EXPLORING THE SENSE OF COHERENCE OF WOMEN WHO ARE ACTIVE IN THE INFORMAL LABOUR MARKET IN SOUTH AFRICA.

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ABSTRACT

Working in the Informal Labour Market (ILM) can be a vulnerable and uncertain time for pregnant and new mothers. However, some can do well despite the working conditions. Informal workers are neglected from social protections (e.i. paid maternity leave). These characteristics of the ILM put pregnant women at a greater risk to suffer from antenatal and postnatal depression. However, despite these challenging conditions, some new mothers can maintain positive health outcomes. This study adopts a salutogenic approach, exploring how informally-working women comprehend their situations, portray their problems, utilize resources, and what provides them meaning. The latter aspects provide essential information on the strength of their sense of coherence and if it links to better coping ability.

This study adopted a qualitative approach, exploring the subjective experiences of informally-working women and how it impacted their mental well-being. Interviews during pregnancy and after childbirth were analyzed for nine participants.

The findings indicated that informally-working women understood that their work was vital to secure before giving birth, as they were frequently the primary breadwinners for the family. Participants experienced numerous challenges before and after childbirth, which they managed by relying on support networks at their workplaces and their immediate families. The desire to deliver a healthy newborn was a motivational component mentioned by participants. The study findings are also discussed in relation to the Ottawa Charter for Health Promotion and the Sustainable Development Goals.

Keywords: *informal labour market, informally-working women, South Africa, depression, mental well-being, challenges, resources, sense of coherence*

LIST OF ACRONYMS AND ABBREVIATIONS

AND	Antenatal Depression
BDPA	Beijing Declaration and Platform of Action
CCGs	Community Caregivers
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHWs	Community Health Workers
CRC	Convention on the Rights of the Child
CRH	Centre for Rural Health
CSG	Child Support Grant
EPDS	Edinburgh Postnatal Depression Score
FAO	Food and Agriculture Organization of the United Nations
GRRs	Generalized Resistance Resources
HIV	Human Immunodeficiency Virus
ILM	Informal Labour Market
ILO	International Labour Organization
LMICs	Low-and Middle Income Countries
LINCs	Livelihood and Nurturing Care Project
MBOs	Membership Based Organizations
MDGs	Millennium Development Goals
MPI	Multidimensional Poverty Index
OCHP	Ottawa Charter for Health Promotion
PND	Postnatal Depression
SA	South Africa
SDGs	Sustainable Development Goals
SOC	Salutogenic Model of Health
SOC	Sense of Coherence
SRRs	Specific Resistance Resources
UN	United Nations
UNICEF	United Nation International Children's Emergency Fund
WB	World Bank
WHO	World Health Organization
WIEGO	Women in Informal Employment: Globalizing and Organizing

CHAPTER 1: INTRODUCTION

1.1 Background

The ILM can be a cause of great vulnerability for pregnant women and mothers of newborns, and yet, some women in this situation do remarkably well. The official definition of the ILM is controversial within research as its debated which work domains are included in these markets. Most often, the ILM combines both the informal sector, "the production and employment that takes place in unincorporated or unregistered enterprises" and informal employment, "employment without social protection through work — both inside and outside the informal sector" (Carré & Chen, 2020, p. 4-5). On a global scale, a staggering 2 billion workers, 61% of the global workforce, work within ILMs (Bhan et al., 2020; Horwood et al., 2019). South Africa (SA) has a substantial population of ILM workers. Horwood and colleagues (2019) suggest that 90 per cent are women workers.

The ILM working conditions vary significantly from those in the formal labour market. For example, ILM workers do not obtain social benefits and protections, a decent minimum wage, or experience job security. These differences can create vulnerabilities for workers impacting their overall health outcomes, particularly females. Due to various factors, informally-working women are at risk for experiencing poor mental well-being, especially depression (Rochat et al., 2013). Galderisi and colleagues (2015, p. 231) definition of mental well-being is used within the thesis as it takes a comprehensive and holistic approach, "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This study adopts a salutogenic perspective to explore the sense of coherence[1] (SOC) of new mothers working within various work domains of the ILM. Moreover, this study will explore if the SOC links to coping better and thus increase mental well-being.

[1] The sense of coherence is further explained within Chapter 2: Theoretical Framework.

1.2 Context

In SA, women tend to work in the ILM as a means of economic need and often not by choice (Ruzek, 2014). Pregnant women working in this sector typically work until very close to their expected delivery date due to a lack of maternity leave benefits. In combination with earning a very little wage and other negative factors that accompany working in this sector, poverty and food scarcity, heightening the vulnerability of experiencing poor mental well-being. Women are more vulnerable to experiencing lower mental well-being throughout pregnancy, specifically those residing in low-and middle income countries (LMICs) (Biaggi et al., 2016). This population commonly experiences depression during pregnancy. According to Dadi and colleagues (2020, p. 2), "antenatal depression is thought to be exacerbated by the high rate of peptide and steroid hormone fluctuation occurring during pregnancy and childbearing age". Existing research studies suggest that AND is more common in SA than globally, with prevalence rates ranging from 16.4% to 47% (Kathree et al., 2014).

There is a correlation between mothers experiencing depression before childbirth and afterward as well. Postnatal depression (PND) is the "inability to sleep or sleeping much, mood swings, change in appetite, fear of harming, extreme concern and worry about the baby, sadness or excessive crying, feeling of doubt, guilt and helplessness" (Norhayati et al., 2015, p. 35). The competence of new mothers to take care of their newborns is challenged when they experience PND. To reduce the public health threat that depression causes for the SA population, the government insists that all pregnant women attend antenatal clinic sessions (Jinga et al., 2019). Unfortunately, these classes often do not address mental well-being concerns, thereby omitting valuable health education for this population.

1.3 Problem statement

Many new mothers experience depression which compromises their ability to take care of themselves and their newborns. However, very little is known about how informally-working women who work within precarious situations can experience drastic decreases in AND and PND rates. The purpose of this study is to understand how SOC is linked to mental well-being

and, correspondingly, whether it has an impact on mental well-being. This study contributes to the limited amount of research available regarding new mothers who are active in the ILM and who, while pregnant were depressed, but experienced a reduction in depression after delivery. The factors that account for this reduction are essential to identify as these may assist other women in different work segments to promote their mental well-being. The findings of this study will serve a bigger purpose, as it will provide recommendations to assist these populations better and boost their health. In addition, it provides valuable knowledge to the limited research available on health-promoting behaviours of informally-working women.

1.4 Outline and structure of thesis

The thesis is organized into eight chapters —chapter 1 provided information regarding the nature of the study and stated the problem statement. Chapter 2 explains the theory that guides this study, The Salutogenic Model of Health (SMH). Chapter 3 provides an in-depth review of the informal labour market characteristics and the most common challenges experienced by informally-working women. Chapter 4 presents the overall research and sub-objectives. Chapter 5 outlines the research methodology. Chapter 6 explains the empirical findings derived from the participants transcripts. Chapter 7 discusses the findings in relation to the theory, the Ottawa Charter for Health Promotion (OCHP), and the Sustainable Development Goals (SDGs) and existing literature. Moreover, this chapter also explains the limitations of the study. Lastly, Chapter 8 summarizes the thesis and provides recommendations for future practice and research.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 Introduction

This chapter explains the SMH that guides the study's research questions, literature review, data analysis, and discussion sections. This chapter begins by describing how the SMH originated along with its two core components. Following this, it describes why the SMH is the most appropriate framework for this study.

2.2 Salutogenesis

Salutogenesis, *the origins of health*, was identified by Aaron Antonovsky while examining the health of Holocaust survivors (Eriksson, 2017). He noticed that despite experiencing the same phenomenon, survivors had contrasting health outcomes. He was intrigued to figure out and understand how this could be and therefore began posing the question, *"what are the origins of health?"* (Eriksson, 2017; Vinje, Langeland & Bull, 2017). Antonovsky's ontological background, how he portrayed the nature of reality, is that individuals are within an environment that makes them vulnerable to constantly being bombarded with stressors (Eriksson, 2017). He believed that an individual's health is a part of a continuum that fluctuates, "we are all somewhere between the imaginary poles of total wellness and total illness, the whole population becomes the focus of concern" (Eriksson, 2017, p. 93). Antonovsky referred to the imaginary poles as "health ease" and "dis-ease" (Joseph & Sagy, 2017, p. 85). Salutogenesis offers a different perspective on health than the well-known pathogenic orientation, which considers one to either healthy or diseased, instead of fluctuating (Mittelmark & Bauer, 2017). The figure below illustrates Mittelmarks' interpretation of how a stressful event can either result in a negative or a positive health outcome. For example, when informally-working women go to work despite feeling unwell but do not want to miss a days worth of income, their health will most likely shift to H-, leading to a breakdown. Alternatively, if they comprehend that they need to rest in order to recover and have resources that they can engage, they are more likely to manage the stressor better than the former example, leading to a more successful management of a stressful situation.

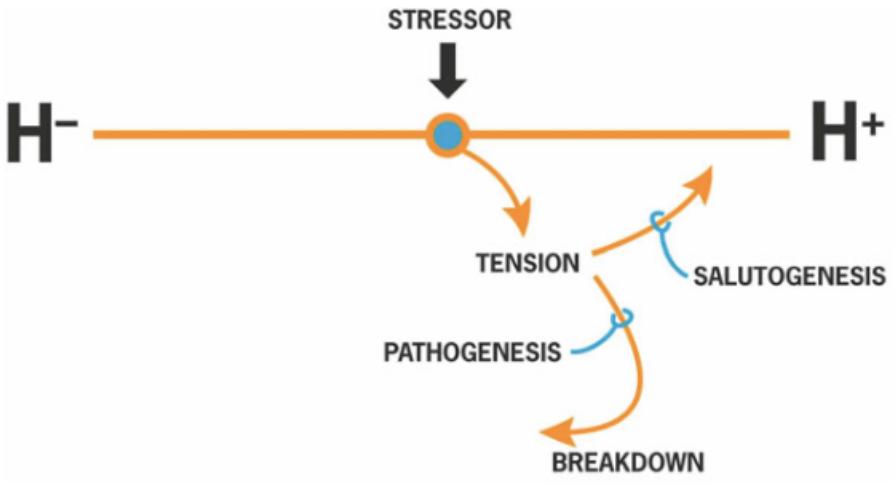

Figure 1: Visual representation of the health ease-disease continuum (Source: Eriksson, 2017, p.93)

Antonovsky (1979, p. 72) defines stressors as "a demand made by the internal or external environment of an organism that upsets its homeostasis, restoration of which depends on a nonautomatic and not readily available energy-expanding action". The tension that arises from a stressor is not inherently 'bad' or 'negative' since positive stressors also create tensions (Antonovsky, 1979, p. 96). However, how one manages stressors indicates to which side of the continuum our health moves. When a woman discovers she is pregnant after a desire and a longing to become a mother is an example of a positive stressor. The woman most likely understands that this will create tension in her life, but it is associated with positive stress such as; meaning, purpose, fulfillment, and gratification. Stressors are subjective experiences that require different resources to manage the corresponding tensions.

Sense of coherence

As noted above, two key concepts within the SMH allude to where an individual falls on the health continuum. Antonovsky (1987, p.19) defines the first concept, SOC, as a

> *dynamic feeling of confidence that (1) the stimuli from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement.*

Life experiences are central to developing the SOC and how individuals respond to sources of tension (Antonovsky, 1979). Antonovsky (1979, p. 187) describes "from the time of birth, or even earlier, we constantly go through situations of challenge and response, stress, tension, and resolution". When these challenges can be characterized as consistent, partaking in shaping outcomes and experiencing a good load balance, the more predictable one beings to view life, thereby contributing to a more resilient SOC (Antonovsky, 1979). The SOC is developed and shaped through three pillars, the first being a cognitive component (comprehensibility). When consistent messages and stimuli appear, the more likely a stable environment is fostered (Antonovsky, 1979). The stability makes it easier to identify predictable challenges and allows for health-promoting solutions to occur. For those who work in the ILM, its working conditions are often unsupportive in creating a stable environment, as financial and food insecurity is prevalent for its workers (Luthuli et al., 2020). Nonetheless, Horwood et al., (2021) demonstrate that ILM workers must maintain their work as it provides essential income for the household.

The second pillar of the SOC is a behavioural component (manageability). This component revolves around finding and utilizing available resources to avoid or combat challenges successfully. Once resources are identified, a good load balance is established, it strengthens the SOC and increases positive health (Antonovsky, 1987). When an uneven load balance occurs, one is likely to experience adverse health outcomes. Overload results in experiencing too many stressors and lacking resources to avoid the tensions it creates, moving one's health towards the disease end of the continuum (Slootjes et al., 2017). In contrast, under-load refers to not experiencing enough stimulation or "when one's life is so structured that one's skills, abilities, interests, and potential have no channel for expression" (Antonovsky, 1987, p. 108). Street trading, market vending, and domestic workers are the ILM domains considered to be low-skilled jobs that are non-engaging or thought-provoking areas of work (D'Souza, 2010). These areas are characterized by completing routinized tasks and the potential to think critically is missing (D'Souza, 2010). Literature has presented that ILM workers often experiencing under-load as skill development and further enhancement is not evident (D'Souza, 2010).

The last pillar of the SOC is the motivational component (meaningfulness). It refers to how motivated an individual is to overcome a presented challenge and perceive it as worthy of their investment and commitment (Antonovsky, 1987). Moreover, Antonovsky describes that a crucial aspect within this component is participating in socially valued decision-making. Within the ILM, workers participate in decision-making practices when they participate in labour union meetings, which is an emerging trend and discussed more within Chapter 3.

Ranking high in all three pillars (comprehensibility, manageability, and meaningfulness), corresponds with a stable and positive health outcomes, even when faced with a stressor. A strong SOC is directly associated with "consistent, balanced life experiences and high participation in decision making" (Idan, Eriksson & Al-Yagon, 2017, p. 57). Moreover, they describe the experience as a 'fun' challenge to overcome. In contrast, an individual with a weak SOC (ranking poorly in one or more pillars) considers life as being "inconsistent, low balanced life experiences and low participation in decision making" moving their health towards the H-side of the continuum as shown in Figure 1. Antonovsky believed that all three SOC components are "dynamically interrelated" and that the fostering of the SOC is

> *the responsibility of the society to create conditions that foster the strengths of coping — that is, SOC. It is not a question about a free choice of the person to cope well. The key lies in a society and in people who care about others.* (Eriksson & Lindström, 2006, p. 379)

Antonovsky (1979, p. 183) explained that the orientation of SOC is "not situation - or role specific", that a specific stressor with negative tension can still be challenging for an individual with a relatively high SOC to overcome. Moreover, although the SOC is subjective, Antonovsky (1979, p.183) indicates that it is rare to have some with a very strong SOC, "this would require an unimaginably stable world, an inconceivably unchanging internal and external environment. Only someone who is totally out of touch with reality could claim to have an absolute sense of coherence".

Generalized resistance resources

The second key component of Antonovsky SMH is generalized resistance resources (GRR). These resources can

> *be found within people as resources bounded to their person and capacity but also their immediate and distant environment as of both material and non-material qualities from the person to the whole society.* (Lindström & Eriksson, 2005, p. 440)

Examples of GRRs are; knowledge, social support, and cultural stability. Three characteristics that unite the GRRs, are "they all fostered repeated life experiences which, to put it at its simplest, helped one to see the world as 'making sense', cognitively, instrumentally and emotionally" (Antonovsky, 1996, p. 15). These resources only act as resistance resources when used to mitigate pressures. As a result, they directly impact the SOC's strength because as GRRs are identified and utilized, individuals are better equipped to alleviate tensions (Idan, Eriksson & Al-Yagon, 2017). The existing empirical literature has revealed common GRRs that informally-working women utilize, particularly surrounding childcare responsibilities and support networks such as grandmothers and immediate family (Michel et al., 2020; Aubel, 2012). According to Antonovsky's GRR figure, grandmothers are an interpersonal-relational characteristic for informally-working women.

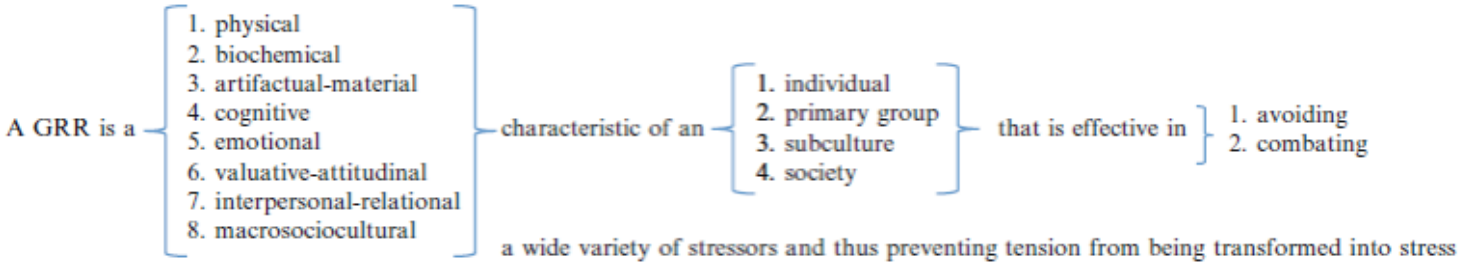

Fig. 11.4 The definition of generalized resistance resources (Antonovsky, 1979, s. 103)

FIGURE 2: "Mapping-Sentence Definition of a Generalized Resistance Resource" (Source: Antonovsky, 1979, p. 103)

Specific resistance resources

A separate category from GRRs is specific resistance resources (SRR) because they are only applicable to particular situations of tension (Antonovksy, 1979, p. 99). According to Mittelmark and colleagues (2017, p.75),

> *specific resistance resources are instrumentalities whose meanings are defined in terms of the particular stressors they are invoked to manage. A generalized resistance resource is a generality and a specific resistance resource is a particularity.*

For example, pregnant women attending antenatal care sessions to ensure the health and development of their unborn child is an SRRs, are solely intended for mothers. Antonovsky (1979) also described that the individuals' use of GRRs determines the extent to which SRRs are available and utilized. Meaning, as individuals acquire more GRRs, their ability to identify and access SRRs increases supporting positive health outcomes.

2.3 Most suitable framework for this study

Other strengths-based theories, such as resilience and positive deviance, have been scarcely explored concerning the ILM and its health implications for workers. Resilience theory explores how individuals can adapt to adverse circumstances. A newly published research study by Horwood and colleagues (2021) hypothesizes that resiliency can be an essential factor in improving mental well-being among this population. They predicated that either resilient women seek out informal work or that informal work contributes to developing resiliency within informally-working women. They established that more research on the topic was to be conducted to understand the situation better. Positive deviance observes unusual behaviours that work well or promotes health. However, the SMH and the three components of the SOC provide a more valuable and relevant framework to explore the topic at hand. This theoretical framework provides a more holistic perspective to fully understand individual perceptions and how they understand, manage and give meaning to stressful situations influencing their health outcomes.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

This chapter provides a critical and short overview of ILMs globally and specifically in South Africa (SA). First, it explains the characteristics of this market, namely how the lack of social protection, benefits, and low wages has implications on health outcomes. This market is characterized by predominately working women, which increases their vulnerability to experiencing poverty. Afterward, the challenges experienced by new mothers who work within the ILM surrounding childcare and breastfeeding are explained. Many informally-working women suffer from poor mental well-being, specifically antenatal and postnatal depression, as they are vulnerable to various risk factors. The last section will discuss the emerging trend of labour unions within the ILM and its positive health implications.

3.2 Literature search process

The three primary websites consulted for this literature review are; Google Scholar, Oria, and Web of Science. Keywords that searched in combinations were; “informal labour market”, “informal sector”, “precarious employment”, “South Africa”, “global south”, “developing countries”, “India”, “informal-workers”, “informal- working women”, “informal mothers”, “street vendors”, “street traders”, “mental well-being”, “well-being”, “health inequities”, “unfair health outcomes”, “depression”, “anxiety”, “challenges”, “stressors”, “resources”, “benefits”, “breastfeeding”, “feeding techniques”, “HIV”, “community health worker”. A time period of 2010 to 2021 was selected when searching for empirical literature. I also included a few articles from the early 2000s because they were highly informative, and literature was lacking in these areas. I selected appropriate journals from the reference lists of highly relevant articles. All the papers were peer-reviewed and written in English.

3.3 Informal labour market characteristics

The following paragraphs will provide a better overview of the ILM characteristics, first in a global context and then exploring these within SA. Existing literature has presented that workers

within the ILM are without labour and social protection and generally work long hours for wages not regulated by the government. Furthermore, the ILM is a primary domain for women workers who work predominately within two areas; street vending and domestic workers.

Lack of social protections and benefits

Globally, ILMs workers are excluded from government regulations and from receiving social protections and benefits. They do not enjoy worker rights such as; employment security, governmental income assistance, and occupational health and safety measures or obtain health services, maternity benefits, nor have access to an old-age pension fund (Bhan et al., 2020; Horwood et al., 2019). As a result, informally-working women cannot enjoy paid maternity leave, making them vulnerable and at risk for experiencing poverty if they do not return to work shortly after giving birth (Horwood et al, 2021). Carré and Chen (2020, p. 3) describe a "significant overlap between informal employment and non-income dimensions of inequality" disproportionally affecting ILM workers' overall health outcomes. The social and economic deprivations experienced by those working in the ILM result from the lack of policies and worker rights violations, contributing to increased stress and depressive symptoms.

Low pay and long working hours

Another staple and characteristic of the ILM is the poor working conditions, (i.e. low wages and long working hours). ILM workers are not paid according to a minimum wage and spend long days working to acquire a decent living wage (Alfers & Rogan, 2015; Cassirer & Addati, 2007). In SA, ILM workers earn around R1 733 (US$120) per month compared to R5 000 (US$340) for formal labour workers (Horwood et al., 2020). In India, the earnings were shockingly lower for both informal and formal workers, INR 205 (US$3) and INR 411 (US$6) (Horwood et al., 2020). In both India and SA, large segments of the population work in the ILM. India has 90% of its population working within this sector, with an astounding number of women workers (90%) (Horwood et al., 2020). South Africa has a relatively smaller ILM, consisting of 34% of the total working population, with 35% of that percentage being women workers (Horwood et al., 2020). As ILM workers spend an extended amount of time engaging in work that can be physically

tiring and emotionally exhausting, in combination with low job control and low earnings, depressive symptoms are common to arise (Ludermir & Lewis, 2003; Horwood et al., 2021). The high volume of ILM workers demonstrates that many rely on this work to earn a living, despite the low wages.

Gender differences

Both men and women work within the ILMs; however, gender disparities are evident. Globally, the representation of informally-working women is slightly lower than informally-working men (ILO, 2018). However, the literature suggests that within specific developing countries, such as sub-Saharan African (90 per cent), Southern Asian (89 per cent), and Latin American countries (75 per cent), informally-working women are more dominant. (Horwood et al., 2019; ILO, 2018). Further, as in the formal labour market, a hierarchy of positions and wages is also present within the ILM. Literature has demonstrated that women work within the most vulnerable forms of informal work (street vendors and domestic workers), almost two million in SA alone (Cassirer & Addati, 2007; Chen, 2020; Horwood et al., 2021). Street traders are known for selling all types of goods and services, while women street traders are well-known to specifically sell more food items (fat cakes, sausages, and fish and chips) than men (Mkhize, Dube & Skinner, 2013). Men are more dominant at selling clothing and electronics, which provides them more profits compared to women. Some scholars contest the statement that women are concentrated predominantly within the lower segments of work and rather explain that they perceive women as overrepresented in these areas (Horwood et al., 2019). Similar studies by Alfers (2016) and Skinner and Valodia (2003) also confirm the latter conclusion and call for further research to understand the discrepancies. Figure 3 is from a recently published study in 2020 illustrating the segmentation of gender and labour in the ILM.

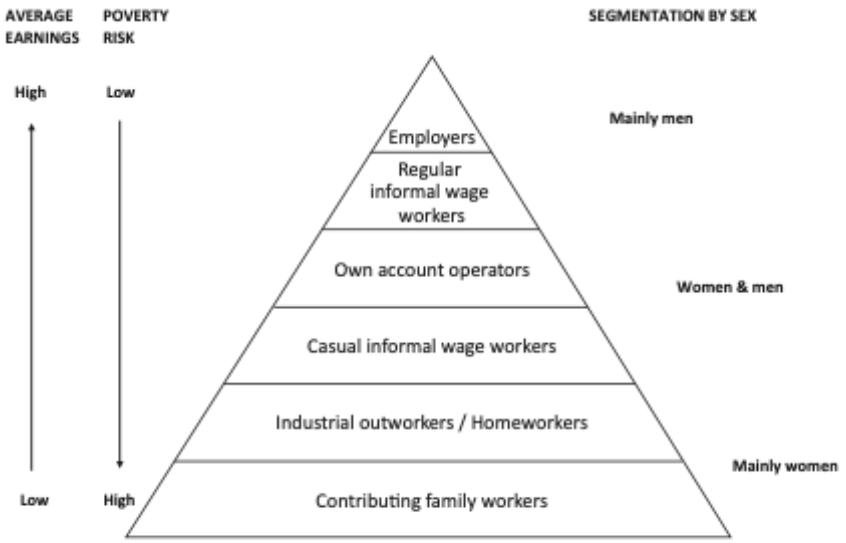

Figure 6.1 WIEGO model of the informal economy: segmented by status in employment and sex with average earnings and poverty risk.

Figure 3: Representation of ILM work based on average earnings, poverty risk and gender division (Source: Chen, 2020, p. 71)

Poverty

There is a significant overlap between working in the ILM and being poor. Different indexes with various components measure poverty. For this thesis, Multidimensional Poverty Index *(MPI)*, the definition of poverty is used in this thesis, which assesses the following three dimensions, health, education, and living standards (Organization for Economic Co-operation and Development, 2015). These three dimensions coincide with the Ottawa Charter prerequisites for health promotion, discussed in greater detail in Chapter 7. Within developing countries, 50-98 per cent of workers within the ILM are from impoverished backgrounds, and in SA roughly 88.5 per cent are from poor neighbourhoods (Bonnet, Vanek & Chen, 2019). As informally-working women dominant within lower work segments of ILM they are at risk for poorer health outcomes. Street vendors and market sellers are particularly vulnerable because of the constant exposure to toxic pollutants due to being located in heavy traffic areas. This relationship has been well established within the literature, "a higher percentage of informal workers than formal workers are from poor households; a higher percentage of all workers in poor households, than in

non-poor households, are informally employed" (Carré & Chen, 2020, p. 3). Working long hours while experiencing poverty is an unfortunate yet very realistic occurrence for many ILM workers.

3.4 Challenges

Working in the ILM comes with numerous challenges and difficulties, particularly for women. Childcare is one of the most mentioned concerns for those working informally, notably if there is no immediate family or support network. This specific challenge can be related to urbanization, as support networks are left behind once individuals move to urban centers to search for work (Alfers, 2016; Yuki, 2007). Breastfeeding is another challenge for informally-working women face as, without maternity leave, many have to head back to work shortly after birth cannot continue breastfeeding. As a result, mothers opt for different feeding approaches, which also have health implications for both mother and newborn. The challenges associated with childcare and breastfeeding for informally-working women are explained in the coming paragraphs.

Childcare

Responsibility for childcare is overwhelmingly regarded as women's work in SA. According to Moore (2013), in the middle of the 1900s, the fertility rate of African women was almost at seven children, requiring women to be the primary caregivers while men were primary breadwinners. In 2018, the fertility rate for South African women had dropped to around 2.4 children per woman (WB, 2021). For example, compared to developed countries such as Canada, the fertility rate per woman is 1.5 children (WB, 2021). Although, the decrease in children per woman, South African women are still expected to look after and be the primary caregivers, which is particularly challenging for those who work in the ILM (Horwood et al., 2021). Research has demonstrated that grandmothers tend to look over the newborn when informally-working women return to work or if no support system is in place, mothers will bring their children to work within them in the ILM **(**Korotayev et al., 2016; Cassirer & Addati, 2007). Alternatively, domestic workers within the ILM are often responsible for taking care of their employers' children while also completing household tasks. Since apartheid segregated work

based on skin colour, black women could only obtain work within the lower concentrated domains of the ILM, mostly as domestic workers (Gradín, 2019). The empirical literature suggests that these segregations are still visible today and that a large percentage of domestic workers are black and take care of the white South African children (Gradín, 2019).

Breastfeeding

The WHO recommends newborns be exclusively breastfed for the first six months and preferably until the newborn is two years old (WHO, 2021). Literature has demonstrated that breastfeeding newborns provide them with "protective antibodies," which safeguard them against diseases such as pneumonia and diarrhea and promotes "sensory and cognitive development" (WHO, 2021, pg.1). For the breastfeeding mother, positive benefits are also widespread. It continues to create an emotional connection and reduces the risk of life-threatening diseases such as ovarian and breast cancer (Tuthill et al., 2016; WHO, 2021). Moreover, there are also economic benefits associated with breastfeeding, as it reduces the likelihood of childhood disorders and diseases, thereby decreasing expenditures on treatment in later years (Rollins et al., 2016). Low rates of exclusive breastfeeding remain within developing countries despite the positive individual and societal outcomes. Informally-working women are challenged to balance breastfeeding and returning to work (Horwood et al., 2019; Remmert et al., 2020). Workplace limitations (lack of supportive breastfeeding environments) combined with social and economic factors are often cited as primary challenges for breastfeeding (Horwood et al., 2019; Luthuli et al., 2020). Moreover, individual preferences and individual-level factors (being a smoker or experiencing depression) also play a vital role if mothers choose to breastfed (Rollins et al., 2016). Literature suggests that breastfeeding rates among ILM women have increased in SA, "exclusive breastfeeding rates among infants under six months improved from 7% in 2003 to 31.6% in 2016"; however, it is still not at the desired percentage (Horwood et al., 2019, p. 5). Wider contexts and recommendations influence a mother's choice to breastfeed her newborn. Without necessary protections to assist new mothers who work in the ILM, adhering to the recommended breastfeeding guidelines remains challenging.

Breastfeeding for HIV-positive women

The breastfeeding advice and recommendations for mothers diagnosed with Human Immunodeficiency Virus (HIV) have changed numerous times. It is important to note that around 30 per cent of women living in KwaZulu-Natal are HIV-positive, which is amongst the highest rates within all of Africa (Kharsany et al., 2020). Existing literature had described that breastfeeding was highly discouraged for HIV-positive patients at the beginning of the pandemic when there was insufficient knowledge regarding transmission pathways (Nieuwoudt et al., 2019). As a result, the SA government instructed all nurses to recommend HIV-positive mothers to formula feed as a substitute for breastfeeding (Nieuwoudt et al., 2019). However, as the topic was researched more thoroughly, new recommendations encouraging and promoting breastfeeding were developed (Nieuwoudt et al., 2019; Rollins et al., 2016). Research points out that "in the past 20 years, the HIV epidemic has significantly affected policy and programmatic recommendations, community and family attitudes, and healthcare worker confidence in breastfeeding, all of which have detrimentally affected individual feeding practices" (Rollins et al., 2016, p. 492). In addition, evidence suggests that there is a strong link between being HIV-positive and poor mental well-being, specifically throughout pregnancy (Baron et al., 2016; Sawyer, Ayers & Smith, 2010). As HIV became more researched, breastfeeding recommendations changed. However, the information was often slow to get related to HIV-positive mothers, and this added worry increased the risk of depression.

3.5 Mental health and well-being

The poor working conditions experienced by those working informally also have negative implications on their mental well-being. Depression is a massive public health concern, and it affects a large percentage of the population in developed and developing countries (WHO, 2020). The WHO estimates that globally, more than 250 million individuals suffer from this illness, divided into three categories; mild, moderate, and severe. The literature demonstrates that depression is more prevalent for socially and economically disadvantaged (Tsai et al., 2016). Formally diagnosed depression is quite low and often undetected within resource-scarce settings

such as SA (Dadi et al., 2020; van Heyningen et al., 2018). There is a lack of research exploring the positive health outcomes for informally-working women. Researchers Alfers & Rogan (2015) and Bhan and colleagues (2020) recognize that this segment of the population is neglected from research studies. As a result, this section focuses on two dominant pathogenic health outcomes experienced by informally-working women.

Antenatal depression

Antenatal depression is a mood disorder that many women suffer from, specifically in resource-scarce settings. According to Dadi and colleagues (2020, p. 2), "antenatal depression is thought to be exacerbated by the high rate of peptide and steroid hormone fluctuation occurring during pregnancy and childbearing age". It occurs for 10 to 35 per cent of pregnant women in developing countries. Risk factors for depression and antenatal depression are very similar, partner rejection, infidelity, lack of support, and unwanted pregnancy (Horwood et al., 2021; Kathree et al., 2014). However, risk factors heightened for women residing in low-and middle-income countries are "associated with poverty, unstable income, food insecurity" (Horwood et al., 2021, p. 2). Furthermore, HIV-positive women are at greater risk for depression throughout pregnancy and afterward (Rochat et al., 2013). Horwood and colleagues' (2021) study determined that depression is frequently disregarded within SA's overburdened health care systems. Depression is still stigmatized in SA and is rarely discussed and restricted for the most severe cases of mental diseases (van Heyningen et al., 2018). Antenatal depression, or rather undiagnosed and untreated antenatal depression, is common among mothers who live in poverty; however, stigmatization and limited resources are two frequently mentioned difficulties in accessing help.

Postnatal depression

Postnatal depression (PND) rates are three to four times higher in developing countries than developed ones (Mokwena & Masike, 2020). Postnatal depression is the "inability to sleep or sleeping much, mood swings, change in appetite, fear of harming, extreme concern and worry about the baby, sadness or excessive crying, feeling of doubt, guilt and helplessness" (Norhayati

et al., 2015, p. 35). There are three different stages of PND, ranging from mild to severe; “baby blues, postpartum depression (PPD), and postpartum psychosis” (Manjunath & Venkatesh & Rajanna, 2011). All three of these make completing daily tasks and tending to the newborn challenging for new mothers (Mokwena & Masike, 2020). Mothers in low and middle-income countries (LMIC) are particularly vulnerable to experience PND as they are more likely to struggle with food and financial insecurity, unexpected pregnancy, poor social support, and abusive relationships (Coast et al., 2012; Kathree et al., 2014). Moreover, the prevalence of antenatal depression increases the risk of PND, negatively affecting both mother and newborn (Kathree et al., 2014). Research by Kathree and colleagues (2014, p. 1-2) explains that newborns whose mothers suffer from PND also experience implications for their “socio-emotional and cognitive development as a result of maternal neglect, poor maternal responsiveness and impaired attachment relationship between mother and infant”. Mothers residing in LMIC are vulnerable to experiencing PND, impacting how they interact with their child.

The empirical literature has demonstrated that mental well-being has not been researched substantially. Scholars such as Kathree and colleagues (2014, p. 2) argue that there is a need to explore how PND is comprehended within African countries as it could differ from the definition used in western countries. They also explain the need to develop culturally appropriate interventions to support those suffering from this disorder (Kathree et al., 2014). Many African countries have implemented one intervention to integrate and advocate for mental well-being among new mothers called Community Health Workers (CHW). The CHWs are an external resource of health systems within Africa that provide healthcare to rural areas (Scott et al., 2018). Decreases in depression rates and seeking mental health treatment are two positive associations when CHWs visit new mothers, enhancing their health and reducing health disparities (Scott et al., 2018). Moreover, their work supports the physical health of new mothers, lower rates of maternal and neonatal deaths and increases in breastfeeding rates (Horwood et al., 2017; Scott et al., 2018). The CHWs are also vital as they are “culturally adept members of comprehensive and people-centered primary health care teams that will enable universal health care” (Scott et al., 2018, p. 2). Although depression is under-researched within low-income settings, CHWs are a

positive resource to help new mothers in a culturally appropriate fashion. The hospitals tend to be overburdened and lack the resources to assist all patients properly.

The WHO has implemented numerous programs to improve maternal mental health in LMICs. From 2012-2016, the *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa,* focusing on providing postnatal support to new mothers. Despite the vital initiative, Baron and colleagues' (2016, p. 6) research describes the program's implementation as being "inconsistent". Working within the ILM, where unpredictable incomes and lack of social protection is unavailable, informally-working women are vulnerable to depression.

3.6 Emergering trends

The emergence of trade and labour unions has been slow despite the increasing development of ILMs. As a result, many ILM workers have collectively joined unions (Bonner & Sponner, 2011; Ryklief, 2012).

Labour Unions

More research on increasing social protection for ILM workers through labour unions and membership-based organizations has occurred recently. Much literature has suggested the necessity of establishing labour unions within the ILM, but this has been slow to implement as governments are not involved in these markets. As a result, informal workers have resorted to collectively uniting to start unions to increase their voices and demands for better working conditions and do not require a financial contribution (Bonner & Sponner, 2011). Membership-Based Organizations (MBOs) refer to the electing of one informal worker to represent the opinions of the majority (Bonner & Sponner, 2011). MBOs have been widely understood as a strategy for workers to voice their concerns (Bonner & Sponner, 2011). These types of organizations believe that "it is crucial that informal workers are agents rather than subjects; to move from dependency to independence and to speak for themselves through their elected representatives" (Bonner & Sponner, 2011, p. 128). MBOs are not required to have a certain

number of members; however, the smaller the group, the harder it is to have their voices heard (Bonner & Sponner, 2011). There are varying degrees of unions; MBOs, community-based organizations, co-operatives, non-governmental organizations, trade unions, and research has described that there are currently approximately 200 informal economy associations, with MBOs being the most widespread (Ryklief, 2012). Informal workers fight for protections and "democratic rights" available to those in the formal labour market through their own unions' establishments.

3.7 Conclusion

This chapter briefly summarizes the ILM characteristics and highlights the challenges that arise for informally-working women. There is a clear trend within the literature. The majority of studies are focused on a qualitative approach and conducted in SA. However, there have also been large amounts of research completed in India and South America. The most prominent researchers within this field are; Martha Chen, Michael Rogan, Christiane Horwood, Francine Lund, Laura Alfers, and Caroline Skinner. Two organizations that have produced numerous reports about the ILM are the International Labour Organization (ILO) and the Women in Informal Employment: Globalizing and Organizing. This section also reveals a gap in research identifying positive health and mental well-being outcomes for informally-working women. In addition, there is also a gap in resources identified by informally-working women themselves. This study aims to build on the latter two points and contributes to the limited amount of studies focusing on health-promoting behaviours and coping strategies.

CHAPTER 4: RESEARCH OBJECTIVES

4.1 Introduction

As the literature review has described, most women who experience AND are more vulnerable to experiencing PND. However, there is a gap in the literature explaining how women with high AND scores experience a significant drop in PND scores while working within an environment that is not conducive to supporting those working informally. This study contributes to the limited existing knowledge available and will provide a deeper understanding of how neglected populations such as informally-working women manage their situations.

4.2 Overall research aim and objective

The overall objective of this study is to explore the link between SOC and experiences of AND and PND.

4.3 Research sub-objectives

1. What are the challenges that participants face that affect depression?
2. What resources are available — and utilized by participants — to reduce depression?

CHAPTER 5: METHODOLOGY

5.1 Introduction

The original research study is presented in detail in this chapter, including the study area, participants, and recruitment strategies. The ontology and epistemology are described next, followed by the presentation of the current research study. Subsequently, data management and analysis are carefully detailed, which touches upon the four components of establishing trustworthiness in research. Additionally, I reflect on how my position as a researcher has influenced the decisions made throughout the study. Lastly, ethical considerations and clearance are detailed.

5.2 Original research project

The original research project[2] aimed to better understand childcare practices of informally-working women. Particularly regarding feeding practices, creating child-friendly environments, and breastfeeding perceptions of male partners (CRH, n.d.). The project was of mixed methods design, incorporating both quantitative and qualitative methodology. The former design includes surveys and questionnaires to obtain a broad understanding of the situation (Creswell, 2013). Participants filled out a structured questionnaire during the recruitment stage and after each in-depth interview, which asked questions regarding food security, child illness, 24-hour feeding recall (CRH, n.d.). In contrast to a quantitative design, a qualitative approach seeks to uncover subjective experiences by asking participants structured or semi-structured questions (Creswell, 2013). The original study incorporated two methods (in-depth interviews and focus group discussions) to obtain participants' perspectives on feeding practices and subjective experiences. Between five to six in-depth individual interviews were carried out for each participant at particular points of "*transition*" which were at; (1) 32-36 weeks pregnant, (2) 2 weeks after

[2] The original research project, *"Livelihood and Nurturing Care Project (LINCs)"* was conducted by Christiane Horwood, a senior researcher with the Center for Rural Health at the University of KwaZulu-Natal. The timeline for the project was from May to September 2019 and was funded by many influential organizations; the Bill and Melinda Gates Foundation, Children's Investment Fund Foundation, WHO, and Asiye eTafuleni (CRH, n.d.)

delivery, (3) after postnatal but before returning to work (when newborn was approximately 10 weeks old), (4) when returning to work, (5) on leaving the newborn with a caregiver (if applicable), and (6) when data collection was completed or after the newborn reached six months of age. The fifth interview was only applicable to those participants that left their newborn with a caregiver. As a result, between five or six interviews were conducted depending on this condition.

Study area & recruitment of participants

The project was conducted in Durban, South Africa, where around two million informally-working women work (Luthuli et al., 2020). Participants were purposively selected based on specific inclusion and exclusion criteria. Tong, Sainsbury and Craig (2007) define this criterion as "selecting participants who share particular characteristics and have the potential to provide rich, relevant and diverse data pertinent to the research question" (p. 352). Participants inclusion criteria were; (1) women, (2) aged 18 years or older, (3) who were in their third trimester (between 32-36 weeks), (4) who had worked in the informal sector for a minimum of six months, and (5) who work at least three days per week. The exclusion criteria were; (1) women who plan to leave the area before or (2) after the baby is born and (3) women who intend to stop working for more than six months when the baby is born. In total, the original study recruited 20 participants. Recruitment of participants was conducted outside of two primary antenatal health clinics (KwaMashu Community Health Centre and Inanda clinic) in Durban, South Africa.

5.3 Philosophical assumptions

Ontology

It is essential to acknowledge that every researcher has a different approach to perceiving ontology (nature of reality) is shaped (Creswell, 2013). One can identify two ontological assumptions, either a realist or a nominalist (Creswell, 2013). I believe we all observe our reality through a lens that has been constructed throughout our lives and cultural upbringing, I fall within the nominalist category (Creswell, 2013). "A moderate nominalist says subjective-cultural

factors greatly shape all of our experiences with the physical and social world, and we can never totally remove such factors" (Creswell, 2013, p. 94-95). This way of thinking about how nature of reality is created, I recognize that I will never completely understand how participants find themselves and that my interpretations are subjectively concluded.

Epistemology

Our ontology view also frames our epistemology orientation (nature of knowledge). How we create our knowledge is based on how we perceive reality, both of which are subjective. Neumann (2014, p. 100) explains that knowledge is produced when researchers "observe, interpret, and reflect on what other people are saying and doing in specific social contexts while we simultaneously reflect on our own experiences and interpretations". This study follows the interpretative social science approach (ISS), with Neumann (2014, p. 103) describes as, "emphasizes meaningful social action, socially constructed meaning, and value relativism". Analyzing the text through in-depth inquiry and with a critical lens, I attempted to obtain the true meaning and accurately represent the participants' perspective.

5.4 Current research study

Participants

The current study follows a qualitative research design. From the original 20 participants, I purposively selected those whose postnatal depression scores were lower than the antenatal depression scores after childbirth. In total, nine participants exhibited this decrease and were chosen to be a part of the secondary analysis. I decided upon two interviews (the baseline interview completed before delivery and the postnatal interview but before returning to work). I selected these two sets as they represented the interviews with the most responses for the Edinburgh Postnatal Depression Scale (EPDS) test from participants. This test is the most widely used tool to measure depression within developing countries (Rochat et al., 2013; Tsai et al., 2017). These sets provided me with the most varied data and reduced the possibility of over-simplifying the results. The table below provides more information regarding each of the chosen participants with pseudonyms to protect their identity. Furthermore, it also displays their

depression scores, work domain, first pregnancy, relationship status, and food insecurity level. These are all important factors to consider to understand better how participants shape their SOC and contribute to health outcomes. In APPENDIX 6, a copy of the EPDS with its associated questions is visible.

Pseudonym	AND	PND	Work domain	First pregnancy?	Relationship status	Food insecurity level (during pregnancy/pre-work)
Ayanda	14	9	Newspaper deliver	Yes	In a relationship and living with partner	moderate/severe
Buhle	13	7	Call centre worker	Yes	In a relationship and living with partner	moderate/secure & mild
Isisa	15	2	Domestic worker	No	In a relationship and not living with partner	moderate/secure & mild
Khethiwe	16	7	Dress maker	No	Married	secure & mild/ moderate
Liyana	13	8	Hairdresser (works from home)	No	In a relationship and not living with partner	moderate/secure & mild
Nolwazi	14	12	Domestic worker	No	In a relationship and living with partner	secure & mild/ secure & mild
Sizani	20	3	Hairdresser (works in salon)	No	Single	severe/secure & mild
Thadie	14	7	Street trader	No	In a relationship and not living with partner	secure & mild/ moderate
Zanele	19	2	Domestic worker	No	In a relationship and living with partner	secure & mild/ secure & mild

TABLE 1: Table describing the participants, AND and PND score, form of work within the ILM, if this was their first pregnancy, relationship status and food insecurity level.

5.5 Data management

The original research project audio-recorded all the interviews and transcribed them into English in Microsoft Word. The researchers from the original project emailed me the two sets of interviews which I have safely stored on my laptop that is password protected. All identifiable information (name, address, telephone number) was removed. Participants were assigned numbers to secure their anonymity. I later changed the numbers to pseudonyms.

5.6 Data analysis model

After receiving the 18 anonymized interview transcripts, I uploaded them into the qualitative data analysis software tool, NVivo 12. This software assists in storing and managing data and is an excellent platform to begin the first steps of data analysis. Data analysis is an iterative process, highlighting the necessary aspect of continually reviewing the data to find its true and accurate meaning. To assist with this, I followed Attride-Stirlings' (2001) six-step thematic network analysis to help organize and interpret the data. Attride-Stirlings' (2001, p. 387), thematic network analysis "seeks to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes". Within this model, six key steps are to be followed, which I will briefly discuss. First, I familiarized myself with the content, which meant I actively read through the interviews. I approached the coding with an inductive mindset, which begins "with concrete empirical evidence and works toward more abstract concepts and theoretical relationships" rather than a deductive approach (Neumman, 2014, p. 70). I began to label segments of the text into shortened codes to synthesize and combine the data without distorting its meaning, also referred to as latent coding (Neumman, 2014). At this stage, I found similarities and differences between the interviews, which with the assistance of NVivo was useful to sort, recode, and merge codes. Using this network, I labeled text into codes, identified the lowest-order themes (basic themes), and grouped these into more abstract concepts (organizing themes). The concepts provided information to which more extensive themes could be presented (global themes). In total, I identified 90 codes which were grouped into 31 basic themes. From these, six organizing themes and three global themes emerged. The analysis table is presented at the beginning of Chapter 6.

5.7 Ethical considerations

Overall ethical issues

Following ethical procedures throughout a research study is a top concern for researchers. According to Neumann (2014, p. 150), "ethics defines what is or is not legitimate to do or what "moral" research procedure involves". Two critical ethical components are informed consent and

confidentiality (Neumann, 2014). According to Grady and colleagues (2017, p. 856), informed consent is obtained when a researcher presents the research study to the participants and voluntarily agrees to be a part of it. Informed consent is necessary to get as it protects "the rights and welfare of participants while contributing to the advancement of knowledge". This study did not require informed consent from the original participants since I did not possess identifiable information or was not in direct contact with them. Tripathy (2013, p. 1478) describes that if data "is completely devoid of such information or is appropriately coded so that the researcher does not have access to the codes, then it does not require a full review by the ethical board". However, a copy of the informed consent form from the original project is visible in APPENDIX 7.

Maintaining confidentiality is the second key component of ethics (Neumann, 2014). Confidentiality refers to providing security and anonymity for all participants involved in the study (Neumann, 2014). A protective measure that the original project employed to ensure confidentiality was assigning and referencing participants with numbers (e.g., SL02). I chose to change the numbers to pseudonyms as it was easier to follow along their journey. In addition, another matter of confidentiality measure that the researchers took was to store all identifying information, including the consent forms, in a securely locked cabinet within their offices at the University of Kwa-Zulu Natal. This information was going to be stored for longer than five years once they completed the study. The current research study upholds the two ethical concerns as informed consent was not required and participants' identifiable information was not provided to me, ensuring their privacy and confidentiality.

Ethical clearance

The original study obtained ethical clearance from the Humanities and Social Sciences Research Ethics Committee at the University of Kwa-Zulu Natal and the WHO. I did not need to obtain additional clearance for this study.

5.8 Quality assurance

Four concepts are crucial in producing trustworthy qualitative research (Graneheim & Lundman, 2003). As briefly mentioned above, a qualitative study explores participants' subjective experiences in "a socially constructed dynamic reality through a framework which is value-laden, flexible, descriptive, holistic, and context sensitive" (Yilmaz, 2013, p. 312).

Credibility

Credibility is one of the four concepts that needs to be considered. Korstjens and Moser (2018, p. 121) define this concept as "the confidence that can be placed in the truth of the research findings". The original study completed measures that ensured credibility. They incorporated triangulation through multiple approaches, mixed methods design (questionnaires and in-depth interviews) and focus group discussions. All of which increased the confidence and plausibility of the research study (Korstjens & Moser, 2018; Yilmaz, 2013). The credibility of this study was increased as my supervisor and I had regular meetings to discuss the meaning and analysis of the data for correct interpretations. Moreover, I was in contact with the original researchers for clarification purposes as well.

Transferability

Transferability is carried out when the study's findings can be transferred to other similar settings (Yilmaz, 2013). This component requires "thick description of the setting, context, people, actions, and events" (Yilmaz, 2013, p. 320). The original study incorporated transferability by again providing very detailed descriptions of the participants and study area. I have explained that methodological approach in detail, which could be transferred. The findings of this project are contextualized in the rich literature and at the same time, provide new insight on the subject.

Dependability

Dependability is another component needed for trustworthy research. Yilmaz (2013, p. 319) explains that it revolves around ensuring "the process of the study is consistent over time and across different researchers and different methods or projects". The original study created a

dependable study as they used audio recordings to record the participants. Moreover, the researchers asked the same interview guides and probing questions to each participant, also heightening dependability. Graneheim and Lundman (2003), explain that dependability can be challenging to achieve since environments constantly evolve and change. I ensured dependability by co-coding various interviews with a classmate who is also pursuing a Master's in Global Development, focusing on health promotion. We each coded the same interview separately and then came together to discuss and review our results. According to Yilmaz (2013), this method refers to "data quality checks" to reduce inherent bias and discrimination. This important approach ensured dependability and strengthened the analysis of the interviews without losing their meaning and established a consistent procedure that other researchers could also follow.

Confirmability

Confirmability is the last key component of guaranteeing trustworthiness. Yilmaz (2013, p. 320) describes that "the study enjoys *confirmability* when its findings are based on the analysis of the collected data and examined via an auditing process, i.e., the auditor confirms that the study findings are grounded in the data". To ensure confirmability of the study and reduce the researcher bias, I completed an extensive literature review to establish the findings from the project to other data.

5.9 Role of the researcher

Reflexivity

I had assumptions and preconceived notions about how the participants might answer the research objectives. Miles and Hubermann (1994) explain that becoming conscious and explicitly stating one's beliefs is crucial as they play a role in how the researcher describes the findings. Neumann (2014, p. 98) explains that if a researcher can reflect upon their assumptions, "rather than accepting them without awareness — will help you to think more clearly". Being reflective of my preconceived notions was vital as I did not want them to impact the study findings. For my assumptions to not take over my thinking and affect the quality of the study, I

was in regular contact with one of the key researchers from the original project, Silondile[3], who kindly answered my questions and helped me understand the circumstances. Self-awareness is also a critical element to being an ethical researcher and producing good quality qualitative research (Creswell, 2013).

[3] Silondile and Christiane consented to be named in this study

CHAPTER 6: FINDINGS

6.1 Introduction

This chapter presents the findings from the individual interviews following Attride-Stirling's (2001) thematic network analysis. Each global theme and its corresponding organizing theme and basic theme are presented. Quotes from both pre and post-delivery interviews are given.

Global theme	Organizing theme	Basic theme
6.2 Comprehensibility	*6.2.1 Vital to keep the work*	Finding a temporary work replacement Short maternity leave Reliant on work Arranging childcare
	6.2.2 Implications of returning to work	Planning and preparation needed Balancing expectations
6.3 Manageability	*6.3.1 Stressors*	Negative workplace conditions Decrease in physical and mental health Complications with baby arrival Feeding challenges Childcare concerns Unsupportive resources Limited financial resources
	6.3.2 Resources	Good workplace relations and environment Supportive family and friends Supportive partner Community resources
6.4 Meaningfulness	*6.4.1 Healthy baby*	Antenatal sessions Stress free environment
	6.4.2 Desire to succeed	Financially stable Well prepared and organized Longing for a connection

Table 2: Thematic analysis table.

6.2 Comprehensibility

The work within the ILM revolves around enormous uncertainty, lack of job security, and precariousness. In this context, participants understood that the work they had acquired was critical to maintaining and therefore had to secure it. Participants expressed that giving birth would drastically change their familiar and routinized way of life. As a result, to reduce the amount of work after birth, many planned particular aspects ahead of time. Moreover, the

balancing of motherhood and being an informal worker, among other responsibilities, was reflected on by participants.

6.2.1 Vital to keep the work

In the context of the ILM, all of my participants described the necessity of keeping their work. Their income was predominately used for food and to pay rent. They knew that if they were to take off longer than a few weeks, they risked that their position would not be available for them anymore.

Finding a temporary work replacement

Numerous participants mentioned that they were required to find a replacement while away for childbirth. The latter was a shared expectation from the employers of Isisa, Nolwazi, Thadie, and Zanele, who worked as domestic workers and market sellers. An employer shamed a participant for requesting time off.

> *He said I must look for a person when I am about to give birth because it would not be right for him to find me in that situation because he would get into trouble when I go into labour. He is a male person.* (Ayanda)

Buhles' employer was quick to mention how easily replaceable she was and that they would have no problem finding and replacing her with a worker who has better qualities. *"They said they found someone to replace me who is not pregnant and is always on time. They cannot fire her. They do not have reason to fire her".* On the other hand, finding a working replacement provided participants with a sense of control and security. It also empowered many to think that it would be easier for them to return to their former work positions.

> *Yes, there is this lady that I spoke to. This man also spoke to [her]. He then said I must talk to her and ask her to work in my place temporarily. When I go back, she will leave. There is no problem. People get people to work in their places all the time if they are not available.* (Ayanda)

Since the ILM does not offer its workers protection nor social benefits, workers are negatively impacted as they are not provided with work security while on leave. As a result, the findings

indicated that searching for a temporary work replacement was a common experience for many participants. This responsibility provided some with a sense of security, knowing that they would return to their job after giving birth.

Short maternity leave

Sustaining the work that participants had within the ILM was crucial. Nonetheless, all participants planned to take taking a short leave after childbirth, varying in lengths. The period in which participants considered taking off ranged from one month to no longer than six months. Khethiwe, Liyana, Nolwazi mentioned that they would only stay home for around one month.

> *I was planning to take a month off so that I can take care of the child and after a month I will be able to continue platting people's hair, and at the same time go out and look for work because if you go to look for work you have to leave early in the morning. It is a matter of waking up early and looking for work online, and then come back and continue with everything else during the day* (Liyana)

Most of the participants were not planning on taking time off before birth, as they needed to acquire as much income as possible before the baby's arrival. Sizani was uncertain about the length of time she should stay at home after childbirth, as she had a supportive partner who also provided financial security for her family. However, she also understood how fundamental it was to keep her work and continue as a hairdresser. The participants were conflicted about the timeline in which they should return to work. However, it was agreed that short maternity leave was required to secure their position and obtain an income.

Another factor that ruled into having a short maternity leave for two participants was that their partner was currently unemployed. Buhle and Liyana were the primary breadwinners within the household, meaning that others relied on their income to purchase household items and food.

> *I was worried […] that the baby's father is unemployed and I am the only one who gets some income for now. He also manages to get some money but it is not the same. He is not someone that I can be dependent on because he does not have a full time job. I worry about the fact that I am the only that can manage to raise some income even though sometimes I struggle.* (Liyana).

In contrast, Thadie determined to stay at home for a more prolonged period than the rest of the participants. She felt uneasy about returning to work as a street trader and leaving her newborn to get paid a very merger wage. *"I will return if I can find a better job than my current one. I will not leave my child for R30 per day. That would mean my child is not valuable. I will not be able to do it".* Participants understood that they needed to return to work as soon as possible and find a suitable temporary replacement to maintain their position.

Reliant on work

No minimum wage is set for those working in the ILM. As a result, participants expressed being underpaid for their work. However, they were also reliant on the income it provided, despite the work being physically and emotionally demanding. As a worker who delivered newspapers within her community, Ayanda noted that she had to wake up early in the morning, which was a challenge. "*Right now? I have gotten used to it. It is difficult but I work long hours. I am tired as it is".* Ayanda also explained that this would be more challenging once her baby was born. Isisa and Sizani recalled that they also experienced many challenges but continued and preserved as they depended on the income. Working as a hairdresser, Sizani was physically exhausted as she was expected to be on her feet all day long, with minimal breaks to rest her feet.

> *When I get to work, you find that maybe there is someone that wants to do braids. When we get to work there are already people waiting for us to open so that we can work on their hair. I stand the whole day at work until 20h00. Sometimes we knock off at 22h00 if it is busy, but there is no time to sit down. There are no breaks. You work continuously. You only take a break when you are hungry and you say "I would like to grab something. I can feel my stomach is not fine", and then you get a break and eat and rest a little bit, but you have to go back again and work on the clients' hair.* (Sizani)

Buhle also mentioned that her work was tiring, but more emotionally than physically. She worked at a call centre, Monday to Friday, in addition to alternative weekends. "*Yes, because it is tiring. Most of the time you have to talk on the phone. You drop one call and another comes through straight after. So it is tiring".* Participants knew that their work was vital as it contributed to the household financial expenditures.

Arranging childcare

Finding a caregiver to look after the newborn was another aspect that participants understood as being essential to arrange. This was a daunting task for some who did not have support from family or friends. Ayanda highlighted that she understood the necessity of leaving her baby but also referenced how challenging it was.

> *It is difficult because we wake up very early. Imagine leaving your child at dawn, taking it to someone and knocking on their door and asking to leave your child with them, even though you will come back early. When you count the hours they are normal. I think it is because we wake up very early in the morning and you have to leave your child at dawn. It is difficult and it is not right but there is nothing that I can do about it.*

Ayanda emphasized that because she did not have a support system who helped her take care of the baby, she was forced to drop off her baby at a daycare center. The hiring of a nanny to look after the newborns was not a typical response from the participants. However, Isisa mentioned that this was the only solution to go back to work shortly after giving birth.

> *Yesterday I was with the lady that had promised to look after him. I told her that I would like her to look after my baby when I return to work in six months' time. She said she does not have [a] problem, but she wants R50 for the hours that I will be working. I said I do not have a problem with that.* (Isisa)

Organizing childcare was a task that participants deemed fundamental for keeping their work within the ILM. Childcare challenges were also prevalent for participants, which are further described within section 6.3 Stressors.

6.2.2 Implications when returning to work

With the arrival of a baby happening soon, participants were aware that new challenges would be added to their everyday lives. Particularly in regards to how they would cope and balance the childcare responsibilities and working in the ILM. To reduce some of the anticipated stressors, participants planned.

Planning and preparation needed

As to be expected, several participants mentioned that their responsibilities would increase when the baby was born. Ayanda, Isisa, and Nolwazi described that they needed to develop a new routine after giving birth.

> *Yes, it is difficult. I just think about it. It is difficult. It is better for now because I am the only one that has to wake up. Now when I have to leave the baby behind at dawn, plus around 03h00, you wake up and heat up your bath water and you leave your baby at 05h00.* (Ayanda)

In preparation for returning to work, many participants deliberated on how they would best feed their baby. Ayanda, Nolwazi, Sizani, and Zanele believed that the best method was to formula feed their newborns once they returned to work. They planned to replace breastmilk with formula brands such as Nestum, Purity, and Infacare. Liyana was worried that her newborn would not feed properly while away at work or if her body could produce enough breastmilk. As a result, she also introduced formula feed when her newborn was still very young.

> *So that I can be able to do things according to how I had planned because as much as I would have loved to breastfeed until she is older, I was not going to be able to. This is why I say [my plans] had an influence in my decision to feed her formula.* (Liyana)

Only Khethiwe and Sizani had planned to express breastmilk for their newborns once they returned to work. Buhle was uncertain how she would feed her newborn once she searched for new work because she could not secure her position at the call centre while on leave. On the other hand, Isisa prepared to mix-feed, breastmilk, and formula feed for her newborn once she returned to work. All the participants had reflected upon which type of feeding would be best suited for their lifestyle.

Balancing expectations

A significant implication was that participants explained that incorporating and finding a manageable balance between the multiple roles would be a challenge. Buhle reflected on how she might best handle her new roles as a worker in the ILM, a partner, and a mother to a

newborn. She described that her duties would most likely increase tremendously, but attempted to give her best effort in all roles. *"So the challenge is that in the morning I will have to prepare for the child and also prepare myself for going to work. So all of that is going to be challenging to me".* Buhle was not the only participant who highlighted finding a balance between work and parenting. Ayanda, Isisa, and Liyana also expressed this concern.

> *I am worried about finding a balance between my duties as a wife and as a mother. I do not know how I am going to manage doing laundry, cleaning, cooking and also caring for a small child. I really do not know how I am going to manage all that. I will just cross that bridge when I get to it. It is already difficult where I am right now. It is not easy. It is difficult.* (Liyana)

Khethiwe was also a student, which added an extra responsibility to her list. Although she had thought about balancing roles, it continued to make her feel uneasy and something she needed to further prepare for. *"Yes, having a child, having to go to work and going to school is going to be a heavy burden. I will need a lot of time but there is nothing that I can do. I have to study so I can get a better job and be able to take care of my children".*

6.3 Manageability

For this particular global theme, I assessed what participants described as stressors and resources within their lives. While analyzing the in-depth pre and post-delivery interviews, participants highlighted numerous challenges that heightened the risk of experiencing poor mental well-being. Moreover, the resources that participants accessed pre-delivery and post-delivery are also described. Stressors and resources are the organizing themes, and the basic themes are discussed in detail in the coming paragraphs.

6.3.1 Stressors

The stressors that exist for those working within precarious employment are widespread. For the participants, the first and foremost most predominant stressor was their working conditions. In addition, a commonly cited stressor experienced by participants during pregnancy was poor physical health. While participants after childbirth frequently mentioned labour complications

and feeding challenges were frequently mentioned by participants after delivery. Other stressors mentioned before and after birth included lack of community resources, unsupportive relationships, and scarce financial resources.

Negative workplace conditions

The majority of work within the ILM is characterized as unpredictable regarding working hours and set working days. For the majority of the participants, the hours they worked were inconsistent and differed every day. As Liyana and Sizani worked as hairdressers, they expressed having to be available for their clients at all times of the day.

> *It depends on how many clients I have. Sometimes I service two clients in a day. That takes about 6 hours maximum. It also depends on the style that the client wants to do. Sometimes there are days where I will not have any clients. So it is difficult for me to say how many days I work in a week. It depends on the clients that I get. We could probably say four days is the maximum that I work in a week.* (Liyana).

Other participants who experienced similar situations were Khethiwe, Nolwazi, and Zanele. The problem was particularly challenging for Zanele, a domestic worker who resided in the same household as her employer. This made her working hours very unregulated and complex as the family expected her to assist them at all hours of the day. Although she stopped working there towards the end of her pregnancy because it was too physically challenging, she considered returning after giving birth.

> *We work from 6 o'clock, you go inside you work, you work, maybe [until] 12 o'clock…if you [do not] finish [are expected to stay until it is finished]. When you finish maybe it past one you go and then you eat and then you [go back to complete your duties] until 4 o'clock [then] you go to your room. At 7 o'clock you go wash dishes and then you back tomorrow at half past six or seven [in the morning] you go back inside again and clean.* (Zanele)

The family that Zanele worked for expected her to work long hours each day, which she mentioned was a stressor. Ayandas' working hours and her workplace were constantly changed. *"It can be two days maybe towards the end of the month, when it is busy and there are sales. It*

can also be three days We work from 06h00 and knock off at 12h00". Khethiwe also worked irregular and unpredictable hours, and she heavily relied on support from her customers. *"It depends on the amount of work that I have. Making a garment from scratch is different to doing alterations".* Buhle was the only participant who had set working hours and days, Monday to Friday, including every second weekend, from 9 am till 5 pm.

A workplace attribute which created negative tension for Thadie and Zanele was the unpleasant interactions they had with their employer.*"Sometimes he scolds me and sometimes he scolds me for nothing. He gets upset if someone did not manage to sell anything. That upsets him a lot and he starts shouting in a way that I do not understand"* (Thadie).

The lack of basic needs at work was another highlighted stressor that some participants had difficultly managing. Ayanda explained that she did not have access to clean water. *"We ask for it from the people. So if I am thirsty I ask for water whenever I am putting the sales pamphlet. I would ask for water and put it in a container".* Ayanda also explained that she often needed to ask customers for water if she was extremely thirsty and unable to locate a water station. Due to Ayandas' line of work and not having an office to access the washroom, she was expected to go searching for one. *"When you need the toilet, you find that sometimes we go to the mall if there is a mall nearby".* Having access to clean water from a fountain was also a challenge for Thadie, a street trader, who resorted to drinking the water from a tap in the washroom. *"I use the toilet at the rank. I have to cross the traffic lights and go to the rank. I get drinking water from the same toilet. There are no taps on the side".*

The uncertain and long working hours, the disrespectful manner in which employers treat their workers, and the lack of necessities were adverse workplace conditions that participants expressed as being stressors.

Decrease in physical and mental health

Many participants felt unwell and sick while pregnant. This finding had two negative implications for the participants, first on their physical well-being and second on their financial security, as many had to take time off work unwillingly. Stomach pains and nausea were two

typical health affects mentioned by Isisa, Khethiwe, Nolwazi, and Sizani. These hindered the completion of their work duties. *"Ever since I fell pregnant I became ill. Initially I thought I had stomach cramps. I am still ill now. When I walk it gets sore here"* (Isisa).

Sizani was in the same circumstance and was struggling with standing on her feet all day.

> *It has affected it a lot because at work we stand, you cannot sit down while plaiting a client's hair. You have to stand. So for me the more I stand, the more my lower back gets tired and then I start feeling pain, these pains that cause cramps. So I have to stay at home. I can no longer continue to work.* (Sizani)

The findings also demonstrated that Nolwazi was in a different situation than the rest of the participants. She was not forced to complete all of her work duties on days she felt unwell. The adjustment of her work responsibilities was extremely beneficial for Nolwazi and attributed this to her positive relationship with her employer.

> *I can now decide what I can and cannot do. They do not have a problem because I explained to them there are certain things that they will see that I did not do because I can no longer do them. I will do them when I come back [after delivery]. I cannot do them for now.*

Since working in the ILM does not provide benefits for workers, including paid sick leave, when participants did not attend work due to sickness, they did not get paid.

> *There I was affected because I lost money. If I went to the clinic I lost [money]. When I did not feel well I would call her and inform her that "I am not fine. I am going to check what is happening with me". I would still lose money even though I reported. What can I say? I would get one day off per week. If I took the day off on Monday I cannot take another one on Thursday if I am not feeling well. They would deduct money [from my salary]. I would have one day off per week and four days in a month.* (Sizani)

Feeling unwell throughout pregnancy was a common finding; however, participants were often forced to work as they did not have another financial alternative. Moreover, in addition to feeling unwell and losing income, Thadie faced a third stressor which decreased her physical health and increased depression. She was infected with HIV through sexual assault, which

further complicated her overall physical and mental health. Many participants also spoke about a decrease in mental well-being, particularly while pregnant.

The pregnancy itself was very shocking for most participants, and therefore, many were extremely unhappy about the situation. *"I do not want to lie. I was not happy about my pregnancy because I was not expecting it.* (Ayanda). Khethiwe recounted a similar experience. *"You can say so because I was not planning to have a child when I fell pregnant. It just happened. When the baby is here there is nothing else that you can do".* Interestingly, Liyanas' partner was hoping to begin a family, and therefore she believed that he prepared and planned accordingly. *"So I guess I could say he planned it because it is something that he had always been talking about knowing very well that I did not want to have a child yet and it is not something that I was planning to go through".* Liyana's expressed that she was very stressed due to her unplanned pregnancy. However, she was comforted by her partner, who was excited and prepared to take on the fatherhood. The pregnancy was a surprise for Nolwazi as she mentioned to be using injectable contraceptives. Sizani had also been using contraceptives but decided to stop briefly, during which she accidentally became pregnant.

> *Right now I have accepted the situation. I have accepted that I am pregnant. Initially I was angry with myself that "oh my God, I am pregnant! How come?" I was angry at myself for falling pregnant. […]. I really did not expect it.* (Sizani)

The participants identified feelings of anger, sadness, and despair once they received the news that they were pregnant. The situation for Thadie seemed to be more intense than for the rest of the participants. Her mental well-being throughout her pregnancy was very low and she even considered suicide. *"I was waiting for the 11h30 train to arrive so that I would jump in front of it and die because his child does not have a father. How could I give birth to a fatherless child?".* Participants experienced both physical and mental health challenges while pregnant.

Complications with baby arrival

A significant number of participants mentioned that they had complications during labour and shortly after that. A stressor described in detail for many participants was experiencing very

painful labour. Buhle, Nolwazi, Sizani, and Thadie had difficult delivery experiences. *"It was difficult. I do not wish for anyone to go through it. It was 18 hours of labour"* (Buhle). Sizani also had a terrifying labour experience, and was still in pain from the Caesarean section.

> *Birthing through a caesarean section is painful. I do not want to lie. The first three days out of the hospital are a struggle because at the hospital you get painkillers and they take care of you. When you are at home you do not receive that level of care. You also find that the people at home do not understand anything about caesarean section birth. So you have to try and do things on your own little by little. I can stand up but not straight. I have to arch my back a little. So there is a lot of difficulty during [this] time. I even said that a vaginal birth is better because pain only lasts for one week. Now I will have pain for a month, you see.* (Sizani)

Thadie was concerned about her newborns' heart rate, which had rapidly increased while still in the womb, leading to an emergency Caesarean section having to be completed. Another participant concerned about her newborns' wellbeing was Buhle, whose baby arrived prematurely due to a physical altercation with her partner. *"Almost immediately after being born the doctors said she was having seizures, and was struggling to breathe. They then put [her] on oxygen"*. Buhles' newborn was required to stay at the hospital for an extended period because of her difficulty. *"About two to three weeks, because we were discharged on 20 October"*. Buhle described that not knowing if her baby would be alright was highly stressful for her. Ayanda, Khethiwe, and Nolwazi also explained anxiety and stress around the complications that resulted for their newborns during or shortly after labor.

Feeding challenges

Participants expressed that they experienced many challenges regarding how to feed their newborns best. Ayanda, Buhle, Isisa, Khethiwe, Sizani, Thadie, and Zanele resorted to exclusively breastfeeding for a short while as it was less expensive than purchasing formula feed. Although breastfeeding the favourable option, Buhle and Sizani experienced painful episodes. *"When you feed her continuously without burping her, she ends up burping while she is still feeding then it gets swollen. When you feed her after that it becomes painful"* (Buhle). Khethiwe

was already thinking about the foreseeable challenges that may appear when she returns to work. She was worried about how this return might impact her newborns feeding practices and her overall health.

> *Yes, while I am at home, I can feed her whenever she is awake and I see that she wants to feed. Now that she is going to stay with a carer I do wonder whether she will continue to feed normally or perhaps she will start getting sick because she will be feeding from a bottle instead of an actual breast, since I will be expressing the milk for her.* (Khethiwe)

A concern expressed by Liyana, Sizani, and Thadie related to feeding their newborn was eating enough nutritious foods. Not eating enough all day and then trying to produce sufficient breastmilk was a significant problem and stressor that Liyana had been thinking about while pregnant. *"Let us say if you are a person who does not have money, and you do not have anything to eat and until you go back home in the afternoon at 14h00, especially as a pregnant person, it gets really difficult".* Sizani explained that she was taking supplements rather than eating food, which helpfully strengthen her blood. *"Since falling pregnant I am taking supplements. Sometimes I do not get time to eat. Sometimes I spend the whole day without eating. However, I have to take these supplements for the blood."* Breastfeeding was cheaper for participants to consider. However, many mothers had to switch to formula feeding once they returned to work. A handful of participants were stressed about producing enough breastmilk while experiencing food insecurity.

Childcare concerns

Participants who lacked a support system to assist them with childcare responsibilities described feelings of anxiety and uncertainty. These feelings arose for participants who had to leave their newborn at a daycare facility as they felt unsure if they could trust the caregivers. Due to the large number of children who attend daycare daily, Sizani believed that neglect and mistreatment were prevalent, which caused her immense sadness.

> *I do not trust creches, and I do not like them because at the creche children are mistreated. There are too many children and the minders cannot pay attention to all of*

them at once. You may find that your child gets neglected and is always crying as a result. Maybe the minders at creche will ignore the child because they perceive her to be a crier. (Sizani)

Sizani exhibited strong feelings in regards to how children at daycares are treated. Ayanda, Isisa, Khethiwe also expressed concerns about the level of care their newborn would receive in the hands of an unfamiliar caregiver. Thadie contemplated taking her newborn to work with her to reduce costs and ensuring its well-being.

Once I return to work I will be forced to go with the child to work because I will not afford to pay for someone to look after her. That is the challenge I can think of. I will have to carry her on my back. (Thadie)

In the post-delivery interview, Thadie decided not to go through with her original plan and bring her newborn to work with her as a street trader. Instead would stay at home for the time being and search for new work. Participants were hesitant about leaving their baby with an unfamiliar caregiver. Many felt anxious and nervous about leaving their child, but this was the only alternative with limited options.

Unsupportive resources

Lack of support and assistance was also a problem reported by participants. In particular, challenges that lead to stress were most often mentioned concerning the participants' partners. Ayanda described that her partner did not support her throughout her pregnancy and was still distant after giving birth. Buhle also highlighted that her relationship with the baby's father was non-existent. *"I do not know how I can explain this to you. I do not know whether he does not understand what is going on or he is someone who does not show that he cares or whether he does not care".* Isisa expressed having an unhealthy relationship with her partner and how his dramatic behaviour was upsetting. Her relationship did not improve once the baby arrived; however, Isisa mentioned that he was trying to do what is best for his child.

He did not speak to me. The only thing that is important to him is his baby and the baby's stuff that he has to buy. He does not ask me. He just arrives with it. However, not a

day passes without him seeing the baby. He also does not go to work without seeing the baby. He comes every morning to wake him up. (Isisa)

Moreover, several participants reported that family members, despite their living proximity, were also unsupportive. Most of Buhle family lives in uMlazi, a neighbouring town. She describes that her sisters had only come to visit her when seriously ill and was admitted to the hospital. Ayanda, also has some family members that lived in other towns and others that lived near. However, the ones who lived near her were just as unsupportive. *"My family is not here. They are at home. The family member that I live with here does not give me any support".* Sizani hesitated to tell her father, who lived in a neighbouring town, about her pregnancy because she anticipated he would be critical of her. *"I mean my father is strict! So anything and anything that happens to someone that he feels is not right, for him it is an embarrassment. He is a church minister. All he sees is embarrassment".* Ayanda, Buhle, Liyana all reported that they did not have any friends to rely on or who they could ask for help. Unsupportive family and friends were described as significant stressors for participants throughout their pregnancy and afterward as well.

In all the transcripts, participants were asked about being visited by community caregivers[4] (CCG), were another unsupportive resource described by all the participants. Sadly, the majority of participants did not even know that they existed. Ayanda expressed that "I have never seen them. Are there CCGs here. I have never heard that they are there". Participants also explained that how nurses responded to and acted towards them was often unpleasant. Ayanda spoke about how nurses treated her when she arrived late to a session. "*I would go to the clinic late. I would start by going to work and knock off at 12h00 and go to the clinic. The clinic staff scolds you when you do that".* Furthermore, Ayanda also explained that support provided by nurses was lacking and therefore did not stay long after the antenatal session to chat with them. "*There is no support that one gets from the clinic. When I get to the clinic I do what I am there to do and leave soon after. There is nothing much that we talk about with the clinic staff".*

[4] A question regarding the CCGs does not appear within the interview guides (See APPENDIX 5)

Limited financial resources

Limited financial resources were significantly highlighted by participants. This matter became even more stressful when participants took time off work due to illness or visited the health clinic. *"You do not get paid for a day that you did not work"* (Buhle). Sizani struggled with standing on her feet all day, and if her customer complained, it negatively impacted her income. *"There would be deductions sometimes. If a client complains they deduct R100. If I am not at work, maybe I am attending clinic, as I have to attend clinic once a month, they would deduct R100 for that day. So I would end up getting paid less than what I expected".* Buhle was especially stressed as she could not afford to lose her wages, given how expensive it is to raise a child.

> *Being pregnant is stressful. That is the first thing. It comes with a lot of costs. It is stressful. It comes with a lot of costs, you see, such that you will always be spending money because I am the only one that is employed.* (Buhle)

Participants relied on the CSG to purchase necessary food and supplies since they did not obtain a paid maternity leave. Liyana was mainly dependent on this grant as her partner was unemployed. *"We are also dependent on the child support grant. It helps out a lot".* As briefly highlighted earlier within this chapter, a compelling reason for breastfeeding was because it was more affordable than formula feed. Ayanda, Buhle, Isisa, Khethiwe, Sizani, Thadie, and Zanele decided to breastfeed for this reason, even though it was only a short while for some.

> *We were encouraged to breastfed children. I will not say it is because I do not have money to buy formula because it is expensive. You could find that you have run out of money and then you can no longer serve the same amount of formula that you are used to serving* (Khethiwe).

Participants expressed that inadequate financial resources was a significant stressor, especially as they needed to take unpaid time off to give birth. The majority relied on the income assistance provided by the government grant to purchase food and baby supplies.

6.3.2 Resources

Resources that assisted in overcoming stressors varied in forms. For many participants, frequently mentioned support networks came from positive workplace relationships, and immediate family, and friends. In addition, participants also explained being supported by a few community resources.

Good workplace relations and environment

Ayanda, Buhle, Isisa, Nolwazi, Sizani explained that they had a good relationship with their colleagues and employers. Nolwazi was very fond of her employer and described their relationship as 'mother-daughter'. *"She supports me in every way. If there is something that is bothering me I can talk to her about it and she advises me. Even if I do not have money I can talk to her and she gives it to me".* Nolwazi and Sizani also noted that their employers donated baby supplies to them, which tremendously supported them as they could not afford to purchase new supplies. Nolwazi explained that her close relationship with her employer benefited her immensely. She could adjust her working tasks and hours if she felt unwell and incapable of completing her work duties. Isisa was the only participant who was provided with maternity compensation for a short while away from work. Khethiwe and Liyana were the only two self-employed participants. For Khethiwe, a dressmaker who worked from home adjusted her schedule as she felt it was appropriate and took time off when needed. The adjustment did not affect her clients or her income. She readjusted her working hours positively affected both her physical and mental well-being, particularly when she had very morning sickness or she attended antenatal sessions. Liyana, a self-employed hairdresser working from home, also empathized that she could make necessary working adaptions to not compromise her physical and mental well-being. Positive workplace relations was a resource revealed by some participants.

Supportive family and friends

A resource that several participants mentioned was their supportive network. Participants (Buhle, Liyana, Nolwazi, Sizani) noted that their grandmothers would be the primary caregivers to their babies. As previously highlighted, Buhles' partner was not very supportive, and despite being

unemployed, she considered paying someone to take care of her newborn. After delivery, Buhles' grandmother provided her with unwavering support and was the primary caregiver to her newborn. *"My grandmother. We take turns to care for the baby at night. As I am here with you my grandmother is looking after her so that I can sleep during the day".* Sizani and Zanele sisters were planned to look after their newborns. This allowed for Sizani to return to work and reassured her that the baby was properly looked after. "*We had agreed that the child will be looked after by my sisters when I return to work because the child's father is also looking for another job".* The situation is similar for Zanele, who was relieved that her sister owns a daycare and will look after her baby. *My sister. […] my sister […owns a] creche so she said when you go back to work you gonna give me the baby we gonna take care of him.* In addition to being supported with childcare, check-ins from family members were also spoken about by participants.

Buhle detailed that she suffered from pain during her pregnancy and needed to be transferred to the hospital. *"My sisters [came] to check on me. When I was sick I was transferred to King Edward [Hospital]. So since then they come to check up on me".*Despite the fact Buhles' sisters lived within a different town, they were a resource that she very much appreciated. Sizani and Zanele expressed that they had similar support networks that provided emotional support. In addition to this type of support, Khethiwe, Liyana, Sizani explained that they received financial support from family members. "*My family helps me out by giving me some money at the end of each month because I told them we are renting. So there are a lot of things that one has to pay for at the end of the month"* (Khethiwe). Material support was also commonly mentioned by participants.

> *The child's father is there for buying things that are needed or running short because we had bought few clothes since I had not yet given birth. So now that I have delivered and it is a girl we can go and buy pink and white clothes, you see. Then he bought the child clothes and nappies.* (Sizani).

Not only has family been an excellent resource for many participants, but they also valued the support of friends. For Ayanda and Isisa, these have been work friends who had assisted them

when they were sick. *"She used to worry about me. So she would spend her money to visit me at the hospital. She did not have a problem. Not a day would pass by without her coming to see me. Even if she went to work, she would stop by and check on me and the baby"* (Ayanda). Thadies' new boyfriend has supported her emotionally, financially and reassured her that he would assist in raising her child, although he was not the father.

Participants also expressed support from partners who reassured them about their current situation. Khethiwe explained that her partner was in high spirits when he heard the news, despite the timing not being as she had hoped. *"He supports me because the child is his. It is just that we were not planning to have a child now. However, he did not have a problem".* She further explained that even after giving birth, he was still very invested, happy and supportive. Liyana also explained that her partner was committed to building a relationship with their child, making her feel happy.

> *He spoke to the baby as if he could see her. He would touch my belly while I was sleeping and when I woke up I would find him busy holding my belly and talking to the baby and I could feel the baby responding inside my womb.* (Liyana)

Sizanis' partner had been very supportive of the pregnancy and showed a lot of affection and responsibility when caring for the newborn.

> *He is the first one that hears when she is crying and then he wakes me up. He tries to get her to stop crying but the child does not stop because she wants to be fed. So if he tries to quieten her down and fails, he wakes me up. He is very supportive.* (Sizani)

The social, emotional, and financial support from co-workers, family, and friends was highly discussed.

Community resources

Participants were required to attend antenatal care sessions, which provided them with essential and insightful information.

> *They educate you about a lot of things that you may encounter, such as the baby turning. They tell you about that and prepare you for it. They teach you everything about the child and what will happen and so on. They also tell you what to eat and what not to*

> *eat. They allocate time for that. I think it is from 07h00 to 08h00, a whole hour, where they tell you* (Buhle).

Isisa described that when she communicated with the nurses from the clinic over the WhatApp program titled "Mom-Connect" when she had a question. *"If you have a problem you say and they answer you. That helped me a lot".* Isisa was the only participant who mentioned this resource. Thadie explained that one nurse, in particular, enriched her clinic experience and provided her with important information on best feeding her newborn. Another community resource that only one participant highlighted was seeking health advice from a traditional healer. Nolwazi detailed that she had gone to visit one to understand better the nightmares she was having.

> *I also went to a traditional healer who is also a member of the Shembe church and got help from him because I used to have nightmares at night. I also used to feel like the baby was sitting on me. I also used to dream that I was giving birth to animals. I ended up going to see a traditional healer, because initially it was something that I did not pay much attention [too].* (Nolwazi)

Moreover, the findings demonstrated that the child support grant (CSG) was another essential resource. It was very vital to participants who did not have a supportive partner. *"I hope I can register her for a child support grant because I cannot rely on her father because he is not supporting me even now".* Many participants mentioned that they had to first apply for a birth certificate to apply for the CSG. Participants noted that this grant would contribute positively to their households.

> *I was thinking of buying him formula and porridge because I think by then his child support grant money would have been approved. That will ensure that he eats and stays full, because he eats a lot. He is only breastfed but he does not get full. However, he will not be able to drink formula only. He must also eat porridge.* (Ayanda)

Participants also spoke about how they relied on other grants that their family members received. Khethiwe obtained two additional CSG for her two older children, which benefitted her immensely. Liyana lived with her grandmother, who also obtained an old age grant that she also relied on to purchase household items.

6.4 Meaningfulness

Overcoming a challenge depends on ones' motivation. Participants mentioned that their primary motivations were to ensure their baby was healthy and happy despite experiencing numerous stressors. Simultaneously, to try their best in succeeding as mothers, despite numerous stressors they experienced.

6.4.1 Healthy baby

Participants were determined to ensure that their newborns would grow up in the best circumstances. Choosing the best way to feed their newborn and ensuring that they reside in a stress-free environment were two critical components motivating participants.

Antenatal sessions

While pregnant, almost all the participants (Ayanda, Buhle, Isisa, Khethiwe, Liyana, Sizani, and Thadie) missed work when they had scheduled clinic appointments. Isisa was able to rearrange her working hours so that she would not miss the income. *"I went to the clinic on Thursday. The day for the antenatal care at the clinic is always on Thursday. I would go to the clinic on Thursday and go to work on Friday to make up missing work on Thursday".* Sizani was not as lucky as Isisa, and got deductions from her paycheck when she missed work. *"I used to take a day off. But that day off was treated as if I was absent. So they would deduct money from my salary".* Deductions from pay were a similar experience for many; however, participants believed that attending the clinic sessions was essential. The nurse's educated participants about the importance of breastfeeding.

> *We learned that we should breastfeed. I told her that I will not be able to breastfeed because I will return to work soon. They told me that I am not allowed to come with a bottle when I come to give birth. They also said that they will only discharge me once they have seen that the baby can breastfeed from you. I then asked whether the child will not be infected because I am on treatment. They said no.* (Nolwazi)

Ayanda breastfed her newborn but switched to formula feed once she returned to work.

I will not give her formula straight away. She will be too young. Maybe I will see later on when I can afford it. Formula is very expensive. I cannot give her formula straight away. Maybe if her father was giving me money [inaudible] then I would give her formula early if I felt like it.

Only two participants explicitly mentioned the health benefits of breastfeeding. Khethiwe noted the importance of breastfeeding on her children's health, *"children that are breathed also do not get sick easily. I breasted all my other children and I did not have any problems so that is why I depend on breast feeding"*. Thadie response was similar, and she was the only participant who planned to breastfeed for two years. Attending clinic sessions where participants learned about breastfeeding techniques inspired many to feed this way.

Stress-free environment

Many participants highlighted the fact that they lived with several family members. For some, this worked out well as they helped one another out. For example, Buhle resided with her grandmother and uncle. They got along well and supported each other. Sizani also had a positive experience living with family members and committed to helping her in raising the baby. However, Sizani had conflicting views about this as there were instances when she felt uncomfortable leaving her baby with her family.

Another thing that makes me sad is that at home my family members drink alcohol. Today […] called me told me that [the boy's] mother bought two wines. So on Fridays I will not be comfortable leaving my child but I will be forced to leave her. My family drinks a lot and all three of them drink. They all drink. They could be around during the day and help out with caring for my child, however, I could come back in the evening and find that my child has been left with the kids. That is what I always think about, the fact that I have this situation at home. One the sun sets, they leave. They bath and leave for their drinking spots. (Sizani)

Participants also spoke about searching for a new place to live before giving birth. Ayanda had begun searching for a new home while pregnant and was still searching once she gave birth.

Zanele and her partner had decided to move out of the shared apartment they resided in to prioritize the baby's health and their own.

> *You know the person I'm staying with is not [alright], sometimes she's happy, she's not happy…. You know sometimes in life you must help each other. When someone has got problem you must help her because tomorrow you've get the problem I'm gonna help you but other people do not think about that.* (Zanele)

The motivation to ensure the well-being of their baby, participants who resided with family members, were often in situations of stress. Participants spoke of the desire to move out and find a place on their own.

6.4.2 Desire to succeed

All participants had a strong motivation and commitment to make decisions that would result in positive changes. They expressed a desire to succeed as a mother, even more so now than at the beginning of their pregnancies when they were upset about the pregnancy. Some participants noted that they wanted to become mothers and so they had put money aside when possible. Participants indicated that they relied on a close network of friends and family to assist them in overcoming stressful situations. Participants also spoke about longing to make a connection with their newborn once they gave birth.

Financially stable

Some participants noted that they wanted children, and so they had started to save money early on. For Ayanda, she had been encouraged by her family to begin saving as early as possible. Buhle also remarked a similar experience, but she believed it was her responsibility to save as her partner was frequently unemployed. Therefore she began saving when she could. *"I have some savings because I knew [this time would come]. The baby's father works at the car wash. Most of the time they are not working. Sometimes they are working".* Saving money was a similar story for Liyana as well.

Well prepared and organized

The desire to be a good mother was evident for many as they had planned and prepared ahead of giving birth. Participants were determined to have all the necessary baby materials ready, despite earning little and having minimal support from their partner.

> *There is nothing that we can do. However, it is not right. You see you walk a lot there. There is no time to play. We get tired. If the baby's father was supporting I would not be working. I do not get any money. This is my child and she needs clothes"* (Ayanda).

These were also the sentiments for Liyana and Sizani, who explained that they repeatedly worried about having an inadequate amount of clothing prepared for their baby. Ayanda was positive that she would do what it takes to be a good mother, *"I do what is within my means. I do not know whether that is the way to do it or not".* Raising a child without the support of the baby's father was difficult, but Buhle had the self-confidence that this would not destroy her relationship with the baby nor her parenting skills. Sizani also expressed in a confident tone her wish to become a good mother for her child. *"I expect to be an honest mother and I am happy that I am going to be a mother. I intend to care for my child properly and give her the love that she needs".* After childbirth, many participants explained that they had not encountered any demanding challenges.

> *Yes, everything is going as I had expected because I had chosen to breastfeed him because I wanted to reduce expenses. I only bought nappies, body lotion and soap. His father also bought the same stuff and added linen because he had never bought it before. He also added clothing items. There are not too many expenses if he is breastfed* (Isisa).

Sizani related to this and explained that she does not expect any challenges in the future due to her planning.

> *"I do not think there will be any challenges. We will see as time goes if what will come our way that could be challenging us in terms of supporting our child the way that we want. However, the way I have planned things, I do not foresee any challenges".* (Sizani)

By preparing and planning certain aspects ahead of time, such as childcare and baby materials, participants wanted to ensure that this baby would be well taken care of.

Longing for a connection

Even though almost all the pregnancies were unforeseen, participants expressed excitement about seeing and meeting their newborns. Liyana remarked that she found it easier to bond with her newborn once it was born than throughout her pregnancy.

> *There is an air of excitement because the child is here now. We are happy. The man of the house is also happy and he is very supportive. […]. There is nothing that I can say I enjoy more than the other things. I enjoy caring for her holistically, feeding her and just staying with her. It is a totally different experience from when I was still pregnant. We did not have as much connection as we do now.*

Ayanda, Buhle, Isisa, Nolwazi, Sizani, and Thadie had very similar reactions to caring for their newborns. Sizani also explained that her favourite detail was developing a bond.

> *Just bonding with her, you know, when we are sitting with her on my chest laughing. She laughs even though she cannot yet see me. She pretends like she can see. She even opens her eyes and look on both sides. She does funny things [and] I enjoy being with her".* (Sizani)

Thadies' story was comparable. *"There is that bond that is created. I get to watch her laughing. The milk sometimes get sprayed onto her face. It is fun to watch her trying to duck from it".* Creating that bond through breastfeeding, despite it being painful, was detailed by many. *"I want to experience being a mother. I have never been a mother fully because my first child was fed formula. Anyone could feed her. I never got a chance to bond with my child, you see".* (Sizani). Participants often described the creation of a bond between mother and child as being meaningful. Moreover, making decisions about feeding practices and living situation were essential aspects for participants to consider.

CHAPTER 7: DISCUSSION

7.1 Introduction

The study's overall objective was to explore the link between SOC and experiences of AND and PND. With the salutogenic model of health (SMH), I explored how these participants understood their predicaments, which resources they utilized to cope with their situations, and what provided them with meaning. The discussion section is categorized into the following seven sections. First, the three components of the SOC, comprehensibility, manageability, and meaningfulness, are discussed in relation to the findings. Moreover, this section also tentatively analyses two of the participants' SOC. The second section explains unexpected and surprising findings of the study and how these relate to or contradict existing literature. The third section links the findings to three of the main action areas of the Ottawa Charter for Health Promotion (OCHP). As the preconditions of health identified by the OCHP and the Sustainable Development Goals (SDGs) are similar, the latter is discussed in the fourth section. In addition, this section reflects on whether the findings progress the SDGs. The fifth section presents emerging themes surrounding the implications of the current pandemic for ILM workers. The last section focuses on what could have enhanced the study.

7.2 Discussion in relation to the SOC

7.2.1 Discussion in relation to comprehensibility

Comprehensibility is fostered by receiving consistent messages and stimuli which promote a stable environment (Slootjes et al., 2017). The findings indicated that participants experienced consistency in the messages they received. First, regarding how important work was for them, the need to search for a trusted replacement and find a reliable caregiver for their baby.

Importance of work

First and foremost, the findings indicated that all participants understood the importance of maintaining their work. Literature reveals that many households rely on the income that informal work provides. Informally-working women are often financially pressured to return to work soon after giving birth (Addati, Behrendt, Wagenhäuser, 2016; Luthuli et al., 2020). Buhle, Khethiwe,

Liyana, Nolwazi, Sizani expressed not liking having to return to work so soon after giving birth but that they had no other choice as they were desperate for the income. The fact that pregnant ILM workers have to secure their work due to the non-existent maternity leave seems to have become a standard within the ILM. The generated data from findings point to a unique 'culture' has been formed in the ILM. The norms and patterns (finding a working replacement, not receiving benefits, unstable income) developed in this market create health implications for its workers (Horwood et al., 2020; Horwood et al., 2021). Thus, a clear implication of this study is that participants felt pressure to return to work shortly after childbirth to acquire an income.

Work replacement

Another finding that has become a familiar and normalized aspect of the ILM 'culture' for the participants concerning the importance of work was finding a short-term work replacement. The ILM does not guarantee work security for participants who are away for an extended period (i.e. paid maternity leave). The ILO states that "maternity protection is essential to promote the health, nutrition and well-being of mothers and their children, to achieve gender equality at work, prevent and reduce poverty and to advance decent work for both women and men" (Addati et al., 2016, p. 1). To ensure the ability to return to their workplaces, participants mentioned asking their family or friends to fulfill these short-term positions. Maternity leave is a right that organizations such as Women in Informal Employment: Globalizing and Organizing (WIEGO) and ILO advocate for as positive effects for mother and newborn are widespread (Addati et al., 2016; WHO, 2019). Interestingly, for those required to search for a working replacement (Ayanda, Buhle, Isisa, Nolwazi, Thadie, and Zanele), this extra measure seemed to provide them with some stability and comfort. Finding a working replacement was a task asked of many participants, particularly for the three domestic workers. An implication drawn from this study is that participants who were domestic workers were required to search for temporary replacements to secure their work position.

Finding childcare

Another frequently mentioned finding was the task of searching for a suitable caregiver for their newborns. This responsibility also aroused feelings of anxiety and stress for Ayanda, Isisa, Khethiwe, Nolwazi, Sizani, Thadie, and Zanele when they had to leave their newborn for work. Leaving a newborn soon after birth also impacts its development and their level of attachment. During their first year, the care newborns receive is the foundation in which a secure or insecure attachment is formed to their primary caregiver, frequently the mother (Cooper et al., 2009). When a secure attachment between mother and newborn prevails, it increases health and developmental outcomes for the baby (Cooper et al., 2009). However, developing a secure attachment can be difficult for mothers who reside in resource-scarce settings and experience poor mental well-being (Cooper et al., 2009).

Furthermore, existing literature explains that mothers who return to work shortly after birth may have difficulty forming a secure attachment with their newborn (Cooper et al., 2009). Frequently, this leads newborns to be left with a caregiver who may not pay much attention to them or ignores their needs, leading them to experience an insecure attachment (Benoit, 2004). This scenario was evident within the findings, as participants who had to leave their newborns with unfamiliar caregivers (i.e. daycare), experienced fear, mistrust, and heightened anxiety about their babies' safety. Alfers (2016) confirm that these feelings are not uncommon for mothers to experience. Thus, childcare was essential for participants to return to work; however, an implication was that it made many feel sad and anxious about the care provided to the newborn.

7.2.2 Discussion in relation to manageability

Challenges

Workplace conditions

Manageability encompasses identifying, accessing, and utilizing resources to manage the stress associated with negative tensions (Slootjes et al., 2017). A commonly cited stressor for the participants was the unfair and unequal working conditions of the ILMs. Specifically the lack of worker contracts, maternity leave, job security, and negative consequences such as long working

hours and minimal pay. Literature confirms that these characteristics are deeply embedded within the ILM 'culture' and produce vulnerabilities for its workers (Alfers & Rogan, 2015; Bhan et al., 2020; Vinje, Langeland & Bull; 2017). The working conditions of the ILM environment also have implications on the health and well-being of the workers. Existing literature has also explained that the combination of long working hours with minimal pay and taking care of the household increases the chances of informally-working women experiencing the double burden effect (Alfers & Rogan, 2015). Although the literature has also confirmed that women from all social classes are prone to experiencing this effect, those working without social protections and minimum wage experience additional stressors (Alfers & Rogan, 2015; Bhan et al., 2020). Consequently, as was evident with the participants, their workplace conditions produced challenges which those working in the formal labour market are less likely to encounter.

Nutrition concerns

Food insecurity was another commonly mentioned finding. Many participants said this challenge during the first interview (while 32-36 weeks pregnant), where the minimal pay received resulted in many experiencing difficulties acquiring a sufficient diet. This challenge led to additional stress once the participants gave birth, as it was still present. Moreover, this had implications on how participants chose to feed their newborns (breastmilk or formula). At this point, a large portion of the participants considered alternative feeding options. Research studies confirm that many new mothers working in the ILM face breastfeeding challenges and are forced to reconsider their feeding approaches, with many resorting to mixed-feeding (Horwood et al., 2019; Luthuli et al., 2020). Mixed-feeding implies that newborns are fed with various substitutes, including breastmilk, formula feed, and maize meal porridge (Luthuli et al., 2020). Although these seem like suitable alternatives, existing literature also describes that this can be an additional stressor for informally-working women due to financial limitations (Luthuli et al., 2020). The latter concern was evident in the findings, as participants did not receive any income while away from work to give birth. As a result, most participants decided that breastfeeding was the best option for its nutritional benefits and its low cost, despite food insecurity levels. The

implications are that participants went periods without eating and hoped that they would produce sufficient breastmilk for their newborn to become satisfied.

Once back at work, the findings revealed that many participants decided to stop breastfeeding and switch to formula feed for two reasons. First, as now they received an income again, and second due to the unpredictability of their working hours. The changing of feeding technique once back at work is a common finding which has also been demonstrated within existing literature and is discussed more in section 7.3 Unexpected findings (Horwood et al., 2020). This switch also has health implications, particularly for the newborn who does not obtain the same nutritional benefits (protective antibodies) from the formula as it does from breastmilk (Remmert et al., 2020). Furthermore, this switch also has negative implications for the mother, as she is forced to work longer hours to afford the formula and still complete house chores and take care of her newborn. These responsibilities increase the potential of informally-working women to experience the double burden effect (Alfers & Rogan, 2015).

> *Many women spoke of feeling torn between working and being mothers, expressed anxiety about managing domestic and work pressures, and struggled with a sense that they were not good mothers. While these debates on the double shift of women's work are not new, they are exacerbated within the context of informal work and manifest differently than in formal work.* (Bhan et al., 2019, p. 4).

Thus a clear implication of this study is that participants faced nutrition concerns during pregnancy and afterward. They were required to return to work soon after giving birth, leading to crucial decisions having to be made about what practices are best to feed their newborn.

Childcare options

Childcare was a predominant concern and stressor for most participants as it is still believed to be the main responsibility of mothers. A noteworthy example of how embedded these responsibilities are was highlighted by Buhle, who searched for a caregiver to look after her newborn even though her partner was unemployed and stayed home. This extra incurred financial responsibility pressured Buhle to return to work as soon as possible. Literature has

demonstrated that as more women are working within the ILM and searching for private or public childcare options, this responsibility which has been overwhelming thought of women's work in SA is being put into question (Cassirer & Addati, 2007). Moreover, Moussié & Alfers, (2018, p. 121) explain that collective caregiving occurs frequently and is "both a function of historical social arrangements, and the strains brought on by poverty, migration, conflict and disease". Sizani was an example of this as she hoped her sister would babysit her newborn. However, as was also evident in the findings, some participants moved away from their families, leaving them feeling anxious about finding suitable caregivers. According to Moussié & Alfers (2018, p. 127), "access to child care is a key element of income security as well as a necessary public service". This study implies that childcare created stress for most participants, specifically for those who did not have it arranged before giving birth and relied on public services.

Resources

Generalized resistance resources

The GRRs effectively manage tensions and strengthen the manageability component of the SOC, when enabled by individuals. The participants mentioned multiple GRRs which had been successful in coping with stresses and maintaining their SOC. The most common GRRs referred to in the findings were social support provided by the participants' grandmothers and the baby fathers. For half of the participants (i.e. Buhle, Liyana, Nolwazi, Sizani) their grandmothers supported them in various ways (morally and financially) and were extremely grateful for their assistance and guidance. This social support assisted in lowering the participants' tension surrounding breastfeeding and childcare challenges. Michel and colleagues (2020, p. 4) confirm that grandmothers are highly valued within African cultures and complete many essential roles. "In traditional cultures, grandparents often have a direct and clear role in relation to the care and nurture of children" (Michel et al., 2020, p. 4). According to the GRR description provided by Antonovsky and as viewable on Figure 2, grandmothers would be an example of an interpersonal-relational characteristic of an individual that is effective in combatting the tensions that arise with challenges such as childcare, financial concerns, and food insecurity. A clear

implication from this study is that grandmothers were a vital resistance resource participants engaged to overcome stressful situations.

Specific resistance resources

The participants mentioned two SRRs, which assisted in managing negative tensions. The first was the governmental Child Support Grant (CSG) provided by the Department of Social Development and considered one of its kind in Africa's largest cash transfer program (Horwood et al., 2021; Luthuli et al., 2020). According to Horwood and colleagues (2021, p.9), "the CSG is a cornerstone of poverty alleviation in SA but access to the grant remains a challenge, particularly for mothers in extreme poverty". At the time of the study, all nine participants were still in the process of applying for the grant, as eligible applicants can only apply once they have received a birth certificate (Horwood et al., 2021). This particular resource was vital for the participants of this study as financial security was not a GRR they relied on.

The second SRR mentioned by the participants was the antenatal care sessions. All participants were expected to attend these sessions as they provided them with educational information surrounding birth and what to expect. Existing literature demonstrates that these sessions offer educational services to pregnant women to test for complications (Jinga et al., 2019). The SA government highly recommends all pregnant mothers take advantage of these sessions. Moreover, they encourage no fewer than eight visits to lower "the risk of adverse obstetric outcomes" and increase "fullterm delivery and normal birth weight" (Jinga et al., 2019, p. 2). Empirical literature suggests that in 2018, 75% of all pregnant South African women had an average of four antenatal care visits (Jinga et al., 2019). Although the SA government suggests all expecting mothers attend these sessions, they do not provide income remedies for women who miss a day's pay. The findings of this study demonstrated that the participants were committed to attending these sessions despite obtaining less income and being disregarded by nurses.

7.2.3 Discussion in relation to meaningfulness

Healthy baby

The last component of the SOC is meaningfulness, which is the motivational component that identifies challenges as being worthwhile to engage in (Slootjes et al., 2017). One of the main aspects that heighten meaningfulness is engaging in socially valued decision-making (Slootjes et al., 2017). Meaningfulness increased for the participants once they had accepted and come to terms with their pregnancies. Although all were unanticipated, participants explained being both nervous and excited to meet their babies. Moreover, the decisions needed to be made regarding childcare, time off from work, work replacement, income assistance, searching for a new place to live were all in the best interest in raising a healthy baby. In addition, all participants prioritized the need to attend the antenatal care sessions even though this meant they would not be able to go to work, which impacted their income. The generated data provided evidence that participants comprehended that to be successful, preparation was essential in balancing their roles while returning to unpredictable and uncertain work situations. Thus, the study demonstrated that although all pregnancies were unplanned and created stress for the participants. Towards the end of their pregnancies, participants highlighted that these provided them with meaning and a sense of hope.

7.2.4 Discussion in relation to the overall research objective

The study's overall objective was to identify a link between participants' SOC and mental well-being. From the transcripts, it was possible to identify and analyze comprehensibility and manageability. Despite this, it was highly complicated to explore the participants' level of meaningfulness, as the transcripts did not support this component. As a result, I cannot confidently interpret the participants' SOC because it lacks the meaningfulness component. However, I did reflect and attempted to analyze two of the participants comprehensibility and manageability. This analysis is found in APPENDIX 10.

7.3 Unexpected findings

The following section will discuss findings that I was surprised to discover and contrast or compare with existing literature.

Adjustment of work duties

The rearranging of work duties is an unconventional finding and typically not decided upon by the ILM worker. As a result, this was a surprising finding that was revealed within Nolwazis' interview. D' Souza (2010), explains that domestic workers are frequently undervalued, discriminated against, exploited, and belittled for their work. Furthermore, domestic workers have a long-standing history of being unrecognized as its "low social status and the myth that no special skills are required to perform it" (D'Souza, 2010, p. 1). The low job control of workers linked to high demands creates negative health implications for workers, resulting in higher stress, exhaustion, and fatigue (Benach et al., 2014; Söderfeldt et al., 2000). Moreover, when individuals continuously apply the same skills every day without further development or training, Slootjes and colleagues (2017) concur that this also impacts the strength of the SOC, likely decreasing it and impacting the ability to promote health (Labonté & Laverack, 2008). Thus, an implication from this study is that the adjustment of working tasks was possible for some of the participants, however, it is often not negotiable for many ILM workers.

Employee benefits

A brilliant example that counteracts the traditional ILM characteristics was the maternity compensation received by one participant. Isisa detailed that she received a small payment from her employer while away from work. She used the money to purchase baby food and other necessary supplies. While searching for existing literature on this topic, only a handful of articles appeared. Stumbitz and colleagues (2018) suggest that this type of compensation is highly dependent upon the "perceived staff loyalty and trustworthiness" as well as based on reciprocity. Isisa explained she had a good relationship with her employer, even so, that. she was able to modify her work tasks. A positive relationship between workers and employers demonstrates that their input was valuable and they had decision-making power. According to Antonovsky, this

strengthens the motivational component, strengthening the SOC and ultimately improving health outcomes (Slootjes et al., 2017). Isisa's relationship with her employer and her excellent work ethic made her an invaluable asset. As a result, her employer appreciated her and provided supplemental monetary support to showcase her gratitude. Despite this gesture, literature has explained that, even if ILM employers would like to support their workers with financial compensation, they do not possess the financial resources (Stumbitz et al., 2018). Isisa was the only participant who received maternity leave benefits from her employer. Thus, a clear implication of this study is that employee benefits and protections are rare for the most ILM workers.

Childcare

Thadie was the only participant who considered bringing her newborn to work with her. This was a surprising finding, however, one that has been constituent within the literature. Existing literature has demonstrated that ILM mothers often resort to this method when there is no other option (Heymann, 2006; Moussié, 2021). According to Cassirer & Addati (2007), 40% of mothers in Indonesia bring their newborn to work in the ILM, and 54% of informally-working mothers did the same in Nairobi. This solution solves the immediate needs and concerns for mothers, but they may negative long-term health implications. Literature has described that children are often exposed to hazardous and toxic conditions when brought to work, leading to developing harmful and irreversible illnesses (Moussié, 2021; Muntaner et al., 2020). Within Jody Heymann (2006) book titled, "*Forgotten Families: Ending the Growing Crisis Confronting Children and Working Parents in the Global Economy",* she described that working in the ILM, in particular with street trading and vending, there is a high risk of being exposed to harmful pollutions. For example, a seamstress was working in the ILM in Vietnam while pregnant. She gave birth to a son who has epilepsy. While this health condition is not limited to those residing in poverty, there is speculation that such problems occur when working around harmful toxins or pollutants (Heymann, 2006). If this seamstress would have been able to access good prenatal health services, then these conditions could be detected and treated (Heymann, 2006). Furthermore, children are susceptible to acquiring and developing health issues at all ages when

brought to the ILM; however, as childcare is unaffordable for many, women resort to bringing their children to work. Health implications are widespread and harmful for both young children and adults (Heymann, 2006). Two conventions (CRC and CEDAW), both signed by the SA government, acknowledge that childcare should be considered a priority (Davis & Powell, 2003, p.837). More literature and discussion surrounding childcare as a fundamental human right are found within the section Violation of human rights. This study highlighted that participants felt deep mistrust for public childcare services. Participants considered other childcare options, some of which would negatively impact health.

Unsupportive community caregivers

The lack of support from the community caregivers (CCGs) or also referred to as community health workers (CHWs), was another unexpected finding. The findings revealed that participants were not supported or had been visited by the CHWs. This finding contrasts with existing literature about CHWs, as literature describes that their services have been implemented successfully within many other Sub-Saharan African countries (Benin, Ghana, Mali, Senegal, Uganda) (George et al., 2012). The design and implementation of CHWs within rural areas of Ghana have been exceptionally successful (Adongo et al., 2014). These workers are highly resourceful and have been given many different names: village health volunteers, peer health educators, and traditional birth attendants due to the various tasks and duties they complete (Adongo et al., 2014; Baatiema et al., 2016). "These different characterizations generally reflect the diverse and ambiguous identities of CHWs in the international health literature and health policy programmatic interventions (Baatiema et al., 2016, p. 2). Thus, this study implies that the CHWs are not resources for the participants, despite the previous literature, which has proven effective health-promoting resources within other African countries.

Unfriendly nurses

A finding that has been constituted in empirical literature yet still surprising was the unfriendly manner in which nurses interacted with the participants. Literature has described that most antenatal care sessions provided to pregnant women in SA are completed by nurses (Jinga et al.,

2019). Participants perceived the nurses as being unfriendly and often displaying a sense of superiority. As a result, they limited their interactions with them during the antenatal care appointments. Despite the nurses' manners, participants still did not cancel their appointments. Rochat and colleagues (2013, p. 401) contradict the earlier finding and suggest "depression during pregnancy has been associated with poor uptake of antenatal care and adverse fetal and obstetric outcomes", which has not been the case for the participants. Literature reveals that there has been a long-standing negative perception about nurses throughout Africa (Jinga et al., 2019; Lambert et al., 2018). Jinga and colleagues (2019) provide insight into the possible reasons why nurses treated their patients with hostility and coldness. For example, if pregnant women began to attend antenatal care sessions late into their pregnancy, it had repercussions for the mother and the newborn and the health system and the support nurses can provide (Jinga et al., 2019).

Furthermore, staffing shortages, system failures, high workload, and managing "multiple responsibilities" are other consequences that impact the nurses' hospitality (Jinga et al., 2019; Lambert et al., 2018). Other literature suggests that nurses in SA tend to value "procedure-centered care rather than patient-centered care", meaning that the completion of tasks is more important than "caring behaviours" (Lambert et al., 2018, p. 260). Speaking firmly and being direct with patients are two examples of focusing on procedure-centered care (Lambert et al., 2018). The participants were quick to mention the lack of kindness and friendliness they received from nurses during antenatal care sessions, but they still attended the appointments.

Alternatively, Lambert and colleagues (2018) research highlights an established reputation regarding the African nurses being harsh and rude. This reputation is long-standing and cultivated by different sources, including the media and word of mouth (Lambert et al., 2018). Existing literature has described that when nurses try to build rapport with patients, it surprises them, as this is not how society has projected their reputation. Many nurses have confirmed that these commonly held opinions negatively impact their character as some try to do their best despite working in stressful situations (Lambert et al., 2018). These long-standing perceptions

are difficult to change once established, and many expecting mothers become skeptical of the nurses' motivations, as was revealed within the findings.

Breastfeeding duration

A surprising finding was that despite the necessity to return to work shortly after childbirth and food insecurity levels, many still chose to breastfeed their newborns for a short period. However, the majority of women switch to formula feed once they start working again. This is also the case as ILM does not have appropriate breastfeeding spaces and is regarded as unhygienic and vulnerable for breastfeeding (Horwood et al., 2020; Luthuli et al., 2020). Furthermore, cultural perceptions and being publicly shamed for breastfeeding is another frequently mentioned cause to stop breastfeeding (Horwood et al., 2020; Luthuli et al., 2020). Although being humiliated and embarrassed was not evident within the participants' transcripts, research studies have confirmed that this can frequently occur for informally-working women (Horwood et al., 2020; Luthuli et al., 2020).

The short duration that newborns are breastfed can have negative health implications for their growth and development. Heymann (2006) study describes that mothers working in the ILM are often compelled to stop breastfeeding at a risky stage of the newborns' development and at a time point when they may not be able to afford to purchase an adequate number of substitutes. Luthuli and colleagues (2020, p. 12) explain that this leads to an unpleasant cycle for mothers, "for some mothers these challenges led to a vicious cycle, whereby adding formula milk to the baby's diet increased the financial pressure on women, leading to early return to work". Other literature describes that mothers' mental well-being also suffers when they are expected back at work without a proper recovery from childbirth which, combined with other factors, food and financial insecurity, increases the chances of experiencing PND. Werner et al., (2014, p. 41-42) explain that numerous psychological and social factors contribute to women facing a greater risk of PND, "previous meta-analyses have identified 15: (1) lower social class, (2) life stressors during pregnancy, (3) complicated pregnancy/birth, (4) difficult relationship with family or

partner". The latter factors had also been highlighted by the data generated through the findings; the study implied that participants deemed it essential to breastfeed over formula.

On a positive note, a study conducted by Lakati, Bings, and Stevenson (2002) in Nairobi revealed that not all informally-working women end up shortening the duration in which they breastfeed. This study compared mothers from lower economic statuses who worked within ILM to mothers with a stable financial situation. The research established that the former mothers had longer and more successful breastfeeding rates despite working uncertain and unpredictable hours and earning little income (Lakati et al., 2002). The primary motivation behind breastfeeding was that it is the best method of nourishment and its low financial cost (Lakati et al., 2002). This study concluded that "the mothers in this study were generally able to find ways of successfully combining work and breastfeeding" (Lakati et al., 2002, p. 717). The study by Lakati and colleagues provides an alternative and contrasting view about the otherwise well-researched direct relationship between shortened breastfeeding period and working in lower precarious forms of work (Johnson, Kirk & Muzik, 2015; Lakati et al., 2002; Mills, 2009).

Violation of human rights

South Africa is a leading example of acknowledging that an overwhelming number of women work within the lower-paying segments of the ILM and have therefore committed and subsequently implemented gender equality reforms (Skinner & Valodia, 2003). During the apartheid years, blacks were discriminated against and segregated from the whites, which reinforced and "legitimize social difference and economic inequality" (Dlamini, Tesfamichael & Mokhele, 2020). The segregation of blacks forced many skilled and talented workers out of the labour force, making it "largely stratified by race" and ultimately led to ILM creation (Gradín, 2019, p. 555). As Nelson Mandela became the president of SA in 1994, his government was very inclined to support predominantly blacks who had been discriminated against during the colonial regime (Dlamini et al., 2020; Ryklief, 2012). In 1995, Mandela ratified two critical international conventions (the Convention on the Elimination of All Forms of Discrimination Against Women [CEDAW] and the Beijing Declaration and Platform of Action [BDPA]) (Skinner & Valodia,

2003). Interestingly, the CEDAW also addresses childcare and how this is one aspect within womens' lives that take up a lot of time, energy, and commitment. Cassirer and Addati (2007) argue that childcare has predominantly been womens' responsibility while earning an income and taking care of household needs. As noted by Davis and Powell (2003, p. 691-692), the "CEDAW encourages provision of necessary supportive services to parents, and urges the "establishment and development of a network of childcare facilities" in participating states". A clear implication drawn from the study's findings was that searching for childcare was a stressor that caused tension.

The importance of maternity leave has also been mentioned within the CEDAW; however, this is something that the SA government has not implemented 25 years after its ratification (Davis & Powell, 2003). As illustrated by empirical literature and the study findings, informally-working women do not receive maternity leave. Many studies suggest that this is another violation of the workers' human rights, since mothers are entitled to a leave from work, without fearing for their job security (Addati, Cassirer & Gilchrist, 2014; Addati et al., 2016). Despite ratifying the CEWAD, informally-working women are still neglected from policies surrounding basic human rights and are vulnerable to experiencing health inequities as a result of it. If the SA government were to implement this essential benefit, mothers would be encouraged to utilize this resource to improve their well-being.

Childcare is a basic human right that is neglected and a particular stressor for informally-working women. The Convention for the Rights of a Child (CRC) was created by the United Nations in 1989 and is to date "the most widely ratified human rights treaty in history. It has inspired governments to change laws and policies and make investments so that more children finally get the health care and nutrition they need to survive and develop. There are stronger safeguards in place to protect children from violence and exploitation" (UNICEF, n.d., para. 3). Furthermore, this convention considers the balance between parents' ability to care for their children and how governments should assist parents with this obligation (UNICEF, n.d.). South Africa has ratified

the CRC; however, it has not been supportive in helping ILM workers with childcare and therefore poses health risks for children who are brought to ILMs and violate their rights.

7.4 Implications of findings in relation to the field of health promotion

Ottawa Charter for Health Promotion

The overarching goal and elements of health promotion (equity, participation, and empowerment) and the SMH (increasing salutary coping mechanisms) compliment each other. Eriksson and Lindström (2006) explain that linking the two approaches by creating fair and just health policies that empower individuals to control their health is critical to creating a healthy and salutogenic community. Empowered individuals can comprehend, manage and find meaning in their lives, contributing to a healthier and more resilient society in which social, economic, and political changes are health-promoting (Eriksson and Lindström, 2006). The OCHP was established in 1986 and is the guiding document for health promotion and describes the essentials for improving health outcomes within societies (WHO, 1986). Although most of the prerequisites of health highlighted in the OCHP apply to this study, only two are discussed below (food and income insecurity). The OCHP also describes five main action areas for governments to consider when implementing new policies to ensure healthy environments are created. Two of the action areas are discussed below in relation to the findings (creating supportive environments and developing personal skills).

Food insecurity

Proper nutrition is vital to improving and enabling the health of individuals, but it is a barrier to many ILM workers. According to statistics, “in 2019, close to 750 million - or nearly one in ten people in the world - were exposed to severe levels of food insecurity” (FAO, 2021). The findings provided evidence that participants experienced food insecurity issues, ranging from mild to very severe. The consequences of malnutrition and undernutrition are well researched and can contribute to; infant mortality, stunted growth, tuberculosis, and iron deficiency anemia (Labonté & Laverack, 2008). Moreover, the literature also establishes a link between experiencing food insecurity and maternal depression (Abrahams et al., 2018; Horwood et al.,

2021; Luthuli et al., 2020). Accessing healthy food is a prerequisite and a resource to ensure that health is a resource for everyday life and that it is maintained. However, the findings demonstrated that participants could not afford nutritious food, impacting their overall health and worrying about the implications this had for breastfeeding.

Income insecurity

Financial stability is a necessity to promote and enhance health, as indicated by the OCHP. Although all the nine prerequisites to health identified by the OCHP are essential, Labonté and Laverack (2008) believe income to be the determinant that has the most considerable impact on health. Informal workers cannot rely on income as it is minimal and fluctuating, particularly for street traders and market vendors. Moreover, the findings also demonstrated that fluctuations in wages were typical for the participants since their pay was deducted when they attended antenatal clinic sessions. The disadvantages of income insecurity are far and widespread, requiring those with low incomes to work longer hours to obtain a decent living wage and prioritize their work over other commitments (Alfers & Rogan, 2015). As a result, income does have a significant influence on health outcomes. It is a GRR that can promote health and be a resource utilized to manage tensions, enabling a stronger SOC.

Creation of supportive environments

The environment in which individuals spend most of their time, either at work, home or leisure, directly impacts their health outcomes. The WHO (1986, p. 2) promotes that the creation of supportive environments should be adopted in all areas to produce "living and working conditions that are safe, stimulating, satisfying and enjoyable". As detailed in the findings, informally-working women's work can be physically and mentally exhausting, resulting in many experiencing depressive symptoms. Moreover, some participants expressed heightened feelings of stress and anxiety when they needed to take an unpaid leave from work. The introduction of paid maternity leave for informally-working women would be an instrumental step in enhancing workers' health outcomes. Many research studies have highlighted the importance of maternity leave as a necessary step and one that contributes to creating a supportive work environment

(Horwood et al., 2021; ILO, 2018). Moreover, this was a recommendation mentioned within the CEDAW, which the SA government ratified in 1995 to promote gender equality and support women (Davis & Powell, 2003). A paid maternity leave would support the health and well-being of mother and child, as this allows for the mother to recover from pregnancy, not stress about losing income or her work position. In addition, it increases the likelihood that breastfeeding will continue past the critical time point, positively affecting the newborns' development. Lastly, in sequence to the earlier paragraph about the Violation of human rights, the implementation of this protection is a move towards good governance and strengthening community action. The WHO (2021, para. 5) explains that, "where health is sacrificed for perceived economic gain - whether in working conditions, […] inequities and disparities widen, making inclusive economic growth harder - not easier - to achieve". Health-promoting policies need to be created by governments to support individuals of all income levels so that work, among other vital areas, is a source of health and not stress (WHO, 1986).

Development of personal skills

As previously explained, the SA government recommends all expecting mothers attend antenatal sessions. The findings demonstrated that participants enhanced their personal development and skills when they participated in these sessions and therefore, it increased their ability to "exercise more control over their own health and over their environments, and to make choices conducive to health" (WHO, 1986, p. 3). Ayanda, Buhle, Isisa, Khethiwe, Sizani, Thadie, and Zanele mentioned that they resorted to breastfeeding and that attending the antenatal sessions impacted their decision. The SA government is trying to increase health literacy among expecting mothers by providing them with "information, effective communication and structured education" (WHO, 2021, para. 1). Through the recommendation that all expecting mothers, despite financial stability attend these sessions, "strengthening participatory and representative decision-making about health literacy development and equity at all levels will promote individual and community action for health" (WHO, 2021, para. 3). When governments promote personal skills through health promotion and education, leading to healthy environments.

7.5 Implications of findings on the progress of the SDGs

The subsequent paragraphs discuss the implications of the findings on the SDGs progress. The United Nations (UN) developed 17 goals encompassing social, environmental, and economic development targets to improve people and the planet (WHO, 2021). Although this study relates to numerous SDGs such as gender equality and zero hunger, only three SDGs concerning the study findings are discussed.

No poverty (goal one)

Eradicating poverty has been a goal of the UN since 2000, with the creation of the Millennium Development Goals (MDGs). Receiving less than 1.90$ USD per day is considered to be living in extreme poverty, and according to the UN SDG tracker (2021), one in five people live on less than this per day. As illustrated in the literature review, there is a high correlation between those working within the ILM and residing in poverty, particularly for women (Bhan et al., 2020; Bonnet et al., 2019). This correlation was also present within the findings as participants discussed insufficient income levels and lacking sufficient food. There was a heavy dependence on the income that the CSG would provide to participants, lowering their vulnerability and risk to poverty. Existing literature has also revealed that the importance of grants is crucial for those who are low income (Granlund & Hochfeld, 2020; Agüero, Carter & Woolard, 2007). The WHO (2021, para. 1) also notes the benefits of cash transfer programs, "a range of impacts in health, spanning nutrition, maternal and child health, health service demand and uptake, and, increasingly, HIV and STI prevention". However, despite the grant's supplemental income assistance, they only receive income for a limited period making their situations vulnerable again. At the same time, the CSG encourages long-term dependence, which should also be taken into consideration. The study demonstrated that participants experienced poverty and relied heavily upon the transfer money given by the SA government.

Good health and wellbeing (goal three)

As illustrated throughout the findings, numerous challenges affect the health and well-being of workers in the ILM. Health disparities and equities are standard for this population due to the

toxic and polluted environments, long working hours, meager wages, lack of proper childcare arrangements, lack of social protection (Alfers & Rogan, 2015; Cassirer & Addati, 2007). Reducing health inequities can be completed by enforcing and advocating for a fair minimum wage and paid maternity leave for informally-working women, supporting health as an everyday resource. However, participants were provided a bit of compensation while away on leave due to the good relationship with their employer; existing literature has described this as being very rare (Bhan et al., 2020, Horwood et al., 2021). Focusing on implementing the latter two measures would decrease the stressors and tensions that arise for ILM workers and reduce adverse health consequences (Alfers and Rogan, 2015; Labonté & Laverack, 2008).

Decent work and economic growth (goal eight)

Informal labour market work is increasing steadily within developing and developed countries. Benach and Muntaner (2007) reported that the ILM is slowly replacing the standard full-time permanent positions apparent within developed countries, attributed primarily to three causes. First, the patterns of economic growth; second, the impact of financial crises and their restructuring; third, to globalization (Chen, 2013). As capitalism and globalization continue to be prevalent worldwide, scholars such as Chen (2013) hypothesize that the ILM will persist and most likely expand further within developed countries. Literature has demonstrated that this type of work cannot be considered ““decent ” by comparison with recognized, protected, secure, formal employment” (ILO, 2002, p. 299). The ILM characteristics have been detailed throughout the thesis, indicating that this work is not decent. Some participants were required to search for work replacement and asked family or friends to complete this task. Moreover, as ILM workers do not contribute to paying taxes, the SA government incurs low tax revenues, directly impacting and reducing their citizens' services, preventing “growth and inclusive development” (Kanbur, 2016, p. 79). The findings in connection with existing literature suggest that the ILM characteristics hinder the development of decent work and economic growth, slowing the progression towards the eighth SDG (Webb & McQuaid, 2020).

7.6 Emerging trends

This section presents the emerging themes surrounding the effects of the current coronavirus pandemic and its implications for ILM workers. Governments worldwide were quick at implementing lockdown measures to ensure the health and well-being of their citizens. However, these measures had negative ramifications for those working within ILM.

Financial hardship

Informal labour market workers were tremendously impacted by the lockdown measures implemented as they heavily depend on daily earnings. Existing literature has described that their livelihoods have been disproportionally affected (Rogan & Skinner, 2020; Webb & McQuaid, 2020). According to the ILO (2020, para. 4), "an increase of more than 56 percentage points in relative poverty for informal workers and their families", is estimated to occur due to the measures. The SA government introduced new financial support measures to assist those most vulnerable to poverty; however, ILM workers were excluded from these grants. According to the ILO (2020), ILM workers "are excluded from contributory insurance mechanisms through which government relief can be channeled, and yet are more likely to lose income during the crisis than formal workers" (ILO 2020). Additionally, this pandemic will affect the developmental work and efforts completed by non-governmental organizations as their operations were reduced or shut down (Webb & McQuaid, 2020). Despite the SA government's grants to support its citizens, ILM workers are neglected and perpetuated even further into financial hardship during this uncertain and unpredictable time.

Negative implications for informally-working women

As the literature review explained, women comprise a larger percentage of workers in the ILM than males, leading them to be more vulnerable to the coronavirus lockdown restrictions. Rogan and Skinner (2020) state that informally-working women were more likely to have lost their jobs than men. "Among those who were employed informally in February and April, women in the informal economy saw a decrease of 49% in the typical hours worked in April while men in informal employment saw a 25% decrease in typical hours" (Rogan & Skinner, 2020, p. 1).

Working less also meant that more time is spent within the home, leaving those who experience violence in vulnerable situations (WHO, 2020). Moreover, limiting contact with friends and family was a central element to protect individuals from acquiring the coronavirus. According to Usher et al., (2020, p. 549), "social isolation requires families to remain in their homes resulting in intense and unrelieved contact as well as the depletion of existing support networks". The uncertainty of the current pandemic combined with the inability to access community resources and other supports heightened the risk of violence.

> *Isolation paired with psychological and economic stressors accompanying the pandemic as well as potential increases in negative coping mechanisms (e.g. excessive alcohol consumption) can come together in a perfect storm to trigger an unprecedented wave of family violence* (Usher et al., 2020, p. 550).

Thus, informally-working women are more susceptible to the lockdown measures implemented by governments, impacting their economic stability and family circumstances.

7.7 Limitations of the study

The following section presents some of the study limitations, including challenges with secondary data analysis, limited studies use strengths-based theories, and how the definition of terms is interpreted differently in other contexts. Moreover, this section also provides suggestions on the study could have been enhanced.

Secondary data analysis

Probing

Collecting data first hand would have improved the study as more specific interview questions would have been developed to better answer the overall research objective. Due to the coronavirus pandemic, I could not follow my original travel plans and collect data firsthand. As a result, I used secondary data analysis. There have been some challenges with using this type of analysis, for instance, probing or asking further questions to clarify answers. Often the transcripts

demonstrated that participants provided one-sentence answers, such as "*No, there is none.*" or "*There is no problem. It is fine*". I would have asked the participants to elaborate more when given these answers. The probing and further clarification of answers are strengths when conducting primary data within qualitative research to gather subjective experiences.

Transcript

A limitation that I had not considered before beginning the secondary data analysis was how difficult it might be to understand a translated transcript. When participants were asked a similar question during the interview, some slightly or entirely changed their answers. Further exploring the true meaning of participants' answers and digging deeper by completing firsthand interviews would have enhanced the study and eliminated any confusion in reading the translated transcripts.

Research questions

A common challenge with using secondary data analysis is that the original study objective and research questions do not necessarily align with your studys' aim. It was particularly challenging to find participants' answers concerning the third component of the SOC (meaningfulness), as the original project did not ask participants about socially valued decision-making. Among the participants, it was clear that a significant motivational aspect that motivated and encouraged participants was the newborn. All the participants explained that they wanted to give birth and raise a healthy baby. As a result, finding aspects in which participants contributed to socially valued decision-making was very challenging, making this a limitation of the study.

Theoretical framework

Minimal research articles have used strengths-based theories. Even less have incorporated Aaron Antonovsky's salutogenic model of health. As a result, it was very challenging to find appropriate and peer-reviewed articles that have explored the sense of coherence for informally-working women. In addition, finding peer-reviewed journal articles focusing on positive mental well-being among this population required much effort as extremely few have been written. As a

result, this study could have been enhanced if more studies incorporated strengths-based theories into their framework for comparing and contrasting purposes.

Generalization

Since qualitative data explores the subjective experiences of a small group of participants, generalizations to other populations are not possible to make. However, when the study provides context-rich and thick descriptions, it benefits the reader as they can draw similarities between this study and theirs. As this study revolves around an important topic, it was vital for me to be very descriptive. This study provides valuable information in regards to how informally-working women promote their mental well-being. Moreover, Creswell (2013) explains that generalizations are not the purpose of a qualitative research study; however, some aspects of the study described in detail-rich accounts may be helpful for researchers exploring the same topic.

Terminology

The terms well-being and depression are frequently defined and measured within research studies, with slightly different definitions. However, these two terms can be interpreted differently in other settings, such as sub-Saharan Africa. For example, certain aspects of the two terms may be disregarded in one definition but not the other. Moreover, the PND was measured using the EPDS developed in Britain. Shrestha and colleagues (2016, p. 1) argue that its ability to identify anxiety and depression within LMICs is challenging. Moreover, they also argued that culturally appropriate definitions of depression and its interventions must be considered (Shrestha et al., 2016). As a result, how definitions are established and which criteria they follow is essential to acknowledge, making it a constraint of the current study.

CHAPTER 8: CONCLUSION

8.1 Introduction

This section of the thesis briefly presents the study's main findings concerning the study objectives. Afterward, recommendations for future practice and policy are given.

8.2 Key findings in relation to the research sub-objectives

(1) "What are the challenges that participants face that affect depression?"

The findings revealed that working conditions, lengthy and unpredictable working hours, lack of paid maternity leave, low wages were stressors experienced by the participants. Moreover, unsupportive family and friends, food insecurity, and unplanned pregnancy as challenges. After childbirth, many participants encountered difficulties regarding the babys' health, with complications arising during labor resulting in many newborns requiring to stay in the hospital for an extended period, heightening feelings of anxiousness and stress. Furthermore, food insecurity was a prevalent issue as many feared producing sufficient breastmilk for their babies.

(2) "What resources are available — and utilized by participants — to reduce depression?"

Attending antenatal care sessions and receiving the CSG were two specific resistance resources which were key findings highlighted. Although none of the participants had received the grant, all mentioned that it would relieve some financial concerns. The nurses providing the antenatal care sessions were described as being unkind and very direct. However, participants continued to attend these sessions to ensure that their pregnancy was progressing positively and the baby was healthy. Generalized resistance resources that were instrumental for participants was the support provided by their grandmothers. They assisted with childcare duties, housing concerns, and when able, offered financial support. Other generalized resistance resources deemed essential by the participants was family and friends, the positive relationship and hospitality between employer and participant, and supportive partners who contributed to managing negative tensions.

8.3 Key findings in relation to the overall research objective

"Is there evidence in the participants' narratives that SOC plays a role in mental well-being"

In conclusion, based on the findings, I attempted to identify the participants' SOC. Participants seemed to understand and comprehend their situations and how the birth of their child impacted their daily life, with a special focus on their working life. The study also brought forth numerous challenges expressed by participants, including negative workplace conditions, childcare concerns and limited financial resources. To counterbalance these stressors and reduce the negative tension associated with them, many relied on the support from family and friends. All participants relied on support from the CSG offered by the SA government. Finding appropriate data to answer what participants found meaningful was extremely difficult. Although I provided a few conclusions on this component, I do not feel that this was sufficient. As a result, the overall research question of this study could be answered confidently.

8.4 Recommendations

Recommendations for future research that arose are explained in detail below. Recommendations for policymakers to promote health and reduce the inequities for informally-working women are presented after.

Recommendations for future research

- Why were the CHWs not resources as expected by the original research study? Although they were not in the interview questions (see APPENDIX 5). Why have they been more successful in other African countries, such as Ghana, but not in South Africa? If these CHWs did visit the participants, would their feeding techniques or breastfeeding rates have been different?

Recommendations for policy

- The SA government is challenged and recommended to follow through on its commitment to human rights as stated in the CEDAW and CRC.

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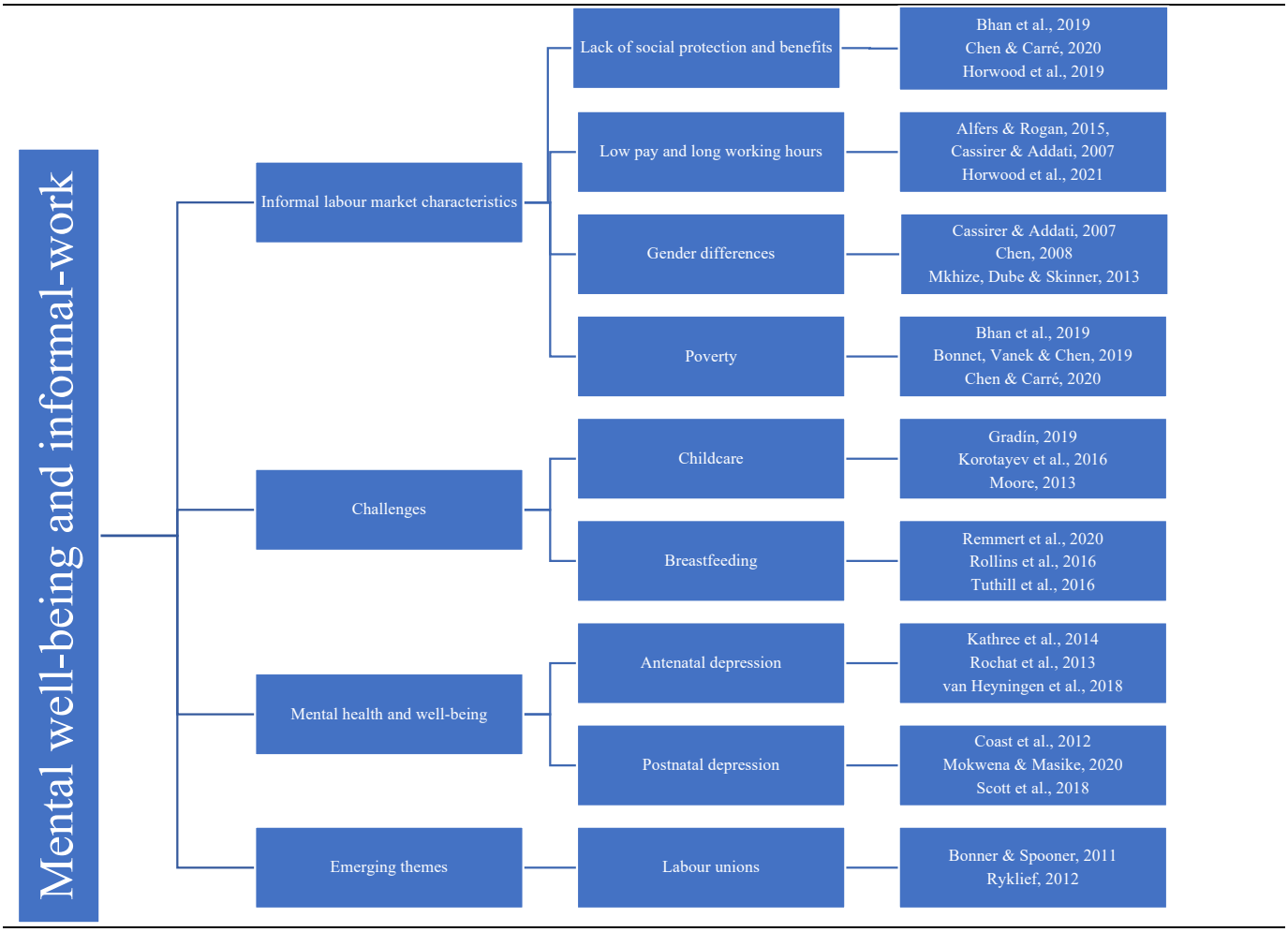
APPENDICES

APPENDIX 1: Literature review chart



APPENDIX 2: Baseline questionnaire

LiNCs study: Baseline questionnaire – Sections 1-5

LINCs Baseline questionnaire

The baseline questionnaire consists of the following sections

1. **Administration and informed consent**
2. **Mothers information**
3. **Fathers information**
4. **Household information**
5. **Health services and plans for work and the baby**
6. **Postnatal depression scale (separate sheet)**
7. **Food security (separate sheet)**

Section 1: Administration and Informed consent									
1.1	Was informed consent obtained? **Uchazeliwe, imvume itholakele?**	1 = Yes				2 = No, participant refused to participate ➔ ***End interview***			
1.2	Site of recruitment **Indawo la kuxoxisanwa khona**								
1.3	Tracking number **Inombolo yokulandelela**								
1.4	Interviewers name / initials **Igama lomphenyi mibuzo/ Inishiyali**								
1.5	Date of interview **Usuku lwenxoxo mibuzo**	D	D	M	M	Y	Y	Y	Y

Section 2: Mothers information

I would like to start by asking you some questions about yourself. **Ngizoqala ngokukubuza imibuzo emayelana nawe**									
M2.1	What is your date of birth? **Ingabe wazalwa nini?**	D	D	M	M	Y	Y	Y	Y
M2.2	Mothers population group (observe) **Ubuhlanga bukamama (bheka)**	1 = African							
		2 = Indian							
		3 = Colored							
		4 = White							
		5 = Other							
M2.3	Mothers most recent relationship status? **Ingabe ukhona umuntu ozwana naye?**	1 = Single							
		2 = Married							
		3 = Separated / divorced / widowed							
		4 = In a relationship and living with partner							
		5 = In a relationship and not living with partner							
M2.4	What is the highest grade you passed at school? **Ingabe iliphi ibanga oliphumelele esikholeni?**	1 = Never attended school							
		2 = Primary school: grade 1 to grade 7							
		3 = Secondary school: grade 8 to grade 11							
		4 = Completed schooling: grade 12							

APPENDIX 3: Follow up questionnaire

LiNCs study: Follow-up questionnaire

Follow-up questionnaire

Section 1: Administration

Section 1: Administration and Informed consent									
A1.1	Site of recruitment **Indawo la kuxoxisanwa khona**								
A1.2	Tracking number **Inombolo yokulandelela**								
A1.3	Interviewers name / initials **Igama lomphenyi mibuzo/ Inishiyali**								
A1.4	Date of interview **Usuku lwenxoxo mibuzo**	D	D	M	M	Y	Y	Y	Y
A1.5	Is this the first visit after your baby was born? **Ingabe uyaqalwa ukuvakashelwa kusukela umntwana wakho ezaliwe?**	1= Yes				0= No ➔ ***Skip to 2.5***			

Section 2: Feeding practices

To be asked of all mothers regardless of which field visit this is Kuzobuzwa kubobonke omama , noma ingabe ukuphi ukuvakashela			
FP2.1	How old is your baby now? **Ingabe mudala kangakanani umntwana wakho**	***Write date of birth***	
I am going to talk about how you are feeding your baby now Manje ngizoxoxisana nawe mayelana nendlela omupha ukudla ngayo umntwana wakho			
FP2.2	Where was your baby Born? **Wazalelwa kuphi Umntwana?**	1= Outside a health facility 2= In health facility	
FP2.3	What type of delivery did you have? **Ingabe wamuteta ngaluphi uhlobo lokuteta umntwana?**	1= Vaginal delivery 2= Caesarean section	
FP2.4	How much did the baby weigh when he/she was born? **Sasithini isisndo somntwana ngesikhathi ezalwa?**	…… **N/A if you do not know**	
FP2.5	Have you ever breastfed your baby since he/she was born? **Ingabe wake wamuncelisa ubisi lwebele umntwana wakho kusukelwa ezelwe?**	1= Yes	0= No ***Skip to 2.8***
FP2.6	Are you still breastfeeding your baby? **Ingabe usamuncelisa umntwana wakho?**	1= Yes ***Skip to 2.8***	0= No
FP2.7	For how long did you breastfed? **Wamuncelisa isikhathi esingakanani?**	…… ***(days, weeks or month)***	

APPENDIX 4: Pre-delivery interview guide

Interview questions	Probing questions
Describe the work that you do	• Describe work type (e.i. employed, own account, employer in an informal business) • Describe the number of hours and days that you work • Describe your relationship with your employer and with other workers in the area, your colleagues or co-workers?
Describe how you feel about being pregnant- describe your expectations regarding this pregnancy?	• Is there anything that you worry about when you think of the birth of this baby?
How has being pregnant affected the work that you do	• How has the type of work, working hours or workload changed since you became pregnant? • Describe how your co-workers and your employer have responded to you being pregnant? • Describe whether being pregnant has affected your income in any way? • Describe whether being pregnant has affected your health in any way
Describe any people who have given you support since you have been pregnant and how they have supported you	• Describe support you have received from family members? Friends? • Describe how your father has responded to the pregnancy and any support that he has provided
Describe your experiences of receiving health care during pregnancy?	• Are you able to attend ANC? If yes, how do you manage working and going to clinic visits? • How have you experienced attending clinic visits? • Describe whether being an informal worker affects your experiences at the clinic and if so how? • Apart from the clinic, describe any other health services you have attended during this pregnancy (private doctors, traditional healers or faith healers)
Describe your plan to care and feed your baby, and how you will manage your work responsibilities once the baby is born?	• How much time do you plan to take off work when they baby is born? • How are you going to financially support yourself while you are not working? • How do you plan to feed the baby after birth?

APPENDIX 5: Post-delivery interview guide

Interview questions	Probing questions
How are things going with your baby?	• Experiences of caring for the baby, did everything go as you expected? • Have you experienced any challenges in caring for your baby? • Is there anything in particular that is worrying you about how things are going in caring for your baby?
Can you tell me how you have experienced feeding overall since your baby was born and how are you feeding your baby now?	• What is the reason why you made the particular feeding choice? • Explain whether your work plans affect the feeding choice that you made in any way? • Are you feeding your baby as planned, or did the plan change? If so, why did you change your planned feeding method?
Describe any people who have given you support since the baby was born and how they have supported you?	• Describe support you have received from family members? Friends? • Describe how your father has responded to the pregnancy and any support that he has provided
Describe how you plan to care for and feed your baby, as well as how you will manage your work responsibilities when you go back to work?	• How long will you take time off work? • How are you going to feed the baby when you go back to work? • Would you consider expressing breastmilk to give to the baby while you are away from them?
How are you currently financially supporting yourself and the baby?	• Do you have another source of income while you are at home? • Role of family members and father of child in supporting mother and childcare? • Role of employers in supporting mother and childcare
Is there anything that is making you feel anxious or unhappy?	

APPENDIX 6: Edinburgh postnatal depression scale

In the past 7 days, I have been able to laugh and see the funny side of things	1. As much as I always could 2. Not quite so much now 3. Definitely not so much now 4. not at all
In the past 7 days, I have looked forward with enjoyment to things	1. As much as I ever did 2. Rather less than I used to 3. Definitely less than I used to 4. Hardly ever
In the past 7 days, I have blamed myself unnecessarily when things went wrong	1. Yes, most of the time 2. Yes, some of the time 3. Not very often 4. No, never
In the past 7 days, I have been anxious or worried for no good reason	1. No, not at all 2. Hardly ever 3. Yes, sometimes 4. Yes, very often
In the past 7 days, I have felt scared or panicky for no very good reason	1. Yes, quite a lot 2. Yes, sometimes 3. No, not much 4. No, not at all
In the past 7 days, things have been getting on top of me	1. Yes, most of the time I have not been able to cope at all 2. Yes, sometimes I have not been coping as well as usual 3. No, most of the time I have coped quite well 4. No, I have been coping as well as ever
In the past 7 days, I have been so unhappy that I have had difficulty sleeping	1. Yes, most of the time 2. Yes, sometimes 3. Not very often 4. No, not at all
In the past 7 days, I have felt sad and miserable	1. Yes, most of the time 2. Yes, quite often 3. Not very often 4. No, not at all
In the past 7 days, I have been so unhappy that I have been crying	1. Yes, most of the time 2. Yes, quite often 3. Only occasionally 4. No, never
In the past 7 days, the thought of harming myself has occurred to me	1. Yes, quite often 2. Sometimes 3. Hardly ever 4. Never

APPENDIX 7: Informed consent form

Centre for Rural Health, University of KwaZulu-Natal

If you wish to participate in this study, you should sign below. By signing this informed consent you are signing

- I have been informed about the study called: The livelihood and nurturing care study (LiNCs): a longitudinal qualitative study to explore experiences and practices of childcare and infant feeding among women in informal work
- I understand the purpose and procedures of the study.
- I have been given an opportunity to ask questions about the study and they have been answered properly.
- I understand that my participation in this study is entirely voluntary and that I may withdraw at any time without any negative consequence to me or my baby.
- I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this study.
- I understand that this consent form will not be linked to my responses, and that my answers will remain confidential.
- You have been given a copy of this consent form to keep.

If you wish to participate in this study, you should sign below.

I UNDERSTAND THAT I HAVE AGREED TO PARTICIPATE IN THIS STUDY.

Participant's name and signature

.....	.....
Date (*dd/mm/yyyy*)	Name (Print)
.....	.....
Thumb print	Signature or cross

STUDY STAFF

.....	.....
Date (*dd/mm/yyyy*)	Name (Print)
	.....
	Signature or cross

APPENDIX 8: Attempt at analyzing participants SOC

The following section attempts to tentatively analyze the SOC of two participants based on the subjective experiences they reported in their pre and post-delivery interviews. Comprehensibility, manageability, and meaningfulness for Zanele and Liyana are described. First, Zaneles' SOC is explored and how she understands and views the challenges and resources in her life. Second, I detail how Liyana comprehends her situation and reflects on her challenges and resources. These two were chosen as I believe they demonstrate contrasting examples of relatively strong and weak SOC. I will not analyze their meaningfulness since data was lacking for this. The paragraphs begin by explaining each participants' SOC during pregnancy and after childbirth.

Zanele

SOC while pregnant (AND score of 19)

Comprehensibility is fostered through experiencing and receiving consistent messages (Antonovsky, 1987). While pregnant, Zanele worked as a domestic worker, residing within her employer's household. Her work could be described as consistent, as she performs the same duties every day, with slight variations. Zanele decided to stop working shortly before giving birth as her work duties became too strenuous and she experienced negative health implications. I would describe Zanele's comprehensibility concerning her working environment as fairly stable. She understood and could predict the challenges she faced due to her work's routinized and organized nature.

Perceiving that one has adequate resources to manage negative tensions is central to the manageability component (Antonovsky, 1987). Zanele expressed experiencing an uneven load balance. Her employers expected her to be available at all hours to help out. She expressed feeling frustrated about the overload, mainly since she did not receive overtime pay for working more than her 'normal working hours'. She described her work as more challenging than engaging, a crucial component that Antonovsky described as leading to overload, weakening the manageability component (Slootjes et al., 2017). Financial concerns and poor overall health were

also stressors mentioned during pregnancy. Zanele relied heavily on social support from her husband and brother-in-law. However, these were the only two resources she noted which were not adequate to meet the posed demands. She experienced higher demands than she could meet, resulting in experiencing overload. However, despite this conclusion, according to Antonvosky's description of comprehensibility, Zanele also experienced underload. Her domestic work responsibilities did not further enhance her skills, and according to Antonovsky, this area of work "is not one of frustrated potential" (Antonovsky, 1987, p. 108). Existing empirical research has also concluded that "a lack of opportunity to use skills at work was negatively associated with SOC, however, that too much strain at work was also negativity associated with SOC" (Slootjes et al., 2017, p. 572). As the interview guide did not explicitly ask about GRRs, it can also be that Zanele engaged with many more resources, which she did not describe at the time of the interview. However, due to the asked questions, the lack of GRRs and an uneven load balance contributed to Zanele experiencing weak manageability.

SOC after childbirth (PND score of two)

Before giving birth, Zanele had stopped working because it was too demanding and contributed to health consequences. In her post-delivery interview, Zanele explained that she had not yet returned to work. She explained that her situation at home was chaotic with negative family tension arising. Her stable environment which was previously characterized as predictable and consistent has now shifted to unstable and disordered, resulting in a lower level of comprehensibility.

Due to not receiving an income, Zanele was now more dependent on support from her husband and brother-in-law. She was also going to apply for the CSG, which would also be essential support. However, the challenges she experienced at home and the limited resources she utilized continued to result in Zanele feeling overwhelmed and experiencing overload. Due to the lack of GRRs and an uneven load balance, her manageability post-delivery was still relatively low.

Liyana

SOC while pregnant (AND score of 13)

Liyana was a self-employed hairdresser who described her working schedule as unpredictable since it revolves around her clients. Some days she did not have any appointments and other days, she worked very long hours. She described the benefit of being able to control and adjust her working position when she felt uncomfortable. She asked her clients to move to sit on the ground while she sat on the sofa instead of continually standing. She understood that some days were busier than others, but she has come to terms with this aspect of her work as she very much enjoys her work. Moreover, Liyana described her home environment as stable and structured, leading her to experience relatively high comprehensibility. Liyana has a highly supportive partner and grandmother who were both excited and supportive of the pregnancy. Additionally, Liyana mentioned that she drew upon her previous knowledge and skills of caring for her newborn. Liyana experienced tension regarding financial security, as her partner was unemployed and she was the primary breadwinner. Therefore she is required to return to her work shortly after birth. Due to the various resources she resources at her disposal, I would assess her manageability level also to be relatively high.

SOC after childbirth (PND score of eight)

Liyana explained that she did not anticipate any challenges with taking care of her child, and she demonstrated a sense of confidence that things would work out. These feelings contribute to an understanding that she views her world as stable and prepared to take on challenges, mainly since this was not her first child. It appears that Liyana continues to experience high comprehensibility after childbirth. Her partner is still highly supportive, helpful, and excited to bond with their child. However, she doubts his commitment to her and his whereabouts when he leaves the house. She does mention this stressor as occupying her thoughts a lot when he is not at home. Her grandmother also ensures that she eats proper meals to stay healthy, provides sufficient amounts of breastmilk to her newborn and watches her. In addition, Liyanas' knowledge, skills and self-confidence are internal resources that she also relies on. These

resources reflect that she continues to experience a relatively high manageability component, potentially slightly decreasing.