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AN EXPLORATION OF THE INDIGENOUS NEONATAL CARE PRACTICES OF MOTHERS AND CAREGIVERS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

By

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DECLARATION

I, Patience Mashudu Tulelo (Student Number: 17054932), hereby declare that:

An Exploration of the Indigenous Neonatal Care Practices of Mothers and Caregivers in Vhembe District, Limpopo Province is my own work, and has not been previously submitted by me or anyone else for a degree at this university or any other university. I further declare that I have acknowledged all the materials contained herein by means of complete bibliographic reference.

Signature: **Date:** 23 July 2020

Patience Mashudu Tulelo

DEDICATION

I dedicate this dissertation humbly to all the below-stated individuals:

- My mother, Mrs Nomsa Victoria Sadiki who is my spiritual arsenal and ardent prayer partner. Her methods of raising her grandchildren made me gain interest in understanding the indigenous neonatal practices of my own people, the Vhavenda. I thank her for her relentless support and for always reminding me to rest.
- My husband, Mr Vusi Tulelo who is my best friend and pillar of strength, for the unwavering support and encouragement he has shown me throughout my academic milestones. I thank him immensely for allowing me to tap into his fountain of strength to recharge whenever I felt like giving up. I have drawn so much strength from him throughout my studies, and I am eternally grateful for that.
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- My late father, Mr Silae Petrus Sadiki for teaching me the importance of language in understanding my roots as a Venda woman.
- My late grandfather, Mr Freddy Thulani Sithole for valuing education and encouraging his children to be learned, and for teaching me the importance of family bonds through his actions.

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"For lack of guidance a nation falls, but victory is won through many advisors" (Proverbs 11:14)

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ABBREVIATIONS

IKH	Indigenous Knowledge Holder
IMCI	Integrated Management of Childhood Illness
INC	Indigenous Neonatal Care
MDG	Millennium Developmental Goal
NDoH	National Department of Health
NRF	National Research Fund
PHC	Primary Health Care
SDG	Sustainable Developmental Goal
SIDS	Sudden Infant Death Syndrome
THP	Traditional Health Practitioner
UNICEF	United Nations Children's Fund
UP	University of Pretoria
UPERC	University of Pretoria Research Ethics Committee
USA	United States of America
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

ABSTRACT

Background

South Africa is amongst countries with high neonatal mortality rates. The Department of Health has introduced strategies to promote good neonatal care practices within the healthcare institutions around the country. On the other hand, different communities throughout the country still adhere to their own indigenous neonatal care practices in caring for their neonates at home after discharge from clinics/hospitals. Some of these practices could prove to be beneficial to the neonates' health, while others may pose a health risk to the very neonates.

Purpose

The study explores and describes indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province.

Methodology

A qualitative, explorative and descriptive research design approach was employed to collect data from 18 participants situated in three Makhado villages across Vhembe District in Limpopo Province, South Africa. Given the heterogeneity of both the participants and the research sites, the purposive and snowball sampling methods were used for their selection according to the researcher's predetermined range of criteria. Semi-structured one-on-one interviews were made use of in collecting data over an interrupted period of two weeks (one week in August 2019 and another in February 2020) at Siloam District Hospital's post-natal ward and at the participants' homes in selected villages of Makhado district. Additional to the interview guide, an audio recorder and field notes were also utilised to maximise the data collection instruments, after which the same data was analysed according to its emerging patterns of themes and sub-themes.

Findings

The study found that indigenous health practices were the primary mechanism for caring for neonates in Vhembe District, and that not all such practices were harmful or unsafe. This study revealed further that women use indigenous neonatal care practices across age groups, social standing and level of education. Younger mothers receive guidance from the older women in their family or community, but also adopted biomedical options to some extent.

Key concepts: caregiver, indigenous neonatal care practices, neonate, traditional health practitioners

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CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

People of different cultural origins and influences are imbued with different neonatal care practices (Ngomane and Mulaudzi, 2012:2; Ngunyulu, Mulaudzi and Peu, 2015:2; M'soka, Mabuza and Pretorius, 2015:4). Vhembe district is not an exception as mothers and caregivers also practice the indigenous care practices for their neonates. In the present study, mothers' and caregivers' indigenous neonatal care behaviours in Vhembe District were explored and described. The neonatal period is viewed as a delicate and sensitive period in every human's life (World Health Organization, 2017:4). Hence, most people, particularly mothers and caregivers, seek to offer safe protective care to their neonates during this period. According to Latha, Kamala and Srikanth (2017:869), health outcomes of neonates are not only determined by their biological factors, but also by the socio-cultural environment of their place of birth.

This chapter encompasses the study background, problem statement, purpose and its attendant research question, study significance, including a brief description of key concepts entailed in the study. The study's preferred design and methodological orientations is also presented briefly in this chapter. The chapter then concludes on a short description of the chapter layout of the study. Notwithstanding the various aspects of the research process addressed by these chapters, it is noteworthy that the organisation and structure of the self-same chapters is interstitially linked to the core phenomenon being investigated; namely, indigenous neonatal care practices. Furthermore, the structure and organisation of the chapters reflects the logic of research, in terms of which the theoretical/secondary or literature-oriented perspectives and empirical/primary domain of the study are posited as a seamless and perennial process intersected by the core tenets of the study topic itself (Brink, van der Walt and van Rensburg, 2018:65).

1.2 BACKGROUND

South Africa was amongst countries that were unable to achieve a two-thirds infant mortality reduction rate as expected by the Millennium Developmental Goal (MDG) number four. (The MDGs have since been replaced with more emphasis placed on Sustainable Developmental Goals (SDGs) in 2016). The target of the Millennium Developmental Goals was a two-thirds reduction in the under-five mortality rate. One

of the target's indicators would be 18 deaths per 1,000 live births decrease of the infant mortality rate (Tilahun, 2017:1).The United Nations International Children's Emergency Fund (UNICEF), reported that in 2018, Sub-Saharan Africa experienced a high neonatal mortality trend among infants, with 27 deaths reported per 1,000 live births (United Nations International Children's Fund /UNICEF, 2018:10). The main causes of death amongst children within the first month of life included pneumonia, diarrhoea and neonatal sepsis (UNICEF, 2018:18). The report further indicated that deaths of new-borns are the result of diseases and conditions that are associated with quality of care around the time of childbirth (UNICEF, 2018:18). The Department of Health has institutionalised the Integrated Management of Childhood Illness (IMCI) approach and promotion of exclusive breastfeeding as initiatives to thwart the infant mortality scourge (Department of Health, 2014:1).

Despite the implementation of these initiatives, neonatal mortality rates did not decline as expected (Latha et al., 2017:869). This lack of decline in the neonatal mortality rate is attributable to a variety of unrecorded factors, as attested to by a study conducted by Rhoda, Velaphi, Gebhardt, Kauchali and Barron (2018:12). This study also states that some of the infants do not die in hospitals, and they could not be adequately accounted for in the statistics pertaining to infant mortality.

Several studies were conducted on indigenous neonatal care practices in other countries. These studies highlighted the link between the causes of neonatal death and other indigenous neonatal care practices adopted by mothers and caregivers outside the jurisdiction of healthcare institutions. For example, a study in India revealed that mothers applied harmful substances such as cow dung to the baby's umbilical cord stump to expedite its drying process (Sujatha, 2014:22), which may expose the neonate to neonatal sepsis and tetanus. Another study in Odisha, India, also revealed a different cultural practice amongst mothers regarding medical help in the case of a neonate experiencing breathing problems (Pati, Chauhan, Madhusmita Swain, and Hussain, 2014:240).

A Zambian study conducted by Herlihy, Shaikh, Mazimba, Gagne, Grogan, Mpamba, Sooli, Simamvwa, Mabeta, Shankoti, Messersmith, Semrau and Hamer (2013: e79191) identified the community's fervent belief in the umbilical cord not being left to dry following the birth of a child. Such a practice is contradictory to the World Health

Organisation's dry cord recommendation since it constitutes a neonatal risk of infection (WHO, 2017:5). The same study by Herlihy et al. (2013:e79191) revealed further that the community perpetuated their indigenous practice by applying substances to the cord stump with the aim of maintaining its soft texture in order to enhance its falling off easily and quickly.

Earlier studies have shown that cultural practices do influence how families seek and apply neonatal healthcare (Sutan and Barkat, 20014:2). Such culturally entrenched practices could be an influential factor leading communities to adhere to their indigenous neonatal practices, regardless of the standards for neonatal care that the Department of Health has instituted; such as safe cord care practices to prevent neonatal sepsis. Ngomane and Mulaudzi (2012:2) also found in their study that women in traditional contexts still preferred to be seen by traditional health practitioners who practiced indigenous ways of healthcare during the antenatal period, despite their exposure to clinic and hospital maternal and child care services. Ngunyulu et al. (2015:2) also mention further that traditional birth attendants still rendered postnatal home care immediately after the mother's discharge from hospital. It was against the background of such neonatal care practices that the researcher realised the importance of exploring the neonatal care practices of mothers and caregivers. The aim is to reveal harmful practices and those that are safe for endorsement in the biomedical healthcare system.

Other studies have been conducted on indigenous practices and cultural beliefs amongst women during their pregnancy, labour and the post-natal period. All these studies confirm that women do rely on indigenous practices during pregnancy through to the post-natal period (Ngomane and Mulaudzi, 2012:2; Ngunyulu et al., 2015:2; M'soka et al., 2015:4). These studies affirmed not all indigenous practices are harmful. As such, these studies collectively recommended that health systems should endorse such safe practices.

1.3 PROBLEM STATEMENT

In essence, a research problem fundamentally outlines the difficulty or challenge(s) presented by a particular state of affairs/ situation or phenomenon and requiring methodological or systematic evidence-based adjudication for the resolution of such a situation (Kumar, 2012:86; Brink et al, 2018:65). It is on account of such systematic

resolution or methodological intervention that undertaking of the study is justified (Matua and Van Der Wal, 2015:22). Therefore, the investigated problem premises on the extent and impact of indigenous neonatal care practices on the health of newly born children generally, and in the Vhembe District particularly.

In traditional and culturally dominated contexts, it is normal for parents to organise their caregiving duties around indigenous cultural beliefs and behaviours (Bornstein, 2012:2). Most of these indigenous cultural beliefs are not known to biomedical healthcare professionals. Some are risk-free, such as the practice of allowing only the mother to be in the same room with the neonate for a month. The underlying belief is that the neonate's immunity is not yet strong enough to be exposed to many people. Imbued with the same cultural imperative, Ngunyulu and Mulaudzi (2009:48) confirm that women in Sikhunyane village are confined to their rooms after childbirth in order to rest and avoid the physical demands of household chores, which is a good practice to allow the woman's body to recuperate adequately. However, some practices are unsafe and may endanger the life of the neonate, such as applying substances on the umbilical stump; which may expose the neonate to sepsis (Sinha, Kaur, Gupta, Dalpath, Goyal and Murhekar, 2014:27).

As a midwife, the researcher has observed that most mothers that came for post-natal care still adhere to administering substances on the neonate's umbilicus to enhance healing, despite the health education they receive from the post-natal care clinic during follow-up visits. This form of resistance to change is mostly the result of the influence the caregivers and older family members exerted on the mothers after childbirth (Sutan and Barkat, 2014:2). The current study's findings also indicate that mothers are compelled to perform indigenous neonatal care practices as advised by their elders; they have no choice, but to conform for fear of losing family bonds and disappointing their elders. The latter concurs with studies undertaken in Nigeria, Tanzania and Ethiopia by Iganus, Hill, Manzi, Bee, Amare, Shamba, Odebiyi, Adejuyigbe, Omotara and Skordis-Worral (2015:1261), which affirms that new mothers were expected to utilise the services of female relatives for the first days or weeks after the delivery of the child.

Having grown up in the Vhembe District, where cultural beliefs are still adhered to and respected uncompromisingly, the researcher was galvanised by the curiosity to gain

knowledge regarding the extent to which mothers in the Vhembe district were caring for their neonates; as well as the extent to which they adhered to the available principles of neonatal care provided at the clinics. To that extent, this study is of paramount importance as it captures safe and unsafe indigenous neonatal care practices by mothers and caregivers.

1.4 STUDY AIM/PURPOSE

The study aim underpins the overall (general or broadly stated) intentions and reasons for the undertaking of the study (Green and Thorogood, 2014:16). Accordingly, the study aim is: *To explore and describe the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province.*

1.4.1 Study objectives

The objectives of the study were to

- Describe the indigenous neonatal care practices of mothers and caregivers in selected villages of Makhado municipality in Vhembe district, Limpopo Province
- Identify the safe and unsafe indigenous neonatal care practices of mothers and care givers in selected villages of Makhado municipality in Vhembe district, Limpopo Province
- Explore factors contributing to the use of indigenous neonatal care practices of mothers and caregivers in selected villages of Makhado municipality in Vhembe district, Limpopo Province

1.4.2 Research Question

Articulation of a research question identifies and interrogates the critical focus of the study aim/ purpose (de Vos, Strydom, Fouche and Deport, 2012:196). In that regard, the research question is necessarily formulated in tandem with the research aim. Therefore, the following main research question is: *What are the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province?*

1.5 SIGNIFICANCE (CONTRIBUTION OR VALUE)

Significance of the study specifically identifies its value or worth insofar as its epistemological (knowledge-based), organisational and practical socioeconomic contribution or relevance is concerned (Carter, Bryant-Lukosius, DiCenso, Blythe and Neville, 2014:545; de Vos et al., 2012:196). The epistemological significance signifies

the study's contribution in respect of knowledge generation in theory and practice pertaining to the particular field of study or discipline (Vyncke, 2012:14). On the other hand, the organisational significance refers to the value added to the organisations or institutions most affected by the study. Meanwhile, the practical significance or value of the study premises on any potential or actual socio-economic contribution that could be derived from the study.

1.5.1 Epistemological Value

The indigenous practice of neonatal care is not unique to the Vhembe district. However knowledge of such practices tends to be frowned upon as an anachronism, which has created a knowledge gap between neonatal care practices of mothers and caregivers in the indigenous context and their biomedical variants in South Africa. Based on the limited studies conducted on issues of indigenous neonatal care practices in South Africa, a study of this nature will effectively contribute towards better understanding of these practices. In this regard, the study contributes to the body of knowledge in both indigenous and biomedical spheres of neonatal care. Thus, epistemological egalitarianism and diversity (Goduka, 1999) is posited as realisable, especially in an era when the "museumisation" of African indigenous knowledge systems (IKS) has correctly been outmoded over time (Etieyibo, 2016:6). The "museumisation" perspective relegates IKS as a mere cultural relic not worthy of any intellectual value and pursuit.

1.5.2 Organisational Value

The study aim is not to devalue indigenous neonatal care practices of mothers and caregivers. The researcher anticipates that the study will serve as a framework for suggestions and recommendations for healthcare authorities and health policymakers to incorporate as an integral component of formal neonatal care guidelines in the biomedical sphere of healthcare provision. In its capacity as the primary neonatal policy making organisation/ institution, the National Department of Health (NDOH) is directly linked with the drafting or reformulation of neonatal policies. Accordingly, the NDOH (provisional on adoption of the study's recommendations) would be able to determine the type of awareness campaigns to be conducted to help reduce incidents of neonatal deaths and illnesses that are related to the indigenous neonatal care practices. The latter proposition is similar to the amalgamated approach adopted by the NDOH's collaboration with traditional leaders by advocating for voluntary medical

male circumcision (VMMC) to reduce the high incidence of initiation health risks in some traditional communities (Department of Health, 2016:24).

1.5.3 Significance to Nursing Practice and Nursing Education

Emanating from the study's recommendations, NDOH-inspired neonatal policies have the potential to incorporate indigenous service providers who are the midwives in their respective communities, with relevant skills and knowledge (community education) to be change agents and champions in the creation of awareness to the mothers and the care givers concerning the risks posed by unsafe indigenous neonatal care practices. However, this should not be construed as suggesting these practices are entirely unsafe. Based on both its findings and recommendations, this study could potentially influence neonatal healthcare policymakers to incorporate indigenous neonatal care practices into the midwifery curriculum to equip future midwives with the requisite skills and knowledge to better understand the cultural perspectives of neonatal care.

1.5.4 Community Significance

Mothers and caregivers could benefit by having their indigenous practices recognised and not rejected by the Department of Health and healthcare professionals in the Vhembe district. Midwives and PHC practitioners at healthcare facilities will disseminate the information to the rest of the reachable population by educating the mothers and care givers on both the safe and the unsafe neonatal care practices, thus reducing the knowledge gap on neonatal care practices that are currently unknown.

1.6 DEFINITION OF KEY TERMS

The key terms mentioned here are conceptually and operationally aligned to the core tenets and units of analysis embedded in the research topic (Brink et al., 2018:72). In this regard, the key terms also project the thematic logic and coherence embedded in the core units of analysis, especially the study topic and its associated processes of investigation (Green and Thorogood, 2014:16). Moreover, the definition of these terms is embedded in their contextual (connotative) application, rather than in their literal and denotative lexicon. Furthermore, the alphabetic sequencing of the terms does not particularly have any bearing in their prioritisation or order of appearance in the chapters of the study (Bryman, 2012:161).

Caregiver

According to Umemura, Jacobvitz, Messina and Hazen (2013:102), a caregiver is a person who is primarily responsible for the infant's care. In this study, the caregiver specifies any individual rendering care to neonates. Such caregiver could be the mother of the neonate, a female family member, or a female community member.

Indigenous neonatal care practices

Indigenous knowledge is the prevailing traditional and local system of thought that is developed through the experiences of the community in the process of managing the conditions or contexts that challenge their daily lives (Matsika, 2012:209 as cited in Mapira and Mazambara, 2013:92). For this study's purposes, indigenous neonatal care practices refer to culturally inspired neonatal care behaviours and attitudes amongst mothers and caregivers in Vhembe District.

Neonate

Childhood period from the first day to 28 days after birth (Sinha et al., 2014:24). In this study, a neonate refers to the newly born child from birth to one month of age.

Traditional health practitioner

Someone who uses traditional medicine for diagnosing, treating or preventing physical or mental illnesses; or any curative or therapeutic purpose, including maintenance or restoration of human physical and/or mental health or well-being (South Africa, 2007:6). In this study, traditional health practitioner refers to an individual who is consulted by the community for the diagnosis and treatment of neonatal ailments

1.7 RESEARCH DESIGN

This study is philosophically premised on the constructivist/ phenomenological research paradigm, which emphasises the interpretation of phenomena from research participants' worldview or lived experiences, considering they are primary sources of 'inside' information (Polit and Beck, 2017:11). Consequently, a qualitative, explorative, descriptive research design approach enabled the detailed investigation of mothers' and caregivers' indigenous neonatal care behaviours in Vhembe District.

The goal of a descriptive design was to describe the indigenous neonatal care practices of the mothers and the caregivers in Vhembe District. The researcher was interested in gaining knowledge on the indigenous neonatal care practices of mothers and caregivers and believed that the most cogent way of gaining this knowledge was

through personal interaction with selected participants who narrated their experiences (Ritchie, Lewis, Nicholls and Ormston, 2013:12).

The research was undertaken in the Makhado municipality of Vhembe District. Participants were recruited from Siloam District Hospital and Madombidzha Clinic. The study was conducted at both the participants' homes and at the hospital for those who did not grant the researcher access to their homes for interview purposes. All the participants signed consent forms before the interviews commenced as a formal agreement for their voluntary involvement in the study (Langford and Young, 2013:69).

The category of participants included mothers of neonates from 3 (three) days to one month, caregivers who generally assisted in the caring of healthy neonates from birth to the age of one month, the indigenous knowledge holders, as well as the traditional health practitioners. The rationale for selecting the two above-stated research sites is the fact that both healthcare institutions offer a functioning baby clinic and post-natal care clinic at three days, ten days and six weeks after the birth of a neonate.

Complementing a systematic review of secondary/literature-based data, semi-structured individual interviews served as the primary mode of collecting data with all of the four participant categories; that is, mothers, caregivers, traditional health practitioners, and the indigenous knowledge holders.

1.8 DISSEMINATION OF INFORMATION

The findings will be disseminated principally to Pretoria University through a research report submitted to the researcher's academic supervisor. The findings and related units of analysis will also be presented at academic conferences. It is further anticipated that a series of journal articles will be published in accredited scientific journals.

1.9 CHAPTER ORGANISATION

The research report is organised into five chapters:

Chapter One: Overview of the Study

A synoptic overview of the entire study is presented in terms of the background, research problem, aim and questions attendant to the research topic. The chapter further provides lexical clarity of the main concepts, and concludes with the research

design/ methodology opted for by the researcher. It is worth noting that each of these research variables is discussed extensively in the ensuing chapters.

Chapter Two: Research Design and Methodology

Both the conceptual/ philosophical and empirical premises of data collection processes and instruments utilised in the collection of data are discussed. Sampling and ethical contexts of the study are also presented and discussed in this chapter, concluding with the measures of ensuring the study's trustworthiness.

Chapter Three: Data Presentation and Analysis of Research Results

The chapter focuses primarily on the participants' interview-based statements and their thematic analysis as the critical framework against which these findings have been established.

Chapter Four: Discussions of Main Findings

The chapter focuses on the thematically analysed statements that have been converted into the findings linked to the investigated problem and study aim. Most importantly, the main findings are discussed in tandem with the literature related to each specific theme and finding being presented and discussed.

Chapter Five: Main Conclusions, Limitations and Recommendations

This chapter incorporates perspectives of the researcher to conclude the study, with emphasis on discipline-specific and practice-related implications of the study, including recommendations proposed to improve more research into practices on neonatal care. The study concludes with possible factors that could weaken or limit the study's intended outcomes.

1.10 SUMMARY

The essence of this chapter was to highlight the centrality of indigenous neonatal behaviours and practices of mothers and caregivers in Vhembe District. An outline on the problem statement, significance of the study, research design and the organization of chapters was provided. The next chapter outlines the research design/ methodology adopted in this study.

CHAPTER TWO: RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

The preceding chapter presented the study's overview. The research design and methodology is presented in the current chapter, highlighting the philosophical paradigm or assumptions that guided the data collection processes, as well as the nature or types of the instrument used to collect the data (Creswell, 2017:72). Furthermore, the chapter describes and presents the preferred research approach, methods, sampling context, ethical protocols, including steps taken to indicate the trustworthiness of the findings within the validity and reliability framework of quality assurance (Polit and Beck; 2017:11).

2.2 RESEARCH DESIGN

Research design refers to a broad plan according to which the study and its processes were managed (Rossman and Rallis, 2012:14). In addition, the research design encapsulates the philosophical perspectives (paradigms) and research instruments that guided or directed the collection of pertinent data and information deemed relevant for achieving the study purpose and resolution of the investigated problem that the researcher has identified and articulated accordingly (de Vos et al., 2012:221).

Largely as a factor of its heterogeneous participant category, the study embraced the constructivist-phenomenological philosophy since it allows for participant-focused data collection, interpretation and analysis with minimal influence of the researcher in the proceedings (Brink et al., 2018:74; Creswell, 2017:88). The researcher considered the constructivist approach to be relevant also because of its allowance of data to be collected in an ecological environment to which the participants are familiar and comfortable, such as their homes and hospital in this study. Most importantly, the participants (rather than the researcher) become the reliable insiders who are well conversant with the experiences they face daily in relation to the investigated phenomenon, which is the indigenous neonatal care practices in this study.

The philosophical premises of the study (i.e. constructivism/phenomenology) informed and influenced the types of assumptions the researcher made concerning various research stages and aspects. Assumptions refer to statements of proposition that do not necessarily rely on any proof regarding the reality of the phenomenon being

investigated (Kumar, 2012:108). Creswell (2017:88) mentions further that the assumptions made about the reality of the investigated phenomenon also direct the approach preferred for collection of data in the context of ontological, epistemological, and methodological assumptions based on indigenous neonatal practices in the Vhembe district of Limpopo Province.

2.2.1 Ontological Assumptions

According to Ormston, Spencer, Barnard and Snape (2014:4), ontology is premised on the nature of reality, what can be known about the world. In this study, the researcher as a midwife has identified that people of different communities have their own indigenous neonatal care practices. The indigenous neonatal care practices of the Vhembe mothers and caregivers can be better known and understood only if they are told by them. According to Mertens (2014:18) reality is socially constructed, it changes from time to time and it is viewed differently from one person to another. Therefore, the researcher assumes that the neonatal care practices of the Vhavenda people in the Vhembe district can only be relevant to them, and may not be generalised to other populations around the province or the country at large.

2.2.2 Epistemological Assumptions

Epistemology premises on the philosophy of knowledge and its explanation (Botma, Greef, Mulaudzi and Wright, 2010:40). Accordingly, epistemology is concerned with the researcher-participant engagement during the process of exchanging information (Lincoln and Guba, 2000 as cited in Mertens, 2014:19). The latter author further illuminates that the researcher and the participants are engaged in an interactive process by virtue of the reciprocity of their information sharing transaction. To avoid bias in such interactive engagement, the researcher used bracketing (self-monitoring) to prevent her assumptions to influence the results of the study.

2.2.3 Methodological Assumptions

According to Killam (2013:9), methodology involves systematic discovery of knowledge. Methodology provides researchers with the tools they can follow when acquiring knowledge (Botma et al., 2010:41). A qualitative, explorative and descriptive study design was employed as the premises and reflection of the researcher's methodological assumptions. In addition, one-on-one interviews with selected

participants were employed as tools to gain knowledge about their indigenous neonatal care tendencies and behaviours.

2.3 RESEARCH APPROACH

Research approach concerns a detailing of a plan or procedure adopted for directing the systematic and most efficient steps in collecting, analysing and interpreting data regarding the problem to be resolved (Bryman, 2012:161; Creswell, 2017:88). Hence, this study embraced a predominantly qualitative, exploratory and descriptive design to address indigenous neonatal care practices of mothers and caregivers in Vhembe District.

2.3.1 Exploratory Design

The study's exploratory focus is undertaken for insight about a situation, phenomena, individual, or community (Blaikie, 2000 as cited in de Vos et al., 2012:221). The researcher was seized with gaining insight into the indigenous neonatal care practices of Vhembe district mothers and caregivers. Botma et al. (2010:50) further explain that exploration is relevant for qualitative studies, with the goal of describing the particularities of a phenomenon, especially where little is known about it. The consulted literature proved that there are limited studies on indigenous neonatal care practices of mothers and caregivers in South Africa. Hence, selection of the exploratory design to gain as much information as possible from a range of participants with different knowledge and skill sets.

2.3.2 Descriptive Design

Descriptive designs specify details of a social setting or situation, focusing on *why* and *how* questions of the study (Kreuger and Neuman, 2006:23 as cited in de Vos et al., 2012:218). The researcher's intention was not only to "know" the indigenous neonatal care practices of mothers and caregivers in Vhembe district, but to also describe them according to the data provided by the participants themselves. To achieve this goal, the researcher detailed every stage of the research journey extensively, especially the proceedings of the interview-based data collection methods and their attendant methods of analysis and interpretation (Bryman, 2012:162; Rossman and Rallis, 2012:15).

2.3.3 Research Methods

Research methods are specific techniques or data instruments preferred for gathering and analysing relevant information addressing the research problem, study purpose and pertinent research-related questions (Brink et al., 2018:106; Polit and Beck; 2017:11). For purposes of logical concatenation, these techniques are presented in detail in Section 2.5 of this chapter.

2.4 RESEARCH ENVIRONMENT AND SAMPLING CONTEXT

In this study, the research environment and sampling context is categorically situated within the constructivist and phenomenological in terms of which empirical (interview-based) data was obtained at specific places according to defined processes for the selection of the required categories of participants (Creswell, 2017:90; Grove, Burns and Gray, 2013:373). Against this background, the research environment and sampling context encompasses the research setting, gaining access to the research site, the study population and recruitment of participants, sampling method, sample size and the sampling criteria.

2.4.1 Research Site/ Setting

The research site is described as the physical location of the study in real time (Grove et al., 2013:373). Streubert-Speziale and Carpenter (2011:27) further describe a research setting as the place where participants live. The study was conducted in Vhembe District, which is one of the five Limpopo Province districts. Vhembe District comprises four local municipalities, namely: Makhado, Musina, Thulamela and Collins Chabani. Participants were recruited at Siloam Hospital and Madombidza Clinic. Home visits were conducted in villages around Nzhelele, Madombidza and Magau in the Makhado municipality.

2.4.1.1 Accessing the research site

Gaining of access or entry to the research site/setting is contingent on permission being granted by the relevant authority or gatekeeper to enter the research site and access the selected participants (Epstein and Carlin, 2012:897). In the context of this study, the relevant authorities pertain to the mayor, councillor or the headman of a tribe. It is worth noting that the researcher first received ethical clearance from the University of Pretoria's Research Ethics Committee (UPERC) before applying the steps to gain entry to selected research sites.

Subsequent to the ethical clearance approval, the researcher applied for, and received approval to undertake the study from the Limpopo Province Department of Health, Vhembe District Executive Officer, Siloam Hospital Chief Executive Officer and the Facility Manager of Madombidzha Clinic. The researcher then telephonically briefed the Operational Managers of Madombidza Clinic and Siloam District Hospital about the study a week before its commencement. Permission for visiting the participants at their homes in the villages for data collection was also received from the local tribal council office. This was necessary because the Chiefs should know about all activities taking place in the community, especially that the community members would be sharing some sensitive indigenous information (de Kadt and Larreguy, 2014; Williams, 2010). All volunteering participants subsequently signed the informed consent form (see Annexure F), and also gave the researcher the appropriate time for the interview home visits.

2.4.2 Study Population

The population of a study is described as the researcher's essential interest group that is also compliant with certain predetermined criteria in relation to the research problem and study objectives (Brink et al., 2018:116). The study's target population were mothers of healthy neonates from three days after birth to one month of age, and caregivers who assist in the caring of healthy neonates from birth to one month. Indigenous knowledge holders and the traditional healthcare practitioner were also included. Mothers of neonates (up to one month) were included because both the institutions used for recruitment of participants offered a well-baby clinic and post-natal care clinic at three days, ten days and at six weeks. Healthy neonates were selected because sick neonates would be hospitalised and there could be limitations of indigenous care to a neonate who has been sick and not cared for at home. The age of the neonates is specified because the researcher was seeking to obtain rich information on current practices of the mothers and caregivers, rather than past care information.

2.4.3 Selection and Recruitment of Participants

Sampling is described as a process of systematically selecting a representative section of the broader population group (Botma et al., 2010:124). For this study, sampling was conducted with the assistance of the operational and the facility

managers of the selected healthcare institutions. They allocated a schedule of days on which the well-baby and post-natal clinic was offered at the facilities, which assisted the researcher in deciding on the days to visit the institutions to recruit participants. They also assisted by identifying clients who had neonates whose ages were within the researcher's predetermined inclusion criteria. The participants were recruited on the first day of entry to the research field. Those who were willing to be interviewed in the institution were interviewed on the same day, and those who agreed to be interviewed at their homes were followed up according to their availability. The researcher made sure healthcare service delivery was not unduly interrupted during the selection and recruitment phase of the study.

2.4.4 Sampling Method

The non-probability sampling method was used to select participants. Purposive and snowball sampling techniques were opted for, in terms of which not all cases or elements in a population is guaranteed selection or involvement in a study (Grove, 2013:263). The reason for this type of sampling was that the researcher needed participants who will share rich information about indigenous neonatal care practices. Purposive sampling is described as a method used when the researcher's knowledge about the population can be used to handpick sample members (Botma et al 2010:201). Information about the ages of the neonates, parity and ages of the mothers was made available to the researcher by the Facility Manager at Madombidzha Clinic and the Operational Manager of the outpatient post-natal clinic section of Siloam Hospital, which assisted in selecting the most appropriate prospective participants. In purposive sampling technique individuals in the study are chosen according to the researcher's personal judgement of who will be the most informative participant (Polit & Beck, 2012: 739; Botma et al., 2010: 201).

Initially, the number of participants meeting the sampling criteria was insufficient, requiring the researcher to seek and recruit more participants. It was in this regard that the researcher employed the snowball sampling technique. Snow balling sampling is a type of sampling where the researcher uses other participants to enable her to locate other individuals who meet the eligibility criteria (Etikan and Bala, 2017:2). The participants themselves were asked in the initial stages whether they knew of a household with a neonate. Obligingly, most of them were able to provide the requested

information, which assisted in the researcher's eventual selection of the indigenous knowledge holders and the traditional health practitioner. The snowballing effect of sampling enabled the researcher to identify and recruit caregivers through other young mothers at the health facilities and through other participants during home visits.

2.4.4.1 Sample size

Sample size refers to the precise case numbers, individuals or units selected for involvement in the study (Streubert-Speziale and Carpenter, 2011:28). The researcher interviewed 18 participants, of whom 9 were mothers, 6 were caregivers, 2 were indigenous knowledge holders (IKH) who specialise in the prevention and treatment of childhood illnesses, and 1 was a traditional health practitioner (THP). From this category of participants, 14 were the target group in terms of the inclusion criteria, the other 4 were interviewed for verification of the data generated from the target population. Two of the four participants were indigenous knowledge holders, one was a traditional health practitioner, while the other one was a caregiver.

The sample size was controlled by data saturation (Polit and Beck, 2017:497), which was reached at participant 13. However, the researcher continued to the next 5 (five) participants for purposes of generating new data, which did not materialise as anticipated. Four of the five participants were included in the study for verification of information received, based on their vast indigenous neonatal care practices knowledge. The involvement of the latter was also necessitated by their voluntary participation and appointment dates they had already finalised with the researcher. Most of these participants were reliable informants who provided sufficient data about their own indigenous neonatal care practices to the point of data saturation (Polit and Beck, 2017:497).

2.4.5 Sampling Criteria

Sampling criteria premise on the repertoire of characteristics and considerations or normative values informing the researcher's decision to include or exclude prospective participants from any study involvement (de Vos et al., 2012:234; Walliman, 2015:47). In this regard, the researcher basically aimed at selecting participants who were both knowledgeable and insightful on indigenous neonatal care practices of women in Vhembe District. Mothers' ages and parity constituted critical factors for consideration in the decision to include or exclude prospective participants. During the pre-testing

phase of the semi-structured individual interviews, the researcher noticed that teenage and first-time mothers did not have enough insight on the phenomenon of indigenous neonatal practices. In addition to the age and parity factors, voluntary participation was also a determinant for consideration (Langford and Young, 2013:69).

2.4.5.1 Inclusion criteria

The following factors rendered participants eligible for involvement in the study:

- Women who reside in the Vhembe district, specifically in the villages of Nzhelele, Madombidza and Magau located within the Makhado municipality;
- Women who are aged 20 years and above, given birth and cared for a neonate before, and are now mothers of neonates whose ages ranged between 3 (three) days and 1 (one) month. The main consideration was that they were already experienced in neonatal care;
- Caregivers who assist in the caring of healthy neonates from birth to one month. The snowballing effect of sampling enabled the researcher to identify and recruit these women through other young mothers at the health facilities and through other participants during home visits; and
- Indigenous knowledge holders and traditional health practitioners who reside within the parameters of the three villages cited above. These participants were included in the study for information verification purposes, since they were knowledgeable on the traditions and rituals associated with the care of neonates.

Any prospective participant who did not possess any of the criteria above, was categorically excluded from any participation in the semi-structured interviews (Kumar, 2012:109).

2.4.5.2 Exclusion criteria

The following factors were considered in the decision to exclude anyone from any involvement in the study:

- All mothers unwilling to participate, irrespective of ‘compliance’ with all inclusion requirements;
- Any Vhembe District male of any age, regardless of their knowledge status concerning indigenous knowledge practices; and

- Mothers aged 20 years and younger, who also have never previously cared for a neonate. These teenage and first-time mothers were excluded because of their inexperience in indigenous neonatal care.

Any prospective participant who 'subscribed' to any of the above, was summarily declared ineligible for any involvement in the study (Walliman, 2015:47).

2.5 DATA COLLECTION

Data collection is concerned with precise and systemic gathering of relevant facts, information and data for resolving the research problem and fulfilling the study objectives (Botma et al., 2010:201; Streubert-Speziale and Carpenter, 2011:33) In addition to the review of literature for the predominantly secondary (theoretic or abstract) data, secondary (empirical) data was obtained through pre-testing of the research instrument; the semi-structured individual interview following its pre-testing; as well as field notes.

2.5.1 Pre Testing of Interview Guide

Piloting is defined as a trial investigation (pre-investigation) designed to test the feasibility of protocols, methods and procedures when applied in a larger scale intervention (Thabane, Ma, Chu, Cheng, Ismaila, Rios and Goldsmith, 2010 as cited in Polit and Beck, 2017:624). The interview guide was tested to measure the feasibility, accuracy and appropriateness of the eventual interview guide, and the researcher's skills in an actual, real-life setting such as the envisaged home visits (Brink et al., 2018: 161; Creswell, 2017:102). Furthermore, the researcher needed to estimate in advance, the time spent with each participant during an actual interview.

Four participants agreed to be part of the pre-investigative initiative. This category of participants was not involved in the actual administration of the interviews with the final sampled 18 participants. They were excluded in order to obviate any bias as they would have been privy to the nature of the questions prior to the final/actual interview sessions, which would also become a factor of both unfair and unequal treatment of the research participants (Bryman and Bell, 2015:4).

The four participants on whom the interview guide was pre-tested were mothers and caregivers. Two of them were mothers who had given birth for the first time but cared for nephews and nieces before, and the other two were mothers who had more than

one child. Their preliminary (pre-testing) interviews took place in the Siloam District Hospital's outpatient post-natal unit in a pre-arranged cubicle to avoid any potential interruptions induced by activities in the main section of this unit. The insightful results of the two adult mothers in the pre-test interviews were not discarded, but included for refinement of the final interview questions. The two first time mothers, on the other hand, did not have enough insight or knowledge even though they cared for nephews and nieces before. They were unsure of traditional neonatal care practices and were assisted in this regard by an elder in the family assigned for such responsibilities. The duration of the pre testing phase interviews was 30 to 40 minutes per participant.

2.5.2 Semi-structured Interviews

Consonant with this qualitative study (as influenced by the adopted constructivist/ phenomenological research paradigm), the researcher opted for the semi-structured individual (one-on-one) interview mode of enquiry to obtain relevant facts, information and data about indigenous neonatal practices in the Vhembe district. The interview was the ultimate refined product of the pre-tested questions administered previously with four participants referred to earlier in sub-section 2.5.1 above.

Semi structured interviews are useful for gaining a detailed picture of a participant's experiences, knowledge, beliefs and perceptions about a particular phenomenon, situation or state of affairs in which the researcher is interested for purposes of resolving a specific problem; while also advancing the achievement of the study's purpose/aim (Botma et al., 2010:208; de Vos et al., 2012:235). The researcher selected this type of interview mode due to its allowance for the gathering of more detailed and spontaneous information on a phenomenon, especially from individuals who are not comfortable speaking in a group (Carter et al., 2014:545).

The interview guide was in English and translated into Tshivenda, the dominant indigenous language in the three Vhembe villages that constituted the physical research settings. The interview guide (see Annexure H) comprised five open-ended questions for the facilitation of participants' unconstrained verbal responses (Kumar, 2012:111). Such flexibility is not common in close-ended questions that generally characterise the structured questionnaire mode of data gathering. The interview questions were structured such that they directly answered the study aim, objectives and its attendant question. The researcher sought the assistance of a retired

registered nurse for the efficient administration of the interview sessions. The assistant is highly knowledgeable in qualitative research and its concomitant data collection processes. Her role was primarily to support the researcher and taking notes, collated later with the researcher's after each session of the interviews.

The interviews were conducted in the outpatient post-natal clinic of Siloam Hospital for those women who could not accommodate the researcher at their homes due to cultural restrictions. The interviews took place in a safe and secured cubicle, with doors closed to prevent any undue intrusions. For those without any such restrictions, the interviews were held at their homes, at scheduled suitable times for them. Natural settings depict uncontrolled, real-life environments of the participant that is not subject to manipulation by the researcher for the study (Grove et al., 2013:277).

Participants, particularly young mothers who were averse to 'hosting' the interviews at their homes, mentioned they were told by their elders (who are caregivers) that neonates and their mothers were not supposed to be in contact with strangers or non-family members. According to this commonly held belief, external forces (i.e. strangers) would cause illnesses to the neonate. Therefore, inviting the researcher to their homes would only cause them trouble with their elders. For those who did not have any restrictions the interviews were conducted at their homes as it was their natural setting.

There was no need for both translation and interpretation during the interviews because communication with the participants was in Tshivenda, home language of the participants, the researcher and her assistant. An audio recorder was used to ensure that the original versions of the interviewees were obtained and retained in an uncontaminated manner (Epstein and Carlin, 2012:899). While other participants agreed to be audio recorded, others volubly expressed their discomfiture and only allowed the use of field notes. Their objections were based on the fact that the subject in discussion was sensitive, and they were not sure whether the researcher would not divulge the audio- recordings to third parties, despite the researcher's assurance and guarantee of confidentiality. Similar to the time taken during the pre-investigative interviews with the four participants, the actual interviews with the selected 18 participants lasted for 30 to 40 minutes per participant.

In some instances, the conversations with the interviewees lasted up to an hour for due to intermittent disruptions such as feeding or changing a soiled nappy of the neonate. The same interview questions were followed for all interviews, with the sequencing altered where necessary according to the particularities of each interview session (Edmonds and Kennedy, 2012:39). Consistent with the "unstructured" nature of this interview mode, the researcher ensured a welcoming, unconstrained and relaxed ambience throughout each 30-40 minute interview session. Accordingly, probing questions facilitated the prompting and encouragement of interviewees to respond as elaborately as possible (Brink et al., 2018:144; Green and Thorogood, 2014:17). For the very knowledgeable participants, there were fewer probing questions than for those whose responses to questions were brief and/or unclear.

2.5.3 Field Notes

Field notes are basically a record of the researcher's thoughts, experiences and observations made during data collection (Botma et al., 2010:217). Participants were notified that the researcher and the research assistant would be taking notes during the interviews. Such notification ensured that any discomfort and suspicions of ulterior intentions by the researcher were eliminated. In addition to the reviewed literature and the individual interviews, field notes were employed in order to triangulate and optimise the generation of data (Polit and Beck, 2012:548). Such triangulation was indispensable, considering that some participants considered some information as 'forbidden territory'. Field notes were also utilised to document all other unrecorded, but pertinent details of the interviews, such as observing the participants' emotional engagement and attitudes during proceedings.

For observational notes, the researcher included a range of factors, such as: the non-verbal communication between participants; the surroundings of the venue (cubicle setting and homes); and the distances travelled between their homes and clinics. For *theoretical* notes, the researcher documented and compared what was seen and heard during the interviews against what was read and studied from the range of consulted literature sources (Yin, 2016:147). For the *methodological* notes, the researcher documented strategies as a constant reminder of the research role during the interviews. For instance, key words such as "reflexivity" "objectivity" and "self-monitoring" were a reminder for reservation and non-imposition of preconceived views

above those of the interviewees. In any event, the study was not about the researcher, but the study participants who were recruited for the purpose of resolving the phenomenon entailed in the research problem.

For the personal aspect of field notes, the researcher documented interview-based feelings, assumptions and emotions (Polit and Beck, 2017:522). Among others, the researcher noted the uncertainty on the type of reception to be received at the participants' homes, as well as fatigue between interview sessions. While the assistant researcher's notes were also useful for comparison purposes, the researcher further realised the importance of mental notes because field note-taking is an elaborate process characterised by a series of contiguous, related and unrelated activities and events occurring either simultaneously or randomly (Jeffries, Phipps and Howard, 2017:3).

2.6 DATA ANALYSIS

Data analysis pertains to a systematic conversion process of original data (raw audio-recorded statements) into thematic and intelligible categories to generate the evidence of the study (Babbie and Mouton, 2010:113; Flick, 2014:36). Based on their relevance to this study, the researcher adopted the following six-step data analysis approach as proposed by Creswell (2009, cited in Botma et al., 2010:223):

- The researcher listened to audio recordings and subsequently transcribed them verbatim, after which they were then translated from Tshivenda to English with the assistance of the researcher's academic supervisors as they speak and understand the language;
- Reading through all the transcribed data to develop and obtain intelligible meaning;
- Coding the data by means of categorising it into segments of similar context and emerging patterns of occurrence;
- Generating themes from the coded data. Four themes, together with nine sub-themes (categories), were generated, described and contextualised within the narrated statements as evidence;
- Discussing both themes and attendant sub-themes as evidenced by participants' abstracts; and
- Data interpretation and discussion with literature support to respond to the research questions and achievement of the study purpose.

2.7 TRUSTWORTHINESS MEASURES

Trustworthiness is the degree of the researcher's confidence in the quality of collected data as reflected in the findings and concomitant research processes and methods (Van Griensven, Moore and Hall, 2014:367). The researcher ensured trustworthiness of the research process by applying the credibility, dependability, confirmability and transferability criteria. Such a framework ensured the overall outcomes of the study as reflecting the participants' true account and version, and not the preferred viewpoints of the researcher (Grove et al., 2013:392; Polit and Beck, 2017:559).

2.7.1 Credibility

Credibility (internal validity in quantitative studies) is the extent or degree of correspondence between research participants' viewpoints and the researchers' representation and reconstruction of the same views (Brink et al., 2018:158; de Vos et al., 2012:419). Accordingly, the prolonged engagement, triangulation and peer debriefing strategies were utilised as measures of ensuring credibility of the findings.

2.7.1.1 Prolonged engagement

Prolonged engagement specifically relates to the extended periods of time the researcher spent with the research participants beyond the normal time allocated for the interviews (Creswell, 2017:124). Such engagement also enabled more time for the researcher to understand their experiences and perspectives of the participants. The researcher further achieved the purpose of prolonged engagement through data saturation in the field, until no new participant responses were obtained (Birt, Scott, Cavers, Campbell and Walter, 2016:1802).

The study was conducted for two weeks. In August 2019, the interviews were held over five successive days. In February 2020, the interviews were held for another five successive days. The reason for the almost six-month 'break' was induced by the researcher's work commitments. The researcher ensured that the length of the interviews was contingent on the data saturation facilitated by probing questions. Some of the participants were revisited during the second week of data collection to corroborate their narrated statements. Some were contacted telephonically to verify their interview-based statements and to confirm the names of the herbs they mentioned.

2.7.1.2 Triangulation

Triangulation is posited as the application of multiple referents for drawing conclusions regarding the truthfulness of the findings (Polit and Beck (2017:563). Meanwhile, Carter et al. (2014:545) posit triangulation as establishing the basis on which to draw comprehensive conclusions about the study. The researcher used space and person triangulation for the credibility of the findings.

2.7.1.2.1 Space triangulation

Space triangulation involves the collection of the same data on a phenomenon from multiple research contexts for consistency cross these sites (Donley and Graueholz, 2012:35; Polit and Beck, 2017:563). Data was collected from different villages within the same district and municipality jurisdiction. For instance, the villages around Nzhelele are approximately 56 kilometres apart from Madombidzha and Magau villages. Such spatial triangulation ensured that the results were as representative of a larger part of Makhado District as possible.

2.7.1.2.2 Person triangulation

Person triangulation involves the collection of data from varying types and levels of people or cases (e.g. individuals and their family members Edmonds and Kenendy, 2012:51; Polit and Beck, 2017:563). Consonant with the study's 'insider' perspective of data collection, different categories of participants who possessed the knowledge and information sought by the researcher (in terms of the sampling inclusion criteria). In this regard, mothers, caregivers, indigenous knowledge holders and a traditional health practitioner were interviewed for exploring and describing their knowledge, perceptions and experiences in terms of indigenous neonatal care tendencies of mothers and caregivers in the Vhembe district. The participants' educational and age distribution was disparate, and so was their knowledge, experience and perception. Hence, the need for involvement of a traditional health practitioner who specialises in neonatal care and indigenous knowledge holders for verification of the collected data.

2.7.1.3 Peer debriefing

Brink et al., (2018:158) and Carter et al. (2014:545) define peer debriefing as the deliberate action of seeking the advice and expert opinions of peers not linked to the study and have the same professional or academic status, and knowledgeable in the field of study in which the investigated phenomena is located. The researcher

submitted the field notes, transcripts and the preliminary research report to an expert on Venda indigenous knowledge systems and research methodology to determine the authenticity and reliability of the findings and the research processes as a whole.

2.7.2 Dependability

Dependability is premised on the extent of repeatability, consistency and stability of research results in the event that the same study is undertaken with different participants in a different context, but under similar conditions as the original site (Brink et al, 2018:159). The researcher instituted an audit trail strategy to document all processes and stages of the study, from its conceptualisation (incubation) to implementation at the three Vhembe District villages. An audit trail is dependable in that it provides a clear, traceable and detailed written account of how the study developed from both the theoretical and practical stages (Brink et al., 2018:159; Carter et al., 2014:546). As such any aspiring researchers in the field of indigenous neonatal care practices would be fully informed of the documented (audited) processes and decisions taken for the actualisation of the various research stages.

2.7.3 Confirmability

Confirmability is premised on the extent of potential congruence from two or more people about the relevance, accuracy or meaning of data (Streubert-Speziale and Carpenter, 2011:351). Additionally, confirmability (objectivity in quantitative research) focuses on the corroboration of data as the true and accurate representation of the participants, and not the researcher's preferred version, imagination, preconceived worldview and value systems concerning the enquiry (Babbie and Mouton, 2010:114). It is by means of the study's confirmability that any possible distortions and exaggerations are obviated (de Vos et al., 2012:114; Polit and Beck, 2012:733). Confirmability was ensured with the utilisation of an audio-recorder for capturing participants' responses in their original and unaltered state. These responses, together with the analysed themes and associated sub-themes, were transcribed verbatim and submitted to the academic supervisor for an independent verification and relevance check. The researcher did not impose her own belief systems during the data interpretation and analysis phase, but gave prominence to the participants' voices (Grove et al., 2013:393).

2.7.4 Transferability

Transferability (external validity in quantitative studies) is described as the findings' applicability to other contexts, with different participants (Brink et al., 2018:159; Polit and Beck, 2017:560). The implication is that knowledge acquired or generated at the original research setting should also be applicable and relevant to other contexts exhibiting similar research dynamics, and researchers who are interested in the investigation of the same phenomenon should enable replication of the concepts of the initial study and reach approximately the same conclusions (Van Griensven et al., 2014:367). Although the study was undertaken at a specific geographic location in a specific municipality area, the study enhanced a modicum of generalisability by selecting villages that were more than 50 kilometres apart. Participants of this study were purposefully selected based on their location/setting and the fact that they cared for neonates before.

2.8 ETHICAL CONSIDERATIONS

Ethical protocols or considerations are based on a system of professional, moral and legal values and principles or obligations to which the researcher has to adhere in her relationship with, and treatment of her research subjects (de Vos et al., 2012:114; Wahyuni, 2012:69). Ethical considerations also regulate the researcher's behaviour with regard to all the organisations or institutions involved directly with the study.

2.8.1 Permission and Approval

Approval was first granted for conducting the study by the University of Pretoria's Research Ethics Committee. Thereafter, formal approval for similar permission was granted by the Limpopo Provincial Department of Health, the District Executive Officer of Vhembe District, the Chief Executive Officer of Siloam Hospital, and the Facility Manager of Madombidzha Clinic. Operational Managers at the hospital and the clinic were notified and given a telephone briefing about the study a week before the beginning of the data gathering phase. Permission for interviewing participants at their homes was also received from the local tribal council office. This was in compliance with the requirement that the local Chiefs should know about all activities taking place in their communities, especially that information about traditional or indigenous knowledge would be shared with an outsider (de Kadt et al., 2014: Etieyibo, 2016). Additional to obtaining permission from relevant institutional authorities, the

researcher also instituted and operationalised the principles of justice, beneficence, as well as respecting human dignity as part of the study's ethics regime.

2.8.2 The Principle of Beneficence

Beneficence entails that participants should not under any circumstances, be directly or indirectly exposed to any form of physical, emotional or psychological distress or harm (Bryman and Bell, 2015:6; Kendall and Halliday, 2014: 307). Human research should produce a situation and environment for the common benefit of participants, other individuals and society (Polit and Beck, 2017:139). The risk of harm to participants ranged from minimal to negligible (virtually non-existent). Instead some of them derived immediate benefit from the research.

2.8.2.1 The right to freedom from harm and discomfort

It is imperative for researchers to minimise and prevent harm in studies that entail human involvement (Polit and Beck, 2017:140). Accordingly, participants were not exposed to either emotional, psychological or physical harm in any way. For instance, the researcher ensured that all interview questions did not offend the participants, given the cultural sensitivity of some aspects of indigenous neonatal practices.

Rather than exposure to harm, participants derived benefit from their involvement in the study. There were those observed to be practising unsafe neonatal care, such as administration of laxatives to neonates. This could cause severe diarrhoea and complicate the neonate's health. These practices were subsequently corrected, and mothers were appropriately advised by the researcher for the benefit of the neonate and the family concerned. Health education was provided to other mothers who were observed to be lacking knowledge concerning safe neonatal care practices. In this regard, the study was not harmful in any way to the participants, the neonates and the community at large.

2.8.2.2 The right to protection from exploitation

This right entails that study participants should not be exposed to any harm, disadvantage and any practices that are inconsistent with the full disclosure of the study purpose (Saldana and Omasta, 2018:192). In this regard, a participant information sheet and informed consent form were issued in English and Tshivenda to respective participants and gatekeepers ahead of the study's undertaking (see Annexures F and G respectively). Amongst others, the annexures provide details of

the expected levels and nature of participation. In addition, participants' age, educational level and socio-economic status were not translated into an exploitable condition by the researcher.

All participants were notified of their right to withdraw from the study if they perceived any violation of any of their rights as articulated in the two annexures mentioned above. Notwithstanding the need for prolonged participant engagements and debriefings (for ensuring trustworthiness), the researcher did not exploit the situation by taking advantage of the participants' voluntary involvement in the study. In fact, the researcher conducted each semi-structured interview session for a period not exceeding sixty minutes, despite instances of the researcher's neonatal healthcare advice (e.g. dangers of laxatives to an infant) to a specific individual mother. Participants were not taken advantage of by using more of their time just because they have already started taking part in the study.

2.8.3 Respect for Human Dignity

This principle entails the fair treatment of participants as juristic persons who have the capacity to make their own (autonomous) decisions (Langford and Young, 2013:69). In a country such as South Africa, a human right culture is guaranteed in the Constitution (Act 108, 1996:8). As such, it is a truism that participants' human dignity was already protected even before they were approached by the researcher.

2.8.3.1 The right to self-determination

This right entails that prospective participants can autonomously and voluntarily choose participate in the study, ask their own questions, refrain from providing information, or withdraw without risk of prejudicial treatment (de Vos et al., 2012:116; Polit and Beck, 2017:140). Accordingly, participants fully volunteered to be involved without any coercion by the researcher. No monetary reward or gifts were promised or given to participants to attract or induce their involvement in the study. One of the participants exercised her self-determination right by objecting to be recorded during the interview her wishes were respected and she was not treated with prejudice.

2.8.3.2 The right to full disclosure

Full disclosure implies all relevant study details and information and participants' rights were provided and explained to ensure their voluntary and autonomous involvement in the study (Polit and Beck, 2017:140). The researcher ensured that all participants

were fully conversant with the contents of the informed consent prior to participation, especially details pertaining to the use of the findings (Almalki, 2016:290). Their consent was formalised by means of their uncoerced signatures.

2.8.4 Justice

The justice principle entails the participants' entitlement to fair treatment and selection (Creswell, 2017:104; Saldana and Omasta, 2018:193). To that extent, the justice principle is already contiguous with respect for the human dignity of participants, since both emphasise on the inviolable right to the dignity of participants as humans; not mere experimental subjects.

2.8.4.1 The right to fair treatment

In ensuring fairness, participants' selection was based on specific requirements of the study, and not on their vulnerability (Polit and Beck, 2017:141). Accordingly, the researcher fairly applied the sampling inclusion and exclusion criteria to ensure that no participant was discriminated against (Brink et al., 2018:30). Those participants who objected to being audio-recorded, continued to be treated fairly and equally. Ineligible participants wishing to be part of the study were cordially provided with reasons for their exclusion.

Furthermore, both the information leaflet and informed consent form ensured participants' awareness of their legal right to recourse. To that extent, the e-mail contact details of the researcher's academic supervisor were provided for participants to report any undue conduct on the part of the researcher.

2.8.4.2 The right to privacy and confidentiality

The principles of privacy and confidentiality entail that the identity, information and human rights of the participants are protected uncompromisingly for the duration of their involvement in the study (Kendall and Halliday, 2014:308). Participant's information, such as their attitudes, beliefs, behaviour and opinions should be gathered with their knowledge and accord (Botma et al., 2010:13; Raman, Nicholls, Ritchie, Razee and Shafiee, 2016a:88). Therefore, they should not be made vulnerable as a direct consequence of their participation in the study. To this end, the researcher did not ask for any interviewee to divulge their names. Coded identifiers

were allocated to their narrated statements during the data analysis process (Almalki, 2016:289).

Field notes were taken with permission of the participants. They were fully aware that the researcher was taking notes of their verbal and non-verbal communication during the interviews. The hospital-based interviews took place in a safe and secured cubicle, with doors closed to prevent any undue intrusions (Kendall and Halliday, 2014: 308).

2.9 SUMMARY

This chapter provided specific focused on the study's research methodology. The chapter also presented a sampling context in terms of which the empirical aspect of the study was brought to fruition. The next chapter discusses the key findings in accordance with the accumulated interview-based data and its thematic analysis.

CHAPTER THREE: DATA PRESENTATION AND ANALYSIS

3.1 INTRODUCTION

The preceding chapter specifically focused on the study's theoretical and pre-investigation aspects in terms of its adopted research design and methodology. The current chapter is a presentation of findings concerning indigenous neonatal care practices of mothers and caregivers in the Vhembe district as outlined in the purpose of the study (see Section 1.4). It is in this specific context that the current chapter transcends the philosophical and the theoretical (Matua and Van Der Wal, 2015:27) by presenting the practical and empirically generated data as also a determinant of the study's achievement of its stated intentions (Fetterman, 2010:11). Using the semi-structured individual interview mode, data was collected at two research settings: the outpatient post-natal clinic of Siloam Hospital and at some of the participants' homes. These participants were mothers, caregivers, traditional health practitioners and indigenous knowledge holders. Their responses are stated verbatim and contextualised in terms of the particular theme they address (De Vos et al., 2012 236).

The study objectives were: To explore and describe the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province in order to identify the safe and unsafe indigenous neonatal care practices of mothers and caregivers and to explore factors contributing to the use of indigenous neonatal care practices by mothers and caregivers.

The main research question was: What are the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province?

Both the study objectives and its associated research question assisted in directing the interviews on relevant aspects of indigenous neonatal care practices. Such relevance was critical in that issues outside of the study's objectives and scope could be identified and discarded (Creswell, 2017:64; Walliman, 2015:39).

3.2 PARTICIPANTS' DEMOGRAPHIC DATA

The participants' demographic data pertains to the same group of participants' characteristics relative to the larger study population. The participants' demographic data is of particular significance for determining the extent of both representatively of

traits, trends or behaviours; and transferability of the findings (Anney, 2014:273; Flick, 2014:41). The study population comprised mothers, indigenous knowledge holders, traditional health practitioners and caregivers. In total, 18 participants were interviewed, 9 of whom were mothers of neonates, 6 were caregivers, 1 a traditional health practitioner, and 2 were indigenous knowledge holders.

Table 3.1 below summarises the participants' demographic data in terms of their age, gravidity, parity, participant's relationship to the neonate, the neonate's age, as well as the educational and employment statuses of the participants. The effect of the differences in ages, employment and educational levels of the study participants provided an opportunity for the researcher to gain knowledge about indigenous neonatal practices from different perspectives. An alphanumeric coding system was used to protect the participants' identities, consonant with the ethical requirement of safeguarding their privacy, confidentiality and autonomy (Creswell, 2017, 128; Van Griensven et al., 2014:369).

The researcher's self-designed coding system encapsulated the participant's number, the research site (whether clinic or home interview). For instance, the first interviewed mother at a clinic would be represented as (P1CM), or (P7HM) for the seventh interviewed mother who was interviewed at home. The caregiver would be represented as (P8HC), to indicate that she was the eighth to be interviewed at home from the list of 18. Meanwhile, (P17HIKH) shows that an indigenous knowledge holder was the 17th participant from the list of 18, and was interviewed from her home. On the other hand, (P18HTHP) represents the traditional health practitioner, who was the last (18th) interviewee, and she participant in a home interview.

Table 3.1 Sample of the demographic information (n=18)

Participant	Age	Gravidity	Parity	Relationship to Neonate	Neonate Age	Educational Level	Employment Status
P1CM	36	5	5	Mother	2 weeks	Matric	Employed
P2CM	25	2	2	Mother	3 weeks	Grade 12	Unemployed
P3CM	26	2	2	Mother	4 weeks	Grade 12	Unemployed
P4CM	35	4	4	Mother	3 weeks	Matric	Employed
P5HM	29	2	2	Mother	1 week	N6	Employed
P6HM	39	3	3	Mother	4 week	Standard 10	Employed
P7HM	22	2	2	Mother	3 weeks	Grade 12	Unemployed
P8HM	40	5	5	mother	2 weeks	Matric	Unemployed
P9HC	59	4	3	Aunt to mother	2 weeks	Standard 2	Unemployed

Participant	Age	Gravidity	Parity	Relationship to Neonate	Neonate Age	Educational Level	Employment Status
P10HM	40	5	5	Mother	4 weeks	College certificate	Employed
P11HC	49	4	4	Mother to mother	3 weeks	Standard 10	Unemployed
P12HC	63	7	8	Grandmother to mother	4 weeks	Grade 1	Pensioner
P13HC	76	5	5	Grandmother to mother	2 weeks	Grade 2	Pensioner
P14HC	45	2	2	Sister to mother	4 weeks	College certificate	Unemployed
P15HC	56	4	4	Mother to mother	3 weeks	Standard 6	Unemployed
P16HIKH	77	4	4	Not related but known to the family		No schooling	Pensioner
P17HIKH	72	7	7	Aunt to mother		No schooling	Pensioner
P18HTHP	37	2	2	Not related but known to the family		College certificate	Unemployed

3.2.1 Participants' Age

The participants' ages ranged between 22 and 77 years. The age range of mothers was 22 to 40 years, which presents an age average of 20 years for these participating mothers. Notwithstanding their age differences, the mothers cared for their neonates as advised by the caregivers who were also family members. Some of them were advised by either an indigenous knowledge holder (IKH) or traditional health practitioner (THP) known to the family.

Caregivers were aged 45-76 years, while the only traditional health practitioner in the study was 37 years, old and the two indigenous knowledge holders were aged 72 and 77 years. Mothers and caregivers mentioned that they were taught how to care for the neonates by their mothers or older female relatives. The younger mothers depended more on the assistance from their elders, the mothers or grandmothers in this study.

3.2.2 Participants' Gravidity and Parity: Mothers

The gravidity and parity of the mothers ranged between two and six. The caregivers were not asked about the number of their children, but on how many they have raised in their lives. Both the mothers and caregivers who raised two or more babies in their

lifetime were confident of their knowledge of indigenous neonatal care practices. First-time mothers lacked knowledge, hence, their exclusion from the study.

3.2.3 Participants' Relationship to Neonates

Both the mothers and the caregivers showed the same level of knowledge regarding indigenous neonatal care. It is common practice in African traditional contexts to have a relative to assist or advice in the care of the neonate. In this regard, it was also noted that the caregivers were related to the neonate either paternally or maternally.

3.2.4 Neonates' Age Distribution

The type of indigenous neonatal care offered to the neonates largely depended on their ages and family circumstances. The ages of the neonates in this study were between one week and four weeks. Type of care and family circumstances are exemplified in the case of pre-lactial feeds being provided on the first day of life and a traditional bath within the first four to five days of the neonate's life; while other rituals such as those of protecting the neonate from illnesses and evil spirits are carried out after two to four weeks of the neonate's life.

3.2.5 Participants' Educational Levels

There was insignificant difference among mothers of low educational status and those with higher educational attainments in the care of neonates. Both groups of mothers followed the same indigenous neonatal care practices and principles as taught by their elders. This is similar to the practice by Native American women in the study by Cousik and Hickey (2016:434) referred to earlier. The women in this study were well-educated, possessing either a Bachelor's, Master's or higher degree, but were not reluctant to practice indigenous neonatal care as advised by their elders. Contrastingly, the caregivers and the indigenous knowledge holders only had primary school education, while the traditional health practitioner had a college certificate.

3.2.6 Participants' Employment Status

Both the employed and unemployed participants adhered to indigenous neonatal care practices. However, the employment status of mothers and caregivers had an impact on the timing of the performance of protection and illness prevention rituals that the neonate should undergo. Due to work obligations, neonates of employed mothers had to perform the rituals earlier than the unemployed mothers who had more time at home and were unconstrained by any employment obligation.

3.3 FINDINGS: INDIGENOUS NEONATAL CARE PRACTICES

The findings of the study accrue from the data analysis process proposed by Creswell (2009 cited in Botma et al., 2010:223) (see Section 2.6 of this study). After careful review of the transcripts, the results were categorised into themes and sub-themes. Table 3.2 (next page) is a synoptic depiction of the findings presented according to the frequency/ pattern of their emergence or occurrence during the data analysis process (Edmonds and Kennedy, 2012:57).

Table 3.2: Summary of themes and sub-themes

Themes	Sub-themes
1. Indigenous neonatal feeding practices	- Feeding of *ntswu* to neonates (mixture of boiled water and indigenous herbs) - *Feeding madi a ngwedi* (water kept in a container with a river stone inside) - Provision of plain drinking water to the neonate - Feeding of *khongodoli* to neonates (fine, watery soft porridge made from brown maize meal and some indigenous herbs)
2. Indigenous neonatal bathing practices	- Neonate bathing using *gumululo/swandzo* (bath water mixed with indigenous herbs) - Body massages and application of animal fat / oil
3. Protection of the neonate	- Performance of *mithuso* ritual to protect the neonate from goni , ngoma (anterior fontanelle) and mirundzi ya vhathu (evil spirits carried by people) - Protection from illnesses and infections (such as: tshilala, colds and flu, eye infections and umbilical cord infections) - *Promotion of environmental hygiene/ cleanliness of the surroundings to prevent illnesses* - Protection from environmental and external harm (namely: prevention of falls and prevention of convulsions (zwa thavha)
4. Contributory factors for using indigenous neonatal care practices	Adherence to cultural indigenous family practices.

Table 3.2 above reflects 4 main or global themes and 11 sub-themes that emerged from the synthesised and systematically analysed data. In the ensuing sections of this chapter, italicised excerpts of participants' statements are cited for purposes of authenticity and support of the specific finding being referred to in each case. Such an orientation also the authenticity, veracity and accuracy of the findings as reflective of

the participants' contribution, and not the researcher's own preferred version or beliefs about indigenous neonatal practices (Creswell, 2017:105).

3.3.1 THEME 1: INDIGENOUS NEONATAL FEEDING PRACTICES

Table 3.3 below represents the theme of indigenous neonatal feeding practices and its attendant sub-themes (categories).

Table 3.3: Theme 1: Indigenous neonatal feeding practices

Themes	Sub-themes
Indigenous neonatal feeding practices	- Feeding of *ntswu* to neonates (mixture of boiled water and indigenous herbs) - *Feeding madi a ngwedi* (water kept in a container with a river stone inside) - Provision of plain drinking water to the neonate - Feeding of *khongodoli* to neonates (fine, watery soft porridge made from brown maize meal and some indigenous herbs)

Participants shared almost the same views concerning indigenous neonatal feeding practices. Most of them believed that the neonate should eat and drink enough to maintain its wellbeing. Mothers and caregivers supplemented the feeding within the first week of life, based on their belief that the neonate's stomach needed to be full and not allow hunger. They alluded that a hungry neonate will often cry and not sleep peacefully, which may eventually lead to ill health. It was vital for participants to ensure that the neonate was not hungry, because it was easy to tell when the baby was crying due to other reasons not related to hunger. Different types of feeds were mentioned by the mothers, which are *ntswu, madi a ngwedi*, plain water and *khongodoli.*

3.3.1.1 Feeding of ntswu to neonates

'Ntswu' is a mixture of boiled water and indigenous herbs. Some participants reported the importance for the neonate to eat or drink in the very early days of life. During this stage, the mother does not produce enough milk. It is then imperative for mothers to provide liquid supplementary feeds to sustain the nutritional needs of the neonate. *Ntswu* and *madi a ngwedi* were mentioned as two of the most preferred methods of liquid supplementary feeds. *Ngwedi* is a stone found in the river. *Ntswu* is made from three traditional herbs: *mugwiti* (combretam molle sond), *mudzidzi* (artabotrys monteiroae oliv*) and Musehze (cussonia spicata thunb)* (Mabogo, 2012:80, 55, 59).

The three herbs are boiled together in a water-filled pot, cooled down and kept in a container. The neonate should be fed with this liquid mixture from five days to six months after birth while the mother is also breast-feeding. The efficacy and use of *ntswu* in its liquid form is based on the culturally-steeped belief that it does not cause constipation. Some of the participants explained the meaning and purpose of using *ntswu*. In this regard, the perspectives of ***P11HC and P13HC*** were captured respectively as indicated below.

"Neonates are born hungry. Their stomach is empty and full of wind. If the mother does not eat good food during pregnancy, the fetus does not get enough food as well. The neonates should be fed after bathing to prevent crying. When the neonate is fed early, it give the new mother the time to rest after delivery, as she is exhausted. Giving birth is hard work. The neonate is given prepared ntswu within days of birth." (***P11HC)***

*"It is important to give ntswu, the mother's breastmilk is not enough, and besides, Ntswu helps with the prevention of Tshilala (frequent reflux that could develop due to vomiting accompanied by stomach winds and cramps) and diarrhoea. Babies who are breastfed and not given this mixture struggle with regurgitation and the green stools do not come out completely and that my child will cause the baby to be sick." (**P13HC)***

Participants were also asked about the frequency and dosage when administering *ntswu,* to which they mentioned:

"Three times a day, in the morning, afternoon and in the evening. You do not have to give too much. You can't give a whole cup a few tablespoons is enough, and in between the mother should give the breast." **(*P16HIKH)***

3.3.1.2 Feeding madi a ngwedi to neonates

Ngwedi is the name of a particular stone found in the river. The caregiver or an indigenous knowledge holder takes the stone from the river, puts it in a container of clean water, and keeps it there. The neonate should drink this water regularly for a period of three days. It is important to ensure that the neonate drinks *ngwedi* water for strictly three days to avoid complications such as gaining excessive weight.

Participants reported that *ngwedi* water assists with weight gain and general wellbeing of the neonate. One participant expressed this as follows:

"I give madi a ngwedi to assist the baby to gain weight, but we give it for only 3 days because we are afraid that the baby will gain too much weight. It also helps to make the neonate's general health stronger." (***P18HTHP)***

3.3.1.3 Provision of plain drinking water to the neonate

Participants further reported that they were giving plain water to the neonate to prevent thirst and dehydration. A mother who gave water to the neonate using a baby bottle was asked about this practice, and she averred:

"My mother said that if I do not give water the baby would be thirsty and begin to be a crying child." (***P3CM)***

P7HM supported her, adding:

"Water is healthy, and it helps to flush out the green stools, which causes cramps so if I give water my baby is free from cramps and will grow well." ***(P7HM)***

P3CM alluded that the nurses in the hospital told her not to give water to the neonate because breastmilk already contains water. She 'defied' the advice in preference of the advice she received from her elders. She recounted her belief thus:

"I was advised at home that I should make sure that my baby is not hungry or thirsty and I should make sure that the baby feeds enough on the breast. I give baby water as well if the baby has had enough breast milk." ***(P3CM)***

P3CM was supported by another mother ***(P1CM)*** who continued to feed the neonate in the same manner regardless of the exclusive breast-feeding health information received at the clinic:

"He [neonate] *gets thirsty he will lose water because his stools are also loose Yes, the nurses here do tell us that we do not have to give water, but I do not believe it because I gave all my babies water and they grew up fine."* **(*P1CM)***

3.3.1.4 Feeding khongodoli to the neonate

Khongodoli is a very watery soft porridge mixed with a herb called *munengeledzi* (*salix mucronata thunb*) (Mabogo, 2012:127). The elders give *khongodoli* to the neonate in the first few days of life. It is prepared using very fine brown *(mabele)* maize meal and water. The porridge must be very watery so that the neonate is able to drink and swallow. It is believed that the soft porridge helps to prevent dehydration in the event the neonate contracts diarrhoea. It also assists with weight gain.

Some participants mentioned that their culture prohibits the feeding of the first milk (colostrum) to the neonate. They believe that colostrum is 'stale' milk as it has been in the breast since conception, and that the colour is not as white as milk should be; therefore not safe to neonate feeding.

Mothers are encouraged to eat warm food, especially liquids to assist with milk production. The milk that is considered fresh can come out immediately, or normally after 12 hours of birth. The mother is then encouraged to apply warm compress using a warm face towel and express the colostrum to prevent breast engorgement. The participants mentioned that they fed *khongodoli* to the neonate while awaiting the mother to produce more of the fresh milk. Therefore, *khongodoli* ensures that the neonate does not go hungry and starts crying. Those who opt to feed *ntswu* to the neonate do not feed *khongodoli* because the two cannot be administered at the same time. Caregivers and indigenous knowledge holders in particular, provided reasons for their preference of *khongodoli* as follows:

"Remember you cannot give the baby the breast milk on the same day that it (the baby) was born. The milk is not that fresh and white it is a bit slippery and yellow it needs to come out so that the baby can get fresh milk. In the meantime, while we are waiting for the milk to come we need to make sure that the baby is eating, that is where Khongodoli comes in, if you don't feed the baby it will not sleep the baby will be crying throughout because of hunger. But you will notice that after feeding khongodoli baby will calm down and sleep." ***(P18HTHP)***

Participants mentioned that feeding was the most important part of caring for the neonate. The researcher noted that all participants were aware of exclusive breast-feeding, but were not confident that the neonate could survive on breast milk only.

Their feeding practices were not for hunger satisfaction purposes only, but for protection against illnesses and promotion of health as well.

3.3.2 THEME 2: INDIGENOUS NEONATAL BATHING PRACTICES

Table 3.4 below is a representation of the theme of neonatal bathing practices.

Table 3.4: Indigenous neonatal bathing practices

Themes	Sub-themes
Indigenous neonatal bathing practices	- Neonate bathing using *gumululo/swandzo* (bath water mixed with indigenous herbs) - Body massages and application of animal fat/ oil

Indigenous neonatal bathing and hygiene practices emerged when the mothers and the caregivers were asked to describe their ways of meeting the daily hygienic needs of the neonates. Two sub-themes emerged, namely: neonate bathing using *swandzo*/ *gumululo,* body massages, and application of animal fat/ oil.

3.3.2.1 Neonate bathing using gumululo/swandzo

Baby bath is amongst the important activities in neonatal care for both mothers and caregivers. The bath is referred to as *gumululo* or *swandzo*. Three herbs are boiled in water and put in the bath water. Only two herbs were revealed to the researcher which are: *musenhze* (cussonia spicata thunb) and *tshisesana* or *gumululo (elephantorrhiza elephantine (burch) skeels).* Culturally, vernix was viewed as a sign of residue from sperm and should be removed as soon as the neonate arrived home from the hospital. Apart from bathing the neonate for hygienic purposes, participants mentioned that in their culture, a neonate should receive a special bath for protection during the first three days of life. Subsequently, the neonate is bathed with plain water and soap. The bathing concoction is made from water mixed with some traditional herbs derived from plant roots. No soap is used with the bath, the purpose of which is to strengthen the neonate, weight gain and protection from evil spirits.

This bath also helps the neonate to withstand the presence of other neonates and toddlers around him/her who have been to *Vhomaine* (indigenous traditional practitioner) for *mithuso* already. It is believed that a neonate who has not been to Vhomaine will be ill when meeting other neonates who have been through *mithuso*. It was reported that it was also necessary to make the neonate drink some of the bath

water after bathing in order to strengthen the effect of *gumululo* or *swandzo*. ***P17HIKH*** expressed the following when asked about this practice:

"Gumululo is a special bath that we give to the babies in the first 3 to 4 days of life. We do not use soap in the early days of life. We mix three traditional medicine with water and boil it, that mixture is then put in the bath water to bath the baby." **(*P17HIKH)***

The same participant was asked to explain the traditional herbs used for gumululo she revealed thus:

"Aah! My child, now you want me to reveal the herbs I use? We use musenhze and *tshisesana/gumululo. There is a third herb we use which it is so scarce this days. Some of the woman I work with get it in their villages, but here it is scares so I no longer use it. The two are still effective."* **(*P17HIKH)***

Another participant intimated as follows:

"This kind of bath helps to make the baby strong, protect the baby from mirunzi ya vhathu (evil spirits carried by people with bad intentions) and it also helps the baby to gain weight. Isn't it the baby will be weak if it meets with other babies who went through mithuso if we do not do this? To complete the bath and make it effective for protection we need to make the baby drink a little bit of the water after bathing." (***P16HIKH***)

3.3.2.2 Body massages and application of animal fat/ oil

Several participants mentioned that the practice of neonatal body massages was intended to help the baby relax, to sooth the baby from stomach cramps, and helping the baby burb after breastfeeding, as well as maintaining the neonate's warmth. Different substances are used for body massages, from petroleum jelly to pork oil. On the other hand, some participants viewed baby massages as a method of protecting the neonate from harm and evil spirits. One mother agreed with these views, and stated:

"I also massage him on the back to prevent stomach cramps." ***(P1CM)***

She was supported in her views by another participant, who mentioning that:

"Oh, I forgot to mention that I also massage the baby on the back after a feed but not too much pressure to help him burb. After a bath I put him on the bed and massage his body. My mother said it helps with relaxing the baby and helps baby to sleep." ***(P4CM)***

The practice of pork oil neonatal massage was further attested thus:

*"In our days we used to smear the baby with pork oil all over the body after a bath, especial for the pre-mature babies. This was because the small baby cannot make her own body warm, so we made sure that the baby is warm by smearing the pork oil all over the body. Pork oil is very effective in chasing away evil spirits and protect the baby from mirundzi." (****P16HIKH)***

One of the indigenous knowledge holders mentioned that the pork oil body massage was also used to maintain the warm body temperature for neonates because they are fragile and easily catch cold. As such, she still recommends the practice to other mothers today for protection from evil spirits.

She indicated thus:
"Our youth today do not like visiting Vhomaine, so their babies are vulnerable to evil spirits. I normally recommend the use of pork oil to young women I know, especially the ones who believe in church just to protect the baby you see. Because the pork oil does not smell nice I advise them to use small amounts to rub on the body where the baby will be covered in clothes to disguise the smell." ***(P17HIKH)***

Similar to feeding practices, bathing is not singularly for hygienic purposes. It is also implemented for other purposes such as protection from *mirundzi ya vhathu* (evil spirits carried by people), *mutsiko* (general wellbeing), relaxation and warmth. It is a practice that participants respect and hold with pride.

3.3.3 THEME 3: PROTECTION OF THE NEONATE

Table 3.5 below is an illustration of the theme of protection of the neonates and its attendant sub-themes.

Table 3.5: Protection of the neonate

Themes	Sub-themes
Protection of the neonate	- Performance of *mithuso* ritual to protect the neonate from goni , ngoma (anterior fontanelle) and mirundzi ya vhathu (evil spirits carried by people) - Protection from illnesses and infections (such as: tshilala, colds and flu, eye infections and umbilical cord infections) - *Promotion of environmental hygiene/ cleanliness of the surroundings to prevent illnesses* - Protection from environmental and external harm (namely: prevention of falls and prevention of convulsions (zwa thavha)

This study revealed that mothers and caregivers cared for the neonates in a manner that seeks to protect them from both traditionally known natural and unnatural neonatal illnesses that sometimes cause death. Similarly, they also seek to protect the neonate from developing common illnesses and infections that are known to the Western biomedical system. Four sub-themes emerged in this regard. The sub-themes relate to performance of *mithuso ritual*, protection from illnesses and infections, promotion of environmental hygiene and protection from environmental and external harm.

3.3.3.1 Performance of *mithuso* ritual

To the mothers and caregivers, it was found necessary to protect the neonates at all times by observing certain cultural protocols in order to ensure optimum protection and good health. The sub-theme performance of the "*mithuso*" ritual emerged when participants mentioned the need for neonates to be protected from illnesses that were either unknown or misunderstood in the Western biomedical system. They mentioned further that death could be caused by illnesses that were unknown to Western medicine, such as *goni*, *ngoma* (anterior fontanelle) and mirundzi ya vhathu (evil spirits carried by people).

The purpose of the *mithuso* ritual is to protect the neonate from natural and unnatural illnesses, as well as from environmental and external harm. In this regard, families consult a traditional health practitioner or an indigenous knowledge holder for performance of *mithuso* ritual, in terms of which the neonates are protected from specific conditions such as: *goni, ngoma* and *mirundzi ya vhathu* (evil spirits carried

by people). During the *mithuso,* the indigenous knowledge holders or the traditional health practitioners use different types of herbs and traditional medicines. Some of them are boiled in water for the neonate to drink. Others are powdered to mix with the neonate's food, smeared on the body, or burnt and used as smoke inhalations. The traditional medication used could be plant roots or leaves; animal fat, skin, or dung; or amulets for the neonate to wear on the wrist or waist.

The timing of performing the *mithuso* ritual depends on the circumstances and preference of the mother or caregiver. Most participants mentioned that the ritual should be performed as early as two weeks after the neonate's birth.

On the other hand, some of the participants intimated that it should be performed after three months, because that is the period during which the neonate is ready to be taken out of house isolation to meet other people. The researcher noticed that neonates of working mothers had to go through *mithuso* earlier in life than those of unemployed mothers, who waited for a month or three before they could take the neonate for *mithuso*. The reason for employed mothers to perform the ritual earlier was for the neonate to be exposed to people earlier in life, than those of unemployed mothers. Other mothers mentioned that they left the neonate with a non-family caregiver, or took the neonate to a day-care centre. For that reason, it is necessary for the ritual to be performed earlier. One caregiver was asked about the timing of *mithuso,* and she stated:

"When the baby is four weeks now she is still small, normally I will take all my grandchildren when they are three months old but now because the mother has to go back to work and they are taken to the clinic for the injections it becomes very difficult to wait until baby is three months old. If we wait, the baby might get illnesses and because people out there perform different rituals for themselves when baby meets them, she will get sick." (***P13HC***)

3.3.3.1.1 Prevention of goni

Goni or *rigoni* was another concern for mothers and caregivers. According to the participants, including the indigenous neonatal holders and the traditional health practitioners*, goni* is a sexually transmitted infection from the mother to the neonate. The infection presents with a red mark seen on the occiput of the neonate, sometimes running down the neck and the back. It is a serious neonatal illness that needs both

the mothers and the caregivers to be always vigilant. Participants mentioned that parent and grandparent of a neonate ought to ensure the neonate's protection against the illness. They pointed out further that the neonate should be assessed after a few days of birth for signs of *goni.*

The participants were certain that this dangerous illness was amongst those illnesses that were still not understood in Western biomedicine, and that only a traditional health practitioner or indigenous knowledge holder could treat this deadly illness. One participant even mentioned that she knew of neonates who died very early due to *goni*. Those who survive have a sick appearance and struggle to gain weight due to *goni,* their parents do not believe in traditional medicine, and did not consult with traditional health practitioners. ***P7HM*** explained the situation thus:

"Goni kills babies, I know of babies who died because of goni. I will not risk my baby's life by not taking her to be checked for goni." ***(P7HM)***

Another mother supported (P7HM) and stated:
"Goni is a deadly illness that attacks babies if the baby has it cannot survive if you do not get it treated, and the doctors cannot heal it." **(*P1CM)***

Another participant elaborated:
"Goni is the sickness that attacks the babies, my baby was checked for it and they found that she does have it. There is a big red mark at the back of her head that runs down to the neck. So, we have an appointment with the healer tomorrow. So, I am worried because I don't know what they are going to do to my baby." **(*P4CM)***

A mother of four said it was her responsibility to protect her children in a culturally prescribed manner using indigenous practices. She explained:

"This are the things we were raised with, we grew up like this. Look, this is my fourth child and I have protected all children in this fashion none of them have ever been admitted to a hospital because of childhood illnesses. I have to protect my children from evil spirits and illnesses, especially goni children are dying due to this thing we can't ignore and pretend as if these things are not there." ***(P5HM)***

3.3.3.1.2 Prevention of ngoma

Ngoma is a Tshivenda name for anterior fontanelle. A wide or sunken anterior fontanelle is viewed as a sign of illness. Accordingly, a neonate presenting with a wide or sunken fontanelle with a fast pulsation is a cause for immediate treatment. Diarrhoea and dehydration are the most commonly identified causes of *ngoma*. A concoction of different traditional herbs is boiled for the neonate to drink until such time that the fontanelle appears to be normal or stops to pulsating. Another method for healing *ngoma* involves mixing powdered herbs with animal fat, and smear the substance on the fontanelle. The indigenous knowledge holder and the traditional health practitioner who took part in this study did not want to reveal the herbal names used in the *ngoma* treatment. Some indigenous knowledge holders and traditional health practitioners perform this ritual during the *mithuso* ritual. The practice of preventing *ngoma* is not common. It is mostly used when the neonate presents with signs and symptoms of an unhealthy *ngoma*.

A caregiver mentioned this about *ngoma*:

"Ngoma you cannot treat before, the baby will have to present with symptoms. For you to tell that the baby is suffering from ngoma, the vomiting and the type of stools the neonate will have will be the one telling you that the baby is struggling with ngoma and the baby will be losing weight, the eyes and the fontanelle will appear sunken." **(*P13HC*)**

A caregiver who is also an indigenous knowledge holder reiterated:

"…… with goni we check and see before the baby can be physically ill we see the marks, with ngoma the diarrhoea is there already that is the reason most babies with this ngoma don't make it if they are not treated fast, it is eating them fast from the inside." ***(P17HIKH)***

3.3.3.1.3 Protection from evil spirits (mirundzi)

It is widely believed that evil spirits from other people can easily attack a neonate who is exposed to strangers. It is common practice in traditional contexts to isolate the neonate from people by observing certain protocols and rituals early in the life of the neonate to protect him/ her from attacks by evil spirits carried by other people who may cause *mirundzi ya vhathu*. As such participants believed that the neonate needed

to be isolated from the rest of the family and other people except the mother and the designated caregiver. In such instances, it was believed that the neonate should remain isolated from people other than the mother and the caregiver until the *mithuso* ritual is performed.

Isolation was practiced differently in different families. Some families were stricter than others. In stricter households, the researcher could not gain access to the room in which the mother and the neonate were isolated from other people. In this regard, the caregiver came to the researcher and spoke on behalf of the mother in the living area of the house. This was to protect the neonate from *mirundzi* ya *vhathu*, which is explained as evil or unclean sprits that other people might carry with them. Some women did not even grant the researcher an opportunity of a home visit, preferring to be interviewed at the clinic only.

Participants also mentioned that parents of the neonate were not supposed to be intimate or engage in any sexual act during the isolation period. It is believed that such intimacy would expose the neonate to ill health and an inability to gain weight. For those women who had to leave the house with the neonate before three months after birth, the family had to perform some rituals for the neonate. Some families consult a traditional health practitioner or an indigenous knowledge holder for the performance of such a ritual. Participants explained the neonate isolation practice as follows:

"My baby and me we stay in my mother's bedroom, we do not share other rooms with anyone we are always in the bedroom." ***(P3CM)***

*"Because in our culture a small baby cannot sit with other family members, we are afraid of mirundzi. The baby might be very sick if many people enter the room where the baby is in, some people even use muthi or perform rituals that can be very heavy for the baby and make the baby sick." (****P3CM****)*

"Whenever we go to the clinic with the baby we make sure that we prepare smoke inhalation for the baby so that the people do not overcome her on the road and at the clinic." ***(P3CM)***

Participant *P3CM* and *P9HC* mentioned the following with regard to isolation and abstinence from sexual intimacy:

"Whenever we go to the clinic with the baby we make sure that we prepare smoke inhalation for the baby so that the people do not overcome her on the road and at the clinic." ***(P3CM)***

"My grandmother gets it from the traditional healer who helps children with Mithuso." ***(P3CM)***

Some parents are not allowed to be intimate for about three months, in order to ensure the neonate's growth and weight gain. One of the caregivers mentioned that it is taboo to be intimate while the neonate is still small. She explained thus:

"….Yes, he does but they are not supposed to be intimate in any way when the baby is small." ***(P9HC)***

"It is because the baby will not be healthy and will not gain weight he will look like a baby that does not eat if we do that. We abstain for at least three months for the sake of the baby's health." **(P9HC)**

3.3.3.2 Protection from illnesses and infections

All the participants mentioned that a neonate is vulnerable to various dangerous illnesses and death, which necessitated a special way of treatment and handling. Thus, it is the responsibility of the mother, caregiver and all members of the family to protect the neonate from any form of illness. All family members have a role to play and rules to follow to ensure the neonate's protection against illnesses such as simple colds and flu, to more complex infections.

3.3.3.2.1 Prevention of tshilala

Most mothers and caregivers raised their concerns with *tshilala*, an illness which presents as frequent reflux that could develop to vomiting accompanied by colic stomach winds and cramps. However, they mentioned that *tshilala* was not fatal, but renders the neonate very uncomfortable to a point of crying. It was for that reason they ought prevent or treat the *tshilala*. Most of the participants indicated that they did not rely on Western biomedicine for its prevention or treatment. They relied strongly on their indigenous prevention systems by using a herb called *munengeledzi (salix*

mucronata thunb), which is mainly tree leaves boiled in water and fed to the neonate three times a day with a tablespoon. Those who are using *ntswu* do not use the *munengeledzi* herb because *ntswu* also helps with *tshilala*.

One of the indigenous knowledge holders mentioned the efficacy of *tshilala* thus:

"Tshilala can be prevented by giving ntswu, if you do that the baby will not have it. But if you did not give the baby starts regurgitating frequently then you will know that the baby has tshilala. It should not be left untreated because it also indicates that the baby has a lot of the green poop inside the stomach hence it will be having cramps in the stomach and not sleeping at night." **(P17HIKH)**

3.3.3.2.2 Protection from colds and flu

The mothers and caregivers ensured thermal care for protection from colds and flu by keeping the neonate warm at all times, even during bath times. They indicated that they bathed the baby once daily, to ensure that the neonate does not catch the cold. Only a small number of mothers mentioned that they bathed the neonate twice daily, mornings and evenings. They stated that it was hot during the day, and the neonate would sweat a lot during the day. It was for that reason in particular, that an evening bath was preferred for the neonate's comfort and restful sleep. It was evident that the number of times to bath the neonate is different from person to person, as demonstrated in the following statements:

"Our bath time is not in the morning or night; we bath the baby in the midday it is warm enough the baby will not catch a cold." **(P15HC)**

One mother stated:
"I bath my baby during the day with warm water I make sure that the room is also warm, and I don't expose him for too long I don't want him to catch a cold." **(P1CM)**

A caregiver also supported the practice of thermal care, and mentioned:
"I bath my grandchild first thing in the morning just after I have taken my bath, I then bath the baby. I normally switch on the heater before even preparing the water to make sure that the room is warm its bad to bath baby in a cold area because baby will catch a cold." **(P12HC)**

Swaddling appeared to be a common practice amongst participants. They intimated that swaddling is effective in keeping the neonate warm, especially those born prematurely. This was because the neonate's hands are somewhat restricted and not able to uncover or disentangle himself/herself from the blankets. An indigenous knowledge holder stated:

"For a baby who came before time we wrap that baby with two or three blankets to maintain a warm body temperature, we also ensure that the room is warm and steamy by putting hot water inside the buckets and put it on the sides of the bed. That way you know that the room is warm enough." **(*P17HIKH*)**

3.3.3.2.3 Prevention of eye infections

When participants were asked about their daily care of the neonate, it emerged that they were also concerned and worried with the possibility of the neonate contracting eye infections. They felt obliged to prevent such occurrences, such as in the prevention and treatment of other natural and unnatural illnesses. They did not take the neonate to the healthcare facility to be assessed for eye infections. Rather, they relied on their own indigenous neonatal care practices and knowledge. A number of participants reported that they used the mother's breastmilk in the eyes of the neonate after a bath or in the event that the neonate woke up with a lot of mucus around the eyes.

Eye care is as important as caring for the umbilical cord. Some participants mentioned that they perform eye care every time during a bath, or when the neonate wakes up in the morning, dependent on the mother's and caregiver's choices. Participants pointed out that they must instil breast milk on the neonate's eyes to clean them. This practice helps to clear the eyes from infections of the eye that the neonate might have.

One of the mothers who adhered to this practice explained:
"Normally, in the mornings when we wake up if baby has a lot of mucus on the eyes I wipe it off using a cotton wool and breastmilk, I spray the milk on the eyes and wipe it off with the cotton wool." **(*P4CM*)**

Another proponent averred:

"Breastmilk assist in prevention of infection of the eyes, we do not use anything else eye medication from the clinic is too strong, but the breastmilk is ok because there are no chemicals in it." **(*P8HM*)**

Another mother supporting this practice said:

"For the eyes I spray him with my breast milk on both eyes and wipe with cotton wool." ***(P1CM)***

"It helps with the eye mucus and the snots I have been using it since my first child my mother taught me these things it is our culture." ***(P1CM)***

3.3.3.2.4 Prevention of umbilical cord infections

Participants mentioned that they care for the cord as soon as the neonate arrives at home, and cord care is a procedure carried out after bathing the neonate. Mothers revealed that they are aware that they should be using surgical spirit to clean the cord with surgical spirit and cotton wool as per the health care professionals' advice. However, they are reluctant to do that because they have a unique way of caring for the cord that promotes fast drying and detachment. Some of the mothers and caregivers mentioned that they apply oil extracted from pork on the cord.

Participants explained that they used pork oil because it helps the cord to detach fast and it is what they used for all the neonates in the family and nothing wrong had happened, hence they do not think it is necessary to change a practice that is working perfectly well. They further explained that after the cord has fallen they take *tshidongo* (a piece of a broken clay pot) and grind it into powder mix it with pork oil, and smear on the umbilicus this promote complete closure of the skin. Some participants also pointed out that they first tried to use the surgical spirit which was very slow in detaching the cord, then later resorted to using the pork oil as it was used before with other babies in the family and it is known to work fast.

Participants who used pork oil had the following to say:

"*The cord has now fallen off, but I used the pork fat for the first two days which helped it to dry quickly and fall and later I started using the surgical spirit to clean the area where there was the cord*" **P11HC**

"*I know pork oil works it dries the cord fast and it falls off in no time I have always done it with my other babies it works very well*." ***(P7HM)***

Another participants was asked how she gets the oil she expressed as follows:
"*I buy fresh pork meat and put it in a pan without water and cook it to extract the oil. The meat you have to choose the one with the fat so that you get enough oil out of it"* **(P10HM)**

A caregiver who is taking care of her grandchild (mother is a teenager) confirmed the practice when she explained her cord care practice:

"*I started by buying the surgical spirit because she insisted that at the clinic they said so. So, I did that, but it took long for the cord to dry up and fall off I was afraid it will rot and create a wound which is what we want to avoid. Then I decided to use pork oil to treat the cord. I started on Wednesday during the day, on Thursday morning it was off*." **(P11HC)**

"*I cook pork without spices or salt when the oil starts coming from the meat I then take the oil and put it in clean container and close it tight we use that oil on daily basis"* **(P11HC)**

One mother also indicated that she knows she is supposed to use the surgical spirit for cord care but never used it because it did not work for her sister's child. This is how she expressed herself when asked about her cord care practices:

"*I used pork oil, I also know that we are supposed to use the white spirit but honesty it does not work it takes too long for the cord to fall. My sister tried it on her second born child it did not work it took about seven days to fall and there was a wound that was so stubborn to heal thereafter. So, I am not going to take chances*." **(P8HM)**

3.3.3.3 *Promotion of environmental hygiene/ cleanliness of the surroundings to prevent illnesses*

A hygienic environment is considered a crucial factor in preventing neonatal illnesses and infections. Mothers and caregivers intimated that it was important to clean the neonate's room to prevent germ infestation, which could cause sickness to the neonate. Participants in the study had the same view concerning environmental hygiene. Participants *P4CM*, *P1CM*, *P9HC* and *P10HM* mentioned the following about the state of cleanliness of the neonate's room:

"Well I stay in my bedroom with the baby, I always keep the room warm and very clean to prevent germs." ***(P4CM)***

"The place where I keep the baby should always be clean and warm, it helps with preventing germs that can make the baby sick." ***(P1CM)***

"I make sure that the room is clean the baby cannot stay in a dirty room." ***(P9HC)***

"The room where I keep the baby is always clean my mother-in-law comes and clean the room because now I am not as strong; I am still healing so she is helping me." ***(P10HM)***

All participants, including those who were interviewed at home, considered hand washing a common practice every time after using the toilet or changing a nappy. Some of these mothers went as far as wiping off their breasts with a clean and wet face cloth before breast-feeding the neonate. The following excerpts by the participants confirm the views expressed above in relation to the grandmothers' teachings.

"I wash my hands after each nappy change to prevent illnesses." ***(P7HM)***

"I make sure that I always wash my hands after I uses the toilet or after I have changed the nappy." ***(P9HC)***

Another participant interviewed at the post-natal clinic supported the statement above, and stated:

"I wash my hands to prevent germs that will cause infections and illnesses as I was advised by my elders, my grandmother said dirty hands and a sweaty breast can cause the baby to have sores in the mouth and have a runny tummy." ***(P2CM)***

3.3.3.4 Protection from environmental and external harm

Safety considerations proved were important factors in the life of the neonate. All participants explained how they ensured the neonate's safety through interventions such as protecting the neonate from harmful events such as falls, aspiration, prevention of fear of thunder and fainting (convulsions) when the neonate hears the sounds of baboons (*zwa thavha*) from the mountains or forests.

3.3.3.4.1 Prevention from falls

Participants mentioned that they were taught to always ensure that the neonate sleeps in the middle of the bed rather than on side or at the tip of the bed to prevent falls. Mothers and caregivers shared the same view that the fall of a neonate precipitates the possibility of the neonate hitting the floor with the head, which could lead to mental and intellectual disturbances as the neonate grows. A mother was asked how she prevents falls, and she responded as follows:

"I make sure that I do not make him sleep in the tip of the bed, they fall these ones." ***(P1CM)***

Another participant was asked whether she shared a bed with the neonate, and how she ensured safety of the neonate. She explained:

"Yes, I do! She is still too small those things of babies sleeping in the cots or in separate rooms are for white people (laughing). Since my first child I was taught that I should sleep with my baby in the same bed to make sure the baby is still breathing how will you see that if baby is sleeping elsewhere? You will wake up in the morning with a corpse these little ones can just stop breathing. It is better now, with my first child I was assisted by my grandmother she has passed on now, she refused that I sleep on the bed with baby we slept on the floor she said it is very safe because there is no way the baby can fall." ***(P5HM)***

3.3.3.4.2 Prevention of zwa thavha

All the indigenous knowledge holders and traditional health practitioners viewed the neonate as having the natural capacity to sense events taking place around his/ her

environment. They mentioned that an environment that is afflicted with *mirundzi ya vhathu* (evil spirits carried by people), other events taking place in the environment, such as sounds of animals and thunder, can affect the neonate negatively. When *mithuso* ritual is performed, it also includes a procedure to prevent the neonate from experiencing convulsions/fits when baboons bark in the mountains or in the forests. This prevention procedure is referred to as *zwa thavha*, loosely translated as "things of the mountains", referring to baboons. It is believed that a neonate who did not go through the *mithuso* ritual will experience convulsions whenever a baboon barks from the mountain or in the forest.

The need to prevent convulsions was emphasised because the neonate could suffer irreparable harm later in life, such as mental retardation or madness. The traditional practitioner and indigenous knowledge holder mentioned during the interviews that the ingredients of the concoction prepared for the *mithuso* ritual include baboon dung and baboon skin for the prevention of *zwa thavha*, which is completed with throwing the neonate on top of a roof of a thatch hut and catching him/her with *luselo* (a large indigenous tray made from reeds) as he/she comes rolling down. In the case of a neonate who experiences a fit before *mithuso*, the same procedure of throwing the neonate on top of a hut is performed. It is believed the practice is the solution to the problem of neonatal convulsions. ***P18THPH*** expressed the following views of *mithuso*:

"When I perform mithuso for the baby, I don't make a mistake of not adding the baboon poop and the skin of baboon in the mixture that I used to burn for smoke inhalation." ***(P18HTHP)***

"I add them to protect the neonate from Zwa Thavha and high temperature, it is very important to do that especially this days we do not have huts anymore. If a child starts to fit where you are going to throw the baby to stop the fit you can't throw the baby on top of a zinc roof it must be a thatch." (***P18HTHP)***

"This kind of a fit is different, a baby fits each time a baboon or a monkey cries in the mountain is not like the baby is sick or anything like that, we know it we understand it." (***P18THPH)***

3.3.4 Theme 4: Contributory Factors for Using Indigenous Neonatal Care Practices

Table 3.6 below is a depiction of the final theme derived from the analysed narrative participant statements and their attendant sub-theme of adherence to cultural indigenous family practices.

Table 3.6: Contributory factors for using indigenous neonatal care practices

Theme	Sub-themes
Contributory factors for using indigenous neonatal care practices	Adherence to cultural indigenous family practices

Participants stated that their practices of neonatal care are strongly influenced by their elders. Most participants alluded that any deviation from the culturally induced neonatal care practices was most likely to place the neonate at a greater risk of ill health and death.

In the current study, not all participants believed in the indigenous neonatal care practices. Some women mentioned that they only adhered to these practices because they were compelled by societal and family pressures to conform.

3.3.4.1 Adherence to cultural indigenous family practices

During interviews, it was evident that most participants - particularly mothers - adhered to everything prescribed to them by the caregivers. These mothers were imbued with the uncompromising sense of upholding their culture as taught by the elders in the family. One of the participants expressed this view as follows:

"In our culture we do not raise babies on our own we raise babies with our elders. Therefore, the elders inform everything we do to care for the baby and we conform to that to ensure that baby grows well." ***(P10HM)***

Another mother elaborated as follows:

"In our culture we respect babies meaning there is no one that should come in the room where I am with the baby except for the only person that is helping me from the beginning and it should be someone older not these young ones who are all over the place doing wrong things. That is another reason why even when your husband is sharing a bed with you, you cannot be intimate; it could harm baby's health. Therefore,

to avoid temptation we just sleep in separate bedrooms from the onset as soon as the baby arrives home. My grandmother said it is the best thing to do." ***(P5HM)***

Another participant intimated further:

"This are the things we were raised with, we grew up like this. Look, this is not my first child and I have protected all my children in this fashion none of them have ever been admitted to a hospital because of childhood illnesses. I have to protect my children from evil spirits and illnesses, especially goni children are dying due to this thing we can't ignore and pretend as if these things are not there." ***(P8HM)***

3.4 SUMMARY

The main purpose of this research was to explore and describe indigenous neonatal care practices of mothers and caregivers of Vhembe District in Limpopo Province. Four main themes emerged during the data analysis process: indigenous neonatal feeding practices; indigenous neonatal bathing practices; protection of the neonate; and contributory factors for using indigenous neonatal care practices. These themes provided a framework of the findings as irrefutable evidence and culmination of the empirical phase of the research process (Babbie and Mouton, 2010:201; Creswell, 2017:132). The findings were thematically presented in conjunction with their respective sub-themes and authenticated by the participants' verbatim statements in response to specific questions posed to them during the individual interview sessions. The following chapter presents the discussion of findings as supported by literature.

CHAPTER FOUR: MAIN FINDINGS AND DISCUSSION

4.1 INTRODUCTION

The preceding chapter presented the data analysis/ interpretation processes accruing from the researchers' engagement with the participants at both their homes and the outpatient postnatal clinic. Following these interview-based discussions, the participants' statements were then analysed according to their respective thematic categories and attendant sub-themes, all of which served as the evidence of the study (Polit and Beck, 2017:628). The current chapter thematically presents the main findings in more detail as they pertain to the participants' views, experiences, and knowledge concerning indigenous neonatal care practices of mothers and caregivers in the Vhembe District, Limpopo Province. Abstracts from participants are referred to as a verification mechanism of the particular themes being addressed (Fetterman, 2010:16). In this chapter, relevant literature is referred to, for purposes of linking the findings with the existing body of knowledge concerning indigenous neonatal care practices.

Whereas the previous chapter mostly reflected a participant-centric orientation to the collected data, the present chapter essentially reflects a researcher-focused analytical perspective according to which the original (verbatim) statements or abstracts of the participants are tested (i.e. supported or disproved) with reference to the existing literature in indigenous neonatal care practices (Wahyuni, 2012:69). It should be mentioned, however, that the conventional (Western) biomedical context was not the subject of investigation in this study, but is referred to insofar as the participants occasionally related both their ante- and post-natal experience from what they were taught at the Vhembe district outpatient clinics.

Similar to the previous chapter's approach, the main findings in the current chapter are sequentially structured in accordance with the main (four) themes and their related sub-themes. Accordingly, the four themes are cohesively linked to four dominant aspects of indigenous neonatal care practices.

4.2 INDIGENOUS NEONATAL FEEDING PRACTICES

The theme of indigenous neonatal feeding practices encompasses two essential sub-themes, namely: the feeding of *ntswu* and *khongodoli* to the neonate at home after discharge from the hospital. The indigenous neonatal feeding practices expressed by participants in this study are not only concerned with hunger satisfaction of the neonate, but also with protecting the neonate from developing illnesses such as t*shilala (*neonatal vomiting or reflux), stomach cramps, as well as gut cleansing.

4.2.1 Feeding ntswu to the neonate

The participants intimated unequivocally that *ntswu* (boiled water and mixture of indigenous herbs) and *madi a ngwedi* (water kept in a container with a river stone inside) were fed to the neonate to ensure his/her growth and strength. This practice is not exceptional to the Vhavenda women of Vhembe District to introduce non-breastmilk feeds before six months. Many other cultural practices require the introduction of non-breast milk feeds in the neonate's diet before its first six months (Premji et al., 2014:9). The same practice of boiled water and mixture of indigenous herbs is also found in Pakistan, where women feed *sulemani chaye* (tea from boiled clover and cardamom) to the neonate until the milk comes in to purify the stomach (Premji et al., 2014:12).

In Egypt, herbs/decoction are used to moisten the baby's mouth and throat (El-Gilany and Abdel-Hady, 2014:5). In a study conducted by Saaka and Iddrisu (2014:7) in Ghana, it was found that women only gave water to their neonates because of the dryness of the throat due to the inadequate supply of the mother's breast milk. In Nigeria, mothers and caregivers also did not agree to exclusive breastfeeding, arguing that the baby needs a sufficient supply of water because of the hot weather (John, Nsemo, John, Opiah, Robinson-Bassey, and Yagba, 2015:239). The findings of a study conducted in Pakistan revealed the low exclusive breastfeeding rates amongst mothers was due to supplementary feeds such as honey and *ghutti*, a known liquid neonatal feed (Gul, Khalil, Yousafzai and Shoukat, 2014:173).

When asked on any known side effects of the herbs given to neonates, the participants responded that *ntswu* did not have any known side effects, and was beneficial to the neonate in that it relived the neonate's digestive problems. The thinking that traditional herbs do not have side effects is common among people who use them, as in the case

of a study conducted by McIntyre, Saliba and Moran (2015:4). This Australian study revealed that people experiencing anxiety used herbal medicine because it is safe, possesses natural healing powers, and has limited side effects compared to pharmaceuticals.

It may not be safe to use *ntswu* because its benefits have not been scientifically proven. It can be harmful, even to healthy adults because of the unclear dosages. The purpose of this study was not to interrogate the ingredients of any indigenous medicines used in the care of the neonate, but explore and explain the indigenous neonatal practices. Hence, there is no report on the details of all the indigenous traditional medicines used. The names of such herbs and medicines are mentioned as indicated by the traditional healthcare practitioner (THP) and the indigenous knowledge holders (IKH).

4.2.2 Feeding the neonate k*hongodoli*

As indicated in the previous chapter, *khongodoli* is a fine, watery soft porridge made from brown maize meal and some indigenous herbs). Participants viewed nutrition (prevention of hunger and dehydration) as the core of the neonate's health and growth. A crying neonate indicated the prevalence of hunger and thirst. Mothers and caregivers agreed that they fed the neonate whenever he/ she cried. These findings are congruent with those of a study conducted in Pakistan, which reported that the baby cried as a cue to initiate feeding by the mother or caregiver (Premji et al., 2014:10). In this study, participants intimated that breast milk was not enough to constitute the main source of nutrition. All mothers expressed the view that breastfeeding was initiated within the first hour of birth at the hospital or clinic, but also provided the first feeds according to their culture immediately when they returned home after the birth of the neonate.

Mothers and caregivers insisted that they are practicing exclusive breastfeeding despite the provision supplementary feeds. They did not view supplementary feeds whilst breastfeeding as mixed feeding, because the purpose of giving water is to prevent, thirst and not still the baby's hunger; while *khongodoli* was given to satisfy hunger. This development is consonant with those of an Egyptian study, which revealed that sugar/glucose water and infant formula were the most common pre-lacteal feeds (El-Gilany and Abdel-Hady, 2014:5).

Participants also mentioned that *khongodoli* was fed on the first day of the neonate's life to prevent hunger while waiting for the mother's fresh breast milk to come out. Feeding colostrum was not accepted, because the breast milk was viewed as unhealthy and 'dirty' due to its long stay in the breast since conception. This finding is similar to the results of some studies conducted in Guatemala and Indonesia, which reported that colostrum was discarded for cultural reasons and was a factor that prevented early initiation of breast-feeding (Patel, Bucher, Pusdekar, Esamai, Krebs, Goudar, Chomba, Garces, Pasha, Saleem, Kodkany, Liechty, Kodkany, Derman, Carlo, Hambidge, Goldenberg, Althabe, Berrueta, Moore, McClure, Koso-Thomas and Hibberd, 2015:11; Sutan and Berkat, 2014:8). Meanwhile, Mugadza (2018:1206) mentions that in Zimbabwe, thin porridge was not viewed as a form of pre-lactial feeding, but as treatment for gut cleansing to prepare for the breast milk's arrival. This practice should be discouraged because colostrum boosts the immunity of the neonate. It has a high nutritive value and can be easily digested.

The World Health Organisation recommendations of exclusive breastfeeding of up to six months (WHO, 2020:2) is known to both the mothers and caregivers, and was taught at the clinic. However, this study found that exclusive breastfeeding was poorly practiced by most mothers due to culturally prescribed beliefs. For instance, *khongodoli* was highly esteemed by the mothers and caregivers based on its merits, such as satisfying the neonate's hunger, ensuring growth, strength and weight gain. Furthermore, participants expressed that *khongodoli* is inexpensive and easy to prepare.

4.3 INDIGENOUS NEONATAL BATHING PRACTICES

The theme of indigenous neonatal bathing practices encompasses two essential sub-themes, namely: the use of *gumululo or swandzo* and body massages to the neonate at home after discharge from the hospital. These findings are resonant with those of a study in Gambia, where neonates are given traditional bath on the first day of life (Sarah, Clarke, and Grietens, 2017:140).

4.3.1 Neonatal bathing using *gumululo/swandzo*

In the Vhembe district, *gumululo or swandzo* (indigenous herb-infused bath) is considered vital due to its strength and protection of the neonate from *mirundzi ya*

vhathu (evil spirits carried by people). Participants explained that they made the neonate drink some of the bathwater. From the perspective of the researcher, the *gumululo* water provided to the neonate is viewed as risky because the herbs in the bath water that the neonate is expected to drink already contain microorganisms accumulated during the bathing of the neonate. However, the practice is not unique to the Vhembe people. Herbal neonatal baths are common in Nigeria, where they are used to protect neonates from illnesses and treatment of other diseases (John et al., 2015:242). In Uganda, the same practice is known, with neonates bathed in a medicated bath called *ekyogero* to prevent skin rashes and bring the neonate luck (Kayom, Kakuru and Kiguli, 2015:4; Nankumbi and Muliira, 2015:106). In the current study *gumululo* is supposed to be performed immediately after birth. In the event that the neonate was born in hospital, the *gumululo* bath is then performed as soon as the neonates arrives home.

The mothers and caregivers expressed that another reason for the *gumululo* bath is to remove vernix from the neonate's body as soon as possible. According to the participants, vernix is considered a taboo signalling that the mother of the neonate engaged in sexual activity a few days or hours before birth. Thus, it needs to be removed before other people come to see the neonate. The same practiced is found in Pakistan, where mothers take the neonate for an early bath because he/she cannot be prayed for unless the vernix has been removed (Gul et al., 2014:173). The practice of removing vernix should be discouraged because of the anti-infective properties and hydrating effects of the vernix to the skin (Visscher and Narendran, 2014:145). In Nepal, three in four neonates were bathed within 24 hours for cultural reasons (Khanal, Gavidia, Adhikari, Mishra, and Karkee, 2014:173). This practice is viewed as complying with WHO recommendation in terms of which bathing should be delayed for 24 hours, but can be carried out after six hours for cultural reasons (WHO, 2013:25). In this study, neonates who were discharged from hospital within six hours of their birth, were bathed before 24 hours of life when the mother returned home from delivery but after 6 hours as recommended by WHO.

4.3.2 Body massages and application of animal fat/oil

Some mothers expressed that they also practiced neonatal massage after each bath to help the neonate relax, ease abdominal pains and winds, and enabling the neonate

to sleep well. They also mentioned that they did not massage the neonate on a dry skin, but applied either petroleum jelly or pork oil, which they preferred for protecting the neonate from evil spirits. The practice of massaging the neonate is not exclusive to the Vhembe women. In other parts of Africa such as Nigeria, women performed this traditional massage practice on the neonate's muscles, limbs and spine with different oils, ash or native clay to strengthen the baby, keep him/her warm, reduce abdominal colic and aid bowel movement (John et al., 2015:242).

Although the practice of neonatal massage is considered safe, caution should be exercised, because it could endanger the life of a neonate with underlying conditions. Peterside, Duru and Anene (2015:151) conducted a study in Nigeria on the practice of neonatal massage and found this practice was responsible for neonates experiencing severe injuries such as prolapse of the rectum and blunt injury to the intestines. Therefore, such practices should either be discontinued or exercised with extreme caution. In this study, the participants contended the indigenous neonatal massages were used when the neonate was already showing signs of abdominal discomfort (Bas et al., 2019:119).

4.4 PROTECTION OF THE NEONATE

The theme of protection of the neonate encompasses three essential sub-themes, namely: the performance of *mithuso,* protection from illnesses and infections, and protection from environmental and external harm of the neonate at home after discharge from the hospital.

4.4.1 Performance of *Mithuso*

The socio-cultural backgrounds of the mothers and the caregivers in Vhembe district influenced the manner of their neonatal care. Participants asserted that they were diligently perpetuating practices and knowledge taught to them by their elders, who knew and understood that many things could go wrong during this stage of the neonate's life as a result of ignorance. A traditional health practitioner or an indigenous knowledge holder had to be consulted for the performance of the *mithuso* ritual, which is well known and commonly practiced amongst the Vhembe women. In terms of the *mithuso* ritual, the findings are in concurrence with those of a Nigerian study, which revealed that Yoruba people consulted traditional healers for herbal medicines to rid

the neonate of illnesses perceivably caused by evil supernatural forces, including witches and sorcerers (Borokini and Lawal, 2014:22).

Similarly, the participants in the current study needed to be protected from evil spirits were also of the view that the neonate needed the neonate to be protected from evil spirits which can cause unnatural illnesses. It is believed that a neonate coming into contact with people who used *muti* (practised witchcraft) will afflict the neonate with evil spirits, and that would cause the neonate not to sleep. The mothers in the study further expressed that the neonate could become restless in the presence of others (including family members) even when they did not use *muti*.

A study conducted by Kayombo (2013:4) revealed that similar practices were also prevalent in Tanzania, where mothers and caregivers used traditional remedies to protect neonates from illnesses supposedly caused by supernatural evil forces or spirits. It is evident that in the different contexts referred to so far, all show that different traditional remedies are used and applied differently, depending on the beliefs of the mothers. In some contexts, neonates drink the traditional remedies, while neonates are bathed in those remedies in other traditional contexts.

4.4.1.1 Assessment of *goni*

There are illnesses that are believed to afflict neonates that are unknown and misunderstood in the Western biomedical system (Sharkey, Chopra, Jackson, Winch and Minkovitz, 2011:384). Participants alluded to the importance of ensuring that neonates were protected from such illnesses, one of which is *goni.*

Goni is believed to be a lethal mother-to-child illness transmitted during pregnancy, and mostly attacks neonates. Participants highlighted is the need for all neonates to be taken to either a traditional health practitioner or an indigenous knowledge holder who specialises in neonatal illnesses for the treatment of *rigoni*.

This practice is very common in African countries. A significant number of participants alluded to the cultural importance of rituals such as assessment of *rigoni*. As such, they were not prepared to compromise this practice, regardless of available Western biomedical interventions. John et al. (2015:240) aver that a similar practice of opening

traditional incisions for the protection of neonates from illnesses was common in Nigeria as well.

The participants believed that such illness could only be cured by a specialist traditional healer or an indigenous knowledge holder. In the event that a healer confirmed the mother to be the source of rigoni, she would have to undergo treatment as well. However, the treatment of rigoni in mothers was not addressed in the study.

4.4.1.2 Prevention of *ngoma*

Participants explained that *ngoma* (anterior fontanelle) presents with a wide, sunken and pulsating skull. In such cases, an indigenous knowledge holder is consulted to cure the neonate. In treating *ngoma*, indigenous knowledge holder will then smear a mixture of herbs and animal fat on the fontanelle to cure the neonate. This practice was also found in the study conducted by Nethra and Udgiri (2018:4) in India. That study found that 89% of the mothers applied oil on the baby's anterior fontanelle to expedite its fusion. This practice is viewed unsafe as it can lead to delay in seeking medical intervention for a neonate suffering from dehydration. In the Western biomedical system, it is known that a larger sunken anterior fontanelle is a sign of dehydration, which necessitates that the neonate should be rehydrated with immediate effect. In this regard, participants were advised to take the neonate to the clinic for medical assistance, notwithstanding that *ngoma* treatment had been administered to the by the indigenous knowledge holder.

4.4.1.3 Protection from evil spirits

It is evident that caregivers and mothers strive to protect their neonates from both natural and unnatural illnesses. *Mirundzi ya vhathu* (evil spirits carried by people) was one of the common unnatural causes of neonatal illnesses, and this posed serious concerns to the mothers in Vhembe District. The concern with optimum protection of the neonate from ill-health and evil spirits necessitated that both the mother and the neonate should be placed in confinement.

In strict families, confinement even meant abstinence from any sexual intercourse between the mother and her spouse/husband. A similar orientation was observed in a Botswana and Tanzanian study in which sexual abstinence of the neonate's parents is enforced for a specific period of time (Kayombo, 2013:3; Rempel et al., 2016:84;

Mwape, Muleya, Mukwato and Maimbolwa, 2018:152). The belief is that such a protective measure will enhance neonatal weight gain while also protecting both the neonate and the mother from other illnesses caused by evil spirits.

In the strict families, the isolation for the mother and the neonate after returning from delivery is 3 months, depending on social circumstances. In less strict families, the isolation depends on the cord stump falling, or the performance of the *mithuso* ritual after which the neonate will then be declared by a neonatal care consultant or family elder, fit to be in contact with people in public. The practice of confinement is also common in Nigeria (John et al., 2015:239), where the mother and the baby are isolated until the umbilical cord drops.

Neonate isolation is viewed as the most effective way of protecting the neonate from evil spirits (Al, 2019:11). In some instances, it may not be possible to observe the required three-month isolation period. Other circumstances, such as work imperatives, may cause the mother to return to work earlier than the end of the prescribed three-month isolation period. This study revealed that neonatal protection rituals were induced by the belief that the mother's return to work would inevitably expose her to contact with other people. Such contact was understood as also exposing the neonate to possible illnesses and evil spirits when the mother returned from work. Mothers who work far from home and leave the neonates in the custody of the caregiver also had to perform rituals for the neonate as early as two to four weeks after birth. It is not only in this study that indigenous neonatal care practices were adjusted in accordance with the life situations of mothers and caregivers. Rempel et al. (2016:83) corroborate that the traditional roles of breastfeeding mothers were changing due to the involvement of women in full- time employment.

In cases where the neonate should be in public areas, such as visiting the clinic for immunisations and follow-up visits, it is incumbent on the mother or caregiver to prepare a smoke inhalation session for the neonate when returning from that public place. Other participants mentioned that they performed the smoke inhalation session even before the neonate is taken out in public. This practice is also true to the community of Tamil Nadu, India, for the neonate's protection against evil spirits and helping him/her to sleep well (Latha et al., 2017:873).

In other traditional contexts such as in Nigeria, charms and amulets made from different substances are used to ward off sorcery-induced illnesses (John et al., 2015:241). In Nigeria, the 'evil eye' is exorcised by applying cream behind the neonate's ears and putting salt over his/ her head (Bas et al., 2019:118). Furthermore, a study conducted in Pakistan revealed that *kohl* is applied to the baby's eyes to ward off evil spirits (Gul et al., 2014:173). While some of the neonate protection practices were relatively innocuous, smoke inhalations may carry potential respiratory risk for the neonate.

4.4.2 Protection from Illnesses and Infections

During engagements with the participants, the illnesses and infections from which the neonates needed to be protected included colds and flu, as well as eye and umbilical infections caused by unhygienic living conditions.

4.4.2.1 Prevention of *tshilala*

Tshilala (neonatal vomiting or reflux) and colic (abdominal cramps) are some of the ailments of concern to the participants. Despite the extensive health education provided at the clinic on the merits of the six-month exclusive breastfeeding period, the researcher observed that *ntswu*, *khongodoli* and traditional herbs were still used by the neonates' mothers to prevent *tshilala* (neonatal vomiting or reflux and abdominal cramps), to relieve constipation and colic, and to promote the flushing-out of meconium. In many traditional contexts, colic is viewed as a problematic condition that needs attention. The latter statement is supported by a Jordanian study, which revealed that boiled herbs or sweetened water were bottle-fed to neonates to facilitate sleep by relieving abdominal pain and colic (Mrayan, Abujilban, Abuidhail and Alshraifeen, 2018:486.). The practice of relieving colic with gripe water was also found in Nigeria (Jimoh, Adaji, Adelaiye, Olorukooba, Garba, Mfuh, Bawa, Idris and Shittu, 2018:40).

Meconium was viewed as a substance that needed to be flushed out of the body as it could cause illnesses in the event it remained dormant inside the neonate's gut for long. It is believed that a neonate not passing meconium for three successive days was symptomatic of a problem in the neonate's gut. Hence, the importance of ensuring that the neonate passes the green stool as soon as possible after birth. To this end,

neonatal traditional herbs such as *ntswu* and traditional herbs were opted for, in order to clean the neonate's gut. Mothers were reminded that breast milk, especially colostrum, is nutritious and possesses immunological properties that help in the prevention of infections. Breast milk consists of lactose, which prevents hypoglycaemia and helps the neonate to pass meconium (Motee and Jeewon, 2014:62).

The participants mentioned further that the range of these remedies mentioned above were also administered on neonates who did not present any signs of discomfort, to ensure that the neonate remains healthy and strong. They also had received appropriate advice when visiting the healthcare facility in the event of a suspected or observed neonatal illness.

4.4.2.2 Protection from colds and flu

All participants affirmed that they always ensured a warm environment for the neonate by using optimal thermal measures such as swaddling, using heaters or fires and keeping the windows closed at all times for the retention of warm room temperatures. In spite of the participants' performance of the *gumululo* ritual, it was only after six hours of delivery, which is the recommended timeframe by WHO (WHO, 2013:25).

At other households, the researcher had the opportunity to gain access to the neonates' room. The researcher then observed that the rooms were either warm, too hot or stuffy. The neonates were either covered in two to three layers of clothing, including a hat, and swaddled into two to three layers of baby blanket. That is rather excessive for a neonate. The World Health Organisation recommends appropriate neonate clothing for ambient temperature as one to two layers more than adults, and a hat (WHO, 2017:5). The researcher also established that advice was proffered to mothers to refrain from overheating the neonates' room and rather open a window for ventilation, while also reducing the number of layers of the neonate's clothing in order to prevent the neonate from being overdressed. The number of blankets or clothing items covering the neonate's body, as well as room temperature were linked to increased risks sudden infant death syndrome (SIDS) (Marinelli, Ball, McKenna and Blair, 2019:512). In this study, it is also unclear whether overheating is an independent factor or merely a reflection of the SIDS.

In India, cow dung cakes with *ajoan* seeds were kept burning to keep the mother and the neonate warm the smoke is beneficial for the benefits of colds and coughs (Baş, Karatay, Arıkan and Baş, 2019:114). Participants who used swaddling, contended that it keeps the baby safe from falling and suffocating rather than when the baby is left to sleep freely. However, there is paucity of evidence in support of swaddling as a risk-reduction strategy for possible SIDS eventualities (Moon, 2016:19; Moon, 2017:1). It is axiomatic that swaddled infants face increased death risks when placed in or roll over to a prone position. In the event of a swaddling option being applied, it is always advisable to place infants on their backs. When an infant begins to roll or crawl, swaddling should be discontinued forthwith. Similarly, the practice of overheating the room, overdressing and swaddling the neonate should be discouraged.

4.4.2.3 Prevention of eye infections

Mothers indicated that they did not take their neonates for healthcare of minor ailments such as suspected eye infections. They also mentioned that they used breast milk as an eye infection remedy every morning, believing that medication was too strong for the neonate. This practice among the Vhembe women was also common among women in Pakistan, as evidenced in a Karachi study on the effects of socio-cultural influences on a new-born's health in the first six weeks of his/ her life. These women instilled drops of breast milk in the neonate's eyes and nostrils to treat infections (Premji et al., 2014:10).

The current study's findings on participants' use of breast milk for neonate eye infections concur with those of an Iranian study by Ghaemi, Navaei, Rahimirad, Behjati, and Kelishadi (2014:3), which found that maternal milk, especially colostrum, contains leukocytes and various kinds of immunoglobulins that are effective in inhibiting the growth of *N gonorrhoeae* and *staphylococcus aureus*, which are amongst the main causes of *ophthalmia neonatorum* in developing economies. Meanwhile, a University of California (San Francisco) study on the antibacterial impact of breast milk for common paediatric conjunctivitis causes, proved that human milk consistently inhibited the growth of the *N gonorrhoea* (Baynham, Moorman, Donnellan, Cevallos and Keenan,2013:377).

The study by Baynham et al. (2013:378) posits the use of colostrum is advocated for, based on its cost-effectiveness, safety and effective agency in preventing blindness

caused by *neonatorum ophthalmia*. However, the same study recommended that mothers should wash their hands and breast before dropping the milk/colostrum into the neonate's eyes. The washing of hands safeguards contamination of the milk/colostrum. In this study, the risk of contamination of breastmilk is minimal; because the mothers adhere to hand washing, and also clean their breasts before dropping the milk into the neonates' eyes.

4.4.2.4 Prevention of umbilical cord infections

It was observed that most care givers and mothers took care of the cord stump as biomedically recommended by guidelines of the World Health Organisation of using dry cord care or daily chlorhexidine/surgical spirit (WHO, 2013:25). Most mothers were using chlorhexidine daily, as it was provided by the healthcare facility after delivery of the neonate. The participants mentioned that they continued with the use of surgical spirit when they ran out of chlorhexidine as advised by the healthcare professionals at the healthcare facilities on discharge.

However, most mothers and caregivers indicated that they preferred indigenous umbilical cord care practices because the surgical spirit did not expedite the healing of the cord stump. They applied pork oil on the cord stump to encourage its quick detachment to prevent it from becoming septic. As far as the researcher is aware, few published studies have examined the ingredients of pork oil and its capacity to cause the quick detachment of the umbilical cord. The participants themselves did not know, but could vouch for the efficacy of pork oil in this regard.

Some participants mentioned that they used a piece of *tshidongo* (a clay pot) after the cord has detached and pulverised it into powder mixed with pork oil. The resultant paste was then applied on the umbilical area to enable healing and closure of the area. In Brazil, grandmothers dressed the umbilical stump of new-borns with products such as ethyl alcohol, copaiba, castor, or cotton oils after bathing the neonate following his/ her discharge from hospital discharge (da Silva, Silva, and Praca, 2016:1103). The cotton seeds were roasted and pulverised, and then mixed with mineral oil. Some women (in Brazil) saw ethyl alcohol as a non-indigenous product and a cause of dryness of the umbilical stump. The use of oils was part of the village traditions, and castor oil was considered better than ethyl alcohol.

It is common cause in Africa and elsewhere in the world that the practice of applying indigenous substances is more preferred amongst mothers and caregivers than those prescribed biomedically by the health system (Bee, Shiroor and Hill, 2018:6; Moro, 2018:12). A study undertaken in India showed that 26% of the sampled mothers believed they were aware of safe cord care practices. They did not keep it clean, and applied multiple substances on the cord following the advice of the traditional birth attendants (Sinha et al., 2014:24).

In the present study, participants pointed out they initially cleaned the umbilical cord using the surgical spirit as advised by the healthcare practitioners. However, they found it to be very slow in detaching the cord stump the cord. They later resorted to using pork oil as it was used before with other babies in the family, and it worked fast. The study found further that health advice on the dangers of an unclean umbilical cord was provided to all the mothers and caregivers who were not practicing safe cord care.

4.4.3 Promotion of environmental hygiene

The promotion of environmental hygiene is fundamentally located on ensuring cleanliness in the surroundings of the neonate for the purpose of prevent illnesses (Margeson and Gray, 2017:589). In this study, the participants accentuated the importance of keeping the neonate in a clean and healthy environment based on the understanding that the neonate's immunity was still very weak to withstand germs causing illnesses. On its own, cleanliness of the neonate's room constitutes a significant part of neonatal care. This was basically the reason that motivated mothers and caregivers to keep the neonates' rooms clean at all times. Some participants mentioned they were taught these skills by their mothers or grandmothers in order to prevent infection and illnesses such as oral thrush and diarrhoea. Such views are in concurrence with those expressed by Aitken, Rose, Mullins, Miller, Nick, Rettiganti, Nabaweesi and Whiteside-Mansell (2016).

There is limited literature on the link between household environmental hygiene and neonatal illnesses. However, there is data on the relationship between neonatal illnesses and hospital/health facility environmental hygiene. A study conducted in a Toronto neonatal intensive care unit of a children's hospital supports these beliefs of mothers and caregivers. It provides evidence that the environment act as a Group B

streptococcal reservoir and playing a key role in nosocomial transmission (Al-Maani, Streitenberger, Clarke, Yau, Kovach, Wray, and Matlow, 2014:176; Margeson and Gray, 2017:589). Participants in this study were encouraged to keep washing their hands and keeping the neonates' rooms clean.

4.4.4 Protection from Environmental and External Harm

This study revealed that mothers and caregivers believe that neonates were sensitive to everything that happened around them. To this end, they faithfully depended on, and trusted the indigenous mode of neonatal care for its capacity to mediate against environmental factors that portended negatively on the neonate's health. Caregivers play an important role in educating the mothers about different approaches in neonate protection; from environmental harm of household accidents to changes in the atmosphere.

It is the view of the researcher that the measures of protection taken to protect neonates from environmental harm could be equated to the approach adopted in workplaces to provide and ergonomically conducive environment for the safety and health of employees (Carayon, 2016:4). For instance, the arrangement of furniture in the neonate's room is still an important ergonomic factor of preventing accidents and optimising health benefits to the neonate. In addition to quality of nutrition and illness protection strategies, measures such as room temperature, neonate's positioning on the bed, position of the bed, and ventilation complement the entire range of what could be referred to as 'the environmental value chain' of a new-born in home surroundings.

4.4.4.1 Prevention from falls

Preventing neonates from falling was an important factor in the maintenance of safety. Mothers and caregivers in this study ensured that neonates were always kept safe from harm and injuries at all costs. Some of the women mentioned that elders of the family instructed that the neonate should sleep on the floor for the first ten days to obviate any possibilities of falling if they were put to sleep on a bed. For those who slept the neonate on the bed, the neonate was never put on the edge of the bed because that would increase the risk of falling. The fear of falling was justified on the grounds that a falling neonate would hit the floor headfirst, with possible head or brain injuries that could pose learning difficulties as the neonate grew older. The thinking

that neonates may fall from bed is not unfounded, as there are studies that reported on neonatal falls both at home and in hospital settings (Moon, 2016; 2017).

A USA study on patterns of injury associated with routine childhood falls, reported that falls from a bed or chair were more frequent in children aged two years and younger, and mainly caused head injuries (Pitone and Attia, 2006:274). A study undertaken in a Brazilian hospital environment reported 11.36 occurrences of unintended falls per 10.000 live births (Torino, Tsunechiro, Santos, Aragaki and Shimoda, 2016:4). These studies from different parts of the world validate the Vhembe district mothers' and caregivers' fear of neonates falling from their beds were valid and relevant.

4.4.4.2 Prevention of *zwa thavha*

Zwa thavha is a fit emanating from a neonate's reaction to the bark of a baboon in the mountains or forest. The Vhavenda people in Vhembe district believe that neonates are affected by the bark of a baboon to a point of having high temperature and fits. To prevent this from happening, the traditional healthcare consultant performing *mithuso* for the neonate must add baboon dung and skin on the concoction to make medicine that the neonate will inhale. The researcher is convinced of the practice's potential harmfulness, and may cause respiratory problems for the neonate. Equally, the practice of *luselo* (a large indigenous tray made from reeds) could be deleterious to the neonate's intellectual development as a result of the neurological problems that may occur in the event the child is negatively affected by hitting the rooftop. The practice of performing a ritual for a neonate presenting with convulsions is common in Nigeria as well. Findings of a study conducted by John et al. (2015:241) in Nigeria found that it is believed that a neonate with fits is seeing demons thus they instil palm kernel oil and herbal juice on the neonate's eyes to prevent the neonate from seeing demons and relieve convulsions. The practice of feet roasting (the feet of the neonate are placed near a fire) is also performed when a neonate experiences convulsions. Similar to the smoke inhalations performed by the traditional healthcare consultant in the current study, the practice of feet roasting is not safe, as the heat from the fire can further increase the neonate's temperature and exacerbate the convulsions (John et al., 2015:242).

4.5 CONTRIBUTORY FACTORS FOR USING INDIGENOUS NEONATAL CARE PRACTICES

The theme of contributory factors for using indigenous neonatal care practices encompasses the essential sub-theme: adherence to cultural indigenous family practices relating to the neonate at home after discharge from the hospital.

4.5.1 Adherence to Cultural Indigenous Family Practices

Participants stated that indigenous neonatal care practices were strongly influenced by how they observed their elders raising neonates. They averred further that any deviation from their ages-old cultural approaches would make the neonate vulnerable to ill health and possible death.

Younger participants also affirmed the roles of their mothers, grandmothers or female elders in the family in the inter-generational transmission of knowledge concerning the use of herbs. Their caregivers are the ones who recommended a traditional health practitioner or an indigenous knowledge holder for the protection of the neonate through *mithuso*. This is similar to a Limpopo study on using herbal medicine during pregnancy, which found that indigenous practices to protect pregnant women were mostly guided by their female elders (Mogawane, Mothiba and Malema, 2015:4).

A Kenyan study reported that family and friends were the key advisers in connection with herbal medicine for improve one's health, and herbalists were the key advisers to consult when someone was ill (Mothupi, 2014:3; Talbert, Ngari, Tsofa, Mramba, Mumbo, Berkley and Mwangome, 2016:10). On the other hand, Premji et al. (2014:12) ascertains that parents followed a multi-generational approach in the care of the neonate. They did not entirely make decisions on their own regarding neonatal care, including the feeding style of the neonate. Not all participants in this study believed in the indigenous ways of neonatal health promotion. Some women expressed that their adherence to the indigenous practices was based on the obligation imposed by society and their families. This resonates with an Indonesian study which reported that young parents were carrying out indigenous practices of neonatal care due to family pressure and the need to please their elders (Sutan and Berkat, 2014:2). Young mothers and those that lacked experience in neonatal care depended on the elders' feeding advice, which is common amongst traditional families. Premji et al (2014:12) describe how parents followed a multigenerational neonatal care approach. They did not entirely

make decisions on their own. This practice and approach is similar to that observed in a study conducted in Indonesia, which reported that young parents were carrying out indigenous neonatal care practices due to family pressure and the need to please their elders (Sutan and Berkat, 2014:2).

4.6 SUMMARY

The research findings constituted a significant part of the current chapter. The four themes that emerged in Chapter Three were discussed and validated in the context of reviewed literature in order to test the findings' reliability (Babbie and Mouton, 2010:118). To a greater extent, this chapter could be viewed as also presenting the findings as a fundamental response to the main question posed by the investigation.

The findings' overall perspective is not monolithic. The participants' abstracts on a variety of neonate-related aspects show that indigenous practices in the Vhembe district of Limpopo Province were dominant, but not hegemonic. Despite reference to "indigenous", the (Western) biomedical factor and influence could not be attenuated. For instance, many neonates were delivered at clinics and hospitals (where indigenous rituals are not allowed), but the rituals came into the picture as soon as mother and neonate returned home. Therefore, the "indigenous" coexisted with the "biomedical" to various levels of application, depending on the extent of the individual family's socialisation (Asfaha, Comeau, Spangler, Spratt, Alamineh, Gobezayehu and Cranmer, 2020:7).

CHAPTER FIVE: MAIN CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter Three and Chapter Four explored and described the indigenous neonatal care practices of mothers and caregivers in varying degrees, with the reviewed literature incorporated in the latter chapter to either support (validate) or invalidate (disprove) the participants' views, experiences and perceptions. Meanwhile, Chapter Five concludes the study by specifically referring to salient research variables in the entire study, followed by possible study limitations, the researcher's recommendations encompassing contributions or significance of the study. In this regard, all of these units of analysis or research variables logically present an integration of both the theoretic and empirical aspects of indigenous neonatal care practices.

5.2 STUDY OVERVIEW

The study's overview is essentially a reflection of the extent of the study's efficacy or otherwise inefficacy in respect of the research design approaches that were adopted to bring the study's stated intentions to fruition (Creswell, 2017:203; Polit and Beck, 2012:545). To that effect, the research purpose and question are the main reference points for determining the efficacy or otherwise of the investigation.

The study purpose is: *To explore and describe the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province*

The study objectives were to:

- Describe the indigenous neonatal care practices of mothers and caregivers in selected villages of Makhado municipality in Vhembe district, Limpopo Province
- Identify the safe and unsafe indigenous neonatal care practices of mothers and care givers in selected villages of Makhado municipality in Vhembe district, Limpopo Province
- Explore factors contributing to the use of indigenous neonatal care practices of mothers and caregivers in selected villages of Makhado municipality in Vhembe district, Limpopo Province

The main research question is: *What are the indigenous neonatal care practices of mothers and caregivers in Vhembe District, Limpopo Province?*

The reiteration of both the study purpose, objectives and its attendant research question in this particular chapter is a demonstration of their affinity with the findings as the absolute and most accurate indication of the study's relevance, significance and ultimate achievement of its original intentions (purpose) (Anney, 2014:273; Kumar, 2012:112). The very affinity between the research purpose, objectives, question and findings, has presented a synergetic and seamless structure of the chapter that logically flows from the analysed data. Accordingly, the chapter is mainly organised according to the unique demographic features of the participants, as well as the thematically constructed main findings accruing from the participants' experiences, perceptions and knowledge regarding indigenous neonatal care practices.

The present study adopted a qualitative, explorative and descriptive research design in its exploration and description of indigenous neonatal care practices of mothers and caregivers in three villages situated across the Makhado municipality in Vhembe District, Limpopo Province. Eighteen participants were selected for participation in the empirical data collection process. They comprised eight mothers of neonates aged three days to one month; seven caregivers assisting the mothers of the neonates; one traditional health practitioner and two indigenous knowledge holders. The semi-structured individual interview mode of enquiry was utilised to facilitate insights into the participants' perceptions, experiences and knowledge in respect of indigenous neonatal care practices. These interviews were conducted over an interrupted period of two weeks (one week in August 2019 and another week in February 2020). Creswell's (2009) data analysis strategy was employed to analyse data. Four themes emerged from the data analysis: indigenous neonatal feeding practices, indigenous neonatal bathing practices, protection of the neonate and contributory factors for using indigenous neonatal care practices.

5.3 OVERALL CONCLUSIONS

The themes that were generated and discussed in this study focused mainly on answering the study question to fulfil the initial study intentions. In tandem with both the study question and purpose, this investigation succeeded in exploring, identifying

and describing safe and unsafe indigenous neonatal care practices. The latter aspect is supremely critical. Failure of the study to have identified these safe and unsafe practices would have rendered the study utterly insignificant (Saldanha and Omasta, 2018:199; Walliman, 2015:53). The main four themes of the study are still perennial in this chapter, albeit they are synoptically referred to as a continuous indication of their relevance and significance to the study as a whole.

5.3.1 Indigenous Neonatal Feeding Practices

The findings revealed that participants were passionate about their traditions and were not in a state of being readily convinced otherwise in respect of Western biomedical practices which they adopted to some degree. The crying of a neonate was understood as a cue for hunger and thirst. Crying also served as a cue for the neonate's state of health. For instance, a neonate crying on a full stomach suggested that he/ she was sick or afflicted by evil spirits in the surroundings.

In this regard, supplementary feeds served to prevent crying and illnesses such as *tshilala* and weight loss.

Ntswu and khongodoli were the main supplementary feeds for preventing both hunger and illnesses. However, the researcher was concerned with the lack of a standardised dosage mechanism when providing these two supplementary feeds (*ntswu* and *khongodoli*) to the neonates. The researcher is convinced that non-standardised dosages may pose a health risk to the neonates. To some extent these practices encourage mixed feeding, it could be detrimental to the HIV-positive mothers who must adhere to strict measures of exclusive breastfeeding. The importance of breastfeeding was clarified to the participants. They were also educated about the risks of mixed feeding especially if one is HIV-positive.

5.3.2 Indigenous Neonatal Bathing Practices *Using Gumululo*

There are culturally prescribed methods of neonatal bathing, the purpose of which was, amongst others, to remove vernix to protect the neonate from evil spirits and to facilitate weight gain. Culturally, vernix was viewed as a sign of residue from sperm and should be removed as soon as the neonate arrived home from the hospital. Although the WHO encourages delayed bathing, it also recommends that the neonate can also be bathed six hours after birth for cultural reasons. In this study, adherence

to these recommendations was by default because most mothers were discharged from the clinic after 12 hours of delivery of the baby.

5.3.3 Protection of the Neonate

Virtually all the participants held the same view pertaining to the importance of neonate's protection from illnesses and evil spirits in the vicinity of the newly born child. Such protection is two-fold, based on the belief that neonatal illnesses have both natural and unnatural causes. According to the participants, the Western biomedical need for protection necessitated that immunisations should be administered on the neonates at certain stages of their growth. Secondly, the participants contended that from a cultural perspective, diseases such as *tshilala, ngoma* and *goni* were not known in the Western biomedical system. Therefore, the cultural perspectives and approaches of treatment were justified with the involvement of a traditional health practitioner or an indigenous knowledge holder performing the *mithuso* ritual for the protection of a neonate from illnesses, evil spirits and environmental harm.

Maintenance of thermal care was exceptional, with participants ensuring warmth of the neonate at all times to prevent colds and flu. A few participants overdressed their neonates, a practice that needs to be discouraged. The usage of breast milk to prevent eye infections was common among the participants. Since there is insufficient data supporting this practice, the researcher concludes that there is no harm in its continuation. It was observed that the conventional biomedical guidelines of dry umbilical cord care were scantily adhered to. Instead, a significant number of participants adhered to the use of pork oil to expedite detachment process of the cord. Some used *tshidongo*, a piece of crushed clay pot mixed with pork oil to cover the umbilicus after the detachment of the cord. This encourages the integrity of the skin. Notwithstanding the value placed on these practices, the researcher considers them risky, especially that the ingredients of the pork oil are unknown. Generally, it was observed that the participants practised good personal and environmental hygiene.

Participants knew little about dehydration. Moreover, turn of indigenous neonatal care consultants mentioned whether they gave advice to the mothers concerning neonatal rehydration; alternatively, referring them to the clinic for such. It is mention worthy that the researcher provided on-the-spot health information to the participants in a culturally sensitive manner in order that they did not feel antagonised.

To the participants, protecting the neonate from environmental and external harm was important. This includes prevention of falls and convulsions resulting from the bark of baboons. It is in this specific context that participants were encouraged to continue using these protection measures since they posed no significant health risks to the neonates. However, the practice of throwing the neonate on the rooftop of a thatched hut could cause serious neurological complications, while the practice of smoke inhalation have a potential of causing respiratory problems. Isolation of the neonate was practised as a form of exorcising evil spirits (m*irundzi ya vhathu*) from the neonate's life. Some practised isolation until the cord detached on its own, while others practised it for the duration of the prescribed period of three months. They were generally content doing so.

5.3.4 Contributory Factors for Using Indigenous Neonatal Care Practices

The inter-generational mode of knowledge transmission from the elders to mothers was prominently evident in the study. Young mothers followed the lead of their elders who acted as caregivers following the birth of the neonate. It was during these stages that the caregivers would proffer advice to young mothers, which was also practised when the caregivers themselves were still young mothers. Other participants mentioned that they were keen to integrate both the indigenous and biomedical neonatal care practices, but were reticent to do so for fear of acrimonious retribution by the elders, which could also lead to them being labelled defiant and not proud of their cultural heritage which defines who they are.

Some of the participants contended that they preferred indigenous neonatal practices because the Western biomedical system was unable to treat illnesses that were already curable by traditional means. Others intimated that they adhered to the indigenous neonatal ways for fear of accusations should the baby die, in which case they would be blamed for defying the advice of their elders. Ironically, indigenous knowledge holders and the traditional health practitioners mentioned that the young mothers were not compelled to comply with the imperatives of the indigenous neonatal care practices. However, they cautioned that the young mothers who followed their instructions should not deviate in any manner. Should any deviation occur, they were not to blame for any fatalities occurring.

5.4 LIMITATIONS OF THE STUDY

Notwithstanding its possible limitations, they do not necessarily render the study insignificant (Altuntuğ et al., 2018:95). The study has optimally achieved its primary objective as articulated in Section 5.2 and other parts of the preceding chapters. This study was limited to three villages of a single municipality in Vhembe district. Data was obtained through individual semi-structured interviews with only 18 participants. Other municipalities in the Vhembe district could not be covered due to time and other logistical constrains, such as the reluctance of ardent traditionalist chiefs who erroneously viewed the research as an infraction to their own heritage. Therefore, the findings could not be transferable to the whole Vhembe district, Limpopo Province, or other part of the country. Other possible limiting factors were:

- The researcher introduced herself as a midwife to participants for transparency purpose. This caused other participants to be reluctant in sharing information about their neonatal care practices for fear of being recriminations. Some simply 'regurgitated' the health information provided at the clinic to impress the researcher.
- Younger mothers did not have enough information regarding indigenous neonatal practices. However, they were able to impart their indigenous neonatal care experiences to the researcher, notwithstanding that they could not explain the reasons behind each practice in detail.
- Indigenous knowledge holders and traditional health practitioners were reluctant to reveal other names of herbs used during the care of the neonate. Only a few were revealed due to the norm of secrecy that is characteristic of many other cultural practices.
- The researcher could not collect data through observations as planned, owing to the restrictions of access into the neonates' homes while they were less than three months.

5.5 RECOMMENDATIONS

In essence, recommendations reflect the researcher's propositions regarding the investigation (de Vos et al., 2012:119). This study has revealed a crucial finding of a form of an 'assimilated' or 'amalgamated' adoption of both indigenous and public healthcare approaches (Idang, 2015:99). The researcher contends that in the South

African context, modernisation has imposed an unfettered dominance of Western modes of living, such that the 'purity' of cultures is more of an exegetic ideal than a practical reality. Against such a background, the current study also found that there were significant numbers of participants who adhered to both indigenous neonatal care practices and the western biomedical system for the general wellbeing of their neonates. Based on these findings, three main recommendations are proposed in respect of nursing practice, nursing education, and further research.

5.5.1 Nursing Practice Recommendations

- Healthcare professionals, particularly the midwives and the PHC nurses, should be informed about indigenous neonatal care practices of the communities they serve in order to plan relevant culture-sensitive health education programmes for their clients.
- The Department of health at provincial level should include information of benefits and dangers of indigenous neonatal care practices on platforms such as MomConnect.
- Health education on the use of herbs for the neonate should be offered from antenatal care to postnatal care. Healthcare professionals should encourage the mothers to bring the caregivers with them to the postnatal visits so that they can also receive health education.
- Health care workers should encourage safe indigenous neonatal care practices to show the community that the biomedical system is willing to work collaboratively with the community, and not completely eradicate the use of indigenous neonatal care practices. This will also encourage the mothers and caregivers to disclose their use on indigenous neonatal care practices.
- Indigenous neonatal knowledge holders and traditional healthcare practices ought to be informed on the dangers of unsafe indigenous neonatal care practices.

5.5.2 Nursing Education Recommendations

Information on indigenous knowledge should be incorporated in the midwifery curriculum. Indigenous neonatal care practices be included as a midwifery module to equip future midwives with relevant information in the provision of culture-sensitive midwifery care.

5.5.3 Future Research Recommendations

Essentially, these recommendations are framed in the context of improving some aspect of the study to enhance the overall impression of the research process and validity of the findings for aspiring researchers in the same field of indigenous neonatal care practices (Donley and Graueholz, 2012:34). In this regard, the following are recommended:

- Clinical research that will look into the safety of herbs and animal fats/oils used in the prevention and treatment of neonatal illnesses.
- An ethnographic study that will conduct similar research in neighbouring villages outside of Vhembe District.

5.6 STUDY CONTRIBUTION

This study contributes to knowledge creation on indigenous neonatal care practices of mothers and caregivers. The study could make healthcare professional particularly midwives aware of the neonatal care practices carried out by mothers and caregivers in their community. Other studies could be conducted to look into the scientific healing properties of pork oil and other herbs used by mothers and caregivers in the care of the neonate. This study has the potential to propel similar studies by other researchers in other settings around South Africa.

5.7 CONCLUSION

Indigenous neonatal care practices of mothers and caregivers in the Vhembe district of Limpopo Province were explored, identified and described by employing a qualitative, explorative, descriptive research design approach. Data was generated through semi-structured individual interviews with the mothers, caregivers, indigenous knowledge holders and the traditional health practitioners.

This study revealed that women use indigenous neonatal care practices across age groups, social standing and level of education. Younger mothers receive guidance from the older women in their family or community. It was also found that women cared and protected neonates in the same manner that their elders did for centuries before them. However, some assimilated Western biomedical healthcare practices were also adopted in some instances to ensure that the neonates were afforded optimal protection against illnesses and a range of other environmental and external threats

or hazards. Safe and unsafe indigenous neonatal care practices were identified and described and made known to the participants on the spot by the researcher. They were also commended for using safe practices, which validates the study's optimal achievement of its stated purpose.

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Annexure A: Approval Certificate from UP Health Ethics Committee

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved on 22 May 2002 and Expires 03/29/2022.
- IRB 0000 2235 IORG0001762 Approved on 22/04/2014 and Expires 03/14/2020.

9 May 2019

Approval Certificate
New Application

Ethics Reference No.: 107/2019
Title: AN EXPLORATION OF THE INDIGENOUS NEONATAL CARE PRACTICES OF MOTHERS AND CAREGIVERS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

Dear Mrs PM Tulelo

The **New Application** as supported by documents received between 2019-04-01 and 2019-04-24 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-04-24.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-05-09.
- Please remember to use your protocol number (107/2019) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:

- Approval is conditional upon the Research Ethics Committee receiving permission from the Research sites.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 46 and 45. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2016 (Department of Health).

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
Email dericeka.tshaki@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Annexure B: Letter of Approval from Limpopo Province Department of Health

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref: LP_201905_004

Enquires : Dr Ramalivhana NJ
Tel : 015-2936206
Email : Naledzani.ramalivhana@dhsd.limpopo.gov.za

PATIENCE MASHUDU TULELO
FACULTY OF HEALTH SCIENCES SCHOOL OF HEALTH CARE SCIENCES
DEPARTMENT OF NURSING SCIENCE
41 HESSEA STREET DOORNPOORT
PRETORIA 0086 ; CELL: 079 496 7220 E-MAIL: MASHTULE@GMAIL.COM

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

AN EXPLORATION OF THE INDIGENOUS NEONATAL CARE PRACTICES OF MOTHERS AND CAREGIVERS IN VHEMBE DISTRICT, LIMPOPO PROVINCE.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1-year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

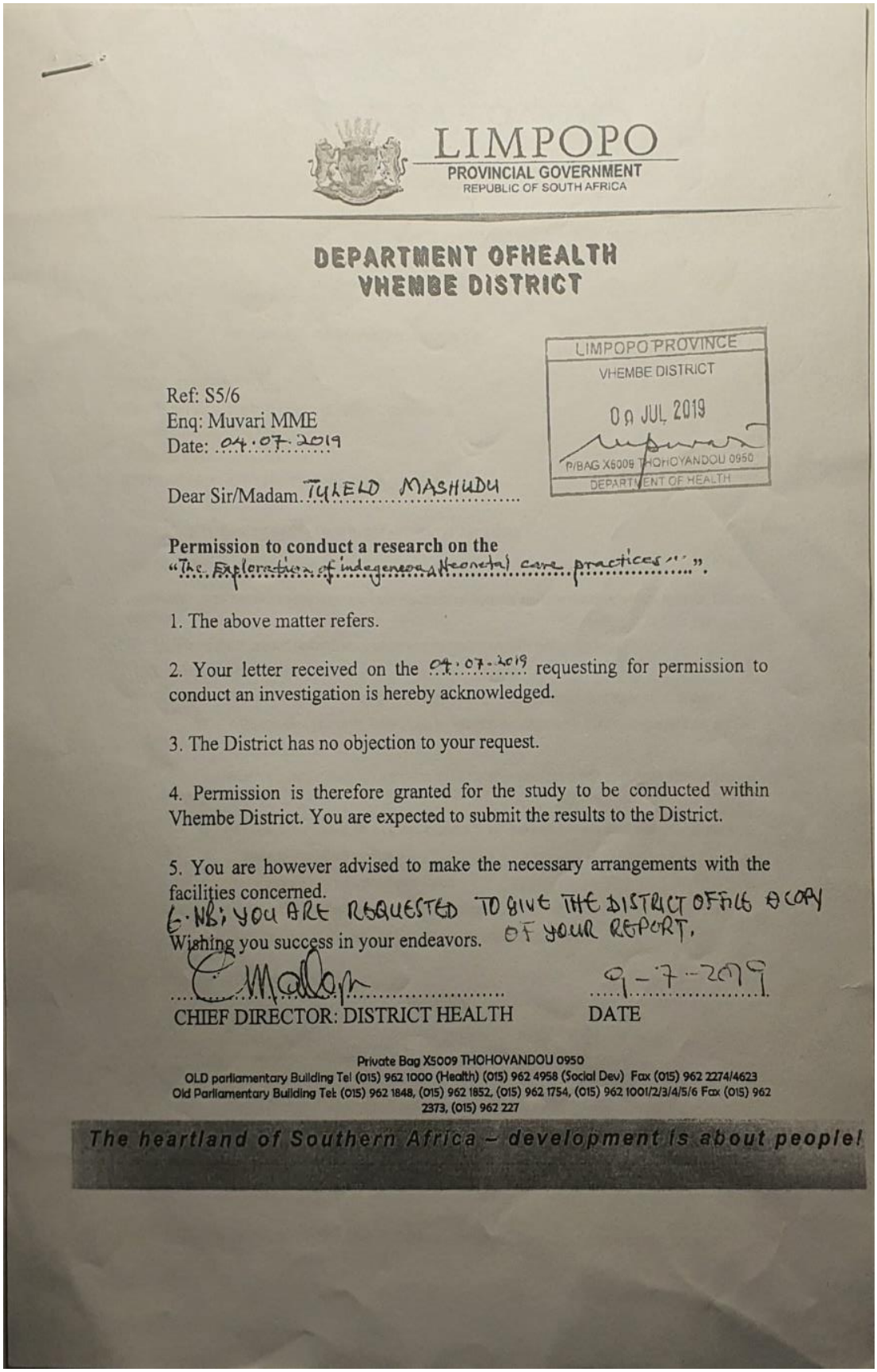
Your cooperation will be highly appreciated

Head of Department
Dr Mhlongo TF

27/06/19
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.

Annexure C: Approval Letter from Vhembe District Department of Health



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

LIMPOPO PROVINCE
VHEMBE DISTRICT
09 JUL 2019
P/BAG X5009 THOHOYANDOU 0950
DEPARTMENT OF HEALTH

Ref: S5/6
Enq: Muvari MME
Date: 04.07.2019

Dear Sir/Madam. TULELO MASHUDU

Permission to conduct a research on the
"The Exploration of indegenous Neonatal care practices".

1. The above matter refers.

2. Your letter received on the 04.07.2019 requesting for permission to conduct an investigation is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the study to be conducted within Vhembe District. You are expected to submit the results to the District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

6. NB; YOU ARE REQUESTED TO GIVE THE DISTRICT OFFICE A COPY OF YOUR REPORT.

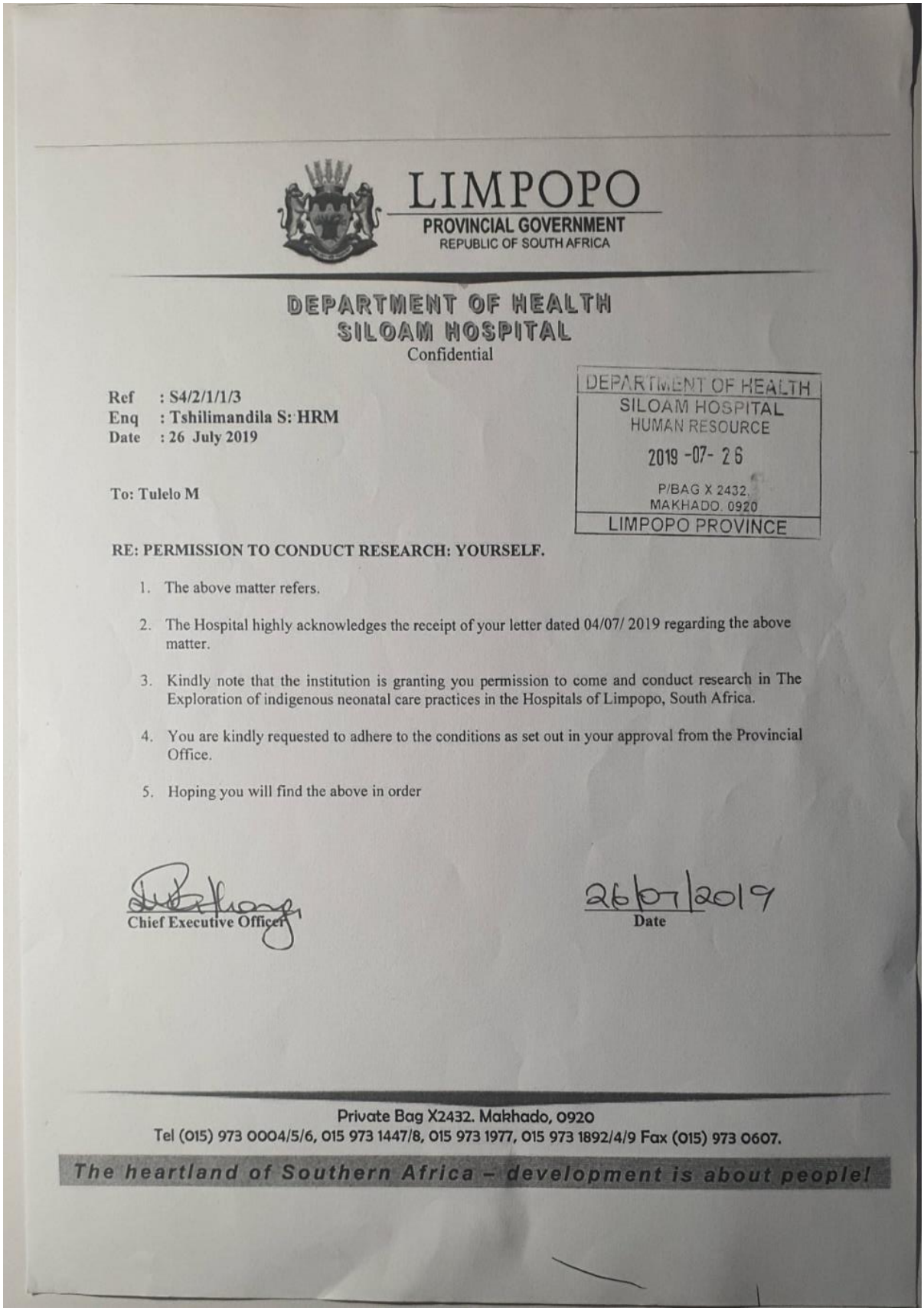
Wishing you success in your endeavors.

CHIEF DIRECTOR: DISTRICT HEALTH — DATE 9-7-2019

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

The heartland of Southern Africa – development is about people!

Annexure D: Approval Letter from Siloam Hospital



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SILOAM HOSPITAL
Confidential

DEPARTMENT OF HEALTH
SILOAM HOSPITAL
HUMAN RESOURCE
2019 -07- 26
P/BAG X 2432,
MAKHADO, 0920
LIMPOPO PROVINCE

Ref : S4/2/1/1/3
Enq : Tshilimandila S: HRM
Date : 26 July 2019

To: Tulelo M

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

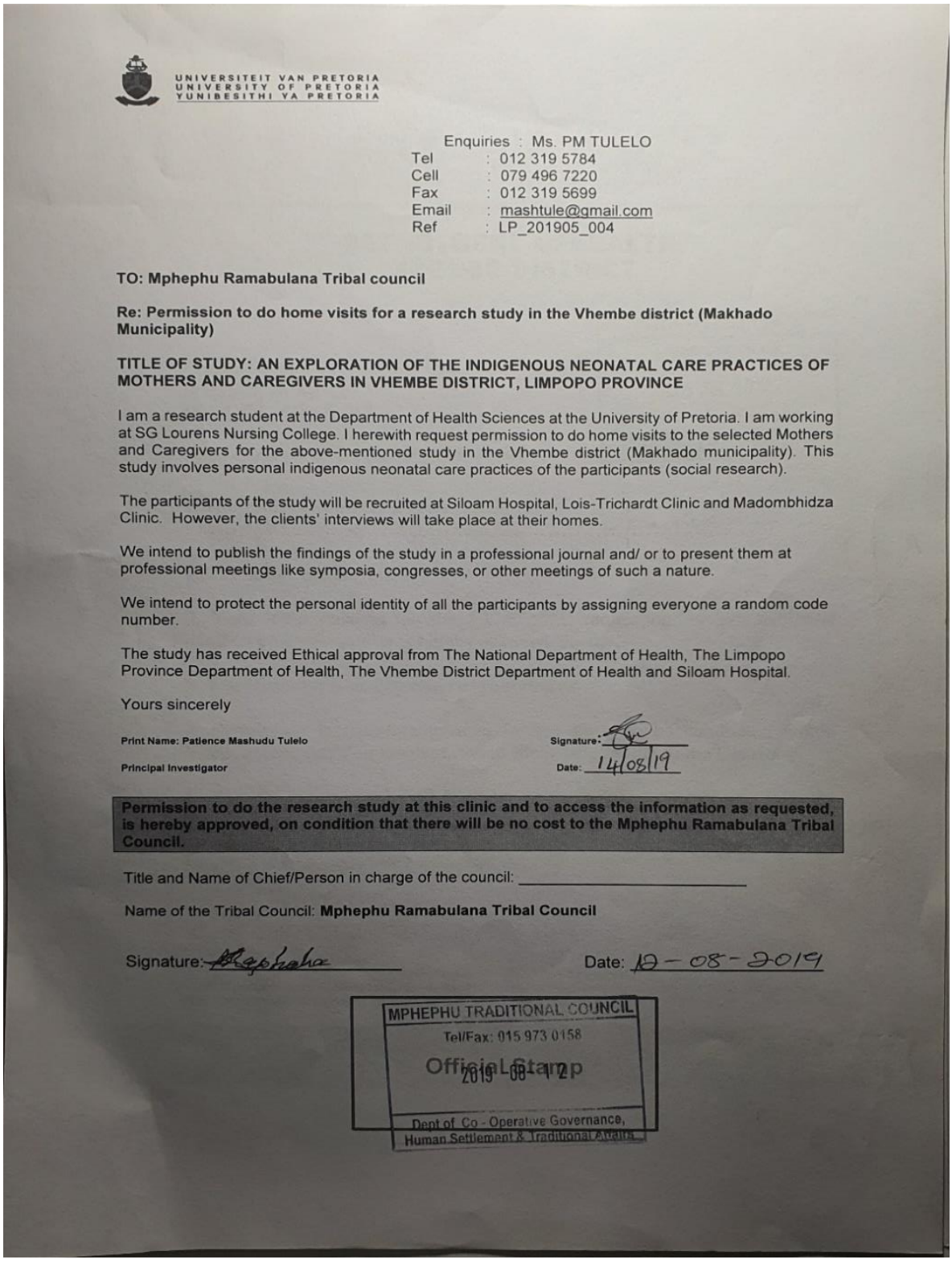
1. The above matter refers.
2. The Hospital highly acknowledges the receipt of your letter dated 04/07/ 2019 regarding the above matter.
3. Kindly note that the institution is granting you permission to come and conduct research in The Exploration of indigenous neonatal care practices in the Hospitals of Limpopo, South Africa.
4. You are kindly requested to adhere to the conditions as set out in your approval from the Provincial Office.
5. Hoping you will find the above in order

Chief Executive Officer

26/07/2019
Date

Private Bag X2432. Makhado, 0920
Tel (015) 973 0004/5/6, 015 973 1447/8, 015 973 1977, 015 973 1892/4/9 Fax (015) 973 0607.
The heartland of Southern Africa – development is about people!

Annexure E: Permission Letter form the Mphephu Traditional Council



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Enquiries : Ms. PM TULELO
Tel : 012 319 5784
Cell : 079 496 7220
Fax : 012 319 5699
Email : mashtule@gmail.com
Ref : LP_201905_004

TO: Mphephu Ramabulana Tribal council

Re: Permission to do home visits for a research study in the Vhembe district (Makhado Municipality)

TITLE OF STUDY: AN EXPLORATION OF THE INDIGENOUS NEONATAL CARE PRACTICES OF MOTHERS AND CAREGIVERS IN VHEMBE DISTRICT, LIMPOPO PROVINCE

I am a research student at the Department of Health Sciences at the University of Pretoria. I am working at SG Lourens Nursing College. I herewith request permission to do home visits to the selected Mothers and Caregivers for the above-mentioned study in the Vhembe district (Makhado municipality). This study involves personal indigenous neonatal care practices of the participants (social research).

The participants of the study will be recruited at Siloam Hospital, Lois-Trichardt Clinic and Madombhidza Clinic. However, the clients' interviews will take place at their homes.

We intend to publish the findings of the study in a professional journal and/ or to present them at professional meetings like symposia, congresses, or other meetings of such a nature.

We intend to protect the personal identity of all the participants by assigning everyone a random code number.

The study has received Ethical approval from The National Department of Health, The Limpopo Province Department of Health, The Vhembe District Department of Health and Siloam Hospital.

Yours sincerely

Print Name: Patience Mashudu Tulelo
Principal Investigator

Signature:
Date: 14/08/19

Permission to do the research study at this clinic and to access the information as requested, is hereby approved, on condition that there will be no cost to the Mphephu Ramabulana Tribal Council.

Title and Name of Chief/Person in charge of the council: _____

Name of the Tribal Council: **Mphephu Ramabulana Tribal Council**

Signature: Mphaha Date: 12-08-2019

MPHEPHU TRADITIONAL COUNCIL
Tel/Fax: 015 973 0158
Official Stamp
2019 -08- 12
Dept of Co - Operative Governance, Human Settlement & Traditional Affairs

Annexure F: Information Leaflet and Informed Consent

Dear Participants

1. Introduction

You are cordially invited to participate in this research study entitled:

An Exploration of the Indigenous Neonatal Care Practices of Mothers and Caregivers in Vhembe District, Limpopo Province

This information leaflet should enable you to make a well-considered decision. Before you decide to take part, you should fully understand what is involved. Should this leaflet fail to produce all the needed clarification in relation to the study, feel free to ask the researcher for further information.

2. The nature and Purpose of the Study

The purpose of this study is to understand the indigenous neonatal care practices of mothers and caregivers.

3. Explanation of Procedures to be Followed

This study will be conducted by means of semi-structured interviews and observations which will last for a maximum of 60 minutes. The researcher will ask you some questions about the traditional baby care practices that you carry out in raising the child. Notes will be taken down during the interview, audio recorder will be used to record the interview with your permission. Participation in the study is voluntary. If you decide to withdraw from the study at any time, you can do so without an explanation.

4. Risk of Discomfort Involved

There are no risks resulting from your participation in this study.

5. Possible Benefits of the Study

Through the interviews nurses and other health care professionals may learn more about how indigenous mothers and caregivers take care of neonates. This will assist us in knowing the kind of health awareness the community needs.

6. What are your rights as the participant?

Your participation in this study in voluntary. You can refuse to participate or stop at any time during the study without an explanation. Your withdrawal will not affect you in any way.

7. Has the study received ethical approval?

The study has been approved by the University Of Pretoria Faculty Of Health Sciences Research Ethics Committee. If you have questions regarding Ethical clearance of this study, please contact the secretariat of the Faculty of Health Sciences Research Ethics Committee on: 012 356 3085

8. Information and contact person

The contact person for the study is Ms. PM Tulelo. If you have any questions about the study kindly contact me at the following telephone numbers: Ms PM Tulelo: 012 319 5672/ 0794967220, alternatively you may contact my supervisor Dr R Rikhotso on 012 356 3155

9. Compensation

Your participation is voluntary. No compensation will be given for your participation.

10. Confidentiality

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your clinic.

CONSENT TO PARTICIPATE IN THE STUDY

I confirm that the person asking for my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had the time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to withdraw or discontinue with the study.

Participant's name: _____ (Please print)

Participant's signature: _____ Date _____

Investigator's name: _____ (Please print)

Investigator's signature_____ Date _____

Witness's name: _____ (Please print)

Witness's signature: _____

Annexure G: Tshivenda Participant Leaflet and Informed Consent Form

Bambiri la a Shelaho Mulenzhe na Fomo yau Tendelana na Thodisiso

Thoho ya Thodisiso: Thandavhudzo ya Ndila ya Sialala ya u Londa Vhana ine ya Shumiswa Nga Vho Mme na Vhathusi kha Tshitiriki Tsha Vhembe, Vunduni la Limpopo

Ha vha shelaho mulenzhe,

1. Mvula tswinga

Mutodisisi u vha ramba u shela mulenzhe kha thandela u ita thodisiso. Fomo iyi I do vha thusa u dzhia tsheo ya shela mulenzhe kha thodisiso iyi. Vha saathu u dzhia tsheo ya u shela mulenzhe, vha tea u pfesesa uri zwi tshimbila hani. Arali fomo iyi ya kundelwa u bvisela khagala mbudziso dzavho, vho tendelwa u vhudzisa mutodisisi uri a talutshedze hafhu.

2. Tshiimo na ndivho ya thodisiso

Ndivho ya thodisiso ndi u linga u pfesesa ndila dza sialala dza u londola vhana nga vhathusi na vho mme vhone vhane.

3. Thalutshedzo ya ndila ine ya do tevhelwa

Thodisio iyi I do tshimbizwa nga ndila yo dzudzanywaho ya nyambedzano ine ya do dzhia miniti ya furathi. Mutodisisi u do vha vhudzisa nga ha ndila dza sialala dza u alusa nwana. Hu do vha na u nwala fhadzi phindulo dzavho, ha do vha hafhu ha rikhodiwa musi vhone vho no tendelana nazwo. Vha shela mulenzhe hu sina u kombetshezwa. Arali vha dzhia tsheo ya u di bvisa kha thodisiso naho yo no vha vhukati, vha nga zwi ita vha songo talutshedza uri ndi ngani vho dzhia iyo tsheo.

4. Khonadzeo dza khombo kana masia-ndaitwa a u shela mulenzhe

A hu na khombo kha u shela mulenzhe kha thodisiso iyi.

5. Mbuelo dza thodisiso

Nyambedzano zwi do thusa uri ri divhe ndila zwavho zwa u londa vhana.

6. Pfanelo dzavho ndi dzifhio sa muthu ane a khou shela mulenzhe?

Vha shela mulenzhe nga u funa. Vha nga hana kana vha litsha vhukatini hu sina thalutshedzo. U litsha havho a zwi nga vhi na masiandaitwa.

7. Thodisiso yo tendelwa?Thodisiso yo tendelwa nga komiti ya thodisiso kha muhasho wa zwa mutakalo na saintsi University ya Pretoria. Arali vha na mbudziso nga ha iyi thodisiso vha nga kwama mungwaleli wa komiti ya thodisiso kha nomboro dzi tevhelaho: 012 356 3085

8. Hune vha toda ndivho na vhane vha nga vha kwama

Vhane vha nga davhidzana navho ndi. PM Tulelo. Arali vha na mbudziso nga ha iyi thodisiso vha nga vha kwama kha nomboro dzi tevhelaho: Vho PM Tulelo: 012 319 5672/ 079 496 7220, Vha nga dovha hafhu vha kwama mulanguli wanga Dr R Rikhotso on 012 356 3155.

9. Ndiliso

U shela havho mulenzhe ndi u tou di nekedzela. A hu na ndiliso kha u shela havho mulenzhe.

10. U tsireledzea ha maambwa

Zwothe zwine vha bula zwo tsireledzea. Musi ro no sedzulusa mafhungo othe a huna ane a do divha zwe vhone vha bula. Manwalwa othe a bugu dza thodisiso a dzi nga kateli zwine zwa nga ta vhone sa muthu kana vhuongelo havho

THENDELO YA U SHELA MULENZHE KHA THODISISO

Ndi a tenda uri muthu ane a khou humbela uri ndi shele mulenzhe kha thodisiso o talutshedza nga ya ndivho, ndila ine ya do tevhelwa, khombo na zwidodombezwa zwothe nga ha thodisiso iyi. Ndo dovha hafhu nda tanganedza, ndo vhala na u pfesesa zwothe zwo nwalwaho afho ntha zwi kwamaho thodisiso iyi. Ndi a divha uri mvelele dza thodisiso iyi dzi do gandisiwa kha mivhigo ya thodisiso hu songo bulwa dzina. .Ndi khou shela mulenzhe ndi songo kombetshezwa. Ndo newa tshikhala tsha u vhudzisa mbudziso nahone a thi kolonwi kha u shela mulenzhe. Ndi a pfesesa uri a huna ndatiso arali nda khetha u litsha u isa phanda na thodisiso.

Dzina la a shelaho mulenzhe: _____ (Kha vha dodombedze)

Tshigando kana signature: _____ Datumu _____

Dzina la mutodisisi: _____ (Kha vha dodombedze)

Tshigando kana signature: _____ Datumu _____

Dzina la thanzi: _____ (Kha vha dodombedze):

Tshigando tsha thanzi: _____ Datumu: _____

Annexure H: Interview Guide

SECTION A: PARTICIPANT CHARACTERISTICS				
Age				
Gravidity				
Parity				
Born in Vhembe?	**No**		**Yes**	
Number of years living in Vhembe				
Relationship to neonate				
Educational level				
Employment status				
SECTION B: STUDY QUESTIONS (INDIGENOUS NEONATAL PRACTICES)				
Which indigenous neonatal care practices do you use when caring for neonates at home from the day it was born until now? Probing questions or follow up questions according to the answers given.				
Why do you care for the baby in that way?				
Who is helping you or advising you on the care of the baby				

Annexure I: Editor's Letter

PROOF OF ACADEMIC EDITING

This serves as proof of comprehensive academic editing, language control, text redaction, research methodology compatibility, and technical compliance for **Ms Patience Mashudu Tulelo (Student Number: 17054932)** in respect of her manuscript submitted to me for her Master in Nursing Education degree registered with the University of Pretoria, with the title:

An Exploration of the Indigenous Neonatal Care Practices of Mothers and Caregivers in Vhembe District, Limpopo Province

In my capacity as an independent academic editor, I attest that all possible measures have been expended to ensure that the final draft of **Ms PM Tulelo's** document reflects acceptable language control standards expected of postgraduate research studies.

I have further provided editorial support in respect of her academic supervisor's suggested corrections and recommendations in compliance with acceptable practices in research methodology.

Consistent with conventional ethical principles in research, I have further undertaken to keep all aspects of **Ms PM Tulelo's** study confidential, and as her own individual initiative.

Sincerely.

TJ Mkhonto
BA Ed: North-West University, Mahikeng Campus (1985)
M Ed: University of Massachusetts-at-Boston, USA, Harbor Campus (1987)
DTech: (Higher Education Curriculum Reform), University of Johannesburg (2008)

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Signed: _____ **Date:** _23 July 2020_

Dr TJ Mkhonto dd/mm/yyyy

Independent Academic Editor

Annexure J: Example of a transcript

INDIVIDUAL INTERVIEW

15 February 2020

Participant: P6HM (home interview not allowed in the house, interview took place outside while mother-in-law was in the house with the baby)

Age: 39

Baby Age: 4 weeks

Gravidity: 3

Parity: 3

Born in Vhembe: yes

Years staying in Vhembe: born and raised here

Educational level: standard ten (Matric)

Employment status: Employed

Key: R—Researcher

P—Participant

R— Good afternoon

P— Afternoon

R— my name is Mashudu Tulelo I am a student from the University of Pretoria. Like I have explained when we met at the clinic that I am conducting a research for my studies. Today for our appointment I am with Mrs Mavis Masutha who will be assisting me during our interview to take notes. We want to find out how do mothers of new babies in this area are taking care of their babies traditionally from the day the baby is born.

P— oh! Ok that is interesting!

R— do you agree to be part of the study to assist us with the information we need?

P— yes I do, I do not have a problem.

R— we need you to read the information leaflet and sign a consent form before we start asking you questions.

P— ok I will read and sign its fine.

(Read and signed the consent form)

R— we also are requesting to use a digital tape recorder to record you as you talk to us so that we can be able to write a complete report of what you and other participants has told us about your traditional care practices of new babies. Feel free to ask me anything during the interview if you need to.

P— there is no problem about that.

R— can we start with interview?

P— yes we can start

R—can you tell us how did you care for the baby hear at home since the baby was born until now? The question is focused on the traditional things that you did when you cared for the baby.

P— in our culture we do not raise babies on our own we raise babies with our elders. The elders tell us how we need to care for the baby and we conform to that to ensure that baby grows well.

R— is there an elder who is assisting you currently?

P— yes I am with my mother-in-law, she is the one helping me with the baby. She has been with me since a week before I delivered.

R— may you please share the things your mother-in-law is teaching you about caring for the baby with us?

P— the first day we arrive at home from the Hospital, my mother-in-law prepared a special bath for my baby. Baby needs to be bathed immediately we arrive at home.

R— I hear you refer to the bath as special how special is the bath?

P—it is special bath because it is not the bath that we are used to that we use soap and all the nice oils and powders. On the first day we do not have to use soap, we use water mixed with some herbs to bath the baby. We call this bath gumululo. The soap and the nice things we will use from the third day. After the baby have bathed then we make the baby drink a little bit of the water to complete the bathing ritual.

R—why is it important for the baby to be bathed in this way?

P— this kind of bathing frees the baby from mirundzi (evil spirits) and it helps the baby to be healthy and gain weight. It also protects the baby from the illnesses.

R—you have mentioned that you bath the baby in this way for only 3 days, how do you bath the baby after that?

P—after the three days we now bath the baby as normal with warm water and soap. Me and my mother-in-law we ensure that the room is warm before we can bath the baby. We ensure that the process is a fast one because if you take long it will cause baby to catch a cold. The eyes needs to be cleaned and wiped with breast milk and cotton wool after the bath

R— why do you use breast milk to wipe the baby's eyes?

P— it prevents and heals eye problems. Breast milk is the best medication you can ever find for a baby. It does not have chemicals it is natural, some of the medication they give at the clinics for the eyes is strong so it is safe to use breastmilk.

R—how did you care for the cord, do you also clean it after a bath as well?

P— the cord has fallen now, but I was advised by the clinic sister to buy the white spirit and cotton wool to clean the cord with. I used it but still three days passed the cord was still attached so I stopped using. I decided to use pork oil and it come off in two days after I have used pork oil.

R—how did you know that the pork oil helps?

P— oh! Pork oil, I have been using it with all my children. From home we have been using it my mother used it with her other grandchildren as well. It works very well the cord just falls off on the second or third day. The white spirit takes forever.

R—where do you get the oil?

P— I extract the oil from the meat by putting it in a saucepan and allowing the heat to melt the oil from the meat. Then that is our oil.

R— do you put any salt or flavouring?

P— no it has to be clean that is why we do not put any salt or spices.

R— oh I see, and when it comes to feeding how is the baby fed?

P— we feed the baby on the breast and we also give khongodoli.

R— what is Khongodoli?

P— it's just soft porridge made of brown maize meal mixed with a herb munengeledzi. But we prepare it differently from how the adult one is prepared. We make it to be very soft so that the baby will be able to swallow.

R— why is it mixed with the herb what does it do?

P— it helps the baby to be well and gain weight. Babies who are fed khongodoli are not troublesome, they do not get easily sick and they are calm. If you are not giving khongodoli your baby will always be crying and will have problems in the belly like tshilala (reflux and stomach cramps).

R— where do you get the herb from?

P— my mother-in-law got it from the woman who performs mithuso (a ritual performed for neonates) for babies.

R— how much porridge do you give and how much munengeledzi do you give the baby?

P— when the baby was small we used to give khongodoli once a day in the morning. But now we give twice, in the morning and in the evening. As for the munengeledzi we use a tip of the teaspoon because it is powder then we mix well with the khongodoli.

R— I heard you talking about mithuso what is that?

P— mithuso is a kind of ritual that is performed for the baby by Vhomaine (Traditional health practitioner).

R— why does a baby have to go through the mithuso ritual? Was it done for your baby?

P- We take the baby for mithuso for different things, but mostly is for protecting the baby from illnesses and mirundzi.

R— do you know what kind of illnesses is the baby protected from?

P- I am not sure exactly what illnesses are those but I know that tshilala and zwathavha are some of the illnesses that the baby needs to be protected from.

R— did you take your baby for this ritual?

P- Yes we went during the week already

R— was your baby sick when you took baby there?

P- (Laughs) No! Baby doesn't have to be sick first for us to take to Vhomaine, if you wait until the baby is sick it might be too late to protect the baby. It will mean you have to treat the baby because there is a problem already.

R— oh I see, I thought you need to take the baby for mithuso only when there is a problem.so you say even when the baby is not sick you still have to take the baby for mithuso?

P- Yes.

R— earlier you mentioned that the baby must be protected from mirundzi and zwathavha may you tell us what are those?

P- Mirundzi is the spirits that people carry that can make the baby sick. Athiri some people use muti for their own personal reasons, now if such a person comes in contact with the baby, the baby might get sick. Also if the baby comes in contact with other babies who went for mirundzi already the baby will get sick those babies vha kho mulemela (they are heavy for her).

R— oh I understand and zwathavha what kind of an illness is that one?

P- Yes I am coming to that, apparently as I hear the elders say it, they say if the baboon barks in the mountain or in the forest the baby might be hot and get a fit. I don't know how but that is what our elders tell us and I believe them.

R— so are you saying the baby will get a fit from a baboon bark even if the baboon is not nearby?

P- Yes that is what we are told and we choose to believe it. At least if your baby has went for mithuso she will not get a fit. Who wants a baby who has a fit time and again? You rather take your baby for mithuso and have a peace of mind.

R— I hear you? So at how many weeks must the baby go for mithuso?

P- It is different I don't know if there is a specific age but with me my babies do not go there at the same age. With my other babies they went when they were around 2 to 3 months I don't remember well. This one I went a bit early my mother-in-law advised as such because I took maternity leave early so I need to go back to work soon. It is better to take baby early for mithuso if you have to go to work. Like my baby will be going to day care my mother-in-law will go back to her house. So if I don't take baby for mithuso other babies will be heavy for her at the day care and my baby will start to be sickly.

R- I understand you are caring very well for your child. You are protective indeed. Is there anything Vhomaine gives you to make the baby drink or eat?

P— yes, we are given some medicines. The other one is for mixing with khongodoli the other one is to bath with the other one is for drinking.

R— do you know the names of the medicines or what they are made from?

P— no, I only know munengeledzi the one we mix with the food. But the drinking one and the bath one I don't know them.

R— how much do you make the baby drink of the drinking one?

P— we were told to give two teaspoons three times a day after the baby has fed on the breast.

R— do you know what is it for?

P— it is given to help prevent tshilala and help to flush out the green poop. Some people give gripe water we don't use gripe water we use the ones from Vhomaine.

R— oh I see, and the bath one? Why is it important for baby to be bathed with the medicines?

P— it helps with mirundzi, and because since we have been to Vhomaine we can now sit in the living area with other family members. We don't know where the others have been so they might be carrying mirundzi so the bath helps with that.

R— oh now I understand. When you say now you can sit in the living area with other family members, were not sitting with them?

P— (laughs) no we were not. Immediately when we come back from the hospital until the baby has been for mithuso we can't sit with everyone, it should just be me and the baby in the bedroom also my mother-in-law is allowed because she is the one helping me. Apart from her no one else. We are afraid of mirundzi.

R— oh I see, and are there any challenges that you face in raising the baby the way that you do?

P— no not at all I am a proud Venda woman I am not shy of how I care for the child.

R- that is interesting, thank you for all the information you have shared with us today. Is there anything you would like to ask us before we leave?

P- Pleasure I am happy I could help you, no I don't have any questions. Good luck with your studies

R- Thank you, good bye have a nice day going forward take care of the baby.

P- Good bye.