rasweswe

The questioning acronym PHOTO will be used to contextualize the meaning of each of the participants' chosen photos (Hussey, 2006)

- Describe the activities on dysmenorrhea in this **picture**?
- What is **happening** in this picture related to dysmenorrhea or treatment modalities?
- How does a picture **of** this object link to dysmenorrhea or treatment modalities?
- What does this picture **tell** us about dysmenorrhea or treatment modalities?
- How does this picture provide **opportunities** to improve knowledge of dysmenorrhoea and treatment modalities?

After discussing each photograph, using the "PHOTO" acronym participants will be asked if they like to say anything else about the photograph that might not have been captured by the five questions and if there is anything missing from each photograph to be discussed.

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE H

**PHOTOVOICE LEKGOTLA
DISCUSSION
GUIDE**



Melitah Molatelo Motlalepula Rasweswe

PHOTOVOICE LEKGOTLA DISCUSSION GUIDE

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

Date: 09 March 2019

Time: 09h00

Duration: 2 - 3 hours

Location: Botlokwa

Venue: Private, chosen by the participants

Purpose of the meeting:

1. To introduce participants to each other 2. To provide the opportunity for participants to share their photographs and collaboratively synthesize their themes. To engage participants in debates and dialogue, to enable them to record and reflect on their photographs. 3. To promote group discussion to identify common themes, concerns, or issues that may help in influencing knowledge about dysmenorrhea. 4. To use the information from this workshop to draft strategies to empower Batlokwa women with dysmenorrhea knowledge.

Meeting materials:

All materials required for workshop is free of charge. The materials include flip charts, folders, books, pens, and photo prints.

Prior to Beginning:

Key elements will be highlighted with participants (i.e. meeting rationale, group dialogue procedures, timeline, risk, safeguards, voluntary nature of the study and rights to withdrawal without penalty)

- Individual questions will be answered
- Photo Release form will be signed

General meeting requirements and ground rules:

1. Participants are expected to attend Lekgotla meetings. If you are unable to attend, please inform Ms MM Rasweswe in advance. There will be no make-up sessions. 2. An important part of the Lekgotla meeting is to share and discuss the photographs and descriptions that you would like to convey. Each participant will have the opportunity to contribute to group discussions. We will work together to allow space and time for all to participate. It is important that everyone have a chance to be heard, so please speak one at a time and be respectful when others are speaking. 3.

Melitah Molatelo Motlalepula Rasweswe

Confidentiality of information expressed in the meeting is important for respect of others. You will decide which photographs you want to make public and what message you want others to hear. 4. Treat your fellows and facilitator with respect. 5. Feel free to step out quietly if you feel that it is necessary. 6. When giving feedback to other fellows about their pictures/stories, be respectful and compassionate.

Dialogue Questions Guide:

1. Are there any photographs and/or themes that you would like to share with the other participants in this study related to dysmenorrhea?
2. What have you been thinking about since the individual interview session in regard to things you said or new things you would like to talk about?
3. What recommendations do you have to empower Batlokwa women with dysmenorrhea knowledge?
4. If you had the undivided attention of other women in the community, what would you say to them about dysmenorrhea?

Discussion:

- a. As they discuss their photographs, the group will collectively identify issues, themes, theories that emerge from all of their photographs
- b. This process will give participants the chance to voice individual and collective experiences, and to reflect on issues that might not have been addressed in the individual interviews.
- c. The ideas that participants come up with for each research question will be written on a flip chart, to assist in forming themes.
- d. These agreed upon themes will be compared to the literature and Africana Womanism theory.
- e. Participants will also have a discussion around how to use the findings to develop strategies to empower Batlokwa women with dysmenorrhea knowledge

Melitah Molatelo Motlalepula Rasweswe

ANNEXURE I

**PHOTOVOICE LEKGOTLA
DISCUSSION PROGRAM**



Melitah Molatelo Motlalepula Rasweswe

PHOTOVOICE LEKGOTLA DISCUSSION PROGRAM

The indigenous perspective of the meaning and treatment modalities of dysmenorrhoea among the Batlokwa women of Limpopo province.

Date: 17 December 2019

Time: 09h00

Duration: 4 - 5 hours

Location: Botlokwa

Venue: Private

Purpose of the meeting:

1. To introduce participants to each other 2. Presentation of phase 1 study findings and preliminary statements to guide in the discussion. 3. Engaging participants in debates and dialogues for the development of strategies. 4. To promote group discussion to identify common ideas, opinions, concerns, or issues that may help in developing strategies. 5. To verify and refine strategies to empower Batlokwa women with dysmenorrhea knowledge.

Meeting materials:

All materials required for workshop is free of charge. The materials include flip charts, folders, books, pens, and photo prints.

General meeting requirements and ground rules:

1. All experts are expected to be fully involved in the discussion to develop sound strategies. 2. Each participant will have the opportunity to contribute to group discussions. We will work together to allow space and time for all to participate. It is important that everyone have a chance to be heard, so please speak one at a time and be respectful when others are speaking. All the opinions and ideas should be highly debated on. 3. Confidentiality of information expressed in the meeting is important for respect of others. Treat your fellows and facilitator with respect. When giving feedback to other fellows about their ideas and opinions, be respectful and compassionate. 5. Feel free to step out quietly if you feel that it is necessary.

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PROGRAM

Time and duration	Main topic	Exercise/activities
45 Minutes	Arrival and Welcome	Knowing each other, completing provided puzzle as know each other. Welcoming all, introducing the purpose of the meeting. Obtaining verbal consent.
1 hour 10 minutes	Engaging participants	Presentation of phase 1 study findings and preliminary statements. Engaging participants in debates and dialogues regarding dysmenorrhea. Scrutinizing the provided information. Sharing, discussing and comparing ideas and opinions regarding dysmenorrhea.
1 hour 30 minutes	Reaching consensus on the strategies to empower Batlokwa women with dysmenorrhea knowledge	Drawing and selecting relevant and appropriate ideas and opinions to be considered rationale, objectives, activities and strategies to empower Batlokwa women with dysmenorrhea knowledge. Reaching agreement on the developed strategies.
45 minutes	Verification and refinement of the strategies to empower Batlokwa women with dysmenorrhea knowledge	Reformulating, adding and removing statements from the draft set of strategies to refine the strategies. Set of strategies to empower Batlokwa women with dysmenorrhea knowledge were finalized

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ANNEXURE J

**ETHICAL APPROVAL LETTER:
UNIVERSITY OF PRETORIA**



Melitah Molatelo Motlalepula Rasweswe

ETHICAL APPROVAL LETTER: UNIVERSITY OF PRETORIA

The Research Ethics Committee Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
• FWA 00002667, Approved on 22 May 2008 and Expires 03/20/2022
• IRB 0000 2730 IRB00001762 Approved on 2/04/2014 and Expires 03/14/2020.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

9/02/2018

Approval Certificate
New Application

Ethics Reference No: 20/2018

Title: AIL INDIGENOUS PERSPECTIVE OF THE MEANING AND TREATMENT MODALITIES OF DYSMENORRHOEA AMONG THE BATHOKWA WOMEN OF LIMPOPO PROVINCE

Dear Ms Melitah Rasweswe

The New Application as supported by documents specified in your cover letter dated 8/02/2018 for your research received on the 8/02/2018, was approved by the Faculty of Health Sciences Research Ethics Committee or its quorate meeting of 9/02/2018.

Please note the following about your ethics approval:

- Ethics Approval is valid for 3 years
- Please remember to use your protocol number (20/2018) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:

- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the modulus or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Samuels; MBChB; MMed (Int); MPharm, PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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ANNEXURE K

**TRANSCRIPT INDIVIDUAL
INTERVIEW**



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TRANSCRIPT INDIVIDUAL INTERVIEW

Interviewer: Good morning, I have already introduced myself and the purpose of this interview. As you know from the review of the consent form, the general focus of this interview is on your perspectives regarding the meaning and treatment modalities of dysmenorrhea

Participant: Hello, how are you my child. Be specific, what do you want to know exactly?

Interviewer: I am interested in hearing what you have to say about indigenous perspectives of the meaning and treatment modalities of dysmenorrhea. I will start out by asking some general questions. I will take you through specific questions as we continue.

Participant: Okay, no problems.

Interviewer: As indicated earlier, I'm recording the session as agreed. I would like you to speak freely about anything related to your experience with and views of indigenous knowledge regarding dysmenorrhea. I hope that our meeting will be more like a conversation than a question and answer period.

Participant: No problem, I did sign that form to grant my permission

Interviewer: Do you have any questions before we start?

Participant: No

Interviewer: Could you start by telling me a bit about yourself: What is your ethnic group?, Where do you live?, What kind of work do you do?, What title does your community use when they talk about you or introduce you?

Participant: I'm Motlokwa, I live in Eisleven Botlokwa, I was born and breed here over 60 years ago. I'm an indigenous holder, I didn't train to be a healer, but I know several medicines and their functions to assist people in the community. They call me "ngaka tshupe" (untrained traditional healer)

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Interviewer: Ok..., I heard you saying that you're untrained?

Participant: Yes

Interviewer: Then, how do you know about medicines?

Participant: I used to assist my grandfather with administration of traditional medicine, especially when treating women, she giggles and laugh out loud

Interviewer: Ohoo, what do you know about dysmenorrhea

Participant: What is dysmenorrhea

Interviewer: Period pains

Participant: Okay, ka Setlokwa ke selumi (In our ethnicity Setlokwa is "something that bites". "selumi" is well known in this community. It affects child-bearing women. Most women who suffers from it, find it difficult to fall pregnant. It also affects other women reproductive system. It is important to treat the whole body to fight it efficiently.

Interviewer: Are there other names that are used to refer to dysmenorrhea?

Participant: Yes, names like *mahlaba a letlhapo*, letlhapo hloko" (painful menstruation), "tshilwana or kgwele"(lower abdominal cramps occurring immediately after giving birth), "bohloko ba o ya kgweding" (painful menstruation), and "letlhapo la o loma or tshega (cleansing that bites or cuts). Some they call it period pains

Interviewer: Why are the names used and what do they mean?

Participant: The names reflect the action or symptoms of period pains. Ehee...they are used because the Batlokwa people came up with those names themselves for easy understanding of the illness. The names assist us when we explain the illness to others.

Interviewer: What do you understand about dysmenorrhea?

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Participant: It is the illness that is related to menstruation. Our forefathers discovered it long time ago. It mostly occurs to the women who don't have children or immediately after giving birth. It can be cured if treated well by someone who is knowledgeable. The treatment was also discovered by our forefathers. The two types are not treated the same way.

Interviewer: Since you saying it related to menstruation, what do you think is the cause of dysmenorrhea?

Participant: From what I learnt from my grandfather, there are different causes, one just need to know and understand the way a woman present herself or behaves when experiencing dysmenorrhea. I know that young girls can get it from their mothers, sisters and aunts. This kind affects the virgins. The other cause is witchcraft.

Interviewer: Really!!!!

Participant: Yes, usually jealous people inflict it to innocent woman, just to cause pain or infertility. I'm telling you. Sometimes is due to infectious sores inside the womb, when a woman is menstruating the sores swells and cause pain.

Interviewer: Mhh...What do people in Botlokwa think is the cause of dysmenorrhea?

Participant: Most think is witchcraft.

Interviewer: Why do they think so?

Participant: Because they say so when looking for treatment and usually is about infertility, people doesn't want others to have children and inflict them with period pains to make it difficult for them to have children.

Interviewer: How do you identify a woman experiencing dysmenorrhea?

Participant: It is easy, through their action. Some describe their experiences when seeking help.

Interviewer: You spoke of action and description, can you elaborate, please be specific

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Participant: Pain, squeezing abdomen and waist due to pain during menstruation or few days before menstruation, lot of bleeding during menstruation. Just looking at the face of the woman, you can just tell from the expression the woman is making. Some walk with difficulty because of the pain on the thighs.

Interviewer: With your knowledge how serious is dysmenorrhea?

Participant: It is very serious; the way the women describing the pain you can measure the severity. Others report mild or moderate pain, but they still come for treatment because they are afraid of infertility at the later stage. It doesn't cause physical pain only. Others isolate themselves when experiencing dysmenorrhea. Isolation is a social and mental disorder. Some women are affected to the extent of being unable to carry on with other life activities. School children do not even go to school. You see how serious it is..., you see!

Interviewer: Ohoo, I see. Is there anything else that shows the seriousness of dysmenorrhea apart from what you have mentioned?

Participant: Errr...It affects the family members as well because isolation disrupts the lifestyle. Actually, the whole community is affected. We all face the consequences that the women experience when having period pains.

Interviewer: Thank you. In your knowledge and practice, is there any indigenous treatment available for dysmenorrhea?

Participant: Yes, there are indigenous ways of treating dysmenorrhea. The methods cure it.

Interviewer: You mentioned methods, what are those methods?

Participant: We use medicinal herbs in different forms, others perform rituals, while some combine the two. It depends on the type of period pains and knowledge of the healer.

Interviewer: Can you describe some of the treatment modalities that you use and how you use them?

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Participant: I have already mentioned herbs; I use guava leaves, fresh or dried. I prefer fresh leaves, you see I have a tree, I just pick it from the tree and boil it, cool and swift it. I prepare this for young girls because I don't want to perform rituals for them, otherwise they fall pregnant in an early age. She giggles, they will never tell you when they a sexually active.

For young women who are acceptable to have children by the society, I use a mixture of herbs, that I will not mention to protect my knowledge, or I perform rituals "gaola noka" (cut the waist). I take the women under the specific tree called "mokgalo" (buffalo tree) and do my things. The woman should be menstruating for it to be effective. After that I bathed her with a mixture of some herbs. Most of them fall pregnant the same month and will never experience "selumi" (dysmenorrhea) unless infected with sores in the womb.

Interviewer: What kind of treatment do you think women with dysmenorrhea should receive?

Participant: The woman should have a choice, on the advice of the family members and the healer.

Interviewer: Okay. What do you think are the roles of traditional healers in prevention and treatment of dysmenorrhea?

Participant: The traditional healers should diagnose and treat women experiencing dysmenorrhea. They should teach them about dysmenorrhea and counsel women and family members who are finding it difficult to cope.

Interviewer: Is there any difficulties that women with dysmenorrhea have in your community?

Participant: Yes, because of the stigma attached to menstruation and causes of dysmenorrhea, most women experiencing dysmenorrhea, suffer in silence. They are secretive about the issue.

Interviewer: What kind of actions can be taken to address the kind of things you mentioned?

Participant: Educate them that menstruation is a normal process, when having menstrual problems, they should seek help. They can talk to any of the family members or anyone they trust for help. You understand this neh!

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Interviewer: Mhhhh...I understand. What can enable such actions?

Participant: Genuine sisterhood, confidentiality, respect and support system offered.

Interviewer: Thank you very much for your time and contribution to the study. This is the end of the interview.

Participant: I'm also thankful for having interest in our knowledge and practices

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ANNEXURE L

**LANGUAGE EDITOR'S
CERTIFICATE**



Melitah Molatelo Motlalepula Rasweswe

LANGUAGE EDITOR'S CERTIFICATE



05 Gwal Place,
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28 September 2020

DECLARATION OF PROFESSIONAL EDIT

I declare that I have edited and proofread the Doctoral Thesis entitled: **THE INDIGENOUS PERSPECTIVE OF THE MEANING AND TREATMENT MODALITIES OF DYSMENORRHOEA AMONG THE BATLOKWA WOMEN OF LIMPOPO PROVINCE** by **MS Melitah Molatelo Motlalepula Rasweswe**.

My involvement was restricted to language editing: contextual spelling, grammar, punctuation, unclear antecedent, wordiness, vocabulary enhancement, sentence structure and style, proofreading, sentence completeness, sentence rewriting, consistency, referencing style, editing of headings and captions. I did not do structural re-writing of the content. Kindly note that the manuscript was not formatted as per agreement with the client.

No responsibility is taken for any occurrences of plagiarism, which may not be obvious to the editor. The client is responsible for ensuring that all sources are listed in the reference list/bibliography. The editor is not accountable for any changes made to this document by the author or any other party subsequent to my edit. The client is responsible for the quality and accuracy of the final submission/publication.

Sincerely,



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