

**DECOLONISING HEALTHCARE:
BREATHWORK AS A TRADITIONAL AND COMPLEMENTARY MEDICINE**

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This report is submitted in fulfilment of the requirements for the degree of
MASTER OF ARTS

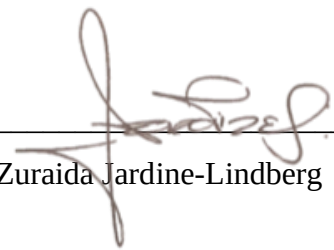
in the department of
CRITICAL DIVERSITY STUDIES

at the
UNIVERSITY OF THE WITWATERSRAND
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Date of submission: 15 March 2023

Declaration

I, the undersigned, declare that this research report is my original work. Any ideas in this report that are not my own are acknowledged through proper references and citations. This report is being submitted for a Master of Arts in the field of Critical Diversity Studies at the University of the Witwatersrand, Johannesburg, and no part of this report has been submitted in the past, or is being submitted, or will be submitted in the future for any degree or examination at any other university.



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15.03.2023

Date

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List of Abbreviations and Acronyms

TCAM: Traditional Complementary and Alternative Medicine

TM: Traditional Medicine

THP: Traditional health practitioners

CAM: Complementary and Alternative Medicine

CDL: Critical Diversity Literacy

IKS: Indigenous Knowledge Systems

NCD: Noncommunicable Diseases

WHO: World Health Organisation

Acknowledgements

I am immensely grateful for the life-changing experience that pursuing a Masters Degree in Critical Diversity Studies has been. This program has challenged and inspired me to reflect on my own privilege while remaining aware of how power dynamics continue to perpetuate social inequalities. Through this journey, I have been able to learn, unlearn, and rewire my thinking, resulting in a positive and transformative change in myself.

I would like to extend my sincere thanks to the Wits Centre of Critical Diversity Studies, particularly to my patient, optimistic, and compassionate supervisor, Haley McEwen, and our inspiring head of department, Mellissa Steyn. Your unwavering encouragement and support have been instrumental in helping me complete this thesis, especially during the personally challenging time of the Covid-19 pandemic.

I am grateful to my wonderful classmates, who have become my confidants and friends, namely Sarah, Nyami, Jane and Amber. Your kindness and critical engagement have enriched my life over the last couple of years.

Lastly, I want to express my heartfelt appreciation to my loved ones, my partner Josh and our children, Zaria and Shia. Your persistent support, encouragement, and dedication to my dream have been my source of inspiration during moments when I felt like giving up. The philosophy of ubuntu, which emphasizes the interconnectedness of all beings, has been most profoundly highlighted for me throughout the process of this degree. I am who I am because of others, and I am deeply grateful for all the love and support.

Thank you all for igniting my passion for learning and nurturing my curiosity.

Abstract

This study investigates the potential for Breathwork as a traditional and complementary medicine to promote decolonisation in healthcare. The study utilised qualitative interviews with healthcare practitioners who integrate Breathwork into their practice, in order to explore their viewpoints on the potential therapeutic benefits of this modality. Colonisation has played a significant role in historically discriminating against indigenous knowledge systems when it comes to healthcare, leading to an epistemic ignorance around various healing modalities. To address this issue, a shift towards pluralistic healthcare systems that integrate traditional and complementary medicines is needed. This can provide patients with a wider range of medical options and a more holistic approach to healing, empowering the individual to take control of their own health. However, change needs to start at policy level, with a commitment to inclusivity and cultural sensitivity within healthcare systems. Academic institutions also have a critical role to play in transforming their healthcare curricula to be more inclusive of traditional, complementary, and alternative medicines. This involves recognising the extent to which Euro-western teachings still dominate healthcare education today and working towards greater diversity in curricular content. The observations made in this study suggest that socially constructed definitions of health require transformation, particularly in countries as diverse as South Africa. In conclusion, this study aimed to highlight the possible impact Breathwork as a traditional and complementary medicine may offer the healthcare sector. By acknowledging the historical discrimination against indigenous knowledge systems and embracing a more pluralistic approach to healthcare, South Africa can work towards building a more equitable and culturally sensitive healthcare system that not only meets diverse needs but offers empowerment for individuals to become active participants in their wellbeing.

Chapter 1: Introduction

Breath is a powerful material and spiritual force, a point not only of harm but also recovery. It can show us how Black people experience multiple convergences of racial violence, health and environmental hazards, socioeconomic precarity, and disaster through time and space. (Jolaosho, 2021)

Breathing is a vital function of the body's need for air, while air is a critical constituent for life preservation. Remarkably, the act breathing is unique to the body in that it can be accomplished both consciously and unconsciously and is hardly considered until the body faces suffocation. Social scientists have started assessing the significance and urgency of the breath (Jolaosho, 2021) concerning systemic and structural oppressions (Ingold, 2020; Apata, 2020; Huval, 2021). Using concepts of breath and suffocation, the following is an effort to uncover the impact that socio-political dimensions have had on suppressing indigenous ideas of knowledge in health and medicine. Unpacking power dynamics responsible for establishing whose lineage of knowledge is deemed un/breathable affords opportunities for transformative interventions towards an inclusive, pluralistic healthcare system. Medical pluralism, the co-existence of multiple medical methods, can benefit how practitioners and patients engage with healthcare and each other; this pluralism is crucial considering the multiplicity of worldviews that exist (Moshabela, Zuma & Gaede, 2016).

Decolonising healthcare is the process of liberating healthcare practices and systems from the historical and ongoing influences of colonialism. Breathwork has roots in various cultural and spiritual practices, including indigenous healing traditions. Incorporating Breathwork into mainstream healthcare helps to not only preserve but revive important indigenous knowledge practices that were suppressed by colonialism, leading to losses of knowledge production and marginalisation. Integrating Breathwork into healthcare can aid in revitalising traditional and complementary medicines, promoting cultural diversity in healthcare, and expanding the range of effective treatment options available to patients. This study examines how politics of knowledge have contributed to structural inequalities in healthcare – whose world views of health and medicine are deemed in/valid and left out of the global narrative? Further, the

paper explores the ancient traditional medicine¹ (TM) of Breathwork² by healthcare practitioners and how its use can aid a strained healthcare population.

In 1948, The World Health Organization (WHO) defined health as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (WHO, 2020). Seventy-three years later, this health classification has shifted minimally (Nkemjika, Escobar, & Marin, 2020). The definition appears reassuring and comprehensive; however, it can be argued that the definition of health bears significant practical implications, extending beyond its theoretical underpinnings. The definition of health holds considerable implications across different domains including health policy, health services, and health promotion. It serves as a significant determinant in shaping the attitudes and behaviours of healthcare professionals, thereby influencing the social construction of health in contemporary societies (Leonardi, 2018).

The social representations of health exert a profound influence on the expectations and requirements of healthcare services, policy makers, and other salient aspects of health. Furthermore, perceptions of health hold considerable sway over individual health behaviours and, consequently, the capacity to make informed decisions about health. For example, Indigenous Knowledge Systems (IKS) are structures embedded within communities specific to a geographical location, comprising a complex set of knowledge, rituals, and skills developed over time and central to a lifestyle (Centre for Indigenous Knowledge Systems, 2005). IKS share comparable epistemological essentials grounded in interconnectedness, community, and culture concepts. The concept of spirituality alone is practised as an essential TM in numerous societies such as Aboriginal, African, African-American, Asian, Indian, Māori, Mexican and Native American cultures (Marks, 2006). In summary, the definition of health carries strategic significance across all domains of health-related activity.

What constitutes medicine or health? The answer largely depends on perception, politics, culture, beliefs, location, time, socio-economic factors, and varying intersections. Due to the impact of these influential social contexts, the concept of health is inherently interconnected

¹ The term 'traditional medicine' (TM) will be used throughout this paper. TM is often used interchangeably with 'complementary and alternative medicine'. Breathwork falls under 'traditional, complementary and alternative medicine' (TCAM). For this paper Breathwork is referred to as a traditional medicine (TM).

² Breathwork is an ancient medicine that uses conscious breathing practices for the purposes of physical, psychological, emotional, and spiritual healing.

with hegemonic views around health formations. This is evident in former colonies such as South Africa, where the practice of TM predates biomedicine³. Yet, despite this antecedent, the blueprint for health is biomedicine (Hassim et al., 2007). Biomedicine applies scientific principles of biochemistry and biology like pharmaceuticals and surgery to diagnose, treat and prevent illness (Hassim et al., 2007). TM, on the other hand, applies:

diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain wellbeing, as well as to treat, diagnose or prevent illness. (WHO, 2008)

The establishment of colonial powers was facilitated by their projection of knowledge as superior and legitimate, leading to a shift in the perception of health from a multidimensional approach to one that solely focused on biomedical perspectives. This shift, however, was fundamentally unjust, as it entailed the dismissal of IKS, particularly TM which was considered invalid owing to its lack of scientific validation (Marks, 2006). Additionally, Euro-western media referred to traditional healers, commonly known as sangomas, as "witchdoctors" (Parle, 2003). In South Africa, herbalists who practiced traditional healing were only permitted to do so until 1928 when the Medical, Dental and Pharmacy Act was enforced, prohibiting all herbalists from practicing, except for those in KwaZulu Natal (Flint, 2008). This Act also imposed significant restrictions on traditional healers, including prohibiting the use of Western medical instruments, effectively reducing their profession to that of herbal merchants (Flint, 2008).

Examining the relationship between biomedicine and TM exposes the dichotomy between science and sociocultural affiliations, revealing the underlying politics of inclusivity and exclusivity in healthcare. Establishing a connection between biomedicine and TM has the potential to transform the socially constructed norms of healthcare into an all-encompassing and multidimensional healthcare system. Such an integration would particularly benefit South Africa's diverse population, comprising individuals from different cultural, traditional, and spiritual backgrounds (Van Vugt & Cloete, 2000). Among the country's 59.3 million inhabitants, 92% belong to historically marginalized racial groups who rely on TM (World

³ Biomedicine is also referred to as 'western medicine', 'mainstream medicine' 'conventional medicine' or 'modern medicine'. The term 'biomedicine' will be used throughout this paper.

Population Review, 2021; Pillay & Serooe, 2019). A study by Pillay & Serooe (2019) found that in South Africa, Christian, Hindu, Islamic, African and Asian cultures practice health-seeking behaviours supervised by traditional healers. These include but are not limited to Christians accessing a pastor/priest, Hindus seeking help from a priest/guru, Muslims accessing a Moulana/Hakeem, Asians seeking out Ayurvedic Therapy/Acupuncture/Herbs, and Black Africans using Sangoma/Inyanga/Herbs. During apartheid, a pluralistic healthcare system was not a requisite as practicalities pertaining to healthcare favoured Western medicine as functional while traditional medicines were viewed as outdated (Mthembu, 2020).

The utilisation of TM in South Africa has gained prominence and recognition in recent times, particularly when the government enlisted the assistance of traditional healers to aid the healthcare sector in combating the COVID-19 pandemic. This call to action requested traditional health practitioners (THP) to refer patients exhibiting symptoms of the novel coronavirus to the appropriate level of care (Maphanga, 2020). Within the primary healthcare system, THPs play a crucial role in alleviating the burden of diseases in South Africa. The Department of Health has expressed appreciation for the contributions of THPs in the fight against COVID-19 (Maphanga, 2020). The request for traditional healers to aid the primary healthcare sector during COVID-19 also indicates the necessity of implementing a plural healthcare system that benefits practitioners and patients. Despite the hope that the democratic era has raised, the social reality is that the impact of colonialism persists and remains as exclusive as during the apartheid period, resulting in continuous marginalisation and segregation. A shift would require support from all structures contributing towards the practice and delivery of healthcare, inclusive of this, would be the role of higher education universities. Research and scholarship sit at the centre of producing new and alternative knowledge. Academic institutions, therefore, play a crucial part in disseminating knowledge and the monitoring this execution. Decolonising current biased biomedicine curriculums while expanding a medically pluralistic syllabi inclusive of IKS would benefit healthcare and further influence overall growth towards an inclusive, multi-knowledgeable healthcare sector.

During the initial stages of the COVID-19 pandemic, which is arguably one of the most significant health crises of the past century, knowledge formation revolved around comprehending the disease, its treatment, and vaccine development. Meanwhile, traditional forms of medicine were being employed globally. For instance, Asia reported positive

outcomes in using Traditional Chinese Medicine (TCM) to manage COVID-19 (Chang et al., 2020; Gao et al., 2020). According to Mirzaie et al. (2020), some Indian, Iranian, and Chinese herbs were effective in preventing, rehabilitating, and treating diseases, including COVID-19. Consequently, the World Health Organization (WHO, 2020) constituted a "25-member Regional Expert Committee on Traditional Medicine for COVID-19" to aid countries in conducting clinical trials on traditional medicines according to international standards. The WHO's backing of this medicinal pluralistic realm endorses the benefits of TM and attempts to re-centre IKS. The urgent need to find a cure for COVID-19 has undoubtedly necessitated a rearrangement of healthcare structures to embrace, collaborate with, research, and teach pluralistic approaches.

This research aims to examine how politics of knowledge as well as epistemic ignorance have overlooked vital contributions by marginalised sectors. A theoretical framework adapted from Critical Diversity Studies (Steyn, 2015) will form the lens of this research by attempting to answer questions such as: Whose knowledge is deemed valid? By who? Whose stories get represented in the global narrative? Why? How functional is the current status quo in healthcare? How can the use of a TM such as Breathwork aid healthcare?

1.1 The Research Problem

Even with a new constitution in place, remnants of apartheid remain active in the quotidian life of many marginalised South Africans. The prelude to the Constitution states, "We, the people of South Africa, believe that South Africa belongs to all who live in it, united in our diversity." This statement, while idealistic, is fraught with political complexities in that belonging is an intrinsically subjective embodied experience, impacted by multiple dimensions and social relations. According to Yuval-Davis (2006), there are a variety of levels attached to the concept of belonging, including social locations such as identity, emotional attachment, ethical and political views. The political intricacies that accompany post-apartheid South Africa are indicative of a deficiency in transformation, thereby highlighting the substantial challenge of fostering a shared sense of purpose and belonging. This challenge is intricate, given that it encompasses rifts that stem from the interplay of diverse social differences and identities, encompassing variables including ethnicity, class, race, gender, sexuality, religion, language, geography, region, as well as other related forms of social differentiation. Such differentiation occurs within contexts of heightened social tension, as the nation continues to navigate the process of transitioning from its apartheid past

(Hino et al., 2019). Looking at healthcare for example, inadequate human resources pose a significant weakness in the health systems, according to Fonn et al., (2011). In Africa, the health worker-to-population ratio is below one per 1000 individuals, which stands in stark contrast to Europe's ratio of 10 per 1000. The disproportionate allocation of healthcare practitioners amongst private and public sections including the unequal distribution of public sector healthcare professionals across different provinces, exacerbates health challenges in South Africa, culminating in physical and mental fatigue (Barron & Padarath, 2017). Moreover, the deterioration of medical conditions further exacerbates the issue, leading to additional burnout and disillusionment of healthcare practitioners (Barron & Padarath, 2017).

Post-apartheid, the South African government has officially regulated TM. The Traditional Health Practitioners Act No. 22 (2007) was a crucial milestone in acknowledging indigenous knowledge. More so, legitimising TM was imperative considering that the South African National Department of Health requires medical students to serve two years of training in rural areas where majority of their patients are likely to use TM in tandem with biomedicine. However, with medical students having limited exposure to TM, they pose a risk of service-inadequacy when dealing with diverse belief systems (Chitindingu et al., 2014). Pillay and Serooe (2019) have emphasized the issue that healthcare professionals in South Africa are bound to come across a complex interplay of diverse beliefs and practices related to race, spirituality, and religion. Hence, a functional healthcare system necessitates not only the regulation of TM but also the inclusion of pluralistic frameworks in higher education curriculums to equip healthcare practitioners with the necessary skills to support their patients.

1.2 Purpose of the Study

The primary aim of this study is to examine the transition of healthcare practitioners in South Africa towards embracing TM, particularly Breathwork, as a modality to decolonise healthcare. In doing so, the research investigates the power relations inherent within the healthcare sector that promote certain medicinal models while marginalising others, particularly those grounded in Indigenous Knowledge Systems (IKS) of health. Through this lens, the study further explores the meaning-making around healthcare delivery in South Africa and investigates the extent to which academic training in South Africa prepares practitioners to engage with TM practices to serve a diverse population. Breathwork was selected as the primary TM focal point due to the researcher's experience as a Breathwork

practitioner as well as the increased attention of the breath in the wake of the COVID-19 pandemic. Breath has illuminated how respiration transcends race, gender, politics, and socio-economic status.

The global impact of COVID-19 over the past two years has emphasized the importance of the breath, with the respiratory virus causing widespread devastation across the world. The researcher anticipates that Breathwork may hold significant value, as despite its association with contemporary science, it represents an ancestral traditional healing modality utilized by various indigenous communities. Its efficacy has been historically documented within global spiritual practices of antiquity (Gopal, Bhatnagar, Subramanian & Nishith, 1973; Conger, 1988; Farhi, 1996; Hendricks, 1995; Victoria & Caldwell, 2013; Kuppusamy, Kamaldeen, Pitani, Amaldas, & Shanmugam, 2018). The medicinal benefits of Breathwork are also rooted in early African philosophy (Mutwa & Larsen, 2003; Edwards, Makunga, Thwala, & Nzima, 2007), making this indigenous knowledge relevant; as it is not imported or imposed – it is owned (Noyoo, 2007).

This research proposes a re-examination of the contemporary definition of healthcare. By utilising a critical approach, the intention is to clarify the epistemological implications of the entrenched biomedical model. Pascale (2010, p. 52) asserts that scientific research has contributed to the perpetuation of various forms of prejudice. By scrutinizing "taken for granted" perspectives, there is an opportunity to deconstruct the historical "givens" and evaluate which individuals or entities are benefited, legitimized or privileged, versus those who are harmed, oppressed or disqualified (Canella & Lincoln, 2012, p. 74).

1.3 The Research Question

What prompted healthcare practitioners to evolve their practices towards a pluralistic offering?

Sub-questions

- To what extent do practitioners view Breathwork as a tool for decolonising healthcare?
- How do power relations within the healthcare sector impact the promotion or marginalisation of particular medical models, particularly those rooted in IKS?
- What challenges are encountered by healthcare practitioners in providing pluralistic healthcare that integrates TM practices such as Breathwork?

- How are academic institutions in South Africa preparing healthcare practitioners for engaging with TM practices that aim at decolonising healthcare?
- To what extent does the current academic curriculum support understanding and engagement with TM practices?
- How does the practice of Breathwork reflect broader social transformation occurring within the South African healthcare sector?

Chapter 2: Theoretical Framework

Many stories matter. Stories have been used to dispossess and to malign. But stories can also be used to empower, and to humanise. Stories can break the dignity of a people. But stories can also repair that broken dignity. (Ngozi Adichie, 2009)

Stories emotionalise information, and they are laden with the power to protect, shape, destroy, elevate, enhance and marginalise people, places, events and ways of being in the world. In Chimamanda Ngozi Adichie's Ted Talk (2009), she poignantly describes the danger of believing a single story. Explaining that if we only hear about a people, a place or an event from one viewpoint, we inevitably risk accepting that one story as the *only* one, never questioning that narrative's construction. She posits how power is intrinsically linked to a single story and how this single story is often responsible for producing stereotypes: "the problem with stereotypes is not that they are untrue, but that they are incomplete" (Ngozi Adichie, 2009). She encourages shaping the mind to be open and curious so as learn, unlearn and relearn facts from fiction.

Over a prolonged period, the worldwide discourse on health has reinforced a one-dimensional portrayal of traditional healing systems as primitive, superstitious, and illegitimate, thereby perpetuating stereotypes (Marks, 2006). To redress this loss of dignity and revive the credibility of IKS, it is imperative for scholars to be attentive to the power dynamics embedded in everyday operations and to remain cognisant of the harmful consequences faced by marginalised groups (Smith, 1999). Fortuitously, the COVID-19 crisis has forced several mainstream operations, such as healthcare, to fall under scrutiny. With global consciousness centred on health, the pandemic emphasised inequities by bringing racial and social injustice to the forefront of public health. This period has not only highlighted the fragility of this weapon-less war but by what means operations of structural violence have impacted how health is perceived and accessed (Büyüm et al., 2020). Within this calamity exists an opportunity to shift the perception of health. Complexities underlying historically situated politics of knowledge require the implementation of diverse methodologies when researching in order to advance literature (Pascale, 2010). Gaining an understanding of the origins of healthcare services, including their geographical and socio-historical context, is crucial in comprehending the full narrative. According to Langdon (2013, p. 384), "Beginnings matter because they set the tone for what is to follow in explicit and implicit ways." By examining

the past, it becomes possible to comprehend how biomedicine, touted as the pinnacle of healthcare, gained its status as the preferred standard of medicine.

In order to unravel the intricate complexities of the landscape under investigation, this research will adopt a critical diversity literacy perspective. To achieve this, the analytical framework proposed by Melissa Steyn (2015), titled "*Critical Diversity Literacy: Essentials for the twenty-first century*," will be employed. This lens aims to elucidate how hegemonic orders surreptitiously infiltrate social channels to validate dominant ideologies, thereby shaping the discourses and practices in healthcare. Through this scrutiny, the study aims to illuminate the nuanced dynamics of power relations within the healthcare sector, the marginalisation of IKS and the potential role of TM practices like Breathwork in decolonising healthcare in South Africa.

2.1 Critical Diversity Literacy

In 2015, Professor Melissa Steyn, Head of the Centre of Critical Diversity Studies at the University of the Witwatersrand, developed the Critical Diversity Literacy (CDL) framework. This framework was conceptualised out of a necessity for advancement in higher education's role post-apartheid towards improved "transformation, integration and greater equity" (Steyn, 2015, p. 381). The framework proposes that:

Critical diversity literacy can be regarded as an informed analytical orientation that enables a person to 'read' prevailing social relations as one would a text, recognising the ways in which possibilities are being opened up or closed down for those differently positioned within the unfolding dynamics of specific social contexts.

Further, the CDL framework highlights the complexities underlying globalisation. As the world condenses through crossing borders and transitioning of social relationships, a "multilayered and multiperspectival, shifting, ambivalent and open to yet unknown possibilities" is brought to the forefront (Steyn, 2015, p. 380). This shift necessitates new contextual ways of navigating critical and social literacy in a rapidly changing world. According to Anderson and Irvine (1993, p. 82), critical literacy is concerned with the practice of inequalities and social injustices:

The importance of critical literacy being grounded pedagogically in a politics of difference offers learners, regardless of their particular class, race, or gendered subjectivities, opportunities to become 'border crossers.' Critical literacy, then, is

learning to read and write as part of the process of becoming conscious of one's experience as it is historically constructed within specific power relations.

Social literacy is concerned with the ability to effectively engage with and participate in the world from dimensions related to; technology, media, science, emotional literacy to health literacy (Steyn, 2015). An alienation from any one or all of these scopes can be experienced as a dysfunction (Steyn, 2015). The foundation of CDL is a commitment to uncovering dominant powers at play while being conscious of one's blind spots. The following ten criteria form the basis of the framework.

1) An understanding of the role of power in constructing differences that make a difference.

A fundamental awareness of the establishment of power in issues concerning diversity is the first tenet of CDL. It is imperative to be conscious of the behaviours in which we have come to think about differences, knowing that these differences have been socially constructed (Steyn, 2015). There is a “constant ideological” framing required to maintain a “natural hierarchy” (Steyn, 2015, p. 381). This results in polarisations of human variability and the binaries we have come to view as standard, such as black/white, heterosexual/homosexual, man/woman, masculine/feminine (Steyn, 2015). Binaries manifest in a currency that values one over the other in social, psychological and economic settings. These groupings produce a plethora of experiences rooted in the sense of belonging, exclusion or othering. On this axis, hegemonic order successfully establishes the privileged from the othered (Steyn, 2015).

2) A recognition of the unequal symbolic and material value of different social locations.

Much of our knowledge formation is founded on the hegemonic dispositions of identities related to “whiteness, heterosexuality, masculinity, cisgender, ablebodiedness, middleclassness etc.” (Steyn, 2015, p. 382). Here, Steyn highlights the positions of the privileged and how blind spots reinforce “denial and unwillingness to acknowledge how one benefits from the systems which continue to hoard advantage for those like oneself” (Steyn, 2015, p. 383). However, it is essential to note that not all in a position of privilege benefit in the same way. For example, when looking at allowances afforded to maleness, heteronormativity and whiteness, privilege positions vary according to spaces and otherness (Steyn, 2015). A white heterosexual male in a heteronormative setting will encounter a different experience than a white homosexual male in the same space. So, although the order

of position diminishes, the privilege continues through the proxy of being white and male (Steyn, 2015). While some social positions are centred, others lie on the margins where the powerful define who the *othered* is. This way, “they retain their own psychological and material comfort” (Steyn, 2015, p. 382). With this, for the othered, comes navigation of shaming, humiliation and challenges of psychological wellbeing, particularly if there is a challenge to the status quo of the ideologically hegemonic way of being (Steyn, 2015).

3) Analytical skill at unpacking how these systems of oppression intersect, interlock, co-construct and constitute each other, and how they are reproduced, resisted and reframed.

Intersectionality plays a crucial role in understanding how systems of oppression and dominance get reproduced in quotidian life—being aware of the powerplays that normalise particular identities while alienating others is key to CDL. With intersectionality, individuals experience ambiguities such as “class and gender, gender and race, race and nation, masculinity and nation, sexuality and race, disability and race, gender and sexuality”, to name a few, all of which connect in the constructural matrix of identity (Steyn, 2015, p. 383). Acknowledgement of these multiple layered realities is crucial to social justice and, as such, requires voices of the marginalised to be legitimised to counter the functions of hegemonic forces.

4) A definition of oppressive systems as current social problems and (not only) a historical legacy.

The epistemology of knowledge interrogates the foundations of knowledge. What is knowledge? How is knowledge acquired? What knowledge is deemed popular? How have we come to know what we know and why? Dominate discourses have historically rewritten the past to assert their narrative, doing so with no “moral accountability” contributing to what is known as the epistemology of ignorance (Steyn, 2015, p. 384). An example of this has been the distortions of Africa, represented globally as deep *dark* Africa or traditional medicine being witchcraft. Many misrepresentations require a redressing to fully understand the “axes of difference that shape social orders” (Steyn, 2015, p. 384).

5) An understanding that social identities are learned and are an outcome of social practices.

The social self is positioned to the prevailing powers within a social context. Shared social identities benefit from belonging to the majority leaving the minority feeling unseen and often stereotyped. This tenant of CDL seeks to recognise that “there are no immutable

characteristics attributed to a group of people that would be evident regardless of the historical processes of location, socio-economic conditions and other such influences” (Steyn, 2015, p.385). The propensity to favour one group over another impacts distribution of resources, be they material or psychological, resulting in how the social self gets understood. In sum, an awareness that social identities are learned behaviours due to socially constructed practices (Steyn, 2015).

6) The possession of a diversity grammar and a vocabulary that facilitates a discussion of privilege and oppression.

A crucial key in CDL is being fluent in the discourses surrounding power, privilege, oppression and dominance. When we understand the language around domination and oppression, we’re able to locate the people and events subjected to these positions, making it easier to “insist on the reality of the practices, strategies and effects of the operations of power on difference” (Steyn, 2015, p. 385). The aptitude needed in recognising these dynamics and practices will foster diverse, informed discussions in the field.

7) The ability to ‘translate’ (see-through) and interpret coded hegemonic practices.

“Power never names itself as such” (Steyn, 2015, p. 386). This statement is central to framing the work of CDL. Attaining the skill to detect and un-code hegemonic practices can reveal how hegemonic orders strategically “recast issues in ways that suit prevailing interests”, with this deflecting attention away from how power stays within the operations of social injustices.

8) An analysis of the ways that diversity hierarchies and institutionalised oppressions are inflected through specific social contexts and material arrangements.

Assumptions and constructions around gender, for example, are distinct globally. It is imperative that we understand the intricacies of this matrix and how location, space and time impact the material worlds of this distinction. The influence of varying historical processes and geographical areas has impacted how gender was/is expressed. It is dangerous to assume a generalised ideology as “misleading and imperialising in effect” (Steyn, 2015, p. 386). Instead, unpacking how hegemonic forces ‘translate’ between certain circumstances and their mutation over time will highlight how diversity hierarchies and institutionalised operations get inflected (Steyn, 2015, p. 386). The social and material worlds are intimately linked with symbolic and emotional substance retaining a significant position in determining how

relationships are maintained or subverted (Steyn, 2015). Here, the unequal distribution of resources deepens social divisions resulting in the dependence-cycle of the oppressed having to hinge on the oppressor to survive.

9) An understanding of the role of emotions, including our emotional investment, in all of the above.

Our emotional patterns of behaviour result in who we connect with, distance ourselves from, and are protective over or repulsed by having all been socially constructed (Steyn, 2015). Our sense of self and how we “matter to all other mattering objects” is what Sara Ahmed (2004) calls *an affective economy*; this is how our emotions attach subjects into collectives that then take on an existence of its own. This affective state is induced by hegemonic forces reproducing power and oppression cycles. The CDL framework thus encourages a constant state of reflexivity to critically reflect on how our subjectivities are occupied in these collectives so that we may ask ourselves, “What do we learn about our participation in processes of social formations” (Steyn, 2015, p. 386).

10) An engagement with issues of the transformation of these oppressive systems towards deepening social justice at all levels of social organisation.

Here, the CDL criterion challenges the question of praxis and how we actively and intentionally begin to practice the above theory in our quotidian lives. A socially just world requires a constant examination of the intricate ‘messiness’ of our planet and the awareness of how power will never name itself as such. How then do we participate in centring the margins and becoming active agents of change to “those whose oppression would otherwise be further entrenched through conscious and unconscious assumptions of privilege” (Steyn, 2015, p. 388).

These ten criteria of the CDL framework serve as the analytical orientation for addressing the research questions and illuminating any obscured power dynamics present in the healthcare context.

Chapter 3: Literature Review

The vision of a truly global knowledge partnership will be realised only when the developing countries participate as both contributors to and users of knowledge. (World Bank, 1998)

The core catalyst for social injustice in South Africa has been the impact of colonialism, characterised by its domination, exploitation, and belligerent occupation of indigenous people's land (Griffiths, Coleman, Lee, & Madden, 2016). A wide range of injustices, spanning personal and political domains and encompassing aspects such as culture, stigma, gender, unemployment, and socio-economic status, have contributed to the dysfunction in healthcare (Nkemjika, Escobar, & Marin, 2020). Economic, sociocultural, environmental, and other external influences have primarily determined how health is viewed, expressed and experienced by marginalised South Africans. Colonial hegemony centred itself as the superior, legitimate knowledge, restructuring conceptualisations of health from a multidimensional perspective to a siloed biomedical one. A fundamental injustice has been the dismissal of IKS around TM, which was deemed unfounded due to the absence of *scientific* validation (Marks, 2006). Scholars like Smith (1999) have critiqued these dominant discourses of superiority and highlighted how colonialism's version of truth and validity is situated within the very social systems that require urgent dismantling. In this system, TM was proclaimed as evil and considered uncivilised enforcing the 1957 Witchcraft Suppression Amendment Act, prohibiting TM practitioners from practising (Le Roux-Kemp, 2010).

3.1 Background

South Africa's healthcare system is intertwined with its history. According to Van Rensburg and Harrison (1995), six phases of history impacted healthcare policy and legislation:

- Phase 1 before 1919 was when the first health legislation was promulgated for the Union of South Africa.
- Phase 2 was between 1919 and 1940, which saw the introduction of South Africa's first health legislation incorporating national jurisdiction.
- Phase 3 was between 1940 and 1950, a phase that was considered progressive within the health sector.
- Phase 4 between 1950 and 1990, when apartheid had its most significant impact on the country.

- Phase 5 between 1990 and 1994, a transitional time that saw the apartheid regime decline and democratic elections.
- Phase 6 is the period after 1994.

During the colonial era in South Africa, a series of laws were enacted to regulate the utilisation of TM. The laws introduced in 1862 prohibited sangomas (traditional healers who employed spiritualist powers to diagnose illnesses) from practicing (Parle, 2003). European newspapers often portrayed sangomas as uncivilized "witchdoctors" (Parle, 2003). Inyangas (traditional herbalists who did not use supernatural powers) were allowed to practice until 1928 when the Medical, Dental, and Pharmacy Act was passed, which prohibited all herbalists from practicing, with the exception of those in KwaZulu Natal (Flint, 2008). Additionally, the Act restricted the use of Euro-western instruments such as stethoscopes by Inyangas. These measures effectively constrained traditional healers during this period, relegating them to the role of herb merchants (Flint, 2008).

As with other colonised countries, South Africa encountered a conflict between the biomedical fraternity and the TM network. Biomedical doctors were not open to sharing the healthcare space with traditional healers and regulated the parameters traditional healers were allowed to practice in. The bifurcation of locations was a way of white doctors monopolising the field (Flint, 2001). TM's strict regulations and control remained in place during apartheid, which only shifted once South Africa gained its democracy (Flint, 2001). All phases under apartheid aided further racial segregation, failing to adequately consider South Africa's diverse population and freedom of expression in practising religious/spiritual beliefs. As previously mentioned, these beliefs are intricately woven into many traditional healthcare practices. Today, the Freedom Charter, Bill of Rights acknowledges:

Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community to enjoy their culture, practise their religion and use their language; and to form, join and maintain cultural, religious and linguistic associations and other organs of civil society. (The South African Bill of Rights, 1996)

3.2 New Democracy in Healthcare

The new democratic government, aware of the significant role played by traditional healers within communities, integrated TM into the healthcare system (Flint, 2001). The recognition

of TM was made formal with the 1996 National Drug Policy, followed by the Traditional Health Practitioners Act in 2004, which was reintroduced in 2007 to integrate and institutionalise TM. The Department of Health's (2008) Traditional Health Practitioners Act 22 of 2007 aims:

- To establish the Interim Traditional Health Practitioners Council of South Africa.
- To provide for a regulatory framework to ensure the efficacy, safety and quality of traditional health care services.
- To provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioner's profession, and to provide for matters connected in addition to that.

Towards the end of the 1990s, South Africa confronted a national medical crisis of significant proportions with the advent of the HIV/AIDS pandemic. In response, the South African government sparked controversy by declaring TM as a key approach in tackling the epidemic (Bishop, 2010). However, devising effective strategies to address the outbreak was fraught with difficulty, mainly due to persistent socio-political challenges that plagued the country at the time. The emergence of HIV/AIDS cases in 1982 was compounded by a state of emergency resulting from discriminatory healthcare policies (Van de Vliet, 2004). By the end of the apartheid era, approximately 4.3% of pregnant women were HIV positive, with the prevalence of the disease skyrocketing by 1997.

In spite of appeals from various health organisations and activist groups, President-elect Thabo Mbeki publicly rejected the notion that HIV causes AIDS and discouraged the use of antiretroviral drugs (ARVs). He suggested that these drugs may be detrimental to the body (Van de Vliet, 2004; Butler, 2005). Reports have extensively documented the government's reluctance to acknowledge the effectiveness of antiretroviral drugs and their deliberate questioning of the relationship between HIV and AIDS (UNAIDS, 2006; WHO, 2003; Amon, 2008; Okome-Nkoumou, 2005). Instead, the health administration promoted the use of TM and nutritional remedies, such as garlic, beetroot, and lemons, as legitimate treatments for HIV/AIDS (Setswe & Zungu, 2017). The government's refusal to finance ARV treatments resulted in mothers passing the virus on to their babies during pregnancy (Bishop, 2010). According to Butler (2005), the South African government faced two options during this crucial period, one being "a 'mobilisation/biomedical' paradigm that emphasised societal mobilisation, political leadership and antiretroviral treatments" while the second was "a

'nationalist/ameliorative' paradigm that concentrated on poverty, palliative care, traditional medicine, and appropriate nutrition" (p. 592). The Mbeki administration opted for the latter.

In 2003, after being sued by the Treatment Action Campaign, an AIDS activist group, the government was forced to make ARVs available (Chigwedere et al., 2008). The initial and detrimental decision to not make ARVs available to the public resulted in 330,000 people losing their lives to HIV/AIDS (Chigwedere et al., 2008). Currently, antiretroviral drugs (ARVs) have become easily accessible in South Africa. Out of the 7.5 million individuals living with HIV in the country, approximately 71% are utilizing ARVs as a part of their treatment regimen (UNAIDS, 2020). Despite the increased use and availability of ARVs, many South Africans still use TM in isolation or with ARVs to treat HIV/AIDS (Mncengeli, Manimbulu, & Panjasaram, 2016). Pluralistic healthcare options allow for multiple approaches to healthcare and healing, including both conventional biomedicine and traditional complementary and alternative forms of medicine. An inclusive health system such as this offers patients a wider range of choices hereby allowing them to choose the treatment that best suits their individual needs.

South Africa's healthcare practitioners and research associations have earned global recognition for their expertise. Recently, Professor Marietjie Venter of the University of Pretoria (UP) was appointed as the chair of the WHO's Scientific Advisory Group for the Origins (SAGO) of Novel Pathogens, where she leads investigations into the origins of COVID-19 (WHO, 2021). Additionally, Professor Salim Karim, an esteemed clinical infectious diseases epidemiologist, has been acknowledged for his research contributions in HIV and his proficiency in COVID-19 research. He was appointed by the WHO Science Council as one of nine international experts tasked with investigating a range of disciplines, from scientific research to public health implementation (WHO, 2021). Finally, Professor Motlalepula Matsabisa, of the Department of Pharmacology at the University of the Free State (UFS) leads Africa's response to the COVID-19 pandemic as the chairperson of the WHO Regional Expert Advisory Committee on Traditional Medicines for COVID-19 (WHO, 2021). This 25-member team supports countries in conducting clinical trials on TM in compliance with international standards. The WHO's recognition of Africa's indigenous knowledge, health proficiency, and the significance of a medically pluralistic realm in research and practice highlights the need to re-spatialise healthcare delivery and experience.

3.3 Indigenous Knowledge Systems (IKS)

IKS pertains to the comprehension, competencies, and beliefs that have been cultivated by communities with extensive experience in engaging with their natural environments (Ebijuwa, 2015). For indigenous populations, this knowledge system serves as a basis for making informed choices regarding essential facets of their daily existence (Moshabela et.al, 2016). Globally, communities are renowned for their indigenous approaches to health, food, functionality, shelter and overall ecosystem (Ebijuwa, 2015). These skills, developed through communal societies, have long histories encompassing language systems and social and spiritual interfaces that have informed day-to-day living long before colonialism (UNESCO). These unique ways of being are fundamental to understanding cultural diversity so that service deliveries are locally appropriated towards sustainable advancement (UNESCO). In the global knowledge economy, which is a country's ability to go beyond finance, goods, and production, and to foster innovative markets of knowledge capital is crucial for ecological expansion (World Bank, 2002). IKS are intimately interwoven into cultural value systems that have and continue to be developed and passed down through generations adding significant value to the knowledge economy.

Literature on IKS doesn't deliver a singular definition; however, according to South Africa's Department of Science and Innovation (2023), IKS may be comprehensively characterised as the knowledge and customs accumulated by a local, native community through generations of dwelling in specific locations. This embodies varieties of knowledge, practical abilities, practices, and beliefs that equip a community with the capacity to attain a sustainable subsistence within their ecological setting. Similarly, the World Bank (2002) describes it as:

- Local knowledge.
- Unique to every culture or society.
- The basis for local-level decision-making in agriculture, healthcare, food preparation, education, natural resource management and a host of other community activities.
- Providing problem-solving strategies for communities.
- Commonly held by communities rather than individuals.
- Tacit and therefore challenging to codify, it is embedded in community practices, institutions, relationships and rituals.

TM is an example of IKS that is inherited generationally through apprenticeship and practice, and its preservation is detained through story-telling and proverbs. However, there is a dearth

of literature on IKS compared to biomedicine, and it is in danger of dilution (Ebijuwa, 2015). It is therefore essential to document and preserve this knowledge and incorporate it into mainstream university curriculums, particularly within the faculties of medicine, health and wellness. Euro-western epistemology has historically marginalized IKS in efforts to find sustainable solutions for developmental issues, such as addressing health equity and public health challenges (Nlooto & Hassan, 2017). In order to attain health equity, it is crucial to acknowledge and appreciate the variety of knowledge systems and incorporate them into health policies and practices. The integration of IKS into mainstream healthcare can assist in building a more comprehensive and integrated approach to healthcare. By working collaboratively with traditional healers, biomedically trained healthcare practitioners can provide culturally appropriate healthcare that is more responsive to the needs and preferences of indigenous communities. This can help address current inequities in healthcare delivery and promote the unique Africanisation of healthcare delivery (Nlooto & Hassan, 2017).

TM practitioners use an integrated, holistic approach in diagnosing disease, where consideration of the psychosocial, psychological, physiological, spiritual and environmental determinants plays a crucial role in treating disease (Nlooto & Hassan, 2017). This treatment approach is echoed by the recent addition to WHO's definition of health which initially stated that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity", and now further includes "*the ability to lead a socially and economic daily productive life*" (WHO, 2014). For these political goals to be achieved, organisations and leaders are required to "embrace the virtues of inter-disciplinarily in a poly-epistemic world, where knowledge systems are complementary rather than competitive" (Nlooto & Hassan, 2017, p. 2).

3.4 Interdisciplinary Healthcare

Globalisation affords immediate access to vast knowledge economies and ever-connected societies. With this, the pattern of approach to disease is evolving. In the past, communicable diseases were most prevalent, though today the health burden resides mainly in noncommunicable diseases (NCD), also known as chronic disease (WHO, 2021).

Noncommunicable diseases kill over 41 million people annually, which is equivalent to 71 percent of all deaths globally (WHO, 2021). NCDs are typically characterized by their extended duration and their emergence from a complex interplay of physiological, genetic, environmental, and behavioural factors. Examples of such diseases include but are not

limited to diabetes, hypertension, addiction, depression, and anxiety (WHO, 2021). Key noncommunicable disease factors, according to WHO (2021), are:

- Annually more than 15 million people die from NCD between 30 and 69 years; 85% of these "premature" deaths occur in low- and middle-income countries.
- Cardiovascular diseases account for most NCD deaths, or 17.9 million people annually, followed by cancers (9.3 million), respiratory diseases (4.1 million), and diabetes (1.5 million).
- These four groups of diseases account for over 80% of all premature NCD deaths.
- Tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets increase the risk of dying from NCD.
- Detection, screening and treatment of NCDs, and palliative care, are vital components of the response to NCDs.

Traditional, complementary and alternative approaches can play an increasingly important role in advancing healthcare delivery. Lifestyle, nutrition, physical inactivity, addiction, and stress are contributing factors in the causation of noncommunicable diseases. With this, the probability of individuals subscribing to numerous belief systems about health and wellbeing are likely. Likely too is the possibility of using multiple methods of medicine that may be traditional, complementary, alternative medicine (TCAM) to the one potentially prescribed by a biomedical practitioner. Biomedical practitioners often view these diverse approaches in a dualistic manner, as mutually exclusive and in competition with each other (Kieffer et al., 2006). Patients, however, are opting for more pluralistic healthcare “moving freely between TCAM and biomedicine, based on what they can access, what they can relate to, and what they believe works” (Kieffer et al., 2006, p. 223).

3.5 Biomedicine versus Traditional, Complementary and Alternative Medicine

In biomedicine, illnesses are understood to be caused by various reasons, from predisposed (inherited) genetic ailments to diseases that occur by an outer organism causing infection or other diseases attributed to lifestyle factors. Martin (1994) perceives biomedical concepts of health to be war-like, a “*fight*” against the disease, the battle armoured using science-based drugs and/or surgery. On the other hand, integrative practitioners who have backgrounds ranging in traditional, complementary, alternative and biomedical spaces focus on identifying the *root cause* of disease, not symptoms. These practitioners practice a broader scope of

medicine cognisant of the biopsychosocial elements, using various therapeutic methods (Koithan, 2009).

Integrative practitioners believe that diseases occur due to several causes, such as depression for example, which can result from several factors, including inflammation in the body. The aetiology of the disease encompasses intersecting domains of physical, emotional, spiritual, psychosocial and environmental factors (Tabish, 2008). Treatments that address the precise causes of disease are the ones that have “lasting benefits beyond symptom suppression” (Institute of Functional Medicine, 2022). Interventions are essentially low risk, often including lifestyle adjustments aimed at reversing drivers of disease (Institute of Functional Medicine, 2022). This integrative matrix prioritises personal, family, social and medical history in treating disease. Treatments are patient-focused, utilising therapies that are both evidence-based and experience-based. Notably, the role of the practitioner-patient partnership is crucial to eradicating the disease. Studies have shown that the variety of traditional and complementary options individuals desire is limited to the ones their biomedical practitioners offer (Mothibe & Sibanda, 2019; Chitindingu et al., 2014). Also, the available offerings are often considered costly, inaccessible, universal and depersonalised (Mothibe & Sibanda, 2019; Chitindingu et al., 2014).

For more than half a century, biomedical physicians and clinical researchers believed that evidence-based information obtained in randomised controlled trials (RCTs) delivered definitive diagnoses to disease (Jones & Podolsky 2015). This diagnosis is referred to as the “gold standard” in biomedical research and health. As a result, evidence-based research has long been hailed as the superior standard of knowledge production in the sciences and academia where constructs such as validity, replicability and controlled experiments are preferred over subjective experience-based knowledge (Cannella & Miller, 2008).

The emergence of medical “big data”, which are technologies used to amass healthcare information, generated at an exceptional speed has resulted in “increasing methodological self-reflection” (Jones & Podolsky, 2015, p. 1502; Costa, 2014). Jones & Podolsky (2015) have critiqued areas such as pharmaceuticals, psychiatry and psychology for failing to recognise cultural bias. For example, neuropsychological assessments, which are evaluations that focus on mental status, motor and sensory functions, vital signs, and cognition to identify any abnormalities that impact quotidian living have been found to be biased to western norms

(Rank, 2010). These types of assessments are critiqued for their omission of socio-cultural consideration (Fernández & Abe, 2017; Ardila, 2007; Nell, 2000; Manly, 2008). This includes challenges related to sociocultural contexts globally. For example, researchers have raised questions of what constitutes appropriate norms, and whether standard test assessments are suitable for individuals with varying education levels, literacy and social beliefs. Fernández & Abe (2017) argue concepts of test scores when assessing culturally diverse populations. No one-size-fits-all measurement can be applied universally, reflecting an inherent test bias towards the cultural norms of western produced assessments (Fernández & Abe, 2017). Culture pervades all facets of these psychological evaluations, from belief systems to identifications and definitions of relevant concepts (Ardila, 2007). While distinct cognitive processes are common to all humans, what differs is how these functions evolve in culturally-distinct populations.

Considering the social determinants that underwrite social injustices birthed through colonialism is fundamental to understanding healthcare holistically. Furthermore, there exists a deficiency in acknowledging individuals as holistic entities whose attributes are essentially moulded by personal, societal, familial, and historical factors (Pillay & Serooe, 2019). An important question to consider is how we begin to recognise these key roles that influence and intersect with cultural diversity to better address varied health issues in diverse populations (Henrich et al., 2010). According to Koithan (2009), Integrative medicine represents a positive stride towards optimising health outcomes. This approach considers the entirety of an individual's life history, as well as the interconnected elements of their lives. As such, it plays a pivotal role in promoting overall wellbeing. Nurses have historically operated within the holistic framework, providing patients with therapeutics that facilitate biopsychosocial healing. To this end, they have incorporated a range of traditional, complementary, and alternative healing modalities into their practices. These modalities include but are not limited to guided imagery, therapeutic touch, prayer, body-based massage/manipulation, and Breathwork therapy (Hanley, Coppa & Shields, 2017; Koithan, 2009).

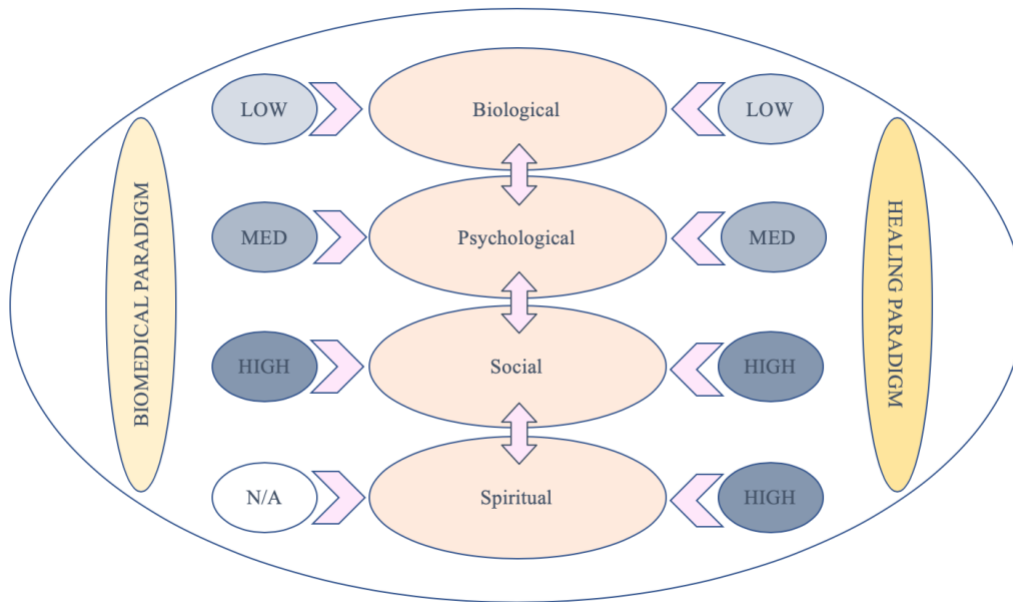


Figure 1: *Biomedical Paradigm vs Integrative Healing Paradigm*

3.6 Breathwork: Ancient Art, New Science

Breathwork has become a relatively new science but is historically, an ancient practice. Referenced as a foundation to the spiritual self across ancient civilisations, Breathwork holds to this day a simple yet effective method to heal and invigorate one's biochemistry. The health functioning role of the breath has been documented in several spiritual practices globally (Gopal, Bhatnagar, Subramanian & Nishith, 1973; Conger, 1988; Farhi, 1996; Hendricks, 1995; Victoria & Caldwell, 2013; Kuppasamy, Kamaldeen, Pitani, Amaldas, & Shanmugam, 2018). The phenomenon has been referred to by Hindus as the *prana*, Chinese as the *chi*, Japanese the *ki*, Africans *umoyo*, and by Christians as the *Holy Spirit* (Gopal et al., 1973; Young, Cashwell & Giordano, 2010; Edwards, Makunga, Thwala & Nzima, 2007). The term spirit stems from the Latin word *spiritus* translating to "breath" or "breath of life" (Young et al., 2010, p. 113). Breathwork has been an ancient healing practice, its function in health preservation rooted in earliest African philosophy and belief systems (Mutwa & Larsen, 2003; Edwards, Makunga, Thwala, & Nzima, 2007). In his book, *Zulu Shaman* (2003, p. 13), traditional healer, philosopher, artist and author Vusamuzulu Credo Mutwa noted his experience and introduction to Breathwork as a young child:

My grandfather also taught me how to control my powers of seeing and how to sharpen them and make them more accurate and efficient. He taught me the art of breathing properly. He taught me the secret art of joining my mind to that of the great

gods in the unseen world. He taught me how to sit still - very, very still - and eliminate all thoughts from my mind and call upon the hidden powers of my soul. In short, my grandfather taught me the Zulu version of what is called in English, "meditation". How to breathe softly and gently like a whisper until you feel something like a hot coiled snake bursting through the top of your head - a fearsome thing that is known as the *umbilini*. This *umbilini*, my grandfather told me, is the source, the primal source of the sangoma's powers. A sangoma must be able to summon this *umbilini* at will through the beating of the drum and through meditation, very, very deep meditation.

This release of the *umbilini* through breath that Mutwa speaks of is similarly found in the East's yogic practice of *Kundalini* and the "breath of fire". *Kundalini* means "to coil or spiral" (Khalsa, 1975). *Umbilini* and *Kundalini* are both aroused through the practice of conscious Breathwork to elicit deep states of healing. Healing is multifaceted, fundamental to any medicine method, with the primary objective being the transition from illness to wellness (Kirmayer, 2004). Healing practices globally include:

The use of medicines that are drunk, smoked, injected or otherwise taken into the body; methods of getting things out of the body by emetics, cathartics, purgatives, bloodletting or surgery; manipulations of the body through touch and gestures or with specific materials; diagnostic or divinatory practices that establish the nature of the affliction in terms of its causes, consequences or some other classificatory scheme; and the use of rituals and ceremonies incorporating words, music, costumes and other theatrical devices that may involve the afflicted individual or the healer alone, the interaction between patient and healer, or the participation of a whole group or community. (Kirmayer, 2004, p. 34)

Breathwork's potential therapeutic advantages have captured the attention of academic scholars, social media influencers, and celebrities alike, including figures such as Justin Bieber and Ellen DeGeneres (Collinge & Yarnold, 2001; Young, Cashwell, & Giordano, 2010; Lalande et al., 2011; Cronshaw, 2019; Turner, Wooten, & Chou, 2019). Harper's Bazaar (2021) published an extensive article on Breathwork, entitled "*Breathwork has gone mainstream during the Covid-19 era*," which explores the method's surge in popularity during the pandemic, the various Breathwork techniques and their applications, its contribution to stress reduction, and its potential to address generational trauma in

marginalised communities. Breathwork has also garnered attention from the entertainment industry, as evidenced by actress and entrepreneur Gwyneth Paltrow's Netflix series, *The Goop Lab*. In this program, Breathwork is demonstrated through a method developed by Dutch speaker and athlete Wim Hof, which utilises breath and cold exposure to enhance athletic performance, boost immunity, alleviate chronic disease symptoms, and address mental health concerns (Netflix, 2020). The Wim Hof method arguably resembles ancient Indian yogic practices of pranayama dating back to 1500 BCE and documented in the *Vedas*, the oldest Sanskrit scriptures of Hinduism. (Gopal et al., 1973; Zainuddin, 2020). *Prana* is defined as the flow of life force, or breath that sustains the body and *yama* is controlled together pranayama is breath control (Kuppusamy et al., 2018).

The globally-trending documentary, *The Goop Lab*, missed a crucial opportunity to engage with the genuine heritage of Breathwork, instead popularising and attributing credit to white, Western "experts" in the field while ignoring the originators of this IKS and traditional healing method. According to Zainuddin (2020, p. 3), *The Goop Lab's* "whitewashing of these alternative therapies represents a form of colonisation and commodification of non-Western practices that have existed for centuries," motivated by profits for marketing purposes rather than medicine. Despite being based on IKS, the creative content of shows such as *The Goop Lab*, will continue to flourish financially, reflecting how knowledge is political, and who disseminates the knowledge determines how and what becomes mainstream. The West's politicisation of IKS calls for accountability to prevent consumers from being exploited at the expense of marginalised communities. In this context, questions arise about who gets to breathe and who suffocates.

3.7 Breathwork in Biomedicine

Excluding Crockett et al.'s work (2016), the existing corpus of literature corroborating the effectiveness of Breathwork is circumscribed to antiquated investigations, anecdotal testimonials, and conjectures derived from other healthcare domains. The lack of extensive research on this practice may be due, in part, to the ambiguity in the conceptualisation of Breathwork. Breathwork encompasses a diverse range of techniques, characterised by significant complexity in terms of type, application, and outcomes (Young et al., 2010, Grof, 2014, Zope & Zope, 2013, Aideyan et al., 2020). There is a pressing need for greater specificity regarding the types of Breathwork interventions being utilised, the populations for

whom they are intended, and the conditions under which they are administered and its subsequent efficacy.

From a biomedical perspective, it was doctor and psychoanalyst Wilhelm Reich who, in 1942, documented the correlation between breath and health, suggesting how people unconsciously restrict breathing to control feelings of discomfort. This dysfunctional breathing pattern results in individuals holding their breath as a defence mechanism, usually against physical or emotional threats (Victoria, H. K., & Caldwell, 2013; Sharaf, 1994; Totton, 2002). Integrative practitioners and biomedical clinicians agree that functional/dysfunctional breathing is impacted by both conscious and unconscious efforts to suppress intense emotional states, with each state producing a corresponding breathing pattern (Aideyan et al., 2020; Brulé, 2018; Crockett et al., 2016; Victoria & Caldwell, 2013; Young et al., 2010). By learning to harness effective use of the breath, four levels of healing become possible: these being cognitive, physical, emotional and spiritual restoration (Young et al., 2010; Brulé, 2018; Crockett et al., 2016; Grof, 1988; Taylor, 1994; Collinge & Yarnold, 2001; Sointu, 2006; Orr & Ray, 1977).

With growing evidence that health and wellbeing involve biological considerations, a need to develop methods that address psychological, physiological and sociological functioning is required. Breathwork can influence clinical practice, holistic practice, research and, importantly, empower self-regulation. With Breathwork being a self-regulated activity, it allows individuals to process physiological resistance and emotional challenges, which typically are not accessible in conventional therapeutic settings (Young et al., 2010). Empirical studies related to the efficacy of Breathwork in therapeutic spaces have previously and primarily been anecdotal. This dearth is perhaps due to the unclear classification of Breathwork (Aideyan et al., 2020). With Breathwork being based on ancient healing traditions, there are numerous techniques, complex or simple in method, application and outcome (Aideyan et al., 2020). Hence, there is a requirement for more interventions that investigate specific circumstances, using straightforward methods, be it conscious breathing, mindfulness breathing, breath-awareness, yogic breathing, holotropic breathing or one of the many existing methods (Young et al., 2010; Aideyan et al., 2020; Grof, 1988; Brulé, 2018).

Currently, there exists a notable trend in the advancement of research within the biomedical arena, specifically in the area of neuroscience. Researches have uncovered that the limbic

system, which serves as the brain's crucial emotional centre, is intricately involved in regulating respiratory patterns (Kamath et al., 2017; Victoria & Caldwell, 2013; Aideyan et al., 2020). This respiratory phenomenon occurs throughout the limbic system, connecting breathing patterns to emotions, perceptions and speech where unpleasant feelings derived from mental stressors alter breathing patterns (Masaoka & Homma, 1997; Fried & Grimaldi, 1993). Masaoka & Homma (2001, p. 171) found that “respiratory patterns are influenced by cortical and limbic factors and generated by a complex interaction between metabolic requirements and their behavioural effects”. This implies that there may not be a direct correlation between brain arousal and the body's metabolic demands, which can affect breathing patterns and physiological arousal. In this case, the individual under stress does not consciously select their breath pattern at a given moment, but “the mode of breathing seems to be selected automatically depending on what is anticipated in the next few seconds” (Gilbert, 2002, p. 119). An emotional stimulus impacts breath regulation and breath-holding; for example, “a positive emotion such as laughter, will decrease inspiratory time and tidal volume, and negative emotions, particularly disgust, induce both breath-holding and prolonged inspiratory pauses” (Victoria, & Caldwell, 2013, p. 217).

Gilbert (2002, p. 111) believes that “regardless the presence or absence of disease, transience or permanence, functional or organic, there is a person experiencing it all, and a person in distress can disrupt his breathing so much that other interventions are thwarted”. Further, Victoria and Caldwell (2013) assert that the relationship between breath, emotion and perception is paramount to emotional fluency. Dysfunctional breathing patterns impact the capability to sense emotional states arising from trauma, disease, chronic illness and distress. In sum, the role of the breath plays an integral role in regulating optimal function or dysfunction in the mind-body system.

3.8 Breathwork Classifications

Breathwork therapy is classed as a mind-body tool used for healing (Collinge & Yarnold, 2001; Sointu, 2006). Breathwork can generate biochemical responses that result in the surfacing of emotional and physical tensions linked to unresolved psychological and physical traumas (Collinge & Yarnold, 2001). It can promote wellbeing on various levels of functioning such as cognition, emotion, physical and spiritual (Taylor, 1994). Globally, there are several Breathwork techniques that fall into two distinct categories. One type promotes conscious breathing that stimulates and triggers psychological breakthroughs, while the other

type focuses on restoration and relaxation (Victoria, & Caldwell, 2013; Kamath et al., 2017; Aideyan et al., 2020).

3.8.1 Mindfulness/Conscious Breathing

The health impact of mindfulness is widely researched and recognised as a beneficial treatment in depression, anxiety, post-traumatic stress disorder, addiction, heart rate variability and trauma (Creswell, 2017; Chung et al., 2010; Tsai et al., 2015; Brulé, 2018; Dowling, 2000; Taylor, 1994; Lalande et al., 2011). Mindfulness or conscious breathing incorporates various techniques used to promote an awareness of one's breath and physical sensations, which ultimately result in an alerted state of consciousness. These techniques require direction from a qualified practitioner and are typically administered as a stand-alone treatment or within a group setting (Aideyan et al., 2020). Breathwork therapies include conscious-connected breathing, circular breathing, holotropic breathing, integrative breathing, Wim Hoff breathing, and guided respiration (Lalande et al., 2016; Young et al., 2010; Aideyan et al., 2020; Grof, 1988; Brulé, 2018; Manne, 2004; Orr & Ray, 1977; Taylor, 1994). What differentiates a conscious connected breathing style from a relaxed breathing style used in meditation, yoga or clinical settings, for example, is that the conscious connected breath is an uninterrupted breath rhythm, free of pauses between the inhale and exhale (Lalande et al., 2011). Although there are subtle variances in conscious breathing techniques, all fundamentally encourage deeper quicker breaths in a sustained manner that ultimately results in an altered state of consciousness (Young et al., 2010; Brulé, 2018; Grof, 1988). Young et al. (2010, p. 116) describes the altered state as follows:

An altered state of consciousness is a mental state other than normal waking consciousness in which one loses the sense of identity with one's body or with one's perceptions. Such non-ordinary states of awareness include dream states, meditative/prayer states, hypnosis, sensory deprivation, some psychoactive drug states, and social activities such as frenzied dancing or chanting. These experiences are thought to allow access to experiences of the self not possible in ordinary consciousness. Breathwork is a self-regulated controlled process that allows access to an altered state of consciousness.

These Breathwork sessions are usually one or more hours and involve the individual lying comfortably on their back while mindfully applying one of the above-mentioned Breathwork techniques (Lalande et al., 2011). In this setting, the Breathwork practitioner aims to guide

the individual into a relaxed state by aiding in maintaining the breath cycle (Dowling, 2000). The practitioner supports the individual in integrating any inner emotional breakthroughs that may surface during the session. Practitioner verbal guidance may include statements such as, “*Focus on the dominate sensation in your body—whatever stands out—study that and whatever is happening right now, just allow it to be there*” (Lalande et al., 201, p. 114). During this phase, individuals may experience psychological and/or physiological breakthroughs manifesting in muscular tightening up. This results from defensive responses to somatic experiences. If this state occurs, individuals are encouraged to cultivate an awareness of their reactions and endeavour to address them through controlled breathing techniques (Dowling, 2000). After a conscious Breathwork session, mental clarity and relaxation are commonly reported (Brulé, 2018; Dowling, 2000; Taylor, 1994; Lalande et al., 2011). According to existing literature, the utilisation of Breathwork to induce emotional arousal has been purported to facilitate the acquisition of improved coping strategies, heightened self-regard, and enhanced capacity to express one's emotions to healthcare providers and the wider social milieu (Collinge & Yarnold, 2001, Dowling, 2000; Taylor, 1994; Lalande et al., 2011).

3.8.2 Deep Relaxation Breathing

Nurses and numerous other health disciplines commonly prescribe this particular technique; also referred to as deep breathing, abdominal breathing, belly breaths, relaxation breathing and diaphragmatic breathing (Aideyan et al., 2020; Consolo, Fusner, & Staib, 2008; Rickard, Dunn, & Brouch, 2015). Deep relaxed breaths involve slow, deep inhalations through the nostrils and even slower exhalations through the nose or mouth. Deep relaxation breathing can incorporate counting and pausing such as:

- *The box breath*, also known as square breath, requires inhaling for a count of four seconds, pausing for four seconds, exhaling for four seconds and pausing again for four seconds (Ahmed et al., 2021).
- *The 4-7-8 breath* requires an inhale of four seconds, pausing of seven seconds and a slow exhale of eight seconds (Weil, 1998).

The practice of deep relaxation breathing has an impact on the autonomic nervous system (ANS), which is comprised of two divisions: the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). These two systems operate unconsciously and have opposing functions in regulating bodily processes. The SNS governs the fight or flight

response, while the PNS regulates the rest and digest response (Liza, 2011; Pal & Velkumary, 2004). Evidence shows that regular practice of deep relaxation breathing increases PNS while decreasing SNS: this, in turn, lowers blood pressure, reduces heart rate, lowers anxiety and increases overall feelings of wellbeing (Kaushik et al., 2006; Mourya et al., 2009). Notably studies have also indicated that deep relaxation breathing is advantageous for students in managing chronic stress (Perciavalle et al., 2017). Moreover, research in nursing has demonstrated a significant correlation between deep relaxation breathing and a reduction in symptoms of depression (Chung et al., 2010; Tsai et al., 2015).

3.9 Breathwork Findings

Researchers are increasingly reporting favourable findings supporting Breathwork as a traditional, complementary and alternative healing method. Sudres, Ato, Fouraste and Rajaona (1994) investigated the benefits of a ten-session Breathwork intervention on 12 depressed and anxious patients and found that 10 of the 12 participants achieved significantly improved clinical results. Findings by Holmes, Morris, Clance, and Putney (1996) revealed that people who practised regular Breathwork therapy instead of psychotherapy achieved significantly higher gains in self-esteem and reduced anxiety. Another study carried out on married partners who served as sitters for each other during a Breathwork session reported increased affection, more in-depth communication, increased physical connection and an all-round acceptance for one another (Chou, 2004). Scholarly literature indicates that individuals who engage in Breathwork frequently report experiencing a profound sense of relaxation and a heightened state of mental and physical wellness following a session (Holmes et al., 1996; Lalande et al., 2011; Brulé, 2018; Grof, 1988; Manne, 2004; Orr & Ray, 1977; Taylor, 1994; Young et al., 2010; Chou, 2004). Conversely, prolonged patterns of constrained breathing can manifest as a response to environmental factors that elicit heightened levels of arousal leading to a reduction in serotonin synthesis, resulting in anxiety and depressive symptomology (Lalande et al., 2011). Thus, acquiring the skill of regulating one's breath effectively may lead to favourable health consequences. In contrast to biomedicine's emphasis on the body's biochemistry, traditional modalities such as Breathwork centre on the individual's human experience (Ventegodt, Morad, Andersen, & Merrick, 2004).

The demand for easily accessible therapeutic interventions to mitigate or build resistance against diseases is escalating worldwide. Breathwork has emerged as a prominent technique owing to its prospective therapeutic advantages. Nevertheless, there is a possibility that the

enthusiasm surrounding Breathwork may not always be substantiated by strong empirical evidence. A meta-analysis by Fincham et al., (2023) revealed that Breathwork produced a significant small-medium effect in reducing self-reported/subjective stress, anxiety, and depression when compared to non-Breathwork control conditions. Despite preliminary evidence of Breathwork's effectiveness, efficacy around deeper mental illnesses in particular requires more research (Aideyan et al., 2020). Despite the dearth, therapeutic benefits of Breathwork began emerging in counselling literature decades ago with a distinct emphasis on informative, educational contexts where participants showed positive results in their ability to distinguish between states of relaxation and tension and how through Breathwork, stress reactions declined (Rossman & Kahnweiler, 1977; Wilkinson, Buboltz, & Seemann, 2001; Taylor, 1994; Zaichkowsky, & Yeager, 1986).

The aforementioned findings propose that Breathwork may represent a viable solution for addressing the demand for accessible therapeutic interventions. Nevertheless, to ensure that any suggestions made be grounded on research data, it is imperative to conduct additional studies employing low risk-of-bias designs. By engaging in robust research, a more comprehensive comprehension of Breathwork's therapeutic potential can be attained, thereby potentially facilitating its integration into public healthcare in an effective manner.

3.10 Decolonising Healthcare

What does it mean to be human? For decades, this has been the ethical and epistemological question in the social sciences and an essential factor in addressing dynamics of knowledge, positionality, prejudice and power (Carolissen and Duckett, 2018; Fanon, 1963). As mentioned, cultural imperialism and biomedicine, influenced by modernity and the enlightenment age, ushered in a vastly different medicinal culture to that known by indigenous Africans (Matheson, 2009). Disparities included the “supremacy of reason, scientific objectivity, the compartmentalisation of life into facts versus values and belief in the autonomous individual” (Matheson, 2009, p. 1192). In Africa, relationships to land and country carry vital significance for indigenous people experienced through spiritual connections (Dudgeon, Bray, D'costa, & Walker, 2017). A country can be considered “a living entity said to give and receive life while providing nourishment for body, mind, and spirit” (Rose, 1996). This divine connection to land, living and wellbeing was uprooted with the emergence of colonialism and apartheid. Evidence of this oppression is found in pervasive epistemologies that reveal disparaging narratives of IKS in healthcare, such as

traditional practices being barbaric, bewitched, superstitious, primitive, obsolete and savage (Harvey, 2003; Smith, 1999). Yet, despite the dominance of the biomedical healthcare model and systematic efforts to suppress IKS, indigenous healing traditions have stood the tests of time globally (Marks, 2006; Ndubani & Hojer, 1999).

Currently, a pervasive theme encompassing the world demands the immediate reassessment of human rights. The Black Lives Matter movement, for instance, meticulously emphasizes that issues of race and discrimination extend far beyond the asphyxiation of black individuals and the continued systemic injustices resulting from power and privilege imbalances. Externally, support for the Black Lives Matter movement has mobilised educational institutions, corporations, academics, and laypeople alike to demonstrate solidarity while consciously striving to become antiracist. Crucially, this collective movement seeks to eradicate the deeply entrenched injustices that have persisted in silence (Sobo, Lambert, & Heath, 2020).

This literature review has highlighted the historical discriminations of indigenous knowledge in healthcare and raised valuable questions around a pluralistic healthcare. In Marks' (2006) study: *Global Health Crisis: Can indigenous healing practices offer a valuable resource*, she argues for decolonisation in healthcare:

Indigenous healing practices can no longer be ignored by conventional medicine. These practices are potentially invaluable in addressing the ongoing global health crisis. However, to ethically address the role of indigenous healing practices within a Westernized worldview, certain policy, methodological, and conceptual changes will be necessary. (Marks, 2006, p. 471)

Marks (2006) posits that the relentless global health crisis, due to socio-economic challenges, HIV and AIDS, overpopulation, substance abuse, inadequate resources and infrastructures, breaks down important cultural structures, such as indigenous knowledge, while increasing overall anxiety. Attending to this predicament would require addressing the healthcare framework holistically: this will include academic institutions where medical healthcare services are born. Healthcare delivery should consider the biopsychosocial, which essentially recognises the integrative role biological, psychological, and social influences play in promoting health and wellbeing (Engel, 1977). It is imperative for healthcare practitioners

from all backgrounds and training to be cognisant of the unequal distribution of political and social agency and to work together towards an efficient healthcare for all.

3.11 The Curriculum

Healthcare is one of the many areas in which decolonisation requires attention. Post-apartheid, the South African government has made significant progress in acknowledging the roles of traditional healers and TM. However, minimal evidence illustrates the carryover and inclusion of IKS in medical training and learning institutions. The healthcare system continues to be plagued by stark inequalities, with biomedicine being the exclusive model of healthcare.

A study conducted by Chitindingu, George & Gow (2014) titled, *A review of the integration of traditional, complementary and alternative medicine into the curriculum of South African medical schools*, investigated the extent to which medical schools in South Africa were incorporating traditional, complementary and alternative medicines into their curricula. Out of the eight medical universities approached to participate in the study, seven consented. All were asked to provide evidence of the courses assigned to alternative medicines and identify the graduate level at which these courses were taught. The study found a profound lack of commitment to teaching alternative medicines other than biomedicine by all schools except for the University in KwaZulu Natal. If schools were covering any form of alternative medicine, this was introduced in a “tokenistic” manner (Chitindingu et al., 2014).

In sum, this crucial study revealed that South African medical schools were failing to adequately recognise the ongoing interplay between biomedicine and alternative medicines in patient care. The inclusion of additional medicinal options in medical education has the potential to enhance healthcare outcomes and promote a stronger practitioner-patient relationship. Medical pluralism, which encompasses the coexistence of diverse medical practices, can have a favourable impact on how healthcare professionals and patients interact, particularly in light of the multiple worldviews that exist (Moshabela, Zuma & Gaede, 2016).

Chapter 4: Methodology

It appals us that the West can desire, extract and claim ownership of our ways of knowing, our imagery, the things we create and produce, and then simultaneously reject the people who created and developed those ideas and seek to deny them further opportunities to be creators of their own culture and own nations. (Smith, 1999)

Smith (1999) critiques the persistent coloniality residing in academia and research methodologies. She invites reflection on the historical links between the Euro-western development of scientific inquiry that centred on the dehumanisation and appropriation from indigenous people and calls for a decolonised and decontextualised framing of normality. Decolonisation refers to the dismantling of hegemonic rule, questioning all positions of power. In academic research, decolonisation recognises assumptions around rationality by identifying that historically, literature was developed in specific locations at particular times for certain populations (Griffiths, 2017; Radcliffe, 2017). Therefore, decolonising research seeks to highlight how "truths" presented as universal are laden with invisible power, constructed to preserve, protect and maintain distorted notions of histories (Maldonado-Torres, 2007).

When attempting to impact policy frameworks, delving into discrepancies between governmental policies and academic institutions, the use of critical qualitative research can bring awareness of unknowns about the social world (Fielding, 2019). Healthcare practitioners' experiences of navigating power relations within the healthcare system suggest that a critical qualitative approach would be most suitable for this study. Critical qualitative inquiry examines the significance behind testimonies which aid in decolonising research, particularly those that perpetuate ongoing marginalisation (Atallah, Shapiro, Al-Azraq, Qaisi, & Suyemoto, 2018). A critical qualitative approach also explores the richness of human experience, permitting flexibility that delves into individual experiences where themes about the personal and professional can emerge (Padgett, 2004). Further, this approach can amplify social change by challenging western hegemonic understandings of IKS around TM which have been misrepresented in the social sciences (Fielding, 2019).

In undertaking research that adopts a critical approach, it is essential to go beyond a superficial acceptance of findings and engage in a process of self-reflection that can facilitate transformation (Fossey et al., 2002). In so doing, the researcher recognises the subjective nature of their perspectives, including their personal worldviews and the potential influence of these views on their understanding of the participants' realities and the larger context (Spinelli, 2005). Such a reflective approach is fundamental to ensuring a rigorous and unbiased inquiry that addresses the complexities inherent in the research study. This chapter comprises a discussion of the research methodology as mentioned above, data sources, data collection techniques, the data analyses used for the study, reflexivity, and finally, ethical considerations.

4.1 Data Sources

A qualitative method was chosen to explore the complexities around this research. Qualitative research is suitable when concerns warrant further investigation or if issues are complex and cannot be clearly measured (Creswell, 2013). Qualitative research typically involves smaller sample sizes compared to quantitative research which relies on larger samples. Creswell (2005) recommends that a qualitative sample range be between one and 25 participants, while Polkinghorne (2005) recommends between five and 25. Patton (2002) believes there should be no specific sample size rule, suggesting instead that the researcher decide what works best for the study as “sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility, and what can be done with the available time and resources” (Patton, 2002, p. 244).

For this study, a sample consisting of five healthcare practitioners who incorporate diverse traditional and alternative modalities into their practice was utilised. The inclusion criteria included (a) practitioners who integrated Breathwork into their practice, (b) practitioners who studied and graduated at South African universities, and (c) practitioners who had at least 10 years of working experience in the South African healthcare sector. Exclusion criterion were healthcare practitioners who were not favourable towards practicing TM.

A snowball sampling method was used to recruit eligible participants. Snowball sampling uses a network where each individual is connected to another through either direct or indirect association (Neuman, 2003). For this study, participants were recruited through their affiliation to a globally recognised Breathwork organisation. This organisation trains

Breathwork practitioners and works closely with other healthcare professionals, NGOs, educators, athletes, students promoting improved healthcare (Breathwork Africa, 2021).

From the five participants interviewed for this study, Mila is a General Practitioner (GP) who transitioned into Integrative Medicine (IM) and now exclusively practices as a Breathwork practitioner. Lebo is a Cardiologist practicing as Functional Medicine (FM) practitioner. Kajal holds a PhD in Social work and lectures at a university, she is also a Breathwork practitioner. Zak is a Physiotherapist and Breathwork practitioner. Unathi has a background in Psychology but practices as Breathwork practitioner exclusively.

4.2 Data Collection Techniques

All participants were based in South Africa. All were contacted through an email invitation with information about the study. Participants were sent consent forms to sign for their participation in the study (Appendix A). They were invited to ask any additional questions regarding the study prior to the interviews. Three of the interviews were conducted in-person at the practitioners' office and two on-line via Zoom. Interviews ranged between 30 – 45 minutes. Using a semi-structured interview (Appendix B) allowed participants to engage in an open-ended narrative, using opportunities to contextualise their experiences as healthcare practitioners (Hydén, 1997; Dejonckheere & Vaughn, 2019). All interviews were recorded as an audio file on a mobile phone and later transcribed and coded. Participants were assigned pseudonyms (Mila, Lebo, Kajal, Zak, Unathi) for anonymity to protect their identities.

At the outset of each interview, the study was explicated to the participant, encompassing the measures that would be undertaken to safeguard the confidentiality of the participant. Signed consent forms and recordings were saved in password protected files on a computer. Before the formal interview process began, there was an easy social interaction between the researcher and each participant, creating a comfortable atmosphere (Moustakas, 1994). Field notes were recorded during each interview which complimented the reflexive journaling process for the researcher. Field notes included key points raised by participants (Moustakas, 1994). Lastly, all interviews were transcribed verbatim, and as mentioned, all participants' names were replaced with a pseudonym for anonymity.

4.3 Data Analysis

This research used a combination of thematic analysis as an initial step in deriving themes from the raw data and then applied Critical Discourse Analysis to interpret the data in depth.

4.3.1 Thematic Analysis

In this study, the researcher used thematic analysis to derive meaning from the raw data collected from practitioner interviews. The methodology was adopted because it draws on the use of language objects, which derive meaning from the terms that are applied. According to Philips and Jorgenson (2002), thematic analysis is a useful tool for identifying themes implicit across all interviews. To conduct the analysis, the researcher followed recommendations by Miles & Huberman (1994) and Braun & Clarke (2006). The researcher began by reading through each practitioner's interview transcript several times to get familiarised with the data and identify themes implicit across all interviews. Through this process, a thematic structure for each participant was identified by analysing the data. The researcher reviewed transcripts according to emerging themes that included epistemic ignorance, Breathwork as a bridge, affective economies and social transformation.

To further analyse, the data was grouped for macro themes and specific data was labelled with an identifier linked to the participant who shared the information. All macro themes were further analysed to develop an understanding of the micro subthemes. For example, with the macro theme of epistemic ignorance, the micro theme of purpose activism surfaced from meaning-making words such as political understanding, paradigm shifts, and scepticism. Once the analysis was complete, the researcher noted how many participants narrated each theme, highlighting all familiarities shared by participants. As a final step, the researcher reviewed the data with consideration of personal biases and/or blind spots. In summary, this study used thematic analysis to derive meaning from the raw data collected from practitioner interviews. The findings of this study provide insight into the experiences of practitioners working in the integrative medicine field and adopting Breathwork as TM.

4.3.2 Critical Discourse Analysis

Critical discourse analysis (CDA) was used to examine the data as it emphasises the constructions of identities through language (discourse) by scrutinising taken-for-granted assumptions (Phillips & Jorgensen 2002). CDA recognises that the formation of knowledge is subject to time and place and that associations occur between social development, knowledge and social action (Phillips & Jørgenson, 2002). The CDA approach facilitates a thorough assessment of the nuances behind how language is utilised to describe phenomena. Broadly, it is an examination of language as a social and cultural practice, and involves a process:

To systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power. (Fairclough 1995, p. 132)

CDA is grounded on the principle that language carries a constructive impact, influencing how we experience ourselves and others, and our reactions to these experiences. An example of this can be the role that healthcare practitioners play in prescribing particular medicines (Fairclough et al., 2011). The choice of prescriptions by practitioners is crucial to understanding the social, cultural and historical backgrounds to language, where ideologies around power may reside. Working from a critical diversity theoretical framework, this study aimed to analyse what the experiences of healthcare practitioners could reveal about power relations in healthcare. According to Steyn (2015, p. 383), “dominant formations do not act singly, and are not experienced discretely within people’s lives,”. The ways in which hegemonic forces intersect are reproduced, resisted, or reframed is vital in deciphering data (Steyn, 2015). Therefore, understanding of dominant discourses around which knowledge systems get included and excluded in healthcare is crucial to the findings of this study.

Critical diversity literacy critiques positions of power by addressing questions pertaining to how assumptions have come to exist. With that, two specific criteria were selected from the CDL framework to ascertain to which degree IKS and TM are marginalised in healthcare. The remaining eight principles of CDL aid in supporting this examination. The two main tenets are:

A definition of oppressive systems as current social problems and (not only) a historical legacy. Interrogating the epistemology of knowledge is crucial to centering IKS.

What is knowledge? How is knowledge acquired? What knowledge is deemed mainstream? How have we come to know what we know and why? Medically, dominant discourses have historically rewritten the health narrative into a western one, bearing little consideration of IKS while simultaneously misrepresenting the image of Africa's ancient traditional therapies as distorted.

An engagement with issues of the transformation of these oppressive systems towards deepening social justice at all levels of social organisation.

To navigate a socially just world requires a constant examination of how power never names itself as such. Playing an active role in accountability and decolonisation can benefit the advancement of social justice for “those whose oppression would otherwise be further entrenched through conscious and unconscious assumptions of privilege” (Steyn, 2015, p. 388).

4.3.3 Reflexivity

At its core, reflexivity is about researchers recognising their own roles during the research and how previous experiences, belief systems and assumptions may impact and interpret findings. Achieving emancipation, particularly within a critical paradigm is what McCabe & Holmes (2009) refer to as a Foucauldian sense where *technologies of the self* are used during the research process to question the researcher's own assumptions, and general acceptance that they could unintentionally influence the results of the project.

An important distinction that requires consideration is that being reflexive is not the same as being reflective. Researchers reflect on their data by making judgments about it, but reflexivity extends further by examining these judgements. For example, a researcher may question “Do my beliefs in the efficacy of Breathwork make me predisposed to reasons that my findings point towards a specific outcome.” If any underlying belief systems can potentially impact the conclusion of a study, it is imperative that the researcher identify them upfront. Being reflexive on the other hand demonstrates the connection of the researcher's role to the cultural realm of the study (Ellis & Bochner, 2006). Smith (1999) suggests that researchers be cognisant in critiquing their “gaze” (perceptions) and reflecting on accurate representations when encoding data.

As with all methods of research, risks are taken when applying this personal approach. Much like autoethnographic research, critically and continuous reflexivity has been criticised for

being self-indulgent due to its use of the self as a source of data (Duncan, 2004). However, with decolonisation of research methods being a critique of the cultural assumptions behind dominant discourses, critical reflexivity offers an opportunity to highlight personal biases so that these can be encoded in transparency and truth. Furthermore, reflexivity in critical qualitative methods recognise that no researcher is ever neutral in a research process but instead imbued with life experiences and systems of meaning that can become blind spots or biases should the research not involve ongoing critical reflexivity (Canella & Lincoln, 2012). With that, the researcher's position of conducting research within a field that is familiar could be viewed as an insider to the community hereby impacting the ethics of knowledge production in this study (Moya, 2011).

4.4.4 Ethical Considerations

Ethics approval for this study was granted by the University of the Witwatersrand's School of Social Sciences Ethics committee (protocol #DIV200831). Research for this study took place during the COVID-19 pandemic. The researcher remained cognisant of the psychologically challenging time this period represented for the participants as well as the researcher's own anxieties around the pandemic. During the timeline of these interviews, the researcher was mourning the loss of eight close family members to COVID-19. This psychological state served as a reminder to bear cognisance of potential triggers that could surface around discussions about the pandemic.

Critical research intersects with various systems of power and representation. That said, for research to be grounded in ethical integrity, Madison (2005) suggests that "critical ethnography begins with an ethical responsibility to address processes of unfairness and injustices within a particular lived domain" (cited in Fitzpatrick, 2013, p. 130). Further, Madison (2005) defines ethical responsibility to be "a compelling sense of duty and commitment based on moral principles of human freedom and wellbeing, and hence a compassion for the suffering of living beings" (cited in Fitzpatrick, 2013, p. 130). These statements are all endorsed by the core principles of Critical Diversity Literacy (CDL) that affords the voices of those that have and continue to be marginalised, to be seen, heard and valued (Steyn 2015). This too, speaks of the essential role researchers play when producing and disseminating knowledge, particularly around marginalised groups. Ethics is a critical consideration in terms of how participants are engaged with in the research process. This includes, but is not limited to, protection of the identification of the healthcare practitioners

and their clients. To this point, participants were informed of their right to withdraw at any stage of the research process.

The beneficence principle was addressed so that participants felt free from harm and discomfort and exercised their rights to protection from exploitation in any way (Sims, 2010). Additionally, the researcher endeavoured to keep all shared information in their strictest confidence and privacy to observe the participants' anonymity and/or confidentiality (Sims, 2010). All interviewees were assigned pseudonym codes which were used in the research and during audio transcriptions to protect the anonymity of the participants. The researcher upheld all ethical considerations required by the Human Research Ethics Committee (non-Medical) at the University of the Witwatersrand, Johannesburg. Moreover, throughout the process of research, the researcher endeavoured to remain cognisant of the researcher-participant relationship, and how positionality could shape interpretation of the data particularly with the researcher being a Breathwork practitioner, an insider and intrinsically familiar with the Breathwork framework, this position could likely have informed the interview schedule.

4.4.5 Limitations

Critical Discourse Analysis aided the critical exploration of the participants' discourses and reflections around healthcare and how best to become agents of change in shifting towards a pluralistic and inclusive healthcare delivery. Verbatim quotes from the participants are presented in support of themes. Framing the analysis in the upcoming chapter, it is important to note that (a) the data was derived from in-depth, semi-structured interviews with South African healthcare practitioners from a variety of backgrounds, who practice within a holistic/integrative paradigm; (b) there was no ethnographic component to this study with which to observe for example, patient outcomes that participants spoke of. This analysis is based solely on the discourses and reflections of the participants' experiences. Exploration of patient experience would have yielded richer data to further supplement the discursive data, but it is unfortunately beyond the scope of this specific research. The following findings and analysis are not an attempt to make a generalisable comment on this study but rather to provide themed patterns of phenomena among healthcare practitioners as they surfaced during interviews.

Chapter 5: Findings and Analysis

Imagine an ignorance militant, aggressive, not to be intimidated, an ignorance that is active, dynamic, that refuses to go quietly—not at all confined to the illiterate and uneducated but propagated at the highest levels of the land, indeed presenting itself unblushingly as knowledge (Charles W. Mills)

This analysis section utilised the mentioned Critical Diversity Literacy (CDL) framework to derive meaning from the narratives of the five healthcare practitioners interviewed for this study. The analyses used thematic network analysis to assist in identifying categorisations of themes. Themes are divided into a main theme and sub themes, all of which are interconnected and intersecting with one another to develop a meaningful analysis of the five practitioners in the study. Discussions were nuanced and layered, despite – and because of – their similarities and differences as healthcare practitioners. The aim of the research was to explore power relations within the healthcare sector that support particular medicinal models while marginalising others. Questions around indigenous knowledge systems (IKS) of health and meaning-making around healthcare delivery in South Africa was addressed.

Use of the CDL framework as a guide aided the exploration around the limitations behind hegemonic orders that reside within healthcare. Experiences of the participants demonstrated complex negotiations around how best to aid disgruntled patients seeking a more holistic healthcare offering while simultaneously acknowledging that healthcare, and the training thereof, requires a reframing. Guiding this analysis were the following questions: what challenges do healthcare practitioners experience in dealing with patients seeking pluralistic healthcare? What are the differences between practicing from a biomedical paradigm compared to an integrative paradigm? How, if at all, can awareness of and practice in Breathwork aid health and wellbeing and ultimately aid the healthcare sector? To what extent does academic training prepare healthcare practitioners in treating a diverse population and enable a vision for the future healthcare? Presentation of the main and subthemes are structured as follows:

An overarching theme that arose during the data analysis was *epistemic ignorance*. Ignorance continues to marginalise alternative types of knowledge while eradicating knowledge that was once historically practiced. More so, to even call a type of knowledge *alternative*

Macro theme	Micro theme	Meaning-making words in participants' responses
Breathwork as a Bridge	Integrative Medicine	Empowering, transformational, self-regulation, mind/body connection, partnership, community, universal, generational trauma, parasympathetic, empathy.
Epistemological Ignorance	Purposive Activism	Political understanding, politics of knowledge, head versus heart, perceptions, paradigm shift, scientific, siloed, integration, quack, evil, scepticism, formulaic, ignorance.
Transformation Agents	Shape Shifters	Academic training, conventional, data driven, colonised, scientific, myopic, self-trained, exclusive, vision, hope.

Figure 3. *Theme Chart of Macro and Micro Themes from Data*

5.1 ‘Integrative medicine is supporting the patient to become more empowered’:

Breathwork as a Bridge

Participants were asked how Breathwork was brought to their attention and what impact, if any, the modality had on their lives and the wellbeing of their patients. Participants in the study described that the use of Breathwork aided their own personal health challenges, further iterating how the benefits of Breathwork had significantly altered the trajectory of their wellbeing with transformative effects on their lives. One participant discussed how they discovered conscious, connected breathing, which had a profound personal impact on their health. Another explained that before prescribing Breathwork to patients, they had to trust in its effectiveness personally and experienced the outcome to be beneficial. A participant who

previously suffered regular panic attacks described how transformational Breathwork was to a point that she no longer experiences panic attacks or anxiety. A psychiatrist was credited for introducing one of the participants to Breathwork as a treatment option for mental illness instead of utilising pharmaceutical medication. The quotes below illustrate how Breathwork has had a significant impact on the personal and professional lives of the participants. The voices of the participants highlight the significance of personal experience in building trust in the effectiveness of Breathwork and its potential as a treatment option. Anecdotes from the participants about Breathwork included:

Eight years or so, after practicing as an integrative doctor, yoga, very much a part of my life [...] that I came across Dan Brule, and it was then that I had my first conscious, connected breathing session which was, personally, completely transformative. (Mila)

I think it was my own personal experience with Breathwork, that before I could prescribe it for my patients I had to trust that it worked, or that it does help, and I went for my first Breathwork session maybe 18 months to two years ago and it had such a major impact in my personal life. (Lebo)

I had the most profound experience that I have ever, ever had [...] it has been the most transformational, with no talking, it's been the most transformative. I think it's the kind of modality that has brought about the most profound transformation in me as a person [...] I'm a good example of how Breathwork completely transformed my life from where I was when I did my first Breathwork session, to where I got to two years later. (Kajal)

I used to have chronic panic attacks, you know, a good at least 10, 20 per month and I had just been, I was just always medicated for it. So, I never left the house without tranquillisers, you know, I was taking a tranquilliser in the morning, a tranquilliser in the evening, and I suppose I was in a zombie state for a lot of the time. And then once I'd heard the science behind this breathing, that it could actually calm my parasympathetic system, and I wouldn't have to live in this state of feeling so hypervigilant all the time [...] I'm on about 4, 500 sessions later [...] I didn't think I would be able to rid myself of anxiety, but I thought I'd be able to manage my panic

attacks. And so now I don't ever have panic attacks, and I have probably close to zero anxiety. (Unathi)

Breathwork probably only came to me about 12 years ago, when I met a psychiatrist who was interested in treating psychiatric mental illness through Breathwork rather than medication, and that's where the interest sparked. (Zak)

As discussed by the participants, Breathwork, when used as a mind-body tool used for healing generates biochemical feedback ranging from emotional to physiological reactions linked to unresolved psychological and physical traumas (Collinge & Yarnold, 2001; Sointu, 2006). Kajal, who treats children and adults, shared recent reactions from two patients on the therapeutic benefits of Breathwork: “One of the children said to me the other day, ‘When I get nervous, I still do those Breathwork exercises,’. Another patient who had been seeing a psychologist said, ‘I have never had that kind of shift in me before,’”. Mila sees the benefits of Breathwork in her practice with patients who suffer panic attacks:

I had someone coming to see me with debilitating panic attacks, just out of nowhere. And, you know, he's on the beta blockers, and he's on antidepressants, and he's just, you know, really feeling like, incapacitated by this. And just in showing him how to release his diaphragm and work with his diaphragm, this experience of anxiety shifted immediately. And it was simply the pattern of breathing, his baseline breathing, was feeding the stress response without him even knowing.

Panic disorders are a common psychiatric ailment, the trademark of the syndrome being the frequent arise of unexpected panic attacks (Wemmie, 2011). Panic attack characteristics include sympathetic overdrive, such as shallow breathing, heart palpitations, trembling and excessive sweating among a multiplicity of other symptoms (Wemmie, 2011). Unathi, who had been on medication herself to alleviate her anxiety and panic attacks said that after experiencing the physiological benefits of Breathwork she thought, “I can actually go off this medication,” that she'd been beholden to for years. Biomedicine and pharmaceuticals have been criticised for perpetuating a cycle of symptomatic attention that fails to empower patients to make their own healing decisions. This model of medicine prioritises the treatment of symptoms rather than addressing the underlying causes of illness, thereby creating a dependence on pharmaceuticals that offer temporary relief without promoting lasting health. One of the key issues with this approach is that it tends to treat patients as passive recipients

of medical care rather than active participants in their own healing process. Patients are often told what to do and what medications to take, rather than being encouraged to take an active role in managing their health. This situation frequently results in a sense of disempowerment and a lack of agency, leading to feelings of frustration and hopelessness. These inherent dominant formations emphasise the importance of recognising how individuals resist or reframe intersecting hegemonic forces brought upon by healthcare norms. Acknowledging the agency and resilience of individuals to partake in their own healthcare highlights what Steyn (2015) emphasises around a more nuanced and intersectional approach to understanding the complex ways in which dominant formations intersect and shape individuals' experiences. Moreover, the focus on treating symptoms rather than addressing root causes can lead to a never-ending cycle of medical interventions that fail to promote long-term healing leaving individuals disheartened. Mila sees this discouragement regularly in her practice with patients:

They often come to me as the last port of call. They've tried everything, they are desperate, nothing's working, they've been from one doctor to another, they're not getting any joy, and so they come to me in a state of desperation. Or just feeling like they are feeling inspired to just live differently, approach their health differently.

Lebo has found in his practice that the most effective way to treat the body's central nervous system is through Breathwork. Lebo shared a case about a patient who had been experiencing severe sympathetic overdrive leading to chronic anxiety, and said, "I sent him to a Breathwork practitioner, and after the second Breathwork session, a month apart, showed significant improvement in all his manifestations". As demonstrated by Craske and Stein's (2016) research, one out of every 14 individuals satisfies the diagnostic criteria for an anxiety disorder. Given that anxiety disorders represent the most widespread mental health condition globally, with over 301.39 million documented cases, disseminating effective mental health tools and related knowledge is essential in alleviating the burden of disease (Yang et al., 2021). A world mental health study by Wang et al. (2007) revealed that from the 17 low-medium- and high-income countries that were surveyed, health care necessities were not efficiently sustained. More recently, it was cited that current healthcare and medical interventions have yet to sufficiently address the mental health crisis, stressing an urgency to explore alternative evidence-based interventions such as traditional, complementary and alternative medicines (Lake & Turner, 2017).

The pharmaceutical marketplace prescribes medications to alleviate anxiety using a variety of drugs to treat anxieties symptomatically, the most common being beta blockers (Dooley, 2015). Beta-blockers are a class of drugs largely utilised to treat cardiovascular diseases such as congestive heart failure, cardiac arrhythmias, hyperthyroidism, coronary artery disease and other medical conditions which are known to potentially carry adverse effects. Furthermore, beta blockers have the potential to aggravate some arrhythmias, therefore, patients on beta blockers require heart rate and blood pressure monitoring as well (Farzam & Jan, 2022). A major drawback of this medical approach is its tendency to view patients as passive recipients of medical treatment, rather than active participants in their own process of recovery.

Patients are often told what to do and what medications to take, rather than being encouraged to take an active role in managing their health. This can result in a sense of disempowerment and a lack of agency, leading to feelings of frustration and hopelessness. Moreover, the focus on treating symptoms rather than addressing root causes can lead to a never-ending cycle of medical interventions that fail to foster long-term healing. To promote healing and empower patients, Mila believes that a pluralistic healthcare approach which “...Is part of the paradigm of integrative medicine is supporting the patient to become more empowered”. Kajal shared that while Breathwork as a health tool would not remove challenging life situations, such as the “Problems of poverty, and unemployment and hunger and so on, but I think it gives people a different set of tools so that they are better empowered to deal with their life situations,”.

Participants in the study felt that it is necessary to shift the dominant healthcare focus from treating symptoms to addressing root causes of illness. A comprehensive strategy that perceives the patient as a complete individual, as opposed to merely a set of symptoms, is necessary. Unathi believes that for as long as the concept of binaries dominate the healthcare system, we will remain stuck: “We need to start opening up to the possibilities of what is really ancient wisdom, and what sits in Africa, what sits with our traditional healers”. Noted in this study is how IKS have much to offer healthcare, as they provide unique perspectives and approaches to health and wellness that have been nurtured over generations. These knowledge systems are rooted in traditional practices, cultural values, and beliefs that have been shaped by the land, environment, and community. This approach recognises that health is not just the absence of illness, but rather a state of balance and harmony within oneself, with others, and with the natural world (Moshabela et al., 2016). Unathi stresses that she is

“Quite concerned and confused as to why systems, and all systems, be it the health system, the education system, the academic system, are closed to other ways of doing things that will benefit people”. Unathi’s concern addresses the ideological framing that forms a cornerstone of CDL which relies on a natural hierarchy that establishes dichotomies where one group or dominant ideology is favoured over the other, especially in socio-economic contexts. As a consequence, those who belong to the dominant group are privileged and benefit from their position of power and privilege, while those who do not belong to that group are left out. This power imbalance is evident in healthcare, where certain groups receive better care and treatment than others due to their socio-economic status. For example, studies have shown that individuals from marginalised communities are less likely to receive timely and adequate healthcare services than their privileged counterparts. It is therefore crucial to understand and address the role of power establishments in perpetuating these hegemonic orders in healthcare to ensure equitable and fair treatment for all individuals (Steyn, 2015).

With the COVID-19 pandemic highlighting the limitations of healthcare, the United Nations has emphasised the crucial value in identifying alternative modality measures as a necessity for all countries (UNSDG, 2020). It is critical that healthcare policy, strategies, and medical schools consider the limitations of merely addressing the symptomatic relief of diseases. By prioritising prevention and alternative approaches to healthcare, promotes inclusivity and overall health and wellness. This shift in focus can also lead to more cost-effective and sustainable healthcare solutions, ultimately benefiting both patients and healthcare systems.

Long before biomedicine interventions became the standard healthcare, IKS embedded in TM led the way. Breathwork, being one of these medicines is a preventative healthcare tool that participants in this study believe is not only effective in navigating mental health challenges, such as panic disorders related to anxiety, but is also safe. As a cardiologist, Lebo believes that:

Sympathetic overdrive underlies almost all chronic cardiac conditions and we don't have an effective means of reducing sympathetic function. So, we can use beta blockers to block the effect, but we have no medication or means of bringing down those adrenaline or stress hormone levels. And, for me, Breathwork was, from the literature, one of the key mechanisms to help improve that.

An in-depth systematic review of the efficacy of Breathwork as an intervention was recently examined by Malviya et al. (2022). The investigation yielded positive results in all areas. The Breathwork interventions examined in the systematic review ranged from a 5-minute relaxation technique to a longer 90-minute deeper Breathwork technique, from one singular Breathwork practice up to a longer eight-week practice. Breathwork's effectiveness on anxiety produced statistically significant reductions across all 15 studies. Breathwork's effectiveness on depression revealed reduction in depressive symptoms in all eight studies and further highlighted how the continued practice of Breathwork correlated to the decline of depression levels. Additionally, Breathwork's effectiveness on stress and post-traumatic stress disorder (PTSD) all showed significant reduction in symptoms after Breathwork intervention, all of which was maintained after a one year follow up (Malviya et al., 2022). The reason for the positive outcome in studies, Mila says is that:

By changing the breath, we are able to shift our state by activating the relaxation response through the vagus nerve and that immediately shifts the part of the brain that is more active. So, it shifts people out of that fear-based fight/flight mode that is directed by the limbic system, the amygdala, and it makes the prefrontal cortex come online, dampens the response of the amygdala, and this offers an opportunity to break the cycle of the stress response, balance the autonomic nervous system and in doing so, the body kind of finds its homeostasis.

Continued studies are required to expand knowledge in this field, however the current results are promising, taking into consideration the high prevalence rate of anxiety and depression where around 50% of individuals respond unfavourably to pharmaceutical antidepressant medication (Sharma et al., 2017; Connolly & Thase, 2011; Sinyor et al., 2010). While a fair amount of the literature on traditional, complementary and alternative medicines are behavioural measures, the study by Malviya et al. (2022) was consistent with an investigation around mental outcomes after the application of yoga, using Breathwork. This study used measurements such as neuroimaging, neuro-physiological changes and biomarkers to test the efficacy of Breathwork on the brain and body (Bhargav et al., 2020). Above, Mila speaks of this brain-body relationship and the benefits of Breathwork intervention. Consistent studies and research methodologies on different outcome measures are encouraging and continue to inspire higher confidence and reliability in the practice of Breathwork, the prevention of chronic disease and empowerment of the patient. The aim and ethos of integrative medicine according to Lebo is to:

Support the understanding of seeing the body, mind, spirit as one, one kind of system and works with creating the solid foundation of health by the most natural therapies and then conventional medicine being the last resort rather than the first resort. It also is based on the connection and the relationship between doctor and patient, which is more as partners rather than the doctor being kind of prescriptive.

It is important to note that while the literature on the efficacy of Breathwork as a TM in clinical settings is promising, limitations warrant consideration as to how applicable and feasible it will be to apply Breathwork in clinical settings at large. Focused studies on the integration of Breathwork in mainstream medical settings signify the next step in research towards social transformation. This sentiment is concurred by Unathi who believes: “One of the drawbacks is the lack of research”. The shift towards incorporating diverse healing practices in South Africa hinges on social change and the dissemination of IKS in institutional settings. As long as Biomedicine is viewed as the ultimate standard for healthcare, the collaboration between Biomedicine and TM will persist in an atmosphere of animosity (Moshabela et. al, 2016).

5.2 Epistemology of Ignorance

Michael Smithson, one of the first sociologists to investigate the epistemic phenomenon of ignorance, provides this overview of what ignorance may be: “Ignorance can be viewed as an absence or neglect of information, a failure to understand information, a mental state, a moral condition, a public problem, an economic commodity, a manufactured product, or an aspect of a culture” (Smithson, 2015, p. 385).

Like Smithson, Steyn (2012) impresses on the importance of ignorance-awareness, which is not simply a lack of still to be acquired knowledge, but rather an understanding of how this phenomenon may intricately inform our perceptions around social events and relations. Ignorance then, can be situated within a group or individual’s positionality and social ranking, highlighting that “Ignorance is actually constructed in social interaction for social purposes” (Steyn, 2012, p. 21). The epistemology of ignorance is therefore not only an absence or neglect of knowing but can be a deliberate choice not to know, choosing instead to turn a blind eye on matters of importance. Smithson (1985, p. 159) claims that ignorance plays a vital role in human relations, culture and within organisations and have a

“fundamental influence in human cognition, emotion, action, social relations and culture”.

Further, according to McHugh (nd, p. 1), epistemology of ignorance is also:

The study of not knowing or unknowing and the study of the generation of subjects that are ignorant. It is also the study of the refusal to be ignorant and the active reconstruction of one’s knowing. The study of the epistemology of ignorance has been an overtly political project in the academy, one that seeks to disrupt the structures of unknowing, reveal patterns of active ignorance and insert *Others* as knowers.

Recognising the integral connection between ignorance and knowledge is critical to this study. In that, ignorance needs to be investigated not merely as an absence of knowing but as an active social accomplishment relating to injustice (Steyn, 2012). Similarly, like knowledge, ignorance can be accessed through communicative practices, distributed across social platforms and nurtured mutually through activities (Steyn, 2012). Doing so can result in reframing ignorance, raising questions of social memory and addressing “How we have come to forget what was once known (Steyn, 2012, p. 10).

Reframing ignorance is important to understanding the role of IKS in healthcare in order to reclaim what was once a knowing. Feminist philosopher Nancy Tuana (2004) is influential in informing the links between dominance and ignorance where said knowledge is often constructed by those in positions of power to stay in power. The nuances and varying degrees of the epistemology of ignorance are beyond the scope of this study, however its overarching value foregrounds how it can be directed at social transformation while working towards “Deepening social justice at all levels of social organization,” and provide ‘The Others’ with a platform to openly and freely have a safe and just space in all social institutions” (Steyn, 2015, p. 387).

5.2.1 ‘It’s about people recognising differences’: Epistemic ignorance

For this study, participants navigating ignorances around alternative ways of approaching health was evident during their scope of practice. They discovered that conventional healthcare was not only limited in its offering but also within the field of practitioners. The theme of *Epistemic Ignorance* suggests a focus on the ways in which patients, healthcare practitioners, and the population at large may lack knowledge or awareness of alternative healthcare practices, and how this lack of knowledge impacts healthcare experiences and

outcomes. The practitioners involved in the study acknowledge that inadequate knowledge may stem from various sources, including insufficient exposure to alternative healthcare practices, cultural or societal biases, or the predominance of a western healthcare paradigm. The theme suggests that addressing epistemic ignorance is vital in order to provide patients with a range of healthcare options and to improve healthcare outcomes. In order to address epistemic ignorance in healthcare, this research explores ideas around:

- How patients and healthcare practitioners perceive and understand alternative healthcare practices
- What are the barriers to accessing or providing alternative healthcare options
- How healthcare providers can be trained or educated to incorporate alternative healthcare practices into their service
- The role cultural beliefs and societal attitudes play in shaping healthcare choices and access to alternative healthcare practices

Overall, the theme of epistemic ignorance highlights the importance of recognising and valuing the diversity of healthcare practices and IKS, and the need to address biases and gaps in knowledge in order to provide the best possible care for patients. Kajal, who is a social worker, reflected on how she felt compelled to leave her vocation as she struggled to come to terms with the ignorances surrounding how social work was practiced:

I was supposed to make them feel better by talking to them and I couldn't adapt my own head and my mind and my heart to the fact that I had to almost help them come to terms with their poverty, you know. So, I left social work for many years and I worked in the NGO sector.

Counselling people to talk about their feelings and then having them return home to their destitute realities, conjured up a sense of hopelessness for Kajal. Counselling tools such as talk therapy, which is practiced in South Africa, can potentially be a challenge to people who have been historically excluded or share different therapeutic belief systems such as those aligned to indigenous knowledge. This is largely because much of the research that informs clinical thinking is Euro-western where cultural and socio-economic backgrounds may differ to those that have been historically marginalised. Kajal, who considers herself to be historically marginalised, reflected on talk therapy as a western concept, “We grew up in families where you don't talk about these things”. Historically, conventional counselling like talk therapy in South Africa lacks integration of socio-cultural and religious beliefs. Mila

finds that, “The western medical model kind of has organised the body into systems, which is then part of a certain specialisation. And so, it's kind of silo-ed our approach. Whereas Breathwork is an amazing way to see the interconnectedness of everything”. For example, Beuster (1997) posits that mental disorders extend beyond the inter-and intra-psychic dimensions and are characterized by social relationships that are fractured and discordant, as opposed to being limited to abnormal behaviours.

Behaviours such as aggressiveness, selfishness, protectiveness that can disrupt organised social systems are deemed pathological according to conventional healthcare. This poses a problem when there is gap in knowledge or when epistemic ignorance prevails as Mila experiences, “I definitely don't think that there was enough understanding of the role of the traditional healer”. According to African philosophy, abnormal behaviours can arise when conflicts exist between family members, individuals, communities and ancestors. Traditional African cosmology⁴ assigns such behaviours to personalised and external forces that transcend western psychic dimensions (Beuster, 1997). Considering this philosophy, Lebo believes that “A more holistic approach to patient care is imperative”. Zak reflects on the importance of treating patients holistically but argues that unfortunately this modality of treating patients was not something she came across in her studies as a physiotherapist: “I don't think we were taught, any holistic approaches, I adapted this later on in life, post graduating”. Similarly, Mila feels that “When I studied, there wasn't enough of an understanding of how that all worked and the important role that it plays in communities”.

In African and Eastern cultures, the healing journey of mental disorders can be intuitive, non-verbal, experiential and even symbolic, such as breathing, meditating, dancing and chanting (Aideyan et al., 2020; Brulé, 2018; Buhrman, 1987). Biomedical approaches to healing involve diagnosis by an authority in the field and can result in a prescription of medication for symptomatic relief. Kajal established that:

What also was important is when I worked with this really poor community where language, English wasn't their first language for one, but they also were not very verbal in being able to explain themselves and that sort of thing. I found they didn't

⁴ African cosmology is the way Africans perceive, conceive and contemplate their universe; the lens through which they see reality, which affects their value systems and attitudinal orientations.

need it. Breathwork doesn't need a language. You can do Breathwork, whether you are someone educated or someone who has little education.

Further, Kajal believes that “Western models of practice are quite middle class, you have to have a certain level of education and language to say what you're feeling”. Language, when it comes to healthcare, is thus a vital consideration in health service. Fanon (2008) in *Black Skins, White Masks* (1952) explores the dynamics of language as a means of exploring the repercussions of colonialism and racism in society. Fanon argued that barriers in language have led to subjugation, feelings of dependency and ultimately inadequacy, this being one the many causes of structural oppression. One way in which language can contribute to ignorance is through the use of technical jargon and medical terminology that may not be accessible to patients whose first language is not English. This can create a barrier to effective communication between healthcare practitioners and patients, leading to misunderstandings, misdiagnosis, and ineffective treatment.

There has been a global shift in healthcare towards a patient-centred focus that recognises the value of autonomy in promoting practitioner-patient partnership decisions with an aim of improving healthcare outcomes (Van den Berg, 2016; Heidenreich, 2013). However, this undertaking can only be fully realised with effective communication between the patient and healthcare provider. In Kajal's position as a social worker she says, “This is why I said the issue about language, but even just the whole issue about talk therapy, that there are times when talk therapy doesn't work because people cannot verbalise what they are feeling or what they are going through”. With South Africa's multilingual population, language barriers between practitioner and patient can render healthcare services less than optimal. Healthcare consultations in South Africa are traditionally conducted in a patients' second or third language, proving to be a challenge. A study by Levin (2006) at a paediatric hospital in Cape Town found that only 6% of medical interviews with caregivers of young patients were in their first language. In this study, caregivers largely cited cultural and language barriers, as opposed to socioeconomic barricades as the predominate block to efficient healthcare outcomes (Levin, 2006; Van den Berg, 2016). Further, the Levin (2006) investigation found that patients navigated shame and blame when they struggled to communicate effectively with healthcare practitioners. This contrition highlights the inadequacies Fanon addresses in *Black Skins, White Masks* (1952). With South Africa having eleven official languages, more

research is required to ascertain the impact lingo-cultural barriers have on healthcare outcomes (Van den Berg, 2016).

Recognition of the need for effective communication between practitioner and patient inevitably strengthens rapport, however, with South Africa's lingo-cultural challenges, the constitutional right of every citizen to experience equitable healthcare, will remain limited. Lebo believes that "An integrated, outcome inspired, health and wellbeing ecosystem" is what's needed to aid South Africa's healthcare delivery. Doing so calls for an interdisciplinary collaboration between all healthcare service providers, practitioners and higher education institutions to find sustainable solutions to optimal healthcare outcomes. Starting with the recognition of socio-economic and cultural differences and how to bridge these differences.

5.2.2 'How would they view you? Would you be accepted?': Paradigm shift

Much of what passes as common knowledge or the *epistemic value of testimony* is acquired through society, where one is dependent on the suggestions of experts to reveal what is right or wrong with everything from our automobiles, to appliances, to our bodies (Longino, 2019). Should one not know much about something, that something is met with scepticism. Scepticism from peers was experienced by all participants when they started practicing within an integrated healthcare paradigm. Unathi shares that "In the psychological field, there was quite a bit scepticism", however years on she is finding that psychologists who initially frowned upon her holistic way of practicing are now using Breathwork in their own practices, "Particularly in trauma cases". Kajal found that with some of her clients and peers, "It doesn't fit within their religious orientation", and as a result she feels judgment around how she practices but ultimately believes it comes down to "A fear of the unknown". In healthcare, most of what we have come to know is dependent on previously acquired knowledge from caregivers, societies and learning institutions. From a clinical perspective, ignorance has always haunted medicine, in the diagnosis of disease and the constructions of what constitutes optimal health (Whooley & Barker, 2021). Medical ignorance reinforces structural inequalities in healthcare, and as such, scientific standards have to be viewed through a lens that acknowledges the sociology of the ignorance. For Lebo, he reflected:

I think probably the biggest challenge in the last 20 years has been, what would your peers think of you? What would other physicians or cardiologists or medical

professionals think of you if you integrated this into your practice? How would they view you? Would they view you as a quack? Would you be accepted?

This experience of medical ignorance centres around medical uncertainty. Medical sociologist Renée Fox dedicated her research career around the “Microcosmic inquiries into medical uncertainty” (1980, p. 4). Fox investigated how medical practitioners should be trained for awareness around uncertainty where they learn to navigate three bases of uncertainty, that which:

- a) results from incomplete or imperfect mastery of available knowledge
- b) that which stems from limitations of current knowledge
- c) that which originates from trying to distinguish between the two in a given situation (Fox, 1980, p. 208).

Ignorance is often omnipresent when considering what is known versus what is unknown. Whooley & Barker (2021) speak of a noticeable sort of medical ignorance, which are *known unknowns*, the gaps in the knowledge foundations which health practitioners must become cognisant of. Lebo had to rely on himself to make the mental transition, “I think once you create the paradigm shift in your own mind and see the value of a holistic approach to care for your own patients, then it reaches a certain point of where it really doesn't matter”. Some of the practitioners however are still struggling for recognition from their peers such as Mila, who says “I don't think there's enough of an understanding of how I work”. Or Zak who experiences that “There are very few practitioners, medical practitioners around me that would support Breathwork at the moment, you know, it's a whole load of education that has to happen. So, for example, my GP thinks I'm absolutely cracked”. In spite of this judgement, Zak remains hopeful that eventually her peers “Will come around, we're slowly educating them”. Through the lens of ignorance, it becomes possible to see how the laypersons and medical practitioners navigate ignorance as part of the power relations of medical knowledge (Whooley & Barker, 2021). Biomedicine places value on cause-effect laws, reliability of measurements and rational thinking. These assumptions in the sciences have largely influenced healthcare, prioritising one perspective over another. Lebo disagrees with this thinking, “You need a more holistic approach to patient management, rather than the standard way in which we were trained to look at the sign symptom complex, come to diagnosis, and issue a prescription”. Simply stated, to favour one viewpoint is to refute all other worldviews and other potentialities of healing. Integrative practitioners agree that biomedicine has

notoriously siloed the healthcare approach instead of embracing the interconnectedness of it all. Mila feels that:

Western medicine is really based on treating symptoms, you know, there's a formula, you make a diagnosis based on the symptoms, and there's a, you know, kind of formulaic response to that is a specific prescription based on what the diagnosis is.

Zak concurs:

I think typical traditional western medicine wants to implement a technique that has been backed up by a series of case studies, you know, it has to be evidence based. And unfortunately, particularly in physios and our careers, it has to be evidence based before it's deemed appropriate or adequate, and that doesn't leave a lot of room for, but what if it just works? There are many techniques that I would use as a physio that I don't have necessarily evidence-based things for it or articles to prove, but I know it works, and breathing being one of those things.

Take psychotherapy for example, where the language used is presumed to express a universal meaning across all cultures hereby minimising the effect that cultural norms have on meaning construction. Herein lies the potential to inaccurately diagnose someone whose first language is not English or who comes from a non-western culture as abnormal and dysfunctional (Yeh et al., 2004). Lebo argues the critical value in treating patients holistically for optimal healing and wellbeing, “For me, that neuro psycho immuno endocrinology access is absolutely crucial in terms of getting patients well or better”. Psycho-Neuro-Endocrine-Immunology (PNEI) is a science-based field that studies the association between bidirectional communications amongst the endocrine, immune and nervous system and the correlations of these connections with physical health. This PNEI approach represents a novel medical paradigm shift from a largely compartmentalised biomedical lens of health and disease to an integrated interdisciplinary method (Lotti & França, 2019). In a first of its kind systematic review study, *Traditional, Complementary and Alternative Medicine use in Sub-Saharan Africa* carried out by James et al., (2019), it was found that interdisciplinary medicine, such as TCAM, was prevalent across many countries including South Africa, Nigeria, Uganda and Ghana. The study concluded the necessity for all healthcare stakeholders to be cognisant of the critical role of TCAM in healthcare delivery.

Different approaches to health, such as TCAM, are popular in the USA too. According to a study carried out by *The National Centre for Complementary and Alternative Medicine* at the National Institute of Health, over 50% of Americans use TCAM. The study found that many of the participants surveyed did not communicate these TCAM treatments with their healthcare practitioners (AARP & National Centre for Complementary and Alternative Medicine, 2012). The neglect to share and communicate with biomedical practitioners suggests a greater understanding and an urgency of authentic partnership between practitioners and patients so as to better understand the patients' needs, thereby offering assisted guidance towards alternative treatment plans.

Western approaches to health and wellbeing have roots in modernism, placing emphasis on the laws of cause and effect, objective thinking and scientific measurement (Sue et al., 1998). In other words, this worldview favours one perspective while pathologising and negating alternative standpoints. The biomedical approach is distinctly linear when it comes to dynamics associated to human behaviours, viewed mostly as unidirectional, contrasting the more universal approach used by TM practitioners. TM practitioners apply healing frameworks that go beyond objectivity and deduction reasoning. These realms are subjectively characterised with an innate qualitative and circular understanding that the patient's health is impacted by multidimensions and not necessarily a single, symptomatic cause (Lee & Armstrong, 1995). Zak believes that through recognising and integrating TM, and acknowledging the epistemology of ignorance, healthcare delivery stands to provide a more inclusive holistic treatment, as she observes, "There's a lot of science that doesn't explain what is actually happening to a person, I don't think science meets everybody where they're at".

Evidence based medicine is straightforward in its understanding, it is essentially medicine practiced exclusively on the bases of data evidence. This ideology places clinical data in a hierarchy of reliability while resigning anecdotal evidence and mechanistic reasoning as less reliable (Sheridan & Julian, 2016). Starting out, Unathi shared that her studies were limited, "I don't think it took any things like cultural behaviour, social behaviour, traditional healing, into consideration at all". She expressed that an increasing in awareness of varying worldviews and exploring multiple concepts of therapeutic perspectives is a responsibility that health practitioners ought to consider given patient diversity. She says that as a psychologist, it was her study of *African psychology* that supported her to gain greater

understandings around human behaviour, particularly in diverse cultures found in South Africa. This speaks closely to the normative orders outlined in the CDL framework, of what/who gets privileged or disadvantaged. To unveil hegemonic practices, the field of Biomedicine must be willing to shift and open to interrogating all dimensions of healthcare and medicine, so as to foster an inclusive, relevant, patient-empowering future.

5.3 ‘Issue of decolonising and indigenising our curriculum has been high on the agenda’: Social Transformation

The pressing imperative globally is a need to shift the deep rooted, long standing, institutionalised, siloed education of health and tackle how medical schools disseminate knowledge. Current medical modules hardly address the legacy of colonialism in healthcare or how, for example, power inequalities and epistemic injustices have shaped healthcare practice, service and research thereof (Garba et al., 2021). To this point, a 2019 release by the South African Human Rights Commission (Pillay, 2019) on the status of mental health services revealed the current found:

- One in six South Africans suffer from anxiety, depression, or substance-use disorders
- 40% of South Africans with HIV suffer from a mental disorder
- 41% of pregnant women are depressed
- If motor vehicle crashes and crime are considered, about 60% of South Africans could be suffering from post-traumatic stress
- Only 27% of South Africans with severe mental disorders receive treatment

Healthcare in South Africa with its limited access to, as well as quality of, inclusive health services is critically urgent. Many of the practitioners in this research felt that Breathwork as a TM can significantly benefit marginalised communities. Mila believes that:

In a country that is so under resourced, the communities that have no access to food, that are living in abject poverty, that are living in circumstances where, you know, they just can't see their way out, okay. Breathwork provides them the opportunity to relate to their situation differently. May not solve a problem, but gives them the opportunity to relate to it in a different way, feeling like they have something that they're in charge of.

Unathi agrees that empowerment is crucial to cultivate from a young age to foster shifts around mental health:

I think if that you can empower a child when they are very young, and enable them to always feel safe within themselves, that you'll not only change their lives, but you'll change the generations, the absolute generations that come after them.

Aside from the medical benefits, Mila thinks that:

Breathwork is the greatest resource. It's cheap, it's free – not cheap, it's free. It's available, it's a powerful medicine that resides right within us and in our context, with so much intergenerational trauma, and ancestral trauma, you know, and I think so much of our societal problems and addiction and crime, they're just symptoms of trauma that has not been addressed.

Studies have found an association between structural inequalities and poor mental health (Khumalo, Temane & Wissing, 2012). For example, individuals living in rural areas with lower social economic status who are uneducated and unemployed showed lower psychological levels of wellbeing (Pillay, 2019). Similarly, a report by Jack et al. (2014) noted that high levels of anxiety and trauma in South Africa were due to, amongst other challenges, inequalities, racial discrimination, language barriers, socio-economic status, interpersonal violence and stigma. In colonised spaces such as South Africa, mental health changes are often symptomatic of current as well as generational trauma.

Unathi and Kajal who both work and teach Breathwork tools in marginalised communities believe that Breathwork has much to offer. Unathi says that “Breathwork can be used across the board in communities, it can be used in all ages, it’s not classist, it's not exclusive”. Kajal experiences that “Breathwork is effective because it is not in the nature of many communities to do talk therapy, especially when it comes to mental health challenges, so Breathwork is almost instantaneous, it relaxes you and calms you”. More so, Kajal states that where she works:

In really poor communities where English wasn't their first language for one, but they also were not very verbal in being able to explain themselves and that sort of thing, I found they didn't need to because Breathwork doesn't need a language.

Studies around the correlation between mental health and structural inequality highlight the very contextual complexities within which mental health and healthcare are to be considered. Further, concentrating purely on treatment of mental health issues without equal attention on

prevention of disease will not adequately address the crises at hand. Kajal says that Breathwork, in her experience, “Serves as a preventative measure”. Preventative measure practices are imperative to long term health, says Lebo, “Primordial prevention is generally people who are well, and Breathwork becomes an important tool to keep you well”.

A study by Bantjes, Swartz and Niewoudt (2017) on mental health in prisons noted that while many describe South Africa as a post-apartheid country, the reality is far from a society of equality and inclusivity, suggesting rather that:

Post-apartheid South Africa is a context in which there continue(s) to be endemic social problems that create conditions of oppression and violence (and) it is incumbent on South African mental health professionals to begin to formulate new ways of engagement in activism in the service of improved mental health. This activism and advocacy are arguably part of good mental health practice in all contexts. (p. 7)

Due to the ongoing systemic racism and a lack of adequate resources and infrastructure to address the healthcare needs of all South Africans, particularly those from marginalised communities, has resulted in unequal access to quality healthcare. This has led to persistent health disparities and inequities. To address these ongoing issues, it is important for the healthcare systems to decolonise and indigenise by incorporating a more culturally sensitive and inclusive approach to healthcare and addressing the root causes of health disparities through targeted policies and resources. It is no secret that at the institutional level, conventional medical curriculums place heavy emphasis on biomedicine, often ignoring the contributions and perspectives of other cultures and traditional medicine practices. This has only resulted in a narrow understanding of health and illness, leading to cultural insensitivity and a lack of understanding of the beliefs and needs of diverse populations. Further, it entrenches a lack of trust and a breakdown in the practitioner-patient relationship, hindering effective medical treatment.

Lebo found that the transition in his practice from purely biomedical to an integrative practice was patient driven due to patients seeking alternative methods to health and wellbeing. He said, “For me, that paradigm shift was largely driven by my patients, the patients actually requested an alternative or a more different approach to their wellbeing”. Increasingly, more individuals are shifting due to a growing recognition of and frustrations in

the limitations of biomedicine, which as Lebo notes is limited by symptom complex management and not addressing the underlying cause of disease. Integrative medicine, on the other hand, seeks to address the root cause of the problem by identifying and addressing lifestyle, diet, and environmental factors that may be contributing to the issue. Patients want to be considered as a whole person, as a result, the integrative healthcare approach is becoming increasingly popular as “It doesn't compartmentalise things”, says Unathi. Mila believes the challenge with Biomedicine is that the “Western medical model has organised the body into systems, which is then part of a certain specialisation and so it's kind of siloed our approach, whereas Breathwork is an amazing way to see the interconnectedness of everything”.

To address the healthcare crisis shifting from an exclusive paradigm to an inclusive one, Kajal stresses the importance of education and acceptance around traditional, complementary and alternative medicine (TCAM). She notes that “There is a big challenge in that the councils and many health professions, haven't seen or recognised that yet as legitimate modalities, and that is the problem we face”. Lebo reflected on his limited training approach around treating patients holistically:

Our sum total of lectures on nutrition were two, okay, vitamin A to Z, yet we are expected to give people lifestyle advice around their chronic condition, and many doctors are either self-taught or figure out what they need to say to patients, but we were not trained to deliver that type of approach.

Similarly, Mila shared that her training was also limited in that it failed to prepare her to treat communities who, for example, also obtained healthcare guidance from traditional healers, “I definitely don't think that there was enough understanding of the role of the traditional healer when I studied, there wasn't enough of an understanding of how that all worked and the important role that it plays in communities”. Kajal attributes this academic deficit to her discouragement around healthcare services and subsequently leaving her job:

My training as a social worker in no ways did it prepare me to work with the kind of communities that I worked with, in no way. It was basically white, middle class western approaches that we were taught and I was taught that in my undergrad, my Honours, my Masters. So, it didn't prepare me. And in fact, that is why I was so despondent with the profession and I left, because, for me, it didn't address the issues that were impacting the majority of people in our country.

Kajal, who lectures at a South African university, shared the dichotomy she finds herself in where purposeful advancement is being made in her faculty, “Decolonising and indigenising our curriculum has been high on the agenda, we centre Africa in our work and how we teach, and in social work, we are introducing complementary and alternative practice”. However, on the other hand, epistemic ignorance remains a concern: “We have got a big challenge in that the council and many health professions are aligned to certain councils, ours is the Social Work Council. They haven't seen or recognised that yet as legitimate modalities, and that is the problem we face”.

How then do universities endeavour to shift towards an inclusive system of teaching? Primarily, it is incumbent on institutions to address the epistemologies of ignorance by training decolonisation to genuinely understand the complicated frameworks and historical inequities in healthcare so as to better serve the diverse communities they endeavour to impact. The proposal of Poka Laenui, and Chilisa (2012) suggests implementation of five phases towards decolonisation: *rediscovery and recovery; mourning; dreaming; commitment and action*. Their work highlights the importance of addressing the legacy of colonialism and promoting indigenous perspectives and practices in order to achieve true decolonisation. The five phases towards decolonisation offer a framework for understanding the process of decolonisation and its cultural, psychological, and political implications.

- Rediscovery and recovery are an important foundational process, setting the tone for all other phases and the intersections thereof. This is the space within which colonised peoples rediscover and recover a sense of belonging, the nuances of their own identity, history, culture and language.
- Mourning refers to the process of lamenting the prolonged assault on the world's colonised people and its injustices. This phase is intricately linked to healing which leads to dreaming.
- Dreaming is the most critical phase of decolonisation. This is when colonised people explore their cultures and histories: where futures aspirations grow and worldviews are reclaimed. This is a phase of reimagining and hope for alternative possibilities, where indigenous knowledge systems are accredited – in this case, an inclusive curriculum.

- Commitment is when academics/students become agents of change demonstrating consciousness and commitment to hear other people's stories and include these voices in knowledge production.
- Action is the phase of fruition, where dreams and commitments transmute into the necessary strategies for transformational change. It is here where institutions transform curriculums for they serve as a dual microcosm of and movement for a broader societal shift.

The call for Africanisation of universities and detachment from colonial chronicles has come to a head with calls for the curriculum to dismantle the western/eurocentric epistemologies as the all-knowing narrative and for the resuscitation of IKS (Mahabeer, 2018; Santos, 2014). Nearly three decades into democracy, Mbembe noted in 2015 that we had touched a 'negative moment', referring to the 2015 Rhodes Must Fall student protests: a moment when new hostilities arise while others stay unsettled; a moment when old contestations and unresolved colonial and apartheid legacies of the past are perpetuated in universities and through the curriculum. The reality is that since 1994, universities have done very little to open up to alternative knowledge or the exploration of new knowledge production (Heleta, 2016). Scholars believe that in spite of universities having frameworks and policies in place for transformation and equity, epistemological traditions have remained somewhat stagnant (Mahabeer, 2018; Heleta, 2016; Santos, 2014; Mbembe, 2015). Universities persist in functioning as colonial outposts that maintain and reproduce hegemonic identities, rather than working towards their eradication (McKaiser, 2016).

To change this trajectory, universities and government policy ought to not only endeavour, but implement the development of strong foundations of cultural safety, self-awareness, and cultural humility within all spaces impacting healthcare; from education to equitable licensing of all TCAM practitioners. Lebo suggests that "Change needs to start at university level around engaging with departments of medicine or family medicine at the various universities and saying, 'Well, look, there is a different approach called functional medicine',". The formation of clear policies, procedures, and protocols for decolonisation, including the recognition of IKS and the restoration of its intellectual property, is imperative. Importantly, this involves genuinely engaging in ongoing dialogue and collaboration with indigenous communities and IKS to ensure that the process of decolonisation is grounded in the perspectives and needs of the othered. Finally, it is critical to monitor and evaluate progress that seeks to continuously adapt and refine the decolonisation framework to ensure

its effectiveness and relevance. These undertakings towards decolonisation offer a framework for understanding the process of decolonisation and its cultural and political implications. Reflections by the participants emphasise the crucial necessity that belies institutions to decolonise and indigenise the curriculum by incorporating a diverse range of perspectives and practices; and engaging with the communities on how better to enhance the practitioner-patient partnerships. This can aid to create a more culturally sensitive and inclusive approach to healthcare, and improve the quality of medical treatment for all. Through such efforts, medical practitioners can attain a more profound comprehension of their patients' needs, thereby enhancing their capacity to provide adequate care and contributing to the establishment of a more equitable and efficacious healthcare system.

The CDL framework proposes a persistent state of reflexivity on how one's prejudices reside in the collective framing of social norms (Steyn, 2015). The idea is to constantly examine and question one's own role and behaviour within groups or organisations at large, and to learn about our own participation in the formation of society. The goal is to gain a deeper understanding of how these social formations impact our subjectivities. This process of critical reflection can aid in understanding our own participation in these processes and gain insights into how these perceptions contribute to social inequalities. For example, how the emotion of shame is used to regulate and control bodies, particularly those that are marginalised or oppressed, such as in the policing of gender and sexual norms, or in the case of this study, it would be the peer-judgment practitioners navigate because they have chosen to pursue a path of medicine deemed to be *alternative* to the mainstream.

Chapter 6: Conclusions and Recommendations

The strength of the people of the First Nations to control the content of the school curriculum is enhanced by their ability and willingness to put into writing the stories of their ancestors. (Lafond, 1991)

Historically, the relationship between biomedicine and TM has been characterized by tension and strain, with the biomedical field often expressing criticism that TCAM lacks scientific knowledge. This conflict has impeded efforts to establish successful collaborations between the two disciplines, perpetuating and reinforcing the dichotomy between them (Moshabela et al., 2016; Wreford, 2005). Traditional health practitioners struggle to comprehend the lack of acknowledgement demonstrated by biomedical practitioners regarding the crucial role that IKS play in the healing of a significant proportion of communities (Flint & Payne, 2013; Zimba & Tanga, 2014; Moshabela et al., 2016). This dichotomy often creates a dilemma for patients who feel torn between the two healthcare systems and are hesitant to disclose to their biomedical practitioners their consultations with traditional, complementary, or alternative practitioners due to fears of being judged. This conflict between the two healthcare systems can result in a lack of transparency in patient care (Moshabela et al., 2016). The conflicting positions of practitioners create a challenge for achieving effective transformation in healthcare. The establishment of trust and open communication is essential for building successful interpersonal relationships between healthcare practitioners and patients (Tasaki et al., 2002). Therefore, in order to achieve successful social transformation in healthcare, it is imperative that both parties strive for a mutual, respectful, equal, and empathetic understanding of one another.

Biomedicine has undoubtedly played a significant role in advancing modern medicine, leading to numerous breakthroughs in disease treatment and prevention. Its importance in contemporary healthcare cannot be denied. However, it is equally crucial for healthcare to acknowledge the role that TM can play in providing comprehensive care to patients. The integration of a pluralistic offering can facilitate greater collaboration between practitioners, bridging the gap between different healthcare systems and promoting a more patient-centred approach to care. This research report aimed to emphasise the significance of liberating healthcare systems from the lingering effects of colonialism. In colonial societies like South Africa, TM was repressed in favour of Euro-western medical practices, resulting in the

marginalisation and suppression of IKS. This paper contends that the absence of historical evidence of the efficacy of TM can be attributed to systemic disparities in knowledge dissemination and the utilisation of exclusive research methodologies in academia.

More so is the consideration that higher education has been turned into a commodity “bought and sold by standard units” (Mbembe, 2015). While the concept of statistics and measurements may not entirely shift within university settings, we must, according to Mbembe (2015), “Create alternative systems of management because the current ones, dominated by statistical reason and the mania for assessment, are deterring students and teachers from a free pursuit of knowledge”. One of the approaches towards a universal transformational shift would be to openly and credibly incorporate traditional, complementary and alternative medicines, such as Breathwork, into mainstream healthcare. Furthermore, and critically would be to acknowledge the importance of IKS and make credible this knowledge source in higher education settings, trainings, and policy frameworks. The merging of varying worldviews can only be successfully executed if the majority of the population is prioritised over and above power structures. For successful transformation, medical students are required to be exposed to pluralistic types of medicine in an equal manner as they are to biomedicine.

Medical courses should be enhanced with training on the nuances of health equity and cultural sensitivity. Courses should explore the critical role of rapport, building partnerships with patients that are grounded in open, empathic, sustainable, ethical and inclusive approaches. Scholars should be prompted to engage in critical self-reflection regarding their motivation and function in healthcare provision, persistently examining the ways in which their perspectives influence the global healthcare exchange. Universities must recruit personnel who are passionate about developing equity, committed to dismantling power dynamics, and proponents of IKS who are dedicated to alternative research methodologies based on contextual understandings. In conclusion, universities have a responsibility to ensure that scholars and faculty prioritize equity within the institution. Attending to individual and collective consciousness is crucial in expanding healthcare services positively and promoting an inclusive, holistic, and integrative approach to health and healing. Although decolonising healthcare will not transpire instantaneously, the moment for action is opportune, and it is time to move beyond discourse towards tangible measures.

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Annexure A: Participant Information Sheet



Participant Information Sheet

Dear Sir / Madam,

My name is Zuraida Jardine-Lindberg, and I am a Masters student in Critical Diversity Studies at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project. I am exploring Decolonizing health and wellbeing using breathwork therapy as a traditional and complimentary medicine, under the supervision of Dr Haley McEwen.

The aim of this research project is to understand the role of colonial hegemony and epistemology concerning healthcare in South Africa. The study will also investigate the impact of academic institutions on how health is perceived, and the depth of access to indigenous, complementary and alternative methods of knowledge that is afforded to healthcare scholars in preparation for their careers that will inevitably involve working with diverse population.

As part of this project, I would like to invite you to take part in an interview. I am interested in investigating the roles of licensed healthcare practitioners who use the Western biomedical model of healthcare in tandem with traditional methods (TM) and/or Complementary and Alternative methods (CAM) such as Breathwork Therapy, to heal clients.

This activity will involve an online interview and will take no more than ninety minutes. With your permission, I would also like to record the interview using a digital device. There will be no personal costs to you if you participate in this project, and you will not receive any direct benefits from participation. There are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. This interview will be completely confidential and the information you share to me will be held securely and not disclosed to anyone else. I will be using a pseudonym to represent your participation in my final research report. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. The data collected from this research project will be stored in a password protected computer. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,
Zuraida Jardine-Lindberg

Researcher:
Zuraida Jardine-Lindberg, 1240743@students.wits.ac.za 0833035419

Supervisor:
Dr Haley McEwen, Haley.McEwen@wits.ac.za 011 717 4418

Appendix B: Consent Form



DECOLONISING HEALTHCARE: BREATHWORK AS A TRADITIONAL AND COMPLEMENTARY MEDICINE

Name of researcher: Zuraida Jardine-Lindberg

I, ..., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous YES NO

I agree that the researcher may use anonymous quotes in her research report YES NO

I agree that the interview may be audio recorded YES NO

I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained. YES NO

I agree that I do not have to answer any questions I don't feel comfortable with and can withdraw my participation at any stage. YES NO

..... (signature)
..... (name of participant)
..... (date)

..... (signature)
..... (name of person seeking consent)
..... (date)

Appendix C: Interview Schedule

Open-ended questions

Please share your background, your training and how long you have been practicing?

How did Breathwork come to your attention and why did this modality resonate with you?

Why did you start prescribing Breathwork to your patients?

What are the benefits and/or the drawbacks of Breathwork compared to the Western biomedical model?

Can you share patient cases where significant impacts were seen from Breathwork?

What are the differences your patients are experiencing, being treated in a holistic manner?

How did your academic training prepare you in treating South Africa's diverse population?

What are some of the challenges you face in your medical field with being a practitioner that practices from a pluralistic medical paradigm?

How can Breathwork aid South Africa's most significant healthcare challenges?

What is your vision for South Africa's healthcare system?

Appendix D: Ethical Clearance Certificate



SCHOOL OF SOCIAL SCIENCES ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: DIV200831

PROJECT TITLE

Decolonising Health and Wellbeing; Breathwork Therapy as a Traditional and Complimentary Therapy

INVESTIGATOR

Zuraida Jardine-Lindberg

SCHOOL/DEPARTMENT OF INVESTIGATOR

Centre for Diversity Studies

DATE CONSIDERED

19 February 2021

DECISION OF THE COMMITTEE

Approved Unconditionally

RISK LEVEL

Minimal RISK

EXPIRY DATE

27 February 2024

ISSUE DATE OF CERTIFICATE

28 February 2021

CHAIRPERSON


(DR C. Tagwirei)

cc: Supervisor: Dr. Haley McEwen

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.



Signature

Date

28 / 02 / 21

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES