UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

TRADITIONAL DISEASE PREVENTION PRACTICES PERFORMED DURING INFANCY IN A DESIGNATED MUNICIPALITY WARD IN TSHWANE DISTRICT

Elizabeth Masetopana Ramaube

Student Number: 254 418 51

Submitted in fulfilment of the requirements for the degree

Magister Curationis (Clinical)

in the

Faculty of Health Sciences

at the University of Pretoria

July 2018

Supervisor: Dr RS Mogale

Co-Supervisor: Dr RN Ngunyulu

DECLARATION

I, **Elizabeth Ramaube**,

Student Number: 254 418 51

declare that:

"TRADITIONAL DISEASE PREVENTION PRACTICES PERFORMED DURING INFANCY IN A DESIGNATED MUNICIPALITY WARD IN TSHWANE DISTRICT"

is my own work and all the sources I have used or quoted, have been indicated and acknowledged by means of complete references, I further declare that this work has not been submitted for the degree at any other institution.

_____ _____

Signed **Date**

DEDICATION

This study is dedicated to the following important people in my life:

1. My loving husband Magomarela Caesar Ramaube for the support he gave throughout the study.
2. My mother Sarah Matheko Mofurutsi for her support and constantly praying for me during my entire study.
3. My beloved children Thabang, Moleseng and Bonolo, for their support and encouragement.
4. My loving sister, Mirriam Mofurutsi and her daughter Lesedi Seheri for their support to ensure that I complete the work.
5. My brother Michael Mofurutsi for his words of encouragement.
6. All my friends for their support and words of encouragement when I wanted to give up.

ACKNOWLEDGEMENTS

- I would like to thank God for giving me the strength and courage to complete my study.
- I would like to express my sincere gratitude and appreciation to the following people who made this study a success:
- Dr Ramadimetja Mogale, my supervisor, for her tireless support, guidance, motivation and encouragement throughout the study. I could not have proceeded to the finish line if it were not because of her patience and high level of skills to deal with students of my nature and character, may God bless her abundantly.
- Dr Richard Rikhotso for the support, guidance and assistance with coding.
- Dr Ntombifikile Klaas, my friend, for her support and who has been an inspiration to me and our friends.
- Both Drs Beth le Roux and Maretha De Waal for editing the proposal and the dissertation.
- Mr Mohlabani Chauke and Ms Moleseng Ramaube for your valuable computer skills.
- Ms Sarah Mpshane, my classmate, for the support, motivation and words of encouragement when I wanted to quit.
- The Gauteng Department of Health and City of Tshwane for granting me the permission to conduct the study at the health facility.
- The parents who participated in the study, thank you so much for trusting me with your confidential and valuable information, this study could not have been a success without your support.
- All my colleagues at work for their support, motivation and words of encouragement.

ABSTRACT

The aim of the study was to explore the traditional disease prevention practices performed during infancy in a designated area in Tshwane District. In South Africa, the majority of African people continue to perform traditional disease prevention practices in all stages of life; from pregnancy, infancy, childhood to adulthood. These practices are performed despite the outlaw of African Traditional Medicine by the Medical Association of South Africa in 1953 and unconstitutional Witchcraft Suppression Act of 1957 as amended in 1970.

Research design

This study followed a qualitative research approach that used sensory ethnography as a design. Sensory ethnography uses multisensory perceptions such as smell, touch, sight, taste and hearing concurrently with interviews and other forms of data generation techniques to develop knowledge. In this study, observations and documentation of artefacts and semi-structured interviews were used to explore the traditional disease prevention practices that are performed during infancy. Data were analysed using principles expounded by Roper and Shapiro (2000).The analytic processes were aided by Atlas.ti 7 qualitative data management software.

Insights

The analysis of the data yielded six motifs as: types of artefacts worn as the traditional practices, socio-cultural practices, type of healer performing the practices, period and duration for the effectiveness of the practice and ethnicity. Each motif has sub-motifs.

Conclusion

African communities perform traditional practices for disease prevention and health promotion, no matter where they are in the world. It is necessary for nurses, especially in primary health care settings, to have knowledge of such practices as they are constantly in contact with patients or clients throughout their careers.

TABLE OF CONTENTS

CHAPTER 1

OVERVIEW OF THE STUDY

CHAPTER 2

PARADIGMATIC, PHILOSOPHICAL PERSPECTIVES AND RESEARCH METHODOLOGY

CHAPTER 3

DATA ANALYSIS AND INTERPRETATIONS

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

LIST OF REFERENCES

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

LIST OF ABBREVIATIONS

CBD	Central Business District
ECD	Early Childhood Development
GP	General Practitioner
NHS	National Health Service
RDP	Reconstruction and Development Programme
UK	United Kingdom
WHO	World Health Organisation

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

"…the century of colonialism, cultural imperialism in Africa and apartheid in South Africa have held back the development of African traditional health care in general and medicines in particular. During several centuries of conquest and invasion, European systems of medicine were introduced (reinforced) by colonisers. Pre-existing African systems were stigmatised and marginalised. Indigenous knowledge systems were denied the chance to (be) systematise(d) and developed" (Hassim, Heywood and Berger, 2007: 200).

The knowledge of traditional disease prevention practices and health in humans has developed over many centuries and has been practised in many different parts of the world (Hassim, Heywood & Berger, 2007: 200). Mukoko, Coil and Bart (2015:225) indicate that traditional disease and health practices existed long before colonisation and still continue to outnumber biomedical healthcare practices. Adefolaju (2014:121) indicates that biomedical medicine was introduced to the African continent during colonisation by missionaries of the Christian faith. This led to the relegation of traditional medicine; with traditional healers being ridiculed and called "witch doctors". According to a study by Kayombo (2013:1), traditional remedies such as oral or bathing medication and wearing of an amulet on the arm or waist, that were administered to infants in sub-Saharan countries were suppressed by missionaries and the colonial governments in the period of 1930s – 1960s. The study further indicated that missionaries and biomedical personnel saw traditional practices for disease prevention as fetishes and paganism. Hence the colonial missionaries replaced these practices with baptism and Western health services.

The African health care system is considered to be part of cultural heritage, which has been accumulated over the years and has been passed from one generation to the next (Jali, 2012:213). Every culture has a health care system both for adults and children and is focused on socio-cultural practices (Kayombo, 2013:1). African people perform traditional disease and health practices, no matter where they are in the world (Thomas, 2010:606). A traditional health system is practised in high, middle and low-income countries, developed and developing countries, rural and urban areas as well as in informal and formal settlements, where African people exist in those areas.

In a study conducted in the United Kingdom, it was revealed that African people were still performing different traditional disease and health practices they were used to from their countries of birth, and also treating different ailments through traditional medicines (Thomas, 2010:607). The participants cited various reasons for why they continued to utilise traditional medicines and practices. The reasons included lack of trust and confidence in the National Health Service (NHS) of the Department of Health in the UK, unpleasant encounters with general practitioners, the short nature of GP consultations, widespread perceptions that doctors in the UK do not take their patients' needs seriously, and the difficulties people experienced in getting referrals to specialists (Thomas, 2010:608). Ngozi and Ugwuanyi (2014:3) in their study mention that the use of traditional medicine is almost universal. They further indicate that in Latin American countries, Asia, Africa and North America, traditional medicine is used to fulfil regular health necessities. In Africa, 75–80% of the population still uses traditional medicine for their health needs due to the fact that it is accessible, affordable, culturally acceptable, socially sanctioned and easy to prepare with little or no side effects (ibid). In South Africa, it is estimated that 60–80% of the population use the traditional medical sector as their first contact for advice and the treatment of health concerns. There is also an estimation that there are 250 000 to 300 000 healers in the country, which outnumbers biomedical health care practitioners, who are about 30 000 doctors and 200 000 nurses (Ayibor, 2008:11).

The services of the traditional health system are utilised both in urban and rural areas with high percentages of clients and healers in rural areas due to accessibility, low costs and the traditional healer's understanding of the culture of the clients (Semenya & Potgieter, 2014: 2). In their study, Shizha and Charema (2011:173) state that more than 70% of African people south of the Sahara, mostly in rural areas, rely on traditional medicine as their primary source of health care. In the rural areas of South Africa, traditional healers operate in close proximity and association with community members to treat various diseases and ailments since modern health facilities are either sparsely located or non-existent (Semenya & Potgieter, 2014: 2). These authors further revealed that most of the population in rural areas seek health advice from traditional healers before consulting biomedical doctors.

Traditional disease prevention and health practices result from the values of a specific culture. Mothers and caregivers who are unequipped with sufficient knowledge about infant care and using traditional disease prevention practices may cause harm to their infant's health and even cause disabilities (Beşer, Topçu, Coşkun, Erdem, Gelisken & Özer, 2010:137). The biomedical health system is a model that focuses mainly on biological factors in understanding illness. In accordance with the biomedical health system, health comprises of physical and biomedical processes that can be studied and manipulated (Grant, Haskins, Gaede & Horwood, 2013: 175). The authors further

explain that biomedical health professionals, in particular, nurses, in their line of duty are in attendance of patients who have previously been treated by traditional healers. On the realisation of complications, the patients from the traditional health care practitioners are self-referred to a primary health care setting and hospitals. This becomes difficult for biomedical health professionals to attend training. This study was intended to explore traditional disease prevention practices that are performed during infancy in a designated municipality ward in the Tshwane District. There was a need for practising health professionals who were in direct contact with infants to know and understand the different traditional disease prevention practices that are performed during infancy. to these patients, due to lack of knowledge on traditional health practices, as it is not included in their.

1.2 RATIONALE

The researcher, as a primary health care nurse, works in a diversified community and has been exposed to different cultural practices. For example, parents bring their infants to the health facility for immunisations and minor ailments. Some of the infants have different artefacts on their bodies that indicate exposure to traditional disease prevention practices. Health workers attending to these infants do not have knowledge of these traditional disease prevention practices. The researcher saw a need for biomedical health professionals to be capacitated with knowledge on different traditional disease prevention practices that are performed in infancy in the designated municipality ward in Tshwane District.

1.3 PROBLEM STATEMENT

The Medical Association of South Africa, in 1953, declared alternative therapies illegal and unscientific, and included provisions in the medical code that prohibited cooperation between biomedical and alternative health practitioners. The laws outlawed the practice of African Traditional Medicine believing that it was witchcraft (Abdullahi, 2011:116; Hassim, Heywood & Berger, 2007:200; Osuji, 2014:96). The Witchcraft Suppression Act of 1957 and the amended Witchcraft Suppression Act of 1970 prohibited diviner traditional healers from practising their trade. In 1974, during Apartheid, the Health Act together with the 1982 amendments restricted the performances of any act related to medical practices performed by traditional healers. Despite these restrictions, the majority of the South African population continued to use traditional health practices interchangeably with biomedical health services (Osuji, 2014: 96). Conversely, the ban and misinterpretations of traditional health practices in South Africa led to the recognition of the

training of biomedical health professionals (nurses, doctors included) only with an accompanying marginalisation of traditional health practices and knowledge. Health care professionals, particularly nurses, are placed to work with different ethnic groups on completion of their training. The placement is done despite the little or lack of knowledge of African traditional knowledge among the health professionals (Grant, Haskin, Gaede & Horwood, 2013: 175) regardless of them being Africans. When working with these different ethnic groups, nurses are expected to accept and respect the ethnocultural beliefs and values of their patients. This becomes a problem for the nurses as there are challenging traditional health practices that are perceived by biomedical health professionals as factors that pose health risks to their patients, and in this case infants.

Importantly, the Constitution of the Republic of South Africa, in the Bill of Rights, states that everyone has a right to access to health care services, and children have the right to basic health care services. In addition, persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community, to enjoy their culture unless inconsistent with any provision of the Bill of Rights. The current study explored and described the traditional disease prevention practices performed during infancy in a designated municipal ward in Tshwane District.

1.4 SIGNIFICANCE OF THE PROPOSED STUDY

The insights of the study might provide information and knowledge on different traditional health practices during infancy in different ethnic groups in a designated ward in Tshwane District. This knowledge could assist biomedical health professionals who provide health services to infants to appropriately integrate traditional disease prevention practices that are performed during infancy in a designated ward.

1.5 RESEARCH QUESTION

In this study, the research question was: What are traditional disease prevention practices that are performed during infancy in a designated municipality ward in Tshwane District?

1.6 AIM

In this study, the primary aim was: To explore and describe traditional disease prevention practices performed during infancy in a designated municipality ward in Tshwane District.

1.7 CONCEPTS CLARIFICATION

ARTEFACTS

Artefacts are things that people shape or make from natural resources (Spradley, 1980:5) and use in their day to day lives as part of their culture. Artefacts are active life presences that signal dimensions of participant histories that might be hidden or at least veiled in observations and interview dialogues (Rowsell, 2011:331). In this study, artefacts were the objects that infants were wearing on their bodies as part of their families' cultural tradition.

ETHNICITY

Ethnicity is a complex coalition of shared culture, values, traditions and perceptions of belonging (Higginbottom, 2004:586). In the study, ethnicity implied a group of people sharing a common nationality and cultural practices.

INFANCY

Infancy is a state or period of being an infant-child between birth and 12 months of age (Clarke, 2014:347). In this study, infant referred to a child from six weeks to 12 months, when they are taken for child health services by their parents or guardians.

CHILD HEALTH PRACTICES

Child health practices are practices which are performed for individual children or groups of children to enable them to develop and realise their potential, satisfy their needs and realise their necessities and develop the capabilities that allow them to interact successfully with their biological, physical and social environments (Kuo, Etzal, Chilton, Watson & Gorski, 2012). In this study, child health referred to any activity tailored towards the holistic development of an infant.

TRADITIONAL HEALER

A traditional healer is defined as an educated or lay person who has the ability or healing power to cure ailments traditionally. The traditional ability to cure or heal may be based on power or religion, the supernatural, experience, apprenticeship or family heritage (Traditional Health Practitioners Act, 2007:6). In this study, a traditional healer was someone who was consulted for traditional health practice or acquisition of the artefact for the infant.

TRADITIONAL DISEASE PREVENTION PRACTICE

Traditional disease prevention practice means the performance of the function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practices, this includes the diagnosis, treatment or prevention of physical or mental illness, and the rehabilitation of the person to enable that person to resume normal functioning within the family and community (Traditional Health Practitioners Act, 2007:6). In this study, traditional disease prevention practices were visible artefacts in the form of amulets and charms on the bodies of the infants.

TRADITIONAL MEDICINE

Traditional medicine refers to the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain wellbeing (Traditional Health Practitioners Act, 2007:6). In this study, traditional medicine was the African herbs such as *serokolo, dupa, stuipdruppels* as well as any object, or process that was followed before placing the artefact on the infant's body.

MUNICIPALITY WARD

According to the Local Government: Municipal Electoral Act, no 27 of 2000, a ward is a defined geographical area within a municipality, for the purpose of electing councillors who represent that area (SALGA & GTZ 2006:11). In this study, a ward meant a selected area within Tshwane District.

1.8 PHILOSOPHICAL ASSUMPTIONS

RESEARCH PARADIGM

Paradigm is the lens through which the researcher views the reality of the world and natural phenomena (Gerrish & Lacey, 2010:530). The research paradigm for this study was African philosophy which emphasises that African communities have a unique worldview that relies on cultural experiences (Lyons, Bike, Johnson & Bethea, 2011). This philosophy highlights that the traditional practices of African people are predominantly collective and similar (Chuwa, 2014:36). African philosophy falls under the naturalistic paradigm where reality is seen as an unfixed entity (Polit & Beck, 2008:15) but a construct by different individuals. The aim of choosing this paradigm is because the researcher, as a primary health care nurse, sought to study how the participants perform traditional health practices for infants from their African viewpoints. Chapter 2 will discuss African Philosophy as a paradigm for this study.

ASSUMPTIONS

Assumptions are basic principles that are believed to be true without proof or verification (Polit & Beck, 2012:12). As this is a qualitative study, the working assumptions were on ontology, epistemology and methodology as entailed in African philosophy. The discussion on African philosophy and its assumptions are detailed in Chapter 2.

1.8.1 ONTOLOGICAL ASSUMPTIONS

Ontology is the theory of the essence of things and their true nature (Terre Blanche , Durrheim & Painter, 2009:561). Ontology is about how the world is viewed (Botma, Greef, Mulaudzi & Wright, 2010:40). In this study, ontology as related to the paradigm of African philosophy, reality is determined by grounded cultural experiences and collective practices (Botma et al. 2010: 45).

1.8.2 EPISTEMOLOGICAL ASSUMPTIONS

Epistemology is the process of thinking; the relationship between what we know and what we see (Denzin & Lincoln, 2011:103). Epistemological assumptions deal with the nature of knowledge in terms of methods, theories, rules and procedures (Botma et al., 2010:40). In this study, the researcher explored and described traditional disease prevention practices that were performed

during infancy. Artefacts and semi-structured interviews assisted the researcher to come to know and understand the different traditional practices that are performed in infancy in the selected municipality ward.

1.8.3 METHODOLOGICAL ASSUMPTIONS

The methodology is the study of procedures or methods used in research to create new knowledge (Terre Blanche et al, 2009:104). Methodological assumptions are about the rules and procedures that specify how the researcher must study the phenomenon of interest (Botma, Greef, Mulaudzi & Wright, 2010: 41). This study followed a sensory ethnographic research design that used the senses and other ways of knowing (artefacts and semi-structured interviews) to explore and describe the traditional disease prevention practices performed during infancy in the selected municipality ward.

1.9 DELINEATION

The focus of this study was on traditional disease prevention practices that are performed specifically in infancy, and not in childhood. Only caregivers or mothers of infants with visible artefacts on their bodies who attended the clinic in the selected ward were the units of analysis in this study.

1.10 RESEARCH METHODOLOGY

This study followed a sensory ethnographic research design that used the senses and other ways of knowing (artefacts and semi-structured interviews) to explore and describe the traditional disease prevention practices performed on infants in a selected municipal ward in Tshwane District. Sensory ethnography is a critical and innovative qualitative research method which departs from a classic observational approach (Pink, 2009:8). In sensory ethnography, sensory perceptions and receptions are concurrently used with other forms of knowing in order to grasp knowledge that is otherwise inaccessible (Pink, 2009:8). In this study, the researcher collected data at the health facility when the mothers or caregivers brought their infants for child health services. In ethnographic studies, there is a need for a direct involvement and sustained contact with human agents, within the context of their daily lives, watching what happens, listening to what is said and asking questions (Pink, 2009:9). The researcher used a purposive sampling technique to recruit participants. The population in this study were the mothers or caregivers who brought the infants with visible artefacts on their bodies to the designated clinic. These mothers or caregivers had

knowledge of the processes that were followed as traditional disease prevention practices during infancy.

Through the permission of the parents, photos of the artefacts were taken without showing the face of the infant. The researcher conducted semi-structured interviews with the parents regarding artefacts and the processes they had to follow before acquiring them. The focus of the interview depended on the artefact that the researcher documented and observed from the infant (See Annexure B). Three questions were posed to the parents in order to acquire an understanding of the artefacts. An audiotape was utilised for recording entire interviews for easy transcription after consent was given by the participants. Field notes were also taken throughout the interviews.

Roper and Shapira's (2000: 98) framework of analysis was followed to analyse ethnographic data in this study. The analytic processes were aided by Atlas.ti 7 qualitative data management software. All collected data in the form of transcripts, photos and field notes were converted into rich text files (RTF) in order to be uploaded into the software. The researcher implored the assistance of the supervisors with the use of this software. The analysis yielded six motifs as types of artefacts worn as the traditional practices, socio-cultural practices, the type of healer performing the practices, period and duration of the effectiveness of the practice and ethnicity. Each motif has sub-motifs.

1.11 TRUSTWORTHINESS

Trustworthiness is defined by Polit and Beck (2012:745) as the degree of confidence the qualitative researchers has in their data. The researcher used the term "trustworthiness" to indicate how the qualitative validity of the findings were enhanced using the model of Lincoln and Guba as described by Yin (2009:40), Botma et al., (2010:233-234) and Brink, van der Walt and van Rensburg (2014:172-173). In chapter two, the researcher discusses trustworthiness in detail following criteria which are based on epistemological standards: credibility, dependability, transferability, confirmability and authenticity. A brief application of trustworthiness is explained under the following headings: Truth value, applicability, consistency and neutrality.

1.11.1 Truth value

According to Botma et al. (2010:233), the researcher uses truth value to determine her confidence that the information provided by the participants is truthful. In this study, credibility strategies were followed to establish the truth value. The anonymity of participants was maintained through the use of codes. Participants were reassured that the information collected during interviews would not be used against them.

1.11.2 **Applicability**

Applicability refers to the degree to which the findings can be applied to different contexts and groups (Botma et al. 2010:233). Applicability is the ability to use findings in another population or group applying the transferability strategy. The researcher selected participants purposefully; she selected participants who had infants with visible artefacts on their bodies. Data were collected until saturation was achieved.

1.11.3 Consistency

According to Botma et al., (1023:233) consistency is when the findings are consistent in case an inquiry should be replicated with the same participants in a similar context. Data were collected by the researcher, the voices of participants were recorded on an audio tape and transcripts, consultation with the supervisor were done to ensure consistency.

1.11.4 Neutrality

As stated by Botma et al., (2010:233) neutrality entails freedom from bias during the research process and results description. The confirmability strategy was followed in this study by the researcher to ensure freedom from biases. The data collected reflected the voices of the participants. To ensure triangulation, the researcher posed questions using different methods considering that the topic was sensitive.

1.12 ETHICAL CONSIDERATIONS

According to Burns and Groove (2011:61), ethics is defined as a branch of philosophy that operates with certain principles and standards. It is about how we distinguish between right and wrong, good or evil in relation to the actions, violations and characters of human beings (Caulla, 2014: xvii). Research ethics address the question which ethically and relevantly influences the researcher's intervention, which could bear on the research, in addition, is concerned with the procedures that should be applied for protecting those who participate in the research (Flick, 2014:47). In this study, the researcher adhered to the following ethical considerations:

1.12.1 Permission to perform a study

The researcher received permission to conduct the study from the Ethics Committee of the University of Pretoria and Gauteng Department of Health (See Annexure D).

1.12.2 Informed consent

Burns and Groove (2011:201) define consent as the permission or agreement to participate in the study; after the essential information has been provided to the participant. Protection of participants from harm and voluntary participation as basic ethical principles were maintained through the concept of informal consent (Brink et al, 2014, 38). In the study, the participants were provided with information verbally and then received the leaflet which explained the aims and objectives of the study. The participants were all above 18 years and displayed a normal degree of understanding. They were informed of their rights to withdraw from the study at any stage should they choose to. In chapter two, the researcher discusses in detail the principles of beneficence, respect for human dignity, justice and right to confidentiality.

1.13 OUTLINE OF THE STUDY

Chapter 1: Overview of the study

The chapter introduces the topic and background of the study, the purpose, objective and questions of the research are also discussed in this chapter. The concepts of importance to the study are clarified with a brief introduction of the research method that was followed in this study.

Chapter 2: Research Method

The second chapter presents a detailed description of the paradigm that underpinned the study, the research design and methodology. The research population, sampling and data collection techniques used in the study are outlined in this chapter. Furthermore, this chapter describes the ethical considerations and discusses the processes used for data collection. In conclusion, the chapter discusses the strategies applied to ensure the trustworthiness of the study.

Chapter 3: Discussion of the data analysis and interpretation

The chapter reports on the data analysis and interpretation of the insights. The chapter outlines the steps that were followed to analyse the data and how the motifs in this study were reached.

Chapter 4: Discussion of the insights of the study

The chapter discusses the insights of the study with the support from relevant literature.

Chapter 5: Implications, Recommandations, Limitations and Conclusions

This chapter discusses the conclusions and implications of the study. Recommendations and limitations are also discussed.

1.14 SUMMARY

This chapter provided an overview of the study through introduction and background, rationale, and problem statement, the significance of the study, research questions, aims, objectives, concepts clarification, delineation and overview of the research methodology as well as an outline of the chapters. The next chapter will discuss, in detail, the paradigmatic and philosophical perspectives as well as the research method of the study.

CHAPTER 2
PARADIGMATIC, PHILOSOPHICAL PERSPECTIVES AND RESEARCH METHODOLOGY

2.1 INTRODUCTION

The previous chapter discussed the introduction, rationale, problem statement, significance of this study. Additionally, it presented the research questions, aim, objectives, concepts clarification, delineation and overview of the research methodology. This chapter describes the research paradigm as African philosophy that underpinned this study, together with its philosophical assumptions. The chapter also discusses the research methodology that was followed to answer the posed research question: What are the traditional disease prevention practices that are performed during infancy in a selected municipal ward in Tshwane District?

2.2 RESEARCH PARADIGM

Paradigm is the lens through which the researcher views the reality of the world and natural phenomena (Gerrish & Lacey, 2010:530). According to Ndubuisi (2013:223), a paradigm provides a conceptual framework for seeing and making sense of the social world. Kuhn (1970:184) defines a paradigm as the underlying assumptions and intellectual structure upon which research and development in a field of inquiry are based. Ndubuisi (ibid) elaborates further on the description by stating that a paradigm is a rational inquiry or reflection on the basic beliefs, worldview, thoughts and assumptions of the people.

This study was underpinned by African philosophy as a paradigm. African philosophy emphasises that African communities have a unique worldview that relies on cultural experiences (Lyons, Bike, Johnson & Bethea, 2011:155). African philosophy highlights that the traditional practices of African people are predominantly collective and similar (Chuwa, 2014:36). African philosophy falls under the naturalistic paradigm, where reality is seen not as a fixed entity (Polit & Beck, 2008:15), but a construct by different individuals. The aim of choosing this paradigm was because the researcher, as an African primary health care nurse who is in constant contact with infants wearing traditional artefacts, wanted to have a better understanding of the lives of African people from their viewpoint.

Airoboman and Asekhauno (2012:14) explain African philosophy from the classical work of Mbiti as understanding, attitudes of mind and perception, behind which Africans think, act or speak in different situations of life. They further explain that African philosophy is extracted from proverbs and morals of oral tradition. Still, in support of oral tradition as the key factor in African philosophy, Jaja (2014:11) defines African philosophy as the reflection based on experiences of ancestors. This simply means that the living people continue to practice what was performed by their ancestors. African philosophy is also explained as a discourse according to which people's understanding, organisation and enactment of their cultural experiences are being made sensed of.

According to Ndubuisi (2013:224), to develop a clear understanding of African philosophy, African identity should be clarified. He outlines a few characteristics of African identity. The first characteristic is called the African mind or consciousness, which plays an important role in philosophical inquiries and search for identity. This type of identity develops first in an individual as self-consciousness and later develops to become group consciousness. People living together in the same community become aware that they share common experiences, goals and culture (Ndubuisi, 2013:224).

The second characteristic in African philosophy is colour. Ndubuisi (2013:224) explains that black has been an element of African identity in a large continent where most of the people are Black, and known as Africans.

The third characteristic, which identifies the African people from the non-African group, is the high level of generosity and hospitality (Ndubuisi, 2013:224). African people easily welcome unknown people into their community. At the centre of African identity, there is an element self-hood which later develops on others. The African is not just being but being with others. The theory of communalism which has been seen in different groups and norms of African societies develops.

From a spiritual perspective, Momoh (1998:40) states that African philosophy is about African doctrines or theories on reality (being) and the universe which is made up of things such as God, gods, life, life after death, reincarnation, spirit, society, man, ancestors, heaven, hell, things, institutions, beliefs, conceptions, practices, and more. Okolo (1990:10) opines that African philosophy is a path to a systemic coherent discovery and disclosure of the African as a being in the African world. Through African philosophy; Africans disclosed themselves to their world by critical reflection to grasp African realities such as the artefacts which are worn in infancy as traditional disease preventive measures.

2.2.1 EVOLUTION OF AFRICAN PHILOSOPHY

In his critique on the question of African Philosophy, Omotosho (2014:62) outlines the three phases in which Makinde explains the evolution of African philosophy. Those three phases are known as unwritten philosophy and unknown philosophers, a reorientation in philosophy and the colonial ethnographers and Ethno-philosophers, the third phase is a critical reorientation in philosophy and the contemporary African philosophers.

First phase: Unwritten philosophy and unknown philosophers. The Africans in this era did and taught philosophy but had not documented it. The philosophical thoughts were kept in the mind of the people and passed from generation to generation through proportion learning. During that time, missionaries and anthropologists mistakenly considered African thoughts as the collective thought of the people of Africa – Ethno philosophy (Makinde1989:89; Omotosho, 2014:63).

In the second phase: Reorientation in philosophy and colonial ethnographers and Ethno-philosophers. During this phase, there were mainly colonial scholars, European missionaries, ethnologists, ethnographers and indigenous African scholars whose main aim was to study Africa through their traditional religious culture. Their efforts revealed that there is African thought wherein both philosophical and ontological thought lies (Makinde1989:89; Omotosho, 2014:63).

The third phase: This phase entails a critical reorientation in philosophy and the contemporary African Philosophy where mostly, the trained African philosophers react against colonial ethnographers and ethnophilosophers. This is the phase wherein the current study was premised with the aim of exploring and describing the traditional disease preventive practices that are performed during infancy among the African people of South Africa.

2.2.2 Tenets of African philosophy

Tenet is a Latin word which means the body of principles that underlie the beliefs, customs and practices of a culture (Schonfeld, 2013:98). According to Umeogu (2013:113), some of the tenets of African philosophy are that it must be rational, scientific and organised.

The rational aspects of African philosophy

According to Verharen, Gutema, Tharakan, Bugarin, Fortunak, Kaidoa, Lui and Middendorf (2014), in the most practical sense to be rational means to pursue a goal with appropriate means and use of reason to connect experience through concepts. Umeogu (2013:113) explains that rationality is based on rational thoughts. If a man is said to be a rational being, he must possess rational thoughts to philosophise by showing the ability to probe, enquire, ask questions, understand, explain and ability to clarify issues happening in a cultural environment.

All the philosophers either Chinese, European or Indian pose varying characteristics. However, the common thing about them is that they address issues of ontological, epistemological and moral philosophy from a rationally critical point of view. The same applies to African philosophy as it raises cosmological, ontological, epistemological and ethical questions (Gutema, 2015: 140-141).

The scientific aspect of African Philosophy

According to Waghid (2016:11), science is the term that explains justifications that are offered in defence of a particular view. He further explains that African Philosophy is a way in which people's cultural, social, political and economic practices are justified (ibid).

The other base of African philosophy is being scientific, this implies that science in African philosophy has to be organised and proven. As a science, African philosophy must be specific, public, impersonal and objective (Umeogu, 2013:114). The use of artefacts for traditional disease prevention practice has been justified by parents.

Bondurin (1981:162) explains that African philosophy is about critically thinking as African philosophers have thoughts and judgement that are guided by the power of reasoning and insight, rather than the authority of communal consensus. Waghid (2004:57) echoes that African philosophers made reasoning more noticeable, as people are able to articulate clear, logical and defensible arguments.

Critical thinking in African philosophy

According to Letseka (2013:749), critical thinking entails judging authenticity, worth or accuracy of something that is essentially evaluative. The critical aspects of African philosophy can be seen on sources such as proverbs to indicate the presence of a traditional thought system (Lajul, 2013:75). When there are people in Africa who are engaged in the critical investigation through questions in a study, writing, teaching and practice, that it is African philosophy and indicate that African tools and techniques were used to explore the reality of things in the African viewpoint (Mawere & Mabaya, 2016:48).

Ubuntu in African philosophy

Ubuntu is the core principle of African philosophy, which emphasises the importance of culture in the community. The term "Ubuntu originates from the Xhosa expression "*Umuntu ngumuntu*

ngabanye abantu", which means that an individual's humanity is ideally expressed in relationship with others (Battle, 1996:99, Mabovula, 2011:38). Dolamo (2014:216) outlines the definition of Ubuntu by Shutte (2001: 2) as humanity or humankind, which is clearly explained as the concept that embodies an understanding of what it is to be human, and what is necessary for human beings to grow and find fulfilment (2001:2). To other people, "Ubuntu" means humanity, a comprehensive ancient African value, which refers to the inner core of an individual as it deals with the soul of the person, integrity and dignity (Dolamo, 2014:217). Letseka (2012:29) explains Ubuntu as a part of idiosyncrasies of traditional or communal African customs, poems, taboos, songs and dances as part of philosophy.

Communalism in African philosophy

According to Amaku (2014:2), communalism is a strong allegiance in African philosophy but it is not limited to one's own ethnic group. Communalism is commonly based on sharing history and cultures, characterised by collective cooperation and ownership by members of the community. Furthermore, communalism is a belief in or communal ownership, as goods and property, strong devotion to the interest of one's minority or ethnic group rather than those of society as a whole (Amaku, 2014:2). In communalism, people live together and share their possessions and responsibilities. The statement is supported by Eze (2012:8) when he explains that communalism is concerned with the welfare and mutual assistance of the people living in the society, as there is a belief that success is for all in the community and not the individual.

Indigenous knowledge in African philosophy

Most researchers are in consensus that the vehicle to the practical understanding of African philosophy is through indigenous knowledge systems research (Mulaudzi, 2006; Masoga, 2015; Ngunyulu, 2012; Mphuthi, 2015; Rikhotso, 2017). Indigenous knowledge is also referred to as traditional, endogenous or classical knowledge (Maila & Loubser, 2003:276). Indigenous knowledge system refers to intricate knowledge systems acquired over generations by communities as they interact with the environment (Adeniran & Ukuteyijo, 2017:284). Indigenous knowledge systems include technological, social, economic, philosophical learning and governance systems (Khan & Mantzaris, 2006:281). Indigenous knowledge systems had the following benefits to society: the elders of the society such as the grandparents, uncles and aunts were tasked with the responsibilities of enculturation because Africans have always believed that age and experience represent wisdom (Mutekwe, 2015:1300).

Oral history played an important role in transmitting indigenous knowledge to the next generation. It was passed by senior relatives particularly grandparents, through stories and riddles told around

the fire after the evening meal (Mutekwe, 2015:1300). The same principle was noted in this study where the participants indicated that artefacts that their infants were wearing were acquired from not only the traditional health practitioners; they were also from indigenous knowledge holders. The knowledge that indigenous knowledge holders have is mostly acquired orally and experientially from the elders, particularly senior relatives (ibid).

Throughout the study, the researcher noticed that African people are similar in their ways of living and even in addressing their wellbeing. The knowledge that they have which addresses their day to day activities is underpinned by the tenets of African philosophy. Importantly, the knowledge that they possess, for an example, the knowledge on wearing of artefacts in infancy is organic knowledge as it is given by ancestors; hence it is unwritten. This knowledge circulates and it is contextualised in each African locality.

According to Amaku (2014:2), communalism is a strong allegiance in African philosophy but it is not limited to one's own ethnic group. Communalism is commonly based on sharing history and cultures, characterised by collective cooperation and ownership by members of the community. Furthermore, communalism is a belief in or communal ownership, as goods and property, strong devotion to the interest of one's minority or ethnic group rather than those of society as a whole (Amaku, 2014:2). In communalism, people live together and share their possessions and responsibilities. The statement is supported by Mutovosi (2014:1) who explains that in communalism people have a sense of belonging, as the communal part indicates that an individual belongs to the community, and it simply means that an individual associates him or herself with the community or family.

Indigenous knowledge systems include technological, social, economic, philosophical learning and governance systems (Khan & Mantzaris, 2006:281). Indigenous knowledge systems had the following benefits to society: The elders of the society being the grandparents, uncles and aunts were tasked with the responsibilities of enculturation because Africans have always believed that age and experience represent wisdom (Mutekwe, 2015:1300). Oral history played an important role in transmitting indigenous knowledge to the next generation. It was passed by senior relatives particularly grandparents, through stories and riddles told around the fire after evening meal (Mutekwe, 2015:1300). The same principle was noted in this study where the participants indicated that artefacts that their infants were wearing were acquired from not only the traditional health practitioners; they were also from indigenous knowledge holders. The knowledge that indigenous knowledge holders have is mostly acquired orally and experientially from the elders, particularly senior relatives (Mutekwe, 2015:1300).

2.3 ASSUMPTIONS

In research, the assumptions are basic principles that are believed to be true without proof or verification (Polit & Beck, 2012:12). The working assumptions for this study were: ontological, epistemological and methodological assumptions of African philosophy.

2.3.1 Ontological assumptions in African philosophy

Ontology is the theory of the essence of things and their true nature (Terre Blanche et al, 2009:561). Ontology is about how the world is viewed (Botma, Greef, Mulaudzi & Wright, 2010:40). In this study, ontology as related to the paradigm of African philosophy views reality as determined by grounded cultural experiences and collective practices (Botma et al., 2010: 45).

The African continent is rich in philosophy that is in diverse cultures and traditions that are embedded in oral form (Ekanem, 2012:306). Ekanem (ibid) further indicates that the nature of African philosophy is embedded in tradition, of which its innermost essence is rooted in and nourished with the context of African culture, history and experiences that are metaphysical and spiritual (Ekanem, 2012:308).

According to Tempels (1969:190) and Ekanem (2012:308), the nature of reality in African philosophy is that life forces are in hierarchical order. The highest force is God followed by divinities, ancestors, spirit, man, animals, plants, and minerals. Ekanem (ibid) indicates that superior or higher forces can directly influence the lower, while the lower can only indirectly influence the higher or superior and nothing moves without affecting the other. An African conception of reality is summed up by the existence in relation to being-for-self and others. The reality in African philosophy is based on the fact that metaphysical analysis of the underlying principles is both material and immaterial (Lajul, 2013:36). The scientific judgements about reality in African philosophy reflect the background myths, biases, beliefs, values and imaginations of the people who engage in the observations of reality. This is seen in this study where wearing artefacts in infancy reflects the beliefs and values attached to the African indigenous system.

2.3.2 Epistemological assumptions in African philosophy

Epistemology is the process of thinking and the relationship between what we know and what we see (Denzin & Lincoln, 2011:103). Epistemological assumptions deal with the nature of knowledge in terms of methods, theories, rules and procedures (Botma et al., 2010:40). Epistemology as a theory of knowledge and rationality is concerned with the origin, nature, limits, methods and justification of human knowledge (Ukpokolo, 2017:3). Zagzebski (2009: 1) explains that epistemology is the theory of knowledge, outlining the criteria by which cognitive agents understand reality. It is central to the discourse of philosophy because it links human beings and

the world, which are the two most important objects of philosophical inquiry. Mawere and Mubaya (20I6:16-17), quoting Barnett (2008), explain that in general, epistemology is the branch of philosophy concerned primarily with nature, sources, limits and criteria knowledge.

The idea of African epistemology is based on acceptance of such concepts as knowledge, truth, and rationality. These concepts are interpreted using African categories and concepts as provided by the African cultural experience (Udefi, 2014:108). Thus epistemology in African philosophy is abstracted from the collective worldview of Africans and learning essentially on materials such as myths, folklore, proverbs, folk wisdom and more. In the traditional African view, knowledge is not acquired by labour but is given by ancestors. Secondly, knowledge is immediately social: in the African view, there is no "I know", but rather "we know". Thirdly the knowledge is not universal but it is tribal or ethnic-bound (Hamminga, 2013:57).

According to Ndubuisi (2013:308), African epistemology has three perspectives and one of such is intuitive, epistemology. According to Ruch (1984:46), in intuitive knowledge Africans know through all the senses, emotions and intellect. This implies that African indigenous knowledge does not follow the fragmenting activity of abstractive knowledge; its contact with the real is more immediate and involves the whole person. Likewise, in this study, the researcher conducted a sensory ethnography to explore traditional practices performed on infants. Artefacts and semi-structured interviews were used to explore and understand the different traditional practices that are performed in infanthood in the selected municipal ward.

2.3.3 Methodological assumptions in African philosophy

Methodological assumptions are about the rules and procedures that specify how the researcher must study the phenomenon of interest (Botma, Greef, Mulaudzi & Wright, 2010:41). Methodological assumptions in African philosophy are archival methods, narrative methods, observational methods and relational methods (Keane, Khupa & Muza, 2016:166).

***Archival methods*:** Information on African philosophy such as people's artefacts is found from historical research with data sources being letters, newspapers, photographs, tools and objects (Keane et al., 2016:166).

Narrative methods: There are three narrative methods in African philosophy known as narratology, autobiography and oral history. The methods provide data on own stories as well as other people's stories. The sources of data are in-depth interviews, stories and songs (Keane et al, 2016: 166). Observational methods such as ethnography, participation, action and listening, study

people's behaviour. Data sources are participatory observation, field notes and participatory assignments (Keane et al., 2016: 166).

***Relational methods*:** provide information on people's shared learning and understanding. Methodological approaches are transformation research, intuition, listening, co-creating, the participation of researcher and community sharing. Data sources on the approaches include dialogue, community discussions, ceremonies and meeting notes (Keane et al., 2016: 166).

Other methodologies used in African philosophy include hermeneutic-reconstructionism and Afrocentrism. According to Odera, on the critique work conducted by Kazeem (2012:185), hermeneutic-reconstructionism is a novel methodological model in African philosophy, integrating the strength of cultural reconstructionism and cultural hermeneutics methods. Kazeem (ibid) further explains that cultural reconstructionism is used to combine due reflection on indigenous African languages, oral tradition and culture, conceptual elucidation, comparative criticism and reconstruction of emerging ideas without attenuating the exploitation of the literary and scientific resources of modern world pursuit of synthesis. According to Wiredu (1992:36), a rich tradition of modern African philosophy can be developed and sustained if there is a reconstruction of the philosophical elements of African culture and foreign influences for the benefit of African living.

Though hermeneutic is of Western origin, when used under African philosophy perspectives in most cases it will be on issues of cultural intellectual heritage such as symbols, oral tradition, languages and history through careful interpretation of the socio-historical context that produces them (Kazeem, 2012:200). Furthermore, hermeneutic under African philosophy perspectives can be used to establish a rational connection between the past and the present ideas nested in historical, linguistic and cultural horizons of meaning. Most importantly, the hermeneutic approach exposes hidden meanings of supposedly lost thoughts and provides a deeper interpretation of indigenous ideas (Kazeem, 2012:200). As an approach in contemporary African philosophy, hermeneutic-reconstructionism as a method has the goal of retrieving the authentic philosophical heritage of Africa (ibid). Hermeneutic-reconstructionism seeks to utilise strengths in the methods of cultural reconstructionism and hermeneutics respectively, as it does not interpret the African intellectual heritage for its own sake, rather it seeks to deploy such interpretation for solving current problems (ibid).

That said, the current study followed a sensory ethnographic research design that uses the senses and other ways of knowing (artefacts and semi-structured interviews) to explore and describe the traditional practices for disease prevention in infancy in a selected municipal ward in Tshwane District.

2.4 RESEARCH DESIGN

A research design is a plan that guides the researcher on how to gather relevant information to address the research question (Nieswiadomy, 2012:37). In this study, the researcher used sensory ethnography to explore traditional disease prevention practices that are performed during infancy in a selected municipal ward in Tshwane District. Sensory ethnography is a critical and innovative qualitative research method which departs from a classic observational approach (Pink, 2009:8). Pink (2009:121) explains sensory ethnography as a way of knowing and engagement by the researcher during the research. The sensory ethnographer seeks to understand other people's way of being in the world; simultaneously being aware of their involvement as part of the research process that will eventually abstract these experiences to produce academic knowledge. In sensory ethnography, sensory perceptions and receptions are concurrently used with other forms of knowing to grasp knowledge that is inaccessible (Pink, 2009:8). Marcus (2015:11) explains that the researcher in sensory ethnography engages and interconnects the senses, uses different media together and goes beyond textual representation by engaging with the art in practice. During sensory ethnography, evocative materials such as photos or videos are created in order to re-sense and represent the participants.

Sensory ethnography is an expansive research methodology that is suitable for social research and interventions that seek to understand or shape "place" as a meta-determinant of health and wellbeing. In contrast to other forms of ethnography, sensory ethnography emphasises what it feels like to inhabit social contexts, spaces, and places and in turn how people make meanings, act, and react in response to sensory experiences. Sensory ethnography builds an understanding of how people's 'multisensorial' experience of place (i.e. touch, taste, smell, sight, sound, movement, and so on) shapes their experience and subsequent health and wellbeing, values, behaviours, and dispositions (Sunderland et al., 2010:2). The researcher opted for a sensory ethnography design as it can uncover and unearth issues that are not verbally expressed during interviews. In this study, the researcher documented the artefacts using multiple senses such as sight, smell, hearing and touch and interviewed the parents and caregivers in order to acquire information regarding the traditional disease prevention practices performed during infancy.

2.5 CHARACTERISATION OF SENSORY ETHNOGRAPHY

According to Sunderland et al. (2010:2), sensory ethnography emphasises the feeling of inhabiting a specific social context, spaces and places and in turn how people make meanings, act and react in response to sensory experiences. Sensory ethnography goes beyond the definition of ethnographic studies in three ways: 1) Sensory ethnography is informed by the understanding of the interconnected senses, (2) Sensory ethnography incorporates innovative methods to go

beyond listing and watching using multiple media, and (3) Sensory ethnography goes beyond the use of writing in ethnographic representation, looking towards the practice (De Chesnay, 2015:130; Pink, 2010:25). In sensory ethnography, ethnographic practice entails the ethnographer's multisensorial embodied engagements with others, perhaps through participation in activation or exploring their understanding verbally and with their social, material, discussion and sensory environments (Pink, 2015: 25). Emplacement in sensory ethnography is viewed as a relationship between bodies, minds and the materiality and sensorality of the environment (De Chesnay, 2015:130; Pink, 2010:25).

Through all the days that the researcher was in contact with the participants, using all the senses during the interviews, she learned from the participants and developed the understanding on the traditional practices performed during infancy in the selected ward.

Sensory ethnography is a re-thinking of the ethnographic method with attention to sensory perception, experience and categories we use to talk about our sensory experience, and not simply ethnographic research about the senses. Several characteristics emerged as the layers of re-thinking ethnography. Such characteristics include: reflexivity, visuality as the dominant sense and embodied ethnography. See Figure 2.1 below:

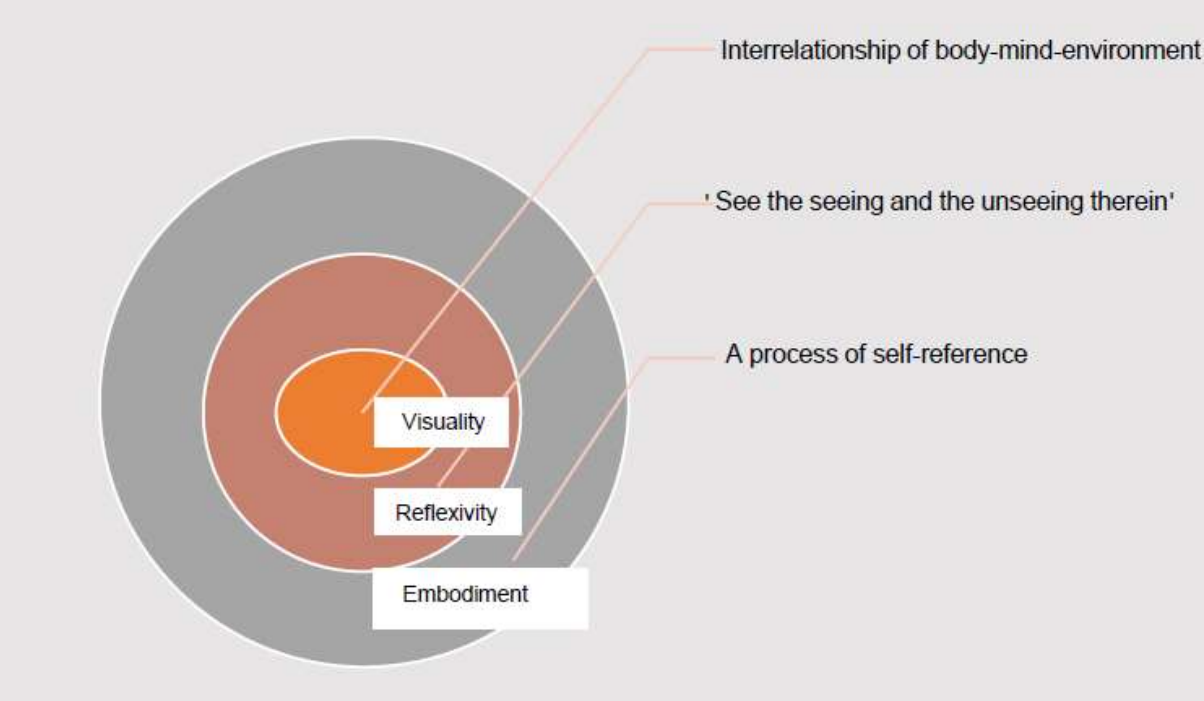


Figure 2.1 Source: Researcher's own interpretation Characterisation of Sensory ethnography

- **Reflexivity**

The important characteristics of ethnography are reflexivity which is defined as turning back on oneself or a process of self-reference. Reflexivity in social research refers to the ways in which the products of research are affected by personal and processes of doing research. Self-absorption is also considered a part of reflexivity in which boundaries between subject and object disappear; the one becomes the other (Davies, 2008:5). Pink (2013: 36), who is the pioneer of sensory ethnography, explains that a reflexive approach recognises the centrality of the subjectivity of the researcher to the production of ethnographic knowledge.

Throughout the current study, the researcher reflected on herself as she was born in a family where both the grandmother and mother practiced spiritual healing. Through cultural assimilation, the researcher considered these ancestral and traditional practices as superstitions and barbaric. This situation deprived the researcher an opportunity to learn about the practices from home. However, through the study, the researcher was taken back and compelled to reflect and revisit her roots throughout the entire research project.

- **Visuality**

Visuality refers to the way in which vision is constructed in various ways such as how we see, how we are able, allowed, or made to see, and how we see the seeing and the unseeing therein. Visuality is also known as the scopic regime. Both terms refer to the ways in which what is seen and how it is seen are culturally constructed (Rose, 2007:2). Visual is the most dominant sense among all the senses. The researcher observed and took photos of different artefacts worn by infants who took part in the study. The researcher had the opportunity of using different senses to learn about the artefacts that were worn by the infants.

- **Embodiment**

In sensory ethnography, experiences are embodied in the researcher. This implies that the researcher learns and knows through her wide experiences together with the knowledge and experiences of the participants. Coffey (1999:59) in Pink (2015:27) explained that the bodies of ethnographers and the bodies of objects studied are central to the practical accomplishment of the fieldwork. The physical being of the researcher and those of the participants negotiate the spatial context of the field. Pink (2015:28) further quoted Coffey (ibid) who argues that fieldwork relies on the body and bodywork. The two are situated along each other. Howes (2005: 67), in Pink (2015:28), support this by indicating that “embodiment” implies an integration of mind and body, the emergent and emplacement that suggests sensuous interrelationship of body-mind-environment. The researcher, during the research process, was reminded of the faith practices that

her grand-mother and mother used to perform while simultaneously acknowledging and conceptualising the artefacts as the objects that represent the various types of traditional practices that are performed in infancy.

2.6 RESEARCH SETTING

According to Polit and Beck (2012: 745), context is the physical location and conditions in which data collection took place in the study. In this study, the researcher collected data at the health facility where the parents and caregivers bring their infants for child health services. This is because in sensory ethnography, like all ethnographic studies, there is direct involvement and sustained contact with human agents, within the context of their daily lives, watching what happens, listening to what is said and asking questions (Pink, 2009:9).

The study was conducted in Tshwane District in Gauteng Province, South Africa. The designated township is based in region six on the structure of the local municipality in the district. The designated ward in Tshwane District is located in the eastern part of Pretoria about 20km from the CBD (Central Business District). The area consists of nine extensions (wards). The selected ward is an urban area with formal houses (RDP). The area has been turned into an informal settlement area as most of the house owners have informal settlement structures (shacks) in their yards, with families renting those shacks. Most of the tenants in the area are immigrants from other provinces and other African countries.

The population in the designated ward is diversified, with the population of different cultures from different parts of Africa including South Africa, Mozambique, Malawi, Somalia, Nigeria, Lesotho and Swaziland, as well as Pakistan. The setting has one clinic which provides health services to approximately 5500 individuals on a monthly basis, with 4000 adults and 1500 children under five years of age. The facility is open for eight hours during weekdays and five hours on Saturdays. The services provided include integrated chronic service, curative, mother and child health services.

2.6.1 Gaining access to the research setting

Creswell (1998:112) describes access and rapport as gaining permission from individuals or relevant institutions and obtaining access to information from the participants. In this study, the researcher received permission letters from the Researcher Ethics Committees of the University of Pretoria, Gauteng Department of Health, and the facility manager at the clinic in the selected ward in Tshwane District. The study participants were identified by the researcher and her colleagues who identified infants wearing any artefact during weighing. Without telling the parent in front of others, the parents of the identified infants were redirected to the researcher's queue. In the

consultation room, the researcher informed the prospective participant about her study, provided an information leaflet and attached an informed consent letter.

A thorough explanation was given prior to the commencement of the data collection. If the prospective participant agreed to take part, then the researcher started first with the collection of data and continued to render the service of the day to the infant. For those who did not want to take part, only the service due for that day was rendered. The participants were made aware that all information obtained during interviews would be kept confidential.

2.6.2 Selection of participants

The study population is the entire targeted aggregation set of objects, persons, behaviour or events or any other single units of a study sometimes called elements or sampling units (Botma et al., 2010:199). The population in this study comprised of parents or caregivers who brought their infants with visible artefacts on their bodies to the selected clinic.

The participants were purposively sampled. Purposive sampling is a judgemental or selective sampling method that involves conscious selection by the researcher of certain subjects or elements to include in a study (Grove et al., 2013:705). There are participants who made a request for their information not to be documented, hence they are not added to the table of participants (table 2.1). These thirty-eight participants were selected because of certain characteristics that were of interest. Four of the participants made requests for the parents or caregivers of infants with artefacts on their bodies and were selected for the study as they had knowledge of the traditional disease prevention practices performed during infancy. Two of the participants were the fathers who brought their infants to the well-baby clinic. See Table 3.2 for the demographic information of the participants.

2.6.3 Inclusion Criteria

The inclusion sampling criteria specify the population characteristics that the subject or element must possess to be part of the target population (Grove et al., 2013:353). In this study, the inclusion criteria were the parents of infants (three days to 12 months of age) who visited the clinic in the selected ward with infants having visible traditional artefacts on their bodies. The parents who gave consent were considered for the study.

2.6 4 Exclusion Criteria

Exclusion sampling criteria refer to characteristics that cause a person or element to be excluded from the target population (Grove et al., 2013: 353). In this study, parents of children older than 12 months with visible artefacts were excluded from the study.

2.7 DATA COLLECTION

Botma et al. (2010:131) describe data gathering as the precise and systematic collection of information to address and resolve the research problem. Data collection is the process of selecting and gathering data from the participants (Burns & Grove, 2009:441). In this study, the researcher collected data through documentation of artefacts and conducting semi-structured interviews with parents of the identified infants.

2.7.1 Data collection process

2.7.1.1 Documentation of Artefacts

In the observation room, during weighing of the infants, the researcher or her colleagues identified infants wearing artefacts. Their accompanying parents were directed to the queue where they were assisted by the researcher. Due to the sensitivity of the topic, the researcher addressed the participating parents individually as they entered her consultation room. The researcher explained the study thoroughly to all the prospective participants. The parents who agreed to take part in the study were given the information leaflet to read. Once understood, they signed the consent form. The researcher started first with the observation of the artefact using different senses such as vision, smell and touch. The observation was followed by taking photos of the artefact provided the parent gave consent. The documentation of the artefact was followed by a semi-structured interview with the parent.

2.7.1.2 Semi-structured Interviews

A semi-structured interview is an interview in which the researcher has a list of topics to cover rather than a specific set of questions to ask (Polit & Beck, 2012:742). The researcher conducted semi-structured interviews with the parents regarding the traditional disease prevention practices performed on the infant. The focus of the interview depended entirely on the artefact that the researcher documented and observed from the infants (See Annexure B). Audiotapes were utilised for recording the entire interview for easy transcription after consent had been given by the participants.

Three questions were posed regarding the artefact. These questions were (i) Can you tell me more about the object, what is the meaning of the object? (ii) How did you obtain this object? and (iii) why did you obtain the object? The researcher had two tape recorders to record all the semi-structured interviews with all the participants. One of the participants returned to the researcher after a few weeks to withdraw her participation especially the documented artefact as she did not want it published anywhere. The request was respected, and the photo was deleted from the research file.

2.8 FIELD NOTES

Field notes refer to the notes created by the researcher during the act of qualitative fieldwork to remember and record the behaviour, activities, events and other features of an observation (Labaree, 2009:1). Due to time constraints, during the interviews, the researcher was unable to record other valuable information such as the age of infants, ethnicity and gender. However, this information was obtained from the patient files and incorporated in the field notes shortly after the interviews (Birks & Mills, 2011:40). According to Maharaj (2016:114), taking field notes in qualitative research is an integral part of documentation and analysis, from the same notes and audiotaped data, the researcher was able to proceed with the coding stage.

TABLE 2.1 Artefacts table

CODE	ARTEFACTS	COLOUR	AGE AND GENDER OF INFANT	ETHNICITY	PURPOSE
A1	Amulet around the waist	White – turned cream	12 months old female	Shangaan "Tsonga"	Heal sunken fontanelle and rigoni (reddish mark behind head)
A2 (a)	Greyish beads around the neck (necklace)	Greyish (light)	7 months old male	Xhosa	To ensure the infant teething process went well without her being sick.
A2 (b)	Amulet around the waist	Whitish	7 months old male	Xhosa	For the protection of the infant when he is around children from different cultural beliefs and not to get sick

CODE	ARTEFACTS	COLOUR	AGE AND GENDER OF INFANT	ETHNICITY	PURPOSE
A3 (a)	Necklace (beads)	Greyish (light)	8 months old male	Xhosa	Teething purpose
A3 (b)	Beads occipital area	Blue and white	8 months old male	Xhosa	Prevention of diseases associated with sunken fontanelle
A3 (c)	Earrings	Silver	8 months old male	Xhosa	Paternal culture to welcome him into their clan.
A3 (d)	Bangle or bracelets	Wool (white)	8 months old male	Xhosa	Protection purpose
A4	Necklace	White, made of beads	11 months old male	Northern Sotho	The spiritual purpose of protection
A5	Amulet on the waist	Green – made of wool	7 months old male	Shona	Healing of the sunken fontanelle
A6 (a)	Amulets – waist, Arms bracelets	Green made of wool	9 months old female	Northern Sotho	Protection from evil spirits. They are spiritual
A6 (b)	Amulet across the chest	Yellow rope. Something white at the centre.	9 months old female	Northern Sotho	Cultural protection against the evil spirits
A7(a)	Necklace across the chest	Green, made with wool and one with beads	8 months old male	Tsonga from Zimbabwe	Green necklace is the protection of the fontanelle. Healing of *hlogoana*
A7 (b)	Necklace	White beads	8 months old male	Tsonga from Zimbabwe	Renaming of the infant according to ancestral instructions
A8	Necklace	Greyish beads	8 months old female	Northern Sotho	Teething purpose
A9 (a)	Beads around the neck	Grey and brown	6 months old female	Xhosa	Teething purpose
A9(b)	Amulet tied around the waist	Green	6 months old female	Xhosa	Casting off evil spirits.

CODE	ARTEFACTS	COLOUR	AGE AND GENDER OF INFANT	ETHNICITY	PURPOSE
A10	Amulet around the neck Armlets and amulet on legs	Green	4 months old female	Shona from Zimbabwe	The casting off of evil spirits
A11	Amulet around waist	Green	7 months old male	Swahili from Mozambique	Healing fontanelle
A12	Amulet around the chest	Black	8 months old male	Northern Sotho	Healing fontanelle and casting off evil spirits
A13	Amulets around the neck and waist	Cream woven rope	8 months old male	Northern Sotho	Prevents "hlogoana" fontanelle to sunken and *ligoni/rigoni*
A14	Twins with beads around the necks	Shades of grey (light and dark)	10 months old male	Northern Sotho	They prevent diseases when infants are teething
A15(a)	Beads around her neck	Shades of grey (light and dark)	10 months old female	Northern Sotho	She said they will assist the infant with teething easily without being sick, without having diarrhoea.
A15(b)	Amulet around waist	Cream	10 months old female	Northern Sotho	Protection of the infant by her ancestors
A16	Beads around the neck	Blue and grey	11 months old male	Ndebele	Prevent diseases during teething, and make teething easy
A17	The beads around the neck	Mix of gold, amber and grey colours	10 months old female	Venda	Assist the infant to teeth faster without being sick
A18(a)	Amulet around the neck	Pink, blue and grey	11 months old male	Northern Sotho	This is for teething
A18(b)	Amulet around the waist	Scottish material	11 months old male	Northern Sotho	To prevent evil spirits from attacking the infant

CODE	ARTEFACTS	COLOUR	AGE AND GENDER OF INFANT	ETHNICITY	PURPOSE
A19	Amulet with "dupa" on the chest.	White cloth	10 months old male	Tsonga	Protection from evil spirits
A20	Amulet around the waist	Green	8 months old male	Malawi	Ancestral amulet for protection against evil spirits
A21	Charm around the waist	Green	3 months old male	Zulu	Healing the fontanelle
A22	Amulet around the waist	Mixed colours of white, red and green + plain red	6 months old male	Zimbabwean	Prevents childhood diseases
A23(a)	Beads around the neck	Greyish and amber	8 months old male	Swahili from Mozambique	Prevent diseases during teething
A23(b)	Amulet around the waist	Green and black centre	8 months old male	Swahili from Mozambique	Prevents childhood diseases
A(24)	infant with black charm around the waist	Maroon (NB Please do not publish picture, mothers request)	6 weeks old male	Northern Sotho	Healing of fontanelle and *ligoni/rigoni*
A25(a)	Amulet around the arms	Clear button on a blue armlet	4 months old male	Northern Sotho	Prevention of squint of the eyes
A25(b)	Amulet around the waist	Multi-coloured, green, white and green	4 months old male	Northern Sotho	Prevent evil spirits
A26	The amulet around the waist	White with blue at the centre	14 weeks old male	Northern Sotho	Prevent evil spirits
A27	Amulet around the waist	Green	5 months old female	Shona from Zimbabwe	Healing of fontanelle
A28	The black charm necklace	Black	6 months old female	Molobedu Northern Sotho	Assist in teething, to make it faster
A29	Amulet around waist	Green	7 months old female	Southern Sotho	Healing of the fontanelle
A30	Amulet around waist	Whitish	10 months old female	Northern Sotho	Protection from falling ill when exposed to strong *muthi*

CODE	ARTEFACTS	COLOUR	AGE AND GENDER OF INFANT	ETHNICITY	PURPOSE
A31	Amulet (pointing at the infant's waist),	Blue	4 months old male	Malawian	Prevents the child from being used as a zombie at night
A32	Beads around his neck	Greyish beads	7 months old male	Xhosa	Prevents fever and other diseases during teething. It also speeds up the teething period
A33(a)	Beads around neck	Grey and light brown	5 months old male	Tswana	To ease teething. To teeth without being sick.
A33(b)	Amulet around the waist	Whitish	5months old male	Tswana	Has *dupa* which prevents childhood illnesses such as fever, diarrhoea and vomiting
A34	Beads around the neck, arms and legs	Whitish	8 months old male	Zulu	Welcoming into the family (introducing him to the ancestors)

Table 2.1 outlines a total of thirty-four infants' artefacts that were documented in this study as the traditional preventive practices that are performed during infancy. The table delineates each artefact, the area on the body where the artefact was worn, the colour of the artefact, its purpose, and ethnicity of the infant. The information was asked during the documentation and semi-structured interviews with the mothers/ caregivers. In some other cases one infant was wearing two to three different artefacts for different purposes.

2.9 MEASURES TO ENSURE TRUSTWORTHINESS

According to Polit and Beck (2012:754), trustworthiness is the degree of confidence the researcher has in the data, based on the assessment done through the criteria of credibility, transferability, dependability, conformability and authenticity. In this study, the researcher ensured trustworthiness by focusing on credibility, dependability, transferability, conformability and authenticity.

2.9.1 Credibility

Credibility refers to the confidence in the truth and interpretations of the data (Botma et al., 2010:233; Polit & Beck, 2012:585). In this study, the participants were assessed based on the inclusion criteria to participate. Findings of the study were taken back to them for their input, accuracy checking and interpretations before publishing the research.

Credibility was achieved through the following means:

- Prolonged engagement: In this study, the researcher collected data for two weeks until data saturation was reached and a deep understanding on the traditional practices that are performed during infancy was developed (Brink et al., 2014:172).
- Peer debriefing: The researcher presented her study to her supervisory team as well as an indigenous scholar in the Department of Nursing Science, who were of assistance through each step of the research process (Brink et al., 2014:172).
- Persistent observations: The researcher consistently pursued interpretations in different ways to determine what counted or what did not count (Brink et al., 2014:172). Through the capturing of the artefacts, the researcher was able to continuously revisit and relook at the artefacts for a better understanding.
- Triangulation: The researcher asked different questions and used different ways and methods to gather information on the sensitive topic (Brink et al, 2014:172) of traditional health practices.

2.9.2 Transferability

Transferability is the ability to apply the findings in other contexts or with other participants (Brink, van der Walt & van Rensburg, 2014:173). In this study, participants were purposefully selected because of their knowledge of the visible artefacts on the infants' bodies. Furthermore, data collection continued until data was saturated.

2.9.3 Dependability

Dependability is the degree to which the researcher can be convinced that the findings did occur (Terre Blanche et al., 2009). In this study, all the steps of data collection and analysis might be replicated. Data was collected by the researcher independently and the data reflected the voices of the participants through their quotes and not the researcher's perceptions.

2.9.4 Confirmability

Confirmability is a process criterion of trustworthiness that entails freedom from bias throughout the research process (Botma et al., 2010:233). In this study, the data reflect the voices of the

participants, not the researcher's biases and perceptions on wearing of the artefact as a traditional preventive practice.

2.9.5 Authenticity

Authenticity is the extent to which qualitative researchers fairly and faithfully show a range of different realities in the collection, analysis and interpretation of data (Polit & Beck, 2012:720). This was a sensitive topic to explore and the researcher conveyed and represented the knowledge from the participants in a culturally sensitive manner.

2.10 ETHICAL CONSIDERATIONS

According to De Vos, Strydom, Fouche and Delport (2011:114) and Polit and Beck (2012: 727), ethics is defined as the system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants. It is deemed the professional nurses' responsibility to design research that upholds the human rights of the participants (Botma et al., 2010:3). In this study, the researcher considered and adhered to the research ethics principles as follows:

2.10.1 Permission to conduct the study

The researcher obtained the approval from the Ethics Committee of the University of Pretoria and Gauteng Department of Health to conduct the study at the designated ward in Tshwane District (Refer to Annexure C). The approval letters that were obtained by the researcher were utilised to execute the study at the selected primary health care facility.

The following ethical principles were adhered to when carrying out the study: (1) Beneficence, which includes the right to freedom from harm and protection from exploitation; (2) Respect for human dignity, which includes self-determination and the right to full disclosure, and (3) Justice, which includes fair treatment and the right to privacy.

2.10.2 Beneficence

Beneficence requires the researcher to decrease harm and increase benefits for participants and others through the participant's right to protection from discomfort and harm (Polit & Beck, 2012:152). The following statements explain how the researcher adhered to this principle:

2.10.2.1 Right to Freedom from Harm and Discomfort

The researcher needs to secure the wellbeing of the participants, who have the right to protection from discomfort and harm (Brink et al., 2014:35). In this study, the researcher ensured that there was no harm inflicted on participants. The participants were informed of their right to withdraw from

the study at any stage should they wish and they were not forced to expose the artefacts worn by the infants.

2.10.2.2 Right to protection from exploitation

The researcher ensured that the participants were not exploited by maintaining their privacy and the right not to be discriminated against (Cresswell, 2013:209). The researcher protected the identity of participants with the allocation of codes alongside their names. As advised by Polit and Beck (2012:153), the researcher assured the participants that the information gathered during the interviews would not be used against their will.

2.10.3 Respect for Human Dignity

The second ethical principle is respect for dignity which is concerned with the right to self-determination and the right to full disclosure (Polit & Beck, 2012:154).

2.10.3.1 Right to self-determination

The right to self-determination indicates the individual's right to decide whether or not to participate in a study with no risk of penalty or prejudice (Polit & Beck, 2012:152). The participants had the right to refuse to give any information if they felt uncomfortable and to ask for clarification of the purpose of the study where it was unclear. One participant withdrew the photos of her infant one week after participation and her wishes were granted and never used against her will.

2.10.3.2 Right to full disclosure

Polit and Beck (2012:154) define the right to full disclosure as revealing information to participants regarding their rights and the benefits of the study. The researcher informed all the participants verbally and with the use of an information leaflet on the nature of the study, before they gave informed consent.

2.10.4 Justice

Justice is the third ethical principle which includes the participants' right to fair treatment and right to privacy and dignity.

2.10.4.1 The right to fair treatment

The right to fair treatment involves the fair treatment of people who decline to participate in the study or who choose to withdraw from the study (Polit & Beck, 2012:155). Participation was voluntary and participants who refused to participate were respected. The participants were

informed that no incentives were to be gained in participating in the study and all participants were treated with fairness and courteousness.

2.10.4.2 The right to privacy and dignity

The researcher should maintain the privacy of the participants at all the times (Polit & Beck, 2012:155). The private consultation room was used for the data collection from the participants. The participants were identified with codes. For example, P1, P2 and even the photos of the artefacts were given codes such as Code A1. A camera and voice recorder were utilised with the permission of the participants.

2.10.5 Right to confidentiality

The process of ensuring confidentiality refers to the researcher's responsibility to prevent data gathered during the interviews from leaking (Brink et al, 2014:38). Throughout the study, the participant's anonymity was maintained by addressing them in codes. Unauthorised people did not have access to the consultation room where the interviews took place. The materials that were used for the interviews, which included a tape recorder, camera and filled consent forms, were kept under lock and key to prevent unauthorised people from gaining access to them.

2.11 SUMMARY

This chapter discussed the research paradigm which is African philosophy, its evolution and tenets. Also discussed were the assumptions (ontological, epistemological and methodological), research design, data collection as well as the process thereof. As well as field notes, measures to ensure trustworthiness and ethical considerations. The next chapter will discuss data analysis and the interpretation of the data.

CHAPTER 3
DATA ANALYSIS AND INTERPRETATION

3.1 INTRODUCTION

The previous chapter discussed the research paradigm, African philosophy, which underpinned this study together with its philosophical assumptions. The chapter also discussed the research method, design and methodology thoroughly. This chapter will discuss analysis and interpretation of the data, and field notes. The data reflect the different traditional disease prevention practices performed during infancy in a selected area in Tshwane District.

3.2 DATA ANALYSIS

Polit and Beck (2012:556) explain data analysis as a labour-intensive activity that requires creativity, conceptual sensitivity, and sheer hard work to organise, provide structure to and elicit meaning from data. As this study was an ethnographic research, inductive reasoning as a basic premise was followed. The inductive reasoning of qualitative research is a process that starts with details of the experience and moves to a general picture of the phenomenon of interest (Bell 2010:91; Prill-Brett, 2013:1). Prill-Brett (ibid) further expands that inductive approach in data analysis is usually applicable in cases of sensory observations that are relevant to provide overall impressions of a phenomenon. The researcher saw Roper and Shapira's (2000: 98) framework of analysis as a relevant approach to analyse data in this study. The framework was appropriate as it permitted the researcher to incorporate the senses and observations of the documented artefacts that the infants were wearing on their bodies. The sensorial processes were followed by the semi-structured interviews on the artefact, its meaning and its acquisition. The accounts about the artefacts assisted the researcher who was occupying an etic (outsider) stance about these traditional practices to analyse the data appropriately while she remained an insider (emic) to South Africa.

Emic and etic stances in the analysis of ethnographic data

In ethnographic data analysis, the terms emic which are outsider perspective and etic as insider perspective are accomplices for the study. The two perspectives are usually acknowledged in ethnography to demarcate the position of the researcher in the entire research for suitable insights

(Bell, 2010: 93). The two terms are significant in research especially in sensory ethnography as they impact on the research process, the insights of the study and the arguments of the researcher on the implications of the findings (Bell, ibid; Naaeke et al., 2010:1).

Emic perspective refers to the description of behaviours and beliefs in terms that are meaningful to people who belong to a specific culture (Katie, 2017:4). Emic perspective in qualitative research especially ethnography is about the stance of the researcher who is not part of the culture under study (Bell 2010: 93, Naaeke et al, 2010:1). The emic perspective in this regard came from two distinct viewpoints: Born a citizen of South Africa and a specialised primary healthcare nurse. The researcher is a primary health care nurse specialist working at the designated clinic offering maternal and child health care services. On a daily basis, the researcher attends to infants who have undergone different traditional practices recognised by wearing different artefacts. As a citizen of South Africa and Africa, she possessed an etic knowledge of the research setting and the processes that were followed to access and recruit the participants. The researcher was born, raised, educated and is working in South Africa despite her limited knowledge of the traditional practices that are performed in infancy. The researcher achieved an emic perspective by using different senses such as observing (seeing), touching, smelling the artefacts that were worn by the infants. The hearing sense functioned when the researcher listened to the parents as they explained what the artefacts were and the purpose of them being worn by the infants.

The etic perspective refers to the explanations for behaviour made by an outside observer in ways that are meaningful to the observer (Katie, 2017:4). An etic perspective is about the stance the researcher takes, who is a member of the culture being studied (Bell 2010: 93, Naaeke et al, 2010:1). The etic perspective afforded the researcher to approach data collection with an open mind without any preconceived ideas about the traditional preventive practices that are performed during infancy. The semi-structured interviews with parents or caregivers of the infants wearing artefacts were regarded as an etic perspective. Furthermore, the abstraction that occurred during data analysis was part of the etic perspective (Bell, 2010: 93).

In sensory ethnography data analysis is explained as a way of knowing and engagement where the researcher, during the research, occupies the multiple roles (Pink, 2009:121). The different roles that the researcher occupied in this research through insider - outsider continuum demanded a commitment. According to Bell (2010: 94), the researcher was compelled to dissect, integrate and look beyond both the viewpoints through a scientific stance that balanced the exploration of the research question. The attempt in sensory ethnography is to understand other people's way of being in the world. Moreover, the researcher became aware of her involvement as part of a

process that assisted her to abstract the experiences to produce academic knowledge (Pink, 2009:121). The two stances together with data analysis, according to nurse ethnographers Roper and Shapiro (2000:98), informed the entire data analysis. Atlas.ti 7 was also utilised for data storage and management.

3.3 PREPARATION FOR DATA ANALYSIS

Semi-structured interviews were conducted with parents and caregivers of the selected infants who were wearing artefacts (participants). With the permission of the parents and caregivers, the digital voice recorder and camera were used during the interviews. A digital voice recorder was used to record interviews and photos of the artefacts were taken using the camera. The photos did not include the faces of the infants nor the parents or caregivers. The digitally recorded interviews were transcribed, providing the main source for data analysis. The interviews were re-read by the researcher and confirmed by the supervisor.

Training to use Atlas.ti 7

Atlas.ti 7 is one of the popular software programmes for qualitative research. According to Roper and Shapira (2000), Atlas.ti 7, like other qualitative data analysis software, aides in coding, retrieving and analysing the data. However, the software does not provide a methodological or analytical framework (Lewin & Silver, 2007). The most important function of the software in qualitative research is for the management of the volumes of data produced from the research study (Bell, 2010:100). In this study, Atlas.ti 7 was the software of choice for the high volume of photos of the artefacts that were part of the data set; interview data and field notes.

The researcher did not have prior experience of using the Atlas.ti 7 software. However, the supervisor and an Indigenous Knowledge scholar in the Department provided hands on and continuous training on the use of the software. Prior to the training, the researcher had already bought the software under the University of Pretoria's licence as a student and uploaded it onto the computer. The training included various functions of Atlas.ti 7 which are: data storage, retrieval, visual mapping and inventory or output functions of codes, code families and primary documents. Additionally, all forms of data generated for this study, that is transcripts, photos and field notes were first converted to Rich Text Format (RTF) format to be uploaded and ready for the analysis.

3.4 DATA MANAGEMENT AND DATA STORAGE

The transcribed interviews were uploaded onto the computer together with the photos of the artefacts and field notes. The transcripts were converted to rich text format (RTF), in order to be uploaded onto Atlas.ti 7 for data management. The researcher ensured that the data were

managed under the following categories: protection, confidentiality, data storage, record keeping, data ownership and data sharing (Lin, 2009:132).

Protection: The participants were made aware of how their information would be used and was also informed that their information would not be used for any other purposes. The data were kept safe and secure from unauthorised loss, damage or destruction.

Confidentiality: Participants were reassured that their identity would be kept confidential as well as the information they provided. Each participant was assigned a code that was linked to the artefact of her or his infant.

Data storage: Data has been safely stored on the Atlas.ti 7 software.

Record keeping: The researcher's records included transcribed interviews, the researcher's field notes and the photos of the artefacts.

Data ownership: The primary researcher has full ownership of the data together with the supervisor and co-supervisor. The research will be kept for a period of fifteen years after the study has been completed, as required by the Ethics committee of the Faculty of Health Sciences, University of Pretoria.

Data sharing: Data was shared with only the supervisor and co-supervisor to strengthen the research. Some of the photos of the artefacts will be used to develop a gallery with no name attached to each artefact.

3.5 DATA ANALYSIS PROCESS

Roper and Shapira's (2000: 98) framework of analysis was followed to analyse ethnographic data in this study. The chosen framework originated from nurse ethnographers and it is widely used by the nurses (Higginbottom, Pillay & Baotou, 2013; Bell, 2010). The analytical steps in this framework included (a) coding for descriptive labels, (b) sorting for patterns, (c) identification of outliers or negative cases, (d) generalising with constructs and theories and (e) memoing including reflective remarks. These analytic processes were aided by Atlas.ti 7 qualitative data management software. As indicated before, the researcher implored the assistance of the supervisors with the use of this software. The features of Atlas.ti 7 assisted in storing, visually mapping and continuous retrieval of transcripts, photos and fields notes (Bell, 2010: 94).

Step 1: Coding for descriptive labels

According to Henning et al. (2004) and Neuman (2011:510), codes are names or labels assigned to specific units or segments of related meaning identified within the field notes and transcripts. A code in qualitative inquiry is most often a word or a short phrase that symbolically assigns summative, salient, essence-capturing or evocative attribute for a portion of language-based or visual data (Saldana, 2008:3). By incorporating more cycles into the coding process, richer meanings, categories, themes and concepts can be generated (Saldana, 2013:5, 8). The researcher's objective was to explore the traditional disease prevention practices during infancy. Coding assisted in describing the practices that were performed in infancy from an African philosophy perspective. The researcher made constant comparisons of data from the interviews and named those categories that were alike. This was made possible through the code comment box in the Atlas.ti 7 software (Neuman, 2011:510).

The role of Atlas. ti 7 in coding

A new project on Atlas.ti 7 was created and a document was opened. The relevant texts from the transcribed data were selected for coding. Codes were given definitions using the codes' comment box to assist in explaining assigned meanings. An output function that could generate codes lists with definitions was created. In total, two hundred and forty-six raw codes were created from thirty-four interview transcripts. Upon further transcript reviews, some of the codes were discarded and others were merged. For example, spiritual code was merged with *inyanga* and type of healer, the church was merged with acquired knowledge and experience assists with teething was merged with teething with no illness and facilitate teething. Preventive measure merged with protective. Artefact merged with the acquisition, preparation and application of such. Finally, the merging process resulted in two hundred and thirty-seven codes.

Step 2: Sorting for patterns

This step lead to a greater abstraction of the data and development of themes, in this case, motif. The term sorting means the process of selecting sections of data and putting them together in their category (Taylor-Powell & Renner, 2003:7). According to Roper and Shapira (2000:99), the step involves grouping the descriptive labels into a smaller number. These patterns reflect similarities and differences between the interviews. The same patterns are grouped together to develop themes or motifs (ibid). In this study, the researcher was assisted by Atlas.ti 7 to sort coded data to motifs, which were supported by sub-motifs. The motifs and sub-motifs were reviewed for their

relevance in the study and the negative cases were identified and put aside for discussion. Five motifs and twenty-five sub-motifs emerged from the interviews.

Step 3: Identification of outliers or negative cases

The outlier is defined as the cases, situations, events or settings that do not fit with the findings of the study (Roper & Shapira, 2000:99). In this step, the researcher identified and excluded cases that were not relevant to the study which emerged during the sorting of patterns. Identification of negative cases can help revise data analysis and confirm emerging patterns in the data majority. Seven codes: Bless them, '*ditsiba'*, incisional, ritual performance, superstitions, religious practice and cultural practice were identified as the outliers. However, they were not discarded for strengthening analysis and explaining the findings (ibid). Attentiveness and reflection were applied throughout this process in order to ensure motifs were true to the narratives of the traditional disease prevention practices in infancy.

Step 4: Generalising of constructs and theories

Generalising of constructs and theories is abstraction at a higher level with the aim of developing an abstract network about the culture under study. In this step, the researcher used her emic perspective as an African nurse, though she never performed the traditional practices. However, through her daily encounters with infants who have undergone different traditional practices, she had insignificant knowledge about them. This stance assisted the researcher to have a reasonable understanding of the traditional health practices in infancy from an African perspective.

Step 5: Memoing

Memoing included reflective remarks from the field notes. In this step, both the emic and etic stances of the researcher intersected in relation to the data. From the field notes, personal reflective journals and memo entries using Atlas.ti 7, the researcher was able to ask questions of the data or reflect on ideas and insights in close relation to the data. Through memoing, the researcher had cues for deeper data mining (Roper & Shapira, 2000: 93) about the traditional preventive practices that are performed during infancy.

Table 3.1 Characteristics of participants

		NUMBER OF PARTICIPANTS
Gender	Male	2
	Female	36
Relationship of the participant to the infant	Mother	36
	Father	2
Ethnicity	Zulu	2
	Ndebele	1
	Xhosa	3
	Southern Sotho	1
	Northern Sotho	14
	Tswana	1
	Tsonga	2
	Venda	1
	Malawi (Chichewa)	2
	Shona Zimbabwe	5
	Swahili Mozambique	2
Age of infant	3 days to 2 months 29days	1
	3months to 5 months 29days	12
	6 months to 8 months 29 days	16
	9 months to 12 months	5

Table 3.1 outlines the number of participants that took part in this study and the relationship with the infants that were wearing the artefacts. The age and ethnicity of the infants were also included. A total of thirty-eight participants took part in the study, with only two fathers. The participants were from different ethnic backgrounds that are part of the South African population and from other African countries. However, among the participants, none was from the SiSwati background. The infants' age in the study spanned from three days to a year old.

3.6 MOTIFS

In this study, the concept "motif" replaced "theme". A motif is defined as a frequently recurring theme, pattern or idea that appears within the boundaries of a larger structure (McBirnie, Abigail, Urquhart & Christine, 2011:1). According to Baldick (2001:162), the term motif is explained as a situation, incident, idea, image or character type that is found in many different literary works, folktales, myths or any element of work that is elaborated into a more general theme. Motif differs from a theme in the sense that a theme is a subject on which a person thinks or writes. The motif is supported with indirect emerging themes. In this study, the researcher opted to use a motif because of a paradigm which is African philosophy, with its ontology (nature), epistemology

(knowledge) and narrative methodology which are rooted deeply in the history of diverse African cultures and traditions that are embedded in the oral form.

TABLE 3.2 Summary of motifs and sub-motifs

MOTIFS	SUB-MOTIFS
Motif 1: Types of artefacts	• Spiritual artefacts • Cultural artefacts • Ancestral artefacts • Family lineage
Motif 2: Socio-cultural practices	• Prevention and healing of childhood illnesses • Protection from evil spirits • Protection from people using *muthi* • Lineage of the family name • Protection from the ancestral totem
Motif 3: Type of healers	• Pastors or church elders (faith healers) • *Isangomas* • *Inyanga* • Indigenous Knowledge Holders (IKH)
Motif 4: Period and duration of the effectiveness of the practice	• Duration of spiritual/faith artefacts • Duration for a cultural artefact • Duration for ancestral artefacts • Duration for preventive or protective artefacts
Motif 5: Ethnicity	• Zulu, Ndebele, Xhosa • Southern Sotho, Northern Sotho • Tswana • Tsonga • Venda • Chichewa from Malawi • Shona

3.6.1 Framework of motifs and sub-motifs

The table highlighted the motifs and sub-motifs identified during data analysis. The identified motifs are types of artefacts worn as the traditional practices, socio-cultural practices, type of healer performing the practices, period and duration of the effectiveness of the practice and ethnicity. There are sub-motifs that emerged from the motifs.

3.7 INSIGHTS

The above table describes the identified motifs and sub-motifs from analysed data. The researcher identified five motifs and twenty-four sub-motifs on traditional disease prevention practices in infancy in a designated ward in Tshwane District. The motifs and sub-motifs are discussed below:

3.7.1 Motif 1: types of artefacts worn as the traditional practices

The first main motif in the study was the types of artefacts that are worn by the infants as part of the popular traditional practices. This motif has four sub-motifs namely: spiritual, cultural, ancestral and preventive or curative artefacts. The participants explained the different types of artefacts which were worn by their infants.

3.7.1.1 Sub-motif: Spiritual artefacts

From the participants' voices, not all artefacts worn by the infants are received from traditional healers. Others are from spiritual healers and have been issued in the church.

Participants 4 explained that:

> *"These are beads, they are spiritual beads (white). They were recommended by the priest from the church."*

Participant 6 supported this by stating that:

> *"The charms/amulets that the infant is wearing on the arms, legs and waist are from the church. They were applied while the infant was still very young. The church elders who were instructed by the Holy Spirit prayed for the charms/ amulets before tying them up."*

Participant 26 echoed what the previous participants said while elaborating on how the charm was prepared. She said:

> *"The charm made with the white and blue cotton cloth is received from the church. The pastor immersed it in water with coarse salt added, [the mother was demonstrating with hands how the pastor is doing it]. He also patted it with papers, prayed for it, gave it to the parent to pray for it as well. As a parent, if you believe that it will help your infant then you will do that. Thereafter the pastor tied it on the infant's body. The main aim is to protect the infant from bad things."*

Participant 31 summarised this by saying:

"This amulet (pointing at the infant's waist), isn't that I'm a Christian, I didn't put this amulet to treat "hlogoana". I received it from the church. I was told that there are evil people who are using my son as zombie at night. This amulet will stop and prevent that from happening further."

3.7.1.2 Sub-motif: Cultural artefacts

Cultural practices are traditional means and ways of doing things in the society or certain ethnic group. Usually, the practices are transferred from one generation to the other. The use of artefacts on the infants is one of such practices and is part of fulfilling cultural practices. The participants in this study confirmed that cultural artefacts differ from one family to another.

Participant 6 confirmed this statement when saying:

> *"[I] the carcass of the animal that the family believes is burned, then an artefact in a form of a charm is made from that. Applying that on the infant's body will protect him against the same animal could it happen that we follow in its footsteps. If the ritual is not performed the infant can develop sores or can be scarred. In our culture, we call them "Ditsiba."*

Participant 3 attested this by saying:

> *"In their [infant's father] paternal culture boys put on earrings."*

Participant 19 added on what the other two participants said by explaining the ritual she normally performs on her infants. She had undergone it herself according to what she had been told by her mother. She said:

> *"This is called "dupa", it comes in a stone form – small stones, I have taken a white cloth and covered it before I tied it on the infant. I have used it on my other three children. It protects the infant from "mekgato" and evil spirits the infant can come across while young."*

When the researcher asked, who told you about it, she said:

> *"My maternal grandmother and my mother. I have used it on all my other children."*

It was important to get to know that the artefacts that are worn by infants were not only acquired from traditional and spiritual healers but also from the indigenous knowledge holders, some of whom were part of the infant's heritage.

3.7.1.3 Sub-motif: Ancestral artefacts

To ensure that the ancestors of the family are pleased, there are certain rituals that the family must perform. The infant as the new member of that family must be introduced to the ancestors through specific practices that are preferred by the family.

Participant 7 supported the statement by saying:

> *"The infant was not sleeping at night, was crying a lot. We had to enquire from traditional healers on what the cause of the infant's continuous crying. We were informed that the particular ancestor from their clan was not pleased with the name given [to the infant] by the father."*

Participant 20 expounded on this by stating:

> *"We e were to name the infant after her great-grandmother (from the paternal site), and [I] hence we had to rename the infant with same name of her great-grandmother who was a traditional healer. These "beads" are [part] of that name and process."*

Participant 7 summed the notion of ancestral artefacts when saying:
"The` charm, they gave it [ancestral artefact] to me for protection [of the infant]. I was told that this infant belongs to the ancestors".' Ke ngwana wa badimo'. The participants indicated that the ancestors play important roles in their lives and throughout their lifespans starting from infancy. One such role is protection.

3.7.1.4 Sub-motif: Preventive and curative measures of artefacts

The participants indicated that most of the artefacts in the study were acquired after traditional practices had been performed. The purpose of the artefact(s) was for the prevention of the occurrence of the disease(s), and curative measures for the infants. For this, participant 1 eloquently explained this by saying:

> *"This lady did steam inhalation on the infant with traditional muthi, gave another muthi for her to drink. Thereafter the infant sneezed, sneezed then that thing moved from the head to the chest, pointed upper part of the abdomen (epigastric area). When she was done, (healer) she told me again that the infant was suffering from "hlogoana", that the infant was born with that from the inside (utero). After completing her work, she gave muthi to the infant to drink. She gave it to me in a bottle and said I must give it to the infant until she grows older. And she made this serokolo (pointing at the artefact that the infant had on the waist). In making the charm, mixed serokolo with the infant's nails, hair and muthi. She bound all of that together with a white cloth before tying it on infant's waist. The healer said*

the artefact will ensure that the infant is protected when exposed to people who use dangerous things. The infant will also have strength and will not be troubled spiritually."

Participant 24 added by saying:

"She steamed the infant with water mixed with muthi, thereafter I expressed my breast milk on the muthi she has set aside, she mixed the two together, and I was then instructed to use my elbow to stare the mixture on the air without touching it. The infant was passed on the mixture of muthi and breast milk. The mixture was also applied around the incision, not inside the incision. Thereafter she tied the charm around the waist."

Participant 18 supported participants 1 and 24 by stating that:

"*They took muthi, put it in a plastic bag then tied it together in the plastic bag, then took the cloth (cotton material) then cover the plastic with that material. Then the same artefact was then tied on the waist."*

The different types of artefacts that were worn by the study's participants were described. The artefacts, among others, were spiritual, cultural, and ancestral. The intention on putting all these different types of artefacts was to protect and strengthen the infants: "*Ba thekga bana ba bona*".

3.7.2 Motif 2: socio-cultural practices

The second motif was from the findings on how traditional practices are the protection strategies for the infants. Most participants explained how the traditional practices that they were performing on their infants are the means and ways of protection. The protection was for various aspects. Some of the participants indicated that their infants were once exposed to illnesses. Through the performance of such traditional practices, they were preventing further infection. The protection strategies yielded four categories as prevention from childhood illnesses, evil spirits, *hlogoana*, inappropriate or incorrect naming of the infant, and people using strong muthi and totems.

3.7.2.1 Sub-motif: Prevention and healing of childhood illnesses

Participants emphasised that "*hlogoana"* was the main source that contributes to the ill health of their infants. The participants indicated how diverse indigenous people are. Most participants knew about "*hlogoana*" and its harmful effects on the health of the infants. If not managed well in the early stage "*hlogoana",* which manifest itself with diarrhoea, vomiting and fever, can complicate to severe illnesses like seizures, kidney and heart failure.

Participant 7 said:

> *"The green charms are used for protection of "hlogoana". When they remedy the "hlogoana" it is like what the medical doctors are doing."*

Participant 13 said that the artefact worn by her infant, would not only protect her from hlogoana, but also from another source that contributes to the illness of the infants. She said:

> *"My mother in law is the one who tied them, she said she prevents "hlogoana" and ligoni."*

The word *hlogoana* and *intlokwana* were used interchangeably as participants had a Sotho and Nguni background. Participants 5, 11 and 21 were quoted as saying:

> *"My child was sick from the disease caused by "intlokwana", [I] hence he was wearing the artefact."*
>
> *"Inside that cloth he (traditional healer) has added muthi and the other muthi he gave it to me for the infant to drink. He said the muthi will assist in closing "Intlokwana". The muthi was not too much."*
>
> *"The prophet tied this rope after treating him for intlokwana, he said he's doing that to make him strong."*

To promote the wellbeing of their infants, the participants had to seek traditional ways of protecting them against illnesses.

The participants confirmed that there are illnesses that could manifest during the developmental stage of an infant. These illnesses or diseases can be fatal to the health of their infants hence the participants, as primary caregivers, employ different types of practices other than the biomedical practices for the health of the infants. According to the participants, if the preventive strategies or measures are not implemented, the illnesses can lead to fatal circumstances.

Participant 2, clarified this by saying:

> *"This charm is for teething. If he is teething he won't get sick. For instance he won't vomit or have fever. He will teeth without complications."*

Additionally, Participant 15 indicated that:

> *"The charms were tied by my grandmother. She bought them from the chemist. She said they will assist the infant with teething easily without being sick, without having diarrhoea."*

Participant 16 attested to this by saying:

> *"My mother said this charm is for teething, they assist the infant in teething, make teething easy. The infant will teeth without being sick, without vomiting nor diarrhoea."*

Participant 17 echoed what had been said by others on the practice of wearing teething charms in infanthood by stating:

> *"I was told that this charm will assist the infant to teeth faster without being sick."*

Supporting the other participants and also indicating the different areas where the protective charms are worn, participant 15 added by saying:: *Pointing on the infant's neck – [these beads] are for teething, [they] help the infant to teeth properly without been sick, without fever and vomiting. [Just] to teeth well."*

The participants reiterated the importance of preventing illnesses related to teething as one of the infants' milestones. According to the participants, conditions related to teething are viewed as fatal hence they warrant protection.

3.7.2.2 Sub-motif: Protection from evil spirits

Evil spirits have been established as another problem that contributes to the ill health of developing infants. Some participants believed that there are evil spirits that their infants can contract from the environment. The same spirits can expose them to ill health. Protective strategies need to be implemented to ensure that infants do not get those evil spirits exposing them to fatal conditions. Participant 8 said:

> *"The purpose of this charm is to protect the infant from evil spirits that the infant can be exposed to when she comes across different people".*

Participant 12 said:

> "*This charm is tied to protect the infant. [Isn't that the children are not the same], the mother was trying. This prevents the infant from catching evil spirits. To ensure that he does not get sick when he comes across another sick child/infant."*

Participant 18 elaborated on the issue of protection from evil spirits by stating:

> *"The one [artefact] on the waist was done by the traditional healer. Its purpose is [to] protect the infant from evil things, at times if he can be taken (held) by somebody who knows the she/he is sick, or somebody whom I share the husband with, this charm will protect the infant, not to get sick."*

Participant 19 supported this by indicating that

"It [artefact] protects the infant from "mekgato" and evil spirits that the infant can come across while young and other people who use strong muthi from traditional healers.

So this charm was put on the infant to protect him from "meleko" [troubles] which are evil spirits. The elders at the church prophesised that there will be evil things that could happen to the infant, therefore this motlamo will protect him from that. The blue part around the centre prevents all kinds of evil spirits from entering his body, for instance, he can't be sick and.hesitation.

Participant 21 summarised this by stating that -

"This charm (pointing at the infant's waist), was tied to protect infant from evil spirits."

The participants indicated the importance of performing traditional practices in infancy to shield the infants from the evil spirits around them.

3.7.2.3 Sub-motif: Protection from people using muthi

People using strong muthi on themselves or their environment place and expose the infants at risk of ill health, according to the participants. To ensure that the health of infants is not at risk, the parents perform traditional protective measures. Participant 9 highlighted this by saying:

"….. This amulet around infant's waist was tied to protect him from people who use strong muthi".

Participant 3 added on by stating:

"This one on his hands protects him from people who use strong muthi so that he does not become sick."

Participant 30 explained in detail the issue of the protection against people using muthi by saying:

"[I] this artefact has "dupa" in it, my mother is the one who tied it on the infant. At home we were preparing to host a birthday party for my dad, so we were expecting lots of people. My mother then decided to protect the infant from "meriti ya batho". As you know people are not the same, there are those who use strong muthi, and others are not. Among the guests there could be those who had recent deaths in their families (still mourning the deaths of their loved ones), in our culture we say, they have "makgome". When an infant gets exposed to such person with "makgome" or the one who has applied or has strong muthi in his/her body, the infant will get sick and might die. To prevent that, the ritual with dupa needs to be performed before the exposure."

The participants highlighted the importance of performing traditional practices as the way of protecting infants from people as well as witchcraft and other related illnesses.

3.7.2.4 Sub-motif: Lineage of the family name

The naming of the infant in the African culture is important. The naming process follows a set of rituals as it is believed that if the infant is not appropriately named, he or she will grow up as unhealthy or will experience difficulties throughout his or her entire life. Participant 7 explained this by saying:

*"The infant was not sleeping at night, was crying a lot. We had to enquire from traditional healers on what the cause of the infant's behaviour could be. We were informed th*at *we were supposed to name the infant after her great-grandmother (from the paternal site) who was inyanga."*

To confirm that the naming of the infant is important to the Africans, participant 34 had this to say:

> *"Few days after birth of my son, my mother in law did a ritual in their Zulu culture to welcome the infant into the family and also gave him the name that is within their lineage."*

Participant 16 also confirmed the naming of the infant in Ndebele, she said:

> *"My in-laws did a welcoming ceremony for my son, he was also given the name of one of the family elders who passed on already."*

3.7.2.5 Sub-motif: Protection from the ancestor's totem

The infant needs protection from his or her own ancestors. Participant 6 said:

> *"[I] the carcass of the animal that the family believes in burned, then an artefact in a form of a charm is made from that. Applying that on the infant's body will protect him against the same animal should it happen that we follow where it has passed. If the ritual is not performed the infant can develop sores or can be scarred."*

Participant 15 reiterated on what had been said by the previous participants on the protection carried out by the ancestors through the artefact. This is what she said:

> "*Yes, she is wearing an amulet around the waist connecting with the ancestors who will protect her throughout when she is growing up."*

Participant 20 also explained that her son had an amulet that connects him with his ancestors. She explained as follows:

> ''*I was told at the church that my infant belongs to the ancestors hence he must grow up with this amulet until teenagehood."*

Motif two explained and described the various reasons why study participants protect their infants. Those reasons included prevention from childhood illnesses, evil spirits, people using strong *muthi,* and illnesses caused by unstable "*hlogoana".* If the ancestral traditional prevention or protection practices were not performed, the life of the infants would be at risk.

3.7.3 Motif 3: type of healer performing the traditional practice

The participants in this study indicated the different healers who were responsible for performing the traditional practices in infancy. The participants expounded about these healers and the processes that the healers followed to acquire and put the artefacts on the body of the infant. The main sub-motifs identified on this motif were: pastors for spiritual artefacts, traditional healers, *inyangas* and indigenous knowledge holders.

3.7.3.1 Sub-motif: Pastors or Church Elders (Faith Healers)

Pastors or church elders were mentioned by participants as among the ones who provided spiritual healing. The pastors or church elders used prayer and artefacts to protect the infants from evil spirits. The statement was supported by the participants

Participant 6 explained this by stating that:

> *"After delivery, on discharge from hospital I took the infant to church, to the pastor who prayed for him and thereafter tied the charms around arms, legs and waist. The pastor was instructed by the Holy Spirit to tie the charms to protect the infant as he is still young."*

And participant 10 clarified this by indicating that:

> *"Before the infant (she) could be taken outside, the Ladies (chosen) from the church paid us a visit to check on her. They bought wool from the shops to make the charms. They bathed the infant in water with few drops of stuipdruppels added, then prayed for her holding the areas where charms had been applied. They didn't use any muthi."*

Participant 25 summed this up by saying:

"The prophet from our church is the one who tied this charm after treating him for intlokwana, he did that to strengthen him. …This amulet around the infant's waist was tied by the pastor from our church. It is the culture within the church to do that on newly born infants to protect them from evil spirits."

The participants indicated that priests, church elders and even prophets have the duty to perform traditional practices during infancy as part of the church rituals.

3.7.3.2 Sub-motif: Traditional healers (*Isangomas*)

According to the study participants, *sangomas* were the most common healers performing traditional health practices on infants. This was evident in the following quotes:

Participant 3 said:

> "*All of the artefacts were put on by his paternal grandmother, who is Isangoma (traditional health practitioner known as diviner).*"

Participant 7, when asked about the person who performed the ritual on the infant, answered by saying:

> "*Is another granny, who is a sangoma*."

To confirm that *isangomas* are popular within the community, participant 9 also confirmed that her infant had a ritual performed on him by the *sangoma.* This is what she said:

> *"Xhosa sangoma gave my mother in law muthi to add in there, to make that artefact."*

Sangomas live within the communities and they form part of the African health system, hence most participants rely on them to perform traditional health practices on their infants.

3.7.3.3 Sub-motif: *Inyanga*

Inyanga in Africa are the traditional healthcare practitioners known as herbalists. *Inyanga* goes through intensive training to learn about traditional health practices. The participants indicated that most herbs that were used as part of the traditional prevention practices were from the *inyangas*. Participants 2, 11 and 12 said the following:

Participant 2 said:

> "I *got [charm with muthi] this from other female Inyanga."*

Participant 11 said, about the amulet on her infant's waist:

> "*This amulet tied on the infant's waist is muthi. Muthi for this (pointing on the anterior fontanelle). I got it at home in Mozambique, from "inanga" we called them floor men."*

And participant 12 clarified this by stating:

> *"I got this from inyanga (traditional healer) that heals the fontanelle "ba alafang hlogoana"*

Traditional practices in infancy are used across Africa and by many African people wherever they are or have knowledge of such practices**.**

3.7.3.4 Sub-motif: Indigenous Knowledge Holders (IKH)

Some of the participants in the study acquired the artefacts from indigenous knowledge holders who were not healers but ordinary people who acquired the knowledge on the traditional practice from others.

Participant 1 said:

> "*The lady is not a traditional healer, she's a born-again Christian, who has acquired traditional knowledge from her mother. She works in a Shangaan traditional way. Her mother was a professional nurse who has undergone training on traditional medicine "othwasitse" so this lady has been observing what her mother was doing. When her mother passed on, she continued with the traditional healing*."

Participant 6, when asked how she obtained the artefact, said:

> "*Elderly people in our family said that as the Department of Home Affairs offices are far from our place; the infant will need protection from "ditsiba". This artefact called "ditsiba" will protect him from our totem animal if it happens to pass where the infant will pass. He will be able to sleep at night."*

Participant 15 confirmed what others had said:

> "*The beaded charm was tied up by my grandmother, she bought the beads from the chemist. She said they will assist the infant with teething easily without being sick, without having diarrhoea*."

Participant 18 supported this by saying:

> "*My mother said the beads around the neck is for teething, they assist the infant in teething easily without being sick from vomiting nor diarrhoea."*

In motif three, the participants explored and described the types of healers used by study participants to perform traditional health practices in infancy as well as the artefacts for the infants. Depending on the period when the practice is done and the participants' beliefs and those of their

families, different healers were used. Some participants used two different healers performing two different rituals on the single infant. The type of healers included pastors or church elders, *inyanga, sangomas* and indigenous knowledge holders.

3.7.4 Motif 4: period and duration for effectiveness of the practice

The motif that emerged was on how long the artefact should remain on the infant's body or the period the practice is meant to serve. In infancy, different artefacts and health practices are for different purposes, and their duration is not the same. The sub-motifs in this motif followed the same as in motif two: Duration for spiritual, cultural, ancestral and preventive artefacts.

3.7.4.1 Sub-motif: Duration for Spiritual or Faith Artefacts

The participants revealed that infants acquired different spiritual artefacts from different churches and religious beliefs. Though the spiritual artefacts were from different churches, duration of care appeared to be almost the same. The following are the quotes from participants 4, 25 and 26:

The question was posed to participant 4 on when the artefact would be removed, he responded by saying this:

> *[The artefact is removed] "When the infant has grown up a bit."*

However, Participants 25 explained that:

> *"In our church, even the adults wear these artefacts, therefore he will not remove it, and he will wear it to adulthood."*

Participant 26 said:

> *"He will grow up wearing it, even when he is an adult as long as he is still in the same church."*

Participants indicated that some of the spiritual artefacts are worn from infancy to adulthood as a method of prevention from illness.

3.7.4.2 Sub-motif: Duration of a cultural artefact

Cultural practices differ from one group to the other and study participants were from different cultural backgrounds. The cultural artefacts worn by their infants were also not the same; so was their effectiveness. Participants 3 explained this by saying:

"The beads behind the head will fall off by itself. They are not supposed to be put back when that happens. The earring I cannot take off. The ones on his hands, I don't have any idea when they will be taken off."

Participant 19 said:

[The artefact will be removed] when "he [in turns [a] year [old]."

Some participants did not provide a definite timeframe. For instance, Participant 6 said:

"They will be removed when the infant has grown a bit and is also strong."

3.7.4.3 Sub-motif: Duration of ancestral artefacts

Participants indicated that the ancestors of the family play a significant role in infant care. Normally, the ancestors communicate the instructions through dreams to the healers on how long the prevention practice should last or even how long the ancestral artefact should be worn by the infant. Participant 7 said:

"She said (the traditional healer) they [artefacts] will reap themselves off, then muthi will be given again when the infant is five years old. Then this one (pointing at the waist) cannot be taken out., the infant will have it forever on his body. Yes, she will grow up having it."

Participant 20 elaborated by stating*:*

"Until he grows up – he's a grown up to a teenager. If [artefact] gets loose, I can go to get another one."

Most of the ancestral artefacts or the practices are performed from infancy up until adulthood. Additionally, the parents in this study were content with that.

3.7.4.4 Sub-motif: Duration of preventive or curative artefact

To have a healthy infant is the aspiration of most parents. The duration of care on this sub-motif differed depending on the purpose the artefact was supposed to serve. Participant1 had this to say:

"She gave muthi to me in a bottle and said I must give it to the infant until she grows older. If the artefact becomes loose on its own that is also not a problem; it will not be preplaced.

In other cases, a definite period applies. The infant of participant 2 had two artefacts, one for teething and one for curative purpose. The duration of care for both was explained as follows:

"This (pointing at the infant's waist) will be put on until he is three years old. The beads around the neck will be removed after all the teeth has developed."

Participants 10 and 18 had this to say about the duration of care of the artefacts that their infants were wearing:

"The infant has to have it always, more especially the one around the waist. The infant has to grow up with it tied there."

"Can have it on his body for two years maybe."

The third motif indicated the different time frames in which the traditional health practices are performed and artefacts used in order to fulfil its purpose of traditionally protecting infants against various factors already explained above. The time frames were not the same, depending on the type of artefacts.

3.7.5 Motif 5: Ethnicity

Ethnicity emerged as the fifth motif in this study. The participants all originated from different ethnic groups and held and believed in almost the same cultural practices from different ethnic backgrounds. As already explained in the field notes, additional information on ethnicity was documented shortly after the interviews. Some participants, without being asked, also indicated their ethnicity.

Participant 1 said:

"When I took the infant for the ritual, is like, in Shangaan we call it "xitshongolo"

Participant 9, when the question was posed to her on her country of origin, answered by saying:

"I'm Shona from Mozambique"

The same applied to participant 21, who responded by saying this when the question of country of origin was asked:

"I'm a South African citizen, yes, I'm Zulu."

The fifth motif has indicated that the participants who took part in the study were from different ethnic backgrounds, believed in traditional practices in infancy. Traditional preventive practices performed in infancy differ from one ethnic group to another. However, in some cases, the rituals that are performed for these practices are common and are applied for the same outcome.

3.8 SUMMARY

Chapter 3 discussed data analysis, interpretation and discussions of motifs and their sub-motifs in relation to the quotes from the participants. The analysis revealed five motifs as types of artefacts worn as the traditional practices, socio-cultural practices, type of healer performing the practices, period and duration of the effectiveness of the practice and ethnicity. These motifs answered the posed research question which was: What are the traditional disease prevention practices that are performed in infancy in the selected municipal ward? In this ward, artefacts are put on the infants by different healers, for different purposes, and on different parts of the body. The artefacts in infancy are preventive practices that the African people continue to undertake concurrently with the biomedical practices. Chapter 4 will present the discussion on the insights with literature support.

CHAPTER 4
DISCUSSION OF THE INSIGHTS AND LITERATURE CONTROL

4.1 INTRODUCTION OF INSIGHTS

The previous chapter discussed the analysis and interpretation of data, the motifs and sub-motifs in relation to the quotes from the participants. This chapter will discuss the insights in relation to available literature. The discussion in this chapter reflects on the aim of the study: to explore and describe traditional disease prevention practices in infancy in a selected municipal ward in the Tshwane District.

4.2 DISCUSSION

The five identified motifs are types of artefacts that are worn by the infants, socio-cultural practices, the type of healers, duration or period of the traditional practice and ethnicity.

Figure 4.1 illustrates the insights of the study as discussed below.

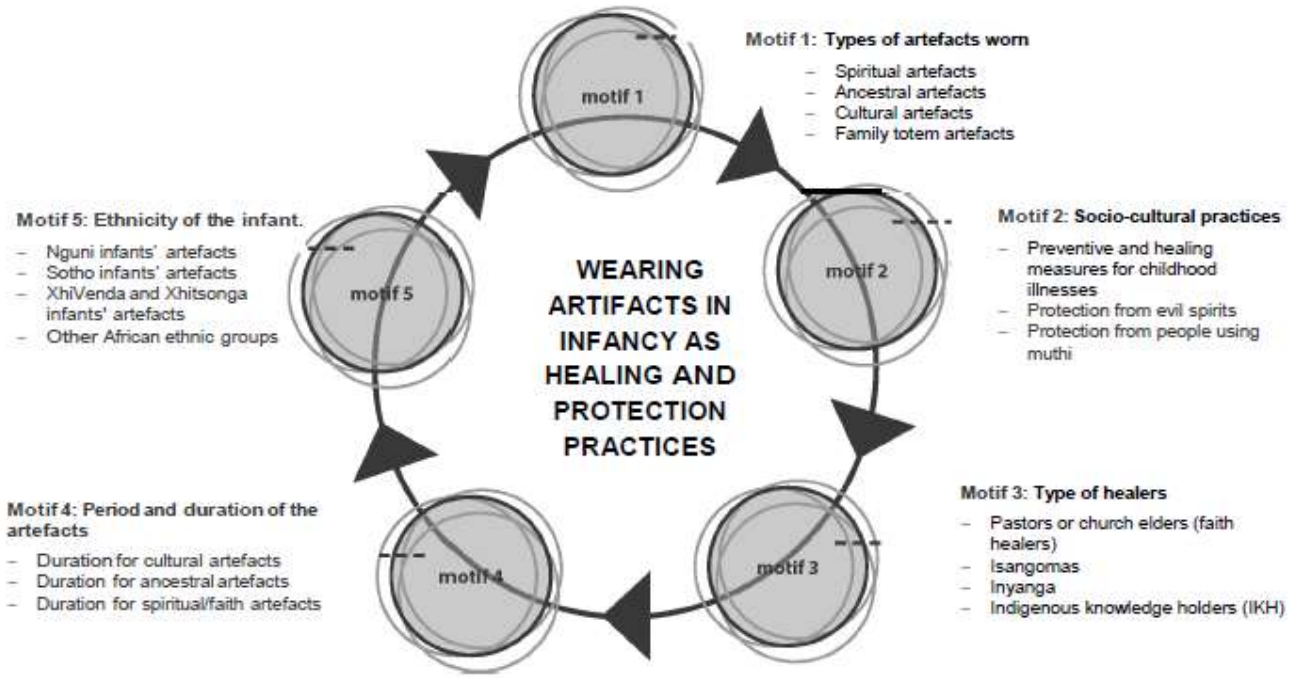


Figure 4.1 Pictorial representation of the insights

4.2.1 TYPES OF ARTEFACTS WORN AS TRADITIONAL PREVENTIVE PRACTICES

In ethnographic studies, artefacts are the objects that signal essential dimensions of lived realities as they are seen as the assets of life that account for the culture and social process of the communities (Roswell, 2011:334). Through the artefacts, researchers are able to unearth stories that provide a broader understanding of the community and its processes. In this study, the artefacts gave the researcher an opportunity to develop an understanding of the traditional preventive practices performed in infancy in the selected municipality ward.

The insights revealed that the infants were wearing different artefacts, some around their necks, wrists, legs and waists as part of the traditional preventive practices that are performed in infancy. The artefacts symbolised different issues and they were in accordance with the parents' belief system, culture, ancestral calling and the family lineage. Of importance was that the artefacts in this study were made of different materials. Some were made of wool, cotton material, velvet material and beads of different colours. It is noted that in other countries such as Thailand and South East Asia, amulets signify the value of faith (Srichimpa, 2014:49; Armer, 2014:1). Most people in these countries and infants wear these artefacts for religious purposes. Contrarily, in Malawi in the Zion Church, amulets are used to treat diseases hence the person acquiring them needs to have faith in order to receive healing (Munthali et al., 2016:133).

From the insights, the participants indicated that the acquisition of the artefacts usually goes with the performance of traditional practices. Some of those practices that the participants indicated were the seclusion of the new-born with its mother for a few months after delivery. The participants indicated that seclusion is very important in infancy. During this period, the infant is kept in the house for three months. Should he or she leave the house and pass on a path where the totem animal had passed, the infant could fall ill. To protect the infant, the amulet with an animal totem should be tied around the chest or waist.

According to the participants, ancestral amulets were worn by the infant to appease the ancestors, to ensure that they recognise the infant and protect him or her from diseases and misfortunes. Bogopa (2010:3) indicates that Zulu speaking people have a belief that diseases and misfortunes are linked to angry ancestral spirits. With the Tswana speaking people, there are illnesses that are associated with ancestors. In most of the ethnic groups in South Africa, the ritual called "Imbeleko" is performed to welcome the new-born infant into the family and introduce him or her to the ancestors (Bogopa, 2010:5). After performing the ritual whereby an animal such as a goat is slaughtered, a band is made from the same goatskin and is tied on the wrist of the infant as a symbol of introducing and connecting him or her to the ancestors. The artefact is known as

"*isiphanda*" or wristband (Makunga et al., 2011:373). In Southern Sotho, the ritual is known as "*ho ananela"*, which is performed using sheep or ox fat from the entrails that is tied around the infant's neck for some time (Opong, 1997:28). According to Gearhart (2013:9), in the Islamic religion, the welcoming and naming happen seven days after birth.

Furthermore, the insights revealed that the naming of the new-born baby is important in the African culture. If the infant is inappropriately named, he or she can be ill or have misfortunes in his or her life. According to the participants, the infant will cry continuously for no apparent reason. According to Ngidi (2012:40), the naming of the infant is the duty of the grandfather or the father. During the naming process, the grandfather or father commemorates the living dead when naming the infant (ibid). The Aboriginal elders maintained the practice of naming ceremonies in order to meet the child's physical and emotional needs (Muir & Bohr, 2014: 69-76). The names of the infants are not given randomly even if given immediately after birth. There is a belief that the name will protect the infant as he or she grows in the community (Mphela, 2010:29).

4.2.2 SOCIO-CULTURAL PRACTICES

Socio-cultural factors are known as shared values, norms, and attitudes in a given society (Apsalone & Sumilo, 2015:276). Culture comprises the distinctive habits of people. In essence, culture is seen as a unifying factor and also performs a directive role in that it involves the cultivation of people towards common goals (Wambungu, 2012:23). The norms, values and economic activities that are shared by a single group of individuals in the society are regarded as part of their culture. Culture is passed from one generation to the next. In the African tradition, the passing is through oral tradition and role modelling (Wambungu, 2012:24-25). As a social entity, culture manifests itself in its constituent parts which are language, ideas, customs, traditions inherited and studied artefacts, belief systems and their expressions, moral values, art forms, social organisation, institutions, occupations and habits of various types, as well as progress and development in science and technology (Effa-Abibo, 2005:93, 97). In traditional medicine, more particularly in infancy, these practices, among others, include the wearing of artefacts around the different parts of the body as a way of ascribing to the tradition and culture of the specific ethnic group. Of importance is that the artefacts in this study were meant for healing and protective purposes.

Phyllis (2008:10) defines healing as the physical, mental and spiritual processes of recovery, repair and reintegration that increases order, coherence and holism in the individual, group and environment. Healing may result in a cure. Explanation of healing in Aboriginal society means mending bodies and souls, rekindling the flame that strengthens the spiritual as well as the

physical, mental and psychological wellbeing (Fearns, 2006:11). Kubeka (2016:10) explains the African orientation of healing as everything being in spirit; the vital life forces known in extrasensory fashion as energy, consciousness, gods and guards, and appearing materially known through the five senses. For African children to experience this wholeness, parents frequently visit the traditional healers for consultation shortly after birth.

The insights of this study indicated that the primary caregivers of infants (parents) use the services of the different traditional healers for healing and protection purposes. The statement is supported by Popova (2005:65) as he mentions that a new-born baby is much more susceptible to the influences of various supernatural forces and spirits of illnesses, hence many treatment methods are based on that understanding.

In line with these consultations of the traditional healers, the National Department of Health in South Africa put strategies in place to protect the infant and to ensure that they are raised well. These strategies include the Expanded Programme on Immunisation and Integrated Management of Childhood Illnesses, as well as postnatal care of the mother and infant post-delivery. From the Western perspective, the strategies assist in bringing up healthy and well infants. Considering these strategies, one realises that they are intended for the same purposes as the traditional practices that are performed in infancy. These are for healing and protection. However, from an African perspective, for healing to occur, one must be in peace with the ancestors as they are the ones that offer infinity protection (Vaughn, Jacquez & Baker, 2009: 66).

Some participants in the study had indicated that their infants presented with different symptoms such as fever, diarrhoea, vomiting and not sleeping at night before they were taken for consultation. According to the participants, these signs were attributed to childhood illnesses associated with teething, exposure to evil spirits, people using strong *muthi* and getting in contact with the infant and also failure to please the ancestors (Elter, Kennedy, & Chesla, 2014:5). As part of tradition, when the infant presents with these symptoms, the primary caregivers (participants) took the initiative to consult different traditional healers who assisted them in offering the healing of those illnesses. During the consultations, rituals were performed in some cases and for further protection of the infant, specific artefacts were placed on the infant's body. Elter et al., (2014:5) support these practices of ritual performance for healing and protection when indicating various rituals that are performed for the health and wellbeing of the new-born such as entering and exiting basket. This ritual is performed in infancy to bless the baby with a healthy and successful life. The rite of entering and exiting the basket, according to the Isans, has to do with communication between the spiritual healer and the ancestors of the infant. Entering the basket means that the

new-born spirit is presented back to the previous mother as they (Buddhists and Animists) believe in reincarnation. In the study the authors has further explained that the healer used a holy word, tied the new-born's wrist with money and cotton thread and also put the notebook and a pencil underneath the basket. In exiting the basket the new-born is brought back to the spirit reigning in the new world. On the third day the exiting of the basket takes place when the healer hit the rim of the basket. Talking loud to the spirit of the previous mother the healer instruct her to take the new-born back if she feels that she/he belongs to her, and if the new-born's life has been restored it indicates that she/he has exited the previous life. In Kenya, Gearhart (2013:8) indicates that to avoid teething problems in Swahili babies, the anti-hex markings with black kohl are drawn on their heads until they begin teething. To ward off the evil eye, infants wear red and white cloths around the wrist, ankles and neck (Gearhart, 2013:9).

The participants highlighted that evil spirits are believed to cause physical harm to the infant and they manifest as fever, headaches, or a sore throat (Killion, 2017:1&6). Killion (2017:16) further reports five cultural healing practices that are intended to manage exposure to evil spirits among the infants. These are, among others, the practices that are performed in America, Asia and the Middle East :(*caogio*) coining, spooms (*guasha*), lapping (*hijama*), moxibustion to treat sunken or fallen fontanelle (*caida de mollera*). Similar to these traditional practices in Africa are the treatment of *inyoni* (sunken anterior fontanel, *ibala* and *rigoni* (Kayimbor, 2008; Rikhotso, 2017). Most of the time the treatment of these infant illnesses are accompanied by the wearing of different artefacts and amulets (Kayimbor, 2013:3; Gearhart, 2013:9), which are an indication of exposure to traditional preventive practices performed during infancy. According to the participants, only the traditional healers are able to heal the infant when suffering from these illnesses.

4 2.3 TYPES OF HEALERS

According to the WHO (1978) as cited by De Joy (1991:1), a traditional healer is defined as the person who is recognised by the community in which he lives in as a competent person to provide health care using vegetable, animal and mineral substances and other methods based on social, cultural and religious backgrounds as well as on the knowledge, attitudes and beliefs that are prevalent in the community. The traditional healer is the name that is used mostly in the community for all the different types of healers practising traditional medicine. Traditional healing is healing based on indigenous knowledge practised by generations of the tribes depending on the culture, religion or custom (Ekor, 2013:1).

In this study, some participants indicated the preference of faith healers to *inyangas* and *sangomas*. In South Africa, there is diversity as far as religion is concerned. The major religious

groups are of African traditional religion, Christianity, Islam, Hinduism and Judaism (Kubeka, 2016:8). Faith healers or *Abathandazi* comprise a sophisticated combination of traditional African religion and Christianity. According to Mlisa (2009:185-186), Xhosas regard faith healing as a Western practice because of its association with religious spirituality. The author further explains that connection of ancestral ties and the burning of sacrifices in the Old Testament are linked to ritual activities that are performed in societies. According to Edward et al., (2009) and Kubeka (2016:21) *Abathandaz*i practise in indigenous churches such as Zionist and Apostolic churches in villages and cities.

Not only are faith healers found in Africa; in Germany, the faith healers are known as the spiritual healers or Helpraktiker. Helpraktiker mostly pray, meditate or lay hands on those who require healing (Stockigt, Besch, Jeserich, Holmberg, Witt & Teut, 2015:1). The faith healers are also found in the Muslim community known as imams. In as much as that the imams do not receive formal training in spiritual healing (Isgandarova, 2011: IV), they assist with various health problems. The participants consulted different healers to seek help when their infants were born and needed to be introduced to their ancestors, or when they were sick, showing different signs of illnesses. It is estimated that 80% of the people worldwide in 2003 were utilising services of traditional medicines for different health-related problems (WHO, 2003:2). The services that are offered by traditional healers are vast as well as their specialisations. In the study, the participants utilised the services of different specialists to perform the traditional preventive practices in infancy.

The participants indicated that when they consulted the faith healers for traditional preventive practices in infancy, faith healers (*Abathandazi)* use the spiritual energy (*umoya*) together with holy water, steaming baths, purgatives and enemas as healing methods. After the performance of the rituals, they usually tie amulets made of wool, cloth or beads of different colours on the infants. The amulets are tied around the neck, hands and waist as the artefacts. Essentially, the practice to consult faith healers is based on the spiritual standing of a person (Munthali, Marnan, MacLachlen & Swart, 2016:133). Spirituality refers to feelings or experiences of connectedness with sacred beings and a way of being through relationships with oneself, other, nature or life (Ramanand, 2016:7). Bhahnan in Ramanand (ibid), further explain that spirituality is not always connected with religion or experience related to faith or tradition or religious groups, as one can have a spiritual experience outside the confines of organised religion. Lydon Lam (2012:19) in Ramanand explains that spirituality is about the content of the belief system and significantly linked to the experiences and relationships with those around us. The parents and caregivers in this study believed that *Abathandazi* provide healing to the infants by performing the traditional disease preventive practices for their infants.

Some participants consulted *isangoma* or a diviner. In Xhosa, *isangoma* are known as *Amagqira*, *ngaka* in Northern Sotho, *selaodi* in Southern Sotho, in Tsonga they are *mungome* and *vhomaine* in Venda (Truter, 2007:57). Most South Africans refer to them as *Sangomas.* They are consulted by the primary caregivers or parents to perform traditional preventive practices on infants. *Isangoma* explain illnesses and may or may not have knowledge of herbal medicine. Mostly *isangoma* act on intermediate connection with ancestral spirits, focusing on diagnosing what could be explained (Kubeka, 2013:20). They receive the direct intervention of the spiritual world to treat illnesses that are associated with inappropriate behaviours (Obinna, 2012:142). According to Asamoah-Gyadu (2014:83) and White (2015:5), the diviner receives spiritual intervention to understand the cause of illnesses and prescribing the cure to the particular illness. The insights revealed that when consulted, s*angomas* perform traditional preventive practices during infancy. They commence by consulting the bones and interpret their array. As they are in a trance state, they then begin communicating with their ancestral spirits who impart the gift of healing for whoever came for consultation through them. Herbs (*muthi*) that are relevant to cure or prevent the illnesses or evil spirits are used to perform rituals immediately, while another *muthi* is given with instructions to be used at home. The participants were also told when to return for follow up sessions.

It was also noted in the study that some participants consulted the *inyanga or* herbalist (Kubeka, 2016:21) to perform the traditional preventive practices for their infants. The herbalist in Xhosa is *ixhwele* (Truter, 2007:57). Most South Africans refer to them as *inyanga* or *dingaka.* The herbalist specialises in the use of herbal or other forms of traditional medicinal preparations to treat illnesses. *Inyangas* manage specific illnesses, so those who specialise in indigenous infant health care are the ones to perform traditional preventive practices. The participants in this study revealed that when consulting the herbalists to perform traditional preventive practices, the *Inyangas* enquired from them how they could be assisted; meaning that they record history from the client, they may or may not consult the bones and then prepare the herbs that are needed for the infant. Using the appropriate herbs, they perform the ritual on the infant immediately; thereafter make an amulet with *muthi* added on it. The parent is then given the herbs to continue using at home with verbal instructions to follow. They are then informed how the ritual will be repeated.

Most importantly, the insights showed that the participants consulted indigenous knowledge holders. Indigenous knowledge means knowledge which has been developed within an indigenous community and has been assimilated into the cultural make up or essential character of that community, including (a) knowledge of a scientific or technical nature, and (b) knowledge of natural resources and indigenous cultural expressions (Protection, Promotion, Development and

Management of Indigenous Knowledge Systems Bill 2016: 5). A holder in relation to indigenous knowledge means the members of the indigenous community from which indigenous knowledge originates (ibid). In essence, indigenous knowledge is generational as it is transferred from one generation to another (Okka, Durduran & Degerli-Kodaz, 2015:501). The indigenous knowledge holders are the elders such as grandmothers (Gottlieb, 2004:16; du Preez at al., 2008:3). These are the source of sacred knowledge (Kwame, 2008:28, 43).

The insights revealed that participants' mothers and grandmothers gave them information on the performance of traditional practices to prevent, cure and protect diseases during infancy. These knowledge holders performed the rituals simultaneously demonstrating to the mothers and caregivers the practices. According to Popova (2005:65) in North East Udmurtia, among the Besermian ethnic group, the tradition regarding prevention of disease in infancy has been retained, by ensuring that the senior Besermian told stories about the infants' clothing. Children's clothes were preserved carefully and passed on to the next generation. The design of the clothing had meaning, and to retain that meaning there was a way of washing and keeping them, the clothes had beliefs connected to them (Popova, 2005:72). In countries such as New Zealand, there is a template that has been designed by the indigenous knowledge holders regarding the child-rearing practices that involves the entire community (Jenkins, 2011: iv).

In sub-Saharan African countries, knowledge regarding the traditional disease prevention during infancy is still being transferred from the elders to the next generation, according to Futhwa (2011:28-29). The elderly in the African society are regarded as indigenous knowledge holders as they have great life experiences; they are great historians who transfer knowledge through storytelling, and they are the advisers or counsellors as well as childminders with vast knowledge (Futhwa, 2011:28-29). Globally, and in Africa in particular, the informants on the traditional practices are usually senior women or grandmothers who are familiar and have experience on the practices (Popova, 2005:66; Kayombo, 2013:3).

In this study, it was noted that the participants were either informed or made aware of the symptoms that indicate a need for traditional disease prevention practices by an elderly neighbour or close family members such as the mother -in- law or the mother. As the knowledge holders, the family members performed the rituals and provided the artefacts to the infants. Most products that the IK holders used in this study were teething beads, *serokolo, dupa* and *stuipdruppels*. These products are available at pharmaceutical outlets throughout South Africa (Moshabela, 2012: cxi).

4.2.4 DURATION OR PERIOD OF TRADITIONAL PRACTICE

In every society, there are cultural practices (rituals) that are followed by some members in all developmental stages from childhood to adulthood. There is a specific period (duration) of when to start and end such practices.

Popova (2005: 66) mentions that the stage from birth to early infanthood is crucial because the child is considered weak and believed that she or he is in danger, which persists until she or he learns to walk. Hence, it is important to maintain a healthy lifestyle medically and traditionally to achieve the main goals of treatment and safekeeping of the child's life (ibid). Among most Africans, there is a belief that infants, before reaching a year, should be treated for '*hlogoana*' among other illnesses. Traditionally they believe that it is the period whereby infants are vulnerable to suffer from it (De Villers & Ledwaba, 2003:664) and other detrimental childhood illnesses that are not easy to explain except culturally. According to some Africans, '*hlogoana*' can be treated spiritually or traditionally. If not treated earlier and accordingly, it leads to excessive dehydration due to diarrhoea and vomiting at times resulting in death. As part of treatment in some cultural practices, traditional or spiritual healers endorse or suggest that artefacts such as amulets are worn or used to curb, cure or prevent certain illnesses (De Villers & Ledwaba, 2003: 664).

This study has established that the Ngunis (Zulus, Xhosas and Ndebeles) have more or less similar traditional practices. For instance, the '*Imbeleko'* practice which is the rite of passage, is celebrated shortly after birth by both cultural groups for the same purpose, using the same artefacts. However, the manner in which they use the artefacts differs.

In the study conducted by Makunga, Thwala and Edwards (2011:373), when welcoming an infant into the Zulu family, a ritual is performed and it is called '*Imbeleko*'. A goat is slaughtered during the ceremony. A small part of the goat's skin is used to make a wristband called '*Isiphandla'* which is worn by both male and female infants. In this way, a child is also connected to the ancestors. According to Neingo (2012:34), the mother undergoes a purification ritual. While in seclusion with the infant, she will be given *muthi* to protect the child against evil spirits and this amulet is worn for up to a year. The nursing mother of a new-born infant should be pure before her return to her husband after two or three months, as said by Mwamwenda (2003) in Neingo (2012:34).

Bogopa (2010:4, 5) also researched '*Imbeleko*' in the Xhosa culture. He says they perform the ceremony for the same reasons as Zulus. However, in his study, this ceremony differed from that of the Zulus because a male goat is slaughtered and the skin of that goat is put underneath the bedding as an under blanket. As it is in the Zulu culture, this is done to prevent the infant from

bedwetting in late childhood to adulthood. In the case of the Xhosas, it is performed after 14 days of the infant's birth, while the mother is in the *Ifuku* stage. *Ifuku* is a secluded place where the mother stays with her new-born. The meat from the goat is half cooked and eaten by the mother while in front of the fire prepared in the same *Ifuku*. It is said that the infant accesses the meat through breast milk.

In the Basotho (Southern Sotho) culture, the firstborn has to be born at the mother's place as it is a special occasion. The pregnant woman's mother and the old ladies from her kin look after her and give her guidance or teach her about how a child is raised.

The Southern Sothos slaughter a sheep as a sacrifice to the ancestors when the child is born. In the case of the birth of a chief's son, an ox is slaughtered. To perform the ritual, the fat from an entrail of the slaughtered animal is wrapped around the neck of the infant for a few moments, the gall is then poured over him or her and the '*motswetsi*' (a nursing mother) as a symbol of prosperity. This process is called *hlatsuo ya nyooko*. Basotho call this whole ritual '*ho ananela'* – 'welcoming the new-born child'. The mother and infant stay in a secluded place until the navel-string dries and falls off. This is considered another milestone to be celebrated. A Thanksgiving ceremony is held and another sheep from the mother's father is slaughtered (Opong, 1997:28).

The birth of a child in Sepedi culture is as important as in the other cultures. The process before birth is also fundamental for the welcoming of an infant. Mankga's (2013:39) research informs us that a pregnant mother needs a pure environment for the survival of a healthy infant to be born. In that confined place (*ko setswetsi*), female relatives who had to be around her were not supposed to be menstruating, or have had sex recently or even have '*letseka*' a gap in between the top front of their teeth. All the fore mentioned things were considered impure and therefore the child could not be born around such women. After the infant was born, the umbilical cord was cut and the remaining part of it (*kalana*) was wrapped around a piece of reed until it fell off naturally; when the child was between seven or ten days.

Considering the information gathered by Neingo (2012:34), the Basotho and the Bapedi cultural practices strictly require the nursing mothers and infants to observe the period of '*setswetsi* - seclusion*'* well in order to be purified and protected from the evil spirits. The process was also imperative in ensuring that the mother recuperates well to breastfeed healthily. The period of seclusion, according to his study, encompassed the period before the infant's birth, the arrival of the new-born and up to twelve months after birth.

The Tswana have their own ritual that they follow. According to Nkomazana (2002:1), their culture has a distinctive patriarchal element in it. The family ancestors, considered as special guardians in their custom, were believed to favour the son's birth as compared to the birth of a girl child. It is said the birth of a boy child was highly celebrated in the family and by the relatives. The birth of a male infant ensured the continuity of the patriarchal lineage hence it was important to them.

Among the Hmong in Australia, the infant puts on a silver necklace immediately after birth before the umbilical cord is cut off. The purpose thereof is: (i) for the protection of the new-born from the evil spirits who may wish to take the infant with them; (ii) for the formation of the bond between the mother and the infant claiming that she or he belongs to her, and (iii) it was also symbolic for tying the infant's soul to his or her body. They have a belief that a person has three souls: the first soul enters the body through conception, the second enters the body when the necklace is worn and the third is the morning after birth (Liamputting, 2002:817).

According to Khoza (2009:70) in Xitsonga the first born child is delivered at the in law's home. The infant's father has to undergo a hands' cleansing ceremony before he could see and hold the infant. The new-born's maternal relatives bring with them new clothes and homebrewed beer in the calabashes upon receiving the good news about the birth of their grandchild. They also bring a slaughtered goat with its skin; this is to be used to carry the infant. He further says that the *inyanga* performs the immunisation of the infant during the seclusion of the mother and her infant. The incision is done on the forehead, at the back and at the centre of the head and sealed by *muthi* made of herbs and traditional medicines. The *inyanga* then weaves the bands '*xitshungulu*' to tie around the infant's waist and across the chest as a way to prevent diseases from affecting the infant. Whenever the infant gets sick, the mother removes one of the bands, boils it and lets the infant drink that water (Khoza, 2009:71).

In Venda culture, more or less the same cultural practices are followed as in Xitsonga. In their case when it comes to the amulets worn, the infant has no specific attire. The infant remains half naked except that piece of wild cotton string around the waist called '*Ludede*'. It remains on the waist until the child is weaned off of the breast, then they are given '*Tshidega*'. It is a basic square garment made to cover their back and front private parts. When the child is immunised, it is given '*Lukunda*' to be worn around the wrist and one ankle to protect him or her from the evil spirits. As the child is weaned, clothes are used to differentiate the gender of the child.

The amulets or beads that were worn for teething were reported to be removed when most teeth had developed, or in case they got loose, they would not be replaced. Most of the spiritual and

ancestral amulets were removed, while some remained with the infant until she or he grew up. Cultural artefacts had to come off by themselves and not be replaced. According to Zungu (2000:21), Zulu and Ndebele infants used to wear one row of a white beaded amulet around the waist until the age of seven. The white colour is chosen to signify purity. Beaded necklaces were worn around infant's necks to facilitate teething. The mother also made a beaded purse worn around the neck and waist as a charm against fever, teething as well as other sicknesses (Zungu, 2000:21-22). In rural Goa, India, the practice of tying a black thread around the neck and waist to ward off evil spirits from the infant was observed. The duration of this practice is not stated (Cacodcar et al., 2015:71)

4.2.5 ETHNICITY IN PREVENTIVE PRACTICES IN INFANCY

The word ethnicity, according to Da Silver Santos, Palomares, Nomando and Quintao (2010:122), stems from the Greek's adjective *Ethnikos* meaning heathen. The same adjective was also derived from the noun *ethnos* meaning foreign people or nation. The authors further explain that the concept of ethnicity is multifaceted thus building the identity of an individual, through among others kinship, language, shared territory, and physical appearance. For example, an individual may belong to a certain ethnic group. Clarke cited by John (2013:235), however, believes that religion may or may not form part of that person's ethnic group as such taking the definition of ethnicity forward.

Relevant to this study is that the main function of kinship is to bring together successive generations, thereby providing social continuity such as passing on tradition. In this study, the traditional prevention practices are passed on to the next generations orally (Ferdinand, 2006:1). The participants in this study maintained and emphasised their mother tongue as an aspect of ethnicity (Lucky, 2010:36) when communicating about the artefacts that were worn by their infants. On the consideration of shared territory as a component of ethnicity, the insights clarified that participants who originate from the same physical environment had almost the same traditional practices that they performed in infancy as preventive measures (Lucky, 2010:36).

Ethnicity is closely linked to physical appearance, customary practices (beliefs and behaviour) and dress code, including accessories worn or used by different ethnic groups (amulets and symbols) on their different body parts. These markers help to a certain extent to distinguish different cultures within the ethnic groups or locations (Ahmed, 2014:284 - 285). In this study, the insights revealed that the participants' infants were wearing different artefacts obtained through different traditional practices.

4.3 SUMMARY

Chapter four discussed the insights of the study. The five motifs and sub-motifs that emerged from the study were discussed in relation to the literature. The healing and protection motif revealed the causes of illnesses and diseases during infanthood and traditional practices that were applied to heal and protect the infants. The socio-cultural practices, which are part of a culture that is transferred from one generation to the next, explained how different artefacts are used on infants to protect them from illnesses when growing up. The discussion explored the knowledge and understanding of various traditional healers which included *isangoma, inyanga,* faith healers and indigenous knowledge holders as key providers of traditional practices. The artefacts that were identified had a specific duration wherein they should be worn according to the infant's ethnic group.

Chapter five will discuss the implications, limitations, recommendations and conclusions of the study.

CHAPTER 5
CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

The previous chapter discussed the motifs and sub-motifs that were created from the insights. The insights were supported by the existing scientific evidence. This chapter will discuss the identified conclusion, recommendations and limitations of the study.

5.2 AIM OF THE STUDY

This study was intended to explore and describe traditional disease prevention practices performed during infancy in a designated municipal ward in Tshwane District.

5.3 RESEARCH QUESTION

The research question posed by the study was: What are traditional disease prevention practices that are performed during infancy in a designated municipal ward in Tshwane District?

5.4 RESEARCH METHODOLOGY

The qualitative research approach was followed to meet the aims and objectives of the study. The methodology was influenced by the African philosophy paradigm. A sensory ethnographic research design was conducted in a designated ward in Tshwane District, to explore traditional disease prevention practices performed during infancy. The researcher used a purposive sampling technique to recruit participants. Semi-structured interviews and relevant documents such as the clinic records were used to obtain rich information on traditional practices performed on the infants related to the artefacts worn. An audiotape recorder and camera were used to support the process of data collection. Roper and Shapira's (2000: 98) framework of analysis with the aid of Atlas.ti 7 was used to analyse data in this study. Five identified motifs were created as the insights of the

study. The motifs were: types of artefacts that are worn by the infants, socio-cultural practices, the type of healers, duration or period of the traditional practice and ethnicity.

5.5 SUMMARY OF RESEARCH INSIGHTS

5.5.1 Types of artefacts

The artefacts that were worn by infants in this study were related to the parents' spiritual, cultural, social and ancestral beliefs. The spiritual artefacts were obtained from the faith healers of different churches across Africa. These were made either of wool or beads. The colours of the wool were red, green, blue or white. In some instances, the artefacts were of a combination of different colours. These colours play a significant role in the healing and protective practices hence they are continuously used in African religious churches. In this study, almost all the bead artefacts for spiritual practices were white in colour, which signifies purification of the infant.

Some infants had artefacts from faith healers who use a combination of faith and spiritual type of healing; thus using the church and cultural or ancestral based artefacts. In other cases, before tying the artefact on the body of the infant, the healer had to first perform a ritual. Different churches have different beliefs about such practices. The ritual included bathing of the infant with water with *stuipdruppels* added or plain water that is prayed for, steam inhalations and praying for both the mother and the infant. The artefact was then tied by the healer or was given to the parent to tie. In some instances, the ritual was not done. The healer simply prayed for the artefact and tied it on the infant's body. The main aim of utilising faith or spiritual artefacts according to the participants was to cast off evil spirits or to protect the infants from being exposed to witchcraft.

Both the ancestral and cultural artefacts were similar though they were intended for different preventive practices. According to the participants, ancestral and cultural artefacts connect the infants with ancestors throughout their lives (Elter, Kennedy & Chesla, 2014: 5). The lineage artefacts are normally tied around the infant's body if the infant is named after a paternal relative who is no longer alive. The aim is to connect the infant with that particular ancestor. According to the participants' belief, wearing such an artefact ensures that the infant does not get sick often. There is a strong belief that the ancestors whom the infant is named after will look after him or her as a guardian angel. According to the participant's failure to abide by the practices to acquire the ancestral and cultural artefacts, rendered the infant prone to some illnesses.

The participants indicated that there is a ritual performed before the artefact is tied on the infant's body. The ritual included slaughtering of a goat or a chicken. Before offering an animal, the patriarchal aunt or patriarchal grandmother speaks with the ancestors whereby they introduce the infant and plead with them to welcome him or her into the family. The bile or blood of the slaughtered animal is applied on the infant's body and remains with for some time before washing it off. The skin is, therefore, used in different ways of creating an artefact.

The insights indicated the other artefacts that are commonly worn are the beads that assisted the infants with teething which can cause infants to be severely ill; most of them were greyish or amber in colour. These beads are obtainable from pharmaceutical chain stores across Africa and obtainable without a biomedical prescription. There are several social related processes that are followed for the infant to acquire the teething beads. These social related processes are usually performed by indigenous knowledge holders. In some instances, the beads are tied without any ritual being performed. Whereas in other cases, the beads are boiled in water and when cooled, the water is given to the infant to drink before tying up the beads around its neck. Most participants reported that the application of beads was effective as the teething process was fast and illnesses were minimised.

The applied artefacts caused no harm to the infants and appeared to be effective in performing their intended purposes. Hence they are continuously used from one generation to the other in African communities.

5.5.2 Socio-cultural practices

Different ethnic groups perform preventive practices for their livelihood. The same was evident in the study through the use of various artefacts worn by the infants. From insights, the preventive practices were part of the methods of healing and protection during infancy. The practices were performed concurrently with the biomedical preventive practices such as immunisation. It was evident that the participants rely on both traditional and biomedical practices when they see it necessary (Rankoane, 2012:1). The insights clarified that parents performed these practices as part of their socio-cultural background.

The participants indicated that the artefacts that were worn by their infants represented their culture, which was practised by all members of the community to maintain their norms, values and beliefs. Cultural artefacts appeared different from the spiritual (faith or church based) artefacts. The artefacts were made from cotton materials or cloths of different colours. The participants indicated

that performance of these socio-cultural practices is to prevent childhood diseases as well as a method for healing in infancy as all cultures have disease theory systems (Vaughn et al., 2009:66). It was noted that some infant diseases or illnesses such as hlogoana *and rigoni,* which had tendencies to recur, could be prevented, healed or cured traditionally through rituals and by wearing of artefacts. The diseases manifested themselves with fever, diarrhoea and vomiting that might complicate dehydration which could lead to death if not treated.

Parents who participated in the study and used this traditional approach, believed that infants are not only faced with naturalistic or biomedical illnesses but there could also be personalistic illnesses attributed to supernatural forces. For example witchcraft, sorcery or evil spirits (Matlala, 2013:31&41), hence they revert to traditional approaches when modern medicine are inefficient to their infants' situation. The so-called naturalistic illnesses mean the ones which originate from inside the body due to specific identifiable medical causes or pathogens; either viral or bacterial (Matlala, 2013:31-41).

The parents also indicated that when their infants do not get better after receiving treatment from the biomedical centres, they are taken to traditional healers for a second opinion. Other parents indicated that it is a norm in African societies to seek traditional assistance for their infants even before they get sick, hence wearing of artefacts is considered a socio-cultural practice in African communities. The same practices are transferred from one generation to the other; hence the practices are still in existence even in the twenty-first century.

5.5.3 Types of Healers

In Africa, it is a known trend to obtain all of the aforementioned artefacts from the different healers such as *isangoma*, inyanga, abathandazi and indigenous knowledge holders. The insights provided an understanding of the different healers that the participants were consulting to perform traditional preventive practices in infancy. Isangomas are the most popular type of healers in the community. Isangomas use both the divine powers, conduct spiritual cleansing and also administer herbs to sick or troubled infants (Nyabwari & Kagema, 2014: 11). The inyangas were reported to be providing different herbs, some were sewn into the artefacts and others were given to participants to be administered orally at home. Abathandazi, according to the participants, use the Bible, prayer, purgatives such as enema and saline water, plain water and laying of hands on the infants. Most of abathandazi originate from African traditional religious churches. The indigenous knowledge holders were elders, parents, who accumulated knowledge orally from those who

preceded them. Some of the IKHs are community members who acquired knowledge through participating in traditional activities. In this study, most of the IKHs were the ones that provided teething beads. They were the ones to acquire the beads and prepare them for the infants.

5.5.4 Duration or period for effectiveness of the practice

As different artefacts are worn as traditional preventive practices, their duration or period varies. The duration of wearing artefacts depends on the type and the purpose thereof. The participants indicated that artefacts related to spirituality are worn until adulthood. When the initial knot of the artefact becomes too tight for the infant, a new one is tied (Matlala, 2013:44). The insights provided an understanding that the ancestral and cultural artefacts are used at different stages of childhood. The participants in this study indicated that the ancestral and cultural artefacts are acquired immediately after the birth of the baby. There are traditional rituals that are performed such as the slaughtering of an animal where the piece of the skin of that animal is cut into a wristband. The band is placed under the blanket where the infant sleeps because the infant would still be too young for that amulet. Depending on the ethnicity of the infant, around three months the animal skin wristband is then put on the infant. From the insights, it was noted that the teething beads are removed from the infant's neck when all the milk teeth have developed.

5.5.5 Ethnicity

Given the ethnic landscape of South Africa, the participants in this study were from different ethnic groups. Most participants were from the main ethnic groups: Ngunis, Sesotho, Venda and Tsonga. There were participants from other African countries such as Malawi, Mozambique and Zimbabwe. The interesting part from the insights was that there was a thread of commonality in most of the traditional preventive practices that are performed in infancy within the African ethnic groups. An example is the practice of imbeleko. This is a ritual of gathering of the clan and slaughtering of an animal, usually a goat depending on the ethnic background of the family, to name or introduce the infant to the family and ancestors. The processes entailed in *imbeleko* are similar in most of the ethnic groups of South Africa. However, the artefact that is tied on the infant is ethnically bound.

5.6 IMPLICATIONS

The study highlighted that traditional practice are utilized together with biomedical practices during infancy in urban areas. The following implications are therefore relevant.

5.6.1 IMPLICATIONS FOR THE GOVERNMENT

- The promulgation of the *Traditional Health Practitioners Act* (No 22 of 2007) was assumed by many people, mostly the African people as the act that will bring change on how the traditional practice is treated when comparing it with biomedical practice. There has been a call to integrate the two practices post passing of the above interim act, and now ten years later it has not materialised. It has not been put in full action as clinics, hospitals or all health facilities do not have traditional healers of any sort side by side with the biomedical practitioners working together under one roof. The main reason for integration is because majority of Africans still access the services of traditional healers as much as they do with the biomedical practice.

- The study brought again the need to have multi-disciplinary health care centers which include the services of traditional health practitioners to support what was highlighted by the Alma Ata conference in 1978 which recommended that government should include the services of traditional medicine in the national drug policy and regulations (Mark, 2012:23) This is also contained in the WHO document of 2002.

5.6.2 IMPLICATIONS FOR THE HEALTH CARE PROFESSIONAL/FACILITIES

- The research has highlighted the role played by the traditional healers at primary health care level. They are easily accessible to the community that they serve hence they are preferred by the majority of people. Through the participants it is evident that some of those community members also make use of the biomedical health services, where they are in contact with the biomedical health care professional who are nurses, doctors and others. The health care facilities such as the clinics and hospitals are faced with the challenges of severe shortage of personnel. There is also lack of equipment that is needed by available staff to render efficient and effective service to the community at large.
- The reasons stated in other peer research(Ngqila,2015:45) on why people prefer the services of the traditional healers than the biomedical, was that their local clinics are always

full, the services are slow, the health professionals are failing to give feedback on the illnesses they have and the negative attitudes displayed by health professionals. Since the community members are utilizing both services there is a need to fast track the integration of the two services. The training of the biomedical health professionals on traditional medicine will be necessary in this case.

- There are some members of the community who consult the traditional healers only without considering the biomedical practice. If those patients had to access biomedical health care facilities regularly there would have been even a bigger problem of long queues with increased waiting period/time.

5.6.3 IMPLICATIONS FOR THE COMMUNITY

- The integration of traditional medicine with the biomedical health care will alleviate the stigma on consulting the services of traditional medicine as it has been the case presently. There are professionals who also consult the traditional healers on daily basis or occasionally but don't want to be seen when they go there.
- When the health services are rendered in the same environment the community will benefit from the multidisciplinary type of approach that will be offered by the system. The legalization and accessibility of such fused health care service will help curb different types of diseases and illnesses. It will also prevent and protect patients from some of risky practices/diagnosis offered by traditional healers.

5.7 RECOMMENDATIONS

5.7.1 RECOMMENDATIONS FOR THE POLICY DEVELOPMENT

The study highlighted that traditional practices are utilised concurrently with biomedical practices during infancy in African communities. The following implications are therefore relevant.

- The study presented the need to have multidisciplinary health care centres which include the services of traditional health practitioners to support what was highlighted by the Alma Ata conference in 1978 which recommended that government should include the services of traditional medicine in the national drug policy and regulations. This is also contained in the WHO document of 2002. The co-existence of two healing practices is promoted.

5.7.2 RECOMMENDATIONS FOR THE HEALTH CARE SERVICES

- The research has highlighted the role of the traditional healers at primary health care level. They are easily accessible to the community that they serve hence they are preferred by the majority of the people. Through the participants, it is evident that some of those community members also make use of the biomedical health services, where they are in contact with the biomedical health care professionals who are nurses, doctors and others. The healthcare facilities such as the clinics and hospitals are faced with the challenges of severe shortage of personnel. The integration of THPs into the current PHC might address such shortage.
- The biomedical health care professionals should have frequent in-service training or workshops in IKS.
- Heath education and promotion at facility level should also cater for traditional health practices. In the curriculum for the training of all the biomedical healthcare professionals including nursing, indigenous knowledge systems should be included.
- Appropriate and efficient control, monitoring and supervision of both traditional and biomedical health services ought to be carried out by health inspectors, to ensure that it accomplishes its mission of good service delivery.
- Regular briefings for counterbalancing influences should take place for all the members of the multidisciplinary team which will include traditional practices.
- Further research on this topic is recommended as there are limited studies in South Africa.

5.7.3 RECOMMENDATIONS FOR THE COMMUNITY

- The integration of traditional medicine with the biomedical health care will alleviate the stigma on consulting the services of traditional medicine as it is the case presently.
- When the health services are rendered in the same environment, the community will benefit from the multidisciplinary type of approach that will be offered by the system. The legalisation and accessibility of such fused health care service will help curb different types of diseases and illnesses.
- The community ought to be educated on traditional practices.

5.7.4 RECOMMENDATIONS FOR OTHER STAKEHOLDERS

- The Department of Health ought to have slots in different media spaces to inform the community on health matters relating to traditional practices.
- The Department of Social Welfare ought to be involved so that the crèche teachers could be aware of the practices.

- More effort could be put in organising and bringing interested private entities on board to sponsor some activities or projects that will support the collaboration of both practices and initiative that would have been established.
- To bring advertising agencies on board. The use of billboards, newspaper and other types of media will be beneficiary to this project.

5.8 LIMITATIONS

- This study was sensory ethnography and is part of the focused ethnographic approaches that entail short-term field visits. In this study, the researcher took two weeks to collect data.
- The research was only limited to a single ward in Tshwane sub-district and other districts in the area were not covered therefore findings could not be generalised.
- The language was another barrier as some participants who were Shona and Swahili speaking could not express themselves confidently and fluently as they were not fluent in English or the other South African languages.
- The researcher conducted her research at her workplace in her uniform and that created a barrier as some participants were not so eager to open up to provide detailed information as they did not want to be discriminated against.
- The researcher also conducted her research while on study leave. However, due to a shortage of personnel, she had to render services to clients who came in throughout the day. As a result, that impacted negatively on the time spent with individual participants to gain rich quality data.

5.9 FINAL CONCLUSION

The aim of the study was to explore the traditional disease prevention practices during infancy in a designated Tshwane District. The African Philosophy Paradigm underpinned the entire study. The qualitative research approach was used following sensory ethnographic research design in order to achieve the aim of the study. Purposive sampling was used to select the participants who were parents of the infants who were wearing artefacts on their bodies. Data were collected using semi-structured interviews and review of relevant site documents. Roper and Shapira's (2000) framework of data analysis with the aid of Atlas. ti 7 was used to analyse collected data. The following motifs were identified: types of artefacts that are worn by infants, socio-cultural practices, type of healers, period and duration for the effectiveness of the practice and ethnicity. The motifs were discussed and controlled by literature.

Different types of artefacts are worn by the infants as part of traditional disease preventive practices. These artefacts are intended to prevent, protect and heal the infants from common infant

illnesses. In order for the infants to acquire the artefacts, a traditional health practitioner of choice is consulted by the parent. The traditional healer will then perform rituals as part of the process to tie the artefacts to the child. Most of the artefacts do not have a time frame assigned to their duration as they wear out naturally. Of importance is that the artefacts that the infants wore depend on the ethnicity of the parent(s). Through the symbols (artefacts) it is evident that most Africans still use the traditional approach for their physical and social wellbeing hence they consult traditional healers.The study highlighted that traditional practices are utilised concurrently with biomedical practices during infancy in African populations.

LIST OF REFERENCES

Abdullahi, A. A. 2011. Trends and challenges of traditional medicine in Africa. *African Journal of Traditional, Complementary and Alternative Medicines*, 8(5S).

Adefolaju, T. 2014. Traditional and orthodox medical systems in Nigeria: The imperative of synthesis. *American Journal of Health Research*, 2(4): 118-124.

Adeniran, A.I. & Ikuteyijo, L.O. 2017.*Afrika now! Emerging Issues and Alternative Perspectives*. 1st ed. Switzerland: Springer.

Ahmed, F.U. 2014. Ethnicity and Environment. Tribal Culture and the state of Bangladesh. Dissertation (Phd in Anthropology). London: University College.

Airoboboman, F.A. & Asekhauno, A. A. 2012. Is there an African epistemology. *JORIND* 10(3): 13-18.

Amaku, E.E. 2014. Are Africans truly communalistic, socialistic and hospitable by nature? *US Open Sociological Journal*, 2(4): 118-124.

Apsalone, M. & Sumilo, E. 2015. Socio-cultural factors and international competitiveness. *Business, management and education,* 13(2): 276-291.

Armer, C.E. 2014. Cult of the Amulets in South Asia: Origin, function and transformation. Dissertation (Masters of Arts). Canterbury Christ Church University. United Kingdom.

Asamoah-Gyadu, J.K. 2014. The therapeutic strategies in African religions: Health, herbal medicines and Indigenous Christian Spirituality. *Edinburgh Universsity Press,* 20(1), 70-90.

Ayibor, P.K. 2008. *Treatment received by children who visit traditional healers*. Johannesburg: University of the Witwatersrand.

Beşer, A., Topçu, S., Çoşkun, A., Erdem, N., Gelişken, R. & Özer, D. 2010. Traditional child care practices among mothers with infants less than 1 year old. *Deuhyo Ed.* 3(3): 137-145.

Bell, R. H. 2010. Understanding African Philosophy across – Cultural Approach to Classical and Contemporary Issues. *Journal of Krishna Institute of Medical Sciences University*, 4 (4).

Behind the Numbers: Race, Ethnicity and Ancestry. The centre for rural Pennysylvania.www.ruralpa.org.1P0107- 50. [Accessed Nov 2017].

Birhan, W., Giday, M. & Teklehaymanot, T. 2011. The contribution of traditional healers' clinics to public health care system in Addis Ababa, Ethiopia: a cross-sectional study. *Journal of EthnobiolEthnomed*, 7(39):1-7.

Birks, M. & Mills, J. 2011. *Grounded Theory: A practical guide*. 2nd ed. London: Sage.

Bodunrin, P.O. 1981. "The Question of African Philosophy. *Philosophy*, 56 (126): 161 – 179.

Bogopa, D. 2010. Health and Ancestors: The case of South Africa and beyond. *The Pacific Journal of phenomenology,* 10(1), 1-7.

Botma,Y., Greef, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. *Research in Health Sciences*. The Cape Town: Heinemann.

Brittingham, A. & de la Cruz G.P. 2004. *Journal. U.S Bureau.Ancestry*, 2000. Brief.

Brink, H., van der Walt, C. & van Rensburg, G. 2014. *Fundamentals of Research Methodology for Healthcare Professionals.* Cape Town: Juta.

Broome, B. & Broome, R. 2007. Native Americans: Traditional Healing. Culture and Diversity Issues. *Urologic Nursing April 2007*, 27(2): 161-163.

Burns, N. & Grove, S.K. 2011. *Understanding nursing research: Building an evidence based practice.* 5th ed. St Louis: Elsivier.

Burns, N., Grove, S.K., & Gray, J.R. 2013. *The Practice of Nursing Research: Appraisal Synthensis and generation of evidence*. 7th ed. St Louis: Elsivier.

Chuwa, L.T. 2014. *Interpreting the culture of Ubuntu: African Indigenous Ethics in Global Bioethics. Interpreting Ubuntu.*1st ed. Pennsylvania. Springer.

Ciulla, J. B. 2014. *Ethics, the heart of leadership*. 3rd ed. California: Praeger.

Clarke, M. 2014. *Vlok's Community.* 6thed. Cape Town: Juta.

Clarke, V. & Braun, V. 2013. Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26(2): 120-123.

Clark, C. 2013. *Religion and Ethnicity as Differentiating factors in the social structure of the Caribbean.* Gottingen. Oxford University.

Coffey, A. 1999.*The ethnographic Self: Fieldwork and the representation of Identity*. London: Sage.

Cacodcar, J., Dubhashi,A. & Joglekar, S. 2015. A cross sectional study on child rearing practices in rural Goa. *Journal of Krishna Institute of Medical Sciences University*, 4(4): 64-74.

Cousik, R. & Hickey, M.G. 2016.Pregnancy and childbirth practices among immigrant women from India :" Have a healthy baby". *The qualitative Report*, 1a (4): 727 – 743.

Creswell, J.W. 1998. *Qualitative Enquiry and Research Design Choosing Among Five Traditions*. Thousands Oaks London, New Dehli. Sage Publications.

Creswell, 2007. *Qualitative enquiry and research design*. 2nd ed. London: Sage.

Creswell, J.W. 2013. *Research design: Qualitative, quantitative and mixed methods approaches*. London. Sage.

Da Silva Santos, D.J. Palomares, N.B. Normando, D. & Quintao, C.C.A. 2010. Race versus Ethnicity. Differing for better application. *Dental Press Journal Orthod.* 15(3): 121-124.

Davies, C. A. 2008. *Reflexive Ethnography: A guide to researching selves and others*. London: Sage.

De Chesnay, M. 2015. *Nursing research using data analysis: Qualitative designs and methods in nursing.* 1st ed. New York.Springer.

Denzin, N.K. & Lincoln, Y.S. 2011. *The Sage Handbook of Qualitative Research*. 4th edition. London: Sage.

De Villiers, F.P.R. & Ledwaba, M.P.J. 2003. Traditional healers and paediatric care. *South African Medical Journal*, 93(9): 664-665.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.L.S. 2011. *Research at grass roots: for the social sciences and human service professions*. 4thed. Cape Town: Creda Communications.

Dolamo, R. 2013.Botho/Ubuntu: The heart of African Ethics. *Scriotura*,112(20130): 1-10.

du Preez, N.S., Griffiths, P. & Cameron, N. 2009. Spuits, stuips and saline drip. A framework of health seeking behaviour for childhood illnesses in urban South Africa.146 (2009):1-36.

Effa-Ababio, K. 2005. The nature and dynamics of culture and its social, moral and religious dimensions. *Journal of Science and Technology*. 25(2): 91-102.

Elter, P.T, Kennedy, H.P. & Chesla,C,A. 2014. Spritual Healing Practices Among Rural Postpartum Thai Women. *Journal of Transcultural Nursing,* 27(3): 1-7.

Ekanem, F.E. 2012. On the Ontology of African Philosophy. *Parkistan Journal of Social Sciences* 9(6): 306 – 310.

Ekor, M. 2013. The growing use of herbal medicines: Issues relating to adverse reactions and challenges in monitoring safety. *Frontiers in Pharmacology*, 4(177): 1-10.

Etim, F. 2013. African Metaphysics. *Journal of Asian Scientific Research,* 3 (1): 11-17.

Eze, E. 2012. *Implications of rapid development on Igbo sense of communalism*. Dissertation (Masters programme). Lagos: University of Nigeria.

Fearns, T. 2006. *A sense of belonging: Supporting healthy child development in Aboriginal families*. Best start: Ontario's maternal, newborn and early childhood resource centre.

Gearhart, R. 2013. Seeing life through the eyes of Swahili children of Lamu, Kenya: A visual anthropology approach. *AnthropoChildren,* 3(3): 1-22.

Gebrekirstos, K., Abebe, M. & Fantahun, A. 2014. A cross sectional study on factors associated with harmful traditional practices among children less than 5 years in Axum town, North Ethiopia, 2013. *Reproductive Health,* 11(1): 46.

Gerrish, L. & Lacey, A. 2010*. The Research Process in Nursing*. 6thed. Goodridge: John Wiley & Sons.

Gottlieb, A. 2004. Babies as ancestors, Babies as spirits. The culture of Infancy in West Africa. *Penn Museum*, 46(3): 13-21.

Grant, M., Heskun, L., Gaede, B. & Horwood, C. 2012. Bridging the gap: exploring the attitudes and beliefs of nurses and patients about coexisting traditional and biomedical health care systems in rural setting in KwaZulu Natal. *South African Family Practice*, 2(55): 175-179.

Groove, S. K., Burns, N. & Gray, J.R. 2013. T*he Practice of Nursing Researcher: Appraisal, Synthesis and Generation of Evidence.* 7th ed. Saunders: Elsevier.

Gurung, G. 2008. Practices on immediate care of newborn in Kailadi district. Napa*; Med Coll.* 10(1): 41-44.

Hassim, A., Heywood, M. & Berger, J. 2007. Health and Democracy: A Guide to Human Rights. *Health Law and Policy in Post-Apartheid South Africa*.1st ed. Cape Town. Siberlink.

Hamminga, B. 2005. Epistomology from African point of view. *Pzonan Studies in the Philosophy of the success and Humanities*, 88 (1): 57-84.

Henning, R. J. & Neumann, W. L. 1987. *An introduction to codes and coding*. Anselm L Strauss

Higginbottom, G.M.A. 2006. 'Pressure of life': ethnicity as a mediating factor in mid-life and older peoples' experience of high blood pressure. *Sociology of Health & Illness*, 28(5): 583-610.

Higgs, P. 2003. African Philosophy and Transformation of Educational Discourse in South Africa. *Journal of Education*, (30): 5-10.

Higginbottom G.M., Pillay,J.J. & Boadau, N.Y. 2013.Guidance on Performing Focused Ethnographies with an emphasis on Healthcare Research. *The Qualitative Report*, 18(9): 1 – 16.

Hofer, B.K. 2000. "Dimensionality and Disciplinary Differences in Personal Epistomology" *Contemporary Educational Psychology*, 25 (4): 378 – 405.

Hountondji, P.J. 1983. *African Philosophy: Myth and Reality*. Bloomington: Indiana University Press.

Walker, R.S. & Hountondji, P.J. 1985. *The pitfalls of being different*. Diogens33(131):46-56.

Isgandarova, N. 2011. *Effective Islamic Spiritual Care: Foundations and Practices of Imams and other Muslim Spiritual Caregivers. Doctor of Ministry in Spiritual Care and Counselling.* Waterloo: Lutheran Seminary of Wilfrid Laurier University.

Jaja, J.M. 2014. Myths in African concept of reality. *Internal Journal of Educational Administration and Policy Studies*, 6 (2): 9-14.

Jali, M. N. 2012. Collaboration of indigenous African and biomedical practices in the provision of health services. *African Journal for Physical, Health Education, Recreation and dance (AJEPHRD),* 18(2): 213-227.

Jenkins, K. 2011.*Traditional Maori Parenting: An historical Review of literature of traditional Maori child. Rearing practices in Pre-European times*. New Zealand.Te Kahui Mana Rikiri, Auckland.

Kayombo, E. J. 2013. Traditional Methods of Protecting the Infant and Child Illness/Disease Among the Wazigua at Mvomero Ward, Morogoro, Region, Tanzania. *Alternative and Integrative Medicine*, 2(1):1-6.

Klopper, H. 2008. The qualitative research proposal. *Curationis,* 31(4): 62-72.

Kanu, I. A. 2013. Trends in African Philosophy: A case for Eclectism.Filosofia Theoretica. *Journal of African Philosophy, Culture and Religion,* 2 (1).

Kuo, A.A., Etzel, R.A., Chilton, L.A., Watson, C. & Gorski, P.A. 2012. Primary care paediatrics and public health: meeting the needs of today's children. *American Journal of Public Health,* 102(12): 17-23.

Kazeem, A. 2012. H.Odera Oruka and Question of Methodology in African Philosophy: A Critique. Thought and Practice: *A Journal of the Philosophical Association of Kenya*, 4(2):185 – 204.

Keane, M., Khupe, C. & Muza, B. 2016. It matters who you are? : Indigenous Knowledge Research and Researchers. *Education as change,* 20(2): 163-183

Khan, S. & Mantzaris, E. 2006. Indigenous Knowledge and the African Curriculum: A case study at the University of KwaZulu Natal. *Alternation,* 13(1): 279-297.

Khoza, M.A. 2009. *Symbolism in Xitsonga Cultural Ritual Ceremonies*. Dissertation, (Masters of Arts in African Languages-Humanities). Limpopo: University of Limpopo.

Killion, C.M. 2017. Cultural Healing Practices that Mimic Child Abuse. *Ann Forensic Res Annal*, 4(2): 1-4.

Kubeka, N.P. 2016. *The Psychological perspective on Zulu ancestral calling: A phenomenological study*. Dissertation, (Masters of Arts in clinical Psychology).Pretoria: University of Pretoria.

Kwame, A. 2008. *Treatment received by children who visit traditional healers*. Dissertation, (Master of Science in Medicine in Paediatrics). Johannesburg: University of Witwatersrand.

Labhardt, N. D., Aboa, S. M., Manga, E., Bensing, J. M. & Langewitz, W. 2010. Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon. *Tropical Medicine & International Health*, 15(9): 1099-1108.

Letseka, M. M. 2012. *An analysis of undergraduate Philosophy of Education Students perceptions of African Philosophy.* Dissertation, (Doctors of Education). Pretoria: University of South Africa.

Letseka, M. M. 2013. Understanding of African Philosophy through Philosophy for children (4PC). *Mediterranean Journal of Social Science,* 4 (4): 745-753.

Lewicki, Z. 2010. One Community, Many identities: Language, Ethnicity and Nationality among Bhutanese Refugees in Philadelphia. Dissertation. Swartmore College.

Liamputtong P. 2002.Child Rearing Practice and Child Health among the Hmong in Australia Implications of Health Services. Pranee Liamputtong *International Journal of Health Service*, 32 (4): 817-836.

Lin, L. C.2009. Data management and security qualitative research. *Dimensions of critical care Nursing*, 28(3): 132-137.

Lincoln, Y.S. & Guba, E. A. 1985. *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lydon Lam, J. 2012. Models of Spiritual and Consideration of Spiritual Assessment. *International Journal of Childbirth Education.* 27(1): 18-22.

Lyons, H.Z., Bike, D.H., Johnson, A. & Bethea, A. 2011. Culturally competent qualitative research with people of African descent. *Journal of Black Psychology*. 38(2): 153-171.

Maila, M. & Loubser,C. 2003.Emancipatory Indigenous Knowledge system: Implications for Envronmental Education in South Africa. *South African Journal of Education*, 32.31-35.

Mabovula, N.N.2011. The erosion of African communal values: a reappraisal of the African Ubuntu philosophy. *Inkanyiso journal & Social Science*, 3(1).

Maharaj, N. 2016. Using field notes to facilitate critical reflection. *Reflective practice,* 17(2): 114-124.

Mahomoodly, M.F. 2013 Traditional Medicines in Africa: An Appraisal of Ten Potent African Medicinal Plants. *Evidence Based Complementary and Alternative Medicine*.ID 617459 http:// dx.doi.org/10.1155//2013/617459.

Makinde, A. 2007. *African Philosophy: The Demise of A controversy*. 11e – 1fe: Obafemi Awolowo University Press limited.

Makunga, N., Thwala, J. & Edwards, S. 2011. The meaning of an animal wristband (isiphanda) in KwaZulu Natal, South Africa. *Journal of psychology in Africa* 2011, 21(3): 373-376.

Mankga, R. W. 2013. *Language usage and some traditional rituals in Northern Sotho*. Dissertation (Master in Language and Communication Studies. Limpopo: University of Limpopo.

Mark, G. 2012. Rongoā Māori (Traditional Maori healing) through the eyes of Māori healers: Sharing the healing while keeping the Tapu. Dissertation (Doctor of Philosophy). Massey University.

Marcus, A. 2016. Designers, User Experience and usability: Design Thinking and method part 1: 5th International Conference, DUXU. Part of HCI International 2016, Toronto, July 17-22.

Mateos, P. 2014. *Names, Ethnicity and Populations: Tracing Identity in Space*. London: Springer Science & Bussiness Media.

Matlala,B. S. 2013. None-Divulgence by patience who used traditional medicine in the critical care units of a Western Mire Hospital. Dissertation. (Master in Nursing Medical and Surgical Nursing). Johannesburg: University of Johannesburg.

Mawere, M. & Mubaya, T.R. 2016. African Philosophy and thought systems-A search for a culture and philosophy of Belonging. Cameroon. Langaa: Research and Publishing, CIG.

McBinnie, A, Ugbart, C. 2011. Motif: Dominant Interaction Patterns Event Structures of Serenddipity: *Information Research*,16 (3):1-5.

Mlisa, R. N.2009. Ukuthwasa initiation of amagqirha: Identity construction and the training of Xhosa women as traditional healers. Dissertation (Doctor of Philosophy in Humanities). Bloemfontein: University of Free State.

Momoh, C.S.1989. *African Philosophy. Nature Schools and Substance in Jim Unah(Ed) Philosophy for all disciplines.* Lagos. Joja Ed. Research and Publications.

Mojalefa, H.M. 2014. *Indigenous Healer's views regarding the causes, treatment of chronic diseases: The case of Ga-Dikgale*. Mini-Dissertation. (Masters in Clinical Psychology). Limpopo: University of Limpopo.

Morekwa. O. 2004. *The interchange, exchange and appropriate of traditional healing modern medicine and Christian healing in Africa today*. Dissertation. (Master of Theology). Pretoria: University of South Africa.

Mphela, K.L. 2010.*An analysis of personal naming in the Moletjie area of the Limpopo Province: An onomastic approach.* Dissertation, (Masters of Arts). Limpopo: University of Limpopo.

Mphuti, D. 2016. *Perceptions of Indigenous Women of obesity*. South Africa. 4th International Conference and Exhibition on Obesity and Weight Management, December 07-09, 2015 Atlanta, USA.

Mudimbe, V.Y. 1988. *The invention of Africa: Gnosis, Philosophy and the order of knowledge (African Systems of thoughts)*. Bloomington: Indiana University Press.

Muir,N. & Bohr,Y. 2014. Contemporary Practice of Traditional Aboriginal Child Rearing: A Review. *An Interdisciplinary Journal*, 9(1): 66 – 79.

Mulaudzi, F.M. 2007. Indigenous Health Beliefs, Attitudes and Practices among VhaVhenda: A challenge to the Promotion of HIV-AIDS Prevention Strategies. *Curations*, 30 (3): 31-38.

Mukolo, A., Cooil, B. & Victor, B. 2015. The effects of utility evaluations, biomedical knowledge and modernization on intention to exclusively use biomedical health facilities among rural households in Mozambique. *Social Science & Medicine,* 138: 225-233.

Munthali, A.C., Mannan, H., MacLachlan, M. & Swart, L. 2016. Seeking Biomedical and Traditional Treatment is a Spiritual Lapse among Zionist: A Case Study of the Zion Church in Malawi. *Ufahamu: A Journal of African Studies:* 39(2), 127-146.

Mutekwe, E. 2015. Towards an Africa Philosophy of Education for Indigenous knowledge systems in Africa. *Creative Education,* 6: 1294-1305.

Naaeke, A. Kurylo, A., Grabowski, M., Linton, D. & Marie, L. 2011. Insider and Outsider perspective in Ethnographic Research. Proceedings of the New York State Communication Association: 2010(9), 151-160.

Ndubuisi, F.O.2013. The Philosophical Paradigm of African Identity and Development*. Open Journal of Philosophy.* 3(1): 222-230.

Ndubuisi, C.A. 2013. Appraisal of African Epistemology in the global system. *Alternation,* 20 (1): 295-320.

Neingo, S. 2012. *A study of a child rearing, practice and beliefs among Aambalantu and Aambandja of the Omusati region of Namibia*. Dissertation (Master of Education). Windhoek: University of Namibia.

Ngidi, E. B. 2012.*The use of personal names in respect of the living-dead within traditional polygynous families in Kwamabulu, Kranskop.* Dissertation, (Doctor of philosophy). Durban: University of KwaZulu Natal.

Ngozi, O. R. & Ugwuanyi, F. C. 2014. Strategies for the enhancing information access to traditional medical practitioner's to aid health care delivery in Nigeria. *Library Philosophy and practice journal,* paper 1179.

Ngqila, K. H.2015. An investigation of methods used by the Southern Nguni in healing ukuhanjwa illness. Dissertation (Doctor of Philosophy in Athropology). Univerrsity of KwaZulu-Natal.

Ngunyulu, R. N, 2012. *A model for incorporating "Indigenous" Postnatal Care Practices into the midwife Health Care System in District, Limpopo Province*. Dissertation (Doctorate of Philosophy), Pretoria: University of Pretoria.

Nieswiadomy, R. 2012. *Foundation of nursing research*. 6th edition. United States of America: Pearson.

Nkomazana, F. 2008. The experience of women with Tswana Culture history and implication for the history of church in Botswana. *Journal Stadia Historia Ecclesiasticae*, 34 (2): 83-116.

Nyabwarii, B. G. & Kagema, D. The impact of magic and witchcraft in the social economic, political and spiritual life of African Communities*. International Journal of Humanities and Science Education,* 1 (5): 9-18.

Nyoni, C.N. 2015. *Perceptions of Patients regarding Diabetes – related health Communication Strategies in the Free State*. Dissertation, (Magister Societies Scientiae (Nursing). Bloemfontein: University of the Free State.

Nyundu, T. & Naidoo, K. 2016. Traditional healers, their services and the ambivalences of South African youth. *Commonwealth Youth and Development,* 14(1): 144-155.

Obinna, E. 2012.Life is a superior to wealth? Indigenous healers in an African community, Amariri, Nigeria, in A. Afe, E. Chitando & B Bayete(eds). *African traditions in the study of religion in Africa,*Farnham: Ashgate: 137-139.

Okka, B., Durduran, Y. & Degerli-Kodaz, N. 2015. Traditional practices of Konya women during pregnancy, birth, the postpartum period and newborn care. *Turkish Journal Medical Science,* 46: 501-511.

Okolo, C.B. 1990. Problems of African Philosophy and other Essay. Nigeria. Ntsukka Celta.

Omotosho, I.F. 2014 A Critique of the Question of African Philosophy. *Journal of Humanities and Social Science.* 19 (7): 61-66.

Opong, A.K.1997. *The religious significance of ritual practices conducted at births, weddings and funerals in Lesotho*. Dissertation, (Masters in Religious Studies). Pretoria: University of South Africa.

Oruka, H. 1990. *Trends in Contemporary African Philosophy*. Nairobi: Seirikon Pub.

Oruka, H.O. 2002." *Four trends in African Philosophy," in Philosophy from Africa*.2nd edition. edited by PH Kotzee and APJ Roux. Oxford University Press : Cape Town: 120 -124.

Osuji, P, I. 2014. *African Traditional Medicine: Autonomy and Informed Consent*. 3rd ed. Pittsburg. Springer.

Palacio, M.B.A., Palaciao, C. S., Valadolid, E. S. Ebuenga, L. C. 2014. Maternal-infant health beliefs and practices of mothers in resettlement sites in the province of Albay *International Journal of Technical Research and Applications*, 2(5): 38-42.

Pink, S. 2009. *Doing Sensory Ethnography.* 1st ed. Los Angeles: Sage Publications.

Pink, S. & Marcus, G. 2015. *Doing Sensory Ethnography*. 2nd ed. Los Angeles: Sage Publications.

Phyllis, J.W.2008. *Characteristics of a healing environment as described by expert nurses who practice within the conceptual framework of Roger's Science of unitary human beings: A qualitative study.* Dissertation (Doctor of Philosophy in Nursing). Texas: University of Texas Graduate School of Biomedical Sciences at Galvestone.

Polat, S., Ozyazicioglu, N, & Bicakci, H. 2014. Traditional Practices used in infant care. *Indian Journal of Traditional Knowledge*, 1(1): 47 – 51.

Polit, D.F. & Beck, C.T. 2008. *Nursing Research: Generating and Assessing evidence for Nursing Practice*: 8TH ed. Philadelphia: Lippincott. Williams and Wilkins.

Polit, D.F. & Beck, C.T. 2012. *Research Nursing Generating Assessing Evidence for Nursing Practice.* 9th ed. Amsterdam: Wolters Kluwer Health.

Popova. Y. 2005. *Traditional Childcare and treatment of children's diseases among the Besermian*. Doi: 10.7592/FEJF2005.30.popova.

Prill-Brett, J. 2013. Ethnographic Research Methods. College of Social Sciences. University of the Phillipines Baguio.

Ramanand, A. 2016. *The childbirth experience among women from diverse spiritual backgrounds: An exploratory study at public hospitals in the Umgungundlovu district of KwaZulu Natal*. Dissertation (Masters of Health Sciences: Nursing), Durban University of Technology.

Rikhotso, S.R. 2017. *Indigenous knowledge of Traditional Health Practitioners in the management of Rigoni: A grounded Theory approach*. Dissertation. (Doctor of Philosophy). Pretoria: University of Pretoria.

Roper, J.M. & Shapira, J. 2000. *Ethnography in nursing research (methods in nursing research*). London: Sage Publications.

Rowsell, J. 2011. *Carrying my family with me: artefacts as emic perspectives.* Qualitative Research*,* 11(3): 331-346.

Ross, E. 2010. Inaugural lecture: Africa, Spiritualty, ethics and traditional healing – implications for indigenous South Africa social work education and practice. *SAJBI. 3(1):44-51.*

.

Saldana, J. 2013. *The coding manual for qualitative researchers.* 2nd ed. London: Sage

.Saldana, J. 2008. An introduction to codes and coding. 1st ed. London: Sage.

Schonfeld, M. 2013. *Global Ethics on Climate Change: The Planetary Crisis and Philosophical Alternatives.* Canada: Routeledge.

Schraw, G. Conceptual integration and measurement of epistemology and ontological beliefs in educational research. 2013. International Scholary Research Notices Education, (2013): 1-19.

Sogolo, G. 1993. Foundations of African Philosophy. A definitive Analysis of conceptual Issues in African thought. Ibadan.Ibadan University Press.

Semenya, S. S. & Potgieter, M. J. 2014. Bapedi traditional healers in the Limpopo Province, South Africa: Their socio-cultural profile and traditional healing practice. *Journal of EthnobiolEthnomed,* 10(4):1-10.

Setswe, K.G., Naude, M. & Zungu, L. 2011. *Basic Community Health Nursing.* Cape Town: Pearson Education.

Shizha, E. & Charema, J. 2011. Health and wellness in South Africa: Incorporating indigenous and Western healing practices*. International Journal of Psychology and Counselling*, 3(9): 167-175.

South Africa. 2007. *Traditional Health Practitioners Act. Government Gazette, 30660*: 6. Jan.10. Pretoria: Government Printer.

Spradley, J.P. 1980. *Participant Observation*. Fort Worth: Harcourt Brace Jovanovich College Publishers.

Speziale, H.S & Carpenter, D.R. 2007. *Qualitative Research in Nursing: Advancing the humanistic imperative.* Hippincott: Williams and Wilkins.

Srichimpa, S. 2013. Thai Amulets: Symbol of the Practice of the Multi-faiths and Cultures: Contemporary Social-Cultural and Political Perspectives in Thailand. *Springer Link*, 49-69

Stockigt, B. M. H., Besch, F., Jeserich, F., Holmberg, C., Witt, C.M. &Teut, M. 2015. Healing relationships: A qualitative study of healers and their clients in Germany. *Evidence based Complimentary and Alternative Medicine. 2015.*

South African, Republic, Constitution of the Republic of South Africa. 1996. Pretoria: Government Printers.

Sunderland, N., Gudes.,O., Bristed,H., Da Sylvia, M & Baddy, J. 2010.*What does it feel like to live here? Exploring sensory ethnography as a method for investigating lived determinants of health in place*. Grifiths University: Grifiths Research.

Sutterlüty, F. 2006. The belief in ethnic kinship: A deep symbolic dimension of social inequality. *Sage journals*. 7(2): 179-207.

Taylor-Powell, E. & Renner, M. 2003. *Madison, Winconsin, Programme Development & Evaluation. Analysing Qualitative Data*. Winsconsin: University of Winconsin-Extension.

Terre Blanche, M., Durrheim, K. & Painter, D. 2009. *Research in Practice: Applied Methods for the Social Sciences.* 2nd ed. Cape Town: UCT Press.

Thomas, F. 2010. Traditional health and treatment networks: Meaning, value and place in health seeking Southern African migration in London. *Health and Place Journal*, 16(3): 606-612.

Timyan, J. 1988. Cultural Aspects of Psychosocial Development: An examination of West African childbearing Practices. The Consultative Group on Early Childhood Care and Development. 1-26.

Truter, I. 2007. African Tradition healers: Cultural and Religious belief intertwined in a holistic way. *Complementary and Alternative Medicine,* 56-60.

Waghid, Y. 2004. “African Philosophy of Education: Implications for teaching and learning”. *South African Journal of Higher Education*, 18(3): 56-64.

Wellman, C., Kruger, F. & Mitchell, B. 2009*. Research Methodology*. 3rd ed. Cape Town: Oxford University Press.

Udefi, A. 2014. The Rationanale for an African Epistomolgy: A crtical Examination of the Igbo views on Knowledge Beliefs and Justification. Canadian Social. Science. 10(3): 108-117.Ukpokolo,

I.E. 2017. *Themes, Issues and Problems in African Philosophy*. BOOK 2. Palgrave. MacMillan. Springer Nature.

Ukwamedua, N.U. 2014. A meta-empirical discourse on the concept of pure disembodied spirits in African metaphysics. *Sophia: An African Journal of Philosophy and Public affairs*, 15(1): 32-40.

Umeogu, B. 2013. Open Journal of Philosophy. *The Place of symbols in African Philosophy*, 3(1A): 113 – 116.

Wabungu, W.J. 2012. *The effects of socio-economic and cultural factors on access and participation in secondary school education in Igembe North District Meru country*. A research project submitted to the school of Education in partial fulfilment for the recruitment of the award of the Master degree of Kenyatta University.

Waghid, Y. 2004. African Philosophy of Education: implications for teaching and learning. *South Africa journal of higher education*, 18(3): 56-64.

Wiredu, K. 1992-93. "An African Philosophical Tradition: A case study of Akan". *Philosophical forum,* 24(1-3): 35-62.

White, P.2015. The concept of disease and health care in African traditional religion in Ghana. *Theological Studies,* 71(3).

WHO. 1978. Fact sheet no 134.2008, http: www.who/int/mediacentre/factsheet/2003/5134/en/.

Xulu, C.B.S. 2002. *Colour Coding and its Meaning in Zulu. Women's Beadwork: A study of Zulu Women's Beadwork in Fashion Design and Decoration*. (Master of Arts in the Department of isiZulu Namagugu). University of Zululand.

Zagzebski, L. 2009. *On Epistemology*. 1st ed. Canada: Wadsworth.

Zuma, T., Wight,D., Rochat,T. & Moshabela,M. 2016. The role of Traditional health practitioners in rural KwaZulu Natal, South Africa: generic or mode specific? *BMC Complementary and Alternative Medicine*, 16(304) DOI 10.1186/s12906-1293-8

Zungu, B.K. 2000. Meaning behind the use and wearing of traditional Beadwork at Msinga Area. Dissertation, (Masters of Arts in the isiZulu programme). Durban: University of Durban Westville.

ANNEXURE A

PERMISSION TO CONDUCT THE STUDY

Permission to access information/ Files / Data base at Nellmapius Clinic

TO: Ms R Moloto
Chief Executive Officer/Information Officer

Director of Primary Health Services
City of Tshwane

FROM: Elizabeth M. Ramaube
Investigator

Nellmapius Clinic

Re: Permission to conduct research at Nellmapius Clinic

TITLE OF STUDY: Traditional disease prevention practices performed during infancy in a designated municipality ward in Tshwane district
……..

This request is lodged with you in terms of the requirements of the Promotion of Access to Information Act. No. 2 of 2000.

I am a researcher / student at the Department of Nursing at the University of Pretoria. I am working with Dr RS Mogale and Dr RN Ngunyulu. I herewith request permission on behalf of all of us to conduct a study on the above topic on the clinic grounds. This study involves access to patient records. This study involves clinical research.

The researchers request access to the following information: clinical files, record books and data bases.

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 nature.

We intend to protect the personal identity of the patients by assigning each individual a random code number.

We undertake not to proceed with the study until we have received approval from the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

Yours faithfully

_____
Signature of the Principal Investigator

Official Stamp

Elizabeth Masetopana Ramaube

ANNEXURE B

DRAFT OF DATA COLLECTION INSTRUMENTS

Elizabeth Masetopana Ramaube

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Documentation and observation of artefacts and semi-structured interviews

The focus of the semi- structured interviews will depend on the artefact that the researcher observed from the infant. These will be the guiding questions:

1. Tell me more about the object.
2. What is the meaning of the object?
3. How and why did you obtain the object?

ANNEXURE C1

PARTICIPANT'S INFORMATION LEAFLET AND INFORMED CONSENT FORM

PARTICIPANT'S INFORMATION LEAFLET & INFORMED CONSENT FORM

TITLE OF STUDY: Traditional practices for disease prevention in infancy in a designated municipality ward in Tshwane District

Researcher's name : Elizabeth Ramaube

Student Number : 25441851

Department of Health Sciences

University of Pretoria

Dear participant,

1) INTRODUCTION

I invite you to participate in a research study. This information leaflet will help you to decide if you want to participate. Before you agree to take part you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator.

2) THE NATURE AND PURPOSE OF THIS STUDY

To explore traditional practices for disease prevention in infancy in a designated municipality ward in Tshwane District.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

The researcher will document the artefact/s that the infant is wearing on the body and will only take the photo/s of the artefact/s without exposing the infant's face if allowed by mother. The researcher will conduct semi-structure interviews with the participants. An interview guide is used to guide and direct both interviewer and participants to reach the

objectives of the study.

4) RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study.

5) POSSIBLE BENEFITS OF THIS STUDY

Although you will not benefit directly from the study, the results of the study might assist in providing knowledge to all stakeholders involved in promoting and maintaining the health status of infants. In addition, the study might create an opportunity for traditional healers and biomedical health professionals to work comprehensively.

6) WHAT ARE YOUR RIGHTS AS A RESPONDENT?

Your participation and of your infant in this study is entirely voluntary. You can refuse to participate or stop at any time during the study without giving any reason. Your withdrawal will not affect you and your infant in any way.

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, telephone numbers 0123542245 / 0829214130.

8) INFORMATION AND CONTACT PERSON

The contact person for the study is Elizabeth Ramaube If you have any questions about the study please contact her at the following telephone number: 0829623047, or alternatively you may contact her supervisor Dr R.S. Mogale at telephone number 0715591327.

9) COMPENSATION

Your participation is voluntary, and there is no compensation.

10) CONFIDENTIALITY

All information that you give as an individual will be kept strictly confidential. Once we have analysed the information no one will be able to identify you and your infant. Research

reports and articles in scientific journals will not include any information that may identify you or your infant as there will be no photo/s of the infant but only the artefact/s shown.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking 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 time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect my treatment in any way.

I have received a signed copy of this informed consent agreement.

Participant's Name			**(Please print)**
Participant's Signature		**Date**	
Investigator's Name			**(Please print)**
Investigator's Signature		**Date**	
Wittness's Name			**(Please print)**
Wittness's Signature		**Date**	

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant's information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the participants whom I have asked to participate in the study.

The participant indicates that s/he understands that the results of the study, including that personal details regarding the interview will be anonymously processed into a research report. The participant indicates that she/he has had time to ask questions and has no objection to participate in the interview. She/he understands that there is no penalty should she/he wish to discontinue with the study and his/her withdrawal will not affect the study in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name			(Please print)
Person seeking consent			(Please print)
Signature		**Date**	
Witness name			**(Please print)**
Signature		**Date**	

ANNEXURE D

APPLICATION LETTER FOR APPROVAL

Elizabeth Masetopana Ramaube

The Assistant Manager

Nellmapius clinic

610 Lorriesfontein Street

Nellmapius Ext 5

0162

The Manager

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY

Dear Sir/Madam

I Elizabeth Ramaube hereby apply for permission to conduct a research study in the clinic.

The study focuses on exploration of traditional health practices performed during infancy in designated ward of this area.

The study might assist in identifying practices that pose risk in the health of the infants, capacitate all stakeholders involved in promoting and maintaining health status of the same infant. Could also create an opportunity for traditional healers and biomedical health professionals to work comprehensively in attaining the above goal.

It would be appreciated if approval is granted to conduct the study.

Thank you in advance.

Ms: Ramaube E.M.

Contact no:0829623047

Elizabeth Masetopana Ramaube

ANNEXURE E

ETHICAL APPROVAL LETTER

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/07/2016

Approval Certificate
New Application

Ethics Reference No.: 250/2016

Title: Traditional disease prevention practices that are performed during infancy in designated municipality ward in Tshwane district

Dear Elizabeth Ramaube

The New Application as supported by documents specified in your cover letter dated 31/05/2016 for your research received on the 31/05/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 27/07/2016.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year.
- Please remember to use your protocol number (250/2016) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:
- Recommendation to revise the title to "Traditional practices for disease prevention during infancy in designated municipality ward in Tshwane district."

We wish you the best with your research.

Yours sincerely

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

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 356 3084 deepeka.behari@up.ac.za http://www.up.ac.za/healthethics
Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

ANNEXURE F

TSHWANE RESEARCH COMMITTEE CLEARANCE CERTIFICATE

Kuyasheshwa! Gauteng Working Better

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

427 Hilda Street, 4th floor, The Fields Building, Hatfield Pretoria 0001 South Africa. Tel: +27 12 451 9036
Enquiries: Dr. Molapane Chueu
e-mail: Molapane.Shabangu@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 45/2016

Title: Traditional Practices for Disease Prevention in Infancy in a Designated Municipality Ward in Tshwane District

Researcher: Elizabeth Ramaube

Supervisor: Dr. RS Mogale

Co-Supervisors: Dr RN Ngunyulu

Department: Nursing Science, University of Pretoria

DECISION OF THE COMMITTEE

Approved

NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 04/10/2016

.....
Dr. Molapane Chueu
Chairperson Tshwane Research Committee
Tshwane Health District

.....
Mr. Pitsi Mothombone
Chief Director: Tshwane District Health
Tshwane District

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

ANNEXURE G

TRANSCRIPT: INTERVIEW EXAMPLER CONVERSATION WITH PARTICIPANT

Conversation with Participant No 1

E.M: Mama, my name is Elizabeth neh, mama by the way what is your name?

PP#1: I am

E.M: Okay

E.M: I see your infant is wearing something on the waist, I am requesting you mama to tell me, explain to me the thing the infant is wearing.

PP#1: When I took the infant for the ritual, is like, in Shangaan (Tsonga) we call it “xitshungulu”

E.M: Okay.

PP#1: When I took my infant there, post-delivery she had (infant) a mark behind her head, “pointing at the area just above the neck at the back”

E.M: Okay

E.M: Where at the back?

PP#1: Points at the cervical area just above the neck.

PP#1: That mark was reddish in colour, head at the centre was sunken (fontanel was sunken), not in beating well. I bought her here to this clinic, when I got there at the clinic, I was told “no your infant is fine”. I delivered her July, then on the 23rd December the infant head was abnormally bending down “a lahla hlogo”. I initially told myself that the infant is tired, but no. I delivered a healthy and well-baby, in the meantime “this thing” is busy eating my infant inside, busy eating my infant inside, busy eating my infant inside. Then I told my mother I am not happy with this child, she is having diarrhoea and vomiting. Then her caregiver, the lady who was looking after her during the day when I go to work told me that she (infant) has “hlogoana”. She did show me that there is a hole at the centre of the head and the beating there is abnormal, she also pointed on the mark at the back of her head. And I have been reporting the same problem at the clinic several times. The caregiver told me about one lady at …….Street who can heal the infant. When we arrived there she told us that infant is suffering from sunken fontanel “hlogoana”. I asked her what “hlogoana” is she explained.

E.M: The lady you took your infant to, who is she? Is she a traditional healer or not?

PP#1: No she is not a traditional healer, she’s a born again Christian, who has acquired knowledge from her mother. She works in a Shangaan traditional way. Her mother was a professional nurse

who has undergone training on traditional medicine “othwasitse” so this lady has been observing what her mother was doing. When she passed away/on, she continued with the traditional healing.

E.M: Okay

PP#1: This lady did steam inhalation on the infant with traditional muthi, gave another muthi for her to drink. Thereafter the infant sneezed, sneezed then that thing moved from the head to the chest, pointed upper part of the abdomen (epigastric area). When she is done (healer) she told me again that the infant was suffering from “hlogoana”, that the infant was delivered with that from the inside (utero). After completing her work she gave muthi to drink. “She gave it to me in a bottle” and said I must give it to the infant until she grows older. And she made this serokolo (pointing at the artefact that the infant had on the waist). In making that serokolo she used the infant’s nails, hair and mixed it together with muthi. She bound all of that together with a white cloth before tying it on infant’s waist. The healer said the artefact will ensure that the infant is protected when exposed to people who use dangerous things. The infant will also have strength and will not be troubled spiritually.

E.M: Sorry mama, you said people use dangerous things. Can you please explain what those things are?

PP#1: There are other people who use dangerous muthi unlike us born again Christians. So the healer said serokolo will protect the infant when entering a house whereby the muthi is used.

E.M: Did the healer tell you which muthi she used?

PP#1: Mm (she shook her head indicating no) she didn’t tell me but those were African muthi. After the infant drank muthi she vomited a lot of some green stuff. Till today it is Amen. My infant has never been sick.

E.M: You said the infant had the artefact since when?

PP#1: From the time she was four months old.

E.M: Ok when are you going to take it out?

PP#1: If it becomes loose on its own that is also not a problem.

EM: Okay, how old is your infant now?

PP#1: She is now twelve months old.

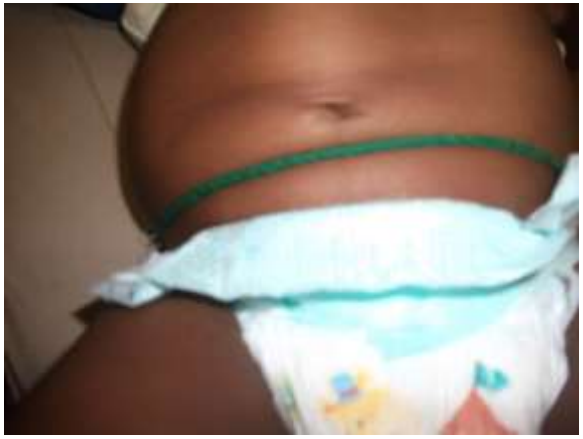
E.M: Okay, mama thank you!

ANNEXURE H

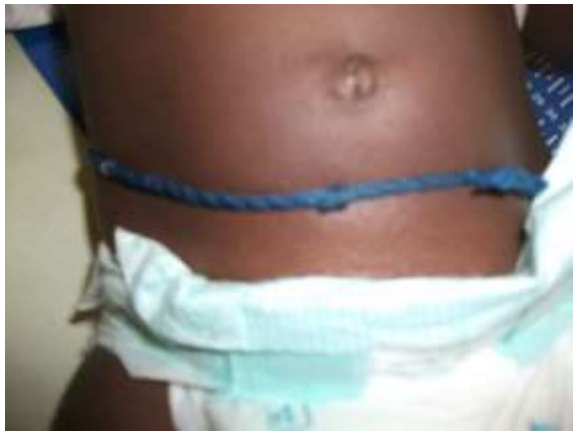
CATALOGUE OF TRADITIONAL ARTEFACTS IN INFANC

Elizabeth Masetopana Ramaube

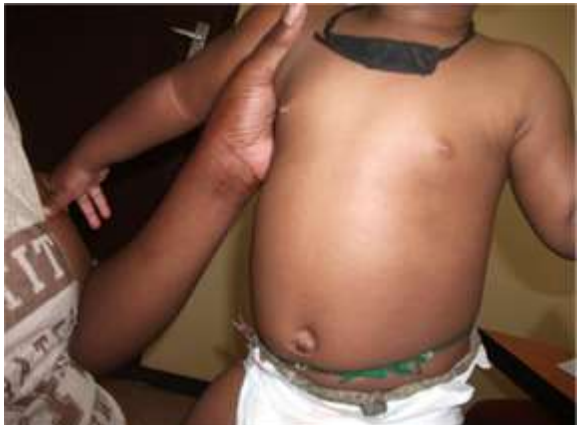
SOME OF THE SPIRITUAL ARTEFACTS



Purpose: Casting of evil spirits



Purpose: Prevents the child from used as zombie at night



Purpose: Facilitate teething (velvet)

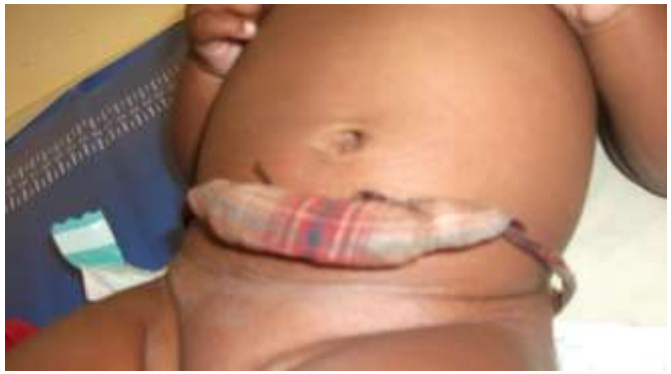
Protection against evil spirits (Wool)

Purpose: Casting of evil spirits

SOME OF THE SOCIO-CULTURAL ARETEFACTS

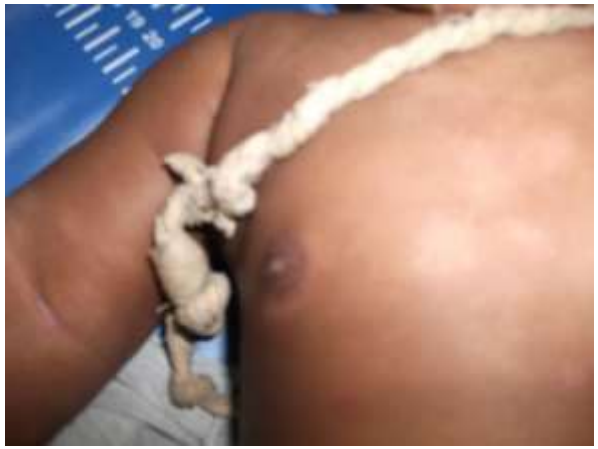
Purpose: **Earing**: Welcoming of the infant in family

Beads around the neck: Healing and protection

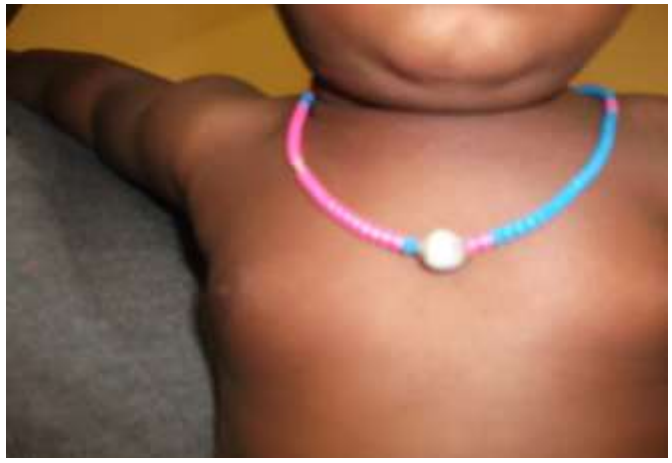


.

Purpose: To prevent evil spirits from attacking the infant

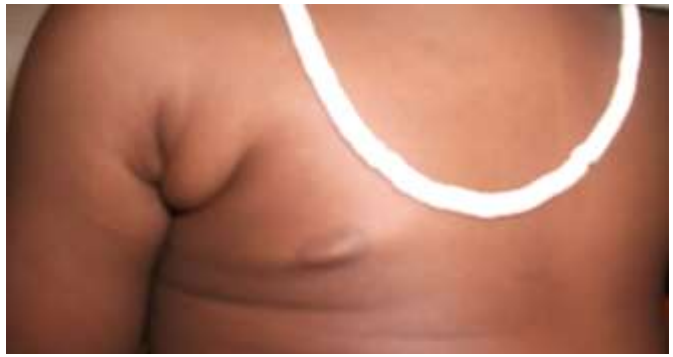


Purpose: Protection from evil spirits



Purpose: Facilitate easy teething

SOME OF THE ANCESTRAL ARTEFACTS



Purpose: Protection from evil spirits

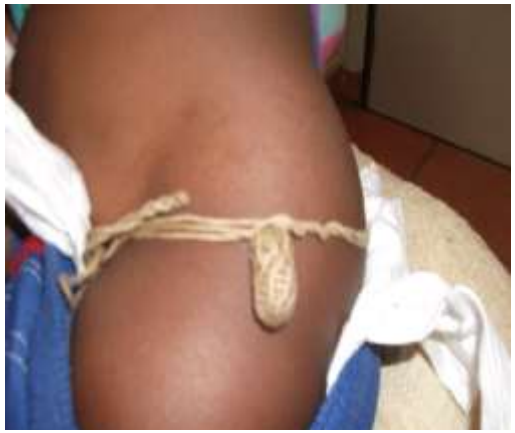
Purpose: Protection from evil spirits

Purpose: Welcoming and introducing the baby to the ancestors

Purpose: Renaming of the infant according to ancestral instruction

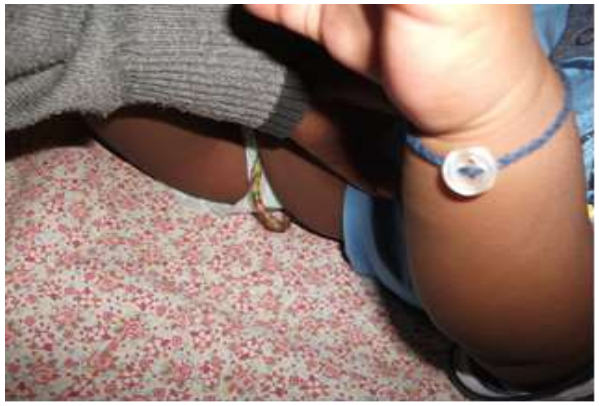
SOME OF THE HEALING AND PROTECTION ARTEFACTS

Purpose : To protect from evil spirits

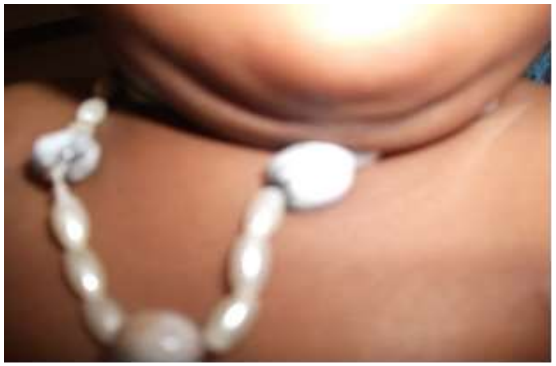


Purpose : To heal hlogoana and rigoni.

To protect from evil spirits



Purpose: Prevention of predicted strabismus of the eyes



Purpose: To facilitate teething, to make it fast without complications