

**Socio Cultural and Philosophical Importance of Rituals in Traditional Medicine:
Focus on HIV And AIDS Treatment in the Vhembe District, Limpopo Province**

BY

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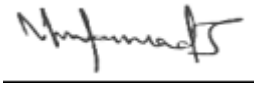
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DECLARATION

I, Jane Mufamaḽi, declare that this research study is my original work and has not been tendered for any degree at any other university or institution. The study does not contain another persons' writing unless specifically acknowledged and referenced accordingly.

Signed (Student):



Date: 20 February 2023

DEDICATION

I dedicate this work to my whole family: My parents, my partner, my son, and my siblings, for the contribution they have made in my social, academic, and spiritual growth.

ABSTRACT

Indigenous healing is largely holistic in its approach. When a patient consults with a headache or a painful knee, there would be a deliberate intent on the part of the healer to look at the entire body and its relation to the environment, ancestors, and spiritual aspects. However, this approach is often misunderstood and ridiculed at times. This study sought to examine the socio-cultural importance and philosophical stance of rituals followed by indigenous healers during the process of diagnosis and administration of HIV and AIDS treatments. While there is recognition and acceptance that indigenous healers have a part to contribute to the treatment of HIV/AIDS, this has been done in a manner that requires indigenous healers to conform to western approaches and methodologies, thus losing the authentic value and form in which they have been used since time immemorial.

This is an exploratory study, which entails aspects of participant observation, where selected indigenous healers were observed and interviewed to provide key information regarding the phenomenon in question. Sixteen indigenous healers were purposively selected. Responses from semi-structured interviews with these indigenous healers from the Vhembe District in the Limpopo Province, South Africa, were the main sources used for the knowledge acquisition process. Being the conduit through which these participants' stories were told, the researcher's own account and viewpoints on the subject were interwoven throughout this report.

The study revealed that indigenous healers perceive rituals as the backbone of the healing process. The study also found that there are no specific rituals reserved for HIV/AIDS patients, as rituals are embedded and are considered as the 'DNA' of all aspects of healing for all diseases and illnesses. Meaning that rituals serve as both ground and a centre within which transformation for the patient, the family, and the community at large occur. The most significant finding in this study, as articulated by all participants, is that rituals give one purpose and an opportunity to reconnect with oneself, the family, ancestors, and the community, bringing one to the centre of who they are. This is because participants believe that rituals are necessary because, in their understanding, sickness or disease is not just physical, but a way for the body to communicate what the soul or the ancestors need, and therefore, participation in the ritual fulfils, not just the physical disease, but the socio-cultural, and spiritual issues.

This highlighted the need to properly contextualise and acknowledge the multi-layered, complex process of indigenous healing within the socio-cultural frame works. I, therefore, recommend the establishment of a clear and definitive role for indigenous healing within government framework for primary health care so that indigenous healers can play a decisive part in the provision of healthcare within the South African population.

KEY WORDS

Indigenous Medicine; HIV; Indigenous healers; traditional healers; healers; biomedical science; biomedical medicine; Living heritage; Intangible heritage.

NB: the words, 'indigenous healer', 'traditional healer', or 'healer', are used interchangeably in this study because many authors use them to refer to the same population/community of practice.

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LIST OF ABBREVIATIONS

AIDS	=	Acquired Immuno-Deficiency Syndrome
HIV	=	Human Immuno-Virus
IDP	=	Integrated Development Planning
IKS	=	Indigenous Knowledge Systems
NDP	=	National Development Plan
WHO	=	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1. Background

South Africa is a country with a rich and diverse culture, comprised of indigenous knowledge, technologies, and systems. These forms of practices and knowledge are as old as humankind as they have remained part of the African tradition and belief systems. From time immemorial, the traditional practices and knowledge systems have been used to solve social and cultural problems, and to address the health and development requirements and challenges of African people. However, with the emergence of colonial and Western domination, African culture, indigenous knowledge systems and technologies have been shunned and downgraded to the margin. It is out of this observation and realisation that this study is being pursued.

African culture, indigenous knowledge systems and technologies have relied mainly on the indigenous healers' practices. Thus, numerous studies have indicated that indigenous healers are effective in the treatment of ailments and diseases based on the belief systems of the patients that are being treated and the level of indigenous healer precision and accuracy in terms of appropriate targeting of the environment in which the ailment or the disease is located within the patient body (Walsh, 1989; Harner, 1990; Thorpe, 1993).

Mokgobi (2012), has indicated that the reasons for the success of the indigenous healers in the treatment of ailments and diseases are because the indigenous healer's understanding of the disease is more in line with the patient's belief system, as compared to the modern medical concept of ailment. The other contributory factor to the success of the indigenous healers has been that such healers treat both the disease, and the symptoms simultaneously with the psycho-social problems that accompany the disease (Ngobe, Semenya & Sodi (2021). It has also been found that indigenous healers' healing processes would include amongst others, two interconnected functions: affording effective control of the disease and illness manifestations and ascribing personal and social meaning to the experience of being sick in a particular cultural setting (Ngobe, Semenya & Sodi;2021). This means that

the overall, treatment given to the patients is holistic, addressing the body, soul, and spirit, and not exclusively focused on a single disorder.

Indigenous healers' entire cosmos is an integrated system. So, indigenous healing involves dealing with the whole person to assist them to heal, not just the physical, but the mental, emotional, and spiritual issues. This holistic process encompasses an integrative approach that attempts to balance the body, the mind, and the spirit with the environment. Furthermore, it is indicated that to prepare their medicines, indigenous healers make use of the healing materials found on the land and in the water to help people suffering from physical diseases, along with healing ceremonies that help people with mental, emotional, and spiritual disorders. This combination that promotes an all-inclusive wellness (Berube, 2018).

Notwithstanding all efforts to exterminate the indigenous medicine and practices, it is interesting to find that contrary to that, the numbers of indigenous healers has been increasing substantially (Karlson & Moloantoa, 1984). Truter,(2007) and Molebatsi, Breed & Stafford(2020), estimate that there are about 200,000 indigenous healers in South Africa as equated to 25,000 modern-trained doctors. Other authors have indicated that the ratio of indigenous healers in Sub-Saharan Africa, is approximately 1:500, to the population, while the ratio of medical doctors is 1:40 000 ratio to the population (Karim et al., 1994). Green, (1994) attributes the high number of 'indigenous healers' to the fact that they also serve as religious ritual specialist. They also function as family and community therapists, moral philosophers, as well as teachers and visionaries. Indigenous healers are also perceived as 'change brokers' who support society to adjust to socio-cultural dynamics that are brought about by urbanization (Green, 1994). This implies that the indigenous healers' role within communities go beyond healing the physical ailments, but also, they serve as counsellors and social workers.

In South Africa, several studies have investigated indigenous healing as it is practiced in various indigenous African communities (Hadebe, 1986; Buhrman, 1979; Muelelwa et al., 1997; Sodi, 1998). For instance, Mkhwanazi (1989), while studying the psychological relevance of traditional healers in the Zulu community, found that the three therapeutic conditions of empathy, warmth and genuineness were existing in

various degrees in the clinical practice of an Isangoma (indigenous healer). Mkhwanazi (1989), is of the view that despite being convincing, authoritative, charismatic, and confident, the indigenous healers are also empathic, sincere, and can display measured warmth towards clients.

Sodi (1998), indicates that the reason for indigenous healers to be empathic, sincere, and ability to display measured warmth is because they ascribe culturally consistent labels to clusters of physical and mental symptoms that are presented by the patients. Sodi's (1998), standpoint is that indigenous healers have developed a nosologically framework that helps them to comprehend, categorize and label groups of symptoms that are a source of suffering or illness to their clients. The point of advantage is that indigenous healers can adequately express diagnostic labels in a language that is comprehensible and aligned with the patient's cultural worldview and perspective. In indigenous healing and treatment, treatment of illness or diseases is managed at two levels: the physical and the mental or ritualistic levels.

Indigenous healers offer a client-centered, tailored health care that is culturally fitting, holistic, and personalized to meet the wishes and expectations of the patient. This is because these doctors are culturally close to their patients, which enables clear communication about disease and associated social issues (Mufamadi, 2001). Accordingly, the services of indigenous healers extend beyond the use of medicine for physical treatment. An essential part of indigenous healing is ceremony because physical and spiritual health are closely related, whereby the physical body and the spirit must heal together. These entail songs, prayer, drumming, chants, and the use of a diverse sacred objects.

The Institute of Scientific Research (1981) suggests that treatment could be directly curative, it may comprise protective and preventive aspects. Treatment is said to include the traditional healer and the patient, but it could also include the sick person's family and community. Treatments of illnesses could be ritual or natural, but most therapies do combine elements of both. Treatment through rituals is based on symbols and beliefs. These rituals may be peripheral, integral, or universal. For example, where peripheral rituals are to be conducted or where there is a brief ceremony at the beginning of treatment such as a prayer to the ancestors or observance of certain

taboos before commencement of treatment. During rituals, problems and illness are not individualized but are interpreted within the social and kinship systems and traditional norms. This implies that indigenous healing would be applied from a holistic approach, where it covers the physical, social, medicinal, and mental aspects of the sickness. Likewise, ceremony and the power of faith and belief are important elements of indigenous healing in the sense that they offer guidance, and initiate healing or help it along. van Wyk, van Oudtshoorn & Gericke (1999), maintains that several purification practices can be administered in preparing muti (a mixture of traditional herbs) and healing. In addition, the atmosphere for healing goes far beyond the simple administration of medicines. The cure results from a process that is not only physiological, but also symbolic (Hoogasian & Lijtmaer, 2010).

HIV/AIDS is one of the illnesses and diseases that are a burden in Africa in the sense that it has, in recent years, emerged as the top reason of death in Africa (Ng'ang'a, 2017). Research indicates that HIV/AIDS is the second cause of death next to lifestyle diseases. While acknowledging that there has been a great improvement towards the handling of HIV/AIDS, it is estimated that 760,000 people died from HIV/AIDS and related problems in Africa in 2015. HIV/AIDS is a virus that not only physically affects people, but mentally and socially, as well as economically. Consequently, care for affected people requires a multi-dimensional method that includes psycho-social treatment and support including treatment that is offered to the patient, the family, and the community to improve the health of the patient. This means that there is a need for varied approaches to deal with the extensive and multifaceted cultural, social, environmental, and financial circumstances in which HIV continues to circulate.

The above is the basis through which this study intended to comprehend the degree to which the effect of HIV/AIDS could be reduced using indigenous medicinal practices. This is because in countries like South Africa, the exorbitant cost and shortage of anti-retroviral drugs have made people resort to using indigenous medicinal treatments for HIV conditions, which includes opportunistic infections like diarrhoea. Hoppenbrouwer (1997), suggests that for the world to address and effectively deal with HIV/AIDS, the best mechanisms would be working in collaboration with other sectors, in particular indigenous healers. This point is cemented by Green (1994), who indicates that working with indigenous healers is important because they

are well respected in the communities where they work based on their experience in treating other ailments.

South Africa is amongst the most highly infected and affected countries in Africa and the world with HIV/AIDS. This is due to inadequate resources and limited awareness campaigns. It is also estimated that by the end of 2000, 40 million people were living with HIV/AIDS, and of these, about 4.7 million were South Africans (Department of Health, 2000). Therefore, preventive interventions to reduce the spread of HIV have been devised because of this situation. These include treatment options, application of preventive strategies that focus on sexual behaviour, the use of condoms, education, and information campaigns. Despite all these efforts in curbing the HIV pandemic, the rate of infection remains high in South Africa.

This study moves from the premise that indigenous healers are an essential part of the health care system, and they have a role and obligation to play in preventing and combating the spread of HIV/AIDS. Despite all these efforts and the fact that South Africa has been experiencing a wide range of health challenges, not much has been done to integrate indigenous healers into the primary health care system. The lack of participation of these healers in the health system could be recorded as far back as the time when the World Health Organization (WHO, 1978)'s statement to recognise the significance of indigenous medicine in primary health care, which includes the necessity to integrate healers in national health plans and policies (WHO, 1978, 1991).

In South Africa, since the promulgation of South Africa's Traditional Health Practitioners Act no 22 of 2007, and the recent Protection, Promotion, Development and Management of Indigenous Knowledge Act 6 (Government Gazette no 42647,2019), indigenous healers are still not participating in primary health care. This is because there is still a lot of scepticism, and negative connotations associated with indigenous healers despite the formal recognition as per the Acts above. There has also been limited research work done on the relevance of indigenous medicine in the treatment of diseases such as HIV/AIDS. Rather, more emphasis has not been put on the treatment procedures when using indigenous medicine in the HIV treatment efforts.

1.2. Problem statement

The basic challenge is that indigenous medicine and practices by the healers remains unrecognised within the modern health system. This is despite the fact that the most Africans choose to approach indigenous healers for the treatment of their illnesses and diseases. This lack of recognition, perpetuated by the continued social, economic, and technological ties between African countries and their former colonisers, renders it difficult for the development of a health care system that embraces indigenous knowledge and practices.

After decades of colonialism and apartheid, and the attainment of democracy, time has arrived for South Africans to begin to question the effectiveness of inherited western development strategies for sustainable development, in dealing with amongst others, the increasing poverty challenges and overreliance on western medicine and health systems. This study argues that the indigenous healers are well positioned to provide indigenous healing to some of the modern illness and diseases, such as HIV/AIDS. Therefore, there is a need to consider Indigenous healing systems as a resource in addressing the current burden of diseases within communities.

The holistic and community-based approach of indigenous healing systems requires that further research be conducted on its role and relevance in the African knowledge practices. The use of indigenous healing systems in the continent of Africa goes back to the history of humankind. The acknowledgement of the role of indigenous healing systems in the promotion of health, education and other spheres of community livelihood and development is a recent occurrence.

Interestingly, the current indigenous healing literature puts emphasis on the practical application and not the acknowledgement of the significance of the socio-cultural context, and the specific rituals, in which the healer, the patient, and the remedy exist, and have to be administered. For example, in the indigenous healing context, there are rituals that are performed to consecrate some herbs because in certain instances, medicine without consecration for Africans is meaningless. This implies that before medicine is harvested, certain rituals will be performed, to imbue them with the healing powers. Also, before or during the administration of certain medicines, specific rituals

would be performed and some abstentions, like celibacy, or avoiding certain foods may also be imposed.

Most research done in indigenous healing is focused on medicinal plants, focusing on the extraction of specific medicinal property, or the active compound material of interest, which then is explored further using numerous tests for pharmacological and toxicological activities, typically neglecting the full mixtures, the whole process or the context that indigenous healers follow in their treatment regimes.

The main concern is that neglect of the holistic process associated with indigenous healing is disempowering to indigenous healers and may be compromising to the authenticity and efficacy of indigenous method of healing (Te Karu, 2021). Ozioma & Chinwe (2019) suggest that divine and ancestral sanctions are essential before and during the preparation and administration of medicine. Furthermore, South Africa's history of oppression and stigma attached to indigenous healers bears a legacy of ignorance and downplaying of the importance of indigenous rituals, to the extent that many black African people themselves, deny their own spiritual tradition.

Although Indigenous healing methods are gradually gaining a space and place in the political, cultural and to some extent, academic frameworks, there remains a host of challenges and blockades to fully integrate and accept indigenous healing systems in its authentic form. This study sought to analyse and understand the socio cultural and philosophical importance of rituals in traditional medicine, specifically focusing on HIV and AIDS treatment.

1.3. Justification of the study

The recent COVID-19 pandemic has shown that Western knowledge systems do not necessarily have all the solutions to global challenges. To deal with the Covid-19 pandemic, many countries, especially communities within the African countries, have opted to utilize home-grown solutions indigenous healing methods, to deal with the pandemic. This shows the resilience and relevance of African indigenous knowledge systems in the 21st century.

In Africa, indigenous remedies are often utilized as a key treatment for HIV/AIDS and related problems. WHO (2002) indicates that eighty per cent of the African population utilize some form of indigenous medicine, and the worldwide annual market for these products is estimated at US\$ 60 billion.

Indigenous medicines are often utilized for the treatment of various diseases in developing countries, especially in rural areas where there is usually lack of an efficient primary health care system. Many patients who are infected with HIV are also believed to be taking indigenous medicines in combination with antiretroviral medication, and the implication is that if this is not properly monitored, drug-herb interaction may occur in these cases. This is supported by Audet, Ngobeni & Wagner (2017), who found that 69% of HIV infected patients from Bushbuckridge in the Mpumalanga Province of South Africa, reported that they routinely visited both practitioners to treat HIV, opportunistic infections, as well as side effects from antiretroviral medication.

Furthermore, the WHO (2013), lately published a 10-year strategy (2014-2023), to inspire member states to develop policies that incorporate indigenous medicine in the planning of their health systems. The objective of the strategy is to assist member states to, “harness the potential contribution of Traditional Medicine to health, wellness and people-centred health care” (WHO, 2013:8), and to encourage the safe use of Traditional Medicine through “regulating, researching and integrating Traditional Medicine products, practitioners and practice into health systems, where appropriate” (WHO, 2013:11). Furthermore, to support Universal Health Coverage through appropriate incorporation of traditional medicine services and self-health care into the national health-care system. The current study will contribute to this initiative as per WHO’s directive.

Various stakeholders, including UNICEF (1978), and Summerton (2006), have also proposed the inclusion of indigenous healers in government-sponsored health programmes in the fight against HIV. However, this suggestion is met with resistance, mainly from western-trained doctors who believe that indigenous healing employs unsafe practices, has many abuses, and is shouldered in myth. The promulgation of the Traditional Health Practitioners’ Act has also caused a stir in South Africa, with those who think it is a positive move and those who think that this will cause a lot of

harm. For example, *Doctors for life* (2004), argue that indigenous medicine contains certain substances that are harmful to the human body. In addition, Latif (2010), in her study found that Western doctors believe that traditional healers ought to only focus on treating patients spiritually, unless they have a scientifically tested scope and limitations on their field.

Furthermore, the general media in South Africa frequently carry horror stories of indigenous medicine and its practitioners, while scandalous articles have escalated with the rise of the AIDS epidemic. Reports of the prescription of strange herbal treatments, or of traditional healers who claim to have discovered the cure for AIDS, and unethical and unpleasant behaviour relating to treatment of patients can regularly be found in the newspapers or magazines (City Press, 2000; Mercury 2000). While a number of these allegations and reports may be true, the negative publicity generated might have contributed to a damaging sentiment that is held towards all indigenous healers and to all indigenous healing practices. This means that the role that ethical and well-educated healers could play in South Africa's response to HIV/AIDS and its efforts to build up its health system has mainly been overlooked.

Research that has been conducted regarding the contribution of indigenous medicine towards health care in South Africa has tended to put aside the role and significance of rituals in the healing process (Flint, 2015). Therefore, more often, when discussions on the role and participation indigenous healers takes place, we expect them not to acknowledge their connectedness to nature and their cosmos. This lack of acknowledgement of the significance of the rituals has resulted in lack of understanding of indigenous healing in its holistic form and proper context.

On the other hand, approaches, and efforts to protect and preserve indigenous healing, as part of indigenous knowledge systems, are fragmented as different entities, including government departments, and indigenous healers' organisations themselves, are implementing their own initiatives (Flint,2015). There is also not enough global support, as this is viewed in direct competition to modern health care systems and the pharmaceutical companies. There is, therefore, a need to promote indigenous healthcare systems, like rituals, in a coordinated effort to ensure its promotion and preservation in its authentic and holistic form.

It is therefore hoped that this study is adding value, as it offers contributions towards educating scientists and biomedical practitioners to better understand indigenous healing in its proper context, as used by a huge section of South Africans, as well as new insights to the current debates on the modalities of how indigenous medicine can be better utilized to play its part in alleviating the spread of HIV infections, and deepens a clear understanding of the significance of socio-cultural and philosophical facets of rituals performed during various aspects of healing. Finally, this study contributes to redressing the previous socio-cultural and socio-economic imbalances as brought upon by the legacy of colonialism and apartheid.

1.4. Significance of the study

There is an increasing demand for indigenous remedy to contribute to the general health delivery system predominantly in Africa. Some authors (Redvers et al., 2019 & Mokgobi, 2013) have even suggested that an indigenous medicinal system should be integrated into the conventional of health care services to improve access to health care. The momentous democratic transformation in South Africa has presented many opportunities, including the emancipation of the African voice. As part of the movement towards building a culture of democratic pluralism, informed by the twin principles of truth and self-determination, there has been a double challenge of constructing a balanced inclusive history, knowledge and of retrieving and preserving primary materials from which such knowledge would be woven.

This study is not only an integral part of the efforts to generally understand rituals or HIV/AIDS but uses HIV/AIDS as a case study to look at broader aspects and challenges of transformation in South Africa. This study contributes to the process of properly contextualizing indigenous knowledge systems, and to recognize the role and contribution of Africans, not just in the history and heritage of the Vhembe district, but the contribution of indigenous knowledge within the health system of the nation at large.

There is an increasing demand for indigenous medication to contribute to the total

health delivery system, particularly in Africa. However, there is mistrust and lack of understanding between indigenous and western forms of healing that needs to be overcome before any attempt at co-operation and or integration of the two healing systems is made. Furthermore, where indigenous healing is acknowledged, often there is little or no acknowledgement of the importance of rituals performed during the healing process (Bhuda & Marumo,2020). This has led to the absence of holistic understanding of treatment and healing process. I hope that this study would contribute to ensuring that people have adequate knowledge and information required for effective use and understanding of indigenous medicine.

Like in numerous African countries, the 90-90-90 strategy for HIV management has not been successful in South Africa. This implies that the District Implementation Plan as developed by the department of Health, as an attempt at improving processes for HIV and TB health services focusing on outcomes to achieve 90-90-90 targets by 2020 is not as successful as government would have hoped for (Grobler, Cawood, Khanyile, Puren, & Kharsany,2017). This requires that 90% of people to know their HIV status. This means that, despite a few countries that have achieved this target, the 90-90-90 strategy for HIV management remains a failure. This initiative is an attempt by government, through the department of health, to fortify existing health systems, and embark on evidence-based decision making. The outcome of this study will, therefore, contribute and add value to this process as indigenous healing is integral in dealing with HIV/AIDS and its related opportunistic infections.

1.5. Research questions

Specifically, the present study focused on these research questions:

- 1) What are the indigenous healers' understanding of HIV and AIDS?
- 2) What is the philosophical stance regarding the performance of rituals during the treatment process of HIV and AIDS clients treated by Indigenous healers?
- 3) What is the socio-cultural significance of the rituals that are performed as part of the treatment procedures?
- 4) How are the HIV and AIDS treatment rituals performed by indigenous healers?

- 5) Which guidelines will facilitate collaborative healing processes for HIV and AIDS between Indigenous healers and Modern health practitioners?

1.6. Objectives and aim of the study.

The primary focus of the study is on the socio-cultural significance and philosophical importance of holistic indigenous healing procedures.

The primary aim of this study is to explore the role that the indigenous medicine could play in health care delivery in South Africa, specifically the treatment procedures in dealing with HIV infections. This study moves from the basis that in South Africa, as in other parts of the world, the use of indigenous medicine and rituals are facing tremendous challenges, and are threat of extinction due to neglect, modernisation, globalisation, environmental degradation, and lack of access to resources. This study, therefore, is an attempt to address the continuing marginalisation of indigenous practices and rituals, as practiced mainly towards the treatment HIV/AIDS.

The objectives of this study are as follows:

- 1) To describe the South African indigenous healers' health and healing paradigm.
- 2) To describe the philosophical stance on the performance of rituals during a healing process.
- 3) To explain the socio-cultural significance of the rituals that are performed as part of the treatment procedures by indigenous healers.
- 4) To give an in-depth analysis of rituals associated with selected diseases, especially HIV/AIDS.
- 5) To provide facilitative guidelines for the collaborative healing processes of selected diseases.

1.7. Summary and overview of the study

This study comprises seven chapters as follows:

Chapter One outlines the background, the research problem, and justification of the study, the significance of the study, and the aim and objectives of the present study.

Chapter Two addresses several important aspects from the literature. The first two parts of the chapter will outline a brief synopsis of health care in the third world and HIV/AIDS in South Africa. This will be followed by a review of international studies done to demonstrate the importance of culture in the way people perceive, interpret, and react to illness. The last two parts of the chapter will focus on what various authors have said about the treatment of sexually transmitted diseases using indigenous methods as well as the role that indigenous healer should play in the care and management of HIV/AIDS. The concluding section of the chapter will look at Cosmology, belief systems in Africa as well as the socio-cultural aspect of healing.

Chapter three will focus on the theoretical frameworks that guided the study and interpretation of participants' responses.

Chapter four outlines the method of investigation used in the present study and also the design of the study. The first part of the chapter provides a rationale for adopting a qualitative method, and specifically, a Phenomenographic approach. The next section articulates the profile of the district where the study was conducted. The location, size of the district, the characteristics such as climate, soil, vegetation, history, socio-economic features, rationale for choosing the site, the HIV integrated plan within the district and the significance of these features in the topic under study. Furthermore, the chapter provides a description of the study population and selection of cases (sampling), as well as data collection techniques and procedures, and the ethical considerations.

In Chapter five, the results of the investigation are presented. Firstly, a summary of

findings, followed by a presentation of results and report of data obtained from the field, broken down per each research question and brief summaries per theme.

The findings of the study are discussed in relation to the literature reviewed as well as other sources of data in chapter six.

Chapter six provides the discussion of findings. This chapter will mainly comprise discussion of results, challenges, recommendations, guidelines and finally, the limitations of the study.

Finally, Chapter seven present the overall summary of the study and the conclusion of the study.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

In societies that comprise both indigenous and modern health care systems, the modern health care system is, more often than not, the official and professed superior of the two healing systems. It also receives greater acknowledgement in the professional sector than the indigenous healing system. This is despite the acceptance of the latter system by a suggestively large proportion of populations in developing countries (Summerton, 2006). This is supported by Beyers (2020), who found that the South African government's response to COVID 19 excluded traditional healers despite many people resorting to traditional methods of prevention and treatment. One of the reasons for this is the bias towards science versus indigenous knowledge, as a foundation for knowledge on health matters.

Ramphela (in Bateman, 2005), suggests that the foundation of our society is built on conquest that undermined the structure and socio-economic fabric of indigenous people and inhibited their ability to evolve and adapt to meet the challenges of modernity. The only way to protect and defend the dignity of a wounded people is adherence to cultural and customary practices that may contradict the value of science in areas where universally accepted practices save lives. Ramphela (in Bateman, 2005), further argues that in our society, we have a serious challenge of distrust that prevents us from acknowledging our problems, and using the resources we have to address them.

The above statement is also true in the case of the relationship between modern and indigenous health care practitioners, where modern health care practitioners view indigenous health care practitioners as backward and 'harmful' (Freeman & Motsei, 1992; Doctors for life, 2004; Amzat & Abdullahi, 2008; Mngqundaniso & Peltzer, 2008). The clash between these two systems must be acknowledged, challenged, and addressed, more so because there is ample evidence that most Africans (80%) use indigenous medicine (WHO, cited in Richter; 2003; Mngqundaniso & Peltzer, 2008; Shetty, 2010). This is also particularly significant in a society that is highly affected and infected by the HIV/AIDS pandemic, and with such low levels of literacy, numeracy

and understanding of conventional basic scientific facts, including how our bodies work (Bateman, 2005).

The HIV pandemic has become a human, social and economic disaster. It is one of the leading causes of death in Sub-Saharan Africa that is threatening to extinguish the fabric of society. Despite some success, people in sub-Saharan Africa continue to face the highest burden of disease worldwide. Additionally, progress within vulnerable populations has been slower in sub-Saharan Africa than other parts of the world, with adolescent girls and young women at disproportionate risk. AIDS is the leading cause of death among women of reproductive age (UNAIDS, 2015c). As currently there is no treatment for HIV, preventing the transmission of HIV must lie at the heart of any meaningful response to the pandemic.

In their study, Mulaudzi, Chinouya and Ngunyulu (2015), suggest that HIV and AIDS epidemic has put African indigenous practices and knowledge in the spotlight of public scrutiny, with several studies commissioned to identify 'risks' and 'dangers' to African women's health in sub-Saharan Africa. Consequently, the studies are often ignorant of the complex cultural make-up of the indigenous African people and the world views influencing their cultural practices. According to them, most such studies focus on the damaging and harmful practices and beliefs which are considered as fuelling the spread of HIV/AIDS and those perpetuating women abuse.

South Africa, like many other African countries, is struggling to contain the HIV pandemic. This is even though long before the advent of biomedicine, indigenous medicines were the main medications that were used for nearly all diseases. Today, notwithstanding the increasing use of biomedicine, indigenous medication is also vastly utilized, and many continue to depend on it for their health care. In current times, people have been turning growing in numbers to the use of herbal medications as both an alternative and complementary to modern medicine (Lucas, 2010). A culture-centred approach to prevention, care and support is progressively being recognised as a critical strategy as the impact of HIV/AIDS in Africa remains unabated.

Recent cases have demonstrated that most cases of dualism in health seeking strategies involve the treatment of HIV infection. Most people living with HIV/AIDS

consult indigenous healers first before consulting modern medicine practitioners. Numerous persons on antiretroviral treatment (ART) also reported the use of indigenous medicine concurrently (Blabb et. al. (2007). While indigenous healers claim to refer suspected HIV patients to modern health care centres, they continue to treat the patients with higher CD4 counts, and those who are on ARTs (Mothibe & Sibanda, 2019).

Based on the above, this chapter reflects on the literature that addresses several important aspects related to the current study. The first two parts of the chapter give a brief overview of health care in the third world and HIV/AIDS in South Africa. This is followed by a review of international studies done to demonstrate the importance of culture in the way people distinguish, interpret, and react to illness. The last two parts of the chapter concentrate on the role played by indigenous healers in the care and management of HIV/AIDS, cosmology, and belief systems in Africa as well as the socio-cultural aspect of healing. The closing section of the chapter looks at some of the historical and current challenges that led to the suppression of the cultural and indigenous healing systems, and lastly, the gap related to the socio-cultural aspects of healing as well as indigenous knowledge from within will be highlighted.

2.2. Overview of the health care situation in the third world

There is a general perception that developing countries must learn and adopt the so-called global standards. However, the time has come when the world should be challenged to acknowledge the significance of African indigenous medicine. Mulaudzi (2001) suggests that the acknowledgement has greater consequences in the development of a new paradigm shift in the culture of health. Without undermining the influence of western medicine, the power of indigenous medicine has led to new conceptualizations in medicine. Consequently, one of the subjects of focus in primary health care is how to create synergy between indigenous knowledge systems, modern medicine, and scientific research. This new paradigm interrogates the predominance of western medicine over the years, particularly in Africa.

Mulaudzi (2001) indicates that many patients from African countries still seek help from indigenous health care systems. Therefore, to achieve the goals of Health Care for All in the 21st century, the role played by indigenous health practitioners, as well as those practicing complementary health care methods, must be acknowledged. Several studies (Tilburt and Kaptchuk, 2008; Birhan et al., 2011; Mbatha et al., 2012; Sato, 2012b; Gude, 2013; Merriam & Muhamad, 2013; Ekor, 2014), and the press (BBC News, 2014; Modern Ghana, 2014), have indicated that 80% of people in African countries, use indigenous medicine to meet their healthcare needs. Interestingly, for Sub-Saharan Africa, in which South Africa is located, the figures are believed to be much higher, since most of the people use indigenous medicine for their health needs rather than biomedicine (Gbodossou, Floyd, & Katy, 2005).

This is because most people in the region do not have access to modern health services owing to costly prices or lack of health personnel and infrastructure. Additionally, biomedicine is not accessible to everybody, hence many people depend on indigenous medicine. The other challenge is that although the role of indigenous medicine is well recognized in South Africa and the Sub-Saharan Africa region, it is not included in most of the official health care systems in most countries.

METRAF Editions (2005), states that the number of people living with HIV/AIDS throughout the world in 2005 was about 37.8 million, and 25 million of these are Africans located in 21 countries in Africa. HIV/AIDS has had a devastating effect in that in 1999 alone, for example, about 2.8 million deaths due to HIV/AIDS were recorded, as compared to over 250 000 people who died due to armed conflict in Africa. This implies that HIV/AIDS death toll has surpassed the numbers of those who died in various conflicts in Africa. In 2002, the number of infected women had reached 50% of the African population. This implies that the highest rates of HIV infections in the world are found in Africa and 55% of these cases are affecting African women (METRAF Editions, 2005).

The gains of the last two decades in life expectancy have been completely reversed with life expectancies falling by over 25 years in Zimbabwe, 22 years in Botswana, 11 years in Uganda, 9 years in South Africa and Tanzania. Four countries; Botswana,

METRAF Editions (2005), reports that Mozambique, Malawi, and Swaziland now have a life expectancy of under 40 years. At least 10% of those between the age of 15-49 are infected in 16 countries in Africa, including several in Southern Africa, where at least 20% were infected. Based on these, HIV/AIDS has been declared the single greatest threat to national welfare and development in Africa while 80% of the means to fight it are in the northern developed countries (METRAF Editions, 2005).

2.3. The HIV/AIDS situation in South Africa

South Africa has a total population of 60 million (Stats SA, 2021). South Africa, like in most developing countries, is struggling to deliver quality, accessible and efficient health care services to its people. The current health care system, which is mainly originated on the allopathic approach, is struggling to meet the basic health needs of the people. South Africa has the highest HIV epidemic profile in the world, with an estimated inclusive HIV prevalence rate at approximately 13,7% amongst the South African population.

According to Statistics South Africa (2021), the number of people living with HIV (PLWHIV) is projected at approximately 8,2 million in 2021 in the country. It is estimated 19,5% of the population of adults aged 15–49 years, is HIV positive. According to the UNAIDS, (2014) 180,000 South Africans died from AIDS-related illnesses in 2015. Furthermore, of the 35 million people living with HIV/AIDS in the world, 19 million do not know their HIV-positive status. Amongst the adolescent girls and young women, they account for one in four new HIV infections in sub-Saharan Africa (South African National AIDS Council, 2015).

In 2002, the total number of persons living with HIV in South Africa increased from an about 4,94 million, to 7,06 million in 2017 and to 8.2 million in 2021. Moreover, with the advent of the Covid -19 pandemic, several authors have suggested that PLWHIV with immunosuppression, do present a higher mortality risk due to COVID-19 and multi-morbidity (Mirzaei et al., 2021; Ssentongo et al., 2021), emphasizing the critical need for access to continual treatment. Data also indicate a decline in the annual number of patients remaining on ART by approximately 4% (DHIS in Stats SA, 2021). The COVID-19 pandemic has to a certain extent, interrupted HIV prevention and

treatment programmes in South Africa, as it did globally. According to UNAIDS (2020), the existence of a competing pandemic such as COVID-19 in South Africa does bring challenges that are likely to obstruct progress to reach annual targets and goals set by the country and international organizations concerned with the extermination of HIV and AIDS.

The UNAIDS, (2014) suggests that South Africa has the largest antiretroviral treatment (ART) programme globally, and this has largely been financed from its own domestic resources. The country presently invests more than \$1.5 billion annually to run its HIV and AIDS programmes. However, HIV occurrence remains high at about 19.5% amongst the general population, although this fluctuates markedly between regions or provinces.

HIV/AIDS has been declared by the World Bank, IMF, UNAIDS, UNDP and others to be the number one development problem for the entire continent of Africa, and at the heart of this development issue lies the stark reality of poverty engulfing the continent. Poverty creates a major problem since it locks the people into a vicious cycle that hinders education, employment, self-sufficiency, decent housing, health care, food and other necessities that are required for daily living. During the World Summit on Sustainable Development (2002), it was indicated that, AIDS drains the human and institutional capacities that drive sustainable development (United Nations, 2002), thereby robbing communities and nations of their greatest asset, the people. However, while most of the people do not have access to primary health care services, except that they continue to have access to indigenous health services and practitioners.

While the heaviest disease burden is disproportionately found in the developing world, the greatest resources are in the developed world. The United Nations estimates that \$165 million was spent on AIDS prevention in Africa in 1996, while the developed world spent \$600 billion to ward off the Y2K bug in 1999. Therefore, with modern treatment options not fiscally viable for Africa, education, and alternative health care services, remain the major avenue for positive impact in the AIDS crisis, especially in the light of minimal progress that has so far been reported on the AIDS vaccine.

On the policy front, the persistent high level of new HIV infections happening in South Africa mirrors the difficulties that have been confronted by Government's AIDS education and prevention campaigns (Anonymous). The future of the pandemic at partly depends on the course that Government's HIV and AIDS policies take. Even though the Government has been widely criticized in the past for its AIDS policies, current strategies, including the development of a new framework to guide the national response to AIDS from 2007 until 2011, suggest a more balanced position for delivering some economic relief from the pandemic. The application of a multi-sectoral integrated HIV/AIDS response in South Africa largely depends on the successful practice of co-operative governance principles. This multi-sectoral integrated response should seriously consider the role of indigenous healing if it hopes to succeed.

Despite these formal policy changes, however, the sentiments between health practitioners remain imbalanced. In the HIV/AIDS context, efforts have been made to mass-educate traditional healers on identifying the signs and symptoms of the disease, so that they might refer suspected HIV-positive patients to biomedical practitioners; as the literature suggests, this has generally been complied with. However, biomedical practitioners have demonstrated reluctance to refer patients to traditional healers. According to Flint (2015), the South African interaction is, in effect, the 'education' of traditional healers into the biomedical perspective, rather than a 'meeting of minds.

South Africa finds itself in a disadvantaged situation to create access for many AIDS patients to life-long antiretroviral treatment due to the exorbitant costs associated with this treatment. As such, the country needs to resort to other measures as the inclusion of indigenous healers in the strategies to fight and prevent AIDS/AIDS infections. The inclusion of these strategies would reduce HIV/AIDS linked morbidity and mortality rates amongst the population that survives below the poverty line and is beset by malnutrition and other factors that aggravate the onset of full-blown AIDS.

It is based on this assertion that this study maintains that health care is mainly belief sensitive and any health strategy that hopes to succeed should take this point into consideration. The afore-mentioned point is the one that creates a gap between the

African belief system and the western belief system, particularly when it comes to their understanding of illness and health. The indigenous perspective perceives culture as the bedrock on which health behaviour including HIV/AIDS related matters should be expressed and regarded as mechanisms through which health must be well-defined and understood.

The importance of culture in health was also expressed in the UNESCO Declaration on Science and the Science Agenda Framework that was espoused in 1999 in Budapest, Hungary. This urged members to define a strategy to ensure that science responds better to society's needs and objectives in the 21st century. It accentuated the need for political commitment for scientific activities to make science more responsive and more inclusive. To be more accountable, more communicative, and more dialogical. The declaration further articulates that the vision of science in the 21st century should be a science that can translate the meaning of words like 'responsibility' and 'ethics' in the use of scientific knowledge; and a science that can comprehend the fact that science is a product of culture, or cultures, and that its varied manifestations must be recognized; and science that can be seen by all to be a collective asset (extracted from Odora Hoppers, 2002).

The above declaration is a positive shift in encouraging for the change in mindset by scientists and researchers when it comes to working with, or within communities. This supports the argument that science is based on belief systems and human experience and therefore, calling for a centred approach. Therefore, the implication in the South African context is that Government bears the responsibility of recognizing the health care needs of all South Africans in a non-biased manner. The South African government, just like other African governments, should therefore explore the role of indigenous healers in the treatment, care, and management of HIV/AIDS and other associated diseases.

2.4. The role of Indigenous healers in the care and management of HIV/AIDS

The World Health Organization (2000) describes traditional medicine as 'the sum total of knowledge, skills and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, that are used to maintain

health, as well as to prevent, diagnose, improve, or treat physical and mental illnesses. This practice mainly depends on past experiences and explanations handed down from generation to generation in verbal or written form. Indigenous medicine has gradually been forced underground in many societies due to pressure from missionaries and governments who viewed such practices as witchcraft or backward. Contrary to these beliefs, however, indigenous medicine has proved to be fairly effective in treating both chronic diseases and psychological problems, especially those associated with stress, which frequently originate from social alienation, anxiety, or loss of self-esteem.

UNAIDS (2000), maintains that HIV/AIDS does not only affect people in physical form, but in mental, social, and economical as well. Therefore, for such patients, care is a comprehensive package which includes support, psychosocial care and treatment provided to individuals, families, and communities to improve the quality of life. This implies that there is a need to identify various strategies to confront the broad and complex social, cultural, environmental, and economic context in which HIV continue to spread. These strategies must be investigated, tested, assessed, adapted, and adopted.

In South Africa, the excessive cost and shortage of many essential drugs, including anti-retroviral medicines, implies that most people with HIV may be compelled to use indigenous medicinal treatments for HIV conditions, including opportunistic infections, for example, diarrhoea. This absence of affordable drugs to treat HIV infection and related conditions has eventuated the need to involve indigenous healers in the care and support for HIV patients. This view is buttressed by Hoppenbrouwer (1997), who suggests that if we are to effectively deal with the HIV/AIDS challenge, the only way is to involve all relevant sectors, including indigenous healers.

Green (1994) suggests that the inclusion of indigenous healers is attributed to the resilience that indigenous healers carry and the multi-disciplinary nature in which they operate as spiritual ritual specialists, family and community counsellor, moral and social philosophers, teachers, and seers. Indigenous healers also function as change agents who also assist society to adjust to socio-cultural changes that are brought forth by urbanization. The multiple roles of indigenous healers put them in a more

relevant position to help the community in managing HIV/AIDS. One additional advantage is that community members respect, believe and have faith in the indigenous healers.

UNAIDS (2002) believes that indigenous healers make a unique contribution that could also help as complementary to other methods. In essence, one could argue that indigenous healers are the first point of call for help in various African communities as well as for the multifaceted illnesses and diseases such as HIV/AIDS that frequently destabilizes family dynamics and destabilise community stability. Indigenous healers usually have high standing and deep respect amongst the population they service, and they also have knowledge about home-grown treatment choices, the physical, emotional, and the spiritual lives of the community, they are also capable of influencing behaviours.

Based on this understanding, the UNAIDS suggests that it is imperative to consider indigenous healers as partners in the extended response to HIV/AIDS, and to maximize the possible contribution that they can make towards meeting the magnitude of requirements for care, support, and prevention. This point was also asserted by King (2000), when reporting on the outcome of collaboration projects that were undertaken with traditional healers in HIV/AIDS in eight Sub-Saharan countries. The findings of this study indicates that, one of the most significant lessons learned was that collaboration was not only possible, but it had yielded valuable public health benefits.

Even though the government has already put in place strategies to accommodate indigenous health practice, critics still feel that the procedures for diagnosis, treatment, as well as their medications are not scientific enough (Mulaudzi, 2001). However, despite modern health practitioner's concerns with indigenous remedy use, patients still pursue, and often prefer, alternate treatments. Traditional healers usually speak the same languages as patients. In addition, indigenous healers devote more time with their patients, clarifying the source of the disease and the required treatments, offer greater perceived concern than clinicians, who in most cases will listen to the patient's concern and provide the patient with a prescription of which even consultation is timed. This is contrary to the indigenous healers who are often more easily accessible and

involved in the healing procedure. They are involved in the healing process in the sense that whenever the patient experiences illness, it becomes more easier for the patient to go back.

However, this does not prevent the patient to seek medical assistance from western health care practitioners or to go back and forward between the western health system and the indigenous health system. This, Medical pluralism, is common amongst individual dealing with a diversity of chronic and serious ailments, including HIV/AIDS, which leads to perceived poorer health outcomes among individuals who delay or abandon western treatment for biomedical conditions. For this reason, therefore, it is important to understand the healing system in its entirety, including the philosophical and socio-cultural aspects.

2.5. Culture and health

This section gives an appraisal of some national and global literature that has sought to investigate how the experience of sickness, together with the various healing procedures, are culturally patterned. This will be followed by a discussion of how culture influences conceptualization and the healing approaches that will be adopted in a particular setup. Indigenous knowledge is developed and adapted continuously to increasingly changing environments and handed down from generation to generation and is closely intertwined with people's cultural ethics.

Bodley (1994), views the contemporary technical definition of culture, as a socially patterned human thought and behaviour, was initially proposed by the nineteenth-century British anthropologist, Edward Taylor. The first account of cultural categories was undertaken in 1872 by a committee of the British Association for the Advancement of Science, which was assisted by Taylor. Bodley (1994), presents the diverse definitions of culture in the table underneath:

Table 1. Definitions of Culture

Topical	Culture entails of everything on a list of themes, or categories, such as social organization, religion, or economy
Historical	Culture is social heritage, or tradition, that is handed on to future generations
Behavioural	Culture is a shared, learned human behaviour, a way of life
Normative	Culture is ideals, values, or guidelines for living
Functional	Culture is the way humans resolve problems of adapting to the environment
Mental	Culture is a complex set of ideas, or learned habits, that constrain impulses and differentiate people from animals
Structural	Culture consists of patterned and interconnected ideas, symbols, or behaviours
Symbolic	Culture is based on randomly assigned meanings that are shared by a society

The above implies that culture comprises at least three components, that is, what people think, what they do, and the material products they create. Therefore, psychological processes, beliefs, knowledge, and values are parts of culture. The above aspects have a direct effect on perceptions and beliefs about the causes and treatments of certain diseases and illnesses using indigenous practices and belief systems.

Maclachlan (1997), describes culture as that which defines the way in which groups of people experience, think, feel, and behave. Cushman (1995) distinguishes culture as that which permeates individuals by fundamentally shaping them and influencing how they perceive themselves, others, and the world, as well as how they make choices in their everyday world.

Furthermore, in any society, culture is passed on inter- and intra-generationally. It is a totality of what the inhabitants practice and understand as valuable. Culture is their history and their future, informing how they identify and understand themselves to be

who they are in relation to others. According to Hlela, (2017), culture is a system of meaning that evolves with time.

Somma and Bodiang (2003) believe that culture is one of the many attributes influencing human behaviours; it is a determining factor of socially accepted behaviour, value systems, beliefs, and everyday knowledge, means of communication, such as music, dance, theatre, and art, are those creative aspects of culture that we often define narrowly as culture itself. Therefore, culture is deeply rooted in various aspects of a society, including local perceptions of health and disease and health seeking behaviours.

Culture is shared patterns of behaviours and interactions, cognitive constructs, and affective understanding that are learned through a process of socialization. These shared patterns distinguish the members of a culture group while also identifying those of another group (CARLA (2012)).

Kluckhohn & Kelly (1945), believe that culture comprises all those historically created designs for living, explicit and implicit, rational, irrational, and no rational, which exist at any given time as possible guides for the behaviour of men. This suggests that culture becomes the foundation for any behavioural process, including rituals.

Mayhew (2018), summarizes culture as follows:

- learned and passed on through generations,
- shared among those who agree on the way they name and understand reality,
- integrated into all aspects of an individual's life.
- dynamic and evolving,
- is often identified 'symbolically', through language, dress, music, and behaviours, and

On the other hand, Banks, Banks, and McGee (1989), perceives culture as primarily symbolic, ideational, and intangible features of human societies. According to them, the spirit of a culture is not the artefacts, or other tangible cultural elements, but how

members of the group interpret, utilise, and perceive them. According to them, what distinguish one people from another in modernized societies is the values, symbols, interpretations, and perspectives, and not material objects and other tangible aspects of human societies. Furthermore, people within a culture typically interpret the meaning of symbols, artefacts, and behaviours in similar ways. Therefore, from the above definitions, these assumptions could be made about culture:

First, culture always evolves in a social context. A culture is a way of life of a group of people, the behaviours, beliefs, values, and symbols that they accept, usually without thinking about them, and that are handed down by communication and imitation from one generation to the next (Hofstede, 1997).

Second, culture shapes behaviour, and is closely related to traditions, customs, and beliefs systems. Culture is the collective deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group effort, (Hofstede, 1997).

Third, some cultural practices may be regarded as normal or taken for granted by those practicing them, but these may be perceived as bizarre by people from another cultural background (Gilbert, Selikow & Walker, 1996).

Fourth, culture is not static, but changes with time. Culture is continually produced and also being reproduced, rediscovered as well as being lost; although it is often perceived as being somewhat static by external observers, even when new knowledge is added, because repetition helps in the preservation and reinforcement of culture, and these are the elements that make it seem static as they are retained through generations.

Finally, Somma and Bodiang (2003) define culture as a collective, learned, and symbolic system of values, beliefs, and attitudes that shapes and influences perception and conduct. It is also the customs and artifacts which are used by members of society to cope with one another and is transmitted from one generation to another through learning. Based on the above aspects, it can therefore be argued

that culture is learned through the process called enculturation and socialization. This means that cultural practices are meaningful activities that happen routinely in everyday life, and widely shared by members of the same group, and they carry with them normative expectations about how things ought to be done (Goodnow, Miller & Kessell, 1995).

Culture, according to Helman (1994), might be part of the aetiology or reason for certain diseases, and may influence the clinical appearance and distribution of illness, and it determines the way that the disease is recognized, categorized, and treated by other members of the same culture.

Helman (1994) summarises this by suggesting that culture is the core factor that shapes experiences, perceptions and understanding of health and disease. It is, imperative, therefore, to understand the influence of cultural belief systems of the person that one is dealing with before commencing any treatment procedure. It is on this basis that it has been suggested that since indigenous doctors share the social and cultural values, including beliefs regarding the origin, significance, and treatment of illness, they are better placed to treat members of their own communities. It is similarly vital to understand the socio-cultural and philosophical features of the treatment procedures.

Mazrui (1986) suggests that culture is a system of interconnected values active enough to influence and condition perceptions, judgment, communication, and conduct in a particular society. Hahn (1995) accentuates the role of culture and society in relation to illness and healing and signifies the usage of language in understanding of illness concepts. Brody (1987), further postulates that the individual's cultural belief system influences his or her social roles and relations when one is sick. Finally, Lupton (1994), suggests that the practice of healing is a cultural construction, particularly in relation to the concentration on the body rather than the framework that define and shape the body.

However, there are varying controversies and understandings of culture. For example, in defining culture, Wallerstein (1990), points out the intrinsically paradoxical nature and character of culture. This paradox is demonstrated in the bipolar interaction

between culture's particularistic and universalistic points of reference. From this point of view, culture is perceived as a set of values or practices of certain parts smaller than the whole. This is true either when an individual uses culture in the anthropological sense to mean the values and the practices of one group as opposed to another group at the same level of discourse or when one uses culture in the belles-lettres sense to mean the 'higher' rather than the 'baser' values and practices within any group. This meaning generally views culture as representation, and culture as a production of art-forms. Based on the definitions above, culture and people's identities are closely intertwined.

With the afore-mentioned viewpoints on culture, it becomes clear that culture is intrinsic in health as it impacts not just the view of health, but sickness and death, perceptions about causes of illness, strategies to health promotion, how sickness and pain are felt and articulated, where patients seek assistance, and the forms of treatment patients desire (Mayhew, 2018). Mayhew (2018) was elaborate not only in defining what culture is, but in identifying the impact of culture on health as well as how culture affects health. These aspects are briefly reflected below.

Mayhew (2018) believes that health is a cultural concept since culture frames and shapes how people view the world and their experiences. In addition to other factors of health and disease, culture aids to define:

- the way in which patients and health care providers perceive health and disease.
- What patients and health care providers believe about the causes of disease? For example, ignorance of the germ theory and belief in evil spirits or demons.
- Identification of illnesses or conditions that are stigmatized and why they are.
- The kinds of health promotion actions that are practiced, recommended, or assured?
- In what manner is disease and pain experienced and articulated.
- Where patients search for assistance, how they request for assistance and, perhaps, at what point they make their first step towards help.

- Patient's engagement with health care providers. For example, avoiding direct eye contact is considered a gesture of respect in many cultures, but a medical practitioner may come to a different conclusion.
- The extent of understanding and adherence to treatment options suggested by health practitioner who do not come from similar cultural background.
- The manner on which patients and health practitioners distinguish chronic disease and diverse treatment options.

Finally, Mayhew (2018), believes that culture similarly affects health in various forms, such as:

- Acceptance of a diagnosis, and this includes who should be informed, at what point and how this should be conveyed.
- Accepting preventive or health promotion procedures (e.g., prenatal care, birth control, screening tests, vaccines, etc.).
- Awareness of the amount of control that patients possess in preventing and managing the illness.
- Views on death, dying and who may be involved.
- Using direct as opposed to indirect communication, for example, making or evading eye contact can be perceived as rude or polite, depending on culture that one belongs to.
- Preparedness to talk about symptoms with a health practitioner, or with a translator being present.
- The role of family dynamics, traditional gender roles and forms of support amongst family members.
- Views on being youth and aging.
- Level of accessibility the health care services and how well they operate.

2.6. The politics of culture and identity

The emergence of Europe as an economic and political powerhouse in the eighteenth and nineteenth centuries has brought the need to expand its political and economic

dominance further by venturing towards Africa and other continents in the quest to create colonies for its benefit. In this 'adventurous' process of conquest, there arose the conflict between the conqueror (read Europe), and the conquered (read colonies), that later shifted from the political terrain into the 'battlefield' of identity and the cultural expression of the vanquished (Mashige, 2008). This is because in most cases the colonized were forced to abandon their identity and culture in favour of those of the colonizers, and this is where western practices including the usage of western medications at the expense of indigenous medicine and the process to undermine the indigenous healers has begun which has resulted to the current situation wherein indigenous healers are not offered an opportunity to partake in the health care system. This kind of discord between western and African identity has always been a contentious argument. The tendency to use identity and culture to undermine certain practices is the motive behind the existing argument about the usage of culture, race and ethnicity as identity and cultural practices for the maintenance of one's dominance over the other's practice.

In the same way that identity plays a role towards influencing the use of certain medicinal practices over others. Culture also contributes a key role in defining the level of health for individuals, the family, and the community at large. This is especially pertinent in the context of Africa, where majority of households still believe in the indigenous medicine and are dependent on indigenous healers. It is also in Africa whereby the extended family and community is valued and significantly influence the behaviour of the individual. This view is supported by Hernandez and Gibb (2019), when indicating that cultural behaviours have important implications for human health, and further state that understanding how behaviours are rooted in an individual's unique cultural experience can better equip medical professionals with the context, skills and empathy necessary for holistic care.

This is one element that make indigenous healing a step further as compared to the western healing methods in the sense that whenever diagnosis and treatment is made, such diagnosis and treatment must be compared with the values of the community in which the patient lives as the cultural behaviours of either the family or the community has a bearing on the healing process of an individual. It is, therefore, the argument of this study that western medicine seems to be lacking in this area and that is where the

indigenous healing could come in to complement the western medicine in the South African health care system.

It is the argument of this study that the introduction of modern medical care has not succeeded in stopping Africans from using indigenous medicine. From the 1960's when majority of African states were gaining independence, Africans increasingly revived their socio- cultural identity and culture with indigenous medicine being an essential part of their cultural heritage (Kirkland, Mathews, Sullivani & Baldwin, 1992). This was a fundamental development in the sense that cultural heritage or religion was found to be instrumental to the healing process. Traditional medicine and custom are instrumental in the healing process in the sense that indigenous healers play multiple roles within their communities that ranges from being medical specialists, religious consultants, political advisers, marriage counsellors, police detectives, and social workers. This is because indigenous healers have the capacity to diagnose and treat illnesses and diseases, serve as lay counsellors, spiritual counsellors including as advice-givers on matters of culture and a range of other issues.

Statistics have shown in the South African context that in order to build a viable health care system there has to be a multi-disciplinary approach to health care system that is capable to safeguard health care for all (Abdool, Karim, Ziqubu-Page and Arendse, 1994). This calls for an essential need for the revival of indigenous healing and its integration into the modern health care system.

Mashige (2008) argues that culture is a disputed terrain in which several groups struggle to assert meaning. Understood from whichever viewpoint, the point that one readily concurs with is that culture entails, on the one hand, what and how some people do or feel about certain issues, and on the other, those who may not feel or do anything about the same things. This is called culture's particularistic point of reference. On the other hand, there is the acknowledgement that cultural values and practices are authenticated when constructed against a universalistic matrix. Within this context, Wallerstein (1991;92) warns against the essentialisation of the values and practices of specific groups as this may lead to "an absolutely paralyzing cultural relativism because the argument would hold equally for any other group's values and practices. This means that there would be no tolerance of either group by the other.

Swartz (1996) suggests that the concept of culture as used in the psychiatric field in South Africa is changing. In the past cultural relativism was utilized as validation for subjugation by the previous apartheid government, leading to some researchers therefore de-emphasising difference. In recent times, there has been an increasing focus on diversity. The increasing diversity is posing new challenges culturally appropriate care. Linked to the challenge for culturally appropriate care, is an unequal development in the understanding of indigenous healing in South Africa, a factor that could be associated with the ongoing ideological tensions between the use of modern medicine and indigenous healing practices.

In another perspective culture is understood as a product and property of diverse people. As part of this perception, each community possesses its own culture, which is a unique way of life for that community and that would be stated as cultural artefacts and belief systems. It is the same cultural belief system that the Apartheid government has used to subdivide the country into tribes or separate groups, each with its own systems, lifestyle, and political identity. Sharp (1988), contends that this conception leads to the system of domination which serves to benefit those exercising power. This is the same notion was used in South Africa to develop the apartheid policy and discrimination as a principle that enabled whites to dominate Africans, and that communities should pursue separate development.

The above notion led to not only the separation of people based on ethnicity, but also the general subjugation and conquest of indigenous people, including their healing systems. The domination and suppression of indigenous people resulted in people becoming dependent on the modern medicine as they were not allowed to utilize alternative healing systems, including their own indigenous healing systems, which was not promoted or recognized either in part or being integrated in the health care system or on the point of it being regarded as an alternative health care system.

The view that promotes separate development on account of communities possessing their own culture, and that they each should have its own legal system, lifestyle, and political identity, misrepresents the nature of culture, and must be corrected due to the fact that it has been exploited to validate oppressive and ruthless forms of government

by contending that a cultural community should defend itself from internal and external adversaries. Thornton (1988) argues that culture is not something that people are born with but the information that they require to interact with one another in societal life. In essence, people do not adapt to the environment through genetic predispositions, but rather through cultural strategies. The importance of the above-mentioned statement is that culture can be learnt, and cultural strategies can be learnt, rather than been inherited. In the context of the study, indigenous healing could still find its space in the modern health care system and how the two could operate together could be a lesson that could be explored or learnt. The modern medicine practitioners could also have to learn from the indigenous healers as culture is not hereditary.

Basically, culture can be removed from individual's methods and procedures and be attributed to the community that belong to such a culture at a time. This point is intensified by Carbaugh (1990), who defined culture as a system of expressive practices fraught with feelings, a system of symbols, guidelines, procedures, and the spheres and dimensions of mutual meanings related with these. He also supported the view that culture is a set of shared understandings about beliefs, values, and norms, which influence the behaviours of a large group of people. It is evident that within all these definitions, culture is associated with communication and a varied range of human experience including feelings, identity, and meaning construction.

Therefore, culture pervades all our lives and forces as active interrelationship between the social milieu and the personality of everyone, and consequently, the roles, norms and personal experiences should be interpreted through the culture in which we all operate. From the above, an argument could be made that culture would be central not only to the patient's experience of HIV/AIDS, but also to HIV/AIDS prevention, treatment, and support in Africa. As it has earlier been indicated, the modern doctors could also have a lot to learn from indigenous healers, especially when it comes to the handling of diseases and illnesses such as HIV/AIDS.

It is on this basis that this study moves from the premise that matters of identity and culture are appropriate to the socio-cultural and philosophical interpretation and management of health in almost every society. It is thus vital that modern health care practitioners recognize both culture and the political necessity of integrating African

cultural systems, traditions, and cultural values into health care initiatives within communities. The argument, therefore, is that including identity and culture in health care design and considering identity and culture as inherent assets can be valuable for all types of healthcare initiatives. This approach will also contribute to social cohesion and community development.

2.7. Cultural embeddedness in health, sickness, and healing

The reality of the situation in Africa is that indigenous treatment is an ever-present certainty in rural, peri-urban, and urban societies. The acknowledgement of the reality that indigenous healers constitute the primary source of health care in the developing world is long overdue. For indigenous Africans, health is more than just the appropriate functioning of bodily organs. Decent health comprises spiritual, mental, physical, and emotional stability of the individual, the family, and the community. This interconnected understanding of health is founded on the African unitary view of reality.

Decent health is understood in relation to the connection with a person's ancestors. Health among Africans is not simply based on how it impacts on the living, it is of supremely important that the ancestors keep healthy so that they can defend the living (Iroegbu, 2005). Good health is, in their understanding, believed to be the outcome of proper behaviour, meaning living according to the values, norms and traditions of society (Iroegbu 2005).

Akande (2013), says Africans believe that humans are not the only occupants of the universe, but that is also the realm of the spirits, whereby the Supreme Being is thought to preside over plethora of sub-divinities and ancestral spirits. Indigenous medicine, therefore, has at its foundation, a deep belief in the interface between the spiritual and physical well-being of community (Setswe 1999). Furthermore, it is important to highlight that decent health also comprises the understanding of the individual as an integrated member of the community, and therefore, good health entails better relationship with ancestors and the community.

Katz (1982) believes that indigenous healing systems highlight community context and the spiritual dimension. Katz (1982) defines healing as a process of transition towards

greater meaning, balance, connectedness, and wholeness, both within the individual and their environment. Katz (1982) further suggests that this definition perceives healing as a process rather than a cure. This definition stresses the concept of illness, or the social construction of the sickness, rather than disease or the specific biomedical sickness (Kleinman & Sung, 1979). This definition, therefore, focuses on a person-environment unit, holistically considered, and emphasizing the importance of interrelations in healing, as opposed to secluded patients or distinct illnesses.

Mashego (2000), suggests that in most African cultures, ill health may be due to ancestral punishment for transgressions of norms such as committing incest, non-performance of prescribed rituals or any unacceptable behaviour. Marks, et al. (2000), suggest that Africans also have definitions of health that are centred around communal beliefs. People's beliefs about health and illness are also intertwined with broader belief systems.

One such definition of health centred around the communal beliefs for example, is the Ndembu, from Central Africa, (Turner, 1964) who believe that a patient "will not get better` until all tensions and aggressions in the group's interrelations have been brought to light and exposed to ritual treatment". The Ndembu healers view illness as being caused by supernatural forces which are prompted by human actions such as violations of taboo and violations of kinship rules. According to this group, healing focuses on the group's reaction to the patient's illness, rather than to the illness itself. This would then imply that treatment or intervention deals with modifying the solutions to the problem rather than the problem. The Ndembu's approach recognizes the fact that everyone is linked to everyone else and that an illness in one person affects everyone in the community. Treatment would involve all individuals who might in some way contribute to the patient's problems, restructures the group and in many instances resolve the tensions causing the problems.

Sodi (1998), suggests that resolving the tensions that are causing problems to the patient do not simply mean the provision of cultural support, but also changes the patient's capacity to express the symptom and the group's pattern of responding to the patient and is also in a way, re-organising the lives of everyone affected by the illness. Some reorganization comes through the healer's redefinition of vague

complaints in terms of the violation of specific taboos or the anger of a specific god. As such, by focusing on something specific, the healer can describe the kinds of investigations that must be made further to explore the problem, the kinds of solutions that must be sought, the results as well as the kinds of steps that needs to be taken to address the problem.

The Ndembu healer demonstrates the special knowledge and abilities that distinguishes the healer from non-healers, which enables him/her to deal with presented problems. According to Turner (1964), the knowledge an ability demonstrated by the Ndembu healer as the initial labelling procedure is important not only for defining the condition, but for establishing the patient's willingness to enter into the role of the patient. It is argued that unless this labelling process occurs and unless acceptance of the definition by the patient occurs, the process of treatment or therapy is unlikely to evolve in such a way as to permit predictable expectancies and results. The assumption therefore is that much of what may be therapeutic is the engagement of the patient and the healer, that is, the actual commitment to a process which has as its goal the alleviation of the patient's distress. Without such a commitment on the part of the patient, the treatment or therapeutic process cannot proceed or evolve (Turner, 1964).

Sue and Zane (1995), contend that the most significant explanation for the problems in service delivery includes the failure of health practitioners to deliver culturally responsive methods of treatment. The perception here is that some doctors are not acquainted with the cultural backgrounds and lifestyles of several groups and have primarily been trained in methods intended for Western cultures and understandings of diseases. Consequently, these approaches to healing are perceived as strange, foreign, and unhelpful by patients. Sue and Zane (1995), further contend that healing procedures should match or fit the cultural experiences of the patients, or else, these patients would continue to underutilize the services, prematurely terminate, or fail to display positive outcomes.

Based on the above, indigenous healers seem to be in an advantageous position to treat patients from their own cultural backgrounds because their approaches match the cultural lifestyles and experiences of their patients. The above considerations and

references to the roles of culture in healing makes the study of this nature, the Investigation of the Socio Cultural and Philosophical Importance of indigenous medicine that is connected to the management of HIV disease more relevant. Using HIV/AIDS as a case study, the researcher intended to understand the role of the indigenous healer in the treatment of health problems that are associated with HIV/AIDS in a similar way that the Ndembu healer is intrinsically involved in the entire health process.

2.8. African cosmology and illness

Just as there is an African method of understanding God, there is, in the same way, an African method of understanding the world, that is, the observable world around us. Oduro, et al., (2008), suggest that this includes all things, like the plants and animals, the people, diseases, the invisible world, and the supernatural world of spirits. Notwithstanding the introduction of Western health care systems in Africa, several African societies still depend on indigenous health care for their health needs (World Health Organization, 2001).

Thornton (2002) suggests that African cosmology is demonstrated by a sense of interconnection and interdependence of the natural, social, and spiritual forces, with a focus on the protective, and causal role of the ancestors. Fundamental to the understanding of African cosmology and initiation into its indigenous healing practices is ancestral reverence. The indigenous African worldview continues to shape the orientation of most Africans, and makes no distinction between body, mind, and spirit. Similarly, the same connections between people, nature, ancestors, and the Supreme Being is made. Africans derive their identity by embedding their whole being on the creator because the creator is the cause of their being. In the African traditional world, no one is independent, and no human being is alone. Therefore, Africans do not encourage the cartesian cogito ergo sum, meaning I think therefore I am they promote what is called existential cognatus sum, ergo sumus, meaning I am known therefore we are. This is well established through numerous rituals, like the naming and important rites of passage, as well as authentic communion with the ancestors (Karangi, 2019).

Indigenous medicine is viewed within this context as a set of exclusive, culture bound health care practices that occurred before the arrival of Western medical practitioners (Swartz, 1998). Based on the above, several authors have indicated that Africans, to a certain degree share the same cosmology (Chavunduka, 1978; Malan, 1985). Malan (1988) assumes that although the overt manifestations of the cultures of South African Blacks differ in many respects, the underlying cosmological assumptions from which they arise are similar. Onwuanibe (1978) maintains that Africans hold a view of a moral universe in which humans, spirits and gods interacts.

Africans, assumes that there is only one Supreme God (Mbiti, 1986). They similarly believe in the ancestral spirits; the perception is that they are all entwined and are in constant connection with living beings. Accordingly, the spirits dictate reverence and hold supernatural powers, through which they chastise or reward their worshippers (Sarpong 2002). According to Mbiti (1986), factors such as language, geographical location, culture, social and political factors influence the perceptions about God. He further suggests that in the worldviews of African people, the indigenous names of God are constantly in existence and have been passed down through generations via oral tradition.

In his conclusion, Mbiti stresses that there is therefore, no place for atheism or rejection of God's existence in traditional African communities. The assertion is that Africans are ontologically connected to God. In understanding by African traditional practitioners, God is for all everywhere (Mbiti, 2012). However, God delegates responsibility to the ancestral spirits and diviners (Chavunduka, 1999). This suggests that God is a healer who works through mediums like spirits, herbs, and deities with the assistance of diviners or indigenous healers (Obinna, 2012).

The relationship between people, the information and the technologies for its usage are under-girded by a cosmology, a world view. The affiliation with, and to nature, human agency, and human solidarity, for example, reinforces the knowledge system and the human existence around it. However, it is important, as with various other matters about Africa, Ikenobe (1999), to remember that given the many cultures in Africa, it is generally acceptable in the philosophical literature that whenever a 'thought' or 'tradition' is founded of Africa it does not mean homogeneousness of

cultures, but focus is mainly being made on dominant themes, in the sense of common themes in African cultures.

It is with this intellectual understanding that this section discusses African Cosmology which is based on the principles and philosophy of Ubuntu. Basically, the philosophy of Ubuntu is an indigenous philosophy of social co-existence that expresses the connection that ought to exist amongst members of the society. The distinctive features of this philosophy are welfarism, philanthropy, universalism and fundamentally its utilitarian outlook. The lesson central to this is the general lesson that to be human is to uphold one's humanity by upholding the humanity of others (Viriri & Mungwini, 2010).

Equally, Ubuntu could be defined as a value system that directs our behaviour and thinking at the personal, family, and community levels. This value system helps us to deal with challenges facing us and is a system evolved by African people to ensure that families and communities are founded on a value system that will bind them together. Furthermore, an understanding and exercise of Ubuntu means that *"my humanity is caught up with and inextricably bound with yours"* - in other words, we belong in a package of life (Desmond Tutu).

The common expression of Ubuntu is in the adage *"Muthu ndi muthu nga vhathu"*, meaning that a person is who they are because of other people. This implies that it is not *"I think therefore I am"*, but rather *"I am human because I belong"*. This philosophy of Ubuntu stands out as one characteristic of the African Cosmology that promotes a humane social existence, which extends to indigenous healing. The process of healing is based on the balance of the four states that is the physical, mental, spiritual, and emotional. This involves the understanding of the interconnectedness humans have with all life forms. Thus, a balanced state of well-being requires a deep sense of connection with the plants and water beings, the sky beings and the four legged and crawler beings. The patient is treated within his or her spiritual, and emotional, physical, environmental, the past and the present. This, therefore, is a value chain, or cycle of life within which as human beings, we are anchored. In most cases family members are almost always present during the treatment or healing procedure, and

the procedure is further enabled by involving members of the community. Healing is group oriented and the idea of the family members as the 'extended patients' gives opportunity to iron out differences that might be found (Mufamadi, 2001).

The holistic health models in indigenous healing do not emphasis just the bacteriological infections. The physical symptoms are scrutinized from a social, historical, and spiritual standpoint, and the concept of intangible dimensions of wellness is brought to the centre to determine whether dis-ease in these realms has displayed itself as disease in the physical space. The quest is to find the trigger that has created the dis-ease to determine the process of true healing (Glavish, 2002). Looking at this in the context of Ubuntu, one could indicate that Ubuntu is an organizing principle of African morality, a unifying vision, a spiritual foundation, and a social ethic. Ubuntu describes the standard for morality, kindness, communalism, and worry for the interests of the collective, which also encompass health (Pityana, 1999).

Indigenous healing emphasises the important interrelationship and interdependence of all phenomena - social, physical, biological, psychological, and cultural aspects. African cosmology centres on the co-evolution of the natural, spiritual, and human worlds. For example, several indigenous people in Africa still exercise the ritual of burying the umbilical cord and afterward, planting a tree on the spot to create a connection with the plant life. This, to a very large degree, must be seen within the wider framework for a need for self-definition, self-history, and self-knowledge, which are prerequisites for the creation of a more cogent and caring people who seek to co-exist with the flora and fauna as vital components of African cosmology. Thus, a balanced state of well-being requires a deep sense of connection with the plants and water beings, the sky beings and the four legged and crawler beings (Mulcahy, 1999). Thus, highlighting the role of indigenous identity in a holistic approach to healing. The well-being of the individual mainly depends not on him/herself but on the individual's affiliation with others.

It is important to note that the role of African indigenous healing in the South African community is varied and indivisible from daily life. The significance and prevalence of the indigenous healers in South Africa is also unquestionable (Edwards, 1985, 1986; Fipaza, 2003; Hammond-Tooke, 1989; Ngubane, 1992). The indigenous healer

serves as healer and ancestral medium, interceding between the dead and the living (Edwards, 1985; Gregory, 2003; Lambert, 1997; Ngubane, 1977). Africans believe that a human being is composed of a body, soul, and a spirit, and that at death the soul and spirit depart from the body and unite to form an 'ancestral spirit', which is given special powers by God to influence their living descendants. West (1975) assumes that this belief in ancestral spirits becomes the essence of the indigenous religion of most of the South African Blacks. These spirits are also often associated with diseases and disasters.

The indigenous healer's relationship with the ancestral world, forms the foundation of existence. An example of this is the popular belief that humans are most vulnerable to sorcery and malevolent forces when the ancestors are '*facing away*'. Ancestral protection for the return and maintenance of good fortune is ensured through ritualistic solutions that serve to provide both ancestral protection, and confirmation of the social kinship structure (Berglund, 1976; Burhman, 1979; Edwards, 1985; Mkhize, 1981; Ngubane, 1977; Preston-Whyte, 1974). According to this belief, indigenous healers are the ones who have the special powers to divine these causes of diseases (Hammond-Tooke, 1974).

A large proportion of South Africans, hold firm indigenous cultural beliefs and traditions, which informs their responses to illness. Rukobo (1992), maintains that it is the belief system that influences perceptions of health, sickness, and disease. In African indigenous societies the perception of the world is one where all elements of society are connected and functionally unified. Thus, medication, sickness, disease, and death are understood within the framework of religion and from time to time, myth, and mysticism. There is a basic distinction between theories of natural and supernatural causation in the conception of sickness, which forms the foundation of indigenous cosmological, religion, social and moral worldviews of health and disease (Abdool Karim et al., 1994).

Finally, the indigenous African worldview of causation supposes that, in addition, the question of 'who' instigated the illness and 'why', should also be addressed. This is a crucial part of the healing procedure. Consequently, any form of treatment provided without this understanding might confuse the patient, consequently, compromise the

treatment's efficacy and acceptability (Abdool Karim et al., 1994). Therefore, most Africans, even if they go to allopathic medicine, will always seek answers to these questions to address the why aspect. Finally, Sodi and Bojuwoye (2011), suggest that culture influences the understanding about sickness, health, and healthcare. The authors argue that Western-oriented health care models results in limited success when applied to health situations of people of non-Western cultures and contend that culture is a significant factor in health, sickness, and healing, thereby placing African healing at an advantageous point.

2.9. The practice of complementary medicine/ alternative medicine

The concepts 'complementary medicine' and 'alternative medicine' are sometimes utilised interchangeably with "indigenous medicine" in some countries. Complementary medicine includes a varied range of therapeutic practices and diagnostic procedures that stand isolated from, or in some cases, opposite to conventional scientifically based modern, Western medicine (Vincent & Furnham, 1997). In other words, Complementary medicine is a group of various medical and health care systems, products, and therapies, that are not currently perceived to be part of conventional or biomedicine (Barnes et al, 2004).

This implies that these therapies or treatment approaches are perceived as supplements to modern or Western treatments that enhance and strengthen the overall care offered to sick people. However, this can be deceptive because in some countries, the legal position of complementary or alternative medicine is equal to that of allopathic medicine; various practitioners are certified in both complementary or alternative medicine as well as modern medicine, and the primary health care. Fulder and Munro (1985), report that complementary medicine is widely used in countries like Austria, Britain, Europe, and US.

In a study that was conducted on complementary and alternative medicine use amongst Adults in the United States in 2002 (Barnes, Powell-Griner, McFann and Nahin, 2004), it was found that sixty-two percent of adults used some form of complementary therapy during the past twelve months. When prayer was included

specifically for health reasons, it was found that seventy-five (75%) percent of adults over the age of 18 years had used complementary medicine (Barnes, et. al., 2004). The same study also found that Black adults were more likely than white adults to utilize mind-body therapies and intercessions for health reasons.

However, Kofi-Tsekpo (2004), notes that the expression 'traditional medicine' has become a slogan amongst the peoples in all countries in Africa. This is partially because the utilisation of herbal medicines has grown in popularity worldwide and the exploitation of these medicines has become a multimillion industry. He further contends that the term African traditional medicine is not identical with alternative or complementary medicine. In his view, African traditional medicine is a fully fledged health care system on its own right and, therefore, cannot be an alternative. In Africa, there is a significant motive why African traditional medicine has become increasingly popular. Furthermore, the high cost of modern medical health care and the costly pharmaceutical products have become inaccessible to many people.

It has been indicated that orthodox medicine is organ specific, that is why they have specific specialists like, cardiologists, ophthalmologists, neurologists, etc. while, alternative medicine, including indigenous healing, consider each individual as unique and to use a holistic approach in treatment whereby they treat each person as an individual rather than what is specified in a rule book which often leads to a "one size fits all" approach. It is, therefore, important to unpack the above aspects because even countries like Britain, US, and Europe, who have advanced medical systems as compared to Africa and South Africa, are moving towards complementary medicine.

Barnes et al. (2004), suggest that the reason for the growth in the use of complementary medicine comprise marketing, availability of information, the wish by patients to be actively involved in medical choice making, and unhappiness with biomedicine. This dissatisfaction may be connected to the inability of biomedicine to sufficiently treat numerous chronic diseases and their symptoms such as incapacitating pain. It is further indicated that rates of complementary medicine use are remarkably high amongst persons with life threatening ailments such as cancer and HIV/ AIDS (Barnes et al., 2004).

Vincent and Furnham (1997), argue that the fact that so many people opt for complementary practitioners in countries where health care is mostly free at the point of delivery implies that they are getting something that is significant to them, that is not received in the dominant health care system. Vincent and Furnham (1997) further note that the difference with modern medicine is that in complementary approach patients are questioned more widely and at a considerably greater length than in average general practice consultation. The physical examination is also done probably more leisurely, gentler, and more soothing than the National Health Service allows most doctors to be. The most striking aspect of complementary diagnosis is that it provides a radically different explanation of the patient's symptoms than biomedicine.

There are a wide variety of therapies and treatment techniques that fall under complementary therapy. Murray and Rubel (1992), have divided complementary therapy into four categories:

- Spiritual and Psychological techniques- these range from faith healers, paranormal healing, divination as well as visualization and hypnosis.
- Nutritional therapies- these include herbal treatments, vitamin and mineral supplements and specific dietary regimes.
- Biological and pharmacological therapies- Herbal remedies, drugs, serums, and vaccines.
- Physical Interventions-Manipulative therapies, massage, and acupuncture.

Irrespective of the varied ways in which these systems and treatments are developed and are managed, they seem to have numerous features in common: the usage of multifaceted interventions, usually including the administration of several medications or medicinal substances at the same time; personalized diagnosis and treatment of patients; an emphasis on amplifying the body's intrinsic healing ability; and treatment of the 'whole' person by dealing with their physical, spiritual and mental attributes, rather than concentrating on precise pathogenic procedure as emphasized in conventional medicine.

Pietroni (1987) indicates that holistic medicine involves these processes:

- Responding to the individual as a whole, the body, the mind, and the spirit within the framework of culture, family, environment, and ecology.
- Preparedness to utilise a wide range of interventions, from drugs and operation to meditation and diet.
- An emphasis on a participatory affiliation amongst doctor and patient.
- A consciousness of the influence of the 'health' of the practitioner on the patient, that is, the notion of physician, heal thyself.

Like in the rest of sub-Saharan Africa, 80% of Black South African people are projected to make use of indigenous healers' services in both rural and urban areas (UNAIDS 2006). This is due to a variety of reasons, including the belief that healers are more easily reachable geographically, and deliver a culturally recognized treatment. WHO's opinion about traditional medicine (TM) is considered to entail various health practices, methods, knowledge, and beliefs integrating plants, animals, and mineral based remedies, spiritual treatments, manual techniques, and activities applied individually or in combination to sustain well-being, and also to treat, diagnose or prevent sickness. This definition and the explanation of some practices of indigenous healers, is largely like what is referred as complementary medicine.

However, in the South African context, where biomedicine coexists with indigenous beliefs and practices concerning diseases and illnesses, the problem that exist is lack of satisfactory accommodation between the two systems. According to Indigenous Knowledge Systems of South Africa (IKSSA, 2004), most black South Africans consult indigenous doctors before western doctors. In some instances, some patients have dual consultations, that is, using both biomedicine and indigenous methods simultaneously. Therefore, while the majority Africans consult indigenous healers due to lack of access to biomedicine, you will still find many African patients who still consult, even though they have full access to biomedicine.

It is important to find out why this is the situation in South Africa, whether it is due to challenges in biomedicine as highlighted above, or if there are other reasons why people consult indigenous healers. Vincent and Furnham (1997), argue that although there seems no doubt that a doctor can practice in a holistic way, the daily pressures and the increasingly specialized and technical nature of modern medicine may prevent

the doctor from providing the kind of care that he/she would wish. Other reasons why patients consider complementary medicine are the following:

- The belief that complementary medicine combined with western medical treatment would help.
- Curiosity, the thought that the utilization of complementary medicine will be interesting.
- The idea of utilizing complementary medicine was suggested by medical professionals.
- The belief that orthodox medicine would not assist them.
- Patients believed that orthodox medicine was too costly (Barnes et al., 2004).

2.10. Indigenous healing systems in South Africa

South Africa is a multifaceted country with varied cultural beliefs. The colonial masters and later the apartheid regime forced a Western worldview on the South African society without an effort to validate the African worldview on matters such as indigenous African healing and indigenous African spirituality, which in most cases, are mutually intertwined (Mokgobi, 2015). This idea is well articulated by Gumede (1990) who asserts that it would be challenging to comprehend indigenous healers and their skills without taking into consideration, the concept of indigenous African religion or spirituality.

Chavunduka (1999), provides an explanation as to why it is challenging to make a distinction between indigenous African healing from indigenous African religion or spirituality. The main being that the indigenous African understanding of sickness in most instances incorporates the relationship between God, ancestors, and the cosmos, and in various circumstances, indigenous healers double up as religious leaders in the African independent churches and vice versa.

The definition of indigenous healing varies. The World Health Organization (1976:8) defines traditional medicine or traditional healing, as “the sum total of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past

experience and observation handed down from generation to generation, verbally or in writing”. They further look at aspects like health practices, approaches, knowledge, and beliefs incorporating plants and animals as well as spiritual treatments, amongst others. Furthermore, indigenous healing includes treating ailments with herbal remedies as well as the spiritual treatment (UNAIDS, 2006). The healing approach is holistic and includes the collective wisdom of indigenous knowledge passed down from generation to generation (Ashforth, 2005).

Gilbert, Selikow and Walker (1996), suggest that the growing acceptance of alternative healing and the rising visibility of indigenous healers have brought to light the need for a serious scrutiny of the impact of culture in medicine. The method used by indigenous healers is holistic. It covers all aspects of life, comprising the relationship with other individuals, the environment, supernatural forces, the physical, and the psychological symptoms. Traditional healers offer a culturally discernible way of clarifying the cause and timing of illness and the connection to the social and supernatural domains. This healing approach may be considered as a therapeutic enterprise that applies the basic principles of several disciplines, like psychology, psychiatry, theology, social work, and medicine (Sodi, 1997). This means that the healers provide treatment for physical, mental, and also the social symptoms. The contrast, based on the above is that the allopathic doctor treats the disease while the indigenous healer treats the individual who is sick.

Indigenous healers are thought to be the custodians of the philosophies of healing, and the inspiration to society. They acquire knowledge about the cause, the cure, and deterrence of disease. They also learn about misfortunes, barrenness, poor crop harvest, magic, witchcraft, and how to fight, or utilise these cures to heal their patients. They are able to identify the cause of illnesses, the offender who sent the illness, they diagnose the nature of the illness, administer proper treatment, and avert misfortune from happening yet again (Sundermeier, 1998).

In short, the contribution indigenous healers are wider in some instances, than that of a modern medical doctor. The indigenous healers guide their patients in all features of life, comprising the physical, mental, spiritual, moral, and occasionally legal matters. They also comprehend the importance of ancestral spirits and the notion of witches.

The indigenous healer frequently includes the family in the diagnostic procedure, and they also provide clarifications and the management of aspects like feeling guilty, shame and anger, by attempting to address personal problems. This means that indigenous healers espouse the psycho-social-environmental method in their work (Sodi, 1997). The healers are also easily accessible and more accepted than modern health counterparts, especially in rural communities.

In Africa, the living and the dead have a responsibility towards one another, henceforth the performance of certain rituals during the healing process. Health is characterised by the harmonious relations between the person, the natural environment, including the departed ancestors, and with other community members (Dawes & Honan, 1996). Consequently, healing is attained through a dual strategy of divination, to mitigate the social causes, and physical healing, to manage the bodily symptoms.

Indigenous healing operates within a cultural framework that does not categorize certain phenomena as psychological and others as not. This (indigenous) healing system is considered as an enactment of communications received from the ancestor spirits as messengers of God. This view, therefore, enables the patient to accept what the healer says as valid. Makgopa (2004), suggests that during the diagnosis process two questions are answered, that is, how the disease originated and why the disease manifested itself. Felhaber and Mayeng (1997), differentiate three stages of the diagnosis process:

- Observation – which involves symptoms that can be observed, and great attention is related to the physical symptoms.
- Patient self-diagnosis – where the patient relates the symptoms of the disease and its development. During this stage impressions of other family members may also be obtained. This aspect requires skills in attentive listening, history taking and the ability to make the patient relax.
- Divination – which may be done via three methods:
 - Bone throwing, which involves ancestral spirits and enables the healer to go deeper into the causes of the disease and method of treating. The

position in which the bones fall is interpreted and related to the diagnosis.

- Psychic, the ancestral spirits empower the healer to detect the cause and treatment of illnesses. This method usually does not involve bone throwing.
- Dreams and visions, the healer experiences visions of what the causes of the disease are and how the disease is to be treated. These visions can be experienced at any given time of the day or night.

The divination by the healer exposes the power and the existence of ancestral spirits. It is this power of the ancestral spirits that enables the indigenous healer to establish the patient's problem and manages to relate all the matters associated with the problem. Matters such as the beginning of the problem, conditions of the patient, analysis, and interpretation of the message of the ancestral spirit as well as the medication suitable for the treatment are orally transmitted (Makgopa, 2004).

This means that the world of the living, and the world of the spirits, play a significant role in both the causality and healing process. This perception places indigenous healers in a better position to contribute to the management and care of HIV positive patients largely because the healers would be able to explain holistically why the patient is ill by focusing on the spiritual, moral as well as physical behaviour that led to the contraction of the disease.

Sickness or ailment is considered as any disorder or tension within an individual or amongst diverse aspects of the universal whole, whatsoever the reason of these turbulences might be. Illness is considered by most indigenous African societies as a misfortune that involves the whole person. The general belief is that 'if part of me is sick, then the whole of me is sick'. This understanding has a direct impact on the relation between the patient and the spiritual or supernatural world and other members of community. Healing, in this instance, takes place in the framework of religious or spiritual belief systems. Illness is considered as a religious or spiritual matter and people return to religious practices to address it. From the indigenous African perspective, health and life are compatible concepts and suggest that there is congruence between the seen and the unseen worlds, the human, and the spirit

realms.

These domains are not distinct but are interconnecting dimensions of one reality. Health implies having moral and spiritual influence and being congruent with one's social and spiritual environment (Dube 1989). Accordingly, illness will occur, and calamity will attack only when this balance and harmony are disturbed. The ill-fated division between the mind, the body, the spiritual, secular, and physical, has led to the reduction of the anticipated influence of biomedicine on the African population with regards to their understanding of health and illness (Gumede, 1990). Furthermore, the interpersonal and psychological features are of significance because sickness and calamity in Africa are generally described in terms of bad interpersonal relationships. Holdstock (1979), indicates that the key questions in defining the quality of an individual or group's existence, is the recognition of a person or people in terms of their spiritual and emotional values.

Indigenous healers possess a revered and influential position in Southern African societies. They serve as, therapists, psychiatrists, and priests, and physicians. Patients consult indigenous healer for ailments ranging from social problems to main medical issues. The World Health Organization (WHO, 2002) and other official groups like (UNAIDS, 2000) recognize the possible efficiency of indigenous healers as main health providers and the potential effectiveness of their treatments in the fight against HIV and AIDS, sexually transmitted disease, and other communicable diseases. WHO also supports the incorporation of western medicine and indigenous healing, especially promoting referrals between the two systems. In South Africa and in Mozambique, indigenous healers have established organizations that are acknowledged by the Department of Health and by the Ministry of Health, respectively (Hewson, 1998).

Karim, Page and Arendse (1994) shares that the indigenous healers' clinics are their homes, where both physically and psychologically sick live together without any stigmatization and isolation of one group by the other. They become part of the healing community where both staff, patients and relatives share the same amenities. The non-isolation of patients from their social environment help to foster the healing process and makes the readjustment to society much simpler.

The other aspect is the financial implications of indigenous healing. Holdstock (1979), argues that the implementation of costly Westernised methods, such as hospitalization, one-to-one therapy and the use of highly qualified academic specialists are financially wasteful, due to the fact that they do not denote the most effective means of treating indigenous communities. Holdstock (1979), also suggests that biomedicine approaches can learn a lot from indigenous healing. For example, community participation in healing process, the reliance on visions, disregard for labelling patients, acknowledgement for the potential of the individual even if that individual is 'sick', holistic method to healing, absence of prominence on the procedures and apparatus, the importance of rituals and the close interpersonal relationship between the healer and the patient.

2.11. Controversies about Indigenous healing and competing health views.

Thornton and Ramphela (1988), contend that the debate on indigenous healers commences on the foundation that Africans are 'irrational' and 'superstitious', and that these features will disappear under the impact of scientific medicine. It is, therefore, astounding to discover that instead of declining in numbers and impact due to the growth of western health services, the numbers of indigenous healers are considerably growing (Karlson & Moloantoa, 1984). It is, therefore, important to find out why this is the case.

Indigenous healing methods are viewed as far detached from the clinical measures and logical thought sequence of biomedicine. One reason why indigenous healers and their techniques have been ignored is that they are relegated to the realm of mere magic and superstition (Torrey, 1986). Numerous authors have undermined indigenous healing as unhealthy and unsafe (Van Eerden, 1993; Bourdillon 1989). Motlana, (in Freeman and Motsei, 1992:1186) criticizes indigenous healing as irrational, "meaningless pseudo-psychological mumbo-jumbo, by dangerous charlatans".

A few disadvantages related to indigenous remedies have been identified by some scientists and the advocates of modern medicine (Mabogo,1990) Amongst others, criticism stems from the following perceptions about indigenous healing:

- That occasionally disregards the significance of dosage,
- The medicines are frequently arranged in unclean conditions,
- The information about the remedy is not generally shared but kept by those who possess it,
- It is not standardised, and
- Some of the healers rely on divination which makes it problematic for people from other belief systems like Christians to consume their services (Gyasi, Mensah & Osei-Wusu Adjei, 2011).

Other areas of criticism of indigenous healing, or medicine are highlighted by Mabogo (1990), as follows:

- Indigenous medicine lacks scientific proof of efficacy. The absence of scientific evidence does not automatically imply that the remedies utilized are not important, but only that much scientific work is required to increase the field of medicine. This becomes challenging due to underdeveloped technology in third world communities.
- The methods of diagnosis by indigenous healers are inaccurate. Although traditional healers rely on divination to identify health challenges, in most cases they also rely on normal noticeable symptoms to diagnose their clients' problems. Usually, divination is utilized to determine that supernatural forces are not involved. This plays a crucial social role amongst indigenous people as witchcraft and ancestral curses are constantly suspected to be involved.
- Indigenous medicine does not rely on accurate Diagnosis. This is one common feature of indigenous medicine. The lack of prescriptions related to the patient's age, weight and condition of illness has also been pointed out. This is not always true as traditional practitioners do specify doses for adults and for children. In such cases they also use different plants for the same diseases in children and adults. Dilution is used as one method of prescription that

differentiates between strong patients and those weakened by serious conditions (Mabogo, 1990).

- Indigenous medicine is intangible. The intangible characteristics of indigenous medicine like magic and beliefs in witchcraft and ancestral spirits cannot be validated scientifically and are therefore observed with misgivings by modern practitioners.

African culture and healing are a disputed terrain whose systematic obliteration was pursued in a systematic manner. This has led it to become a practice sentenced to mystery (Serote, 2002).

Reports of the provision of strange herbal treatments, healers who claim to have discovered the remedy for AIDS, and unethical and distasteful behaviour relating to treatment of patients can frequently be covered in the newspaper pages or magazines. While a few indigenous healers have systematically merited the negative publicity created by their scandalous conduct, these stories may have influenced the negative sentiment held concerning all indigenous healers and all indigenous healing practices. This implies that the role that authentic, ethical, and well-educated indigenous healers can play in South Africa's response to HIV/AIDS and its efforts to build up its health system has mainly been overlooked.

Apart from these and other disadvantages, Mabogo (1990), and Sofowora (1982), note that indigenous medicine also has a few positives, perhaps even more than the negatives, and still helps the greater percentage of the African population for the ensuing reasons:

Traditional remedies are cheaper compared to modern medicine. In a country with growing numbers of joblessness, underemployment, and inflationary increases, it is more cost-effective to go for inexpensive treatment if the outcomes are the same or comparable. Indigenous healers usually permit for treatment on credit, allowing the patient to reimbursement when able to do so. Furthermore, resident patients are sometimes treated free of charge out of virtuous gesture. One motive for inexpensive treatment might be that most remedies are sourced locally and at very little, if any, cost.

Traditional medicine is easily reachable to most of the people in the Third World. Sofowora (1982), estimates that 60 to 85% of the people in every country of the developing world depend on indigenous types of medicine. This is perhaps due to scarcity of formal health institutions and professional staff. The price of transportation to these establishments may also be contributing.

Furthermore, traditional remedy is extensively recognized among the African population. Sofowora (1982), also asserts that a chief contributing aspect may be that Indigenous remedy is deeply rooted and blends readily into the sociocultural life of the African people. In this respect he gives examples of people in Guatemala, Kenya, Nigeria, Ghana, and Ethiopia, who see indigenous healers as a first choice even though they live very close to hospitals. In addition to the high price of modern medical treatment which keeps many people away, there are those who believe that certain kinds of sicknesses can only be treated effectively only by traditional healers and are disinclined to consult modern practitioners, especially concerning those illnesses assumed to be caused by witchcraft and ancestral spirits.

Notwithstanding the introduction of antibiotic treatments for most sexually transmitted diseases such as venereal disease, many people still suppose that the treatment only suppresses the symptoms and does not heal the illness completely. Another reason, it is claimed, is that modern practitioners typically do not wish to notify their patients about the outcome of their diagnosis, the prognosis and implications of further treatment or the side effects associated with the treatment. While this is not true for the majority of practitioners, it stays a strict rule in many hospitals that patients and their relatives are not permitted to read their medical files, let alone ask about the diagnosis and nature of treatment.

Traditional medicine is a possible source of new treatments. This source can be used in the synthesis of known drugs. Research on the medicines utilized by indigenous practitioners could lead in the unearthing of new drugs for treating such diseases as cancer, diabetes, and AIDS. There is great fear currently that if AIDS is permitted to spread, it may annihilate the human population (Mabogo, 1990).

Indigenous healing has no red tape related to consulting a modern practitioner. Where there are two queues, one for registration and payment of fees, and another for a nurse to take disease history like blood pressure, temperature, and weight. Finally, another queue to see a doctor, and probably another one for diagnostic tests, then coming back for a prescription, and last of all, a queue to the dispensary. Even though an indigenous practitioner may have more than one patient at a time, the process is not similar.

The above account clearly indicates that none of the two methods is without its inadequacies. It is also apparent that indigenous medicine, like modern medicines, requires extensive scientific research. Such a study should request that effective and appropriate methods be pursued to lead to the development of suitable methods of research aimed at providing maximum utilization of the positive features of indigenous medicine, and the removal of negative and irrelevant ones. All such approaches will necessarily necessitate that indigenous drug be standardized. Sofowora (1982), points out that the problem of standardizing a basic drug preparation is not only that of specifying the amount of the medicine to be taken by the patient, but also that all stages leading to the preparation and application of the drug must be standardized.

However, modern approaches also present some noteworthy problems; for example, they do not always align to people's subjective perception of their own health. They also ignore the spiritual aspect of health that may be equally, or even more important to the people concerned. The problems encountered by biomedical doctors when treating diseases include among others, the conceptualization of the problem, the fact that the doctor uses a different frame of reference than their patients. For treatment to be effective it is important that the community perspective be reflected in the design and delivery of services.

Modern medicine distinguishes sharply between physical and psychological illness and have separate doctors for both. However, one indigenous healer treats a wide variety of psychological, physical, and social problems. The biomedical doctor's diagnosis entails what germ caused the illness, but for the indigenous healer, it is not only what illness, but also who caused the illness. Modern treatment is specific, individualized and streamlined to meet the presenting problem, for example if

someone is HIV positive, the doctor would only give that patient appropriate drugs for the virus and then refer the patient for counselling by another specialist.

Biomedical doctors terminate the imposing organism, and the patient will be well. The indigenous healer's method, on the other hand, is holistic because they consider an individual as a whole being including the mind, body, and soul. Therefore, healing is a total procedure (Gumede, 1990). It can therefore be argued that while the indigenous healer treats the patient within his/her environment, that is physical, spiritual, and emotional, it is more economical when compared with biomedicine because in their case there is a specialist for the natural, spiritual, and emotional problems. The indigenous healer's approach is more in line with the World Health Organization's (1978), definition of health as a complete state of physical, psychological, and social wellbeing, and not merely the absence of disease or infirmity.

Holdstock (1979), argues that the neglect and avoidance of indigenous healing border on professional irresponsibility, not only within the applied framework of community health, but also within the academic world of information processing, theory, and research. Holdstock (1979), identifies several 'compelling' reasons why traditional healing should be recognised and accepted.

Holdstock (1979), further asserts that the indigenous healer is not only a physician, psychologist, and priest, but he or she is also the ethnic historian. Equally important is the role indigenous healers play in maintaining social stability. Since indigenous healing fulfils such a prevalent role in black society, perhaps the first and most important reason why we must recognize indigenous healing is that in so doing we will not only be able to do something about the psychological needs of most black inhabitants of South Africa, but we will also afford the black population the ultimate respect for the spiritual dimension of their lives. The indigenous healer is part of a holistic world in which ancestor, plant, dream, animal, and other individuals all belong together. It is for this reason that understanding the philosophical and socio-cultural aspects of this healing system is important.

2.12. Socio-cultural and philosophical aspects of healing and rituals

Anyu and Ruch (1981), define African philosophy as that which preoccupies itself with the manner in which African people of the ancient and the current generation make sense of their purpose and of the world in which they live. Viewed this from this perspective, African philosophy becomes that kind of viewpoint which must essentially be produced by African people and must use unique African philosophical approaches (Janz, 2009).

Maphela (2021) says that there is agreement amongst scholars that the definition of philosophy has continued to be a theoretical challenge, especially from the African perspective, which leads to less consensus on what philosophy means for African societies. Within the same study, Oyeshile (2008), also suggests that scholars tend to agree on the description of philosophy rather than the definition. Scholars agree that philosophy means 'love of wisdom', which is developed over time by a society through life experiences and existing African knowledge systems. Thus, for the purpose, of this study, philosophy refers to the indigenous knowledge repository that varies over time, shaping African belief systems to resolve modern-day challenges (Maphela, 2021).

Maphela (2021), further argues that the only point of consensus within the society of African scholars is that the principles used to define what is and what is not philosophy in the world today are unfairly biased and constrained by Western cultures. This is also supported by Bongmba (2004), who states that the word 'philosophy', in the African perspective, has not been handled with fairness. Van Hook (1997) adds that, in some circumstances, even Africans themselves, in their pursuit for philosophy, reflect the impact of Western philosophical paradigms, to which the African philosophy arbitrarily conforms. The present study, consequently, is an effort to address, and move away from this conformism.

2.12.1. The Meaning of Rituals

Cultural heritage is not just about monuments and collections of objects but incorporates traditions or living expressions bequeathed from our ancestors and passed on to our descendants, for example, performing arts, oral traditions, social

practices, rituals, other events, knowledge, and activities concerning nature and the universe or the knowledge and skills to create traditional crafts.

The 2003 UNESCO Convention for Safeguarding Intangible Cultural Heritage, in which South Africa has endorsed, perceives living heritage as “manifested inter alia in the following domains, (a) Oral traditions and expressions, including language as a vehicle of the intangible cultural heritage (b) Performing arts (c) Social practices, rituals, and festive events (d) Knowledge and practices concerning nature and the universe (e) Traditional craftsmanship”.

Mbiti, (in Mensele, 2011) describes rituals as the usage of good magic by specialists, largely the traditional diviner-healers or rainmakers who utilize their knowledge and deployment of the mystical powers for the well-being of their communities. On the other hand, Boyer (2001), suggests that rituals could be characterized as occasions where people connect with ancestors, gods, and spirits. Tolbert (1990) defines ritual as a set of actions mostly executed for their symbolic value, which is prescribed by a religion or by the practices of each community. He suggests further that a ritual may be executed on special occasions, either by one individual, a group of people or the whole community. Rituals might also be limited to a certain place and time, whether in private, in public or before specific individuals or audience and in most incidents, allows the channel between religious or social states.

Rituals are further perceived as the domain where the world as lived, and world as perceived, become bonded together and translated into one reality for it is suggested that man transcends himself and connects directly with the divine on almost every ritual occasion Ray (1976). Heij (2001), not only perceives ritual as a second way of transforming into a higher state of consciousness but believes that rituals are moulded by predetermined actions which comprise certain chants, gestures, recitation or invocations, imaginings, and meditation. Heij (2001), further stresses that the same ritual can be used repeatedly, or people can choose to alter rituals from time to time in accordance with their own desires and ideas, because what really counts is the significance a certain ritual has to individuals.

Traditionally rituals are the main mediators for both stability and change advanced by the human society. Throughout history and across cultures, rituals have delivered an interactional form for continuing established social structures and world views, and for making and marking major change. Though safeguarding group cohesion, rituals dramatically mark and enable entrances and exits from group membership as well as position changes within the group.

Moore and Myerhoff (1977), say that a ritual is a multifaceted type of behaviour which generally has a stable purpose, rigid form, utilizes symbols or symbolic method of communication, hence it typically refers to more than it says. Ritual reconfirms and shapes cultural ideas, buttresses social ties, can rearrange as well as create them.

Ritual maintains the stability or the identity of a system while allowing transformation by connecting change to the accepted, basic doctrines of a culture or social group. Norbeck (1961), suggests that traditional rituals generally fall within three categories: (1) rituals focused on events in the environment such as seasonal changes and planting, (2) rituals of healing and atonement, and (3) rituals that mark developmental changes in the human life cycle.

Davis (1984), and Mead (1973), agree that individuals have constantly utilized ritual to navigate crucial moments in life, but now frequently find themselves without it. Rituals, therefore, are predetermined symbolic acts that must be executed in a particular way and in a particular order and may or may not be performed with verbal formulations. They include preparation and meaning. Accordingly, Smith and Stewart (2011), suggest that rituals could provide meaning, articulate important values, dispel uncertainty and anxiety, exemplify, and reinforce the social order, manage work structure, and recommend and reinforce important events.

Furthermore, rituals may extend past the individual or personal level, like when addressing the whole family or community matters. In such cases, veneration will be directed to the ancestors of the tribe, the village, or the country. For example, in South Africa, the government has established a memorial, the Freedom Park in Pretoria, to honour those who died for freedom and humanity. Within this memorial, a space called Isivivane (a sacred circular space made of boulders from different Provinces of South

Africa) has been erected in recognition of the significance of rituals in contributing to healing and cleansing.

Bell (1992) suggests that fundamentally, theory on ritual developed from studying the contrast between thought and action. Ritual is commonly considered as action where conceptual features such as beliefs, symbols and myths were practically exhibited. In this, ritual is acknowledged as how thought and action, including comparable dichotomous categories (e.g., irrational vs. rational; expressive vs. pragmatic), could be reintegrated.

As far back as 1897 and 1915, Durkheim suggested rituals as a significant social behaviour that operates to foster certain mental and behavioural patterns within individuals and groups that intensify societal longevity. This view is supported by Haidt et al., (2008). Literature has often discussed the three key and vital psychological variables that are impacted by rituals, namely, affect, group unity/cohesion, and pro-sociality.

2.12.1.1. Positive Affect

The initial factor that has been connected to rituals as a psychological consequence is improved feelings of positive affect - that is, the experience of positive feelings (Watson, Clark, & Tellegen, 1988). The emotions experienced in collective effervescence are the psychological variables that moderate, generate, and uphold long-term group cohesion. Collins (2004) proposes that emotional energy is engendered as participants participate in various interaction ritual chains. This collectivization and augmentation of a group's emotional energy contributes to the development and reproduction of social solidarity. This psychological phenomenon of joy experienced in rituals has been suggested by Haidt, Seder, & Kesebir (2008), to be a result of sense of self-loss due to coordinated movements of the group.

2.12. 1.2. Group Unity

The next factor that has been continually linked to rituals as a psychological product is feelings of intra-group unity. This ethical community is a group that connects people

to a common set of values and social norms. The communities with the highest well-being are those that employ activities that permit self-consciousness to be reduced so that individuals integrate into an identity greater than themselves.

2.12.1.3. Pro-sociality

A third factor that has been linked to rituals is a behavioural outcome. Prosocial behaviours are those activities that profit other people, or society even at cost to the individual like serving, sharing, giving, co-operating, and volunteering (Brief & Motowidlo, 1986). Anthropologists have also accepted and deliberated on the connection between ritual, group unity, and co-operation (d'Aquili & Newberg 1999; Hayden 1987; Ridley 1996; Sosis 2000; Steadman and Palmer 1995; Turner 1969). Durkheim in 1912 and 1995 respectively, suggested that in rituals movement is stereotyped across participants, increases conformity to the group, and by this moving collectively as a unit, participants are inclined to think and value themselves as a unit, which augments their subsequent co-operation.

Apisugah (2008), contends that the other theorists purport these rituals are normal actions founded on underlying theoretical beliefs. He references as a challenge that cultural people usually cannot explain the reasons why they are executing certain rituals other than to say, "that's the way it is done in our culture". Lambert (1993) maintains that rituals invoke a feeling of shared effervescence.

Lombo (2017), suggests that rituals have very basic systems of meaning, that outline a set of etiquettes and rules that allow consistency just as they allow slight differences without weakening their constitution. Ritual may serve as a window to a specified culture or religion's understanding of itself and its relationship to the world. Some of the aspects of rituals are as follows:

- Ritual guides personal change within a community context.
- Change in ritual, arises within the context of stability.
- Ritual enables intermittent or second order change.
- Ritual resolves paradox by unifying opposites.

- Ritual links various levels of a system such as the level of social structure and the level of world view.
- Ritual introduces transformation in a structure on the level of action and on the level of meaning.

The strength of ritual rests in its capacity to operate on various levels and link these levels so that they support each other. It is through performances of various rituals that people express vital messages about themselves, their affiliation to each other as well as their existing links with the ancestors. Rituals continually have particular effects on the partakers in that they (participants) can also obtain ancestors' protection. Wilce (2006), and Ray (1976), agree that rituals of various types are a feature of nearly all known societies, and that they play a vast role in African societies, for in Africa and somewhere else, ritual activities are a way of communicating with the divine for the purpose of transforming the human situation.

Mbiti (1969) states that the traditional diviners, healers, and herbalists utilize rituals in the treatment of illnesses, in encountering misfortunes and in weakening and obliterating evil spirits and powers. They are performed to safeguard homes, families, fields, animals, and other assets as well. Rituals and ceremonies maintain the human spirits, making it richer and deeper even though contemporary culture tends to tone down this, but rituals remain as vital as ever. They include gratification of spiritual or emotional needs of the practitioners, solidification of social bonds, social and moral educations, demonstration of reverence or submission, stating one's association, obtaining social acceptance or endorsement for some event or, at some point, just for the pleasure of the ritual itself.

2.12.2. The socio-cultural aspects of rituals and healing

Kiev (1989) argues that indigenous healing rituals are culturally organized, symbolically meaningful event which offer regulated therapeutic experiences for the lessening of anxiety and emotional anguish. Most indigenous healers in indigenous settings depend on a belief system which connects all community members to the same set of spiritual forces, which links those who are alive and those that are

departed. By evoking these spirits, the healer offers a powerful system of care connecting the afflicted patient to a larger community of sympathetic or concerned people. This view is supported by WHO (1982), when they suggest that Psychosocial factors are the main factors in the accomplishment of health and social actions, and further proposes that if actions are to be effective in the inhibition of illnesses and in the advancement of health and well-being, they must be based on an understanding of tradition, beliefs, culture, and patterns of family interface.

Within health-care situations, culturally proficient practice presumes an understanding of the socio-cultural meanings connected to illness and incapacity and the people who are likely to be consulted with regard to delivering health care and repairing well-being. African spirituality is perceived as a holistic and all-encompassing approach to see the world which can assist to overcome, religious, cultural, social and lifestyle variations and strongly correlates to the development of ethics, as well as physical, psychological, and spiritual well-being (Roux, 2006). Morality and ethics are powerful elements of Ubuntu African philosophy and spirituality (Ross, 2007).

Ubuntu is depicted as African humanism which positions humanity into its centre (Broodryk, 2005), whereas humanity is characterized as a communal construct, as a person being a person through other people, which is the direct interpretation of Ubuntu. Given that spirituality is a concept which promotes wholeness and interconnectedness in many African contexts, it is traditionally part of health professions and healing processes, because traditional healing concepts refer to a holistic integration of spiritual and mental guidance (Ross 2007). Professional traditional African healers refer to their power as a power of God or a higher power and do not make a distinction between religion and spiritual, magic, or physical health, and materialism (Moodley & West, 2005).

In Africa, it is difficult for Africans to discover their own culture's relevance. Practicing African indigenous ceremonies is scowled upon, perceived as barbaric and unchristian (Hlela, 2019). In South Africa, the majority of South Africans are well-known to consult with indigenous healers in preference to or in combination with western, conventional health-care professionals. The culture of a people is vital part of its historical and

spiritual heritage and forms part of their rich and proud legacy. For this reason alone, the understanding of the significance of socio-cultural aspects becomes much more relevant.

Since the focal point of this study is on the socio cultural and philosophical importance of rituals in traditional medicine, with special focus on HIV/AIDS, it will be important to also look at the definition of socio-cultural system. A socio-cultural method focusses on human population perceived in its ecological framework and as one of the many subsystems of a bigger ecological system. The perspective seeks to understand why people act as they do based on the influences of socio-cultural viewpoint seeks to unpack why people behave the way they do. The Business dictionary perceives socio cultural aspects as a set of beliefs, customs, practices, and behaviour that exist within a population. Wikipedia suggests that the term sociocultural system, incorporates three ideas; that is society, culture, and system.

YourDictionary (2018), describes philosophy as a set of ideals, standards and beliefs utilized to explain behaviour and thought. Philosophy, therefore, is the analysis of general and fundamental challenges regarding matters such as existence, knowledge, values, mind, and language. Webster's New World College Dictionary (2014) sees philosophical aspects as any system of belief, values, or tenets. The above aspects form the basis of this study, which focuses on socio cultural and philosophical importance of rituals in traditional medicine, used to treat HIV/AIDS.

Ceremony is a vital part of indigenous healing. Since physical and spiritual health are deeply linked, body and spirit must heal together. Indigenous healing ceremonies stimulate well-being by reflecting understandings of Spirit, Creator, and the Universe. Occasionally rituals are performed to sanctify some herbs. Rituals constitute the way of consecrating African traditional remedies; remedies without sanctification are meaningless Africans. Divine and ancestral injunctions are deemed necessary before and during the formulation and application of remedies (Idowu, 1973).

In some instances, herbal medicines are prepared for the individual to bathe with a particular time for a few days. Occasionally an animal can be killed, and the blood

would be emptied on the head and foot of the person who is ill; the blood poured on the ill person operates as a way of cleansing. This practice is common among the Ewes communities in Ghana (Westerlund, 2006). In the case of illnesses that are triggered by an invocation of a curse or violation of taboos, the diviner placates the ancestors, spirits, or the gods. This is done in accordance with the seriousness of the case, by either sacrificing an animal or by pouring of libation. In numerous cases, the person would be instructed to buy the ritual items for the procedure as directed by the gods or the spirits.

One of the rituals performed is pouring of libation. Libation is a rite by which some liquid is poured on the ground or sometimes on objects followed by the chanting or reciting of words. According to the practitioners, it is a form of prayer. The liquid could be water, wine, whisky, schnapps, or gin. Some cultures also use palm wine, palm oil, and coconut water (Adjaye 2001; Van Dijk 2001). The Ga and Ewes of Ghana sometimes use corn flour mixed with water.

Libation pouring amongst the Akan communities in Ghana has three main parts: invocation, supplication, and conclusion (Kilson, 1970; Sarpong, 1996; Yanka, 1995):

- **Invocation:** They first invoke the presence of *Twereduapong Kwame* (the almighty God), *Asase Yaa* (mother earth) and the ancestors by saying, *Twereduapong Kwame ye kyere wo nsan na yen mmawo nsan, Asase yaa, begye nsan, nananum nsamanfo nsa nia*, meaning 'Almighty God, we show you drink but we don't give you drink'. (This is said because they believe that all that is on this earth belongs to God, and therefore he does not need a drink offered by man; mother earth we offer you drink, and we call on you our ancestors to come for a drink). They say 'we offer you drink' because in Ghana, whenever you have a visitor, the visitor is first welcomed with water or a drink. According to the practitioners of libation pouring, offering the ancestors and spirits drink is a way of welcoming them (Agawu 2007; Van Dijk 2002).
- **Supplication:** At this point, they present their requests to the invoked spirits, gods, or ancestors to act on their behalf or to have mercy on them. They sometimes ask the ancestors and the spirits to forgive offenders of taboos and to seek for spiritual consecration (cleansing) of either the community or

individual(s). The content of the prayer depends many times on the purpose of the occasion for the pouring of libation (Adjaye, 2001).

- **Conclusion:** At the end of the libation pouring, they thank the invoked ancestors and spirits. They finally invoke curses on those who wish them evil or failure:
- **Physical issues:** The following are some of the healing processes, when the case or sickness is deemed to have physical causes:
- **Prescription of herbs:** Depending on the kind of disease the person has brought to the diviner or the traditional healer, he would prescribe herbs to the sick person. These prescriptions come with some specific instructions on how to prepare the herb, the dose and timeframe (Ayim-Aboagye, 1993; Lartey, 1986).
- **Clay and herbs application:** In some of the healing processes, the traditional healer would prepare white clay with some herbs for the sick person to apply on his or her body for several days. This is mostly what is done for those with skin diseases. The theory behind this concept is taken from Genesis 2:7. Their view is that the human body is made of the dust or ground, therefore, if the body has any problem, you will have to go to where it came from to fix it. This could also be traced to John 9:6-7, and Mark 8:22-23, when Jesus Christ mixed his spit and clay for healing. The use of clay and herbs is also sometimes used for preventive rituals. There are special herbs for preventive rituals. When the sick person applies the herb and the clay on his or her body, it prevents the spirits behind the illness from attacking the patient.
- **Counselling:** Sometimes, the sick person is advised on how to live his or her life, especially the kind of food the person should or should not eat. This is mostly done when it is an issue of a violation of a taboo.

They are also advised to be of good behaviour should it be that it was discovered that the disease occurred because of impolite behaviour (Sundermeier, 1998). Good behaviour, according to African traditional belief, includes following and practicing values and behaviour established by society and culture, participation in religious rituals and practices, and proper respect for family, neighbours and [the] community. Failure to follow these behavioural

guidelines often results in the good spirits withdrawing their blessing and protection and, therefore, opening doors for illness, death, drought, and other misfortunes.

There is another ritual called Mophaso, which is ritual and magical healing, and is conducted to cleanse and strengthen the patients. Usually a sacrificial animal (chicken, goat, or sheep) is killed and specific parts such as hair, bones and skin are magically prepared to render remedial care to the patient. Blood is used to cleanse ritual defilement and evil spirits (Rankoana, 2012).

In her study, Mensele (2011), found that ritual activities at the sacred sites need to be taken seriously due to their association with ancestral and religious Basotho beliefs which have been an integral and is still said to be an important part in the cultural, spiritual, and religious beliefs of most local user communities of the sacred sites under study. Furthermore, ritual activities were found to be not merely superstitious or traditional African dilemma, but as healthy, informative, religious, and valuable practice that should be acknowledged and contextualized with the respect that it deserves.

Neba (2011), suggests that indigenous healing is an art that consist of two major elements that are often used in combination. The application of natural products and an appeal to the spiritual forces. Abdool Karim, Ziqubu-Page and Arendse (1994), expand this further by indicating that herbal medication, psychosocial counselling, simple surgical procedures, rituals, and symbolism are the most common therapeutic method used by indigenous healers. They go further to say that the medications used by indigenous healers can be classified into three categories, namely: preventative and prophylactic medication, treatments for ailments and lastly, medications used to destroy the power in others.

Ozioma and Chinwe (2019), indicate that rituals are sometimes performed to consecrate some herbs without which the medicine is meaningless. This is because divine and ancestral sanctions are considered necessary before and during the preparation and application of medicine. Neba (2011), elaborates that the medicinal plants used by indigenous healers cannot be gathered at any time of the day. They have their proper time, and the healer must first pray to the ancestors/guardians of the plant using incantations.

This notion is also supported by Washington (2010), who in his study found that Zulu healers held a view that there are certain herbs that are extracted only in the morning, day, evening, or night. It is believed that the full healing power is manifested at specific universe time periods, and one must approach that herb at the proper time. Neba (2011), further argues that a healer's power is not determined by the number of medicinal plants he knows but by the ability to apply an understanding of the intricate relationship between the patient and the world around him. The above knowledge and ability are based on the socio-cultural and philosophical understanding and belief system of the community.

Neba (2011) suggests that unlike a Western medical doctor, the indigenous healer looks for the cause of the patient's misfortune in the relationship between the patient and his social, natural, and spiritual environment. Sokhela (1984), Dlamini, (2006), and Kale (1995), agree that after a diagnosis, the indigenous healer then plans a course of treatment and that the procedures for treatment generally incorporate the patient and his social group into the treatment program. This implies that the healer studies the patient in a holistic manner and lastly, considers the patient as an integral part of family and community rather than an isolated individual.

Hillenbrand (2006), states that indigenous healers typically try to reconnect the social and emotional equilibrium of patients centred on community rules and relationships, unlike orthodox doctors who treat only the diseases in patients. Using powerful symbols and impressive, impersonal roles, the healer performs the healing ritual in a supernatural environment. Sokhela (1984) believes that these indigenous healing practices are unique from Western treatment techniques, which often take place in isolated quiet rooms. Richter (2003) argues that traditional healers are culturally close to patients, which enables communication about the disease and other related social concerns.

Freedom Park (2007) views the significance of rituals in the healing process from a broad perspective. For example, individual, family, community, as well as spiritual levels. Sickness distances a person from themselves, family, and community. Sickness can also be a result of evil, transgressions of taboos or natural causes. Therefore, as part of healing, the individual will need to reconcile with him/herself first,

then with the (extended) family, and the ancestors. In other instances, the community may also be involved. Once an individual has achieved this, he or she is able to heal physically, psychologically, socially, and spiritually. These ceremonies also create the opportunity to move away from individual pain to shared pain, where both family and the ancestors provide moral support to the patient. Therefore, the illness of a person, and the treatment thereof, provides an opportunity for the family, to come together as a united force.

The indigenous healers' powers are not self-determined but derived from the strength of their relationship with ancestors. Diagnosis and treatment would therefore be acquired through communication with the ancestors. They can offer rituals to cleanse the body symbolically. Sanctified water focused on symbolic cleansing and purification of the body to break any psychosocial and spiritual factors that might be connected to or a part of the patient's illness (Zuma, Wight, Rochat, & Moshabela, 2017).

South Africa introduced the world's largest antiretroviral treatment (ART) program in 2004 and since 2016 the Department of Health implemented a universal Treatment as Prevention (TasP) strategy. However, some studies have shown that expanding the availability of ART is inadequate for the comprehensive treatment of HIV. Traditionally, when communities are faced with disasters that interrupt the known way of life, the elders instinctively resort to cultural strategies that illuminate coping mechanisms. In the case of illnesses or deceases, indigenous healers would be consulted. Furthermore, culture is often demonstrated to be a factor in the different ways that HIV/AIDS has impacted on the African population.

Moshabela, Schneider, Silal and Cleary (2012), argue that there is evidence that socio-cultural beliefs and dissatisfaction with biomedical public health systems drives significant levels of medical pluralism and the continued use of the indigenous healing system alongside ART care, particularly in rural populations. Wagner and Audet (2017), suggest that keeping a cautious, yet open mind to the complementary role that indigenous healer can play could help further reduce and support the ultimate end of the HIV/AIDS pandemic.

Numerous studies have attributed the common use of indigenous medicine by People Living with HIV to a combination of traditional beliefs in supernatural causes of HIV infection and the perceived need to treat both physical and mental manifestations of HIV/AIDS to restore social and spiritual health, scarcity and high cost of ART and health services and side-effects of ART (Merten, et al., 2010; Peltzer, et al., 2011).

Differences in the approaches and methods used by physicians and indigenous healers, which in the past represented an almost insurmountable barrier to collaboration in HIV prevention and AIDS control, are increasingly seen as an opportunity and even a prerequisite for treating the whole patient, particularly emotional and spiritual aspects that have largely eluded Western medicine and to enlist traditional healers in health promotion and patient referral (Green, 1994).

There is increasing evidence that religion and spiritual therapy may facilitate psychological coping and stress reduction for a wide range of diseases, including HIV/AIDS (Barirega, et al., 2012). Mental disorders among PLHIV are significantly higher than in the general population (Freeman, Nikomo, Kafaar, Kelley, 2008), with many of them feeling guilty and even contemplating suicide.

Kaaya, et al. (2013), and Freeman, et al. (2008), recommended that community and home-based care and support services, including spiritual and traditional healing systems, be integrated into HIV programs and play a central role in comprehensive HIV/AIDS support, care, and treatment programs. Faith healing, defined as the treatment of illness through religious belief and prayer (Hall, 2010), is a well-established global practice that has considerable potential as a care and support approach, even though its effect on HIV/AIDS interventions is underreported in the public health literature and remains inadequately understood (Burchardt, Hardon, de Klerk, 2009; Trinitapoli & Weinreb, 2012).

Faith healing of AIDS through prayer and various other spiritual practices proliferated with the increase in morbidity and mortality from HIV/AIDS prior to the availability of free ART and has been associated with the widespread belief in both natural and supernatural causation of illness and the holistic approach used by healers in Sub-Saharan Africa to treating diseases. Burchardt, et al. (2009), associated the increasing

interest in faith healing in Sub-Saharan African countries with the realization that AIDS is incurable with ART and the hope for treatment that ensures not only the physical wellbeing but also meets the spiritual and psychological needs of patients.

Disclosure of HIV status determined which indigenous medicines could be prescribed or prepared, and which rituals could be performed. For example, indigenous healers did not prescribe potent medicines for PLHIV. Potent medicines, with potential for harm in weak patients, were those considered to cause diarrhoea and vomiting. Rituals such as skin incisions were also avoided among PLHIV. Indigenous healers manage illness in PLHIV in varied ways, using both biomedical and sociocultural accounts to explain their understanding of HIV/AIDS and their responses to patients' healthcare and treatment. In addition, they use approaches including divination, indigenous medicines, and rituals to manage aspects of patients' illness that required psychosocial and spiritual healing. Engagement with the supernatural can also enable people to find a measure of meaning in their suffering, even if these same individuals are prepared to accept the "germ theory" of disease as the immediate cause of their illness (van Wyk, 2005).

The belief that supernatural forces cause all diseases and that holy water in combination with prayer is curative has traditionally brought people afflicted with a wide range of diseases to holy springs, among Orthodox Christians and among Moslems (Kassaye, Amerbir, Getachew, Mussema, 2006; Pankhurst, 1990; Fullas, 2001), This belief continues to generate a strong interest in the use of water from holy springs in conjunction with the use of the cross, holy oil, ash of incense and prayers by a priest to treat symptoms of AIDS. In addition to the use of holy water for the treatment of AIDS, holy water is preferred over modern medicine for the treatment of mental illness, epilepsy, and several other diseases because they are thought to be more appropriately and effectively treated in the church (Berhanu, 2010).

Major factors in the demand for indigenous medicine include a combination of the perception that both physical and mental manifestations of illnesses must be treated appropriately and consistently with the cultural construction of health and disease, the ready accessibility and culturally appropriate indigenous treatments and the side effects of ART. Though extensive research has been done to understand the use of

indigenous healers in the context of HIV/AIDS, few studies have explored the specific rituals and their significance in healing in the context of HIV/AIDS. This thus formed the basis of this study.

Within our Indigenous ways of knowing we recognize that we are related to everything in creation we are connected and depend on one another. Underwood (2014) suggests that when you stop and do ceremony you literally clear your mind, your heart and your spirit, the answers come freely to you. Ceremonies are associated with maintaining and restoring balance, renewal, cultivating relationships and creative participation with nature. Therefore, participation in the ceremony does not derive its origins or standing from the individual but from the collective epistemological understanding and rationalization of the community. On the other hand, the aim for healing is concerned with attaining and maintaining balance between the four dimensions of the person: physical, mental, emotional, and spiritual (McCormick, 1994).

From the above literature, rituals afford us a sense of belonging. When we engage in the ritual process we are, in essence, connected to "original time." Rituals awaken that which is eternal within us and show us how our individual lives are part of a much grander design. They basically remind us of the interconnectedness of all of life. In essence rituals give us a way to connect to family, past and present. Their creation and performance help us to understand where we come from. As a bridge between past and future, they enable us to access, honour, and strengthen our own identity.

Brenner (2015) believes that rituals help us access our authentic selves by carrying us into deeper levels of consciousness. They give our lives a sense of meaning and help form our identities, both individually and communally. Rituals are how we pass on wisdom and beliefs across generations. Because physical and spiritual health are intimately connected, body and spirit must heal together. Furthermore, Rituals thrive in all cultures of the globe and have been used in dealing with life issues. Rituals play a significant role in the healing process in traditional African setting and evoke sacredness and intentionality. Rituals anchor the individual to the community and give structure and meaning to life. It is against this backdrop that the current study sought

to explore the place and significance of rituals that are performed during the treatment of HIV/AIDS.

2.13. Indigenization from within

Nkondo (2012), argues that the western perception of African indigenous knowledge as mere repetition of practices without any theory to explain them, and that it is a depiction of western cultural and intellectual arrogance. In the perception of African scholars, a traditional healer who can cure a particular disease using specific herbs has the knowledge and theory of the plant species and their characteristics. There could be several reasons for this, but the paper argues that one of the key factors is that education, especially higher education, in Africa has not been relevant to the needs and concerns of African societies. The curriculum and research have been conducted from an outsider perspective, instead of it being designed from an insider perspective, thus presenting a biased view both in terms of relevance and ability to address specific challenges.

In South Africa particularly, there is a growing understanding that the broader cultural and social context may influence engagement with biomedical public health care systems or inform the acceptability of lifelong treatments such as Anti-Retroviral Treatment (ART). There is evidence that socio-cultural beliefs and dissatisfaction with biomedical public health systems drives significant levels of medical pluralism and the continued use of the traditional healing system alongside ART care, particularly in rural populations.

Although existing psychological theories and concepts are assumed to be objective, value-free, and universal, they are deeply enmeshed with Euro American values that champion rational, liberal, individualistic ideals (Enriquez, 1993; Kim, 1995; Kim & Berry, 1993; Koch & Leary, 1985; Shweder, 1991). As such, they can be characterized as imposed or pseudo ethics, and not as true universals.

Furthermore, these authors point out that many theories are ethnocentric, biased, and culture-bound (Berry, 1980; Shweder, 1991). Often researchers use their own culture implicitly as the standard by which other cultures are judged. They argue that each

culture should be understood from its own frame of reference, including its own ecological, historical, philosophical, and religious context.

Kim (2000), believes that the primary goal in the indigenous psychologies approach, is to understand how people think, feel, and behave in a particular context. The authors advocate a bottom-up model-building paradigm that examines the generative capabilities of human beings. In the indigenization from within, theories, concepts, and methods are developed internally, and indigenous information is a primary source of knowledge (Enriquez, 1993).

Indigenous psychology also advocates for examining knowledge, skills, and beliefs people have about themselves and how they function in their familial, social, cultural, and ecological context. It emphasizes obtaining a descriptive understanding of human functioning in a cultural context. With the theoretical, conceptual, and empirical description, ideas are developed and tested to explain the observed regularities. It is “an evolving system of psychological knowledge based on scientific research that is sufficiently compatible with the studied phenomena and their ecological, economic, social, cultural, and historical context” (Yang, 2000).

Therefore, indigenous psychology is a part of the scientific tradition where an important aspect of the scientific endeavour is the discovery of appropriate methods for the phenomenon under investigation. Most psychologists in non-Western countries adopt conceptual frameworks and research methods developed by Western psychologists when conducting research in their native societies (Kao & Sinha, 1997; Mehryar, 1984; Sinha, 1986). This implies that their research findings may be irrelevant to the psychology of the local people, and thus are unable to solve problems faced in people's daily lives. The same can be said in relation to indigenous healing, that treatment and healing methods that are developed in Western traditions may never fully address the health challenges of all South Africans.

Consequently, findings derived from replicating Western research paradigms might be irrelevant to or inadequate for understanding the mentality of people in non-Western countries (Sinha, 1986, 1988). The imposition of a Western research paradigm on non-Western countries can be viewed as a kind of cultural imperialism or colonialism (Ho,

1998). By ignoring the fact that many Western theories are culturally bound, duplication of a Western paradigm in non-Western countries may result in neglect of cultural factors that may influence the development and manifestation of human behaviour.

Based on such reasoning, many indigenous experts advocate a bottom-up model building paradigm (Kim, 2000), which entails promoting the study of human behaviour and mental processes within a cultural context that relies on values, concepts, belief systems, methodologies, and other resources (Ho, 1998), and treat people as interactive and proactive agents of their own actions that occur in a meaningful context (Kim, Park & Park, 2000). They call for the scientific study of human behaviour that is native, that is not transported from other regions, and that is designed for its people (Kim & Berry, 1993). The above is calling for a strategy based on and responsive to indigenous culture and indigenous realities (Enriquez, 1993), or a strategy whose concepts, problems, hypothesis, methods, and test emanate from, adequately represent, and reflect upon the cultural context in which the healing system is developed (Adair, Puhan & Vohra, 1993).

2.14. Concluding remarks

The primary objective of this study as articulated elsewhere in this document, is to offer a conceptual analysis for using a culturally based strategy for implementing and evaluating HIV/AIDS prevention, care, and support in Africa. To advance an African-based cultural strategy to address African issues and problems. It concludes that participation in the cultural practice for the local community is not only empowering, promoting both indigenous knowledge systems and Ubuntu but is also part of redress of past imbalances and bias.

There is no doubt about the significant contribution of indigenous medicine in the current health care system. However, it will appear that the challenge facing both government as a facilitator of health, and scientists alike is their lack of understanding of the significance of a holistic approach to healing, including the acknowledgement

and consideration of rituals performed before, during and after the administration of herbal medicine.

This study, therefore, has been prompted by the fact that very little has been recorded or written up mostly by way of scholarly analysis, on the significance of rituals at various stages of healing, and what their impact is. The literature above, seems to point to the need to also consider historical perspective needed to understand both past and present influences like colonization, apartheid, globalization, and the current post-colonial dispensation. The lasting impact of colonialism on Africa needs to be taken into consideration. Furthermore, the cultural basis of indigenization and the notion that culture is more central than values (which simultaneously inform, flow from and mold culture); and looking at indigenization as cross-cultural practice, and the need for dialogical rather than continuing with existing models is required.

Finally, the concept of indigenization and Pan Africanism as a form of resistance and a medium for transformation from externally imposed to locally developed models of practice and solutions, should also be considered. There also seem to be a general perception that conventional approaches imply that development processes always require technology transfers from locations that are perceived as more advanced. This has led often to overlooking the potential in local experiences and practices, including healing systems.

Many indigenous knowledge systems are at danger of becoming extinct due to rapidly changing natural environments and fast pacing political, economic, and cultural changes on a global scale. Practices disappear, as they become unsuitable for new challenges or because they adapt too slowly. However, many practices vanish only because of the imposition of foreign technologies or development concepts that promise short-term gains or solutions to problems without being capable of sustaining them. The tragedy of the imminent vanishing of indigenous knowledge is most apparent to those who have developed it and make a living through it. But the implication for others can be detrimental as well, when skills, technologies, artifacts, problem solving approaches and expertise are lost. The terrible condition of primary

health care in South Africa clearly shows that there is a need to start the procedure to put indigenous healing on par with allopathic health care.

There are various authors who have argued for the inclusion of indigenous healers in South Africa's response to HIV/AIDS, and that more resources should be channelled towards research into the efficacy and safety of indigenous medicines. The enactment of the 'Traditional Health Practitioners Bill' in South Africa can be seen as a step towards achieving this and addressing the recommendations that indigenous healers should be included into the activities of government, non-governmental organizations (NGOs) and community-based organizations (CBOs) in the response to HIV/AIDS, as well as to set out advocacy strategies. With this process underway, there is a risk that the socio-cultural aspects which forms part of the management and indigenous healing process may be overlooked. This may lead to the gradual demise of the authenticity of indigenous healing process and this therefore, formed the basis for the rationale of the current study.

From the above, it can be deduced that indigenous healing is an intricate process that is integrative of various aspects that must be considered collectively without privileging one aspect over the other. Within the Indigenous ways of knowing, the perception is that we recognize that we are related to everything in creation and in healing, we are connected to the whole process holistically. Furthermore, when you do ceremony, you literally clear your mind, your heart and your spirit, the answers come freely to you (Underwood, 2014). Questions that need to be answered then includes what would happen if these rituals were excluded from the healing process? Would indigenous medicine remain effective or authentic?

Fewer literature on the role of culture and the socio-cultural aspects in health care necessitated this enquiry into the philosophical importance of rituals in indigenous health care among rural communities in the Vhembe district in Limpopo Province of South Africa. Furthermore, a culture-centred approach to prevention, care and support is increasingly recognised as a critical strategy in health care across the world. This is to address the view that indigenous healing is treated as an auxiliary source, and not as the primary source of knowledge or healing. The next chapter will focus on the theoretical framework that informed the approach to this study.

The inclusion of socio-cultural aspects is in line with the World Health Organization (WHO,1948)'s definition of health as “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity”. This calls attention to the complexity and multidimensionality of the notion and adding social well-being to the definition opens the way to conceptualizing the individual as a social being, part of bigger entity than his/her own body.

CHAPTER 3: THEORETICAL FRAMEWORK: THE AFROCENTRIC PARADIGM

3.1. Introduction

A theoretical framework is a foundation for any study. In the present study, two theoretical frameworks were adopted, the Afrocentric paradigm and Leininger's Sunrise model were chosen as frameworks that generally guided and oriented the attainment of the study objectives.

Miles & Huberman (1994), describe conceptual frameworks as labels necessary to organize intellectual information with various discrete events and behaviours. These factors are borne out of theory and experience as well as the objectives of the study. Bereda (2002), suggests that a conceptual framework explains, either graphically or in narrative form, the main things to be studied, like the key factors, constructs or variables, and the presumed relationships among them. A framework can be rudimentary or elaborate, theory-driven or commonsensical, descriptive, or casual. Since colonial invasions, African indigenous culture has weathered rapid change.

Many researchers made some genuine attempts to get inside the African culture, but even so, there was a tendency to see culture in terms of the coloniser's precepts and to assess educational needs in terms of the coloniser's agenda (Mkabela, 2005). When establishing formal education there was no adequate reference to the indigenous education that Africans already had or to the depth of the ancestral opinions that influenced African thinking.

Furthermore, the momentous democratic transformation in South Africa presented many challenges and opportunities. As part of the movement towards building a culture of democratic pluralism informed by the principles of freedom, equality and human dignity, there has been a double challenge of constructing a balanced inclusive heritage and culture and of retrieving and preserving primary materials from which such a heritage would be woven from a Pan-African perspective. This heritage is expressed in various aspects of life, including health and healing procedures.

Now as a democratic country, South Africa is engaged in the unfolding process of bringing African indigenous knowledge systems into focus as a legitimate field of academic enquiry. The understanding is that unless the African voice is emancipated, Africans will never be truly free. The Afrocentric method is derived from the Afrocentric paradigm which deals with the question of African identity from the perspective of African people as centred, located, oriented, and grounded. This idea has been named “Afrocentricity” by Molefe Asante (1987), to convey the profound need for African people to be re-located historically, economically, socially, politically, and philosophically (Mkabela, 2005).

This study, therefore, was conceived with the aim of exploring such aspects in relation to the philosophical and socio-cultural aspects of HIV in the Vhembe District of the Limpopo province. The Afrocentric paradigm was for this reason, found to be the most relevant for this study.

3.2. Afrocentric Paradigm

Afrocentricity is a philosophical and theoretical paradigm which its origin is attributed to Asante ‘s works, *Afrocentricity* (1988), *The Afrocentric Idea* (1987), and *Kemet, Afrocentricity, and Knowledge* (1990). Afrocentricity as an intellectual attitude and an approach to analysing data, and dates to the 1960s (Asante, 2009). Molefi Kete Asante is considered as the founder and an authority of Afrocentricity (Turner, cited in Pellebon, 2007). As an intellectual idea, Afrocentricity was used in the 60s and 70s as a philosophy and conceptual framework. The paradigm was born out of a need to preserve and empower the African ways of knowing or ways of analysing data (Asante, 1990), while on the one hand, rejecting the universalist notion of Eurocentrism, more especially positivism, which is a philosophical paradigm that originated in the 19th century and dominated the early 20th century (Kaboub, 2008).

In the context of this study, the terms African worldview, Afrocentric worldview and African thought are regarded as synonymous. Asante (1987) defines Afrocentricity as meaning literally placing African culture at the centre of any analysis that involves studying African people. Afrocentricity is a perspective that allows Africans to be subjects of historical experiences rather than objects on the fringes of Europe. This

implies that Afrocentrists are concerned with discovering the centred place of the African in every case (Asante, 1999).

According to Gray (2001), the term Afrocentric, refers to an idea and a perspective which holds that African people can and should see, study, interpret and interact with people, life, and reality from the vantage point of African people rather than from the vantage point of European people, or Asian, or other non-African people, or from the vantage point of African people who are alienated from Africanness.

Asante argues that the European perspective has brought us to a highly technically managed and structured society where all knowledge flows upward to control and dominate society more efficiently (Asante, 1980). The emphasis made was that the ruling ideologies of the time continued to abuse positions of power on questions of knowledge and its production. It is in this context that Asante maintained that there was an urgent need to free Africans epistemologies from the constraints of Eurocentrism in connection with critical theory (Mkabela, 2005). Accordingly, Afrocentricity put forth the knowledge of this "place" perspective and sees it as a fundamental rule of intellectual inquiry (Asante, 1990). Afrocentricity locates research from an African viewpoint and creates Africa 's own intellectual perspective. It focuses on Africa as the cultural centre for the study of African experiences and interprets research data from an African perspective (Mkabela, 2005,). This means that Afrocentricity is generally opposed to theories that 'dislocate' Africans in the periphery of human thought and experience.

In essence, when traced back historically, the aim of Afrocentric scholarship has always been and still is to shift, construct, critique, and challenge the way of knowing or discerning knowledge from an epistemology engendered within a European cultural construct to one which is engendered or cantered within an African or probably more correctly an African American cultural construct (Baker, 1999).

As a philosophy and theoretical paradigm, Afrocentricity advocate for pluriversal perspective in research (Mkabela, 2005). Kaboub (2008), lends support by highlighting that the lack of internal consistency of positivism in the social sciences commanded its abandonment and acceptance of critical multiplism.

In his book, 'I am an African: Embrace your identity, escape victimisation', Muendane (2006), argues that physical colonialism may have ceased but that mental colonialism continues to this day – and nowhere more starkly than in academia. Muendane (2006), suggests that Africans need to go back to their roots, their own traditions, to find and embrace their own identity.

3.3. Basic propositions of the Afrocentric paradigm

Afrocentricity is undergirded by the notion that our main problem as African people is our usually unconscious adoption of the Western worldview and perspective and their attendant conceptual frameworks (Mazama, 2001). The unintended outcome of this tendency or attitude is that African people are de-centred, essentially meaning that we have lost our cultural footing or identity and have become dis-located and dis-oriented (Asante, 1980). In response to this, the Afrocentric scholars, systematically advanced the Afrocentric paradigm to explain the African human condition. Afrocentricity can be easily understood as using the African worldview to understand all manner of phenomena (Carr, cited in Conyers, 2011). It deals with the question of African identity from the perspective of African people as cantered, located, oriented and grounded (Mkabela, 2005).

To be centred is to be located as an agent instead of as 'the Other' (Mashige; 2007). Such a critical shift in thinking means that the Afrocentric perspective provides new insights and dimensions in the understanding of African indigenous culture, in a multicultural context. Therefore, Afrocentricity is about placing African ideals, values, and philosophies at the centre of an analysis that involves African culture and behaviour (Alkebulan, 2007). Ontologically, Afrocentricity argues that cultural location takes precedence over the topic or the data under consideration. As an enterprise, it is framed by cosmological, epistemological, axiological, and aesthetic issues that reflect African centeredness and experiences (Asante, 1990; Mazama, 2001).

Serote (2008) believes that Africans need to shift and enter the centre of the world stage and do so in their own right. They must find out what to do to shift from the margins and understand why they are in the margins. Odora-Hoppers (2002), seems to agree with Serote, and argues that on the surface, the issue around Indigenous

Knowledge Systems revolves around explaining and justifying its existence, over centuries, and pleading with mainstream "keepers of the gate" to please allow this body of knowledge to come in and kindly play its part in local, national, and global development.

Furthermore, the scope in Afrocentricity is Pan-African and cuts across various fields that specialises in African studies, including communicative, social, cultural, political, economic, and psychological, while recognizing three possible approaches: functional, categorical, and etymological (Mazama, 2001). Afrocentricity, therefore, foster scholarly collective agency and open discourse in favour of multiculturalism, which becomes imperative for the preservation of African culture and society (Asante, 2007). The paradigm has been labelled pseudoscience by scholars such as D 'Souza and Lefkowitz, and merely an ideology that lacks rigor to be accepted as an empirically based theory of practice (Appiah, 1993). Despite the criticisms, Alkebulan (2007), has argued that the Afrocentric idea is valid and need to be defended and vigorously pursued.

3.4. The implications of the Afrocentric paradigm for the present study

Makgahlela (2016) argues that the fundamental problem for us as African people is our usually unconscious adoption of the Western worldview and perspective and their attendant conceptual frameworks. This assertion speaks volume to the present study. This study is in one way, a response to current developments in South Africa, the scourge of HIV/AIDS, the promulgation of the Traditional Health Practitioners Bill of 2003, the Protection, Promotion, Development and Management of Indigenous Knowledge Bill of 2016 as well as the debate on the role that indigenous healer can play in the care and management of HIV/AIDS. The current research in indigenous medicine by various research institutions also necessitated the current study, as these seem to be neglecting the rituals, philosophical and socio-cultural aspects.

This study was also necessitated by the challenges encountered by the researcher on her current job, which includes dealing with indigenous African healing systems and practitioners on a regular basis. Particularly with the treatment and management of HIV by indigenous healers, where healing methods are rooted in African cultural

beliefs, ideas, and ideals. Unfortunately, the Western approaches and interpretation of the role that indigenous healers play in the treatment and management of HIV/AIDS; the conceptual models and intervention strategies accessible to the researcher at the time of the commencement of the study mostly neglected the holistic nature of indigenous healing systems and excluded the understanding of the philosophical and socio-cultural aspects of indigenous medicine. The inadvertent consequence of this omission is that the authenticity of indigenous medicine could be compromised. This resonates with Sodi and Bojuwoye 's (2011), sentiment that Western-oriented health care models have limited success when applied to the health conditions of non-Western cultures.

Amongst others the researcher was concerned that if socio cultural aspects like performance of rituals during the treatment of HIV are left behind, the authenticity of indigenous healing processes would be compromised. The researcher believes that most of the African population still believe in the holistic approach to treatment and if certain cultural practices are not performed, the treatment approach becomes ineffective and unresponsive when applied to some of the cases. The unintended consequence of the lack of the African ways of interpreting and dealing with such lived experiences was that some of the patients abandoned the treatment. This is supported by Sodi and Bojuwoye 's (2011), argument that Western-oriented health care models have limited success when applied to the health conditions of non-Western cultures.

Considering the above considerations, it therefore became imperative for the researcher to consider an alternative orientation to conceptualising and conducting the present study. It is for this reason that Afrocentricity became the guiding framework for the present study. Similarly, the researcher in the present study adopted the Afrocentric paradigm which enabled her to understand and describe the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus and its related rituals in the context of indigenous healers in Vhembe District municipality of Limpopo Province, considering their belief systems and cultural practices. The themes that emerged from this study added a new dimension towards the understanding of the phenomenon being studied.

According to Mojalefa (2014), research based on the Afrocentric framework seeks to understand African people and their experiences and interpreting research data from their perspective. Therefore, the researcher, in the present study intended to explore indigenous healers' views regarding aspects affecting their development and further compiling and interpreting results based on their opinions and experiences. It is for this reason that Afrocentricity became the guiding framework for the present study. Indigenous healing and its socio-cultural aspects are shaped primarily by people 's worldviews and cultural practices (Laurie & Neimeyer, 2008; Breen & O 'Connor, 2007; Eyetsemitan, 2002). It is, therefore, important for indigenous healing processes and procedures to be culturally located and understood from its context.

The Afrocentric perspective starts with the questions like: 'Does this study place Africans in the centre?' and 'Is it in the best interest of African peoples?' The researcher in the current study believes that the study is an attempt to understand and place the study participants (indigenous healers) in order to learn how their practices are structured and why they are in the manner that they are. It is hoped that the findings in this study will add value the preservation and protection of the authentic value of indigenous healing practices. An Afrocentric perspective reorganises the African frame of reference so that African history, culture, and worldview become the context for understanding Africans. Understanding African clients within their context begins the process to place them in the centre of their conception of reality.

The researcher in the present study adopted the Afrocentric paradigm to be able to understand and describe Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus in Vhembe District municipality, considering their belief systems and cultural practices. The themes that emerged from this study added a new dimension towards the understanding of these cultural rituals and procedures.

3.5. African worldview

Barker (1999) defines worldview as the way a person tends to understand his or her relationship with social institutions, nature, objects, other people, and spirituality. The African-centred or Afrocentric worldview is, according to Asante (1987), one that is

based on African cultural beliefs, practices, and values. Barker (1999) defines culture as the customs, habits, skills, arts, values, ideology, and religious behaviour of a group of people. Culture is further defined by Graham and Al-Krenawi (2003), as the totality of ideas, beliefs, values, knowledge, and a way of life of a group of people who share a certain historical, religious, racial, linguistic, ethnic, or social background.

Thabede (2008) maintains the above definitions and descriptions suggest that the Afrocentric perspective entails the need:

- for the helping professions and the related social sciences in South Africa to create space for the subjugated, marginalised African culture-based epistemologies, such as the African culture-based theories/ideas of clinical intervention,
- for the helping professions in South Africa to acknowledge the significance of African culture in providing social services to the African people,
- to accept that phenomena can be viewed from the point of view of the Africans themselves. Afrocentrism affirms the validity of the African worldview and epistemology as an alternative perspective to understanding phenomena.,
- to accommodate the Afrocentric perspectives as a significant part of the knowledge base and practice alongside current Eurocentric intervention theories and practices,
- to predicate the theory and practice of the helping professions in South Africa on African culture, so that the helping professions will reflect the worldview and cultural values of those who mostly are recipients of health services in South Africa,
- to acknowledge that African cultural knowledge is important in addressing the psychological, physical, intellectual, spiritual, and emotional needs of African people,
- to move away from foreign frameworks and notions used to analyse Africans' psychological, social, and psychosocial problems, and
- to develop a multicultural curriculum for the helping professions, with an emphasis on African culture.

Modupe (2003), elaborates that this framework seeks to advance the African's collective cognitive will, understanding their psychic and cultural origins. According to Mkhize (2003), it is relevant to give attention to how communities defined, understood, interpreted, and realized their traditions in personal experiences.

Mkhize (2003), further suggests that this perspective views the manifestations of all forms of ill health because of conflicts between the patient and other individuals, dead or alive, spirits, and the non-material forces that pervade society. Therefore, to understand the African viewpoint of chronic and other forms of diseases, it is important for one to understand the African concepts of the causes of illness (Lambo, 1965; Neki, Joinet, Hoga, Hauli & Kilonzo, 1985), as well as how different forms of illness are treated.

Mkabela (2005) maintains that Africans are known for their strong orientation to collective values, particularly a collective sense of responsibility. She believes that research has largely ignored, misunderstood, or disregarded the value of African indigenous communities' "collective ethic". This approach calls for an understanding indigenous knowledge, and in this context, healing, and African cultures, in a manner that deals with the question of African identity from the perspective of African people as centred, located, oriented, and grounded. This idea, as Asante (1987), says, conveys the profound need for African people to be re-located historically, economically, socially, politically, and philosophically.

Asante says that Africans are decentred and have essentially lost their cultural footing and become dis-located and dis-oriented. This means that we needed to find ways to ensure that the history and cultures that are at the centre of various initiatives. An example can be made of Freedom Park (2014), who took the approach of not relying on objects, text or even media in the hope that they will speak for their makers, but by involving and working with custodians of knowledge and culture. This was a way for ensuring that the living memory and knowledge of custodians, pass through the place from generation to generation, through its own holders, and by so doing, ensuring to a large extent, authenticity of the knowledge.

This is further illustrated in the diverse nature of the healing programmes and religious ceremonies that are hosted at its sacred space, Isivivane. The Cleansing and healing ceremonies, the return of the spirits as well as participation in the return and reburials of the mortal remains of those who paid the ultimate price are just but some examples. The Pan African Archives is a unique Centre for knowledge production based on the utilization of the memories of the participants in the struggle for freedom and humanity. The dynamism of the concept of the living archives emerges from the fact that all the people that participated in the struggles for freedom become potential archives of human memory that could be tapped into.

This, in plain terms, is a call for creating a context within which human solidarity becomes a lived reality and experience, a context within which the worth of human beings is determined by the content of their values and character. The researcher also moved from the premise that researchers need to be sensitive to the African worldview when dealing with African clients, because this worldview informs the way in which Africans relate to phenomena, including challenges that life presents to African clients. Another theoretical framework found to be relevant for the current study is Leininger's Sunrise model. Although this framework has been mainly associated with the nursing profession, the researcher found it applicable to the current study, especially the aspect that deal with cultural care and the social structure dimensions.

3.6. Leininger's theory of culture care diversity and universality

Globalization has brought about significant changes to societies around the world. Increased immigration has led to increasing diversity among patients, making culturally congruent healthcare an absolute necessity. Healthcare fields are expected to adopt a global practice of culturally congruent care. Thus, health care providers must acquire an in-depth understanding of cultural beliefs, practices, and differences, thus developing a practice of avoiding premature generalizations. Cultural competence models have and will continue to play a crucial role in making health care practice more efficient and effective.

Cultural factors seem to be very important in the study of indigenous healers in a transcultural society. Determining the indigenous healers' role and their actual

practices is critical for the successful integration process. Several factors have been used to describe indigenous healing in a transcultural setting. The theoretical framework that seems to provide a somewhat relevant model is the one provided by Leininger (1991), called the Sunrise model. The Sunrise model is the mechanism by which health care consumers, health institution and/ health practitioners, as well as health professionals seem to collaborate effectively provided all the factors involved are reconciled.

Cultural care models encourage culturally competent care for patients belonging to different cultures by helping health care professionals become more understanding and adaptive to various circumstances, and better able to apply culturally focused interventions. Culture care emphasizes consideration of a patient's beliefs and heritage when developing a healthcare plan.

In the nursing profession, Leininger (1991), suggests that to accomplish such goals, the model utilizes three concepts: Culture care maintenance/preservation, Culture care negotiation/accommodation, and Culture care restructuring/re-patterning. Cultural preservation refers to nurses' provision of support for cultural practices, such as employing acupressure or acupuncture for anxiety and pain relief prior to medical interventions. Similarly, cultural negotiation refers to the support provided to the patients and their family members in carrying out cultural activities that do not pose threats to the health of the patients or any other individual in the healthcare setting. Finally, cultural restructuring refers to nurses' efforts to deliver patient-centred care by helping patients modify or change their cultural activities. Cultural restructuring is suggested only when certain cultural practices may cause harm to the patient or those in the surrounding environment. The above do not only apply to the nursing profession but may be applicable to various helping or healing scenarios.

Leininger (1991) says that cultural care and social structure dimensions are influenced by multiple factors. Amongst others, are the following:

3.6.1. Educational Factors

Jackson and Meadows (1991) believe that the educational background of the specific group may affect belief systems or one's cultural worldview.

3.6.2. Economic Factors

Some indigenous healers may adjust their practices based on their financial or economic standing. For instance, currently indigenous healers' services are not covered by medical aid. This incentive could promote the practice of indigenous healing system. Some indigenous healers treat their patients on credit, for them to pay later or use any other non-cash substitute for the payment.

3.6.3. Cultural Values

Indigenous healers are the ones who fully acknowledge the idea of cultural beliefs, values and norms of each individual client or patient.

3.6.4. Kinship and Social Factors

Modern health care tends to temporarily break bonds between patients and their next of kin except in the case of a breast-feeding mother. The traditional healer accepts the family to come and stay with their patients throughout and give help and care, this includes the family in the teamwork.

3.6.5. Need for Collaboration

The theoretical framework the two services (traditional and modern) need to merge to complement each other for the benefit of the health care consumers.

3.6.6. Need for Communication

There should be a two-way communication style for both indigenous healers and health professionals. It will then be necessary for them to consider each other services and promote referrals to and from.

3.6.7. The Appropriateness of Leininger's Model

The Sunrise model by Leininger (1991), is quite suitable for the study because it deals with some of the critical areas that may act as confounding variables.

3.6.8. Awareness

The level of knowledge or cognizance regarding indigenous healing as health care delivery system is essential for determining the extent to which people utilize these services.

3.6.8. Collaboration

The partnership among the community members and those practicing indigenous healing needs to be explored. The stronger the association, the more frequent would be the utilization of these services.

3.6.9. Acceptance

One of the principles of primary health care include the notion of acceptance. affirmation, deference, or compliance is essential for the traditional healing process to be effective and acknowledged as significance.

3.6.10. Legalization

The state has the obligation to determine the lawfulness or validity of such healing system. Once this has been deemed permissible then an authoritative structure will through a judicial system provide license for practicing.

This theory of culture care diversity and universality addresses clients as ‘humans’ who are ‘cultural beings’, having survived through time and place because of their ability to care for infants, young and older adults in a variety of environments and ways (Fitzpatrick & Whall, 2005). Viewing humans as cultural beings supports the idea that humans cannot be separated and understood apart from their cultural background. Humans need to be viewed and understood in their context; and culture is the broadest and more holistic perspective that allows this perspective.

For Leininger (1991), the contextual aspects in which individuals and cultural groups live are important. These aspects include physical, ecological, social and world view features and all other immediate factors that influence their lifestyles. Human behaviour, therefore, is meaningful only within specific environmental and cultural contexts.

Leininger (1991) further states that all human cultures had some forms, patterns, expressions, and structures of care to know, explain and predict well-being, health, or illness status. Cultural values and beliefs are thus held to be the strongest and most powerful predictors of health and care patterns of individuals, families, and communities (Fitzpatrick & Whall, 2005).

Health is thus more than just the absence of disease. It refers to beliefs, values and action patterns that are culturally known and used to preserve and maintain personal or group well-being and to perform daily role activities. According to Leininger’s theory, health is embedded in the social structure and must be abstracted from this frame of reference.

Leininger’s theory of transcultural care diversity and universality provides a unique conceptual, theoretical, and research approach and was found to be appropriate in this study as participants come from different cultures with different world views about health and illness. Furthermore, this theory fit perfectly with Afrocentricity, and the two were found to complement each other very well.

From the above two theoretical frameworks, there is an acknowledgement that health is more than just the absence of disease and that health is embedded in the social

structure. Furthermore, African indigenous knowledge systems are placed into focus as a legitimate field of academic enquiry. However, none of these focus on the social aspects in the treatment process, especially where aspect such as rituals are concerned. The current study, therefore, focused on addressing this gap.

3.7. Concluding remarks

The chapter provides a conceptual framework, which assembled relevant themes to organize intellectual information to various events and behaviours in a narrative form. The variables that have been discussed, among others, include cultural values, kinship and social factors and the legal factors that are borne out of theory and experience.

Although this study focuses on the socio-cultural aspects pertaining to HIV, there is a parallel challenge to engage in further research studies that will investigate how the worldviews of other population groups in South Africa can be aspects of the worldviews that inform the recognition and integration of indigenous healing in South Africa.

CHAPTER 4: RESEARCH METHODOLOGY

4.1. Introduction

This Chapter presents the description of the research process and information concerning the method that was used in undertaking this research as well as a justification for the use of this method. The chapter also describes the various stages of the research, which includes the selection of participants, the data collection process, and the process of data analysis as well as tools and techniques upon which the entire research is based.

These include the data collection methods, instruments, sampling and sample size, procedure used to collect data, and methods for data analysis. The information on the participants, that is, the criteria for inclusion in the study, who the participants were and how they were sampled is also included. The section also highlights a brief description of the geographical location/setting where the research was conducted. The researcher concludes with a brief overview of ethical issues that were considered in conducting the study.

4.2. Study design and implementation

This research is exploratory in nature as it attempts to explore the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of HIV. The Indigenous healers' subjective perceptions and understanding formed the core data of the study; hence, it needed the method that would deal with the topic in an exploratory nature. An exploratory approach was chosen as there is limited prior research done, and because the existing ones do not answer the research problem precisely enough. The approach also offers a lot of flexibility and can adapt to changes as the research progresses (Swaraj, 2019). This is what the researcher wanted since research in indigenous healing requires flexibility to be led by the pace of the participants, which is important to acquire authentic information. Finally, the findings of this study will assist future researchers to study the problem in detail.

4.2.1. Research design

In this study, a qualitative approach was adopted, using semi-structured interviews, which will be discussed later. Qualitative method is considered as the appropriate paradigm to learn more about the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the HIV in the Vhembe District, Limpopo Province. Leedy (1993), suggests that qualitative research is based on the belief that first-hand experience provides the most meaningful data. Qualitative data gives large volumes of quality data from a limited number of people. According to Walker (1985), qualitative research is aimed at understanding the world of participants from their frame of reference.

During this process, the researcher was in continuous interaction with the participants to discover the participants meaning of their life world, as recommended by Mashego (2000), and Neuman (2000). Berg (1995) states that qualitative researchers are mainly interested in how humans arrange themselves and their settings and how the inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, and social roles. Qualitative researchers also share the understandings and perceptions of others and explore how people structure and give meaning to their daily life.

Mouton and Marais (1992), argue that a major distinguishing characteristic of qualitative research is that the researcher attempts to understand people in terms of their own definition of their world. Qualitative researchers also focus on the insider-perspective, rather than the outsider-perspective. Mouton (2001) indicates that this approach is sensitive to the contexts in which people interact with each other. Dyer (1995) argues that by using qualitative approach, a researcher can capture information, which might be difficult, or impossible to express by quantitative means. For example, understanding the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus is descriptive and entails subjective information.

4.2.2. Philosophical Approach in Qualitative Research Method

The understanding and choice of a paradigm sets the tone for the research and influence the choices regarding the methodology, methods, literature, or research design (Mackenzie & Knipe, 2006). Qualitative method explains the social world in terms of overt behaviour because each behaviour or action carries meaning which needs to be explored. Qualitative researchers see people and contexts as being shaped by the norms and conventions of the society. These norms, conventions, and social institutions find their final form in cultural and belief systems. This is important because people's personal and social meanings cannot be treated as a statistical variable. This approach is subjective because it focuses on how the respondent experiences and understand the situation. Therefore, the researcher adopted the qualitative method for this study.

Qualitative methods also allow the researcher to understand how the respondents perceive their situation and their role within this context. When researchers undertake a qualitative study, they are in effect agreeing to its underlying philosophical assumptions, while bringing to the study their own worldviews that end up shaping the direction of their research. Creswell (2012), describes the following four philosophical assumptions:

- **Ontological - The nature of reality:** This relates to the nature of reality and its characteristics. In this scenario researchers embrace the idea of multiple realities and report on these multiple realities by exploring multiple forms of evidence from different individuals' perspectives and experiences. In this context, the researcher wanted to understand the philosophical and social aspects related to the treatment of HIV/AIDS by indigenous healers.
- **Epistemological - How researchers know what they know:** Researchers try to get as close as possible to participants being studied. Subjective evidence is assembled based on individual views from research conducted in the field. The researcher in this study used semi-structured interviews, participant observation to gather information and understand the phenomenon being studied.

- **Axiological - The role of values in research:** Researchers make their values known in the study and actively reports their values and biases as well as the value-laden nature of information gathered from the field.
- **Methodology - The methods used in the process of research:** inductive, emerging, and shaped by the researcher's experience in collecting and analysing the data.
- **Cosmology-** Most Africans continue to draw most of their values from a traditional cosmology. Africans acknowledge that people have a history and culture that forms a pedestal in which they can address issues of value and meaning of life as well as their position in the world. African indigenous religions strongly influence matters related to health and well-being, and these give people a sense of purpose and direction in their daily lives. African cosmology is the way Africans perceive, conceive, and contemplate their universe. This is the lens through which they see reality, which affects their value systems and attitudinal orientations. African Cosmology is the African's search for the meaning of life Kanu (2013).

Chilisa (2019) suggests multiple ways that Indigenous research can be linked to, among others, ethics, methods, cultural responsiveness, participatory research, and postcolonial research paradigms. She also argues that Western knowledge disconnects relationships between researchers and communities and asserts that Indigenous research is about finding connections. Chilisa further encourages researchers to avoid, in their research, perpetuating self-serving research paradigms that constructs Western ways of knowing as superior to the Other's ways of knowing.

4.3. The qualitative and quantitative approach

Qualitative research is research that produces findings not arrived at by means of statistical procedures or other means of quantification (Hughes, 1990). Qualitative data can be collected through interviews, focus groups, observation, or review of documents. On the other hand, quantitative research is research that produces data that can be statistically analysed and whose results can be expressed numerically. Surveys using structured questionnaires and IQ tests are both examples of quantitative research (Huberman & Miles, 2002). Another choice was

whether to adopt a quantitative or qualitative approach, or some mix of the two. Many authors (Cavaye, 1996; Darke, et al., 1998; Hussey & Hussey, 1997; Lee, 1991; Miles & Huberman, 1994; Myers & Avison, 2002), have written about the factor influencing the choice between qualitative and quantitative methods in fieldwork (empirical) research.

Myers and Avison (2002), distinguish between qualitative and quantitative research methods. They suggest that quantitative research methods were originally developed in the natural sciences to study natural phenomena. Examples of quantitative methods now well accepted in the social sciences include survey methods, laboratory experiments, formal methods (e.g., econometrics) and numerical methods such as mathematical modelling. On the other hand, qualitative research methods were developed in the social sciences to enable researchers to study social and cultural phenomena. Examples of qualitative methods, as suggested by Myers and Avison (2002), are action research, case study research and ethnography. Qualitative data sources include observation and participant observation (fieldwork), interviews and questionnaires, documents and texts, and the researcher's impressions and reactions.

The selection of a qualitative approach also fits well with Hussey and Hussey's views (1997:12), who defined qualitative research as, "a subjective approach, which includes examining, and reflecting on perceptions in order to gain understanding of social and human activities." Hughes (1990), suggest that qualitative research produces findings not arrived at by means of statistical procedures or other means of quantification. Qualitative data can be collected through interviews, focus groups, observation, or review of documents.

On the other hand, quantitative research is research that produces data that can be statistically analysed and whose results can be expressed numerically. Surveys using structured questionnaires and IQ tests are both examples of quantitative research (Huberman & Miles, 2002). Another choice was whether to adopt a quantitative or qualitative approach, or some mix of the two.

4.3.1. The qualitative approach

Mason (2002), believes that through qualitative research, we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings they generate. We can do all this qualitatively by using methodologies that celebrate richness, depth, nuance, context, multidimensionality, and complexity rather than being embarrassed or inconvenienced by them.

Borg, Gall, and Gall (1993), and Mcmillan (2000), elaborate that a qualitative research approach is associated with the study of behaviour as it occurs and provides an in-depth understanding of context and behaviour. They say the focus is on how and why behaviour occurs as well as the participants' understanding and meaning they assign to this. The current study focused on participants' understanding and meaning that they assign to the performance of rituals during the treatment of HIV/AIDS.

Furthermore, in the collection of data, a qualitative method of design was adopted since the aim of the study was to learn more about the phenomenon in question (The Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus (HIV) in the Vhembe District, Limpopo Province.). Banister, Burman, Parker, Taylor, and Tindal (1994), indicate that qualitative research is: (a) an attempt to capture the sense that lies within, and that structures what we say about what we do, (b) an exploration, elaboration, and systematization of the significance of an identified phenomenon, and (c) an illuminative representation of the meaning of a delimited issue or problem.

Berg (1995) indicate that qualitative researchers are mainly interested in how humans arrange themselves and their settings and how the inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, and social roles. Qualitative researchers also share the understandings and perceptions of others and explore how people structure and give meaning to their daily life. Mouton and Marais (1992), argue that a major distinguishing characteristic of qualitative research

is that the researcher attempts to understand people in terms of their own definition of their world.

Qualitative researchers also focus on the insider-perspective, rather than the outsider-perspective. Mouton (2001) indicates that this approach is sensitive to the contexts in which people interact with each other. Dyer (1995) argues that by using a qualitative approach, a researcher can capture information, which might be difficult, or impossible to express through quantitative means. For example, the way indigenous healers perceive, understand, and interpret the significance of socio-cultural aspects of the performance of rituals in the treatment of HIV/AIDS is descriptive and entails subjective information. These considerations served as guidelines for adopting this method for the current study.

4.3.2. Rationale for using the qualitative approach.

International debates suggest that the 'qualitative-quantitative' terms represent what Kuhn refers to as the paradigm clash (Rennie, 1995). Qualitative and quantitative research could be viewed as representing two paradigms, each historically assuming different ontologies and epistemologies. A paradigm in this sense refers to what Cornblentz (1991), suggest as our working assumptions of the world, how we know and respond to it. If we separate the levels relating to paradigms, methods, techniques, then the methods and techniques are compatible (Mouton, 1996), regardless of the paradigm they might have originated from or be associated with. For example, methods can be triangulated (Durrheim & Wassenaar, 1999). One approach can facilitate the use of the other approach or different approaches can be used to complement each other.

Central to this study was to explore into the lived experiences of participants as they relate to the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the HIV/AIDS in a particular cultural setting. Through the interpretivist tradition the researcher was able to gain an in-depth understanding of participants 'lived experiences or as Creswell (1998), suggests, to gain insight of the world of human experience.

Furthermore, the literature presented in the literature review chapter suggests that the Socio Cultural and Philosophical Importance of Medicine used the Management of HIV/AIDS is relative to cultural contexts. More so, rituals associated with the management of HIV/AIDS are shaped by people 's belief systems and cultural practices (Breen & O 'Connor, 2007; Rando, 1993; Eyetsemitan, 2002; Laurie & Neimeyer, 2008; Radzilani, 2010).

Therefore, this supports Lincoln and Guba 's (1985), five major assumptions about the qualitative paradigm; that is, there are multiple constructed realities, knowledge is both context and time dependent. Hence, the researcher employed the qualitative paradigm to explore into this area of philosophical importance of rituals related to management of HIV/AIDS in a new context, which previous studies have not covered.

Qualitative research is essentially concerned with observation and experience, and it is for this reason that it was adopted as a suitable approach for the current study. Furthermore, some have suggested that qualitative research is pivotal to our understanding of the socio behavioural aspects of HIV disease (Robert, 1998).

The traditional quantitative concept of reliability rests on the assumption of stability, rather than change in subject matter (Evans, 2001). However, when conducting qualitative research, we focus on, and articulate the process of change (Parker, 1997). This is buttressed by Wolcott (1990), who asserts that qualitative researchers seek to understand a world that is continuously being constructed, not a ready-made one, and these have implications for the entire process.

Qualitative research has been described as the interpretive study of a specified issue or problem in which the researcher is central to the sense that is being made (Parker, 1994). Therefore, what is now commonly called qualitative research can be traced to Dilthey, who in 1883 argued that the human being (especially the psyche) is qualitatively different to the subject matter of the natural sciences, which is physically and materially measurable. The realization that Psychology, as an empirical science, which aims to predict and control behaviour, is inappropriate for the subject matter is also gaining recognition among South African academics (Durrheim, 1997). However,

qualitative psychological research has often been marginalized as a valid means of knowledge production.

Qualitative methods explain the social world in terms of overt behaviour because each behaviour or action carries a meaning, which needs to be explored. The researcher in the present study wanted to understand the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus. Specifically, why the performance of rituals is so important during the treatment of HIV. Qualitative researchers see people and contexts as being shaped by the norms and conventions of society. These norms, conventions, and social institutions find their final form in cultural and belief systems. This is important because as alluded somewhere in this section, people's personal and social meaning cannot be treated as a statistical variable. In addition, this approach focused on how the respondents experience and understand the significance of the rituals.

Qualitative methods also allowed the researcher to understand how the respondents perceive their situation and their role within this context. This method also helped to find out why the behaviour occurs or why people hold certain views. The data also consists of descriptions of people and of conversations. The qualitative approach was deemed relevant for the present study because the researcher wanted to find out why it is important to perform certain rituals before, during and after treatment of HIV symptoms.

4.3.3. Uses of Qualitative research

Qualitative research is often the only method used when the aim is to get an in-depth sense of what people think of a particular object or event. This can be as part of a process to establish some form of action or campaign in a community. In this study, the researcher wanted to gain an in-depth understanding of the Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the HIV. Qualitative research can also be used along with other types of research to get an additional perspective on the problem. Furthermore, it can also be used on an explanatory basis to establish hypotheses for future research.

Ragin (1994) maintains that qualitative research often involves a process of reciprocal clarification of the researcher's image of the research subject, on the one hand, and the concepts that frame the investigation, on the other. These images are built from cases, and sometimes by looking for similarities among several examples of the phenomenon that seem to be in the same general category. Furthermore, because of its emphasis on in-depth knowledge, the qualitative approach gives voice, interprets historical or cultural significance as well as advancing a theory.

Ragin (1994) further indicates that there are many groups in society that are called marginalized groups, who are outside society's mainstream and often they lack voice in society. Their views are not usually heard and if they are, often they are misrepresented. Therefore, techniques that can help identify subtle aspects and features of these groups can go a long way toward helping researchers to construct a better representation of their experiences. Qualitative approach also makes us pay closer attention to historical detail in the effort to construct new understanding of culturally or historically significant phenomena. For example, the issue of indigenous healing is both cultural and historical, and has often been suppressed and therefore, needs a new understanding in the wake of HIV/AIDS. Indigenous healing as a field is also fraught with criticisms and marginalization in favour of modern approaches to health problems. Therefore, qualitative approach becomes an appropriate method of studying this phenomenon.

In-depth knowledge that is gained through the qualitative approach provides rich raw data for advancing theoretical ideas. The initial goal of knowing as much as possible also eventually gives way to an attempt to identify the features of the case that seem most significant to the researcher and her questions. This in-depth knowledge also assists in elaborating concepts such as commitment and for direct examination of the connections among the phenomena that the researcher believes illustrate and elaborate the concept. The emphasis on commonalities that exist across cases in the qualitative approach also helps in advancing the theory.

Qualitative research is an analysis of words, and images rather than numbers. It is a

preference of meanings rather than behaviour, that is, it attempts to document the world from the point of view of the people being studied (Harmmersley, in Silverman, 2000). In other words, the qualitative approach is a preference inductive, hypothesis-generating research, rather than hypothesis testing (Glasser and Strauss, 1967). Therefore, in this study a qualitative approach was adopted to gain a cultural or contextual understanding of rituals and HIV/AIDS, which has a bearing on the treatment procedure.

Silverman (2000) believes that qualitative research is stronger on long descriptive narratives than on statistical tables. However, there are few concerns about qualitative research. Firstly, the mechanisms that a researcher adopts to categorise the events or activities described is not clear, the issue of reliability, which can be defined as the degree of consistency, also poses some challenges. Secondly, even when the people's activities are tape-recorded and transcribed, the reliability of the interpretation of transcripts may be seriously weakened by failure to record apparently trivial, but often crucial, pauses and overlaps.

To address the above concerns, the researcher adopted phenomenography, as developed by Marton (1986). Phenomenography is the empirical study of the different ways in which people think of the world. In other words, its aim is to discover the qualitatively different ways in which people experience, conceptualize, realize, and understand various aspects of phenomena in the world around them (Martin, et al., 1992). In phenomenographic research, the researcher chooses to study how people experience a given phenomenon, and not to study a given phenomenon. Marton (1986), and Booth (1997), support the view of phenomenography as the ways of experiencing different phenomena, ways of seeing them, knowing about them, and having skills related to them. The aim is, however, not to find the singular essence, but the variation and the architecture of this variation by different aspects that define the phenomena (Walker, 1998). This is what guided the current research.

4.4. Research setting and the participants (selection of cases)

The participants consisted of sixteen indigenous healers from the Vhembe District municipality in Limpopo Province. The Vhembe District Municipality, with its headquarters in Thohoyandou, was established in 2000, through the process of transformation of Local Government. It was established in terms of South Africa's Municipal Structures Act 117 of 1998 as a demarcated sphere of governance. The Vhembe District Municipality is a sphere of Local Governance. It is a constitution's third sphere of government after the national and provincial tiers. It derives its mandate primarily from the constitution and enabling acts of parliament and regulations. It remains an independent sphere of government within the inter and intra governmental context of relations. The district municipality hierarchically exists between provincial governments and local municipalities.

4.4.1. Location

The study was conducted in the Vhembe District Municipality region in the Limpopo Province of the Republic of South Africa. The Vhembe District municipality is one of the five districts of Limpopo province of South Africa. It is located at the Northwestern tip of South Africa in the Limpopo Province. The district consist of all territories that were part of the former Venda Bantustan and two of the large densely populated districts of the former Tsonga homeland of Gazankulu, in particular, Hlanganani and Malamulele were also incorporated into Vhembe, which explains the ethnic diversity of the District.

The district is bordered by Zimbabwe to the north and Botswana to the northwest. The Limpopo River valley forms the border between the District and its International neighbours. Through the Kruger National Park, the Vhembe District also Borders Mozambique on its Eastern border. Within South Africa, the Kruger National Park to the east, the Mopani District to the Southeast, and the Capricorn District to the Southwest border the Vhembe District. Furthermore, the district is composed of four local municipalities, namely, Makhado, Musina, Thulamela, and Collins Chabane, which are category B executive municipalities. The district covers 27 969 148 square

km of land with total population of about 1 393 949 people according to Stats SA, 2016 Community Survey.

The majority (55%) of the residents of the Vhembe District Municipality are women. In each of the four Local Municipalities, most of the total population per municipality is female: Musina (52%), Collins Chabane (55%), Thulamela (55%), and Makhado (55%). The average number of Men to Women, across age groups, is the same as that of the District in the Makhado and Mutale Local Municipalities (0.7). There is a higher average ratio of Men to Women in Musina (0.9) and a lower one in Thulamela (Vhembe IDP, 2022/2023).

4.4.2. Population Demographic for Vhembe District Municipality

The table below provides the breakdown of the Vhembe population per group. This assists in providing the context within which the study is located.

POPULATION PER GROUP						
Municipalities	Black African	Coloured	Indian/Asian	White	Other	Total population
Musina	127621	337	406	3645	-	132009
Makhado	406543	1308	1843	7024	9	416727
Thulamela	493780	749	2479	229	-	497237
Collins Chabane	347109	294	301	271	-	347975
Vhembe	1375053	2689	5029	11170	9	1393950

Source: Stats SA, Community Survey, 2016

Table 4.4.2 above shows that the majority population group within the district is the Black African population (1 375 053) followed by 11170 white, 5029 Indian/Asian and 2 689 coloured which is the lowest population within the district. This means that the district is dominated by Black African population, which is likely to consult Indigenous healers.

4.4.3. Households Trends in Vhembe District Municipality

The table below shows that most households are headed by women, which means that they are decision makers, not only in health issues but every other aspect within the household.

Number of households per municipality			
Municipality	Male Headed Households	Female Headed Households	Total
Musina	24764	18966	43730
Thulamela	64593	65728	130321
Makhado	59387	56984	116371
Collins Chabane	38634	53302	91936
Vhembe	187378	194980	382358

Source: Stats SA, Community Survey 2016

The above table is important in that within the indigenous healing set up, the treatment, healing process, which includes the performance of rituals, is facilitated within the homesteads and households, as opposed to hospital or health care centres. Therefore, the above households become potential centres for the expression and ritual practices.

4.4.4. History, Heritage, and Culture

The name 'Vhembe' has been chosen amongst several suggested names for the district. Vhembe is a Venda name for what is also known as the Limpopo River. In essence, Vhembe means Limpopo River. The name Vhembe symbolizes a fountain of life. This is captured in the Venda legend which says "Vhembe yo alama, yo ela, yo beba vhana vhayo"(Vhembe River has laid wide like an ocean, flowing, and giving rise to its children) (Vhembe IDP, 2019/2020).

Vhembe comprises of many different cultures. Namely:

- English
- Afrikaans

- Venda
- Tsonga
- Batlokwa
- Indian/Asian
- Coloured

The Vhembe region became the Vhembe Biosphere Reserve in 2009, which was officially declared a biosphere reserve in 2011 (Evans, 2017). The reserve includes the Blouberg Range, the Kruger National Park, the Makgabeng Plateau, the Makuleke Wetlands, the Mapungubwe Cultural Landscape and the Soutpansberg. It is famous not only for its bird and for animal life, but for its rich cultural history, dating far back to the awe-inspiring rock paintings of the San people. Vhembe encompasses the ancient African kingdoms of Thulamela and Mapungubwe. The latter is one of South Africa's eight world heritage sites and was inscribed on the UNESCO list in 2003.

Economy in the region is driven mainly by agriculture. As it falls into the subtropical belt of the country, crops are usually fruits and vegetables. There is also a substantial cattle-farming industry. In general, the Vhembe LED Strategy depicts that, the district economic growth potential is in Agriculture, Tourism and Mining (Vhembe IDP, 2022/2023).

4.4.5. Health Services

The Vhembe District has functional six District hospitals, 01 Regional hospitals, 01 Specialized hospitals, 115 Clinics, 8 Community Health Centres and 19 mobile clinics. Eight (08) District hospitals are offering first level of care and one (01) Regional hospital offers secondary level of care. Outreach health service is provided by the mobile clinics to the community. Municipal Ward Based Outreach Teams provide health promotion, support, and follow up to patients in the communities. All PHC facilities are providing comprehensive Primary Health care package. All clinics have good communication system and as well access of internet connectivity. Facilities have supply of electricity, clean water, and good sanitation. The total number of clinics providing Primary Health care services for 24 hours on call system is sixty (60). Eight (8) Community Health Centre and five (5) clinics provide 24 hours' service straight shift

(night duty). Central Chronic Distribution and Dispensing of Medicine (CCMDD) is implemented in 123 clinics and 23 private pick-up points (Vhembe IDP, 2022/2023).

However, despite the existence of this infrastructure, many people still value and consult indigenous healers, either as the primary source of health care provision or to offer a second opinion. Furthermore, there is also reported shortage of health care facilities, or poor infrastructure, and long distance, which may influence people to opt to consult indigenous healers, as they are readily available within communities. Some of the key challenges identified are as follows (Vhembe IDP, 2019/2020):

- Poor or bad roads to access some of the health facilities.
- No sheltered structures in some mobile clinic visiting points.
- Shortage of Professional and support staff.
- Infrastructural challenges compromise the provision of quality primary health care services.
- High level of crime where armed robbery and burglary occur in health facilities, which affect the provision of 24 hours' services to the community.
- Communal water not connected to the clinic and clinic depends on water from boreholes.

Some of the above challenges have led to many community members rather going to indigenous healers for treatment of various ailments. This is in line with Krah, de Kruijff & Ragno (2018) who found that biomedical health care system continues to face profound challenges, and that the primary challenge is its accessibility, particularly in smaller rural communities. The same could be said about Vhembe District, which is also largely rural with limited access to health care as indicated elsewhere in this study.

4.4.6. Land cover/ Flora and Fauna

The Vhembe area has amazing biological diversity of flora and fauna; this rich biodiversity can be attributed to its biogeographical location and diverse topography. The district falls within the greater Savanna Biome, commonly known as the Bushveld with some small pockets of grassland and forest Biomes. These and other factors have produced a unique assortment of ecological niches, which are in turn occupied by a wide variety of plant and animal species. The area is comprised of the Mountain

Fynbos, Sacred Forests as well as centuries old Baobab Trees (Vhembe 2019/20 IDP Review).

Vhembe 2019/20 IDP Review further states that there are large extensive areas within the Vhembe District that are conservancies' areas among others the Natural Protected area within the district includes the Kruger National Park (Pafuri and Punda Maria Gates in Musina and Collins Chabane Local Municipalities respectively), Makuya Park, which is part of the Kruger National Park. There is also a Mapungubwe National Park in Musina Local Municipality, which is also known as the World Heritage Site.

The Vhembe Biosphere Reserve in Makhado municipality is declared conservation area by UNESCO. The Biosphere Reserve provides a habitat to a diverse number of species including those that are on the brink of extinction. The Biodiversity of the Vhembe District is a strategic resource in nature, which provides the district communities with a lot of potential mostly in rural areas. It provides materials for shelter, food, fuel wood as well as medicinal plants (DEDET, 2006). The district Fauna and Flora is under some enormous pressure primarily due to uncontrolled development activities, which also protrudes to the sensitive ecosystems thereby negatively affecting even the endangered species that are on the brink of extinction.

4.4.7. Rationale for choosing the Research Site

Born and bred in the area, the researcher is familiar with both the languages and cultures of the inhabitants of these areas. Most of the population lives in rural villages and still practice their cultural activities and diverse rituals. The indigenous healers selected were recommended by their peers through their organization, the Vhembe traditional Healers Association. The healers are also well recognised and respected in these communities (Mufamadi; 2001).

Furthermore, the Vhembe region has, according to its IDP Plan (2019/2020), real, authentic, and mostly un-spoilt resources and has real people, real animals, real live culture, and historical sites that hold the myths and legends of the ancestors and forefathers. Vhembe is also rich in cultural activities and has more than 70 heritage and cultural attractions, a sign that culture and indigenous knowledge still play a crucial

role. Against the above factors, the area was considered reasonable research site for the present study.

In the Vhembe district, most people still believe in indigenous knowledge systems, and it is widely practiced in rural areas. Indigenous healers are the first to be visited whenever people do not feel right or if they have some personal problem. Indigenous healers treat various diseases including those that may be incurable in hospitals. This study will contribute to the knowledge base and understanding of why rituals and other socio- cultural aspects are important. The cultural, social, and philosophical facts about the rituals will properly be contextualised as the study was conducted in the healers' environment, culture, and society.

4.4.8. Integrated HIV/AIDS Plan

The Vhembe IDP Review (2019/2020), states that the Integrated HIV/AIDS Draft Strategy for Vhembe District Municipality is a planned response of the district municipality to alleviate effects of HIV and AIDS in the District. It is an integrated approach in that it seeks to encompass the collective efforts of various organizations in the district that have chosen to respond to the challenge of HIV/AIDS. In furthering the principle of integration, the plan also insists on soliciting the commitment of other organizations and individuals that may have the potential to make a difference but not committed.

The plan is holistic and comprehensive in as far as providing a wide span of services and in providing the quality of services that is determined by the beneficiaries. VDM has and will continue to consult with stakeholders on the strategy and do so again during its implementation. VDM believes that its role is to coordinate the different facets of responses to HIV/AIDS and to provide leadership towards achieving the goal of conquering HIV/AIDS through the AIDS councils. The municipality (Vhembe IDP Review, 2019/2020) has also committed to review the Strategy regularly to remain current and relevant in their response to the epidemic. Amongst others, the municipality wants to:

- Expand HIV/AIDS Legal & Human rights.

- Introduce education and promotion of HIV/AIDS rights.
- Improve access to justice by HIV/AIDS patients.
- Improve Research, Monitoring, Evaluation, and surveillance.
- Improve management of information and communication.

4.4.9. Implementation status

VDM is focusing on the co-ordination of programs that are spearheaded by sector Departments, Non-governmental organizations. District Aids Council, Vhembe District Health Council, and the Vhembe District Home Based Care Forum, are the relevant structures which ensures that implementation can be realized in the whole District. The following programs are done by District together with the relevant stakeholders namely:

- Awareness campaigns on HIV and AIDS.
- Workshops of Home-based care on Management skills, budget, health and hygiene, Communicable and non-communicable diseases in the district.
- Assisting the Department of Health and Social Development in the adjudication of the NGOs regarding the funding process.
- Running all the meetings of health council, Aids council and home-based care forums.

From the above activities by the municipality, there is no collaboration with indigenous healers or an attempt by the municipality to understand this sector and how they manage HIV/AIDS. The findings of this study will, therefore, provide insight in the understanding of the role that indigenous healers play regarding the management of HIV/AIDS as well as the socio-cultural aspects related to their treatment procedures.

4.5. Sampling

Having identified the research site for research, the researcher moved to consider the items of sampling. As suggested by Kruger (1988), the following guidelines were followed in choosing the participants: (a) Participants should have an understanding

of the socio cultural and philosophical Importance of rituals. (b) Participants should speak the same language as the researcher since this will limit the possible loss of semantic nuances resulting from translating textual material from one language to another. As a resident of the Vhembe District municipality, the researcher can fairly speak and understand the languages and culture within the region.

Sixteen indigenous healers were identified as respondents through purposive sampling. As reflected in Neuman (2000), the focus of the qualitative researcher is more on the selected participants' ability to clarify and deepen the understanding of social life than its representativeness. Furthermore, as qualitative research, the researcher was more concerned with obtaining cases that can enhance her learning process about social life in a specific context, and that is the reason why I used a non-probability sampling method.

The rationale for selecting sixteen is that this study is partly an ethnographic participant observation, whereby the researcher also spent time observing and learning about the phenomenon under study. Furthermore, the approach adopted was also based on the concept of information power and sample specificity, whereby those with more information and experience were chosen. While issues like gender, culture and tribe were considered, the primary focus was on experience of the healer rather than ethnicity or gender.

In this study, participants were chosen according to their relevance to the research topic because the aim was to gain a deeper understanding rather than to generalise to a larger population (Neuman, 2000). The researcher followed a purposive non-probability sampling. This implies that the researcher only interacted with experts who are informative and work within the area being studied to get relevant information. Neuman further indicated that this method is mostly useful in exploratory research of a difficult to reach group as the researcher uses the locations she knows to access to suitable cases. For this study, the researcher adopted this approach because the issue of understanding the significance of rituals is rarely a focus for many studies.

The researcher relied on her own judgment when choosing members of the population to participate in the study. This approach was effective because only a limited number

of people could serve as primary data sources due to the nature of research design and aims and objectives. The researcher approached the leader of a local association of indigenous healers, whom after interviewing, was requested to refer the researcher to other healers who specialize in treating HIV/AIDS. Through this approach, the process also became a snowball or chain referral method as those with information under study were also requested to act as informants and to identify other members that would be relevant to the study.

4.6. Inclusion criteria

The inclusion criteria identify the study population in a consistent, reliable, uniform, and objective manner. On the other hand, the exclusion criteria include factors or characteristics that make the identified population ineligible for the study. Establishing inclusion and exclusion criteria for study participants is a standard, required practice when designing high-quality research protocols (Patino & Ferreira; 2018). Inclusion criteria are characteristics that the prospective participants must have if they are to be included in the study. Inclusion criteria are defined as the key features of the target population that the researcher will use to answer their research question. In contrast, exclusion criteria are those characteristics that disqualify prospective subjects from inclusion in the study. In other instances, exclusion criteria may include features of the potential study participants who may meet the inclusion criteria but present with additional characteristics that could interfere with the success of the study or increase their risk for an unfavourable outcome.

Some of the factors considered for inclusion in this study included the following about participants:

- The participants had to be residence of the Vhembe District Municipality
- They had to have had an experience in treating a person with HIV/AIDS using indigenous methods.
- They should understand the socio cultural and philosophical importance of rituals in traditional medicine:

- Participants should fit within existing categories in the target population as specified by the research questions.

Those without the above were excluded as potential participants in the study. This is due to the fact that the researcher wanted participants who not only had the practical experience and understanding of the local belief systems, but also, participants who would offer an insider perspective on the subject of the study.

4.7. Procedure

The preliminary contact was made with the Secretary of the Vhembe Traditional Healers Association. The letter sent out to him explained the research aims to them and requesting assistance with obtaining a list of indigenous healers who are known to treat HIV. Before each participant could be engaged in the interview, a brief overview of the study, the purpose, ethical aspects, and the nature of the interview were explained. The participants were then given the consent letter and form to read through and sign (See Appendices) The researcher firstly informed the participants about the purpose of her interviews.

To establish rapport, the participants were told that their names had been suggested by their own colleagues (thus mentioning the name of the colleague(s) who recommended them as experts in the healing field) and thus making them suitable participants for the research. The interviews were mostly conducted in local languages and then translated into English. The protocols were read again to ensure that objectivity is maintained and that there was no loss of information due to the process of translation.

Some interviews were conducted in the homes of the participants while others were conducted at the home of the patients where the rituals were taking place. This was at the invitation of the participants.

The researcher also considered what Windchief, Polacek, Munson, Ulrich & Cummins (2018) suggest that working with communities must demonstrate a level of

commitment, responsibility, and respect for community values as a whole. They further propose that research within Indigenous communities must be done in a way that centres indigenous paradigms to the degree that it is done in multiple Indigenous languages, thus asking questions, and finding answers that are relevant to Indigenous communities. This is supported by Mbah, Leal Filho & Ajaps (2022), who posit that there is a need to articulate, as well as bring to the nexus of research, a decolonising perspective in research design and practice. This is what guided the current study.

4.8. Data collection

Data was collected from the indigenous healers by means of semi-structured individual interviews, field notes, and modified participant observation. Although the researcher prepared a list of questions, these were merely used as a framework for conversation. Furthermore, the researcher participated during the performance of certain rituals by indigenous healers. Thus, a two-pronged approach to knowledge acquisition and synthesis was used for this study.

4.8. 1. Data collection techniques

For this study, the researcher used semi-structured in-depth interviews as tools for data collection, which involved both direct questioning and the observations of the rituals being performed. In other instances, the researcher was asked to partake in the group rituals. In instances where the researcher was granted permission to observe or participate in the rituals, permission to record was not granted as this is considered the most sacred aspects healing. The rest of the data collected was recorded and stored using digital audio recorders with the permission of the study participants. All the interviews were conducted in Tshivenda and audio recorded. This was later translated to English. This did present with minor challenges in capturing the multi-faceted cultural connotations in translating cultural rituals. This difficulty is not uncommon in African rituals research as many of the terms or phrases referring to rituals and ceremonies are difficult to translate directly. An example of this can be seen in the phrases, 'malombo and nowa yo kumeliwa' or 'nowa yo hambeliwa', 'u rerela' and 'midzimu ya thohoni', used by several healers in describing some of the rituals and concepts used in healing. The researcher decided to use these concepts,

as they are so as not to lose or dilute their meanings. The researcher also found that semi-structured interviews afforded participants the opportunity for further input and explanation of specific cultural rituals.

Semi-structured interviews provided an opportunity for exploration of specific aspects of the research focus. They also provided the researcher with an opportunity for optimal collection of data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics were being explored. Furthermore, since this is an exploratory study, the use of a semi-structured interview allowed the researcher some flexibility in the way she worded the questions for each individual participant. This also gave the researcher the opportunity to probe for more information and clarification where necessary (Kvale, 1996; Walker, 1985).

Furthermore, in-depth interviews were utilised because they allow one to "obtain true meaning that individuals assign to events and the researcher can observe the complexities of participants' attitudes, behaviour and experiences" (Bowling, 1997). Semi-structured interviews also assisted the researcher to gain a detailed picture of the participant's beliefs and perceptions of the socio cultural and philosophical importance of rituals. This technique allowed the researcher to probe interesting areas that arose, and this means that it enabled the researcher to enter novel areas, which led to the production of rich data. Since the interviews were semi-structured, the researcher introduced the theme and few questions and then motivated participants to participate spontaneously as is recommended by Schurink (1998). The participants, in this type of interview, described the situation in their own words and at their own time.

4.8.2. Motivation for using interviews as an information collection method.

It is important to note that the purpose of the research must guide the researcher to choose the most effective method. Interviews were considered the most common and relevant mode of data collection in this study. During interviews, the interviewers are expected to create meanings that reside within participants (Manning, in Holstein & Gubrium, 1995). During the interviews, both the researcher and participants were active and involved in meaning-making work. Interviewing, during this study, involved

a description of the experience.

4.8.3. Participant observation

It was indicated earlier on in this study that participant observation would be done to collect in-depth data that may assist in understanding the rituals related to the socio-cultural aspects. It is worth noting that the potential risk of this method is that researcher may lose objectivity. Being directly involved with people and their daily concerns for an extended period may predispose one to be emotionally involved and thus lose objectivity from the people and events. In addition, because notes must be taken from memory, it is possible that inaccurate information could have been recorded. Furthermore, the researcher is in fulltime employment, and participant observation is a time-consuming activity involving extended periods of residence among the participants, the researcher opted for a modified participant observation method (Bless & Higson-Smith, 2006). In this method, participation is restricted to major events and activities. Thus, participation in this study was restricted to selected rituals, activities, and ceremonies.

Of the sixteen participants, four of the participants allowed the researcher to observe and or participate during the performance of rituals. Furthermore, one of the four participants allowed the researcher during two different sessions of ritual performance, meaning the five sets of data was collected through modified participant observation. This means that the researcher not only observed the research participants, but also in few instances also actively engaged in the activities of the research participants. This required the researcher to become integrated into the participants' environment while also taking objective notes about what was going on. In other instances, the researcher had informal conversations with the participants while keeping a detailed record of what she observed and what happened during these encounters. Below is a summary of some of the activities that the researcher participated in amongst others, the following:

- Attendance of Malombo (ritual dance).

One of the ceremonies attended by the researcher was the Malombo ritual dance held in Ha-Mashau Thondoni. This ritual is characterised by singing, clapping of hands and performance of a special stamping dance. This was specifically held for a patient whose illness was thought to be caused by the ancestors' unhappiness, and as a result of his promiscuity, they struck him with HIV/AIDS. The ceremony commenced on Friday afternoon and ended on Sunday morning. Amongst the family members other healers who came to support by clapping and dancing, there was open communication and integration. The researcher blended in as one of the participants in order to be fully accepted by the group.

- Attendance of initiate handover ceremony

The researcher also attended a ceremony to induct a newly qualified healer and an event where she was returned home to be handed over to her family as a newly qualified healer. This event also entails dancing, clapping, and singing where participants go into trance. Participants also randomly pick and diagnose people, telling them of their illnesses or about their social problems. The researcher noticed that the issue of confidentiality was not considered as the ailments and social problems were publicly disclosed. This, nevertheless, did not seem to bother the affected 'patients', judging from their constant agreement with the statements made by the healer.

Once more, the researcher participated by joining the group and sharing in some of the activities. Becoming an insider allowed for a deeper insight into the specific phenomenon since one enjoys the confidence of the participants and shares their experiences without disturbing their behaviour. The researcher mainly participated in the singing and clapping of hands only, while observing all health-related procedures.

- Attendance of a cleansing ceremony

Another ritual attended by the researcher was a cleansing ceremony conducted at the homestead of a patient who stayed at the healer's home for a few weeks, as he was critically ill and suspected to be HIV/positive. The researcher also noted a link between religion and indigenous healing during this ceremony. For example, before departure to the patient's home, the delegates performed rituals and prayed to both God and the not ancestors for a safe journey and on arrival, a short ceremony was performed to announce the arrival. In ceremonies like this, the value attached to ancestral clan was also noted because the healer referred to and called upon the patient's ancestors to lead the process. This confirmed what the researcher learnt during initial interviews that the presence of the client's ancestors is important whenever they conducted divination, a ritual or provided treatment. The cleansing was meant to remove all bad luck and evil spirit that may be lingering around and pose danger of re-infecting the patient. Furthermore, the cleansing ritual is intended to fortify the homestead, the patient, and the rest of his family.

Participant observation provided the researcher with access to different types of information that may not have been easily accessible to outsiders. This provided researcher with ways to check for nonverbal expression of feelings, determine who interacts with whom, grasp how participants communicate with each other, and check for how much time is spent on various activities as part of the healing process (Schmuck, 1997).

Participant observers integrate themselves into the environment and are often considered part of the culture and group. It is not uncommon for research participants to forget that they are being observed, which reduces the likelihood that research participants will modify their behaviour or try to 'act well' because they are being observed (Uwamusi & Ajisebiyawo, 2023). They at times considered the researcher as part of the group and acted as they normally would around her.

Participant observations helped the researcher to fine-tune the questions or were relevant, probe further as compared to instances where it was only interviews. However, this assisted the researcher to formulate better follow up questions in subsequent interviews. By being part of the group, the researcher got a better feel of

what was important to the research participants. She also noticed the language that they used and what certain words meant. This will be further elaborated during presentation of data.

4.9. Data analysis

For the analysis of data, a thematic analysis approach was adopted for this study. According to Komori (retrieved, 2015), researchers use thematic analysis to gain insight and knowledge from data gathered. The analysis of data involved interpretation and an attempt to understand the participants world "...as they construct it" (Jones, cited in Hooper, 1992). The method enabled researcher to develop a deeper appreciation for the group and situation that she was researching. By using thematic analysis to distil data, the researcher determined broad patterns that allowed her to conduct research that is more granular and analysis. Furthermore, thematic analysis was highly inductive, themes emerged from the data that was gathered and were not imposed or predetermined by the researcher.

Using the findings, the researcher applied a statistical analysis to validate themes. Given the context of the research study, thematic analysis included a bit of grounded theory, positivism, interpretivism and phenomenology. According to Braun and Clarke (2006), thematic analysis entails 'identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic.' One of the benefits of thematic analysis that inspired the researcher is its flexibility. In this instance, the analysis followed a phenomenographic analysis.

Once the series of interviews for the study were complete, the researcher transcribed the conversations that took place. One of the first decisions required of the researcher was to specify how accurate a transcription is necessary, as that act of transcription is itself an 'interpretive process' (Kvale, 1996). The researcher argues that since a phenomenographic analysis does not have the same focus on linguistic elements as a method such as discourse analysis, it was not necessary to record every tonal inflection or pause in speech. What was important was that the 'spoken word' was transcribed as accurately as possible as it formed the basis for the analysis to follow.

Thus, with due recognition given to Kvale's (1996) concerns that the oral language of an interview is decontextualised into the written word, the transcripts needed to accurately capture how a person has reflected over their experience of a phenomenon during the interview.

During data analysis, the researcher identified qualitatively separate categories that described the ways in which different people experience a different concept. As per Sjöström & Dahlgren's study (2002), the analysis included certain steps. These steps are as follows:

The first step was familiarization, which means the researcher became familiar to the material by means of reading through the transcripts. This step is important in making corrections in the transcripts. The second step was the compilation of answers from participants to a certain question. The researcher identified the most significant elements in the answers given by participants. The third step was a condensation, or reduction, of the individual answers to find the central parts of a dialogue. The fourth step was the preliminary grouping or classification of similar answers. The fifth step was a preliminary comparison of categories. The sixth step entailed the naming of categories. The final step was a contrastive comparison of categories. This included a description of the character of each category and similarities between categories.

4.10. Quality criteria

The quality of quantitative research projects is judged in terms of their reliability, validity, replicability, and generalizability. On the other hand, qualitative research projects are guided by the four quality criteria of dependability, credibility, confirmability, and transferability (Brown, 2004).

4.11. Credibility

Research credibility relates to the confidence that can be placed in the truth of the research findings (Macnee & McCabe, 2008). Credibility strategies such as prolonged and varied field experience, time-sampling, reflexivity, triangulation, member checking, peer examination, interview technique, the authority of the researcher and structural coherence helps the researcher strengthens the rigour of the study if

adopted by the researcher (Anney, 2014). The data-collection lasted for a period of about eight months, plus a one-month period during which validity-checks were being conducted. Duration of the interviews, the period of data collection and the validity checks, suggests that the researcher developed rapport with the participants and immersed herself in the participants' worlds as suggested by Bitsch (2005). The researcher also made use of members of the academic staff and his supervisor to review this study at various phases prior to the formal submission of the completed project. Therefore, these processes are considered to have added credibility to the study.

4.12. Transferability

It should be noted that since this study comprised members of only few South African cultural groups based in one district of Limpopo Province, the study results might not necessarily be generalisable outside these groups. However, considering the scientific nature of this study and all the relevant procedures and methods employed, it is suggested that the findings of the study may be useful in other settings.

4.13. Reliability

Reliability involves the extent to which the studies can be replicated. However, it must be noted that repetition is never a fixed notion. When people repeat an event or activity, it is usually under different conditions and contexts can never be the same. People will make inferences or theoretical interpretations in terms of what they have observed (Nunan, 1992). When one utters what has been said before, "it is not a repetition because it occurs in a new context" (Wood and Kroger, 2000:165).

Researchers, however, agree that if events are repeated, they can yield the same results, but that there are possibilities of different results too. In such cases, it is pointed out that the results could be both right and wrong because, as stated above, repetition would involve different times, scope, levels of analytic concepts and so on. The researchers reflected above, further argue that every observation of an event brings with it new interpretations. Wood and Kroger (2000:166) indicate that their argument should not be interpreted as avoidance of repetition because, "they do not

make repetition a criterion of warrantability”.

4.14. Ethical issues

Research ethics deal primarily with the interaction between researchers and the people they study (Mack, et al., 2005). Researching human experience as sensitive treatment and rituals related to HIV/AIDS requires greater care and sensitivity during such interaction between the researcher and the participants. Not only are HIV/AIDS patients stigmatized, but indigenous healing itself is associated with scepticism as reflected some in this study.

4.14.1. Permission to conduct the study.

Prior to undertaking the study, the researcher obtained ethical clearance from the University’s Ethics Committee (See Appendix 1: Ethical clearance letter and certificate). Ethical clearance is important ensure that the humanity and dignity of participants is preserved. Furthermore, this is to ascertain that the research would not cause harm, distress, anxiety, pain, or any other negative aspect to the participants. Finally, the ethical clearance is important research in determining that the research being conducted is worth doing, that it is relevant to broad health, well-being and development needs of the Vhembe district and South Africans at large.

4.14.2. Informed consent

One of the mechanisms for ensuring that people understand what it means to participate in a research project is through informed consent. In this study, the researcher openly discussed with the participants, the nature of this study, the potential benefits, and risks associated with participating in the study. Upon which they signed the informed consent letters (see Appendices) for the informed consent letter and form.

The right to full disclosure and informed consent implies that participants of the research were fully informed about all aspects of the study. Therefore, at the beginning

of the study, before interviews could be conducted, the participants were informed about the nature of the study and that their participation is voluntary, and that they were free to withdraw from participating in the study at any stage should they wish to do so. Participants were informed about the type of information needed. The researcher further ensured that they understood the fact that they have the choice of whether to give consent (Brink, 2006). Furthermore, participants were informed that the researcher intended to participate during the treatment and healing process as the rituals were performed. They were also asked to advise on the level of detail that the researcher was allowed to report on and the aspects that they did not wish documented.

4.14.3. Confidentiality, privacy, and anonymity

Canterbury Christ Church University, (2006) suggests that maintaining study participant 's privacy and confidentiality, protecting the access, control, and dissemination of participant 's personal information are standards that help to protect their mental or psychological integrity. In this study, participants were assured of their confidentiality, during and after the interviews. Information that the researcher deemed private, and possibly damaging, was removed and where necessary, was disguised to protect the identity of the participants. Where the limits of confidentiality and privacy were envisaged, such as with supervisions, this was also discussed with participants.

4.14.4. Right to anonymity

The process of ensuring anonymity refers to the researcher's act of keeping the participants' identities a secret regarding their participation in the study (Eungoo & Hwang, 2023). While some participants did not have a problem with their identities being made public, the use of real names of participants was prohibited as a rule in this study. Each participant was provided with a number or code name. The code name was used when discussing data. A master list of participants and matching code name is kept in a safe place.

4.14.5. Confidentiality

The process of ensuring confidentiality refers to the researcher's responsibility to prevent data gathered when conducting the study from being divulged or made available to any person. In case the information is requested for use in another study, the researcher must first inform the participants and ask for permission for the use of data in another study (Brink, 2006). Data gathered during the study was made available only to individuals who are directly involved with the study like the supervisors. The data will only be published for the benefit of the researcher. Anonymity will be protected.

4.14.6. The right to self-determination

Self-determination is based on the ethical principle of respect for person, it means that human beings can control their own destiny and therefore, they should be treated as autonomous agents who have the freedom to conduct their lives as they choose without external controls (Burns & Grove, 2009). In this study, participants were allowed to make choices about their involvement, without coercion. Participants were informed that they have the right to stop participating at any time, are free to refuse to give information on any question and are welcome to ask for clarification at any point (Polit & Hungler 1993).

4.14.7. Minimising harm (non-maleficence)

Pietilä, Nurmi, Halkoaho & Kyngäs (2020) identify the principles that form the basis for protecting participants in qualitative research. Babbie (2007), also argues that the fundamental ethical norm of social research is that there must be minimal or no harm to participants and the environment. Due to the nature of the topic under investigation, it was possible that some participants may be harmed, either socially or mentally, by participating in this study. However, on completion of this study, none of the participants needed any form of intervention. Significantly, during validity-checks all participants reported that it was a learning process for them and some of them reported that they found meaning through their participation in this study, as it reflected that

they are beginning to be acknowledged and recognized as legitimate health care providers.

4.14.8. Principle of beneficence

Beneficence means that the researcher is required to do good and above all do no harm (Brink, 2006). Freedom from harm involves the researcher taking any measures necessary to reduce risks to the participants of the study including physical harm such as injury or fatigue, harm to the participant's development, loss of self-esteem, stress, fear, or economic harm such as loss of wages (Bryman 2001; Polit & Beck 2004). The researcher made all attempts to ensure that during this study, the well-being of participants was secured and protected from discomfort and harm. Participants were also informed that there would be no legal implication towards sharing knowledge about their practices and rituals.

4.14.9. Principle of justice

This principle is concerned about fair selection of participants and treatment (Burns & Grove, 2009). Participants were selected fairly and in accordance with their knowledge and experience related to the subject of study. Furthermore, participants' rights were not infringed upon, and they were not harmed in any way. Their participation was voluntary.

4.14.10. Intellectual Property

Participants were also informed that their intellectual property in terms of information provided will be protected, and that in case this study leads to material benefit, a benefit sharing mechanism, in the form of a Material Transfer Agreement (MTA) will be developed (Mahomed & Sanne, 2015). Benefit sharing is the process or act of sharing in the benefits that derive from research in a manner that is fair and equitable. However, the idea of benefit sharing will be balanced with public interests and public health.

4.15. Conclusion

The main purpose of this chapter was to present the description of the research process followed in undertaking this research. Various research stages like the selection of participants, the data collection process, data analysis as well as research techniques we described. The research setting, and context, showing the relevance of the setting or location, to the nature of the study, was also elaborated. The last part of this chapter articulated the ethical considerations reflected upon an implemented during the research process.

CHAPTER 5: RESULTS

5.1. Introduction

The aim of this chapter is to present a detailed description of the results of the study. The results of the study are presented in line with the phenomenographic approach, whose aim is to discover the qualitatively different ways in which participants experience, conceptualize, realize, and understand various aspects of the phenomena in the world around them. The focus, therefore, was to understand how participants experience and understand the socio cultural and philosophical importance of rituals.

Verbatim quotations from the participants, which provide valuable evidence, is presented. However, since this is a phenomenographic study, the researcher did not necessarily record every tonal inflection or pause in speech during the interview but focused on the 'spoken word' and ensured that it is transcribed as accurately as possible as it forms the basis for the analysis to follow.

The data collected from the participants was intended to answer the following research questions:

- What is the indigenous healer's understanding of HIV and AIDS disease?
- What is the philosophical stance regarding the performance of rituals during the treatment process of HIV and AIDS clients?
- What is the socio-cultural significance of the rituals that are performed as part of the HIV and AIDS treatment procedures?
- How are the HIV and AIDS treatment rituals performed?
- Which guidelines will facilitate the provision of ritual performances during collaborative healing processes of HIV and AIDS?

As the interviews were semi-structured, the questions were not necessarily answered in a specific order.

The researcher presents the demographic profile of the participants. This will be followed by a compilation of answers from participants to a certain question, in doing

so; the researcher will specifically identify the most significant elements in answers given by participants. Lastly, a grouping of similar answers, which will become the main themes emerging from the study, will be presented. In this regard, the following themes identified will be presented: 1. The indigenous healer's understanding of HIV/AIDS; 2. The philosophical stance regarding the performance of rituals 3. The socio-cultural significance of the rituals that are performed as part of the HIV and AIDS treatment procedures; 4. HIV and AIDS treatment rituals; 5. Views on collaboration with Western health practitioners.

It is important to note that while there was consensus amongst the participants in the understanding of HIV/AIDS, treatment and rituals, the participants' healing modalities or processes, were not necessarily uniform. Each participant lies somewhere different on the spectrum, and this comes from years of past experiences, learned sentiments, culture, education, or other aspects.

5.2. Demographic Details of Participants

5.2.1. Participants' description

The participants comprised both male and females and their ages ranged from 31 to 84 years old. 12 (67%) of the 18 participants are over the age of 50. Most of the participants interviewed were experienced healers, with experience ranging from 2 to 59 years of practice as indigenous healers. Of these, the majority had more than 15 (72%) years' experience. Furthermore, 10 (56%) of the participants are female. Therefore, participants were included in the sample because of their profession and experiences in relation to their understanding of rituals.

It is also important to note that during participant observation, the researcher interacted with more healers than those specifically interviewed for the study. Below is a table indicating the breakdown in terms of age, gender, and experience. This will be followed by a brief background explanation per participant. It should be noted that only first names, titles or *pseudonyms* of the participants were used. This is to protect their full identities.

5.3. Emerging Themes and Sub-Themes

This section will focus on the presentation of the themes and sub-themes that emerged after the collected data was transcribed. Five themes, and eleven sub-themes, emerged from the narratives of the eighteen indigenous healers who participated in this study. These themes and sub-themes, as reflected in the table below, were used to guide data presentation, analysis, and interpretation.

Table 5.3.1: Themes

	Main theme	Sub-theme
1.	Understanding of HIV/AIDS	(i) Symptoms of HIV/AIDS (ii) The disease that came. (iii) An old disease (iv) Diagnosis
2.	The philosophical stance regarding the performance of rituals	(i) Types of rituals
3.	The socio-cultural significance of the rituals that are performed as part of the HIV and AIDS treatment procedures	
4.	Rituals related to HIV/ AIDS treatment procedures.	(i) Treatment of HIV/AIDS (ii) Assessment of successful treatment for HIV/AIDS (iii) Handling of medicine
5.	Views on collaboration with western health practitioners.	(i) Mistrust (ii) Location/venue for treatment (iii) Cross referral

5.4. Presentation of findings

This part of the thesis reports on the findings from the semi-structured interviews, which were conducted with eighteen indigenous healers who were selected using purposive sampling. While the original target was sixteen healers, the additional two were part of the participant observation sessions and were approached during that time.

5.4.1. Indigenous Healer's Understanding of HIV and AIDS Disease

This section focuses on the healers' understanding and description of HIV/AIDS. The indigenous healers' understanding of the symptoms, diagnosis and general perception will be presented. This data was collected to answer the question, what is the indigenous healer's understanding of HIV and AIDS disease?

Most healers acknowledge that they do not fully understand HIV/AIDS. The study found that vho- Maine sometimes confuse HIV/AIDS with other sexually transmitted diseases and tend to use different indigenous concepts to describe the disease. Furthermore, most of the healers confirmed that they focus on the symptoms and avoid speaking directly about the disease with patients. The focus is mainly on treating the symptoms. Below are extracts from the interviews on the participants' understanding of HIV/AIDS:

Vho-Makonǀelele says, "HIV/AIDS is a combination of various diseases, and we do categorize them, we have diseases that we call *madevhu* (from the explanation this is gonorrhoea), *uwela* (when a man sleeps with a woman who has recently aborted a child), drop and other STDs. Majority of these diseases are transmitted sexually and when they are all combined and advanced that is where HIV/AIDS arises".

Vho-Nemadandila calls HIV/AIDS Ndongondela, he says, "When we treat this person from these diseases that we called then *ndongondela*. we call AIDS *ndongondela* because it is a type of disease that is incurable because it has advanced. Incurable diseases are mostly those diseases that are transmitted sexually, and we called them

Ndongondela because they have advanced and passed a stage where they can be cured”.

Another healer, Vho-Margaret, associates HIV with blood, which she believes she can ‘cleanse’, “What I do not understand is whether it can be cured or not, but what I know is that they say that HIV/AIDS is found in the blood, but as indigenous healers we have remedies that we use to cleanse a person’s blood system”.

Vhavenda understands that HIV is sexually transmitted, but he believes that this is a modern disease. “This disease called HIV/AIDS is a modern disease that did not exist in the past and the symptoms of this diseases are the same as those of people who are infected by Sexual Transmitted Diseases due to engaging in sex without using protection”.

Thinawanga seems to clearly understand HIV and AIDS and was very articulate in explaining HIV as affecting the immune system, “So HIV/AIDS is a combination of different diseases, the immune system of the infected patient cannot fight this disease. A person will be having different diseases inside and when all this disease come together that were we call it HIV/AIDS”.

Vho-Mashudu associates HIV with dirt inside the body as well as the effects of birth control, “We have many men who always complain about back pains even if they take pills the pain won’t go way. The pain will not go away because that person has dirt inside his system, and such will lead to HIV. There are women who are on birth control that won’t see their periods for like 6 months, and where is that dirt supposed to go? Moreover, if a man has sex with that woman what will happen then? That’s how all these diseases started, and people nowadays do not want to use traditional remedies in which they can help to prevent all these diseases”.

On the other hand, Vho-Sara believes that disregard of customs and traditions leads to infections, she says “So, the generation of today is much more exposed to HIV/AIDS because they do not follow the customs. In the past, there were no incurable diseases because people then relied on traditional medicine to fight diseases”.

Randima uses indigenous concepts to describe HIV, he says that “We as healers do not always speak directly that the patient is HIV positive, we say ‘nowa yo kumeliwa’ or nowa yo hambeliwa’, meaning that you have a serious disease. We then tell them what the bones told us and then we start with the treatment and monitor the reaction, whether the medicine is causing diarrhoea, loss of water or blood. The bones will show us”.

Randima’s interpretation seems to be supported by vho-Matshavhanga, who also uses the concept of *nowa yo hambeliwa*, he says “As for people who are HIV positive, when both male and females come to us as indigenous healers, what we find is that they have sores/wounds in the stomach (*nowa yo hambeliwa*). The cause of this is that a person will be having different diseases inside and when all these diseases come together, we call it HIV/AIDS”.

Sipho’s description of HIV is also symptomatic, and also shares the concept of *nowa yo hambeliwa* he gave a long explanation, saying “But if the patient comes to us and we see that the patient is still on stage 1 (wounds in the stomach) then we will give that patient medication to treat the wounds in the stomach, then we come to a stage where a female has cervical growth and then we will give her medications to treat and other medications that are suitable for females.

Then there will be a male whom it will start with wounds in the stomach then it will affect the bladder and the patient will feel pain when urinating, which sometimes might have resulted from diabetes. Therefore, we will give the patient medicines to treat those illnesses. When a patient goes to the doctors and indicate that he’s feeling pain when urinating or pushing urine, the doctors will tell the patient that he is not drinking enough water, even if the patient drinks enough water the pain will remain, indicating that there are infections that needed to be treated (*nowa yo hambela*) because people nowadays no longer wait. They do not abstain or observe certain rules”.

Sipho further believes that lack of abstinence against sex during or soon after menstruation contributes to HIV. “As indigenous healers, we know that once a girl finishes her menstrual period, she needs to wait for two to three days before engaging into sex, so that she can be clean and avoid passing infections to the male partner.

So, if a female did not wait after menstruating, it will affect the male and that's where you will hear a male stomach making a 'krrrrr' sound because the dirt from the woman is inside him (*n̄owa yo hambela*). Another thing is that these boys will force to have sex even when their private part is not erect, that's why we call it *tshitungulo* (in Tshivenda language 'u tungula' is to diagnose, using divining bones, and a penis is called 'tshitungulo') in Tshivenda because it can be able to tell if is safe or not to enter/have sex. So, most boys/men will force to have sex even when they did not get an erection because their penis is trying to warn them that it is not safe to enter, it might because the girl is sick or had an abortion".

Several participants like Vho-Tondani, associate HIV with sores in the stomach, "HIV is a precursor for many other diseases. It is in the stomach. One of the causes HIV are sores in the stomach, caused by the food that we eat".

Mukovhe understands HIV in this manner, "The cause of this is that a person will be having different diseases inside and when all these diseases come together, we call it HIV/AIDS".

Based on the above extracts, it appears that indigenous healers have a basic understanding of HIV/AIDS, and they acknowledge that these are diseases that cannot be cured. However, most of them seem to think that stomach sores or some problem in the stomach causes HIV. These quotes indicate the different notions that they hold; and some of these explanations appear to be based on cultural beliefs. Nevertheless, most of the participants also understands that HIV is a Sexually Transmitted Disease.

5.4.1.1. Symptoms of HIV/AIDS

This study found that weight loss, sores in the stomach, as well as diarrhoea, were significant and common symptoms identified by healers as indicative of HIV/AIDS. Participants also described various other symptoms, like dry skin, and coughing as other symptoms of HIV/AIDS.

Vho-Mamuremi, "The skin of an infected person is always dry, or this person's skin is no longer nourishing to show that a person is alive and healthy, even if the person

applies Vaseline or pork fat within 5 minutes the skin will be dry again that is when we know that that person is sick”.

In addition to other general symptoms, Vho-Mahandana also relates HIV with TB, “The symptoms of the diseases included losing weight, hair thinning, and your skin begun to fall. The person does not eat and even coughs a lot. In the past, we used to say that the person ‘u na lufhia’-he/she has TB. This means that when the person has those symptoms such as losing weight, diarrhoea, or not eating, then at the end this cause the person to suffer from AIDS”.

Vho-Nemadandila says his focus is on the opportunistic infections and not so much on the HIV, “So the things that we traditional healers see is that the patient is coughing, high temperature diarrhoea, etc. but when we treat as indigenous healers we do not say that we are treating HIV/AIDS but treating those different illnesses, we will treat coughing, treat high temperature, and treat diarrhoea and all those illness that are present to the patient”.

Vho-Mashudu says, “The patient may also have stomach cramps or be paralyzed without a cause. These symptoms sometimes mean something different in our world, like a calling to become a healer, or a need to perform a specific ritual if the ancestors are not happy”. The association of HIV and the stomach, especially stomach sores, seems to be a popular view amongst healers.

Vho-Khorommbi has this to say regarding the symptoms, “The disease starts when someone start to develop sores in the stomach. It might be caused by (*dorobo*) drop or for a female, it might be caused by cervical wounds/ cervical growth, so once a patient starts to have all these diseases, it will result as HIV positive”. Vho-Mukonḁeleli says, “HIV is a combination of different diseases which are in a human stomach and another cause of it is the sores in the stomach that are cause by the food we eat”.

Vho-Makonḁelele says, “Then there will be a male whom it will start by wounds in the stomach then it will affect the bladder and the patient will feel pain when urinating, which sometimes might be resulted by diabetes so we will give the patient to treat those illnesses. Some of the symptoms that healers believe to be indication of HIV

may be due to other health problems and not necessarily an indication that a person is HIV positive, for example, coughing, high temperature, as well as dry skin”.

Vho-Nemadandila also talks about the diet, exercise, and many sexual partners: “What I can say is that as I am an indigenous healer and I have a lot of knowledge than an average person. When a person is positive, that person’s diet will change, the movement will change, and that person should exercise often. Therefore, once a month the body should also be serviced because we are getting these diseases through sex, so if as man today I am having sex with this girl and tomorrow is another girl, I am getting illness from this one and to another. I am spreading at the same time. In Tshivenda a man should clean his system, unlike women’s who see their cycles every month, a man should go to a healer and be given remedies that will clean his system and get rid of the dirt inside him that can lead to such diseases”.

Vho-Ndiambani says, “Those who will be assisting that sick person will find that the patient has lost complexion, hairs air falling off, etc.”.

5.4.1.2. HIV/AIDS ndi vhulwadze ho daho na vhanḁa (The disease that came).

Few of the participants hold a view that HIV/AIDS is a foreign disease that was brought to Africa by outsiders.

Mukovhe says, “My understanding is that this is a disease that came with white people”.

Vho-Sara had this to say, “when we grew up this disease was not here, it came with outsiders, and they infected our people”.

Vho-Matshavhanga also agrees, “You see, those who came without respecting our culture and who do not abstain, caused this disease to spread and infect our children.” Tshikosi also shares the same view, “This is a foreign disease that was brought by apartheid, they deliberately infected our people.”

Vho-Khorommbi: "AIDS is something new and this disease confuses one as a traditional doctor. Some people associate AIDS with 'Thusula', but I do not want to say they are the same because they share similar symptoms, but also it differs in other symptoms".

5.4.1.3. HIV/AIDS ndi vhulwadze ha kale na kale (An old disease)

There is also another view that supposes that HIV is not a new disease but has always been there. This is what participants had to say:

Phaṭhe: "The disease did not start now. It started a long time ago. In the past when I was still young, we used to call this disease "Khwasha".

Vhaventḁa: "This is not a new disease it existed in that past it is just that now people are going to the doctors to get tested".

Vho-Mamuremi: "These diseases have always been there; they are just returning in a different format. When I say they are returning, it is because years ago there were sick people whom we were told that other people are not allowed to be close to them".

Vho-Ndiambani: "We did it many years ago, and even now we are treating these people, it is just that people are undermining us as indigenous healers".

5.4.1.4. Diagnosis

Diagnosis of HIV is not uniform, there are various ways in which this is done, depending on the healer's experience, knowledge, and exposure.

Thinawanga says, "I am not able to see it with my eyes, but when I am diagnosing through bones, I can see that this person is always tired, has diarrhea and is always vomiting. When I see this in my bones when I am diagnosing, I send this person to the clinic to be tested".

Mamuremi says “I tell the patients about the illness that I have seen when I was diagnosing with the bones. Then the patient will have to agree on the treatment, because I do give patients medications if they are not agreeing to it”.

Vho-Mashudu says, “we use *ṭhangu* (divining bones), we throw the bones and if this disease is there, we will find out. However, the bones will not say AIDS, but will only show us that there is a serious disease (*vhulwadze vhuhulu*). Our *ṭhangu* (bones) normally are able to tell us the nature of the disease that an individual is suffering from”.

5.4.2. The philosophical stance regarding the performance of rituals

Despite the unique personal interpretations shared, the healers seem to arrive at one convergent point that, rituals are in the DNA of their healing practices. They also agree that rituals are not done just for HIV/AIDS, but as a general healing practice as reflected in the extracts below; the healers also seem to agree that rituals are performed for individual ancestors.

Nemadandila says “There is no specific *uphasa* that is done for advanced disease. The only thing we can do is that when the patient is taking medication that is when we can call *Makhadzi* (Aunt/father’s sister) for that person and do *uphasa* ritual asking the ancestors to protect and help the patient to be cured”.

Vho-Mahandana was very elaborate on this question, “Rituals are part of the DNA (*ndavhuko*) of our people as Africans. Our lives are anchored in it. However, rituals are not specific to HIV/AIDS; they are performed for various diseases. Rituals can be performed by the maine on behalf of the patient, or the family. Some rituals are performed for thanksgiving, after the patient is healed. Others are performed for the protection of the whole family. Before the patient is discharged, rituals to fortify him/her are performed. Other rituals are for healing and forgiveness. You see, rituals are broad”.

Vho-Mashudu also equates rituals to prayer, “Rituals are important to us because it is the foundation of our lives. To us rituals are similar to praying. *Uphasa* is when we are

communicating or talking to our ancestors so that they can transfer the message to the creator whom we do not know. *Uphasa* is the backbone or foundation of our being. Uphasa anchors us. It is important to us Vhavenda and we cannot separate ourselves from *uphasa* as it is crucial to our culture”.

Vho-Margaret says “You must also understand that other rituals are procedures that are important to healing. Before we throw the divining bones, we ask the patient to blow or breathe into the bones. That is a very important thing to do, you know. When we do this, we want his/her ancestors to come and help in the diagnosis and treatment that will follow. It is not only my ancestors that heals, but also the patient’s ancestors and God must be present”.

Thinawanga agrees with Vho-Mashudu that rituals are a prayer, she says, “Uphasa or therelelo is a prayer or a tribute to those who passed on, our grandmothers and grandfathers and those whom we don’t know, by *uphasa* we are remembering them so that we do not forget about them as they did not forget about us, that is why we do *uphasa* when whole family is present including the children so that each and everyone has a good path. So, during the healing process, we summon the ancestors as a form of acknowledgement and also to invite them to lead the process because without them, I may not see what the problem is, and I may not know which medicine to use.”

Nemadandila acknowledges the significance of rituals, but do not perform rituals for HIV patients, he says “*Uphasa* is important to us because it is our tradition, if we don’t do that, things do not go accordingly, and children will get sick or misbehave and there will be no joy at home. So, if we do *uphasa* everything will go accordingly because it is our tradition. We do not do *uphasa* for this patient, this patient will go to clinics and get tested and then be given medications by the doctors and me as a traditional healer I will give the patient the medication that I know will work”.

Vho-Mukonǵeleli also confirms that Uphasa is a prayer, “The importance of rituals is similar to when a pastor is praying at church, the pastor will be praying to Jesus Christ, so we don’t pray to Jesus Christ, we pray to our ancestors. Our ancestors will take our prayers to the creator. We are unable to send our request directly to God without passing through the ancestors. *Uphasa* is also different we don’t only use water and

tobacco sometimes we also add remedies if the patient is every sick so that the ancestors can be with the patient depending on the patient's state.

Khorommbi says, "I grew up in a family where uphasa ritual was performed. The significance of rituals is that sometimes you may find that there is someone in the family who is sick because of the ancestors who departed a long time ago. The elders would say, uphasa must be performed and the child must be given the name of those forebears. There is also a specific time to perform rituals, especially with us healers, we come together on our own and perform the necessary rituals for each, asking for blessings from the ancestors. I know rituals helps and we found this practice when we were born. This is part of our culture and belief system of the Vhavenda people, and we believe that once we perform the rituals, things progress positively for us." Yes, rituals can be performed during the treatment process, but they go beyond the individual who is sick and can also be done by a family on an annual basis."

Vho-Makonḡelele was very clear in answering the question on the significance of rituals, "U phasa, or the performance of rituals, is not about treating HIV/AIDS, it is a sacred ritual which was bequeathed to us by our forebears. What you see happening here, performance of malombo (therapeutic dance) is an important ritual. This is following the instructions of the ancestors, who tells us what to do because they are the ones who are in charge. Therefore, they do not necessarily cure HIV/AIDS but are a way of calling on them to guide us and also to protect the patient. They only ask us to please them and to acknowledge them, just like the hospitality we show to you as visitors. Therefore, even the ancestors want to eat or to be pleased. That is why we perform rituals, because if we do not, they keep their distance, or move away from us and once they do that, we will not know what to do without their guidance. When we are asleep, they tell us to wake up to go and collect a particular medicine and when you get there, do these rituals, and give the medicine to the sick person so that he/she can be healed".

Randima also agrees that rituals are broad and not exclusive to HIV, "Yes, there is a need to do rituals *or uphasa* for that person, it will be done, but it will not be to cure HIV/AIDS because *uphasa* does not cured HIV. When a patient is HIV positive

indigenous healers will conduct rituals to strengthen the patient and give that person medication”.

Vho-Mamuremi says, “I am a Maine and what I understand about *uphasa* is that it is a ritual that is done in all the families of Vhaventḁa people. A ritual is a prayer or a tribute to those who passed on, our grandmothers and grandfathers and those whom we do not know. By performing rituals, we are remembering them so that we do not forget about them as they did not forget about us. That is why we perform *uphasa* when whole family is present, including the children’s so that each and everyone has a good path”.

Vho-Sara says “*Uphasa* is not a thing that is only supposed to be done by a traditional healer, every person who belongs to Vhaventḁa culture will do this ritual starting from the origin, many people who do not understand this ritual think that it is done by confused people who do not know what they want. When I do this ritual, I know that I am doing it for my family and my forefathers so that they can know that I have not abandoned them, so that they can take my wishes to the creator. Rituals are different, and based on based on each family’s practices, but it is important to an African Venda person who was born in Vhaventḁa culture, and this ritual will open a good path, and everything will go well. When we do rituals, we are doing it so that we do not fall for other religions and leave ours behind”. The rituals that we do for healing are specific and we do them for all patients because the ancestors guide us during the process, they are the ones that gives power to our medicines or who tells us which medicine to use in order to heal a particular disease”.

Sipho was very specific “With regards to rituals, my dear, everybody has their own ancestors. You have your own ancestors; I have my own ancestors. When we perform these rituals, the rationale is to request the ancestors from the maternal side (*midzimu ya ḁamuni*) and the paternal ancestors (*midzimuya ṭhohoni*) so that as you use the medicines that we are going to give you, they heal you. The truth is when we talk about *u phasa*, we are mainly talking about water and tobacco/ snuff, and this is part of our lives. We also use other items in other instances. However, when the situation is too serious, we also use certain herbs”.

Mukovhe says, “The purpose is to ensure that things should go well during the treatment process and looking at the condition of the patient. For example, if the person is struggling to find a job, we will ask the family to perform rituals so that his/her ancestors open the way for whatever I will be doing as a healer”.

Vho-Ndiambani was focused on the procedures, “We have certain observances, and we also abstain from certain things before or while we are busy treating a patient. The challenge is that for young couples, this may affect or break marriages. Some ancestors do not want the healer (a woman) to be with a man, they chase him away. The same applies to male healers, they are also expected to abstain from sex, and this may cause problem and suspicion of affairs. There are many sacrifices. Another thing is that if you engage in sexual intercourse under a medicinal plant/tree, you will never be able to heal or cure anyone. You lose your powers.”

From the above extracts, participants revealed that rituals are performed for a variety of reasons, amongst others, the veneration of ancestors, inviting the ancestors to guide the healing process as well as for prosperity and success. Furthermore, most healers agree that performance of rituals is not only reserved for healers, but individual family members also perform rituals as they venerate their individual ancestors. Participants also equate performance of rituals to prayers and view ancestors as mediators between the living and the Creator or God. Snuff and water are the common items used in the performance of rituals. The participants identified several rituals that will be briefly outlined below.

5.4.2.1. Types of rituals

Responses to the question regarding the socio-cultural significance of rituals, it was clear that rituals are much broader and cut across various scenarios. According to the indigenous healers interviewed, rituals are the backbone of life. Furthermore, the participants mentioned several types of rituals. Below are some of the extracts regarding rituals.

Vho-Sara says, “*Uphasa* is not a thing that is only supposed to be done by an indigenous healer, every person who belongs to Vhavanḁa culture will do this ritual

starting from the origin, many people who do not understand this ritual think that it is done by confused people who do not know what they want. When I do this ritual, I know that I am doing it for my family and my forefathers so that they can know that I have not abandoned them so that they can take my wishes to the creator. *Uphasa* is different based on families, but it is important to an African person who was born in Vhavenda culture, and this ritual will open a good path, and everything will go well”.

Tshikosi, “*uphasa* is a part of *urerela*; *urerela* is a part of respecting (*Uluvha*) our forefathers, *uluvha* comes from any form of seeking from our ancestors. Therefore, we come to our ancestors whom we respect very much and ask or seek for whatever that we want. It can be for the children to have good manners, healthy body and to be protected. *Urerela* is similar to praying in a modern way”.

Vho-Mahandana says, “Healing rituals are also broad because if when I throw the bones, I find that the patient has unresolved issues with other family members, I can suggest that the family participate in the healing process like Malombo. Sometimes if someone died far away from home, the family must collect his/her spirit and return it home (u vhuvisa) because if this spirit is wondering out there, it can cause diseases to family members and these diseases come in different forms”.

Vho-Mamuremi says, “There are different types of rituals. As a healer, I can do *uphasa*, thanking my ancestors for everything that they have done for me or to convey my request depending on the need. For this kind of rituals, I will invite other indigenous healers and the rest of my family, both my paternal and maternal side. Then another scenario is if things start falling apart, either at work or home, then we invite our grandmothers or aunt to perform certain rituals. There is another situation where these rituals must specifically be performed by the father’s sister(makhadzi)”.

Vho-Tondani says, “*Uphasa* is when we drink water hold it in our mouth and spit out like a spray and another type of *uphasa* is when we are like pouring water on the ground, which is called *thevhula*, for this one we use traditional beer called *mpambo*, we pour it at kholomo (a special space or special stone) or at our sacred sites. And we use tobacco (u tota fola). This is the way in which we communicate with our ancestors. Then there are specific rituals conducted during healing of patients that are a code of

practice for us healers. One of these is the breathing(femba) on the divining bones in order to connect the spirit of the patient with his or her ancestors”.

Vho-Makonǵelele also specialises in training those who have a calling to become healers, and this is what he had to say regarding the associated rituals, “When a person has a calling to become a healer, there is a healing ritual, or acceptance ritual, which is performed to indicate that the person accepts to become a healer. If this person has a double calling or called by both the mother’s and the father’s ancestors, the acceptance rituals must be done separately for each, and this will be done on different days. Starting from the stronger and then the other. U hwedzela is the accepting ritual, for the person with a calling. This is done so that the person whose spirit wants you to become a healer will come and live in you. We will see this by the behaviour. If the person used to love being topless, even the patient will do that”.

Vho-Matshavhanga was also elaborate on the general rituals, “The other rituals are cleansing rituals, this is done after a funeral so that if a family lost a loved one, the cleansing ritual removes the ‘bad’ spirit or tshiswiswi and this facilitate the process of healing. If this is not done, when that person who is bereaved meet other people, for example, a wife who lost a husband, if she sleeps with another man before the rituals are performed, she can inflict that man with a disease. The woman is an incubator, and this is done to protect her and her future husband. For a man, he can develop a big stomach because of that bad spirit. So, the cleansing rituals are done to protect people from diseases. You see even when a patient is being treated for any disease, sometimes if there is a need, or if the ancestors showed me, I could perform the rituals of fortification, so that the patient does not easily get sick in the future”.

Ndiambani says, “The importance of rituals is in the fact that amongst the Vhavenda people, if a child is going for a visit, they first report. They first perform the ritual so that wherever he/she is going things can go well. They will pour snuff tobacco and other rituals to dedicate the child so that the child is protected and succeeds. If the child is going to school, he/she will pass. They will use snuff and water to protect the child from diseases and other problems that may arise. It is, therefore, natural that even before, during and after the healing process, rituals are performed to invite the ancestors to guide the process”.

Vhavenda says, “When we perform these rituals, they have a positive impact in the country, there will be peace, if there are conflicts at home or other problems like money issues, they will be resolved. So, rituals do not only help the patient who is being treated, but they benefit everybody”.

Randima responded in the following manner, “Rituals are important; they are part of our culture and heritage. Rituals are life. For this ritual, we use Mufhoho (type of Millie) and Mpambo (a type of traditional beer) which is grind into a soft powder. The spear, mpambo and snuff are used for rituals and the liquids are poured using a calabash while they are making incantations, calling on the ancestors, and ‘those that we do not know. Finally, I want to say, rituals, bring peace, makes the environment to be good, heal the soul. Rituals preserves our traditions”.

While the socio-cultural significance of rituals will be discussed holistically, at a later stage, it is important to identify the different types of rituals as coming out of the interviews with participants. These can be summarized as follows:

- **Thevhula (thanksgiving) ritual:** this ritual is performed before or during harvest to acknowledge and thank the ancestors for a good harvest. There are also rituals that are performed to thank the ancestors for the protection of the family. Usually in these circumstances, Makhadzi, or the paternal aunt, is the one who leads in these kinds of rituals. However, thanksgiving rituals are also performed after the successful treatment of the patient, to acknowledge the role and guidance that the ancestors played in the healing process.
- **Thabelo/mbidzo (Invocation) rituals:** these can be equated to a prayer, and are rituals performed to invoke, or invite the Spirits and ancestors to participate in the healing process. An example of this is the inhaling of snuff or the breathing into the divining bones.
- **Tsireledzo (Rituals for protection):** also called the closing ritual, these rituals are performed after the treatment, during the send home ceremony, and at the homestead, to protect the patient from further illnesses and diseases. What is important is that this is also performed to thank the spirits and the ancestors for being present during the healing process, and for revealing the cause of illness

as well as the solution, or treatment to address the problem.

- **Rituals for U thwasa or training to become a healer:** these rituals are performed for someone who has a calling to become a healer and are often performed during the training process. Firstly, performed to mark the individual's acceptance for the calling, and if the patient has a calling from both the maternal (vhadzimu vha ḁamuni) and paternal (vhadzimu vha ṭhohoni) ancestors, the acceptance or acknowledgement rituals would be performed separately. More rituals are performed when the trainee healer is sent back home after the training, to test his/her healing abilities as well as protecting, and informing the family and the neighbours that there is a new healer in the neighbourhood.
- **Phodzo/dzilafho (Healing) rituals:** these are rituals that are performed before, during and after the healing of various diseases. Amongst others, these include, taking off shoes, blowing or breathing on the divining bones as well as burning of incense. Furthermore, healing rituals are also performed during the harvesting of medicine, so that the herbs are imbued with healing powers. Over and above these, healing rituals include Malombo/therapeutic dance as well those performed to invite the ancestors to guide the diagnosis and healing process.
- **Rituals for a safe journey home:** these rituals are performed when an individual is travelling, or when someone is going far away to study or to seek a job. The rituals are for protection and success.
- **U handulula (Cleansing) rituals:** these rituals are performed after a funeral. The ritual removes the 'bad' spirit or tshiswiswi and this facilitate the process of healing. Cleaning rituals are also performed to someone who has been bewitched or has bad luck.
- **U vhuyisa (Return of spirit) ritual:** this is performed if someone died far away from home, the family must collect his/her spirit and return it home. Specific herbs or tree are used for this ritual.

From the above extracts, the healers equate rituals to a prayer. The healers, in the extracts above, also agree that Makhadzi plays a significant role in the performance of rituals. The study found that rituals are considered central and a significant part of

not just the healing process, but health in general. However, the healers were very clear that rituals are the backbone of any treatment, and not specific or special to HIV/AIDS. Below are extracts that emphasize these points.

5.4.3. Rituals that are performed as part of the HIV/AIDS treatment procedures.

Based on the interviews conducted with indigenous healers for the current study, most healers revealed that rituals are part of their healing procedures. They indicated that not only for the treatment of HIV/AIDS, but as a general practice, specific rituals are performed during the healing process. It was revealed that prior to any intervention; there is a consultation with the ancestral world for guidance.

Makonǃelele says, “There are also general aspects of rituals, for example, before diagnosing a person, I ask them to breathe into the bones. Sometimes before I use certain medicine on the patient, I must conduct a ritual to ask permission, or to call on the power for the medicine to heal”.

Vho-Margaret says, “You see even when a patient is being treated for any disease, sometimes if there is a need, or if the ancestors showed me, I could perform the rituals of fortification, so that the patient does not easily get sick in the future. So, I do the same for HIV/AIDS patients. This is our practice”.

Mukovhe says, “When we do this, we want his/her ancestors to come and help in the diagnosis and treatment that will follow. It is not only my ancestors that heals, but also the patient’s ancestors and God must be present. Therefore, whether the patient has HIV or another disease, I will do this ritual”.

Makonǃele was very elaborate regarding rituals and procedures, “rituals are not about HIV. Rituals are for our ancestors. There is a specific time that we are told to perform this ritual. We then prepare traditional beer; we follow instructions as dictated by the ancestors. By the time we beat the drums; we would have concluded the uphasa ritual and communicated with our ancestors. We communicate, feed, and make them happy because if we do not, they will also not do anything for us. They will distance themselves and if they do, everything will go wrong. We do it so that things can go

well. So that we can heal people. After performing these rituals, we get new strength and further guidance from the ancestors. They will also reveal the medicines that we must collect and sometimes without knowing what we are going to do with them. However, during our sleep, they will then visit us and give us further instructions on how to utilize those herbs. Our ancestors do communicate with us, it is just that we, as healers understand them better as we are always closer, and we understand their language. They will not visit you if you are not close to them, but if you are, they will tell you that there is a snake there and you will see it". So, the same will happen when I am treating a patient with HIV. After the revelation of which medicine, I must use, or what else to do, I will then do that with the patient."

Mukondeleli says, "That is when I, as a healer, must do a ritual asking my ancestors and the patient's ancestors to work together for the speedy recovery of the patients. What I do is to invite my ancestors and the patient's ancestors join hands so that the patient can be cured."

Mahandana says, "Firstly the patient will take off their shoes when we enter in my house where I treat my patient. Secondly, when we are inside were, I treat the patient does not sit next or closer to me, there should be a distance between us".

Vho-Sara says, "No, because usually HIV/AIDS patients are already weak in their bodies. If we do a ritual like u thwasa or malombo, that might be leading that patient to death, because the patient won't be strong enough for the ritual and when the ancestors' spirit come to this person it might finish (too strong) the patient. I normally focus on giving the patient the herbal remedies. Only someone who is related to the patient does uphasa. If you are a patient and come to me, I cannot do *uphasa* for you because we are not related. The only thing I can do is to give the patient medicines and treatment. If there is a ritual like uphasa which is needed to be done, those who are related to the patient will do the ritual. It is the same as if you are asking if we can perform *malombo* for an HIV/AIDS patient, because I do not do that".

Vho-Thinawanga says, "Therefore, we will let the ancestors know that you are taking HIV treatment, even if it is pills. We do this so that they can protect you going forward. As for our patients, there are small rituals that we ask them to observe when they

come to see us, to show respect and for them to also connect with their ancestors because without this connection, the medicines may not work”.

Sipho says, “That is when we say the father’s ancestors (midzimu ya thohoni), the mother’s ancestors (midzimu ya damuni) of the patient, my father’s ancestors, and mother’s ancestors must come and work together so the patient can be cured”.

Vho-Ndiambani says, “Before I treat the patient firstly, I will treat the patient’s soul. If you come here to me for treatment, and your soul is not complying with me I cannot treat you. I will firstly welcome a patient here as any person that comes here, and they must understand that we have rules here. Firstly, the patient will take off their shoes when we enter in my house where I treat my patient. Secondly, when we are inside were, I treat, the patient does not sit next or closer to me, there should be a distance between us and I only see one patient at time so that the patient can feel accommodated, and this is not just because the patient is HIV positive, but as a general rule. If you go to where I treat my patients now, you will see that there are gloves and I always make sure that there are enough gloves”.

Vho-Makonǵelele says, “So once you have a calling and HIV positive at the same time, you will undergo the accepting ritual and then undergo training but that does not mean your HIV is cured, you will still need to take your medication for HIV. But there is a need to let the ancestors know because the one who is inside you or the angel that chose you and chose to work through you does not know HIV as at their time such things did not exist”.

Mukovhe, does not do rituals for HIV patients, “I have never come across a situation whereby a ritual is specifically performed to heal an HIV positive person. This is because it is an acquired disease, which is different from when a person’s illness is due to the ancestors. Moreover, in such a case, we can perform rituals and the person will be healed. For this one, we throw the bones and use herbs to improve his/her health so that the virus does not cause too much damage. We can also provide medicines that boosts and strengthens the individual. Once the person takes these medicines, you would not believe that the person is positive or that they were so thin. We know how to boost.

Khorommbi says, “There is no specific ritual that is done for the HIV patient, and if I see that there is a need for a ritual, I tell the family to do that in order to appeal or appease their own ancestors. The only rituals for this patient are the same as for any other disease, which is part of the healing procedure. For example, I will ask the patient to abstain from sex when taking my medicine, this will help as HIV is also transmitted sexually. I also do rituals to fortify the patient to be strong emotionally, spiritually, and physically, because other people give up because they are scared. So, I fortify them and their homes to be protected for any evil thoughts or spirits”.

Vho-Phaṭhe says, “First of all I will use tobacco snuff to connect with the ancestors before I diagnose the patient. Once the patient has breathed on the bones (u fembedza), I will throw them and make a diagnosis because a patient is not supposed to tell me what the problem is, the bones will tell me. Sometimes my ancestors tell me beforehand that there is patient who is HIV positive, coming from such a place. We see this in our visions. After discovering that the patient is HIV positive, the main thing is to strengthen the body, we prescribe medication to drink and also to put on soft porridge so that we can defeat the virus by boosting the immune system. That is why the patient will regain weight through our herbs”.

Vho-Mashudu says, “Our view of this disease (HIV) is different from the western way. When a patient comes, we firstly pour tobacco snuff to inform the ancestors that the patient has arrived, and we want to commence with the divination and please tell us what the problem that has afflicted the patient is. We perform a ritual, we dedicate him/her to our ancestors, we ask them for guidance on which medicine to dispatch and they will guide. Sometimes even after I have given the patient another medicine, I will still find out if the patient is reacting well and if not, the ancestors will show me another through vision. Some rituals are performed for thanksgiving, after the patient is healed. Others are performed for the protection of the whole family. Before the patient is discharged, rituals to fortify him/her may be performed. Other rituals are for healing and forgiveness. You see, rituals are broad”.

Vho-Mukonḡelei says, “Yes, we are able to diagnose that the patient has HIV/AIDS through divination. I remember that I once attended training for HIV. I have a certificate

to that effect. We were trained/workshopped about HIV for a week near Pietersburg (Polokwane). I once raised my hand and asked a question because when we throw the bones, we see that the patient has ancestral disease, the divining bones reveal that connection with the ancestors. People clapped hands, all the healers who were there said it was true but because we know this, we are thorough to check whether it is the ancestral calling or the disease. Because if we do not do that, we run the risk of making the patient perform the ancestral dance and the patient may collapse and die on stage due to weakened body. Therefore, the bones will further show that this person has sores in the stomach and how these came about, and we will know that the person is HIV positive.

Findings of the study suggest that rituals are performed to summon the ancestors to be part of the healing process, rather than to treat or cure HIV or any specific disease. However, almost all healers (94%) emphasized the importance of various rituals during treatment process.

5.4.3.1. Treatment of HIV/AIDS

Many healers who participated in this study, reported having good success in treating the symptoms of people living with HIV and AIDS.

Tshikosi says, “If the patient comes to us and we see that the patient is still on stage 1 (for wounds in the stomach) then we will give that patient medication to treat the wounds in the stomach”.

Vho-Matshavhanga, “When we are treating, we do not only focus on the wounds and pain on the body we also include ancestors, because not only the medication makes the patients better but the ancestors too. The important thing that I will always support is that us traditional healers not only treat the body of the patients, but we take into treatment the mind, body and soul of the patients and include the ancestors of the patients so that the patient can recover quicker”.

Vho-Thinawanga says, “We are able to treat the disease (HIV/AIDS), because if a patient comes to us complaining that he/she is sick. You know that a person who is

HIV positive will have diarrhoea, we therefore, give the patient medicine to stabilize the diarrhoea and it will stop. We know that the diarrhoea is caused by sores in the stomach. We will, therefore, give medicine to treat those sores. Some medicine to drink and another to put in the soft porridge. We do this so that we deal with the stomach because HIV is like a sore that is inside the person/body”.

Vho-Ndiambani says, “But as traditional healers, we don’t say we are treating HIV/AIDS. We don’t know HIV; we treat symptoms that are present and what we diagnose but there are few things that we are unable to treat that we need doctors. We are unable to treat high temperature on a patient so we refer the patient to the doctors, but we can put our hand on patient’s forehead so that we can feel the patient’s temperature”.

Tshikosi says, “Remember I can cure with any plant if my ancestors have directed me, what is important is the power that they bestow on it. So, respect is important”. “My ancestors reveal in my dreams and divulge remedies that are relevant to my patients, sometimes even before the patient arrives at my place”.

Vho-Margaret says, “Therefore, when we treat, we mix the medications of those various diseases that we see a patient suffering from, it can be *uwela*, drop, etc. So, we mix medicines for all those diseases to fight AIDS. As traditional healers we are able to cure the disease, the problem is that in the past, the government used to regard us as witchdoctors”.

Vhavenḡa says, “As for me, I do not use the divining bones; I simply look at the patient and listen to what they say. I also do not physically touch any patient; I do not make any incisions. I give herbs and other medicines and once you use them, you are healed. I also do not fortify homesteads”.

Vho-Mahandana says, “There are three different types of mushonga/herbs that we mix. There is one, which destroys the eggs inside the bladder (dundelo). We also have the one, which is used to clean women. The other mushonga is the one which is used to cure sexual transmitted infections such as ‘Drop’. There is also this red mushonga, which I use if you have problems with your ribs and when you are unable to use the

toilet (have trouble when passing urine). This mushonga cleanses dzitswio (kidneys) and blood”.

Sipho says, “The medicine is mixed with water. You mix half a litter of water and small amount of the herb. When you use it, it even cleanses your blood, and lungs. We measure the quantity of the medicine and then give the patient the measured one, which is appropriate for their intake. If for instance, I give the patient 1, 25 litters, such medicine can be shared by two people”.

Mukovhe says, “When the patient has recovered and the treatment is complete, we fortify the body so that the disease does not come back. So that when this disease comes back, or any other disease for that matter, tries to inflict the patient, the body would have been strengthened or fortified”.

Vho-Ndiambani says, “I use specific herbs and I give the patient to drink, and the disease disappears, and he/she becomes better. If a person is suffering from diarrhoea, we have remedies for that, and we have one for vomiting too. Now that’s what set as apart from doctors because we are able to cure all these infections brought by HIV”.

Vho-Mukonḡeleli says, “We treat this patient with medicines, we dig the relevant medicines, and we mix some in soft porridge and the others we give the patient to drink. We have gloves, we once went to Tshilidzini hospital and asked for gloves, but they told us that we have to buy our own gloves. Therefore, we buy our own and keep them because sometimes HIV patients get swollen legs, and we prepare the relevant mixture and wash the patient’s legs wearing gloves. This we do so that we stimulate blood circulation and address the clots or the sores. Therefore, after this we discard the gloves”.

Vho-Mahandana says, “We use “Muonze”. Did you write “muonze”? write “muonze”. I burn “Muonze”, and the patient has to smoke it through the mouth.

Sipho says, “As healers our ancestors are not the same. This one may use a mango tree (medicine) to treat, and I may use a papaya tree (medicine) to treat the same

disease. The gift of healing is in one's hands and one's blood. You can come for HIV treatment, I can take some leaves of a mango tree and squash or grind them for you to drink, and you get well. We do not use the same herbs or medicine, even when we summon the ancestors (u wisisa) we do not use the same things. For example, there are healers who have gone through training (u thwasa) and those who did not undergo the same training.

Therefore, the same goes for the treatment of HIV, we do not treat it in the same manner, he may use a particular medicine and I may use another. It not the same as modern doctors who will say if you have AIDS, you must take the purple pill, to a point that if you forget yours, you can take someone else's. Therefore, we do not do that, everyone has their own dreams/visions from their own ancestors, who guide how a particular patient should be treated for a specific disease. Everyone asks their own ancestors to guide them so that the patient can be healed. Even if the patient sleeps over, the ancestors will reveal which medicine to administer until the patient is healed”.

There seem to be a common understanding that the patient's ancestors play a significant role in their healing process. The healer's ancestors also help guide the healer in determining the cause of action, or healing procedures. During participant observation was also observed that the healing procedures and medicines vary from one healer to the other, even though they may be treating one disease, as this depends on the guidance from one's specific ancestors.

5.4.3.2. Assessment of successful treatment for HIV/AIDS

The findings of the study reveal that indigenous healers relies on feedback from the patient regarding recovery progress. This came out from the individual interviews as well as discussions and observations. They also mainly rely on physical observation of the patients.

Vho-Ndiambani says, “Like I said from the start as indigenous healers, we cannot see that the patient is HIV positive we can only notice the symptoms like, diarrhoea, *thusula* and other illnesses and once I am done treating the patient then I will refer the patient to go back to the doctors to get tested again. I do not have HIV test kits, like as I was

saying about the cooperation that if we could cooperate things would be much simpler. So, I cannot say this patient is HIV positive so the patient will go to the doctors where he/she was tested that, they are positive. The only thing I will see are the symptoms that I will treat but as for HIV/AIDS, that disease we do not know it as traditional healers”.

Mukovhe says, “To me don’t say HIV/AIDS patient, rather say a patient who has HIV/AIDS symptoms, because the people who came up with that name are not Vhavenda people, what we see are different illnesses in which when they are combined, people say is HIV. Therefore, I have had many patients who came to me with symptoms that are cured”.

Vho-Mukonḡeleli says, “It will be clear if the patient is improving, as the healer, I will also be monitoring each time I give the patient medication. However, if I see that the patient is getting worse, I will transfer the patient to the hospital because I do not want to give medicine to a patient who is in a bad shape”.

Nemadandila says, “Even if the patient goes back to the doctor to be tested and finds that there is only one line on the test kit, it does not mean that the patient is cured, it only means that the immune system is stronger again. This is because the doctors do not believe that there is cure for HIV”.

Vho-Tondani says, “I ask the patient to give me feedback. They will tell me if they are feeling fine or if the symptoms are gone, and then I will fortify them.

We make sure that we make the patient strong, that he/she will be protected from the disease, and we will look at the root cause of the disease, if it was caused by evil people or it is natural”.

Vho-Mamuremi says, “However, we will not be sure that this is HIV, we will be sure that there are sores in the stomach and the person will have diarrhoea. We do not know about HIV in our belief systems, what we focus on is healing the symptoms with relevant medicines. After that, we observe how the patient is recovering. The same as the hospitals where they ask you how you are feeling, we do the same. This is how

we assess the recovery progress. Yes, we throw the divining bones even for HIV patients. There is no healer that you will visit who will treat you without throwing the bones first. After this the healer will then explain to you what your ancestors used to do”

Vho-Thinawanga says, “The patient will give me feedback/results, to inform me that he/she is feeling fine. This is because sometimes I do not admit patients, I only give them medicine to take home and drink in the morning, during the day and in the evenings. Yes, and we fortify the patient so that the disease does not come back. We also check what caused the disease, whether people (witchcraft) caused it or a natural cause. There are diseases that occur because of other people, even this disease (HIV), sometimes it presents as HIV whereas people caused it.

Going back to HIV, you will find that sometimes others brought it but sometimes the individual was the one who took the wrong step, resulting in contracting the virus. The person becomes successful and forgets where he/she comes from. Finding a job and forgetting the roots, that, rituals were performed so that I can get this job, or when I bought a car, there were rituals performed so that my ancestors grant me the car. Therefore, when you forget to thank the ancestors, they can inflict you with a disease to remind you of your roots, so that you do not enjoy and forget yourself. Therefore, we go back to check all these. Even the bible says check where you set your foot wrong”.

Nemadandila says, “I cannot say they get cured because when HIV/AIDS started, and even now the doctors are saying it is incurable. That is why I encourage my patients, even those who are having a single line on test kits to carry on with medications. But I can tell you that my patients improve, and their immune system becomes stronger, that is why the test gives them a single line. I do not tell my patients that they are cured because western doctors said HIV is incurable. Now because these doctors are the ones that found that HIV lives in the blood, and as traditional healers we don't have machines to check it in blood. We follow the guidance and do not tell our patients that they are cured, we advise them to keep on taking medication even if they are feeling better.”

5.4.3.3. Handling of medicine

There are certain processes, and taboos that are observed when medicines are administered. This is to ensure that the sanctity, or potency of the medicines, is not tampered with, otherwise, the medicine will lose its healing powers.

Vho-Phatxe says, “Before we touch the medicine, we do a silent meditation in our hearts or sometimes louder, to invite my ancestors and the patient’s ancestors to please join hands and become one. I also ask that they pass a message to the creator so that the patient can be cured or healed”.

Vho-Margaret says, “We are very orderly, if you are a female traditional healer and you are still young it can destroy your family because your ancestors won’t allow you to be near a man for a couple of days and if you have a partner your partner might start to think that your seeing other people. The same applies to the male traditional healer, you must abstain before you handle certain medicines, and if you go against what your ancestors are telling you about abstaining, then all your patients won’t get cured or all your medicines won’t be effective. And another thing, a traditional healer is not supposed to be involved in sexual intercourse under a medicinal treat, or else your ancestors will take back the calling. We respect our healing trees”.

Vho-Mashudu says, “Sometimes I tell my patients not to do certain things, like sex or a woman cannot touch the medicine when she is menstruating, this may cause the medicine not to work. We do rituals for all diseases, not specifically for HIV/AIDS. Some of rituals are only for us preparing to touch our medicines.

Vho-Mahandana says, “For example, before we touch our medicines, we make sure that we are ‘clean’ (ritually clean) and not defiled. Sometimes we abstain from certain things ourselves, and there are times when we advise our patients to abstain, say, from sex or eating certain foods while they are using certain medicines”.

From the above, it is clear that both the patient and the healer, must be ritually clean when they handle the medicines, or herbs.

5.4.4. Views on collaboration with Western health care practitioners

In general, there is willingness to collaborate. There are certain aspects that they believe should be addressed for that to happen. Amongst others, the participants feel that western health care practitioners do not respect them or recognize them. However, most of them do not necessarily want to work in hospitals, but through referrals. The study also found that few healers feel that collaboration may compromise their authenticity. Below are some of the responses:

Vho-Mahandana, “If the western systems approves that we do our rituals and we use tobacco too, that’s where we can start to collaborate because traditional healing is not only focused on the using medicine, but we use ancestors so that they can connect use with the creator”.

Vho-Margaret, “Yes, I would love to work together with them. I have observed that clinics are using medication inappropriately (zwi songo tea). Nurses are giving HIV positive medicines inefficiently. I am not against them as professionals because I know that they have been educated and are qualified to do their job, but they are not using the medicine efficiently. If a person is sick and then go to the clinic with the prescription of the medicine s/he wants, nurses often turn the person back claiming that they do not have such medication. They are jealous if a layperson seems to have more knowledge than they do. If possible, I want to meet with the officials from the Department of Health. They should take me to the hospital to meet HIV positive patients”.

Vho-Ndiambani, “We as African traditional healers our treatments are based on our African religion but when it comes to working with doctors there are different ways that we can be able to cooperate with doctors. For example, doctors will tell their patient to take their medication in the morning, noon and afternoon and we traditional healers tell our patients to take medication in the very same manner”.

Mukovhe, “If we hold hands, there can be a collaboration because there are certain diseases that the doctors in hospital cannot treat successfully. These are African

diseases like drop and thusula, usually patients are given an injection in hospital, which does not fully cure them, and the disease recurs. However, we know the cause is the sores within the stomach, and our medicines can permanently cure these. The same applies when somebody develops a sore on the leg, which the hospital calls diabetic sores, which normally leads to the cutting of the leg. We call this sore pfuko and we are able to treat this successfully. Therefore, collaboration is important as because we will be focusing on diseases that the hospital cannot treat successfully”.

Vho-Mashudu, “Yes, it is true; the doctors do tell us to bring patients if the disease is serious because we don’t want a situation where we force to keep a patient if they are seriously sick and not responding to treatment. What I want to say is that those of you who are there on top must work hard to ensure collaboration between western doctors and indigenous healers. When we host our meetings, the doctors or nurses must attend or send one person so that they can listen and take the issues forward because there are diseases that the doctors cannot see or treat. Some of them are inherited from the mother and treatment entails treating both the mother and child. I have never seen any healer who goes to hospital to work with doctors or any of our colleagues who has ever been called to assist in hospital”.

Vho-Tondani, “If I am treating you and I find that something is confusing me regarding your condition, or if you do not have enough blood or water in your system, I will take you to the clinic and they will assist you. The department of health needs to educate doctors about traditional health so that there can be a cooperation. Our government should learn from Zimbabwe and Mozambique where there is a good relationship between hospitals and traditional healers. Another thing is that if a patient dies when using traditional medicine, they will say a traditional healer killed a patient, but when it comes western medicine and doctors, they do not say a doctor has killed a patient, which is really unfair”.

Randima, “As healers who base our healing processes in religion or belief systems, there are many things that we believe can be done to collaborate with western health practitioners. When the doctors give a prescription, they say the patient must take the medication in the morning, during the day and in the evenings. Therefore, even us as healers, we do not give our patients overdose, we have our own measurements. If we

prepare medicine in a bottle, we will tell the patient to drink a cup in the morning, during the day or in the evening”.

Sipho is also very passionate about the issue of collaboration and raised several pertinent aspects, “Therefore, collaboration will entail ensuring that we do not compromise the wisdom and knowledge given to us by our ancestors (it is like being given lotto numbers in a dream and then giving them to someone else, they will never gift me again, I will have chased them away because when the person wins and he/she does not give me even R20 to buy snuff to thank the ancestors for the gift). Therefore, at the doctors, there will be gloves, and many other things and they will not allow us to use tobacco snuff.

This means we may need to find doctors who believe in the ancestors and our practice to collaborate with in order to help patients. You will find that they administer treat through an injection or measure medicine with a very small cup whereas we as healers use a bigger cup to administer our own medicines. Because when I help my patients at home, I start by drinking the medicine that I will administer to the patient to test the potency of the medicine. This assures the patient that I am not giving poison and that I trust my own medicine.

Vho-Mukonǵeleli, “And also, we check on the knowledge that I as traditional healer I am given by my ancestors are the doctors not going take an advantage of my knowledge and make it their own without even recognizing me or even paying me for what I know. Also, the application of medicine between doctors and traditional healers is not even the same you will find that doctors will give their patient medicine through injections and small cups, which is very small, compared to the cup that I will give to my patient”.

5.4.4.1. Mistrust

One of the major challenges raised by indigenous healers is the mistrust, and lack of cooperation between themselves and modern health practitioners. The healers also fear that their knowledge may be appropriated, without compensation or acknowledgement.

Vho-Makonǵelele, “There is no cooperation with the modern health care system because they do not want us, and they want to send our medicines to laboratories. What hurt us the most as traditional healers is that if a patient has a broken bone, we have to send that patient to the hospital but us as traditional healers we do have medicines that can repair the broken bone. Like when a person is stabbed, I will look for a *bopha* or *mutondo* plant then squeeze the fluid out of the plant and apply it to the wound to stop the bleeding. That’s our first aid”.

Vho-Thinawanga, “What we are refusing most is that the doctors take our medicine to test it, as they will be undermining our medicine, because we know that our medicine works, and it is effective. Also, they will be taking our knowledge because once they are done with their test, they will say it is theirs”.

Vho-Ndiambani is very passionate about discussing the issue of collaboration and its challenges, he has this to say, “Doctors do not recognize us; they only recognize remedies or medicinal plants that we use so that I can help them. If doctors really cared about us, they would have included us traditional healers at their workshops. The government only consider us when they are doing research like what is happening now. So, I do not like the fact that the doctors know that we can save lives, but they say our African traditional medicine to pass by laboratories to get tested, they will say that there is no research to prove that this medicine can really cure, but if doctors really took us seriously there would have been a good cooperation. If there is a workshop for us traditional healers, we do everything and preparations on our own the government never gets involved.

However, when doctors do their workshops, the government will provide them with everything. Now there are research that are needed to be done and we as traditional healers are invited you will find they will only give us plates of food so as for me I do not attend such meetings because the government do not take us seriously. Another thing that brings me to the very same point that the government doesn’t care about us is that instead for the department of health to give us traditional healer’s gloves for free they are giving people condoms, which cannot treat anything. And another thing that I do so that my patients can be safe, is that I have enough razors so that I do not repeat

razors on my patients, and I wash my hands before and after I enter or leave my treatment house and I've done all these long before even covid-19 started".

From the above, it is clear that the healers are not happy about the relationship, and how they are treated by their western counterparts. The feeling is that they are only used by both western health practitioners, and government as research subjects, or when they need to use their medicine. So, the mistrust is on both sides.

5.4.4.2. Location for treatment

For the indigenous healers, location for treatment seems to be a critical aspect of healing. While there is a general support for collaboration by indigenous healers, they, however, don't want to compromise on the location where treatment should happen.

Nemadandila, "With collaboration, I agree that we must work together, but not for us to go to hospital, only on cross referral. We must also recognize and enjoy the respect and benefit that they have because even they are not able to heal many diseases which we as healers can cure".

Mukovhe, "We have our huts that we gather our ancestors there and when we go to hospitals there are no such things, it is just modern buildings which our ancestors died without knowing such. This may compromise us. There has to be another way, not us going to work in hospitals".

Khorommbi, "Those (doctors) work from the book and we have a calling from our ancestors. Therefore, they will not agree for us to go to hospital to throw the bones. It is better for us to work on our own. Being a healer is not a choice, the ancestors choose whom they like. But what we ask is that you must work hard until the healers are allowed to work in hospitals because many lives are lost unnecessarily".

Vho-Matshavhanga, "It can work, and I cannot work at the same time because we as traditional healers we will use tobacco (*ushela fola fhasi*) to communicate with the ancestors tell them there is a patient here please show us the way. We have our huts that we gather our ancestors there and when we go to hospitals there are no such

things it is just modern buildings which our ancestors died without know such, our ancestors were able to help the pregnant women to deliver a baby at home before they died, so traditional healers are unable to go the hospitals because our bodies are used/owned by our ancestors who knows nothing about the new generations and hospitals”.

Nemadandila, “Coming back to the issue of collaboration, it is a catch situation. It may work but there are aspects that may not work. For example, in our case we before commencing with treatment, we start by dedicating the patient to the ancestors, to say, ‘you with eyes to see, show us the way’. We are not rejecting collaboration or working in hospitals, but there is a space we require to gather our ancestors. We pour tobacco snuff, therefore, when hospitals are Modern houses that our ancestors do not recognize. Our forebears use to conduct delivery of children at home”.

Tshikosi, “They perform the services that they are familiar with but because we are in the modern generation, we experience certain challenges. We rely on our traditions because our bodies carry the spirits of the many who came before us. Even though I am still young, and this is my body, but it has its masters who controls/guides it. Even before I go to hospital, I must first ask permission by pouring snuff on the ground so that they can facilitate healing through modern doctors as we are living in the physical world in modern times”.

Sipho further says, “After preparing the medicine, I will first perform rituals by pouring snuff on the ground. If I am seeing the patient in hospital, I must first invite the ancestors to go with me, to lead the way. This is to ensure that even the nurses, those who wear white. Remember I will be wearing my own ancestral gear, mapalu na malungu (beads). Sometimes my nails will not be so clean because I use snuff and the doctors and nurses may not like that, I may be accused of being unclean. That is where we feel mistreated.

We also have our own consulting room and pharmacy where we collect our ancestral spirit, where I ask for guidance on which medicine to prescribe, so that the patient will recover the following day. When I sleep, they will reveal another one. Therefore, coming back to collaboration, we think we will be forced to compromise a lot. We want

to collaborate, but we are afraid that they will take our ancestral knowledge and medicines to the laboratory and reduce the potency. We prefer our medicines in its authentic form, and we know how to prepare and mix them without causing an overdose”.

From the above extracts, there is consensus that indigenous healers prefer to work from their own spaces. The feeling is that hospitals are not appropriate locations for the healers as this may compromise certain aspects of their healing procedures.

5.4.5. Participant observation

This study also entailed participant observation, whereby the researcher spent some time and participated in several activities and treatment procedures, where both the healer and the patients felt comfortable. After the individual interviews some healers invited the patients to participate in the healing processes and rituals. While these were mainly observations, the researcher was able to ask questions to the healer during breaks for clarity on certain activities.

5.4.5.1. Returning a patient who spent three months at the healer’s home.

The researcher participated in the performance of some rituals for some of the patients. This patient was brought to the healer barely able to walk. The healer was informed that the patient tested positive in a clinic almost a year before but has not been taking any medicine because he could not accept his status. The parents decided to bring him to the healer because he refused to go back to the clinic. The session that the researcher participated on was the final stages and a session where a patient was being brought home after having spent some time at the healer’s place.

During these sessions, researcher learned that the rationale for rituals is many folds. It is done to convey requests to the creator through the ancestors. It is done to ask for forgiveness, to forget the past pain and mistakes. The understanding is that everybody makes mistakes when that happens, we must humble ourselves and plead for forgiveness. Through rituals, the individual also makes requests/wishes known by the ancestors.

In preparation for the return of the patient, the healer must go ahead of the patient, to perform rituals of fortification for the homestead and to officially inform the family that the patient has recovered and is ready to come back home. The healer will also provide a list of items required. One important item is a sheep that is used to cleanse the homestead. Since the patient was gone for a long time, the healer must make sure that the evil that was there, or any evil intent, is removed before the patient returns. The researcher was informed that the forebears used a sheep and therefore the healer is following in the footsteps. This the researcher learned, was an old age tradition. The rituals will ensure that no one amongst family members falls sick. The whole family is also protected and partake in the activities.

In the specific session that the researcher participated in, a cow was also slaughtered within the homestead. The researcher was informed that this is merely for the consumption of the guests who will be there to welcome the patient back. The healer also brought with him an entourage of other healers who were there to support him and to be part of the dance/therapeutic ritual. The festivities took place over three days. The first day started with dzitshela (see image below) to summon the ancestors before the drums or dzingoma (see figure 2 below) can be played. The researcher also learned that the cow must be specifically slaughtered inside the homestead.

Figure 1: Dzitshele, dzitsanga and other items



Source: Picture taken by researcher in T̄hohoyandou, 2021

Figure 2: Dzingoma



Source: Picture taken by researcher in T̄hohoyandou, 2021

The researcher also learned that urerela (ritual) is considered very important. The healer who was leading the process explained that his approach is that when a patient comes to him, he starts by throwing the bones, which will reveal the cause of the sickness, whether he/she committed transgressions like stealing, killing or any other taboo, whether he/she was bewitched, or whether its natural illness, the bones will reveal this, and then further questions will be posed to the patient to confess. Treatment will commence to address the source of the illness or disease. Treatment will also depend on whether the patient can walk or not. If the patient cannot walk, there is medicine to test whether the patient is going to live or not. The bones will also reveal whether the patient will live or not.

If the illness is due to the ancestors, the bones will reveal whether the paternal or maternal ancestors are responsible. If the ancestors want the patient to fulfil their wishes, this will be revealed. Furthermore, the practice is that when a patient visits a healer, he/she will be accompanied by a family member, preferably an elder. The patient is also free to accept or reject the diagnosis.

If the illness is due to theft or any transgression by the patient, this will also be revealed. The patient will have to confess because he or she cannot lie in front of the healer or family members.

In this case, the healer believed that the disease was due to carelessness, and not witchcraft. The patient got the illness because of the many girlfriends he had and having sex without a condom. But because of this bad behaviour, the ancestors turned their backs on him, and he lost their protection. When he arrived, the patient was too weak and therefore, other than the water and tobacco rituals, not other rituals were performed.

The healer also confirmed that he does not use standardized or same medicine to treat patients who have the same disease, as this will depend on the healer's ancestors who guide the healing process, at times the patient's own ancestors once summoned through rituals, provide guidance on how the patient should be treated.

During this session, the researcher also determined that the understanding of HIV by the healer is the association with mbumbelo (womb). The understanding in this context is that both males and females have mbumbelo. It was said that mbumbelo yo hambela or nowa yo pfudela. The healer's objective therefore is to assess, through the bones, the state of mbumbelo, whether there are sores or any other problem. After this, he then determined the cause of treatment as guided by the ancestors.

The healer believes that the ancestors have given humanity many plants, which are life giving and these are utilized to treat or cure diseases. As to whether and HIV patient should partake in malombo, guidance comes from the ancestors through the divining bones and therefore this depends on a specific case.

The healer observes certain taboos, abstinence, and observations while he is treating patient. There are also instances where the patients are expected to observe certain practices, for example, if a woman is menstruating, she will be discouraged from using the medication as this can weaken or reduce the potency of the medicine. In this case these did not apply as the patient was male.

Regarding collaboration, the healer who was part of this ritual ceremony felt that collaboration with modern doctors or hospitals may be challenging because his healing comes from the ancestors. Therefore, it means he will have to consult them for permission. It is believed that sometimes they ancestors may just show signs that they do not want collaboration, for example, the healer may be involved in an accident while on the way to the hospital, or the car can simply break down. Another would be the ancestors revealing themselves through dreams/visions. The preferred route is that where patients feel the need to consult healers, they be allowed to go to the healer's place to consult and come back to hospital to continue with the treatment.

5.4.5.2. Training to become a Maine (healer)

The second case where the researcher participated in was the return home of a patient who was training to become a healer. This healer was trained for 3 years, however, the researcher learnt that the healer spent three months in the beginning, and later she was allowed to go home, but she had to come to spend the final year living with

the healer fulltime. During this time, she was taught how to interpret the diving bones, how to interpret her dreams and how to collect and prepare medicines. In addition, the trainee healer also assists with general chores and errands around the healer's homestead. In this case, the healer also arranged with the family. Like in the case of an HIV patient, the healer also fortified the family before the patient, or the new healer arrived. A sheep was also slaughtered for the ancestors. Furthermore, a cow was slaughtered for the participants, but certain parts from the cow were used for the rituals.

The researcher also learned that great emphasis is placed on slaughtering within the homestead and the blood is considered to appease the ancestors or cleanse the home. The event was preceded by dzitshela and malombo over the weekend and on a Sunday, the final activities were performed. This was mainly the introduction of the new healer to the community. The day started around 3 am with dzitshela (no drums) to summon the ancestors. Then u phasa rituals were performed using snuff, water and traditional beer and certain medicines. Incense was also burnt. This was followed by malombo around 5 am. The entourage, led by the senior healer, went to the traditional leader (Musanda), to introduce the new healer and to explain what was going on over the weekend.

At the homestead in the presence of community members, certain tests were conducted, like hiding items and asking the new healer to find them. The researcher learned that this is to test the healer's power or visions as guided by her own ancestors. Few patients were also brought for the new healer to diagnose under strict observation by the senior healer.

The whole family was fortified, their properties were fortified, for example, the son of the new healer's car was 'prayed for' by the healers so that he can be protected on the road. They danced around the car and the senior healer also sprinkled a liquid mixture in the car. This was also thanking the ancestors for the gift. Once everything was done, final rituals were performed using snuff, traditional beer, and other items that the researcher was not allowed to record. There was then the clapping of hands and ululating. It was after this that the rest of the community was allowed to participate in the malombo rituals and general dancing as part of the celebrations. The cow that

was slaughtered was cooked and served to the community members and there was a great feast all around.

5.4.5.3. Observation for an HIV patient

The researcher participated in a session where a patient who came to consult had HIV. On arrival the patient, took off his shoes, and was asked to seat a slight distance away from the healer. The patient brought with him two family members, his brother, and his father. After the greetings and introductions, the healer informed them that he knew they were coming. He was spot on in identifying who the patient amongst the three is. He then asked them (all three) to blow in the little bag that contains the divination bones. After throwing the bones, he began the diagnosis.

The main message being that the patient has angered the ancestors because he refuses to acknowledge them. To this, the father agreed that the patient refuses to perform certain rituals at home. And because they turned their backs on him, he became vulnerable, and his stomach was inflicted (u hambeliwa). The patient was told that because this is a punishment from the ancestors, he must go with the healer to fetch the herbs that will heal him. This was to be done the following morning. The patient was told not to eat anything and to abstain from sex when he comes. They were to fetch the medicine before sunrise. The healer also indicated that if there are further messages from the ancestors, he will communicate in the morning.

The medicines were prepared in bottles and the patient was instructed to drink a cup three times a day. This was to remove the 'dirt' from his body (nowa). This outpatient only visited the healer on specific days. He was asked to report progress to the healer. After about three weeks, the patient reported that he feels fully recovered, and that the symptoms, the diarrhoea and dizziness were completely gone. It was at this stage that the patient was asked to go a bath in a flowing river, to wash away the bad spirits. Incisions were made on his body and some herbs were administered to strengthen and protect him.

The healer used a new razor, and he wore gloves. To this he said that is what they were told to do by the department of health. The healer also promised to visit the

homestead to fortify it (the researcher was not part of this process at the homestead as it was done very late in the night. The healer also said that no one else is supposed to know what was done as this may compromise the family).

As the patient was discharged, he was advised to stay away from women and to become faithful to his partner to avoid re-infection. The healer also advised the patient to use condom during intercourse. This he later explained to the researcher that he was told during HIV/AIDS workshops conducted by department of health.

5.4.5.4. Cleansing, healing and return of the spirits.

This ritual is performed when someone died far away from home. It could be difficult to bring the mortal remains home, or even if the remains are brought back, it is important for the spirit to be brought home, integrated with other ancestors at the appropriate time, so that it continues to protect the living.

The specific case that the researcher observed was the return of the spirit of the deceased who died in a car accident. The healer was asked to accompany the family to collect the spirit and bring it home before the burial. On the day of this ritual, the healer prepared a liquid medicine, took a branch of a tree called Mukhalu/ mutshetshete (*Ziziphus mucronata*) to carry the spirit of the deceased from the place of death to the new resting place. The researcher was told that another tree called Muswoswo (*Synadenium cupulare*) commonly known as the buffalo thorn tree can also be used to carry the spirit.

On arrival to the place of the accident, the healer used to branch to sprinkle the medicine, while talking and calling the name of the deceased. Then one family member also spoke to the spirit, calling it and informing it that they came to fetch it home. They also took some soil and little stones, and these were to be taken to his grave.

As they left, they kept informing the spirit of all the places they were passing, including rivers or bridges. The branch was not immediately brought home but was taken to the mortuary to integrate with the body. Because the deceased died a violent death (car

accident), the body was not to be brought into the homestead as this is believed to attract more accidental death.

Once the body was placed on the coffin, the person carrying the branch, and supported by the healer, led the cortege, continuing to speak to the spirit. On arrival home, the branch was placed on the coffin until the burial. While people were at the graveyard, the healer prepared some medicine for the whole family to bath with in order to remove the bad spirit. There were to be further rituals after a few days, but the researcher did not partake in these. According to the healer and the family, these rituals are important as they prepare a passage for the spirit to join other ancestors at the appointed time. The cleansing medication also strengthens and helps the family to heal.

From the above, several findings are made, firstly, and in line with the individual interviews, the researcher found that rituals cut across various diseases and conditions and not specific to HIV/AIDS. While indigenous healers have a fair understanding of HIV, they seem to generally associate it with sores in the stomach. Finally, all healers place sacred significance on the performance of rituals. Finally, rituals are also performed in observance of certain cultural rituals. The next chapter will look at an in-depth analysis and discussion of data as presented above.

5. 5. Participants' brief background

This section presents a brief background of the study participants. This is important to provide context, experience, and expertise. Furthermore, this section provides testimony that the participants have real-world experience in the subject under study. A short summary of each participant's age, number of years' experience and areas of specialization are presented for ease of reference.

VHO-MAKONDELE. Vho-Makondelele is a 71-year-old male who resides in a peri-urban area called Shayandima. He has been a healer for 18 years. While he went to school until grade 8 (form 1), he can read and write and can converse in English. He did not finish school because his calling does not allow him to further his studies. Vho-Makondelele is a well-known Maine (indigenous healer) who also specializes in the following:

- Treatment of HIV/AIDS
- Training of initiates (u Thwasisa)
- U ŋea mashudu (blessing of giving people luck)
- Nḁivho ya Mishonga (knowledge of medicinal plants)

VHO- MAHANDANA. Mr Mahandana is a 65-year-old healer who has been practicing for over 30 years. He has a large collection of herbal remedies in his house. He also went to school up to high school but did not specify the grade. He is known to treat many diseases like:

- Sexually transmitted diseases,
- Erectile dysfunction,
- as well as Infertility.

NDIAMBANI. Ndiambani is a 64-year-old woman who comes from Nzhelele. She has been a healer for 34 years. She passed form 3 (grade 10) she has worked in various companies as a panel beater because she furthered her studies at an FET college. She has also worked as a Human Resource Officer. She considers herself a general practitioner because she treats a variety of diseases, like:

- Mental Illness (Tshipengo),
- Infertility (u vhumbela uri thumbu l fare),
- Piles,
- Gokhonya (indigenous diseases affecting infants and mothers),
- Goni (Indigenous disease affecting children),

In addition, she

- trains those who have a calling to become indigenous healers,
- serves as a midwife (ubebisa), helping women who are pregnant and also during labour, and
- has knowledge of medicinal plants.

VHO-NEMADANDILA. Vho-Nemadandila is a 48-year-old male with 20 years' experience as a healer. He passed grade 12 and furthered his studies at a tertiary institution. He is a former lecturer of a local FET/TVET college. He stopped lecturing due to the calling to become a Maine. He is a farmer and owns a scrap yard, but he sees himself as a fulltime indigenous healer. He is a general practitioner who specializes in:

- Treating mental illness
- Training new indigenous healers
- Ritualistic/ancestral dance- u lidzela malombo
- Cancer
- Sores

VHO-PHAṬHE. Mrs. Phaṭhe is a 51-year-old woman with about 25 years' experience. Besides being a healer, she runs a cultural centre whose purpose is to preserve the Venda culture and heritage. She is also currently studying for her Masters degree in African studies. She comes from a family of healers; her father and older sister are also healers who, according to her, have healed more than 50 patients who were HIV positive. She specializes in the following diseases:

- Children's diseases
- Traditional birth attendant
- Women's diseases

VHO-MASHUDU. is an 81-year-old male with 59 years' experience as a healer. He passed grade 12 (standard 10). He previously worked at the Venda Development Corporation from 1983-1998. He has also worked for the department of Tourism as a Tour guide. Furthermore, he was worked as a police Reservist. He is now a founder of his own tourist company. He is a general practitioner who treats amongst others, the following:

- Breast cancer
- Prostate cancer

- Infertility (u simetshela)
- Different types of sores including diabetic sores

VHAVENDA. VhaVenda is a 68-year-old who has been working as a healer for 34 years. He passed standard 6 (grade 8) and worked at AGRIVEN). He us an herbalist (Nangathubwa) who is knowledgeable about many diseases and their remedies. He also assists many other healers in the collection and preparation of medicinal plants. He has acquired a wealth of knowledge over the years regarding the use of herbs to treats various ailments.

VHO-THINAWANGA. Vho-Thinawanga is a 72-year-old female with 10 years' experience as a healer. She passed standard 5 (grade 7) and is working fulltime as a healer. She treats the following diseases:

- Children's diseases
- She is a traditional birth attendant.
- She performs rituals for newly born babies (u thusa vhana)
- She is knowledgeable in medicinal plants.

VHO-SARA. Vho-Sara is a 77-year-old female who has 55 years' experience as a healer. She is an herbalist who is knowledgeable about medicinal plants and has helped many people in treating various ailments, including HIV opportunistic infections. She is currently on retirement after working at a tertiary institution as a cleaner for many years.

VHO-MAGORO. Vho-Magoro is a 56-year-old female with 16 years of experience as a healer. She is currently working as a teller in one of the large grocery chain stores in South Africa. She previously worked at KFC and Steers. She is a general practitioner who has also treated patients who are HIV/AIDS positive. Amongst others, she treats the following diseases:

- Tshipfula (a sore that does not respond to conventional treatment)
- Ngozwi (Assisting women who struggle to conceive)

- Bringing families together after divorce or on the verge of divorce
- Fortifying homesteads
- U i lafha musu muthu ana khumela (miscarriages)
- U lafha lukuse lwa munna (male infertility)
- U tshinisa malombo (Ritualistic dance- ancestral dance)
- U vumba (Predictions for the future)
- U lafha nowa gudu- Healing problematic legs (pain and swelling that does not respond to conventional treatment)
- U bvisa maqingani- Facilitation of the cleansing and reintegration of bereaved spouses (male and female) after the death of their partners

MUKOVHE. Mukovhe is a 31-year-old male who has two years' experience as a healer. he passed standard 7 (grade 9). He is self -employed and has never worked for anyone or a company in his life. He is a general health practitioner who specializes in the following:

- Uthwasisa,
- Malombo-Ritualistic/ ancestral dance for the sick
- Epilepsy
- Drop-
- Sores in the stomach- zwilonda zwa dangani
- Sickness because of sleeping with a woman who has aborted a pregnancy.
- Ngoma ya vhana- Children's disease
- Tshipfula (a sore that does not respond to conventional treatment)

VHO-MUKONDELELI. Vho-Mukondeleli is a 74-year-old female who has been practicing as a healer for 49 years. She passed sigisi (standard 6/grade 8) ya kale she worked at Tshilidzini hospital from 1969 until 1989 as a floor worker, but she quit because of the calling to become a healer. She committed herself in this field. Her specialization is:

- U thwasisa (training new healers),
- U thusa vhana - She performs rituals for newly born babies.

- U simetshela/ngozwi (helping with infertility problems)
- Magokhonya (indigenous diseases affecting infants and mothers)
- Children's diseases.

TSHIKOSI. Tshikosi is a 38-year-old female who has 18 years' experience as a healer. She passed grade 12 and was admitted at university to study for a Bachelor of Social Work. However, she dropped out and could not complete her studies due to the calling to become a healer. Her specialization is in the following areas:

- Tshifakhole (Epilepsy)
- Tshipengo (Mental illness)
- General diseases

VHO-RANDIMA. Vho-Randima is a 47-year-old female who has been practicing as a healer for 3 years. She passed standard 7(grade 9). She has never been employed and she specializes in treating the following ailments:

- Tshipfula (a sore that does not respond to conventional treatment)
- Malombo/Ritualistic/ ancestral dance for the sick
- And many other general diseases

KHOROMBI. Khorombi is a 42-year-old male who has been practicing as a healer for 24 years. He passed standard 7(grade 9). He has never worked in his life and focuses on his healing calling fulltime. His specialization is:

- Tshipfula (a sore that does not respond to conventional treatment)
- U tshinisa Malombo/ Ritualistic/ ancestral dance for the sick
- U thwasisa/ training new healers,
- U thusa vhana- rituals for newly born babies
- General diseases

VHO-MAMUREMI. Vho-Mamuremi is a 54-year-old male. He has been a healer for 22 years. He passed standard 10 which is now grade 12. He worked at Anglo American as a security officer. He specializes in:

- Sexually transmitted diseases
- Other diseases affecting men and women.
- U vhea midi (protection and fortifying of homesteads)

SIPHO. Sipho is a 48-year-old Male with 15 years' experience as a healer. he passed standard 7 which is now is grade 9, he has never worked but is self-employed. he is a general health practitioner who specializes in the following:

- U thwasisa (training to become a healer)
- U lidzela muthu atshi khou lwala (ritual drumming/malombo for the sick)
- Vhulwadze ha tshiivha(epilepsy),
- Dꞗorobo (Drop/STD),
- Zwilonda zwa dangani (stomach sores),
- U wela (a disease believed to emanate from sleeping with a woman who has just aborted a pregnancy),
- Ngoma ya vhana (children's diseases),
- Tshipfula (a sore that does not heal through modern treatment)

VHO-MATSHVHANGA. Vho-Matshvhanga is an 84-year-old female. She is the oldest in terms of age, and the 2nd most experienced of all healers interviewed for the current study. She has been a healer for 54 years. She is well vested in many diseases and related rituals. She has also trained hundreds of new healers. While she says she has treated many diseases and illnesses, she specializes in the following:

- U thwasisa (training trainee healers)
- Performance of various rituals
- Children's diseases
- Ngozwi (Fertility)
- Malwadze u muhumbulo/tshipengo (mental illness)

For the current study, it was important to capture and provide brief biographies of the participants, in order to enable the reader to develop of an understanding of who they are, but most importantly, the meaning that the participants ascribe to their experiences. This also shows their relevance and why they were chosen for the current study, as they have insider perspective, and are practitioners and experts of the subject being studied. This was another form of validation on the authenticity of information acquired.

5.6. Conclusion

This chapter presented a detailed description of the results of the study, from the demographic profiles of participants of this study, as well as the themes and subthemes that emerged from the data collected. The results show that there are different types of rituals that are performed at different stages of treatment, both by the healer and the patients. The views of the healers regarding collaboration, also emerged. The results as presented, will be discussed in detail in the next chapter below.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1. Introduction

The purpose of this study, as reflected in the introductory chapter, was to understand the Socio Cultural and Philosophical Importance of Rituals in Traditional Medicine, focusing on HIV and AIDS treatment in the Vhembe District of the Limpopo Province. The previous chapter presented the findings or results of the present study. In line with the previous chapter, the current chapter, provides a discussion of the main findings of the study as presented and based on the review of the primary information as obtained.

The analysis of data was done in accordance with the research objectives as well as the aim of the study. The aim of the study was to explore the role that indigenous medicine could play in health care delivery in South Africa, specifically in dealing with HIV infections. The objectives of this study were as follows: The first objective was to describe the indigenous healers' health and healing paradigm; The second was to describe the philosophical stance on performance of rituals during a healing process; The third objective was to explain the socio-cultural significance of the rituals that are performed as part of the treatment procedures by indigenous healers. The fourth objective was to give an in-depth analysis of rituals associated with HIV/AIDS, and finally, the fifth objective was to come up with facilitative guidelines for the provision of ritual performances during collaborative healing processes of selected diseases.

The main findings of this study can be summarized as follows:

- There is a general understanding of HIV/AIDS and its causes by indigenous healers.
- Rituals are not specifically reserved for a specific disease like HIV/AIDS, as was the intended focus of this study, but rather part of the integrated holistic healing process for any disease handled by indigenous healers.
- There are various types of rituals performed at different stages of healing, by both the healer, the patient and at times, the family. For example, rituals

performed to consecrate the herbs by the healer, rituals to summon the power to heal, and the healing rituals conducted at various stages of healing.

- Rituals deepen the individual's connection with the ancestors and restore harmony and balance in an individual, and therefore, serve as a gateway to the land of ancestors and the realm of spirits or the supernatural.
- The most significant finding in this study, as articulated by all participants, is the significance of the socio-cultural practices embedded in the healing process. That is, rituals and ceremonies give one the purpose and an opportunity to reconnect with oneself but also the family and community. Ritual is the gateway to healing, and is necessary because, of the belief that sickness, or disease is a way for the body to communicate what the soul needs or what the ancestors need.
- The study found that rituals, and ceremonies are the backbone of the traditional healing practice, without which the healing processes become futile.
- While the researcher wanted to do an in-depth analysis of specific socio-cultural practices, or rituals associated with HIV/AIDS treatment, the results of the study found that most rituals that are performed, are not specifically set aside, or delineated for HIV/AIDS, but cut across all illnesses and diseases as they are embedded in the healing process itself.
- In articulating their understanding of HIV/AIDS, most of the healers' explanations of the causes of HIV/AIDS was that it was a behavioural disease caused by physical aspects, rather than a spiritual disease or illness. However, at least three participants believed that one can contract HIV because the ancestors would have turned their backs or removed their protection from an individual who has transgressed.

The above findings will further be unpacked below. From the interviews conducted, the participants, one can sum up that rituals are to the soul, what food is to the body, because if the soul is not nourished, the body suffers and in a similar way if the spiritual part is not nourished, the body will get sick or 'dis-ease'. It also became clear that the socio-cultural and philosophical aspects of healing move beyond just the healing process, but are a significant part of intangible cultural heritage, which must be transmitted from one generation to the next. It is this knowledge that needs to be

preserved for future generations, but most importantly, this must be explored as potential area to address the many health challenges that our country faces.

Four main themes, as reflected in the previous chapter, emerged from the data collected and these are aligned to the study objectives. Furthermore, sub-themes were also identified as embedded in the main themes. These themes are discussed hereunder in line with the data as presented in the previous chapter.

6.2. Understanding of HIV/AIDS

During the collection of data, it was easy, from the responses, to tell between indigenous healers who have been exposed to HIV/AIDS education, from those who have not been exposed to same. For instance, those trained or attended workshops by the Department of Health or other organisations, seemed to be more knowledgeable about HIV/AIDS, in terms of definition and explanations, than those indigenous healers who have never been exposed to training, especially regarding the myth associated with HIV/AIDS. The 'trained' healers were also prepared to negate some of the claims that are generally made by healers, for example, that they can completely cure or heal patients with HIV/AIDS as opposed to managing opportunistic infections.

This is consistent with Zuma, Wight, Rochat & Moshabela, (2017), who states that after training indigenous healers became able to define and describe HIV accurately and to give the correct symptoms of HIV/AIDS. More specifically, the healers who participated in this study, and who attended workshops, were able to articulate that there is no cure for HIV/AIDS, and that they refer patients to clinics, as opposed to those who believed that they could cure HIV/AIDS. Most of the healers interviewed understand and define HIV, at least in terms of the biomedical cause and the symptoms.

As indicated in the literature, South Africa has the biggest HIV epidemic in the world, and accounts for a third of all new HIV infections in Southern Africa. Naidoo, Ferreira, Subramaney & Paruk (2021) estimates that the HIV prevalence among the general population is high at 20.4%. Therefore, with such high rate of infection, we cannot

afford, as a country, not to have an integrated and coordinated system to deal with this scourge. To do this, there needs to be serious and determined involvement of indigenous healers in government strategy to deal with HIV/AIDS.

(i) Symptoms of HIV/AIDS

There is a consensus amongst most participants who were interviewed for this study regarding the symptoms of HIV/AIDS. Most described as dry skin, weight loss, sores in the (inside) stomach, coughing, high temperature, hair thinning as well as diarrhoea. Loss of appetite was also believed to be another symptom. There are instances where HIV/AIDS was associated with Tuberculosis, cervical growth/cancer, or other sexually transmitted diseases.

Another common symptom associated HIV/AIDS is stomach cramps. Most of these are in line with the World Health Organization (2013); Treatment Improvement Protocol Series (2000) and Medical News Today's (2020) findings. One healer also mentioned paralysis without a cause. Although few equated certain symptoms with the call to become a traditional healer or understood the infection as being caused by the removal of protection by the ancestors, most of the healers' explanations of the causes of HIV/AIDS, was associated, not with witchcraft or ancestral call, but by physical aspects.

However, as alluded above, at least three healers believed that one can contract HIV because the ancestors would have turned their backs or removed their protection from you. The study found that certain symptoms sometimes mean something different in the indigenous healing world, like a calling to become a healer, or a need to perform a specific ritual if the ancestors are not happy. What is interesting in this instance is that it seems that certain patients may be misdiagnosed as being called to become healers, whereas they are HIV positive. The risk here is that this misdiagnosis may delay the treatment, putting the patient's life at risk.

HIV/AIDS is also associated with Gonorrhoea (commonly known as drop) which is a common Sexually Transmitted Disease, whereas other participants move from a view that once a patient starts to have all these Sexually Transmitted Diseases, they will

result in HIV. This assertion is supported by the Centre for Disease Control and prevention (2021), who found that if you get an STD, you are more likely to get HIV than someone who is STD-free, and that people who get syphilis, gonorrhoea, and herpes often also have HIV, or are more likely to get HIV in the future. The association of HIV/Aids with Gonorrhoea is an indication that healers acknowledge that HIV/AIDS is associated with risky sexual behaviour, and not necessarily witchcraft or other spiritual causes.

From the above findings, there is a need for continuous training of indigenous healers regarding their understanding and proper definition of HIV/AIDS and clear identification of opportunistic infections and associated symptoms. This is important as there are always new healers being trained in the profession. The gap in knowledge between healers exposed to training and those who are not should also be addressed. However, it seemed the exposure to training on HIV/AIDS has in some way influenced the healers' responses, to a point of almost negating their own indigenous processes to healing or influencing a move towards encouraging patients to use both biomedicine and indigenous medicine at the same time.

This is consistent with Audet, Ngobeni & Wagner (2017), who found that 69% of HIV infected patients from Bushbuckridge in Mpumalanga Province of South Africa, reported that they routinely visited both types of practitioners to treat their HIV disease, opportunistic infections, and side effects from antiretroviral medication. The dual consultation, and usage of both biomedicine and indigenous medicine, therefore, bring forth concerns and possible toxicity as patients may be taking similar medicine prepared as pills and in its herbal forms. This area warrants further research.

(ii) Diagnosis

From the data collected, diagnosis is procedure in which the healer identifies the disease or illness in terms of natural or unnatural causes, through an independent assessment, most commonly, bone throwing or other means. What is important here is the identification and labelling of the problem, which gives the patient hope that as the healer knows, or has identified the cause, he or she will be able to treat or heal the

disease. The diagnosis of patients is acquired through guidance and communication with the ancestors. Most healers diagnose HIV/AIDS by throwing bones, and according to them, this is their way of asking the ancestors about the patient's problem. The bones would reveal even the underlying causes beyond the physical symptoms. However, some participants explained that the oracles would not always clearly articulate or recognise the disease as HIV/AIDS but would show that the patient has an incurable disease, or the patient has the disease of the blood or affecting the blood. Therefore, because of their knowledge of the symptoms, and of HIV signs, the healers would know that this is HIV/AIDS.

The course of action also differs and vary from healer to healer. Some would advise or give the patient the option to go for an HIV test or continue with the treatment, while others would proceed with the treatment of the patients without necessarily offering this option to patients. There are those who indicated that when initiating the diagnosis process, they sometimes accompany patients to the health care facility or simply refer the patient to go for HIV test. One healer reported that he does not use divining bones to diagnose HIV, but simply rely of the physical symptoms that the patient present with. Healers who claimed to cure HIV reported diagnosing the illness through indigenous practices, like throwing the bones, for example, while others discussed accompanying suspected HIV cases to the clinic for testing.

From the above, and the data as presented, there are inconsistencies or lack of standard regarding the diagnosis of HIV/AIDS by indigenous healers. These inconsistencies may be due to exposure levels and the experience that specific healers may have. This points to a need to work with healers to develop a standard for the procedure for diagnosis that can be used or followed by all healers dealing with HIV/AIDS. This guideline or procedure would be based on their healing framework and not imposed on the healers. It would be important to acknowledge the uniqueness in approach to healing by different healers.

(iii) Vhulwadze ho ḁaho na vha nnḁa (The disease that came)

There are varying views regarding the origin, or cause of HIV/AIDS. Five of the participants believe HIV/AIDS originated from 'whites or those who came. They said

that this is a disease that came with white people from foreign countries. Another healer also indicated that HIV/AIDS is the disease that came and was deliberately infected to black people as a way of curbing the black population. Some participants, particularly in individual interviews, considered HIV/AIDS as one of the “new” diseases which could not be handled within the indigenous healing framework. This is a contradiction from those who claim to have been successfully healing HIV/AIDS patients for a long time. It is also a contradiction to those who believe that HIV/AIDS is an old disease as reflected below.

(iv) Vhulwadze ha kale (An old disease)

As opposed to the assertions above, other healers who participated in this study believe that HIV/AIDS is an old disease, that indigenous healers have always cured. They even give them indigenous names in line with this belief. This assertion seems to be due to the healers confusing HIV/AIDS and other sexually transmitted diseases, that are known to be cured by indigenous healers.

As reflected elsewhere in this section, there is no common understanding amongst indigenous healers, of what HIV/AIDS is, how it originated and whether it is curable or not. Clearly there is need for training and information sharing so that healers can be fully informed about HIV/AIDS. Should this not be properly done, patients may be at risk if they fall within the hands of those who claim that they have always cured the disease.

6.3 Philosophical and socio-cultural significance of rituals

From the data collected several sub-themes emerged and these shed more light on the understanding of the true nature of healing rituals. Indigenous healers in this study understood the management of HIV/AIDS patients in varied ways, using both Western and socio-cultural insights to explain their understanding of HIV/AIDS and their responses to patients’ healthcare and treatment. The healers covered aspects of health ranging from religion, physical, social, cultural, and emotional well-being. It is

clear from the data presented that, indigenous healers place value on the significance of rituals and their centrality on the treatment or healing procedures.

It is important also to reiterate that this study found that rituals cuts across the healing system and procedures, and not necessarily specified for HIV or any other illness, unless it is prescribed as part of prescription for a particular illness. This is consistent with Mensele (2011), who found that ancestral healing involves all dimensions of health and growth on psychological, spiritual, physical, and social levels. Furthermore, while rituals cuts across all illnesses, a different instruction, as well as a different healing procedure from one's own ancestors, would be prescribed.

During the interactions, and through informal chats with healers during participants observation, it was found that that some of the rituals usually involve the slaughtering of an animal, either cow, a goat, sheep, or chicken, depending on the purpose, the significance or simply the instruction from ancestors. The slaughtering, which must be done properly, is very critical as the blood signifies the connection between the individual and the ancestors, in other words, the eternal bond between the ancestors and their descendants.

Therefore, the slaughtering is done according to specific instructions, and must be done at the right place which often is the homestead (see below images). This spiritual healing provides a sense of security, rootedness, anchoring and validates the identity of the descendants and a sense of belonging and purpose in life. This, therefore, implies that these ritual activities reflect respect, acceptance, or degrees of beliefs in the powers of and the role played by the ancestors in the patient's health and welfare. This view is buttressed by Thinawanga, who says.

“Therelelo is a prayer or a tribute to those who passed on, our grandmothers and grandfathers and those whom we don't know, by uphasa we are remembering them so that we do not forget about them as they did not forget about us, that is why we do uphasa when whole family is present including the children so that each and everyone has a good path. So, during the healing process, we summon the ancestors as a form of acknowledgement and to invite them to lead the process because without them, I may not see what the problem is, and I may not know which medicine to use.”

The findings of this study therefore suggests that the physical and spiritual aspects of health are intimately connected, that is, it is a process where the body and spirit or spiritual dimension, must heal together. These healing ceremonies promote wellness by connecting the patient's spirit with the Creator (through the ancestors), and the Cosmos. This therefore suggests that the incorporation of explanatory models and symbols into the social, and ritual context of spiritual healing is essential to traditional healing therapeutic effect.

Furthermore, the findings also suggest that rituals offer transformative power, giving the patient the courage to believe and feel whole again. At the same time, offering stability, emotional support and becoming an integrating force in the community. Rituals thus have an important place in assisting people to move through periods of turmoil and change in both cognitive and non-cognitive capacities. Rather than serving as a fixed form of culture, rituals help people to adapt to new situations through the reciprocal action and interaction of ceremony. This is consistent with Some (1997) who also found that before getting started with any aspect of life, travel, a project, a meeting, we first bring the task at hand to the attention of the gods or God, our allies in the Otherworld, through rituals.

From the above it can be concluded that, the act of ritual is to openly admit to the ancestors, what we are facing, and that we need them, and are prepared to subject ourselves to their wishes to maintain the connection. By ritually putting what we do in the hands of the ancestors, gods, or God, we make it possible for things to be done better because there is then more than we are involved in, to getting it done. The performance of rituals also shows or symbolizes the willingness by the patient, and those supporting, to surrender to the higher power, or the Spirit, and this then ensures greater alignment, not just of the person who is sick, but the family, the community as well as the environment. The healing process, therefore, becomes fully holistic, focusing not only on the physical, but repurposing the individual and the community at large.

As embedded in and being part of the healing process, rituals have a therapeutic role. This process is facilitated through the realization that the healer has similar

characteristics as the patient, especially in terms of belief system, which encourages the patient to have confidence and confides in the healing person, and the process in general. Rituals are part of an explanation for patient symptoms and form part of a system for treating them. Furthermore, as rituals require active participation by both healer and patient, and to a certain extent, family, and community members, this offers an opportunity for both to accept the method for restoring the patient's health. But this also provides an opportunity to resolve any tensions that may be there, thereby reuniting members of the family or community at large. This is consistent with Mufamađi (2001), who found that healing is group oriented and the concept of the family members as the 'extended patients' gives opportunity to iron out differences that might be found.

As per the findings of this study, rituals contribute to providing a protective space and help the patient to better respond to the disease or illness. As Sodi (1998), suggested, resolving the tensions that are causing the problem do not simply provide cultural support, but also changes the patient's capacity to express the symptom and the group's pattern of responding to the patient and is also in a way, re-organising the lives of everyone according to certain principles of group processes.

From the findings of this study, we learn that rituals, be they for healing, supplication, cleansing or protection, ancestral summon, they form the backbone of who a people are as a community. The above statement strengthens numerous revelations made in this research of the significance and value of ritual activities performed by traditional healers. The rituals therefore become a source of strength to individuals and other people who participate in the performance of these rituals, and through them, patients believe that they are cured of their diseases. The rituals are not just socially and psychologically therapeutic, but also contributes to family and group cohesion.

(i) Significance of rituals

Rituals prepare patients for healing by building their confidence and encouraging them to deal with forthcoming events, as well as providing an opportunity for re-entering the community and group support, which becomes part of social integration, where the

patient gains support from members of the family and community at large. Rituals, therefore, provide anxiety- reducing performances.

Furthermore, as most rituals and healing practices forms an integral part of an individual's cultural heritage, or a set of community or cultural belief systems, they reinforce a sense of collective connections, connecting the individual with family, community as well as the ancestors or supernatural powers. In essence, the researcher suggests that rituals serve both the individual and group needs.

Most healers agree that African indigenous healing is intertwined with cultural and religious beliefs and is holistic in nature. In addition, the study found that the rituals themselves are not limited to focus on, or be specific to a particular illness or disease, but are an integrated part of the healing process, either before, during or at the end. Furthermore, rituals are cross cutting in that both the healers and the patients do engage in rituals. The healers perform certain rituals to empower themselves and to become closer to the ancestors, whereas patients may perform rituals as part of their healing process. The impact of the rituals is said to be central to good health and success during the healing process, and at various levels. This is in line with von Wolputte & Devisch, (2002), and Richter (2003), who found that the impact is not only on the physical conditions, but also on the psychological, spiritual, and social aspects of individuals, families, and community rituals during treatment.

Indigenous healing is physically, socially, and culturally more available than allopathic treatment. Also, the practice of indigenous healing is client centred and personalised, and as such, even though the disease or illness is the same, like HIV in two patients, the treatment procedures, and the rituals performed, may be different, depending on the perceived cause, or the healer's treatment method. The healers also pay attention to social and spiritual matters that are essential to African cultures. In addition to healing of the mind, body and spirit, indigenous healers serve many roles in the community, including counselling, social mediation, cultural education and being custodians of African traditions and customs. Therefore, consulting indigenous healers also gives a sense of going back to one's roots, providing an opportunity to reconnect with oneself.

Overall, it is important to note that the necessity and significance of rituals, which are part of our living heritage, is created by the historical imbalances in the way the living heritage and practices of different communities has been degraded during our historical past of colonialisation, segregation and apartheid. The history of apartheid ensured that the practice and promotion of, amongst others, languages, the performing arts, rituals, social practices, and indigenous knowledge of various social groups were not balanced, and in some cases, it was actively discouraged. As indicated above, rituals were not spared.

From the responses in this study, rituals are a connecting thread that brings everything together, the patient, the healer, family, community as well as the ancestors and the soul or spirit together. Without rituals, there is no healing as both the healer and the medicines are rendered meaningless, powerless, and therefore, ineffective. It is gathering with others to feel Spirit's call, to express spontaneously and publicly whatever emotion needs to be expressed, to create, in concert with others, an unrehearsed and deeply moving response to Spirit, and to feel the presence of the community, including the ancestors, throughout the experience. Furthermore, it is through ritual that a diagnosis is made, that a not only a treatment course is identified, but the specific herb is identified. When a patient takes the treatment, it is through ritual that the medicines derive their power.

Based on the responses from the participants, it seems rituals are considered a yardstick that people use to measure how they are connected to their ancestors. Rituals restores health, balance and reconnects the individual, family, and the community at large.

(ii) General rituals

From the data collected, the researcher found that rituals are not only performed during the healing procedure but can also be performed during specific times and events, including those performed by indigenous healers as part of their elaborate procedures for prevention of diseases. For example, it is said that periodically the head of the family or the Makhadzi, would organize the performance of muphaso

(supplicatory sacrifice-usually made when assistance from ancestors is sought for protective purpose).

The purpose of the ritual, as reflected in many testimonies by the participants, is to strengthen the family members both physically and spiritually so that they can repel any attack by disease and witchcraft attempts. Furthermore, these rituals are also performed to solicit the blessing, peace, success, and good fortune. In this instance, rituals are used as preventive mechanisms. In this way, the patient and the rest of the participants are informing or pleading with the ancestors that they are their last hope.

The researcher also learned that there are distinctions in some of the rituals as to who should lead in certain ritual activities. While some families would be proactive, it is the responsibility of a traditional healer to assist in terms of communicating with the ancestors as to what could be the cause of the illness or disease, and who and how the situation should be remedied, and through performance of which specific healing or protection ritual. Through this process the healer will guide or identify the lead person within the family to perform the required ritual for the patient.

One can, therefore, conclude that while it would be the individual who is sick, through the performance of rituals, the rest of the family, and the community, as they partake in the rituals, become the extended patients who are also being healed. A bond is then forged and a commonality of vision, or purpose then emerges.

In the case of patients who are sick, some of these rituals include rituals to cleanse the body symbolically, it could be using sanctified water, or blood of an identified animal, which is purified to break any psychosocial and spiritual factors that might be connected to or are part of the patient's illness. This spiritual cleansing may be required of the sick person to cleanse at specific times for a set number of days. Furthermore, other rituals would be 'uphasa', or libation, which entails either the use of snuff or the water that is released from the mouth onto a designated area within the homestead. The belief is that the cleansing ritual, or libation, has not only protected the patient from evil and misfortunes, but it has also strengthened his or her roots in terms of self-image and self-identity, in knowing that one can turn to ancestors for protection healing.

This is consistent with Mensele (2011), who found that the significant role played by cleansing or protection rituals to the patient and other user communities involves various dimensions in their lives and experiences such as re-establishing their positive thinking, therefore, enhancing their positive expectations and commitment to healing. Furthermore, rituals provide a structure to express intense emotions, anxiety, and fear, and to mark transition to enable the patient to describe what usually cannot be said. This would lead to change and inspire positive thoughts and confidence that the patient will get better. As Some (1999), suggests, rituals provide a spiritual connection, and we all need to be connected to something bigger.

6.4 HIV and AIDS treatment rituals

(i) Treatment of HIV/AIDS

Thornton (in Strydom, 2010), says that a clear distinction needs to be made between the words 'cure' and 'treat' as there seem to be considerable confusion about this because some methods and herbs appear to treat the symptoms of HIV, but not cure the infection itself. In the current study, this seems to be the case, with some healers claiming to cure the disease and those that only claim to treat HIV/AIDS symptoms. However, this may be due to ignorance of the differences between the two concepts, or due to the limitations in translation from one language to the other.

For most indigenous healers who participated in this study, treatment is a combination of both rituals and herbal medicine. Medicinal plants are prepared and administered in different methods according to the method that specific healers use to treat HIV. From the data collected, the main objective of the treatment is to cure the disease, boost the immune system of the patient and to protect the patient, and in other instances, the homestead, to prevent further attacks by the disease or evil people or spirits.

Indigenous healers who participated in this study reported that their approaches to treatment included divination, herbal medicines, as well as rituals to manage aspects of the patients' illness that required psychosocial and spiritual healing. For example,

they would do the cleansing rituals to symbolically cleanse patients so that they could break the psychosocial and spiritual factors that are connected to the illness.

Some healers confirmed that while they can strengthen immunities and treat severe symptoms of HIV/AIDS with herbal remedies, they are by no means able to cure HIV/AIDS but are able to alleviate all the symptoms to enable the patient to live a long and successful life. It emerged that the reason they put it like that, is for them to comply or align with modern doctors, or science, that claim that HIV/AIDS cannot be cured. However, few Healers were bold enough to claim that they could cure HIV, leaving patients with no negative health implications after treatment. Most of the healers decried the fact that they are not taken seriously and that their efforts and contributions are not recognised, or in certain instances, there is no willingness to verify or test their successes, as modern doctors are too scared to admit that healers treat HIV better than them.

From the explanations by the participants, indigenous healers often offer treatment for symptoms suggestive of HIV infection, without knowing as fact, whether a patient is HIV-positive or not. This they do based on their observations of the symptoms, what the patients tell them, or from what the bones show them. Healers who claimed to cure HIV reported diagnosing the illness through traditional practices, like throwing the bones, while others discussed accompanying suspected HIV cases to the clinic for testing or sending them there to bring back the test results to confirm whether indeed, they are positive or not.

Treatment strategies included providing herbal remedies to be ingested. One healer describes the treatment process, whereby he offered the patient 'two litters of the treatment containing a mixture of several herbs, to drink'. Furthermore, the indigenous healers interviewed were generally confident in their ability to treat HIV/AIDS. This is consistent with AIDS Action (2000) who found that traditional medicines and health practices have been shown to help alleviate symptoms (such as pain or itchy skin rashes), strengthen the immune system (by restoring appetite and general well-being), and treat the opportunistic infections associated with AIDS.

Due to mistrust, the healers were generally hesitant to disclose their strategies and sources of medication to treat HIV on record. However, some shared these with the researcher only for illustrative purposes. They discussed the use of unspecified herbs mainly for drinking, baths, and ceremony to cure the patient from HIV. The study also found that healers do refer patients to the modern health care system to ensure that patients suspected of being HIV-infected are tested and, in some cases, treated for HIV using ARVs.

Most of the Indigenous healers that participated in this study are also confident about successfully treating or curing HIV. This assertion is like what N̄dou-Mammbona, (2022) found, the effective treatment, by healers of some opportunistic infections, such as diarrhoea, skin lesions and childhood diseases. He also revealed that there are plants that Africans use as prevention against the epidemic as well as plants that are used to prevent STDs in young people. He said that there are trees that treat stomach illnesses and cure gonorrhoea.

The current study also align itself to Njanji (1999), who found that traditional herbs were more effective in treatment of herpes, chronic diarrhoea and other ailments associated with HIV/AIDS than available pharmaceuticals. Healers' medicines also help to reduce symptoms such as pain, strengthen the immune system, and treat opportunistic infections. This is consistent with what the current study found, more especially the consensus by healers interviewed that they successfully treat sores, pain, diarrhoea as well as other sexually transmitted diseases. Njanji (1999), further suggests that African traditional medicine has proved in some instances to be superior to western drugs in the treatment of HIV/AIDS infections. This is according to some findings presented at the AIDS conference in Lusaka. Once more, most healers in this study also believed that they treat HIV/AIDS better than modern health care workers, a fact, they lamented, that is not acknowledged.

Smith (2001), in his study interacted with healers who claim that the reason that they claim they can cure HIV/AIDS is because the signs and symptoms of the illness disappear after the treatment. Whether this necessarily mean that patients are cured or not, is another matter, but the fact is that all the symptoms disappear. The same sentiment was raised by the healers who participated in this study, where most of them

firmly believes that they can successfully treat the disease. Only three admitted that HIV/AIDS cannot be cured.

As indicated above, the treatment is comprehensive and has curative, protective and preventive elements, and is either natural or ritualistic, or both, depending on the cause of the disease as revealed by the divining bones. Amongst others, the treatment may also include ritual sacrifice to appease the ancestors, and strengthening of people, their possessions, as well as their homesteads. Some healers also reported wearing gloves when treating patients. This, they indicated, is not necessarily due to COVID 19, but a longstanding practice to protect themselves from HIV and other related diseases.

The most important aspect emanating from this data is the healers' understanding, and differentiation of the meaning of curing or treating HIV/AIDS. This in most of the languages used, seem to denote a similar meaning, 'u fholá' which can either be interpreted as to be healed or to be cured. It is also interesting that the study reveals that healers believe that they have been successfully treating HIV/AIDS patients, without acknowledgement, and that they believe they can help allopathic medicine, whom they believe has not done well in the treatment of HIV/AIDS. It is also important to note that some healers are aware that there is no cure for HIV/AIDS, and therefore, openly acknowledge that all they do is to alleviate the opportunistic infections and symptoms, rather than completely cure the disease.

These inconsistencies in interpretation of whether HIV/AIDS can be cured or not, raise a challenge that needs to be addressed. It seems there is no coherence in the message being sent by healers regarding whether HIV/AIDS is curable or not. Therefore, depending on who a particular patient approaches for treatment, they may be exposed to further risks if they are led to believe that they are cured.

(ii) Handling of medicine

The healers interviewed in this study also indicated that there are certain protocols, or rituals observed before or when handling the medicines. These range from prayers, taking snuff and observance of certain taboos, for example, women who are

menstruating cannot touch the medicine as this is believed to weaken the medicine. Furthermore, both men and women healers are expected to abstain from sex before handling the medicines as these may weaken them. For some, sex is acceptable only if it is with someone whom they are married to, and not a girlfriend or boyfriend, or someone else outside the marriage. The issue of abstinence was also raised as a challenge as this requires partners who are understanding and patient. As few have been divorced due to observing these practices/rituals.

From the above, the medicines, or herbs are also handled from a ritual point of view. This implies that rituals are part of the social fabric of the healing processes and procedures. However, it is important to note that even where consultation of the divining bones is done, there is lack of coherence among indigenous healers on the preparation procedures and correct dosage of herbal remedies. Each healer would do this in their unique way as directed by the ancestors, or spirits.

6.5 Guidelines on collaboration with Western health practitioners

The Tshivenda saying “Munwe muthihi a u țusi mathuthu”, loosely translated as ‘one finger cannot pick a grain’, and emphasising the importance of working together, seems more appropriate in addressing the issue of collaboration between allopathic and indigenous medicine.

The Alma Ata Declaration emphasises the need for redistribution of functions and responsibilities of key stakeholders in health care services to reduce the cost and increase efficiency and productivity in the achievement of primary health care. In this case, the role of cultural values and belief systems was not clearly stated. More emphasis is on the adoption of indigenous healing practices such as herbal medicine and employment of indigenous health practitioners’ services to meet primary health care needs.

In this study, at least 65% of healers reported that they have previously referred patients to modern clinics, either for treatment or for testing of HIV. This shows that there is willingness from the side of healers to have some level of engagement

between them and modern health care system. The same can hardly be said from their modern counterparts.

From the onset, healers have suggested that such collaboration should be based on areas of compatibility as well as aspects that are mutually beneficial rather than only them reaching out without reciprocity. The most critical and common area identified by most healers is around genuine referral between the indigenous and modern healthcare systems. Furthermore, the sentiment shared by most healers is that collaboration should not be based on an attempt to change the authentic form and context within which indigenous medicine is based on.

One area of weakness identified by healers is that the current healthcare system continues to function in a fragmented manner, without clear guidelines on how the two healing systems should operate. Thereby exacerbating the already existing access barriers to healthcare in in the country. On the other hand, the lack of capacity by modern health care, and on the other, the stigma attached to indigenous healers and those who consult them.

This pointing to the need for an integrated or collaborative healthcare system that recognises both indigenous and modern health care system. The biggest challenge is that the process of integrating herbal medicine with biomedicine has been slow and difficult at time, usually being a one-way process initiated by healers. as revealed in this study, many healers are already referring patients to hospitals or clinics, either for HIV test, treatments or post treatment exam or assessment.

Furthermore, healers lamented the fact that while government has recognised indigenous healers, they have not necessarily recognised or promoted the observance of the cultural or ritualist processes that are associated with the maintenance of good health. Thereby, fragmenting and compromising the authenticity of indigenous health practices. The view, therefore, is that cultural beliefs and practices relating to ill health should be taken into consideration in the development and implementation of primary health care programs.

On the other hand, indigenous healers in this study highlighted their concern and fear of the theft of their intellectual property, which they believe happens frequently. Some of the specific areas identified for collaboration are as follows:

(i) Cross referral of patients

The current study found that most of the healers have admitted to sending their patients to go to clinic for testing to officially confirm the diagnosis, as they believe that the divining bones do not directly reveal that the patient is HIV positive. Healers indicated that the bones only reveals that the patient has an incurable disease, or has the disease related to the blood. Wagner and Audet (2017), also found that some traditional healers continued to treat HIV-positive people for HIV and their associated opportunistic infections. The fact that healers referred their patients for HIV testing at public health facilities suggest that they saw the value of HIV testing.

This, therefore, forms the basis for the first area or aspect of collaboration, where doctors can conduct tests and then release patients back to healers for treatment. The same can be done at the end of treatment, to test again and see if there is any change or improvement. Healers can also be encouraged to send patients to doctors if they see that the patient's health is not improving or in cases where the patient is deteriorating.

The healers raised a concern that they never receive patients referred to them from clinics and hospitals, whereas they frequently send their patients to same, mainly for testing of HIV or for drips and blood as they do not have machines to test. This they believe, is due to the lack of respect and trust by their counterparts. The recommendation is for a genuine referral system between the two systems. Given the number of patients that indigenous healers see, strengthening the referral system between the two can also help increase early diagnosis of HIV/AIDS and treatment uptake, including adherence, support, and to a certain extent, avoidance of herb-drug interactions and toxicity, ultimately improving health outcomes for people with HIV.

One important aspect to note in terms of collaboration is the role that patients play. From the literature, just like in this study, it was discovered that patients play a larger

role in the integration of the two systems, the modern and indigenous health systems as they consult both systems at the same time. This fact alone, should enhance collaboration and complementarity between the practitioners of the two systems to deal with potential challenge, as reported above, of drug-herb interactions, amongst others, which may put the patients' health at risk.

(ii) Respect

Mutual respect is a pillar of the collaboration initiative. This would entail the promotion of honest and targeted dialogue between the two systems, which will allow for greater coordination between the two systems and an ultimate improvement in HIV patient care, especially in rural communities.

This can include contacting the spirits for help. Indigenous healers often see patients together with other family members, and in the case of HIV/AIDS, which is fraught with stigma, this can play an important role in family counselling and in reducing not just the stigma and discrimination against people with HIV/AIDS, but can serve to enhance social relations (AIDS Action, 1999).

From the 18 healers who said they had treated cases of AIDS, three mentioned giving advice and counselling to their clients without being prompted. When prompted, 15 described promoting positive attitudes about people with AIDS or showing care and understanding as to the type of advice or counselling given, while eight mentioned advising on condom use. This is consistent with Green's (1994) findings.

Within the context of governance, the two systems can forge a beneficial working relationship and harmony, whereby they complement each other to address certain weaknesses from each system. Furthermore, integration should not only be viewed as the combination of pharmaceutical and herbal medicine, but most importantly, an understanding of the philosophical, social, and cultural constructions of each healing system and the complexity of the whole. Only when this happens would the collaboration, or integration become authentic, mutual, and real.

King (2000), reported about collaboration projects with traditional healers for HIV/AIDS in eight Sub-Saharan countries. From his findings, one of the most important lessons

learned was that collaboration was not only possible, but that it had yielded valuable public health benefits.

Collaboration is crucial as it will provide an enabling environment to promote capacity building, research, and development, as well as production of indigenous medicines of high standards, which would put indigenous herbal medicine in a worthy position in the World health care system.

(iii) Issues of Trust

Indigenous healers were generally hesitant to disclose their strategies and sources of medication, or to specify the names and mixtures of the herbs that they use to treat HIV/AIDS related symptoms. This they highlighted their concern with the theft of their intellectual property and the propagation and use of such without acknowledging them, and to a certain extent, barring them from further utilisation of such plants or herbs. This has therefore, reduced the indigenous healing practice to a system shrouded in secrecy (Ozioma & Chinwe,2019), which comes about because of a common fear amongst most indigenous healers that scientists would appropriate their ideas and herbs and modify them as if it's theirs.

Furthermore, two healers who participated in this study were clear that they thought modern health care practitioners looked down on them, considering them to be less competent. So, while it is commonly known that most modern health care practitioners do not trust indigenous healers and their herbs, it seems the same is also the case when it comes to herbs, where indigenous healers also do not trust the intentions of modern health practitioners, fearing that they will steal and propagate for themselves.

The crux of this mistrust is amongst others, the suspicion about government, scientists and modern health care practitioners' true intentions and commitment to indigenous medicine, and the fear that indigenous medicine practices are being Westernised in the manner that excludes the knowledge holders, either from benefiting from the economic spinoffs of their knowledge, or simply by eroding the authenticity of the indigenous healing practices and procedures.

6.6 Challenges and recommendations

The challenges as identified here are not only related to this study, but generally the field of indigenous healing as a profession and health care system. One of the main challenges identified in the current study is that indigenous healers are not a homogeneous population. This means that not all healers would make effective partners with modern health care workers. This is because some healers not only fear losing income, but others believe that nurses and doctors cannot cure all ailments and when such instances arise, and there are side effects or other negative outcomes, they, as indigenous healers will be blamed unfairly. Furthermore, there is a history of mistrust from both sides, but mainly from modern health care works, which has damaged relationships between healers and modern health workers. This then makes the call for integration by the World health Organisation futile.

The other challenge pertains to the bias of science versus indigenous knowledge, as a basis for knowledge on health issues. The belief that indigenous healing is not scientific or objective. This study, therefore, recommends that indigenous healers should be allowed to perform their activities in accordance with their healing philosophy, as they have a role to play and a contribution to make to the South African healthcare system.

The lack of institutional or government support for indigenous healing or practitioners, pose a challenge for sustainability as well as proper and regulated growth and development. While there are several pieces of legislations and programmes in few government departments regarding indigenous healing, these are often fragmented and not properly coordinated, leaving the sector volatile and isolated and uncensored. This opens an opportunity for anyone to enter the trade and this has consequently led to breeding quacks or what is known as 'charlatans'. Furthermore, this also means that there is no proper investment in research and support programmes and systems, just like in the modern health care, to support practitioners.

As seen in the profiles of healers who participated in this study, most of the time, the practitioners do not have a limit on what they can cure/heal or specific areas of specialisation. While this is somewhat similar to general practitioners in the modern

health care, the difference is that indigenous healers are not compelled to refer patient to other specialist as there are no guidelines. As such some healers may continue to treat the patient even though their chances of success are low, putting patients at risk in cases of severe ailments.

As per Participants' responses, patients move between the two systems, but without a formal referral process. These movements are either as per the recommendation of the healer, or the patient's own volition. It seems at this stage, healers are only able to educate patients in their own specific perspectives, since they are only experts in their own fields, and do not know much about each other, hence the referral is not two ways at this stage.

Furthermore, the issue of drug-herbal interaction is a cause for concern. However, it would be unfair to put the blame on indigenous healers as it is equally the responsibility of modern health practitioners to ascertain if patients are taking other medicines. The biggest challenge here is lack of coherence and coordination, leading to the two healing systems to work in silos instead of collaborating. Integration and referral process may go a long way in alleviating this challenge.

This study also revealed the problem of training and research, or lack of, that needs to be addressed. Whereby healers understand certain concepts in relation to their exposure or training, leading to several inconsistencies of interpretation, understanding and definitions.

Another major obstacle to the use of indigenous medicinal plants is their poor-quality control and safety. Related to the above, is noting that most indigenous healing practices and medicines are not documented, thus making it impossible for both the medicines and the process to be evaluated properly. Furthermore, the current academics, scientists, and researchers, may not be adequately equipped in terms of knowledge on indigenous healing, and may still harbour negative perceptions and prejudices or may be using methodologies that are not compatible or outside the context of traditional healing. This would require that the said academics and researchers to work with indigenous healers, as equal partners, and inviting them to engage with the students directly, while building the confidence and competence in themselves.

One of the biggest challenges, which the Traditional Health Practitioners Act 22 of 2007, is trying to address is that there exist various bodies or associations governing indigenous practitioners. However, these do not collaborate but compete with each other, and are poorly structured and managed. This absence of a national umbrella to coordinate and intervene in the harmonious development of indigenous healing and its healers, have led to the establishment of the Interim Traditional Health Practitioners Council, in line with the guidelines reflected in the Act. However, at the time of writing this, the researcher is aware that more than ten years later, the structure is still interim, and not yet permanent. Furthermore, the said structure within the national department of Health in South Africa, has been vacant, without office bearers, for the last two years, making it difficult to implement certain programmes.

The South African government has taken positive steps towards the official recognition, acceptance and institutionalisation of African Traditional Medicines, or indigenous medicine. However, despite this, traditional healing and its practitioners are not wholly accepted, but rather tolerated because of the enactment of policies and legislations as the Indigenous Knowledge Systems policy (2004), Traditional health practitioners Act no 22 (2007) as well as Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities Act (2002) as per section 185 of the Constitution of the Republic of South Africa.

Other initiatives include the National Drug Policy (NDP) of 1996, which recognises the potential role and benefits of traditional medicine for the national health system. The National Reference Centre for African Traditional Medicine for African Traditional Medicines (the NRCATM) which was established in 2003 by the Medicines Control Council in the National Department of Health in collaboration with the Council for Science and Industrial Research (CSIR) and the Medical Research Council (MRC), is another step taken by the South African government to try and regulate the indigenous healing sector. But, as per the literature review, there is still a high level of scepticism regarding their role and contribution.

The Traditional Health Practitioners' Act (22 of 2007) makes provisions for registration of all traditional healers. However, there has been a reluctance by indigenous healers to register. One of the challenges is that currently, there is no code of conduct in place, and therefore, no way of determining genuine practitioners from false ones.

Some of the reasons for the non-registration is also because of lack of knowledge and understanding of how the Act works as well as the registration process, which brings back the issue of training. Furthermore, there is also a level of mistrust and suspicion about government's true intention and commitment to indigenous medicine and the fear that indigenous medicine practice is being Westernised by conventional health practitioners (Mothibe & Sibanda, 2019).

Finally, some of the challenges may be emanating from competition between the two health care systems, especially on prestige and financial benefits. The perpetual isolation and oppression of indigenous healing systems has clearly led to socio-economic imbalance. Therefore, it is recommended that while the historical legacy of socio-economic imbalances is being addressed through government programmes, there is a need to liberate the potential for South Africans to celebrate their mutual social co-existence by safeguarding their socio and intangible heritage, like rituals, and celebrating their equal entitlement to it.

Another common reason put forward as to why modern health care practitioners are generally reluctant to collaborate with indigenous healers, is because of the perception that indigenous healers practice might be in a way, harmful to patients.

Formally involving indigenous healers in the fight against HIV/AIDS may lead to several benefits, some of which will be reflected hereunder:

- Firstly, the relationship with modern health practitioners will improve as they get an opportunity to understand how each work, how and why,
- Secondly, this may improve on the cross-referral side, addressing the current concern that the referral is one-sided,
- It will also contribute to the understanding of how different worldviews influence the application of medical services with a particular focus on treatments provided,
- Finally, this will build mutual respect, trust and collaboration will also improve.

Moshabela, et. al. (2012), also supports the above assertions, and has identified the implications of including indigenous healers in the fight against HIV/AIDS as follows:

- Recognising their independent existence and functions,
- Reconciling long-standing differences (tensions),
- Identifying possible specific roles in HIV/AIDS care,
- Creating equitable and non-patronising opportunities and incentives,
- Establishing appropriate regulatory systems and institutions,
- Be selfless, initiate dialogue based on mutual respect,
- Move out of our comfort zone to integrate ourselves in and with the community, and
- Promote non-judgmental communication with patients about traditional medicines.

Considering aspects from both sides, there is an urgent need to elevate indigenous healing to be on par with modern healing, as well as the need to retain authenticity, the researcher acknowledges that just like culture in general, intangible heritage, in this instance, indigenous healing and rituals, are constantly changing and evolving, and being enriched by each new generation. Many expressions and manifestations of indigenous healing are under threat, endangered by globalization and cultural homogenisation, and by a lack of support, appreciation and understanding. If this healing heritage is not nurtured, it risks becoming lost forever, or frozen as a practice belonging to the past. Preserving this traditional healing and passing it on to future generations strengthens it and keeps it alive while allowing for it to change and adapt.

There is a risk that certain elements of intangible cultural heritage, including the socio-cultural aspects of rituals, could die out or disappear. One of the biggest challenges is how can we safeguard and manage a system that is constantly changing and part of 'living culture' without freezing or trivializing it? Safeguarding them is about the transferring of knowledge, skills and meaning. In other words, safeguarding focuses on the processes involved in transmitting, or communicating indigenous healing from generation to generation, rather than on the production of its concrete manifestations,

Furthermore, safeguarding also entail making sure that these rituals remain an active part of life for today's generation that they can hand on to tomorrows. These measures aim at ensuring the rituals' viability, their continuous recreation, and transmission. Therefore, initiatives for safeguarding this significant aspect of intangible cultural heritage may include identifying and documenting them, as in the current study, research, preservation, promotion, enhancement, or transmission as well as revitalizing the various aspects of it. The biggest challenge, is to preserve, safeguard and promote indigenous healing systems, without tampering with its authentic form, but to allow it to grow and evolve through its own processes. However, while generally conservative and rooted in the past, the traditional healing practiced today in both areas, whether in the cities or rural areas has not gone unchanged over the years. All systems evolve and traditional healing is no different in this respect. It is dynamic and constantly changes while retaining certain elements of the past.

6.7 Policy recommendations

Many strides have been made regarding the documentation and legislation of indigenous healing. These are through Traditional Health Practitioners' Act and other laws that have already been articulated in this study, research in indigenous medicine, education of both health care and indigenous health practitioners, including the role of collaboration. However, not only are there many gaps, lack of coordination and will in implementation, but also the neglect of the socio-cultural and philosophical aspects is glaring. Therefore, the findings of this study begin to close these gaps. The outcome of this study, based on the research findings, shows that several strategies ought to be developed to enrich the practice of indigenous medicine, especially the preservation of certain authentic practices and rituals. These will also contribute towards the concept of equality and intercultural health care.

South Africa's living heritage, like in other parts of the world, is facing tremendous challenges. Most elements of living heritage, like rituals, are under threat of extinction due to neglect, modernisation, urbanisation, globalisation, environmental degradation, lack of access or deliberate suppression. This sadly, continues post democratic dispensation. This study, therefore, is an attempt to arrest continuing marginalisation of rituals associated with the healing systems and the treatment of HIV/AIDS, as this

is also an important aspect of intangible or living heritage. The goal is also to affirm cultural diversity and mutual social existence.

In line with the above sentiments, indigenous healers have an unmistakable and crucial role to play in building the health system in South Africa and strengthening and supporting the national response to HIV/AIDS. This, they do, while at the same time, preserving our intangible heritage. Indigenous healers serve roles which include, but are not limited to, being custodians of indigenous African religion and customs, educators about culture, counsellors, mediators, spiritual protectors, and in other instances, ritual specialists. The findings of this study sanction the need for new ways of thinking about how indigenous healers could be engaged, and how their roles could be incorporated and enhanced to offer quality care to patients subscribing to both healthcare systems in the era of wide ART availability and medical pluralism.

From the findings of this study, and considering the critical role of rituals in healing, indigenous healing should not be understood as nascent forms of Morden medicine, that, with time and space, it will evolve into something similar to the biomedicine model. Is a system in its own right, that has been used and validated since time immemorial.

The study has revealed that communication around referral interactions seldom occurred between indigenous health practitioners and modern health care practitioners, irrespective of the fact that certain diseases were better handled by a specific health care system. This is particularly because in instances where these interactions occurred, they were not formal. The study, therefore, recommends that there should be an effective and formally coordinated communication strategy or policy, that will facilitate the referral systems in a coordinated and documented manner.

It is recommended that a more inclusive approach to health, that acknowledges, and respects people's belief systems and standpoints should be adopted. It is also recommended that a more integrated system to health care in South Africa be established that will ensure that healers and modern health care practitioners make referrals to one another. The risk of dual or simultaneous usage of both indigenous

and modern medicine should also be assessed to avoid serious drug interactions between the two systems.

This phenomenon of dual usage of medical resources as significant, especially providing a basis for attempts at collaboration between modern and indigenous healing, as well as the acknowledgement of the co-existence of both systems, has been previously suggested (Torri 2012; Pretorius 1991). The recommendation, therefore, is not to immediately, develop and implement a joint master plan to collaboration, but a patchwork or phased approach that will look for windows of compatibility, and collaborate on this to help slow the epidemic.

The National Development Plan states that arts and culture open powerful spaces for engagement about where a society finds itself and where it is going. Promoted effectively, the indigenous health care systems can contribute substantially to the curbing of HIV/AIDS while at the same time contributing to the preservation, promotion, and protection of authentic approaches to indigenous healing processes, which has been part of culture since time immemorial.

Modern health care practice needs to take into consideration the cultural, environmental, social and economic settings of the people that it exists to serve and that is an element that indigenous healing could play in the provision of clear understanding of the historical origin or the cause of the disease and effect of the diseases to an individual, homestead and the community, as well as beliefs system or cultural values of the community that should embedded the medicinal interventions and prescriptions. For instance, if one must be admitted for HIV/AIDS diseases the ancestral spirits could be invited prior through rituals and other cultural and social practices or belief system of the locality.

The South African health care system should be technologically advanced in such a way that it accommodates indigenous health traditions and procedures like rituals for medicinal testing and assessment for treatment in the manner that would contribute towards a multi-disciplinary approach of health care that is able to treat the patient within the context of a family and society. Since in most cases modern health practice focuses on individual, the introduction of indigenous health care system could be a

solution to this problem as it is able to focus on the patient disease on its entirety putting emphasis on physical, spiritual, emotional, social, economic, and environmental aspects.

In the same way, in building an integrated health care system, the modern health care practitioners should incorporate the socio-cultural and philosophy of rituals and healing when treating the patients by ensuring that treatment and healing is considerate of the norms and values of the society. The South African health care system should as such recognise the strategies utilised by indigenous health care practitioners that of ensuring that through rituals like Uphasa, a proper medical prescriptions and medicines are identified and dispensed.

So, working in partnership, the indigenous health care practitioners could be utilised to identify relevant medicinal intervention that modern health care practitioners are unable to identify in the treatment of certain diseases through bone throwing. For this to happen, the health care system should give equal opportunity to both Western and indigenous practices in the sense that it would allow indigenous health care practitioners to issue medical certificates, issuing of referral letters and integration of the practice in the national health system.

It is also recommended that a consideration be made to adopt indigenous practices in what could be referred to as complementary medicine in the South African healthcare system by aligning the modern health care with the indigenous health care like the ones in countries like United States, United Kingdom (UK) and China that have integrated complementary therapy by aligning it with alternative therapy and the use of mind body therapies. The adoption of the approach would bring a multi-disciplinary approach healing approach to disease management including treatment of HIV/Aids. This calls for recognition of indigenous health care practitioners as professional health care providers with training and capacity building interventions provided from time to time so that they are informed of an integrated South African Health Care System and the practice regulations.

This study, therefore, calls for the establishment of cooperation, collaboration, sharing and mutualism that allows the health sector to foster creative relationships and

partnerships with indigenous health care practitioners as professionals inside and outside the sector as both are in pursuit of common goals. The creation of common understandings and goals for collaboration is essential. Collaboration should also include provision of necessary instruments for the use of the indigenous health care practitioners.

Another key recommendation is for government to put in place a strategic route map for integration of indigenous healers with western healthcare practice and that such a roadmap should have a clear timeframe. This may entail research and development on aspects of safety and efficacy within the framework of integration into the primary health care, as well as the national health care system in general. This will help create a stronger evidence base on the safety, efficacy and quality of indigenous medicine and practices on the other hand, while on the other, providing certainty and commitment through the route map.

Furthermore, the protection of intellectual property rights, which is one the areas that indigenous healers are most concerned, should be assured to since some of them have treasured medicinal herbs or products that they have worked with over many generations and therefore, their rights to these should be assured and protected.

Training of traditional medicine practitioners could encompass identifying diseases that can be effectively cured by traditional medicine, to avoid making traditional medicine appear to be a solution for all illnesses. Training will also help to preserve indigenous knowledge systems, and as indicated previously, promote, and protect this aspect of living heritage.

On the other hand, all these efforts will forever, be a challenge unless the curriculum is indigenised, or decolonised by incorporating indigenous medicine in its authentic form. Medical or students in the health sciences in general, should be prepared during their studies, that they will work with a population that still largely believe in or utilise indigenous medicine while simultaneously consulting modern health care. This, therefore, will prepare the students adequately and optimally for the real situation that they will be working in. Guidelines on how to deal with this, and being sensitive to

patients' cultural and belief systems, must be developed. By so doing, this will begin to address the question of decolonising the curriculum.

The researcher acknowledges that to address some of the challenges raised, as well as moving towards integration, a unit for Traditional Medicine was established in the Ministry of Health, including a unit for ethics and deontology and another for legislation and control. These are a step in the right direction and therefore, more effort just needs to be made to ensure commitment and sustainability. In this process, is important to recognize the value and complexity of a culture-centred approach to prevention, care, and support, and that it will take time and resources to fully integrate. Therefore, innovative, and homegrown solutions are needed to fast-track the implementation and turnaround strategy.

Finally, the study by Sundararajan and colleagues (2021) has highlighted implications for health-care delivery not just in South Africa, but Africa in general. The authors move from a premise that it is possible to successfully integrate traditional medicine as a catalyst for accessing quality health care. They reiterate that future implementation efforts will require three key elements: first, integration of traditional healers as a main component of the health-care workforce, which involves proper regulation of care delivery as with all health-care professionals; second, rigorous evaluation and scale-up of effective endogenous treatments and interventions issued from traditional medicine; and, third, strong political will to ensure that traditional healers are equally seated at the discussion table. The current study shares the same sentiment and recommendation.

Therefore, this implies that government should provide the necessary financial support to promote the potential role of herbal medicine in primary health care delivery. If efforts to fight the HIV and AIDS pandemic do not include African traditional healing, most Africans will not be reached, and such efforts might not produce the much-desired results of ridding the continent of the pandemic.

This study points to the importance of developing a culturally appropriate form of treatment that emphasises complementary rather than adversarial engagement between the traditional and biomedical systems.

However, the future of African traditional medicine is bright if viewed in the context of service provision, increase of health care coverage, economic potential, and poverty reduction. Contrary to popular beliefs, culture and behaviour are not always obstacles and challenges to health, but can be supporting factors, if the health strategies developed are aligned, or take cultural practices and behaviours of a people into consideration. The acceptance, recognition, development, and support of a holistic approach to healing, which recognises the central significance of rituals, is not just a matter of redress, but a human right.

6.8 Limitations of the study

This study focused on the socio cultural and philosophical importance of rituals in traditional medicine, and septicly focused only on HIV/ AIDS treatment. However, the study found that rituals are not specifically or uniquely designed for HIV/AIDS but are critical in the whole cosmos of healing of any disease and treatment procedure. The researcher, therefore, allowed the process, and the data to dictate the process, without losing the main objective of the study.

I should also stress that it was not the intention of this study to focus on the quantitative aspects like statistics and numbers, but the qualitative responses, and data that articulate the depth of the subject under research. Furthermore, this study focused on the global approach, or general significance of rituals. However, based on the findings of the study, there may be a need for further research to understand the specific stages in which rituals are performed at various levels of treatment.

Unfortunately, the nature of the data collected does not allow the researcher to determine the views of biomedical practitioners regarding collaboration and cross referral of patients between traditional healers and biomedical practitioners.

One of the biggest limitations for this study has been the impact of the COVID-19 pandemic. It was initially difficult to secure appointments for face-to-face interviews due to the regulations as imposed by government. This impacted on the time frames and completion of the study. Furthermore, the participant observation aspect was also

compromised as the healers could not perform some of the rituals, as they normally would, like drinking traditional or sacred beer from one cup, sharing of snuff as well as the numbers of participants in some of the sessions. This slowed the progress in general but was overcome by the narratives that traditional healers provided.

Finally, there is a need to study and understand in detail, those rituals that are performed for the general well-being of individuals or communities, without the presence of any disease or symptoms. This is important as they are part of health and wellbeing. Although practitioners spoke to their unique experiences and perspectives, a common pattern emerged regarding the significance of the socio-cultural aspects.

CHAPTER 7: SUMMARY AND CONCLUSION

This section provides a summary of the results or findings, as presented above. The results of the study found that indigenous healers are aware of the causes of HIV/AIDS, that, it is caused by engaging in unprotected sexual activities. The fact that they associate the disease with sexual transmitted disease means that they are familiar with the manner and extent in which the disease is protected. Indigenous healers are also aware that HIV/AIDS disease is incurable, and that it is a disease that arises from, or spread through multiple sexual partners. According to the respondents, when the sexual transmitted diseases have reached an advanced stage, it becomes a full-blown AIDS. The fact that others believe that HIV/AIDS could be treated through the cleansing of blood means that there is an understanding or association, that HIV/AIDS is found in the blood system.

According to the research participants, some of the HIV/AIDS symptoms are tiredness, diarrhoea, loss of weight, cough, stomach sores, dry skin, and vomiting. Mostly, these symptoms are based on observations that indigenous healers use to diagnose the disease. Another form of diagnosis being through the bones. The risk of acquiring HIV/AIDS also lies on the engaging in sexual activities with an un-erected penis (Tshitungulo) that in African belief and tradition, could 'search' for any diseases, or 'absorb' the disease, when one engages in sexual encounter. According to the healers, it is these behaviours that lead to an increase in HIV/AIDS. The other aspect to note being that women are engaging in such encounters whilst on menstruation or too soon after menstruation.

According to study participants, whilst ritual is not a treatment, it is an integral part of patient treatment and recovery process, without which healing may not be possible. This process that in most cases is undertaken by Makhadzi (Aunt /father's sister), is very critical. Homestead members including the patient and the healer must participate in uphasa ritual for purposes of ancestral intervention, individual and family protection, healing, and forgiveness. According to the participants or respondents, rituals like therapeutic dance (malombo) is not a form of treatment for HIV/AIDS per se but is practiced as a form of seeking guidance from ancestors on the treatment of the

disease and protection of the patient. Malombo also provides an opportunity to convey 'ancestral' messages regarding the cause of the illness, or what should be done for healing to occur. Indigenous healers also use rituals to communicate important messages such as the site in which the treatment medicine could be located, the medicine to be prescribed and the call for healing and protection of the patient from diseases. The treatment of medicinal prescription is done by providing the patient with soft porridge or drinking medicine to cleanse the body. With all these interventions, including the treatment of infections caused by HIV/AIDS, healers are of the view that they can heal the disease and able to strengthen the emotional, spiritual, and physical well-being of the patient by protecting the surrounding of the patient from evil and attacks.

The findings of this study also point to the fact that healing involves the whole person, the physical, psychological, spiritual, and social aspects. The patient is treated within his/her physical, spiritual, and emotional environment, past and present. Family members are involved in the process and therefore, healing is group oriented. The aim of healing moves beyond the physical and aims to re-establish the social order within the patient's environment and life. Ritual then, seeks to restore balance and harmony in terms of cultural values and beliefs. In this way healing meets medical, psychological, and emotional needs which lead to successful recovery on various levels.

These findings signify the importance of the preservation, and protection and promotion of rituals as a significant aspect of socio-cultural philosophy and living heritage that is critical to the physical, social, and psychological wellbeing of the vast majority of South Africans.

According to some of the participants, collaboration between indigenous healers and modern health practitioners is necessary, if it works in the form of referrals and acknowledges indigenous medicine as a registered health practice with similar level of recognition like their modern health counterparts. Another issue raised was that intellectual property needs to be credited to the healers and not focus on taking the knowledge for the credit of the modern health practitioners. Indigenous healers are of the view that they are not provided with necessary support in terms of required

supplies and materials to operate, such as gloves, training, financial support, and capacity building.

Based on these research findings, ritual activities need to be taken seriously due to their association with ancestral and religious beliefs, which have been an integral and is still said to be an important part, not just in healing, but in the cultural, spiritual, and religious beliefs of most Africans. It is hoped that the study will enable the reader to view rituals as a means through which they can improve their health and well-being, reconnect with their roots, culture, identity, heritage, ancestors, their inner selves, and their origins.

The study has filled gaps in literature, whereby focus has mainly been on understanding the active medicinal component of the herbs that traditional healers use, disregarding the significance of rituals that are performed during the healing process. The finding of this study has articulated the centrality, and potency of the rituals in the effectiveness and efficiency of the traditional treatment procedures.

Indigenous medicine plays a role that cannot be completely replaced by modern medicine. It will remain part of the healthcare option to many South Africans if it is accessible. This medicine has been used by humankind for the treatment of various diseases since long before the advent of orthodox or modern medicine, and to this day, serve the health care needs of most of the world population.

Even though the traditional healing systems are poorly recorded and more often misunderstood, African traditional healing is interwoven with cultural practices, religious beliefs and it forms part of living heritage. This study is a call for the revival and reinstatement of indigenous healing systems, not as a challenge to Western science, but a complementary form of knowledge necessary to steer and promote not just health, but sustainable development in Africa and beyond.

Traditional healing is one of the aspects that is important to preserve for future generations. This is significant due to its present or possible economic value, but also because it creates a certain emotion within us, making us feel as though we belong to something, a family, a community, a country, a tradition, a way of life, or a philosophy.

Whatever shape it takes, it forms part of a people, their lives, and a heritage, and this heritage requires active effort on our part to safeguard. Failure to safeguard it may lead to a loss of our very own identities.

This study, like many others before, has confirmed that indigenous healers have a crucial role to play in the health system in South Africa, and can help with, as they already are helping, in the strengthening and supporting the national response to HIV. This role goes beyond the popular notion that they are good and can only play a role in giving out condoms, promoting safe sex and educating patients on the hazards of the virus. The role referred to here is in them becoming equal partners in the provision of health care, treatment, and management of HIV/AIDS, as well as the reduction of opportunistic infections and boosting immune system.

Furthermore, as alluded above, indigenous healers should be supported to retain the authenticity of their treatment procedure, as opposed to focusing on the extraction of the medicinal properties from their herbs. Should this happen, it would put the survival of this healing system in jeopardy and render it unsustainable. There is, therefore, a need for redress in terms of recognising objective and subjective elements in this healing system and restoring integrity in their socio-cultural logic.

The study points to the importance of developing culturally appropriate forms of treatment that emphasise complementary rather than adversarial engagement between the traditional and biomedical systems and how policymakers can best facilitate this. This, therefore, calls for a dialogue between the two healing systems.

The goal and recommendation by this study is not to negate scientific or modern health care system, objectivity, experimental method, and a search for universals, but to call for an approach to health that is firmly grounded in the holistic understanding of human beings, their beliefs, and behavioural patterns. This is in line with the UNESCO Declaration on Science and the Science Agenda Framework that was adopted in 1999 in Budapest, Hungary, which urged members to define a strategy to ensure that science responds better to society's needs and aspirations in the 21st century. It emphasises the need for political commitment for scientific endeavours to make science more responsive and more inclusive. To become more accountable, more communicative, and more dialogical. It further states that the vision of science in the

21st century should be a science that can decipher the meaning of words like ‘responsibility’ and ‘ethics’ in the use of scientific knowledge; a science that can comprehend the fact that science is a product of culture, or cultures, and that its diverse manifestations must be recognized; and science that can be seen by all to be a shared asset (extracted from Odora-Hoppers (2002)).

There is, therefore, an imperative need for the revival, renewal, and proper contextualisation of indigenous medicine as located within a people’s culture and belief system. To move collectively forward, our educational and health programmes should be approached as a negotiated partnership, allowing the indigenous healers to define for themselves the degree to which they wish to make themselves available either as subjects or partners in the treatment and management of HIV/AIDS. This participatory approach will allow modern health care professionals to learn with, by, and from indigenous healers and to create a working relationship in which people's priorities and values become more fully expressed either in research initiatives or as educators and guides in health initiatives or programmes that talks about their knowledge, healing procedures and the role that they can play.

The role of indigenous healing systems in health provision has occupied a centre stage in political, social, and even economic discourses for several years. This has led to a rapid expansion of African epistemologies and healing systems as fields of investigation that are primarily focused on how they should locate themselves within the context of global discourse and healing. This interest is reflected in the myriad of activities generated within communities that are now recording the traditional healing systems for use in development planning and in their educational systems where indigenous healing systems are being regarded as an invaluable national resource, that build upon and strengthen community-level knowledge systems and organization. The utilisation of this framework should be guided by the quest for the emancipation of the African voice and should be used as a tool for the transformation of the South African knowledge agenda in the health sciences.

Through the data collected, the discourse reflects many of the unresolved tensions that continue to emanate from the colonial and apartheid. The HIV/AIDS pandemic, and the politicised narrative that emerged from it, has served to entrench yet further

the distance between the two systems. Consequently, in South Africa, the two systems are often presented as an “either-or” scenario, where modern health practitioners strongly discourage patients from consulting indigenous healers. If the South African government is serious about its engagement with the merits of traditional healing, as opposed to using the sector to offset deficiencies in public health spending or to redress aspects of the injustices of apartheid, then the current dichotomy of medical choice is an issue that must be addressed.

Thus, the study calls for a paradigm shift regarding traditional medicine, especially from a society that has a history of oppression and exclusion. There is a need to create a society in which all humans, including traditional healers, are valued based on their contribution to the development of South Africa and, ultimately, the African continent. This will begin to address the question of transformation, which must begin first intellectually, in our minds and manifest practically in our actions and interactions with each other.

Furthermore, there is a need for the holistic approach to indigenous healing that is embedded in *vhuthu*, within which indigenous healing, is a tool of survival and sustainability. This, therefore, offers a paradigm shift in knowledge production by adopting a holistic and ecological vision of reality that posits a closer look at the socio-cultural philosophies from indigenous healers themselves as valuable starting points.

Therefore, unpacking and understanding the socio cultural and philosophical importance of rituals in traditional medicine is part of the process towards acknowledgement, preservation, promotion, and redress. This is a necessary prognosis capable of humanizing the health Sciences by reconstituting it in a restorative paradigm that utilizes an analytical framework that foregrounds indigenous healing systems. If this is not done, Africa and the rest of the world will pay a heavy price for failing to diagnose the problem and produce a healing system that accurately reflects African traditions. Indigenous healing, or medicine system, is not just a medical and economic phenomenon, but more broadly as a socio-cultural phenomenon which needs to be preserved.

The HIV/AIDS epidemic has illustrated South Africa's ability to make immense social and political mistakes, as well as its ability to correct them and implement a complex programme effectively. It is also clear from the literature review that over the last few years, the South African government has been successful in managing the epidemic. However, there is a continuing need for education, prevention, testing and treatment. Yet even if the infections rate is lower, there is still a sizeable number of HIV-positive people requiring treatment. The epidemic and its implications for public policy are likely to persist for a longer period.

The NDP 2030 states that life expectancy will continue to be affected by HIV/AIDS, but the extent to which this will happen will depend on the efficacy and impact of treatment and prevention. It further suggests that while the number of new infections is likely to decrease gradually, or at least to remain stable, the number of people with HIV/AIDS is expected to continue to rise, reaching 7.3 million in 2030, while the number of those sick with AIDS is also expected to rise from 800 000 to about 1.3 million. However, the Commission takes a more optimistic view, arguing that if the correct policies are put in place, average life expectancy of 70 can be achieved by 2030. These correct policies, as suggested in the NDP 2030, should include traditional medicine for this vision to be realised.

The National Development Plan (2013) aptly articulate what this study is all about, and has captured this beautifully, when it says, "It is a story of unfolding learning. Even when we flounder, we remain hopeful. In this story, we always arrive and depart. We have come some way. We know: What we do, and how we do it, is as important as what we want to achieve. What we are, is because of who we have been and what we want to become. We will continue to make it to make us, because we are happy with being who we are. Who are we? We are Africans. We are an African country. We are part of our multi-national region. We are an essential part of our continent. Being Africans, we are acutely aware of the wider world, deeply implicated in our past and present. That wider world carries some of our inheritance". The above, say of the NDP, what this study seeks to achieve, a journey of self- discovery, affirmation, and acknowledgement of indigenous healing systems.

This study was not intended as a study of either the efficacy of traditional healing or alternative belief systems. Rather, it is an attempt to move beyond the usual calls for better understanding between traditional healers and biomedical practitioners in South Africa. These generic calls do little to shift the debate past the above very basic point. The study has sought to understand the significance of socio-cultural aspects in healing, so that meaningful and contextual accommodation of indigenous healing might be accomplished.

This study has demonstrated that rituals are our inheritance, and part of our identities as Africans. Rituals are the language of the ancestors, and this communication is expressed through the body as disease or illness. Therefore, when patients participate in rituals, they respond to the call and become healed. They become focused and reconnected. They gain a purpose.

8. REFERENCES

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9. APPENDIX A: CONSENT FORM

CONSENT FORM

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Jane Mufamadi, about the nature, conduct, benefits, and risks of this study - Research Ethics Clearance Number: SHSS/18/AS/19/3105.
- I have also received, read, and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
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.....

I, Jane Mufamadi, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

..... Date..... Signature.....

Full Name of Witness (If applicable)

..... Date Signature.....

Full Name of Legal Guardian (If applicable)

..... Date..... Signature.....

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

9. APPENDIX B: ETHICAL CLEARANCE CERTIFICATE
NAME OF RESEARCHER/INVESTIGATOR:

Ms. J Mufamadi

Student No:
9402956

PROJECT TITLE: Socio cultural and philosophical importance of indigenous medicine associated with the management of Human immunodeficiency virus (HIV) in Vhembe District, Limpopo Province.

PROJECT NO: SHSS/18/AS/19/3105

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof VO Netshandama	University of Venda	Promoter
Adv. Dr PE Matshidze	University of Venda	Co - Promoter
Prof MP Tshisikhawe	University of Venda	Co - Promoter
Ms. J Mufamadi	University of Venda	Investigator - Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: May 2019

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

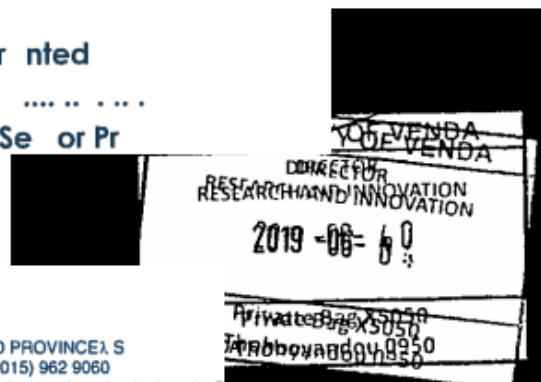
Name of the Chairperson of the Committee: Se or Pr



University of Venda

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10. APPENDIX C: UNIVERSITY HIGHER DEGREE COMMITTEE APPROVAL

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS J. MUFAMADI
SCHOOL OF HUMAN AND SOCIAL SCIENCES

FROM: SENIOR PROFESSOR L.B KHOZA
DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 24 JULY 2017

DECISIONS TAKEN BY UHDC OF 24TH JULY 2017

Application for approval of Thesis research proposal in School of Human and Social Sciences: J. Mufamadi (9402956)

Topic: "Socio Cultural and Philosophical Importance of Indigenous Medicine Associated with the Management of the Human Immunodeficiency Virus (HIV) in Vhembe District, Limpopo Province."

Promoter UNIVEN
Co-promoters UNIVEN

Prof. M.A Masoga
Prof. M.P. Tshisikhawe
Dr. P.E. Matshidze

UHDC approved Thesis proposal



SENIOR PROFESSOR L.B KHOZA

ACTING DEPUTY VICE-CHANCELLOR: ACADEMIC