CHALLENGES AND PROSPECTS OF THE NATIONAL INDIGENOUS KNOWLEDGE SYSTEMS POLICY IN INTEGRATING AFRICAN TRADITIONAL MEDICINES INTO THE PUBLIC HEALTHCARE SYSTEM IN SOUTH AFRICA.

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Declaration

I, Wilondja Muzumbukilwa, declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.
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As the candidate's supervisor, I agree to the submission of this thesis.

Supervisor: Prof Hassan O Kaya

Signed: [redacted]

Date: 12 August 2024

Dedication

This thesis is dedicated to my family's unwavering support and love, who have been my pillars of strength throughout this journey.

To my beloved wife, Furaha Maruba Muzumbukilwa, your endless encouragement and understanding have been the foundation upon which I built this thesis. Your unwavering belief in me has been my guiding light.

To my dear children Jospin Muzumbikilwa, Joyce Muzumbikilwa, Joshua Siyabonga Muzumbikilwa, Sibusiso Jotham Muzumbikilwa, and Sipho Josiah Muzumbikilwa, your laughter and joy have been my motivation. Thank you for your patience and understanding during times when I was engrossed in my research.

To my father, Muzumbukilwa Willy Wabissa, your wisdom, guidance, and sacrifices have shaped me into who I am today. Your belief in my abilities has always been my driving force.

And to the memory of my late mother, Wakusomba Marceline Musaka whose love, strength, and unwavering support continue to inspire me every day. Though you are no longer with us, your spirit lives on in everything I do.

This thesis is a testament to my family's love, support, and sacrifices. I am forever grateful for your presence in my life.

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Abstract

Using a mixed method approach, the study investigated the challenges and prospects of the National Indigenous Knowledge Systems Policy (2004) in integrating African Traditional Medicines into the public healthcare system in South Africa. African Traditional Medicines (ATM) and healing systems are increasingly recognized as an important aspect of the primary public healthcare delivery system within and outside South Africa. This is primarily the case in predominantly rural and marginalized communities with limited conventional healthcare services. ATM and healing systems are integral to African cultures and local knowledge systems.

The study used a comparative case study and participatory approach, focusing on the uGu and uMkhanyakude District Municipalities in KwaZulu-Natal Province, South Africa. The study aimed to understand the knowledge and perceptions of local communities as healers and clients, regarding the prospects and challenges of the implementation of the National Indigenous Knowledge Systems (IKS) Policy (2004), with special reference to ATM. The study followed a comparative approach of two district municipalities in the KwaZulu-Natal Province, South Africa, with different ecological systems, i.e. uGu and uMkhanyakude District Municipalities. The comparative approach was chosen due to ATMs' cultural and ecological specificity, with uMkhanyakude District in the north of the province having an arid environment and uGu in the south being tropical. These ecological differences were considered critical in assessing traditional medicinal knowledge and healing practices. The study suggested that these ecological differences must be considered when implementing the IKS Policy (2004).

Findings revealed that ATM use was prevalent in rural and marginalized communities of both district municipalities, mainly due to limited conventional healthcare services, and the affordability, accessibility, and cultural acceptability of ATM, especially among marginalized communities and social groups such as women, children, and the elderly. However, the majority of traditional healthcare practitioners and their clients in both district municipalities were not aware of the existence of the National IKS Policy (2004).

The study recommended the following:

1. Because substantial numbers of ordinary people in African local communities, including the study areas, consulted ATHPs for primary healthcare, this study suggests the great need for more comparative, culturally and ecologically specific research studies to understand the

significance of this healthcare and associated local community-based knowledge systems in advancing healthcare, social and epistemic justice.

2. The limited knowledge and awareness among various stakeholders, including ATHPs, regarding policy frameworks related to IKS and ATM, calls for a deeper investigation of specific challenges commonly encountered by ATHPs and their clients across South Africa. This investigation should also explore the implications for policy development and implementation.
3. Finally, a critical review of existing legislation and active engagement with relevant policymakers to address the challenges of integrating African traditional medicine into the public healthcare system is recommended for future studies.

Keywords: African Traditional Medicines (ATM), comparative study, Indigenous Knowledge Systems (IKS) Policy, Implementation, Integration of African Traditional Medicine, KwaZulu-Natal Province, Modern Medicine, Public Healthcare , and South Africa.

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List of Acronyms

ABET: Adult Basic Education and Training

AI: Artificial Intelligence

AIKS: African Indigenous Knowledge Systems

ANC: African National Congress

ARIPO: African Regional Intellectual Property Organization

ATHP : African Traditional Healthcare Provider

ATM: African Traditional Medicine

AU: African Union

BAA: Bantu Authorities Act

BHP: Biomedical Health Practitioner

BSG: Bantu Self-Government Act

CAM: Complementary and Alternative Medicine

CBD: Convention on Biological Diversity

CIKS: Centre in Indigenous Knowledge Systems

CIPC: Companies and Intellectual Property Commission

CM: Complementary medicine

CSIR: Council for Science and Industrial Research

CTLSA: Congress of Traditional Leaders of South Africa

CZL: Code of Zulu Law

DACST: Department of Arts, Culture, Science and Technology

DEAT: Department of Environmental Affairs and Tourism

DoC: Discipline of Competence

DPSA: Department of Public Service and Administration

DSI: Department of Science and Innovation

DST: Department of Science and Technology

DTI: Department of Trade and Industry

FDA: Food and Drug Administration

FGDs: Focus group discussions

HPs: Healing practices

ICT: Information and Communication Technology

ICTs: Information and Communication Technologies

IF: Indigenous Foods

IK: Indigenous Knowledge

IKC: IK community coordinator

IKRs: Indigenous Knowledge recorders

IKS: Indigenous Knowledge Systems

IKSDC: Indigenous Knowledge Systems Documentation Centre

IKSDC: Indigenous Knowledge Systems Documentation Centres

ILO: International Labour Organisation

IP: Intellectual Property

IPR: Intellectual property right

IPRs: Intellectual Property Rights

IPS: Intellectual Property system.

ITHPC: Interim Traditional Health Practitioners Council

KZN: KwaZulu-Natal

MCC: Medicines Control Council

MRC: Medical Research Council

NA: National Assembly

NCM: Non-conventional medicine

NCOP: National Council of Provinces

NDA: Non-Disclosure Agreement

NDoH: National Department of Health

NDP: National Drug Policy

NGO: Non-Governmental Organization

NHA: National Health Act

NHTLS: National House of Traditional Leaders

NIKMAS: National Indigenous Knowledge Management System

NIKSO: National Indigenous Knowledge Systems Office

NQF: National Qualification Framework

NRCATM: National Reference Centre for African Traditional Medicines

NRDS: National Research and Development Strategy

NRS: National Recordal System

NW: North West

PGDS: Provincial Growth and Development Strategy

PHC:Primary healthcare

PIC: Prior Informed Consent

PRA: Participatory Rural Appraisal

PSET: Post School Education and Training

R&D: Research and Development

RPL: Recognition of Prior Learning

SA: South Africa

SAQA: South African Qualifications Authority

SDGs: Sustainable Development Goals

THP: Traditional Healthcare Practitioner

THPA: Traditional Health Practitioners Act

TIA: Technology Innovation

TM: Traditional Medicine

TRIPS: Trade-Related Aspects of Intellectual Property Rights

UNCTAD: United Nations Conference on Trade and Development

UNEP: United Nations Environment Programme

UNESCO: United Nations Educational, Scientific and Cultural Organization

WHA: World Health Assembly

WHO: World Health Organization

WIPO: World Intellectual Property Organization

WTO: World Trade Organization

Chapter One: Introduction

1.1. Background

This chapter provides a comprehensive background of the research study, outlining the problem statement, key questions, aims, and objectives. It also explains the research approach adopted, which is elaborated upon in Chapter Three. The study critically examines the challenges and prospects of the South African National Indigenous Knowledge Systems (IKS) Policy (2004), with particular emphasis on Traditional Medicine and Healing practices.

In this study, IKS refers to a systematic body of knowledge, skills, innovations, technologies, and belief systems produced locally and traditionally transmitted orally from one generation to another for sustaining livelihood (Kaya and Seleti, 2013).

The South African government adopted the IKS Policy (2004) to provide an enabling framework for stimulating and strengthening the contribution of IKS to social and economic development in the country. Its main drivers in the South African context include: The affirmation of African cultural values in the face of globalization - a clear imperative given the need to promote a positive African identity; Practical measures for the development of services provided by IK holders and practitioners, with a particular focus on traditional medicine, but also including areas such as agriculture, indigenous languages, and folklore; Underpinning the contribution of IKS to the economy - the role of IKS in employment and wealth creation; and interfaces with other knowledge systems, for example, indigenous knowledge is used together with modern biotechnology in the pharmaceutical and other sectors to increase the rate of innovation.

The following functions, institutions, and legislative provisions would be required to implement this policy: An Advisory Committee on IKS, reporting to the Minister of Science and Technology; A development function, including academic and applied research, development, and innovation in respect of IKS; A recordal system for indigenous knowledge and indigenous knowledge holders; where appropriate, to pro-actively secure their legal rights; The promotion of networking structures among practitioners, to be located in the Department of Science and Technology; and A legislation to protect intellectual property associated with indigenous knowledge, to be administered by the Department of Trade and Industry (DST, 2004).

The World Health Organization (WHO, 2017) defines Traditional Medicine as the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, used in the maintenance of health and the prevention, diagnosis, improvement, or treatment of physical and mental illness. Sometimes referred to as indigenous medicine, it entails medical aspects of traditional knowledge systems developed over generations within the local community belief systems before the era of conventional medicine (Akshaya et al., 2023).

Traditional medicine and healing practices encompass animal, herbal, or mineral-based medicines and spiritual therapies for preventing, diagnosing, and treating physical and mental illnesses and maintaining well-being. In line with the IKS holistic conceptualization of health, WHO (1948) and Schramme (2023) define health as a complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is based on this holistic understanding of the interdependence between traditional medicine, healing, and spiritual aspects of health that traditional healing practices are considered the most important link between the rural people of Africa and health care delivery (Nelms & Gorski, 2006; Flint, 2015; Pemunta & Tabenyang, 2020).

Chikwari (2019) indicates that according to WHO, the most important issues affecting the practice of traditional medicine fall into the following categories: (i) National policy and regulatory frameworks – crucial to overall delivery; (ii) Safety, efficacy, and quality – crucial to extending and regulating traditional medicine care; (iii) Access – making traditional medicine available and affordable; and (iv) Rational use – ensuring appropriateness and cost-effectiveness.

Therefore, to recognize the importance of traditional medicine in South Africa, the Department of Health promulgated the Traditional Health Practitioners Act (2007). It is designed to regulate the registration, training, and practices of traditional health practitioners and serve and protect the interests of members of the public who utilize their services. It proposed the establishment of a regulatory body. It also emphasized the need to intensify research and development (R&D) work in ATMs, particularly regarding recording and supporting traditional healers on safety and accessibility.

Krah et al. (2018) and Subedi, B. (2023) consider the significance of integrating traditional medicine and healing practices as holistic and to provide the overall well-being of a person. Traditional healing takes the body, self, and society within a framework of dynamic equilibrium. This holistic approach to health and wellness considers a person's values, passions, beliefs, social interactions, and spiritual orientation. Examples of traditional healing in African traditional medicine and healing include incantations, religious verses, spiritual methods, amulets, sacrifices, rituals, etc. This holistic

approach to health and wellness tends to be neglected in biomedicine practices, which focus mainly on the biological aspects of health.

African traditional medicine (ATM) and healing practices are increasingly being recognized as an important aspect of the primary public healthcare delivery system in South Africa, especially in predominantly rural and other marginalized communities characterized by limited conventional healthcare services. This is elaborated by Mothibe and Sibanda (2019) and Mutombo et al. (2023), who attribute the importance of ATM and healing systems to accessibility, availability, affordability, cultural acceptance, and spiritual, religious, and sociological values. These holistic elements make them a preferred option for many African people across African cultures over biomedicine, which focuses on the biological aspects of health. Muhammed et al. (2023) emphasize that traditional healthcare practitioners treat patients holistically. They generally seek to recombine sufferers' mental and social equipoise according to social and cultural beliefs and value relationships. The accessibility of traditional medicine is one of the most important reasons for its popularity across Africa. In the study areas, for instance, ATM and healing systems were considered part of African culture, and local knowledge systems founded on traditional beliefs and practices coexist with the Western healthcare system (Mander et al., 2007).

The significance of this study lies in its potential to transform healthcare delivery and uphold cultural heritage. African traditional medicines, deeply embedded in the continent's cultural fabric, present valuable therapeutic options that have been employed for generations. By exploring how these practices can be integrated into the formal healthcare system, this study seeks to address disparities in healthcare access and inclusivity. It underscores the necessity of acknowledging and validating indigenous knowledge systems, which can lead to more comprehensive and culturally relevant healthcare solutions. Additionally, by examining the challenges and opportunities of this integration, the study aims to inform policy development, ensuring that traditional medicines effectively complement modern medical practices. This research promises to contribute to a more equitable and inclusive healthcare system in South Africa, respecting indigenous knowledge and fostering sustainable health practices.

Despite its potential, the integration of African traditional medicine within the formal healthcare system remains underexplored, particularly interms of indigenous knowledge management policies and the challenges faced by rural and marginalized communities across Africa. This study provides empirical evidence on these communities' healthcare challenges, highlighting the current system's inefficiencies and gaps. One major challenge is the operation of African traditional medicine outside

the formal healthcare framework, which leads to issues in regulation, standardization, and collaboration. By investigating potential avenues for collaboration between Western and traditional medicine, this study aims to leverage the strengths of both to offer a more holistic and effective healthcare experience. Ultimately, this research enhances our understanding of traditional healing practices' cultural and historical foundations, promoting their acceptance and integration into mainstream public healthcare.

1.2 The Research Problem

The National IKS Policy (2004) has acknowledged the importance of African traditional medicine. It has mandated the Department of Science and Innovation (DSI) to develop instruments for implementing the policy, including preserving, protecting, and promoting IKS, comprising ATM. However, despite this recognition, African traditional medicine has not been taken seriously in seeking sustainable solutions in primary public health care policy development and implementation, especially at local, district, and provincial levels. In the continued dominance of Western science in academia, research and development ATM and healing practices are still considered primitive and unscientific (Mothibe and Sibanda, 2019; Odede, 2020; Izuchukwu, 2022; Adu-Gyamfi & Anderson, 2022).

Mthembu (2021) elaborates that despite the growing interest in traditional medicine and its relevance to public healthcare and wellness, the legacy of apartheid in South Africa persists against African worldviews, ways of knowing, value systems and methods of knowing and knowledge production, especially at local community levels, where the majority of people, especially women and children, who depend on IKS including ATM and healing practices, for sustainable livelihood, live. The colonial and apartheid policies in South Africa, for example, outlawed all forms of indigenous practices, including ATM and healing practices (McFarlane, 2015; Pemunta & Tabenyang, 2020a). Mokhutso (2021) adds that despite the existence of the IKS Policy (2004) and IK Act (2019), the factors influencing clients' choice of healthcare and healthcare providers, including healers, have not been adequately investigated, regardless of the growing attention given to ATM.

Cognisant of the fact that IKS is culturally and ecologically specific, the study made a comparative examination of two different ecologically located district municipalities in KwaZulu-Natal Province, i.e., the arid uMkhanyakude District Municipality in the North of the province, which is ecologically distinct from the tropical uGu District Municipality in the South of the province. This impacts their traditional medicinal and healing practices, including types and sources of medicinal resources. The

investigation also considered how the differences in the two study areas' historical socio-cultural value systems and ecological backgrounds impacted their understanding and implementation of the IKS (2004) policy.

The study argued that the specific historical, cultural, and ecological particularities of cultural communities in the context of traditional medicine and healing systems tend to be neglected in most IKS policy developments and implementation in Africa, including that of the National IKS Policy (2004) in South Africa. For instance, although the Zulu people are categorized as a single tribe, their localities, including ecological systems, differ. For example, the uMkhanyakude district Municipality in the north experiences a semi-arid climate, while the uGu District Municipality in the south of KwaZulu-Natal province has a sub-tropical climate. These differences made them the focus of this research to ascertain their impact on the implementation of the National IKS Policy (2004) within African traditional medicine and healing.

Furthermore, studies conducted by Bagley (2018) and Mhlongo (2021) reveal that the IKS policy and IK Act, adopted by the government in 2004 and 2019, respectively, remain a national competency. There are no established formal local, district, or provincial structures for implementing the IKS policy at these levels within South African society (Mutombo et al.,2023). Additionally, there is a notable absence of implementation of IKS policy imperatives within the context of ATM, particularly from the perspectives of local community members, including the holders of Indigenous Knowledge (IK) and practitioners themselves (Keane et al., 2023). Shonhai (2016) adds that there have been limited comparative empirical studies at the local community level to ascertain the knowledge and awareness of implementing the IKS Policy (2004) within the context of ATM and healing practices. The factors influencing clients' choice of healers have not been adequately investigated regardless of the growing attention given to ATM and healing in the country (Lor et al., 2017). As a result, the current study has focused on investigating the importance of culture and ecological diversity in ATM. Two diverse ecological zones in KZN province were selected as case studies for the study. These are the uMkhanyakude District (semi-arid) and uGu District (Sub-tropical).

In recent years, there has been a growing interest in traditional medicine and its relevance to public health in developed and developing countries. However, the dominancy of Western world views, ways of knowing, value systems, and knowledge production on healthcare and wellness continue to undermine and threaten the holistic nature of indigenous knowledge systems on healthcare, including traditional medicine and healing practices (Abdullahi, 2011; Martin, 2012; Carrie et al., 2015). The

colonial and apartheid policies in South Africa, for example, outlawed all forms of indigenous practices, including traditional medicine (McFarlane, 2015; Pemunta & Tabenyang, 2020a).

Existing studies and policy strategies have failed to consider ATMs' cultural and ecological specificity in their implementation strategies. They have also not investigated the effects of diversity of ecological factors on the comparative distribution of population size of traditional healers (diviner or sangoma and the herbalist or inyanga) and their clients.

1.3 Research Questions

The following research questions guided the study:

1. To what extent does the implementation of the South African National IKS policy (2004), within the context of African traditional medicine and healing practices, take into account the historical socio-cultural value and ecological systems of the respective local communities in KwaZulu-Natal province, with special reference to uMkhanyakude District (semi-arid) and uGu District (Sub-tropical)?
2. What are the comparative conceptualizations of the socio-economic and demographic characteristics of the research participants from the Zulu people's cultural perspectives?
3. What are the comparative local community members' knowledge, awareness, and perceptions of indigenous knowledge systems and the African traditional medicine policy landscape in South Africa?
4. What is the comparative analysis of the local community members' perceptions of integrating African traditional medicine into the public health care system in South Africa?

The study wanted to achieve the following specific objectives:

1. 1.1 To assess the extent of the implementation of the South African National IKS policy (2004) within the context of African traditional medicine and healing practices, taking into consideration the comparative historical socio-cultural value and ecological systems of the study areas, i.e., uMkhanyakude District Municipality (Semi-arid) and uGu District (Sub-tropical);

   1.2 To investigate the views of the local community members, including the African Traditional Healthcare Providers (ATHPs) residing in the study areas, who possess knowledge of the National IKS Policy (2004) and international policy frameworks, regarding their implementation within the context of African Traditional Medicine and Healing Practices;

2. 2.1 To assess the comparative influences of the socio-cultural and ecological factors in the study area on traditional medicine and healing practices, especially on the implementation of the National IKS Policy (2004) imperatives;
   2.2 To investigate and understand the comparative conceptualizations of the socio-economic and demographic characteristics of the research participants from the Zulu people's cultural perspectives;
3. To assess the comparative level of knowledge and awareness of the local community members, including the African Traditional Healthcare Providers (ATHPs), in the study areas, about the National IKS Policy (2004) and international policy frameworks within the context of African Traditional Medicine (ATM) and healing practices;
4. To conduct a comprehensive comparative analysis of local community members' perceptions regarding integrating African traditional medicine into the South African public health care system.

1.4 Organization of the Study Report

The research study report is organized as follows:

Chapter One is the Introduction. It provided the background to the study, rationale, statement of the problem, research questions, and objectives of the study, including organization of the research report;

Chapter Two is the Literature Review. It provided the researcher with the opportunities to: identify the areas of prior scholarship to prevent duplication and give acknowledgement to other researchers in the field of indigenous knowledge and traditional medicine; find gaps in research, conflicts in previous studies, open questions left from other research on the field and justify the need for additional research.

Chapter Three discussed the conceptual and theoretical framework that underpins the study research process. It critically looks at the relevant theories, key concepts, variables, relationships, and assumptions that underlie the research study on the South African National Indigenous Knowledge Systems (IKS) Policy (2004) with special reference to Traditional Medicine (TM) and healing practices (HPs) in the study areas. This provided the study's theoretical and conceptual foundation, including the research methodological process, i.e., the selection and description of the study sites, study population, sampling procedures, data collection methods, ethical considerations, data analysis, reliability, and data validity. It helped ensure the study was focused, relevant, valid, and reliable to the research problem and questions. This gave the basis for making conclusions and recommendations for the study.

Chapter Four presented the study's research methodology, which followed an indigenous mixed methods approach. The participants, including the African Traditional Healthcare Practitioners and their clients, guided and embodied the research process and results. The researcher was only part of the research process in the co-knowledge production with the research participants. He ensured the research community held ownership, control, access, and data protection.

Chapter Five focused on the research participants' comparative socio-economic and - demographic characteristics from the Zulu people's cultural perspectives.

Chapter Six discussed the comparative local community members' knowledge, awareness, and perceptions of indigenous knowledge systems and the African traditional medicine policy landscape in South Africa.

Chapter Seven was a comparative analysis of the local community members' perceptions of integrating African traditional medicine into the public healthcare system in South Africa.

Chapter Eight provided the Conclusion and Recommendations from the research study.

Chapter Two: Literature Review

2.1 Introduction

This Chapter focuses on the review of related literature for the research study. The review of the related literature provided the researcher with the following opportunities for the study: identification of areas of prior scholarship to prevent duplication and give acknowledgement to other researchers in the field of indigenous knowledge and traditional medicine; finding gaps in research such as conflicts in previous studies, open questions left from other research on the field; and justifying the need for additional research.

For instance, indigenous knowledge's various conceptualizations and articulations have led to controversial debates. Dissimilar terminologies and conceptualizations describe what "indigenous knowledge" is all about. Accordingly, Kaya (2013) includes "native knowledge", "local knowledge", "folk knowledge", "community knowledge", ecological knowledge, etc. All these articulations highlight how indigenous knowledge is a complete knowledge system with its worldviews, ways of knowing, and value systems. In addition, Snyder (2019) also admits that these articulations should include production, management, and protection methods, which comprise bodies of knowledge, skills, innovations, technologies, beliefs, and value systems. The subsection below discusses the background of the South African IKS policy.

2.2 Background to the IKS Policy (2004)

IKS are a set of local information developed over centuries of experimentation and transmitted orally from generation to generation (Sarkhel, 2017; Grigo, 2022). This explains how they are an important promoter of sustainable development due to their direct connection to the environment and resource management.

In the context of this study, IKS concerns South African local communities that can provide the socio-cultural information necessary about TM for community health advantages. Knoess & Wiesner (2019) reveal that this knowledge flourishes within the community's local environmental, geographical, and cultural context; importantly, those IKS facilitate communication and decision-making within a community.

In South Africa, Zuma et al. (2016) substantiate that IKS policy can trigger the understanding, skills, and philosophies that local communities develop with long histories of interaction with their natural surroundings. For rural and indigenous peoples, understanding local IKS policy sounds like an

important tool for informing decision-making about fundamental aspects of people's everyday lives. Therefore, the South African IKS policy needs protection for its sustainability, as the Cabinet adopted it in 2004. This policy identifies the need to establish a recordal system in which communities, guilds, and individual IK holders can record their knowledge to advance future economic benefits and social good (Ramaube, 2018; Maluleka et al., 2020). Furthermore, IKS also has an impact within the South African context because it can contribute to preserving culture, learning community history, income generation, and maintaining the relationship between the community members (Chali et al., 2021).

Consequently, the Post-apartheid government of South Africa has initiated various policies, legal frameworks, and instruments (Marais & de Lange, 2017) as part of its social transformation to redress the limitations of the past since the independence of South Africa in 1994 (Venter, 2018). Most of these initiatives aim to cover up the country's marginalization during that period in different domains, such as the medical domain. Mothibe and Sibanda (2019) endorse that IKS in South Africa was much neglected, as did TM's role in the public healthcare system. Naidoo (2010) reveals how this idea originated from the then Department of Arts, Culture, Science and Technology, which in 1999 approached the Cabinet to formulate a policy on IKS. This led to an interdepartmental task team to embark on a complex process of consultation and research, leading to a national policy. According to Osenia and Shannon (2020), this program embraced a wide range of actions and endorsements relevant to IKS, including, inter alia, integrating IK into national education, mostly the medical domain. Similarly, Maluleka (2020) and Ramaube (2018) emphasize that integration also encompassed research and development systems, proposed administration of IK systems, institutionalization, funding, and legislative imperatives.

Consequently, it was only in 2004 that the South African Government decided to adopt the IKS policy because they deemed it was an area of action. Since then, various government departments have been tasked with developing policies and legislative amendments that will support the objectives of the IKS Policy. The aspirations of the National IKS Policy (2004) include, among others, improving the quality of life of the underprivileged people using their ways of knowing and value systems and contributing to South African globalization based on its traditions and ways of knowing, including solving its healthcare challenges. According to Chakrabarty and Rodricks (2022) and Sreenath (2023), this was so because the protection of IK and the owners of such knowledge were vital for developing the TM countrywide. This ensured that South African communities received fair and sustained recognition and, in some contexts, perhaps, they could receive financial remuneration for using their information. In the mind of Chali et al. (2021), using indigenous information appropriately can boost TM in South Africa because it can help in healing people physically and spiritually.

Many South African local communities appreciate traditional healing. Hence, its use can sustain its existence by connecting it to modern medicine because both can produce wonderful results in the medical domain (Karanja, 2019; Qadir & Raja, 2021). Many people endorse such an opinion because they connect it with its strong impact on patients' lives, legitimizing their support for it in this modern world. This depicts how IKS have the power to promote widespread traditional medicine among South African communities and the masses of people who appreciate it. In effect, TM is becoming increasingly appreciated because Makundi et al. (2006) concede that combining the above variables with IKS, in connection with modern medicine, can immensely improve the health system countrywide and even in the region. Furthermore, learning IKS can help encourage the acceptance of traditional medicine as a societal way of taking care of people's health.

Knoess and Wiesner (2019) suggest that using Indigenous Knowledge Systems (IKS) can effectively address health issues within communities and the country at large. The IKS policy thus remains a valuable framework for expanding the public's understanding of traditional medicine (TM) beyond what they have known since it first emerged in their communities. For the World Health Organization, comprehending how Indigenous Knowledge Systems function, provides a means of linking it to traditional medicine (WHO, 2019). This connection highlights the cultural practices that make traditional medicine more affordable, faster, and more accessible than modern medical alternatives (Adu-Gyamfi & Sophia, 2023).

Additionally, when TM heals South Africans, they understand better how the situation is common in many cultures in the country. In other words, if people fail to recognize how IKS can promote TM, they cannot appropriately use traditional medicine (WHO, 2019). However, when IKS faces challenges of being understood, sometimes patients may remain undecided about what to do to heal. According to Grigo (2022), to alter their way of healing, patients must seek ways communities are familiar with. A focus on IKS illuminates how South Africans adapt to a new community and understand their traditions and values in connection with their health (Berg, 2012; Mashaphu et al., 2021). This shows how people learn about the IKS policy in case it prompts TM and how people use it in their environment. Similarly, the most important model for actively learning about the challenges people face in learning about IKS can arise if society fails to encourage people to know about indigenous healing methods and seek traditional medical assistance (Riordan & Schofield, 2015). In fact, in situations where there is a significant understanding of the national IKS policy in promoting TM, some challenges can hinder understanding the prospects in this field.

Sreenath (2023) believes that these systems fall under different departments, and hence, cognizance must be taken to ensure that issues that are crosscutting in nature are dealt with cohesively. For example, genetic issues should be protected. All participating departments agreed that each should initiate legislative amendments based on the IKS Policy. For instance, the Department of Trade and Industry (DTI) initiated amendments to the Patents Act of 1978, now the Patents Amendment Act of 2005, and DEAT initiated amendments to the biodiversity legislation (Biodiversity Act, 2004). The DTI is proud that the Patents Amendment Act of 2005 is being used at the WTO and, to a certain extent, at WIPO as model legislation. Although patents have been considered and adapted to the IKS Policy, the DTI had to find the appropriate use of remaining IP tools, namely trademarks, copyrights, designs, and geographical indications, to protect and commercialize traditional knowledge. This IP Policy framework, therefore, deals with the protection of IK using the orthodox intellectual property system. This recognizes that, in many circumstances, the IP system is not the best vehicle for protecting IK, especially if not adapted or used in conjunction with other mechanisms.

2.2.1 The Indigenous Knowledge Systems Policy (2004) and African Traditional Medicine in South Africa

Empirical studies have provided evidence supporting the notion that the Indigenous Knowledge Systems (IKS) policy possesses the potential to enhance the status and efficacy of African traditional medicine (ATM) (Shonhai, 2016; Iya, 2017). Correspondingly, Aniah (2015) and Habtom (2018) assert that a significant proportion of the African population, specifically 80%, relies on ATM and its associated IKS for primary healthcare.

During the era of Apartheid, indigenous knowledge systems, including African Traditional Medicine and healing practices, faced systematic marginalization, reaching the extent where, in certain instances, African TM and healing practices were outrightly prohibited (Abdullahi, 2011; Maluleka, 2020). For instance, the South African Medical Association outlawed the traditional medical system in South Africa in 1953 (Ramaube, 2018). In addition, the Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970 also declared TM unconstitutional, disallowing practitioners from doing their business in South Africa (Mothibe & Sibanda, 2019). The ban on TM was partially based on the belief that the conception of disease and illness in Africa was historically embedded in “witchcraft”. In Western knowledge systems, witchcraft reinforced “backwardness”, primitiveness, and “superstition” in Africa. Osenia and Shannon (2020) show that the marginalization of African Traditional Medicine and healing systems continued in most African countries even after independence. In different parts of Africa, local efforts were initiated to challenge the condemnation

and stigmatization of TM during and after colonialism. For instance, Ochwang'I & Oduma (2017) report that the first protest against the marginalization of TM in Nigeria dates back to 1922, when a group of traditional healers insisted that their medicine be legally recognized.

Like the IK, TM has been articulated in various perceptions that comprise ethno-medicine, folk medicine, native healing, or complementary and alternative medicine (CAM). Mahomoodally (2013) and Yuan et al. (2016) explain that TM is the oldest form of healthcare and wellness system that has endured the test of time, especially in low-income communities with limited conventional or modern public healthcare services. Ramaube (2018) asserts that TM is an indigenous knowledge system with an ecologically and culture-bound healing system. Indeed, people have used TM across cultures and ecosystems to deal with various health challenges, such as diseases threatening their existence and survival (Zuma et al., 2016). TM is broad and diverse because various cultural societies have developed countless forms of indigenous healing procedures. These methods mainly deal with traditional medicine from India, China, and Africa, highlighting the absence of a consensus definition of TM or other therapeutic practices (Abdullahi, 2011). In other words, IK still deals with traditional medicine and healing in a wide sector and system.

Since 1978, the WHO has recognized traditional medicine and healing as integral to IKS. Similarly, recently, the African Union (AU), in its Plan of Action on Traditional Medicine (2001 to 2010 extended to 2011 to 2020), has also encouraged the use of TM. In this context, the World Health Organization defines Traditional Medicine as (WHO, 2013:15):

> "*the total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.*"

It is within this context that a traditional healer or traditional health practitioner (THP) is recognized by the community where he lives as someone competent to provide health care by using plant, animal, and mineral substances and other methods based on social, cultural and religious practices (WHO, 2000:11; Gallaher et al., 2020). Mothibe and Sibanda (2019) reveal that before the introduction of Western medical practices in African societies, traditional medicine and healing were the only medical and healing systems available to many Africans in their societies.

However, introducing Western healthcare systems deeply changed the history of this African tradition and culture, including its current challenges. An attempt to regulate the practice of THPs was made in 1982 through promulgating the Associated Health Service Professions Act of 1982 (Zuma et al., 2016). This Act fixed a registration and licensing scheme for herbalists, chiropractors, homeopaths, osteopaths, and naturopaths but prohibited using the title 'Medical Practitioner'. Despite all this, the province of KwaZulu-Natal was the exception because it has a different law on the licensing and control of THPs, which the KwaZulu Act covered on the Code of Zulu Law (CZL) of 1981 (Chali et al., 2021). The CZL allowed licensed THPs to practice and claim a fee for services rendered (Van Ellewee, 2020). Before the first democratic government in SA in 1994, the African National Congress (ANC) submitted in its health plan that THPs would become an integral and recognized part of the health care system in South Africa. It allowed patients to choose their preferred healthcare practitioner. At the same time, the ANC realized the need to regulate the practice of THPs to protect patients from harmful practices. The ANC health plan further stated the need to promote cooperation and liaison between THPs and allopathic health practitioners (Gandugade, 2016).

According to Adu-Gyamfi and Anderson (2019), this process permitted most South Africans to decide on their healing since they already knew the diversity of their traditional healthcare systems well. Similarly, Thornton (2017) describes how South Africans address their traditional healers as Sangoma or Nyanga among the Zulu people (Meyiwa & Maseti, 2016). In African indigenous communities, traditional healers are well known for treating patients holistically. They usually try to reconnect patients' social, spiritual, and emotional equilibrium based on the specific community's socio-cultural, spiritual, and value systems (Marques et al., 2021). This procedure differs from biomedical healthcare providers, who only focus on the biological aspects of the patient's health.

Conversely, Ozioma and Chinwe (2019) elucidate how the South African traditional healthcare structure is a holistic healthcare system organized into divination, spiritualism, and herbalism. Traditional medicine is popular in South Africa because most people prefer to use it through medicinal plants and healing rather than Western medicine (Mothibe & Sibanda, 2019). Most South Africans believe that traditional medicine and healing systems are universal, more efficient, accessible, affordable, and culturally sensitive (Makundi et al., 2006). That implies that South African traditional healthcare practitioners are the custodians of traditional indigenous values and customs, educators of culture, counsellors, mediators, and spiritual protectors.

Furthermore, Mokgobi (2014) elaborates that resorting to a traditional holistic approach in healthcare and wellness mirrors the sense of healers and traditional practitioners to fulfil different social and

political roles in their communities. These functions, in line with Maluleka (2020:45) and WHO (2019), encompass divination, healing physical, emotional, and spiritual illnesses, directing birth or death rituals, finding lost cattle, protecting warriors, counteracting witchcraft, and narrating the history, cosmology, and concepts of their traditions. Notwithstanding, Zuma et al. (2016) state that the spiritual aspects of ATM demonstrate the way the traditional healers often act, in part, as an intermediary between the visible and invisible worlds. The dominion between the living and the dead or ancestors sometimes helps to determine which spirits are at work and how to bring the sick person back into harmony with the ancestors Isiko & Serugo (2021). In democratic South Africa, concerted efforts have been made to recognize TM as an important aspect of the primary public health care delivery system. For instance, through the Ministry of Health, the government encouraged and authorized some universities to research local herbs' medicinal properties to standardize and regulate TM (WHO, 2001). This has led to policies being set to accredit and register traditional healers and regulate their practice. By approving the establishment of a body for traditional healers, their representatives were elected at community and social levels to collaborate with the Ministry of Health through its departments. South Africa's government's current health care reform considers TM an important component of the health care delivery system, especially at the primary care level (Aniah, 2015).

The Government of South Africa also established the South African San Council, a structure to study, collate, document, develop, preserve, and promote traditional medicine products and practices. This structure also fast-tracks the integration of the TM into the mainstream of the modern healthcare system, which is in line with developments in China and India (Abdullahi, 2011). Protection of IK seems paramount because African traditional medicine is gaining attention and innovation interest despite the advances in modern medicine. Andile (2020) confirms that most South Africans know much about traditional medicine, so they often resort to it for at least some of their healthcare needs. This knowledge implies that people know most medicinal plants that grow in their environment. Therefore, WHO (2019) acknowledges that African plants constitute about 8% of the 1 100 medicinal plants commercialized globally. However, most of these plants are exported as raw materials or semi-processed. Commercialized medicinal plants usually do not benefit the local communities whose indigenous information is utilized.

Accordingly, Mothibe and Sibanda (2019) bring up the case of the succulent plant Hoodia, which San communities have used for ages to subdue hunger and quench thirst. In the 1990s, researchers from the South African Council for Scientific and Industrial Research patented the active ingredients of this magical plant that grows in some areas of Botswana, Namibia, and South Africa (Andile, 2020).

It was strange that the San community, which is the guardian of the plant, never knew of the patenting process. In other words, the council as mentioned earlier, never valued this community's indigenous knowledge and claim, which motivated the community to defy this move. The South African San Council vigorously requested that they should benefit from the commercialization of Hoodia's magical ingredients (ibid). Congruent with Zuma et al. (2016), only after a prolonged legal battle in 2002 did both sides agree to acknowledge San's support regarding traditional knowledge regarding the Hoodia plant.

Although many communities still suffer the same as the San community, their traditional knowledge should be valued. Recognizing the protection of traditional specific communities should produce advantages for the locals. According to Osenia and Shannon (2020), preservation implies setting up protective rules that safeguard local communities' paybacks in case of the commercialization of their medicinal plants' information. South Africa has taken several measures to protect biodiversity, including previously marginalized and exploited communities. The country has created laws and institutions that promote the formal recognition of indigenous knowledge, such as the National Environmental Management Biodiversity Act of 2004 and the Bioprospecting, Access, and Benefit Sharing Regulations (Ramaube, 2018). The cooperation between this body and the communities who sent information on traditional African medicinal plants builds up on the conviction that locals deserve a reasonable economic return from these natural resources because of their natural guardianship.

On the other hand, the cooperation in information sharing has caused distrust between South African biomedicine and traditional African healthcare practitioners. Accordingly, Maluleka (2020) and Aniah (2015) believe such disbelief utterly impedes the process of integration and collaboration between the two healthcare systems for improved public healthcare for most South Africans (Ogundaini et al.,2021). Besides, the National Drug Policy (NDP) for South Africa of 1996 is amongst the first documents to recognize the potential role and benefits of traditional medicine for the national health system in South Africa. The strategy aimed to investigate the use of effective and safe traditional medicines at the primary level (Balogun, 2022). Therefore, it suggested the investigation of TM for its efficacy, safety, and quality to include their use in the health care system. According to Habtom (2018), marketed traditional medicine would be registered and controlled, and a National Reference Centre for African Traditional Medicines (the NRCATM) would be established (Aniah, 2015; Knoess and Wiesner, 2019). The NRCATM was a virtual reference center that was recognized in 2003 by the Medicines Control Council (MCC) of the National Department of Health (NDoH). This recognition was the outcome of the collaboration between the Council for Science and Industrial

Research (CSIR) and the Medical Research Council (MRC) (Chali et al., 2021). The centre's main objective was to collect, harness, and synthesize information to promote, regulate and register ATMs derived from plants. Besides, it also functioned as a development spot for a national database of indigenous plants screened for efficacy and toxicity. Finally, it also focused on checking the usefulness and safeguarding of traditional medicines to shield the public from unproven claims within the traditional medicines sector (Grigo, 2022)

On the point of usefulness and safeguarding, research (Abdullahi, 2011; Mwaka et al., 2018; Asare et al., 2021) in different African countries indicates the unwillingness of Western-trained African physicians and other healthcare providers to allow TM and their practitioners to be included in the official medical care systems in their respective countries. Abdullahi (2011) admits that in some African countries, medical students had reservations about integrating TM into the mainstream healthcare provision. This condition depicts how medical schools are not motivated to teach TM-related issues as they are in some countries, such as China and India.

Similarly, Grigo (2022) notes that the uncertainties of leaders regarding the inclusion of TM in the official medical care systems mirror that IK is not given consideration. Consequently, TM is still in use in post-independence Africa after hundreds of years without many reported adverse effects. Uchenna (2018) shows that in Ghana, Mali, Zambia, and Nigeria, the first line of treatment for 60% of children with high fever resulting from malaria is the use of herbal medicine (WHO, 2002). In the same context, Onongha (2022) highlights how increasing demand for TM in the case of rheumatic and neurological complaints in Burkina-Faso has been noted visibly. About 70% of Ghana's population depends primarily on TM (Krah et al., 2018). About 27 million (black) South Africans own IK, such as TM, to treat myriads of sicknesses (Abdullahi, 2011).

Moreover, research by Makundi et al. (2006) confirms that traditional health care has contributed significantly to treating "*degedege"* (convulsions) in rural Tanzania. Sometimes, patients use TM simultaneously with biomedicine to alleviate sufferings associated with disease and illness. On the other hand, Knoess and Wiesner (2019) admit that not only do African countries use their IK to promote public health care and the demand for TM use, but the practice is also on the increase in Europe, Asia, and America as well.

Due to these changes, WHO (2019) has acknowledged the value of traditional healers in healthcare delivery, particularly in developing nations. WHO (2018) states that Traditional Healthcare Practitioners (THPs) have helped with various healthcare needs, including managing and treating

non-communicable diseases and mental and geriatric health issues. Also, mounting evidence shows that TM successfully treats chronic conditions (Geiselhart, 2018; Kim et al.,2018). For instance, Wetzel et al. (2003) mention that teaching TM remains part of the curriculum of American medical colleges.

The effects of using IK on TM remain very crucial if well assessed. Accordingly, Chali et al. (2021) provide the reasons that contributed to the extensive use of TM and the concern for assessing and evaluating the effectiveness of traditional medicines worldwide. Growing research (Baratti-Mayer, 2019; Zuma et al., 2016) across cultures and regions indicates that many traditional medicines are vital and effective therapeutic regimens in managing various health challenges, some of which may not be effectively managed using biomedicines. That is why Mander et al. (2007) and Abdullahi (2011) state that among the South African black population, TM is desirable and necessary for treating a range of health problems that Western medicine does not treat adequately. Similarly, Abd El-Ghani (2016) explains how Nigerian medicinal plants are effective in the treatment of various diseases, which has been documented, including those used for the treatment of opportunistic infections associated with HIV/AIDS. Medicinal values of insects have also been documented in different African countries, including South Africa (Ndhlala et al., 2009; Tamesse et al., 2016). For instance, Ndhlala et al. (2009) and Frimpong & Nlooto (2020) found the Zulu people use the concoction of some insects with herbs and other ingredients for spiritual protection, preparation of love medicine, management of eye and ear problems, as well as prevention and control of convulsion in children. In the same vein, arthropods are equally used to cure thunderbolts, child delivery, bedwetting, yellow fever, and a host of many other ailments that cannot be treated using Western medicines and therapy (Zuma et al., 2016; Olutope, 2020).

On the other hand, Abdullahi (2011) explains that inadequate accessibility to modern medicines to treat and manage diseases in low-income countries, especially in Africa, has contributed to the widespread use of TM, especially in low-income households. The WHO (2015) showed that in 36 low and middle-income countries, modern medicines were reportedly beyond the reach of large sections of the population. This implies that the widespread use of TM in African countries could be attributed to its accessibility. Baratti-Mayer (2019) illustrates that the ratio of traditional healers to the African population is 1:500 compared to 1:40,000 medical doctors.

2.2.2 Post-Apartheid Legal Frameworks Regulating Traditional Healthcare Practitioners

The basis of African Traditional Medicine (ATM) and therapeutic techniques is the relationship between nature, culture, and spirituality as they relate to an individual's health in society (Grigo, 2022). Traditional healthcare providers (THP) deal with health and illness issues using a comprehensive approach in light of this viewpoint. Adu-Gyamfi and Anderson (2019) elaborate that this method conveys the interdependence between the herbalist and the diviner in conventional medicine and healing. Accordingly, Zuma et al. (2016) explain how the Sangoma, in other words, a diviner, works within the indigenous spiritual environment, as opposed to the Inyanga, who uses traditional herbal medicines to heal, in Zulu traditional medicine and healing.

Furthermore, the National Health Act (NHA) 61 of 2003 was meant to provide a framework for a structured, uniform health system within South Africa, considering the obligations imposed by the Constitution and other laws on the national, provincial, and local governments about health services. Mothibe and Sibanda (2019) show that the Traditional Health Practitioners Act (THPA) (2007) was designed to regulate the registration, training, and practices of traditional health practitioners and serve and protect the interests of members of the public who utilize their services. Meanwhile, the Interim Traditional Health Practitioners Council of South Africa was intended to administer the Act effectively, which falls under the ultimate authority of the Minister of Health (Van Ellewee, 2020).

Although THPAs have contributed to establishing the Interim Council and in the evolution of the HSSA, their integration into the NHS still has to happen. Congruent with Van Ellewee (2020), the purpose of the Council as provided for in terms of Section 5 of the Act is to:

- promote public health awareness;
- ensure the quality of health services within traditional health practices;
- protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners;
- promote and maintain appropriate ethical and professional standards required from traditional health practitioners;
- promote and develop an interest in traditional health practice by encouraging research, education, and training;
- promote contact between the various fields of training within traditional health practice in the Republic and set standards for such training;
- compile and maintain a professional code of conduct for traditional health practice and

- ensure that traditional health practice complies with universally accepted healthcare norms and values.

Overall, the primary role of the Interim Traditional Health Practitioners Council was to assist the Department of Health and the country at large in achieving this goal. In the context of the registration of ATHPs and according to the Council, no one may practice as a traditional health practitioner unless registered in that category with the Council.

It is an offence to contravene this directive because any person whose registration has been cancelled must return their registration certificate to the Registrar (within 30 days of being directed to do so). If the concerned person fails to comply with this provision, they have committed a criminal offence. Furthermore, in the case of disciplinary hearings, Nzimande et al. (2021) argue that the council can appoint a disciplinary tribunal to hear and determine charges of improper conduct against any registered person. The tribunal has a wide variety of powers relative to such a hearing. This is because it is an offence for a witness who has been subpoenaed to fail to attend the hearing at the time and place specified in the subpoena. It also applies in case of refusal to be sworn in (or affirmed) as a witness, to fail to answer, fully and satisfactorily, all questions lawfully put to him.

In addition, Krah et al. (2018) also indicate that the same procedure continues in case of misconduct and that the concerned person failed to produce any book, document, or object in his possession, custody, or control that he has been required to produce. He also points out that a witness who has been subpoenaed must remain in attendance until excused by the chairperson of the disciplinary tribunal and commits an offence by not doing so. Furthermore, Sifuna (2022) concludes that a witness may not knowingly give a false statement on any matter and commit an offence if he does. The same researcher admits that preventing another person from complying with a subpoena is a crime. For the same reason, it is also lawbreaking when preventing a person from giving evidence or producing a book, document, or object that he is required to produce.

Looking at the Council constitution, Van Ellewee (2020) confirms that it was made up of 20 people, including practitioners from each of South Africa's nine provinces, a legal expert, a member of the Health Professions Council of South Africa (a medical practitioner), a member of the SA Pharmacy Council (a pharmacist), community representatives, diviners, herbalists, traditional birth attendants, and surgeons. It also included academics, researchers, and the National Department of Health (NDoH). This new regulatory framework was given specific responsibilities for aiding the country in safeguarding and enhancing IKS in the medical field, addressing public concerns regarding dubious

and fraudulent practitioners and practices masquerading as TM, and strengthening the nation's capacity to realize the vision of a long and healthy life for every South African. Finally, there was the legal framework of the Interim Traditional Health Practitioners Council (ITHPC), which was inaugurated in February 2013 (Nzimande et al., 2021). The Traditional Health Practitioners Act effectively conferred its full authority in May 2014 (idem). The ATHPs were registered with the Council, which the Parliament established as a professional body with the power to issue medical certifications according to the terms of the Basic Conditions of Work Act (van Niekerk, 2019). But it did not appear that the Council was yet in a position to carry out its task. Furthermore, the field appeared impossible to regulate because the practitioners could not be submitted to objective assessment procedures. While registered ATHPs had the authority to issue medical certificates (Nzimande et al., 2021), it was questionable whether those certificates should be given full credibility until the intended code of conduct was in place and specific requirements for registration had been developed and made implementable.

On the other hand, ATHPs regulatory frameworks have limitations. In the same line, Nzimande et al. (2021a) indicate that The Alma Ata Declaration (1978) that the International Conference on primary healthcare made was a significant positive shift for the traditional healthcare system. This is true because, for the first time, it acknowledged the role of TM and its practitioners in primary healthcare. This significantly contributed to the growing international popularity of customary medicine, creating benefits and opportunities for TM users and TM as an IKS. Thus, Emeje et al. (2023 (2023) reveal that this recognition enabled biomedical health practitioners (BHPs) to reach out for assistance from traditional health practitioners (THPs), especially in rural areas where diseases have increased mortality and morbidity rates. Nzimande et al. (2021) show that millions of people across the globe currently continue to utilize THPs within primary healthcare, tapping the resourcefulness of THP services, which previously were underutilized in the primary public healthcare systems.

In the same context, Krah et al. (2018) disclose that about 8 in 10 South Africans rely on local traditional medicine for their primary healthcare needs. According to Nzimande et al. (2021), the legislation of the promulgation of the THPs Act (22 of 2007) occurred after several milestones towards the statutory recognition of THPs. However, it was only in 2013 that the WHO allowed countries and South Africa to legalize traditional medicines and recognize their practitioners. Nonetheless, Sifuna (2022) reveals that this call faces several impediments, calling for scientific authentication of THP products and practices. Indeed, many concerns and uncertainties have risen around the practices and issues of witchcraft because the latter is part of TM. Dlamini (2018) argues

that undermining and coopting THPs, in some cases, have been crushed across the world because of the power of Western colonization. Equally, there are difficulties in advancing uniform regulations under practices within different world cultures. This, in line with Qiu et al. (2018) and Zondi (2021), has generated opinions that people who announce national health regulations sometimes lack expertise or research data, which leads to limitations in IKS policy improvement and application.

Besides agreeing to the ITHPC, for instance, Nzimande et al. (2021), in the context of the THPs registration in South Africa, point out that THPs supported that registration with the national THP Council was meaningless to them because they already registered with their ancestors. This depicts how traditional healers and practitioners did not appreciate registering with the THP Council because they argued that even their grandparents, who were also THPs, never registered in that manner (Maluleka, 2020; Ramaube, 2018). Again, Chali et al. (2021) also pointed out that many others wanted to understand if registering with the THP council would allow their IK to produce financial benefits, as with Western medical doctors. Such a question infers that some THPs wanted to know whether they would stop practicing and go to school to attain Western medical knowledge before they could register. This shows that many others believed registering with their THP associations would be another reward because the THP council had nothing to offer them (Andile, 2020).

Another group thought that registration with the Council was associated with the apartheid system, where payment was associated with being black (Mothibe & Sibanda, 2019). These failed to understand why they pay for their IK, yet their culture links them with their ancestral calling and a traditional healing gift from their ancestors (Zuma et al., 2016). Others admitted that their government used registration to collect more tax from traditional healers and practitioners instead of supporting them through their THPs. They argued this because, according to Knoess and Wiesner (2019), they believed the amount they would pay was too much for them, especially since their 'income' was not regular. They were also concerned that even THP trainees would be expected to pay for registration.

Notwithstanding, many others approved the probable benefits of registration in case related fees were directly handled and controlled by the national government instead of paying towards the THP council as a governing body (Grigo, 2022). All this was the people's expression of faith and reliability. Finally, others considered registration with the Council to legitimize their practices. Osenia and Shannon (2020) comment that registering would facilitate their integration with the biomedical healthcare system as it would bring them legality in the government's eyes, which could give them advantages in the healthcare system. In other words, registering with the Council would separate them from charlatans and protect their IK and healing system from those claiming to be THPs. According

to Last (2016), although THPs exposed their popularity among the local communities they served, they still recognized that without the government recognizing them officially, they would not efficiently work like biomedical healthcare practitioners.

That being said, the section below elaborates on TM in the national record structure.

2.3 African Traditional Medicine in the National Recordal System

The National Recordal System (NRS) is a South African structure through which indigenous knowledge is recorded and stored for the benefit of the local communities. The structure was created as more intellectuals arose in the country and pushed to preserve IKS safely (Shonhai, 2016; Malindi, 2021)**.** To protect IKS, the South African Cabinet implemented an IKS policy in 2004 (Munck, 2016). The program established a system of recording communities and individual IKS so holders can keep their information for future societal benefits and growth. However, there are numerous issues regarding recording indigenous knowledge and its transference to other localities. In response to this challenge, the National Indigenous Knowledge Systems Office (NIKSO) created the National Recordal System (NRS) in 2013 (Shonhai, 2016). The NRS collaborates with communities nationwide to safeguard IK aboriginal information relating to ATM, indigenous foods, farming practices, and crafts (Balogun, 2023).

Furthermore, Balogun and Kalusopa (2021) and Mdhluli et al. (2021) define NRS as a large fingerprint initiative of the Department of Science and Technology created to document and stock South African communities' indigenous information. According to Habtom (2018), the NRS documents unrecorded IK in various multi-media formats by promoting positive and defensive protection of communities' IK, including grassroots experiences in local languages. NRS constitutes an IKS network for creating a legal background that connects research and developmental strategy at different layers of government. The National Indigenous Knowledge Management System (NIKMAS) endorses this plan. The NIKMAS comprises a semantic digital repository with custom-developed metadata schemes and a sophisticated security model to protect and preserve the IK (Balogun and Kalusopa, 2021; Balogun, 2023a). In other words, it is an advanced semantic search engine because it encompasses a directory system and an overarching integration architecture that combines its subsystems into a coherent arrangement (Kaya, 2014).

The vision of the NRS is to lead the IKS treasure hub through the recording, storing, management, maintenance, dissemination, and protection of IK (Mazel, 2018) for communal socio-economic

development in South Africa. Alberts et al. (2011) explain how the NRS follows a holistic approach to capturing IKS by considering and supporting the complete IKS ecosystem. Similarly, the structure addresses the socioeconomic challenges in South African communities and facilitates their acquisition of shares. Being an initiative that supports legislation and the benefit-sharing framework, Flint (2015) confirms that the NRS also follows a living lab approach to the project. Therefore, according to Kaya and Seleti (2013), the NRS pursues the objectives of mobilizing, aligning, and empowering communities and related stakeholders. Besides, the initiative builds and supports appropriate networks and achieves national IP objectives for protecting IK. It also initiates, enables, and maintains a secure, accessible national repository for IK management, dissemination, and promotion. Finally, it facilitates the discovery, cataloguing, capturing, authentication, and usage of the national IKS legacy in a suitable context.

Amechi (2015) indicates that the NRS was created as an interdepartmental instrument to facilitate research and development and prior art for intellectual property administration. It also enables the management and examination of bioprospecting information on genetic resources associated with indigenous knowledge and communities. To Grigo (2022), NRS offers IKS associated with biological resources, and any documented information is linked to a person, a community, a geographical area, or biological resources. Melo and Martins (2017) conclude that multimedia supports biological resources by geocoding them to a particular region.

Notwithstanding the context of the Companies and Intellectual Property Commission (CIPC) under the Department of Trade and Industry, CIPC can utilize the NRS for prior art searches (Alberts et al., 2011). Those companies do so because, according to Mazel (2018), the NRS is part of CIPC through research and examination service, which certainly makes the NRS a critical element in preventing the granting of patents in error and biopiracy. To Belanger (2011), this infers that the NRS adheres to a strict set of rules for granting access to the system. Documenting information on the NRS entails that it goes with a prior informed consent agreement, information transfer agreements, and a Memorandum of Agreement. The latter is an official document that the community participating in the project, and the Documentation Centre, which facilitates the recording of IK with the communities, must conjointly sign. Several researchers have confirmed that the NRS also serves as an indigenous knowledge hub for several government departments, including the Departments of Environmental Affairs, Trade and Industry, Health, Agriculture, Forestry and Fisheries, and Rural Development and Land Reform (Banjo et al., 2003; Berger, 2007; Hassim et al., 2007; Yon, 2000). In other words, Flint (2015) points out that, for the Department of Environmental Affairs, the NRS will provide a legal benefit-sharing framework and ensure that minimum standards in Information

and Material Transfer Agreements regarding IK research are available. Besides, Kaya and Seleti (2013) also confirm that NRS can promote the documentation and location of knowledge holders in the bioprospecting permit granting process. Therefore, the legal framework NRS provides makes it an appropriate source for the data they have collected regarding the IK of a specific community.

The development of the NRS was a wonderful process that encompassed some important stages. Similarly, Alberts et al. (2011) indicate that the NRS was developed in phases, with the first one focusing on African Traditional Medicine (ATM) and Indigenous Foods (IF) for implementation. The motivation for focusing on these two indigenous knowledge domains was that they are most at risk regarding Intellectual Property exploitation and bio-piracy. Alleviating this risk required careful system design, particularly regarding security and data organization. In other words, serious attention was paid to the National IKS Management System (NIKMAS) design. The serious design applied because the NIKMAS must support, on a national scale, the recordal management and protection of the IK with potential benefits, especially in the absence of relevant legislation, as is the case of Sui Generis on IKS (Belanger, 2011). The prominence of safeguarding trustworthy and secret information against unauthorized exploitation was also a significant design consideration. In doing the latter, Munsaka and Dube (2018) believe the Intellectual Property (IP) Laws Amendment Bill No. 8 of 2010 remains one of the legislations to consider when designing the system because of the holistic nature of IK. Iya (2017) underscores that the NRS acknowledges the limitations of Intellectual Property regimes and considers the current copyrights, trademarks, biodiversity, and related legislation. That being said, the NRS, therefore, supplemented the Bill.

For instance, Amechi (2015) specifies that the Bill focuses on the IK that resides in the public domain. In contrast, the NRS focuses on unrecorded or uncaptured IK, replicating that IK is not in the public domain. The NRS has been designed to incorporate and link to similar databases to optimize its use and functionality. NIKMAS, the ICT backbone of the NRS, can provide a distinct access point to IK captured at distributed points. It comprises links to other resources and databases containing relevant IK information managed in different establishments or government departments.

Furthermore, Balogun (2023) confirms that the NRS has been designed to give access to International Patent Offices (IPOs) to conduct searches on IK documented in the system to avert misappropriation of South Africa's IK. This originated from the requirements for letting patent offices search the NIKMAS and established provisions for patent offices to search the NIKMAS (Bagley, 2019). For searches and examinations, Khumalo and Baloyi, 2017 and Mazel, 2018) described that approved scientists, researchers, and Intellectual Property Offices are permitted restricted authenticated access

to confidential IK information as determined by adherence to the legal framework requirements. On the other hand, Kaunda and Kumalo (2015) reveal that the NRS should be open to the public through open, restricted, and confidential access. These researchers define open access as community promotional information and recorded knowledge already in the public domain, while restricted access infers authorized admission to constrained details in connection with the IK that is classified as confidential. They equally depict confidential access as an approved contact with complete details regarding definite IK access.

In fact, in the mind of Amechi (2015), these three levels of access show how the NRS initiative IP objective is to prevent placing undisclosed IK into the public domain. In other words, certain norms severely guide access to IK information. Congruent with Belanger (2011) and Majekolagbe (2023), a public member can openly reach any information in the public domain for education, tourism, or awareness. This mirrors how IK regarding traditional medicine remains accessible, but any confidential information remains impenetrable. Still, Mdhluli et al. (2021) agree that the strategy is helpful because it helps preserve communities' important data about their IK that they can still consult whenever they wish since it is their knowledge. The other norm regards what Anderson (2015) and Murove (2018) describe as the adherence to the legal framework requirements for limited authenticated access to confidential IK information as determined. Such IK information remains unlimited to anyone, provided they are searchers, examiners, approved scientists, researchers, and Intellectual Property Offices. Lastly, Demir (2021) expounds on the third rule, confirming how the NRS initiative prevents undisclosed IK from being placed into the public domain. The researcher describes that the people who can still access such data are those dealing with development purposes, mostly, authenticated and approved scientists and researchers. Therefore, Amechi (2015) confirms this category of people can access the NRS confidential IK data on the condition that they agree to sign all relevant legal agreements, including a benefit-sharing agreement.

The section below discusses the National Recordal System IK Holder Catalogue Process.

2.4 National Recordal System and African Traditional Medicine

In South Africa, NRS embeds the IKS network infrastructure to create a legal framework linking research and developmental strategies at different layers of government. Hence, Bagley (2018) agrees that NRS about IK constitutes an important directory because it is the largest South African initiative that records, documents, preserves, and protects IK for the benefit of the communities in the country. The NRS remains a guiding instrument whose role regarding IK and TM remains essential because it records unrecorded IK data in various multi-media formats, links recorded IK, and promotes

community IK. The most significant advantage of this almanac is that it plays an encyclopedic role in collecting interesting IK on TM experiences of South African grassroots communities in local languages (Bam-Hutchison et al., 2022). Therefore, the NRS has become the leading IKS treasure hub in SA because it primarily records, stores, manages, maintains, disseminates, and protects the South African IK for the collective socio-economic development of the country in general and related communities in particular. To Traynor (2017), all this highlights how the South African NRS constitutes an IKS cyberinfrastructure to create a legal framework that links the strategies used in research and development, all being endorsed by SA's national and local governments.

In a word, scrutiny of the above opinions admits that the South African catalogue process is meant to develop an IK registry that captures IK holders' information, knowledge claims, and location (Balogun, 2023). By way of explanation, a directory's main role is to identify the holders and practitioners of knowledge in various indigenous knowledge fields. After that step, it then facilitates the recording and documentation of IK, which preserves and protects its information against unauthorized individuals. According to Jain (2014), this strategy can undoubtedly discourage various commercial exploitation, distortion, and fraudulent acts. The first version of the catalogue process was developed for the Indigenous Knowledge Systems Documentation Centre (IKSDC) located at the University of Zululand (Balogun & Kalusopa, 2021), and it was tried in one of three communities related to this IKSDC (Balogun, 2023a). This makes the IKSDC the local hub for NRS-related activities. An IKSDC coordinator and curator are responsible for coordinating and managing IK activities within the local communities and ensuring the relevance and quality of IK data captured, respectively.

Furthermore, Murove (2018) ascertains that for a local community to partake in the NRS ingenuity, the traditional or tribal authority must establish a legal entity representing the community. The ownership of the catalogue process is then transferred to the representative body. It is also possible for a representative body to represent more than one community.

On the other hand, the NRS cataloguing system has a process it follows for the safety of all the information it enters for documentation. The directory procedure encourages community ownership of the IK activities whilst keeping an active audit trail to protect the communities and IK holders against bio-piracy (Belanger, 2011). Equally, Murove (2018) alludes that the IK audit track guarantees that IK holders and communities gain some benefit from some potential socio- and economic paybacks that may flow from their particular IK. In this vein, Eswarappa et al. (2013) confirm that when starting a new illustrative frame in a community, there must be signed a Non-

Disclosure Agreement (NDA) between the IKSDC and the entity. For that reason, Demir (2021) depicts how it is very important to warrant the confidentiality of all the information collected through the catalogue process. For these researchers, the process must identify an IK Coordinator, and the representative body's very first accountability is to appoint an IK community coordinator (IKC). Khalala et al. (2016) point out that this person is responsible for coordinating all activities of the IK catalogue process within the community. The second point identifies IK recorders (IKRs), which empowers the representative body to appoint those recorders. In line with Kaya and Saleti (2013), the size of the community, the number of recognized IK holders in the public, and the funding accessible can all regulate the number of IKRs.

The other step is to train the IKC and IKRs on the catalogue process and its legal aspects. Their documents, as well as the catalogue questionnaire and IT system (NIKMAS), must be signed (Pretorius and Bezuidenhout, 2011). The community associated with IKSDC and NIKSO is concerned with the training procedure. After this level comes the step of IK holders' identification. Typically, the communal representative body is responsible for identifying all IK holders in the community that require classification. Shonhai (2016) agrees that there must be approval regarding the community representative body to identify the IK holders and place the ownership and authority of the process back into the community's hands.

Nonetheless, some IK holders may fail to get categorized despite having treasured IK evidence. Murove (2018) and Sundararajan (2023) also discussed managing IK cataloging. These researchers opine that the IKC manages the IKRs during the registration process. IKRs are selected to visit explicit IK holders to assemble the catalogue information. To the World Health Organization, the IKC is responsible for the number, quantity, and quality of the questionnaires completed by the IKRs within an agreed time frame (WHO, 2019). An endorsement letter and the catalogue process document are the two main documents signed for use during the catalogue process. Sayed et al. (2017) describe the endorsement letter as originating from the DST/NIKSO, which approves the project's aim. Besides, the catalogue process is a Prior Informed Consent (PIC) form explaining the project and the IK holder's role and participation rights (Igboin, 2016).

The step of verifying catalogue content is also important in the sense that all questionnaires completed must be presented to the community representative body to verify its content. Accordingly, Salaba and Chan (2023) opine that the representative body can decide which information represents the IK data of the concerned community and which one to capture in the NIKMAS index classification. After this phase, the catalogue data is transferred to the NIKMAS System. The respective IKRs enter

all the community-verified questionnaire information into a laptop assigned to a community that hosts a local copy of the NIKMAS catalogue software (Ringuette et al., 2022). In this process, the community's representative body signs an Information Transfer Agreement (ITA) acknowledging the transfer of the information to the IKSDC as per the previous NDA (Kaya & Seleti, 2013). The last stage is the uploading of catalogue content to the central system. Khumalo and Baloyi (2017) explain that it is at the IKSDC where the IK captured on the community's NIKMAS laptop is transferred to the IKSDC's NIKMAS distributed server. Here, it will periodically upload new catalogue information to the NIKMAS central server hosted at the NIKSO offices (Pretorius and Bezuidenhout, 2011). Therefore, the information is stored centrally to ensure secure access, preservation, and responsible management, as the legal documents signed with the community and the IK holder stipulate.

The following section will discuss how prior learning can be recognized and how IKS practitioners can be accredited.

2.5 Recognition of Prior Learning (RPL) and Accreditation of IKS Practitioners

Recognition of Prior Learning (RPL) and IKS Practitioners are important to encourage in this research. RPL is a process through which non-formal and informal learning is measured and mediated for recognition across different contexts (de Paor, 2023). Similarly, RPL measurement and mediation are certified against credit, access, inclusion, or advancement requirements in the formal education and training system or workplace (Cooper et al., 2018). In other words, it is about the skills and knowledge an individual has collected through work and life experiences and then transferring them to current training course requirements. Accordingly, Colonialism and apartheid systems in South Africa marginalized African IKS and practices as primitive and unscientific. This is even though these local community-based knowledge systems and practices contribute to and ensure the sustainable community livelihoods of their respective communities in their specific cultural and ecological settings in terms of food security, health, natural resource management, natural disaster management, governance, and conflict resolution (Shonhai, 2016). In the RPL of IK holders and practitioners, IK refers to the knowledge that grows within a social group or community, incorporating learning from one's own experience over generations but also gained from other sources and fully internalized within local ways of thinking and doing. This knowledge needs to be made visible and interfaced with the other knowledge systems to meet the changes of globalization and contribute to the global pool of knowledge. Therefore, IKS can be mainstreamed in the global knowledge economy and society through the RPL of the IK holders and practitioners.

Based on the above context, South Africa has changed its mind and started laying the groundwork for the accreditation of IKS practitioners by recognizing prior learning. To Demir (2021), the creation of the steering committee to recognize prior learning RPL of IKPs was long delayed. This committee's main objective is to accredit organizations for RPL in ATMs. Its primary goal is to make implementing a Discipline of Competence (DoC) for the THP domain easier. It must function as a pilot program to create and evaluate competence norms and standards in a practical environment. Balogun and Kalusopa (2021) claim that the IKS Policy, which the Cabinet enacted in 2004, established an enabling environment to encourage and deepen IK's contribution to the social and economic development of South African communities and the nation. Establishing procedures to acknowledge some branches of IK as professional disciplines with separate institutions, governance frameworks, and quality assurance methods is crucial in establishing a legitimate branch of that knowledge (Demir, 2021). Similarly, TPs should be involved in nation-building initiatives, which the committee, as mentioned above, must support by recognizing and incorporating IK into the national environment (Munsaka and Dube, 2018). This suggests that TPs may be able to offer some remedies to some of society's health-related problems.

The pilot program's outcomes should offer TPs a sense of identity and end the profession's derision. Therefore, the government ought to promote the introduction of IKS legislative tools to avoid making fun of the profession of TPs. Murove (2018) indicates that the process sounds crucial since IK is a national asset, making it in the national interest to safeguard and advance IK law, policy, and public and private sector initiatives. Mashiyane (2023) confirms that the legislation can address the ongoing marginalization and misappropriation of knowledge. This culminated in 2019 when President Ramaphosa signed the IK Act No. 6 of 2019 to support the IK policy (Demir, 2021).

2.6 IKS and South African Academic Institutions

Higher education institutions stand for the peaks of power in the creation, accrediting, legitimizing, and diffusion of knowledge. Millions of young adults strive to reach these heights yearly and earn the requisite certifications (Munsaka and Dube, 2018). In other words, the cognitive and operational capacities of IKS might greatly vary depending on what these institutions choose to include, exclude, or disparage. According to Demir (2021), from this angle, any specific work on curricula and research on traditional medicine must come before the reconstruction of IKS, the critical examination of existing paradigms and the epistemological foundations of existing academic practice, and the identification of the limitations they impose on creativity. Indeed, this indicates a challenge at the

epistemological foundation level because of the orientations that feed South African traditional medicine in particular and medicine in general through IKS (Balogun & Kalusopa, 2021). If students want to develop a viable and inclusive solution for a path forward, particularly about IKS, Mothibe and Sibanda (2019), contend that they must learn about the more sophisticated subjugation technologies that have been used to keep their IKS in their communities down so effectively, for so long.

Furthermore, the sustainability and inclusion of IKS imply recognition and accreditation of its practitioners. This requires mainstreaming indigenous knowledge systems to work within the Department of Science and Innovation (DSI). Ensuring the legal protection of IK within DSI portrays a deliberate way to mainstream IKS work as an integral part of that department (Balogun & Kalusopa, 2022). The whole process specifically prioritizes the work on IK in more extended plans as one of the missions that include it as part of key performance indicators. This should bring relief to all practitioners because it contributes greatly to that department that values IKS. Treasuring the contribution that IKS and practitioners bring to the entire science and innovation value chain can particularly develop into an instrument to benefit practitioners and communities directly (Munsaka and Dube, 2018).

Such is an attempt to boost Indigenous Knowledge-Based Bio-Innovation in South Africa. South African IK-Based Bio-Innovation Programme has six platforms on African natural medicines and nutraceuticals, such as food and nutrition (Okole, 2021). Besides, IK Bio-Innovation extends it focus to cosmeceuticals, encompassing health, beauty products, and health infusions like beverages (Munsaka & Dube, 2018). Finally, Kruger (2020) concludes that innovation can transfer technology, including incubation and commercialisation, which can boost enterprise development. It is in this context that the South African IK-based bio-innovation program established at the Technology Innovation Agency (TIA) (Okole, 2021) and Industrial Development Corporation (IDC) had been created as a commercialization platform to ensure that the users of IK follow the regulations (Demir, 2021).

That being said, this strategy can allow those individuals who intend to use IK for commercialization purposes to apply in the manner prescribed in the regulations for a license authorizing the use of IK. Balogun and Kalusopa (2022) suggest that the DSI must ensure that they not only develop regulations and set up formal coordinating structures but that they equally provide the necessary financial and skill resources through their National System of Innovation (NSI) and their Post School Education and Training (PSET) institutions to help implement the

work of local communities in the advancement of IKS and products. For instance, Demir (2021) mentions a project in which approximately R58 million were invested for construction. The project is the current Good Manufacturing Practices-based laboratory and medicines production facility. The laboratory is linked to Farmovs, an FDA-accredited clinical trials management research facility.

Consequently, all the above-detailed developments aim to recognize and accredit the IK. By doing so, the RPL framework considers ways to allow us to better discover IKPs in connection with the IKS Policy (2004) (Moichela, 2017). This evidences the importance of IKS in the sustainable development of South African indigenous communities and the country in general. In its third chapter, the IKS Policy (2004) mandates the Department of Science and Technology (DST) to address the elements of indigenous knowledge that are not accommodated within the National Qualification Framework (NQF) (Moichela, 2017). Similarly, DST must also explore the existing opportunities for recognition of prior learning of IK practitioners within the current NQF (Kaya & Seleti, 2013). The IKS Policy further stipulates harmonizing the Recognition of Prior Learning framework with international best practices. The Recognition of Prior Learning of IK practitioners will also promote the constitutional rights of the knowledge practitioners.

In that context, the IKS Policy (2004) emphasizes that recognizing IK holders and practitioners and their practice disciplines should be mainstreamed to enhance community empowerment and organized stakeholder interaction. Loch and Riechers (2021) illustrate the need to bridge the gap between IKS disciplines of practice (DoC) and public awareness to redress various issues, such as lack of recognition of existing IKS disciplines of practice as part of the global bodies of knowledge and innovation; limited understanding of IKS and its importance in sustainable community livelihood and development. In the same context, Shonhai (2016) asserts that joining the breach between public awareness and IKS DoC requires the expansion of the IK holders and practitioners' time-tested knowledge, innovations, and products beyond their immediate communities to become an integral part of the national and global knowledge economy. Finally, Khumalo and Baloyi (2017) submit that covering up the vacuum between public alertness and IKS Doc can harmonize incoherent policy frameworks and integrate the various IKS disciplines of practice; no streamlined criteria for the standardization and certification of the competencies of IKS disciplines of practice, like quality assurance, and eventually no acknowledgement of IKS disciplines of practice as professions.

The RPL system and process provide several advantages for developing and recognizing IK-holders and practitioners as knowledge producers, users, and community educators. Congruent with Munsaka

and Dube (2018), IK holder's and practitioners' knowledge, innovations, and practices will contribute to transforming the current Western-oriented education system by mitigating the gap between living and learning. A mutual professional exchange of knowledge and practices will occur between IK and conventional Western knowledge practitioners. Khumalo and Baloyi (2017) argue that IK holders and practitioners have information, inventions, and observations that can easily equally endorse the role of African IK in the African Renaissance and enable Africa to contribute and participate actively in the global knowledge economy using knowledge systems generated by its practitioners as demonstrated by the other world IKS best practices such as India, China, Brazil, and Malaysia. Recognition of RPL and the experience of IK holders and practitioners reduces the time and costs of formal learning. It allows human capital to be deployed more productively across the economy by giving people access to jobs that better match their true skills.

Furthermore, Maluleka (2020) admits that IK holder's and practitioners' aptitudes can become a solid foundation for forming community-based small and medium-sized enterprises that can provide income and job opportunities in their respective communities. Certainly, this can provide educational benefits such as developing career paths within a lifelong learning framework, which enables skills portability and articulation. According to Shizha (2014), grassroots who own information knowledge have the power to become the basis for the standardization, codification, and classification of IKS and articulation within the NQF, thereby opening access to IK-based learning opportunities and IK-based job opportunities created by community-based IK production enterprises for underprivileged minority groups, disaffected youth and older workers who did not have many opportunities for formal learning. Similarly, Ahearn et al. (2019) confirm that the aptitudes community people own regarding IK can establish and repair social justice as it promotes work that is self-consciously relevant' to the needs of marginalized and underprivileged social groups. This helps make visible the IKS best practices in natural resource management, indigenous approaches to healthcare, food security and nutrition, leadership and governance, climate change, adaptation, and mitigation (Tirivangasi and Tayengwa, 2017). It is a vehicle for interfacing IK with other knowledge systems for sustainable community livelihood.

It is also worth mentioning that the DSI recognition of RPL provides for persons wishing to register their qualifications as IK practitioners. Registration is paramount because it allows the person to become certified and recorded in the Register of Designations. Accordingly, Maluleka (2020) admits that the process caused the formulation of some structures to establish the RPL. The DSI may develop competency norms and standards to partner with the SAQA. For instance, Osenia and Shannon (2020) confirm that those norms and standards may encompass four THP categories: diviners, herbalists,

traditional birth attendants, and traditional surgeons in KZN, North West (NW), and Limpopo. According to Chali et al. (2021), partnership with SAQA should start with the project initiative conception by developing the NQF norms and standards and interfacing them with those that THPs may emit or those from any other areas or disciplines. Through this attempt, the DSI works similarly with the DH, and both present the work they will have done to the THPs Interim Council (Mothibe & Sibanda, 2019). In effect, this effort can also be presented to the House of Traditional Leaders and in the provinces, and the DSI should ensure that the concerned individuals are also mobilized. Accordingly, Maluleka (2020) admits that the work produced in the KZN province was the most complete regarding the scoped fitness standards and ethics that the THP had developed.

On the other hand, the DSI ought to present the RPL pilot program to the National House of Traditional Leaders (NHTLs), the Congress of Traditional Leaders of South Africa (CTLSA), and the KZN Provincial House of Traditional Leaders (Bell, 2019; Habtom, 2018). As a result, all these stakeholders must support and endorse the initiative. In 2019, the Minister of Higher Education, Science and Technology appointed a 13-member steering committee to focus on the accreditation of institutions for the RPL in ATMs (Grigo, 2022). According to Cooper et al. (2018), the selected committee's main objective should be to simplify the execution of a DoC for the THP domain as an experimental program to assess the developed ability norms and standards in a real-life setting. Congruent with Demir (2021), this pilot would result in a model for RPL that could be rolled out to other provinces. This is part of a strategy the Government has chosen to recognize PL and accredit IKS practitioners.

2.7 Government Public Strategies on IKS Development

South Africa's Government is mandated to frame public guidelines regarding IKS, and the public and private actors must execute them. According to Howlett (2019), through public policy, the government produces an action plan to assist the public in attaining definite goals. The public agency enforces and executes the agenda, a wide-ranging action plan formulated to overcome a specific problem and articulated through a precise political process. Demir (2021) considers policy formulation as the phase between agenda-setting and implementing that policy. However, policy formulation remains a 'broken thread', a neglected stage in the study of public policies, mainly on the African continent (Kadio et al., 2018; Howlett & Mukherjee, 2020). The formulation process expands the IKS policy design, referred to as the premeditated decision-making process. In other words, this step involves the development of policy options within the government. In line with Lavigne and Ayimpam (2018), this occurs after officials have narrowed a range of possible policy

choices by excluding infeasible options. In this step, different interested parties attempt to have their favoured policy solution rank high among the remaining options.

The involvement of teams of multi-disciplinary experts in various fields in formulating the IKS policy sounds crucial. Such joint efforts, according to Ntentema (2021), reflect that people can build confidence by clearing the misperceptions that exist toward indigenous knowledge, such as ATM, that colonialism and Apartheid have created and propagated over the years. According to Howlett and Mukherjee (2020), such a process implies that the government can successfully motivate collaboration to develop the IKS policy by creating collaboration with diverse stakeholders for design. This brings together representatives of government departments, science councils, tertiary institutions, NGOs, knowledge holders, and practitioners, including ATHPs (Hall et al., 2013).

Bagley (2018) confirms that the participation of IK holders and practitioners in formulating IKS policy was a testimony of the commitment of the democratic South African government. The government did all it could to ensure that the grassroots were part of the solution to the local problem of marginalization of IKS, especially traditional medicine, including its knowledge holders and practitioners (Chali et al., 2021). The majority of the African people depend on traditional medicine for primary healthcare. The participation of IK holders and practitioners from the initial phase must be an important milestone in the government's efforts to recognize that they were custodians of local community knowledge systems.

On the other hand, the government can also work through its departments to push for the recognition of IKS. In this context, Saurombe (2013) argues that considering the holistic, complementary, and multi-and transdisciplinary nature of IKS, the formulation of the IKS Policy also requires the creation of an Inter-Departmental Committee on IKS. In the South African context, this has included different government departments such as trade and industry, arts and culture, agriculture, health, environmental affairs, and tourism (Munsaka and Dube, 2018). Consideration also went to the ministries of Education, Foreign affairs, Land Affairs, Provincial and Local Government, Water Affairs and Forestry, Public Service and Administration (DPSA), Finance, and Sports and Recreation, to name a few (Munsaka and Dube, 2018). The committee still exists, and many government departments are represented to ensure synergy. Each department focuses on IKS areas of expertise.

To ensure international benchmarking, the IKS policymakers consulted experiences and lessons from Australia, China, India, Latin America, and other African countries (Mazel, 2018). The IKS policy formulation process also considered international imperatives and declarations. This, according to

Ramaube (2018), included the African Regional Intellectual Property Organization (ARIPO), the Convention on Biological Biodiversity (CBD), the International Labour Organization (ILO), and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). In line with Bell (2019), consideration also went to the United Nations Conference on Trade and Development (UNCTAD), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Environment Programme (UNEP), and World Intellectual Property Organization (WIPO), World Trade Organization (WTO).

The issues addressed in the above-mentioned international declarations are featured in South Africa's IKS policy. The points included codification, integrating IKS with science, the contribution of IKS holders in decision-making, rights of Indigenous people to benefit sharing, informed consent, and protection of IKS through intellectual property (Mothibe & Sibanda, 2019). For example, Dreyling (2019) and WHO (2019) indicate how the United Nations Environment Programme (UNEP), as the custodian of the Convention on Biological Biodiversity (CBD), requested WIPO, WTO, and FAO to consider the protection and benefit of local communities that have contributed to an invention or intellectual property development. In this vein, WIPO convened the ICG and UNCTAD to voice support, emphasising the economic value of IKS (Flint, 2015). Regional organizations such as the Asia and Pacific and the African Union have also issued treaties and conventions regarding the regulation of traditional knowledge. The importance of consulting and learning from others indicates how the South African IKS policy formulation is aligned with regional and international imperatives.

However, the efforts deployed by the South African government to promote the IKS policy were helpful for many others. Osenia and Shannon (2020) accentuate that while learning from international approaches and experiences, other countries also learned from South African IKS policy development. For example, The South African IKS policy (2004) was tabled as a working document at the World Intellectual Property Rights and Cultural Heritage at the Digital World Conference in Spain. Several countries use the South African IKS policy (2004) as a framework for formulating IKS policy (Balogun & Kalusopa, 2022).

2.8 The IKS Policy (2004) Environment in South Africa

It is crucial to comprehend the context around the IKS policy in South Africa because doing so can greatly aid in understanding TM in this country. According to Shonhai (2016), it is essential to analyze the IKS discourses that influenced its creation and its objectives to fully grasp the most significant factors that led to the formulation of the IKS policy (2004) in South Africa. The African Renaissance

as an ideology, equity, integrating IKS and science, considering the integration of science with traditional knowledge, and the commodification of IKS need to be well understood.

As mentioned, the IKS must be explored to understand better how cultures play an important role in developing the ATM in South Africa. However, Shonhai (2016) admits that the colonial and apartheid regimes in South Africa were very harmful to IKS, which also negatively impacted the ATM. To change the legacy of the past and provide support and protection for African IKS, Balogun and Kalusopa (2022) argue that its knowledge holders, practitioners, policy, and legislative frameworks had to be considered as vital factors. Thus, it was necessary to create a policy framework that would aid in facilitating a better understanding of the historical and cultural context, as well as the importance of indigenous and local communities, to recognize IK as a knowledge domain and system on its terms (Kaunda & Kumalo, 2015). The IKS policy's main objective was to acknowledge such comprehension, validation, development, promotion, and safeguarding of the knowledge's keepers and practitioners.

Furthermore, between 1996 and 1998, the South African government organized an IKS audit by which it assessed Indigenous Technologies countrywide (Murove, 2018) as part of the social transformation process of post-apartheid society. Therefore, the IKS Program was initiated jointly by the Parliamentary Portfolio Committee of Arts, Culture, Science and Technology and the Council for Scientific and Industrial Research (CSIR), which started in 1996 as a research program at the CSIR (Njiraine, 2015). The process reached the level at which CSIR asked the University of the North to pilot the Indigenous Technologies audit following the nation's debate and conceptualization. Munck (2016) reveals that in December 1996, the CSIR and the University of the North were assigned the practice with 60 students from various professions to engage with communities in the Northern Province regarding IK. Thus, the outcomes of this pilot were presented in a workshop held at the University of the North in February 1997, and a feedback workshop marked the conclusion of the fieldwork. The outcomes of this workshop provided a glimpse into the variety of indigenous technologies utilized on a very modest scale in the Mpumalanga Province and several communities in the Northern Province (Sayed et al., 2017). The results have paved the way for a nationwide audit to catalogue the many indigenous technologies in use across South Africa.

In line with Buthelezi and Hughes (2014), the Portfolio Committee of the former Department of Arts, Culture, Science and Technology (DACST) played a crucial role in developing and supporting IKS. DACST accepted and backed the IKS policy's goal of fostering and enhancing its contribution to South Africa's social and economic development. This was included in the NRDS of 2002, the Ten-

Year Innovation Plan (2008), the Science and Technology White Paper (1996), and the South African Constitution (Balogun & Kalusopa, 2022). The development of services offered by traditional healers, the addition of IK to the economy, the integration with other knowledge systems, and the reinforcement of African cultural values in the face of globalization served as the policy drivers.

In effect, the above involved the CSIR and 9 Universities in the Audit of IK knowledge countrywide. Each university conducted its provincial workshop in 1998 and reported on its findings. As a result, in September 1998, the First National Workshop on IKS took place at the University of the North West from 21 - 23 September 1998 (Fredericks, 2011). This workshop was jointly organized by the Portfolio Committee, DACST, and the CSIR and supported by other stakeholders. The conference represented the broader stakeholder community, including the practitioners of indigenous medicine.

On the other hand, Mothibe and Sibanda (2019) highlight the involvement of THPs, along with key stakeholders, including university staff and students, science councils, government departments, technologists, members of parliament, and international guests. The workshop dealt with the information emanating from the national conference. Ultimately, the workspace discussed the formulation of the policy on IKS and legislative mechanisms in IKS, followed by a regional conference to interact with counterparts in neighbouring countries (Kaya & Seleti, 2013).

2.9 Contestations on Conceptualization of Indigenous Knowledge Systems (IKS)

The IKS had been the subject of debates before they were accepted. Likewise, Tharakan (2017) indicates that even though such knowledge systems have existed for thousands of years, African Indigenous Knowledge Systems (AIKS) concepts and practices have only recently begun to be recognized in the scientific fields. The inadequacies of Western-based development planning and methods and the growing disillusionment of most Africans with the promises of contemporary "Western" science tend to raise public awareness of the importance of indigenous African ways of knowing and value systems. It emphasized the value of "science" in establishing its location in the social and cultural framework of the African people, particularly their native healthcare systems (Owusu-Ansah & Gubela-Mji, 2013).

However, in the Western context, the concept of “indigenous” tends to be taken as similar to ‘traditional’, ‘aboriginal’ or ‘vernacular’ (Loubser, 2005: 76). Osman (2009) indicates that ‘indigenous’ people refer to a specific group of people occupying a certain geographic area for many generations. They possess, practice, and protect a total sum of knowledge and skills constitutive of

their meaning, belief systems, livelihood constructions, and expression that distinguish them from other groups (Dondolo, 2005; Masoga, 2005). However, Haris et al., 2013:8) argue that the contemporary politics of indigeneity and identity imply that people have multiple and overlapping identities shaped by the present political and economic dynamics and their manifestation in the socio-cultural context (Grigo, 2022). Even though many people may express similar worldviews and a common indigenous identity, their cultures are nevertheless based on different creative spirits, environments, and histories. For instance, A-Magid (2011) notes that the forces of AIKS function on two interrelated levels: the empirical and cognitive. The empirical level encompasses natural, technological, architectural, and socio-cultural spheres.

Conversely, the natural sphere includes ecology, biodiversity, soil, agriculture, medicine, and pharmaceuticals. Technological and architectural form the second sphere, which Makundi et al. (2016) say consists of all the crafts such as metallurgy, textiles, basketry, food processing, building, etc. The third sphere is the socio-cultural aspects of life, including social welfare, governance, conflict resolutions, music, art, etc. All these knowledge systems and practices operate within a cultural context involving a harmonious interdependence of all-natural, physical, social, cultural, or spiritual phenomena. It is worth noting that this domain might include rituals and performances such as songs and dances, which Vining et al. (2008: 8) think oppose modern and Western tendencies as they separate humans from their natural environment. The core of indigenous cosmology is about "the co-evolution of spiritual, natural, and human worlds" (Винокурова & Захарова, 2022).

Looking at the above conceptualizations, Bojuwoye and Moletsane-Kekae (2018) support the argument that the main features of AIKS are reflected in its holistic approach to knowledge and life. It is also community-based, predominantly unwritten but preserved in oral traditions and collective memory, and informed by customs, practices, rituals, proverbs, and oral stories. It is dynamic and changing due to its ability to adapt to other ways of knowing and circumstances (Kaya & Seleti, 2013). Indigenous knowledge exists as a "system" due to its holistic nature and relationship to all aspects of life and the natural environment. Osman (2009) elaborates that, like other systems or domains of knowledge, Indigenous Knowledge embodies ethical standards, standards of responsibility, transmission, and a 'system of rules and practices".

Even though AIKS and TM are increasingly gaining a space in the African political, cultural, academic, policy, and legal frameworks, they still face many external and inherent challenges as a knowledge domain on its merit. A-Magid (2011) categorizes these challenges into three main areas: the impact of colonialism that continues to cast its long shadow in the postcolonial era, the barriers

associated with the body of AIKS, and challenges reflected in the passive response of African universities and research institutions. Regarding the impact of colonialism, various methods were employed to subjugate African people and gain complete control over their lands and resources. This also involves the systematic internalization of indigenous cultures and concerted efforts to erase indigenous knowledge systems and replace them with Western- knowledge systems. According to Osman (2029), this was made possible through Western education, Christianisation, and the degeneration of relatively self-sufficient economies into dependent entities. This dominance continues to exist even in the postcolonial period (Kaunda & Kumalo, 2015:3). The challenges embedded in the body of AIKS are divided as (i) alleged ethnicisation (ii) epistemological, conceptual and methodological issues, (iii) restoration and protection of AIKS.

Michalopoulos and Papaioannou (2015) argue that ethnicity, as a dividing factor in the political economy of Africa, is a colonial creation. The dominant characteristics of African pre-colonial societies were mobility, overlapping networks, multiple group membership, and flexible, context-dependent drawing of boundaries. The European Colonial policy of divide and rule introduced the concept of 'individual' ethnic identity with corresponding (cultural and linguistic) components of distinct group identity confined to specific areas. This included various forms of zonation of natural resources, including land distribution and use, censuses, and commercialization of land. Osman (2009) elaborates that when the political borders of African countries were drawn, akin ethnicities were divided further into different groups and communities that became nationalities. This fragmentation of traditions, land, and other resources, separation of groups of people and ethnicities, and restriction to access what used to be boundless created competition and conflict between these groups. In this vein, Griffith and Zuberi (2015) argue that in modern times, ethnicity refers to a social concept that refers to the cultural distinctiveness of a social group. Therefore, an ethnic group, in the mind of Hall (2017), is identified using sociocultural rather than physical-biological characteristics and an attachment to a common home. Besides, Erikson (2017) indicates that ethnicity in its social and political context has been self-indulgently manipulated by colonialism to influence traditional leaders and, currently, by the African elites to lobby their ethnic communities to achieve their own political and economic interests. In the face of these ethnic divisions, African local communities in their specific cultural and ecological environments have used local knowledge systems to mitigate various life challenges, including healthcare, environmental management, food security, conflict transformation, leadership, and governance (Munsaka and Dube, 2018; Khumalo& Baloyi, 2017). Alternatively, IKS connects with the spiritual aspects of life because it is hard to demonstrate that connectivity practically. Onwu and Mosimege (2004) declare that this connection sounds partial because it presents many gaps regarding comprehending the knowledge it encompasses. Additionally,

IK is described as inclusive of all kinds of beliefs, making it short of referring to truth or justifications. Due to this lack of evidence, Munsaka and Dube (2018) think that the status of IKS is just a mere theory or estimation, if not a delusion.

By scrutinizing knowledge production and its methodologies, Ozioma and Chinwe (2019) conclude that given the holistic socio-economic and spiritual dimensions of IKS, its methods of discovery and experimentation are largely communitarian because its transmission mode is oral and collective. Therefore, using them concurrently with the standard scientific methodologies and the IK diachronic experimentation procedure could be crucial since it can pose a logistic inconvenience. However, Mukherjee (2002) states that the field methods currently applied by researchers are predominantly based on Western methodology, and, when required, indigenous procedures are integrated in the form of Participatory Rural Appraisal (PRA), semi-structured interviews, in-depth interviews, and/or group focused interviews, to some extent, interpretation of the data.

Accordingly, Trinos (2022) argues that the challenges facing indigenous knowledge depict some of the devastating consequences of colonialism's carefully designed policies to deconstruct, erase, and relabel the fundamental cognitive of IKS and the rich heritage of Africa and replace them with cognitive and theoretical conceptualizations as demonstrated in the Western hegemony today. Despite all this, IK faces two interrelated challenges, encompassing the search for methodologies (Chaudhuri, 2015). These approaches do not build on blind assertions of African ideas and concepts to replace Western terms. According to Eswarappa et al. (2013), these processes apply critical reflection and identify, filter, provide, and use factual and data-related protocols based on an integrated IKS. The second challenge is also related to the previous one. Olutope (2020) reveals the two challenges are closely related in the way they craft research methodologies that fit the multi-disciplinary field of IK. In other words, the tactics sound natural in that they own rights and context simultaneously as they value the contemporary changes and developments in human knowledge.

Therefore, Eswarappa et al. (2013) state that oppressive and exploitative colonial political and ideological mechanisms have imposed consistent policies of coercion and consent on their African subjects, which led to total compliance of the people and dislodgement of their IK and importance structures. In the same vein, Schoneveld and Zoomers (2015) approve that the dislocation policies designed to appropriate the African people's natural resources, especially land, intensified the estrangement of African communities and, hence, the loss of their knowledge systems associated with these natural resources. In the post-colonial period, national and international pharmaceutical and medical cosmetics companies have become corporations that collaborate with their associate research

institutions through legalized piracy. This is a strategy they use thanks to the licenses they get to manipulate IKS and cultural globalization through Information and Communication Technologies (ICTs), whose aim is to portray such knowledge as primitive and unscientific (Mizuno & Okazawa, 2009).

Given the above arguments, IKS practitioners have considered ways to protect their knowledge. Accordingly, Anderson (2015) shares that protecting IK faces challenges using the Intellectual Property Rights (IPR) regime. Legally, IPRs are individualistic, making them powerless to protect community-based knowledge systems. Khumalo and Baloyi (2017) reveal that this legal obstacle is being addressed. Still, the different cultural expressions of IK, including kills about weaving, basketry, music, songs, costumes, fashion, symbols, etc., are being reproduced and commercially privatized by outsiders with little beneficiation to local communities. Identifying the indigenous communities to which certain knowledge assets and/or products belong creates another challenge. Thousands of social groups and communities in the country and continent also practice these knowledge systems.

The continued dominance of Western knowledge systems is hindering the renovation and protection of IKS. Murove (2018) positions that the hegemony of what was previously colonial and now Western knowledge systems is entrenching itself deep in our countries to ravage our contemporary knowledge. Such new forms of imperialism and capitalist globalization have become very destructive for African IKS. To this issue, Mizuno and Okazawa (2009) underscore that Western knowledge systems dominate the disciplinary and interdisciplinary discourses, paradigms and publications, academic politics, and practices. This is despite the increasing efforts to establish new higher educational and research institutions in the country. This has happened because we see that the same Western hegemony still dominates the majority of new African local institutions, may they be academic, private, or public.

Furthermore, Sayed et al. (2017) note the paradox of African universities: even though they are located in Africa, they teach and research in Africa. However, they have still failed to focus on an African context. This infers that what they do in research and teaching hardly mirrors the local perspective. Only a few higher education institutions in South Africa, such as the North-West University, the University of Venda, and the University of Limpopo, have tried to incorporate AIKS in their teaching, learning, and community engagements. The University of KwaZulu-Natal has adopted an institutional AIKS policy since 2014. These institutions constitute the DST-NRF Centre in Indigenous Knowledge Systems (CIKS), with its hub at UKZN. They also promote a knowledge

domain characterized by challenges, including, according to Mazel (2018), not fully integrated into the core business of higher education and research institutions regarding research, teaching, and learning programs. Again, it lacks a critical mass of human capital conversant with IKS epistemologies, research methodologies, and value systems. It also lacks specific IKS-related employment opportunities for its graduates. Moreover, it has internationally limited IKS platform publications that are recognized and lack institutional commitment.

However, despite the above challenges, the CIKS has proved to be an important instrument for promoting the transformative sustainability of IKS within and outside the partner institutions. According to Snyder (2019), this has been done by advancing the democracy of knowledge systems as a paradigm shift by mitigating Western knowledge system dominance in the global knowledge economy. The CIKS has aided in transformation by improving the ability to supervise research for IKS development. In other words, it arranges works on IKS epistemologies and research approaches for both IKS students and supervisors (Balogun, 2023). Indeed, this aspires to foster international networks, collaborations for postgraduate education and training support, and a shared knowledge of IKS. Following Sayed et Al. (2017), the same initiative intends to expand multi-trans-disciplinarity in IKS research by including and drawing in international students. The same plan, congruent with Osenia and Shannon (2020), proposes to sustain experiential learning for IKS students through collaboration with the public and commercial sectors. It introduces undergraduate and postgraduate IKS research, teaching, and learning programs as a pipeline for developing IKS human capital (Snyder, 2019).

On the other hand, Shonhai (2016) considers paramount the promotion of equity in the context of gender, race, and nationality in all IKS-mandated activities through financial support, education and training, and involvement of postdoctoral and emerging researchers, especially for African women and particularly the South African ones. To end with, Munck (2016) suggests that the above process can only be successful if they work with different stakeholders. The joint efforts would aim to integrate IKS in the educational system at all levels and involve IK holders and practitioners in research, teaching, and community engagement to combine theory and practice to mitigate the disjuncture between learning and living (Sayed et Al., 2017).

Additionally, collaboration with the United Nations can be helpful. Belanger (2011) demonstrates how Indigenous Peoples and their IKS, including those in Africa, have increasingly been formally recognized by the UN and the Civil and Human Rights Movements since 1992. That is why the 21st of August has been accepted as the commemoration of the International Day of the World's

Indigenous Peoples (Mazel, 2018). Many countries, such as India, Brazil, Colombia, Argentina, Bolivia, Mexico, and South Africa, have issued Policy Documents not only to endorse the rediscovery and revitalization of their IKS, including the protection of IP rights of local communities (Pedzisai, 2013). They also encourage researchers and education systems to include IKS in their core research and academic undertakings.

Working in unison is another way to define and consider the indigenous concept. In the same context, several researchers raise existing controversy regarding the concept of indigenous because it is sometimes associated with primitive, naïve, or unscientific (Zent, 2009; Agrawal, 2014; Habtom, 2018; Witt, 2021). Looking at the etymology of this concept, Munsaka and Dube (2018:4) maintain that indigenous denotes a sense of natural belonging to a place, meaning something native. To illustrate this, Sayed et Al. (2017) connect the concept indigenous to "*ezemvelo"* in the Xhosa and Zulu languages as derived from the root "*mvelo"*, denoting the original citizens of a region. Likewise, the concept "*inheems"* in the Afrikaans language refers to what naturally belongs to an area. This connects with "*heemkunde"* (Heimatkunde in German), which studies an environment, the people's morals, habits, historical relics, legends, songs, and stories (Van Wyk, 2002; Habtom, 2018). It illustrates how the concept of culture defines the identity and characteristics of a specific native land and its people, connecting culture to the notion of indigeneity (Hassim et al., 2007) as more than just a form of intellectual expression. Sayed et Al. (2017) elucidate how art and literature should also encompass a particular group of people's customs, arts, technologies, and social institutions. Consequently, ever-changing subjects constantly construct, reconstruct, and reinvent culture (Drzewiecka and Halualani, 2002).

The above points converge to admitting that natives of any land have their specific culture. In other words, every person has their IKS that they can easily use to prompt their role in developing TM in public healthcare in South Africa. In effect, this denotes the historical particularism as a conceptual framework, as Marvin Harris coined it in 1968 from an anthropological perspective (Sayed et Al., 2017). This confirms that each society and culture represents a collective and unique historical past, and each indigenous culture is distinct and unique. To explain cultural and knowledge systems, Boas used three characteristics: environmental conditions, psychological factors, and historical connections (Hassim et al., 2007). We understand the value of history as the most important part of people's culture, but this can still be disapproved. According to Sayed et Al. (2017) and Munsaka and Dube (2018:8), this argument sounds anti-theoretical as it does not advance universal principles that apply to all world cultures. This happens because the analysis can interrogate the concept of IK. After all, it creates controversial debates. That said, different terminologies and conceptualizations have

been used to describe what IK is. In this vein, Senanayake (2006) states that some people use concepts such as native knowledge, local knowledge, or folk knowledge, while others call it community knowledge, ecological knowledge, and so on. This implies that the understanding and implementation of indigenous people and their knowledge and the prospects and challenges of TM can prompt the understanding of their historical and cultural particularities, diversities, and dynamics. Sterling et al. (2017) and Isaac et al. (2018) support this but still argue that local, community, or indigenous knowledge systems need to be conceptualized in the context of their specific historical, cultural, and ecological systems.

Colonizers built on the above misunderstandings, to marginalize IKS and TM. The imperialists' dominance of Western knowledge through colonialism and other forms of imperialism tended deeply to marginalize TM through IKS (Aniah, 2015). This has occurred regardless of 80% of the African people who use TM medicine in their communities. Besides, that was partly due to cultural factors and the inadequacy of modern healthcare services to those who still depended on ATMs for healthcare (Habtom, 2018). Traditional medicine refers to the information and practices based on aboriginal people's concepts, opinions, and experiences regarding ways to diagnose, prevent, and better their health conditions, all leaning on their culture, whether explainable or not. The apartheid regime strongly opposed IK and TM, which means they were marginalized and overlooked (Berger, 2007), and this period effectively obstructed the development of IK and health care in general, mainly regarding ATM. Understanding the European conquest and invasion eras sheds light on how and why the epoch's main goal was the imposition of stems following the colonizer's strategies of bringing and forcing their medicine into SA. Therefore, they had to discredit and ban the African pre-existing knowledge systems to inflict their proper medical principles.

Colonialism and the apartheid system in South Africa further encouraged racial separation where diverse groups remained separated racially, which was key to access to knowledge. Sayed et Al. (2017) comment that the white minority had more access to knowledge, particularly modern scientific and technological knowledge, than the black majority. This easily applied because the white minority controlled and owned all state entities and institutions. Such a plan disadvantaged IKS and TM practitioners, asphyxiating them extremely during the SA apartheid era. In other words, they were marginalized, oppressed, suppressed, and open to humiliation. Due to denying practitioners access to appropriate and relevant opportunities and resources, IKS were similarly left without the opportunity to organize and mature. Consequently, Indigenous Knowledge came to be seen as primitive and unscientific, perceived as unhelpful for the people.

From another angle, it was during the apartheid period that traditional leaders who were responsible for traditional affairs, including IKS, were stripped of their powers and roles as guardians and holders of IKS. Hassim et al. (2007) underline that in the 1950s, the Bantu Authorities Act (BAA) of 1951 and the Bantu Self-Government Act (BSG) of 1959 gave the development and rise of the 'homelands' policy. The strategy was then used during this period to force Africans to move and become citizens of selected rural 'homeland' areas, removing them from their cultural practices and traditions (Flint, 2015). This move allowed people from different cultural backgrounds and knowledge systems areas to meet and share ideas, traditions, and IK. To some extent, this expanded knowledge.

On the other hand, the disadvantage was that the passage caused a loss of indigeneity of the AIK specific to a particular group of people and culture (Igboin, 2016). In a nutshell, it negatively impacted the development of the Africans' IKS. Hassim et al. (2007) admit that ATM has been neglected and marginalized in favour of biomedicine by colonial powers and apartheid policies in SA. Accordingly, Munsaka and Dube (2018:12) elucidate that the 1974 Health Act and its 1982 amendments denied traditional healers the right to perform any act related to medical practice. This made any traditional healing viewed as lawbreaking, causing the practitioners to be subjected to jail terms. If caught, Sayed et Al. (2017) confirm that Traditional Healers and those seeking their services were arrested and charged during the era of apartheid in SA. Despite all these laws and restrictions, ATMs remained resistant, and traditional healers of the era continued to be active (Ross, 2010).

Despite the marginalization of ATMs by colonialism and apartheid, Pedzisai (2013) and Mvula (2021) confirm that a large proportion of Africans at large, and most particularly South Africans in rural areas and marginalized communities, are still dependent on TM for health care. In addition, Kaya and Seleti (2013) state that a more significant number of traditional healers in SA, coupled with their historical role in traditional communities, have demanded that their contribution to the public health system be supported. As a result, policymakers are becoming more open and considerate of the TM role as part of a wider attitude toward the practice of medicine. However, based on its merits, the magnitude to which it can form an integral part of formalized healthcare continues to be much contested nowadays (Kaya, 2014). Colonization in Africa and the apartheid regime in South Africa have been at the centre of ostracism of most indigenous knowledge practices in favour of Western knowledge systems. Customary medicine and all other forms of cultural and intellectual contributions of non-Western knowledge systems were outlawed and forbidden. IKS were portrayed as basic and irrational (Kaya & Seleti, 2013), especially their spiritual aspects (Oyeshile, 2021).

In the post-apartheid era, the South African government initiated various policies, legal frameworks, and instruments to promote the role of IKS and ATMs in the public healthcare system. Since the abolition of the apartheid regime in 1994, the South African government has developed new policy strategies to address legacies of the past, such as the marginalization of IKS (Bakwesegha, 2007), including traditional medicine in public health care and sustainable livelihood as a whole. One of the main functions of public health is formulating public policies designed to solve identified local and national health problems and priorities; policies such as IKS have emerged. For this reason, it was in 2004 that the government of SA adopted the NIKs Policy to promote sustainable socio-economic development of the country and its rural areas in particular (Osenia and Shannon, 2020). The key policy drivers for the implementation of the plan are namely: affirmation of African cultural values in the face of globalization, development of the services provided by traditional healers, contribution of the IK to the economy, and interfacing with other knowledge systems (Department of Science and Technology, 2004; Habtom, 2018; Osenia and Shannon, 2020)

The ambitions of the National IKS Policy (2004) include, among others, enhancing the quality of life of underprivileged people using their ways of knowing their value systems and contributing to Africa-led globalization. This implies that TM must consider globalization while sticking to African traditions and local ways of solving its healthcare challenges. Despite the good intentions of recognizing IKS and ATM legally in SA, they still face various hurdles when looking for sustainable solutions to community livelihood and healthcare challenges, and they are still facing marginalization as well (Zibengwa et al., 2021). This interrogates the planned projections of sponsoring IKS and TM for public health care in South Africa, which therefore must consider the objectives of the National IKS Policy (2004) in endorsing IKS for sustainability.

2.10 Overview of World Health Organization on Traditional Medicine

The World Health Organization (WHO) is the umbrella institution that decides on every medicine used worldwide, which can still be regarded as traditional medicine (TM). The use and exploitation of indigenous knowledge by other nations has become a topic of discussion at numerous international forums. Kuruk (2020) retorts that the use and exploitation of TM in developed and developing countries have engaged in debates and concluded agreements that include the protection of IK. Intergovernmental organizations such as WHO, UNCTAD, UNEP, UNESCO, and WIPO have opened debates on the possible protection of IK, referred to in the Policy as traditional knowledge (TK), using intellectual property systems (WHO, 2018). It is against this international background and considering the systems and processes available locally that the IKS Policy identified the various

means of protecting indigenous knowledge in the SA context, including TM as a domain of IKS (Banjo et al., 2003). These include the intellectual property system, databases, various exceptional laws, and registers.

Picking et al. (2019) admit that TM is an integral part of the medical structure in many countries worldwide, even though its health services are often underestimated because its IKS policies remain unpopular. In some countries, the WHO (2019) revealed that TM or non-conventional medicine (NCM) may be termed complementary medicine (CM). TM has a long history of use in health maintenance and in disease prevention and treatment, particularly for chronic disease (Pradipta et al., 2023). The WHO TM Strategy 2014-2023 was developed in response to the World Health Assembly resolution on TM (WHA62.13) (Aniah, 2015). The strategy's goals were to support member states in harnessing the potential contribution of TM to health, wellness, and people-centred health care. In the same vein, Bell (2019) reveals that the objective was equally to promote the safe and effective use of TM by regulating, researching, and integrating TM products, discussing ways to support IKS, as well as traditional practitioners and practice into health structures in world countries that are focusing on such medicine.

Furthermore, supporting those countries in the WHO may promote proactive policies that can help implement action plans. Congruent with Habtom (2018), such an application has the unmistakable power to reinforce TM and IKS's role in people's health. In other words, the whole process was built upon the WHO TM Strategy 2002-2005, which reviewed the status of TM globally and IKS among countries under its coverage (Zhang, 2018). This development generated four key objectives: policy, safety, access, and rational use. Habtom (2018) illustrates how the policy aimed to integrate IKS and TM within national healthcare systems where possible, allowing the development and implementation of national IKS via TM policies and programs in collaboration with the ministries of health.

The second objective mostly focused on safety, efficacy, and quality. The main vision was to promote TM's safety, efficacy, and quality by expanding the IKS and other basic knowledge to provide robust and widespread guidance about regulatory and quality assurance standards (Osenia and Shannon, 2020). Then came the aim of dealing with access. According to Abdullahi (2011), access in the context of TM and IKS implies an increase in the availability of indigenous knowledge about traditional medicine and its affordability. This strategy emphasized ways underprivileged populations in various countries can access such medicine fully. Access also encompassed rationality by looking at ways underprivileged people can access TM without damaging the ecosystem. The last objective

was about the rational use of TM in various countries where it is in application. Congruent with Habtom (2018) and Ramaube (2018), rationality mirrors therapeutic promotion on how people can use appropriate TM and learn about IKS through practitioners and consumers, all being under the supervision of the Ministry of Health.

On the other hand, despite meaningful progress in instigating this TM strategy worldwide, WHO (2018a) accentuates how countries that belong to the WHO continue to experience challenges connected to development, integration, control, regulation, education, and information. Development connects with the enforcement of policy and regulation. At the same time, integration deals with particular identification and evaluation of the criteria for integrating TM and information regarding IKS into national and primary healthcare (PHC) (Chebii et al., 2020). In the context of safety and quality, the challenge was mostly about assessing TM's products and services, the qualification of practitioners, and the methodology and criteria for gauging usefulness. Furthermore, Habtom (2018) highlights the challenge of controlling and regulating TM and CM advertising and claims without neglecting the challenge regarding research and development.

Another challenge was the education and training of traditional medicine practitioners. These TM practitioners must learn about medicine and ways of getting them. Such education would equally consider how to use all the herbs they need in their domain and understand their products' beneficiaries and needs. Finally, the challenges of TM practitioners regarding information and communication were also discussed. Consequently, Osenia and Shannon (2020) discuss the cruciality of sharing information about TM and IKS policies, regulations, service profiles, and research information or obtaining reliable, objective information resources for consumers. Not only do these challenges exist in South African TM structures, but they are real in the global medical system worldwide.

Discussing how to implement TM and the challenges the process meets requires countries within the WHO institution to determine their national situations concerning TM and IKS policies. In line with Maluleka (2020), the process can trigger the countries to develop and enforce their TM and IKS policies, regulations, and guidelines that reflect these realities. In this condition, each country can address these encounters by organizing activities through their departments and ministries of health, following these three strategic sectors. Firstly, the WHO suggests that when countries must build their proper knowledge base, they focus on a more significant approach that can allow their TM structures to be managed actively through appropriate national policies that understand and recognize the role and potential of their traditional medicine. The second strategy, according to WHO (2019), deals with

ways countries can use TM by reinforcing the quality assurance, safety, proper use, and effectiveness of TM by regulating products, practices, and practitioners through traditional medicine education and training, skills development, services, and therapies. Appiah et al. (2018) and Nsagha et al. (2020) also indicate the need to promote universal health coverage by integrating TM services into health service delivery and self-health care. Hence, Grigo (2022) articulates how this context can promote service delivery and self-health care because health package distribution together with self-health care encompasses the power of capitalizing TM potential contribution, which can easily improve health services and health outcomes by certifying consumers who can make informed choices about TM's self-health care.

Based on the above discussions, Abdullahi (2011) and Olutope (2020) underscore that WHO is the main world institution whose role is to initiate and assess a review of the implementation of strategies regulating traditional medicine and IKS policies across countries. This implies that the WHO must ensure these countries understand how IKS policies function as a knowledge domain and system before their implementation. In other words, IKS' implementation must consider the historical, cultural, and ecological particularities in which traditional medicine works, which must equally apply to South African traditional medicine and healing practices. The subsection below discusses the Value propositions of traditional medicine and public healthcare.

2.11 The Value Propositions of Traditional Medicine in Public Healthcare

In the context of this research, TM can provide helpful medical assistance to South Africans who are using it. That being said, traditional medicines sound like health philosophies, values, and knowledge integrating herbal, innate, and inorganic grounded medications, divine healings, physical methods, and practices used to cure, identify, and avert diseases or preserve health (WHO, 2002:7). Basically, and in the same context, the value proposition of TM and PH specify what makes the service and care traditional practitioners offer attractive, and the main reasons why people should come to them. The proposition here infers that TM has tangible benefits to present to South Africans so they can feel it is good medicine that can defeat many of their health issues. TM deals with public health, and its perfect proposition must quickly transmit the values to any potential South African customer without further explanation. Each of South African TM's propositions remains unique, as it is a method for communicating the distinction between what it offers and Western modern medicine when dealing with South Africans' public health. To avoid misleading South Africans with sayings that might not accurately communicate the advantages of TM and the treatment it provides, TM medical practitioners have done everything they can to avoid doing so.

The significance of the TM value propositions among South Africans is in creating a value position essential for advancing public health. The proposition can be constantly published on the TM marketing website because it allows TM to persuade South Africans that it has successful PH care, which can attract a large audience. Because those outside South Africa's culture may adopt it, the value proposition is a potent instrument for drawing in many South Africans. In other terms, TM is also referred to as ethnic medicine or folk medicine and is also called supplemental or alternative medicine (WHO, 2008). The oldest type of healthcare system that has endured through the ages is native healing, or complementary and alternative medicine, according to other academics like Kala (2019). Humans have employed traditional treatment techniques for centuries to manage a variety of illnesses that have threatened their existence and survival (Khalil et al., 2022). TM is extensive, diverse, and culturally particular because a single, widely recognized definition does not exist. Nonetheless, the WHO has defined TM as the totality of knowledge, skills, and practices based on theories, beliefs, and experiences that are inherent to various cultures, whether or not they can be explained and used in the preservation of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illnesses. Similarly, a traditional healer is someone a community may identify, locate, and recognize as qualified to administer healthcare utilizing natural remedies based on social, cultural, and religious practices that include plant, animal, and mineral ingredients (WHO, 2000:2).

Alternative medicine is another name for traditional medicine, which refers to using traditional techniques in public health. In other words, TM remains either an alternative to Western medicine or a balancing medical technique used with conventional treatment (Jansen et al., 2021). As a result, traditional therapies are commonly distinguished from Western biomedicine, also known as allopathy, conventional, systematic, orthodox, modern, normal, or Western medicine, in situations where they deviate (WHO, 2000:3). It is extremely difficult to group the wide variety of traditional healing practices under a fitting meaning since they draw from endlessly different historical and theoretical contexts (Kiringe, 2005).

The main argument of most researchers is that the African native medicinal notion does not concern the person inherently but rather the system as a whole (Moeng & Potgieter, 2011; Nzue & Pierre, 2009). The point relates to the holistic African native medical paradigm, which does not distinguish between intellect and physical structure on a fundamental level. The knowledge, skills, and habits concerning TM are rooted in theories, viewpoints, and abilities that are unique to various ideologies and have a long history. These factors, which can all be understood or not, are used to prevent illness,

identify it early, treat it, and maintain overall health (Mavundla et al., 2007). Evidence shows that traditional healers may occasionally look for specific plant life or new biological materials for particular conditions because various therapeutic cultures may have persisted and altered over many years.

In other words, as with Chinese, Indian, and African traditional medicines, various communities have created various indigenous therapeutic procedures categorized under traditional medicine. According to Maema et al. (2016), several governments in Africa, Asia, and Latin America have incorporated traditional medicine practices to help satisfy their basic healthcare needs. Approximately 80% of people in these regions use TM regularly. According to Abdullahi (2011), the rise in chronic illnesses and awareness of the limitations of modern Western medicine forced the development of traditional or complementary medicine. Also, there is the combined approach to therapeutic education, accumulating consciousness among doctors, and the tactic that conventional pharmaceutical arrangements are useful in specific situations (Abdullahi, 2011). The advanced superiority of traditional medicine's treatment methods has also been often cited as a major factor in advancing general health and patient happiness. A national policy and guideline for care, effectiveness, and balanced utilization of traditional medicines are a few essential conditions for the efficient use of ATMs, according to the WHO (2002). According to Rosendahl, Bödeker, Mössner, and Teich (2007:2), just 66 of the 213 WHO member nations have policies on traditional medicine.

In contrast, only 43 states have some laws, and 20 member states are in the process of drafting some regulatory rules. They have suggested that crucial elements, such as the classification of TMs, explaining the government's role in developing traditional medicines, and providing security and value guarantees for services and goods, be incorporated into any government-initiated policy. In line with WHO (2002), there is a need for regulation related to the providers of traditional medicines, the provision of training for traditional healers, and the promotion of appropriate consumption. Statistics show that just 50% of Africans have access to Western medical care, while the remaining 50% still rely on traditional medicine and plant remedies (WHO, 2002). Like traditional medicine, which uses verbal communication to convey information, ATM focuses on the "4,000 species employed in traditional medicine, which is primarily (90%) plant-based." In other words, at the moment, more than half of the African countries have clearly defined "traditional medicine policies," and most of them have established national divisions under the Ministry of Health and forward-looking development plans.

On the other hand, many traditional healing methods place a premium on religion, mysticism, and the spiritual world (Joshi & Joshi, 2000). The issue has become more pressing because, in most cases, African TM focuses more on the functioning of physical tissues and more on the psychological, somatic, divine, and expressive strength of the individual, of their family and community, as well as of their ancestors who are thought to be the protectors of the living (Heise et al., 2023). According to Elujoba et al. (2005), the basic, technical, and straightforward submission of plant, physical, or inorganic resources for curative dedications that may be studied, streamlined, and clarified systematically constitute the explicable form of traditional medicine. This TM approach was supported by the use of "Salix alba," the therapeutic herb for "fever and pains" that instructed the extraction of aspirin (WHO, 2000). These facts demonstrate how Western medicine substantially borrowed from the historical use of plants as medicines. The WHO (1991) defined herbal medicines, which directly fall under this category, as completed, labelled pharmaceuticals that contain aerial or underground components of known, verified plant materials, or combinations thereof, in either unprocessed form or as plant preparations. They also contain gums, fatty oils, essential oils, and plant liquids. Aspirin was not the only official modern drug that was created through conventional medicine; others include morphine, digoxin, quinine, ergometrine, reserpine, and atropine, to name a few (WHO, 2000). Orthodox medicine still uses these pharmaceuticals in contemporary hospitals worldwide (Elujoba et al., 2005). On the other hand, the unexplainable form of TM is the spiritual, extra-terrestrial, magical, occultic, mystical, or metaphysical form that is difficult to investigate, rationalize, or explain scientifically, such as the use of incantations for healing or oracular consultation in disease diagnosis and treatment. In other words, the explanation is incomprehensible to the average scientific human mind or intellectual capacity.

The TM practitioner or Traditional Healer is described as a person who is recognized by the community where he lives as competent to provide health care by using herbs, animal and mineral substances, and certain other methods (WHO, 1991). There are many healing roles a traditional healer can execute, including that of a nurse, pharmacist, physician, dentist, midwife, and dispenser. An expert TM practitioner is also considered an herbalist, bone setter, traditional psychiatrist, traditional pediatrician, traditional birth attendant, occult practitioner, herb seller, general practitioner, and so on. Furthermore, they are also and certainly more readily available, accessible, and approachable than the orthodox physicians. At the same time, their services are much more affordable to local communities than modern medical facilities (Ndawonde, 2006). Some traditional healers can easily diagnose and manage various common diseases at the primary healthcare level with various herbal dosage forms. They do so using concoctions, decoctions, infusions, dried powders, ointments, tinctures, and macerates, which makes them much closer to the community than the orthodox doctors

who are mainly found in urban healthcare locations (Elujoba et al., 2005). Looking at these medicines' posology, Loundou (2008) confirms that TM practitioners administer these medications through various routes such as oral, rectal, intra-uterine, sub-cutaneous, external, or topical applications. Whether the government has approved TM or not, it continues to play a very significant role in the medical and dental primary healthcare implementation in Africa and other developing countries of the world, most especially in the rural areas, which cover almost 80% of the entire population (Mabogo, 1990). The WHO has since urged developing countries to utilize TM resources to achieve Primary healthcare goals. This injunction stems from the various advantages of TM: low cost, affordability, ready availability, accessibility and adequacy, and perhaps low toxicity.

An illustration by Joshi and Joshi (2000) confirms that the Nepal people who live in the Kali Gandaki watershed rely on traditional remedies for their basic medical needs. The majority of complex illnesses and other misfortunes are attributed to supernatural causes. This occurs, as Flint (2015) acknowledges, due to soul loss, spells or curses cast by evil spirits, the displeasure of ancestral gods, or the breaking of religious taboos considering the deeply ingrained traditional beliefs and practices. Nepalese herbalists and faith healers, or "jhankri," play a significant role in tribal medicine (Mabogo, 1990). This is because they use various ritual systems in conjunction with magical and religious acts as a first step in determining the cause and course of a disease. In other words, they employ traditional techniques to find the medicinal resources the locals have discovered, such as their incredible understanding of plants and how to use them to cure various physical diseases. According to Fukudze et al. (2023), those who utilize TM in this region frequently demonstrate an understanding of the relationship between toxicity and administered dose, such as when discussing the ripe yellow fruits of Melia azedarach, which are thought to have some utility as an anthelminthic in modest quantities. Large consumption of these fruits, however, may result in nausea, vomiting, and asphyxia. (Jamloki et al., 2022). In the same context, Loundou (2008) notes that Datura stramonium leaves are said to treat asthma in moderate doses but induce vomiting when consumed in large doses. Both men and women can use TM, although women are more knowledgeable about medicinal herbs than men. This sounds to be the case in South Africa since Flint (2015) agrees that women are more frequently responsible for maintaining the health of the family's members, primarily the children, as well as the agroecosystem and woodlands.

According to Hailemariam and Mekonen (2021), there is also a growing interest in understanding why and how traditional populations use animals as medicines. Frequently, this is due to the evolution of the empirical base through generations and scientific validation. However, the historical, economic, sociological, anthropological, and environmental dimensions of such a practice are the

ones that receive the most attention. Depending on the level of harvesting, African healers and indigenous people have been gathering remedies from local plants and animals for millennia without endangering the population dynamics of the species. (WHO, 2001).

Plants and animals must be protected so that TM and IKS can progress; otherwise, a reduction in traditional knowledge and IKS severely impacts modern medicine's advancement. Medical folklore has long been recognized as a helpful resource for screening important modern medications identified by following leads from traditional applications (Dias et al., 2012). Due to the majority of communities rapidly losing their socioeconomic and cultural traits, it becomes urgently necessary to chronicle the IKS of human communities. Medicinal folklore over the years has proved to be an invaluable guide in the present-day screening of important modern medicines discovered by following leads from folk uses (Elamaran, 2020). Given this, it is evident that the IKS of human communities should be documented, mainly because most communities are rapidly losing their socioeconomic and cultural characteristics. Therefore, Kale (1995) believes that traditional knowledge and cultural environmental resources must be protected, especially in light of globalization and the rising demand for natural resources. Again, traditional knowledge is useful for modern medicine, agriculture, and other fields in addition to people directly associated with it. Protection of traditional knowledge, in line with WHO (2020), can also increase awareness of the knowledge and those who hold it. This has ramifications for preserving customs within communities and the relationships created outside communities.

On the other hand, conventional medicine is overlooked and even ignored in several countries, including SA. According to Hassim et al. (2007) and Flint (2015), the advancement of biomedicine by colonial powers led to the downgrading and abolition of TM in Africa. As a result, apartheid policies consistently dismissed TM as being undeveloped and unscientific, a condition that has been widespread in South Africa. Despite colonialism and apartheid's marginalization of TM, today, a sizable portion of South Africans in rural areas and marginalized populations still rely on it for their healthcare (van Vuuren et al., 2015). Due to their historical importance in traditional communities and the growing number of traditional healers in South Africa, their contribution to the public health system must be supported. The extent to which ATMs can form an essential component of formalized healthcare, based on their merits, is still hotly debated (Ozioma and Chinwe, 2019). However, the good thing is that policymakers have started to be more open and considerate of the role that ATMs can play as part of a wider attitude toward the practice of medicine.

Globally, Africa and South Africa, in particular, must overcome obstacles and hurdles regarding traditional medication to fully realize the goal of guidelines, normalization, and inclusion of such medicine. According to Abdullahi (2011: 190), the most horrifying obstacle remains the Western hegemonic mindset's ethnocentric and medico-centric tendencies, typically displayed by most stakeholders in modern medicine. In the therapeutic sphere, there is a widespread belief that TM contradicts technical measures regarding objectivity, dimension, systematization, and categorization (Mothibe and Sibanda, 2019). There are indications, though, that the physical characteristics of conventional treatment can be systematically analyzed and studied.

Traditional medicine encompasses both the material and spiritual worlds. According to Appelbaum (2015), for instance, in the South African cultural setting, the spiritual realm may not be subject to scientific examination using the traditional scientific methods of investigation. Therefore, the largest issue is figuring out how to objectively analyze the spiritual component of South African traditional medicine, like the "*ukuhlabelela"* (incantation) among the Zulu people. Furthermore, Abdullahi (2011) adds that given the ethnocentric tendencies in contemporary medicine, it is vital to have a person who will train medical doctors in the ontology, epistemology, and efficacies of African TM if integrated. Given the inherent epistemological and ideological disparities between the two types of medicine, this illustrates the importance of knowing the person who will assess the usefulness and effectiveness of conventional medicine. Therefore, Heinze and Weber (2016) argue that these problems push other researchers to propose that mutually traditional medication and pluralistic treatment be permitted to function, grow, and blossom autonomously. Abdullahi (2011) maintains that the Western people did not develop their medical aspect to integrate it with anyone else. Theirs was to make themselves and the rest of the world live a healthy life. The above assertion, according to Pretorius (1999: 253), indicates that if traditional medicine is drafted into contemporary medication, it can validate and endorse the hegemony or dominance of Western medicine, risking the uniqueness and reliability of customary treatment in Africa.

The numerous reported instances of pretentious therapists and therapies, which are not just limited to traditional treatment training as a whole, present another ultimate challenge to traditional treatment. According to Nakazwe-Masiya et al. (2017), since skilled therapists may be providing valuable services to several South Africans, it may be common to spot impostors among the practitioners. Pretorius (1999: 253) endorses the aforementioned viewpoint and states that "there is a marked increase in the ranks of traditional healers, among whom there are, sadly, quite a few charlatans, in the current economic climate and amid the concomitant unemployment." Last but not least, the spread and globalization of Western beliefs, ideologies, and events in Africa are disrupting the practice of

traditional medicine. Ozioma and Chinwe(2019) found a strong skepticism toward African traditional medicine and flora in some African populations, especially among the affluent elites. To illustrate this, D'avigdor et al. (2014) find that in Ethiopia, both rural and urban societies have experienced considerable barriers to traditional medicine, claiming both favourable and unfavourable ways. Similarly, Kiringe (2005) notes how Western education and beliefs impact the use of traditional medicine in Africa in general, particularly in South Africa.

Additionally, Kiringe (2005) points out that the Western doctrine of Christianity promoted communication through the global community, which has evolved into an important component of communal spaces. The teachings forbade communal mores, which sometimes affected people's behaviour or entirely banned them. This situation illustrates how the advent of Western values, which were prevalent in many South African community areas, had an extremely negative impact on the position of TM.

2.12 Traditional Medicine in South Africa

Most Africans, especially South Africans, use traditional medicine to remedy health problems. Andile (2020) contends that traditional African healers must maintain the accuracy of their therapeutic modalities. To create an inclusive health system in South Africa, African traditional practitioners must firmly support the country's approach to tackling healthcare issues. Flint (2015) claims that conventional doctors can only fully contribute if the governmental policy acknowledges the importance of TM in the established public health care system. Even those considering its basic tenets continue to classify TM as alternative or supplementary by healthcare professionals and policymakers. Similarly, people operating within the biomedical paradigm gradually value South African traditional medicines, yet both systems are still primarily understood as secondary to biomedicine, considering their importance (Cheung and Leung, 2020).

The value of IKS determines the rate of TM. Mazzocchi (2006) states that proper analysis of the importance and applicability of IKS in a particular circumstance depends on how well we understand its contextual setting. Local ecological, cultural, and social settings are primarily involved in this. Nevertheless, in today's globalized world, local knowledge and its application must coincide with implementing policies. Hence, the complete cultural, ecological, policy, and social context is a prerequisite for applying knowledge and its evolution (Finn et al., 2017).

Similarly, Saslis-Lagoudakis et al. (2014) discuss the significant influence of the environment on the development of traditional knowledge. As an illustration, research conducted in Nepal (Kunwaret et al., 2016) confirms that the environment can enormously shape medicinal plant use in indigenous cultures because similar plants always employ analogous plant medicines. Plant availability within resident populations in South Africa significantly impacts local medicinal flora, cultural aspects, and environmental diversity (Nascimento et al., 2016). Yet, by comprehending the determinants of traditional medicine and the significance of cultural and ecological diversity in TM, one may lay the groundwork for its preservation and anticipate how future government policies will use it. Accordingly, various social groups of TM practitioners have been documented in South Africa to describe them and assign them some responsibilities.

For instance, in Durban, KwaZulu-Natal Province, Puckree, Mkhize, Mgobhozi, and Lin (2002) investigated the social background of Zulu traditional healers, including spiritualists and herbalists to document their roles as TM practitioners. This connected to TM practitioners as diviners, the overall number of patients who consult them, the types of ailments they treat, and those who were treated. These researchers' findings confirmed that most patients preferred to consult a traditional healer for physical and mental diseases, with spiritualists being the most common type of healer sought for both conditions. Additionally, Bereda (2009) explained the duties of VhaVenda customary health-giving as a scheme for health protection provision in the Vhembe district, Limpopo Province. The researcher specified that the majority of male spiritualists are often consulted for the treatment of a variety of ailments, including asthma, diabetes mellitus, hypertension, tuberculosis, and sexually transmitted infections. Bereda (2009) mentioned that most patients consult traditional healers for diseases, including potentially life-threatening conditions. This implies that healthcare professionals should proactively integrate traditional healing with Westernized practices to promote healthcare for all South Africans. Material medicals are also another aspect of the veracity of TM. Research conducted by Mabogo (1990) in Vhembe highlights the role of VhaVenda traditional healers and their substantial medicals. Both herbalists and diviners have a strong influence on the treatment of numerous human diseases, including sexually transmitted diseases, infections (STDs/STIs) as well as tuberculosis. So far, analysis of diseases has mainly concerned the exhibition of symptoms and, occasionally, traditional rituals. Regarding their herbal remedies, Mabogo (1990) noted that TM practitioners could prepare them from a collection of more than fifty local plants.

Another point is that traditional healing is a gender-based procedure, though in some societies, both men and women express their interest in TM and work in it. Loundou (2008) researched KZN and concluded that nearly two-thirds of his interviewees were men, connecting with other countrywide

studies. For instance, in the Limpopo Province, Bereda (2009) also noted that traditional male healers dominated females in the Vhembe district, where the Vha Venda dominates. Similarly, Moeng and Potgieter (2011) confirm that traditional male practitioners controlled the trade in medicinal plants in the Capricorn, Sekhukhune, and Waterberg districts. These examples depict how involvement in TM remains highly partial, perhaps because these males are the breadwinners of their families. Besides, males may be dominant because they are physically fit to collect medicinal plants, such as those found in forests and mountains, since it is a risky exercise for women. In the Western Cape Province of South Africa, Loundou (2008) asserted that males dominate in this field because some plants are located on private land, making collecting medicinal plants highly risky for females. Research by Ndawonde (2006) found that traditional healers in Cape Town are between 41 and 60 years old. In KZN, he found it was 45-54 among the Zulu traditional healers. On the side of the Xhosa traditional healers, Nzue and Pierre (2009) stated that males and females residing in the Western Cape Province of South Africa were between 41 and 50.

Furthermore, Ndawonde (2006) confirmed that this age bracket is dominant because men seek money for their children's education and to support their families' basic livelihood needs. In light of the low life expectancy for South African males and females, the prospects for protecting IK might be at risk. This necessitates an urgent and rapid action: to record any IK related to this industry.

The small number of Bapedi traditional healers between 30 and 40 years of age probably indicates a lack of interest in this profession or is perhaps symptomatic of a transition (Nzue & Pierre, 2009). Many health-related problems treated by Bapedi traditional healers in the low-income rural areas of the Limpopo Province strengthen the fact that traditional medicine and traditional health practitioners represent the first line of healthcare for most people in this province (Bereda, 2009). Furthermore, the diversity of ailments treated indicates that medicinal plants have the potential to satisfy the varied healthcare needs of underprivileged villagers of the Limpopo Province. Most of the ailments treated by healers, as found by Peltzer and Pengpid (2019), including "chlamydia, diabetes mellitus, diarrhoea, epilepsy, erectile dysfunction, eye infection, gonorrhoea, HIV/AIDS, hypertension, malaria, menstrual disorder, mental illness, and tuberculosis, are common amongst the healers of other ethnic groups in South Africa".

Regarding the education factor, most traditional healers have no sufficient formal education (grades 1 to 12) (Howard, 2020). Society is losing its cultural identity through Westernization, making a small portion of TM practitioners attend school. This agrees with Mabogo (1990) regarding the Venda region and Yineger and Yewhalaw's (2007) study in The South-West of Ethiopia. A study in

KwaZulu-Natal by Semenya and Potegeitter (2014) differed from the above study and found that all Zulu traditional healers had attended school, while 20 percent even had a university degree or diploma. Likewise, Nzue and Pierre (2009) noted that half of the Xhosa traditional healers had attended secondary school, 35% had attended primary school, and 3% had attended tertiary institutions. The low level of education amongst Bapedi traditional healers compared to the above-mentioned South African cultures indicates fewer younger and older Bapedi healers. This special case of Bapedi should apply to all South African TM practitioners; otherwise, IK in Africa and South Africa in particular needs documentation so that it does not fall into oblivion. IK has a lot of material and information to protect and study deeply for the noticeable advancement of medicine in South Africa and Africa in general. Nzue and Pierre (2009) noted that educational skills are very important for TM practitioners nowadays because they can empower them with particular competencies. Howard (2020) confirms that one aspect of education is reading, a crucial skill for counselling, and it helps in understanding the necessity of conserving and managing natural resources. Thus, initiating programs such as Adult Basic Education and Training (ABET) is important for empowering more traditional healers in South Africa. Basic educational skills such as writing and reading for traditional healers can broaden their knowledge regarding conservation issues related to protected and threatened species and medically related issues such as diagnoses and treatment of ailments (Maema et al., 2016). Greater levels of education and awareness could contribute to the long-term sustainability of this highly important profession across all the communities in South Africa.

2.13 Gaps in The Literature

The sections developed in the above literature confirm breaches in IKS policy regarding promoting TM in South Africa. The South African strategies about the developmental policy of TM do not integrate IKS as an implementation plan because governmental departments do not have enough information regarding ATM developmental strategies. Conversely, previous research on the South African National IKS Policy (2004), with special reference to TM and healing practices, demonstrates the need for such knowledge within the South African medical system (Mander et al., 2007; Chali et al., 2021). This indicates that the IKS can easily boost TM because they work hand in hand, which can play a significant role in the country's medical domain. Moving away from conceptualizing the effectiveness of traditional medicine in healing, the South Africans who consult traditional healers reflect that medicine still needs deeper exploration. Such consideration seems massively needed countrywide because IKS remains a major route through which TM can emerge beyond where it is currently. In other words, the beneficiaries of traditional healing, particularly those who gain support from modern medicine, can also learn more about the IKS. In addition, such learning can also mean

equipping the traditional healers with appropriate formal education to develop important skills. Such skills like reading and writing can also boost good ways of getting reliable information and protecting IK in South Africa. Education can also allow them access to modern technological information, open up, and connect with other communities worldwide, which is a good way of exchanging ideas regarding TM practices. Another important point is that while curing patients, traditional medicine gains its standing as the primary therapeutic method because it is rooted in the people's experience of medico-therapeutic satisfaction in a purely traditional context.

Therefore, this research aims to provide those missing parts through the information collected on the field. Moreover, IKS policy (2004) aspires to incorporate TM in sustainable development and community livelihood and to assist Africa in contributing actively to the global pool of understanding on its terms and not those others dictate them. It is worth indicating that the implementation of the IKS policy has faced many challenges, and this study also looks at that. Therefore, this research ponders ATMs in public healthcare in KZN with special reference to the districts of uGu and uMkhanyakude.

2.14 Chapter Summary

This chapter has discussed the literature by probing the concept of indigenous knowledge in South Africa. It has demonstrated that IK is a whole information system with its worldview, knowledge, and value systems. Information knowledge must also consider the production, administration, and protection processes, including knowledge, skill sets, technological innovations, and belief and value systems. Local and traditional communities can develop environmentally and culturally significant aspects related to IK and pass them orally from one generation to the next for survival. Given their significance, particularly in the healthcare industry, these features require protection.

To fully understand and apply Indigenous Knowledge (IK) as a domain and system, it is crucial to grasp its unique historical, cultural, and ecological characteristics. In both South Africa and within the framework of the World Health Organization (WHO), such precision is essential. African traditional practitioners need to strongly support the government's strategies for addressing healthcare challenges, which can foster inclusivity. Likewise, these practitioners must ensure the accuracy of their treatment methods. In other words, government policies should integrate traditional medicine (TM) into the existing public healthcare system. This integration may encourage traditional practitioners to support the national healthcare system. For local users to benefit from their IK, it is imperative that both South Africa and the WHO recognize and value of local traditional medicine and

healing methods. Consequently, this chapter has provided a global review of the literature on the WHO and traditional medicine worldwide, while considering the historical context of the IKS policy. Additionally, it has discussed the post-apartheid legislative frameworks in South Africa that govern traditional healthcare providers, the national record IK holder catalogue procedure, and traditional medicine.

In addition, it has also discussed the acknowledgement of prior learning, the IKS policy and ecosystem, and the contestations surrounding African IKS. This suggests that IKS requires assistance because many native medicinal plants are commercialized, yet the local populations who look after them seldom profit from such trade. It is also obvious that society does not preserve many of these plants, which implies that their protection could increase their commercialization and usefulness for their users' improved healing.

Traditional practitioners also need education to effectively interact with the local communities and share their natural environment. They can thus connect with the rest of the world to exchange ideas, and learn more about the need to safeguard medicinal plants. In addition to addressing the many value propositions of TM and public health, the chapter finally highlighted the gaps in the existing literature on Indigenous Knowledge Systems (IKS) and TM.

Chapter Three: Conceptual and Theoretical Frameworks of the Study

3.1 Introduction

This chapter provides the theoretical framework that underpins the research process. Before embarking on the theories that guide this research, key concepts central to the study are highlighted and their relevance to the study is discussed in detail. The theoretical foundation of the study is built upon the Social Cognitive Learning Theory , the Theory of Public Policy, the Rational Theory, and the Policy Implementation Theory.

3.2 Conceptual and Theoretical Frameworks of the Study Research Process

The development of any research project requires a contextual framework that provides a foundation for its progress. Mensah et al. (2020) contend that conceptual and theoretical frameworks establish the direction of the research process by anchoring it in theoretical constructs, thus making the findings more meaningful and acceptable within the relevant research field and ensuring generalizability. These frameworks provide direction and motivation for research inquiries and infuse vitality into the research process (Imenda, 2014; Mensah et al., 2020).

Grant et al. (2022) define a theoretical framework as a 'blueprint' often used to guide or construct their research inquiries. It is a framework based on an existing theory in a related field of inquiry that reflects the study's hypotheses. It consists of concepts and their definitions and existing theories or theories employed in the study. Consequently, a theoretical framework serves as the foundation for constructing research. It is believed to simultaneously convey the researcher(s)' deepest values while providing an articulated lens for processing new knowledge. According to Collins (2018) and Ravitch & Carl (2019), a theoretical framework exists at the intersection of three components: (i) existing knowledge and previously formed ideas about complex phenomena; (ii) the researcher's epistemological dispositions; and (iii) a methodical and analytical approach. Working through these three components makes theory a valuable tool for enhancing the coherence and depth of a study.

Perrin et al. (2019:35) assert that theories explain the meaning, nature, and challenges of a phenomenon often experienced but not explained in the world around us, allowing us to use that knowledge and understanding to act more effectively and intelligently. Therefore, theories are developed to explain, predict, and understand phenomena and, in many cases, to challenge and extend existing knowledge within the bounds of critical assumptions (Darnell, 2020:398). According to Hughes et al. (2019), one of the primary benefits of theories is that they provide a broader epistemological and logical framework for understanding the presented knowledge in the research

study (Proctor et al., 2013). For instance, the current study investigated the knowledge and perceptions of African traditional medicine practitioners and their clients regarding the implementation of the National IKS Policy (2004) within the context of traditional medicine in South Africa, with special reference to uGu and uMkhanyakude District Municipalities in KwaZulu-Natal Province, South Africa.

Therefore, the purpose of the theoretical framework in this study was to interrogate the theoretical conceptualizations and models presented by other researchers and scholars that are relevant to the current research study. As such, the study tried to incorporate these theoretical frameworks to guide the research process, including data collection, data analysis, and interpretation of study results (the meanings contained in the research data). For instance, Mensah et al. (2020) indicate that the conceptual and theoretical framework of a study is an amalgamation of the thoughts of giants in a field of research and the way the study uses those frameworks to understand and interpret the research data (Kivunja, 2018; Ravitch & Carl, 2019).

Crawford (2020) distinguishes between the conceptual and theoretical frameworks by positing that the former presents the study's overall structure, while the latter explains the relationships the study aims to investigate. The theoretical framework, therefore, is the structure that upholds or supports a theory of a research study. It introduces and describes the theory that explains the existence of the research problem. On the other hand, the conceptual framework serves as an instrument to analyze the variables or concepts and their interactions, providing a comprehensive understanding of a phenomenon. Akintoye (2015) and Ridder (2017) state that researchers develop and employ theories to explain phenomena, establish connections, and make predictions, thus making research findings more meaningful and generalizable. Researchers develop theories to explain phenomena, draw connections, and predict outcomes (Mueller & Urbach, 2017; Kivunja, 2018).

For instance, public health practitioners and researchers often aim to influence public policies to improve population health and reduce health disparities. However, these efforts frequently do not draw upon empirically-based theories about policy-making and medicine that have been developed in health and political science. This glossary provides a concise overview of some of the most popular theories, describing how each frames the policy-making process, depicts the relationships and influence of specific policy actors, and portrays the potential for policy change (or inertia). Examples of how these theories have been applied to public health are included to enhance understanding of the material presented. This thesis emphasizes the implications of these different theories for public health researchers and advocates seeking to inform policy decisions. The glossary aims to provide an

accessible overview of key policy and decision-making theories to support public health efforts to achieve healthier implementation of public policies. Policy implementation is translating a policy into actions and assumptions into results through various projects and programs, involving transforming physical, financial, and intellectual resources into service delivery outputs in the form of facilities and services (Sager & Gofen, 2022). Policy implementation theory seeks to explain and generalize a complex policy process. While useful ways to describe and explain policy implementation have been developed, many concepts are aimed at an academic audience rather than practitioners.

Social and political scientists have developed numerous approaches, theories, and models to study policy implementation in the context of traditional medicine. This section discusses the theoretical approaches that are particularly relevant to public policy implementation in the context of traditional African medicine. The cyclic/stages model is one such approach that provides a structured framework for analyzing public policies.

Drawing from the aforementioned discussions and the review of existing literature, the study identified key concepts central to the study's problem statement and research questions. As Imenda (2014) and Varpio et al. (2020) highlight, the theoretical framework must provide clear definitions for such concepts as they often have multiple interpretations. To achieve this, the study utilized relevant approaches in conducting a thorough literature review to ascertain how other researchers defined and established connections between the identified concepts. As Proctor et al. (2013) recommended, the study selected the definitions that best suited its purpose and provided a justification for such choices. Additionally, the study examined established theories and models that did not apply to its research questions and explained why they were unsuitable. Finally, as emphasized by Boas (1920:312), the theoretical framework illuminates how the study applies the aforementioned ideas. Ultimately, theories play a crucial role in interpreting research findings, evaluating theoretical challenges, and integrating study results.

In addition, as per Borsboom et al. (2016), a theory refers to a mental construct that parallels specific groups of entities by integrating their essential characteristics. In the context of the present study, a theory elucidates and reinforces perspectives on how individuals can comprehend the socio-cultural factors that influence the practice of traditional medicine in local communities. Traditional medicine encompasses knowledge and beliefs incorporating plant, animal, and mineral-based medicines, spiritual therapies, manual techniques, and exercises administered singularly or combined with curing, diagnosing, preventing illnesses, or maintaining well-being (Igwillo et al., 2019).

In this context, socio-cultural beliefs and behaviours towards traditional medicine among older citizens' peers must be comprehended. Therefore, in line with this thinking, this study sought to explore the use of traditional medicine in the rural areas of KwaZulu-Natal. This took into consideration the fact that the practice of African traditional medicine, holistically, encompasses knowledge and beliefs that incorporate plant, animal, and mineral-based medicines, spiritual therapies, manual techniques, and exercises administered singularly or in combination to cure, diagnose, prevent illnesses, or maintain well-being (Pemunta & Tabenyang, 2020b).

Most of these factors are grounded in the socio-cultural milieu that shapes the attitudes and dedication of traditional healers (Hlatshwayo, 2017), who become familiar with various traditional belief systems through social adaptation within the community (Marvin, 2019). In this context, socio-cultural beliefs and behaviours towards traditional medicine among older citizens' peers must be comprehended. Therefore, in line with this thinking, this study sought to explore the use of African traditional medicine in the rural areas of KwaZulu-Natal Province.

3.3 Understanding the Key concepts guiding the study

Caballero-Serrano et al. (2019) note that there are diverse conceptualizations of Traditional Medicines (TM), which are culturally and ecologically specific. For instance, Pemunta and Tabenyang (2020) look at TM as the health practices, approaches, knowledge, and beliefs incorporating plant, animal, and mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. According to the World Health Organization (WHO, 2004), Traditional medicine (TM) is the total sum of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health and the prevention, diagnosis, improvement or treatment of physical and mental illness. It has incorporated much empirical knowledge combining physical, mental, emotional, or social well-being. It reflects the cumulative body of local knowledge passed onto generations by oral transmission through traditional health practitioners (THPs) and knowledge holders (Sackey and Kasilo, 2010). Shewamene et al. (2020) add that this conceptual framework of TM embraces a range of practices, from the well-established indigenous concepts and practices of wellness in local communities to formal and structured systems of TM development and practice. It also recognizes and promotes the distinction between traditional medicine, as understood and practiced by indigenous people, and complementary medicine, which may not be indigenous but adopted in many countries as a set of practices and interventions to promote health and well-being (Payyappallimana, 2010).

WHO (2023) emphasizes that TM services that are evidence-based, safe, and of assured quality are valuable in contributing to a holistic patient-centred approach to healing, health, and well-being. An increasing body of evidence across cultures and world regions has shown that the relationships among health, the pace of healing, and more intangible elements of the caring process, including the empowerment of patients, play a central role in their care. There is also growing evidence that other factors, aside from pathophysiological processes and biological agents, have important effects on health-care outcomes – such as the interaction between an individual's social, economic, cultural, linguistic, psychological, and physical environments, on the one hand, and biological susceptibility to illness and responsiveness to treatment and the nature of the care process, as well as its content, on the other. Cultural-based Practices in TM empower individuals and communities to actively participate in their health and prevent disease through daily activities and practices that are amenable to self-care, cost-effective, minimally invasive, and have limited side effects. Central to these approaches are primary prevention and measures that can help maintain health throughout life, improving quality of life rather than just a care-based approach focused on episodic care (Riegel et al., 2017).

Mothibe & Sibanda (2019) look at African traditional medicine (ATM) as having a holistic view of healthcare involving extensive use of physiotherapy and herbalism, sometimes combined with some aspects of African spirituality. In African Traditional Medicine (ATM), disease is often seen as the failure of complex physical, social, and spiritual relationships. Therefore, a diagnosis starts with examining both human and supernatural interactions. For instance, when the disease is mystical, ritual diagnosis is a fundamental part of the African traditional healing process for re-establishing social and emotional equilibrium (Adu-Gyamfi and Anderson, 2019). Particularly, the philosophical clinical care embedded in African traditions, culture, and beliefs has made ATM practices acceptable and highly demanded by African people across continental cultures and regions. The WHO (2022) estimates that about 80 percent of the African population depends on TM for primary healthcare. (Hitziger et al., 2017) indicate that compared to modern Western practitioners, African Traditional Practitioners (ATPs) interact very differently with their patients, using a more patient-centered communication style, to reach common ground with sick persons. It is also more accessible, affordable, and culturally acceptable.

According to the holistic perspective of ATM, a patient's external and internal environments are considered to understand, prevent, and treat diseases. Divergent from the principle of conventional medicine, ATM uses commonly natural products. The advantage over synthetic compounds rests on

their intrinsic potential to provide mild healing effects and induce fewer side effects (Egbuna et al., 2020). Meanwhile, in both ATM and conventional medicine, the foundation of disease treatment relies on the correspondence between the clinically active compounds and their biological targets at the molecular level (Kamsu-Foguem et al.,2013). The diversity of Indigenous knowledge systems on ATM is mostly tacit and, therefore largely shared in an unstructured format.

Charman et al. (2017) conceptualize African traditional medical practices as predominantly an attribute of people in the informal economy (IE). The challenge is how to shape policies and programs to exploit the informality and ensure the advancement of TM through innovation and with an appropriate and facilitative Intellectual Property (IP) system.

The study was also interested in interrogating the public policy conceptualization within the context of traditional medicine. This was based on several considerations:

The advent of modern Information and Communication Technologies (ICT) and the establishment of a global "Information Society" are forcing countries worldwide to take a fresh look at their development agendas in line with developmental challenges, including public health imperatives.

Origa (2019) indicates that the ideal policy model is often presented as a neat linear process starting from problem identification, setting policy objectives, creative alternative options, gathering information on options, applying analysis, and implementing policy choices. However, it is not always this neat and linear in real life. Real-world policymaking happens in a world of constraints, and many of them, including public health constraints, eventually become the objectives of policymaking.

The policy process is the often dynamic and complex path the government takes to provide a solution to a socio-economic problem or concern facing its citizens. Public policy has been defined differently as a purposive action undertaken by the government to deal with a problem or matter of concern (Dye, 2010; Origa, 2019). The policy can either have instrumental or symbolic dimensions—the instrumental perception of policy as a rationally prescribed solution to a perceived social problem. On the other hand, the symbolic perception of public policy sees it not simply as governmental action based on a rational response to a societal problem but more as an instrument of invoking emotions, public interpretation, and perceptions of a societal problem (Birkland, 2010; Origa, 2019).

In South Africa, the public policy framework aims to regulate policy management processes in the country by codifying policy-making practices and entrenching evidence-based policy-making. Further, it seeks to guide officials on policy analysis, policy development, policy authorization, policy implementation, and policy reviews. Gautier and Ridde (2017) identify the policy-making process in South Africa as involving the following five stages: agenda setting or emergence, formulation, adoption, implementation and administration, and evaluation. The institutions involved include the National Assembly and the NCOP. A provincial legislature must ensure public involvement in the legislative and other processes of the legislature and its committee in a regulated manner. Lastly, the local sphere of government consists of municipalities that have been established around South Africa.

However, one important aspect of the public policy debate, which is in line with this study, is the role of citizens in the public policy-making process, across all phases of policy-making, about public participation in the process. To what extent is the policy process democratic, measured in terms of bottom-up orientation and public participation? This is the persistent debate between proponents of rationalism and post-positivism in policy analysis. For instance, post-positivism advocates for participatory policymaking to address the possible abuses of top-down approaches to policymaking. This shifts the power base from top-level prescribed solutions to adopting solutions proposed by the policy targets, whether ordinary citizens or businesses. Hence, the study was interested in interrogating the public policy conceptualization in South Africa within the context of traditional medicine, as most rural and marginalized communities depend on it for primary healthcare. This was based on several considerations.

Mutola et al. (2021) outline the institutionalization of traditional African medicine by indicating that traditional African medicine has become increasingly popular due to the high cost of allopathic medical health care and the expensive pharmaceutical products that have become unavailable to most people. Hence, the many centuries-old alternative sources of healthcare have become handy, often in desperate situations. Addis et al. (2021) add that the frequently quoted statement that more than 80 percent of African people use traditional medicine is an understatement, as the figure could be much higher and continues to increase. The Alma Atta Declaration of 1978 resolved that traditional medicine had to be incorporated into the health care systems in developing countries if the objective of the "Health for All by the Year 2000" was to be realized. Despite this strategy, African countries did not reach the objective at the end of the 20th century. Therefore, the Member States of the WHO African Region adopted a resolution in 2000 called "Promoting the role of traditional medicine in health care systems: A Strategy for the African Region".

The strategy provides for institutionalizing traditional medicine in the health care systems of the member states of the WHO African Region. In addition, the OAU (African Union) Heads of State and Government declared 2000 to 2010 as the African Decade on African Traditional Medicine. The Director General of the WHO also declared the 31st of August every year as African Traditional Medicine Day. All these declarations signify the importance of and the approval by governments and international institutions of the need to institutionalize traditional African medicine in health care. This implies that the mechanisms for institutionalizing traditional medicine must be developed to make these resolutions a reality.

Given the complexity and heterogeneity of African traditional medicine, a system of incorporation in the current healthcare systems has to be developed. The WHO Regional Director for Africa and his Secretariat took up the challenge and have developed model guidelines that the Member States can adapt or adopt as may be appropriate in the respective Member States. Some of the relevant guidelines include the following: 1) Guidelines for the formulation, implementation, monitoring and evaluation of a National Traditional Medicine Policy; 2) Model legal framework for the practice of traditional medicine: The Traditional Health Practitioners Bill; 3) Model Codes of Ethics for Traditional Health Practitioners; 4) A Regional framework for the registration of traditional medicines in the WHO African Region; and 5) A regulatory framework for the protection of intellectual property rights (IPR) and indigenous knowledge of traditional medicines in the WHO African Region.

These guidelines and others create a basis for incorporating African traditional medicine to suit a particular country. The WHO Regional Director for Africa also appointed a Regional Expert Committee on Traditional Medicine to assist in developing these guidelines. It is important to emphasize that as more and more people use traditional healthcare facilities, there is an urgent need for appropriate quality control systems in practice and the production and use of medicines. The systems are meant to protect the public and ensure that the best practices and the most useful medicines are made available in the most affordable manner. Every country in the African region would be expected to adopt a method of incorporation that would be suitable: integrative, inclusive, or tolerant, as the case may be. It is undeniable that we cannot afford to sit on the fence. All the stakeholders stand to gain a great deal in developing and promoting African traditional medicine. In particular, all the practitioners in the present allopathic health care system will gain professionally and economically as they will have access to an additional culture-friendly system to provide services to the people. All the stakeholders must join hands to institutionalize the appropriate African traditional medicine in the health care systems to provide the health services that are urgently needed in the communities.

The South African government has taken steps towards the official recognition and institutionalization of African Traditional Medicine, including establishing a Directorate of Traditional Medicine in 2006 to coordinate and manage initiatives regarding African Traditional Medicine within the Department of Health. Mothibe and Sibanda state that in line with global trends in law and domestic realities, the South African government is one of the few countries to make significant progress in including traditional health practices in the mainstream healthcare system by using the law as a tool for formal integration. The integration process gained momentum by enacting the Traditional Health Practitioners Act 22 of 2007, which provides a legal framework for traditional health practitioners (also known as traditional healers). The Act provides formal recognition to traditional practitioners. It establishes an interim Traditional Health Practitioners Council of South Africa with wide powers to ensure that healthcare services provided by traditional practitioners are efficient, safe, and of high quality (Street et al., 2018).

The services to be provided by African traditional healers in terms of the Act include the maintenance or restoration of physical or mental health or function; the diagnosis, treatment, or prevention of a physical or mental illness; the rehabilitation of a person to enable him or her to resume normal functioning within the family or community; and the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth, and death.

In terms of the WHO definition, a traditional medical practitioner or traditional healer is a person who is recognized by the community in which they live as competent to provide health care by using vegetable, animal, and mineral substances and certain other methods. The Traditional Health Practitioners Act also specifically recognizes diviners ("*sangomas", "izangoma"* or *"amagqirha"*), herbalists (inyangas, izinyanga or amaxhwele), traditional surgeons who mainly perform circumcisions ("*ingcibi"* or "*iingcibi"*), and traditional birth attendants ("*ababelekisi"*, "*ababelethsi"* or "*abazalisi"*) as professionals in ATM and requires all traditional health practitioners to register in terms of chapter three of the Act.

3.4 Theoretical foundation of the study

3.4.1 The Social cognitive learning theory

The objectives of this study could also be theoretically discussed within the context of the Social cognitive learning theory propagated by the Canadian-American psychologist Albert Bandura during the 1960s (Nkhata et al., 2019). It suggests that humans learn behaviours by observing others and choosing which behaviours to imitate. Behaviours that are rewarded are more likely to be repeated,

whereas behaviours that are punished are less likely to be repeated (McLeod, 2011). He later refined his ideas on observational learning and modelling, emphasizing the cognitive components of observational learning and the interaction of behaviour, cognition, and the environment in shaping individuals (Devi et al., 2022; Nickerman, 2022). In contrast to other psychologists, Bandura did not believe that learning stemmed solely from reinforcement, punishment, and conditioning. Instead, he asserted that observation, imitation, and modelling played a significant role in learning human behaviour. According to him, individuals learn social behaviour by observing and imitating the behaviour of others (Horsburgh & Ippolito, 2018; Lutter et al., 2021). This theory has been considered a bridge between cognitive and behaviourist learning theories, as it encompasses motivational processes, memory, and attention (Schunk,2012; Schunk, 2012a; Schultz, 2021; W. Schulz, 2023).

According to Nickerman (2022), in traditional medicine, the interplay between assimilation and accommodation is a process that follows learning. This explains how traditional healers can learn the norms of traditional healing to promote the use of traditional medicine in their local communities. African traditional medicine is based on the accumulated knowledge and experience of older generations transmitted orally, through observation and social practice (Gottlieb et al., 2019:465; Gaurav et al. (2022:13). The practice of traditional medicine varies in different regions of the continent depending on cultural location and environmental factors (Chali et al., 2021; Chali et al.,2021). Each society's culture has unique traits and distinctive historical development, making each culture's traditional medicine and practices unique (Nguyen et al., 2017; Schultz, 2021). Based on this consideration, the study took a comparative case study approach of traditional medicine practices in two distinct district municipalities in KwaZulu-Natal Province, South Africa. It is important to empirically determine who within a particular community has access to what knowledge at a given time and how they gain access to it. Investigating the attitudes of community members towards traditional medicine as a local knowledge system and the extent to which they practice and use it was considered essential. The researcher posits that those who seek traditional medicine have likely learned such behaviour from their environment, including cultural beliefs and practices passed down by older generations. It is widely believed across African cultures that serious illnesses have mystical or supernatural origins.

Despite the remarkable advantages of the social cognitive learning theory, it has limitations. For instance, according to Nickerson (2020), the social cognitive learning theory has a limitation in that it heavily emphasizes learning processes while disregarding biological and hormonal predispositions that may influence an individual's behaviour, irrespective of their experience and expectations. Moreover, Fidel and Ettien (2018:53) argue that the theory overlooks emotion and motivation, except

through reference to previous experience, thereby neglecting their influence on the learning process, which can significantly impact learning outcomes. Additionally, Muhammad and Rob (2015:381) note that the theory's breadth can make it challenging to operationalize it. This is because the theory addresses individual behaviour changes at many levels of the social-ecological model, but not all levels are implemented. Lastly, Gottlieb et al. (2019:458) suggest that the behaviour concept in traditional medicine fails to consider behaviour maintenance, which is critical to achieving the goal of preserving behaviour change over the long term. The objective of the theory is to explain how people regulate their behaviour through control and reinforcement to achieve goal-directed behaviour that can be sustained over an extended period (Prati, 2012:418; Reigeluth & Frick, 2013).

Western theorists have tried to explain the concept of myths within the context of the Mythical approach theory, with attributes also prevalent in African cultural philosophies, including traditional medicine and healing systems. These perspectives range from psychology (the nature of the human mind) to structural functionalism as serving the purpose of social control (Lewis,2017). These Western theorists include the Austrian neurologist and psychoanalyst Sigmund Freud (1966), the Swiss psychiatrist and psychoanalyst Carl Gustav Jung (2020), and the French sociologist David Émile Durkheim (1951). Gottlieb et al. (2019:458) and Nickerson (2020) also indicate that beliefs in myths may differ across communities, implying that myths exist from four primary perspectives regarding their origins: 1) the rational; 2) functional; 3) structural; 4) and psychological perspectives. The first perspective is the myth of rationalism, which highlights how socio-ecological and cultural events and forces inspired the creation of myths. Historically, constructing myths aimed to understand better the natural events and forces that occur in people's daily lives. The rational myth theory states that myths were historically made to understand better natural events and forces that occurred in people's everyday lives. This perspective also suggests that gods and goddesses were viewed as supernatural forces that control all natural events. For instance, creation myths in various cultures described how gods and goddesses formed humans and the substances they used (Long, 2023).

From a psychological standpoint, Sigmund Freud viewed myths as manifesting repressed human desires (Gottlieb et al., 2019:460). According to him, myths are a product of the psychological forces shared by many members of a particular group on a personal level. Carl Gustav Jung (2020), who also believed in the power of mythology, looked at myths and dreams as expressions of the collective unconscious, which contains fundamental concepts all humans share (Pal, 2019). He differed from Freud in his assertion that understanding the mysteries of neurosis and psychosis required knowledge of both mythology and civilizational history. David Émile Durkheim (1892) supported the structural functionalism of myths within the social analysis of society. Society can use myths to create collective

control (Ponizovkina and Agibalova, 2018). Myths could be used to teach good manners and social behaviour for social harmony. Like other structural functionalists, Durkheim focused on the problem of order and the positive effects of social institutions, explaining their existence in terms of their necessary functional contributions (Williams et al., 2019:63).

In his discussion of the holistic nature of African medicine and healing systems in traditional healthcare (Jaja, 2014), he states that in African cultures, myths were culturally the essential and ready tools for thinking and socializing, including spiritual communication. Through their meaningful and communicative features, myths exhibit and enhance society's coherence, stability, and continuity. For instance, traditional healers combine various techniques to find the causes of problems through divination. They could also dispense healing through the use of herbs, the performance of rituals, or the uttering of words. African cultural philosophy considers the human being to be made up of physical, spiritual, moral, and social aspects. The functioning of these three aspects in harmony signified good health, while if any aspect should be out of balance, it signified sickness. Traditional African religions and spirituality, as an integral part of traditional medicine and healing systems, generally hold the beliefs of life after death (a spirit world or realms in which spirits but also gods reside).

Bandura (Ngere et al., 2022) contends that the majority of traditional communities hold the belief that serious illnesses can be caused by mystical or supernatural agencies such as witchcraft and the devil. Supernaturalism is characterized by the belief in forces that exist outside the universe and can affect it. Traditional medicine systems and practices are largely mystical or supernaturalistic. While Kennedy and Lingard (2006) argue that it may be insensitive to evaluate methods solely based on their underlying theories, the context, history, credibility, and plausibility of the methods can provide valuable insights, particularly when relevant scientific evidence is insufficient, inadequate, or conflicting (Linder & Peters, 2020:55). The practice of traditional medicine in local communities is influenced by socio-cultural and ecological factors, resulting in a blend of religion, occultism, folklore, psychology, and medical speculation (Chali et al. 2021).

3.4.2. The Public Policy Theory

According to Stromberg (2021), the term "public policy" originates from the Middle English word "policie" which refers to government or civil administration. The Latin word "politia", which means "polity" or "group", is also a source of the concept of public policy. This concept was developed by politically united groups who worked under the rule of law passed down for centuries by monarchs

and aristocrats (Cochran et al., 2016; Mwikisa, 2019). As Signe (2018) notes, public policy is a crucial means by which governments maintain order and meet the needs of their citizens according to the Constitution. Effective governance requires a clear direction and action relevant to the prevailing circumstances. This study highlights the importance of understanding the socio-cultural and ecological factors that influence the practice of traditional medicine in local communities in KwaZulu-Natal province. Public policy is a collective decision-making process encompassing various plans, programs, and schemes to address societal issues (Crocker, 2019; Andrew, 2020). Those who study public administration and policy gain significant knowledge on how to influence the formulation and revision of public policy and contribute to resolving regional, national, and international problems (Abebe, 2018). This has led to the modernized public policy that government officials or agencies implement today, based on purposeful action rather than arbitrary behaviour (Cochran et al., 2016; Stromberg, 2021).

The preceding discussions highlight how policies can be a response to social demands, which is something that governments must do rather than merely express intentions. Health issues are one of these demands, and policies related to the health of a particular group can cover insurance mandates. Scott, Springfield, and Coldrey (2020) explain that when the AIDS epidemic emerged in the early 1980s, governments had to develop new policies to contain the spread of the disease and educate their populations. This illustrates how the South African government should reform the healthcare system and mandate health insurance for all citizens. Mwikisa (2019) suggests that before implementing such a policy, a series of debates, evaluations, and analyses must take place to persuade the government to recognize how healthcare serves the interests of all South Africans. This practice could trigger the development of bills, insurance mandates, and other legislative provisions to establish a healthcare system that ensures access to treatment for all South Africans, including those who use traditional medicine. Through this legal and political process, the South African government can establish a new public policy comprising several components that serve its purpose for all citizens.

The legal policy of a society is a crucial aspect of its public policy. According to Signe (2018), legal policy encompasses the laws that define criminal behaviour, establish appropriate punishment, and allocate responsibility for administering such punishment. In South Africa, murder is considered a punishable crime with a long prison sentence, while other countries may impose the death penalty for certain crimes (Cochran et al., 2016; Labuschagne, 2021). This illustrates how public policy responds to societal problems by defining criminal behaviour and prescribing punishment. Similarly, Crocker (2019) asserts that medical practitioners must possess adequate knowledge and expertise to prevent patient harm. In cases where a practitioner prescribes incorrect medication, resulting in a patient's

death, the medical law should be applied to prevent future incidents. Such laws should not be partial but should apply to both traditional and modern practitioners, as the government, through the health ministry, is concerned about the health of all citizens.

In addition, public policy can take either a positive or negative form depending on whether the government chooses to take action or refrain from doing so (Antwi-Boateng, 2017; Trowler, 2023:19). This means that the government has the power to either mandate or prohibit certain actions by its citizens (Moran et al., 2021). Public policies are designed to address the needs of different categories of society, as they are established through a political process that reflects the actions outlined in the government's constitution (Labuschagne, 2021). Although this may seem complex, Trowler (2023:23) suggests that public policy can be described as laws, mandates, or regulations established through a political process. In the South African context, Signe (2018) advocates for including traditional medicine practitioners in developing policies that can help promote inclusive laws that serve all South Africans without discrimination.

In summary, the government can adopt any public policy appropriate to address societal issues. This is consistent with Lim's (2018:375) system model policy, which provides guidelines for designing and executing a system in a particular society. Public policy implementation takes place at two levels: local and national. Local policies pertain to city ordinances, which are written directives and regulations of city government departments, including healthcare, police, fire departments, street maintenance, and building inspection (Moran et al., 2021:45). Conversely, at the national level, the state leads through public policies that involve laws enacted by the government legislatures, decisions by state ministries, regulations created by state bureaucratic agencies, and decisions made by governors (Trowler, 2023).

According to Bryce (2021), effective government response to public problems is contingent on collaboration with citizens and various societal sectors to achieve appropriate goals. Cochran et al. (2016) illustrate regulatory policies as a strategy for setting parameters for social sectors such as commerce, business, and safety measures. Lim (2018:379) also presents substantive policies as programs that aim to promote society's overall welfare and development. According to Cotlear and Rosenberg (2018), distributive policies focus on specific societal segments, such as the medical sector, including traditional medicine, which deals with societal medical problems. Another type of public policy is redistributive, which aims to reorganize plans that bring about societal socioeconomic changes (Andrew, 2020; Trowler, 2023). Lastly, Signe (2018) describes capitalization policies as

those in which the central government provides subsidies to subordinate levels of government and other operations.

Advocates of the theory of public policy contend that societal issues are influenced by a range of stakeholders who employ diverse public guidelines to shape policy outcomes. They argue that competition among individuals and corporations can stimulate collaboration and use various tactics to influence policymakers to act in a particular manner (Antwi-Boateng, 2017; Moran et al., 2021). However, when public policies fail to deliver the intended results, Lim (2018:375) maintains that politicians and other actors must share the responsibility. This implies that when individuals do not receive adequate medical assistance, the government, through the Ministry of Health and traditional healer associations, should be held accountable. Consequently, public policies can be the outcome of the actions of specific actors, such as interest organizations, and not necessarily a reflection of the will of the public (Stromberg, 2021).

Moreover, actors involved in the public policy process employ various tactics and tools to achieve their objectives. These include publicly advocating for their positions, educating supporters and opponents, and mobilizing allies on a particular issue (Trowler, 2023). Thus, using effective tools and instruments is instrumental in determining the outcome of a policy. In summary, proponents of the theory of public policy contend that societal issues are complex and require diverse stakeholders to collaborate and employ various tactics to influence policymakers. They also maintain that in cases of policy failure, responsibility should be shared among all actors involved. Finally, using effective tools and instruments is crucial in determining the success or failure of a policy.

Supporters of the theory of public policy contend that various actors play a significant role in the public policy process. Still, ultimately, government officials make decisions regarding public policy in response to the particular public issue or problem at hand. These officials are motivated by their desire to meet ethical standards within the public sector and consider the needs of all project stakeholders (Mwikisa, 2019). However, the ruling party's political stance can also impact the chosen public policy option. Over the past few decades, societal changes have resulted in changes to the public policy-making system. Policy-making is increasingly goal-oriented and decision-centric, focusing on making immediate decisions that can achieve measurable results (Bryce, 2021; Usher, 2023:12).

Moreover, technological advancements such as the widespread availability of the Internet and mass communication have caused the public policy system to become more intricate and interconnected

(Moran et al., 2021). These changes pose new challenges to current public policy systems and pressure leaders to evolve and remain effective and efficient (Phasha et al., 2017:87). Therefore, modern medicine must incorporate modern equipment and updated data to track better and combat diseases. Public policies are derived from all levels of governmental entities, including legislatures, courts, bureaucratic agencies, and executive offices at the national, provincial, and local levels, as Signe (2018) observes. In conclusion, the public policy theory provides a useful framework for understanding policy-making's complex and dynamic nature. It emphasizes the role of multiple actors, effective communication, and political power in shaping policy outcomes and the need for policymakers to remain adaptive and responsive to changing societal and technological developments.

The utilization of the theory of public policy holds several advantageous features. Scott, Springfield, and Coldrey (2020:200) suggest that policy constitutes the structural aspect of politics that pertains to the populace. At its core, policy encompasses the coordination of the outputs of the political process, thereby reflecting the impact of the governmental system on society in a positive way. Labuschagne (2021) asserts that the government's vision and standards necessitate participation from all stakeholders in activities that foster sustainable development. This underscores how public policy is a dynamic, complex, and interactive system that identifies public issues through research and devises strategies to address them (Mwikisa, 2019). The government accomplishes this by introducing novel policies or reinforcing existing ones. The system's approach is beneficial since it incorporates diverse perspectives from various sectors to offer a more comprehensive view and greater control. Modifying each department can often lead to a positive impact on the overall structure.

The previous arguments demonstrated how the system model of public policy functions as an interactive process that aims to address community problems. However, sometimes, policies may not provide sufficient details on implementing these processes. Andrew (2020) and Usher (2023:12) suggest that the system approach is advantageous as it provides policymakers and stakeholders with information about the system's current workings. Furthermore, public policy explores the possible outcomes of implementing various strategies under different future circumstances, which is often impossible to test in a real situation (Akanle & Adejare, 2016; Lim, 2018:379). The systems theory conceives public policy as the political system's response to environmental demands, such as in the post-apartheid South African setting. It involves institutions that make the authoritative allocation of values and resources binding on society (Signe, 2018). In public healthcare, a systems approach to population health goes beyond standalone disease prevention and treatment programs to include

resources to improve health behaviours, quality of life, and safety (Signe, 2018). Similarly, for traditional medicine to be effective, traditional healers must work within a given structure that allows them to seek and address health information, which enables them to operate as modern healthcare organizations. Gerston (2019) suggests that collaboration between traditional healers and modern medical staff to collect, store, manage, analyze, and optimize patient treatment histories and other key data is essential to improving healthcare providers' ability to obtain information about macro-environments, such as community health trends.

Addressing health issues through a structured approach is a recommended strategy that the government, specifically the health ministry, should prioritize. According to Phasha et al. (2017), a public policy strategy can benefit the population if the government executes all necessary steps. The government must establish norms with specific and comprehensive strategies to improve the population's healthcare outcomes (Usher, 2023:18). The implementation of the policy is crucial because, as Gerston (2019) points out, its evaluation can help the beneficiaries and the government better understand its impact. In other words, the policy's success is evident when the beneficiaries have experienced its effects. However, if the beneficiaries have not benefited from the policy, as Signe (2018) noted, there is a need for reform and future implementation. Policymakers can encourage the population to focus on the set agenda through proper implementation. Cotlear and Rosenberg (2018) acknowledge that a policy benefits its intended recipients if it alleviates their difficulties. Gerston (2019) emphasizes the importance of properly implementing public policy to avoid unfavourable outcomes. Therefore, public policy plays a critical role in the government if all stages required for its effective functioning are followed, and this also applies to traditional medicine. As Scott, Springfield, and Coldrey (2020:199) point out, public policy can change based on social expectations, technological advancements, and cultural expectations in each region.

In contrast, public policies are not immune to criticism by anthropologists. Cotlear and Rosenberg (2018) note that anthropologists have raised concerns about popular approaches to public policy, including rational choice theory. Anthropologists argue that an understanding of human beliefs, behaviour, and activities can influence the shaping of societal policy decisions, their implementation, and results (Usher, 2023:15). Similarly, other program methods may fail to capture the current dynamics of today's society as well as the ambiguity of the understanding of many policy processes. While public policies reflect a government's initiatives that must help people improve their lives, critics contend that policy theories are better suited to explaining policy stability than policy change (Akanle & Adejare, 2016; Gerston, 2019). In Africa, for instance, policies sometimes fail due to a lack of interest in science, which is fundamental to public policy research in the medical domain

(Labuschagne, 2021). Furthermore, despite the critical role of technology and scientific findings in contemporary policy-making in the medical domain, many politicians and civil servants presume they can determine medical policy approaches without evidence or research (Phasha et al., 2017:102).

The close relationship between governance and medical science is crucial in developing and implementing appropriate local, national, and international public policies. However, anthropologists have criticised popular public policy approaches, including the rational choice theory. Signe (2018) argues that understanding human behaviour, such as the actors, activities, and influences involved in shaping policy decisions, implementations, and outcomes, is essential. Furthermore, in some cases, certain policy methods fail to capture the current dynamics of society and the ambiguity surrounding policy processes. For example, the global medical domain, including traditional medicine, requires updates to address new diseases and social issues. According to Spiker (2022), policy updates are necessary to keep up with the evolving landscape and to ensure policies remain relevant and effective.

Societal changes can prompt modifications in the public policy-making process. Depending on the situation, public policymaking can be goal-oriented, aiming to achieve quantifiable outcomes, or decision-centric, focusing on urgent decision-making (Abebe, 2018; Cochran et al., 2016). For example, technological advancements, such as the widespread availability of the Internet, have rendered the public policy system more intricate and interconnected. Nevertheless, these changes present novel challenges to the current public policy systems, necessitating leaders to adapt to remain effective and efficient (Usher, 2023:17). In certain circumstances, policymakers fail to comprehend current advancements in modern medical research and instead stick to political decisions that can yield detrimental outcomes by implementing measures that are less beneficial in medicine. Thus, traditional medicine studies prevalent diseases in society, and strategies to mitigate them should not be overlooked. Spiker (2022) suggests incorporating traditional medicine can enable the use of remedies that have demonstrated efficacy in treating specific ailments. Ultimately, this approach, combined with modern medicine, can help determine and enhance the standard of healthcare in South Africa, artificially manipulating the allocation of appropriate medical assistance results from implementing specific public policies, such as universal medical insurance. In reality, this has been challenging due to the inefficiencies in the medical domain, and the decline in the quality of healthcare and insurance in South Africa (Scott, Springfield & Coldrey, 2020:187).

Lobbyists often influence public policy-making, which has been a source of controversy in the field. Powerful political parties like the African National Congress (ANC) may lobby for policies favouring their interests. For example, during the Covid-19 lockdown, the ANC supported the use of Johnson

and Johnson vaccines (Phasha et al., 2017:100). Additionally, policymakers may hold biases that lead them to seek out information that confirms their pre-existing beliefs, creating further controversy (Cochran et al., 2016; Stromberg, 2021). These challenges illustrate the public policy field's difficulties when implementing policies. Such challenges can include opposition from key stakeholders, insufficient financial or human resources, lack of clarity on operational guidelines, or ambiguity regarding roles and responsibilities for implementation.

3.4.3. The Rational theory

According to Birkland (2010), rationalism originates from the Latin word "ratio," meaning reason or calculation. The rational model denotes the ability of humans to link diverse ideas to comprehend the world. The emergence of rationalism can be traced back to 16th century France during the scientific revolution when scientists focused on a novel approach to understanding nature (Antwi-Boateng, 2017; Crocker, 2019).

Adherents of rationalism championed that reason constituted the sole font of knowledge in society, promoting progress through the pursuit of logical comprehension. Notably, its prominent advocates, René Descartes, Baruch Spinoza, and Gottfried Leibniz, vehemently opposed the empirical thinking that predominated in 17th-century England (Birkland, 2010). Empiricism relied on sensory perception to fathom the world. Rationalists rejected empiricism, acknowledging that our senses may be fallible in discerning reality. They contended that reality possessed an inherently logical structure that could be apprehended through reasoning (Abebe, 2018). Reason constituted the primary foundation and proof of knowledge by its logical basis. Consequently, this investigation suggests that traditional healers must rely on reason and structure to substantiate their expertise in traditional remedies and the diseases they treat. Cadwalladr (2018) and Signe (2018) emphasize that the rational model is more effective when implemented through an administrative system that espouses specific policies designed to optimize benefits while minimizing costs.

The concept of rationalism derives from the Latin term "ratio," meaning reason or calculation, and refers to humankind's capacity to connect diverse ideas to comprehend the world (Birkland, 2010). Rationalists, such as René Descartes, Baruch Spinoza, and Gottfried Leibniz, championed the belief that reason was the sole source of knowledge in society, fueling development through the pursuit of logical comprehension and opposed the empiricist thinking that prevailed in England during the early 17th century (Birkland, 2010). Empiricism, by contrast, relies on perceived experience through the senses to comprehend the world. The rationalists countered this by acknowledging that our senses

might fail to reveal what is perceived and posited that reality has an intrinsically logical structure conveyed through an administration (Abebe, 2018). Rationalists contended that structure reflected reality because it was based on logic, which reason or intellect could grasp, making reason the fundamental basis and evidence of knowledge. Accordingly, this investigation reveals that traditional healers must rely on their reason and structure to substantiate their knowledge of traditional treatment and the illnesses they can cure. Cadwalladr (2018) and Signe (2018) emphasize that the rational model functions better via an administrative system that adopts specific policies that yield maximal benefits at lower costs.

The paramount social gain posits that if the cost of any public policy outweighs its benefits, that policy should not be adopted (Spiker, 2022). Policy decision-makers must select the alternative policy capable of producing the maximum benefits at the lowest cost. Rationalism also describes how traditional healers employ reason to select specific medicine, focusing on societal benefits to be achieved through the National IKS Policy. Herbert A. Simon, the founder of the rational model of public policy, described rationality as a suitable style of behaviour that promotes achieving specific goals within the limits imposed by given conditions and constraints (Von Soest & De Juan, 2018:2345; Ankanle & Omobowale, 2023). This implies that implementing the IKS policy imperatives associated with traditional medicine should be analyzed in the context of societal history. Spiker (2022:36) notes that societal history must account for socioeconomic, cultural, and political norms that most African people can benefit from, as colonialism and apartheid public policies denied them access to public healthcare services.

According to Labuschagne (2021), rationalism emerged during the Enlightenment and emphasized a politics of reason centred on rational choice, utilitarianism, secularism, and irreligion. Crocker (2019) also notes that irreligion, as an aspect of antitheism, adopted pluralistic methods that softened regardless of religious or irreligious ideology, ultimately producing a form of worldview. This is relevant to how traditional healers view their society, regardless of religious beliefs in the traditional medicine they use. Rationalists believe that reason is an essential and superior state of mind everyone should possess (Antwi-Boateng, 2017; Abebe, 2018). Furthermore, according to Birkland (2010), the rational model in public policy development seeks to understand important alternatives by considering their consequences and selecting the best course of action. It also seeks to organize government to ensure the undistorted flow of information, the accuracy of feedback, and the weighing of values.

Crocker (2019) defines rationalism as a theory considered the primary source and test of knowledge, although its definition may vary depending on the domain. To be effective, rationalism requires agreement on objectives and a knowledge base that enables accurate prediction of consequences associated with available alternatives (Antwi-Boateng, 2017; Von Soest & De Juan, 2018:2347). However, in many cases, these conditions are not met, rendering the rational method ineffective in guiding policymakers (Mwikisa, 2019). Incrementalism, on the other hand, produces defensible policies that avoid these problems and can be used to defend the implementation of the National IKS Policy within the context of traditional medicine in South Africa, particularly in KwaZulu-Natal, by examining the knowledge and perceptions of African traditional medicine practitioners and their clients.

Conversely, incrementalism is a theory interconnected with public policy-making, which involves interacting and adapting among various actors with different values, interests, and information (Signe, 2018). The origin of incrementalism can be traced back to the work of Charles E. Lindblom, an American political scientist who developed this theory in the 1950s in response to the widespread conception of policy-making as a process of rational analysis leading to a value-maximizing decision (Birkland, 2010; Cadwalladr, 2018). Advocates of incrementalism emphasize the plurality of actors involved in the policy-making process and predict that policymakers will build on past policies, focusing on incremental changes rather than wholesale ones (Von Soest & De Juan, 2018:2342). Incrementalism prioritizes the improvement of tangible problems over the pursuit of abstract ideals such as social justice. Therefore, this study aims to promote the implementation of the National IKS Policy within the context of traditional medicine to improve the health conditions of the people residing in KwaZulu-Natal, South Africa.

Addressing health issues in South Africa involves collaboration between traditional and modern medicines to bridge the social divide in medical assistance. This collaborative approach enables affected individuals to present their health concerns to the government and promotes the acceptance of traditional medicine as a complementary approach to modern medicine. Stromberg (2021) argues that a single institution cannot make rational policy decisions on social issues due to the lack of comprehensive information, but a joint effort is more effective. This supports Spiker's (2022:34) view that policymakers do not identify objectives and examine alternative means, as the rational ideal prescribes. Instead, Von Soest and De Juan (2018:2345) argue that means and ends are typically considered simultaneously, as different policy alternatives represent trade-offs among competing values. In the context of South African healthcare, modern and traditional medicines should not

compete but rather work together towards the common goal of improving the health of South Africans.

Furthermore, it is worth noting that incrementalism allows policymakers to make progress through trial and error, where small, incremental changes are made over time, leading to larger changes in the long run. This process of successive approximations allows policymakers to learn from past mistakes and successes, gradually improving policies through a series of small adjustments (Labuschagne, 2021). As Scott, Springfield, and Coldrey (2020:187) point out, incremental outcomes are virtually inevitable due to the need to negotiate and compromise over a limited number of alternatives that differ only slightly from past policies. However, policymakers can achieve significant change over time by continually making small adjustments and improvements. The policy process's iterative and cumulative nature is another advantage of incrementalism, as it allows policies to adapt to changing circumstances and priorities over time (Labuschagne, 2021). Cadwalladr (2018) and Crocker (2019) support the notion that traditional healers are often uncertain about the effectiveness of their medicine until it successfully treats a patient. This uncertainty highlights the limitations of rational decision-making in policymaking, as conflicting objectives and insufficient information characterize most policy issues. As such, departures from incrementalism in policymaking would be rare, as pointed out by Stromberg (2021). Rational decision-making can only be applied effectively to minor technical or administrative issues, as the knowledge base for rational decision-making on more complex policy issues is often insufficient. While revolutions, new diseases, or other dramatic events may prompt major policy shifts, the ultimate consequences of these sudden changes are often unpredictable and unstable.

In summary, the two aforementioned theories exhibit contrasting features. The rational decision-making model prioritizes centralized decision-making (Birkland, 2010), while incrementalism emphasizes a representative and pluralistic approach (Mwikisa, 2019; Ankanle & Omobowale, 2023). Additionally, the rational model does not consider community input, whereas incrementalism supports broad popular participation in decision-making (Antwi-Boateng, 2017; Abebe, 2018). The section that follows looks at policy implementation theory.

3.4.4. The Policy implementation theory

Linder and Peters (2020) posited that implementation theory systematically examines the social objectives attainable through strategic agent behaviour. In a broader sense, Hogwood and Gunn (2018) viewed policy implementation as the process of translating declared policies into practical

action. The late 1970s and early 1980s saw the emergence of several scholars who synthesized the top-down and bottom-up approaches' insights into a conceptual framework comprising various implementation theories (Lord, 2022; Palumbo & Calista, 1990; Sabatier, 1986). However, this synthesis approach suffers from the issue of being nothing more than a compilation of variables from both perspectives. This tendency leaves the reader with lengthy lists of variables and intricate diagrams of causal chains (Exworthy et al., 2017; Linder & Peters, 2020)

Researchers surfaced in the late 1980s and early 1990s, intending to reduce many variables into a manageable framework (O'Toole, 2000; Jindal et al., 2020). They intended to develop elegant theories that could lead to broader generalizations and more longitudinal investigations (Palumbo & Calista, 1990). However, as Pal (2019) noted, this endeavour was too ambitious, as only a few scholars were willing to undertake such investigations. In the 1980s, policy implementation underwent structural changes in public administration, including decentralization, devolution of responsibilities, partnerships, and restructuring of accountability relationships in service delivery (Exworthy et al., 2017). These transformations have resulted in public policies implemented in cooperation or collaborative partnerships with non-state actors. These new inter-organizational partnerships are not merely transient phenomena but are expected to be permanent features of policy implementation (Sabatier, 1986).

Initially, policy implementation research was regarded as a manifestation of the top-down approach in scholarly literature, with this theory emerging as a field of investigation (Artemov et al., 2021). However, this approach's theoretical and empirical assumptions were quickly censured for being overly mechanistic and failing to acknowledge the intricacies of policy delivery in democratic societies. Critics who advocated for a bottom-up approach were united by their interest in examining the politics and processes of policy implementation, commencing from the frontlines of public administration where street-level public officials often interact with organized societal interests (Pal, 2019). The discourse on the relative advantages of the top-down and bottom-up approaches was categorized as first-generation implementation research (Artemov et al., 2021).

According to Linder and Peters (2020:55), the top-down and bottom-up approaches are advantageous because they require leaders to engage with traditional medicine practitioners to discuss effective implementation processes of the National IKS Policy within the context of traditional medicine. The primary concern of policy implementation, organization, and governance is comprehending how government organizations can engage with their external environment to promote traditional medicine in communities. Despite our understanding of the meaning of implementation, actualizing

it remains challenging, as achieving impeccable implementation through control becomes increasingly difficult (Artemov et al., 2021; Pal, 2019).

Making an empirical decision about what is good for traditional medicine and creating checklists of factors to consider is not enough for implementation. Linder and Peters (2020:53) noted that when examining policy from a top-down perspective, the criterion for policy implementation seems to be clarity to ensure compliance down the line. From a bottom-up perspective, however, the primary criterion appears to be flexibility and discretion, highlighting the importance of simple policy design (O'Toole, 2000). In other words, through the Ministry of Health, the government must collaborate with traditional medicine practitioners and ensure that policy design for traditional medicine is clear and flexible. The critical factors for implementation may depend on how traditional medicine practitioners perceive governance in the country.

To begin with, it is important to comprehend the meaning of implementation theory before delving into its proponents. According to Vedung (2017) and Signé (2017), implementation theory investigates which social policies are compatible with their intended beneficiaries. In simpler terms, it systematically examines the social goals that can be attained when actors act strategically (Lord, 2022). The advocates of this theory are interested in comprehending how government organizations work with their external surroundings to implement policies related to certain domains. With the shift towards complex and multi-actor policy processes, the focus of implementation has moved from building meta-theories to elucidating collective action across institutional boundaries (Amoros, 2020). Consequently, the approach to policy implementation has broadened to encompass a multi-faceted perspective that considers a variety of actors (Bullock et al., 2021).

The proponents of implementation theory, as argued by Amoros et al. (2020), emphasize the need for the government to legitimize certain forms of public policy, such as laws or regulations related to traditional medicine. Once the policy is enacted, it must be implemented, administered, and enforced to bring about the desired change for the people affected. Public policy implementation should produce changes in the targeted population's behaviour, which can address public issues and improve the situation (Chauhan et al., 2017; Pülzl & Treib, 2017; Freight, 2021). Therefore, while the policy process for IKS and traditional medicine in South Africa may be well-intentioned, well-formulated, or universally supported during its adoption phase, it cannot solve the challenges facing South Africans regarding diseases until the relevant government ministries and departments implement it.

Policy actors engaged in political negotiations often hinder a comprehensive comprehension of the public problem, leading to misidentification. As Arrow (2019) corroborates, unsuitable or insufficient policy instruments that may not have a substantial effect are proposed during the policy formulation stage. Therefore, Head and Alford (2015) assert that policymakers should be acutely aware that administrative institutions cannot magically correct the flaws of inadequately designed policies while attempting to construe and implement flawed legislation.

Most proponents of implementation theory acknowledge that the policy process involves various institutions and actors who play a role in policy implementation. As noted by Popoola (2016) and Amoros et al. (2020), some of these participants may be directly involved in the administration and implementation of policy, while others seek to influence the direction of public policy based on its implementation. Administrative agencies fall under the former category, while the latter includes the president, the parliament, the courts, and a wide range of interest groups (Baumer & Van Horn, 2014). This also applies to traditional medicine, where the Ministry of Health structures delegate a bureaucracy with significant power during the implementation stage of the policy process. The implementation stage of the policy process is considered an operational phase where policy is translated into action to resolve a public problem (Corchon, 2013:13).

Notwithstanding, several obstacles hinder the successful implementation of policies, including the clear definition of policy goals, the provision of informative intelligence, and strategic planning (Corchon, 2013:13). Hudson, Hunter and Peckham (2019) identify "implementation barriers" as the challenges to the implementation of public policies, which can stem from various causes, including resistance from key stakeholders, inadequate human or financial resources, unclear operational guidelines or roles and responsibilities for implementation, and the risks of overestimating the government's impact while neglecting other factors. However, these barriers can be difficult to apply when no single, dominant policy or agency is involved, and policies can change as they are being implemented.

According to Awodele et al. (2014) and Hasneezah et al. (2016), the government's public policy on traditional medicine requires the formal adoption of laws, rules, or regulations and subsequent action by the Ministry of Health and its departments. To assess the effectiveness of this policy, evaluation must be conducted to determine whether the desired outcomes have been achieved, as stated by Vedung (2017) and Jankhotkaew et al. (2022). Evaluation of traditional medicine policy must employ an analytical approach that scrutinizes the gap between the policy objectives and the actual outcomes produced by the policy implementation, including its effects. Befani et al. (2015) identify four

commonly used typologies for policy evaluation, namely process evaluation, outcome evaluation, impact evaluation, and cost-effective analysis.

The principles of this theory propose that one of the primary decisions that should be made before conducting any evaluation is to determine the evaluator's identity (Arrow, 2019). Specifically, evaluators must either come from the Ministry of Health or be experts on the topic outside the ministry. Each option has its advantages and disadvantages, and traditional medicine consumers must be aware of who conducted the evaluation and the potential limitations of each alternative. Evaluating traditional medicine policy implementation helps determine the disparity between its policy goals and objectives and its resulting impact during implementation. The Ministry of Health can use this information to make informed decisions about traditional medicine. Amoros (2020) outlines three options for implementing policy: maintain the status quo if the policy is achieving its intended goals, make adjustments to the policy if necessary, or, in the rarest and most drastic case, terminate or repeal the policy altogether. Acknowledging that traditional medicine policy may change for various reasons is important. As Jann & Wegrich (2017) and Birkland (2019) suggest, any proposed modifications will likely go through some version of the six stages of the policy process: problem identification, agenda setting, policy formulation, policy adoption, policy implementation, policy evaluation, and eventually back to the policy change or termination stage in an ongoing cycle.

The theory under discussion is strengthened by the recognition that traditional medicine is critical in healthcare provision in South Africa. The widespread use of traditional medicine throughout the country underscores the importance of effective implementation strategies to ensure that all South Africans have access to safe, quality, and effective traditional healthcare services (Mothibe & Sibanda, 2019). Consequently, it is imperative to develop an integrated approach to traditional medicine within the context of the healthcare system. This approach will enable the government, through the Ministry of Health, healthcare professionals, and patients to have easy access to traditional medicine services throughout the country (Amoros, 2020). To achieve this, traditional medicine must be utilized safely, respectfully, cost-effectively, and efficiently to maximize its benefits for all who choose to use it. Pal (2019) and Lord (2022) further support this view by highlighting the importance of traditional medicine policy implementation as a global strategy to promote its appropriate integration, regulation, and oversight for the benefit of all.

In contrast, despite the theory's strengths, there are also limitations stemming from its theoretical and empirical assumptions, which have been challenged. As noted by Lord (2022), the implementation stage of the policy process is a crucial operational phase where policy is put into action to address

public problems. However, various challenges can impede this stage, including a lack of clarity regarding policy goals, insufficient information intelligence, and inadequate strategic planning.

Critics of this theory argue that it is too mechanical and does not accurately reflect the complexities of policy implementation in democratic societies. Bottom-up critics, on the other hand, focus on the politics and processes of policy implementation at the local level, where public employees interact with organized social interests (Freight, 2021). The debate around implementation policy centres on the relative advantages of top-down versus bottom-up strategies (Lord, 2022). Additionally, the nature of implementation challenges depends on the typical forms of execution. As Lord (2022) notes, accountability and compliance cannot be assumed to be satisfactory, especially when the government provides services directly, such as in the case of health or sanitary education, as the accountability relationships stretch down from the ministry or department of health to the individuals at the local level.

Consequently, adherence to policy and the potential misuse of vouchers could become significant challenges in the implementation process. In various health provinces and departments of South Africa, most policies related to Indigenous Knowledge Systems (IKS) are frequently disregarded. For instance, Shizha & Charema (2011) observe that, although traditional medicine was recognized by the South African government in 2004, many policies do not recognize its historical and cultural distinctiveness. Implementing these policies has not considered traditional medicine's cultural and ecological uniqueness (Freight, 2021). Additionally, little attention has been paid to how different ecological factors influence the relative distribution of traditional healers (e.g., herbalists/Inyanga or diviners/sangoma) and their patients (Freight, 2021).

Consequently, Mutombo et al. (2023) lament the insufficient investigation of the factors affecting patients' choice of healers despite the increasing attention given to traditional medicine in South Africa. Thus, the current study examines the importance of cultural and ecological diversity in African Traditional Medicine (ATM). For this study, the semi-arid UMkhanyakude District and the UGu District (Sub-tropical) were chosen as case studies, representing two distinct ecological zones in the KZN province.

The theory of policy implementation has relevance to the domain of traditional medicine as it can contribute to the analysis of the prospects and challenges of implementing the National Indigenous Knowledge Systems (IKS) Policy (2004). Specifically, the process seeks to identify "instruments that can regulate the use of conventional medicine" (Wang et al. (2016). A key objective of the National

IKS Policy (2004) is to monitor and facilitate the development of traditional medicine and to ensure compliance with policy guidelines. Notably, the policy's distinctive feature is its emphasis on safeguarding South Africa's medicinal plants and other natural resources with therapeutic value, including animals, minerals, aquatic and marine products, and their derivatives (Netnou-Nkoana, 2016; Howes et al., 2020). Effective implementation would entail sustainable management, utilization, and development of domestically grown medicinal plants and other resources employed in traditional medicine (Arrow, 2019). To this end, the ministry responsible should be pivotal in creating or improving the national database or inventory of medicinal plants.

The effective implementation of the national IKS policy must prioritize providing informed choices of traditional medicine products for self-health care to South African consumers. Freight (2021) identifies informed choice as a fundamental aspect of good healthcare practice, provided that shared decision-making promotes people-centred care. Thus, ethical and legal considerations should guide the key aspects of informed choice. Education also plays a crucial role in facilitating informed choice. Brendler et al. (2021) concur that consumers' self-selection of traditional medicine products constitutes a significant portion of traditional medicine in South Africa. Therefore, the government's mandate to protect its population by adopting the precautionary principle in uncertain risk situations may clash with consumers' demand for accessibility and availability, necessitating a balance between the two to avoid disruptions in self-health care. This highlights the need for consistent and rigorous examination of the national IKS policy and its instruments through effective mechanisms and strategies to preserve, protect, and promote traditional medicine while mitigating contestations between traditional and biomedicine in local communities.

Analyzing the intersection between public policy theoretical framework and traditional medicine is significant for the study. This is meant to interrogate the effective collaboration between the South African government, specifically the Department of Health, and traditional medicine policy structures. Scott, Springfield, and Coldrey (2020:203) contend that research conducted by the government on traditional medicine can serve as a catalyst to bring together traditional healers' associations and the Department of Health. Such collaboration can enable both parties to deliberate on implementing the National Indigenous Knowledge Systems Policy (2004). The scientific underpinnings of policy research are integral to implementing public programs. Ankanle et al. (2023) and Birkland (2010) emphasize the importance of policymakers and civil servants collectively selecting policy approaches based on scientific evidence and technology, leading to successful policy implementation. In line with Spiker (2022), science can profoundly influence governmental decision-making concerning public policy at the local, national, and international levels. In the context of this

study, it is critical to establish a symbiotic relationship between governance, science, and traditional healers' associations, as their collaboration plays a pivotal role in public policy formulation and implementation.

Governmental institutions are responsible for enforcing public policy with determination, but they should not do so by excluding other entities with the same vision. Accordingly, South African healers' associations can engage in discussions and collaborations to implement government policies concerning traditional medicine (Bryce, 2021; Labuschagne, 2021). Such collaboration signifies their close relationship, such that traditional norms regarding traditional medicine in South Africa cannot be publicly accepted until deliberated upon between the government and the healers' association. Both parties must agree on the following norms before adopting, implementing, and enforcing them through the Ministry of Health. In line with Abebe (2018) and Cadwalladr (2018), government institutions have the legal obligation to ensure the loyalty of citizens through public policy, which involves the universality of government policies. The latter case implies that "only government policies extend to all people in a society, and the policies of other groups or organizations reach only a part of society" (Scott, Springfield & Coldrey, 2020:189). Violating governmental regulations may lead to severe sanctions because it can endanger people's lives. Akanle and Adejare (2016) and Crocker (2019) assert that traditional healers must adhere to instructions from national health departments because both traditional healers and medical professionals must ensure they heal people using acceptable methods. In other words, the government reserves the right to unlawfully compel those who violate its policies.

In the present study, it is recommended that the South African government, through its Department of Health, establish an agenda and norms for traditional medicine practitioners on managing their medicine and how their clients can use it for their well-being. Additionally, the government should examine the mechanisms and strategies employed by the National IKS Policy (2004) and its various instruments to safeguard, preserve, and promote traditional medicine while mitigating the conflicts between traditional and biomedical practices in local communities. Implementing the National IKS Policy within the context of traditional medicine in South Africa, particularly in KZN, should benefit the people. Labuschagne (2021) suggests that South African health departments should properly implement the national strategy to benefit traditional practitioners and their clients.

To promote a positive impact on the lives of citizens, the government has established norms for traditional medicine practitioners to adhere to in their practices. Compliance with these regulations by practitioners and beneficiaries demonstrates the potential of effective policy to enhance health

outcomes. Implementing a public policy on traditional medicine in South Africa, specifically in KwaZulu-Natal (KZN) Province, is expected to benefit all residents through adherence to established norms that aim to improve their lives. When the government formulates guidelines for traditional medicine practitioners and their clients, both parties must follow these rules to ensure the efficacy and safety of traditional medicine. Thus, implementing the National IKS Policy within the context of traditional medicine in South Africa and KZN, in particular, can greatly benefit the population's medical and health issues. According to Spiker (2022), the success of a policy is measured by its ability to alleviate the difficulties its beneficiaries face. Therefore, the South African public policy on traditional medicine can be implemented to enable traditional practitioners to practice within the confines of government regulations and to provide much-needed assistance to those in need. The policy's effectiveness can be evaluated through its outcomes, which can either make it popular or controversial, as noted by Phasha et al. (2017:98). A public policy that demonstrates remarkable outcomes among its beneficiaries is likely to continue and expand its reach as confirmed by Cadwalladr (2018) and Spiker (2022). This has contributed to the widespread presence of traditional healers across South Africa.

3.5 Limitations of existing studies and theoretical frameworks

The review of existing related literature on the research problem showed that within the context of South Africa, fewer studies have focused on the socio-cultural context of traditional medicine (TM) and indigenous knowledge systems (IKS) Policy in South Africa, as well as the challenges and limitations associated with their recognition and integration into the modern healthcare system. The limited available research has focused broadly on traditional and cultural practices' role in managing conflicts, mainly in the context of IK (Malapane et al., 2022). Studies have also investigated the social background of Zulu traditional healers, including spiritualists and herbalists, to document their roles as TM practitioners (Motau, 2022; Moeta et al., 2022; Hamanyanga, 2019).

Intensive research focusing on the challenges and prospects of the South African National IKS Policy (2004) in integrating African Traditional Medicine and Healing Practices (TMHP) among the Zulu people of KwaZulu-Natal, South Africa, was still lacking. Therefore, this study endeavoured to contribute new knowledge and methodological approaches to fill this gap. The study was based on the argument that despite its divergence from the Western empirical and laboratory-based scientific paradigm, the Indigenous Knowledge System (IKS) holds equal validity and efficacy. This validity stems from its development through the comprehensive comprehension and documentation of natural phenomena and the iterative refinement of practices over time, rooted in sound scientific principles.

While governments have historically prioritized science and technology as pivotal elements within growth and development agendas, the pervasive influence of Western knowledge systems in Africa has resulted in a situation where healing practices within local African contexts are often framed within Western epistemologies and value systems. Recognition of scientific expertise tends to be confined to adherence to Western, standardized, and homogenous practices. In contrast, the Indigenous Knowledge Systems (IKS) Policy provides a framework to promote and enhance the contribution of traditional medicine to social and economic development in South Africa.

The study started from the theoretical premise propagated by the advocates of the historical particularism paradigm, who believe that each society has a distinctive historical trajectory and comprehending a society necessitates understanding how its unique cultural and environmental contexts intersect as a historical process. People live in diverse cultural and ecological settings that influence their systems of knowing, knowledge production, and value systems, including traditional medicines and social practices. This implies the existence of a diversity of knowledge and belief systems, which necessitates the recognition of complementarity rather than competition in the global pool of knowledge. Western knowledge systems promote the idea that there is a universal worldview and knowledge system, thereby marginalizing other knowledge systems, especially indigenous knowledge systems and African traditional medicine.

Based on this consideration, the research emphasized the cultural importance of socioeconomic and demographic factors among the Zulu people. It also delved into the knowledge, awareness, and perceptions of Traditional Health Practitioners and their clients regarding the South African National Indigenous Knowledge Systems (IKS) Policy 2004 and related legislation. Additionally, it explored their opinions on the governance practices surrounding Traditional medicine and its integration into modern healthcare. These perceptions guided the theoretical and methodological approach to this study. This study on Zulu people's beliefs and practices of traditional medicine contributes to the debate that although indigenous knowledge Systems (IKS) as a field of inquiry is a recent phenomenon, it has gained a theoretical and methodological momentum by exposing the diversity of ways of knowing and value systems existing in the life of African indigenous communities. The next section presents the summary of the chapter.

3.6 Chapter Summary

The chapter elucidated the theoretical framework that underpins the research conducted. This framework is based on several theories, including social cognitive learning, public policy, rational,

and implementation policy. These theories have provided the researcher with a means to elucidate, predict, and challenge the current understanding of information within the confines of critical assumptions. This understanding has highlighted how theories and frameworks can offer a proficient way of generalizing findings across diverse settings within implementation research. Moreover, it has the added benefit of situating the presented knowledge within a larger epistemological and logical context.

Additionally, this chapter has explored each theory's origins, proponents, strengths, weaknesses, and connections to the use of traditional medicine. The author has also advocated for the government's implementation of policies that support the formal operation of traditional medicine in South Africa, providing the opportunity to make informed decisions regarding traditional medicine and its benefits. Consequently, the Department of Science and Innovation, in conjunction with its Departments of Health throughout the country, should take action, leading to the implementation of policy regarding traditional medicine in the country.

Finally, the researcher has established the interconnection between the theories employed in the study and related methodological approaches. These theories foster cultural and ecological diversity, ultimately supporting traditional medicine in South Africa. Each theory is crucial until the implementation of Indigenous Knowledge Systems (IKS) policy and act.

Chapter Four: Methodology of the Study

4.1 Introduction

Chapter Three provided a critical analysis of the conceptual and theoretical frameworks of the research. This provided a critical theoretical and conceptual understanding of the research work already done on the study problem. Chapter Four presents an in-depth account of the methodological approach used in conducting the study.

The study followed an indigenous mixed methods approach. This approach required that the collected data reach and draw from the past, occupy and inform the moment, and project into the future. As an Indigenous research methodological approach to the study, participants guided and embodied the research process and results. The community, not the researcher, held ownership, control, access, and data protection. The researcher was part of the research process in the co-knowledge production with research participants on local community views on the IKS National Policy in the context of African traditional medicine. Considering the holistic, multi-disciplinary, and transdisciplinary nature of traditional medicine, mixed research methods involved sampling study cases, data collection and analysis, and quantitative and qualitative study areas, including socioeconomic and demographic characteristics of the research participants.

The overall goal of using the mixed-methods research design was to provide a better and deeper understanding of the research problem and research questions within the context of the research participants. Collecting different kinds of data from different sources provided a wider range of coverage, leading to a fuller picture of the problem under study than would have been achieved otherwise (Ebneyamini and Moghadam, 2018; Hendren et al.,2018).

Considering the cultural and ecological specific nature of indigenous knowledge systems such as traditional medicine, the study followed a comparative case study approach of two ecologically different study areas in KwaZulu-Natal Province. This was based on the consideration that case studies offer an opportunity to innovatively learn from real-world experiences and influence the practice of conceptual, theoretical, and methodological frameworks (Queirós et al., 2017; Ebneyamini and Moghadam, 2018; Rashid et al., 2019).

4.2 The Study Sites and Population

South Africa has nine provinces, and KwaZulu-Natal province is the only province that has attempted to integrate IKS into its Provincial Growth and Development Strategy (PGDS) as part of the

provincial knowledge economy. The promotion of traditional medicine is one of the areas emphasized in its provincial IKS development strategy. The researcher collected data from two different ecological regions of KwaZulu–Natal province, i.e. uMkhanyakude and uGu district municipalities. It is, however, important to mention that while this study was conducted in two different ecological regions, there are many reasons to believe that local communities from both regions shared related traditional medicinal practices. Communities from both uMkhanyakude and uGu district municipalities shared IsiZulu as a related indigenous language.

Furthermore, the local communities have long depended on traditional knowledge, such as traditional medicine, for survival. However, even though they are categorized as a single tribe, their localities, including ecological systems, differ. The arid uMkhanyakude District in the North differs from the tropical uGu District in the South of KwaZulu-Natal Province. This impacted the assessment of their traditional medicinal knowledge and healing practices. To this end, it was worth examining the manifestations of traditional medicine and healing practices in the two cultural and ecological zones. This gave the researcher an opportunity for an in-depth understanding of the research problem from the perspective of local communities in both study areas (De Vos et al., 2011; Babbie, 2020; Kankam, 2020).

In the following map 4.1, eThekwini is shaded white and labelled "E", the district municipalities are shaded in other colours, and the local municipalities are numbered. Figure 4.1 also summarises the study population.

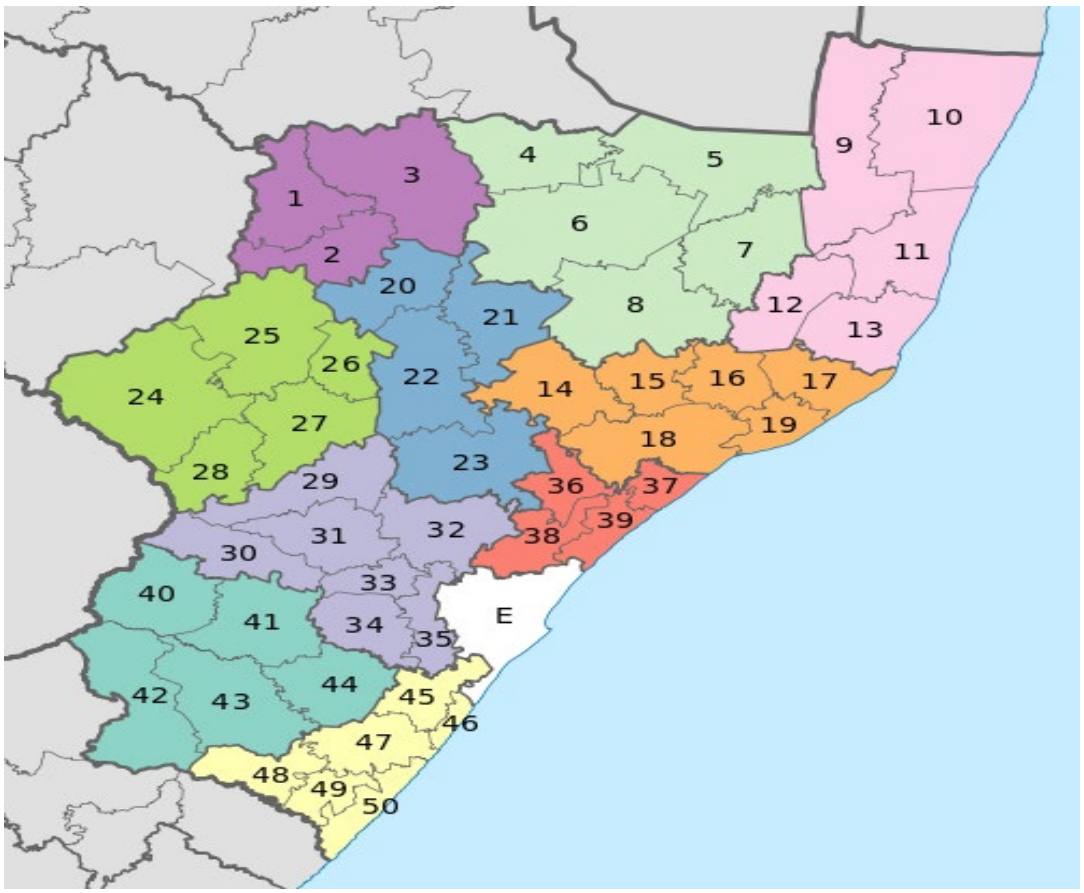

Figure 4.1. Districts and metropolitan municipalities in KwaZulu-Natal (Source: STATSA 2011)

Table 4-1. Study sites and study population (Source: STATSA 2011)

District and metropolitan municipalities

Map key	Name	Code	Seat	Area (km²)	Population (2011)[1]	Pop. density (per km²)
1–3	Amajuba District Municipality	DC25	Newcastle	6,911	499,839	72.3
E	eThekwini Metropolitan Municipality	ETH	Durban	2,292	3,442,361	1,501.90
36–39	iLembe District Municipality	DC29	KwaDukuza	3,269	606,809	185.6
40–44	Sisonke District Municipality	DC43	Ixopo	11,127	461,419	41.5
45–50	Ugu District Municipality	DC21	Port Shepstone	5,047	722,484	143.2
29–35	uMgungundlovu District Municipality	DC22	Pietermaritzburg	8,934	1,017,763	113.9
9–13	uMkhanyakude District Municipality	DC27	Mkuze	12,821	625,846	48.8
20–23	uMzinyathi District Municipality	DC24	Dundee	8,589	510,838	59.5
24–28	uThukela District Municipality	DC23	Ladysmith	11,326	668,848	59.1
14–19	uThungulu District Municipality	DC28	Richards Bay	8,213	907,519	110.5
4–8	Zululand District Municipality	DC26	Ulundi	14,799	803,575	54.3

4.3 Sampling Procedure

The sampling procedure for the study was predominantly purposive and snowball. Obilor (2023) defines a purposive sample as one that is selected based on the knowledge of a population's characteristics and the study's purpose. Traditional healers in the study districts were purposively

selected due to their experience and knowledge of ATM in their specific cultural and ecological communities. Gender construct was considered because of the tendency to neglect female traditional healers in research and policy development (Ogana and Ojong, 2015). Women were given a higher representation (60%) than men (40%) in the sample, as the traditional healing profession and practices among the Zulu communities tend to be female-dominated. Most clients also tended to be women (Nelms and Gorski, 2006; Mathibela et al., 2015).

The sampling procedure was guided by the context in which IKS as a knowledge system was managed in the two study areas, i.e. African traditional medicine and healing, which was categorized as specialized knowledge because only specific people (male and female) in the local communities had this professional knowledge. Therefore, by assisting community leaders and African traditional medicine organizations as gatekeepers, the researcher could select at least five traditional healers from each of the selected local municipalities. uGu District had six (6) local municipalities, namely Hibiscus Coast, Ezinqoleni, uMuziwabantu, Vulamehlo, Umzumbe and Umdoni; and uMkhanyakude had five (5) local municipalities namely Hlabisa, Jozini, Mtubatuba, the Big 5 False Bay and uMhlabuyalingana.

Through a snowball sampling, the selected traditional healers identified at least five (two male and three female) among their clients for interviews and focus group discussion participation. The purpose was to provide both gender categories of healers and their clients with an equal opportunity to express their views on the role of African traditional medicine and healing in the public health care system within the context of the National IKS policy (Creswell & Creswell, 2017; Parker et al., 2019). A total number of 55 traditional healers (22 male and 33 female) and 275 (110 male and 265 female) of their clients were selected due to resource constraints, giving the total number of 330 participants in the study. The criteria used to select participants were also based on the age factor (35 years and above). This considered that among the Zulu people, age was associated with accumulating experience, wisdom, and knowledge of a specific social practice and competency.

4.4 Data Collection Methods

The choice of data collection methods used in this study was based on the researcher's personal experience and preference, the population being researched, the projected audience for findings, available financial resources, time, and other available resources (Hathaway, 1995). According to Asenahabi (2019), a research design is a detailed plan outlining the study, a set of guidelines and instructions to address the research problem. This study was constructed around the historical

particularism conceptual framework to explore how different schools of thought have embraced this approach and how it is applied in African Indigenous Knowledge Systems, specifically promoting traditional medicine in the KwaZulu-Natal province. This theory is rooted around the work of Franz Boas (1920), who argues that "each culture is unique and comprehensible only on its terms and, subsequently, it is not freely adapted to the cross-cultural generalizations and broad evolutionary diagrams that were common in the late ninetieth centuries," i.e. the culture of each society has its uniqueness closely related traits and own distinctive historical development (Diah et al., 2014).

Boas advocated a holistic and descriptive approach to studying culture while challenging the scientific ambitions that led anthropologists to propose laws of change and social organization (Calhoun, 2002; Werbner, 2020). Based on his principle that cultural theories should be derived from concrete ethnographic data, Boas strongly advocated fieldwork. He believes that ethnographic fieldwork should consist of a three-fold approach to include an assessment of environmental impact on the society in question, pertinent psychological factors, and, importantly, historical connections, as he believes that each society is a product of its historical circumstances. He developed the method of participant observation as a basic research strategy of ethnographic fieldwork. This is based on the opinion that using detailed ethnographic studies makes a society understandable only in its specific cultural context, especially its historical process. Historical particularists value fieldwork and history as critical methods of cultural analysis.

Considering traditional medicine's cultural and ecological specificity, two ecologically different districts of uGu and uMkhanyakude in KZN province have different cultural characteristics that impact their traditional medicinal practices. This is even though they are both IsiZulu speaking. This study used more than one method for data collection (the process of triangulation). According to Babbie & Mouton (2001) and du Preez (2018), triangulation is advantageous in social research because it eliminates biases from single-method studies. Triangulation was used in this study to compare research findings from focus group discussions, questionnaires, and policy reviews, including the researcher's reflexive role and influence in the analysis process.

4.4.1 A Questionnaire

The study used a questionnaire with both closed and open-ended questions to collect both quantitative and qualitative data. Patten (2016) and McLeod (2018) define a questionnaire as a "written list of questions, the answers to which are recorded by respondents". Respondents read the questions in a questionnaire, interpret what is expected, and then write down the answers." As the researcher is not available to clarify the questions, these questions should be simple, clear, and relatively easier to

comprehend. Leung (2001) argues that a questionnaire must be structured in a way that is easy to peruse and pleasing to the respondent, and the order of questions must be comfortable to track. According to (McDowell, 2006), a questionnaire must be structured in a two-way communication manner. This implies respondents must have an impression that somebody is conversing with them. A communicating statement elucidating the significance of the inquiry should precede so that the respondents will not hesitate to respond. In the context of this research study, the respondents were dispersed over an extensive geographical expanse. Consequently, the researcher had to employ a questionnaire, as it would have been extremely expensive to interview them individually.

The questionnaire used in this study had both open-ended questions (for qualitative data) and close-ended questions (for quantitative data). According to Züll (2016) and Baburajan et al. (2020), the possible responses are not given in an open-ended question. In the case of a questionnaire, the respondent writes down the answers in their own words where they can. In a closed-ended question, the possible answers are set out in the questionnaire, and the respondent or the investigator ticks the category that best describes the respondent's answer.

Creswell and Creswell (2017) summarise the advantages of the questionnaire. These advantages motivated the researcher in this study to employ this research instrument. The questionnaire was less expensive as the researcher did not have to interview respondents individually, saving time and financial and human resources. It also provided greater secrecy in the absence of a direct interaction involving the respondents and interrogator. Questionnaires allow the collection of both subjective and objective data in a large sample of the study population to obtain statistically significant results, especially when resources are limited.

Considering the multi and transdisciplinary, community, and cultural-based nature of IKS as a new area of study within African traditional medicine, research methods must be as inclusive as possible. IKS has its epistemology, etymology research methods, and value systems, especially when dealing with traditional healers. This study's methodological approach to data collection was predominantly qualitative (Bryman, 2008; Bryman, 2008a; Creswell, 2013; Braun et al., 2017). Interactive research methods such as interviews with traditional healers and their clients, direct observations, focus group discussions, and questionnaires formed the core instruments of data collection. This has allowed the researcher to interact with the IK holders and practitioners in the study communities. A structured questionnaire composed of closed and open-ended questions was used to collect qualitative and quantitative data, including the socio-economic and demographic profiles of the research participants.

A structured questionnaire is one in which the questions are precisely decided in advance. The questionnaire in this study was used as an interviewing method, where the questions are asked exactly as they were written, in the same sequence, using the same style, for all interviews. Considering the use of a structured - questionnaire in the form of an interviewer-administered, Cheung (2014) states that a Structured questionnaire is a document that consists of a set of standardized questions with a fixed scheme, which specifies the exact wording and order of the questions, for gathering information from respondents. Closed or structured questionnaires are a research method advocated by Emile Durkheim (1858 – 1917). It is a positivist research method with low researcher involvement and a high number of respondents.

Interviews are primarily done in qualitative research and occur when researchers ask one or more participants general, open-ended questions and record their answers. Often, audiotapes are utilized to allow for more consistent transcription (Bolderston, 1012; Creswell, 2013). The researcher often transcribes and types the data into a computer file to analyze it after interviewing. Interviews are particularly useful for uncovering the story behind a participant's experiences and pursuing in-depth information about a topic. Usually, open-ended questions are asked during interviews in hopes of obtaining impartial answers, while closed-ended questions may force participants to answer in a particular way (Creswell, 2013; Afolayan & Oniyinde, 2019). Interviews provide useful information when participants cannot be directly observed. Interviews have advantages over self-completion questionnaires (Kawulich, 2005; Mohajan, 2018).

The interview was necessary because the interviewer could explain questions the respondent could not understand and ask for further elaboration of replies. The interviewer could control the context and the environment in which the interview takes place. Therefore, the interviewer made sure that the questions were asked and answered in the correct order and that the interview took place in an appropriate setting, which was conducive to accurate responses. In short, the presence of an interviewer allowed for complex questions to be explained, when necessary, to the interviewee and to complete information with greater understanding. The researcher acknowledges the challenges of data analysis, especially when dealing with more qualitative data. To overcome such, the researcher ensured the analysis was done using NVivo (version 11.4). This computer software helps discover more from qualitative and mixed methods data, uncover richer insights, and produce articulated, defensible findings backed by rigorous evidence.

Considering the cultural nature of IKS and traditional medicine in particular, whose knowledge holders and practitioners are illiterate and speak their language, it was necessary to translate all the

research instruments into isiZulu. The majority of traditional healers in KwaZulu-Natal are illiterates and speak solely their local language. Language is central in all phases, from data collection to analysis and representation of the textual data in publications. Language barriers are most likely to occur in the first phase of a qualitative study when interview data need to be translated into the researcher's language (van Nes et al., 2010). If the interview is translated, the information is distorted. The interview was very important for this study because the researcher realized the importance of language in indigenous cultural research. The Researcher is familiar with the isiZulu language. To overcome the language barrier in this research, the questionnaire was translated into the local language, and all Interviews were conducted in isiZulu. Before the fieldwork, the researcher personally visited the potential area of research to familiarize himself with the area and acquire the gatekeeper's permission. The research period lasted between four and five months. Random visits were carried out beyond the interview period to endorse certain observations and get more elaborate answers to particular issues.

4.4.2 Focus Group Discussions

The researcher conducted six Focus Group Discussions (FGD) comprising six to ten members. According to Yates (2004), FGD differs from an interview as it compasses a group of people instead of a single participant. In this research study, the FGD method helped the researcher get the participants to discuss themselves. The participants were selected based on their knowledge of the indigenous knowledge systems as traditional healers and their patients. Getting these research participants together to discuss among themselves was an easy and quickest means of collecting qualitative data in less time than would be with individual interviews. One of the added advantages of using this method is that members tend to be more open in a group setting, and the dynamics and interactions within the group can enrich the quality and quantity of information needed to answer the research questions.

One drawback of focus group discussions is that participants are placed in an artificial environment, which can influence the responses generated. In the FGD, participants are grouped in a meeting room, and they may behave differently from how they behave when they are not watched, which might affect the quality of research results (Morgan, 1996; Nyumba et al., 2018). However, the researcher countered these disadvantages using various data collection techniques. The overall objective of using various data collection methods was to understand people's knowledge and experience of the research problem. The combination of focus group discussions, participant observation, and questionnaires

provided a better understanding of the research problem from the community's cultural perspective through interaction.

4.4.3 Participant Observation

Questionnaires and focus groups alone were insufficient to gather the information required to answer all the research questions. They were complemented by participant observation to improve the validity of the findings. Bergold and Thomas (2012) and Pearson and Poveda (2016) define a participatory approach as a methodology that argues for the possibility, significance, and usefulness of integrating research partners in the knowledge-production process. Research subjects are considered co-producers of knowledge (Streck, 2016), and the research community can participate in the research process. In addition to serving as participants, traditional healers in this study identified and selected other clients as study participants defined the problem, and interpreted data from their cultural perspectives. A participatory approach is intended to reduce power imbalances and offset biases. This approach assumes that researchers are not eyewitnesses but rather take part in a research situation (Haradhan, 2018). Hence, the researcher maintained a constant high level of self-critical awareness and reflected on their actions, perceptions, and how these were presented.

In qualitative research, participant observation has been used in various disciplines to collect data about people, processes, and cultures. Participant observation has been a trademark of anthropological and sociological studies for many years. This study also used participant observation because of the benefits that are associated with this method, as outlined by Allen (2017), Myasar (2019), and Spradley (2020).

For Allen (2017), participant observation is the process of entering a group of people with a shared identity to gain an understanding of their community. This is achieved by gaining knowledge and a deeper understating of the research site's actors, interactions, scenes, and events. The main aim of participant observation is to gain close and intimate familiarity with a given group of individuals (such as a religious, occupational, or subcultural group or a particular community) and their practices through an intensive involvement with people in their natural environment, usually over an extended period (Spradley, 2020). The researcher encounters their sample population through a passive position, specifically through observing the interactions of the sample while remaining apart from the behavioural decisions made by the individual or the group. However, the observer purposefully monitors the sample population and seeks to identify the frequency of specific behaviours or outcomes (Myasar, 2019).

The rationale for participant observation is embedded in the belief that natural behaviours are more likely to represent certain traits within the group, such as shared perceptions or beliefs. It enables researchers to obtain insights into what it feels like to be another person and to understand the world as others experience it (Baum et al., 2006). Austin and Sutton (2014) described participant observation as a useful tool in qualitative and quantitative research that describes activities, behaviours, actions, conversations, interpersonal interactions, organization or community processes, or any other aspect of observable human experience. Observation can also be used as a stand-alone tool for exploring participants' experiences, whether or not the researcher is a participant in the process (Austin and Sutton, 2014). The observation was critical in both the administration of the questionnaire and focus groups, as nonalignment between verbal and nonverbal data frequently could result from sarcasm, irony, or other conversational techniques that might have been confusing or open to interpretation.

Participant observation provides several advantages over other data collection methods and is used to increase the study's validity. Validity becomes stronger with the use of additional strategies. Like any other research method, participant observation presents its benefits and shortfalls. However, the number of benefits exceeds the shortfalls. The benefits raised by Kawulich influenced the choice of participant observation method. According to Kawulich (2012), participant observation;

- Provides researchers 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;
- Allows researchers to check definitions of terms that participants use in interviews, observe events that informants may be unable or unwilling to share when doing so would be impolitic, impolite, or insensitive, and observe situations informants have described in interviews, thereby making them aware of distortions or inaccuracies in the description provided by those informants;
- It helps the researcher have a better understanding of the context and phenomenon under study; and
- It is used as a way to increase the validity of the study. It produces rich qualitative data that shows a picture of how people live. Researchers can see for themselves. Validity becomes stronger with the use of additional strategies used with observation, such as interviewing, document analysis, surveys, questionnaires, or other quantitative methods.

She acknowledged that advantages and disadvantages are going together. It is impossible to talk about the advantages without touching on the disadvantages. She thus points out that several issues, such as age, appearance, class, ethnicity, gender, language, and nationality, may impact the researcher's acceptance in the community (Kawulich, 2012). Kawulich (2012) further elaborates that all researchers should expect to experience a feeling of having been excluded at some point in the research process, particularly in the beginning. Some reasons they mention for a researcher's not being included in activities include a lack of trust, the community's discomfort with an outsider, and potential danger to the community or the researcher.

The ultimate goal for the research design using participant observation is to develop a holistic understanding of the phenomena under study that is as objective and accurate as possible, given the method's limitations. However, the researcher was aware that one of the limitations of using participant observation as a technique is that sometimes, researchers are not easily accepted in the communities where they are conducting their research.

The strength of using participant observation is that it deals not with what people say they do but what they do, to the extent their behaviour is open to observation and insofar as observation is as objective as it seems (Myasar, 2019). Most anthropologists note the need for the researcher to maintain a sense of objectivity through distance when doing observation. This study's observations were made concurrently with questionnaire administration and focus group discussions (Nyumba et al., 2018). Most of the time, when traditional healers were visited, they would volunteer to take me to their working space. The researcher was allowed to question some of the issues observed. This made it easier for traditional healers to explain further some issues by just showing me.

Some of the issues that were observed were:

- Most traditional healers operate from home, with their offices as an outbuilding next to the main house
- Children and grandchildren are involved from a very young age, as early as seven. Some of these kids can explain the use of some medications. They can easily deliver first aid in cases of emergency in the absence of the traditional healer. This indicates how indigenous knowledge is transferred from one generation to the next.
- On the one hand, though these are deep rural areas, some traditional healers had beautiful houses, and most of their clients coming for traditional medicine were rich and drove expensive cars. I could observe so many cars in and out of the compound of one traditional healer, denoting the frequency of traditional medicine by people of different social and

economic standing. I spent almost six hours waiting before I could see the traditional healer. When asked why he was that busy, he responded that he is a strong traditional healer, which is why rich people always come to him.

- On the other hand, some other traditional healers had just normal rural houses. I was curious to know the choice of traditional healers in the community from the client's perspective.

4.4.4 Documentary Analysis

A document can be defined as "an artifact which has as its central feature of an inscribed text. Documents are produced by individuals and groups in the course of their everyday practices and are geared exclusively for their own immediate practical needs" (Mogalakwe,2006:222). Sankofa (2022) defines document analysis as qualitative research that systematically analyses documentary evidence and answers specific research questions. Bowen (2009) describes this as a form of qualitative research in which documents are interpreted by the researcher to give voice and meaning to an assessment topic. Document analysis is, therefore, considered a systematic review or evaluation of documents. Like other analytical methods in qualitative research, analyzing documents requires coding content into themes similar to how focus groups or interview transcripts are analyzed. It requires repeated review, examination, and interpretation of the data to gain meaning and empirical knowledge of the studied construct (Bowen,2009).

There are several reasons why the researcher has chosen to use document analysis. Firstly, document analysis is a more efficient and effective way of gathering data since documents are accessible, easily manageable, and less time-consuming (Bowen,2009). Secondly, many documents are free, available in the public domain, and obtainable without the authors' permission, making this more cost-efficient. It is often the method of choice when collecting new data is not feasible. The data (contained in documents) have already been gathered. What remains is for the content and quality of the documents to be evaluated. Thirdly, documents are 'unobtrusive' and 'non-reactive'. They are unaffected by the research process. Lastly, documents are stable, exact, provide broad coverage, and are suitable for repeated reviews because the presence of the researchers does not modify what is being studied (Merriam, 1988; Croker, 2009).

The disadvantages of document analysis are not so many limitations since they are mere concerns to be cognizant of before choosing or using the method. Bowen (2009) states that the initial concern to consider is that documents are not formed with data research agendas, necessitating some investigative skills. Some documents may partly provide useful data or sometimes none at all. Some

others will not provide the necessary information required to answer research questions. Other documents may be incomplete, or their data may be inaccurate or inconsistent. Sometimes, document gaps lead to more searching or reliance on additional documents than planned. In addition, some documents may not be available or easily accessible (Bowen, 2009).

Another concern is the potential presence of biases in a document and from the researcher. Both Bowen and O'Leary state that it is important to thoroughly evaluate and investigate the subjectivity of documents and your understanding of their data to preserve the credibility of your research (2009; 2014).

The researcher was well aware of all the advantages and limitations and why he embraced evaluating the quality of all documents gathered. He was prepared to encounter some challenges or gaps when employing document analysis. Concerns surrounding document analysis were easily avoided by having a clear process that incorporates evaluative steps and measures exemplified by O'Leary's two eight-step processes. As long as a researcher begins document analysis knowing what the method entails and has a clear process planned, the advantages of document analysis will likely far outweigh the number of issues that may arise. Before the actual document analysis took place, the researcher went through a detailed eight steps planning process, as outlined by O'Leary (2014), to ensure reliability: 1) Created a list of texts to explore; 2) Considered how texts were to be accessed with attention to linguistic or cultural barriers; 3)Acknowledged and addressed biases; 4)Developed appropriate skills for research; 5) Considered strategies for ensuring credibility; 6) Knew the data one was searching for; and 7) Considered ethical issues; and Had a backup plan.

O'Leary (2014) identifies three primary types of documents to be analyzed: public records, personal documents, and physical evidence. The analysis in the current study focussed only on public records, which are the official, ongoing records related to IKS policy. The document reviews were designed to identify the agencies that formulated and implemented the IKS policy.

The researcher collected data from IKS documentation centres, various agencies, and government departments working on issues related to IKS and traditional medicine. These documents gave an understanding of the perceived challenges of IKS policy in promoting African traditional medicine in South Africa. They also revealed how the communities in KZN responded in the wake of such challenges. Documents in this study section were used to support information from questionnaires, observations, and focus discussions (Yin. 1990). They were also used to access information that was impossible to get from observations.

4.5 Data Analysis

An in-depth analysis of relevant secondary data sources based on content was performed. Secondary sources included books, journals, newspaper reports, and policy documents obtainable through the library, research units, and online research. Secondary sources provided critical conceptual issues and past research experiences necessary to understand the research work already done on the research problem. This gave guidance to the contribution of this study both conceptually and empirically.

Data gathered for this study was analyzed both qualitatively and quantitatively. Wong (2008) and Sutton & Austin (2015) state that data analysis involves making sense of huge amounts of information gathered from research and bringing out meaning from data. The researcher analyzed qualitative data using thematic content methods. Elo and Kyngas (2008) define content analysis as the process of analyzing verbal or written communication in a systematic way to measure variables qualitatively interpreted and discussed thoroughly in the study. It is a systematic method for analyzing textual information in a standardized way that allows assessors to make inferences about that information. This method was used to understand patterns of shared understanding and experience amongst participants and any variability in those patterns. Five steps outlined by Terre Blanche et al. (2014) were key in analysing the study findings. This means that the focus was on searching within transcripts for the emergence of patterns of shared understanding and themes.

Sutton and Austin define theming as the drawing together of codes from one or more transcripts to present the findings of qualitative research coherently and meaningfully (Sutton and Austin, 2015). The advantage of going through this process is that it allowed the researcher to present the data using quotations from the individual transcripts to illustrate the source of the researchers' interpretations. Thus, when the findings were organized for presentation, each theme became a section's heading.

Interviews and participant observation notes were typed and analyzed through content analysis. In content analysis, the researcher classifies key ideas in a written communication, such as an article or a report. The researcher also used content analysis to analyze responses to open-ended questions from the questionnaire. Classifying numerous texts and words in much fewer content categories is a central idea in content analysis (Weber, 1990:12; Drisko & Masch, 2016). Information obtained from questionnaires, focus group discussions, and participant observation was analyzed by categorizing the data into themes to answer the research questions.

On the one hand, quantitative data emanating from close-ended questions, such as the socio-demographic characteristics of participants, were entered into the Statistical Package for Social Sciences (SPSS, version 24). Descriptive statistics were performed to describe the socio-demographic characteristics of the respondents (Bless et al., 2013). The researcher used frequency distribution by grouping the respondents into subcategories. The incorporation of both the quantitative findings and the qualitative results was done concurrently. On the other hand, Qualitative data emanating from open-ended questions were analyzed using the NVivo (version 11.4).

4.6 Reliability and Validity of Data

Reliability denotes the reproducibility of the data, and validity denotes the extent to which data is factual and truthful (Hamed, 2016). Reliability refers to the stability of findings, whereas validity represents the truthfulness of findings (Haradhan, 2017). Reliability refers to a measurement that supplies consistent results with equal values. It measures the consistency, precision, repeatability, and trustworthiness of research. It indicates the extent to which it is unbiased and ensures consistent measurement across time and the various items in the instruments (Haradhan, 2017). The validity of a research instrument assesses the extent to which it measures what it was designed to measure (Robson, 2011). Validity explains how well the collected data covers the actual area of investigation. It means “measure what is intended to be measured”. Validity requires a research instrument (questionnaire) to correctly measure the concepts under the study (Pallant, 2011).

The purpose of validity and reliability in this research was to increase transparency and decrease the probability of recording researchers' biases in qualitative research (Singh, 2014). For all secondary data, a detailed assessment of reliability and validity involved a review of appropriate methods used to collect data. To ensure that the information derived from research data accurately reflects the truth about the phenomena under investigation, different research methods were used. Triangulation often describes using multiple methods or data to develop a comprehensive understanding of phenomena (Patton, 2015). It is defined as using multiple research methods to assess the validity and reliability of data-gathering methods. Renz and colleagues state that triangulation is one method that helps increase the validity, reliability, and legitimation, which encompasses credibility, dependability, confirmability, and transferability of research findings (Renz et al., 2018).

Hence, triangulation was used to test validity by converging information from multiple sources to ensure a more complete perspective. The use of triangulation was an effective way to ensure cross-referencing of sources. In conducting this study, the researcher made a great effort to ensure the

validity and reliability of the research findings. Empirical evidence largely determines the validity of any study (Long, 2014). Besides using empirical data in questionnaires and FGDs, the researcher carried out validation checks through all stages of the study to guarantee the maximum level of data precision. The researcher clarified evidence that might be imprecise or absent by reverting to respondents and revising issues and ideas. Participant observation was used as a way to increase the validity of the study, as observations helped the researcher have a better understanding of the context and phenomenon under study. The validity was strengthened with the combination of participant observation with additional strategies such as interviews, document analysis, and questionnaires were used with observation.

4.7 Ethical Considerations

Ethics relates to how a researcher treats participants in the study (Simelane-Mnisi, 2018). Research ethics is specifically interested in analyzing ethical issues raised when people are involved as participants in research (Shamoo and Resni, 2015). According to them, there are three objectives in research ethics. The first and biggest objective is to protect human participants against any harm due to research activities. The second objective is to ensure that research is conducted to serve the interests of individuals, groups, and/or society. Finally, the third objective is to examine specific research activities and projects for their ethical soundness, looking at risk management, confidentiality protection, and the informed consent process (Shamoo and Resni, 2015).

To support the above assertion, Pieper & Thomson (2014) maintain that research should be based on mutual trust, acceptance, respect and cooperation, and well-accepted conventions and expectations between parties involved in research. The fact that human beings are objects of study in the social sciences brings unique ethical problems to the researcher. The researcher obtained data from primary as well as secondary sources and therefore observed several ethical issues during the research process as discussed below:

4.7.1 Informed Consent

The researcher sought the consent of every respondent before administering the research instruments. The researcher informed the respondents and participants that their participation in the study was voluntary. They had the choice to participate or not, including the choice to withdraw from the study at any time they felt like doing so. The researcher obtained approval from participants to record the interviews and FGD. Nevertheless, the researcher still took down notes on key issues raised during

interviews and FGDs. The researcher listed all questions about the interviews and FGD on the informed consent sheet each participant must sign.

4.7.2 Anonymity and Confidentiality

In addition to obtaining the consent of participants, the researcher ensured that they presented their views anonymously. The study disclosed neither the names nor identities of the participants in any form throughout the study. Their genuine names were kept anonymous to protect participants, and pseudonyms were used when referring to their personal experiences. The researcher provided an environment of comfort and trust throughout the study. This was necessary to facilitate the greatest flow of views and insights from each participant. This was enhanced by the researcher's ability to speak the isiZulu local language.

4.7.3 Anti-Plagiarism

Plagiarism is a serious crime in every university, as it involves stealing intellectual property. The researcher acknowledged and referenced all authors' ideas to avoid the same.

4.8 Chapter Summary

The chapter discussed the research methodology used to carry out the study. This research used the mixed approach indigenous knowledge research paradigm. Due to traditional medicine's cultural and ecological specificity, the researcher collected data from two ecologically diverse KwaZulu–Natal province regions, i.e., uMkhanyakude and uGu district municipalities. The sampling procedures for the study were purposive and snowballing. The study used mixed research methods, including a questionnaire, in-depth interviews, focus group discussions, and documentary sources to collect data. The researcher ensured the research findings' validity and reliability, including adhering to ethical considerations.

Chapter Five: Comparative Cultural Significance of Socioeconomic and - Demographic Variables of Research Participants

5.1 Introduction

The preceding chapter discussed the methodology of the study. This chapter focuses on the comparative research participants' socio-economic and - demographic characteristics from the Zulu people's cultural perspectives. This is based on the following considerations:

Firstly, like other forms of knowledge production, this study on indigenous knowledge about traditional medicine and healing systems among the Zulu people in KwaZulu-Natal province has an interest in identifying patterns of knowledge regarding natural resources and the variables influencing the production process and uses of that knowledge, at the local community and global scale. Ethnobiological studies, such as traditional medicine and healing systems, have identified a range of variables that can interfere with the knowledge of natural resources in social-ecological systems. This is attributed to the fact that it is a structural component of local medical and healthcare systems. Considering the holistic and multi-and transdisciplinary nature of African indigenous knowledge systems on traditional medicine and healing systems, the socio-economic and demographic variables that affect these systems include age group, gender, marital status, and religious affiliations variables.

Secondly, in the Western research paradigm, local community members' socioeconomic and demographic characteristics, including their African Traditional Healthcare Practitioners (ATHPs), tend to be viewed from a statistical perspective. This neglects the cultural meanings attached to them by the research participants in their respective cultural communities, especially how they influence the production of knowledge and uses of that local knowledge and associated resources. Therefore, this study examined these variables as statistical variables and included their cultural meanings and importance, particularly in the context of African traditional medicine and healing systems among the Zulu people in the study areas (uGu and uMkhanyakude district municipalities). These variables were related to cultural practices such as rites of passage, age group, gender, marital status, spiritual relationships, and issues of traditional medicine and healing practices among the community members. Nelson-Becker & Sangster (2019) refer to a rite of passage as a celebration of the life passage that occurs when an individual moves socially and culturally from one age group to another. It involves a significant change of status in society.

This chapter presents the comparative socio-demographic characteristics of the research participants, from the Zulu people's cultural perspectives, in both uGu and uMkhanyakude districts in KwaZulu-Natal, South Africa. These cultural perspectives are presented as research participants' narratives drawn from the data produced through interviews and focus group discussions (FGDs). The main themes emerging from this objective are depicted in the following sections.

5.2 Age Group Distribution of Research Participants

According to Agbo-Ajala and Viriri (2019), an age group refers to a group of people in a place or organization who were born during a particular period. For instance, among the Zulu people of the uGu district (south coast of KwaZulu-Natal province) and uMkhanyakude districts (north coast of KwaZulu-Natal province), South Africa, an age group did not represent a mere number but rather had a significant cultural meaning attached to it.

The understanding that arose from the research participants regarding the cultural meaning of age group was the high regard given to one's mental ability as opposed to chronological age. In-depth interviews and focus group discussions with both ATHP research participants and their clients revealed how the age group was culturally determined. For example, Ubaba Mhlongo, an ATHP from uMkhanyakude district municipality, had the following to say about the Zulu cultural determination and meaning of an age group:

> *"Umuntu angaba neminyaka engamashumi amabili nanhlanu (25) enomqondo othatha kancane wokucabanga kanti ngakolunye uhlangothi umuntu oneminyaka eyishumi nesishiyagalombili (18) angahle abe nengqondo futhi nokuzibophezela emphakathini[1]."*

According to Ubaba Mhlongo, in Zulu indigenous culture, community elders do not emphasize a person's age, expressed by the number of years, but on a person's character, reflecting one's mental ability and maturity. For instance, a person might be twenty-five (25) years of age with minimal mental ability. On the other hand, an eighteen (18) year old person may be fit and mentally and socially responsible.

One of his clients, Ubaba Mazibuko from the uMkhanyakude district municipality, confirmed and elaborated on this.

[1] Over 70-year-old female Traditional Healer from uMkhanyakude district.

"Mntanami, angikwazi ngempela ukuyisho iminyaka yami yangempela ngenombolo ngoba ngazalelwa ekhaya futhi ukuzalwa kwami kwakungabhalisiwe ngokusemthethweni. Engikwaziyo ukuthi iminyaka yami ibukeka imiringi. Kodwa-ke, ngingahle ngithi ngineminyaka engamashumi ayisishiyagalombili nambili (82) ngokucabanga iminyaka yabangane bami umama wami ungitshele ukuthi sazalwa ngonyaka ofanayo futhi sakhula ndawonye njengezingane endaweni efanayo. Lapho sizithola sigqolozela emnyangweni wezindaba zasekhaya kwizicelo zamakhadi omazisi ekugcineni kobandlululo, sichaze izigameko ezenzeka ngonyaka esazalwa ngawo noma ngeminyaka embalwa emva kokuzalwa kwethu okulandisa kwesinye isikhathi esingakukhumbula njengabantwana ukuze sithole usuku olufanele lokuzalwa. Sasikhiqiza amakhadi ethu okubhabhadiswa noma nini lapho bekhona. Ngokusekelwe kulokho, izikhulu zezaseKhaya zazinikeza isilinganiso esibi seminyaka yethu[2]."

My child, I cannot tell my actual years in number. I was born at home, and my date of birth was not officially registered. However, I consider myself eighty-two (82) years of age considering the age of my friends, whom my mom told me were born in the same period and we grew together as children in the same community. When we found ourselves queuing at the Department of Home Affairs for identity card applications at the end of apartheid, we would describe events that happened during the year or period we were born. There are several common experiences and events we can recall as children. We would produce our baptism cards whenever they were present. Based on that, home affairs officials gave a rough estimate of our years.

Most older adults in both research communities believed they had the wrong birthdays registered on their identity documents. The number of years at the time of the identity document's application was either reduced or increased because of inaccuracy at the time of registration. Therefore, both Ubaba Mhlongo and Ubaba Mazibuko could affirm their age groups based on information gained from their peers. Table 5.1 shows the comparative percentage age group distribution of the ATHP research participants in the study district municipalities, KwaZulu-Natal province.

[2] Informal conversation with N. Mpofana, Hibiscus Coast local municipalities,14 April 2018.

Table 5-1. Comparative Percentage Age Group Distribution of the African Traditional Healthcare Practitioners (ATHPs) Research Participants in study district municipalities, KwaZulu-Natal Province

uGu district			uMkhanyakude District		
Age Group	**Frequency**	**Percentage**	**Age Group**	**Frequency**	**Percentage**
30-39	08	27	30-39	05	20
40-49	07	23	40-49	06	24
50-59	11	37	50-59	07	28
60-69	02	07	60-69	05	20
70-79	01	03	70-79	01	04
80 and above	01	03	80 and above	01	04
Total	30	100	Total	25	100

Table 5.1 shows that most ATHP research participants in the uGu district municipality (73%) and uMkhanyakude district municipality (80%) were 40-49 and above. This implies that most of them in both study district municipalities were older adults. The large proportion of older adults in the study sample was influenced by the high regard community leaders had for older adults as custodians of indigenous knowledge about traditional medicine and healing systems, including knowledge of community natural resources in the study areas. In-depth interviews and FGDs with ATHPs in both study areas confirmed this.

The study was also interested in determining the views of the ATHPs' clients on the cultural significance of the age group variable. Table 4.2 shows the comparative percentage age group distribution of ATHP participants' Clients in the study district municipalities, KwaZulu-Natal province.

Table 5-2. Comparative Percentage Age Group Distribution of the African Traditional Healthcare Practitioners (ATHPs) Research Participants' Clients in the study district municipalities, KwaZulu-Natal Province

uGu District			uMkhanyakude District		
Age Group	**Frequency**	**Percentage**	**Age Group**	**Frequency**	**Percentage**
Under 20	20	13	Under 20	22	18
20-29	37	25	20-29	39	31
30-39	38	25	30-39	32	26

40-49	16	11	40-49	13	10
50-59	15	10	50-59	13	10
60-69	17	11	60-69	03	02
70-79	06	04	70-79	02	02
80 and above	01	01	80 and above	01	01
Total	150	100	Total	125	100

Table 5.2 indicates that most ATHP research participants' clients (63% in the uGu district municipality and 75% in the uMkhanyakude district municipality) in the study District Municipalities were 30-39 and below. This implies that they were mostly younger than the ATHP research participants. In-depth interviews and focus group discussions (FGDs) with both revealed that higher age groups, especially ATHP research participants, were associated with wisdom and professionalism in holistic knowledge and experience in traditional medicine and healing practices. Elderly ATHPs were considered by both as custodians of these community-based knowledge systems. The following section discusses the gender distribution of research participants.

5.3 Gender Distribution of Research Participants.

Sociologically, gender describes the characteristics of women and men that are socially and culturally constructed, while sex refers to those that are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men (WHO,2015).

In the context of African traditional medicine and healing systems, gender is one of the socio-economic, cultural, and demographic variables that has been widely studied to understand whether traditional medicine and healing systems, including knowledge of medicinal plants, vary with gender, and how it influences the socio-cultural structure of local traditional medical and healing systems, including practices. The objective of such studies is to ascertain whether there is a gender-based pattern in knowledge systems at different levels of society that could characterize the influence of gender on the structure of local medical and healing systems. This could contribute to the understanding of the way predictive variations in knowledge can relate to the gender variable. Moreover, understanding the variation in knowledge between the genders on African traditional medicine and healing systems at different scales and local community levels is crucial for heritage conservation as it enables the creation of community-based strategies and public policies to this effect.

This section explores the comparative socio-economic and cultural significance and interpretation of gender constructs in the context of traditional medicine and healing systems among the Zulu people in the study areas.

Table 5.3 shows the comparative percentage gender distribution of the ATHP research participants in the study areas.

Table 5-3. Comparative Percentage Gender Distribution of the African Traditional Healthcare Practitioners (ATHPs) Research Participants in the study district municipalities, KwaZulu-Natal Province

uGu District			**uMkhanyakude District**		
Gender	**Frequency**	**Percentage**	**Gender**	**Frequency**	**Percentage**
Male	13	43	Male	10	40
Female	17	57	Female	15	60
TOTAL	30	100	TOTAL	25	100

Table 5.3 shows that most ATHP research participants in the study areas (uGu District, 57% and uMkhanyakude District, 60%) were females. This was attributed to the fact that the identification and selection of the ATHPs were not limited to those who are professionally known at the community level but were done through focus group discussions and snowball methods where other ATHPs could be identified at all levels, including family levels. These were predominantly female ATHPs. The study was interested in establishing the gender distribution of their main clients. The results are reflected in Table 5.4.

Table 5-4. Comparative Percentage Gender Distribution of the ATHPs Participants' Clients in the study district municipalities, KwaZulu-Natal Province

uGu District			**uMkhanyakude district**		
Gender	**Frequency**	**Percentage**	**Gender**	**Frequency**	**Percentage**
Male	61	41	Male	48	38
Female	89	59	Female	77	62
TOTAL	150	100	TOTAL	125	100

Table 5.4 shows that most ATHP research participants' clients in the study district municipalities (uGu District, 59% and uMkhanyakude District, 62%) were female. In-depth interviews and focus

group discussions with ATHPs and clients revealed that the clients included children at the family level.

Consequent to their social and cultural as grandmothers, mothers, wives, and daughters, Zulu women were in charge of health, diagnosing illnesses, and knowing the prognosis of family and other household members. They were the first call for implementing the first treatments. Women and girls were responsible for collecting plants and other resources, including firewood; hence, they had a wide knowledge and lived experience of traditional medicines and other holistic aspects, which constituted a holistic perspective on health as defined by the World Health Organization (WHO, 2005):

> *"a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."*

WHO (2019) also defines Traditional Medicine as: "the total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement ..."

Table 5.3 and Table 5.4, supported by information from the in-depth interviews and FGDs, demonstrate that women as ATHP and their female clients were actively involved in Zulu's traditional medicine and healing practices at local community levels.

One woman ATHP in the uGu district municipality, who was very knowledgeable about traditional healing systems across cultures, expressed the sentiments that testimonies across cultures worldwide on traditional medicine and healing systems, revealing a time when only women knew the secrets of life and death. Hence, women alone could practice the magical art of healing. Mji (2019) supports this assertion by indicating that the dissonance between women's talents and fate deserves much attention. It demonstrates the evolution of contemporary societal institutions that marginalized women's voices. These perpetuate a crisis of lack of gender balance in public healthcare, including the relationships between healthcare and the environment upon which life itself is dependent.

(Mji, 2019) elaborates that the introduction of Western science, mostly in Africa, destroyed the symbiotic relationship between women, the main sources of healthcare at home and family level, and their relationship with the natural environment as the source of traditional medicines and healing systems.

The muscularization of healthcare and medicine in Africa was worsened by the alliance of corporate power and money, whereby the traditional healthcare system, which was a caring profession under women, became part of a class system dominated by men in medical institutions, including medical schools and establishment of laboratories in which women have limited access. Women were mostly delegated to nursing professions. In the case of Zulu traditional medicine and healing practices, male ATHPs in local communities became more prominent and visible at the expense of female ATHPs. Gogo Ntuli from uMkhanyakude district municipality elaborates:

> *"Ngokwesintu abesifazane abangamaZulu babengabagcini bemithi yesintu kanye nokwelashwa. Kwakungabelaphi abakhulu ababeyazi imithi yesintu kanye nemikhuba yokwelapha, eqashelwa umndeni nomphakathi wonkana. Ukwethulwa kwezinhlelo zesimanje zokunakekelwa kwempilo kwenza abesifazane bamaZulu balahlekelwa ukubaluleka kwabo ezinhlelweni zendabuko zokunakekelwa kwezempilo. Kuyinamhlanje abesifazane bangabahlengikazi ezibhedlela, bagcwele izibhedlela ezilapha ngokwesilungu , abaphathi babo odolotela besilisa, abanye basiza odolotela besilisa emasejari abo."*

Gogo Ntuli indicates that, traditionally, Zulu women were the custodians of traditional medicine and healing practices. They were the main healers who knew the traditional medicines and healing practices the family and community recognized. The introduction of modern healthcare systems made Zulu women lose their relevance in the traditional medical healthcare systems. Women have now become like nurses in modern hospitals who are submissive to the male-dominated medical profession. Gogo Gumbi from uGU elaborates:

> "*Abesifazane babengabagcini bolwazi lwendabuko kodwa manje sebelahlekelwe yilokhu. Sesingaphansi kwabesilisa ngendlela yokuthi uma inyanga iyalela isiguli ngokwelashwa, kuba umthwalo wowesifazane ukuthi alungiselele, futhi anikeze isiguli ukwelashwa. Asisavunyelwe ukuxilonga iziguli, Imisebenzi yethu ayihlukile neyabahlengikazi abahlale belindele ukuthi odokotela benze izeluleko futhi banikeze nemithi."*

Women were the custodians of traditional knowledge, but they have now lost this. We are subordinates to men in such a way that when a healer prescribes treatment to the patient, it becomes the woman's responsibility to prepare and administer the treatment. We have been stripped of the ability to diagnose patients; our jobs are no different from that of nurses who rely on doctors to guide and prescribe medicines.

Churches, industries, and sports have contributed heavily to the masculinization of the medical and healthcare professions (Wojczewski et al., 2015). In medical and healthcare institutions, for example, matrons have been placed in positions of power to undermine and persecute other women for the gain of the hegemony of men (Mji, 2020). Gogo Madlopha from the uGu district municipality explains:

> *"Sesingaphansi kwabesilisa ngendlela yokuthi uma inyanga iyalela isiguli ukwelashwa, kuba wumthwalo wowesifazane ukuthi alungiselele futhi anikeze isiguli ukwelashwa. Asisavunyelwe ukuxilonga iziguli; izindima zethu azihlukile kwezabahlengikazi abahlale belindele ukuthi odokotela babonane futhi basinike imithi. Ukwandiswa kwamadoda ekuphatheni kwezinhlelo zokunakekelwa kwezempilo kwendabuko emiphakathini yethu, bambalwa abesifazane ababesetshenziswa njengoMatron futhi banikezwe isikhundla samandla emiphakathini yethu ukuze sisize ukuphusha uhlelo lwamadoda. Umkhakha wezokwelapha ogcwele abesilisa ubuka labomatron besifazane ngokwezinga elithile ngenxa yeqhaza abalibambayo."*

Gogo Madlopha expressed the view that women had become subordinate to men in a way where, for instance, when a healer prescribes treatment to a patient, it becomes the responsibility of the woman to prepare and administer the treatment. She mentioned that they were no longer permitted to diagnose patients; their roles seemed akin to nurses who wait for doctors to perform consultations and prescribe medication. Additionally, she highlighted the exacerbation of male predominance in managing traditional healthcare systems. She noted that a few women were used as Matrons and given positions of power to further men's agendas, contributing to the male-dominated landscape. She conveyed that the male-dominated traditional medical world looked down upon these women Matrons due to their roles.

Dahl-Michelsen (2014) further points out that nursing was not the only women's health profession in the masculinization of the medical profession. The end of the Second World War emphasized services for persons with disabilities, and professions such as physiotherapy, occupational therapy, and speech and language therapy within the rehabilitation field were born. From the outset, the so-called allied health professions emphasized submissiveness and conformity to the male-dominated medical profession.

One female ATHP in the uGu district municipality argued that even though human beings need to be cared for to survive the different stages of life (illness, childbirth, old age, and childhood) because this work is viewed as 'women's work,' it is not given monetary value equivalent to the true value

and worth. Our families, specifically women, are not remunerated according to the true value of their work. This situation is made worse by the silence of modern women, who neglect the fact that according to the African indigenous perspective, every woman is a mother to every child of the village and the world. Gogo Makanya from the uGu district municipality elaborates:

> *"Nakuba abantu bedinga ukunakekelwa ukuze baphile ezigabeni ezihlukahlukene zokuphila (ukugula, ukubeletha, ukuguga nobuntwana), ngoba umsebenzi wokunakekela ubhekwa 'njengomsebenzi wabesifazane,' awunikezwa inani lemali elilingana nokubaluleka nokufaneleka kweqiniso. Imindeni yethu, ikakhulukazi abesifazane, ayikhokhelwa ngokwenani langempela lomsebenzi wabo."*

Gogo Makanya highlighted that despite the necessity of care for survival in different life stages like sickness, childbirth, old age, and childhood, the undervaluation of care work, often labelled as 'women's work,' is not compensated adequately in monetary terms. She emphasized that families, particularly women, are not remunerated based on the genuine value of their labour.

Gogo Zulu, who is a client of one of the ATHPs in the Makhanyakude district, expressed her views on the issues of health, age, and gender. She argued that African women become more powerful and autonomous in old age. This is based on the view that despite their age, they can assume new roles and duties that will be conducted caring and lovingly, with expertise and experience gained through years of understanding, knowledge, and lived experience. She complained that due to the dominance of Western healthcare, the voices and contributions of older African women, especially in the rural areas, were rarely heard on issues of healthcare for family and community, as it was in the olden days. Consequently, very little research has explored how older African women contribute to their communities' health, economy, and social capital. This contribution is rarely researched or documented. For instance, in most African societies, where deaths due to AIDS are prominent, older people, specifically women, as grandmothers, have become a pillar of strength and survival to AIDS orphans. Gogo Zulu explains:

> *"Abesifazane base-Afrika babanamandla futhi bazimele lapho sebekhulile. Ngaphezu kweminyaka yobudala, owesifazane angakwazi ukuthwala izindima nemisebenzi emisha okufanele yenziwe ngendlela yokunakekela nothando ngenxa yobuchwepheshe nolwazi oluzuzwe ngeminyaka yokuqonda, yolwazi, nolwazi olukhaliphile. Kodwa-ke, ngenxa yokubusa kokunakekelwa kwezempilo kwasentshonalanga, amazwi namagalelo abesifazane abadala base-Afrika, ikakhulukazi ezindaweni zasemakhaya, ayengavamile ukuzwakala*

ngezindaba zokunakekelwa kwezempilo emndenini nasemphakathini, njengoba kwakunjalo ezinsukwini zakudala."

Gogo Zulu asserted that African women embody strength and independence as they mature. She pointed out that apart from age, a woman can assume additional responsibilities requiring meticulous attention and affection, drawing from the expertise and insight accumulated through years of experience, learning, and sagacity. She also pointed out that the prevalence of Western healthcare practices led to limited recognition of the perspectives and input of older African women, particularly in rural settings, regarding family and community healthcare matters, akin to past times.

Considering the WHO's holistic approach to healthcare, the contribution made by these older African women needs to be recognized and valued as lay health experts who family and friends regularly consult. This includes a greater understanding and documentation of the knowledge of these women. The negative assumptions and perceptions about the age group, gender, and ill health in mainstream society need to be challenged. Older women's role in fostering a spirit of belonging, participation, and identification in the local community needs to be encouraged, as well as their role in promoting empowerment and change. Data on social participation indicate that older African women in rural communities are more active than older men in terms of voluntary work, group membership, and attendance at social events, including healthcare.

Women's dual roles as caregivers and receivers, especially those caring for people with disabilities, have been underestimated. During focus group discussions in both study areas with ATHPs and their clients, the older male participants were less vocal than their female counterparts on gender-related issues in Zulu traditional medicine and healing systems. For instance, the elderly female research participants were more articulate on the issue of the empowering role of women when describing the Zulu indigenous older women as active ritual leaders and the repositories of spiritual healing knowledge. They indicated having reared children, not necessarily their own, into adulthood and having acquired the necessary knowledge, skills, and lived experience befitting the status of ritual leaders in their respective families and communities. They revealed that through cultural and place-based ceremonies, they nurture; through their health and curing rituals, they resolve conflicts and restore social harmony; and through love rituals, they manage emotions. Thus, their major responsibility as ritual leaders is love, nature, and health. As part of their nurturing nature, they see themselves as the custodians of 'the growing up' of people and nature and maintaining the harmonious relationship between people and their natural environment. They use certain rituals to affirm their commitment and intention to 'grow up' country and kin.

Gogo Qwabe in uGu elaborated that during apartheid in South Africa, it was against the law to practice traditional healing. Despite these legal prohibitions, Zulu indigenous healing practices continued to thrive. The challenge now rests with integrating this knowledge into the highly developed and dominant Western medical system. Previous attempts have shown that practitioners of the Western medical system are resistant to integration, claiming that indigenous healing practices are generally dangerous; instead, they prefer to influence the traditional side to change and embrace Western medical practices. Gogo Qwabe explains:

> *"Ngesikhathi sobandlululo eNingizimu Afrika, kwakuphambene nomthetho ukwelapha ngokwesintu. Ngaphezu kwalemithetho evimbelayo, izindlela zokwelapha zomdabu zamaZulu ziyaqhubeka nokudlondlobala."*

Gogo Qwabe mentioned that traditional medicine faced prohibition under the apartheid regime in South Africa. Despite these stringent regulations, she highlighted that traditional Zulu healing practices persisted and thrived.

However, Kroneman et al. (2016) show that attempts to integrate the two medical systems have shown positive results in some Western countries, such as the Netherlands, Norway, and Sweden. Low maternal mortality rates were reported by the early 19th century in these countries. These were attributed to extensive collaboration between physicians and locally available midwives, especially in rural areas. However, these local community birth attendants were phased out over time due to the introduction of biomedically trained midwives.

Cross et al. (2019) show that similar approaches were experienced in the Guatemalan healthcare system, where health authorities tried refashion Mayan midwifery's vocational framework according to Western medical principles. The ongoing privileging of biomedical knowledge created an environment that favoured health personnel and enabled them to extend their influence on the indigenous Mayan midwives into the community. The Mayan traditional birth attendants encouraged kneeling or squatting during delivery. Nevertheless, these positions were frowned upon by Western-trained biomedical midwives. They argued that with these positions, the child descends with too much force, and the afterbirth can become stuck within the mother or be expelled onto the ground. Instead, they encouraged the lithotomic position (lying flat on the back with knees raised) or semi-reclining. However, a review of the lithotomic position showed that it was dangerous due to the following limitations:

1. it decreases the size of the pelvic outlet;
2. it negatively affects the mother's pulmonary ventilation, blood pressure, and cardiac return, thereby lowering oxygenation to the fetus;
3. it lends itself to the mother pushing too hard for too long and thereby becoming exhausted before accomplishing what is required, namely, the birth of the baby, which is sometimes accomplished by external measures such as forceps deliveries or episiotomies.

The above demonstrates the challenges of the clash of ways of knowing between indigenous and Western cultures and associated knowledge systems. Adatara et al. (2019) indicate that childbirth is not only biological but cultural as well. African young women and mothers, especially in rural and other marginalized communities, face a diversity of challenges, as the most physical, individualistic modern healthcare systems are in contradiction with traditional healthcare systems held by their parents, which are holistic, caring, and supportive. They do not only have to cope with problems of poverty and the transition from the rural to an urban environment but also have to deal with levels of frustration, mistrust, anger, and lost identities.

Although traditionally, Zulu people live in patrilineal and patrilocal communities, where generations are connected through the father's line, and most Western social scientists tend to argue that they still live under a patriarchy, in which men serve as heads of almost every important social, cultural, and political institution including the dominance of knowledge systems. This study demonstrates that in the context of the holistic nature of Zulu traditional medicine, women knew more than men about traditional medicinal medicines and healing systems as a knowledge system. The social and cultural division of labour in most African local communities, including the Zulu people, demonstrates this aspect.

Torres-Avilez et al. (2016) explain that in gender-based comparative studies of the knowledge of traditional medicinal medicines, including plants, the social roles of women and girls, who are classified as wives and daughters, are to be in charge of healthcare of the family including, diagnosing illnesses, and knowing their prognosis. They are responsible for implementing primary healthcare. On the contrary, men might be responsible for maintaining the household economy and providing resources, leading them to know more about natural resources for other family purposes. This aspect tends to be neglected in discussing Zulu indigenous traditional medicine and healing systems.

Gogo Mpofana, one of the ATHP research participants in the uMkhanyakude District, explains:

"Ubulili bubaluleke kakhulu emasikweni ethu. Kodwa-ke, inhlonipho inikezwa labo izindima nezibopho zabo ezibalulekile ebukhoneni bemindeni yabo kanye nemiphakathi[3]."

Gogo Ntuli had the view that the issues of gender in African indigenous social practices among the Zulu people, especially in traditional medicines and healing systems, tend to be distorted by Western knowledge systems and power structures at all levels. The active role of women in traditional medicine and healing among the Zulu people is marginalized. More men as ATHPs than outsiders know women, although most of the knowledge and these practices at the family and local community level are performed by women. Gender is very important in Zulu culture. However, respect is given to those whose roles and responsibilities are important for the sustained existence of their families and communities.

Philisiwe Mthabela elaborates further:

"Phambilini abesilisa babethathwa njengabakhulu kunabesifazane kodwa manje isimo sesishintshe kakhulu. Siyabona manje ukuthi abesifazane sebenikeziwe umthwalo omningi ukwedlula obekuvunyelwe phambilini futhi banikela kakhulu emindenini yabo nasemiphakathini. Ngakho-ke, uma ngikhuluma ngokubaluleka kobulili, angibheki ubulili bakho kepha kunalokho ngibheka iqhaza lakho emphakathini[4]."

Philisiwe Mthabela elaborated that in the past, there was this notion that men were more significant than women. But things have shifted significantly. Nowadays, women carry more responsibilities than before and play a greater part in their families and communities. So, when I emphasize the significance of gender, I'm not focusing on your gender specifically but rather on your societal role. The following section discusses the Marital status distribution of research participants.

5.4 Marital Status Distribution of Research Participants

This section looks at marital status as a socio-economic, cultural, and demographic variable from the Zulu cultural perspective.

[3] Conversation with Gogo Mpofana, Hibiscus Coast local municipality in uGu, 14 April 2018.
[4] Conversation with Mama uMhlabuyalingana local municipality in uMkhanyakude, 02 January2018.

In the context of African traditional medicine and healing systems, marital status refers to the personal status of an individual concerning the marriage laws and customs of a country (United Nations, Department of Economic and Social Affairs, Population Division, 2013). In most traditional societies, like among Zulu local communities, one's marital status was very important. It played a key role in both the cultural and health care system and in one's choice and reasons for choosing that particular health care system. This was attributed to the fact that married, unmarried, divorced, widowed, or separated people had different ways of thinking and put their beliefs in different aspects of life, including healthcare. The cultural aspects of marital status as an important community socio-economic, cultural, and demographic variable are not considered in Western ways of knowing and knowledge production when investigating the socio-economic and demographic characteristics of the ATHPs and their clients in the study areas. Table 5.5 shows the percentage marital status distribution of the ATHP research participants in the study district municipalities in KwaZulu-Natal province.

Table 5-5. Comparative percentage Marital Status Distribution of the African Traditional Healthcare Practitioners (ATHPs) Research Participants in study district municipalities, KwaZulu-Natal Province

uGu District			**uMkhanyakude district**		
Marital Status	**Frequency**	**Percentage**	**Marital Status**	**Frequency**	**Percentage**
Single	12	40	Single	09	36
Married	16	53	Married	14	56
Widow/er	02	07	Widow/er	02	08
TOTAL	30	100	TOTAL	25	100

Table 5.5 indicates that most ATHP research participants in the uGu district municipality (53%) and in the uMkhanyakude district municipality (56%) were married. The size of married people in the study samples was influenced by the high regard community leaders had for married people who were considered knowledgeable of the traditions and customs of indigenous peoples, including indigenous knowledge about traditional medicine and healing systems in the study areas. In-depth interviews and FGDs with ATHPs in both study areas confirmed this.

In-depth interviews and focus group discussions indicated that the majority of the ATHP research participants considered marriage to be very valuable for both the youth and older adults, including ATHPs. According to research participants, marriage gives one respect and wisdom since it forms a significant part of the lives of community members. Hence, marriage was viewed as an important rite

of passage, a great achievement for both men and women in the community, recognized by ancestors, even in performing rituals related to traditional medicine and healing practices. Gogo Makanya in the uGu district municipality elaborates:

> *"Imindeni eminingi emphakathini yethu, eshadile noma engashadile, ithembele emithini yesintu kanye nokwelapheka endabeni yokunakekelwa kwezempilo. Nokho, umshado emphakathini wawuhlonishwa kakhulu, ngendlela yokuthi abantu abashadile kwakuba yibona abahlonishwa kakhulu kunabangashadile, babe nemibono, futhi balalelwa ngabaningi. Lapho indoda noma owesifazane oshadile akushoyo noma akwenzayo, kubaluleke kakhulu ngokwesiko kunalowo ongashadile."*

Gogo Makanya expressed the opinion that many families in the local communities, married or not, rely on traditional medicine and healing in the case of healthcare. However, marriage in the community was highly valued, so married people were more respected, opinionated, and listened to than singles. What the married man or woman says or does is more valued culturally than what the unmarried man or woman says or does.

This shows that marital status in the study communities was viewed as a significant variable related to traditional medicine and healing practices. Focus group discussions involving traditional medicine and healing were mostly attended by those who were married, and most had their own families. They were seen to have the necessary experience to participate in such discussions. People in the study community believed marriage was closely connected to their ancestors and culture. This view on marital status does not exist in its Western conceptualization of a statistical socio-economic demographic variable. There were also many widows and widowers, amounting to 6% (N=2) from uGu and 8% (N=2) in uMkhanyakude district municipalities.

Like most African traditional communities, the Zulu people, in both the study areas, accord respect to the institution of marriage. It is highly valued and is recognized as one of the most important cultural institutions among the local communities. The institution of marriage is a rite of passage that marks the progression into adulthood and of forming a family. It is also a rite of passage that officially separates individuals from the parental unit to being parents in their own right. It also defines the inception of the socially putative time for childbearing. Among the Zulu, marriage as an institution sets childbearing for both men and women. Like in other African traditional cultural communities, the institution of marriage is established as the socially acceptable context for childbearing.

Marriage also assigns an important social status, especially for women as future mothers. Among the Zulu traditional communities, marriage is regarded as the institution that ascribes honour and dignity to women in their families and the wider society. Outside of marriage, the honour of women of marriageable age is highly compromised.

Participants in this study expressed that the Zulu, as a Nguni community, believes marriage is the first and oldest institution ever created and should, therefore, be respected—Zulu people honour, recognize and respect marriage as one of the most important socio-cultural institutions. A person is always considered a child and cannot be given certain responsibilities in the community because s/he is not married. This implies that you should get married for one to be eligible to serve the community. This implies that the institution of marriage is an important rite of passage that marks the movement and transition into adulthood among the Zulu people.

Rites of passage are considered as various rituals that an individual undergoes from one stage of life to another. The transition becomes smooth only once appropriate traditional rituals are performed. These rituals are considered covenants binding the couple together. They are lubricants allowing smooth movement to adulthood, said Ubaba Ngcobo, one of the traditional healer participants during the focus group discussion. He said: "*Amasiko ayizithambisi ezivumela ukunyakaza okushelelayo ekubeni umuntu omdala*[5]". Translated to "Rituals are lubricants allowing smooth movement to adulthood". It is believed among the Zulu people that marriage is not what it is without these rituals. The couple and the marriage are exposed to misfortune and troubles, such as bareness and discouragement, if traditional rituals do not occur[6].

In Zulu tradition, getting married is a cultural expectation when you have reached cultural maturity. Ubaba Zikhali, a Traditional Health Practitioner from uMkhanyakude, elaborated this:

> *"Lapha abantu abashadile baqala ukwakha umkhaya owengeziwe kunokwakha umuntu ngamunye. Ukugxila kuncike ekubeni umuntu ngamunye kodwa kube sekwakhiweni komphakathi nomphakathi wonkana."*

According to Ubaba Zikhali, when you have reached the right age to get married, the family's focus ceases to be on you as an individual but on the growth and the welfare of the family.

[5] FGD in Mtubatuba local municipality, 06 December 2017
[6] Informal conversation with Ayanda Zikhali, Mtubatuba local municipality, 06 December 2017

When probed to elaborate more on the issue of marital status in traditional medicine, Ubaba Zikhali expressed the view that the marital status of a traditional healer plays a significant role in the community, especially when the healer is in consultation with clients of the opposite sex. In the traditional healing setting, marital status would impact the healer–client relationship and affect the overall quality of healthcare delivery, particularly concerning trust issues. There is a tendency for married traditional healers to be more trusted by their clients than their single counterparts.

Table 5.6 shows the comparative percentage marital status distribution of the ATHPs' research participants' clients in the study district municipalities.

Table 5-6. Comparative Percentage Marital Status Distribution of the African Traditional Healthcare Practitioners' Clients in the Study District Municipalities

uGu District			**uMkhanyakude District**		
Marital Status	**Frequency**	**Percentage**	**Marital Status**	**Frequency**	**Percentage**
Single	46	32	Single	28	22
Married	94	63	Married	87	70
Widow/er	10	08	Widow/er	10	08
TOTAL	150	100	TOTAL	125	100

Table 5.6 shows that most ATHP research participants' clients in the uGu district municipality (63%) and in the uMkhanyakude district municipality (70%) were married. In-depth interviews and FGDs with ATHP clients in both study areas revealed that most of the ATHP client research participants considered marriage leading to motherhood. According to Nokwazi Mtshali, an ATHP client participant in the uGu district, Zulu rites of passage into motherhood were usually conducted within formally recognized marital unions. Single mothers were considered to have lost their female value in society and were not expected to advise other women and girls on marital issues in the traditional Zulu community. These views were equally expressed by Umama Ndlovu, a 58-year-old traditional healer, who argued that because of having children before marriage, single mothers tended to be perceived to have lost their responsibilities of preserving cultural values. She thus stated:

> *"Yini ongayifunda kumuntu ohlulekile ukuba nomndeni? Ngeke umethembe umuntu onjalo ngoba izeluleko zakhe zingadukisa. Sizobazi ngezithelo zabo."*

Umama Ndlovu believed that one cannot learn anything from someone who failed to have a family. Such a person cannot be trusted because her advice could be misleading.

The focus group discussions revealed the general opinion that one's marital status carried exclusive cultural privileges outside marriage. For instance, a woman who had a child before marriage was considered a disgrace to the family and society. Hence, she lost the respect of both the family and society. Umama Mlambo, an ATHP from uMkhanyakude, had the following to say:

> *"Uhlonishwa emndenini wakho nomphakathini wakho kuphela uma ushadile. Uma kwenzeka ukuthi uhlale ungashadi noma uhlukane nomyeni/nkosikazi wakho, uyayeka ukuhlonishwa. Ukuze kuvikeleke isithunzi somndeni, abesifazane bagqugquzelwa ngabadala ukuthi babekezele, baphikelele futhi basebenzise konke ukugcina umshado emakhaya imile. Kuhlala kunjalo ukuthi abadala bazokutshela ukuthi akekho umuntu wesilisa ophelele emhlabeni, yingakho kungekho mshado ophelele njengomphumela. Owesifazane uzokufa ukugcina indlu yakhe iphila. Ngenxa yokuthatha lezozeluleko, abesifazane abaningi badonsa kanzima ngokomuzwa futhi balahlekelwe izimpilo zabo beshiya izingane ngemuva nje ngoba befuna ukufihla ihlazo lomndeni [7]."*

According to Mama Mlambo, one earns respect from family and community through marriage. It was considered a person's (male and female) rite of passage and an important societal institution. Hence, if a person remained single or was divorced or separated from a spouse, they tended to lose respect in the family and community. Hence, to protect the dignity of the marriage and family, patience was encouraged as a value in marital relations. The common advice from elders to young people during marriage preparation was that no husband or wife is perfect. Hence, a woman might endure the pains of a marriage relationship due to family expectations.

Tables 5.5 and 5.6 revealed that most ATHPs and their clients were married. Due to these family and community expectations on the sanctity of the marriage institutions and its challenges, young people, especially young women, were thoroughly prepared for married life. They were taught about the responsibilities of married life, including sex and procreation. Many rites and rituals were performed as part of the wedding ceremony. Of particular significance were rituals meant to purify or bless the couple. In the Zulu indigenous culture, traditional weddings are quite different and have distinctive stages. The first stage of Zulu marriage was the payment of lobola and its procedures, followed by *iZibizo*, where gifts were given to the bride's family. Then came the *uMbondo*, where the bride

[7] Conversation with Mama Mlambo, Mtubatuba local municipality, 06 December 2017

reciprocated by buying groceries for the groom's family, and lastly, the actual wedding or *uMabo* would take place.

Marriage rituals were very important during and after the traditional marriage ceremony. It was also after these ceremonies that the new bride was taught about the beliefs and practices of motherhood. The traditional Zulu wedding always took place at the groom's family home. The bride would leave her home early in the morning, covered in a blanket her mother gave her. The bride's father led her to her new family home. She was advised not to look back to avoid inviting bad luck. The bride's father will call out the family's clan names, telling the ancestors that his daughter is officially leaving home to join another family. On arrival at the groom's house, the bride had to walk around the house to be introduced to her husband's ancestors before entering the home through the kitchen, but nobody noticed her. The groom's family would pay a penalty for not being aware of the bride, and they should have gone to fetch her. The bride's family also came early, with the wedding ceremony starting around midday.

The groom traditionally bought two cows, slaughtered and eaten on the ceremony day. He also bought a goat that was slaughtered after the head of the family had spoken. The groom's father opened the ceremony by welcoming his new daughter, with the bride's father also saying some words to sign that he approved the union. After the ceremony, there was dancing and food. In comparison, gifts and money were given to the bride's family prior to the wedding. On the day of the *uMabo,* it was the bride's turn to give the gifts. The exchange of gifts symbolized forming a new bond between the two families.

The bride's family bought grass mats, blankets for the women, beer pots for the men, and some pieces of furniture and brooms, which were given out to guests at the wedding by the bridesmaids and sisters of the bride. The bride sat on a grass mat and refrained from talking or looking at anyone out of respect while her bridesmaids handed out the gifts. The names of the various people receiving the gifts were called out individually. The wedding guests would lie on the grass mats before being covered with a blanket by a family member from the bride's side. They then sang and danced as a sign of appreciation for the gifts. Older women would be called first, followed by the groom's sisters, and finally, the men. The groom would be the last person to be called.

After the groom has been called, the bride would get up and make a mock bed, then look for her husband. When she found him, she would place grass mats on the floor leading to the bed, where the groom would sit. The bride took a basin with a towel and soap and washed the groom's feet. She

then would pull back the bed covers for the groom to lie down. As part of the drama, the bridesmaids and other young ladies from the bride's side would hit the groom with small sticks, after which the groom would run away.

5.4.1 Marriage as a source of blessing from God

African marriages are a spiritual and social family affair, encompassing a combination of two lives or missions, two families, and even two communities (Malesa & Sekudu, 2022). There is a diversity of marriage traditions and systems in the African continent. They might not be identical, but they all share certain core values. Traditionally, the Rite of Marriage represents not only the joining of two families and even communities but also the joining of the two missions of the new couple. This means that in addition to performing marriage rites for the coming together of male and female to procreate, perpetuate life, and join families, it is also an institution to help the husband and wife fulfil their mission and objectives in life, ensuring that they are working together towards the same goal. A very high value is placed on marriage in traditional African societies. Baloyi (2022) indicates that marriage has always been viewed within the African context as an institution that cannot be detached from cultural and traditional value systems. According to him, the meaning and significance of marriage are understood within people's cultural affiliations, and these differ from one culture to another. Every society accepts marriage as vital in maintaining and sustaining that society. It is also a means through which humans can create a chain of human existence within the parameters of African indigenous cultural value systems. It plays a central role when two families, communities, or nations negotiate and legalize a marriage.

Because the focus is on the collective, it is not uncommon that full social standing and adulthood can only be achieved by marriage. In some societies, marriage is not recognized fully until the wife gives birth. In Zulu tradition, as in most African societies, marriage is a rite of passage, celebrated, respected, and held in high esteem. Ogoma (2014) indicates that in the African conception of marriage and Family, marriage occupies an important position in the affairs of Africans. Without marriage, there is no family; one cannot bear children without a family. The connection between marriage and family can hardly be separated among traditional Africans. He argues that a childless marriage cannot be considered a family from an African cultural perspective because a family consists of a man, his wife, and a child or children. Since the family is the basic unit of any political and social organization, erecting it should and was given serious attention among traditional African societies, especially in rural KwaZulu-Natal. For Zulu people, marriage is the focus of existence. It is the point where all the community members meet: the departed, the living, and those yet unborn.

Before a wedding occurs among the Zulu, even if there is only a white wedding (Christian wedding), the bride's family offers a sacrifice, slaughters a goat for her, and burns incense ("*shisa impepho"*). The oldest woman in attendance will spray "*impephu"* (closely associated with the ancestors) on the couple and other relatives to bless the new union. This is to tell the ancestors that their daughter will be a member of another family, and after the wedding, the groom's family should also welcome her with a goat. For *umabo*, the two families slaughter cows (one from each family) and exchange certain parts of the meat as part of Zulu tradition. Ayanda Zikhali, one of the research participants in Umkhanyakude District Municipality, explains*:*

> *"uMabo ubalulekile kakhulu kusiko lamaZulu. Umuntu akakashadi kahle kuze kube kwenziwa isiko lomabo. izithandanani ezingawenzanga lomcimbi ziba nenkinga ebudlelwaneni babo, noma ilwele ukuba nezingane. Impilo zezingane nazo zingathinteka, uthi kungani abanye abantu benze lolusiko ngisho ngemuva kokushona komyeni. Izingane zikwenzela nabazali bazo noma ngabe abazali babo bengasekho emhlabeni. Amadlozi akajabuli njengoba umabo ungenziwanga futhi abamuqali umkhwenyana wabo. lezizithandanani kudingeka ukuthi ziqhubeke nenqubo yokuhamba kweminyaka ngemuva kokuhlangana okokuqala, njengendlela yokujabulisa amadlozi. Kungokusebenzisa umabo kuphela ukuthi amadlozi awamukele umshado wazo[8]."*

Ayanda Zikhali explained that *Umabo* is a very important ritual in Zulu culture. A person is not properly married until the ritual of umabo is performed. Couples who do not perform this ritual will have trouble in their relationships or struggle to have children. Children's lives can also be affected, which is the reason why some people have performed this tradition even after the death of their husbands. Children perform it as well for their parents, even if their parents are dead. The ancestors are unhappy as *umabo* was not done, and do not recognise their daughter-in-law. The couple will have to go through the process of "*umabo*" years after they first get together, as this is a way of appeasing the ancestors. Only through the performance of "*umabo*" will the ancestors recognize their marriage.

Research participants in both study areas revealed that "*uMabo"* was considered the final and most important ritual before a Zulu couple could be considered traditionally married. It is traditionally considered in the Zulu culture that *uMabo* is a ritual that brings together families. In the process, the

[8] Conversation with Ayanda Zikhali, Mtubatuba local municipality, 06 December 2017

bride is also told what her family and in-laws expect of her. This tradition is how ancestors recognize the bride; they are believed to bring good luck. It is also a beautiful tradition where people showcase their traditional attire, sing, and dance. It brings together different elements of the Zulu culture.

While the role of marital status is minimal, it has more influence on becoming a traditional healer. During the qualitative interview, it was revealed that despite marital status playing a limited role, it influences client perception of traditional healers and their standing in the local community about their practice. Examining the marital status of the participants, the findings have shown that 36% and 48% of traditional healer and client participants were single, respectively. There are many reasons to believe that, given the cultural beliefs of the Zulu and other African communities, single people are perceived to be young. This shows that young people are also actively involved in the study areas' cultural practices of medicine and healing systems.

While marital status and its role in the traditional healing profession is discussed, it is worth noting that marriage in the Zulu community, like any other African community, plays a critical role, mainly as married people are considered to have some sense of maturity and responsibility. They do play a critical role in the community's leadership. Many of the women in the study presented interpretations of marriage, which appears as an obligation to the patriarchal nature of the Zulu custom. Research participants also revealed that married men and women continue to command far greater respect than their counterparts who are not married in Zulu society. One could even argue that from the perspective of the Zulu people interviewed, a male or female only becomes a "man" or "woman" by being married. High respect for tradition, cultural pride, and the wish to live a dignified life were significant elements of Zulu manhood and womanhood. Throughout history, Zulu women who were married and bore children have received considerable recognition in the community, gained status, and were given certain domestic powers. The social and linguistic Zulu custom known as "*ukuhlonipha"* (to show respect) is directly linked to Zulu marriage. It regulates, to a large extent, the power dynamic between Zulu men and women. This is supported by Fandrych (2012). Who points out that in a patriarchal African cultural system, marriage changes the position of a woman from being the responsibility of her parents to being the responsibility of her husband and his family.

Participants in this study, particularly women, viewed "*ukuhlonipha"* as the desired component in marriage. Marriage is taken as a sign of "*inhlonipho"* (respect), in the sense that the bride and the groom respect their culture and each other and the parents, the extended family, and the community. Once you are married, you gain respect in the family and the community – as one married female research participant explained: When you are married, all your family and friends respect you. *"Uma*

ushadile, wonke umndeni wakho nabangane bayakuhlonipha". One interviewee, an unmarried woman, went as far as to say that *"owesifazane ongashadile akahlonishwa*" i.e., a woman who is not married is not respected.

A married Zulu man and woman gain significant social status in the family and community, and this position was extremely important to all the research participants. In this context, marriage was perceived as a reward for "good" behaviour. Traditional African health practitioners have expressed having a common doctrine, which is appropriately called "*ukuhlonipha amasiko"* in Zulu, which can be loosely translated as meaning to promote and respect Zulu cultures. Traditional Health Practitioners also expressed practising and promoting "*ukuhlonipha"* when they meet, during consultations, and traditional ceremonies.

Female participants viewed marriage as a reward for behaving well and providing a man and woman additional value. One feature that repeatedly emerged from the data is that "*ukuhlonipha"* is seen that women assume sole responsibility for the household and childcare, regardless of whether they are themselves in paid employment as one married female explained: "*Kunezindlela eziningi zokubonisa inhlonipho. Umfazi olungileyo kufanele anakekele indlu. Kumele aphekele umyeni wakhe. Udinga ukuqiniseka ukuthi umyeni uthola ukudla okufudumele nsuku zonke*" i.e. "There are many ways to show respect. A good wife should take care of the household. She must cook for the husband. She needs to make sure that the husband has a warm meal every day". Although some Christian research participants expressed that they do not practice certain Zulu cultural rituals (such as the slaughtering of animals), marriage is widely regarded as a cultural rather than a spiritual requirement among the Zulu people. However, for most study research participants, marriage is the combination of culture and spirituality that makes the customs and religion so prominent.

5.5 Religious Affiliation of Research Participants

African traditional religion is an important basis of traditional medicine. According to Manganyi and Buitendag (2013), religion refers to a meaningful relationship between the human entity and the Supreme Being, which always dovetails into traditional medicine and healing as an art of restoring and preserving health. Religious beliefs are a generalized system of ideas and values that shape how members of a religious group understand the world around them. Religion, therefore, constitutes an important part of millions of people's lives across the globe. It is an essential element of the human state and culture in particular. It is a social-cultural system of specific behaviours, practices, morals,

worldviews, or organizations that relate humankind to supernatural, transcendental, or spiritual elements (Business of Religion, 2022).

Focus group discussions with research participants from study district municipalities revealed an understanding of the symbiotic relationship between Zulu religious belief systems and practices and the institution of Traditional medicine and healing. Research participants expressed Zulu traditional religion and healing practices as a connection to the ancestors who guided the living and provided a sense of security and order in the community. Thus, according to them, the concept of health and illness in society is filtered and interpreted through religion, culture, and indigenous worldviews of the interdependence between humans, nature, and the spiritual worlds.

According to them, health and illness have a broader dimension, including the religious, cultural, and ecological components. Like other African traditional communities, the Zulu people had diverse ritual practices to ensure good health, prevent danger to health, cure afflictions, remove impurities in people and homesteads, and protect people, their animals, and crops. They understood health and illness not just as physical conditions but also as being linked to the beliefs and practices of the Zulu traditional religious belief system. Hence, health and illness must be dealt with within Zulu religious-cultural traditions and practices.

Ubaba Sibiya explains*:*

> *"Uma ngikhuluma ngenkolo, ngibona ubudlelwano bomuntu siqu nendlela yokuphila eveza amasiko esintu samaZulu. Ngenkolo uyakwazi ukuqonda amasiko nezimiso zenhlalo yamazulu."*
>
> When I talk of religion, I see a personal relationship and a way of life that expresses Zulu human culture. Through religion, you can understand Zulu rituals and social values.

According to Baba Sibiya, for a long time, religion was understood in a Western worldview, separated from the guidance of ancestors and traditional spiritual and healing systems. Research participants in both uGu and uMkhanyakude district municipalities stressed that among the Zulu people, religious beliefs have always played and continue to play an important role in many social practices, including traditional medicine and healing, agriculture, cultural ceremonies, economy, and financial matters. People prayed to their ancestors for good health, good rains and harvest, employment opportunities, and business endeavours.

For instance, Umama Mtshengu[9], a Traditional Health Practitioner from the uGu district municipality, indicated that the spirit called her to be a sangoma. She referred to her calling or "*ubizo*" as an important ancestral, cultural, and religious responsibility, after which she was thrown into a state of unconsciousness for several days before she could have had strange dreams and visions forming part of her calling. When she accepted the calling, she had to undergo the "*ukutwasa*" as part of the initiation process where religious rituals were performed. The training and initiation process included performing rituals and tasks that cure that individual's body and instruct the healing power of herbs and traditional medicine. Upon completing the initiation, a feast was held where a goat was slaughtered as a sacrifice to the ancestors. The participant could then search the ashes for an unbroken bone that became part of the sangoma's "*dingaka"*, or oracle bones, to be used in divination. Umama Mtshengu said:

> *"Sifunda umlando womphakathi kanye nesiko ngoba singabelaphi futhi singabagcini bolwazi olungcwele. ngabe senginikwa amandla nobuholi obuyimfihlakalo ngamadlozi."*

Mama Mtshengu indicated that as Zulu healers and custodians of the sacred knowledge of the tribe, they had to learn and know its history and traditions, as communicated by the ancestors. This implies that Zulu's traditional medicine and healing practices are symbiotically linked to religion and spirituality, especially the role of ancestral spirits. Interviews with the ATHP research participants showed two distinct types of sacrifice performed in Zulu culture, i.e. the thanksgiving or '*ukubonga'* and the scolding sacrifice "*ukuthetha"*. "*Ukubonga"* takes place when something good has happened, such as when a boy reaches puberty, when there is enough food, or when life in the "*umuzi*" or home has gone smoothly and there has been little or no sickness. Meanwhile, the "*ukuthetha*" takes place when people of the "*umuzi"* die unexpectedly or when things seem to go wrong and the individual feels victimized. Sacrifices of cattle or goats are performed according to appropriate cultural rituals and strict observations of cultural procedures and protocols. It is believed that sacrificial giving may be of no good and can bring about a family curse if all the rules and procedures are not observed.

Furthermore, the Zulu also believe in a supernatural being called "*Unkulunkulu*", believed to have 'sprang from a bed of reeds. Zulu people believe that "*Unkulunkulu"* brought humans and cattle from an area of reeds. He created everything, from land and water to man and animals. He created all wild animals, snakes, birds, water, mountains, the sun, the moon, etc. He is considered the first man and

[9] Interview with Mama Phumla Mtshengu, Hibiscus Coast local municipality, 27 March 2018.

the parent of all Zulu people. He is believed to have taught the Zulu people how to hunt, make fire, and grow food (Leeming and Leeming, 2009).

The ATHPs research participants revealed that according to Zulu traditional beliefs, human beings have a body "*umzimba*", a spirit or soul "*idloz*", the heart or feelings "*inhliziyo*", the brain, mind, understanding "*ingqondo"* and the shadow, personality "*isithunzi*". The "*isithunz*i" becomes the ancestral spirit after death, but only after the "*ukubuyisa*" (to reconcile with the dead) ceremony has been performed. This is a ritual ceremony during which Zulu believe the spirit is 'brought back home'. "*Ukubuyisa"* is a Zulu traditional ceremony performed a year after death to call back the departed spirit and integrate it into the community of ancestral guardian spirits. The spirit is ritually brought back to be mysteriously present and guard all the living members of the family.

5.5.1 Spirituality as a Source of Healing in Zulu Culture

In-depth interviews and focus group discussions with the ATHP research participants revealed the interrelatedness and interdependence between Zulu traditional medicine and healing with spirituality. The Sangomas (diviners) are regarded as intermediaries between the living and the spirit world, especially the ancestral spirits. The latter are intermediaries with *Unkulunkulu* (The Greatest One). Consequently, the ancestral spirits are praised, and offerings are made to them. Should something untoward occur, the sangoma (diviner) is consulted to determine whether the event has been caused by witchcraft (in which case there is a witch-hunt) or failure to appease the spirits. In the latter case, a sacrifice is made whilst complaining at the apparent attitude of the spirit. Spirits are also thought to exist in animals in the forest and caves. A female spirit called "*inkosazana*" in Zulu is thought to make maize grow and is fêted in the spring. It is believed that all ancestors must be kept in the memory of the family through religious ceremonies; otherwise, if forgotten, they may seek to be remembered by bringing trouble to the family and the local community. For example, these are the words of Umama Sibiya, a traditional healer in the uMkhanyakude district municipality, on the dangers of "*umsamo*" or Platform for sacrifice:

> *"Umuntu ongathembekile akayishisi impepho futhi nesilwane abamhlabisi ngoba uzocwiya bese aphendule umsamo konakale izinto emndenini."*

Umama Sibiya warned about the dangers of unfaithful performing rituals such as burning incense or slaughtering a sacrificial animal. This can cause danger to the family.

During the in-depth interviews, Umama Mabube Mnguni, a traditional healer from uMkhanyakude, shared her dream experiences at night or during the day when she was having a nap as one way of communicating with her ancestral spirits. During that moment, messages from ancestors were communicated to her, including types of medicinal herbs to use in her practice. She woke up, went to specific places, and collected the plants for healing as directed. Besides guiding her in identifying and using medicinal herbs, the ancestral spirits also indicated to her the state of the clients who would come for a consultation, even before their visit. These were her words:

> *"Ebusuku noma emini ngangiphupha ngibone okhokho bami bekhuluma. Idlozi lingikhombisa isimo samaklayenti azongibona ngaphambi kokuvakasha. Idlozi lingikhombise izindawo nezinhlobo zezitshalo engizozisebenzisa njengomuthi wokwelapha isiguli esizayo. Idlozi lizongikhombisa nokuthi izitshalo zisetshenziswa kanjani noma zixutshwa kanjani. Ngangivuka ngiye ezindaweni ezithile ngiqoqe izitshalo ngizisebenzise njengokuyalelwa. Ngenxa yalokho, iziguli zizophathwa ngendlela eqondisiwe futhi ukuphulukiswa kuzoqinisekiswa."*

Umama Mabube Mnguni indicated that she would have a dream at night or during the day and see my ancestors talking to me. The ancestor shows her the state of the clients coming for a consultation before the visit. The ancestor also showed her the locations and types of plants to use as medicine to treat the coming patient. The ancestors would also show her how to use or mix the plants. She would wake up and go to specific places, collect the plants and use them as directed. As a result, patients would be treated as directed, and healing would be certain.

On the issue of working with Western medicine, ATHP research participants expressed their belief that despite the divergent worldviews and the current state of global health challenges, the different healthcare systems needed one another for improved human healthcare. For them, local communities in both study areas preferred traditional medicine and healing systems to modern medicine because of their links with the ancestors who holistically guided the client's health.

Table 5.7 shows the comparative percentage distribution of the religious affiliations of the research participants, African Traditional Healthcare Practitioners, in the study district municipalities.

Table 5-7. Comparative percentage distribution of the religious affiliations of the African Traditional Healthcare Practitioners (ATHPs) research participants in study district municipalities, KwaZulu-Natal Province

uGu District			uMkhanyakude district		
Religious Affiliation	Frequency	% Distribution	Religious Affiliation	Frequency	% Distribution
Roman Catholic	02	07	Roman Catholic	01	04
Zion Christian	03	10	Zion Christian	04	16
Ibandla lamaNazaretha/ Shembe)	06	20	Ibandla lamaNazaretha/ Shembe)	02	08
African Traditional Religions	19	63	African Traditional Religions	18	72
	30	100		25	100

Table 5.7 shows that most ATHP research participants in the uGu district municipality (63%) and the uMkhanyakude district municipality (72%) were affiliated with African Traditional Religions. African traditional religion refers to the indigenous or autochthonous religions of the African people, particularly the Zulu (Olupona,2014). It deals with their cosmology, ritual practices, and associated symbolism in their respective cultural communities.

Table 5-8. Comparative percentage distribution of the Religious Affiliations of the African Traditional Healthcare Practitioners (ATHPs) Research Participants' Clients in the study district municipalities

uGu District			**uMkhanyakude district**		
Religious Affiliation	**Frequency**	**% Distribution**	**Religious Affiliation**	**Frequency**	**% Distribution**
Roman Catholic	20	13	Roman Catholic	16	13
Pentecostal	06	04	Pentecostal	01	01
Muslim	02	01	Muslim	00	00
Jehovah's witness	08	05	Jehovah's witness	03	02
Anglican	04	03	Anglican	03	02

Ibandla lamaNazaretha/ Shembe)	46	31	Ibandla lamaNazaretha/ Shembe)	54	43
African Traditional Religions	34	23	African Traditional Religions	37	30
No Influence	15	10	No Influence	05	05
None	15	10	None	06	05
Total	150	100	Total	125	100

Table 5.8 shows that the largest number of the ATHPs research participants' clients in the uGu district municipality (31%) and in the uMkhanyakude district municipality (43%) were affiliated with the Ibandla lamaNazaretha/Shembe. This was followed by affiliation to African Traditional Religions (23%) in uGu district municipality and (30%) in uMkhanyakude district municipality. The Shembe religion combines Zulu culture and Christianity based on the Old Testament.

Some of the clients, during in-depth interviews, expressed the fact that despite being Christians, they still believed in preserving their African Ubuntu values, including performing their African traditional rituals and customs, which included ritual practices such as "*ukubuyisa", "imbeleko"* (ritual inclusion of babies into the clan), "*ukwaluka"* (rite of passage into adulthood), and visiting of traditional healers to seek guidance from ancestors. For instance, Umama Mzizi had the following to say:

> *"NgingumKristu osanda kuzalwa. Ngaphandle kokuba yingxenye yalenkolo, kumele ngilandele isiko lamaZulu namasiko ethu. Umuntu ngeke alahle usiko lakhe namasiko akhe. Yebo, ngiyakholelwa enkolweni kodwa kumele ngilandele konke okuhle ngesiko. Isibonelo, inkolo yobuKristu iyenqabela ukuhambela abelaphi bendabuko. Amanye amalungu omndeni wami, abangane kanye nami, asitholanga lutho olungalungile ngokuhambela abelaphi ngokwesiko siyofuna izeluleko kokhokho. Ngenza yonke imicikilisho namasiko ama-zulu. Ngisazijwayeza ukubuyisa, imbeleko, ukuluka…*[10]*."*

Mama Mabube Mnguni indicated that although she was a born-again Christian, she was expected to conform to Zulu cultural traditions as one could not abandon their cultural values. She had to follow all she considered good in African values and practices. She could not just follow all that Christianity preached. She pointed out, for example, that Christianity prohibited visiting traditional healers, but

[10] Informal conversation with Ms Melody Mzizi, Umdoni local municipality, 26 March 2018.

she did not find anything wrong with visiting traditional healers. All her family members and friends consulted traditional healers to seek guidance from their ancestors. She, therefore, practised the practices of "*ukubuyisa", "imbeleko",* and "*ukwaluka".*

For example, during one of the FGDs in the uGu district municipality, Mama Nciki identified herself as a traditional healer and a believer in African traditional religion. During the FGD, she reacted with an ironic smile when some of the participants, also her clients, identified themselves as Christians. During in-depth interviews, Mama Nciki thus commented:

> *"Abakholoni baletha ubuKristu nabo futhi babuphoqa kubantu bakithi ngokuguqulwa kokuzikhethela. Ngoba ukuguqula kungokuzikhathela, asisoze sayeka izinkolelo nemikhuba yethu yomdabu. Amanye amaKristu aguqukile agula ngengqondo futhi anquma ukushiya ngokuphelele amasiko ethu. Abasazenzi izinkambiso zamaZulu ngoba manje sebethathwa njengabanamadimoni. Bakhohlwa ngisho namasiko abo abazalelwe futhi abakhulela kuwo. Kodwa okwamanje uma beshayiwa ukugula kanye nezinkinga kugadla emakhaya abo, beza kithi bezothola imithi yamakhambi futhi benze imikhuba efanayo naleyo ababeyithatha njengokubi. Labo abazibeka njengamaKristu yibona abahlala befuna usizo kubelaphi bendabuko ngasese ngoba abasavikelwa okhokho bethu. Iningi lamakhasimende engiwabona iningi lesikhathi angamaKristu. Uma beza kimi angibaphathi ngendlela ehlukile kodwa ngiyabamukela futhi ngikhonze ngaleso sikhathi njenganoma yiliphi elinye ikhasimende. Ngaso sonke isikhathi kunesidingo sokuwaxhuma kokhokho futhi ngenxa yokuxhuma okuxegayo okubangela ishwa isikhathi esiningi. Kunzima kwesinye isikhathi ukuziqonda, kodwa ngoba izinto sizitshela njengoba zinjalo futhi asifihli lutho ngoba siyaziqhenya ngalokho esikholelwa kukho ngokungazenzisi*[11]*."*

Mama Mabube Mnguni expressed the experience that some community members identified as Christians. Still, the moment misfortunes, sickness, and problems strike their homes, they go to traditional healers for assistance to get herbal medicines and perform the same rituals they were considered evil.

5.6 Chapter Summary

Chapter Five presented and discussed the socio-demographic characteristics of the research participants from their Zulu cultural perspectives, with special reference to research participants from

[11] Discussion with Mama Nciki, Umuziwabantu local municipality, 26 March 2018.

uGu and uMkhanyakude district municipalities in KwaZulu-Natal province, South Africa. The study sought to obtain the cultural meanings that the research participants, as ATHPs and their clients, attached to the socio-economic and demographic variables such as age group, gender, marital status, and religious affiliations healing in the context of traditional medicine.

Chapter Six: Comparative Local Community Members' Knowledge, Awareness, and Perceptions Regarding Indigenous Knowledge Systems and African Traditional Medicine Policy Landscape in South Africa

6.1 Introduction

In 2004, the Post-apartheid government adopted the National IKS Policy. It provides an enabling framework to stimulate and strengthen the contribution of indigenous knowledge to social and economic development in South Africa. Conradie and Du Toit (2015) indicate that knowledge institutions created during and before the apartheid era are still being transformed to express an African intellectual personality. The Policy seeks to creatively advance the course of IKS within the context of complex economic, social, and cultural rights. Therefore, the main objective of the policy was to reverse the injustices of the past and ensure proper protection of African indigenous knowledge and value systems. In the past, there had been a lack of recognition of existing IKS communities of practice and a lack of understanding of the importance of IKS in sustainable community livelihood and development. This was in line with the African renewal call and its activities, which emphasizes the significance of IKS as to provide Africans with both the intellectual and raw material through which the task of reconstructing African societies along African ways of knowing, value systems, and practice can be made possible and attainable.

Mokhutso (2021) and Obiero et al. (2023) look at the benefits of African indigenous knowledge systems and practices by pointing out that Africans, in their specific cultural and creative ecosystems, can understand, handle, and maintain these knowledge systems and practices, better than introduced western practices and technologies. Further still, African indigenous knowledge, including traditional medicine and healing practices, draws on local resources. People and local communities depend less on outside sources, which can be costly, scarce, and irregularly available. Although it is adaptable and can interface with other knowledge systems, IK provides effective alternatives to Western technologies.

6.2 Knowledge, Awareness, and Perceptions of African Traditional Health Practitioners (ATHPS) Research Participants on The IKS Policy (2004)

It is based on the above considerations that the study first wanted to establish from the research participants (both African Traditional healthcare Practitioners and their clients) in both study district municipalities (uGu District Municipality and uMkhanyakude District Municipality) regarding their knowledge, awareness, and perceptions on the South African National IKS Policy (2004) landscape. The comparative results are shown in Table 6.1 and Table 6.2, respectively.

Table 6-1. Comparative Percentage Distribution of Knowledge, Awareness, and Perceptions of African Traditional Health Practitioners (ATHPS) Research Participants on the IKS Policy (2004) in the study District Municipalities

1. Total Number of Male ATHP Participants in uGu District Municipality (12);
   Total Number of Female ATHP Participants in uGu District Municipality (18);
2. Total Number of Male ATHP Participants in uMkhanyakude District Municipality (10);
   Total Number of Female ATHP Participants in uMkhanyakude District (15).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	05	38%	Male	07	62%	Male	03	30%	Male	07	70%
Female	02	11%	Female	16	89%	Female	03	20%	Female	12	80%

Table 6.1 reveals that most of the ATHP research participants (male and female) in both study district municipalities expressed the view that they were unaware of the National IKS Policy (2004). Table 6.2 shows the percentage distribution of knowledge and awareness of African Traditional Healthcare Practitioners (ATHPs) clients on the IKS policy (2004) in the study district municipalities.

Table 6-2. Comparative Percentage Distribution of Knowledge, Awareness, and Perceptions of African Traditional Health Practitioners (ATHPs) Clients on the existence of the IKS Policy (2004) in the study District Municipalities

1. Total Number of Male ATHP Clients in uGu District Municipality (62);
   Total Number of Female ATHP Clients in uGu District Municipality (88);
2. Total Number of Male ATHP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female ATHP Clients in uMkhanyakude District (77).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	25	40%	Male	37	60%	Male	18	38%	Male	30	62 %
Female	21	24%	Female	67	76%	Female	08	10%	Female	69	90%

Table 6.2 reveals that most of the ATHP research participants' clients (male and female) in both study district municipalities were also unaware of the National IKS Policy (2004). During the focus group discussions and in-depth interviews in both study district municipalities, it was expressed that until now, the promotion and implementation of the National IKS Policy (2004) has been predominantly a national imperative. There are still limited, if any, provincial and local structures established to build knowledge and awareness among people at the grassroots level on the IKS National Policy (2004).

The study wanted to know from the research participants, both ATHPs and their clients, in both study district municipalities, their knowledge, awareness, and perceptions on why the post-apartheid government in South Africa adopted the IKS Policy in 2004. The responses were established during focus group discussions from ATHPs and their clients in both study district municipalities. It was generally indicated that the main reason for the post-apartheid government to adopt the IKS policy (2004) was to reverse the past injustices and ensure proper protection and promotion of African indigenous knowledge systems, which were marginalized in the past, limiting their contribution to sustainable development. During colonialism and apartheid, there was a lack of recognition of existing African worldviews, ways of knowing, and value systems. This included a lack of understanding of the importance of African indigenous Knowledge Systems in the sustainable community livelihood of the African people in their diversity of cultures and linguistic domains. Some participants, ATHPs, and their clients knew that the IKS Policy (2004) resulted from interdepartmental efforts to create guidelines for recognizing, understanding, integrating, and promoting South Africa's wealth of indigenous knowledge resources across cultures. The participants also expressed the reasons and benefits of protecting these local community-based knowledge systems:

For example, on the Equity, Gogo Gumbi, a Traditional Health Practitioner in uGu District Municipality, had the following to say in the isiZulu language:

> *"I-Afrika yindawo lapho abantu bomdabu, kuhlanganise nami, kanye nendawo yethu yemvelo nengokomoya ziye zajwayelana ndawonye emakhulwini eminyaka. Abantu base-Afrika ngokwehlukahlukana kwabo kwamasiko nemvelo, bayaqaphela ukuthi abahlukene, kodwa bayingxenye yezinhlelo zemvelo ezixhumene, ezingokwenyama nezingokomoya.. Asiyona nje ingxenye yalezi zinhlelo ezixhumene nezincikene, kodwa sinesibopho ekugcineni lobu budlelwano obuseduze. Inani Lolwazi Lomdabu, ikakhulukazi ekusetshenzisweni kwalo ekuqondeni izinguquko zezinhlelo, liya ngokuya liqondwa kangcono umphakathi wesayensi*

waseNtshonalanga ngenxa yezimo zemvelo ezishintsha ngokushesha, ikakhulukazi ukushintsha kwesimo sezulu. Thina, ma-Afrika kanye nomphakathi wesayensi yaseNtshonalanga sinomsebenzi wokuqinisekisa ubudlelwano obulinganayo phakathi kwabantu nalezi zinhlelo zemvelo nezomoya ocwaningweni, isayensi, inqubomgomo, kanye nokubandakanya umphakathi."

Gogo Gumbi believed that indigenous people, including herself, in Africa, and indigenous natural, cultural, and spiritual environments have symbiotically adapted together for centuries. In their diversity of cultures and ecosystems, African people recognize that they are not separate from but rather a part of the interconnected natural, physical, and spiritual systems. Humans are part of these interrelated and interdependent systems and have responsibilities in maintaining this intimate relationship. The value of Indigenous Knowledge systems, particularly towards its application in understanding the dynamic and changing systems, is increasingly becoming better understood by the Western scientific community due to rapidly changing environmental conditions, especially climate change. Hence, the African and Western scientific communities must ensure equitable relationships between humans and these natural and spiritual systems in research, science, policy, and community engagements.

Andile Zulu, a THP's client in uMkhanyakude said on Indigenous Knowledge and Equity:

"Iqhaza elibanjwe ulwazi lwendabuko (IK) emiphakathini yethu yasendaweni nasemphakathini wonkana, ngeke ibukeke phansi. Ngaphandle kokuqinisa ukwehlukana komuntu ngamunye nomphakathi, izinkolelo nemikhuba yawo kuthiwa ibambe izibopho eziqinile zamasiko nezenhlalo kumalungu awo ukukhuthaza inhlalakahle. Ngesikhathi sobukoloniyali kanye nobandlululo, imikhuba yendabuko kanye nezinhlelo zegugu ezagcina imiphakathi kanye nemindeni yama-Afrika ndawonye, zaqhubeka nokuwohloka, okuholele ekungalinganini okukhulu, ubumpofu kanye nokucekelwa phansi kwemvelo. Ukugudluzwa kwezinhlelo zezomnotho zoMdabu wase-Afrika kanye nokwamukelwa kwezinhlelo zezomnotho zongxiwankulu ezikhuthaza umuntu ngamunye futhi ezigqugquzela inzuzo kwadala izinkinga zenhlalonhleko yezomnotho kanye nezemvelo emiphakathini yase-Afrika. Lokhu kungalingani kungancishiswa ngokwamukelwa kwezinqubo zezomnotho zoMdabu wase-Afrika kanye nezinhlelo zenani elihlobene."

According to the ATHP, Andile Zulu, the role played by Indigenous knowledge (IK) in the local communities and society as a whole cannot be underestimated. Besides strengthening the individual

and community's distinctiveness, its beliefs and practices are credited for holding strong cultural and social obligations on its members to promote well-being. During colonialism and apartheid, Indigenous practices and value systems, which kept African communities and families together, continued to crumble, leading to massive inequalities, poverty, and ecological destruction. The displacement of the African Indigenous economic systems and the adopting of individualistic and profit-motivated capitalist economic systems created socioeconomic and ecological crises in African societies. These inequalities could be mitigated by adopting African Indigenous economic practices and associated value systems.

Gogo Madlopha, a Traditional Healer from uGu District Municipality, expressed the significance of IK holders and practitioners on IK and Biocultural and Spiritual Diversity Conservation. She argues:

> *"Izinhlelo Zolwazi Lwendabuko Yase-Afrika zixhumeke ngaphakathi emibonweni yomhlaba yabanikazi bolwazi kanye nobudlelwano kanye nobudlelwano endaweni yabo yemvelo nengokomoya. Izindlela ezisekelwe kumalungelo ezivamile azikuqapheli lokhu kuxhumana ngakho zikhawulelwe ekuvikeleni ubuqotho bolwazi lomdabu. Kunesidingo sokuthi izinhlelo zolwazi okungezona ezase-Afrika zibone ukuthi abantu base-Afrika ngokwamasiko abo ahlukahlukene kanye nemvelo amakhulu eminyaka babenokuqonda kwabo ngemvelo, izindlela zokongiwa kwemvelo, kanye nezinhlelo zokuphatha izinsiza."*

Gogo Madlopha believed that African Indigenous Knowledge Systems and the worldviews of knowledge holders and practitioners are inextricably linked to their interactions with their natural and spiritual surroundings. Because mainstream rights-based approaches do not acknowledge this interdependence, they can only be used to safeguard Indigenous Knowledge's integrity. Non-African knowledge systems must acknowledge that African people have long had unique ecological understandings, conservation strategies, and resource management systems due to the diversity of their cultures and ecosystems.

Ubaba Mhlongo, a Traditional healer from uMkhanyakude District Municipality, says:

> *"Ulwazi lwendabuko lwase-Afrika kanye nokwehlukahlukana kwezemvelo nezomoya kuyizinto ezihambisanayo ezibalulekile ekuphileni nasekuthuthukisweni komphakathi esimeme. Ulwazi lwendabuko, ikakhulukazi esimweni sase-Afrika, lapho sincike kulezi zinhlelo zolwazi kanye nemithombo yethu yemvelo ukuze siziphilise, seluvame ukubukelwa phansi ekuthuthukisweni kwenqubomgomo kanye nohlelo lwezemfundo, ngamakholoni kanye*

nobandlululo. Nokho, namuhla, inani elikhulayo lohulumeni base-Afrika kanye nezinhlangano zentuthuko yamazwe ngamazwe ziyaqaphela ukuthi lolu lwazi nezinhlangano zasendaweni, zinikeza isisekelo sezindlela zokubamba iqhaza emazingeni aphansi entuthukweni engabizi kakhulu futhi esimeme. Isibonelo, ukugcinwa ngokucophelela nokongiwa kwemithombo yemvelo ehlukahlukene kanye nezinhlelo zolwazi nenani elihlobene phakathi kwemiphakathi yase-Afrika, ikakhulukazi ngabesifazane, ezitshalweni nasezifuyweni ezifuywayo nezingezona ezifuywayo kuyizimpawu zezinhlelo zokulima zomdabu zase-Afrika. Lokhu kunikeza ithuba elibalulekile lokugcinwa ngendlela ehlelekile kwezinsiza zofuzo."

According to Ubaba Mhlongo, the development of sustainable community livelihoods depends on the complementary phenomena of biocultural and spiritual diversity and African Indigenous knowledge. Indigenous knowledge has historically been marginalized in the creation of policies and the educational system as a result of colonization and apartheid, particularly in the African context, where we rely on these knowledge systems and our natural resources for subsistence. However, many African governments and international development organizations realize today that these local organizations and knowledge offer the groundwork for sustainable and affordable grassroots participatory approaches to development. African indigenous farming, for example, is characterized by the meticulous maintenance and conservation of the diversity of bio-cultural resources and the related knowledge and value systems among African communities, particularly by women, in domesticated and non-domesticated plants and animals. This provides an important opportunity for systematic in situ-maintenance of genetic resources.

Gogo Qwabe from uGu District Municipality added:

"Ulwazi loMdabu lwase-Afrika lunethuba lokuba ithuluzi langaphambili lokukhuthaza ukongiwa kwemvelo emhlabeni wonke, ngokusiza ukuqapha izingxenye ezibalulekile zezinhlobonhlobo zemvelo, ukusekela ukusetshenziswa okusimeme kwemithombo yemvelo kanye nokuphoqelela ukuphathwa ngokongiwa kwemvelo ngezinhlelo zenani zomdabu."

Gogo Qwabe indicated that African indigenous knowledge has the potential to be a tool for global conservation efforts by supporting sustainable resource use, monitoring important aspects of biocultural diversity, and enforcing conservation management through indigenous value systems.

In the context of the role of indigenous knowledge in the preservation of traditional practices, Thoko Gumede, one female community member in the uMkhanyakude District Municipality, said:

"Ukucabangela ukuguquguquka kwesimo sezulu okusheshayo kwanamuhla, ulwazi lwendabuko kanye nemikhuba, kunesandla esikhulu ekuqhubekiseni phambili imibono yethu yesikhathi eside mayelana nemvelo yethu eguqukayo. Isibonelo, ukufakwa kokubhekwa kwendabuko kanye nemininingwane mayelana nesimo sezulu kanye nokushintsha kwesimo sezulu kungase kuhambisane nokubhekwa kwesimo sezulu samanje futhi kusize ukunweba amarekhodi emuva ngesikhathi. Ulwazi olunjalo nezinqubo kusiza futhi ukuchaza izinhlobonhlobo zezinketho umphakathi wendawo ongase uzicabangele ukuze uzivumelanise nezimo, ezifanele endaweni ethize yezemvelo nengokwenhlalo namasiko, futhi ezihambisana nezinto eziza kuqala, izindinganiso kanye nemibono yomhlaba."

Thoko Gumede considered today's rapid climate change, traditional knowledge, and practices to contribute greatly to the need to continue indigenous long-term observations regarding the local changing environment. For instance, including indigenous observations and insights on weather and climate change could complement modern meteorological observations and help extend historical records. Such knowledge and practices also helped define the range of options that a local community might consider for adaptation, appropriate to specific ecological and sociocultural environments and conforming with its priorities, values, and worldviews.

In the context of the UN Sustainable Development Goals and Indigenous Knowledge, Ubaba Mazibuko, a Traditional Healer in uMkhanyakude District Municipality, had the following to say:

"Ngokwamukelwa kwe-Ajenda ka-2030 Yentuthuko Esimeme, umphakathi wamazwe ngamazwe wazibophezela ukubhekana nezinselelo eziningi. Kulawa ma-SDG, amanye abaluleke kakhulu emiphakathini yendawo yase-Afrika njengoba enomthelela ezimpilweni zawo zansuku zonke. Lokhu kudala ukunakekelwa kwezempilo, imfundo, ubumpofu, ukufinyelela kwezobulungiswa kanye nokushintsha kwesimo sezulu. Kodwa-ke, naphezu kokuba semseni wezinqumo zezombusazwe ezidukisayo imiphakathi yase-Afrika ayilona nje iqhaza emiphakathini yayo yamasiko nemvelo. Izinhlelo zolwazi abazenze amakhulu eminyaka zibasize ukuba baphendule ngempumelelo ezinseleleni zemvelo nentuthuko okuhlanganisa nokushintsha kwesimo sezulu."

Ubaba Mazibuko believed that the international community pledged to address numerous issues when it adopted the 2030 Agenda for Sustainable Development. Given how they affect African local communities' day-to-day lives, a few of these SDGs are extremely pertinent. These contribute to

poverty, access to justice, healthcare, education, and climate change. Despite being at the mercy of deceptive political decisions, African communities are not passive actors in their respective cultural and ecological communities. Thanks to the knowledge systems they have developed over centuries, they have effectively responded to ecological and development challenges, including climate change.

Nokwazi Mtshali, a local community member in the uGu District Municipality, added the following in a focus group discussion:

> "*Ngaphandle komehluko phakathi kwemiphakathi yase-Afrika, ngenxa yokuhlukahluka kwamasiko nemvelo, kukhona ukufana okutholakala kuyo yonke imiphakathi yendawo etholakala ezimweni ezihlobene nemvelo okuhlanganisa ukubhekana nesimo sezulu esifanayo nesimo sezulu. Izimpendulo nezinqubo ezisekelwe olwazini lwendabuko kulezi zimo ezimbi zokuguquguquka kwesimo sezulu ezamukelwa yile miphakathi yendawo zihlanganisa: (a) ukuhlukahluka kwezinsiza; (b) izinguquko ezinhlobonhlobo zezitshalo nezilwane nezinhlobo ezisetshenziswayo; (c) izinguquko ngesikhathi semisebenzi; (d) izinguquko kumasu asetshenzisiwe; (e) izinguquko endaweni; (f) izinguquko ezinsizeni kanye/noma ezindleleni zokuphila; (g) ukushintshana namanye amaqembu; kanye (h) nokuphathwa kwezinsiza. Lawa maqhinga awavamisile ukusetshenziswa ngawodwana, ngoba imiphakathi yendawo ingase isebenzise amasu okuzijwayeza angaphezu kwelilodwa kanye kanye.*"

According to him, despite differences among African communities due to cultural and ecological diversities, there were similarities found across local communities located in related ecological conditions, including experiencing similar weather and climatic conditions. Indigenous knowledge-based responses and practices to these adverse climate change conditions adopted by these local communities include: (a) diversification of resources; (b) changes in the plant and animal varieties and species used; (c) changes in the timing of activities; (d) changes in the techniques used; (e) changes in location; (f) changes in resources and/or lifestyles; (g) exchange with other groups; and (h) resource management. These strategies are not usually applied in isolation because local communities may use multiple adaptation strategies concurrently.

Gogo Ntuli, a Traditional healer in uMkhanyakude District Municipality, lamented the following:

> *"Emiphakathini eminingi yase-Afrika, amasiko kanye nolwazi lwethu, okusabuswa izindlela zaseNtshonalanga zokwazi nokubaluleka kwezinhlelo, kusewumzabalazo oqhubekayo. Kodwa-ke, siye sakwazi ukuphila iminyaka eminingi ngokuzivumelanisa nezimo zezulu*

ezingezinhle futhi sakhe izinhlelo zokuziphilisa ezisimeme zemindeni yethu. Amafomu ethu olwazi agxilile ebudlelwaneni bethu nemvelo kanye nokubumbana kwamasiko. Lobu budlelwano obuqinile busenze sakwazi ukugcina ukusetshenziswa nokuphatha okusimeme kwemithombo yethu yemvelo nengokomoya, sivikele imvelo futhi siqinise ukuqina kwethu, kuyilapho sibhekene nezinselele ezintsha neziyinkimbinkimbi."

Gogo Ntuli claimed that most African communities still struggle with having their customs and knowledge dominated by Western values and ways of knowing. Nevertheless, they have persevered by developing resilient subsistence for their families and adjusting to harsh climatic circumstances in various ways. Their relationships with the environment and cultural cohesiveness are fundamental to their knowledge forms. Because of this strong relationship, they have been able to preserve the sustainable use and management of their natural and spiritual resources, safeguard the environment, and build resilience in the face of novel and difficult challenges.

Mama Mtshengu from uGu District Municipality complained:

"Abacwaningi nabanye abantu bangaphandle beza emiphakathini yethu yasendaweni futhi bathathe ulwazi lwethu lwendabuko ngaphandle kwemvume, futhi basebenzise amasiko ethu lapho lolu lwazi lusuka khona. Bathatha lolu lwazi kanye nezinsiza ezihlobene ngaphandle kokuhlomula emiphakathini yendawo."

Mama Mtshengu believed that outsiders and researchers enter their communities, steal their traditional knowledge without consent, and take advantage of the cultures from which this knowledge comes. They appropriate this information and related materials without helping the surrounding communities.

6.3 Local Community Members' Awareness and Perceptions of National and International Policy Frameworks on Traditional Medicine

Studies indicate that most South Africans, especially in rural and other marginalized areas and social groups, including women and children, depend on Traditional Medicine and Healing practices for primary healthcare. Mothibe and Sibanda (2019) reveal the importance of traditional medicine as a source of primary healthcare in South Africa, Africa, and the world. It was first officially recognized by the World Health Organization (WHO) in the Primary healthcare Declaration of Alma Ata (1978). It has been globally addressed since 1976 by the WHO's Traditional Medicine Program. In line with cultural values and traditional healthcare practices in Africa, Traditional medicine was recognized as

having a long history before Western medicines. It encompasses a diversity of knowledge, skills, and practices based on our beliefs and experiences, which we use to maintain health and prevent, diagnose, improve, or treat physical, emotional, and mental illnesses.

Ms Melody Mzizi, one of the local community members in uGu District Municipality whose family depends on African Traditional Medicine and healing practices, had the following to say:

> *"Imithi yesintu kanye nokwelapha eNingizimu Afrika akuzona izindlela zokunakekelwa kwezempilo ezihlukile kithina ma-Afrika, njengoba abantu baseNtshonalanga bekubeka ngokwezigaba. Uma sibheka imali yethu elinganiselwe yokukhokhela imithi yesimanje kanye nokungatholakali kwezinsiza zesimanje zokunakekelwa kwezempilo emiphakathini yethu yasendaweni, sincike kulezi zinsizakalo zokunakekelwa kwezempilo zendabuko ukuze uthole iningi lezidingo zethu zokunakekelwa kwezempilo."*

Ms Melody Mzizi asserted that contrary to what Westerners may think, traditional medicine and healing in South Africa are not alternative forms of healthcare for Africans. African people rely on these traditional healthcare services for the majority of their healthcare needs because they cannot afford modern medicine and because modern healthcare services are not available in their local communities.

A traditional medicine trader in the district municipality looked at the significance of African traditional medicine from an income perspective. His family depends on his sales of traditional medicines for survival. This contention is supported by Mander et al. (2007), who indicate that Traditional Medicine in South Africa accounts for 26.6 million consumers, incorporating diverse age groups, cultural and racial backgrounds, educational levels, and occupations. The value of the trade-in raw medicinal plant materials in South Africa is estimated to be approximately R520 million per year (in 2006 prices), with the traditional medicinal plants and products trade in South Africa estimated to be worth R2.9 billion per year (Sobiecki,2014).

Focus group discussions in both study areas among Traditional Healthcare Practitioners and their clients expressed the concern that traditional knowledge related to TM, including resources appropriated, adapted, and patented by scientists and industry, with little or no compensation to the custodians of this knowledge and without their prior informed consent. A superficial observation of South Africa's national legislation reflects the inability and deficiency of current intellectual property rights regimes to accommodate and protect indigenous knowledge fully. It is based on this

consideration the National IKS Policy (2004) and the IK Act (2019) address the protection and promotion of Traditional Medicine.

Maluleka and Ngoepe (2019) show that the Traditional Health Practitioners Act 2007 was designed to regulate the registration, training, and practices of traditional health practitioners and serve and protect the interests of members of the public who utilize their services.

Umama Philisiwe Mthabela, a female traditional healer in the uMkhanyakude District Municipality, emphasized that African Indigenous knowledge systems, especially traditional medicine knowledge and practices, should be included in the teaching and learning of Western science and technology at all levels of education. She had the following to say:

> "*Ngokucabangela ukukhula kokwakhiwa kwamasiko ahlukahlukene emakilasini aseNingizimu Afrika, ezweni elikhulayo lembulunga yonke, izingane zase-Afrika ezikoleni zingahluka kalula kulokho okufundiswa kwisayensi nobuchwepheshe baseNtshonalanga, kanye nendlela izifundo ezifundiswa ngayo. Ukufundisa nokufunda kweNqubo yoLwazi lweNdabuko yase-Afrika, okuhlanganisa Imithi Yesintu kanye nezinhlelo zokwelapha, kuzothuthukisa uhlaka olubanzi lokucabanga ngesimo sakithi sase-Afrika. Izonciphisa inkinga yokuhlanganiswa okunganele kwamasiko nezenhlalo kanye nemfundo yesayensi yemvelo kanye nemfundo yobuchwepheshe.*"

According to her, African students in schools may easily feel alienated from what is taught in Western science and technology classes and how the subjects are taught, given the increasingly multicultural makeup of South African classrooms in an increasingly globalized world. The broad framework for understanding the African local context will be improved by the teaching and learning of African Indigenous Knowledge Systems, including Traditional Medicines and healing systems. It will mitigate the problem of insufficient integration of the cultural-social and academic dimensions of natural science and technology education.

This was elaborated further by another female traditional healer, Umama Gamede, in the focus group discussion in the following words:

> "*Njengengxenye yoguquko lwezemfundo kanye nokuqedwa kwamakholoni eNingizimu Afrika nase-Afrika, ngokubanzi, ukufundisa nokufunda kwamasiko nemvelo ye-IKS kunciphisa ukucabanga okungamanga, phakathi kothisha bethu, ikakhulukazi ezifundweni zesayensi*

nezobuchwepheshe, ukuthi bonke abafundi ziyefana mayelana nobuwena kanye namandla amasiko okuhlanganisa nokutholwa kolwazi. Isayensi yemvelo kanye nobuchwepheshe, okufundiswa ezikoleni zethu, ngokombono waseNtshonalanga, kuthathe isiko eliqondile lamandla, elivame ukubukela phansi iningi labafundi. Ukufundisa nokufunda kwezinhlelo zolwazi lwendabuko lwase-Afrika okuhlanganisa nemithi yethu yendabuko kanye nezinhlelo zokwelapha kuzosebenza ngamasu, kuguqule imibono yaseNtshonalanga bese kucebisa othisha emkhakheni wokufundisa nokufunda wesayensi yemvelo nobuchwepheshe."

Umama Gamede claimed that the teaching and learning of the cultural and ecological specificity of IKS mitigate the false assumptions among our educators, especially in the science and technology subjects, that all learners are the same in terms of identity and cultural dynamics, including knowledge acquisition. This is part of the educational transformation and decolonization in South Africa and Africa at large. Most students are often marginalized by the natural science and technology courses taught in our schools because they are based on Western perspectives and have an established culture of power. African indigenous knowledge systems, including our traditional medical and healing practices, can be taught and learned, which will strategically alter Western viewpoints and benefit educators teaching natural science and technology.

The study wanted to establish from research participants (African Traditional Healthcare Practitioners and their clients) in both study district municipalities their comparative knowledge, awareness, and perspectives on national and international policy frameworks on traditional medicine. The results are reflected in Tables 6.3 and Table 6.4.

Table 6-3. Comparative Percentage Distribution of Comparative Knowledge, Awareness, and Perspectives of Participant African Traditional Healthcare Practitioners (ATHPs) in The Study District Municipalities on National and International Policy Frameworks on Traditional Medicine

1. Total Number of Male ATHP Participants in uGu District Municipality (12);
   Total Number of Female THP Participants in uGu District Municipality (18);
2. Total Number of Male ATHP Participants in uMkhanyakude District Municipality (10);
   Total Female THP Participants in uMkhanyakude District (15).

uGu District Municipality	**uMkhanyakude District Municipality**

Aware (n)		Aware (%)	Not Aware (n)		Not Aware (%)	Aware (n)		Aware (%)	Not Aware (n)		Not Aware (%)
Male	01	8%	Male	11	92 %	Male	02	20%	Male	08	80%
Female	02	11%	Female	16	89%	Female	01	07%	Female	14	93%

Table 6.3 shows that most of the research participants, ATHPs (male and female) in both study district municipalities, expressed the view that they were unaware of the National and International Policy and Legal Frameworks on Traditional Medicine. Table 6.4 provides their clients' comparative knowledge and awareness of these issues.

Table 6-4. Comparative Percentage Distribution of Knowledge and Awareness of the African Traditional Health Practitioners (ATHPs) Clients in the Study District Municipalities on National and International Policy Frameworks on Traditional Medicine

1. Total Number of Male THP Clients in uGu District Municipality (62);
   Total Number of Female THP Clients in uGu District Municipality (88);
2. Total Number of Male THP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female THP Clients in uMkhanyakude District (77).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		Aware (%)	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	07	11%	Male	55	89%	Male	04	08%	Male	44	92%
Female	08	09%	Female	80	91%	Female	05	06%	Female	72	94%

Table 6.4 shows that most of the participant ATHP clients (male and female) in both study district municipalities expressed the view that they were unaware of the National and International Policy Frameworks on Traditional Medicine. During focus group discussions, the participant ATHPs and their clients articulated the need for capacity-building platforms and other knowledge and awareness opportunities to build their knowledge and awareness of these National and International Policies and legal Frameworks on Traditional Medicine and other related issues. Umama Nciki, a Traditional Healer from uGu District Municipality, who was aware of the National IKS Policy, had the following view:

"*Inqubomgomo Kazwelonke ye-IKS (2004) njengoba ngazi ukuthi iyaqaphela ukuthi izinqubo zethu zemithi yesintu yase-Afrika kanye nezinhlelo zokukholelwa kuyingxenye yamasiko ethu kanye Nezinhlelo Zolwazi Lomdabu. Badlala indima ebalulekile ekuhlinzekweni kokunakekelwa kwezempilo okuyisisekelo ezindaweni eziningi zasemakhaya nakweminye imiphakathi enganakiwe. Ukusetshenziswa kwawo okwandayo ngaphakathi nangaphandle kwemiphakathi yethu yasendaweni kukhulisa ukubaluleka kwawo kwezentengiselwano ukuze kuphile umphakathi esimeme mayelana nokwenza imali engenayo nokudala amathuba omsebenzi, ikakhulukazi uma kusekelwa kahle izinqubomgomo zikahulumeni."*

Umama Nciki indicated that the National IKS Policy (2004) recognized African Traditional medicine practices and belief systems as part of African cultures and Indigenous Knowledge Systems. These are important in primary healthcare in most rural areas and marginalized communities. Their increasing use within and outside our local communities increases their commercial value for sustainable community livelihood in terms of income generation and employment creation, especially when well supported by government policies.

Ms Mbuyazi, a client of one of the traditional healers in uMkhanyakude, said:

"*Ukusetshenziswa nokukhuthazwa kwemithi yesintu yase-Afrika kanye nezindlela zokwelapha emiphakathini yakithi kusiza ukulondoloza amasiko nemikhuba yethu yesiNtu sase-Afrika. Enye yezinkolelo zethu zendabuko ezibaluleke kakhulu phakathi kwabantu bakithi ukukholelwa emadlozini angafi anethonya futhi aqondise izindaba zabaphilayo futhi okwenziwa kubo imikhuba yokubuyisana efana nokudla neziphuzo. Ngokwezinkolelo zethu, ukugula namashwa kuvela entukuthelweni yamadlozi, ubuthakathi, noma ukungcola okungokwesiko okuhlanganisa ubudlelwano obuphazamisekile bezenhlalo namasiko. Lezi zinhlelo zenani azitholakali emikhubeni yezokwelapha yaseNtshonalanga kodwa zinomthelela ekuqondeni kwethu konke kwezempilo. Lokhu kuchaza ukuthi kungani emithini yethu yendabuko yase-Afrika kanye nezinqubo zokwelapha, sinezinhlobo ezimbili eziyinhloko zabelaphi bendabuko. Laba bangamakhambi (ngesiZulu inyanga; Xhosa ixhwele; Tsonga nyanga; Sotho ngaka) kanye nombhuli (okuthiwa isangoma ngesiZulu; igqirha ngesiXosa; mungome ngesiTsonga ; kanye selaodi ngesiSuthu)."*

According to Umama Nciki, the use, and promotion of traditional African medicine and healing practices in our local communities helps. One of our most important traditional beliefs amongst our

people is the belief in the immortal ancestors who influence and direct the affairs of the living and to whom conciliatory practices such as food and drink are offered. We believe ill health and misfortune stem from ancestral anger, witchcraft, or ritual pollution, including disturbed social and cultural relations. These value systems are not found in Western medicine practices but impact our holistic understanding of health. This explains why we have two main types of traditional health practitioners in our African medicine and healing practices. These are the herbalist (called inyanga in Zulu; ixhwele in Xhosa; nyanga in Tsonga; and ngaka in Sotho) and the diviner (called isangoma in Zulu; igqirha in Xosa; mungome in Tsonga; and selaodi in Sotho).

The consensus in the focus group discussions in both study areas was that African indigenous people, in their diversity of cultures and ecosystems, building on their centuries of lived experiences combined with that of their ancestors, harbour huge knowledge about the environment and the ecological relationships within them. Tremendous educational opportunities exist where such knowledge can contribute to modern science and natural resource management within and outside Africa.

It was explained during focus group discussions that the diviners were considered to be the spiritual specialists of the local community. They used divination to communicate with the ancestral spirits who helped them to diagnose their patients' misfortunes or medical conditions. The diviner usually recommends the appropriate action in the form of counselling, prescribing medicines, and/or instructing on ritual ceremonies. The participants, African Traditional Health Practitioners, agreed that there is limited knowledge and awareness within and outside African societies on humans' three-dimensional and symbiotic nature, i.e., the biological, social, and spiritual being. It is based on this holistic understanding of a human being and its influence on health and wellness that the diviner will prescribe plant, mineral, or animal-based medicines, often in a ritualized context of use, either drinking, vomiting, bathing, or sprinkling around the home for physical, psychological and spiritual medicinal effects or spiritual protection. This is meant to rectify physical, spiritual, or social (interpersonal) imbalances. Contrary to biomedicine practitioners, the African traditional diviner-healer practices holistic medicine and healing, which addresses the wholeness of a person in relationship to cultural society's natural and spiritual environments. This implies that the African Traditional Healthcare practitioner plays a vital role in health care and wellness through their understanding that nature, humans, and spirits are not separate; hence, they use medicines and healing holistically to influence these interdependent forces on the physical, psychological, and spiritual/transpersonal levels.

During focus group discussions in both study areas, the research study was also interested in establishing the views of the ATHPs and their clients on issues related to the governance of traditional medicine within and outside their local communities. The argument stems from the observation that African rural and marginalized communities, where many people rely on indigenous knowledge systems—particularly traditional medicines—for their livelihood, feel that modern governance systems receive much more emphasis while traditional governance practices, including African traditional medicines and healing practices, receive little to no attention and remain largely undocumented. The community-based perspectives in the study areas are examined in the following sections.

Dumisa Dlamini, a Traditional Healer in uMkhanyakude District Municipality who indicated awareness of some of the National and International Policy and Legal Frameworks on Traditional Medicine, expressed the following concern:

> *"Izinkinga eziningi ezingokomthetho nezingokoqobo eziphathelene nokuvikelwa kweLungelo Lempahla Yobuhlakani (I-IPR) zisazoqondwa futhi zixazululwe ngokugcwele. Lokhu kubandakanya ubunikazi obuhlangene/ukugcinwa kwemithi yesintu; inkinga yobunikazi nokusebenzisa amalungelo olwazi lwemithi yendabuko olukhona kuwo wonke amasiko e-Afrika ahlukene ezweni; izindlela ezisebenzayo zokusetshenziswa nokuphathwa kwamalungelo; izindlela zokusetshenziswa komthetho wesintu ekuvikelweni kwemithi yesintu; kanye nesidingo samazinga aphelele emibhalo, emithini yesintu. Ulwazi lwendabuko oluphathelene Nemithi Yesintu lukhishwe inyumbazane emnothweni wolwazi."*

Dumisa Dlamini asserted that most practical and legal issues about protecting intellectual property rights (IPR) have not yet been properly recognized and resolved. This covers issues such as the need for comprehensive documentation standards for traditional medicine, the issue of ownership and exercise of rights in traditional medicinal knowledge that is present in the nation's various African cultures, practical methods for managing and exercising rights, and the application of customary law to the protection of traditional medicine. Traditional medicine-related indigenous knowledge has been marginalized in the knowledge economy.

Most participants (ATHPs and their clients) expressed the importance of protecting indigenous knowledge of Africa, including traditional medicine and associated resources in local communities. This is meant to guard this valuable knowledge, on which most African people have depended for sustainable livelihood against misappropriation and misuse, preservation of genetic resources and

cultural goods, and protection against unfair competition. This will, in turn, ensure access and benefit sharing for local communities. Promoting indigenous knowledge also has policy implications as it enables policy-makers and other development agencies to comprehensively understand African indigenous world views, cultures, the environment, the social, health, and economic conditions of African people, and the nature of their traditional communities.

The study wanted to know the local community members' sources of knowledge and awareness on national and international policy frameworks on Indigenous Knowledge about African traditional medicine. The comparative findings are shown in Table 6.5 (Participant ATHPs) and Table 6.6 (Participant ATHPs Clients).

Table 6-5. Comparative Sources of Knowledge and Awareness of Research Participant ATHPs On National and International Policy Frameworks on Indigenous Knowledge Concerning African Traditional Medicine

1. Total Number of Male ATHP Participants in uGu District Municipality (12);
   Total Number of Female THP Participants in uGu District Municipality (18);
2. Total Number of Male ATHP Participants in uMkhanyakude District Municipality (10);
   Total Female THP Participants in uMkhanyakude District (15).

uGu District Municipality					**uMkhanyakude District Municipality**				
Sources	**Male**	**Sources (%)**	**Female**	**Sources (%)**	**Sources**	**Male**	**Sources (%)**	**Female**	**Sources (%)**
Radio	01	07%	01	06%	Radio	01	01%		
TV					TV				
Newspaper					Newspaper				
Poster					Poster				
People					People				
Community Leaders	02	17%			Community Leaders			01	07%
Friend					Friend	01	01%		
Family member	01	07%			Family member				
Other places					Other places				
Could not answer	8	67%	17	94%	Could not answer	08	80%	14	93%

Table 6.5 shows that most of the research participants, ATHPs (male and female), in both study district municipalities, could not answer the question on sources of Knowledge and Awareness of National and International Policy Frameworks on Indigenous Knowledge concerning African Traditional Medicine. However, participants who were able to answer the question expressed that they became aware of the National and International Policy and Legal Frameworks on Traditional Medicine through the radio, community leaders, friends, and family members. Table 6.6 provides their clients' comparative source of knowledge and awareness on these issues.

Research findings indicate that while a portion of the respondents demonstrated familiarity with the Indigenous Knowledge Systems (IKS) Policy and various National and International Policy Frameworks, a significant majority of African Traditional Health Practitioners (ATHPs) interviewed expressed, for the first time, a lack of government engagement regarding IKS and International policies and legal frameworks about traditional medicine, which remains the primary source of healthcare for a majority of the population. Notably, some participants acknowledged that the government had previously encouraged the certification of ATHPs to legalize their practice and grant them freedom as African Traditional Health Practitioners. However, they noted the absence of government-supported programs despite the issuance of work permits. These observations align with the recommendation proposed by the IKS policy, emphasizing the need for South Africa to establish mechanisms for certifying Indigenous Knowledge holders and protecting their rights. Consequently, following the discussions, many ATHPs strongly desired to acquire further knowledge about IKS and the International policies and legal frameworks surrounding traditional medicine. This sentiment was eloquently expressed by Umama Albertina Mahlaba, one of the research participants in uGu, who exclaimed:

> "*Lo mgomo ubukeka njengombhalo obalulekile okufanele ufinyelelwe kalula yibo bonke abantu, ikakhulukazi thina basemakhaya. Bengingazi nokuthi ikhona incwadi enjalo. Nginesiqiniseko sokuthi kunedlanzana lozakwethu namalungu omphakathi angazi ukuthi umgomo onjalo ukhona. Kubalulekile ukuthi uhulumeni akhuthaze ukuqwashisa ngeNqubomgomo ye-IKS. Umqulu wenqubomgomo udinga ukuchazwa ngokucacile, ikakhulukazi njengoba iningi lamalungu omphakathi wethu angafundile kodwa futhi angathanda ukuzuza kulo mgomo."*

Umama Albertina Mahlaba indicated that the IKS policy appeared to be a crucial document to which everyone should have easy access, particularly in rural areas. She had no idea that there was even a document like that. Many coworkers and community members are likely unaware of such a policy.

The IKS Policy must be promoted and more widely known by the government. Clarity in the policy document is necessary, particularly since many members of the African community lack formal education but would still like to benefit from it.

Table 6-6. Comparative Sources of Knowledge and Awareness of Research Participant ATHPs Clients on National and International Policy Frameworks on Indigenous Knowledge concerning African Traditional Medicine

1. Total Number of Male THP Clients in uGu District Municipality (62);
   Total Number of Female THP Clients in uGu District Municipality (88);
2. Total Number of Male THP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female THP Clients in uMkhanyakude District (77).

uGu District Municipality					**uMkhanyakude District Municipality**				
Sources	**Male**	**Sources (%)**	**Female**	**Sources (%)**	**Sources**	**Male**	**Sources (%)**	**Female**	**Sources (%)**
Radio	03	5%	01	1%	Radio	02	4%		
TV					TV				
Newspaper					Newspaper				
Poster					Poster				
People	02	3%			People	01	2%		
Community Leaders	02	3%	01	1%	Community Leaders	01	2%	03	4%
Friend					Friend				
Family member					Family member				
Other places					Other places				
Could not answer	55	89%	86	98%	Could not answer	44	92%	74	96%

Table 6.6 shows that most of the participant ATHP clients (male and female) in both study district municipalities could not answer the question on sources of Knowledge and Awareness of National and International Policy Frameworks on Indigenous Knowledge concerning African Traditional Medicine. However, participants who were able to answer the question expressed that they became aware of the National and International Policy and Legal Frameworks on Traditional Medicine

through the radio, community leaders, friends, and family members. Most clients interviewed acknowledged that people in their respective communities valued IKS activities. They affirmed for the first time that despite the high value of IKS in their communities, nobody from the government had come to the community to talk and explain about IKS and International policies and legal frameworks on the same traditional medicine on which the majority of the population continue to rely on to meet their primary healthcare needs. The majority were willing to learn more about National and International Policy Frameworks on Indigenous Knowledge concerning African Traditional Medicine, including the IKS policy.

6.4 Governance and Management of African Traditional Medicine and Healing Systems in Local Communities: Challenges and Prospects

Traditional governance practices are important in local community-based knowledge systems and practices, including traditional medicine and healing systems. They are traditionally shaped by the local communities' socio-cultural beliefs and value systems, which are inclusive and accessible. In comparison, modern governance practices are widely perceived as top-down and alien to local communities' cultural beliefs and value systems, including attitudes toward traditional medicine and healing practices. In healthcare systems, governance refers to how decisions are made and implemented concerning healthcare services (Hamra et al., 2020). From a socio-ecological and environmental viewpoint, governance refers to how collective decisions and goals are made and achieved. Key aspects of governance include transparency, participation, accountability, integrity, and capacity (OECO, 2022).

Hence, traditional medicine and healing systems' governance practices consist of culturally binding customs, taboos, beliefs, and informal societal regulations that silently regulate TM and are informally passed over generations.

Baba Cele, a traditional healer in uGu District Municipality, complained:

> *"Ngokuvamile kugcizelelwa kakhulu ezinhlelweni zokuphatha zaseNtshonalanga futhi kuncane noma kunganakwa nhlobo izinqubo zethu zokuphatha ngokwendabuko, ezaziwa ngabantu bakithi kodwa zihlala zingabhaliwe phansi."*

Baba Cele claimed that while Western governance systems are typically given a lot of attention, African traditional governance practices—which are well-known to African people but mainly undocumented—receive little to no attention.

Interviews and focus group discussions with traditional healthcare practitioners and their clients in both district municipalities indicated that traditional medicine practice and healing practices in local African communities have been public healthcare concerns. This is attributed to malpractices that put people's health at risk. As a result of the juxtaposing of Traditional medicine and Western medicines in the local communities, a concern was raised during a focus group discussion in uMkhanyakude District Municipality that there was widespread contamination of herbal medicine products by outsiders and increasing noncompliance with Western medications among traditional medicine users, which compromised the trust and safety of traditional medicine use. Ntate Zikhali, a client of one of the participant's Traditional Healthcare practitioners, said:

> "*Abantu abaningi baya ekwelapheni kwesimanje kuphela uma behlulekile ukubelapha. Ngeshwa iningi labo alikuvezi ukusetshenziswa kwemithi yesintu kodokotela besimanje, ikakhulukazi ngoba odokotela bayehluleka ukubuza. Ukusetshenziswa kwemithi yesintu kanye nokwelapha abantu abavamile ngokuvamile kubangelwa ukutholakala kwayo kalula kanye nokufinyeleleka kwayo uma kuqhathaniswa nemithi yesimanje. Kukhona futhi abantu emphakathini abakholelwa ezimbangela zezifo ezingaphezu kwemvelo ngakho-ke bakhetha imithi yesintu kanye nezinqubo zokwelapha."*

According to him, many people sought modern medical care only after traditional medicine could not heal them. Regretfully, most do not tell contemporary doctors that they take traditional medicines, mainly because they forget to inquire. The general public's use of traditional medicine and healing systems is frequently linked to its accessibility and affordability compared to modern medicine. There are also members of the community who believe in supernatural causes of disease and prefer traditional medicine and healing practices.

Past research (Mujinja and Saronga, 2022), within and outside South Africa, indicates that these malpractices include false labelling and advertising of TM products; false claims of 'magic' and efficacious treatment; and false self-proclaiming of 'doctor' title by practitioners. Raposo (2019) states that malpractice in TM might be due to imperfect information, among other factors. However, according to the views of the focus groups' discussion participants, imperfect information exists when the practitioners, clients, and sometimes the regulators do not have full knowledge about African

Traditional Medicine and healing practices, regulations, and what is being regulated. They believed imperfect information tends to cause non-adherence to and poor implementation of regulations. Suppose access to TM information is limited among the stakeholders. In that case, the practitioners may be unable to adhere to some regulations, and regulators may not be able to regulate the practice effectively.

One local community leader in uGu District Municipality indicated that information on TM practice is critical for public health safety because many people in the local community access TM when needing primary healthcare before accessing modern medicine or in conjunction with both. This makes accessibility of information on TM regulations among practitioners and regulators critical to public healthcare because regulations protect TM consumers against malpractice. She raised the concern that imperfect information is more noticeable in TM practice due to multiple groups of practitioners, from within and outside South Africa, practicing distinctive modes of the profession. The fragmentation is mostly due to intra-practitioner knowledge differences and the practice's origin; some have not recognized specialized training in their practice.

This concern is supported by (Mujinja and Saronga, 2022), who state that the professional knowledge heterogeneity in TM within practitioner groups in local communities has resulted in demand for a self-regulatory framework among different specialized groups. In addition, the intra-practitioner knowledge differences tend to contribute to the aggravation of the differences in awareness and, consequently, adherence to regulations. The existence of imperfect information in TM practice necessitates governmental regulatory action to protect customers against risky practices. Mothibe and Sibanda (2019) show that the World Health Organization (WHO) developed a Traditional Medicine strategy (2014-2023) to guide TM policies, plans, and regulatory processes. It emphasizes, among other things, that for an effective regulatory framework, there must be clear and adequate legislation, regulation, guidelines, and procedures; human and financial resources; transparency, cooperation, and collaboration between the regulating authority and other stakeholders, including the practitioners.

However, the Traditional Healthcare Practitioners and their clients expressed that African Traditional medicine and healing practices in the local communities also need to consider local customs and indigenous knowledge systems in their governance to have cultural relevance and acceptability. These are traditionally transferred via cultural means, including socio-cultural protocols.

6.5 The Comparative Usage of African Traditional Medicines in the Study District Municipalities

The study was interested in establishing the comparative usage of traditional African medicines, including frequency of usage among the clients of the participant traditional healthcare practitioners in the study district municipalities. The findings are reflected in Table 6.7.

Table 6-7. Comparative Percentage Distribution of Frequency of Usage of African Traditional Medicines Among the Clients of The Participant Traditional Healthcare Practitioners in the Study District Municipalities

1. Total Number of Male ATHP Clients in uGu District Municipality (62);
   Total Number of Female THP Clients in uGu District Municipality (88);
2. Total Number of Male ATHP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female ATHP Clients in uMkhanyakude District (77)

Frequency of Usage	uGu District Municipality				uMkhanyakude District Municipality			
	Male (n)	Male (%)	Female (n)	Female (%)	Male (n)	Male (%)	Female (n)	Female (%)
Everyday	05	08%	08	09 %	03	06%	06	8%
2-6 times a Week	10	16%	47	53%	8	17%	48	62%
Once a Week	15	24%	26	30%	12	25%	18	23%
Once a Month	29	47%	05	06%	23	48%	03	04%
Don't Know	03	05%	02	02%	02	04%	02	03%
Total	62	100%	88	100%	48	100%	77	100%

Table 6.7 shows that most ATHPs' female clients in both study district municipalities took traditional medicines 2-6 times a week. During in-depth interviews and focus group discussions, this was attributed to women and children being frequently vulnerable to illnesses and consulting traditional healthcare practitioners more frequently than men due to ease of accessibility and affordability.

It was also pointed out during focus group discussions that the relevance of African Traditional Medicine in healthcare in local communities is increasing due to several factors: In the absence of modern healthcare services, African Traditional Healthcare Practitioners (ATHPs) provided the

earliest medical care in the local communities, especially for underprivileged women and their family members.

Mama Nciki in uGu District Municipality had the following to say on the benefits of African traditional medicines in local communities:

> "*Izindleko ezikhulayo zokufinyelela izinsiza zemithi yesimanje ziye zaqhubeka nokuthatha ukunakekelwa kwezokwelapha okunjalo endaweni efinyelelekayo kubantu abaningi abavamile abaneholo eliphansi kakhulu. Le nkinga ibhebhethekiswa wukuntula kwemitholampilo eyanele futhi engenazo izinto zokusebenza, ikakhulukazi ezindaweni zasemakhaya kanye nokushoda kodokotela abanekhono. Kweminye imiphakathi yendawo, imithi yendabuko ukuphela komthombo wokulethwa kokunakekelwa kwezempilo owaziwayo, ofinyelelekayo, owamukelekayo, futhi othengekayo. Kushibhile futhi kufinyeleleka kalula kwezomnotho kubantu abavamile. Izinto ezisetshenziswa ekulungiseleleni imithi yethu yesintu imvamisa zitholakala endaweni kanti kwezinye zitholakala mahhala. Emiphakathini yethu eminingi yasemakhaya, abelaphi bendabuko bangabahlinzeki bezempilo abathenjwa kakhulu nabafinyeleleka kalula emiphakathini yabo."*

According to Ntate Zikhali, most common people with very low incomes can no longer afford the rising costs of accessing modern medicine services. Inadequate and ill-equipped clinics, particularly in rural areas, and a lack of qualified medical professionals worsen this issue. Traditional medicine is the only known source of healthcare delivery accessible, acceptable, and reasonably priced in some local communities. It is affordable and accessible to the general public. The ingredients we use to make our traditional medicines are typically found nearby and occasionally come for free. Traditional healers are typically the most dependable and approachable medical professionals in respective rural communities.

These factors make traditional medicine knowledge a powerful tool for national economic growth and development, which deserves preservation and protection. The potential contribution of traditional medicine knowledge to locally managed, sustainable, and cost-effective survival strategies should be promoted in the development process. It is in recognition of the great potential of traditional medicine and its contribution to the continent's sustainable development in the wealth and well-being of African people across cultures and regions, poverty alleviation, and job creation that the African Union declared the period of 2001-2010, as the decade for African Traditional Medicine with a directive that research on African traditional medicine be made a priority. The main objective of the

plan of Action for African traditional medicine is the recognition, acceptance, development, and integration of Traditional Medicine by all Member States into the public health care system (DoHSA,2008). The World Health Organization (WHO) has also recognized this aspect, emphasizing the need to integrate traditional medicine into public healthcare.

Several African countries, including South Africa, have adopted this initiative and maintain specific institutions mandated to fast-track the coordination of research and development, documentation, and promotion of their traditional medicines, not only for improved healthcare delivery but also for the immense job and wealth creation potentials. Ampomah et al.(2022) note that Traditional medicine is appreciated worldwide for its holistic approach to healthcare and well-being, easy access, ready availability, cost-effectiveness, and limited side effects.

These attributes of traditional medicine were emphasized by Ubaba Cele, an ATHP client in the uGu District Municipality, who said:

> *"Imithi yesintu yase-Afrika yangaphambi kwemithi yesimanje e-Afrika. Imvelo yayo ephelele ekunakekelweni kwabantu inamandla kwezinye izindawo lapho imithi yaseNtshonalanga ingasebenzi kakhulu. Kufanele sivume ukuthi kunezinselele ezihambisana nokuphathwa kokunakekelwa kwezokwelapha kwendabuko njengezindaba zokulinganiswa kwemithi yakho, umthamo, ukulungiswa, ukubhalwa kwemibhalo, ukulondolozwa, amandla, kanye nokunqunywa komthelela oseceleni. Kodwa-ke, uma lokhu kushiyeka kulungiswa ngokuyihlanganisa nezinye izinhlelo zolwazi nobuchwepheshe, imithi yethu yendabuko yase-Afrika inokuningi esingakunikeza ekusindiseni izimpilo zabantu base-Afrika nangale kwezwekazi."*

According to Ubaba Cele, African traditional medicine predated modern medicine in Africa. Its holistic nature in human care is stronger in some areas where Western medicine is ineffective. We should acknowledge that there are challenges associated with the administration of traditional medical care, such as the measurability of its drugs, dosage, preparation, documentation, preservation, potency, and determination of the side effects. However, imagine that these flaws are fixed by integrating them with other technological and knowledge-based systems. In that scenario, traditional African medicine can significantly save people's lives in Africa and beyond.

6.6 Local Community Attitudes Towards Preservation, Protection, and Beneficiation of African Traditional Medicine

One of the basic characteristics of indigenous knowledge is its predominantly oral nature. It exists in the minds of the local people who use it daily; hence, it is an essential resource for any local community's livelihood and development process. In most African local communities, indigenous knowledge systems constitute the basis for decisions about food security, human and animal health, education, peace and security, natural resource management, and other crucial social practices. Indigenous knowledge, therefore, is an integral part of local communities' culture and history and their common asset in their effort to gain control of their own lives. This necessitates the interface of these local community-based knowledge systems with other knowledge and technology systems, including digital and artistic technologies, to improve their preservation in some permanent form and public accessibility for sustainable futures. Ubaba Tabula, a traditional healer in uGu District Municipality, emphasized the following:

> *"Ngaphezu kokulondolozwa, ukufinyeleleka ku-inthanethi kolwazi lwemithi yendabuko kanye nezinye izinhlobo zolwazi lwendabuko, kunikeza ithuluzi elisebenzayo lokucwaninga nokusungula izinto ezintsha. Njengamanje kunokubambisana okulinganiselwe kwezinhlaka zikahulumeni ezehlukene, ikakhulukazi emazingeni omphakathi wezifundazwe nasekhaya, abambe iqhaza ekulondolozweni kolwazi lwendabuko. Ukunethezeka kolwazi lwendabuko nolwazi olufakwe kudijithali okungakopishwa futhi ludluliselwe kubantu, kuphakamisa izinkinga mayelana nekhono lemiphakathi yendawo ukuze njalo uqinisekise ubunikazi nobuqotho bolwazi lwayo, ngaphandle kokuyekethisa izici zayo ezingcwele."*

Ubaba Tabula believed that online accessibility to traditional medical knowledge and other forms of traditional knowledge not only preserves them but also serves as a useful tool for research and innovation. A few government agencies currently work in restricted cooperative partnerships to preserve traditional knowledge, particularly at the provincial and local community levels. The ease with which people could copy and disseminate traditional knowledge and information in digital form raises concerns about how well local communities can maintain ownership and integrity of their knowledge without jeopardizing its sacred qualities.

The sentiment was emphasized by different indigenous knowledge stakeholders, including other community members, who participated in focus group discussions in uMkhanyakude District Municipality on the significance of interfacing traditional medicine knowledge with other knowledge and technology systems. They indicated that African traditional medicine knowledge is

predominantly tacit, like other indigenous knowledge systems. It is embedded in traditional social practices and experiences of its knowledge holders and practitioners. While the transmission medium is usually through personal communication and demonstration from the teacher to the apprentice, from parents to children, the traditional channels adopted for preservation include taboos, symbols, myths/legends, rituals, poetry, and folklore. Some societies also appoint traditional gatekeepers of knowledge, such as "*imbongi"* among the Zulu and Ndebele people in Southern Africa. Thus, indigenous knowledge develops incrementally, with each generation adding to the stock, based largely on either the group or individual experience of the practitioner(s).

It was agreed that these traditional methods of preserving traditional medicine knowledge systems in local communities are inadequate in a complex, dynamic, and globalizing world. Since it is predominantly oral and undocumented, the knowledge tends to die with the holders of that particular knowledge if it is not shared or when the chain of transmission is broken. In most traditional African societies, the knowledge of traditional medicinal practices and healing systems tends to be concentrated in the older generation of traditional African healthcare practitioners (ATHPs). Past research studies reveal that these ATHPs are usually farmers, hunters, fishermen, etc., above 50 years of age (Ibrahim et al., 2016). The transfer of knowledge and skills of the practice is mainly through family inheritance, and only very few practitioners developed their skills through apprenticeship.

However, during focus group discussions in both study areas, the challenges of preservation of African traditional medicines and policy implications were critically discussed. It was argued that notwithstanding the benefits of integrating digital technologies in the preservation of traditional medicine knowledge, especially the ease with which information could be copied and transmitted, there are also challenges to the ability of local communities to continuously ensure ownership and integrity of their knowledge, especially that its sacred features are not compromised.

The individualistic and communal aspects of African traditional medicines and knowledge systems concerning protection were also discussed. This was based on the argument that although traditional medicinal knowledge is usually regarded as communal, aspects of this knowledge usually reside in an individual instead of a group or a community. Some participants expressed the view that it is not always proper to claim that the knowledge and skills possessed by traditional healers are all in the public domain or communal. This assertion is problematic because African traditional healers rarely reveal the secrets of their medicinal remedies and healing systems, which they individually possess. According to them, this individualistic aspect of traditional medicine knowledge reinforces the concept of "knowledge is power". It supports the view that knowledge is a source of status and income

(especially where such knowledge is uncommon). In such a situation, the knowledge holder will protect it suspiciously and may not be unwilling to share it.

It was also argued that local communities are hesitant to document their traditional knowledge outside their traditional oral medium for fear that it may be misused, stolen, or used against them or that they will lose claim to the knowledge after documentation, especially in the globalized world. In many cases, traditional healers' suspicions have presented challenges to successful documentation, especially the digitalization of traditional medicine knowledge. The problem becomes more complicated when the field research relating to the documentation of traditional medicines and healing systems is carried out by individuals alien to the local community.

Some participants in the focus group discussions raised the issue of verifying traditional medicinal knowledge. It was pointed out that when a particular plant species is alleged to cure a certain disease, there is a need to verify this claim before documentation. This was raised as a challenge when the individuals or institutions involved in the verification and documentation process are not traditional healers themselves from the local community and may have to depend on some other sources to verify the information they receive from the community. The oral nature of African traditional medicine knowledge also makes it difficult to establish the authenticity of oral sources that are often forgotten over time. It was generally agreed that verification is very important because it serves as a safety measure to counter the fatal effect that may result from applying a wrong or bogus treatment to an ailment. Based on this consideration, the South African government initiated the Recognition of Prior Learning (RPL) as part of the IK Act (2019). The verification problem could be addressed by subjecting the traditional knowledge to peer review and laboratory scrutiny. The documentation of traditional medicine knowledge is also threatened by limited collaboration among various government agencies in most African countries, especially at provincial and local community levels. In South Africa, various government departments, agencies, and even NGOs are actively involved in traditional medicine knowledge documentation. However, the initiatives are not well coordinated and, in most cases, result in waste or duplication of efforts (Christian, 2009).

These discussions at the local community level, involving a diversity of stakeholders, imply that the benefits of traditional medicine knowledge deserve the efforts to deal with the challenges of documentation and accessibility. This is based on the recognition that documentation of African traditional medicine knowledge in some permanent form will benefit the local communities and the common good of all by creating opportunities for innovation and development.

6.6.1 Protection of African Traditional Medicines and Associated Indigenous Knowledge Systems Including Local Community Beneficiation

The study wanted to establish the community knowledge and awareness of African Traditional Medicine and associated knowledge systems on the IK Act (2019). The IK Act's regulatory function provides the conditions for access and use of indigenous knowledge and deals with intellectual property management. It intervenes in transboundary indigenous knowledge, such as between neighbouring countries like Namibia, Lesotho, and Botswana, and serves as a national competent authority. The comparative findings from the two study District Municipalities in KwaZulu-Natal province (uGu District Municipality and uMkhanyakude District Municipalities) are reflected in Tables 6.8 and 6.9.

Table 6-8. Comparative Percentage Distribution of Research Participants African Traditional Healthcare Practitioners (ATHPs) in The Study District Municipalities on the IK Act (2019) Concerning Protection of African Traditional Medicine and Associated Knowledge Systems

1. Total Number of Male ATHP Participants in uGu District Municipality (12);
   Total Number of Female THP Participants in uGu District Municipality (18);
2. Total Number of Male ATHP Participants in uMkhanyakude District Municipality (10);
   Total Female THP Participants in uMkhanyakude District (15).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	01	08%	Male	11	92%	Male	01	10%	Male	09	90%
Female	01	06%	Female	17	94%	Female	01	07%	Female	14	93%

Table 6.8 shows that most of the research participants ATHP (male and female) in both study district municipalities expressed that they had no knowledge and were unaware of the IK Act (2019) concerning the protection of African traditional medicine and associated knowledge systems. Table 6.9 provides their clients' comparative knowledge and awareness of these issues.

Table 6-9. Comparative Percentage Distribution of Knowledge and Awareness of the Traditional Health Practitioners (THPs) Clients in the Study District Municipalities on IK Act (2019) concerning protecting African traditional medicine and associated knowledge systems

1. Total Number of Male THP Clients in uGu District Municipality (62);
   Total Number of Female THP Clients in uGu District Municipality (88);
2. Total Number of Male THP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female THP Clients in uMkhanyakude District (77).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	07	11%	Male	55	89%	Male	04	08%	Male	44	92%
Female	02	02%	Female	86	98%	Female	03	04%	Female	74	96%

Table 6.9 shows that most of the participant ATHP clients (male and female) in both study district municipalities expressed that they had no knowledge and were unaware of the IK Act (2019) concerning the protection of African traditional medicine and associated knowledge systems.

During focus group discussions, the participant ATHPs and their clients articulated the need for capacity-building platforms and other knowledge and awareness opportunities to build their knowledge and awareness of the IK Act (2019) concerning protecting African traditional medicine and associated knowledge systems. Those who had knowledge and awareness of legal and policy framework concerning the protection of African traditional medicine and associated knowledge systems indicated that the applicability of conventional Intellectual Property Rights (IPR) concerning the protection of African traditional medicine and associated knowledge systems, the concept of copyright and individual rights to privately owned and controlled information is at odds with the traditional notion that knowledge is collectively owned and shared. Thus, a challenge to the application of the Western concept of IPR to African traditional medicine knowledge. This calls for a sustainable legal framework that meets the unique characteristics of African traditional medicine knowledge. Based on this consideration, stakeholders such as the government of South Africa embarked on the effort to put in place a *sui generis* legislation that protects and ensures equitable access to traditional medicine knowledge and associated resources.

The significance of African Traditional Medicine knowledge and associated resource protection also lies in its importance to the pharmaceutical industry, especially in drug development. Gaukroger (2016) and Unschuld (2022) reveal that Western science is gradually reaching its apex in providing new treatments for diseases afflicting humanity. Drug Discovery in the current scenario has become unproductive to the point where the economic future of the pharmaceutical industry is questionable. The Research and Development (R&D) thrust in the pharmaceutical sector is now beginning to be focused on developing new drugs, innovative processes for known drugs, and developing plant-based drugs through investigation of leads from the traditional systems of medicine. Unquestionably, traditional medicine can provide unique inputs into the drug development process and boost pharmaceutical drug discovery by a very high margin. The immense benefit of traditional medicinal knowledge in pharmaceutical drug development has given rise to bioprospecting and its illegal counterpart – biopiracy (Pramanik, 2018).

Munyonga (2020) indicates that the increase in cases of biopiracy is making traditional knowledge holders and practitioners in Africa and other developing countries very worried. The fear is not related to the historical trend of expropriation without compensation from pre-colonial times till to date. This is exacerbated by the growing notion by proponents of Intellectual Property Rights (IPR) that it should be applied to traditional medicinal knowledge to preserve and promote their commercial exploitation. It suffices to state, though, that IPRs, such as patents, do not primarily guarantee the commercial exploitation of knowledge rather, they are instruments whose main purpose is to exclude others from the knowledge.

Owiny et al. (2014) add that discussions on the challenges of the digital era tend to focus on the ownership rights of companies and individuals but with limited consideration of the plight of the underprivileged local community knowledge holders and practitioners in developing countries, including in Africa. The Western IPRS regimes tend to reward those who are in a position to patent certain kinds of innovation but do not recognize the originators of the innovations. Based on these challenges, it is argued that the Western intellectual property concept is inappropriate for traditional knowledge. Intellectual Property Rights, especially patents, as the West's primary mechanism for allocating rights over knowledge and its products, exemplify Western scientific traditions. Applying IPR to indigenous knowledge is economically detrimental to African cultural communities and can erode their community-based knowledge systems.

Considering their unequal position in the global knowledge economy, African countries and their indigenous knowledge holders and practitioners, including those in traditional medicine, endure the

greater share of misappropriation of indigenous knowledge systems. It is argued that their main loss is not the money their indigenous population might earn from selling herbs and local seeds. Still, the true price is the induction into a system of trade where the deck is already stacked in favour of existing and highly developed proprietary interests. Long-range economic value cannot be achieved by artificially monetizing shared traditions through patenting, copyrighting, or trademarking components like medicine, genetic materials, or other processes and structures of nature incorporated into the common heritage within African countries (Christian,2009).

It was also reiterated during the focus discussion that applying the Western IPR regime to traditional medicine knowledge will deprive the local people of access to such knowledge as ownership of the knowledge will be vested in the patent holder. At the same time, others had the view that if traditional medicine knowledge and other indigenous knowledge systems are left without any basic form of protection, it will lead to difficulties of access as the holders will be unwilling to disclose for fear of biopiracy together the subsequent effect of expropriation without compensation. This could restrict access to local knowledge systems.

It was agreed that a workable legal framework should meet the diverse interests associated with traditional medicine knowledge and other community-based knowledge systems. The current trend in the globalization of knowledge, especially concerning once relatively obscure indigenous knowledge systems, requires establishing a framework that will address the fear of local communities by making their knowledge systems, including traditional medicine, accessible for beneficial use. A sustainable framework to this effect will be one that will preserve the communal rights characteristic of indigenous knowledge and enhance access to this knowledge for scientific discovery and innovation while at the same time granting local communities and their knowledge holders and practitioners equitable access to any commercial benefits arising from the use of such knowledge. Umama Tabula, a traditional healer in uGu District Municipality who was aware of some of the indigenous knowledge policy and legal framework concerning African traditional medicine knowledge and associated resources, said:

> *"Ukumane unikeze ilungelo lobunikazi, ukusetshenziswa, kanye nokuxhashazwa kolwazi lwendabuko kanye nemithombo yemvelo emiphakathini yendawo nakubantu ngabanye (njengoba kungaba njalo) akwanele ikakhulukazi uma kubhekwa iqiniso lokuthi iningi lalaba bantu abafundile kahle futhi isikhundla esingcono kakhulu sokuxoxisana ngezinkontileka eziyinkimbinkimbi noma izivumelwano maqondana nokuxhashazwa ngolwazi lwabo lwendabuko noma izinsiza. Kunesidingo sokusungula izinhlaka zomthetho ezigunyazwe*

ukusebenza egameni lemiphakathi yendawo ekusebenziseni amalungelo ayo maqondana nokuxhashazwa kwezinhlelo zayo zolwazi lwendabuko kanye nemithombo yebhayoloji. Lokhu kungasebenza ekuxoxisaneni kwezinkontileka nasekunikezeni ilungelo lokufinyelela".

According to Umama Tabula, it was insufficient to merely grant local communities and individuals (as applicable) the ownership, use, and exploitation rights of indigenous knowledge and biological resources. This is because most of these individuals lack formal education and are, therefore, ill-equipped to negotiate intricate contracts or agreements pertaining to commercializing their indigenous knowledge or resources. Legal frameworks that have the authority to represent local communities in exercising their rights regarding exploiting their biological resources and indigenous knowledge systems must be established. This can be relevant when negotiating contracts and granting access rights.

It was pointed out during focus group discussions by those who are aware of the South African National Recordal System on indigenous knowledge systems, including traditional medicines, that currently, access to indigenous biological resources and associated knowledge systems in any local community is subject to the grant of written prior informed consent by the local community and traditional leadership. Using and exploiting indigenous knowledge and biological resources without the legal right of access gives rise to criminal and civil liabilities.

However, it was further elaborated during the discussions that the sheer grant of the right of access does not award the absolute proprietary right to the grantee, nor does it deprive the local community of all rights concerning its indigenous knowledge of the biological resource and associated knowledge system. The grantee is prevented from applying for any intellectual property rights over the resources or associated knowledge without the prior informed consent of the legal frameworks and the local community or recognized individual(s). Even then, where the indigenous knowledge leads to an innovation or discovery, the relevant local community or individual providing the knowledge leading to the innovation or discovery shall be entitled to a share of the earnings arising from there and, in addition, shall be acknowledged in all publications, patents and other intellectual property rights documentation arising from the discovery or innovation.

In addition, the IK Act (2019) envisages a process whereby indigenous knowledge may result in patentable innovation or discovery. Still, it falls short of clearly defining the rights concerning a patent arising from there. If the discovery or innovation is to be patented, the issue then is who has the patent – is the community or the grantee? The research participants wanted clarification on this issue because

of the effect of a patent in depriving the community of its traditional rights. Hence, one would have envisaged a legal framework whereby the patent is held in trust for the local community. Furthermore, some research participants had the view that the legal framework should explicitly provide that the issuance of a patent to a grantee should not deprive the local communities of their customary rights concerning the use and exploitation of the indigenous knowledge system or biological resources in dealing with their local health and socio-economic situations.

This comparative study believes that the Western conventional concept of intellectual property rights does not fit the unique characteristics of African indigenous knowledge systems. The growing global interest in indigenous knowledge systems due to their potential benefits, especially in the area of bioprospecting and drug development, will continue to generate serious debates. This is based on the argument that access to indigenous knowledge will continue to be problematic until an equitable legal framework that addresses the legitimate diverse interests of all the parties in this disagreement is implemented. It is hoped that this comparative study contributes to the ongoing discussions to establish the appropriate framework that will adequately protect the basic characteristics of indigenous knowledge while at the same time ensuring access to this important knowledge, which the majority of African people still depend on for sustainable livelihood and development.

Gogo Ntuli, a prominent Traditional Healer in uMkhanyakude District Municipality, said:

> *"Sengineminyaka engaphezu kwamashumi amane ngibambe iqhaza emithini yethu yesintu kanye nokwelapha kwesintu. Ngayithatha kubaba. Kuyingxenye yesiko lethu nolwazi lwabantu bethu oluhlobene kodwa olungagcini nje ngokusetshenziswa kwezitshalo nezinye izinsiza zemvelo ekwelapheni izimo ezihlobene nempilo. Kusukela kudala, izitshalo kanye nemikhiqizo ehambisana nazo ibisetshenziswa ekwelapheni izifo ezahlukahlukene emiphakathini yethu. Yakhelwe phezu kwesayensi yethu yomdabu, yaqalwa ngokubheka nokuhlola izinhlobo zezitshalo zendawo ukuze kutholakale ezidliwayo, ezokwelapha, nezinobuthi."*

Gogo Ntuli indicated over forty years of experience with African traditional medicine and healing practices. His father taught him. It was a part of their culture and people's knowledge that had to do with, but was not limited to, using plants and other natural resources to treat medical ailments. In African communities, plants and related products have long been used to treat various illnesses. Its foundation was indigenous science, which started with testing and observing local plant species to distinguish between poisonous, medicinal, and edible ones.

She emphasized that Traditional medicine knowledge goes beyond knowledge of what plant species (s) are used to treat a particular ailment. This is based on the consideration that to transform a plant into a medicine, one must know the current species and its location. Moreover, since some plant species are toxic at certain times of the year, one also has to know the proper time for collection and the part to be used (some parts of a plant could have beneficial medicinal use while another part of the same plant could constitute a deadly combination), including how to prepare it as well as the dosage (posology).

6.7 The National Recordal System: A Framework for Digitalization of African Indigenous Knowledge Systems in African Local Communities in South Africa

The preservation and dissemination of Indigenous Knowledge Systems (IKS) are integral to preserving cultural heritage and fostering sustainable development. In the contemporary digital era, the terms "digitalization" and "digitization" often emerge in discussions regarding the documentation and archiving of IKS. Understanding the nuances between these two concepts is crucial in comprehending their impact on the National Recordal System and documentation centres dedicated to IKS in South Africa.

Digitization involves converting analog information into digital formats, such as scanning written documents, photographs, or recordings into electronic versions (Amechi, 2015). This process facilitates easier storage, retrieval, and sharing of IKS within digital platforms (Balogun, 2023). Conversely, digitalization encompasses a broader scope, integrating digital technologies and infrastructure into various aspects of IKS management, including collection, preservation, analysis, and dissemination (Brennen and Kreiss, 2016; Terras, 2015).

Presently, within the National Recordal Systems and documentation centres worldwide, a combination of digitization and digitalization efforts exists concerning the archiving and dissemination of AIKS. Digitization initiatives predominantly focus on converting physical records, artifacts, and oral traditions into digital formats. This facilitates easier access and preservation, aiding in conserving invaluable cultural knowledge. However, integrating digital technologies into the management and utilization of IKS—constituting digitalization—is gaining traction, especially in South Africa (Oguamanam, 2021). This involves leveraging advanced technologies like Artificial Intelligence (AI), machine learning, and big data analytics to enhance the accessibility, analysis, and utilization of IKS. Digitalization initiatives aim to preserve and empower communities by utilizing

IKS for sustainable development, healthcare, environmental conservation, and education (Chigwada and Ngulube, 2023).

Within the National Recordal System and documentation centres in the South African context, the ongoing efforts predominantly focus on digitization, ensuring the preservation of IKS in digital formats. However, there's a growing recognition of the potential of digitalization in revolutionizing how IKS is utilized and integrated into contemporary systems. Oguamanam (2021) explains that the National Recordal System (NRS) is a large fingerprint initiative of the Department of Science and Innovation (DSI), designed as a defensive anti-biopiracy strategy to ward off appropriation of IK in their undocumented forms. It is meant to document, record, and store indigenous knowledge systems for the benefit of the local communities in South Africa. It uses multimedia platforms for recording and documenting IK, especially those relating to traditional medicine. The objective is to protect, preserve, and promote South Africa's indigenous knowledge systems, including traditional medicines and healing systems, by documenting and recording them.

Contrary to other cultures whose history has been documented, South Africa's rich Indigenous Knowledge and value systems rely on the spoken word – a tradition carried over from generation to generation for millennia. However, as communities become more sophisticated and urbanized, much of this IK is lost, misappropriated, or misused. Therefore, launching the National Recordal System (NRS) in Moruleng village, in the North West, the then Minister of Science and Technology, Derek Hanekom, told the community of Bakgatla-Ba-Kgafela, which has been participating in the project initiative, that it was urgent to document IKS as South Africa was rapidly losing its respected elders. He cited the saying, “When an old person dies in Africa, a whole library disappears; the National Recordal System (NRS) is therefore imminent”.

6.7.1 The National Recordal System Process

The NRS was established in response to the Indigenous Knowledge Systems (IKS) Policy adopted by the Cabinet in 2004. The policy directed the need to establish a record system in which local communities, guilds, and other IK holders can record their knowledge systems to assist their interest in future economic benefits and social good based on IK. The NRS initiative addressed issues related to the individualistic nature of intellectual property regimes that create complications when applied to local communities. The system secures rights for communities, guilds, and other IK holders that record their knowledge holdings, ensuring the protection of their interests and educational and economic benefits in the future knowledge economy.

Central to NRS's success was the National Indigenous Knowledge Management System (NIKMAS), an information and communication technology platform. This is supposed to be a secure multimedia digital repository that supports the NRS processes, which include IK holder cataloguing, recording, verification, classification, and authentication. The system is unique because it records African IK in its original oral format, links it to a complex metadata schema, and provides positive and defensive protection mechanisms. The system comprises several subsystems that are combined in an encompassing integration architecture supporting the following features:

- A semantic digital repository with custom-developed metadata schemata.
- A geographic positioning system (to document the locations of IK holders, communities, and plants).
- A sophisticated security model to preserve and protect IK.
- An advanced semantic search engine to aid intelligent searching across several possibly related IK entries.
- An IK holder cataloguing facility.

The NRS currently supports IK on African traditional medicine and indigenous foods. It will be developed later to include arts, crafts, and farming practices. Most importantly, it enables local communities to secure their knowledge and transform it into economic and social benefits while saving it for posterity. It was envisaged that it would be achieved through establishing provincial IKS Documentation Centres (IKSDC), where the collection, documentation, storage, and dissemination of indigenous knowledge and related activities will occur. Communities can record and update information about their knowledge of NIKMAS at these IKSDCs.

Indigenous Knowledge Systems Documentation Centres (IKSDCs) are pivotal in preserving, managing, and accessing IK. They are established as local-level vehicles for capturing IKS wealth in various communities. Established IKSDCs will provide services to communities, local government, national government, and the general public regarding indigenous knowledge systems captured in the National Recordal System (NRS). The information will be obtained from community elders, traditional healers, leaders, and other relevant sources. In addition to being a repository for collecting and organizing informational materials, the IKSDC and the communities involved will actively seek to produce productively shared, disseminated, and distributed information.

Presently, 21 local community members have been equipped with computers and cameras and are being trained to facilitate the NRS recording activities in their communities. Community elders verify

the data before submitting it to the central NIKMAS mechanism, where it is classified, and the necessary security access levels are set according to strict criteria. Currently, IKS documentation Centres have been established at the University of KwaZulu-Natal, Vuwani Science Centre in Limpopo, Tsengiwe in the Eastern Cape, Thaba Nchu in the Free State, and Tshwane in Gauteng. Figure 6.1 below shows the process of the National Recordal System in South Africa.

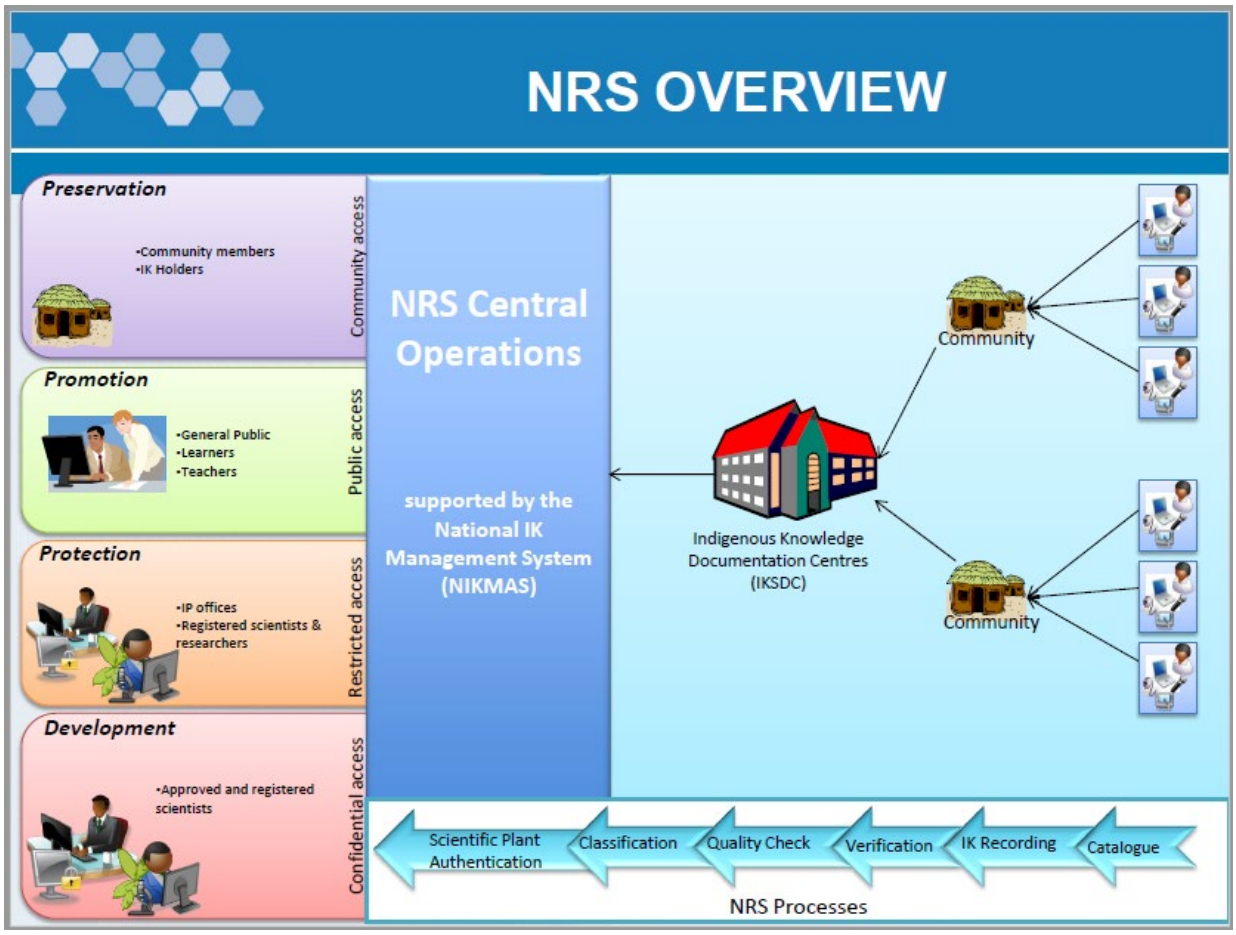

Figure 6.1. The National Recordal System process

Source: Adopted from Seleti Y. (2014, August, 20). *Department of Science and Technology on its role and responsibility in implementing the Indigenous Knowledge Systems policy*. Presentation to PPC meeting. https://static.pmg.org.za/140720pcscience.pdf

The process of the National Recordal System establishment follows a holistic approach to capture IKS characterized by involving the following elements:

- Consider and support the complete IKS ecosystem;
- Addresses both socio and economic challenges in communities and ensure community buy-in;
- Supports legislation and the benefit-sharing framework;

- Follows a living lab approach to the project;
- Standards – Dublin Core (extended), International Classification of Diseases, International Patent Classification Codes

The National Recordal System considers the recording of unrecorded IK in various multimedia formats for promoting community Indigenous Knowledge Systems, including Traditional medicines. It proposes both positive and defensive protection of these knowledge systems by collecting grassroots community experiences in local languages. The process is supported by the National Indigenous Knowledge Management System (NIKMAS), which comprises a semantic digital repository with custom-developed metadata schemata and a sophisticated security model to protect and preserve IK, an advanced semantic search engine, catalogue system and an overarching integration architecture that combines the subsystems into a coherent, fit for the purpose system.

6.7.2 Local Community Knowledge and Awareness of The National Recordal System (NRS)

The study wanted to establish the knowledge, awareness, and perspectives of the Participant African Traditional Healthcare Practitioners (ATHPs) and their clients in the Study District Municipalities on the National Recordal System and the IKS Documentation Centre at the University of KwaZulu-Natal (UKZN). The results are reflected in Table 6.10 and Table 6.11, respectively.

Table 6-10. Comparative Percentage Distribution of Knowledge, Awareness, and Perspectives of Participant African Traditional Healthcare Practitioners (ATHPs) in The Study District Municipalities on the National Recordal System and The IKS Documentation Centre at UKZN

1. Total Number of Male ATHP Participants in uGu District Municipality (12);
   Total Number of Female THP Participants in uGu District Municipality (18);
2. Total Number of Male ATHP Participants in uMkhanyakude District Municipality (10);
   Total Female THP Participants in uMkhanyakude District (15).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	09	75%	Male	03	25%	Male	08	80%	Male	02	20%
Female	14	78%	Female	04	22%	Female	11	73%	Female	04	27%

Table 6.10 shows that most of the research participants ATHP (male and female) in both study district municipalities expressed that they were aware of the IKS Documentation Centre at the University of KwaZulu-Natal.

Table 6-11. Comparative Knowledge, Awareness, and Perspectives of Participant African Traditional Healthcare Practitioners (ATHPs) Clients in The Study District Municipalities on the National Recordal System and The IKS Documentation Centre at UKZN

1. Total Number of Male THP Clients in uGu District Municipality (62);
   Total Number of Female THP Clients in uGu District Municipality (88);
2. Total Number of Male THP Clients in uMkhanyakude District Municipality (48);
   Total Number of Female THP Clients in uMkhanyakude District (77).

uGu District Municipality						**uMkhanyakude District Municipality**					
Aware (n)		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**	**Aware (n)**		**Aware (%)**	**Not Aware (n)**		**Not Aware (%)**
Male	55	89%	Male	07	11%	Male	44	92%	Male	04	08%
Female	80	91%	Female	08	09%	Female	73	95%	Female	04	05%

Table 6.11 shows that most of the participant ATHP clients (male and female) in both study district municipalities expressed their awareness of the IKS Documentation Centre at the University of KwaZulu-Natal.

Coordinators of the IKS Documentation Centre at the University of KwaZulu-Natal have, since its inception in 2013, been travelling around local communities, organizing local community members' knowledge and awareness meetings on the work of the Documentation Centre and the role of community involvement for its success and sustainability. A Provincial Steering Committee has been established to guide the process of IKS documentation and community mobilization. It comprises representatives of African Traditional Healthcare Practitioners, community members, and traditional leadership. The IKS recorders are also recruited from the local communities through the Steering Committee's and traditional leadership's assistance.

6.8 Chapter Summary

This chapter examined the knowledge, awareness, and perceptions of local community members, specifically African Traditional Health Practitioners (ATHPs) and their clients, regarding Indigenous

Knowledge and the policy landscape surrounding African Traditional Medicine at national and international levels. The research aimed to investigate the knowledge, awareness, and perceptions of ATHPs and their clients who participated in the study regarding the Indigenous Knowledge Systems (IKS) Policy adopted by the South African Cabinet in November 2004. Furthermore, the study aimed to understand the perspectives of ATHPs and their clients regarding the governance and management of traditional medicine within their local communities and beyond. Additionally, the research sought to determine the frequency of traditional medicine usage and its comparative usage among clients in the district municipalities under study. Furthermore, the study sought to assess community knowledge and awareness of African Traditional Medicine and the associated knowledge systems concerning the IK Act of 2019. Finally, the research explored the attitudes of the local community towards the preservation, protection, and utilization of traditional medicine, as well as the National Recordal System, serving as a framework for digitalizing and archival preservation of African Indigenous Knowledge Systems within local communities across South Africa.

Chapter Seven: Local Community Members' Perceptions on the Integration of African Traditional Medicine into the Public Health Care System in South Africa

7.1 Introduction

The previous chapters discussed the benefits of consulting African Traditional Health Practitioners (ATHPs) and using traditional medicine for people and local communities. These include being more affordable than conventional treatments, easier to obtain than prescription drugs, stabilizing hormones and the metabolism, strengthening the overall immune system, and there are often few to no side effects. It was also revealed from local community perspectives in the study areas that ATHPs serve many roles, including custodians of African traditional cultural and spiritual value systems, educators of culture, counsellors, social workers, and psychologists. They constitute a significant source of care and provide a belief system that is complementary to individuals' cultural beliefs in terms of the causes of mental health problems and, as a result, the right therapy for them.

Despite the important role African traditional medicine and healing systems play in the primary healthcare system of South Africa and Africa at large, especially in the rural and other marginalized communities, very few studies have been conducted to solicit the views of African traditional health practitioners (ATHPs) and their clients on the integration of African traditional medicine into the public healthcare system in South Africa. This aspect is articulated in the following sections with special reference to uGu and uMkhanyakude District Municipalities in KwaZulu-Natal province. The previous Chapter discussed their knowledge, awareness, and perceptions of indigenous knowledge and the African traditional medicine policy landscape. The purpose was to interrogate how they perceived the integration of the two healthcare systems, i.e., traditional and Western medical systems, as indigenous healthcare providers and as clients of the African traditional healthcare providers, respectively. The literature review in chapter two revealed that African traditional medicine and its healing practices were prohibited under the pretext of witchcraft in South Africa by the British colonial and later the apartheid governments. This led to secrecy in the practice and a lack of infrastructural planning to support it. As a result, traditional healthcare and healing practices are still predominantly informal and unregulated. This raises issues around accessibility and patient safety, as well as the accountability of the healers. Ozioma & Chinwe (2019) indicate that traditional African health practices use symbolic rituals and natural products, including local plants. They also follow certain cultural rules about privacy, and they require specific spatial qualities in terms of scale, sequencing, light, and materials.

Traditional healthcare providers and their clients participated in the study to solicit their comparative views. The results are presented and discussed in the following sections. Furthermore, one client who happened to be a modern healthcare practitioner was also interviewed as Ms Xulu stated that patients generally believe that the two types of healthcare systems found in African communities have different limitations and strengths related to healthcare delivery in terms of costs, accessibility, the accuracy of diagnosis and treatment, ability to treat certain diseases, and practitioners' understanding of patients' cultural and linguistic backgrounds. Canaway (2017) elaborates that patients can decide whether to use traditional or modern medicine by weighing these strengths and limitations. NASEM (2019) further indicates that patients would like healthcare providers to understand both types of medicine and healthcare to play a greater role in integrating the two systems for improved local community healthcare delivery. Umama Mzizi, one local community member in the uGu District Municipality, stated:

> *"Nakuba iziguli njengamanje zibona isidingo sazo zombili izinhlobo zezinhlelo zokunakekelwa kwezempilo, abahlinzeki bezokunakekelwa kwempilo, ikakhulukazi odokotela besimanje, kungase kudingeke baphushwe ukuze kufinyelelwe ekuqondeni isidingo sokusungulwa kwemithi yendabuko ngabakhi bezinqubomgomo."*

Umama Mzizi believed that while many patients already recognized the value of both kinds of healthcare systems, policymakers may need to exert pressure on healthcare professionals, particularly Westerners, to acknowledge the necessity of institutionalizing traditional medicine.

The above statement suggests that African traditional health practitioners and their clients recognize the significance of embracing both healthcare paradigms and have advocated for the formal inclusion of traditional medicine. Nevertheless, their opinions regarding the amalgamation of these two healing systems in the two study regions remain unknown. The following section delves into a comparative examination of their views and willingness to integrate traditional medicine and Western medical practices.

7.2 Comparative Willingness of Research Participants to Integrate African Traditional Medicine and Western Medical Care Systems

African and Western medical systems serve different but necessary functions in the South African public healthcare systems. Their strengths and limitations differ based on various factors such as affordability, accessibility, effectiveness for certain illnesses, patient comfort, and diagnosis and

treatment. Eighty-two percent (82%) of the interviewed local community members in uGu District Municipality and Eighty-five percent (85%) of those in uMkhanyakude District Municipality revealed that they consulted both a traditional healer and Western healthcare provider when they were sick. During focus group discussions in both study areas, they articulated that the difference between the two healthcare systems is how patients combine them. They believed that the two healthcare systems treat different illnesses most effectively. However, traditional medicine tended to be cheaper, easily accessible, and less of a hassle, and traditional healers were more caring than their Western counterparts. Most traditional health practitioners interviewed in both study areas (>90%) indicated that Western medicine had the advantage of modern technologies for quick diagnosis and controlled treatment.

On differences in Illness treatment, the majority of the interviewed community members (72% in uGu District Municipality and 87% in uMkhanyakude District Municipality) were able to name the diseases that were treated better by traditional medicine and which were treated better by Western medicines. Most local community research participants in both study areas indicated that Western medicine was better with anything that required surgery and severe illnesses that required emergency care. Traditional medicine and healing systems were effective in diseases, which were mystic ailments in the form of mental illnesses. They described mystic illnesses as when a person is sick, but none of the Western diagnostic tests can discover the cause of the illness.

The local community research participants in both study areas also expressed the view that traditional and Western medicine served different patient populations due to differences in cost/affordability and accessibility. For instance, people outside urban areas usually had no choice but to see traditional healers because there were no Western healthcare services. The proximity of a Western healthcare facility also played a role in influencing a patient's choice of where to seek medical services. Some local research patients said they went to a clinic because it provided better services and was close to home. Some women in uMkhanyakude indicated they went to a Western clinic only when the local community's traditional health practitioner was unavailable. One traditional health practitioner in uGu revealed that when diagnosed patients, he gave them the choice of using traditional or Western medication, as he saw both were effective. However, most of his patients chose traditional medicine because it was cheaper and locally available.

7.2.1 Comparative Patient Care

During in-depth interviews and focus group discussions, local community members' research participants believed that the ease and comfort of a patient seeing a healthcare provider influenced how long they would wait before they sought treatment. For instance, as articulated before, affordability and accessibility were two factors that influenced patients to seek treatment from traditional or Western medicine. These factors influence why patients often wait before the clinic only when an illness has reached a rather acute stage. On the other hand, a patient might be willing to see a THP at the very first symptoms of an illness as they are more accessible and comparatively cheaper. According to the research participants, another factor influencing patients to consult a healthcare provider (traditional or Western) early is how comfortable they are during the visit with the type of healthcare provider.

It was expressed, especially by most female research participants, that in most Western healthcare facilities, patients often wait a long time to see the healthcare provider. Many research participants expressed the experience of having to wait for hours to get the opportunity to talk to a doctor or nurse for a few minutes. They would wait outside the facility, often on the ground, since there were not enough benches. Whereas those who visited THP rarely had to wait to be seen. They usually waited inside, seated on mats or chairs if they did. The difference in waiting time was partly attributed to the ratio of patients to medical staff. In the rural areas of KwaZulu-Natal province, traditional medical practitioners significantly outnumber modern healthcare practitioners. According to estimates, the ratio of THPs to medical doctors highlights a considerable disparity, with approximately 250,000 to 400,000 THPs compared to 28,000 medical doctors in South Africa (Zuma et al., 2016). One of the research participants expressed that she believed that the unwelcoming attitude of modern or Western healthcare practitioners was mostly reserved for less affluent patients, especially women. Umama Nozipho, one research participant from uMkhanyakude, said:

> *"Ngiyasigwema isibhedlela uma ngikwazi, ngoba odokotela ababonisi umusa kwabampofu, ikakhulukazi abesifazane."*

Umama Nozipho indicated that she tried to avoid going to the hospital since the doctors did not treat the underprivileged well, especially the women.

In addition to the hospital staff being overworked, another possible reason for the perceived unsympathetic attitude of the doctors to patients in rural and other marginalized areas was language and cultural differences between the doctors and the patients. One woman research participant,

Umama Noluthando, had the following to say on the issue of language and cultural differences regarding Western-trained doctors in the local communities in uGu District Municipality:

> *"Abanye odokotela nabahlengikazi emiphakathini yakithi kaningi abaveli kule ndawo, kodwa basuka kwezinye izindawo eNingizimu Afrika noma kwamanye amazwe. Babuye bafundiswe phesheya. Abaningi abasikhulumi isiZulu, futhi abaqondi zonke izici zesiko leziguli zabo. Ngaphezu kwalokho, odokotela bangase bangamukeli ngaso sonke isikhathi ukuhlukana kwamasiko nenkolo njengokwenqaba kwabesifazane abaningi ukukhumula ukuze bahlolwe udokotela."*

She believed that some doctors and nurses in the local communities were often not originally from the areas but from elsewhere in South Africa or other countries. They were also often educated abroad. Many did not speak IsiZulu or understand all aspects of their patients' cultures. In addition, doctors might not always accept cultural and religious differences, such as many women's refusal to undress for a medical examination.

These sentiments were also expressed in focus group discussions with the research participants, indicating that the linguistic and cultural differences between patients and doctors, patient's perception of hospital staff as being unsympathetic, waiting time to see a doctor or nurse at the hospital, and the time and distance constraints for seeing a doctor can all make a trip to the hospital uncomfortable and challenging for a patient. The decision is often made to wait until an illness is more severe before seeking treatment from a hospital, while the decision to see a traditional healer might be made at the first symptoms.

7.2.2 Comparative Different Methods of Diagnosis and Treatment

The study also interviewed some THP clients who happened to be Western-trained medical practitioners to solicit their views on the differences between traditional and Western healthcare systems, especially on the issues of diagnosis and treatment of patients. It was alluded that Western medicine generally uses laboratory tests for diagnosis. In contrast, diagnoses by a traditional healer were a simple clinical diagnosis by judging the patient's symptoms or done through seeing, where a healer uses mystic methods to tell what a patient is suffering from, usually using a tool such as sand, bones, or cowry shells.

The remedies used to treat diseases were also tested differently. Traditional remedies have been tested by the traditional healers and patients using them and seeing them work over generations. In contrast, modern medications have been scientifically tested to know their effectiveness and how they combat the pathogen on a molecular level. The dosage of Western medicine could be carefully controlled. When medications are processed, the active compounds can be measured exactly. However, this was not possible with traditional remedies, and the dosage varied greatly.

The differences in diagnosis and treatment of traditional and Western medicines led some patients to utilize the two healthcare systems differently. Some patients would go to the hospital for a diagnosis and later go to a traditional healer for treatment as well, based on the belief that the hospital had the strength of technology and science for an accurate diagnosis, but was at the same time seen as more expensive and less effective for certain diseases.

Based on past discussions, the study wanted to establish the comparative willingness of the research participants, African traditional health practitioners (ATHPs), to integrate African traditional medicine and the Western medical healthcare system. The findings are reflected in Table 7.1.

Table 7-1. Comparative Percentage Distribution of the Willingness of African Traditional Health Practitioners (ATHPS) Research Participants to Integrate Traditional Medicine and Western Healthcare System

1. Total Number of ATHP Participants in uGu District Municipality (Male=12);
   Total Number of ATHP Participants in uGu District Municipality (Female =18);
2. Total Number of ATHP Participants in uMkhanyakude District Municipality (Male=10);
   Total Number of ATHP Participants in uMkhanyakude District Municipality (Female=15)

uGu District Municipality						**uMkhanyakude District Municipality**					
Willing (no.)		**Willing (%)**	**Not Willing (n)**		**Not Willing (%)**	**Willing (n)**		**Willing (%)**	**Not Willing (n)**		**Not Willing (%)**
Male	10	83%	Male	02	17%	Male	09	90%	Male	01	10%
Female	16	89%	Female	02	11%	Female	12	80%	Female	03	20%

Table 7.1 reveals that most ATHP research participants (male and female) in both study district municipalities expressed their willingness to integrate traditional African medicine and the Western healthcare system. This willingness and desire for collaboration with Modern Health Practitioners

(MHPs) and the integration of African traditional medicine are expressed in the following statement in IsiZulu by Ubaba Mhlongo, a Traditional healer from uMkhanyakude District Municipality:

> *"Abelaphi bendabuko base-Afrika imvamisa yibona kuphela insiza yezempilo etholakalayo noma ethengekayo emphakathini wami. Kodwa kubalulekile ukuthi sisebenzisane nodokotela besimanje ukuqinisekisa ukuthi iziguli zithola ukunakekelwa kwezempilo okungcono kakhulu. Sifuna ngempela ukusebenza nodokotela nabahlengikazi besimanje. Ngicabanga ukuthi kuwumthwalo kahulumeni ukusondeza abelaphi bendabuko base-Afrika kodokotela nabahlengikazi besimanje ukuze sisebenzisane futhi sesekane ekuxazululeni izinkinga eziphathelene nempilo yomphakathi emiphakathini yethu. Uhulumeni kumele aqinisekise ukuthi ulwazi lweNdabuko luyavikeleka kumasela. Kunezifo ezithile esingeke sikwazi ukuzelapha njengabasebenzi bezempilo bendabuko base-Afrika. Ngakho-ke, singathembela Kubasebenzi Bezempilo Banamuhla."*

The above statement from Ubaba Mhlongo indicated that traditional African healers are often the only healthcare service available or affordable to the local community. Traditional healers recognize that certain diseases could be well treated by modern medicine. Hence, there is a need for the two healthcare systems to work together with modern healthcare practitioners for improved and effective local community healthcare. It is the government's responsibility to bring these two healthcare systems closer. However, the government should ensure that traditional healthcare knowledge is not stolen.

This sentiment was reiterated by Gogo Gumbi, a Traditional Health Practitioner in uGu District Municipality, who said:

> *"Kukhona ukushoda kwabasebenzi bezempilo abaqeqeshwe emazweni aseNtshonalanga ezibhedlela zikahulumeni nasemitholampilo eNingizimu Afrika, ikakhulukazi ezindaweni zasemakhaya kanye neminye imiphakathi enganakiwe. Abelaphi bendabuko baningi ezindaweni zasemadolobheni nasemakhaya. Sicela ukuhlanganiswa kokwelapha kwendabuko kanye nokunakekelwa kwezempilo kwaseNtshonalanga. Siyajabula ukuzwa ukuthi uhulumeni waseNingizimu Afrika uyaweseka lo mbono wokuhlanganisa lezi zinhlelo ezimbili zokunakekelwa kwezempilo futhi sekunezinhlaka zenqubomgomo kulokhu."*

Gogo Gumbi had the view that in South African state hospitals and clinics, there was a dearth of medical professionals with Western training, particularly in rural and other marginalized areas. There

are many traditional healers in the nation's rural and urban locations. We are advocating for the integration of Western medicine with traditional healing. She was pleased to learn that the South African government supports integrating the two healthcare systems and that appropriate policy frameworks have already been established.

During focus group discussions in both study areas, it was articulated by the participant ATHPs that there are various ways in which individual healthcare practitioners, both traditional and modern, could work together to integrate the two types of healthcare systems for the benefit of the public. For instance, they could send patients to practitioners of the other healthcare system when they think that the other might be able to treat a patient more effectively; they could share and learn certain healthcare techniques and value systems from the other, such as ATHPs learning about hygiene and the importance of accurate dosage; they could also learn about the remedies of both, either to use both or to avoid any negative interactions between treatments.

It was expressed that their healthcare providers' understanding of both healthcare systems could lead to knowledge and awareness of when the other system could best treat patients. Healthcare providers from each system could send patients to each other when one could not treat a patient or the other could treat the patient more efficiently. This was based on the realization that sometimes patients often decide to see one type of practitioner when the other has not helped, but would generally prefer if the healthcare providers understood better when patients could or should see the other type of practitioner.

It was also revealed, from the ATHPs' experiences, that patients usually had a positive view of traditional health practitioners who sent people to the hospital when they believed they were unable to treat them. This view was expressed by participant patients who mentioned that it was common for ATHPs to send people to modern doctors.

During the focus group discussion with the participant, ATHPs from both study municipalities on the challenges of mixing medications from the two medical systems, as it could have negative effects on the patient due to toxicity and render the treatment ineffective. It was argued by the participant, who happened to be a Western medical healthcare practitioner, that because there was limited information on the chemical characteristics and composition of traditional medications, none of the doctors could describe any specific interactions, including the prospects and challenges of their efficacy. For instance, one participant who was also a medical doctor in the uGu District Municipality indicated

that he would sometimes treat a patient without any improvement, only to discover that the patient had been using a traditional remedy that interfered with modern medication.

It was emphasized during the discussions that other than understanding each other's strengths and limitations. The ATHPs had the view that patients would like traditional and modern practitioners to learn from each other's techniques in medical and healthcare delivery—most specifically, patients believed it is important for traditional healers to learn hygiene practices and to learn to be careful with the dosage of medications.

The study was also interested in establishing the comparative views of the research participants' ATHP clients regarding integrating African traditional medicine and the Western healthcare system. The findings are reflected in Table 7.2

Table 7-2. Comparative Percentage Distribution of the Willingness of African Traditional Healthcare Practitioners (ATHPs) Research Participants' Clients to Integrate African Traditional Medicine and Western Healthcare Systems

1. Total Number of ATHP's Clients in uGu District Municipality (Male= 62);
   Total Number of ATHP's Clients in uGu District Municipality (Female =88);
2. Total Number of ATHP's Clients in uMkhanyakude District Municipality (Male=48);
   Total Number of ATHP's Clients in uMkhanyakude District Municipality (Female=77).

uGu District Municipality						**uMkhanyakude District Municipality**					
Willing (no.)		**Willing (%)**	**Not Willing (n)**		**Not Willing (%)**	**Willing (n)**		**Willing (%) `**	**Not Willing (n)**		**Not Willing (%)**
Male	54	87%	Male	08	13%	Male	41	85%	Male	07	15%
Female	80	91%	Female	08	09%	Female	75	97%	Female	02	03%

Table 7.2 indicates that most of the ATHP research participants' clients (male and female) in both study district municipalities reflected their willingness to integrate traditional African medicine and Western healthcare systems. During in-depth interviews and focus group discussions, they expressed the opinion that incorporating traditional medicine with Western health care would improve the health care of many South Africans. Building on African traditional medicine and healing practices, which are local, community-based, accessible, culturally acceptable, and affordable, will make public healthcare more effective and sustainable.

Gogo Madlopha, a Traditional Health Practioner from the uGu District Municipality, said:

> *"Imithi yesintu ibilokhu iwumthombo othembekile, owamukelekayo, othengekayo, futhi ofinyelelekayo kithina ma-Afrika amakhulu eminyaka. Imithi yesimanje izosebenza kakhulu futhi yamukelwe emiphakathini yakithi uma yamukela futhi isebenza ngolwazi lwethu lwendabuko nezindlela zokwelapha."*

Gogo Madlopha expressed that Africans relied on traditional medicine for ages as reliable, socially acceptable, cost-effective, and easily available healthcare. If modern medicine acknowledges and incorporates our traditional knowledge and healing methods, it will be more effective and well-accepted in our local communities.

The participant ATHPs' clients had divergent views on the issue of the two healthcare systems working together. More than 80% of them in both study areas favoured the two systems working together. Various suggestions were articulated on the use of the two systems. Some believe that if a person chooses to use both remedies, it is better to use one after the other treatment is completed. Others thought that using the two together simultaneously could be more effective than using one another; another suggestion was for the patients to ask their medical doctor or traditional health practitioner if they could use them together. Others indicated that the medical doctors and healers do not even understand the impact of the interactions.

It was pointed out during focus group discussions that the patient's lack of understanding of the risks of mixing medications when the chemical properties of some are not known, and their faith in health care providers to know and warn them of any risks, implies that both systems need to understand the other's remedies, as well as their own. The participant ATHPs' clients expressed the need to consult a medical doctor or traditional healer who knew and used traditional and modern remedies. They believed using both would be the best approach to effective public healthcare. Modern medicine uses laboratories to get an accurate diagnosis. However, when it comes to treatment, patients have the choice for some illnesses, whether they would rather take a traditional or modern remedy.Then, patients can use whichever they are more comfortable with or take the traditional medication if they cannot afford the modern alternative.

7.3 Research Participants' Opinions on the Two-Way Referral System of Patients between ATHPs and MHPs

Several African Traditional Health Practitioners (ATHPs) from both district municipalities recognized some limitations of the traditional healing system. They were of the view that patients with symptoms of mental health, HIV/AIDS, cancer, or TB should first be treated by healthcare workers at clinics or hospitals and then the ATHPs' clinics in cases where there was no improvement. This was elaborated during one of the focus group discussions by Mama Busisiwe, one of the ATHPs from the uGu district municipality, who exclaimed in isiZulu:

> *"Ngidlulisela iziguli zami ezinezimpawu zempilo yengqondo, i-HIV/AIDS, umdlavuza, noma i-TB ezikhungweni zezempilo eziseduze. Ngokubona kwami, ngicabanga ukuthi noma yisiphi isiguli esinezimpawu ezinjalo kufanele siqale siyiswe ezikhungweni zezempilo ukuze sihlolwe ngokwesayensi njengoba ngenza. Ezimweni lapho odokotela bengaboni noma yiluphi uphawu lwezifo ezinjalo, khona-ke kunesidingo sokubambisana."*

Mama Busisiwe indicated that she referred her patients with symptoms of mental health, HIV/AIDS, cancer, or TB to the nearest healthcare facilities. In her opinion, any patient with such symptoms should first be taken to healthcare facilities to be scientifically tested. In cases where doctors do not see any sign of such illnesses, collaboration is needed.

ATHPs made numerous suggestions for facilitating referrals, collaboration with, and integration into MHP, with the theme of increasing respect for ATHPs and economic barriers. This was expressed in isiZulu by Ubaba Ngcobo, one of the ATHPs from the uMkhanyakude district municipality*:*

> *"Igalelo lami ukuthi ukuze kwakhiwe ubudlelwano obuqinile, kungcono ukuthi uhulumeni abeke izindlela zokudlulisela kanye nokuhlanganisa ezizosiza ukudlulisa iziguli phakathi kwama-MHP nama-ATHP. Abasebenzi basesibhedlela bathola imiholo yanyanga zonke kungakhathaliseki ukuthi bayelapha iziguli noma cha, uhulumeni kufanele futhi acabange ukusibekela iholo elincane njengabelaphi bendabuko base-Afrika njengoba kithi iziguli imiholo yethu. Uma singaziboni iziguli, asinawo umholo. Lokhu kungase kwenze abanye bethu bathande imali kunempilo yeziguli zethu kanti abanye bangase bangabaze ukuthumela isiguli esibhedlela, ngoba bangase besaba ukulahlekelwa umholo."*

According to Ubaba Ngcobo, the government should establish referral and integration systems to facilitate patient transfers between MHPs and ATHPs to foster a solid working partnership. In

addition, as hospital employees were paid every month whether or not they treated patients, the government ought to consider setting a minimum pay for ATHPs, given that ATHPs' patients were the sources of ATHPs' income. Because of this, some ATHPs might put their financial security before the patient's health, and others might be hesitant to send patients to the hospital out of concern for their income.

One of the fundamental beliefs in African traditional medicine is that illness is caused by imbalances in the individual's relationship with the environment, ancestors, and the divine (Che et al., 2024). Karanja (2019) states that ATHPs use various methods to restore balance and promote healing, including divination, plant-based medicines, spiritual healing, and ritual practices. These methods are often accompanied by specific cultural practices, such as using specific plants or animal parts in medicines, purification rituals, and offerings to ancestors or deities (Ozioma & Chinwe, 2019). These beliefs and practices are deeply embedded in the cultural traditions of the communities that use them and are often passed down from generation to generation. However, these beliefs and practices can also create barriers to the recognition and use of IKS in the wider health system. Some ATHPs were hesitant to engage with Modern medicine or the formal health system due to perceived conflicts with their cultural beliefs and practice, leading to a lack of integration between traditional and Western medical practices and a lack of understanding of the potential benefits of incorporating IKS into the health system. Umama Hlengiwe, an African Traditional Health Practitioner (ATHP) from the uGu district municipality, recommended explicitly identifying specific doctors to whom ATHPs should refer their patients. These were her words in isiZulu:

> *"Ngeke ngithande ukuthumela iziguli zami kunoma yimuphi uDokotela. Ngizithumela kuphela kulabo dokotela nabahlengikazi abakholelwa ekusebenzeni kwemithi yesintu yase-Afrika. Kufanele ngiphathise iziguli zami kudokotela osondelene kakhulu nomphakathi esihlanganyela nawo izinkolelo nezindlela zamasiko ezifanayo."*

She preferred not to refer any of her patients to a doctor. She only referred them to medical professionals who shared her belief in the efficacy of African traditional medicine. She had to give her patients to a physician who practised medicine closest to the community and had similar cultural practices and beliefs.

Most ATHP participants in both district municipalities acknowledged that they cannot diagnose all sicknesses. In cases where they cannot diagnose, they would first refer patients to the nearest hospitals and clinics to confirm the diagnosis or diagnose them before commencing treatment and for further

treatment when their treatment has failed. This was reflected in words from Ubaba Ndlovu, one of the ATHPs in the uMkhanyakude district municipality, who exclaimed in isiZulu:

> *"Njengengxenye yokuqeqeshwa kwethu, siyalelwe ukuthi sidlulisele iziguli esibhedlela. Nakuba singakwazi ukwenza ukuxilongwa kokuqala ngokusekelwe kuzimpawu zesiguli, siyayiqonda imikhawulo yokuhlinzeka ngemithi ngokusekelwe ekuxilongweni kwethu. Kuyoba kungasebenzi ukunikeza ukwelashwa okusekelwe kuphela ekuhloleni kwethu, njengoba kungase kube nezinye izimo eziyisisekelo okudingeka zicatshangelwe. Ngakho-ke, kubalulekile ukuba sithumele iziguli esibhedlela, lapho kungatholakala khona ukuxilongwa okufanele, kuhlanganise nanoma yiziphi izifo ezengeziwe ezingase zibe khona. Lokhu kuqinisekisa ukunakekelwa kwezokwelapha okuphelele nokunembile kwesiguli."*

He revealed that he had been taught to refer patients to the hospital as part of his training. He recognized the limitations of prescribing medication based only on his diagnosis, even though he might be able to get a preliminary diagnosis based on the patient's symptoms. As other underlying conditions might need to be considered, it would be ineffective to administer treatment based only on our assessment. As a result, ATHPS must send patients to the hospital so that a complete diagnosis, including any coexisting diseases, could be made. This guarantees the patient receives thorough and precise medical care.

When further addressing the referral issue, many ATHPs reported that their first preference is often given to fellow ATHPs believed to be more powerful with access to more specialized kinds of "muti" (of the medicine used to treat patients). They expressed a clear belief that there were sicknesses caused by God and others by evil spirits. These were the words of Ubaba Simeon, an ATHP from the uGu district municipality:

> *"Emiphakathini yami, izinga lokukhethekile nolwazi lwabasebenzi bezempilo bendabuko base-Afrika luyehluka. Sinabo odokotela bemithi nababhuli abakwazi ukwelapha izinhlobo ezahlukene zezifo. Ezinye izifo kukholakala ukuthi zibangelwa ubuthakathi noma imimoya emibi kanti ezinye ziyimbangela yemvelo. Ezimeni lapho ngingeke ngikwazi ukuxilonga isiguli esiza kimi ukuze sithole ukwelashwa, ngiyoqala ngithumele isiguli enyangeni eyisipesheli ngezifo ezibangelwa ukuthakathwa, noma enyangeni enolwazi kakhulu kunami. Uma ehluleka, angadlulisela isiguli emtholampilo noma esibhedlela."*

He indicated that the experience and specialization of traditional African health practitioners varied in local communities. Some herbalists and diviners could cure various illnesses. While some illnesses were thought to have natural causes, others were attributed to witchcraft or evil spirits. When a patient came to him for treatment and was unable to diagnose them, he first referred them to another ATHP who was more experienced than him or who specialized in illnesses caused by, say, witchcraft. He may refer the patient to the clinic or hospital if he cannot help them.

Ubaba Funani, one of the ATHPs from uMkhanyakude, also indicated that patients sometimes referred themselves between the ATHPs and modern clinics or hospitals due to individual preference and choice of treatment:

> *"Ngihlale ngiluleka iziguli zami ukuthi zisebenzise abelaphi abazithandayo. Kodwa-ke, angibakhuthazi ekuhlanganiseni imithi yokwelapha ephuma kokubili ama-ATHP kanye nama-MHP."*

He indicated that he always recommended my patients use their chosen healers. However, he discouraged them from combining treatments from both ATHPs and MHPs.

The examination of ATHPs' opinions regarding the two-way referral system between ATHPs and MHPs underscores the complexity and multifaceted nature of healthcare collaboration in the two research areas. The insights gleaned from this analysis shed light on the complex interplay between cultural beliefs, holistic approaches to health, and the advancements of modern medicine.

ATHPs' perspectives on the two-way referral system reflect diverse attitudes shaped by cultural, historical, and individual factors. The willingness of some ATHPs to engage in referrals can be seen as indicative of their recognition of the potential benefits that medical interventions can offer patients, particularly in acute or advanced illnesses. Concurrently, the hesitancy or resistance exhibited by other ATHPs may stem from concerns related to the perceived erosion of traditional practices, the fear of subjugation to the biomedical model, or skepticism regarding the efficacy of conventional treatments.

The potential benefits of a collaborative referral system between ATHPs and medical doctors are evident. Such a system can harness the strengths of both traditional and modern healing practices, offering patients a comprehensive spectrum of care that addresses their physical, psychological, and cultural needs. Moreover, establishing respectful and inclusive partnerships between these

practitioners can foster mutual understanding, facilitate knowledge exchange, and enhance the overall quality of healthcare delivery.

7.4 The Exchange of Knowledge Between ATHPs and MHPs

During the focus group discussions and interviews, participants were asked what they would like to learn from modern medicine. The exchange of knowledge between African Traditional Healthcare Providers (ATHPs) and Modern Healthcare Providers (MHPs) emerged as a prominent theme. The majority of participants emphasized the importance of this knowledge exchange. ATHPs expressed that they are interested in gaining knowledge of the diagnosis and treatment methods used in modern medicine. Ubaba Thembeka, an ATHP from the uGu district municipality, had the following to say in isiZulu:

> *"Ngicabanga ukuthi kumele sifunde komunye nomunye. Engifuna ukukufunda kubasebenzi bezempilo mayelana nokuxilongwa kwesayensi; bazibona kanjani izinhlobo ezihlukahlukene zezifo besebenzisa izindlela zesayensi zokuhlola isiguli."*

He indicated that he believed that people must learn from one another. He wanted to know how medical professionals diagnosed diseases scientifically—that is, how they used scientific methods of patient examination to identify various types of illnesses.

During focus group discussions, several other ATHPs from both district municipalities wished to learn about techniques and technologies used in modern medicine. These were their words in IsiZulu:

> *"Ngingathanda ukufunda kodokotela besimanje mayelana nendlela yokubona izimpawu nokwelashwa kwezifo ezinjenge-HIV/AIDS, umdlavuza, noma isifo sofuba, umfutho wegazi, isifo sikashukela."*

They expressed the need to learn from modern doctors about how to detect symptoms and treatments for sicknesses such as HIV/AIDS, cancer, Tuberculosis, high blood pressure, and diabetes.

> *"Singafunda futhi odokotela banamuhla ukuthi bampontshelwa kanjani igazi noma bangasiza kanjani umuntu ukuthi aphelelwe amanzi emzimbeni noma ahlole izinga likashukela."*

The view was expressed that ATHPs could also learn from modern doctors how to do blood transfusions, help dehydrate someone, or check sugar levels.

> *"Ngingafunda imikhuba enempilo yokuzivikela ezifweni ezithathelwanayo futhi ngivimbele amagciwane nezifo ezithathelwanayo ukuba zingasakazeki."*

ATHPs could also learn healthy practices to protect themselves from contagious diseases and prevent germs and infectious diseases from spreading.

> *"Ngifuna ukufunda amasu esimanje okugcinwa kwemithi kanye nendlela yokumaketha imikhiqizo yami yemithi yesintu yase-Afrika ukuze ngiqwashise kabanzi lolu lwazi ezweni lonke nasemhlabeni jikelele."*

They expressed the importance of learning modern medicine preservation techniques and how to market their traditional African medicine products to raise more awareness of this knowledge, nationally and internationally.

> *"Kunzima kwesinye isikhathi ukubheka emehlweni esiguli ubone ukuthi siphethwe yini. Isizathu sokuthi kungani ngingathanda ukufunda ukusebenzisa ubuchwepheshe besimanje bezempilo njengemishini ukuze ngikwazi ukubona kalula ezinye izifo. Lokhu kungasisiza ukuthi sithuthukise umsebenzi wethu."*

There was an indication that it was sometimes difficult to look into a patient's eyes and detect the sickness. They would, therefore, like to learn how to operate modern health technologies such as machines to detect other sicknesses easily. This could help improve ATHPs' work.

While many ATHPs believed that there is a lot that Traditional Medicine has to learn from modern medicine, few ATHPs reported that they don't see a need to learn from MHPs because the medication used in hospitals comes from traditional medicine. Ubaba Mbube, an ATHP from uMkhanyakude district municipality, had the following to say in isiZulu:

> *"Akukho engingakufunda kodokotela besimanje. Sekuyiminyaka ngisebenza kahle kakhulu ngaphandle kwemithi yesimanje. Kungani ngingasizwa isidingo sokufunda kubo, ikakhulukazi ngoba imithi esetshenziswa ezibhedlela iphuma emithini yesintu? Iningi lolwazi lokhokho bethu lasetshenziswa kabi ngabakhangisi ukuze benze imithi yesimanje esetshenziswa*

ezibhedlela nasemitholampilo. Uyaqonda ukuthi kungani ngingakwazi ukufunda imithi ecutshungulwe elabhorethri. Ngisebenzisa umuthi wokuqala. Ngicabanga ukuthi sidinga ukugodla ulwazi olubalulekile ngemithi yethu yesintu yase-Afrika."

He indicated that he had nothing to learn from modern medical doctors. He had been working very well without modern medicine for years. After all, the medications used in hospitals emanated from traditional medicine. Pharmaceuticals misappropriated the indigenous knowledge of African forefathers to make the modern medicine used in hospitals and clinics. He was against learning about medication that had been processed in the laboratory. He used the original medicine.

Despite their interest in gaining knowledge of the diagnosis and treatment used by modern medicine, ATHPs expressed the view that as much as they have to learn, MHPs had also a lot to learn from ATHPs. Responses to the question of what modern medicine can learn from ATMs are depicted below as isiZulu statements from ATHPs in both district municipalities:

"Ngicabanga ukuthi abahlengikazi nodokotela kumele bafunde kabanzi mayelana namasu esiwasebenzisa emithini yethu yendabuko ukuhlonza izifo ezingelapheki esibhedlela noma emtholampilo."

They indicated that nurses and doctors needed to learn more about the techniques used in traditional medicine practices to identify diseases that cannot be cured at the hospital or clinic.

"Ngicabanga ukuthi bangafunda kithi ukwenza/ukuxuba amakhambi emvelo ukuze kwenziwe imithi yesintu. Bangathola ulwazi lwendabuko esinalo njengabelaphi bendabuko futhi balusebenzisele umgomo ofanayo wokwelapha abagulayo. Laba bangafunda ukusebenzisa amakhambi athile ase-Afrika lezo zinhlelo ezimbili zezokwelapha ezingase zisetshenziswe ukwelapha izifo ezizophola phakade njengomuthi wesimanje."

The view was expressed that conventional medical practitioners could learn from ATHPs how to make/mix natural herbs to make traditional medicine. ATHPs could get the indigenous knowledge that ATHPs had and use it for the common goal of healing the sick.

"Kubalulekile ukuthi odokotela nabahlengikazi bazi kahle ukuthi umuthi uvelaphi ukuze bakhethe lokho abangenakho futhi bakufake emisebenzini yabo. Isibonelo, kungase kungadingeki benze "umuthi" ube amaphilisi kodwa bangasebenzisa umuthi ngendlela yawo

yemvelo. Ngale ndlela umuthi uzosebenza kakhulu ekwelapheni ukugula ngoba uluhlaza kunalapho usuxutshiwe wagaywa ezimbonini."

The ATHPs indicated the importance of doctors and nurses knowing exactly where the medicine comes from so that they can choose what they do not have and incorporate it into their practices. For example, they may not need to make the "*muthi*" into pills, but they could use the medicine in its natural form. In this way, the medicine would be more effective in healing the sickness because it is still natural than when mixed and processed in industries.

"Bangase bafunde izindlela zethu ezahlukene zokwelapha ezinjengokwethemba uNkulunkulu nokuthandazela isiqondiso lapho sisiza iziguli. Akuyona yonke into eyisayensi, ezinye izifo zidinga umthandazo olula kuphela futhi umuntu uyasinda. Lezi yizintambo okumele bazi odokotela nabahlengikazi ukuze abantu bakithi bangalahlekelwa yimpilo yabo ezibhedlela nasemitholampilo ngenxa yokungazi kodokotela nabahlengikazi."

According to the ATHPs, conventional healthcare practitioners could also learn the different healing methods, such as trusting God and praying for guidance when helping patients, from ATHPs. This was based on the argument that not everything was science; some sicknesses only required a simple prayer, and the person got well. These were the things that doctors and nurses needed to know so that people do not lose their lives in hospitals and clinics because of ignorance on the part of doctors and nurses.

"Bangafunda ukuthi bangasithola kanjani isifo noma babhekane nembangela yenkinga ngaphandle kokubuza imibuzo eklayentini noma kumuntu ogulayo."

They can learn how to detect the disease or deal with the root cause of the problem without even asking the client or sick person questions.

"Baningi odokotela nabahlengikazi abangafunda kithi uma nabo bezimisele ukusicobelela ngolwazi lwabo. Ngicabanga ukuthi ngeke bafunde lutho uma bengafuni ukubambisana nathi mayelana nokwabelana ngolwazi nemishini yabo."

The ATHPs believed that if conventional healthcare practitioners were willing to share their knowledge with them, many physicians and nurses could benefit from what ATHPs could teach them.

The following section looks at what research participants in both research sites had to say about the concurrent use of traditional and modern medicine.

7.5 Research Participants' Opinions on The Concurrent Use of African Traditional and Modern Medicines

The discourse surrounding the concurrent use of traditional and modern medicine among the research participants has shed light on this complex and multifaceted topic. The opinions expressed by these participants reflect a range of perspectives, revealing both the perceived benefits and inherent risks associated with the simultaneous utilization of these two treatment models. There was much concern about the physical health risks of combining traditional and modern medicines. It was also felt that this risk would be reduced through collaboration and integration of the two healthcare systems. This view was expressed in the following statement by Ubaba Kgabu, an ATHP from the uMkhanyakude district:

> *"Ngizotshela iziguli zami ukuthi zingasebenzisi kanyekanye imithi yesintu neyesimanje. Inkinga enkulu ukuxuba imithi lapho angazi ukuthi yimuphi umuthi owanikezwa udokotela esibhedlela noma emtholampilo. Uma kukhona ukubambisana, singavimbela okubi ukuthi kungenzeki."*

He expressed the view that he would tell his patients not to simultaneously use traditional and modern medicine. A major challenge was mixing the medication when he did not know which medication the doctor gave in the hospital or clinic. If there were collaboration, it would be beneficial for the patients.

However, ATHPs interviewed recognized that some traditional African medicines could not be combined with modern treatments because of incompatibility. So, asking clients whether they have visited the hospital and clinic and are using any modern medication is important. Gogo Isisa, an ATHP from the uGu district municipality, had the following to say in isiZulu:

> *"Ngisakholelwa ekutheni kwezinye izimo imithi yesintu neyesimanje ingasebenza kanyekanye. Isibonelo, ngingasebenzisa imithi yesintu kuyilapho udokotela ehileleke ekwelashweni okungezona ezomuthi, ukwelapha okufana nokwelulekwa noma ukwelapha. Lokhu kungase kube njalo esimweni lapho isiguli sidinga umthandazo ngakolunye uhlangothi kanye nemithi yesimanje ngakolunye. Kunesidingo sokugqugquzela."*

Gogo Isisa believed that, in some cases, traditional and modern medicine could work concurrently. For example, she could use traditional medicine while the doctor was involved in treatments that were not in the form of medicines. This involved treatments such as counselling or therapies. This was also the case in an event where the patient required prayer on one hand and modern medicine on the other. She emphasized the need to foster communication and cooperation between the two healthcare systems to improve public healthcare in South Africa.

Furthermore, the participant AHTPs also recognized that their patient's beliefs about their illness and the degree of healing influenced the healthcare system they would seek to use. This was expressed in isiZulu by Gogo Khethiwe, an ATHP from the uGu district municipality:

> *"Ukholo endleleni yokwelapha noma uhlelo lunomthelela omkhulu njengoba kuyisihluthulelo ekwelapheni kwamaklayenti ami kanye nokululama ngokushesha ezifweni zawo. Ngike ngaba nezimo lapho amakhasimende eza kimina avuma ukuthi ake afika esibhedlela noma emtholampilo kodwa abengakaphili. Babike ukuthi bayakholelwa emithini yesintu yokubasiza ukuthi balulame ezifweni zabo."*

Gogo Khethiwe believed that faith in a healing method or system had a great influence because it was key to her clients' healing and quick recovery from their sicknesses. She indicated cases where clients came to her and confessed that they had been to the hospital or clinic but were still ill. They reported having faith in traditional medicine to help them recover from their sicknesses.

However, Gogo Lerato, an ATHP from the uGu district municipality, expressed that implementing a two-way referral system faced challenges that warrant attention. These were her words in isiZulu:

> *"Isistimu yokudluliselwa kwezindlela ezimbili inezinselele ezihlobene nokuzwela Kwamasiko, izithiyo zokuxhumana, kanye nomehluko kumafilosofi okuxilonga nawokwelapha. Lezi zinselele zingavimba ukusebenzisana okuphumelelayo phakathi kwethu."*

She indicated several challenges with a two-way referral system because of cultural sensitivity, communication problems, and divergent treatment and diagnosis philosophies. These difficulties could prevent the two healthcare systems from working together effectively.

The discussions in the research process underscored a prevalent concern among participants regarding the potential physical health risks that might arise from the amalgamation of traditional and

biomedical treatments. This apprehension was rooted in these two approaches' distinctive methodologies and underlying principles, which could lead to adverse interactions, contraindications, or unintended side effects when combined without careful consideration. The apprehension about potential health risks was warranted and reflected the need for a cautious approach to concurrently using traditional and modern medicines.

However, a notable consensus among the participants is that collaborative efforts and integrating traditional and modern medical practices can mitigate the identified risks. A more comprehensive and holistic patient care model can be established by fostering communication and cooperation between practitioners of both modalities. This collaborative approach would enable healthcare professionals to draw upon the strengths of both traditional and modern medicine, ensuring that treatments are tailored to individual patient needs while minimizing the potential risks associated with combining these approaches.

The insights gained from this research underscore the importance of a well-informed and balanced approach to concurrently using traditional and modern medicine. As healthcare systems evolve and diversify, practitioners, researchers, and policymakers must collaborate to develop guidelines and protocols prioritizing patient safety and well-being. By acknowledging the benefits and risks of both treatment modalities and fostering integration within a framework of evidence-based practice, healthcare providers can enhance the quality of patient care, seeking a harmonious blend of traditional and modern medical approaches.

While the past section interrogated the prospects and challenges of the two healthcare systems working together, the following section examines research participants' views about integrating the two healthcare systems within South African public healthcare.

7.6 Research Participants' Views on Integration of African Traditional Medicine into Public Healthcare System in South Africa

Ampomah et al. (2023) reveal that the World Health Organization (WHO) includes the following three approaches to describe the way traditional medicine could be successfully integrated into the public health care system: (i) in an "integrative system", traditional medicine (TM) is "officially recognized and incorporated into all areas of health care provision. This implies that TM is included in the relevant country's national healthcare policy; TM healthcare providers and products are registered and regulated; TM therapies are available at hospitals and clinics (both public and private);

treatment with TM is reimbursed under health insurance; relevant research is undertaken; and education in TM is available; (ii) an "inclusive system" implies that "ultimately, countries operating an inclusive system can be expected to attain an integrative system; and (iii) a "tolerant system" on TM is one in which "the national health care system is based entirely on allopathic medicine, but some TM practices are tolerated by law."

South Africa could be categorized under an "inclusive system" that recognizes TM but has not yet fully integrated it into all aspects of public health care, be this in health care delivery, education and training, or regulation. TM is not yet available at all health care levels, health insurance might not cover treatment with TM, official education in TM might not be available at the tertiary level, and regulation of TM providers and products might be lacking or only partial. However, policy frameworks on TM and its healthcare providers' regulation, practice, health insurance coverage, research, and education are underway. Complete institutionalization of traditional medicine in South Africa would prevent problems of charlatanism of traditional healers, provide ATHPs with training, and allow for increased collaborative scientific research of traditional remedies.

Both the research participants, ATHPs, and their clients, expressed concern about charlatans who were pretending to know about traditional medicine and healing but were only trying to make money while potentially causing harm to innocent people. One ATHP client in the uGu District Municipality explained that when people talk about traditional medicine, there are two things that they are talking about: charlatans and actual healers. Real healers have studied and know the medicines, including plants and other ingredients used to treat patients. Charlatans do not know actual traditional remedies. This also occurs among Western doctors. He felt that the government needed to set statutory bodies and license healers so that charlatans would no longer be able to treat and deceive patients. He indicated that associations of traditional healers, as in modern medical Professions that already exist in South Africa, are a good starting point because they are already checking up on each other to be sure that all members are competent. An example of the TM Association given in KwaZulu-Natal province by the research participants was the African National Healers Association, founded in 1989. It has over 2000 members, including several allopathic doctors interested in traditional healing methods. Its main objectives include: (i) The setting -and maintaining of mandatory standards of traditional healing in South Africa through Cultural Heritage; (ii) Establishing a working relationship with private organizations and companies with the like-minded objective of promoting traditional medicine and traditional healing in South Africa; (iii) To develop and manage knowledge-and management systems in South Africa.

The Association has served as a consultant for numerous Academic Institutions as well as private companies in numerous research, educational, and traditional medicine development projects, including the hosting of the Eight Fact-Finding Workshop on behalf of the Producers of the S.A Traditional Healers handbook, Published in 1997. The sharing of knowledge among traditional healers by hosting seminars was also encouraged.

Based on the above consideration, the IK Act (2019) Clause 14 is on Recognition of Prior Learning (RPL). It outlines the purpose of the accreditation of assessors and sets out an application process. Clause 15 on Certification of IK Practitioners allows persons wishing to register their designations as indigenous knowledge practitioners and be certified and recorded in the Register of Designations.

The study wanted to find out the views of the research participants on the significance of research pertaining to TM as part of facilitating its integration into public healthcare in South Africa. During focus group discussions in both study areas, it was expressed by both participant ATHPs and their clients that for modern medical practitioners to be educated on the significance of TM, especially effectiveness in public healthcare, and the potential negative interactions, research would need to be conducted on traditional remedies. However, the research participants raised the concern that while they recognize that research into TM is essential for ensuring access to safe and effective treatments and that the knowledge of indigenous TM practices and products gained by researchers can be a source of substantial benefits to companies and research institutes, the traditional knowledge and associated resources of TM harvested from local communities is being appropriated, adapted and patented by scientists and industry, with little or no compensation to its original custodians, and without their informed consent. Therefore, while research on TM could be supported at the local community level, the government needs to protect the intellectual property rights of traditional healers and other local community knowledge holders.

It was similarly indicated that collecting research data for preparing traditional remedies from medicinal plants is extremely important. The information is essential for identifying active ingredients and intake of relevant amounts of drugs.

Despite the desire to work and collaborate with MTHPs, most ATHPs believe that modern doctors hypocritically use the media to express the existing collaboration between traditional and modern health practices because of socio-political pressure. However, according to the participant ATHPs, most conventional doctors did not want to work with traditional healers because they did not view them as effective and valuable health professionals. They perceived AHTPs as being inferior. This

viewpoint was summarized in the words of Ubaba Mandla, one ATHP participant from uMkhanyakude district who said:

> *"Kade sizama ukusebenzisana nabo kodwa kubukeka sengathi asamukelekile. Odokotela banamuhla bathi abantu akufanele basebenzise abelaphi bendabuko ngoba bona abafuni ukufunda nokuqonda izindlela zethu zokwelapha. Emakhamera, bahlale bethi bafuna ukusebenza nathi kodwa empeleni abasithathi njengabantu abalinganayo. Eqinisweni, abawunaki umsebenzi wethu. Ngikholwa wukuthi usemkhulu umsebenzi osazokwenziwa endaweni yokusebenzisana. Baqeqeshwe kakhulu njengathi. Lapho isiteshi sokusebenzisana sivulwa ngokusemthethweni futhi sisebenza ndawonye, yilapho bezobona khona ukuthi siqeqeshelwe ukwelapha izinhlobo ezahlukene zezifo."*

He believed that despite the ATHPs' best efforts to work with conventional healthcare practitioners, it did not appear that they had accepted ATHPs attempts to collaborate. Since modern doctors were unwilling to learn and comprehend ATHP healing methods, they advised their patients against using traditional opinion, and there was still more to be done in integrating the two healthcare systems.

In addition, there were some ATHP research participants, such as herbalists and diviners, who were against the idea of collaborating with MHPs and integrating the two healthcare systems. The main reason for their unwillingness to integrate the two healthcare systems was the belief in the efficacy of their practices and healing system and the ineffectiveness of modern medicine to cure their patients. This point of view was articulated by Ubaba Amahle, one of the ATHPs from the uGu district, who said:

> *"Angicabangi ukuthi kufanele sisebenzisane nodokotela nabahlengikazi besimanje. Izindlela zethu nezindlela zokwelapha ziyehluka. Nginguchwepheshe futhi sekuyiminyaka ngelapha izifo eziningi kule miphakathi. Siyakhula isibalo sabantu abashona ezibhedlela ngoba odokotela besimanje abakwazi ukwelapha. Ukuthumela iziguli kuzo kungaba wumgomo wokuzibulala kanye nobungozi ezimpilweni zeziguli."*

He expressed the concern that the practices, worldviews, ways of knowing and value systems of the two healthcare systems differed. He was talking from the position of an expert in African traditional medicine and healing practices, who had dealt with a great deal of illnesses in the local communities for many years. According to his long experience, hospital mortalities were rising due to modern doctors' inability to heal holistically, considering the complexity of increasing health challenges.

Another reason for the unwellness to integrate the two healthcare systems was raised by Ubaba Bhekizizwe, one of the ATHPs from uMkhanyakude District Municipality, i.e., the fear of misuse and misappropriation of African traditional knowledge.

> *"Asikwazi ukusebenzisana ngoba odokotela bezokwelapha bacabanga ukuthi bafunde kakhulu, bahlakaniphe kakhulu futhi bahlakaniphe kunathi. Laba dokotela besimanje akumele bantshontshe ulwazi lwethu lwesintu baqale ukudayisa imikhiqizo okungeyona eyabo."*

He reiterated that medical doctors were used to steal indigenous knowledge systems in medicine for pharmaceutical companies. Some participant ATHPs expressed the willingness to integrate the two healthcare systems on condition that appropriate measures were in place to ensure that their traditional knowledge was protected from misuse and misappropriation. They emphasized the importance of understanding certain symptoms and referring patients to clinics or hospitals for treatment when necessary. ATHPs in both district municipalities expressed the view that MHPs harboured feelings of mistrust towards ATHPs and were unwilling to form a partnership.

Apart from the few research participants against collaboration, most ATHP participants highlighted that collaboration between African Traditional Health Practitioners and Public Health Care Providers in South Africa had some added advantages. For example, Gogo Gumbi, a Traditional Health Practitioner in uGu District Municipality, had the following to say in the isiZulu language:

> *"Inhloso yethu yokubambisana iwukuba ndawonye ngoba sobabili sinenhloso eyodwa - okuwukusiza abantu. Sekuyisikhathi eside abezempilo bendabuko kanye nabasebenzi bezempilo bakahulumeni besebenza ngokuzimela emiphakathini yethu. Lokhu kube kubi kweziguli zethu. Lokhu kubambisana kuzosihlanganisa futhi kusenze sazane kangcono futhi sisebenze njengeqembu. Sonke siyadingana ukuze siphumelele. Uma sisebenza ngokubambisana, kuyosisiza ukuthi sikwazi ukudlulisela amaklayenti kusenesikhathi lapho edinga ukunakekelwa kwezokwelapha kwesimanje futhi okuphambene nalokho."*

He expressed the opinion that the two healthcare systems have worked independently in local communities for an extended period. This has been to the disadvantage of patients. Hence, their integration would bring practitioners from both systems together, allowing them to know each other better and work as a team. It would help them to refer clients promptly in cases where they require modern medical attention and vice versa.

It was generally indicated that the main reason for the current push for integrating traditional medicine into public health care was the inability of modern health facilities in South Africa and the accessibility, acceptability, and affordability of traditional medicine. In both study groups, there was a diversity of views on this issue during in-depth interviews and focus group discussions.

Mr. Sizwe Mbhele, a local community member in uGu District Municipality, who was a client of one of the ATHPs, had the view that the current push for integration of traditional medicine into public health care by different stakeholders, including local communities, is due to the inability of the modern health facilities to meet the healthcare needs of the people, especially the marginalized social groups such as women and children in local communities. Traditional medicine plays a crucial role in providing socio-economic, cultural, and environmental benefits, and supports the livelihoods of local communities, particularly where formal public facilities are lacking. This is especially important given the growing African population.

Ms. Thoko Gumede from uMkhanyakude District Municipality attributed the growing interest in TM to the challenges the public healthcare system faces in treating some chronic diseases and conditions using modern medicine. According to him, the popularity of herbal medicines was also due to the broader cultural belief that people were closer to nature, their accessibility, and affordability. Mr Thabo Qwabe, an ATHP's client in uMkhanyakude said:

> *"Intshisekelo evuselelwe ku-TM emiphakathini yendawo yase-Afrika idonsela umfutho ekwandeni kwesibalo sabantu emiphakathini yase-Afrika okuhlanganisa nokushintsha indlela yokuphila kanye nokucabanga phakathi kwabantu abaku-TM kanye nokwelapha. Imithi yamakhambi ithokozela ukwamukelwa okuphezulu phakathi kwemiphakathi yendawo okuhlanganisa nentsha, ngoba ithathwa njengeshibhile futhi ixhumene kakhulu namasiko."*

In his view, the renewed interest in TM in local African communities drew impetus from the increasing human population in African communities, including changing lifestyles and mindsets among people on TM and healing. Herbal medicines enjoyed high acceptability among local communities, including young people, because they were considered cheap and of intense cultural attachment.

7.6.1 Opinions on Creating ATHPs' Facilities in Clinics and Hospitals

The suggestion to establish ATHP rooms in clinics and hospitals emerged as a crucial consideration during most focus group discussions and interviews with ATHPs and their clients in both district municipalities. This step was viewed as essential for facilitating integration.

The majority of ATHPs interviewed were supportive of the integration of ATMs into modern healthcare facilities. They welcomed the idea of having a designated room for their practice within clinics and hospitals as the opportunity to integrate their healing practices into these health facilities. They believed integrating traditional healing practices into a hospital setting has an added advantage since it can provide them with better access to a broader patient population who may benefit from their expertise. In addition, they view this integration as an opportunity to collaborate with medical professionals, share their knowledge, and contribute to patients' overall well-being.

ATHPs often possess extensive knowledge of herbal remedies, spiritual healing, and other traditional modalities passed down through generations (Che et al., 2024). ATHPs in both research sites believed that by working alongside medical professionals, they could contribute their unique perspectives and approaches to patient care in South Africa. Furthermore, they expressed the view that having dedicated rooms in clinics and hospitals would give them easy access to modern diagnostic tools and technologies that clinics and hospitals provide, which can enhance their ability to assess and treat patients. ATHPs who supported this idea see it as a validation of their skills and an acknowledgement of the value of traditional medicine within the broader healthcare system. Gogo Uluthando, an ATHP from uGu District municipality, had the following to say in isiZulu:

> *"Ngicabanga ukuthi kumele kube negumbi eliyisipesheli elinikezelwe abelaphi bendabuko base-Afrika emitholampilo nasezibhedlela. Lokhu kuzothuthukisa ukusebenzisana nokubambisana okufanele. Kungenza uhlelo lwereferensi lube lula njengoba iziguli zizodluliselwa kwelinye igumbi ziye kwelinye ngaphandle kokumosha isikhathi."*

She believed a special room must be dedicated to African traditional health practitioners in clinics and hospitals. This would foster proper collaboration and partnership. It could make the reference system easy since patients would be referred from one room to another without wasting time.

> *"Igumbi emtholampilo noma esibhedlela elinikezelwe kuma-ATHP lizosikhuthaza ukuthi sifunde komunye nomunye. Iziguli ezingakaze zisebenzise imithi yesintu yase-Afrika ngenxa yenkolelo yazo zingase zinikezwe ithuba futhi zikhuthazwe ukuthi zisebenzise ukwelashwa*

kwesintu noma umthandazo lapho kudingeka ngoba indawo ye-ATHP ingaphakathi kwesikhungo sasesibhedlela."

It was indicated that the room at the clinic or hospital dedicated to ATHPs would encourage practitioners of each system to learn from each other. Patients who have never used traditional African medicine because of their beliefs might also be given the opportunity and encouraged to use traditional treatment or healing when needed because the ATHP's facility would be within the hospital facility.

"Umqondo wokuba namagumbi anikezelwe kithi emtholampilo noma esibhedlela uzosinika ukufinyelela okulula kumathuluzi esimanjemanje okuxilonga kanye nobuchwepheshe obuhlinzekwa yimitholampilo nezibhedlela, obungathuthukisa ikhono lethu lokuhlola nokwelapha iziguli."

Having rooms dedicated to us at the clinic or hospital will give us easy access to modern diagnostic tools and technologies that clinics and hospitals provide, which can enhance our ability to assess and treat patients.

"Umqondo wokuba namagumbi anikezelwe kithi emtholampilo noma esibhedlela ubonisa ngempela ukuqinisekiswa kwamakhono ethu. Lokhu kuwukuvuma ukubaluleka kwemithi yesintu ohlelweni lokunakekelwa kwezempilo olubanzi ezweni."

The participant, ATHP in both study areas, believed that having rooms dedicated to them at the clinic or hospital would demonstrate the validation of their knowledge and skills. For some of the participant ATHPs, integrating ATM into modern healthcare facilities is about cultural recognition and preservation of African medicine and healing systems. They believed that TM practice was essential to their cultural heritage and identity. Integrating their healing methods into clinics and hospitals affirmed their expertise and the importance of traditional medicine and healing practices. In addition, it would show respect for African cultural traditions and help keep ancestral knowledge alive by providing an opportunity for ATHPs to pass down their knowledge and skills to future generations. These sentiments were articulated in isiZulu by participant ATHPs in both study district municipalities:

"Ubuchwepheshe bethu buzothathwa njengobusemthethweni futhi busemthethweni lapho izindlela zethu zokwelapha zethulwa emitholampilo nasezibhedlela."

Our expertise will be considered official and legal when our healing methods are introduced in clinics and hospitals.

> *"Uma ngempela sifinyelela ezingeni lokuthi sibe namagumbi ethu ezibhedlela, kuzoba wubufakazi bokuhlonipha amasiko nezimiso zethu zaseNingizimu Afrika. Lokhu kuzosinikeza ithuba lokudlulisa ubuhlakani nobungcweti bethu ezizukulwaneni ezizayo ukuze sigcine ulwazi lokhokho bethu luphila."*

The above means that if ATHPs got their rooms in hospitals and clinics, it would be proof of respect for their cultural traditions and values in South Africa. This would allow them to pass down their wisdom and expertise to future generations to keep the ancestral knowledge alive. Gogo Thandie said the following in IsiZulu:

> *"Kumina, umbono wokuba namagumbi anikezelwe kithi emtholampilo noma esibhedlela yithuba lethu lokufundisa abanye ngemikhuba yamasiko. Lokhu kuzothuthukisa ukwazisa nokuqonda phakathi kodokotela neziguli."*

According to her, having rooms dedicated to ATHPs at the clinic or hospital allowed them to educate others about cultural practices. It would promote appreciation and understanding of traditional medicine and healing practices among doctors and patients.

Another group of participant ATHPs viewed integrating traditional medicine and healing practices into clinics and hospitals as an opportunity for enhanced collaboration with conventional medical professionals. They advocated for collaboration between the two healthcare systems to offer more holistic care. Working together, ATHPs and doctors could provide comprehensive and patient-centred care. They recognize that each system has its strengths and limitations and believe combining them can improve patient outcomes. ATHPs can share their knowledge and expertise by working alongside medical professionals, contributing to a comprehensive and personalized approach to healthcare. This will help create a more holistic public healthcare system. They emphasized the importance of addressing not only the physical elements but also the emotional, spiritual, and social aspects of a person's well-being. Participant ATHPs from both district municipalities expressed the following in isiZulu:

"Ukuhlanganiswa kwezinqubo zokwelapha zendabuko emitholampilo nasezibhedlela kuyithuba lokuthuthukisa ukusebenzisana nabahlengikazi nodokotela. Bakhuthaza ukubambisana phakathi kwezinhlelo zezokwelapha zendabuko nezesimanje."

The integration of traditional healing practices into clinics and hospitals would provide an opportunity to improve collaboration between ATHPs with nurses and doctors:

"Ukusebenzisana nodokotela nabahlengikazi kunganikeza ukunakekelwa okuphelele, okugxiliswe esigulini, nokubandakanya konke emiphakathini yethu."

Working with doctors and nurses would provide local communities with more comprehensive, patient-centred, and all-inclusive care.

"Asiphelele, sinamandla athile kanye nobuthakathaka. Odokotela nabahlengikazi nabo banamandla abo kanye nobuthakathaka babo. Ngicabanga ukuthi ukuhlanganiswa kwezinhlelo zethu ezimbili zezokwelapha kungaholela ekubhekaneni hhayi nezimpawu zomzimba kuphela kodwa nezici ezingokomzwelo, ezingokomoya, nezenhlalo zenhlalakahle yesiguli."

The above implies that both healthcare systems have some strengths and weaknesses. Hence, their integration would lead to a holistic patient health and wellness approach.

ATHP participants suggested that exploring ways to integrate traditional medicine into existing healthcare facilities, such as hospitals and clinics, was one of the critical considerations and steps that could be taken to facilitate the integration of traditional African medicine into public healthcare in South Africa. They suggested that this can involve creating specialized units or departments within healthcare institutions that offer traditional medicine services alongside modern treatments. However, some ATHPs expressed that setting up ATHPs' rooms in clinics and hospitals can pose operational challenges. Among these challenges are concerns about assimilation and authenticity. ATHPs had expressed concerns about their practices being assimilated, diluted, or altered to fit within a hospital environment or structures of medical institutions. The worry is that Western medical practices could overshadow their unique cultural practices. Traditional practices will lose their authenticity and cultural significance if they become part of a mainstream healthcare system. These ATHPs advocated for maintaining the authenticity and integrity of their healing methods outside the hospital setting,

preserving their traditional knowledge and rituals passed down through generations. These were some of their words in isiZulu:

> *"Ukubeka indawo yegumbi elikhethekile elinikezelwe kuma-ATHP esibhedlela kungase kube inselele. Iningi labantu bakithi likholelwa ekwelashweni kwesintu futhi bebeqala basithinte ngaphambi kokuvakashela odokotela nabahlengikazi besimanje. Odokotela nabahlengikazi banamuhla bangase bazizwe besongelwa ukuba khona kwethu ikakhulukazi lapho iziguli ziqala ekamelweni lethu ngaphambi kokubonisana nazo."*

The ATHPs expressed the concern that putting a special room dedicated to traditional medicine in the hospital may be challenging. The majority of African people believe in traditional medicine and healing. They would first consult the ATHPs before visiting modern doctors and nurses. Modern doctors and nurses might feel threatened by the ATHPS's presence, especially when patients start from their rooms before consulting them.

> *"Lokhu kungase kube yinto enhle ukuyenza. Kodwa izinselele zingase ziphakame lapho sinezimo lapho imbangela yesifo sithathwa njengokuhlasela kwemimoya emibi noma iziqalekiso. Imihlatshelo nokuhlanzwa okungokomoya kungase kudingeke ukuze kushwelezwe unkulunkulu. Kungase kudingeke ngenze i-Exorcism noma umkhuba wokuxosha amademoni noma imimoya emibi. Indawo yasemtholampilo noma yasesibhedlela ingase ingabi mnandi ngoba eminye yale mikhuba ingase idingeke ukuba yenziwe endaweni ethile njengokuyala konkulunkulu."*

They believed that integration might be a good thing to do, but challenges might arise when there are cases where the cause of the disease is perceived to be an attack from evil spirits or curses. Sacrifices and spiritual cleansings could be required to appease the spirits. The ATHP might need to perform exorcism or the practice of expelling demons or evil spirits. The clinic or hospital environment might not be conducive because some of these practices could be required at specific places as commanded by the spirits.

ATHPs who were cautious about integrating the two systems also expressed their concerns about the standardization and regulation of their practices. They were worried about the potential for misrepresentation or misunderstanding of their healing methods within a hospital environment. Hence, they emphasized the need for proper regulation and ethical guidelines before any integration could take place. They expressed a good understanding of the importance of ensuring patient safety

and quality of care. These ATHPs expressed the need for clear guidelines, ethical frameworks, training, certification, and appropriate licensing so that those practicing traditional healing within hospitals have the necessary skills and knowledge. This is to help ensure a safe and effective integration of traditional healing practices into hospitals. These were some of their words in isiZulu:

> *"Izindlela zethu zokwelapha zigxile ngokujulile emasikweni amasiko, izindlela eziphelele, kanye nokuqonda okujulile kokuxhumana kwengqondo nomzimba. Kodwa-ke, ohlelweni lwesimanje lokunakekelwa kwezempilo, kungase kube nokuhlanekezela amaqiniso noma ukungaqondi kahle izindlela zethu zokwelapha, ikakhulukazi phakathi kwezilungiselelo zesibhedlela."*

The concerned ATHPs believed their healing methods were deeply rooted in cultural traditions, based on holistic approaches and a profound understanding of the mind-body connection. However, within the conventional healthcare system, there can often be misrepresentation or misunderstanding of ATHP healing methods, especially within hospital settings.

> *"Izenzo zethu ziyingxenye ebalulekile yamagugu ethu amasiko, adluliselwa ezizukulwaneni ngezizukulwane. Izindlela zethu zokwelapha zigxile kakhulu ezinkolelweni zomphakathi, ezimisweni nasezinkambisweni zikamoya. Esimeni sasesibhedlela esamukela kakhulu imithi yaseNtshonalanga, izinqubo zethu zokwelapha zisengcupheni yokubukelwa phansi noma zikhishwe njengezingasebenzi. Lokhu kuhlanekezela kabi kungase kucekele phansi ubunikazi bamasiko nesithunzi sama-ATHP, okuholela ekulahlekelweni ukwethenjwa kanye nethuba elilahlekile lokunakekelwa kwesiguli okuphelele."*

The sentiment was that their healing practices were integral to the cultural heritage passed down through generations. These were deeply rooted in the community's beliefs, values, and spiritual traditions. In a hospital setting that predominantly embraces Western medicine, ATHP healing practices might be at risk of being marginalized or dismissed as ineffective. This misrepresentation could erode the cultural identity and dignity of ATHPs, leading to a loss of trust and a missed opportunity for holistic patient care.

> *"Njengabelaphi bendabuko, sithatha indlela ephelele yokwelapha, singabheki nje kuphela izimpawu zenyama kodwa futhi nenhlalakahle engokomzwelo, yenhlalo, kanye nengokomoya yamakhasimende ethu. Sikholelwa ukuthi ukugula ngokuvamile kuwumphumela wokungalingani kuzo zonke lezi zici zempilo yomuntu nokuthi ukuphulukiswa kudinga*

ukubuyisela ukuzwana nokulinganisela. Kodwa-ke, ngaphakathi kwesilungiselelo sasesibhedlela, lapho kugxilwe khona ngokuyinhloko esifweni somzimba, ukuhlakanipha okujulile kwama-ATHP kungase kunganakwa noma kuqondwe kabi. Lokhu kungakhawulela ukusebenza."

As traditional healers, they took a holistic approach to healing, considering not only the physical symptoms but also the emotional, social, and spiritual well-being of our clients. The ATHPs believed that illness was often the result of an imbalance in all these aspects of a person's life and that healing requires restoring harmony and balance. However, within a hospital setting, where the focus is primarily on the physical aspects of the disease, the profound wisdom of ATHPs might be overlooked or misunderstood. This could limit the effectiveness of treatment and prevent patients from experiencing comprehensive care.

"Izinqubo zethu zemithi yendabuko zivame ukusekelwe emasikweni adluliselwa ngomlomo futhi adluliselwe kwesinye isizukulwane kuya kwesinye. Kuzoba nzima komunye umuntu ongeyena i-ATHP ukuthi akwazi ukuqonda indlela yokubhala kanye nokuhlanganisa ulwazi lwethu, njengokusetshenziswa kwezitshalo zokwelapha, izindlela zokuxilonga zendabuko, izinqubo zokwelapha zendabuko, kanye nezinye izindlela zokwelapha zendabuko, ukuze londoloza ulwazi lwendabuko futhi alwenze lufinyeleleke ekuqeqeshweni nasekucwaningeni."

Doctors and nurses are always reluctant to undergo training and be educated in traditional medicine because they consider the education they have gained at school more valuable than traditional medicine training. Together, we can develop educational programs and courses to teach traditional medicine knowledge and skills in a structured manner. This can help ensure that doctors and nurses get a certain level of competence and adhere to standardized practices.

"Kunesidingo sokulawulwa okufanele neziqondiso ezicacile, izinhlaka zokuziphatha, ukuqeqeshwa, ukunikezwa izitifiketi, kanye nokunikezwa kwamalayisensi afanele ukuze labo abelapha ngokwesintu emitholampilo nasezibhedlela babe namakhono nolwazi oludingekayo. Lokhu kuqinisekisa ukuhlanganiswa okuphephile nokusebenzayo kwezinqubo zokwelapha zendabuko ezibhedlela."

The view was that there was a need for proper regulation and clear guidelines, ethical frameworks, training, certification, and appropriate licensing so that those practicing traditional healing within

clinics and hospitals could have the necessary skills and knowledge. This would ensure a safe and effective integration of traditional healing practices into hospitals.

Another concern for ATHPs interviewed was the lack of cultural sensitivity and patient autonomy within clinics and hospitals. ATHPs from both district municipalities expressed the following in isiZulu:

> *"Imikhuba yethu yokwelapha ihilela ukusebenzelana eduze neziguli zethu. Sibheka izinkolelo, izintandokazi, kanye nesimo samasiko amaklayenti ethu. Kodwa-ke, esimweni sasesibhedlela, iziguli zingase zizwe ziphoqelekile ukuba zihambisane nephethini yezokwelapha evelele, okuholela ekunqanyulweni kobunikazi bazo bamasiko kanye nemikhuba yokwelapha yendabuko. Lokhu kungaphumela ebuhlotsheni obunzima phakathi kukadokotela nesiguli futhi kuvimbe inhlalakahle yesiguli iyonke."*

They emphasized that their healing practices involved close collaboration with the patients. The ATHPs considered their clients' beliefs, preferences, and cultural context. However, in a hospital setting, patients might feel pressured to conform to the dominant medical pattern, leading to a disconnection from their cultural identity and traditional healing practices. This could result in a strained doctor-patient relationship and hinder the patient's well-being.

> *"Izinqubo zethu zemithi yendabuko zivame ukusekelwe emasikweni adluliselwa ngomlomo futhi adluliselwe kwesinye isizukulwane kuya kwesinye. Kuzoba nzima komunye umuntu ongeyena i-ATHP ukuthi akwazi ukuqonda indlela yokubhala kanye nokuhlanganisa ulwazi lwethu, njengokusetshenziswa kwezitshalo zokwelapha, izindlela zokuxilonga zendabuko, izinqubo zokwelapha zendabuko, kanye nezinye izindlela zokwelapha zendabuko, ukuze londoloza ulwazi lwendabuko futhi alwenze lufinyeleleke ekuqeqeshweni nasekucwaningeni."*

They indicated that traditional medicine practices were often based on oral traditions and passed from generation to generation. It would, therefore, be difficult for someone else who was not an ATHP to be able to understand how to document and codify this indigenous knowledge system, involving aspects such as the use of medicinal plants, traditional diagnostic methods, traditional treatment protocols, and other traditional healing techniques, to preserve the indigenous knowledge and make it accessible for training and research.

Most ATHP clients also had diverse views and opinions regarding establishing a room for THPs in clinics and hospitals to integrate ATMs into modern healthcare facilities. Some clients were supportive of the integration of the two healing systems. They supported having a designated room for ATHPs within clinics and hospitals. They thought it was a positive step towards integrating traditional and modern healthcare systems. They believed that ATHPs offer valuable insights that can enhance patient care and well-being. For them, integrating traditional healing practices into clinics and hospitals is a way to combine the strengths of both systems. They believed that ATHPs possess valuable knowledge and expertise that can complement modern medical treatments. These individuals expressed that they have personally experienced the benefits of traditional medicine and, therefore, view it as a holistic approach to healthcare. They expressed that by establishing a room for ATHPs in clinics and hospitals, patients can access a broader range of treatment options and benefit from a more comprehensive approach to healing. These were their expressions in the isiZulu language:

> *"Amagumbi okusetha anikezelwe ama-ATHP ethu ayisinyathelo esihle ngempela ekuhlanganiseni imithi yendabuko neyesimanje ngoba ama-ATHP anikeza imininingwane ebalulekile engathuthukisa ukunakekelwa kwethu nokuphila kahle."*

The expressed view was that setting rooms dedicated to ATHPs was a positive step towards integrating traditional and modern medicine. ATHPs offered valuable insights that could improve our care and well-being. Ubaba Ndlovu from the uGu District municipality expressed this from the uGu District municipality:

> *"Ngicabanga ukuthi ukuhlanganiswa kwemithi yesintu yase-Afrika emitholampilo nasezibhedlela kuyindlela yokuhlanganisa amandla emithi yesintu kanye nemithi yesimanje."*

He believed that integrating African traditional medicine into clinics and hospitals was a way to combine traditional and conventional medicine strengths.

> *"Lapho imithi yethu yesintu ibuthaka, imithi yesimanje ingasetshenziswa ukuze selaphe kanjalo."*

Where ATHP traditional medicine was weak, conventional medicine could be used to cure people and vice versa:

"Ngibe nokuhlangenwe nakho komuntu siqu ngezinzuzo zemithi yendabuko yase-Afrika. Ngicabanga ukuthi ukusungula igumbi lama-ATHP emitholampilo nasezibhedlela kuzonikeza zonke iziguli ukufinyelela ezinhlobonhlobo zezinketho zokwelapha futhi zizuze."

Ubaba Ndlovu indicated a personal experience of the benefits of African traditional medicine. He thought establishing a room for ATHPs in clinics and hospitals would give all patients access to various treatment options and benefit from a more comprehensive approach to healing.

For some other ATHPs, this was about cultural preservation since their practices were deeply rooted in their cultural heritage. They believed traditional healing methods carried the wisdom and knowledge passed down through generations and should be respected and preserved. They felt it was essential to preserve and promote traditional healing practices and see integrating them into hospitals as a positive step towards cultural inclusivity in healthcare. They believed that having a designated room for ATHPs in clinics and hospitals would be a significant step towards cultural inclusivity and recognizing the value of traditional medicine within their community. These individuals viewed this integration of cultural practices and traditional healing approaches to promote diversity and honour their cultural identity within the healthcare system. These were their expressions in the isiZulu language by Ubaba Kgabu:

"Izindlela zokwelapha zendabuko zase-Afrika ziphethe ukuhlakanipha nolwazi oludluliswa ezizukulwaneni ngezizukulwane futhi kufanele zihlonishwe futhi zilondolozwe."

He says traditional African healing methods carry the wisdom and knowledge passed down through generations and should be respected and preserved.

"Kubalulekile ukulondoloza nokukhuthaza izindlela zokwelapha zendabuko. Ukuba negumbi elikhethekile lama-ATHP emitholampilo nasezibhedlela kuthathwa njengesinyathelo esiholela ekuhlanganisweni kwezamasiko kanye nokuqashelwa kokubaluleka kwemithi yendabuko emiphakathini yethu."

It was important to preserve and promote traditional healing practices. A designated room for ATHPs in clinics and hospitals was thus seen as a step towards cultural inclusivity and recognition of traditional medicine's value within our communities.

The participant clients of the ATHPs interviewed also expressed the idea of Accessibility and Choice. They believed some individuals might appreciate choosing between modern medical treatments and traditional healing methods. They believed that having room for ATHPs in clinics and hospitals provides patients with a broader range of healthcare options, allowing them to make informed decisions about their treatment and healing journey. These were some of their expressions in the isiZulu language:

> *"Ukuba namakamelo anikezelwe i-ATHP emitholampilo nasezibhedlela kunikeza iziguli ithuba lokukhetha phakathi kwezindlela zokwelapha zesimanje nezindlela zokwelapha zendabuko."*

The above meant that having rooms dedicated to ATHP in clinics and hospitals would allow patients to choose between modern medical treatments and traditional healing methods.

> *"Ukuba namakamelo anikezelwe i-ATHP emitholampilo nasezibhedlela kunikeza ukufinyelela ngokushesha kukho kokubili imithi yesintu kanye nemithi yesimanje okubavumela ukuba bakhethe kalula indlela yokwelashwa kanye nohlelo lokuphulukisa abazoluthatha."*

Having rooms dedicated to ATHP in clinics and hospitals provided patients with immediate access to traditional and modern medicine, allowing them to choose their treatment and healing system easily.

It is important to note that the opinions of ATHPs regarding establishing a room for African Health Practitioners in clinics and hospitals encompassed a range of perspectives. One group of ATHPs was eager to integrate their practices into the healthcare system, while others had some reservations because of potential assimilation or dilution. Another group of ATHPs was also cautious about integrating the two systems. They were concerned about the standardization and regulation of their practices because of misrepresentation or misunderstanding of their healing methods and the lack of cultural sensitivity and patient autonomy within a hospital environment. Collaboration, mutual respect, and open dialogue between ATHPs, medical professionals, and healthcare institutions were vital to navigating the complexities of integrating traditional healing practices into clinics and hospitals while preserving cultural heritage and ensuring patient well-being.

The opinions of ATHPs' clients regarding establishing a room for African Health Practitioners in clinics and hospitals was that integrating cultural practices and traditional healing approaches would promote diversity and honour African cultural identity within the healthcare system. Clients believed that dedicated ATHP rooms within modern hospitals and clinics would provide patients with a broader range of healthcare options, allowing them to make informed decisions about their treatment and healing journey. They also view integrating traditional healing practices into clinics and hospitals as a way to combine the strengths of both systems.

Finally, it is worth noting that the opinions regarding establishing a room for ATHPs in clinics and hospitals varied greatly depending on cultural backgrounds, personal experiences, and beliefs of research participants from both district municipalities. Public opinion on the matter was diverse and was influenced by factors such as exposure to different healthcare systems' governance and individual preferences. It was, therefore, essential to consider these diverse factors when discussing integrating traditional healing practices within modern healthcare systems.

7.7 Research Participants' Views on African Traditional Medicine and Government Policies

African nations have undergone transformative socio-political changes, leading to healthcare policies evolving to integrate traditional medicine within the broader healthcare framework (AU, 2016). Recognizing traditional medicine's potential to complement modern medical practices has catalyzed discussions about integrating traditional medicine into the healthcare system, garnering attention from governments, healthcare professionals, and researchers alike. This juncture of traditional healing practices and evolving healthcare policies creates a complex discourse involving various stakeholders with diverse perspectives.

This section explores the views held by ATHPs and their clients regarding African traditional medicine and the associated government policies. It seeks to unravel the multifaceted dynamics that govern the relationship between ATHPs, African traditional medicine, and the prevailing healthcare policies. The perspectives of ATHPs, as custodians of indigenous healing knowledge, offer invaluable insights into the challenges, opportunities, and aspirations that shape the integration of traditional medicine into the contemporary healthcare landscape.

While governments have traditionally prioritized science and technology as crucial components of growth and development plans worldwide, ATHPs believe that scientific expertise is often only

recognized when it adheres to Western, standardized, and homogeneous practices. UBaba Ntshangase commented on this phenomenon:

> *"Ngokuyisisekelo, ulwazi lwethu lugxile emsebenzini wesayensi osuselwe emiphakathini yasemaphandleni kanye nezizukulwane ngezizukulwane. Nakuba ihlukile ohlelweni lwaseNtshonalanga lwe-empirical oluzinze kumalabhorethri, ulwazi lwethu lwendabuko lusebenza ngokulinganayo futhi lusebenza kakhulu. Lolu wulwazi oluthuthuke kusukela ekuqondeni nasekubhaleni izinqubo emvelweni. Ukuphindwaphindwa kwezinqubo ngokuhamba kwesikhathi kuye kwaholela emikhiqizweni nasezinqubweni ezisekelwe kuzimiso zesayensi eziphusile. Kuyadabukisa ukuthi ubungcweti babonwa njengobusayensi kuphela uma buseNtshonalanga. Ubungcweti besayensi obuthuthukiswe kumasiko ethu behlisiwe futhi bashaywa indiva iminyaka emininingi. Izindaba ezinhle ukuthi ukwethulwa kwenqubomgomo kanye noMthetho we-IKS kulethe ukukhanya ekugcineni komhubhe ukuze kuqinisekiswe ukuthi ulwazi lwethu luhlangana nezinye izinhlelo zolwazi ngaphandle kokubandlulula."*

He indicated that the ATHPs' knowledge focused on scientific work based in rural and local communities for generations. Although it differed from the Western empirical system based in laboratories, our traditional knowledge is equally valid and very effective. This knowledge has developed from understanding and documenting the processes in nature. An iteration of practices over time has led to products and processes based on sound scientific principles. Unfortunately, expertise was recognized as scientific only if it was Western. The scientific expertise developed in our cultures has been discounted and ignored for many years. The good news is that the introduction of the IKS policy and Act brought a light at the end of the tunnel to ensure that our knowledge interfaces with other knowledge systems without discrimination.

African Traditional Health Practitioners interviewed also believed that there is a need to harmonize the African traditional medicine systems of governance with the government-formulated policies and legal frameworks passed at different levels of government. On the issue of the sustainability of TM, Ubaba Mbotho from the uGu district Municipality had the following to say:

> *"Izikhungo zezimakethe zendawo kanye nokuhweba nge-TM kuyanda. Kodwa-ke, ubukhulu balokhu kuhwebelana kule miphakathi kanye nezinhlelo zayo zokuphatha akukacaci futhi akukacaci kahle futhi akunamaphepha. Kukhona ukuvuna okusimeme okulinganiselwe kokunikezwa njalo kwemithi yesintu. Lokhu kungafezwa ngokugqugquzela kanye nokuphoqelela izinqubo ezisimeme emiphakathini yendawo kusukela ekongiweni kwemvelo,*

ukulima, ukuvuna okufanele, ukuhwebelana okulawulwayo, kanye nokusetshenziswa okulawulwayo. Lokhu kudinga uhlelo lokubusa oluzinzile oluhlelekile oluhlanganisa ukubandakanywa kobuholi bendabuko."

Local market centres and trade on TM are increasing. However, the magnitude of this trade in these communities and their governance systems is still unclear and remains largely undocumented. There is limited sustainable harvesting for a regular supply of traditional medicines. This can be achieved through promoting and enforcing sustainable practices in the local communities, ranging from conservation, cultivation, proper harvesting, regulated trade, and controlled use. This required a well-structured sustainable governance system, including the active involvement of traditional leadership.

Ubaba Funani, one of the THPs' clients who happened to be also an Official from the KZN provincial government, indicated:

"Ngokuhambisana nemithetho yamazwe ngamazwe ye-Nagoya Protocol ka-2010, emayelana nokuphathwa kwezinsiza zokwelapha zeNdabuko kanye nezakhi zofuzo, eyakhelwe phezu kwe-Convention on Biological Diversity (CBD) ekhuthaza ukuhwebelana nokwabelana ngolwazi lwendabuko oluphethwe imiphakathi yendawo futhi iyaqaphela. ukubaluleka kokwabelana ngokulinganayo nokulinganayo kwemithombo yofuzo etholakalayo. I-Nagoya Protocol ikhuthaza intuthuko esimeme kanye nokongiwa kwezinhlobonhlobo zezinto eziphilayo futhi ngaphezu kwalokho, ibona ukubaluleka komthetho wesintu kanye nemvume enolwazi kusengaphambili yamalungu emiphakathi yendawo eyimithombo eyinhloko yolwazi lwendabuko noma ulwazi lwendabuko. I-Nagoya Protocol isungula uhlaka olusiza abacwaningi ukuthi bafinyelele izinsiza zofuzo zocwaningo lwe-biotechnology, ukuthuthukiswa, neminye imisebenzi, ukuze bathole isabelo esifanelekile sanoma yiziphi izinzuzo ekusebenziseni kwabo. imiphakathi yendawo ingathola izinzuzo ngohlaka lomthetho oluhlonipha ukubaluleka kolwazi lwendabuko oluhlobene nemithombo yofuzo."

According to him, in line with international protocols on the Nagoya Protocol of 2010 on the governance of Traditional medicinal and genetic resources, which builds on the Convention on Biological Diversity (CBD), advocates for the exchange and sharing of indigenous knowledge held by local communities and acknowledges the importance of fair and equitable sharing of available genetic resources. The Nagoya Protocol promotes sustainable development and conservation of biological diversity and recognizes the importance of customary law and prior informed consent of members of local communities who are key sources of indigenous or traditional knowledge. The

Nagoya Protocol establishes a framework that helps researchers access genetic resources for biotechnology research, development, and other activities in return for a fair share of any benefits from their use. Indigenous and local communities may benefit from a legal framework that respects the value of traditional knowledge associated with genetic resources.

Ubaba Kgabu, one of the ATHPs from uMkhanyakude, who was familiar with the IKS policy (2004) and IKS Act (2019), said in IsiZulu:

> *"Njengomsebenzi wobuciko bethu bokuphulukisa okhokho, ngibona ukuthi iNqubomgomo Yezinhlelo Zolwazi Lomdabu waseNingizimu Afrika (2004) kanye noMthetho Wezinhlelo Zolwazi Lomdabu (No. 6 ka-2019) ithinta ngokujulile ingqikithi yesiko lethu. Lezi zindaba eziyingqophamlando zenqubomgomo, emehlweni ami, zikhombisa ukuvumelana ngamabomu kanye nemibono eyamukelwa yi-Nagoya Protocol yowezi-2010 - ikhampasi yomhlaba wonke eqondisa ubuphathi bethu kanye nokusetshenziswa kwezinsiza zethu zokwelashwa kwendabuko kanye nezofuzo osekuhlonishwe isikhathi eside."*

He believed that as a practitioner of ancestral healing arts, he understood that the South African Indigenous Knowledge Systems Policy (2004) and Indigenous Knowledge Systems Act (2019) resonate deeply with the essence of African traditions. These policy and legal frameworks mirrored a deliberate harmony with the ideals embraced by the Nagoya Protocol 2010. This global compass guides the utilization of Traditional Medicinal and Genetic Resources.

It was evident above that the recognition of scientific expertise had historically been limited to Western, standardized, and homogeneous knowledge systems, neglecting the vast body of knowledge developed in diverse societies and cultures. This knowledge, called indigenous knowledge, has been accumulated over generations of scientific work conducted in rural and tribal communities. Despite being different from the Western system of empirical, lab-based science, indigenous knowledge is equally valid and effective, having been developed through understanding and documenting natural processes and iterating practices over time based on sound scientific principles. The Indigenous Knowledge Systems (IKS) Policy (2004) provides a framework to promote and enhance the contribution of indigenous knowledge to social and economic development in the country. One of the main drivers of IKS Policy in South Africa is its interface with other knowledge systems. For example, indigenous knowledge is used with modern biotechnology in the pharmaceutical and other sectors to accelerate innovation. The placement of the IKS policy under the DSI is intentional and appropriate since it is responsible for scientific research in South Africa, including space programs.

From the research participants point of view, it was evident that the South African Indigenous Knowledge Systems Policy (2004) and the IK Act (2019) reflect a strategic alignment with the principles enshrined in the Nagoya Protocol of 2010, which serves as a pivotal international instrument governing the management and utilization of Traditional Medicinal and Genetic Resources. The Nagoya Protocol provides a comprehensive framework that facilitates the responsible exploration of genetic resources for biotechnological research and development. It also emphasizes the necessity of ensuring a just and equitable distribution of benefits resulting from their exploitation.

At its core, the Nagoya Protocol represented a collective effort to address the historical imbalances and potential exploitation that have often characterized the interaction between researchers, biotechnological enterprises, and indigenous and local communities possessing invaluable traditional knowledge and genetic resources. It stands as a testament to the international community's recognition of the intrinsic value of indigenous knowledge systems and genetic resources, emphasizing the importance of respecting and honouring the rights and interests of these communities.

One fundamental tenet of the Nagoya Protocol was the establishment of a fair and equitable sharing of benefits from using genetic resources. This concept acknowledges that using genetic resources, often for commercial purposes, should not occur at the expense of indigenous and local communities who have safeguarded these resources and associated traditional knowledge for generations. Accordingly, the Protocol calls for the negotiation of mutually agreed terms between the parties involved, ensuring that the benefits derived from the utilization of genetic resources are shared in a manner that is not only just but also recognizes the cultural and societal contributions of the indigenous and local communities.

The Indigenous Knowledge Systems Act (No. 6 of 2019) is an essential legislation that seeks to protect and promote indigenous knowledge in South Africa. The act recognizes the value of African traditional medicine and aims to promote its use while ensuring that it is safe and effective. Establishing the Traditional Health Practitioners Council is a significant step towards regulating traditional health practitioners, including those who practice African traditional medicine. The promotion of African traditional medicine is crucial in the preservation of indigenous knowledge and cultural heritage.

The alignment of the South African IKS policy and Act with the principles of the Nagoya Protocol reinforces the country's commitment to fostering a more equitable and harmonious relationship

between the scientific community, biotechnological entities, and indigenous and local communities. The policy underscores the importance of respecting and protecting traditional knowledge and genetic resources, preserving cultural heritage, biodiversity, and sustainable development. Section 1.4 of the Indigenous Knowledge Systems (IKS) Policy expounds on integrating IKS with other knowledge systems. Such integration provides crucial opportunities for developing novel products and services, which should not be underestimated (IKS Policy, 2004:15).

The confluence of the South African Indigenous Knowledge Systems Policy and the Nagoya Protocol underscores a progressive and forward-looking approach that recognizes the need to balance scientific advancement with preserving African cultural identity and community well-being. This symbiotic relationship has the potential to pave the way for collaborative research endeavours that honour the principles of mutual respect, fairness, and shared benefits, ultimately contributing to the broader goals of global sustainability and intercultural understanding.

7.8 Chapter Summary

This chapter presented and discussed the views of the research participants and local community members, both ATHPs and their clients, about integrating African traditional medicine into the public healthcare system in South Africa. Moreover, the chapter examined the perspectives of community members at the local level regarding African traditional medicine and government policy and legal frameworks.

Despite its prevalence, African traditional medicine often operates outside the formal healthcare system, creating regulation, standardization, and collaboration challenges. The opinions expressed by the research participants highlight the complex nature of integrating traditional and modern medicine and underscore the need for cautious collaboration. While concerns about physical health risks were valid, the avenue of collaboration and integration presents an opportunity to harness the strengths of both approaches and provide patients with a more comprehensive and effective healthcare experience.

The opinions of ATHPs concerning the two-way referral system illuminated the complicated tapestry of healthcare perceptions and practices. The coexistence of traditional healing practices and modern medical interventions underscores the need for a nuanced and flexible approach to healthcare delivery. Integrating traditional and modern medical practices within a comprehensive referral system can shape a more inclusive, culturally sensitive, and holistic healthcare landscape by fostering collaboration, understanding, and a shared commitment to patient well-being. However,

implementing a two-way referral system faces challenges that warrant attention. Cultural sensitivities, communication barriers, and differences in diagnostic and treatment philosophies could impede effective collaboration. To navigate these challenges, it is imperative to engage in cross-disciplinary dialogue, develop culturally competent training programs, and establish guidelines for ethical and respectful cooperation between traditional healers and medical doctors.

Integrating African traditional medicine into the public health care system in South Africa requires comprehensive policies that reflect community perspectives, ensure legal recognition, and promote collaboration between ATHPs and biomedical practitioners. By incorporating traditional medicine into existing healthcare frameworks, South Africa can foster a more inclusive and culturally sensitive healthcare system that respects and integrates the diverse healing traditions of its communities. Through research, education, and collaboration, South Africa can create a balanced and effective healthcare system that improves health outcomes and promotes the well-being of all its citizens.

The opinions of users of traditional medicine in South Africa demonstrate diverse perspectives on the governance practices of both traditional medicine and Western medicine. While traditional medicine governance fosters cultural relevance, trust, and accessibility and has improved traditional health practitioners' credibility and safety, it faces integration and standardization challenges. In contrast, Western medicine governance provides evidence-based practices and specialized expertise, but some users perceive it as culturally detached and financially inaccessible.

The two systems need increased collaboration and understanding to achieve a more holistic healthcare approach, encouraging mutual respect. By recognizing the strengths of traditional and Western medicine governance practices and addressing their shortcomings, South Africa can foster a more inclusive and effective healthcare system for all its citizens. Additionally, increasing government investments in education and research for traditional medicine can enhance its governance practices, promoting a more holistic approach to healthcare for all citizens. Ultimately, a balanced and respectful coexistence between traditional and Western medicine is crucial for ensuring the well-being of South Africa's diverse population.

African Traditional Health Practitioners offer a unique perspective on healthcare, providing valuable insights into holistic healing practices deeply rooted in cultural traditions. It is, therefore, essential to bridge the gap between traditional healing methods and the modern healthcare system, recognizing and respecting the contributions of traditional healers. By promoting collaboration, cultural sensitivity, and patient autonomy, hospitals can embrace a more inclusive approach to patient care,

enhancing overall health outcomes and fostering a deeper appreciation for our world's rich diversity of healing practices. As the healthcare landscape evolves, further research and dialogue will be crucial in shaping informed practices and policies prioritising patient well-being.

Chapter Eight: Conclusion and Recommendations

8.1 Introduction

This is the concluding chapter of the research study. It presents the research purpose, findings, conceptual and methodological contributions of the study to African Indigenous Knowledge Systems on African traditional medicine and healing systems and the recommendations regarding implementing the Indigenous Knowledge Systems Policy (2004) within the context of African Traditional Medicine in the case study areas. Following a participatory and case study methodological framework, based on uGu and uMkhanyakude District Municipalities in KwaZulu-Natal province, South Africa, the study investigated the following comparative aspects: the cultural significance of socio-economic and -demographic variables of research participants from the Zulu people's perspective in the two ecologically different study areas; the local community members' knowledge, awareness, and perceptions on indigenous knowledge systems in the context of the African traditional medicine (ATM) policy landscape in south Africa including their awareness and perceptions of international policy frameworks on traditional medicine; local community members' perceptions on the integration of African traditional medicine into the public health care system in South Africa. The study findings and recommendations are outlined below.

8.2. The Study Findings

The concluding aspects of the findings were based on the comparative study as outlined and discussed in the following sections.

8.2.1 African Traditional Medicine and Healing Systems as Culturally and Ecologically Specific

An investigation into the comparative socio-economic and demographic variables, i.e., age group, gender, marital status, and religious affiliations variables, etc. of the participant ATHPs and their clients, from the Zulu cultural perspectives in the two municipal districts of KwaZulu-Natal province revealed the following concluding aspects from the study:

The majority of the ATHPs research participants in both district municipalities were in the age groups of 50-59 and above. Most of their clients in both districts were in the age groups of 40-49 and below. This implies that the ATHPs clients were mostly younger than the ATHPs' research participants. Higher age in ATHP was associated with wisdom and experience in the profession of traditional medicine and healing practices. Elderly ATHPs were considered by both as custodians of these community-based knowledge systems. The gender distribution of the ATHP research participants and

their clients showed that the majority of them, in both district municipalities, were female. In the case of the ATHPs, this was attributed to the fact that the identification and selection of the ATHPs were not limited to those who are professionally known at the community level. It included others who were predominantly women.

Most of the participant ATHPs' clients in both district municipalities were females. Women were the local community caregivers, and in a situation of limited conventional healthcare services, they depended on traditional medicine for family members' healthcare.

The majority of the ATHP research participants and their clients were married. The high-regard community leaders influenced the size of married people in the study samples for married people who were considered knowledgeable of the local communities' traditions, customs, and value systems, including appreciation of indigenous knowledge about traditional medicine and healing systems. Marriage gave one respect in the community as a rite of passage in one's life. It was culturally viewed as an outstanding achievement for both men and women in the community, recognized by ancestors, even in rituals related to traditional medicine and healing practices. It defined the inception of the socially putative time for childbearing. Among the Zulu, marriage as an institution sets childbearing for both men and women. Like in other African traditional cultural communities, the institution of marriage is established as the socially acceptable context for childbearing. This perspective on marital status does not exist in the Western conceptualization of marriage as a statistical socio-economic demographic variable. Among the Zulu traditional communities, marriage is regarded as the institution that ascribes honour and dignity to women in their families and the wider society. Outside of marriage, the honour of a woman of marriageable age is highly compromised. The study also looked at the issue of the religious affiliation of the research participants. This was based on the consideration that traditional religion is an integral part of African spirituality, traditional medicine, and healing practices.

8.2.2 Local Community Members' Knowledge and Awareness of National and International Traditional Medicine Policy Landscapes

The comparative examination of the local community members' knowledge, awareness, and perceptions regarding indigenous knowledge systems and the African traditional medicine policy landscape in South Africa revealed the following concluding remarks:

Most of the ATHP research participants and their clients (male and female) in both study district municipalities were unaware of the National IKS Policy (2004). It was expressed that the National IKS Policy (2004) promotion and implementation has been predominantly a national imperative. There were still limited, if any, provincial and local structures established to build knowledge and awareness of the IKS National Policy among people at the grassroots level (2004). Furthermore, they were unaware of the International Policy and Legal Frameworks on Traditional Medicine. There was the concern expressed by both participant ATHPs and their clients that despite the high value of AIKS placed by community members, especially on the significance of ATM, nobody from the government had come to the community to talk and explain about IKS and International policies and legal frameworks on the same traditional medicine on which the majority of the population continue to rely on to meet their primary healthcare needs. The majority were willing to learn more about National and International Policy Frameworks on Indigenous Knowledge about African Traditional Medicine, including the IKS policy and legal frameworks.

8.2.3 Governance and Management of African Traditional Medicine and Healing Systems in Local Communities

On governance and management of African traditional medicine and healing systems in the study areas, especially on their challenges and prospects, the following: Traditional medicine and healing systems governance practices were important in local community-based knowledge systems and practices. They were culturally and traditionally shaped by the local communities' socio-cultural beliefs and value systems, which were inclusive and accessible. In contrast, conventional Western medical practice governance systems and practices were top-down and alien to local communities' cultural beliefs and value systems, including attitudes towards traditional medicine and healing practices.

Most participant ATHPs' male and female clients in both study district municipalities used traditional medicines. This was attributed to the relative ease of access and affordability compared to conventional medicines. Women and children were frequently vulnerable to illnesses and consulted traditional healthcare practitioners more frequently than men due to ease of accessibility and affordability. The significance and relevance of traditional African medicine in local communities' healthcare increased due to the absence of modern healthcare services. Hence, African Traditional Healthcare Practitioners (ATHPs) provided the earliest medical care in the local communities, especially for underprivileged women and their family members.

The study looked at the local community attitudes toward the preservation, protection, and beneficiation of traditional medicine. This was based on the fact that one of the fundamental characteristics of indigenous knowledge is its predominantly oral nature and exists in the minds of the local people who use it daily. In most African local communities, indigenous knowledge systems constitute the basis for decisions about food security, human and animal health, education, peace and security, natural resource management, and other crucial social practices. However, most of the participant ATHPs and their clients (male and female) in both study district municipalities were unaware. They did not know the IK Act (2019) concerning protecting African traditional medicine and associated knowledge systems. The study was also interested in establishing the knowledge and awareness of the participant ATHPs and their clients on The National Recordal System: A Framework for Digitalization of African Indigenous Knowledge Systems in African Local Communities in South Africa. The study found that most of the research participants, ATHP (male and female) in both study district municipalities, were aware of the IKS Documentation Centre at the University of KwaZulu-Natal and its functions.

8.2.4 Integration of African Traditional Medicine into The Public Health Care System: Local Community Perspectives

An investigation into the comparative willingness of research participants to integrate African traditional medicine and Western medical care systems revealed the following: Most of the research participants consulted both a traditional healer and a Western healthcare provider when sick. They believed that the two healthcare systems treated different illness categories most effectively. Traditional medicine and healing systems were effective in mystic diseases in the form of mental and emotional conditions. The cultural and linguistic differences associated with Western medicine made African cultural communities, especially women, prefer African traditional medicine and healing systems. The differences in diagnosis and treatment of traditional and Western medicines led some patients to utilize the two healthcare systems differently. Some patients would go to the hospital for a diagnosis and later go to a traditional healer for treatment as well, based on the belief that the hospital had the strength of technology and science for an accurate diagnosis, but was at the same time seen as more expensive and less effective for certain diseases.

ATHPs who were cautious about integrating the two healthcare systems expressed their concerns about the standardization and regulation of their practices. They were worried about the potential for misrepresentation or misunderstanding of their healing methods within a hospital environment. Hence, they emphasized the need for proper regulation and ethical guidelines before any integration

could take place. They expressed a good understanding of the importance of ensuring patient safety and quality of care. These ATHPs expressed the need for clear guidelines, ethical frameworks, training, certification, and appropriate licensing so that those practicing traditional healing within hospitals have the necessary skills and knowledge. This is to help ensure a safe and effective integration of traditional healing practices into hospitals.

However, some ATHPs believed their healing practices were deeply rooted in cultural and spiritual traditions and holistic approaches, including a profound understanding of the mind-body connection. They believed that illness was often the result of an imbalance in all these aspects of a person's life and that healing requires restoring harmony and balance. This holism of health and illness tended to be absent in the conventional medicinal systems. Therefore, within a hospital setting, where the focus is primarily on the physical nature of a disease, the profound wisdom of ATHPs may be overlooked or misunderstood. Hence, integration might misrepresent or misunderstand ATM and healing systems, especially in hospitals.

Furthermore, traditional medicine tended to be cheaper, easily accessible, and less of a hassle, and traditional healers were more caring than their Western counterparts. This is even though Western medicine had the advantage of modern technologies for quick diagnosis and controlled treatment. Western medicine was considered better with health challenges that required surgery and severe illnesses that required emergency care.

However, some ATHPs expressed that setting up ATHPs' rooms in clinics and hospitals could pose operational challenges. Among these challenges was that their practices could be assimilated, diluted, or altered to fit within a hospital environment or structures of medical institutions dominated by Western medical practices. The worry was that their indigenous, unique cultural practices associated with ATM and healing practices, which are holistic and culturally sensitive, could be overshadowed by Western medical practices. Traditional practices will lose their authenticity and cultural significance if they become part of a mainstream public healthcare system. These ATHPs advocated for maintaining the authenticity and integrity of their healing methods outside the hospital setting, preserving their traditional knowledge and rituals passed down through generations.

8.3 Conceptual and Methodological Contribution of the Study to Indigenous Knowledge on African Traditional Medicine

The study's primary objective was to contribute to the emerging scholarly body of knowledge on IKS policy challenges and prospects in promoting African Traditional Medicines (ATM) and Healing practices (HPs).

This research adopted a methodology that prioritized their active participation as subjects rather than passive objects to underscore the significance of African Indigenous knowledge systems and the involvement of Zulu indigenous knowledge custodians, particularly African Traditional Health Practitioners, alongside their clients who use traditional medicine. Employing interactive mixed research methods such as interviews and focus group discussions constituted the primary means of data collection. These methods facilitated direct engagement, allowing knowledge custodians and practitioners to actively interact and express their insights and perspectives to the researcher.

The study also brought a new cultural-specific approach to conceptualizing research participants' socio-economic and demographic characteristics, such as age groups, gender, marital status, and religious affiliations. These have always been investigated as statistical variables without looking at their cultural significance to the research community about the research problem. In the context of exploring the challenges and prospects of the South African National IKS Policy (2004) with a special focus on Traditional Medicine and Healing Practices (TMHP) among the Zulu people of KwaZulu-Natal South Africa, the socioeconomic and demographic information of the research participants does not merely serve to provide information about them but endeavours to uncover the indigenous cultural meanings attached to these characteristics in the research community. As such, this study interpreted the demographic information from the Zulu cultural perspective, thereby incorporating the socio-cultural and spiritual meanings attached to the variables.

The study employed several interconnected theoretical frameworks to promote African scholarship on AIKS, focusing on ATM and healing practices, including social cognitive learning, mythology, and policy implementation. These concepts work together to ascertain the significance of cultural and ecological diversity in African Traditional Medicine, supporting traditional medicine practices in South Africa. These conceptual and theoretical frameworks were chosen for the study to investigate their application and relevance to Zulu's local community-based worldviews, ways of knowing, value systems, and approaches to knowledge production in the context of ATM and healing practices.

Hence, this integrated framework helps inform the development of policies and programs that support the preservation, recognition, and integration of traditional medicine into modern healthcare systems. It can also contribute to a better understanding of traditional healing practices' cultural and historical foundations, enhancing their acceptance and effectiveness. Additionally, involving traditional healers and local communities in policymaking can help bridge the gap between traditional medicine and modern healthcare, leading to more holistic and culturally sensitive healthcare services. This comparative study contributes to ongoing discussions aimed at establishing an appropriate framework that effectively protects the fundamental features of indigenous knowledge while ensuring access to this vital resource, upon which most African people rely for healthcare and sustainable livelihoods. Such an inclusive framework would ultimately strike a balance between protecting indigenous knowledge and promoting its responsible utilization for the benefit of all parties involved.

8.4 Recommendations

Because substantial numbers of ordinary people in African local communities, including the study areas, consulted ATHPs for primary healthcare, this study suggests the great need for more comparative, culturally and ecologically specific research studies to understand the significance of this healthcare and associated local community-based knowledge systems, as part of advancing healthcare, social and epistemic justice.

The limited knowledge and awareness of the different stakeholders, including ATHPs in policy frameworks related to IKS and ATM, calls for a deeper investigation of specific challenges commonly encountered by ATHPs and their clients throughout South Africa. This investigation should include the implications for policy development and implementation. A critical review of existing legislation and active engagement with relevant policymakers on the challenges of integrating African traditional medicine into the public healthcare system is recommended for future studies.

The significance of protecting African indigenous knowledge, including Traditional Medicine, associated resources, and knowledge systems, was emphasized. This was meant to guard this valuable knowledge system as a knowledge domain in its own right. The majority of people in marginalized communities depend on it for sustainable livelihood. It needed to be protected against misappropriation, misuse, and unfair competition. This will, in turn, ensure access and benefit sharing for local communities. Promoting indigenous knowledge also has policy implications and epistemic justice imperatives, as it enables policy-makers and other development agencies to comprehensively

understand African indigenous world views, cultures, the environment, and the social, health, and economic conditions of African people and the nature of their traditional communities.

The acceptance of local communities to integrate African traditional medicine and Western healthcare systems implies the need for the two healthcare systems to work together for improved and effective local community healthcare. The government is responsible for developing strategies, including knowledge awareness, to bring these two healthcare systems closer. However, the government should ensure that the associated indigenous knowledge systems of the local communities are protected and preserved for sustainable futures. Local community members articulated several suggestions as ATHPs and their clients if the two systems are to work together for improved public healthcare:

(i) Healthcare providers from both systems could send patients to practitioners of the other healthcare system when they think the other might be able to treat a patient more effectively. This could provide opportunities for both systems to share and learn specific healthcare techniques and value systems from each other. For instance, ATHPs learn about hygiene and the importance of accurate dosage to use both or avoid negative interactions between treatments. Hence, we must understand each other's strengths and limitations in providing public healthcare to local communities. This includes conventional medical practices building on traditional African medicine and healing practices in terms of being local, community-based, accessible, culturally acceptable, and affordable, making conventional medicine more effective, culturally relevant, and sustainable.

(ii) It was suggested that if a person chooses to use remedies from both systems, it would be better to use one after the other treatment was completed. However, due to divergent views on the issue, further research was recommended since the impact of the interactions of the medicines from the two systems was still not even understood by the medical doctors and ATHPs themselves.

(iii) Fostering communication and cooperation between practitioners of both healthcare systems allows one to establish a comprehensive and holistic patient care model of public healthcare. This collaborative approach would enable healthcare professionals to draw upon the strengths of both traditional and modern medicine, ensuring that treatments are tailored to individual patient needs while minimizing the potential risks associated with combining these approaches.

(iv) The insights gained from this research underscore the importance of a well-informed and balanced approach to concurrently using traditional and modern medicines. As healthcare systems evolve and diversify, practitioners, researchers, and policymakers must collaborate to develop guidelines and protocols prioritising patient safety and well-being. By acknowledging the benefits and risks of both treatment modalities and fostering integration within a framework of evidence-based practice, healthcare providers can enhance the quality of patient care, seeking a harmonious blend of traditional and modern medical approaches. The associations of traditional healers that already exist in South Africa, as was the case in conventional medical professions, were a good starting point because they enable ATHPs to check on each other to be sure that all members are competent. The RPL would enhance this contained in the IK Act (2019).

However, the ATHP research participants raised the concern that while they recognized that research into ATMs was essential for ensuring access to safe and effective treatments, the knowledge of indigenous ATM practices and products gained by researchers could be a source of substantial benefits to companies and research institutes. The indigenous knowledge and associated resources of ATM were being harvested from local communities, appropriated, adapted, and patented by these institutions and industries, with little or no compensation to its original custodians and without their informed consent. Therefore, while research on ATM could be supported at the local community level, the government needs to protect the intellectual property rights of the ATHPs and other local community knowledge holders.

It was similarly indicated that collecting research data for preparing traditional remedies from medicinal plants was extremely important. The information was essential for identifying active ingredients and the intake of relevant amounts of drugs. Setting up ATHP rooms in clinics and hospitals was recommended as a critical consideration and step that could be taken to facilitate the integration of the two healthcare systems.

Integrating traditional healing practices into a hospital setting would have an added advantage since it could provide ATHPs with better access to a broader patient population who may benefit from their expertise. In addition, it provides a valuable opportunity for the two systems to collaborate, share knowledge, and contribute to patients' overall well-being. The ATHPs often possess extensive knowledge of herbal remedies, spiritual healing, and other traditional modalities passed down through generations. ATHPs, working alongside conventional medical professionals, provide an opportunity to contribute their unique perspectives and approaches to patient care in South Africa. Furthermore,

having dedicated rooms in clinics and hospitals would give ATHPs easy access to modern diagnostic tools and technologies that clinics and hospitals provide, which can enhance their ability to assess and treat patients. The opportunity provides patients with a broader range of healthcare options, allowing them to make informed decisions about their treatment and healing journey. For some patients, this is about cultural preservation since their understanding of healthcare is deeply rooted in their cultural and spiritual heritage.

The ATHPs who supported this idea saw it as an affirmation of their skills and an acknowledgement of the value of traditional medicine within the broader healthcare system. This would demonstrate respect for their cultural traditions and help keep their ancestral knowledge alive by allowing ATHPs to pass down their wisdom and expertise to future generations. The ATHPs suggested that the process could involve creating specialized units or departments within healthcare institutions that offer traditional medicine services alongside modern treatments.

It was expressed that conventional healthcare providers, including doctors and nurses, tended to be reluctant to be educated on ATM practices and value systems. They considered their education from formal medical institutions more valuable and superior to ATM. It was, therefore, suggested that the government should initiate educational programs and courses to teach traditional medicine knowledge and skills in a structured manner to conventional healthcare providers, as was done in China and other countries. This would create the necessary cultural environment to integrate the two healthcare systems. This could include proper regulation and clear guidelines, ethical frameworks, training, certification, and appropriate licensing so those practicing traditional healing within clinics and hospitals have the necessary skills, knowledge, and cultural understanding of healthcare.

On the issue of ATM governance and government policy frameworks, it was recommended that there was a need to harmonize the African traditional medicine systems of governance with the government-formulated policies and legal frameworks passed at different levels of national governance. This was based on the concern that the local market centres and trade on ATMs were increasing. The magnitude of this trade in the local communities and their governance systems was still unclear, and it remained largely undocumented and not legally regulated. This compromised the sustainable harvesting of medicinal resources for a regular supply of traditional medicines in local communities. Therefore, this called for enforcing sustainable practices in the local communities, ranging from conservation, cultivation, proper harvesting, regulated trade, and controlled use. This required a well-structured sustainable governance system, including the active involvement of traditional leadership.

The recommendation was in line with international protocols on the Nagoya Protocol of 2010 on the governance of Traditional medicinal and genetic resources, which builds on the Convention on Biological Diversity (CBD), advocates for the exchange and sharing of indigenous knowledge held by local communities and acknowledges the importance of fair and equitable sharing of available genetic resources. The Nagoya Protocol promotes sustainable development and conservation of biological diversity and recognizes the importance of customary law and prior informed consent of members of local communities who are key sources of indigenous or traditional knowledge. The Nagoya Protocol established a framework that helps researchers access genetic resources for biotechnology research, development, and other activities in return for a fair share of any benefits from their use. Indigenous and local communities may benefit from a legal framework that respects the value of traditional knowledge associated with genetic resources.

The alignment of the South African IKS policy (2004) and IK Act (2019) with the principles of the Nagoya Protocol reinforces the country's commitment to fostering a more equitable and harmonious relationship between the scientific community, biotechnological entities, and indigenous and local communities. The policy underscores the importance of respecting and protecting traditional knowledge and genetic resources, preserving cultural heritage, biodiversity, and sustainable development. Section 1.4 of the Indigenous Knowledge Systems (IKS) Policy expounds on integrating IKS with other knowledge systems. Such integration provides crucial opportunities for developing novel products and services, which should not be underestimated (IKS Policy, 2004:15).

It was also suggested that despite being different from the Western medical system, which is lab-based science, indigenous knowledge is equally valid and effective. It has been developed through understanding and documenting natural processes and iterating practices over time based on sound scientific principles. The Indigenous Knowledge Systems (IKS) Policy provided a framework to promote and enhance the contribution of indigenous knowledge systems to social and economic development in the country. Therefore, Indigenous knowledge of ATMs should be interfaced with other knowledge and technology systems to enhance their excellence and meet contemporary health challenges in local communities. Therefore, placing the IKS policy (2004) under the DSI is intentional and appropriate since it is responsible for scientific research in South Africa, including space programs.

8.5 Limitations of the study

The study has certain limitations to acknowledge. Firstly, it concentrated on just two of the ten district and metropolitan municipalities in KwaZulu-Natal, South Africa. This decision was driven by budgetary and time constraints, leading to a more contained scope. Additionally, the research is constrained in its ability to generalize findings related to the investigation of challenges and opportunities associated with the South African National Indigenous Knowledge Systems (IKS) Policy of 2004, specifically concerning the advancement and integration of African Traditional Medicines (ATM) and Healing Practices (HPs) within the intricate sociocultural and ecological context of KwaZulu-Natal province, South Africa.

The responses from the selected African Traditional Health Practitioners (ATHPs) and their clients reflect challenges commonly encountered by traditional health practitioners and their clients throughout South Africa. However, it's important to note that these broader issues were not extensively pursued, as they were not the primary focus of the study. Nevertheless, a nationwide research initiative would provide a more comprehensive understanding of African Traditional Health Practitioners and their clients.

8.6 Chapter Summary and Implications

This chapter comprehensively summarises the primary research findings about the study's guiding research questions. Furthermore, the findings are thoroughly examined within the context of the theoretical frameworks that underpin the study. Notably, the study delineates the practical ramifications of its findings about policy and practical application.

In summary, the study concludes that the endeavours to advance and safeguard traditional medicine within the uGu and uMkhanyakude districts manifest alignment with the objectives outlined in the South African Indigenous Knowledge System (IKS) policy of 2004, as well as the subsequent legislation, the Indigenous Knowledge Systems Act (No. 6 of 2019).

Nonetheless, it becomes evident that the successful implementation of various social policies is frequently impeded by the formidable challenges posed by historical legacies rooted in the apartheid and colonial eras. Thus, it is posited that, despite the commendable ideals enshrined within the IKS policy of 2004 and the IKS Act of 2019, many existing challenges necessitate meticulous scrutiny and remediation to ensure the effective promotion and safeguarding of traditional medicine in the South African context.

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APPENDICES

Appendix 1: Informed Consent in English

Dear Participant,

My name is Wilondja Muzumbukilwa (*student number: 205525431*). I am a PhD student studying at the University of KwaZulu-Natal, Howard College campus. The title of my research is: Challenges and Prospects of the National Indigenous Knowledge Systems (IKS) Policy in promoting African Traditional Medicine (ATM) in KwaZulu-Natal, South Africa. The aim of the study is to interrogate the challenges and prospects facing the implementation of the National IKS Policy (2004) with special reference to African Traditional Medicine in KwaZulu-Natal province, South Africa. You've been purposively selected due to your knowledge and experience of ATM in the local community. I would like to interview you so as to share your knowledge and experiences on the status of ATM in the community in relation to the implementation of the National IKS Policy adopted by government in 2004.

Please note that:

- Your participation in this study is very important and voluntary. I rely on you to provide me with accurate information. The information that you provide will be used for scholarly research only.
- You have a choice to participate, not to participate, or to withdraw your participation in the research at any given time. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about 30 to 45 minutes.
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to myself and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- You don't have to answer any question you don't want to answer (I will skip that question and continue with the following questions.
- I would greatly appreciate your help in responding to this interview and your honest answers are very important for the research project.
- If you agree to participate please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

I can be contacted at: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. Email: muzumbukilwaw@ukzn.ac.za; Cell: 0837349635
My supervisor is Professor Hassan Kaya who is located at the DST- NRF Centre in Indigenous Knowledge Systems, Westville Campus, University of KwaZulu-Natal. Contact details: email kaya@ukzn.ac.za , phone number: 0312607237

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office, Email: ximbap@ukzn.ac.za, Phone number +27312603587.

Thank you for your contribution to this research.

Appendix 2: Informed Consent in isiZulu

Umhlanganyeli othandekayo,

Igama lami nguWilondja Muzumbukilwa (inombolo yomfundi: 205525431). Ngingumfundi we-PhD esikhungweni semfundo ephakeme eNyuvesi yaKwaZulu-Natali, e-Howard College. Isihloko socwaningo lwami yi: Izinselele kanye Nezifiso Zenqubomgomo Kazwelonke Yolwazi Lwemvelo (IKS) ekukhuthazeni i-African Traditional Medicine (ATM) KwaZulu-Natali, eNingizimu Afrika. Inhloso yocwaningo ukucubungula izinselelo namathemba abhekene nokuqaliswa kweNqubomgomo kaZwelonke ka-IKS (2004) ngokubhekiselele ngokukhethekile eMnyangweni wezoMdabu wase-Afrika esifundazweni saKwaZulu-Natali, eNingizimu Afrika. Ukhethiwe ngokuzikhethela ngenxa yolwazi lwakho nolwazi lwe-ATM (African Traditional Medicine) noma imithi yendabuko yase-Afrika emphakathini wendawo. Ngingathanda ukuxoxa nawe ukuze wabelane ngolwazi lwakho kanye nolwazi lwakho ngesimo se-ATM noma imithi yendabuko yase-Afrika emphakathini mayelana nokuqaliswa kweNqubomgomo kazwelonke ye-IKS eyamukelwe nguhulumeni ngo-2004.

Sicela wazi ukuthi:

• Ukuhlanganyela kwakho kulolu cwaningo kubaluleke kakhulu futhi ngokuzithandela. Ngithembele kuwe ukuthi unginike ulwazi olunembile. Ulwazi olunikezayo luzosetshenziselwa ucwaningo lwabafundi kuphela.
• Unelungelo lokubamba iqhaza, ukungabambi iqhaza noma ukuhoxisa ukuhlanganyela kwakho ocwaningweni nganoma yisiphi isikhathi. Ngeke ujeziswe ngokuthatha isenzo esinjalo.
• Imibono yakho kule ngxoxo izonikezwa ngokungaziwa. Igama lakho noma ubunikazi bakho ngeke kudalulwe nganoma yisiphi isimo esifundweni.
• Le ngxoxo izothatha imizuzu engama-30 kuya ku-45.
• Irekhodi kanye nezinye izinto ezihlotshaniswa nalolu daba kuzobanjwa efayeleni elivikelwe iphasiwedi elifinyeleleka kuphela kimi nakubamenenja bami. Ngemuva kweminyaka engama-5, ngokuhambisana nemithetho yunivesithi, izobe isetshenziswe ngokushisa nokushisa.
• Akudingeki uphendule noma yimuphi umbuzo ongafuni ukuwuphendula (Ngizokweqa lo mbuzo futhi uqhubeke nemibuzo elandelayo.
• Ngingayithanda kakhulu usizo lwakho ekuphenduleni le ngxoxo futhi izimpendulo zakho eziqotho zibaluleke kakhulu kulolu cwaningo locwaningo.
• Uma uvuma ukubamba iqhaza sicela usayine isimemezelo esixhunywe kulesi sitatimende (ishidi elihlukile lizohlinzekwa ngamasignesha)

Ngiyakwazi ukuxhumana naku: Isikole Sesayensi Yezenhlalakahle, iNyuvesi yaKwaZulu-Natali, i-Howard College Campus, eThekwini. I-imeyili: muzumbukilwaw@ukzn.ac.za; Iseli: 0837349635
Umphathi wami unguProfesa Hassan Kaya otholakala esikhungweni se-DST- NRF ku-Indigenous Knowledge Systems, eWestville Campus, eNyuvesi yaKwaZulu-Natali. Imininingwane yokuxhumana: i-imeyili kaya@ukzn.ac.za, inombolo yocingo: 0312607237

Imininingwane yokuxhumana yeKomidini yokuHlaliswa koLuntu neZenhlalakahle yilezi zilandelayo: Nks. Phumelele Ximba, University of KwaZulu-Natali, Ihhovisi Lokucwaninga, I-imeyili: ximbap@ukzn.ac.za, Inombolo yocingo +27312603587.

Siyabonga ngomnikelo wakho kulolu cwaningo.

Appendix 3: Declaration (isiCelo)

I, …… *(Full name/s and surname of participant*) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate.

Mina,
.....
..... (Igama/amakama nesibongo somhlanganyeli) ngalokhu ngiyakuqinisekisa lokho Ngiyaqonda okuqukethwe kule dokhumenti kanye nemvelo yocwaningo lokucwaninga, futhi ngiyavuma ukuhlanganyela kulo msebenzi wocwaningo.

Ngiyaqonda ukuthi nginelungelo lokuhoxa kwiphrojekthi nanoma yisiphi isikhathi, uma ngifisa. Ngiyaqonda inhloso yocwaningo. Ngiyavuma ukuhlanganyela.

SIGNATURE OF PARTICIPANT
DATE (D/M/Y)
isignesha yomhlanganyeli Usuku(Usuku/Inyanga/ Unyaka

……
……/……/……

Appendix 4: Focus Group Discussion Guide in English

The aim of this study is to interrogate the challenges and prospects facing the implementation of the National IKS Policy (2004) with special reference to African Traditional Medicine in KwaZulu-Natal province, South Africa.

The purpose of the National IKS Policy is to ensure that indigenous knowledge contributes to bringing about sustainable solutions to developmental challenges facing local communities. In the context of African Traditional Medicine (ATM), it is to ensure that IKS contributes to the improvement of public health care in terms of acceptability, accessibility, affordability, and availability.

We want to share your experiences and establish your views on the three themes below:

A. **Status of ATM in public healthcare**

1. What is the status of public health care in your local community? I.e. availability and accessibility to public health care services for community members.
2. What is the role of African Traditional Medicine in your Community? I.e. its contribution to public health care.
3. What are your views on ATM compared to Western/Modern Medicine with regard to public health care in the community: acceptability, accessibility, affordability, and availability?
4. How can the two health care systems work together to improve public health care in the community?

B. **Community knowledge and perceptions toward the National IKS policy and its subsequent legislation**

1. Does the community receive any support from the government and other organizations on promoting community-based knowledge systems (IKS) such as ATM ?

2. What is the community's knowledge and awareness about the National IKS Policy and its subsequent legislation?

3. How could the National IKS Policy and its subsequent legislation help the community to preserve, protect, and promote community-based knowledge systems such as ATM for improved livelihood including public health care**?**

C. **Ecology, environment, climate, and ATM**

1. How does the ATM in the community differ from that of other communities in KZN?

2. How does the ecology/environment/climate of the area impact on the specific type of ATM and healing found in your area?

3. What are the threats to ATM in the area/community?
4. What does the community do to protect ATM in the area?
5. What can the government do to assist in the preservation, protection, and promotion of ATM for improved public health care in the area?
6. What are your views about the governance and management of traditional medicine within and outside your local communities?
7. Is there anything else you want to add? (Here you can write any additional or anything else you wish to add)

THANK YOU FOR TAKING YOUR TIME TO TALK TO US.

Appendix 5: Focus Group Discussion Guide in isiZulu

IZIKHONO ZEMIBUZO UMSEBENZI WOKUXHUMANA

Inhloso yalolu cwaningo ukuhlolisisa izinselelo namathemba abhekene nokuqaliswa kweNqubomgomo kaZwelonke ka-IKS (2004) ngokubhekisela ngokukhethekile kuMnyango WezeMpilo wase-Afrika esifundazweni saKwaZulu-Natali, eNingizimu Afrika.

Inhloso yeNqubomgomo kaZwelonke ye-IKS ukuqinisekisa ukuthi ulwazi lwendabuko lunikeza ukuletha izixazululo ezizinzile ezinselele zokuthuthukiswa ezibhekene nemiphakathi yasendaweni. Kumongo we-African Traditional Medicine (i-ATM), ukuqinisekisa ukuthi i-IKS inikela ekwenzeni ngcono ukunakekelwa kwempilo yomphakathi ngokuvumelana nokwamukelwa, ukutholakala, ukutholakala nokutholakala.

Sifuna ukwabelana ngokuhlangenwe nakho kwakho bese usungula imibono yakho kulezi zihloko ezintathu ezizwakalayo:

A. Isimo se-ATM ekunakekelweni kwempilo yomphakathi

1. Isiphi isimo sokunakekelwa kwempilo yomphakathi emphakathini wakini? I.e. ukutholakala nokutholakala kwezinsizakalo zokunakekelwa kwezempilo zomphakathi kumalungu omphakathi.

2. Iyiphi indima ye-African Traditional Medicine emphakathini wakho? I.e. umnikelo wayo ekunakekelweni kwempilo yomphakathi.
3. Uyini imibono yakho nge-ATM uma kuqhathaniswa neMithi YaseNtshonalanga / Yamanje mayelana nokunakekelwa kwempilo yomphakathi emphakathini: ukwamukelwa, ukufinyeleleka, ukukhokhela nokutholakala?
4. Lezi zinhlelo ezimbili zokunakekela impilo zingasebenza kanjani ndawonye ukuthuthukisa ukunakekelwa kwempilo yomphakathi emphakathini?

B. Ulwazi lomphakathi nemibono mayelana nenqubomgomo kazwelonke ye-IKS kanye nomthetho wayo olandelayo

1. Ingabe umphakathi uthola noma yikuphi ukusekelwa okuvela kuhulumeni nakwezinye izinhlangano ekukhuthazeni izinhlelo zokufunda umphakathi (IKS) njenge-ATM?
2. Luthini ulwazi nokuqwashiswa kwabantu emphakathini mayelana nenqubo mgomo kazwelonke ye-IKS kanye nomthetho wayo olandelayo?
3. Inqubomgomo kazwelonke ye-IKS kanye nomthetho wayo olandelayo ingasiza kanjani umphakathi ukuba ulondoloze, uvikele futhi ukhuthaze izinhlelo zokwazisa umphakathi ezifana ne-ATM ukuze kuthuthukiswe ukuphila okubandakanya ukunakekelwa kwempilo yomphakathi?

C. Ecology, imvelo, isimo sezulu kanye ne-ATM

1. I-ATM emphakathini ihluke kanjani komunye wemiphakathi e-KZN?
2. I-ecology / imvelo / isimo sezulu yendawo ingathinta kanjani uhlobo oluthile lwe-ATM nokuphulukiswa okutholakala endaweni yakini?
3. Yiziphi izinsongo ku-ATM endaweni / komphakathi?

4. Yini umphakathi owenzayo ukuvikela i-ATM endaweni?
5. Uhulumeni angenzani ukuze asize ekuvikelweni nasekukhuthazeni i-ATM ukuze kuthuthukiswe ukunakekelwa kwempilo yomphakathi endaweni?
6. Uthini umbono wakho ngokubusa nokuphathwa kwemithi yesintu ngaphakathi nangaphandle kwemiphakathi yangakini?
7. Noma yini enye ofuna ukuyengeza? (Lapha ungabhala noma yikuphi okunye okufisa ukufaka khona)

SIYABONGA NGOKUTHATHA ISIKHATHI SAKHO UKUKHULUMA NATHI.

Appendix 6: Questionnaire for Traditional Healers (English) and Imibuzo Kubaphili/Inyanga Bendabuko (isiZulu)

Questionnaire identification number (Inombolo yokuhlonza umbuzo): ……
Date (dd-mm-yyyy) Usuku(Usuku/Inyanga/ Unyaka: ……
Site/Community/District (Indawo / Umphakathi / Wesifunda) ……
Language (Ulimi): ……
Recording (Ukurekhoda): ……
Remarks (Amazwi): ……

Signature of the interviewer that a verbal/written consent was obtained (Isiginesha somuntu obuza imibuzo ukuthi kutholakale imvume yokubhala / ebhaliwe)

SECTION I: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF TRADITIONAL HEALER / ISIGABA I: IMIPHAKATHI ZABAPHILI/YEZINYANGA ZENDABUKO

Q.N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	Gender Ubulili	Male (Owesilisa) ……1 Female(Owesifazane)……2	
Q2	What meaning or importance does a person's gender have in your culture? Kuyini ukubaluleka kobulili bomuntu emasikweni akho?		
Q3	Marital status Isimo somshado	Single (Ongashadile)……1 Married (Oshadile)……2 Widow/er ongumfelokazi/ umfelokazi……3 Divorced/Separated(ohlukanisile)……4	
Q4	What meaning or importance does a person's marital status have in your culture? Ngabe isimo somshado womuntu sisho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q5	Age group Iqembu lobudala	30 to 39……1 40 to 49……2 50 to 59……3 60 to 69……4 70 to 79……5 80 to 89……6 90 and above (90 nangaphezulu)……7	
Q6	What meaning or importance does a person's age group have in your culture? Ngabe udala bomuntu busho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q7	Name of District Igama lesifunda	Ugu……1 UMkhanyakude……2	

Q8	Name of Local Municipality Igama loMasipala Wendawo	Ezinqoleni ……..…….....…..1 Hibiscus Coast ……..…..2 Umdoni ……..…..3 Umuziwabantu……..……..…….4 Umzumbe ……..……..…..5 Vulamehlo ……..……..…..6 Hlabisa……..……..7 Jozini ……..…….……..8 Mtubatuba ……..…..……..9 the Big 5 False Bay……..…..10 UMhlabuyalingana ……11	
Q9	Educational Level Izinga lemfundo	Informal Okungahlelekile)……..…..1 Primary (isikole sebanga eliphansi)……...2 Secondary (isikole sebanga eliphezulu)……3 Tertiary -college, university (Isikole esiphakeme – ekolishi, iyunivesi).....4 Others(ezinye)……..…..5 Specify (ucacise)	
Q10	How easy is it for you to read a paper written in Kulula kanjani ukuthi ufunde iphepha elibhalwe nge; i. IsiZulu Ii. Afrikaans iii. English CIRCLE ONE ANSWER FOR EACH (FAKA IMPENDULO EYODWA NGALUNYE)	1=Easy(kulula) 2=difficult(kunzima) 3= Do not read at all(Angifundi nhlobo) 1 2 3 1 2 3 1 2 3	
Q11	Religious Affiliation Inkolo	Catholic (iKatolika)……..…..……..…...1 Pentecostal (ipentekostal)……..…..…..……..…..2 Muslim (Muslim)……..3 Shembe (Shembe)……..……..……..4 Jehovah's Witness (UFakazi KaJehova)……...5 Anglican (ianglican)……..…..6 None (Akukho)……..……..…..7 Traditional religion (Inkolo yendabuko) ……..…8 No influence (Ayikho ithonya) ….……..……..…..9 Others (ezinye)……..…..10 Specify (ucacise)	
Q12	What meaning or importance does a person's religious affiliation have in your culture? Ngabe Inkolo yomuntu yisho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q13	How does religious affiliation influence a person's belief in Traditional or modern /western Medicine? Ngabe inkolo indlala yiphi indima ekushintsheni inkolelo yomuntu kumuthi wesintu noma imithi yasentshonalanga.		

SECTION II: STATUS OF INDIGENOUS KNOWLEDGE SYSTEMS (IKS) IN THE COMMUNITY AND NATIONAL IKS POLICY: TRADITIONAL HEALERS' PERSPECTIVES

ISIGABA II: ISIMO SEZINHLELO ZOLWAZI LWENDABUKO (IKS) EMPHAKATHINI KANYE NENQUBOMGOMO KAZWELONKE YAMA-IKS: IMIBONO YABAPHILI/YEZINYANGA ZENDABUKO

The term Indigenous Knowledge Systems (IKS) is a systematic bodies of knowledge, skills, innovations, technologies and belief systems produced locally and traditionally transmitted orally from one generation to the next for livelihood.

In 2004 the Government of South Africa adopted the National Indigenous Knowledge Systems (IKS) Policy. The main aim of IKS policy was to reverse the injustices of the past and ensure a proper recording, documentation, preservation, protecting, and promotion of IK including African traditional medicine (ATM).The policy aspires to improve the quality of life of the poor people using their own ways of knowing and value systems such as African Traditional Medicine.

Igama elithi I-Indigenous Knowledge Systems (IKS) liyiqembu elisebenzayo lelwazi, amakhono, izinqubo ezintsha, ubuchwepheshe kanye nezinhlelo zokukholelwa ezikhiqizwa emphakathini futhi zidluliselwa ngomlomo ngezizukulwane ezivela kwesinye isizukulwane kuya kwesinye isikhathi sokuphila.

Ngonyaka ka-2004 uHulumeni waseNingizimu Afrika wamukela iNqubomgomo kaZwelonke yoLwazi lwaMdabu (IKS). Inhloso eyinhloko yenkambiso ye-IKS kwakuwukuguqula ukungabi nabulungisa kwangesikhathi esidlule nokuqinisekisa ukurekhodwa okufanelekile, imibhalo, ukulondolozwa, ukuvikela nokukhuthazwa kwe-IK kubandakanya nemithi yendabuko yase - Afrika (ATM). Inqubomgomo izimisele ukuthuthukisa izinga lempilo yabampofu abantu basebenzisa izindlela zabo zokwazi nokwazisa izinhlelo ezifana nemithi yendabuko yase-Afrika.

Q.N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	What are the IKS-based activities that exist in this community? Yiziphi izenzo/izinhlelo ze-IKS ezisekelwe kulo mphakath?		
Q2	How much do these IKS-based activities including traditional medicine contribute to the livelihood in the community? Imisebenzi enhle ye-IKS ihlanganisa kangakanani imishanguzo yendabuko inomthelela empilweni yomphakathi?		
Q3	Do you think people in the community value the IKS-based activities/practices such as African Traditional Medicine (ATM)? Ucabanga ukuthi abantu emphakathini bayayazisa imisebenzi eyenziwe nge-IKS / imikhuba efana nemithi yendabuko yase-Afrika (ATM)?	Yes (Yebo) ……..……..….....1 No (Cha)….……..……..……..2	

Q4	If they still value them, why? Uma besayazisa, kungani?		
Q5	If they do not value them, why? Uma bengayazisi, kungani?		
Q6	Which of these IKS-based practices including ATM, is supported by government or other organizations from outside the community? Yiyiphi yale mikhuba esekelwe kwi-IKS kuhlanganise nemithi yendabuko yase-Afrika (ATM) isekelwa uhulumeni noma ezinye izinhlangano ezivela ngaphandle komphakathi?		
Q7	Have you heard about the National IKS Policy? If the answer is “no”, then go to Q16 Uke wezwa mayelana nenqubomgomo kazwelonke ye-IKS (National IKS Policy)? Uma impendulo ingu "cha", yiya ku-mbuzo 16	Yes (Yebo) ……..……..…...1 No (Cha)….……..……..……..2	
Q8	If “yes”, where did you obtain information regarding the National and International Policy Frameworks related to Indigenous Knowledge in the context of African Traditional Medicine? Uma impendulo yakho ithi “yebo”, ulutholephi ulwazi mayelana neNqubomgomo Kazwelonke kanye Nezinhlaka Zenqubomgomo Yamazwe Ngamazwe ezihlobene Nolwazi Lwendabuko kumongo Wemithi Yendabuko Yase-Afrika?	**Mass media (Imidiya enkulu)** Radio (iRadio….……..1 TV/Video (I-TV / Ividiyo)……..…..…..2 Newspaper (Iphephandaba……..……..3 Poster/pamphlet(Iphosta / ipheshana)…….…4 People (Abantu)……..…..5 Community leaders(Abaholi bomphakathi)……..…..6 Friend(Umngane)…….……..…..7 Family member (Ilunga lomndeni)……..…..8 **Other places** (**Ezinye izindawo)** School (Isikole)……..….9 Place of workshop(Indawo yomhlangano)……..….10 Public meeting (Umhlangano womphakathi)……..……...11 Seminar (I-Semina)…….……..…..12 Others(ezinye)……..……..…..13 Specify (ucacise)	
Q9	What do you know about it? Yini oyaziyo ngakho?		
Q10	What are its advantages and limitations in relation to your work as a traditional healer in this community? Yiziphi izinzuzo kanye nokulinganiselwa kwawo		

	ngokuphathelene/ ngokuhlobene nomsebenzi wakho njengumulaphi/njenginyanga wendabuko kulo mphakathi?		
Q11	Did anybody from government come to the community to explain about the IKS policy? If the answer is “No”, move to section III Ingabe ukhona ovela kuhulumeni oza emphakathini ukuchaza ngenqubomgomo ye-IKS (IKS Policy)? Uma impendulo ingu "cha", yiya kumbuzo-III	Yes (Yebo) ……..……..…..1 No (Cha)…..……..……..……..…….2	
Q12	If “yes”, how is this policy implemented in your local community? Uma impendulo yakho ithi "yebo", le nqubomgomo isetshenziswa/ iqaliswe kanjani emphakathini wangakini?		
Q13	Who is involved in the implementation of IKS policy? Ubani obandanyekayo ekusebenziseni/ ekuqalisweni kwenqubomgomo ye-IKS?		
Q14	How is he involved? Ubandakanyeka kanjani?		
Q15	Why do you think he is involved? Ucabanga ukuthi kungani ebandakanyeka?		
Q16	If you have not heard about it, would you like to know about it? If the answer is “No”, then go to the next section. Uma ungazange uzwe ngakho, ungathanda ukwazi ngakho? Uma impendulo ithi "Cha", yiya kwisigaba esilandelayo	Yes (Yebo) ……..……..…..1 No (Cha)…..……..……..……..…….2	
Q17	Are you familiar with the National Recordal System and The IKS Documentation Centre at UKZN?	Yes (Yebo) ……..……..…..1 No (Cha)…..……..……..……..…….2	

	Ingabe uyayazi iNational Recordal System Kanye ne-IKS Documentation Centre e-UKZN?		
Q18	Are you familiar with the National Indigenous Knowledge Systems (IK) Bill? Ingabe uyawazi uMthethosivivinywa Kazwelonke Wezinhlelo Zolwazi Lomdabu (i-IK)?	Yes (Yebo) ……..……..……..…..1 No (Cha)…..……..……..……..….2	

SECTION III: STATUS OF TRADITIONAL MEDICINE IN THE LOCAL COMMUNITY: TRADITIONAL HEALERS' PERSPECTIVES

ISIGABA III: ISIMO SOMUTHI WENDABUKO EMPHAKATHINI WENDAWO: IMIBONO YABAPHILI/YEZINYANGA ZENDABUKO

Q.N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	Where did you learn your profession as a traditional healer from? Ufundephi umsebenzi wakho njengomlaphi wendabuko?		
Q2	How long have you been practicing as a traditional healer in this community? (in years) Sekuyisikhathi esingakanani usebenza njengomlaphi wendabuko kulomphakathi? (iminyaka)	Less than a year (Ngaphansi konyaka) ……1 01-10……..…..2 11-20……..……..…..3 21-30……..……...4 31 and above (31 nangaphezulu)……..…..5 No answer (Akunampendulo)…..……6	
Q3	What materials do you use for your traditional medicine and healing? Yiziphi izinto ozisebenzisayo zemithi yakho yendabuko nokulapha?	Animal source (Umthombo wezilwane)……..….1 Animal product + herbal medicine for treatment (Umkhiqizo wezilwane + imithi yemithi yokwelashwa)…….……...2 Minerals (Amaminerali)…….……..……..3 Herbo – minerals (Imifino -amaminerali)……..4 Other (ogunye)…….……...13 Specify (ucacise)	
Q4	Where do you get your traditional medicines from? Uyithola kuphi imithi yakho yendabuko?		
Q5	Are there any traditional medicines which are only found in this area? Ikhona yini imithi yendabuko etholakala kule ndawo kuphela?	Yes (Yebo) ……..……..…….....1 No (Cha)…..……..…….……..……2	
Q6	If yes, give some examples Uma kunjalo, nikeza ezinye izibonelo If no, why do you think so? Uma ingekho, kungani ucabanga kanjalo?		
Q7	Does the environment and climate of this area influence the common diseases or illnesses in the area/community ? Ingabe imvelo nesimo sezulu		

	kule ndawo kuthonya izifo ezivamile noma izifo endaweni / emphakathini?		
Q8	Does the environment and climate of this area make your traditional medicine and healing practices different from other parts of KwaZulu-Natal or South Africa ? Ingabe imvelo nesimo sezulu salendawo kwenza imithi yakho yendabuko nemikhuba yokulapha ihluke kwezinye izingxenye zakwaKwaZulu-Natali noma eNingizimu Afrika?	Yes (Yebo) ……..……...1 No (Cha)…..……..…..2	
Q9	If this is the case, can you explain what, how and why is it different? Uma kunjalo, ungachaza ukuthi yini, kanjani nokuthi kungani kuhlukile?		
Q10	What are the common illnesses among the people in this area? Yiziphi izifo ezivamile ukuphatha abantu kule ndawo?		
Q11	Can you treat all the illnesses or clients come to you for specific illnesses? Ungakwazi yini ukulapha zonke izifo noma amaklayenti/ amakhasimende eza kuwe ngezifo ezithile?		
Q12	Where do most of your clients come from? Avela kuphi amaklayenti akho amangingi?		
Q13	Why do you think they come to you? Ucabanga ukuthi kungani beza kuwe?		
Q14	Do you refer some of your clients to other healers or modern medicines? Ingabe uyawadlulisela yini amaklayenti akho kwabanye abelaphi bendabuko noma imithi yanamuhla?	Yes (Yebo) ……..……...1 No (Cha)…..……..…..2	

Q15	If Yes, when do you refer them to other healers or modern medicines? Uma kunjalo (yebo), ubadlulisela nini kwabanye abelaphi noma imithi yanamuhla?		
Q16	Do other healers also send their clients to you? Ingabe abanye abelaphi bayawathumela amakhasimende abo kuwe?	Yes (Yebo) ……..……...1 No (Cha)….……..……..2	
Q17	Do you have cases whereby modern doctors refer patients to you? Ingabe zikhona izimo lapho odokotela banamuhla (nomtholampilo wesimanje) bethumela khona iziguli kuwena?	Yes (Yebo) ……..……...1 No (Cha)….……..……..2	
Q18	If Yes, which are these cases? Uma kunjalo (yebo), yiziphi lezi zimo?		
Q19	Do you have cases where patients from modern medicines come to you for help? Ingabe unazo izimo lapho iziguli ezivela emtholampilo ziza kuwena zifuna usizo?	Yes (Yebo) ……..……1 No (Cha) ….……..……..2	
Q20	How many clients come to you for treatment per month? Mangaki amakhasimende eza kuwena ezokwelashwa ngenyanga?	01-05……..……..1 06-10……..……..2 11-15……..……...3 16 -20……..……..4 21 - 25……..……..5 26 and above (26 nangaphezulu)……..6 No answer (Akunampendulo)…..……...7	
Q21	How many clients did you consult last year? Mangaki amaklayenti owabonana nawo ngonyaka odlule?	01- 20……..……..……..1 21- 40……..……..……..2 41- 60……..……..…..3 61 - 80……..……..4 81 - 100……..……..5 101 and above (101 nangaphezulu)……..6 No answer (Akunampendulo)…..……..7	
Q22	Occupation of the majority of your clients Ukusebenza kweningi lamaklayenti akho	Not mentioned (Akukhulunywanga)……..1 House wife (unkosikazi ongasebenzi) ……..2 Student(umfundi)……..…..……..3 Farmer (Umlimi)……..……..4 Others (Businessmen, Teachers, Auto drivers, Labors, Factory workers, etc.) Abanye (Abamabhizinisi,Bomabhizinisi, Othisha, Abashayeli Bokuzivocavoca, Abasebenzi,Abasebenzi basefemini, njalo njalo).....5	

Q23	What are your views about ATM working together with modern/western medicine for the betterment of clients, especially in the rural areas where most people live ? Yimiphi imibono yakho mayelana ne-ATM esebenzisana nemithi yesimanje / entshonalanga yokuthuthukisa amaklayenti, ikakhulukazi ezindaweni zasemaphandleni lapho abantu abaningi behlala khona?		
Q24	What do you think the modern medicine can learn from ATM? Ucabanga ukuthi yini engafundwa abelaphini besimanje ku- imithi yendabuko yase-Afrika (ATM)?		
Q25	What do you need to learn from modern medicine? Yini okudingeka uyifunde kubelaphi besimanje (umtholampilo wesimanje)?		
Q26	What makes the working together of the two medical systems difficult? Yini eyenza ukusebenza ngokubambisana kwelezinhlelo ezimbili zezokwelapha kubenzima?		
Q27	How can the relationship between the two medical systems be improved for a better public health care? Ubuhlobo obuphakathi kwalezi zinhlelo ezimbili zezokwelapha bungathuthukiswa kanjani ukuze uthole ukunakekelwa kwezempilo okungcono komphakathi?		

THAT IS THE END OF THE QUESTIONNAIRE. THANK YOU FOR TIME TAKING TO ANSWER MY QUESTIONS. I APPRECIATE YOUR HELP.

LOKHO KUWUKUPHELA KWEMIBUZO. SIYABONGA NGESIKHATHI SAKHO SOKUPHENDULA IMIBUZO YAMI. NGIYAZISA USIZO LWAKHO.

Appendix 7: Questionnaire For Traditional Healers' Clients (English) and Imibuzo Amaklayenti/Amakhasimende (isiZulu)

Questionnaire identification number (Inombolo yokuhlonza umbuzo): ……
Date (dd-mm-yyyy) Usuku(Usuku/Inyanga/ Unyaka: ……
Site/Community/District (Indawo / Umphakathi / Wesifunda): ……
Language (Ulimi): ……
Recording (Ukurekhoda): ……
Remarks (Amazwi): ……

Signature of the interviewer that a verbal/written consent was obtained (Isiginesha somuntu obuza imibuzo ukuthi kutholakale imvume yokubhala / ebhaliwe)

SECTION I: SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF TRADITIONAL MEDICINE CLIENTS

ISIGABA I: IZINDLELA ZEMISEBENZI-IZINDABA YAMAMAKLAYENTI

Q. N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	Gender Ubulili	Male (Owesilisa) ……1 Female (Owesifazane)……2	
Q2	What meaning or importance does a person's gender have in your culture? Kuyini Kubaluleka kobulili womuntu ophikisayo emasikweni akho?		
Q3	Marital status Isimo somshado	Single (Ongashadile)……1 Married (Oshadile)……2 Widow/er ongumfelokazi/ umfelokazi……3 Divorced/Separated(ohlukanisile)……4	
Q4	What meaning or importance does a person's marital status have in your culture? Ngabe isimo somshado womuntu sisho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q5	Age group Iqembu lobudala	20 to29……1 30 to 39……2 40 to 49……3 50 to 59……4 60 to 69……5 70 to 79……6 80 to 89……7 90 and above (90 nangaphezulu)……8	
Q6	What meaning or importance does a person's age group have in your culture?		

	Ngabe Iqembu yobudala bomuntu sisho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q7	Name of District Igama lesifunda	Ugu……1 UMkhanyakude……2	
Q8	Name of Local Municipality Igama loMasipala Wendawo	Ezinqoleni ……1 Hibiscus Coast ……2 Umdoni ……3 Umuziwabantu……4 Umzumbe ……5 Vulamehlo ……6 Hlabisa……7 Jozini ……8 Mtubatuba ……9 the Big 5 False Bay……10 UMhlabuyalingana ……11	
Q9	Educational Level Izinga lemfundo	Informal Okungahlelekile)……1 Primary (isikole sebanga eliphansi)……2 Secondary (isikole sebanga eliphezulu)……3 Tertiary -college, university (Isikole esiphakeme – ekolishi, iyunivesi)……4 Others (ezinye)……5 Specify (ucacise)	
Q10	What meaning or importance does a person's educational level have in your culture? Ngabe izinga lomuntu lemfundo lisho ukuthini noma libaluleke kangakanani emasikweni akho?		
Q11	How easy is it for you to read a paper written in Kulula kanjani ukuthi ufunde iphepha elibhalwe kuyo i. IsiZulu Ii. Afrikaans iii. English CIRCLE ONE ANSWER FOR EACH (FAKA IMPENDULO EYODWA NGALUNYE)	1= Easy (kulula) 2= difficult (kunzima) 3= Do not read at all(Angafundi nhlobo) 1 2 3 1 2 3 1 2 3	
Q12	Religious Affiliation Inkolo	Catholic (iKatolika) ……1 Pentecostal (ipentekostal)……2 Muslim (Muslim)……3 Shembe (Shembe)……4 Jehovah's Witness (UFakazi KaJehova)……5 Anglican (ianglican)……6 None (Akukho)……7 Traditional religion (Inkolo yendabuko)……8 No influence (Ayikho ithonya)……9 Others (ezinye)……10	

		Specify (ucacise)	
Q13	What meaning or importance does a person's religious affiliation have in your culture? Ngabe Inkolo yomuntu yisho ukuthini noma kubaluleke kangakanani emasikweni akho?		
Q14	How does religious affiliation influence a person's belief in Traditional or modern /western Medicine? Ngabe inkolo iyishintsha kanjani inkolelo yomuntu emithini yendabuko kumbe yesimanje?		
Q15	Occupational Status Isimo sokusebenza	Employed (Iqashwe)…….1 Unemployed (Ayisebenzi)…….2 Self-employed(Oziqashile)…….3 Others(ezinye)…….4 Specify (ucacise).	
Q16	What meaning or importance does a person's occupational status have in your culture? Yisiphi isimo sokubaluleka kwesimo somsebenzi womuntu esesikweni sakho?		
Q17	If employed, where do you work? Uma uqashwe, usebenza kuphi?	Business/Trade (Ibhizinisi/ ukuhweba) ……1 regular job or Service (Umsebenzi ovamile noma Isevisi) ……2 Labor/wage earning (Umsebenzi /umholo ohola) ……3 Support from Relatives (Ukusekelwa kusuka kwilzihlobo) ……4 Support from friends (Ukusekelwa kusuka kubangani) ……5 Pension (Ipensheni) ……6 Livestock (Imfuyo) ……7 Field Harvest/Farming (Isivuno sezithelo / Ukulima) ……8 Informal work (Umsebenzi ongahlelekile).....9 Child Support Grant (Isibonelelo Sokusekelwa Kwabantwana) ……10 Fishing (Ukudoba) ……11 Brewing beer (Ukubheja ubhiya) ……12 Farming (Ukulima)……13 Others (ezinye) ……14 Specify (ucacise).	
Q18	How long have you been depending on this/se sources of income? (In years) Sekuyisikhathi esingakanani	0 to 5……1 6 to 10……2 11 to 15……3 16 to 20……4 21 to 25……5 26 to 30……6 31 to 35……7	

	uphila ngalomthombo wemali engenayo? (Iminyakeni)	36 and above (36 nangaphezulu)…….…..……..8	
Q19	How would you describe your financial position? Ungasichaza kanjani isimo sakho sezezimali?	Very good (Kuhle kakhulu)…….…….….1 Good (Kuhle)……..…..…2 Reasonable (Kuyaqondakala)……..…..…3 Bad (Okubi)…….……..……..……4 Very bad(Okubi Khakhulu)……..…..…5	

SECTION II: STATUS OF INDIGENOUS KNOWLEDGE SYSTEMS IN THE LOCAL COMMUNITY: TRADITIONAL MEDICINE CLIENTS' PERSPECTIVES

ISIGABA II: ISIMO SEZINHLELO ZOLWAZI LWENDABUKO (IKS) EMPHAKATHINI KANYE NENQUBOMGOMO KAZWELONKE YAMA-IKS: IMIBONO YAMAMAKLAYENTI/KHASIMENDE

The term Indigenous Knowledge Systems (IKS) is a systematic bodies of knowledge, skills, innovations, technologies and belief systems produced locally and traditionally transmitted orally from one generation to the next for livelihood.

In 2004 the Government of South Africa adopted the National Indigenous Knowledge Systems (IKS) Policy. The main aim of IKS policy was to reverse the injustices of the past and ensure a proper recording, documentation, preservation, protecting, and promotion of IK including African traditional medicine (ATM).The policy aspires to improve the quality of life of the poor people using their own ways of knowing and value systems such as African Traditional Medicine.

Igama elithi I-Indigenous Knowledge Systems (IKS) liyiqembu elisebenzayo lelwazi, amakhono, izinqubo ezintsha, ubuchwepheshe kanye nezinhlelo zokukholelwa ezikhiqizwa emphakathini futhi zidluliselwa ngomlomo ngezizukulwane ezivela kwesinye isizukulwane kuya kwesinye isikhathi sokuphila.

Ngonyaka ka-2004 uHulumeni waseNingizimu Afrika wamukela iNqubomgomo kaZwelonke yoLwazi lwaMdabu (IKS). Inhloso eyinhloko yenkambiso ye-IKS kwakuwukuguqula ukungabi nabulungisa kwangesikhathi esidlule nokuqinisekisa ukurekhodwa okufanelekile, imibhalo, ukulondolozwa, ukuvikela nokukhuthazwa kwe-IK kubandakanya nemithi yendabuko yase - Afrika (ATM) .Inqubomgomo izimisele ukuthuthukisa izinga lempilo yabampofu abantu basebenzisa izindlela zabo zokwazi nokwazisa izinhlelo ezifana nemithi yendabuko yase-Afrika.

Q. N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	What are the IKS-based activities that exist in this community? Yiziphi izenzo ze-IKS ezisekelwe kulo mphakath?		
Q2	How much do these IKS-based activities including traditional medicine contribute to the livelihood in the community? Imisebenzi ye-IKS esekelwe kulomphakathi nemishanguzo yendabuko inomthelela ongakanani empilweni yomphakathi?		
Q3	Do you think people in the community value the IKS-based activities/practices such as African Traditional Medicine (ATM)? Ucabanga ukuthi abantu emphakathini bayayazisa imisebenzi eyenziwe nge-IKS / imikhuba efana nemithi yendabuko yase-Afrika (ATM)?	Yes (Yebo) ……...……...1 No (Cha)…….……..2	

Q4	If they still value them, why? Uma besawazisa, kungani?		
Q5	If they do not value them, why? Uma bengayazisi, kungani?		
Q6	Which of these IKS-based practices including ATM, is supported by government or other organizations from outside the community? Yiyiphi yale mikhuba esekelwe kwi-IKS kuhlanganise nemithi yendabuko yase-Afrika (ATM) isekelwa uhulumeni noma ezinye izinhlangano ezivela ngaphandle komphakathi?		
Q7	Have you heard about the National IKS Policy? If the answer is "no", then go to Q16 Uke wezwa mayelana nenqubomgomo kazwelonke ye-IKS (National IKS Policy)? Uma impendulo ingu "cha", yiya kumbuzo-16	Yes (Yebo) ……..……..……....1 No (Cha)….……..……..……..……2	
Q8	If "yes", where did you obtain information regarding the National and International Policy Frameworks related to Indigenous Knowledge in the context of African Traditional Medicine? Uma impendulo yakho ithi "yebo", ulutholephi ulwazi mayelana neNqubomgomo Kazwelonke kanye Nezinhlaka Zenqubomgomo Yamazwe Ngamazwe ezihlobene Nolwazi Lwendabuko kumongo Wemithi Yendabuko Yase-Afrika?	**Mass media (Imidiya enkulu)** Radio (iRadio) ….……..……..1 TV/Video (I-TV / Ividiyo) ……..……..…..2 Newspaper (Iphephandaba ……..……..3 Poster/pamphlet (Iphosta / ipheshana) ……....4 People (Abantu) ……..……..5 Community leaders (Abaholi bomphakathi)……..….6 Friend (Umngane)…….……....7 Family member (Ilunga lomndeni)……..…..8 **Other places (Ezinye izindawo)** School (Isikole).……..……..…..9 Place of workshop (Indawo yomhlangano) ……..10 Public meeting (Umhlangano womphakathi) …….....11 Seminar (I-Semina) ……..……..…..12 Others (ezinye) ……..…..…..13 Specify (ucacise)	
Q9	What do you know about it? Yini oyaziyo ngakho?		
Q10	What are its advantages and limitations in relation		

	to your work as a traditional healer in this community? Yiziphi izinzuzo kanye nokulinganiselwa kwawo ngokuphathelene/ ngokuhlobene nomsebenzi wakho njenginyanga wendabuko kulo mphakathi?		
Q11	Did anybody from government come to the community to explain about the IKS policy? If the answer is “No”, move to section III Ingabe ukhona ovela kuhulumeni oza emphakathini ukuchaza ngenqubomgomo ye-IKS (IKS Policy)? Uma impendulo ingu "cha", yiya kumbuzo-III	Yes (Yebo) ……...……...1 No (Cha) ….……..……..…..……2	
Q12	If “yes”, how is this policy implemented in your local community? Uma "yebo", le nqubomgomo isetshenziswa/ iqaliswe kanjani emphakathini wangakini?		
Q13	Who is involved in the implementation of IKS policy? Ubani othintekayo ekusebenziseni/ ukuqaliswa kwenqubomgomo ye-IKS?		
Q14	How is he involved? uthinteka kanjani?		
Q15	Why do you think he is involved? Ucabanga ukuthi kungani ethinteka?		
Q16	If you have not heard about it, would you like to know about it? If the answer is “No”, then go to the next section. Uma ungazange uzwe ngakho, ungathanda	Yes (Yebo) ……..……...1 No (Cha) ….……..……..……..2	

	ukwazi ngakho? Uma impendulo ingu "Cha", yiya kwesigaba esilandelayo		
Q17	Are you familiar with the National Recordal System and The IKS Documentation Centre at UKZN? Ingabe uyayazi iNational Recordal System Kanye ne-IKS Documentation Centre e-UKZN?	Yes (Yebo) ……..……..……..…..1 No (Cha)….……..……..……..….2	
Q18	Are you familiar with the National Indigenous Knowledge Systems (IK) Bill? Ingabe uyawazi uMthethosivivinywa Kazwelonke Wezinhlelo Zolwazi Lomdabu (i-IK)?	Yes (Yebo) ……..……..……..…..1 No (Cha)….……..……..……..….2	

SECTION III: STATUS OF TRADITIONAL MEDICINE IN THE LOCAL COMMUNITY: TRADITIONAL MEDICINE CLIENTS' PERSPECTIVES

ISIGABA III: ISIMO SOMUTHI WENDABUKO EMPHAKATHINI WENDAWO: IMIBONO YAMAMAKLAYENTI/YAMAKHASIMENDE

Q. N	QUESTION UMUBUZO	CODING CATEGORIES IZIGABA ZOKUBHALA IKHODI	SKIP YEQA
Q1	What is your first point of call when you get sick? Ikuphi ukwenza kuqala uma ugula?	Modern clinic (umtholampilo) ……..……..…….1 Traditional healer (Udokotela wendabuko) ……..……..……..2	
Q2	How many times did you consult a traditional healer/doctor last year? Zingaki izikhathi oye waxhumana nomhlengikazi wendabuko / udokotela ngonyaka odlule?	None (Akukho)……..…..…..1 Once (Kanye)……..……2 Two to three times (Izikhathi ezimbili kuya kathathu) ……3 Four to six times (Izikhathi ezine kuya kweziyisithupha) ……..…..……..…….4 More than six times (Izikhathi ezingaphezu kwesithupha) ……..……..……5	
Q3	Why do you consult a traditional healer? Kungani uxhumana nomdokotela wendabuko?	I want a traditional medicine for healing purpose (Ngifuna umuthi wendabuko ngenhloso yokuphulukisa)……1 I could not be cured at the clinics(Angikwazi ukuphulukiswa emitholampilo)……..…….2 There are no clinics close to where I live(Ayikho imitholampilo eduze nendawo engihlala kuyo)…….3 Other medicines are too expensive(Iminye imithi iyabiza kakhulu)……..……...4 Other (Okunye)……..5	
Q4	Where do you get information about ATM? Ulutholaphi ulwazi mayelana ne-ATM (umuthi wendabuko imithi yendabuko yase-Afrika) ?	**Mass media (Imidiya enkulu)** Radio (iRadio…..……..……..1 TV/Video (I-TV / Ividiyo)……..…..…..2 Newspaper (Iphephandaba……..…..3 Poster/pamphlet (Iphosta / ipheshana)……..…..…..4 People (Abantu)……...5 Community leaders (Abaholi bomphakathi)……..6 Friend (Umngane)…….……..…..7 Family member (Ilunga lomndeni)…….. ….8 **Other places (Ezinye izindawo)** School (Isikole)……..……..…..…..9 Place of workshop (Indawo yomhlangano)……..10 Public meeting (Umhlangano womphakathi)……..11 Seminar (I-Semina) ……..……..……..…12 Others (ezinye)……..……..……..13 Specify (ucacise)	

Q5	Do other members of your family also consult traditional healers? Ingabe amanye amalungu omndeni wakho abuye axhumane nabelaphi bendabuko?	Yes (Yebo) ……..……..…..…...1 No (Cha)….……..……..……..2	
Q6	Have the number of times that you or your family members consulted a traditional healer changed in the three years ? Ngabe inani lezinkathi lapho wena noma amalungu omndeni wakho exhumane nomlaphi wendabuko zishintshile eminyakeni emithathu eyedlule?	I now go more often (Manje ngiyahamba kaningi) …….....1 I now go less often (Manje ngiyahamba kancane kancan.....……2 I now go the same as before (Manje ngiyafana nanjengaphambili) ……..…..3	
Q7	If you have changed your use of ATM, explain why? Uma ishintshile indlela osebenzisa ngayo imithi yendabuko yase-Afrika (i-ATM), chaza ukuthi kungani?		
Q8	Where are the traditional healers you consult located? Batholakala kuphi abelaphi bendabuko obasebenzisayo/obahamba yo?		
Q9	Do you ever consult both ATM and modern clinic? Ingabe uke uthintane nolaphi wendabuko (ATM) Kanye nomtholampilo wesimanje Kanye Kanye?	Yes (Yebo) ……..……..…..…...1 No (Cha)….……..……..……..2	
Q10	If, yes, what are the advantages and limitations of each? Uma, yebo, yiziphi izinzuzo kanye nobubi?		
Q11	What specific illnesses do you consult each of them? Iziphi izifo ezithile ozibonisana nazo?		
Q12	Are there any modern clinic in your local community? Ingabe kukhona imitholampilo yanamuhla emphakathini wangakini?	Yes (Yebo) ……..……..…..…...1 No (Cha)….……..……..……..2	

Q13	If, no, where is the nearest clinic located? Uma, cha, ukuphi umtholampilo oseduze?		
Q14	How do you get there? Ufika kanjani lapho?	Walk……1 Taxi (Itheksi)……2 Bus (Ibhasi)……3 Train (Isitimela)……4 Others (ezinye)……5 Specify (ucacise)	
Q15	If you walk, how long does it take you? Uma uhamba ngezinyawo, kuthatha isikhathi esingakanani?	Less than 10 minutes (Ngaphansi kwemizuzu engu-10) ……1 10 to 20 minutes (Imaminithi engu-10 ukuya kwangu-20) ……2 More than 20 minutes (Imaminithi engaphezu kwengu-20) ……3	
Q16	If you catch a taxi, train or bus how much does it cost you (return fare)? Uma ugibela itekisi, isitimela noma ibhasi kukubiza malini (ukuya nokubuyela emuva)?	[R……]	
Q17	How much do you estimate that you have spent on modern medicine in the past one year? Ungayilinganisela kumalini imali oyichithe ekwelashweni kwesimanje ngonyaka odlule?	[R……]	
Q18	Are there any traditional healers in your local community? Ngabe bakhona yini abanye abelaphi bendabuko emphakathini wangakini?	Yes (Yebo) ……1 No (Cha)……2	
Q19	If yes, how many? Uma kunjalo, bangaki?		
Q20	Are most of the traditional healers in the community men or women? Ingabe iningi labelaphi bendabuko elithokalaka emaphakathini wakini lingamadoda noma amakhosikazi?	Men (Amadoda) ……1 Women (Abesifazane)……2	
Q21	How do you explain this situation? Ungasichaza kanjani lesi simo?		

Q22	If they are located outside your local community, how do you travel there? Uma zikhona ngaphandle komphakathi wangakini, uhamba kanjani lapho?	Walk……..…….1 Taxi (Itheksi)…….……..……..2 Bus (Ibhasi)…….……..…..3 Train (Isitimela)…….…….…..4 Others (ezinye)…….……..5 Specify (ucacise)	
Q23	If you walk, how long does it take you? Uma uhamba ngezinyawo, kuthatha isikhathi esingakanani wena?	Less than 10 minutes (Ngaphansi kwemizuzu engu-10) …….……..…..1 10 to 20 minutes (Imaminithi engu-10 ukuya kwangu-20) …….……..……..2 More than 20 minutes (Imaminithi engaphezu kwengu-20) ……..……...3	
Q24	If you catch a taxi, train or bus how much does it cost you (return fare)? Uma uthola itekisi, isitimela noma ibhasi kukubiza kangakanani (ukuya nokubuyela emuva)?	[R…….]	
Q25	How much do you estimate that you have spent on ATM in the past one year? Uchabanga ukuthi imalini oyisebenzisile emithini yendabuko (ATM) ngonyaka odlule?	[R…….]	
Q26	What particular aspects of ATM would you have wished to be available in western medicine? Yiziphi izinxenye ezithile Zemithini yendabuko (ATM) ongafisa zitholakale emithi yasentshonalanga?		
Q27	Does anybody supervise/guide you in the ATM you use? Ingabe ukhona umuntu oqondayo / okusizayo ngendlela osebenzisa ngayo i-ATM?	Yes (Yebo) …….……..……..…...1 No (Cha)….……..……..…..2	
Q28	Identify the statement that best describes your health care practices. (Check only one option) Thola isitatimende esichaza kahle izindlela zakho zokunakekelwa kwezempilo. (Hlola inketho eyodwa kuphela)	I use ATM only (Ngisebenzisa i-ATM(umuthi wendabuko imithi yendabuko yase-Afrika) kuphela)……..1 I use ATM with treatments given to me by my medical doctor (Ngisebenzisa i-ATM ngemithi enginikezwe udokotela wami)…….……2	
Q29	Identify the statement that best describes your level of involvement with ATM provider. (Check only one option)	I do not see ATM providers (Angiboni abahlinzeki be-ATM) ……..…..1 I see ATM providers on a daily basis(Ngibona abahlinzeki be-ATM nsuku zonke)……...2	

	Thola isitatimende esichaza kahle izinga lakho lokuzibandakanya nomhlinzeki we-ATM. (Hlola inketho eyodwa kuphela)	I see ATM providers on a weekly basis (Ngibona abahlinzeki bama-ATM ngesonto onke) ……...3 I see ATM providers on a monthly basis(Ngibona abahlinzeki bama-ATM njalo ngenyanga)……..…..4 I see ATM providers once a year(Ngibona abahlinzeki be-ATM kanye ngonyaka)……..…..5 I see ATM providers less than once a year (Ngibona abahlinzeki be-ATM ngaphansi kanye konyaka)….……6 Others (ezinye)……..…..…..7 Specify (ucacise)	
Q30	Would you give recommendation of ATM? Ungabeka ukusikisela kwe-ATM(umuthi wendabuko imithi yendabuko yase-Afrika)?	Yes (Yebo) ……..……...1 No (Cha) ….……..…..…….2	
Q31	Why? Kungani?		
Q32	If you could get treated at a clinic, is it more expensive or cheaper than a traditional healer? Uma ungathola ukwelashwa emtholampilo, ingabe iyabiza noma ishibhile kunokwelapha wendabuko?	Cheaper (Engabizi)……..……..……1 Same (Ibiza ngokufana)……..……..……..2 More expensive (Ibiza kakhulu)……..……3	
Q33	If you had the choice between going to a clinic and going to a traditional healer, what would you choose? (Your first choice, forgetting about the cost) Uma ngabe ukhethe phakathi kokuya emtholampilo nokuya kumnakekeli wendabuko, ungakhetha ini? (Ukukhetha kwakho kokuqala, ukukhohlwa izindleko)	Go to a traditional healer (Yiya kumphilisa wendabuko) ….……..…… ……...1 Go to a clinic(Yiya emtholampilo)……..… …..2 It depends on what treatment I need (Kuncike kokwelashwa engikudingayo)……..……..3 Do not know (Angazi)……..……..……..……4	
Q34	Why this choice? Kungani lokhu kukhetha?		
Q35	If the answer is (1), what factor(s) influence(s) the choice of healer to consult? i.e., why do you choose healer A rather than B? Uma impendulo iwukuthi (1), yiziphi izinto (ama) ezithonya (s) ukukhetha kokwelapha ukubonisana? ngukuthi ukhetha ukwelapha/Inyanga A kunokuba B?		

Q36	Do you think that you will use more or less traditional medicines in the future? Ucabanga ukuthi uzosebenzisa imithi yendabuko esikhathini esizayo?	More (Okuningi)……..……..…..1 Less(Ngaphansi)……..……..2 The same (Okufanayo) ……..……..3 Do not know (Angazi) ……..……..……..4	
Q37	If a clinic was closer to your house, would you use traditional medicines more or less often? Uma umtholampilo usondelene nendlu yakho, ungayisebenzisa kaningi imithi yendabuko?	More (Okuningi) ……..……..…..1 The same as before (Kufana nanjengaphambili) …..2 It depends on what treatment I need(Kuncike kokwelashwa engikudingayo)……..3	
Q38	If traditional medicines were more expensive, would you use them less often? Uma imithi yendabuko yayibiza kakhulu, ingabe uyayisebenzisa kaningi?	Use them less(Sebenzisa kacane)……..…..1 Use them the same as before (Zisebenzise ngendlela efanayo nangaphambili) ……..……2	
Q39	Have you obtained any particular benefit from the traditional medicine you used? Uke wathola yini inzuzo kusuka umithini wendabuko oyisebenzisayo?	Yes (Yebo) ……..……..……...1 No (Cha) ….……..……..……..2	
Q40	How satisfied are you with the performance of the traditional medicine you used? Uneliseke kangakanani ngokusebenza kwemithi yendabuko oyisebenzisayo?	Very satisfied (Inelisekile kakhulu) ……..……1 Satisfied (Inelisekile) ……..……2 Disappointed (Ukudangala) ……..……..…….3	
Q41	Have you had to abandon conventional treatment for traditional medicine? Ingabe kwadingeka ulahle imithi yesimanje okuvamile emithi imithi yendabuko yase-Afrika?	Yes (Yebo) ……..……..……..….1 No (Cha) ….……..……..……..2	
Q42	If yes, what were your reasons for abandoning western treatment for traditional medicine? Uma kunjalo (yebo), yiziphi izizathu zakho zokushiya ukwelashwa entshonalanga kwemithi yendabuko?		
Q43	Have you ever mention to the doctor in charge in your clinic/hospital that you	Yes (Yebo) ……..……..……...1 No (Cha)….……..……..……..2	

	have used/are using African Traditional Medicine? Wake wake wakhuluma nodokotela ophetheyo emtholampilo wakho / esibhedlela oye wasebenzisa / usebenzisa umuthi wendabuko yase-Afrika?		

THAT IS THE END OF THE QUESTIONNAIRE. THANK YOU FOR TIME TAKING TO ANSWER MY QUESTIONS. I APPRECIATE YOUR HELP.

LOKHO KUWUKUPHELA KWEMIBUZO. SIYABONGA NGESIKHATHI SAKHO SOKUPHENDULA IMIBUZO YAMI. NGIYAZISA USIZO LWAKHO.

Appendix 8: Ethical Approval from the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

24 July 2024

Wilondja Muzumbukilwa 205525431
School of Social Sciences
Howard College Campus

Dear W Muzumbukilwa

Protocol reference number: HSS/1145/017D
Project title: Challenges and prospects of the National Indigenous Knowledge Systems (IKS) Policy in promoting African Traditional Medicine (ATM) in KwaZulu-Natal, South Africa
Amended title: Challenges and prospects of the National Indigenous Knowledge Systems policy in integrating African Traditional Medicines into the public healthcare system in South Africa.
Degree: PhD

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 19 July 2024 has now been approved as follows:

- Change in title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Best wishes for the successful completion of your research protocol.

Yours faithfully

[redacted]

.....
Professor Dipane Hlalele (Chair)

/dd

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