UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

Research Project

Submitted in partial fulfillment of the requirements for

the Degree of Masters of Arts in Psychological Research (PSYC7022)

in the Department of Psychology, School of Human and Community Development, Faculty of Humanities, at the University of the Witwatersrand, Johannesburg.

The discourses of Western and African medicine in South Africa.

By

Hubela Betty Nkogatse

Student Number: 2199540

Supervised by Dr Daniella Rafaely

Submit on: 17 June 2025

Word Count: 28096

Acknowledgments

First and foremost, I thank God for the opportunity, the wisdom, and the grace that carried me through this journey.

To the mothers who have endured the heartbreak of losing their babies, may you find peace and comfort in knowing that you did everything possible to save your little angels. My deepest sympathies are with you.

To my supervisor, Dr. Rafealy, thank you for your steadfast support and guidance throughout this process.

This accomplishment would not have been possible without my mother's love, encouragement, and understanding. Thank you for always listening to me, and allowing me to focus on being both a student and a child without difficulty. Your financial support ensured I never lacked, and your care for my son gave me the peace of mind to focus on my studies. Thank you for loving him deeply—it made this journey much easier.

To my son, I thank God for the gift of you. You have been my greatest source of motivation—Mama did this for us.

To my tribe, thank you for your understanding and unwavering support. And to Rorisang Dikotope, Katobatoba Nkogatse, and Thuledi Nkogatse thank you for always showing up for me when I needed it most.

Finally, I dedicate this thesis to everyone who has been part of my journey. Your contributions, whether big or small, have brought me to this point, and I am forever grateful. May this achievement serve as a reminder that with faith, support, and determination, anything is possible.

Masters in Psychological Research – Research Paper Declaration

Declaration

I, Hubela Betty Nkogatse, know and accept that plagiarism (i.e., using another's work and pretending it is one's own) is wrong. Consequently, I declare that:

- The research is my own work.
- I understand what plagiarism is, and the importance of clearly and appropriately acknowledging my sources.
- I understand that questions about plagiarism can arise in any piece of work I submit, regardless of whether that work is to be formally assessed or not.
- I understand that a proper paraphrase or summary of ideas/ content from a particular source should be written in my own words with my own sentence structure and be accompanied by an appropriate reference.
- I have correctly acknowledged all direct quotations and paraphrased ideas/ content by way of appropriate, APA-style in-text references.
- I have provided a complete, alphabetized reference list, as required by the APA method of referencing.
- I understand that anti-plagiarism software (e.g., Turnitin) is a useful resource, but that such software does not provide definitive proof that a document is free of plagiarism.
- I have not allowed and will not allow anyone to copy my work with the intention of passing it off as his or her own work.
- I am aware of and familiar with the University of the Witwatersrand's policy on plagiarism.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work, or that I failed to acknowledge the source of the ideas or words in my writing.

Signed: 

Ethics number: MAPSYC/23/09

Date: 2024-12-17

The discourses of Western and African medicine in South Africa

Abstract

Child mortality remains prevalent primarily in developing countries (Madewell et al., 2022), where guardians often seek medical help to save their children from life-threatening illnesses. This study investigates the medical discourses surrounding child deaths in South Africa, focusing on how these discourses shape, reproduce, resist, and contest broader narratives related to biomedical and Indigenous health practices. The research aimed to explore how both biomedical and Indigenous health practitioners construct the causes of child mortality and their understanding of treatments for childhood illnesses.

The study utilized a qualitative research design, drawing on semi-structured interviews with six medical practitioners. The data were analyzed using Foucauldian and Critical Discourse Analysis elements to deepen the insights. Parker's (1992) discourse analysis framework was employed, with steps 1 to 12 guiding the text analysis and steps 13 to 20 focusing on the discourse analysis.

Key findings reveal that all practitioners engage in similar practices, highlighting a shared concern across different medical approaches. However, there are also notable differences in how these practices are carried out. The findings underscore how constructions of responsibility for children and discourses on childhood are reinforced through careful analysis of these practices.

Contents

Chapter 1: Introduction

1.1 Problem statement

The present research study explores the discursive construction of child mortality in South Africa. By examining discourses of health practices described by South African healthcare practitioners, the study intends to contribute to the current literature on childhood, health, and medicine in the global South. In South Africa, the two main ways of practicing medicine are using the biomedical approach and the Indigenous approach (Edward Shizha, 2012). Currently, there is tension between these two approaches in South African society where practitioners of each approach may view the other as irresponsible or causing harm (Ashforth, 2002). This tension results from two competing orientations to medical practice that are rooted in South Africa's history.

South Africa has inherited the tradition of two healthcare systems and it also presently has a high child mortality rate. The research attempts to look at the broader landscape of childhood by looking at how people specifically health practitioners talk about their treatment practices. Investigating how these two approaches discursively contest and negotiate the topic of child mortality may help to understand how the health system in South Africa, operates how it manages child illnesses, and how it intersects with the phenomenon of high child mortality.

1.2 Rationale

Historically Africa and other continents have at some point, or another been colonized by the Europeans. With colonization came the prohibition of using Indigenous medicine (which was the way Africans and other Indigenous people treated their ill) (Kayne, 2010). This resulted in tensions that are evident between Western medicine and African practitioners. Colonial governments introduced the Western allopathic system, which is modern medicine that is made in labs by mixing different types of chemicals to produce medicines as a replacement for African medicinal practices. As a result, Africans sidelined African traditional medicine and healers, and their role in society has been downplayed since (Richter, 2003).

Currently, there is a between these two approaches in South African society where practitioners of each often view the other as irresponsible or causing harm(Ashforth, 2002). Child mortality is a prevalent problem (*Child Mortality - UNICEF DATA*, 2023), and investigating how these two

approaches discursively contest and negotiate the topic of child mortality may help to understand how South Africa's inherited history has shaped the health landscape into two distinct and often contradictory systems that reflect broader cultural, racial, and ideological divisions: Indigenous knowledge systems and scientific biomedical systems. These two knowledge frameworks coexist but are frequently tense, embodying the duality within South Africa's healthcare structure. Child mortality remains a pervasive issue, with alarmingly high rates (Rahman et al., 2022). This makes South Africa a compelling context for examining how childhood and childhood illnesses are understood, managed, and treated within these two healthcare systems.

The childhood mortality rate in South Africa is high (WHO, 2022) and that makes it a useful site for exploring discourses of childhood and medicine. Although the number of deaths has reduced, there is no significant reduction, and this study thus aims to try to persuade critical thinking of how child mortality is caught at the intersection of language, history, and medicine. The study will contribute to literature that focuses on decolonizing aspects of South African life. Health and medicine are one of the cornerstones of a society and understanding the discursive constructions of medicine concerning child mortality in South Africa will help in furthering the opportunities for decolonization.

1.3 Aims and Objectives

The present research study explores the discursive construction of child mortality in South Africa. By examining discourses of health practices described by South African healthcare practitioners, this study seeks to understand how health practitioners define child mortality, construct causes of child mortality and define what counts as preventative treatment. Lastly, the research seeks to uncover how medical language reproduces or resists larger discourses on Africa and the West. Therefore, the goals of the study are to investigate how medical practitioners construct childhood death in South Africa and how these constructions are part of larger discourses of biomedical, Indigenous, and other forms of medicine practiced in South Africa.

This study seeks to explain how child mortality is discursively constructed within the Indigenous and biomedical healthcare frameworks of South Africa. By analyzing how practitioners of biomedical and Indigenous medicine discuss and contest the causes, treatments, and definitions of childhood death, the research aims to provide a nuanced understanding of the tensions and intersections between these systems. This work contributes to critical discourses on decolonization

by foregrounding how historical, cultural, and linguistic dimensions shape the medical landscape in South Africa.

1.4 Overview

This report is organized into seven chapters, accompanied by references and appendices. Chapter 1 introduces the study, detailing the problem statement, aims, objectives, and rationale. Chapter 2 presents a literature review with seven sections: the first explores the definition and evolution of modern medicine, its historical development through colonialism and apartheid, its current state, and a critique of its capitalist nature; the second covers the history of childhood; the third discusses and critiques the Sustainable Development Goals; the fourth examines the causes of child mortality; the fifth focuses on treating childhood illnesses; and the sixth addresses responsibility for sick children, including the roles of the state, parents, and environment. Chapter 3 outlines the methodology, the chapter also discusses ethical considerations. Chapter 4 analyzes the study results, identifying the main and sub-themes. Chapter 5 reviews the results and provides recommendations, and Chapter 6 concludes the report. The report is completed with references and appendices that support the study's conceptualization.

Chapter 2: Literature Review

Section1: Medicine

2.1.1 Definitions of medicine

Every human society has a worldview for explaining and treating life events and milestones, some of which may be influenced by religious or superstitious beliefs (Kajiru & Nyimbi, 2020). This worldview encompasses approaches to dealing with illness and seeking medical intervention, where cultural beliefs and practices often dictate how people perceive sickness and the methods they use for treatment and healing (Helman, 2007). Distelzweig (2015) views medicine as the science of healing, encompassing the treatment and prevention of diseases, diagnostic practices, and health promotion. It further states that it comprises various healthcare techniques developed to maintain and restore health through disease diagnosis, treatment, and prevention.

Medicines can be classified into two main categories: biomedical medicine, which includes public and private healthcare systems, and Indigenous healthcare systems (Mji, 2019). In South Africa, medicine is practiced within a diverse healthcare landscape that integrates modern Western medicine with Traditional healing practices. These traditional practices are divided into three specialty grades: divination, spiritualism, and herbalism, which may sometimes overlap (Ansari, 2021).

The government funds the public healthcare system in South Africa. Due to the high unemployment rate (currently sitting at 32.9%) and widespread poverty (Africa, 2024), many people are dependent on the government to provide essential services such as access to healthcare (Rensburg, 2021). This reliance includes unemployed immigrants living in South Africa, who also depend on public healthcare services for their medical needs (Brown, 1987). However, despite government funding for hospitals, the demand is overpowering the supply, resulting in suboptimal service quality and delivery (Maphumulo & Bhengu, 2019). This strained public healthcare system directly impacts efforts to reduce child mortality, as limited resources and high patient loads challenge effective care, especially in communities navigating both biomedical and Indigenous health practices.

On the other hand, the private sector primarily services individuals with medical insurance (medical aid in South Africa). Private healthcare services are generally considered more advanced

and of higher quality, as they are not accessible to everyone. According to Ellis (2024), only 17.4% of South Africa's population (approximately 9.5 million people) is covered by a South African medical scheme, leaving more than 44 million without access to private medical care. This disparity between public and private healthcare has led some people to seek alternative healthcare options.

Western medicine, also known as modern medicine, scientific medicine, allopathic medicine, or biomedicine, is primarily employed for treating physical and mental illnesses (Wiseman, 2004). It is grounded in scientific, technological, and clinical analytical methods that originated in North America and Europe, evolving alongside advancements in science and technology (Richter, 2003). While its origins are often traced to the above mentioned regions, Western medicine also has roots and influences from medical knowledge and practices from the Global South, reflecting a more complex and interconnected history.

At its core, modern medicine relies on biomedicine to deliver healthcare services across hospitals, clinics, and other medical facilities (Medicine (US), 2008). In the South African context, Western medicine significantly influences healthcare practices. This influence is evident in various hospital settings, including specialized children's hospitals. Moreover, there has been a surge in advanced healthcare technologies, such as medical devices, algorithms, and artificial intelligence, being integrated into hospital operations (Nene & Hewitt, 2023).

2.1.2 History of medicine

The emergence of modern medicine in South Africa has a fascinating history. During the colonial era, European powers introduced Western medical practices to their colonies, including South Africa (Guma & Mokgoatšana, 2020). Christian missionaries established hospitals and clinics, blending Western medical knowledge with religious teachings. In the late 19th century, medical schools were founded, providing formal training for local doctors. Advancements in science and technology, such as X-rays and antibiotics, transformed healthcare practices (Azevedo, 2017b). Indigenous medical practitioners were marginalized in favor of biomedical practices, which align with capitalist and neoliberal frameworks and are promoted as the "mainstream" approach (Poirier et al., 2022). Today, however, South Africa's healthcare system blends evidence-based medicine, modern technology, and Indigenous knowledge, creating a dynamic and diverse landscape (Khanyile et al., 2023).

The history of medicine has seen significant advancements in the understanding and treatment of sicknesses and diseases. The foundation of modern medicine was laid in the 19th century with the establishment of germ theory, revolutionizing the understanding of infectious diseases (Carlsson & Råberg, 2024). Following World War II, medicine continued to advance, and medical imaging technologies were introduced. X-ray technology paved the way, followed by other imaging techniques such as ultrasound, CT scans, and MRI, further enhancing the ability to diagnose and treat various medical conditions (Hussain et al., 2022).

Before the introduction of biomedical interventions of treatment, Africans based their healing and treatment of their sick on the performance of rituals and Indigenous medicinal interventions. These practices were widely accepted as a respected form of treatment (Kayne, 2010). The Indigenous healthcare system relies significantly on a practitioner's ability to provide medical care. The diagnostic method seeks answers to questions such as who or what caused the illness and why it currently affects this person, in addition to exploring immediate causes. The process involves observation, patient self-diagnosis, and divination (Duvenhage & Louw, 2016). Depending on the origin of the sickness, the comprehensive treatment includes curative, protective, and preventive components and can be either natural, ritualistic, or both. Treatment includes among other things, ritual sacrifice to appease the ancestors, ritual and magical strengthening of people and possessions, steaming, and purification (Pretorious, 1999). Traditional medicine formulas are prepared from various natural substances such as the carcasses of animals, minerals, and plants (Pretorious, 1999). Although indigenous medicine incorporates rituals and spiritual practices, this does not imply an absence of an empirical evidence base, as many traditional remedies have been shown to possess therapeutic efficacy through generations of practical use and ongoing research

With the introduction of colonization by the Europeans, such practices and actions were either eradicated or marginalized to introduce a new way of living that promoted the use of biomedical medicinal practices (Abdullahi, 2011). The colonial government introduced the Western allopathic system, which includes modern medicine produced in laboratories using chemical formulae (Oseni & Shannon, 2020). Colonizers introduced Western medicine to manage public health issues affecting both colonizers and the local population, addressing threats like malaria, smallpox, and cholera (Bump & Aniebo, 2022). Healthy colonies were more productive, supporting economic exploitation. Colonial powers justified their presence with a "civilizing mission," presenting

Western medicine as a superior alternative to Indigenous practices. It also ensured the health of soldiers and administrators, reinforcing colonial control and cultural dominance while undermining Indigenous medical systems (Bruhn & Gallego, 2012).

The imposition of Western medicine was part of colonial cultural imperialism, enforcing colonial norms and devaluing Indigenous medical practices. It acted as biopolitical control to ensure the productivity and compliance of colonial subjects, serving the interests of colonial administrations (Hussain et al., 2022). Hospitals, clinics, and medical schools primarily benefited colonial authorities and settlers. Western medicine often included notions of scientific racism, aiming to "improve" or "civilize" Indigenous populations (Wispelwey et al., 2023). This has strengthened the view and belief in scientific methods and techniques, resulting in the sidelining of Indigenous practices (Richter, 2003). The Indigenous people resisted its imposition, selectively adapting and blending it with traditional practices.

The marginalization of African practices is evidenced in insurance policies such as medical aids that are put in place to accommodate people seeking biomedical treatment and not Indigenous treatment (Omotoso & Koch, 2017). This practice and perception, that ailments treated using Indigenous interventions are unacceptable compared to those treated using biomedical interventions in South Africa, has caused tensions among believers of both Indigenous and biomedical practices (Ramavhoya & Nesengani, 2022). The acceptance of doctors' notes for absences due to illness by a biomedical practitioner is an example of such tensions in a workplace setting (Crawford & Lipsedge, 2004). However, currently, some workplaces do accept certificates from Indigenous healers, especially those registered with the Health Professions Council of South Africa (HPCSA), though there remain places that do not accept them, fueling ongoing tensions.

After colonization and the introduction of biomedical medicine in Africa, significant amounts of funding over the years have been given to institutions to advance research focused on the biomedical sector (Peprah & Wonkam, 2013). Efforts to improve the quality of medicinal quality and tools used in biomedicine have seen this sector gain favor with both private and public investors and the South African population at large. This has resulted in the production of large amounts of medicines to treat a variety of ailments and, since this kind of effort has been made on an ongoing basis, biomedical medicine is viewed as top of mind and perceived to have more valuable abilities in healing and treating the sick (The H3Africa Consortium et al., 2014).

Contrary to Western medicine, Indigenous medicines are still in the process of establishing themselves within the South African research community. Minimal effort or funding by either the government or the private sector has been directed to the pursuit of understanding the healing and treatment processes associated with this approach. Questions remain about their development and the specific mixtures used to create potions suitable for human consumption (Mokgobi, 2015). The use of Indigenous medicinal practices is not readily accepted by the biomedical and scientific community, and this has continued to place a stigma on Indigenous practitioners to prove themselves and defend their practice. However, the larger populace of South Africa believes in and uses Indigenous practitioners as the first line of support for treatment (Keikelame & Swartz, 2019).

2.1.3 Indigenous healers

In many African societies, traditional healers play a significant role in the provision of healthcare services, especially in regions where access to modern medical facilities may be limited (Thipanyane, Nomatshila, Musarurwa & Oladimeji, 2002). This reliance on traditional healing practices is deeply rooted in cultural traditions and belief systems, with traditional healers often serving as primary healthcare providers within their communities (Mokgobi, 2015). Despite advances in modern medicine, the services of traditional healers remain integral to healthcare delivery, particularly in developing countries where healthcare infrastructure may be inadequate or inaccessible to large segments of the population (Ledwaba, 1997).

In the context of South Africa, consulting both traditional healers and medical doctors is a common practice, reflecting the pluralistic nature of healthcare-seeking behaviors in the country (De Villiers F.P.R. & Ledwaba M.J.P., 2003). Traditional healers are often sought not only when individuals are ill but also for the protection and well-being of children. It is a prevalent belief among many communities that traditional healers possess unique knowledge and skills to safeguard children from harm and promote their overall health and prosperity (Mwaka et al., 2023).

Research conducted in South Africa has revealed that more than 80% of caregivers of deceased children sought professional healthcare services during the child's final illness at home (*Traditional Medicine | WHO | Regional Office for Africa*, 2023). Approximately one-third of these caregivers sought care on multiple occasions. Doctors avoid responsibility for a child's death because their training equips them to anticipate the progression of an illness through a logical process. Healers, on the other hand, are less accountable for child deaths because their practices

do not follow a strict logical chain of causal events. They can attribute outcomes to factors like ancestors or invisible, non-scientific forces, placing them in a different position from doctors.

2.1.4 Medicine in South Africa Today

2.1.4.1 Medicine laws

Post-colonial governments have implemented a constitution that regulates biomedicine and Indigenous medicine. The Medicines and Related Substances Act (previously Drugs Control Act) 101 of 1965 intends to provide for the registration of drugs intended for human consumption, for the establishment of a Drugs Control Council and matters incidental thereto (Medicines and Related Substances Act (Previously Drugs Control Act) 101 of 1965 | South African Government, 1966). This is the umbrella act that covers multiple acts that help in the control and usage of biomedical substances.

In 2006, South Africa laid out a Directorate of Traditional Medication inside the Department of Health. In 2007 the Customary Experts Act (No. 22 of 2007) was established, which mandated the establishment of a Council of Traditional Practitioners. An African Traditional Medicine Draft National Policy (Government Gazette No. 31271, July 25, 2008) was made available for comment. The law seeks to regulate Indigenous health practices and practitioners to align and eliminate previous misconceptions and marginalization of this practice, in the same way that it has been able to regulate biomedical medicinal practices.

Currently, in South Africa, there are three medical sectors: the public and private biomedical healthcare systems, and the Indigenous healthcare system (Lekgothoane & Ross, 2020). The public and private healthcare sectors are influenced by Western biomedicine. This influence is evident in medical practices adopted by various hospitals, including the hiring of medical practitioners with recognized accreditation from institutions of higher learning and professionals specializing in their respective fields (Cucinotta & Vanelli, 2020).

2.1.4.2 HIV and Covid-19 pandemic in South Africa

In South Africa's recent history, two significant medical events underscored the prominence of biomedical approaches to health. During the early 2000s, the country faced a severe HIV/AIDS crisis. Thabo Mbeki, serving as President at the time, controversially rejected biomedical research in combating the pandemic. Instead, he endorsed alternative theories about the origins of AIDS

and advocated for Indigenous treatment methods, favoring nutritional remedies over antiretroviral drugs (Fassin & Schneider, 2003). Unfortunately, the delayed adoption of proven antiretroviral treatments exacerbated the spread of AIDS, resulting in unnecessary suffering and loss of life. While some Indigenous practices promote general well-being, they proved ineffective in addressing HIV/AIDS. Mbeki's denialism not only impacted public health but also influenced perceptions of Indigenous medicine. Despite their historical significance across cultures, traditional healing methods became associated with AIDS denialism, undermining confidence in their efficacy and credibility (Mncengeli et al., 2016) and reinforcing existing discourses that favored biomedicine.

The AIDS epidemic provided foundational insights into effectively responding to global health crises, shaping South Africa's approach to handling the COVID-19 pandemic. Established practices in public health infrastructure, community engagement, policy development, and ethical considerations informed their response. The COVID-19 pandemic, caused by the novel coronavirus SARS-CoV-2 presented an unprecedented challenge to healthcare systems worldwide since its emergence in late 2019 (Cucinotta & Vanelli, 2020). With a population of over 60 million people, South Africa has faced unique challenges in combating the spread of the virus while striving to safeguard the health and well-being of its citizens (Statistics South Africa, 2022). In response to the COVID-19 pandemic, South Africa's Department of Health prioritized a biomedical strategy to curb the spread of the virus. This approach, rooted in scientific medicine, involved implementing various control measures. While South Africa recognizes traditional healers under the Traditional Health Practitioners Act (2007), the Department of Health primarily focused on biomedical interventions during the COVID-19 crisis, and traditional healers were not formally consulted in the government's response (Zimba & Nomngcoyiya, 2022).

2.1.4.3. Biopower

The focus on biomedical interventions not only provided solutions but has also contributed to profit-making. Biomedicine has significant implications for capitalism and profit-making. The intersection of biomedicine with capitalism and neoliberalism illustrates significant profit-making opportunities within the pharmaceutical industry, where substantial investments in research and development lead to profitable medications (Rajan, 2006). Medical technology also contributes, with high-priced diagnostic tools and devices, enhancing profitability (Riska, 2010). Hospital

services, particularly in private institutions, generate revenue through service fees and insurance coverage for biomedical treatments (Navarro, 2008). Michel Foucault's concept of "biopower" contextualizes these dynamics, highlighting how states and institutions use biomedical knowledge to regulate health and shape policies, often reinforcing social norms and inequalities (Foucault, 1978). Neoliberal policies drive privatization in healthcare, emphasizing individual responsibility and market-driven healthcare models, exacerbating disparities in access to care (Navarro, 2008).

According to Salgues (2016), Medical biopower has become a tool that society as a whole uses to exert its power on the individual . It comes from the effects of globalization. It means that both patients and healthcare workers become controlled parts of a changing worldwide system of power (Salgues, 2016b). Iin relation to this topic, this concept of biopower in the South African healthcare landscape, operates as a tool through which both patients and health practitioners are positioned within a global system of control shaped by historical and ongoing colonial influences.

Critiques challenge this paradigm, advocating universal healthcare and alternative models that prioritize collective well-being over profit because this approach exacerbates health inequalities, as those with more resources can access better care, while marginalized populations face barriers to adequate healthcare (Marmot, 2015). In South Africa, The National Health Insurance (NHI) Bill was signed to achieve universal healthcare coverage by pooling funds to provide accessible and equitable healthcare services to all citizens. The NHI aims to establish a single fund to cover all essential healthcare services, including primary, specialist, and hospital care, funded through mandatory contributions based on income. The bill intends to address current inequalities in healthcare access and quality, promoting a more integrated and coordinated healthcare system across the country (National Health Act: National Health Insurance Policy: Towards Universal Health Coverage, 2017).

South Africa’s healthcare system comprises both biomedical and Indigenous medical practices. The government-funded public healthcare system serves the majority of the population through clinics, community health centers, and hospitals (Rensburg, 2021). Despite challenges like resource constraints and staff shortages, it has made significant progress in combating HIV/AIDS and other infectious diseases. Maternal and child health programs have also improved outcomes. In contrast, the private healthcare system caters to a wealthier segment, offering high-quality care

with better resources and advanced technologies, and attracting skilled professionals due to better remuneration and working conditions (Bekker et al., 2018).

Indigenous healers in South Africa differ in their practices based on cultural traditions, healing methods, and the specific ailments they address within their communities; this diversity is reflected in the roles of sangomas—who primarily perform spiritual rituals and communicate with ancestors—herbalists—who focus on plant-based remedies—and faith healers—who often incorporate Christian prayers and healing practices (Niehaus et al., 2004). These practitioners are deeply respected, particularly in rural and peri-urban areas, where they provide culturally relevant and accessible healthcare (Kayne, 2010). The Traditional Health Practitioners Act of 2007 governs this sector, establishing the Interim Traditional Health Practitioners Council of South Africa to oversee the registration and regulation of traditional healers. Efforts to integrate Indigenous practices into the formal healthcare system include referral systems and research projects to evaluate traditional remedies. However, challenges remain, such as differences in practice standards and the need for scientific validation, making full integration into the biomedical system complex (Krah et al., 2018).

Biomedical care provides essential services such as immunizations and treatment for infectious diseases, while Indigenous medicine offers holistic care, addressing physical, emotional, and spiritual well-being (Ramavhoya & Nesengani, 2022). Efforts to integrate these approaches ensure that children receive comprehensive care that respects cultural traditions while benefiting from modern medical advancements (Makhavhu, 2024). This integrated approach is crucial for addressing the diverse health needs of children in South Africa, contributing to their overall well-being and development.

Section 2: A Critical History of Childhood

2.2.1 Childhood

Childhood is seen in the mainstream as an “actual” thing, and by critical theorists as a “construction” that contributes to certain social dynamics. These constructions were interdependent, meaning they influenced and shaped each other. However, this idea of social construction often placed children under the authority of adults, creating a one-directional dynamic that overlooked children's agency and unique perspectives. As a result, children were frequently viewed through the lens of adult

expectations and societal norms, rather than as individuals with rights and voices (Norozi & Moen, 2016).

Developmental psychology has reinforced this dynamic by presenting a linear definition of childhood, often rooted in Western, middle-class norms (Burman, 2008). This singular narrative becomes the standard by which childhood is measured, marginalizing those who do not fit its prescribed stages and milestones (Misirliyan et al., 2023). Children from diverse cultural, social, and economic backgrounds may be excluded from this dominant model, as it fails to account for the variability in childhood experiences.

Moreover, capitalism significantly influences our understanding of childhood, with different countries setting varying ages at which children are deemed old enough to enter the workforce. This capitalist view often prioritizes productivity over the natural curiosity and exploration essential to children's development. As economic considerations shape societal expectations, there is a shift in how we perceive and nurture children's growth. The emphasis on preparing children for future economic roles can overshadow the importance of fostering their creativity, emotional well-being, and holistic development. This perspective ultimately impacts how societies invest in and value the early years of life (Ba', 2021).

2.2.2 Causes of child mortality

The factors causing child mortality are varied. The primary causes of death for children under five around the world continue to be congenital malformations, preterm birth problems, birth asphyxia, and infectious illnesses like acute respiratory infections, diarrhea, and malaria (United Nations Target 3.2 End Preventable Deaths of Newborns and Children < 5, 2023). In South Africa, the legacy of apartheid continues to cast a long shadow, with its enduring effects on resource distribution and social determinants of health exacerbating malnutrition rates (Graybill, 2000). Some of the primary causes of death for children under five include the high prevalence of unemployment, HIV, parent deaths leading to child-headed households, and a lack of resources that forced people to leave their homes in search of better opportunities elsewhere (Mabaso, Ndaba & Mkhize-Khwishanae, 2014 2014). Systemic issues such as inadequate healthcare infrastructure, poor access to clean water and sanitation, and limited educational opportunities exacerbate these problems. The economic disparity in South Africa also plays a significant role, where

impoverished communities face higher risks of child mortality due to their inability to afford proper healthcare and nutrition (Alaba et al., 2021).s

In addition to the above-mentioned social determinants, factors that can lead to child death include nutritional inadequacies, neglect and abuse by male partners, inattention to reproductive health and violation of reproductive rights, the powerlessness of women, and health system issues such as poor quality and incompetent healthcare (Mmusi-Phetoe, 2016). Although some of these factors may not directly cause child deaths, their impact contributes to increased vulnerability and negative health outcomes for children.

Malnutrition, in particular, weakens children's immune systems, making them more susceptible to diseases. Childhood mortality from malnutrition is often categorized under "natural causes because children suffering from malnutrition are particularly vulnerable to infections. Their weakened immune systems make them easy targets for diseases like pneumonia, diarrhea, and malaria (Rytter et al., 2014). This classification of "natural causes" obscures the reality that these deaths are entirely preventable and result from systemic inequalities rather than unavoidable health issues. Recognizing and addressing the underlying socio-economic disparities and injustices is crucial to preventing these deaths and improving health outcomes for children in South Africa (Rafaely, 2017).

2.2.3 Treating childhood sicknesses

Treating childhood conditions encompasses different approaches ranging from biomedicine to Indigenous healing practices. Both medicine sectors offer unique perspectives on healing often incorporating cultural, social, and spiritual aspects (Mokgobi, 2013). Biomedicine is rooted in scientific principles and evidence-based practice. It emphasizes diagnosing and treating diseases and conditions through pharmaceutical and technological interventions (Keyworth et al., 2018). Biomedicine in childhood care emphasizes specialized pediatric services that integrate multiple disciplines to ensure a holistic approach to health. This includes preventive strategies such as administering vaccinations, conducting routine health screenings, and providing health education for parents and caregivers to promote long-term well-being and early detection of potential health concerns (M. Jain et al., 2024). Biomedical approaches may sometimes overlook the holistic needs of the child, focusing primarily on the physical symptoms of the condition while neglecting the child's spiritual well-being (Jasemi et al., 2017).

Historical and socio-political developments in South Africa make biomedicine the primary choice for treating childhood illness. During colonialism and apartheid, Western medical practices were institutionalized, often at the expense of Indigenous healthcare systems. This legacy has continued to shape health policies and perceptions, making biomedicine the mainstream approach (Wispelwey et al., 2023). The post-apartheid era has seen efforts to integrate and recognize traditional practices (Moeta et al., 2019), but biomedicine remains predominant due to its established infrastructure and global influence (Good, 1995).

Indigenous medicine encompasses a wide range of healing traditions and practices that have been passed down through generations. It is dependent on a practitioner's ability to provide medical care (Mokgobi, 2014). The diagnostic method looks for answers to questions such as who or what created the sickness, why it is currently affecting this person, and the question of immediate causes. The process involves observation, patient self-diagnosis, and divination (Felhaber & Mayeng, 1997).

2.2.4 Child mortality prevalence rate

Biological factors do not solely determine child mortality but are influenced by social, cultural, economic, and political factors (Atashbahar et al., 2022). Malnutrition, exacerbated by poverty and food insecurity, is a leading cause of child mortality globally, with around 27% of children under five suffering from stunting due to chronic malnutrition. Poor sanitation and inadequate housing conditions, particularly prevalent in developing countries, also contribute significantly to child mortality rates by increasing the risk of waterborne diseases. Access to healthcare is crucial for reducing child mortality. Still, in countries like South Africa, where the public healthcare system is strained due to high unemployment and poverty levels, the quality of healthcare services may suffer (*Child Mortality and Causes of Death*, 2024). Immigrants and marginalized populations often face additional barriers to accessing healthcare (Vearey et al., 2017).

Child mortality statistics, while highlighting the urgency of healthcare challenges, often prioritize biomedical solutions such as medical interventions, nutrition, and hygiene. This focus tends to overshadow broader social determinants of health, including poverty, education, and access to clean water, as well as structural inequalities like racial, economic, and political factors (Houweling & Kunst, 2010). By emphasizing medical solutions, the discourse privileges Western scientific knowledge and institutions, marginalizing Indigenous and community-based approaches

that offer holistic and local perspectives (Dagher & Linares, 2022). This framing can reinforce a narrow understanding of the issue, potentially failing to address the root causes of child mortality, such as systemic socio-economic disparities.

Nations recording low child mortality rates typically possess well-developed healthcare infrastructures with extensive access to healthcare services. Such capability reflects a country's capacity to tend to health needs and prevent avoidable child deaths. Equally, countries experiencing high child mortality rates often grapple with economic hurdles, including poverty, inequality, and insufficient access to essential resources (Azevedo, 2017a). Economic development correlates with enhanced access to resources like nutrition, sanitation, housing, and healthcare, contributing to lower child mortality rates. Environmental factors such as clean water, sanitation, and hygiene significantly influence child health outcomes. Countries maintaining robust infrastructure and environmental regulations to ensure clean air and water quality typically exhibit lower child mortality rates (Allel et al., 2021).

2.2.5 Child mortality as a construct

The death of a child was not categorized as infant mortality in the 1800s (Armstrong, 1986). It was only in 1877 that child mortality was reported in Britain, with a statistic of 158 per 1000 deaths (Armstrong, 1986). Today’s child mortality rate contains several categories differentiating stages of birth, infancy, and childhood (Rusnock, 2002). Neonatal mortality refers to the child dying in the first month of life, post-neonatal mortality is newborns dying between 28 and 364 days of age, and infant mortality is the child dying between birth and their first birthday (ur Rahman & El Ansari, 2012).

Infant mortality is not just a medical or biological issue, but a social construct shaped by historical, cultural, and societal factors (Gortmaker & Wise, 1997). Over time, its understanding has evolved through various discourses, particularly with the rise of biomedical frameworks that often reduce infant death to technical failures or medical interventions. Historically, colonialism played a significant role in framing infant mortality within a European biomedical context, sidelining Indigenous knowledge and practices. This shift in understanding contributed to the marginalization of broader socio-economic and cultural influences, such as poverty and healthcare access, in the discussion of infant death.

As infant mortality gained its discursive logic, it became increasingly tied to medical narratives focused on interventions, maternal education, and hygiene. However, these dominant discourses often overlook deeper systemic issues, such as economic inequality and racial disparities, which continue to affect infant mortality rates. The tension between biomedical and Indigenous health systems, particularly in post-colonial contexts like South Africa, reflects the ongoing power dynamics in healthcare.

While child mortality statistics provide important data for healthcare improvements, the notion itself must be acknowledged as a social construct shaped by historical and cultural forces. Critically, this recognition challenges us to look beyond biomedical explanations and address the broader systemic inequities that influence child deaths.

2.2.6 The Sustainable Development Goals (SDG)

The SDGs are a good example of how child mortality statistics have been recruited into discourses of a country's well-being and economic logic. While the SDGs have very good aims, they also do not attempt to change or subvert existing power structures. They aim to keep the existing system intact while ensuring that it does not do "too much" damage, e.g. by reducing climate issues, giving people more water, etc.

The Sustainable Development Goals (SDGs) aim to reduce neonatal and under-five mortality, emphasize numerical targets for child survival rates but often fail to interrogate the deeper socio-political and structural factors driving these figures. While the SDGs are ambitious in their intent to "end preventable deaths" of children, their framing tends to prioritize quantifiable outcomes without critically addressing the root causes of high mortality rates, such as systemic poverty, inequality, or inadequate healthcare infrastructure. By focusing primarily on biomedical solutions, such as access to vaccines and treatments, the SDGs inadvertently sideline critical questions about why these mortality rates persist, who is accountable for addressing them, and how intersecting factors like colonial histories, economic disparities, and political neglect perpetuate health inequities. Furthermore, the SDG on child mortality is a great example of "who is responsible for a dead child" - the SDGs imply that it is the State or the World's responsibility.

2.2.7 Children's Wellbeing at the Intersection of the state, family, and economy.

The responsibility for a sick child is multifaceted, involving a community of people who play distinct yet interconnected roles in ensuring the child's well-being. Parents, as the primary caregivers, are responsible for the day-to-day care and nurturing of their children. They are usually the first to recognize when their child is sick and make decisions about seeking medical help (Palmer, 1993). Despite their crucial role, parents may face barriers such as poverty, lack of education, and cultural practices that hinder their ability to provide optimal care (Baker et al., 2021). Limited access to healthcare, coupled with financial constraints, can delay seeking medical attention, leading to worsened health outcomes (Maphumulo & Bhengu, 2019).

The state provides a robust public health infrastructure, including access to healthcare services, vaccination programs, and public health education. Insufficient investment in public health infrastructure, inequitable distribution of resources, and corruption can result in inadequate healthcare access for marginalized communities (National Academies of Sciences et al., 2018). A lack of comprehensive immunization programs and poor-quality healthcare services increase children's vulnerability to preventable diseases (Anderson, 2014).

Healthcare providers have the professional responsibility to diagnose, treat, and manage childhood illnesses. They offer medical expertise, guidance, and support to both children and their parents, and play a crucial role in educating parents about preventive care, healthy practices, and recognizing symptoms of illness. shortages of skilled healthcare professionals, particularly in rural areas, can lead to delayed diagnoses and inappropriate treatment (Schickedanz & Halfon, 2020). Overburdened healthcare systems and inadequate infrastructure can compromise the quality of care provided. Moreover, disparities in healthcare access based on socioeconomic status can exacerbate health inequities (Malakoane et al., 2020).

The economy significantly influences access to healthcare services. Economic stability and growth can lead to better healthcare infrastructure, more affordable medical services, and increased health insurance coverage. Economic conditions impact social determinants of health, such as nutrition, housing, and education, which in turn affect children's health outcomes (van Rensburg, 2014). Poverty is a primary driver of child mortality, limiting access to nutritious food, clean water, and

adequate housing (Rafaely, 2017). Economic instability can lead to job losses, decreased household income, and reduced ability to afford healthcare.

Additionally, the physical environment, including housing quality, access to clean water, and sanitation, plays a critical role in a child's health. Poor living conditions can increase the risk of illness and exacerbate existing health issues (Krieger & Higgins, 2002). These interconnected factors create a complex web of challenges that contribute to child mortality. Addressing child mortality requires a multi-sectoral approach that tackles these issues simultaneously (Tangcharoensathien et al., 2017).

Section 3: Research Questions

Despite these escalating problems, the current literature on child health and mortality does not include analyses of the power structures that contribute to these problems. The present research my research seeks to answer the following questions:

- How do medical practitioners describe how they practice medicine on children?
- How do medical practitioners talk about preventative treatment for children?
- How do medical practitioners construct the causes of childhood death?
- How do medical practitioners' medical constructions support or refute larger discourses of health and medicine?

Chapter 3: Methodology

3.1 Research paradigm

The research paradigm I use to conduct the study is the Constructivist paradigm. This paradigm argues that the world we study is constructed through language, interaction, and practice. It is an appropriate paradigm to locate the study as it focuses on language and its relationship with reality (Creswell & Poth, 2018). This research study investigates medical discourses that construct child deaths in South Africa and attempts to understand how these discourses also shape, reproduce, resist, and contest larger discourses around biomedical and Indigenous health practices. I analyze how the language used by biomedical and Indigenous medical practitioners shapes discourses.

Using the Constructivist paradigm, this research examines how language and social interactions construct medical discourses surrounding child deaths in South Africa. It explores how these discourses both reflect and challenge broader narratives about biomedical and Indigenous health practices through the ways practitioners use language to shape understanding.

3.2 Research design

The study is a qualitative research design, which focuses on the relationship between language and reality. Discourse analysis is a useful way to surface some of the underlying assumptions that encourage different treatment approaches and outcomes for childhood illness. This critical approach provides perspective on ways to resist and overcome various forms of power or to gain an appreciation that we are exercising power over something we are unaware of. Using discourse analysis, which focuses on different texts that look beyond the literal meaning of language (Kamalu & Osisanwo, 2015), my study aims to explore how biomedical and Indigenous health practitioners construct causes of child mortality and what they understand as treatment of child sickness. Discourse analysis attempts to illuminate how the dominant forces in society construct versions of reality that favor their interests (Parker, 1992). It also aims to uncover the ideological assumptions that are hidden in the words of our written text or oral speech. My research design is, therefore, a discursive study (Maree, 2016).

Discourse analysis helped in this research by enabling a critical examination of how language constructs and maintains differing medical understandings of child mortality, thereby revealing underlying power dynamics and ideological assumptions within both biomedical and Indigenous

health paradigms. This method allowed for the exploration of how practitioners' talk not only reflects but also shapes broader social narratives and tensions around health practices in South Africa.

3.3 Sample

In this study, I use purposive sampling to ensure that participants meet the specific criteria relevant to the research aims. The participants are required to be medical practitioners with experience in treating children. This selection is intended to gather detailed information on the treatment and causes of child mortality. A total of six participants were recruited, as the study does not necessitate a large sample size. The participants comprise three Indigenous medical practitioners and three biomedical practitioners. Biomedical practitioners are registered with the Health Professions Council of South Africa (HPCSA), which oversees the education, training, and registration of health professions as per the Health Professions Act (About Us - HPCSA, 2024). The three biomedical doctors are from public hospitals in Limpopo. Indigenous healers include "sangomas or inyangas, healers, priests, and prophets who have been the backbone of Bantu communities, particularly in rural areas of Southern Africa" (Cumes, 2013). The Indigenous healer participants consist of two sangomas and a spiritual healer.

To recruit participants, I used the snowballing method, relying on word-of-mouth referrals to identify suitable medical practitioners. I was acquainted with a doctor who was a family friend, and she played a key role in recruiting other medical professionals to participate in the study. I visited the traditional healers at their homes to explain the project and request interviews. I began with one sangoma who is well known in my community, who then referred me to others. The participants included three biomedical doctors and three Indigenous healers, all working or residing in Limpopo. Participant One is a biomedical doctor specializing in pediatrics at a government hospital. Participant Two is a physician at the same type of institution, and Participant Three is a general practitioner, also working in a government hospital. The Indigenous healers consisted of Participant Four, a sangoma who initiates others; Participant Five, another sangoma; and Participant Six, a spiritual healer who owns a church. All Indigenous healer participants reside in Limpopo.

3.4 Data Collection

Using interviews for discourse analysis is an emerging methodological innovation that presents both challenges and opportunities (Nikander, 2012). Although this approach introduces complexities like potential biases and the need for nuanced interactional analysis, it significantly enriches the data by providing deeper, contextually grounded insights into discourse. Researchers such as Potter and Wetherell (1987) have pioneered this method, demonstrating its potential and offering valuable methodological guidance. All interviews with the doctors were conducted over the phone due to their remote locations. These interviews took place at night, outside of their working hours. The interviews were semi-structured, allowing for probing to gather more detailed information. The interviews with the traditional healers were conducted face-to-face and were semi-structured. They took place during the day on dates that the healers indicated they were available. The interview schedule is attached to this research report (Appendix C). The phone interviews were recorded via cellphone with the participants' consent, and the face-to-face interviews were also audio recorded using a portable recorder.

3.5 Translation

The traditional healers were interviewed in Sepedi, as many of them were older and did not understand English; their responses were later translated into English. In contrast, interviews with biomedical doctors were conducted in English. The dominance of English as a spoken language can recreate colonial power structures. When working across languages, we risk unintentionally portraying non-English speakers as inferior. This can happen in subtle ways, like presenting interview quotes in grammatically incorrect English to create a false sense of authenticity. When translating certain words simply do not have direct English equivalents (Palmary, 2014). As a native Sepedi speaker who studied it further in high school, I felt uniquely qualified to translate my own Sepedi interviews. Translating myself allowed me to listen to the recordings multiple times, ensuring accuracy. To avoid cultural misrepresentation, I left untranslated concepts specific to Sepedi, explaining them within brackets.

3.6 Data Analysis

The data that was gathered was analyzed, which included the understanding of information collected utilizing analytical and coherent thinking to discern patterns and relations. Discourse analysis is a type of data analysis technique that was used for the study. It is known as the analysis

which covers all forms of spoken interaction; formal and informal, and written texts of all kinds (Potter & Wetherell, 1987).

Discourse analysis was a useful analytic approach for the study, which examined the discursive construction of child mortality, health, and medicine. I did a discourse analysis and included elements of Foucauldian discourse analysis to enrich the analysis.

Using the FDA further provided tools to see how child mortality was constructed and understood as a problem in the South African context, as well as the discursive construction of health and medicine as solutions or treatments for this problem. I used Parker's (1992) discourse analysis steps to analyze the data. Parker's (1994) chapter provided a clear and stepwise procedure for carrying out discourse analysis. Steps 1 to 12 represented the process for analysis of a text. Steps 13 to 20 represented the process for analysis into discourse.

My research began with a well-defined set of questions outlined in the proposal, which were further refined after peer review. Conducting interviews appeared as the most appropriate data collection method due to their direct relevance to the questions. Recording the interviews guaranteed accurate capture, with transcripts created for analysis. Interviews in Sepedi were meticulously translated into English. Immersing myself in the recordings through repeated listening fostered familiarity with the spoken recorded data.

In the analysis stage, I start the analysis by identifying discursive themes in the text based on subjects, objects, and their relationships within the talk. Working with my supervisor, we recognized several themes, which led to ultimately selecting two for an in-depth exploration of the paper. The data was thoroughly analyzed, with different meanings identified and organized into structures that contributed to overall meaning-making. Interpretation delved deeper, uncovering underlying meanings embedded within the participants' discourse.

My supervisor's guidance fostered critical engagement with the data. We probed assumptions, challenged dominant narratives, and explored alternative interpretations. This process also prompted self-reflection, allowing me to identify and mitigate any biases that could influence the analysis. To strengthen the validity of my interpretations, findings were corroborated with evidence from credible sources from Google Scholar and academic journals.

3.7 Data Quality

Data quality was ensured using the validation analytic technique by Potter and Wetherell (1987). Coherence, participants' orientation, new problems, and fruitfulness respectively describe the criteria in qualitative research in pursuit of a validated study with quality findings. Coherence is a method of analytical induction, which involves reaching a cohesive interpretation of the facts by analysing exceptional occurrences as well as routine utterances. Participants' orientation alludes to the idea that the findings should be empirically related to the participants' understanding as reflected in their talk. During the research, new problems come about when discourse analysis discovers new fascinating results that open avenues for future research. For discourse analysis to be considered fruitful, it must have succeeded in making sense of novel discourse types and producing original explanations (Potter & Wetherell, 1987).

To ensure the above, first, I looked for coherence by making sure the interpretations made sense consistently across both typical and unusual statements from the participants. I also made sure the findings truly reflected the participants' own understanding and perspectives. During the analysis, I stayed open to discovering new insights or questions that would arise. Finally, I ensured that the analysis brought new and original explanations to light, ensuring this research is fruitful and meaningful.

3.8 Ethical Considerations

Ethical clearance was obtained from the University of the Witwatersrand- Protocol number MAPSYC/23/09- because the study is considered low risk, meaning the only foreseeable risk is one of discomfort or inconvenience. The potential risk to participants was not greater than what they would encounter in their daily lives. The participants are adults and are not considered to be a vulnerable research population. The research collected opinions rather than personal information, and this information was collected confidentially. There was no potential harm to the participants, as they were only required to answer questions. The informed consent (Appendix D) provided to participants outlined that the study aimed to explore how child mortality is constructed and understood as a problem in the South African context, as well as the discursive construction of health and medicine as solutions. The informed consent not only outlined the study but asked if they were willing to participate, and informed them that they could withdraw from the study should they experience discomfort. Anonymity was not possible due to the face-to-face nature of the

interviews and the discussion of specific professional experiences. However, confidentiality was ensured throughout the study.

Writing the paper involved presenting findings clearly and cohesively, supported by data and relevant literature. Ethical considerations were paramount throughout the study. Informed consent was obtained from the participants. Information sheets and pre-interview discussions were conducted before the recording started. Pseudonyms are used to ensure participant anonymity and recordings are securely protected. Finally, a comprehensive synthesis presented the findings of the study coherently. This synthesis was then reviewed by my supervisor for coherence and faithfulness to the data.

Chapter 4: Presentation of findings

Theme1: Two medical practice paradigms.

Medicine has been divided into two paradigms: the biomedical approach and Indigenous healing practices. These paradigms not only differ in their principles and methods but also in how practitioners view, understand, and respond to child deaths. This divergence is evident in the language practitioners use, which reflects the discursive frameworks of their respective paradigms.

Biomedical practitioners view child death strictly through a medical lens. In South Africa, doctors rely on standardized protocols and clinical definitions, such as the irreversible cessation of all biological functions, including heartbeat, breathing, and brain activity, to determine death in a hospital context (Baker et al., 2021; Nikas et al., 2016). These clear, uniform standards are rooted in empirical evidence and ensure consistency in diagnosing death.

In contrast, Indigenous healers often incorporate both spiritual and medical perspectives when interpreting child deaths. This dual perspective is deeply connected to cultural beliefs about ancestors, who are thought to maintain a spiritual relationship with the living through the soul and spirit (Edwards et al., 2009). Indigenous practices provide explanations for death that go beyond the physical, addressing relational and spiritual disruptions within the community.

The divide between these paradigms is further reflected in their accessibility and relevance to patients. According to the World Health Organization, an estimated 80% of African patients use

both Western biomedicine and traditional healing practices. This dual usage is particularly prevalent in rural and marginalized communities, where traditional healers are more accessible and affordable than formal healthcare services (Mokgobi, 2015; *Traditional Medicine | WHO | Regional Office for Africa*, 2023). Traditional practices resonate culturally, integrating seamlessly with existing beliefs while addressing emotional and spiritual well-being, aspects often overlooked by biomedicine (Kahissay et al., 2017).

These contrasting discourses shape how practitioners from each paradigm engage with the issue of child deaths. Biomedicine emphasizes objective, physical processes, while Indigenous healing situates death within a broader spiritual and cultural framework. This discursive separation underscores the challenges of reconciling the two paradigms, particularly when dealing with sensitive and complex issues like child mortality.

4.1.1 Diagnosis and treatment

Diagnosis and treatment reveal evidence that medical practitioners have a unique perspective on death, which they approach from two paradigms evident in the language and discussions they engage in within their field. Medical practitioners share a common goal of saving the lives of sick children to reduce the rate of child mortality. Despite the shared objective, the different paradigms that medical practitioners practice introduce differences in their approach to healthcare.

In this section, I analyze discourses of diagnosis and treatment from biomedical and Indigenous perspectives. I will begin with a few examples of data about biomedical diagnostic practices. I will then continue with an in-depth discussion of Indigenous diagnostic methodologies, drawing upon cultural insights and traditional knowledge collected by Indigenous medical practitioners.

Biomedical practitioners are grounded in Western medicine and rely on scientific and evidence-based approaches to diagnose and treat illness. This paradigm emphasizes the importance of diagnosing based on symptoms and treating them with standardized methods listed by their governing medical board. The medical discourse of this paradigm is characterized by a focus on pathology, anatomy, and physiology, using terminology that is steeped in science (Wilce, 2009)**.**

> *Extract 1*
>
> *R: ohk and then what signs and symptoms indicate that the condition of the child is serious and possibly life-threatening?*

Dr: yooo there's a lot that you can pick up when the child comes in like it depends on which system is affected like system-wise like with what we are currently exposed to now mostly is respiratory conditions. (Participant 2)

The doctor uses medical terminology like "system," "respiratory conditions," and "system-wise," which are specific to describing the body's anatomical systems (e.g., the respiratory system) and the conditions affecting them. The phrase "there's a lot that you can pick up when the child comes in" points to the diagnostic process, where medical professionals rely on observing and assessing the patient's symptoms. This emphasizes the importance of clinical judgment in detecting potential health issues. The doctor also noted that identifying the affected system is a key step in diagnosing sick children. Additionally, diseases often follow patterns, with predictable types of illnesses occurring at specific times of the year or certain stages in a child's life, providing further indicators for diagnosis.

Extract 2

R: what actions do you take when you realize the child is at risk of losing their life

PD: the action will depend on the condition of the baby right so if I'm going to give an example I've got a baby who is in respiratory distress with severe pneumonia they bring the baby and they are not on oxygen we would put the baby on oxygen I would put a drip and give them intravenous fluids and if the oxygen that we giving is not enough we can always escalate it to ICU where we would ventilate the baby and put them on a ventilator. (Participant 1)

The doctor has diagnosed the baby with respiratory distress and severe pneumonia. This means that the baby is having difficulty breathing and their lungs are severely infected. Respiratory distress is a medical term used to describe a condition where a person struggles to breathe. It can be caused by a variety of factors, including pneumonia, asthma, heart failure, and other respiratory illnesses (Diamond et al., 2025). Pneumonia is an infection of the lungs. Bacteria, viruses, or fungi can cause it. In severe cases of pneumonia, the lungs can become inflamed and filled with fluid, making it difficult to breathe (V. Jain et al., 2025; Sattar et al., 2024). Given the severity of the baby's condition, immediate medical intervention is crucial. This might involve treatment with medication. This highlights the influence of medical discourse and the power dynamics inherent in the field of medicine. For example, the way respiratory conditions are described uses medical

language that shows doctors have special knowledge. This gives doctors power to decide how patients are treated and how their illness is understood.

Although my question was about a child, the doctor's use of the term "baby" emphasized the vulnerability and fragility of young children, underscoring the delicate nature of their treatment. While both children and babies require specialized care, their treatment approaches differ due to variations in their developmental stages and physiological characteristics. They require the investment and attention of a limited number of adults (Phillips & Shonkoff, 2000). Babies and children have distinct physiological traits, including differences in immune system maturity and body size. In treating children, healthcare providers can use age-appropriate language and explanations to help them understand their condition and treatment plan. However, with babies, communication relies more on physical cues and caregiver involvement. Procedures like taking vital signs or administering medications often require different techniques for babies, considering their smaller size and limited ability to cooperate compared to older children.

Extract 3

Dr: children who are dehydrated or have acute or severe malnutrition those kinds of conditions there are a lot of conditions children who are vomiting non-stop and can't retain anything and who are having diarrhoea for days and days and are severely dehydrated ya those are some in a nutshell of a life-threatening condition. (Participant 1)

Medical language uses professional medical terminology, a specialized language used by healthcare professionals to communicate effectively about medical conditions. Terms like "dehydrated" or "acute or severe malnutrition" are examples of professional medical terminology used by doctors to indicate serious conditions that can potentially lead to child death. Layman's medical terminology is a simplified version of medical terms that is easier for non-medical professionals to understand. Symptoms like "vomiting non-stop," "can't retain anything," and "having diarrhea" are described in layman's terms so that regular people can understand. The medical terms "dehydration, malnutrition, vomiting, and diarrhoea are sicknesses frequently identified as leading causes of child mortality (WHO, 2022). This shows how biomedicine discourse is a network that is sustained by practitioners and statistics that track their prevalence and impact on child health.

In this analysis the doctors use biomedical assumptions to guide their treatment and work wholly within the biomedical paradigm, translating it for outsiders and displaying an adherence to its logic. Their use of precise terminology not only structures their clinical approach but also serves to translate the complexity of biomedical concepts for outsiders, reaffirming the paradigm's authority. This adherence reflects the entrenched logic of biomedicine, shaping both the interpretation of the child's vulnerability and the corresponding interventions while leaving little room for alternative perspectives or frameworks of understanding.

4.1.2 Indigenous healers' diagnosis and treatment.

Indigenous medical practitioners draw upon a holistic view of health that often integrates physical, spiritual, emotional, and environmental aspects of well-being. Their practices are deeply rooted in traditional knowledge and cultural beliefs, which have been passed down through generations (Kayne & Kayne, 2010). The diagnosis and treatment processes in these paradigms may involve herbal remedies, spiritual healing, and community-based practices, reflecting a broader understanding of health that extends beyond the physical symptoms of an illness (Abbo, 2011). The medical discourse among indigenous practitioners, therefore, includes a wider range of considerations and employs a vocabulary that encompasses the cultural and spiritual aspects of health.

> *Extract 4*
>
> *R: oh, so since you've seen that we are discussing the deaths of children- Child mortality- so from the definition of child mortality, starting from birth up to 5 years old, I'd like to ask, what is the process that you follow before giving treatment and diagnosis when a parent brings a sick child to you?*
>
> *Th: Here is how our diagnosis goes, even though observation of how the child is breathing, and whether can they speak properly (if the child is of speaking age), we only look for breathing and temperature in infants. Then from there when you consult the bones, you will see the illness and how far the illness has gone and if the child will live or if the child is on the verge.* *(Participant 4)*

Traditional healers use animal bones to connect with the spiritual realm and seek guidance, insight, and healing by throwing them onto a mat or surface and interpreting the patterns they form. The

bones work by relaying ancestral messages in diagnosing and understanding a patient's condition. In contrast to the doctor's approach, the traditional healer begins with a similar process of observing symptoms, though they describe it differently. However, instead of proceeding with the next steps a doctor would take, the healer turns to consult bones as part of their diagnostic method. This blend of practices reflects a dual paradigm in the diagnostic process, illustrating how Indigenous healers perceive illness and death through both traditional and medical lenses. For example, they may refer to "breathing" rather than "respiratory distress," acknowledging the same symptom but using different terminology. Traditional healers often believe that a child's fate is predetermined by destiny. Their approach to treatment focuses on providing spiritual guidance and support, rather than on controlling the illness. In contrast, Western medical practitioners rely on scientific evidence and technology to diagnose and treat illnesses. Their goal is to improve the patient's chances of survival and recovery.

Extract 5

R: okay, so as you have talked about illnesses affecting children, what makes you sure that a child has that certain illness

H: what tells me is my spirit, my spirit tells me i only hold the bible by chance, the bible doesn't speak I am the one who speaks

R: did you say that when you see that the child is at the danger of losing their life you send them to Matlala (Matlala Public Hospital)?

H: yes *Participant 6*

The healer confidently asserts that the diagnosis happens through her spirit. Although she holds a bible (there is a religious component to her practice) she is the one that makes the diagnosis (not God, or a larger force). Due to the limitations of knowledge and abilities to treat she sends the patients to the hospital. The healer is suggesting that her "main" paradigm is Indigenous and that on occasions she will shift to biomedicine when a life is at stake.

In the biomedical paradigm, when a sick child does not show improvement despite treatment, and the prognosis deteriorates, the issue is often attributed to either an incorrect diagnosis or a failure in the treatment approach. This perspective comes from the paradigm within which biomedicine

works, which is heavily rooted in observed evidence and the scientific method. In this paradigm, health conditions are understood through the lens of biological processes and physical symptoms, and treatments are designed based on this understanding. Therefore, when a patient's condition does not improve as expected, it prompts a reassessment of the initial diagnosis or the efficacy of the treatment strategy. This could lead to further medical testing, adjustments in medication, or exploring alternative biomedical treatments.

Extract 6

R: what actions do you take when you realize the child is at risk of losing their life

PD: the action will depend on the condition of the baby right so if I'm going to give an example I've got a baby who is in respiratory distress with severe pneumonia they bring the baby and they are not on oxygen we would put the baby on oxygen I would put a drip and give them intravenous fluids. *(Participant 1)*

In contrast to the evidence-based approach of Western medicine, traditional healers often rely on intuition and spiritual guidance. This can be summarized as "whatever my spirit tells me." While Western medicine emphasizes scientific data and empirical evidence, traditional healing practices often incorporate spiritual beliefs and ancestral knowledge.

and if the oxygen that we giving is not enough we can always escalate it to ICU where we would ventilate the baby and put them on a ventilator so there are certain things we look at the baby *(Participant 1)*

For Indigenous practitioners, options for escalating a situation are limited, with the only alternative often being to refer the patient to a hospital. This highlights the constraints on what they can and cannot treat. In contrast, hospitals are portrayed as having unlimited capabilities, as there is always a way to escalate treatment to address any complications or issues that arise.

And if you can see if the baby's condition is getting worse we have to escalate the treatment and the highest treatment you can get to is ventilating the baby in ICU so depending on the assessment you have done on the baby is how far you can go we escalate as quickly as possible because babies change conditions quite quickly one minute they are like this and

the next minute they are like this so we need to save their live s because they change very very quickly but ya that's what we would do *(Participant 1)*

Infants are characterized by rapid growth and development and their treatments must take into account their growth and changing needs. The statement, "Babies change conditions quite quickly—one minute they are like this, and the next minute they are like this," illustrates the unpredictable nature of their health. This unpredictability underscores the urgency of medical intervention. The phrase "we need to save their lives" highlights the high-stakes, immediate action required in caring for babies, with the doctor emphasizing the necessity of quick response. It also articulates a fundamental assumption of biomedicine - that saving lives is the ultimate value.

The doctor's repetition of the words "very, very" further stresses the rapid shifts in a baby's condition, underscoring the critical need for swift and decisive care. The use of "we" reflects collective responsibility, referring to the healthcare team and their collaborative approach to treatment. Unlike traditional healers who often work independently, doctors share knowledge and work as a unit to ensure the best possible outcome for their patients. The doctor contrasts this teamwork with the individual nature of traditional healing practices, where the healer typically operates alone, relying on personal insight rather than shared medical knowledge. Despite the challenges and the uncertainty of outcomes, the doctor's statement conveys a strong sense of determination and commitment to saving lives.

On the contrary, Indigenous healers approach a lack of improvement in a sick child with a broader perspective that encompasses more than just the physical symptoms. When traditional treatments do not yield the expected results, these healers consider a range of possibilities that extend beyond the physical to include spiritual and environmental factors. The paradigm under which Indigenous healers operate is more holistic, acknowledging the interconnectedness of the physical, spiritual, and natural worlds.

R: and then when you see that the child is about to lose their life like when the bones tell you that it is the end?

Th: It is not easy to tell a person, it is like at the hospital, they won't tell you that the patient will die at any time, it's rare for a doctor to tell you that. *(Participant 4)*

The traditional healer contrasts her approach with that of a hospital. Medical doctors can escalate the patient to higher-intensity care to more intensive treatments when a patient's condition worsens. In contrast, traditional healers rely on the guidance of bones, which reveal the patient's fate, often indicating when a referral to a hospital is necessary.

> *They can admit the patient and put them on the bed and the patient dies while they knew, so it is difficult for us too to face the parent of a dying child,* *(Participant 4)*

The medical doctor was talking about resuscitating and escalating. Here the practitioner speaks about telling the parents of the child. It seems like medical doctors treat death as something that can be fought and avoided/ while Indigenous healer treats it as inevitable.

> *but with our Sepedi language, you can tell the parent that the child "ke kgomo ya pakwa – (a sepedi idiom meaning the person is between life and death) it is too late to treat the illness but you can look for quick help because our medicine doesn't go straight to the bloodstream, you have to drink them first.* *(Participant 4)*

The traditional healer is explaining that the reason that hospitals might be more effective is not because they are “better” but because practically the medicine enters the bloodstream quicker. In other words, if a patient is referred to a hospital, it is because the hospital can treat them quicker, not better.

> *We have referral letters where we refer the patient to the hospital* *(Participant 4)*

The traditional healer's engagement with different communication practices in hospitals serves as a vivid illustration of the contrast between the methodologies employed in conventional medical settings and those utilized within traditional healing frameworks. By actively referring patients to hospitals, the traditional healer not only acknowledges the value and expertise found within the biomedical healthcare system but also highlights a willingness to integrate and collaborate across distinct medical paradigms.

> *Extract 7*
>
> *H: name of illnesses, the one that I am familiar with is when a woman is pregnant and there is something wrong with the pregnancy, I can even help with the delivery of the baby.*
>
> *R: here at home?*

H: yes, but I don't do that anymore

R: okay

H: I have helped deliver many babies here at Letebejane. But when I learned of diseases that can be transmitted through blood I stopped and told them to go to the hospital, but I can deliver babies *Participant 6*

The traditional healer is explaining that there are limits to what she can do with her medicine and that diseases of the blood are obviously beyond the limits of her abilities or knowledge. By sending some of the sick patients to the hospital, she acknowledges that there are limits in Indigenous medicine that are accessible in biomedicine. This is an important discursive strategy for managing the limitations of the paradigms that she is working within.

This act of referral is significant as it demonstrates the traditional healer's recognition of the strengths and limitations inherent in their practices, as well as those within the biomedical system. Traditional healing practices often focus on holistic care, addressing the spiritual, emotional, and physical aspects of health. However, when faced with conditions that require specialized diagnostic tools, surgical interventions, or treatments developed through extensive biomedical research, traditional healers may see the benefit of accessing hospital-based care.

Even the most basic assumptions of medicine—such as what defines a child—are discursively contested within Indigenous paradigms, highlighting how concepts like child mortality are largely biomedical constructs. Legally, the Bill of Rights and the Children's Act in South Africa define a child as anyone under the age of 18 (Children's Rights, 2005.). This legal definition aligns with biomedicine, which standardizes its understanding of a child based on chronological age to ensure consistency in applying age-specific medical knowledge and interventions (Jia Zhang & Chen, 2017). Such standardization enables early identification of potential health issues and facilitates efficient healthcare delivery.

However, this biomedical framing may not fully encompass a child's well-being. Indigenous healing practices often extend beyond chronological age, considering additional factors such as spiritual well-being and cultural context (Sodi, 2009).

Extract 8

R: the next question is, have you ever lost a child where you felt like if the child had gone somewhere else, they could have survived?

Th: I have never lost a child. The only person I have ever lost, I can say they were a child because they were a child of the ancestors, it was in 2002. He was a man, he had a family, and he was initiated here, he was about to go home, and he fought with his wife. It is the stress that took him because they said he died of a heart attack at the hospital. This has been a difficult thing in my life since I started in 1997. (Participant 4)

When defining children's health and development, it's important to consider key stages such as infancy, toddlerhood, preschool years, school age, and adolescence, each marked by specific physical, cognitive, and emotional milestones. Common health concerns vary by age, from developmental monitoring in infants to mental health in adolescents. Standard healthcare practices include regular check-ups, immunizations, health screenings, and parental education, all aimed at supporting the child's overall well-being and addressing age-specific needs

Within Indigenous healing practices, the concept of "child" carries several interconnected meanings for traditional healers. Reincarnation, a common belief in many African cultures, suggests a child could be the reborn spirit of a deceased ancestor, especially if they share physical or personality traits (Walter, 2001). Alternatively, a child might be chosen by the ancestors for a specific purpose, such as becoming a future healer, or leader, or continuing a vital family tradition. Signs of this selection could include unusual dreams, visions, or talents (Cumes, 2013). Additionally, a child with a strong ancestral connection might exhibit heightened intuition, the ability to communicate with ancestors through dreams or divination, or a natural aptitude for traditional healing practices (Mokgobi, 2014). The traditional healer defines a child outside the biomedical paradigm, but the Indigenous paradigm.

The traditional healer's statement of "never losing a child" is nuanced by their acknowledgment of a deceased male patient. This suggests a distinction between biological offspring and those designated as "children of the ancestors." This terminology implies a spiritual connection that transcends both age and biological ties. By utilizing this concept, the healer positions themself as a guardian entrusted with the well-being of these individuals.

Furthermore, attributing the man's death to stress and a marital dispute distances the healer from any perceived shortcomings in their role. Additionally, the metaphorical use of "child of the ancestors" serves to separate the deceased from the category of "child," further protecting the healer's image as someone who does not experience patient loss. The mention of the death occurring at a hospital subtly implies that the cause of death was not related to the initiation process overseen by the healer therefore blaming biomedicine as the cause of death

4.1.3 Referral

This section explores the referral practices within the healthcare system, focusing on both biomedicine and Indigenous healing traditions. The analysis begins by examining discourses surrounding referrals amongst biomedical practitioners, followed by a discussion of referral practices employed by Indigenous healers. The law, Section 45 of the Amended National Health Act (No. 61 of 2003) makes provision for a public health establishment that is not capable of providing the necessary treatment or care, to transfer the user concerned to an appropriate public health establishment, which can provide the necessary treatment or care (*National Health Act 61 of 2003 | South African Government*, 2024).

Biomedically, referral happens when healthcare providers work together to care for a patient. This can involve moving the patient to a different level of care, such as a specialist, a hospital, or even a different department within the same facility to ensure the best transition and continued care (*Referral Policy for South African Health Services and Referral Implementation Guidelines - Google Search*, 2024). The referral system is a key part of healthcare delivery. It allows patients to be directed to the right place to get the care they need. This can involve going to a different healthcare facility or even getting help from community organizations (*Referral Policy for South African Health Services and Referral Implementation Guidelines - Google Search*, 2024).

Traditional healers, beyond their established networks of collaboration, also function as referral agents within the healthcare system. This is evidenced by their documented practice of directing patients toward hospitals and clinics for biomedical interventions. Research suggests that referrals often occur when traditional treatments fail to yield a desired response. Notably, conditions such as hearing impairment, HIV/AIDS, tuberculosis, malaria, and mental illness are frequently cited as reasons for referral by traditional healers (Mokgobi, 2014).

Extract 9

R: I feel like you took my follow up questions if you would ever refer to a healer

PD: Never never not even when they say phogwana (fontanelle) I don't even know what that is every child has a phogwana you know when I was working in Hamanskraal they say every second home someone o thwasitse because I used to wonder why am I getting phogwana and all this names for things and when I ask what's that they cant even explain o tswere ke sebokwana yoo jeso ba re if ngwana a ka gonama o na le di boko(baby has worms). Hamanskrall was one of the worst but I will never in a million years I will never encourage a mother to take their child to a traditional healer and I am very vocal about it I tell them I'm even angry at them every mother I see I tell them.

(Participant 1)

The pediatrician is open about her stance on the topic. She does not entertain the possibility that there might be value in the other approach. Interestingly, she does not justify why she feels this way. It seems to be obvious to her and does not even need an explanation. The repetition of the words ("Never never not even when they say phogwana") places an emphasis the doctor's stance against the use of traditional healers. The use of phrases like "yoo jeso" and expressing anger towards the idea of taking children to traditional healers conveys strong emotional involvement and conviction in the doctor's viewpoint of taking children to traditional healers. The pediatrician critiques the reliance on traditional healers for children's healthcare, expressing a strong belief in the inefficacy or potential harm to children.

Extract 10

R: so basically what you just told me is you have never referred to a healer

Dr: id never do that the thing is what we do is if the guardian or parent they when we busy taking history and they busy telling us that I think I have to say it in Sesotho like rakgadi did this rakgadi said this ba loya ngwanaka (aunty is bewitching my child) then that's when you say ohk if that's the case where you are currently we do not deal with that because we do not deal with rakgadi wa loya ad what what we can't actually help you because we can't see but in order to get help im sure you know where to go and they always say we know so you just say you know where to go so ya they usually say yes we know some will tell you

about a prophet and what what what then you just finish whatever we are doing and they leave so we don't directly refer *(Participant 2)*

The doctor notes that if a problem cannot be observed, it cannot be treated, reflecting a reliance on the biomedical and scientific paradigm. In contrast, when Indigenous doctors refer their patients to hospitals, they simply say "hospital," explicitly naming the biomedical institution. However, this doctor avoids directly acknowledging the traditional healing paradigm, instead saying, "I'm sure you know where to go." This subtle phrasing implies the existence of an alternative framework but leaves it unnamed and somewhat illegitimate. By covertly acknowledging it while avoiding direct reference, the doctor reinforces the dominance of the biomedical model while marginalizing the legitimacy of other paradigms.

The doctor is not just that addressing health concerns due to supernatural causes "falls outside the scope of conventional medicine" but that it directly contradicts conventional medicine. This could be because she wants to create an unnecessary delay for the parent in seeking assistance from a traditional healer. This potentially confuses or reinforces existing power dynamics. It is a tension between what people believe and what they do in practical situations.

4.1.4 Medical practitioners working together

Medical practitioners working together reveal that the goal is to save the lives of sick children and reduce the death of children. South Africa is a country that has a cultural diversity with people having different beliefs (Meier & Hartell, 2009). The integration of traditional healing into primary healthcare systems is a topic of discussion. Some individuals support its inclusion, while others hold reservations (Mokgobi, 2013). The collected data reveal that biomedical and Indigenous medical practitioners do acknowledge each other, and they believe them working together will not only reduce the disagreements between each other but also reduce the rate of child mortality.

In this section, I analyze the discourses of Indigenous and biomedical medical practitioners working together. I begin with a few examples of data on biomedical practitioners expressing their views while working along with the Indigenous medical practitioners. I'll then continue by discussing the views of Indigenous medical practitioners regarding working together with biomedical medicine practitioners.

A divide exists between some biomedical practitioners and traditional healers. Biomedical practitioners express concerns about the scientific basis and regulatory frameworks surrounding traditional healing practices (Hopa et al., 1998). This perspective can be critical, with some medical practitioners labeling traditional healers as illiterate. However, other healthcare professionals hold a more positive view, advocating for the safety and effectiveness of traditional medicine in treating specific conditions like schizophrenia and epilepsy (Addis et al., 2002; Mokgobi, 2013).

Extract 11

R: so I've been seeing articles …

PD: yes you know where the working together comes from where the working together for me personally for us to impart knowledge and for them to tell us I am not dismissing me them completely but for me as a paediatrician I don't see a place for them in children because whatever they give the children there's no dose there's no measurements but we could learn from each other and that I will be able to tell them if the child has 1 2 3 4 please bring them to us and they will be able to tell us that if you see a child doing 1 2 3 4 this is what we think it is but at the same nna I would never advise to take their children or give children traditional medicine because most of them they have major side effects and we've seen it is not saying because we want to discredit traditional or Indigenous healers and we've seen it they give them the medicine and come with liver failure they come with kidney failure we have seen it time and time we can work together just to educate each other about the trades and what we are doing that's where we can work together not me referring to them we can work together by educating them about our work. (Participant 1)

The doctor portrays her role as "helping" Indigenous healers, suggesting a belief in the superiority of her knowledge. While teaching typically involves active instruction, demonstration, and feedback, her approach appears more focused on imparting her perspective, emphasizing the validity of her methods. She acknowledges the coexistence of traditional and modern practices but struggles to fully embrace the expertise of traditional healers. Her stance reflects a tension between maintaining authority and appearing collaborative.

Although she claims to seek collaboration, her language and actions suggest otherwise. She states, "I don't see a place for them," citing a lack of scientific rigor as the reason Indigenous methods

are excluded. Despite efforts to appear open, she dismisses their contributions, implying that "working together" means educating them rather than learning from them. This contradiction underscores her reluctance to truly integrate traditional healing into her medical framework.

Extract 12

R: so I've recently seen articles where traditional healers are saying that the biomedicine and Indigenous healers should work together to help do you think that would work

Dr: it would work yes if people get some health education like the things that I've just spoken about now like when you give a childlike let's say a certain concoction like a traditional concoction you must check the measurements and stuff and if something happens immediately after that is worrisome then they should make sure they take the child to the hospital as soon as possible and when they get to the hospital the parent inform the doctors or the nurses that the child took medicine from the traditional healer and this is what happened after then we know which route to take then that's an easier route to take I think it can work together *(Participant 2)*

The doctor agrees on collaboration between traditional healing practices and medical care, particularly in treating children who have ingested traditional concoctions. The word "concoction" can be very patronizing because it diminishes the cultural value of the remedy, suggesting that it's merely a random mixture rather than something created with care, knowledge, and tradition. It comes across as dismissive. She emphasizes the importance of health education, precise measurement when administering traditional medicines, and prompt communication with healthcare professionals if adverse reactions occur. Additionally, the collaboration appears to favor bringing children from traditional doctors to "real" doctors, rather than the reverse. The doctor expresses doubt about the success of this collaboration, using conditional language like "It would work, yes, if people received proper health education."

Extract 13

Dr: I think we can work together so but there has to be a lot of like education going on in between that will work otherwise we will continue seeing what we are seeing mortality and we do get children who are brought in after ingestion of traditional medication and you find that medication was too strong and whatever whatever sometimes they get brought in

too late and you find that the child is worse and then we can resuscitate and we win but some we don't unfortunately. *(Participant 3)*

The doctor says that if "people" get some health education, she could be referring to the children's parents and the traditional healer. She is implying that the "successful conditions" include Indigenous healers becoming more educated about medicine. As a medical doctor, she does not mention the need to get health education from the traditional healer, making her profession the only one that should be taught. According to the doctor. Working together means that if people take their kids to Indigenous healers and the treatment fails, they should come to the hospital. The doctor is explicitly blaming high mortality rates on Indigenous healers by saying 'will continue seeing what we are seeing mortality'.

Theme 2: Blame shifting

Going back to the social construction of childhood and who is responsible for young children, the practice of blame shifting is a way of negotiating, claiming, or absolving responsibility for a sick child. As the following analysis indicates, responsibility for the death of a child is a primary concern in these practitioners' talk about child deaths. While all the participants engaged in this practice of blame-shifting, differences were also observed which shows how the findings show how these constructions of responsibility of the child, and discourses of childhood, are strengthened through careful analysis of these practices.

4.2.1 Blaming Parents

The following interview excerpts focus exclusively on biomedical practitioners, offering a comprehensive analysis of how blame-shifting occurs within this context. These excerpts respond to various interview questions, revealing patterns in how blame is attributed. Biomedical practitioners frequently shift blame to parents, citing their illiteracy or delays in seeking medical attention for sick children. They also point to systemic issues, such as resource shortages and transport delays, as state-level failures contributing to child mortality. Furthermore, societal challenges faced by communities are often invoked as additional factors in this blame-shifting dynamic.

Extract 14

R: So do you think with more health education put in place will also help in reducing the percentages of child mortality

Dr: I've had cases that could've been avoided for example the caregiver came too late, a mom bringing in a child with three days of gastro. *(Participant 2)*

After the doctor had highlighted the need for health education, I asked if implementing additional health education programs could reduce child mortality rates, specifically by educating parents on health practices, recognizing early symptoms of illnesses, and the importance of timely medical care. This question addresses not only the causes and solutions of child mortality but also emphasizes the role of health education in enhancing parental responsibility and achieving successful outcomes. By asking this question, I encourage doctors to share their experiences and perspectives, shaping the narrative and discourses around child mortality and revealing assumptions about the role of education and parental responsibility.

The doctor's mentioning that the "caregiver came too late " implies a lack of urgency and timeliness in seeking medical care. Using "too late" suggests a missed opportunity or a failure to act promptly to save the child's life. This provides the doctor with the opportunity to implicate the parent in the death of the child. By mentioning "the caregivers", such as parents or guardians, without specifying a particular relationship. She then provides a specific example of a "mom bringing in a child with three days history of gastro." This concrete illustration adds specificity to the discourse, it shows how people assume that "caregivers" are usually "moms", emphasizing a discourse that establishes moms as most responsible for their kids.

Extract 15

PD: The problem starts from home, the child was kept at home for days and days, The Mom brought in a child with three-day history, delayed health-seeking behavior from the parent,

(Participant 1)

The doctor places the responsibility for the child's health on the mother, suggesting that the problem of child death begins at home. This implication highlights the domestic environment, particularly pointing to the mother as the root cause (Bornstein & Putnick, 2016). The doctor emphasizes her role in the child's well-being by focusing on the mother as the primary caregiver.

The mention of the mother bringing in the child draws attention to her involvement in the situation, leading to the accusation that she is to blame for the child's death due to delayed medical intervention.

The reference to the duration of symptoms ("days and days," "three days history") suggests parental neglect. In contrast, "delayed health-seeking behavior" is a medical term that repositions the doctor as a professional. This term implies that the parent did not seek medical assistance promptly, potentially worsening the child's condition, and subtly shifting the blame onto the mother.

Both "days and days" and "delayed health-seeking behavior" highlight the delay in seeking medical help. "Days and days" is informal and conversational, emphasizing the extended period before seeking help, but its casual tone is less authoritative for formally assigning blame. On the other hand, "delayed health-seeking behavior" sets a formal and clinical tone (Ukwaja et al., 2013). This technical language suggests a deeper understanding of the issue, making it more authoritative and professional. It frames the delay as a systematic problem, justifying the blame on parents in a way that appears supported by evidence.

Extract 16

Dr: You find that the child was kept at home for days and days and they had like gastro and you check why wasn't the child brought in because they started being weak but they were still kept at home; you find that the parents are not literate enough so they thought that the child will get better *(Participant 3)*

In cases where a child was kept at home for an extended period despite showing symptoms of gastroenteritis, introducing a reason for the delayed medical intervention becomes clear. For example, if a child became weak over several days but was still kept at home, it might be found that the parents were not literate enough to recognize the severity of the illness, believing the child would naturally recover. This introduces the reason for parental illiteracy, which helps explain why the child was not brought in for medical care sooner. This reasoning sheds light on the parents' actions and subtly shifts blame by suggesting that their lack of education contributed to the delay in seeking medical help. The illiteracy comment is also a potential comment on society, that parents are not sufficiently educated.

In these examples, parents are solely blamed for the delay in seeking medical help, with the blame entirely on their actions or inactions, ignoring underlying factors. The child, suffering from gastroenteritis, was kept at home despite getting weaker, without any consideration of socio-economic or educational barriers. When contextual factors like lack of education or awareness are considered, the blame is shared. The child was kept at home because the parents, being illiterate, did not recognize the illness's severity and believed the child would naturally recover. Without considering the reasons, the blame is harsh and straightforward, often leading to solutions focused solely on parental behavior, such as reprimanding or educating them This accusatory tone contrasts with a more empathetic and analytical approach that includes reasons, "blaming" the parents, contrasting with and without reasons for their behavior. Recognizing systemic issues like illiteracy provides a comprehensive understanding of the parents' actions, and sharing responsibility.

Providing a reason for the parents' actions does not absolve them of responsibility entirely, but it does contextualize their behavior, affecting how they are perceived. While it does not completely excuse the parents, it mitigates their culpability by placing their actions within a broader context, acknowledging that their decisions were influenced by factors beyond their control. Citing illiteracy as a reason fosters empathy and understanding, shifting some focus from parental neglect to the systemic issues that contribute to their behavior. However, it could also be interpreted as an excuse for negligence, reinforcing perceptions of the parents as unfit or incapable. Highlighting parental illiteracy may underscore their deficiencies, making them seem more neglectful, even if those deficiencies result from factors beyond their control. Parental illiteracy is generally seen as beyond the parents' control, often stemming from a lack of access to education, socio-economic conditions, and systemic failures in the education system.

Extract 17

D: find that the parents are not literate enough, you ask about motswako (rehydration solution) those things are on the road to health card very nicely they will tell you no I didn't make it for the child why they don't know why some of them can read some of them cannot read it's just a lot of factors. *(Participant 2)*

Many parents may not be literate enough to read and understand the Road to Health card instructions. This lack of literacy directly affects their ability to comprehend and follow health recommendations, such as making rehydration solutions (like motswako) for their children.

The Road to Health card is designed to provide essential health information and instructions in a clear and accessible manner. It is a government and public health initiative, so it brings in the discourse of governmental and public health, the State educating illiterate parents, a way for parents to be directed by professionals in how best to care for their kids. While the card includes valuable information, its effectiveness is compromised if parents cannot read or understand it.

When asked about using the rehydration solution, some parents admit they did not make it for the child. Their responses indicate a lack of understanding or awareness of its importance, often due to their inability to read or comprehend the instruction. This reveals the irony of a state initiative that educates parents without providing the educational infrastructure that would allow them to read it in the first place. Failure to use recommended health interventions like the rehydration solution can worsen the child's health outcomes. The doctor acknowledges the variability in parental literacy levels, with some parents being able to read and understand health-related information while others cannot. This variability provides the doctor with the gap of placing the blame for the child's death on the parents.

4.2.2 Resource Constraints and Their Impact: System Errors, Transfer Delays, and Teenage Education.

The roots of South Africa's healthcare system lie in the apartheid period (1948-1993). During this time, the system was deeply fragmented and discriminatory, with differences in access and quality of care provided determined by race (Baker et al., 2021). The segregation of Africans led to the deterioration of service delivery because of a lack of resources, and poor communities were especially affected (Maphumulo & Bhengu, 2019).

Despite notable progress in enhancing healthcare delivery in South Africa following the 1994 elections, ongoing public concerns persist. These concerns, as highlighted in news articles, primarily revolve around resource constraints within public institutions (Chassin & Loeb, 2013). Resource constraints are used by practitioners as a commonsense reason or excuse for any failures in medical care. Furthermore, these constraints are identified by reference to apartheid and post-apartheid inequalities in the public health sector so that it is impossible to blame any single individual or organization. The reliance on discourses of race-based health inequities suggests that these are still a major concern and problem in contemporary public health.

Extract 18

R: Are there any cases that you have lost where you feel like something could have been done to help the baby survive?

DR: Mostly maybe the delays in transfers, have more to do with system errors not necessarily on our side. *(Participant 3)*

I asked the doctor if there had been any instances or situations where a baby did not survive. This question aimed to explore the doctor's experiences and to understand their opinions and perspectives on the factors that may have contributed to the baby's death. By inquiring about specific cases, I wanted to gain perceptions of the doctor's thoughts on whether certain actions, interventions, or changes in circumstances might have made a difference in the baby's survival. The goal was to elicit comments from the doctor that you can identify as discourses on childhood and medicine.

The doctor acknowledged the existence of delays in transfers, suggesting that they are a recurrent issue within the system. This acknowledgment indicates an awareness of the problem. The statement suggests that systemic errors rather than internal factors predominantly cause delays. This implies that factors are external to the doctor's control. By stating that the delays are "not necessarily on our side," the doctors appear to distance themselves from direct responsibility for the issue of children dying. The doctor suggests that, although people might assume the fault lies with the doctors, this is "not necessarily" the case. In other words, the doctor is proactively refuting an implied question about their competence that has not been directly asked.

The doctor is also shifting blame by acknowledging the existence of delays in transfers within the healthcare system. By framing these delays as a recurrent issue and predominantly caused by systemic errors, the doctor implies that the responsibility for these delays lies outside their control, not the states.

Extract 19

Dr: Waiting for three hours four hours whatever or maybe they tell you there's no intensive trained like advanced life support paramedic available, Cases that you wish that err

because you can't control, there are no ambulances at the time, lost in the hospital because of transport and stuff, ambulances being delayed. *(Participant 2)*

The doctor indicated extended waiting times of "three hours four hours whatever." This emphasizes the frustration and uncertainty experienced by the doctor when faced with prolonged delays in emergency medical response. The doctor has to work within this context, and they view it as a frequent cause of their treatment failures.

The mention of the unavailability of advanced life support paramedics highlights resource constraints within the healthcare system. This suggests that the lack of trained personnel contributes to delays in providing critical care to patients, potentially compromising the child's health outcome.

The doctor acknowledges the existence of cases where healthcare professionals wish for better outcomes but are hindered by factors beyond their control. This recognition suggests a sense of helplessness when faced with systemic deficiencies and logistical challenges, therefore blaming the lack of resources when death occurs. The doctor mentions available trained paramedics, ambulance shortage, transport issues, and long waiting times for transfers. These are all systemic inefficiencies that are due to insufficient resources.

Extract 20

PD: nursing care in the ward was substandard *(Participant 1)*

The doctor provides us with a direct assertion regarding the quality of nursing care, describing it as "substandard." This choice of language indicates a clear and critical evaluation of the care provided, highlighting significant deficiencies. By labeling nursing care as substandard, the doctor not only emphasizes the gravity of the issue but also distances herself from the perceived failures in patient outcomes. This allows her to shift some of the responsibility away from her practice and onto the broader system of care, particularly the nursing staff. Furthermore, "nurses being substandard" feeds into a larger social issue concerning problems with nursing staff, including potential understaffing making nurses tired and stressed, inadequate training, lack of resources, and systemic challenges that impact the quality of care (Mbombi et al., 2018).

Ectract 21

Dr: There are still some areas in the country where you'll get or those communities where they still walk certain kilometers or distances to get to the clinic. Such contributes to child mortality, there are areas where a particular person calls an ambulance and they are not available there is still a lot to be done (Participant 3)

The doctor highlights disparities in healthcare access, noting that there are areas in the country where communities must travel significant distances to reach a clinic. The after-effects of apartheid of the inequalities of service delivery are still affecting black people in the present day. This barrier highlights inequalities in healthcare provision, particularly in remote or underserved regions.

The doctor further links the limited healthcare access to child mortality rates, suggesting that the lack of nearby clinics or medical facilities contributes to adverse health outcomes for children. The mention of individuals needing to call for an ambulance but facing unavailability highlights logistical and very much under-resourced state services challenges in emergency medical response. This suggests that even when emergency services are needed, they may not always be accessible or readily available, potentially leading to delays in critical care. The doctor highlighted that the ambulance shortage is not only a problem within the hospital but also critically affects rural areas. People in these regions often have to travel long distances to access healthcare and cannot get ambulances for those who are sick or dying. This underscores the ambulance issue even more poignantly, as it extends beyond the hospital context and impacts daily life in rural communities.

4.2.3 Blaming societal issues: it starts from home.

South Africa struggles with a significant burden of maternal and child deaths. This highlights the need for faster improvements in maternal healthcare, including perinatal and newborn health services (Mabaso et al., 2014). There are different societal factors in South Africa that cause mortality. Some communities are challenged by poor access to quality healthcare services significantly impacts child mortality rates. This includes limited access to essential services like prenatal care, childhood vaccinations, and treatment for childhood illnesses. These societal issues all contribute to a cycle of poor health outcomes for children in South Africa (Motloung & Mears, 2002). The struggle becomes more of a resource problem but a psychological problem.

Extract 22

Dr: I think the reason why we have these things is the problem is bigger than we think it starts from home like I said there are a lot of psychosocial elements involved and stuff I don't think there's much that has to do with the hospital the way they are being treated and stuff the problem starts from home *(Participant 2)*

The doctor admits that the underlying reasons for certain issues are multifaceted and extend beyond surface-level explanations. By stating that "the problem is bigger than we think," the doctor suggests a recognition of the issues of child death that the problem is very big, and that yet it is far bigger than we have even understood it to be. She asserts that the origins of these issues of child death lie within the home environment, implying that familial dynamics, upbringing, and socialization play significant roles in shaping individuals. This suggests a belief in the importance of addressing underlying family dynamics and psychosocial factors in addressing broader societal issues.

The doctor further contrasts the influence of the home environment with the role of hospitals, suggesting that the root causes of certain issues are not primarily related to the treatment or care received within healthcare facilities. This differentiation is evidence that the doctor is removing herself from the deaths that are occurring in hospitals by suggesting a causal link between family dynamics and broader societal problems.

Extract 23

R: is there anything from this interview you didn't tell me and you think you can add that will help shed light

PD: what I can say is that yes child mortality in South Africa is high because number 1 we are a third-world country we don't have resources and unfortunately, we have a high rate of people from low socio-economic backgrounds we don't have a lot of educated people.

(Participant 1)

The doctor starts by quantifying child mortality and noting that it is "high". They Identify that there is a problem and attribute high child mortality rates in South Africa to several factors, primarily the country's status as a third-world nation. This causal attribution suggests a belief that

broader systemic and structural issues contribute significantly to the problem. It also assumes a shared common knowledge of what being a “third-world country” means.

She highlights the lack of resources as a primary factor contributing to high child mortality rates. She also mentions the low levels of education among the population as a factor influencing child mortality rates. This implies that education plays a role in health literacy, and access to healthcare services. The doctor here uses the issue of illiteracy in communities as a reason for child mortality.

She further identifies low socioeconomic backgrounds as another contributing factor to high child mortality rates. This suggests a recognition of the impact of poverty, inequality, and socioeconomic disparities on access to healthcare, nutrition, and other essential resources necessary for child health and well-being, providing her with the opportunity to place the cause of child death on the socioeconomic status of the country.

Extract 24

PD: Other people so I think one of the reasons is the lack of education and the lack of knowledge and the fact that parents don’t bring their children in time they can see when their baby is in dire need of medical intervention, and it comes down to poverty and lack of education that’s one thing I can add *(Participant 1)*

The doctor mentions the delayed medical intervention for children due to several factors, including the lack of education and knowledge among parents. This suggests a belief that parental education levels and awareness of health-related issues play a significant role in determining when children receive necessary medical attention. She emphasizes the importance of parents recognizing when their child requires medical intervention. This implies that parental observation and judgment are crucial in identifying signs of illness or distress in children, highlighting the need for parental education and awareness programs and the surveillance requirements that are a feature of modern parenting - we are expected to constantly monitor our children for signs of illness.

The doctor links delayed medical intervention to broader socioeconomic factors, particularly poverty and lack of education. This suggests a recognition of the impact of social determinants significantly influencing the child's poor health and subsequent death. The family's inability to afford nutritious food played a major role, and with better education, the parents might have known to seek medical help or use their knowledge of health education to prevent the tragedy.

4.2.3 Blaming Parents

Extract 25

Th: our people are not attentive, you will find that the child has been sick for days and the parent has not taken the child to the right places, the parent likes taking time, and most of them like to lie. You can see that the child's illness, let's say the child was vomiting and had diarrhea for a long time, she decides to take two days and brings the child to you on the third day and other times the lies of the parents can cause deaths, the child is sick, and they keep them. *(Participant 4)*

The traditional healer perceives a lack of attentiveness among parents regarding their child's health, suggesting a belief that parents may not prioritize seeking timely medical care, potentially leading to adverse health outcomes. She describes instances where parents delay seeking medical attention for their sick children, attributing this delay to factors such as taking time and possibly lying about the severity or duration of the illness. In contrast, biomedical doctors attribute the issue to factors beyond the parents' control, such as illiteracy, presenting it as a reason rather than an excuse. However, the traditional healer places the blame squarely on the parents with statements like "the parents like to wait, like to lie," portraying them negatively as if they are willfully neglectful. Her use of "our people are not attentive" indicates that she is part of the community she critiques (Whitehead, 2013).

The traditional healer further highlights the potential consequences of parental lies or deception regarding their child's health, suggesting that dishonesty can lead to fatal outcomes. Withholding or misrepresenting information about the child's illness may impede timely and appropriate medical intervention. When parents' lies are said to cause deaths, it reveals that in this traditional paradigm, parents are viewed negatively and constructed as irresponsible or neglectful. Discursively, this characterization implies that parents are seen as unreliable, with their actions or inactions directly contributing to severe consequences.

Extract 26

Th: another thing relating to child mortality is that you will find a person getting pregnant while they are stressed, they don't want the pregnancy or the partner denies the child after telling them that they are pregnant then you will find that maybe the mother's mind is not

in the right state, she is not eating right or she is not eating at all or she takes a long time without taking her medication while they are carrying a life. Another thing is the person deciding by themselves to kill the child after giving birth because the father denied the child. *(Participant 4)*

The traditional healer speaks about the impact of psychological stress on pregnancy outcomes, noting that individuals may become pregnant while experiencing stress or without wanting the pregnancy. This suggests that she is aware that the stress during pregnancy can negatively affect maternal health and potentially impact the health of the developing fetus. She is using this kind of medical or scientific information in her account. She discusses scenarios where partners deny the existence of a child or express disinterest in the pregnancy. This denial or lack of support from the partner may contribute to maternal distress and affect the mother's mental and emotional well-being, which is a well-known fact about single-parent households (Langa, 2010). The traditional healer appears to be attributing the child's death to the parents' lack of focus on their mental health throughout the pregnancy. This approach differs from a traditional healer who would typically offer support to ensure a healthy pregnancy and birth.

The traditional healer highlights the importance of maternal nutrition and medication adherence during pregnancy, suggesting that maternal neglect, such as not eating properly or skipping medication, can have serious consequences for both the mother and the developing fetus. She discusses the distressing scenario where a mother may decide to harm or kill the child after birth due to paternal denial. This discourse reinforces traditional gender roles by emphasizing maternal duties and implying that mothers are solely accountable for child health while failing to equally address the responsibilities and societal pressures faced by fathers and other caregivers.

4.2.4 Societal issues.

Extract 27

Th: Another thing is the livelihood of now, you can see, lets say it was the 2nd of September, everywhere I think even if a person can tell us today what was happening yesterday, doctors and those who were in hospitals, the rate that our youth are drinking alcohol, there is no girl there is no boy, imagine the kind of child that a pregnant person may bring.

The traditional healer observes a prevalent pattern of alcohol consumption among youth, noting that it is pervasive and occurs frequently. This suggests a perception that alcohol use is widespread and normalized among young people in the community. She uses the specific date of September 2nd as a reference point to emphasize the closeness and recency of the observed alcohol consumption. This may also relate to payday typically falling on the 1st of the month, implying shared community knowledge about increased alcohol consumption following paycheck disbursement. By fixing the discourse on a specific date, she highlights the relevance and currency of the issue.

The traditional healer expresses concern about the potential impact of alcohol consumption on pregnant individuals and their unborn children. She implies that the high rates of alcohol consumption among youth may result in pregnancies where the health and well-being of the child could be compromised due to maternal alcohol use The traditional healer blames the fact that mothers who drink have babies and are born sick and can die easily. She does this by highlighting the interconnectedness of alcohol consumption among youth and its implications for reproductive health and pregnancy outcomes. The biomedical doctors mentioned poverty and lack of education as factors beyond the parents' control. In contrast, this traditional healer attributes the issue to poor morals, lack of care, and responsibility on the part of the parents, implying that it is fully within their control.

4.2.5 Spiritual forces

In southern Africa, traditionally illness is interpreted through a multifaceted lens. Beyond the biological explanation (e.g., ulcers as a product of aging), social, religious, and witchcraft interpretations also play a significant role. For instance, gastroenteritis might be attributed to "idliso" (bewitchment through food)(De Villiers F.P.R. & Ledwaba M.J.P., 2003). While medical doctors are valued for their surgical skills, powerful medications, and understanding of the biological causes of illness, their communication can be lacking. Additionally, accessibility in certain areas, and perceived neglect of the patient as a whole person including family and social context can be drawbacks. Furthermore, doctors may be unfamiliar with "traditional diseases" attributed to ancestral or witchcraft origins.

Extract 28

Th: we do have sociocultural illnesses, others are caused by the child not sleeping and crying all night and not eating, we try feeding him and he refuses you'll find that those children's ancestors don't want them growing up in other families. Let us say you are born with the ancestral gift and they say that when you give birth your first child will be given this gift, then you give birth to your first child outside with a person you are not even married to, this is where the problems and illnesses of this kind start.

The traditional healer indicates the existence of illnesses that are influenced by sociocultural factors, suggesting that these illnesses are not solely biological or physiological. This implies a recognition of the interconnectedness between cultural beliefs, social dynamics, and health outcomes. She attributes some illnesses, such as those characterized by a child's persistent crying, refusal to eat, and sleep disturbances, to ancestral influence. This suggests a belief in the spiritual or ancestral origins of certain health issues, where ancestors may play a role in determining the health and well-being of children within families. Including herself, in the treatment, and the child is still refusing. In other words, it is "bigger" than the treatment, since it is ancestors. Although this is about ancestors, it strongly suggests blaming the parents, citing a lack of morality and children born outside of marriage. The parents who are perceived as immoral, or having children outside of marriage, are more likely to experience the death of their children. This perspective suggests a direct link between perceived parental immorality and adverse outcomes for their children, effectively blaming the parents for the tragedies that befall their families and it strongly resonates with religious discourses of illness, before modern medicine, where people believed that immorality caused sickness.

Because the traditional healer believes that sickness is not only caused by biological factors but also by spiritual and external forces she discusses the potential consequences of giving birth outside of traditional cultural norms, such as having a child with someone to whom one is not married. This deviation from cultural expectations is believed to contribute to problems and illnesses, particularly those related to ancestral gifts or spiritual influences. The traditional healer blames the spiritual forces that attack the sick child as the cause of the child's death. She does this by highlighting the complex interplay between cultural beliefs, societal norms, and health outcomes suggesting that deviations from cultural traditions or expectations can have implications.

Extract 29

Th: Another thing about child illnesses is giving the child a certain name that can cause the child to have epilepsy while the child is not even a year old.

The traditional healer advocates a belief that the name given to a child can influence their health outcomes, specifically mentioning the potential for a certain name to cause epilepsy in children. This implies a cultural belief in the power of names to affect a child's well-being and health status. She highlights the potential for children to develop epilepsy at a young age, even before reaching one year old. This suggests a perception that epilepsy can manifest early in life and may be influenced by factors such as the child's name.

The discourse stresses the importance of cultural beliefs and practices in shaping perceptions of health and illness. Naming practices are viewed as having significant implications for health outcomes, highlighting the cultural significance attached to names within the community.

The traditional healer is shifting blame by attributing the cause of epilepsy in children to the name given to them. By advocating a belief that certain names can directly influence health outcomes, particularly the development of epilepsy, the traditional healer deflects responsibility away from her role as a healer to spiritual forces from ancestors.

The final section showcases a dynamic where blame is shifted between medical practitioners regarding the tragic loss of a child's life. This blame game, as observed in the research by Ashforth (2002), is indicative of the underlying tension between two distinct medical practice approaches in South Africa. This tension arises from the clash of two competing orientations to medical practice deeply rooted in the country's complex history.

One orientation reflects the legacy of colonialism and apartheid, where Western biomedical practices were historically privileged and often imposed upon Indigenous populations (Ernst, 2002). This approach is characterized by a focus on scientific knowledge, technological interventions, and institutionalized healthcare systems (Stoumpos et al., 2023). In contrast, the other orientation is rooted in traditional healing practices, which have been marginalized and stigmatized by colonial authorities and modern healthcare systems. Traditional healing encompasses a holistic approach to health, incorporating spiritual, cultural, and community elements into healthcare delivery (Abdullahi, 2011).

In this section, I discuss the discourses of medical practitioners blaming each other regarding the death of a child rather than focusing on "shared" factors such as parenting, resources, or society, these practitioners direct the responsibility and failure onto an existing "other" medical paradigm. I begin with discussing excerpts from data collected from biomedical practitioners and I then continue with excerpts from data collected from Indigenous healers.

Extract 30

PD: or the caregiver gave the baby traditional medication, but for me as a pediatrician I don't see a place for them in children because whatever they give the children there's no dose there are no measurements.

This excerpt reflects a biomedical perspective that prioritizes evidence-based medicine, standardized protocols, and precise dosing regimens in pediatric care. This suggests a belief in the superiority of biomedical approaches over traditional healing practices, particularly in terms of safety, efficacy, and precision. The "for me as a pediatrician" identifies herself by her medical pedigree as a way of asserting her authority. The pediatrician assert their professional authority and expertise in pediatric care by dismissing the utility of traditional medication in children.

The pediatrician is indirectly blaming the practice of medicine traditional healers for child deaths by emphasizing the perceived deficiencies and risks associated with traditional medication use in children. Through the discourse, the pediatrician portrays traditional medication as lacking in safety, efficacy, and dosage precision, implying that its use may pose significant risks to pediatric patients. By highlighting the absence of standardized doses and measurements in traditional medications, the pediatrician suggests a concern for potential inaccuracies in dosing, which could lead to adverse effects or even death in children. She also emphasizes the importance and value of scientific approaches to treatment by saying that when they are not adhered to, children die.

Excerpt 31

R: ohk my question was going to be if the child was taken to a traditional healer was there going to be a different outcome but based on what you said traditional healers are a no-go

PD: yes 100% Yoo those people can give adults whatever but can they stop giving kids these things and the enams yooo b aba peita (using enema on kids) Jesus Christ and now Im in Limpopo and yooo I've never seen such a thing in my entire training.

The doctor employs highly expressive language, including repetitions ("100% 100%"), interjections ("yoo", "jesus Christ"), and colloquial expressions ("yooo"), to convey strong emotions and emphasis. This suggests a sense of refusal of traditional healers and frustration regarding the Indigenous healer's practices. She expresses disapproval and concern about the administration of certain treatments to children, suggesting that adults may receive such treatments but questioning their appropriateness for children. Her use of phrases like "ba aba peita" (they use enema on them) suggests a cultural reference or expression specific to the context of Limpopo, further emphasizing the pediatrician's immersion in and familiarity with the local culture and practices.

The pediatrician indirectly blames traditional healers by expressing strong disapproval and frustration regarding their practices. The use of highly expressive language, including repetitions and interjections, conveys the pediatrician's emotional reaction to the observed treatments administered by traditional healers. The use of "Jesus Christ" also implies horror about what is going on. This emotional tone suggests a refusal or rejection of traditional healing practices.

Extract 32

PD: Dying unfortunately especially those that have been to traditional healers because they give them enemas they give them muthi they put things they do scarification and all those things so then that makes the baby's condition worse so the problem is they bring in those babies to us in a very very bad condition

The medical practitioner is not taking the blame for the death of the baby. She partitions the blame by blaming those who are in the baby's life. The medical practitioner does this by expressing her concern about the unfortunate passing of the baby but immediately emphasizes that it is babies whose parents have sought help from traditional healers. She highlights that the traditional healers are the ones causing harm to the babies because they administer enemas, provide muthi, and engage in scarification. The use of the word muthi also indicates that the medical practitioner does

not consider what the traditional healers practice as acceptable. Muthi refers to traditional medication, not “medicine”- but the medical practitioner sees it differently.

According to the medical practitioner, the practice of using muthi, scaring babies, and administering enemas is what worsens the health conditions of the babies. The medical practitioner still blames the babies’ parents as she explains that there is a lack of urgency as the sick babies are brought into the hospital for life-saving medical intervention late. The babies are brought in dire conditions and from the medical practitioner’s side, they cannot do anything to save them leading to the death of the baby.

Extract 33

TH: and there is a possibility that you take a child to the doctor and they find that there is a sociocultural illness that they will treat according to their research

The use of the phrase "there is a possibility" suggests that the traditional healer is introducing a hypothetical scenario rather than asserting a concrete fact. This allows for the suggestion of potential blame without making direct accusations. The traditional healer suggests that the doctor may diagnose a sociocultural illness, implying that the doctor's diagnosis may not be accurate or appropriate. Essentially, doctors do not know how to treat sociocultural illnesses - if they treat it with their research, they get it wrong. By introducing this new category of “sociocultural” illnesses the healer implies that it is not only medical illnesses that cause death, and doctors are not equipped to treat them. The traditional healer implies that the doctor's treatment approach is based solely on research, suggesting a lack of consideration for sociocultural factors or traditional healing practices. This implies a criticism of the doctor's approach to healthcare, positioning traditional healing as a potentially more holistic or culturally sensitive alternative. By introducing the possibility of a sociocultural illness being diagnosed and treated by the doctor, the traditional healer subtly shifts responsibility away from themselves and onto the doctor. This implies that any negative outcomes or misunderstandings related to the treatment of sociocultural illnesses should be attributed to the doctor's actions or decisions.

Despite the blame-shifting practices discussed earlier, a significant finding from this study is the presence of notable cooperation between different types of practitioners. In some cases, evidence suggests collaboration takes precedence over blame.

Extract 34

TH: Even now Mahlako, there is diabetes for kids and it is not everyone who is aware of juvenile diabetes, it is not many traditional healers who know this so if a child is at school and they are like that, let's say they get low sugar levels then they will say its witchcraft. Traditional healers should now go to school, t the new generation of traditional healers should study so that they get information both traditionally and scientifically.

The traditional healer acknowledges the presence of diabetes in children and highlights that not everyone is aware of juvenile diabetes. This suggests a recognition of the importance of raising awareness about this condition, particularly within traditional healers. She points out that not many traditional healers are familiar with juvenile diabetes. Scientific terminology situates her as a traditional healer who is open to scientific discourse, centering the patient rather than one way of doing things. This implies a gap in knowledge or understanding among traditional healers regarding this specific health issue, potentially leading to misdiagnosis or mismanagement of diabetes cases within traditional healing practices. Discursively, what it does is it brings "juvenile diabetes" into Indigenous discourse and says that there is space for both kinds of practice in Indigenous medicine, that you can be scientific and still be Indigenous.

The traditional healer further suggests that due to a lack of awareness and understanding, some children with diabetes may have symptoms misattributed to witchcraft by traditional healers. She advocates for traditional healers to receive formal education and training, both in traditional healing practices and scientific knowledge. This implies a recognition of the importance of integrating traditional healing with biomedical understanding.

Therefore, these discourses communicate the divide between biomedical and Indigenous medical paradigms in South Africa, highlighting differing approaches to understanding, diagnosing, and treating child mortality. They reveal how biomedical practitioners focus on scientific, evidence-based, and clinical methods, while Indigenous healers incorporate holistic, spiritual, and cultural perspectives, resulting in contrasting narratives and tensions between the two healthcare systems.

Chapter 5: Discussion

The study aimed to examine how health practitioners talk about child mortality, its causes, treatments, and possibilities for prevention. It investigates the medical narratives surrounding child deaths in South Africa, focusing on how these narratives shape, reinforce, challenge, and resist broader discussions on biomedical and Indigenous health practices. To achieve this, the study sought to answer several key questions: How do medical practitioners describe how they practice medicine on children? How do medical practitioners talk about preventative treatment for children? How do medical practitioners construct the causes of childhood death? and, how do medical practitioners' medical constructions support or refute how discourses of health and medicine? This chapter will discuss the two key themes identified in the study. The themes are blame-shifting and paradigms of medical practice. Within the blame-shifting theme, biomedical practitioners attributed responsibility to parents, resource limitations, and societal issues. Traditional healers, similarly, blamed parents and societal factors but also emphasized spiritual and external forces. The paradigms of medical practice are evident in areas such as diagnosis and treatment, the referral process, the definition of a child, and the collaboration between medical practitioners.

5.1 Blaming shifting

Blame shifting occurs when medical practitioners deflect responsibility or avoid accountability in cases of child death. This practice may arise in cases when healthcare providers are unable to explain the cause of death or may be cautious about taking responsibility for potential errors or oversights. In such situations, practitioners may seek out gaps in procedures to transfer the blame elsewhere, whether to external factors, other medical personnel, or even to the parents or the child's preexisting conditions. Blame shifting shows exactly how accountable/problematic/blameworthy a child's death is, further reinforcing "child mortality" and "child health" as structuring discourses. By showing that someone always needs to be held responsible for a child's death, these doctors orient to the discourses that make childhood a unique and distinct period where children need more safeguarding than other people

What makes blame shifting particularly concerning is its prevalence across various medical approaches. While the underlying behavior of avoiding accountability is consistent, the methods and justifications for shifting blame differ. In some cases, practitioners may highlight institutional

challenges, such as insufficient resources or systemic failures. In contrast, others may point to cultural or traditional medical beliefs that affect the treatment process.

5.1.1 Blaming the parents

Biomedical practitioners often shift blame onto parents by emphasizing their illiteracy, implying that a lack of education hinders their ability to understand basic health practices. This knowledge gap is seen as a barrier to following essential guidelines, many outlined in the "Road to Health" book provided by the health government. Practitioners argue that because these health practices are clearly illustrated, parents' failure to adhere to them can be attributed to their inability to comprehend the information, ultimately shifting the responsibility for poor child health outcomes onto them. Indigenous healers, much like biomedical practitioners, share the belief that parents play a significant role in the delayed treatment of sick children. They often hold parents accountable for seeking help only after the child's condition has worsened, which can hinder effective intervention. Furthermore, both groups express concern that some parents may provide incomplete or misleading information when questioned about their child's health or the circumstances leading to their illness.

5.1.2 Blaming the state

Beyond the parents, the state is also frequently blamed for the resource constraints plaguing the healthcare system. Hospitals often face chronic shortages of staff, equipment, and essential medicines, along with system errors and transportation delays that can severely impact timely medical interventions. Practitioners point out that these systemic failures are beyond their control, leading to suboptimal care that further endangers children’s health.

The inadequacies of the state's role in healthcare extend beyond the hospital walls, as it fails to provide sufficient public health education that could empower parents to take a more active role in managing their children's well-being. This lack of educational support, combined with broader social issues like poverty and inadequate infrastructure, exacerbates the healthcare challenges facing underserved communities. Poor access to quality healthcare services leaves many families struggling to meet basic health needs, further complicating efforts to ensure the health and survival of children in these vulnerable populations.

In this complex dynamic of blame-shifting, both parents' education and the state's shortcomings are highlighted as critical factors, diverting attention from the responsibility of the practitioners themselves. This deflection creates a cycle of accountability avoidance that prevents meaningful change and hinders the improvement of child healthcare outcomes in disadvantaged areas.

Traditional healers also engage in blame-shifting, often placing the responsibility for a child's poor health or death on the parents. One common accusation is that parents fail to pay proper attention to their child's health, delaying medical care or not prioritizing timely interventions. This delay in seeking treatment is seen as a critical factor in worsening the child's condition, with traditional healers emphasizing that early care could have prevented severe outcomes.

Another point of blame lies in parents' honesty when they finally bring their child in for treatment. Traditional healers often accuse parents of withholding important information or lying about the child's symptoms and health history. This lack of transparency, according to the healers, hinders their ability to diagnose and treat the child effectively.

In addition to individual behaviors, societal challenges are also cited as contributing factors. Traditional healers often note that parents, particularly mothers, endure stressful pregnancies due to various socio-economic difficulties. Poverty, domestic violence, and inadequate access to prenatal care are highlighted as stressors that can negatively affect both the mother and the unborn child. Alcohol consumption during pregnancy is frequently pointed out as a major social issue, with healers attributing many health complications in children to this behavior. In these cases, parents are often blamed for not taking sufficient care of their health and that of their unborn child.

Moreover, traditional healers sometimes attribute the cause of a child's illness or death to spiritual forces or external supernatural influences. In these cases, they may argue that the child's condition is beyond the control of both parents and healers, as it is the result of malevolent spirits, curses, or ancestral discontent. This spiritual framing serves as an additional layer of blame-shifting, as it diverts attention from the possibility of medical or treatment errors.

By invoking a combination of parental neglect, societal pressures, and spiritual explanations, traditional healers can avoid direct accountability while reinforcing the belief that certain outcomes are inevitable due to forces beyond human control. This multifaceted approach to blame-shifting creates a complex web of responsibility, ultimately leaving parents, societal conditions, and

external spiritual forces as the targets while minimizing scrutiny of the healer's practices and decisions. As much as there is blamed to be placed on these systemic issues and individual behaviors within child healthcare, it is important to recognize the efforts and commitment of practitioners working within both biomedical and indigenous healthcare systems. Acknowledging their work alongside systemic limitations ensures a more balanced understanding and opens paths for collaborative improvements in child health outcomes.

5.2 Different medical practice paradigms

The data reveals two distinct paradigms that medical practitioners use to view, understand, and respond to child death: the biomedical and the Indigenous medicine healing perspectives. Medical doctors approach death primarily from a medical standpoint, focusing on physical causes and scientific explanations. In contrast, traditional healers incorporate cultural beliefs that address both the spiritual and physical well-being of the child.

5.2.1 Diagnosis and Treatment Approaches

The diagnostic process in these two paradigms is markedly different. Biomedical practitioners rely on Western medicine, using scientific, evidence-based approaches to diagnose illnesses. Diagnosis in this framework is driven by symptoms, clinical tests, and standardized methods regulated by governing medical boards. The language used by biomedical doctors is technical and rooted in scientific principles, emphasizing objective measurements and laboratory results to inform the diagnosis.

In contrast, traditional healers utilize a different diagnostic language, often rooted in cultural and spiritual beliefs. Rather than focusing solely on physical symptoms, they may use tools such as throwing bones, divination, or spiritual consultations to determine the underlying cause of the child’s illness. This diagnostic process integrates both the spiritual and the physical, acknowledging that a child’s health may be influenced by external spiritual forces or ancestral discontent, rather than just medical factors.

5.2.2 Treatment Approaches

Once a diagnosis is made, the treatment methods in the biomedical and traditional paradigms diverge further. In biomedicine, treatment is based on scientifically tested interventions. Doctors rely on a combination of medical machinery, pharmaceuticals, and surgical procedures, all of

which are highly regulated and standardized. Medication is prescribed according to dosage guidelines, and treatment protocols are based on the latest medical research and evidence.

Traditional healers, on the other hand, follow a more fluid approach to treatment. They may be guided by spiritual forces or instructions received through divination or rituals. The remedies they use are typically natural, such as herbs or concoctions, and the process is not subject to the same level of regulation as biomedical treatments. While biomedicine demands adherence to strict scientific standards, traditional healing practices draw on centuries of Indigenous knowledge and spiritual guidance, with treatments tailored to each case based on a healer's interpretation of spiritual signs.

5.2.3 Escalation and Referral

When faced with particularly challenging or severe cases, both biomedical doctors and traditional healers recognize the need for referral, but they do so in different ways. In biomedicine, referrals are made to specialists or higher-trained doctors with access to more advanced medical technology, such as intensive care units, specialized surgeries, or experimental treatments. The focus is on increasing the level of medical intervention to address the complexity of the case.

Traditional healers, while often attempting spiritual or natural remedies first, will escalate a case by referring the patient to biomedical institutions like hospitals or clinics when the illness is deemed too difficult to treat using traditional methods alone. This referral acknowledges the limitations of their practice, while also recognizing the value of biomedicine in treating conditions that cannot be resolved through spiritual or natural means.

The patterns emerging from my findings reveal that both biomedical and Indigenous medical practitioners are grappling with similar challenges, and they are attempting to address these issues in comparable ways. Despite the differences in their approaches to healthcare, both systems are heavily guided by sets of rules and protocols that shape their decision-making processes.

5.3 Common Challenges

One significant challenge faced by both biomedical and Indigenous practitioners is the difficulty of navigating complex health issues within the constraints of their respective systems. Biomedical practitioners are bound by scientific protocols, diagnostic procedures, and regulatory frameworks that dictate how they should diagnose, treat, and refer patients. These guidelines, while necessary

to ensure standardized care, can sometimes limit flexibility, particularly in cases where more personalized or culturally sensitive approaches might be needed.

Similarly, traditional healers operate within a set of established cultural and spiritual protocols. These are often informed by long-standing practices passed down through generations. While these practices provide structure and continuity, they can also impose limitations when modern medical challenges, such as diseases that require biomedical intervention, arise. The healer's reliance on spiritual guidance, rituals, and traditional methods may not always be sufficient to address the complexity of certain illnesses, leading to similar frustrations in providing effective care.

5.4 Approaches to Problem Solving

Both biomedical and Indigenous medical practitioners strive to overcome these challenges by adhering to the rules and frameworks that govern their practices. Biomedical doctors, for instance, rely on evidence-based medicine and clinical guidelines to navigate the complexities of diagnosis and treatment. They use protocols to ensure that treatment is standardized, efficient, and based on the latest medical research. This approach seeks to ensure that patients receive care that is both safe and effective, even when the healthcare system is under pressure.

Traditional healers, in contrast, follow spiritual and cultural protocols to resolve health issues. Their approach is often more holistic, considering not just the physical symptoms but also the emotional, spiritual, and community-related aspects of a person's health. In doing so, they engage in rituals, divinations, and consultations with ancestors or spiritual forces, following strict cultural guidelines that dictate the healing process. Despite the differences in approach, the reliance on established practices in both systems points to a shared belief in the necessity of structure to guide medical care.

5.5 Impact of Rules and Protocols on Discourse

Rules and protocols, as products of language, not only create distinct discourses within medical paradigms but are also shaped by them. In the biomedical paradigm, the discourse is rooted in scientific language, which informs the formulation of clinical rules and protocols. These are built on empirical evidence, quantifiable data, and measurable outcomes, structuring how practitioners communicate, diagnose, and treat patients. While this framework emphasizes precision and

predictability, it can also feel impersonal, prioritizing medical outcomes over individual experiences.

In contrast, Indigenous medical practices are governed by a discourse that emerges from relational and cultural language. Here, rules and protocols are shaped by metaphors, spiritual terms, and cultural symbols, reflecting the emphasis on spiritual well-being, community ties, and heritage. This language and its associated practices foster a profound connection between healers, patients, and the community. However, the relational nature of this discourse can clash with the clinical rigidity of biomedicine when the two systems intersect. As much as these Indigenous ways are shaped by discourse, there is also formal regulation in place: The Health Practitioners Act 22 of 2007, in South Africa, specifically the Traditional Health Practitioners Act, aims to regulate the traditional health sector and ensure the safety, efficacy, and quality of traditional healthcare services. It establishes an interim council for traditional health practitioners and provides a framework for managing the registration, training, and conduct of practitioners and students.

The interplay between language and protocol creation highlights why tensions arise when practitioners from these paradigms attempt to collaborate. Biomedical professionals, whose protocols stem from a discourse of scientific objectivity, may view traditional methods as unscientific. Conversely, traditional healers may find biomedicine dismissive of the spiritual and emotional dimensions central to their practices. This divergence underscores how discourses and the protocols they generate reinforce the boundaries between these systems, even as they face shared challenges in addressing health and well-being.

Chapter 6: Conclusion

6.1 The study

The study aimed to explore how medical practitioners describe how they practice medicine on children. It was found that both biomedical and Indigenous medical practitioners share a common goal: to save the lives of sick children. Both acknowledge the existence of different medical practices and recognize their respective approaches to healing. Biomedical doctors follow treatment protocols based on scientific knowledge and guidelines found in medical textbooks, while traditional practitioners rely on knowledge passed down through generations. Despite these differences, there are shared practices between the two approaches. Both types of practices begin

by observing the sick child before making a diagnosis and depend on the child's parents for information about the child's condition. This collaborative process between practitioner and parent is central to both systems. Given the complexity of their methods, both biomedical and Indigenous practitioners understand that they coexist within the same communities. Although they sometimes blame each other for shortcomings in healthcare, there is also an increasing acknowledgment of the potential benefits of collaboration. Both sides have expressed a willingness to work together for the well-being of children.

Both biomedical and Indigenous medical practitioners do not offer a single, definitive treatment for children, recognizing the complexities of child health. However, primary caregivers, particularly mothers, are placed at the forefront of ensuring the child's well-being. Mothers bear the responsibility of taking preventive measures to reduce the likelihood of illness, a role that begins from conception and continues through birth and early childhood care.

In the biomedical framework, mothers are expected to attend antenatal classes and regularly visit hospitals during pregnancy, where both the baby's health and maternal nutrition are closely monitored. After birth, the baby undergoes immunizations to protect against various diseases, with a focus on medical interventions and proper nutrition to support healthy development.

In traditional practices, mothers are encouraged to seek protection for their unborn child through spiritual means, often by consulting traditional healers and requesting ancestral blessings. These rituals are seen as safeguarding both mother and child. In addition, traditional practitioners may refer mothers to clinics, blending cultural and biomedical, signaling the prevalence of preventive healthcare discourse within both frameworks.

The study explored how medical practitioners construct the causes of childhood death. Although healthcare providers are expected to save the lives of sick babies, child mortality remains a persistent issue. Medical practitioners in the study often shift the blame for child deaths onto other factors. In both the biomedical and Indigenous sectors, emphasizing the discourse links between the medical and social organization of children and their caretakers.

The historical context of the country is also identified as a contributing factor, with poor service delivery, widespread poverty, and malnutrition among children being major causes of child death.

Societal challenges, such as alcohol abuse and the struggles of impoverished communities, are also recognized as significant contributors.

Traditional healers, however, add a spiritual dimension to their understanding of child mortality. They believe that a child's death is not solely due to physical conditions but may also be determined by ancestral forces, suggesting that spiritual factors play a role alongside medical ones in determining life and death.

The study was conceptualized to understand how medical practitioners' medical constructions support or refute larger discourses of health and medicine. Medical practitioners operate within a framework of established health discourses that shape their approach to diagnosis and treatment. By examining how their medical constructions align with or challenge these larger discourses, the study reveals how practitioners' practices are influenced by, and in turn, contribute to broader health narratives. This helped in understanding their approaches to reinforce and question mainstream medical paradigms. By analyzing how practitioners' individual and collective medical constructions support or refute existing health discourses, the study identified gaps, and inconsistencies that uncover where current health discourses may be failing to address real-world complexities or where alternative perspectives might offer valuable insights.

6.2 Strengths and limitations of the findings.

The study involved a sample of six medical practitioners, although the initial aim was to interview eight participants. Due to availability issues, several practitioners were unable to participate. The interviews were conducted both face-to-face and over the phone, which may have influenced how the practitioners responded. In telephonic interviews, participants were unable to see the interviewer, potentially leading to a less engaging interaction compared to face-to-face interviews, where participants could visually engage with the researcher. The questions I asked in the interviews may have reflexively and co-created some of the answers and thus the discourses that I identified. Although the role of the researcher in qualitative research is as an active co-constructor of the data, it is important to keep in mind that these findings are an outcome of your engagement with your participants.

Another limitation of this study is the limited depth of data regarding mothers' perceived responsibility for child health, which may lead to oversimplified interpretations. Future research

should incorporate follow-up interviews with participants to explore these perspectives more thoroughly and capture a more nuanced understanding.

As a first-time researcher, the process of data collection and analysis may have influenced the quality of the data or the responses from the medical practitioners. Limited research experience could have impacted on the depth and quality of the interviews, possibly affecting how open and forthcoming the participants were. Additionally, the fact that the researcher and participants shared the same cultural background facilitated easier communication, allowing for the translation of technical medical terminology into a more accessible language. However, the study did not include biomedical practitioners from the private sector, leaving an opportunity for future researchers to explore this area in greater depth.

Chapter 7: Bibliography

Abbo, C. (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action*, *4*, 10.3402/gha.v4i0.7117. https://doi.org/10.3402/gha.v4i0.7117

Abdullahi, A. (2011). Trends and Challenges of Traditional Medicine in Africa. *African Journal of Traditional, Complementary and Alternative Medicines*, *8*(5S), Article 5S. https://doi.org/10.4314/ajtcam.v8i5S.5

Addis, G., Abebe, D., Genebo, T., & Urga, K. (2002). Perceptions and practices of modern and traditional health practitioners about traditional medicine in Shirka District, Arsi Zone, Ethiopia. *Ethiopian Journal of Health Development*, *16*(1), Article 1.

Africa, S. S. (2024, May 17). *Unemployment in South Africa: A Youth Perspective | Statistics South Africa*. https://www.statssa.gov.za/?p=17266

Alaba, O. A., Hongoro, C., Thulare, A., & Lukwa, A. T. (2021). Leaving No Child Behind: Decomposing Socioeconomic Inequalities in Child Health for India and South Africa. *International Journal of Environmental Research and Public Health*, *18*(13), 7114. https://doi.org/10.3390/ijerph18137114

Allel, K., Abou Jaoude, G., Poupakis, S., Batura, N., Skordis, J., & Haghparast-Bidgoli, H. (2021). Exploring the Associations between Early Childhood Development Outcomes and Ecological Country-Level Factors across Low- and Middle-Income Countries. *International Journal of Environmental Research and Public Health*, *18*(7), 3340. https://doi.org/10.3390/ijerph18073340

Anderson, E. L. (2014). Recommended Solutions to the Barriers to Immunization in Children and Adults. *Missouri Medicine*, *111*(4), 344–348.

Ansari, S. (2021). Chapter 24—Overview of traditional systems of medicine in different continents. In C. Egbuna, A. P. Mishra, & M. R. Goyal (Eds.), *Preparation of Phytopharmaceuticals for the Management of Disorders* (pp. 431–473). Academic Press. https://doi.org/10.1016/B978-0-12-820284-5.00017-4

Armstrong, D. (1986). The invention of infant mortality. *Sociology of Health & Illness*, *8*(3), Article 3. https://doi.org/10.1111/j.1467-9566.1986.tb00298.x

Ashforth, A. (2002). An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State. *African Studies*, *61*(1), Article 1. https://doi.org/10.1080/00020180220140109

Atashbahar, O., Sari, A. A., Takian, A., Olyaeemanesh, A., Mohamadi, E., & Barakati, S. H. (2022). The impact of social determinants of health on early childhood development: A qualitative context analysis in Iran. *BMC Public Health*, *22*, 1149. https://doi.org/10.1186/s12889-022-13571-5

Azevedo, M. J. (2017a). The Colonial Medical System(s) and the Health of Africans. In M. J. Azevedo (Ed.), *Historical Perspectives on the State of Health and Health Systems in Africa, Volume I: The Pre-Colonial and Colonial Eras* (pp. 183–214). Springer International Publishing. https://doi.org/10.1007/978-3-319-32461-6_4

Azevedo, M. J. (2017b). The State of Health System(s) in Africa: Challenges and Opportunities. *Historical Perspectives on the State of Health and Health Systems in Africa, Volume II*, 1–73. https://doi.org/10.1007/978-3-319-32564-4_1

Ba', S. (2021). The critique of Sociology of Childhood: Human capital as the concrete 'social construction of childhood.' *Power and Education*, *13*(2), 73–87. https://doi.org/10.1177/17577438211011637

Baker, D., Gopalan, D., Ahmed, N., Spruyt, M., Coetzee, I., Levy, B., Welkovics, N., Richards, G. A., Mdladla, N., Rossouw, B., Thomson, D., Baker, D., Morrow, B., McCulloch, M., Mathivha, R., Mokogong, S., Paruk, F., Vasconcellos, K. D., & Joubert, I. (2021). South African guidelines on the determination of death. *South African Medical Journal*, *111*(4), Article 4.

Bekker, L.-G., Alleyne, G., Baral, S., Cepeda, J., Daskalakis, D., Dowdy, D., Dybul, M., Eholie, S., Esom, K., Garnett, G., Grimsrud, A., Hakim, J., Havlir, D., Isbell, M. T., Johnson, L., Kamarulzaman, A., Kasaie, P., Kazatchkine, M., Kilonzo, N., … Beyrer, C. (2018). Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: The International AIDS Society—Lancet Commission. *Lancet (London, England)*, *392*(10144), 312–358. https://doi.org/10.1016/S0140-6736(18)31070-5

Bornstein, M. H., & Putnick, D. L. (2016). MOTHERS' AND FATHERS' PARENTING PRACTICES WITH THEIR DAUGTERS AND SONS IN LOW- AND MIDDLE-INCOME COUNTRIES. *Monographs of the Society for Research in Child Development*, *81*(1), 60–77. https://doi.org/10.1111/mono.12226

Brown, B. B. (1987). Facing the 'black peril': The politics of population control in South Africa. *Journal of Southern African Studies*, *13*(2), Article 2. https://doi.org/10.1080/03057078708708144

Bruhn, M., & Gallego, F. A. (2012). Good, Bad, and Ugly Colonial Activities: Do They Matter for Economic Development? *Review of Economics and Statistics*, *94*(2), 433–461. https://doi.org/10.1162/REST_a_00218

Bump, J. B., & Aniebo, I. (2022). Colonialism, malaria, and the decolonization of global health. *PLOS Global Public Health*, *2*(9), e0000936. https://doi.org/10.1371/journal.pgph.0000936

Burman, E. (2008). *Deconstructing developmental psychology* (2nd ed). Routledge.

Carlsson, F., & Råberg, L. (2024). The germ theory revisited: A noncentric view on infection outcome. *Proceedings of the National Academy of Sciences of the United States of America*, *121*(17), e2319605121. https://doi.org/10.1073/pnas.2319605121

Chassin, M. R., & Loeb, J. M. (2013). High-Reliability Health Care: Getting There from Here. *The Milbank Quarterly*, *91*(3), Article 3. https://doi.org/10.1111/1468-0009.12023

Child mortality and causes of death. (2024). Retrieved May 22, 2024, from https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/child-mortality-and-causes-of-death

Crawford, T. A., & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture*, *7*(2), 131–148. https://doi.org/10.1080/13674670310001602463

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (Fourth edition). SAGE.

Cucinotta, D., & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. *Acta Biomedica Atenei Parmensis*, *91*(1), 157–160. https://doi.org/10.23750/abm.v91i1.9397

Cumes, D. (2013). South African indigenous healing: How it works. *Explore (New York, N.Y.)*, *9*(1), 58–65. https://doi.org/10.1016/j.explore.2012.11.007

Dagher, R. K., & Linares, D. E. (2022). A critical review on the complex interplay between social determinants of health and maternal and infant mortality. *Children*, *9*(3), 394.

De Villiers F.P.R. & Ledwaba M.J.P. (2003). Traditional healers and paediatric care: Issues in medicine: SAMJ forum. *South African Medical Journal*, *93*(9), Article 9. https://doi.org/10.10520/EJC68047

Department of Health (DoH). (2024). *Referral Policy for South African Health Services and Referral Implementation Guidelines—Google Search*. (2024, April 24).

Diamond, M., Peniston, H. L., Sanghavi, D. K., & Mahapatra, S. (2025). Acute Respiratory Distress Syndrome. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK436002/

Distelzweig, P. (2015). *Early modern medicine and natural philosophy*. Springer Berlin Heidelberg.

Duvenhage, A., & Louw, G. (2016). The present-day diagnosis and treatment model of the South African traditional healer. *Australasian Medical Journal*, *9*(11). https://doi.org/10.21767/AMJ.2016.2721

Edward Shizha. (2012). Health and wellness in Southern Africa: Incorporating indigenous and western healing practices. *International Journal of Psychology and Counselling*, *4*(5), Article 5. https://doi.org/10.5897/IJPC10.030

Edwards, S., Makunga, N., Thwala, J., & Mbele, B. (2009). The Role Of The Ancestors In Healing. *Indilinga: African Journal of Indigenous Knowledge Systems*, *8*(1), Article 1. https://doi.org/10.4314/indilinga.v8i1.48234

Ellis, R. (2024). *Millions of South Africans without healthcare cover*. GetSavvi Health (Pty) Ltd. https://getsavvi.co.za/community/health/millions-of-south-africans-without-healthcare-cover#:~:text=According%20to%20the%20report%2C%20out,than%2044%20million%20don't.

Fassin, D., & Schneider, H. (2003). The politics of AIDS in South Africa: Beyond the controversies. *BMJ : British Medical Journal*, *326*(7387), 495–497.

Felhaber, T., & Mayeng, I. (1997). *South African traditional healers' primary health care handbook*. Kagiso Publishers.

Foucault, M. (1978). *The history of sexuality vol. I*. https://philpapers.org/rec/FOUTHO-11

Good, M.-J. D. (1995). Cultural studies of biomedicine: An agenda for research. *Social Science & Medicine*, *41*(4), 461–473. https://doi.org/10.1016/0277-9536(95)00008-U

Gortmaker, S. L., & Wise, P. H. (1997). The First Injustice: Socioeconomic Disparities, Health Services Technology, and Infant Mortality. *Annual Review of Sociology*, *23*(1), 147–170. https://doi.org/10.1146/annurev.soc.23.1.147

Graybill, L. (2000). Lingering Legacy: Apartheid and the South African Press. *Current History (New York, N.Y.: 1941)*, *99*, 227–230. https://doi.org/10.1525/curh.2000.99.637.227

Guma, P. M., & Mokgoatšana, S. (2020). The historical relationship between African indigenous healing practices and Western-orientated biomedicine in South Africa: A challenge to collaboration. *HTS Teologiese Studies / Theological Studies*, *76*(4), Article 4. https://doi.org/10.4102/hts.v76i4.6104

Helman, C. (2007). *Culture, health and illness*. CRC press. https://books.google.com/books?hl=en&lr=&id=uz59BgAAQBAJ&oi=fnd&pg=PP1&dq=Helman,+Cecil+G.+Culture,+Health+and+Illness.+Hodder+Arnold,+2007&ots=6j9KozfIgR&sig=lD3e10WYmKHTRCYBEyA6JxMVwQQ

Hopa, M., Simbayi, L. C., & Du Toit, C. D. (1998). Perceptions on Integration of Traditional and Western Healing in the New South Africa. *South African Journal of Psychology*, *28*(1), Article 1. https://doi.org/10.1177/008124639802800102

Houweling, T. A., & Kunst, A. E. (2010). Socio-economic inequalities in childhood mortality in low-and middle-income countries: A review of the international evidence. *British Medical Bulletin*, *93*(1), 7–26.

Hussain, S., Mubeen, I., Ullah, N., Shah, S. S. U. D., Khan, B. A., Zahoor, M., Ullah, R., Khan, F. A., & Sultan, M. A. (2022). Modern Diagnostic Imaging Technique Applications and Risk Factors in the Medical Field: A Review. *BioMed Research International*, *2022*, 5164970. https://doi.org/10.1155/2022/5164970

Jain, M., Duvendack, M., Shisler, S., Parsekar, S. S., & Leon, M. D. A. (2024). Effective interventions for improving routine childhood immunisation in low and middle-income countries: A systematic review of systematic reviews. *BMJ Open*, *14*(2), e074370. https://doi.org/10.1136/bmjopen-2023-074370

Jain, V., Vashisht, R., Yilmaz, G., & Bhardwaj, A. (2025). Pneumonia Pathology. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK526116/

Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A Concept Analysis of Holistic Care by Hybrid Model. *Indian Journal of Palliative Care*, *23*(1), 71–80. https://doi.org/10.4103/0973-1075.197960

Jia, L., Zhang, W., & Chen, X. (2017). Common methods of biological age estimation. *Clinical Interventions in Aging*, *12*, 759–772. https://doi.org/10.2147/CIA.S134921

Kahissay, M. H., Fenta, T. G., & Boon, H. (2017). Beliefs and perception of ill-health causation: A socio-cultural qualitative study in rural North-Eastern Ethiopia. *BMC Public Health*, *17*, 124. https://doi.org/10.1186/s12889-017-4052-y

Kajiru, I., & Nyimbi, I. (2020). *The Impact of Myths, Superstition and Harmful Cultural*.

Kamalu, I., & Osisanwo, A. (2015). *DISCOURSE ANALYSIS* (pp. 169–195).

Kayne, S. B. (Ed.). (2010). *Traditional medicine: A global perspective*. Pharmaceutical Press.

Kayne, S. B., & Kayne, S. B. (2010). *Traditional medicine: A global perspective*. SciELO Public Health. https://www.scielosp.org/pdf/bwho/v88n12/v88n12a19.pdf

Keikelame, M. J., & Swartz, L. (2019). Decolonising research methodologies: Lessons from a qualitative research project, Cape Town, South Africa. *Global Health Action*, *12*(1), Article 1. https://doi.org/10.1080/16549716.2018.1561175

Keyworth, C., Hart, J., Armitage, C. J., & Tully, M. P. (2018). What maximizes the effectiveness and implementation of technology-based interventions to support healthcare professional practice? A systematic literature review. *BMC Medical Informatics and Decision Making*, *18*, 93. https://doi.org/10.1186/s12911-018-0661-3

Khanyile, N. C., Dlamini, P., & Masenya, T. M. (2023). Techniques in Preserving Traditional Medicinal Knowledge in uMhlathuze in KwaZulu Natal, South Africa. *The Serials Librarian*, *84*(5–8), 148–164. https://doi.org/10.1080/0361526X.2023.2286234

Krah, E., de Kruijf, J., & Ragno, L. (2018). Integrating Traditional Healers into the Health Care System: Challenges and Opportunities in Rural Northern Ghana. *Journal of Community Health*, *43*(1), 157–163. https://doi.org/10.1007/s10900-017-0398-4

Krieger, J., & Higgins, D. L. (2002). Housing and Health: Time Again for Public Health Action. *American Journal of Public Health*, *92*(5), 758–768.

Langa, M. (2010). Adolescent Boys' Talk about Absent Fathers. *Journal of Psychology in Africa*, *20*(4), 519–526. https://doi.org/10.1080/14330237.2010.10820410

Ledwaba, M. J. P. (1997). *Parental perceptions of traditional healers and hospital medicine* [PhD Thesis]. Medunsa.

Lekgothoane, N., & Ross, E. (2020). Attitudes of Black South African Mothers towards the Use of Indigenous Healing and Western Medicine in the Treatment of Newborn Infants. *Africa Journal of Nursing and Midwifery*, *22*(2), Article 2. https://doi.org/10.25159/2520-5293/7497

Mabaso, M. H. L., Ndaba, T., & Mkhize-Kwitshana, Z. L. (2014). Overview of Maternal, Neonatal and Child Deaths in South Africa: Challenges, Opportunities, Progress and Future Prospects. *International Journal of MCH and AIDS*, *2*(2), Article 2.

Madewell, Z. J., Whitney, C. G., Velaphi, S., Mutevedzi, P., Mahtab, S., Madhi, S. A., Fritz, A., Swaray-Deen, A., Sesay, T., Ogbuanu, I. U., Mannah, M. T., Xerinda, E. G., Sitoe, A.,

Mandomando, I., Bassat, Q., Ajanovic, S., Tapia, M. D., Sow, S. O., Mehta, A., … Blau, D. M. (2022). Prioritizing Health Care Strategies to Reduce Childhood Mortality. *JAMA Network Open*, *5*(10), e2237689. https://doi.org/10.1001/jamanetworkopen.2022.37689

Makhavhu, E. M. (2024). Integrating traditional and allopathic child health: A healthcare transformation opportunity. *Health SA Gesondheid*, *29*, 2501. https://doi.org/10.4102/hsag.v29i0.2501

Malakoane, B., Heunis, J. C., Chikobvu, P., Kigozi, N. G., & Kruger, W. H. (2020). Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC Health Services Research*, *20*(1), 58. https://doi.org/10.1186/s12913-019-4862-y

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, *42*(1), Article 1. https://doi.org/10.4102/curationis.v42i1.1901

Maree, K. (Ed.). (2016). *First steps in research* (Second edition). Van Schaik.

Mbombi, M. O., Mothiba, T. M., Malema, R. N., & Malatji, M. (2018). The effects of absenteeism on nurses remaining on duty at a tertiary hospital of Limpopo province. *Curationis*, *41*(1). https://doi.org/10.4102/curationis.v41i1.1924

Medicine (US), I. of. (2008). The Changing Nature of Health Care. In *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK52825/

Misirliyan, S. S., Boehning, A. P., & Shah, M. (2023). Development Milestones. In *StatPearls [Internet]*. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK557518/

Mji, G. (2019). An epistemology on health and illness according to biomedical and indigenous health knowledge perspectives. In G. Mji (Ed.), *The walk without limbs: Searching for indigenous health knowledge in a rural context in South Africa*. AOSIS. http://www.ncbi.nlm.nih.gov/books/NBK559871/

Mmusi-Phetoe, R. M. M. (2016). Social factors determining maternal and neonatal mortality in South Africa: A qualitative study. *Curationis*, *39*(1), 8 pages. https://doi.org/10.4102/curationis.v39i1.1571

Mncengeli, S., Manimbulu, N. M., & Panjasaram, N. (2016). Concurrent use of Antiretroviral and African traditional medicines amongst people living with HIV/AIDS (PLWA) in the

eThekwini Metropolitan area of KwaZulu Natal. *African Health Sciences*, *16*(4), 1118–1130. https://doi.org/10.4314/ahs.v16i4.30

Moeta, M., Mogale, R. S., Mgolozeli, S. E., Moagi, M. M., & Pema-Bhana, V. (2019). Integrating African Traditional Health Knowledge and Practices into Health Sciences Curricula in Higher Education: An *Imbizo* Approach. *International Journal of African Renaissance Studies - Multi-, Inter- and Transdisciplinarity*, *14*(1), 67–82. https://doi.org/10.1080/18186874.2019.1635505

Mokgobi, M. G. (2013). Towards integration of traditional healing and western healing: Is this a remote possibility? *African Journal for Physical Health Education, Recreation, and Dance*, *2013*(Suppl 1), Article Suppl 1.

Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation, and Dance*, *20*(Suppl 2), 24–34.

Mokgobi, M. G. (2015). *Towards integration of traditional healing and western healing: Is this a remote possibility?*

Motloung, B., & Mears, R. (2002). Combating poverty in South Africa. *Development Southern Africa*, *19*(4), Article 4. https://doi.org/10.1080/0376835022000019419

Mwaka, A. D., Achan, J., & Orach, C. G. (2023). Traditional health practices: A qualitative inquiry among traditional health practitioners in northern Uganda on becoming a healer, perceived causes of illnesses, and diagnostic approaches. *PLOS ONE*, *18*(4), e0282491. https://doi.org/10.1371/journal.pone.0282491

National Academies of Sciences, E., Division, H. and M., Services, B. on H. C., Health, B. on G., & Globally, C. on I. the Q. of H. C. (2018). The Critical Health Impacts of Corruption. In *Crossing the Global Quality Chasm: Improving Health Care Worldwide*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK535646/

National Health Act 61 of 2003 | South African Government. (2024, April 24). https://www.gov.za/documents/acts/national-health-act-61-2003-23-jul-2004

Navarro, V. (2008). Neoliberalism and its Consequences: The World Health Situation Since Alma Ata. *Global Social Policy*, *8*(2), 152–155. https://doi.org/10.1177/14680181080080020203

Nene, S. E., & Hewitt, L. M. (2023). Implementing artificial intelligence in South African public hospitals: A conceptual framework. *Acta Commercii*, *23*(1). https://doi.org/10.4102/ac.v23i1.1173

Niehaus, D. J. H., Oosthuizen, P., Lochner, C., Emsley, R. A., Jordaan, E., Mbanga, N. I., Keyter, N., Laurent, C., Deleuze, J.-F., & Stein, D. J. (2004). A Culture-Bound Syndrome 'Amafufunyana' and a Culture-Specific Event 'Ukuthwasa': Differentiated by a Family History of Schizophrenia and other Psychiatric Disorders. *Psychopathology*, *37*(2), 59–63. https://doi.org/10.1159/000077579

Nikander, P. (2012). Interviews as discourse data. *The SAGE Handbook of Interview Research: The Complexity of the Craft*, *2*, 397–413.

Nikas, N. T., Bordlee, D. C., & Moreira, M. (2016). Determination of Death and the Dead Donor Rule: A Survey of the Current Law on Brain Death. *Journal of Medicine and Philosophy*, *41*(3), Article 3. https://doi.org/10.1093/jmp/jhw002

Norozi, S., & Moen, T. (2016). Childhood as a Social Construction. *Journal of Educational and Social Research*, *6*. https://doi.org/10.5901/jesr.2016.v6n2p75

Omotoso, K., & Koch, S. F. (2017). South African trends in medical aid coverage and stated healthcare-seeking preferences: 2004–14. *Development Southern Africa*, *34*(5), Article 5. https://doi.org/10.1080/0376835X.2017.1360175

Oseni, Z., & Shannon, G. (2029). The relationship between Indigenous and allopathic health practitioners in Africa and its implications for collaboration: A qualitative synthesis. *Global Health Action*, *13*(1), 1838241. https://doi.org/10.1080/16549716.2020.1838241

Parker I. (1992). *Discourse dynamics: Critical analysis for social and psycholocigal analysis*. Routledge.

Parker, I. (1994). Reflexive social psychology: Discourse analysis and psychoanalysis. *Free Associations, 4*(32, Pt 4), 527–548.

Palmary, I. (2014). A Politics of Feminist Translation: Using Translation to Understand Gendered Meaning-Making in Research. *Signs: Journal of Women in Culture and Society*, *39*(3), 576–580. https://doi.org/10.1086/674297

Palmer, S. J. (1993). Care of sick children by parents: A meaningful role. *Journal of Advanced Nursing*, *18*(2), 185–191. https://doi.org/10.1046/j.1365-2648.1993.18020185.x

Peprah, E., & Wonkam, A. (2013). Biomedical research, a tool to address the health issues that affect African populations. *Globalization and Health*, *9*(1), 50. https://doi.org/10.1186/1744-8603-9-50

Phillips, D. A., & Shonkoff, J. P. (2000). *From neurons to neighborhoods: The science of early childhood development*.

Poirier, B., Sethi, S., Haag, D., Hedges, J., & Jamieson, L. (2022). The impact of neoliberal generative mechanisms on Indigenous health: A critical realist scoping review. *Globalization and Health*, *18*(1), 61. https://doi.org/10.1186/s12992-022-00852-2

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage Publications.

Pretorious, E. (1999). *Traditional Healers:South Arican health review*. 249–256.

Rafaely, D. (2017). The Making of Childhood Mortality in Modern South Africa. *Children & Society*, *31*(2), 110–119. https://doi.org/10.1111/chso.12170

Rahman, M. M., Alam, K., & Khanam, R. (2022). Socio-economic factors affecting high infant and child mortality rates in selected African countries: Does globalisation play any role? *Globalization and Health*, *18*(1), 69. https://doi.org/10.1186/s12992-022-00855-z

Ramavhoya, T. I., & Nesengani, T. V. (2022). Indigenous practices in health care promotion and diseases prevention. In F. M. Mulaudzi & R. T. Lebese (Eds.), *Working with indigenous knowledge: Strategies for health professionals*. AOSIS. http://www.ncbi.nlm.nih.gov/books/NBK601348/

https://www.google.com/search?q=Referral+Policy+for+South+African+Health+Services+and+Referral+Implementation+Guidelines&oq=Referral+Policy+for+South+African+Health+Services+and+Referral+Implementation+Guidelines&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQIRiPAtIBCDEyMzNqMGo3qAIIsAIB&sourceid=chrome&ie=UTF-8#vhid=zephyr:0&vssid=atritem-
https://www.idealhealthfacility.org.za/App/Document/Download/27

Rensburg, R. (2021). Healthcare in South Africa: How inequity is contributing to inefficiency. *The Conversation*, *6*.

Richter, M. (2003). Traditional medicines and traditional healers in South Africa. *Treatment Action Campaign and AIDS Law Project*, *17*, 4–29.

Riska, E. (2010). *Biomedicalization: Technoscience, Health, and Illness in the U.S.* (A. E. Clarke, L. Mamo, J. R. Fosket, J. R. Fishman, & J. K. Shim, Eds.). Duke University Press. https://doi.org/10.1515/9780822391258

Rusnock, A. A. (2002). *Vital Accounts: Quantifying Health and Population in Eighteenth-Century England and France*. Cambridge University Press.

Rytter, M. J. H., Kolte, L., Briend, A., Friis, H., & Christensen, V. B. (2014). The Immune System in Children with Malnutrition—A Systematic Review. *PLoS ONE*, *9*(8), e105017. https://doi.org/10.1371/journal.pone.0105017

Salgues, B. (2016a). Belief, Myth and Biopower. In *Health Industrialization* (pp. 117–137). Elsevier. https://doi.org/10.1016/B978-1-78548-147-5.50009-6

Salgues, B. (2016b). Mondialisation, the Maker of Biopower. In *Health Industrialization* (pp. 107–115). Elsevier. https://doi.org/10.1016/B978-1-78548-147-5.50008-4

Sattar, S. B. A., Nguyen, A. D., & Sharma, S. (2024). Bacterial Pneumonia. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK513321/

Schickedanz, A., & Halfon, N. (2020). Evolving Roles for Health Care in Supporting Healthy Child Development. *The Future of Children*, *30*(2), 143–164.

Sodi, T. (2009). Indigenous Healers' Diagnostic And Treatment Methods For Some Illnesses And Social Dysfunctions. *Indilinga: African Journal of Indigenous Knowledge Systems*, *8*(1), Article 1. https://doi.org/10.4314/indilinga.v8i1.48243

Stoumpos, A. I., Kitsios, F., & Talias, M. A. (2023). Digital Transformation in Healthcare: Technology Acceptance and Its Applications. *International Journal of Environmental Research and Public Health*, *20*(4), Article 4. https://doi.org/10.3390/ijerph20043407

Tangcharoensathien, V., Srisookwatana, O., Pinprateep, P., Posayanonda, T., & Patcharanarumol, W. (2017). Multisectoral Actions for Health: Challenges and Opportunities in Complex Policy Environments. *International Journal of Health Policy and Management*, *6*(7), 359–363. https://doi.org/10.15171/ijhpm.2017.61

The H3Africa Consortium, Matovu, E., Bucheton, B., Chisi, J., Enyaru, J., Hertz-Fowler, C., Koffi, M., Macleod, A., Mumba, D., Sidibe, I., Simo, G., Simuunza, M., Mayosi, B., Ramesar, R., Mulder, N., Ogendo, S., Mocumbi, A. O., Hugo-Hamman, C., Ogah, O., … Rotimi, C. (2014). Enabling the genomic revolution in Africa. *Science*, *344*(6190), Article 6190. https://doi.org/10.1126/science.1251546

Traditional Medicine | WHO | Regional Office for Africa. (2023, April 4). https://www.afro.who.int/health-topics/traditional-medicine

ur Rahman, S., & El Ansari, W. (2012). Neonatal mortality: Incidence, correlates and improvement strategies. In *Perinatal mortality*. IntechOpen London. https://books.google.com/books?hl=en&lr=&id=FR2aDwAAQBAJ&oi=fnd&pg=PA37&dq=Neonatal+mortality+refers+to+the+child+dying+in+the+first+month+of+life,+post-neonatal+mortality+is+newborns+dying+between+28+and+364+days+of+age,+and+infant+mortality+is+the+child+dying+between+birth+and+their+first+birthday.+&ots=f5UdwMUusM&sig=V0bRPq60a2Ut_LVcwE9maLww-2U

United Nations. (2023). SDG Target 3.2 End preventable deaths of newborns and children < 5. (2023, April 21). https://www.who.int/data/gho/data/themes/topics/sdg-target-3_2-newborn-and-child-mortality

Vearey, J., Modisenyane, M., & Hunter-Adams, J. (2017). *Towards a migration-aware health system in South Africa: A strategic opportunity to address health inequity*.

Walter, T. (2001). Reincarnation, Modernity and Identity. *Sociology*, *35*(1), Article 1. https://doi.org/10.1177/0038038501035001003

Whitehead, K. A. (2013). Managing Self/Other Relations in Complaint Sequences: The Use of Self-Deprecating and Affiliative Racial Categorizations. *Research on Language & Social Interaction*, *46*(2), 186–203. https://doi.org/10.1080/08351813.2013.780342

Wilce, J. M. (2009). Medical Discourse. *Annual Review of Anthropology*, *38*(1), 199–215. https://doi.org/10.1146/annurev-anthro-091908-164450

Wiseman, N. (2004). Designations of Medicines. *Evidence-Based Complementary and Alternative Medicine*, *1*(3), Article 3. https://doi.org/10.1093/ecam/neh053

Wispelwey, B., Tanous, O., Asi, Y., Hammoudeh, W., & Mills, D. (2023). Because its power remains naturalized: Introducing the settler colonial determinants of health. *Frontiers in Public Health*, *11*, 1137428. https://doi.org/10.3389/fpubh.2023.1137428

World Health Organization (WHO). (2022). *Child mortality (under 5 years)*. Retrieved November 27, 2024, from https://www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-under-5-mortality-in-2020

World Health Organization (WHO). (2023) Child Mortality—UNICEF DATA. (2023, April 4). https://data.unicef.org/topic/child-survival/under-five-mortality/

Zimba, Z. F., & Nomngcoyiya, T. (2022). Roles and Challenges of Traditional Healers in Helping Communities to Stay Healthy During Covid-19 Pandemic: Implications for Community Education Model in the Social Work Practice. *Indilinga African Journal of Indigenous Knowledge Systems*, *21*(2), 188–205.

Appendix A: Clearance certificate

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MAPSYC/23/09**
PROJECT TITLE:	The discourses of Western and African medicine in South Africa.
INVESTIGATOR	Nkogatse Hubela Betty (2199540)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	23 June 2023
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Minimal Risk
EXPIRY DATE	31 December 2025
ISSUE DATE OF CERTIFICATE 03 June 2023	**CHAIRPERSON** _____ (Dr Aline Ferreira Correia)

cc: Ms Daniella Rafaely (Supervisor)

DECLARATION OF INVESTIGATOR

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

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

_____ **Signature**

Date __2023___/___07___/___06___

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix B: Information Sheet

The discursive construction of health practices in child mortality in South Africa

Dear Sir/Madam

My name is Hubela Betty Nkogatse and I am a Masters student in Research Psychology at Wits University in Johannesburg. As part of my studies, I have to undertake a research project, and I am investigating *The discursive construction of health practices in child mortality in South Africa*. The aim of this project is to explore the discursive construction of child mortality in South Africa. By examining discourses of health practices described by South African healthcare practitioners, this study seeks to understand how health practitioners define child mortality, how they construct causes of child mortality, and how they define what counts as preventative treatment. Lastly, the research seeks to uncover how medical language reproduces or resists larger discourses on Africa and the West. Therefore, the goals of the study are to investigate how medical practitioners construct childhood death in South Africa and how these constructions are part of larger discourses of biomedical, indigenous, and other forms of medicine practiced in South Africa.

As part of this project, I would like to invite you to take part in a face-to-face or online interview. This activity will involve answering few questions and will take around 45 minutes to an hour. With your permission, I would like to record the interview using a digital device.

I am aiming to write a critical paper that studies the relationship between different medical practices in South Africa with the hope it will contribute to a more fruitful discussion about alternative medical approaches and how to integrate them.

You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any questions if you do not want to. The interview will be completely confidential as I will not be asking for any identifying information, and the information you give me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation, in my final research report. If you experience any distress or discomfort, we will stop the interview or resume another time.

If you have any questions 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 library website. If you wish to receive a summary of this report, I will be happy to send it to you upon request. If you have queries, concerns, or complaints regarding the ethical procedures of this study, you are welcome to contact the University human Research ethics Committee, telephone +27 11 717 1408, email shaun.schoeman@wits.ac.za

Yours sincerely

Hubela Betty Nkogatse

Researcher: Hubela Betty Nkogatse, 076 091 3102, 2199540@students.wits.ac.za
Supervisor: Dr. Daniella Rafaely daniella.rafaely@wits.ac.za
Protocol number: MAPSYC/23/09

Appendix C: Interview Schedule

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG | SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT PSYCHOLOGY

1. Tell me about your decision to become a doctor / indigenous healer.
2. Could you please share your practice-related training experiences with me?
3. When a parent brings a sick child to you with an illness what kind of process do you go through before diagnosis and treatment is provided.
4. When a child comes in what signs and symptoms that indicate that the condition is serious and possibly life-threatening
5. What makes you so sure that your diagnosis is the correct one?
6. What actions do you take when you realize the child is at risk of losing their life?
7. Do you think the child would have survived if they were taken to medical practitioners in a different sector?
8. What value do you see in biomedicine healing / indigenous healing in cases such as this?
9. Filling out gaps
10. Thanking the participant for taking their time to participate in the study
11. Explain the way forward
12. Ask if there are any questions
13. See the participant off

Appendix D: Consent form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Title of project: The discursive construction of health practices in child mortality in South Africa

Name of researcher: Hubela Betty Nkogatse

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 that my participation will remain anonymous	**YES**	**NO**	**(please circle)**
I agree that the researcher may use anonymous quotes. in his research report	**YES**	**NO**	
I agree that the interview may be audio recorded	**YES**	**NO**	
I agree that the researcher may take photos of me (But not my face)	**YES**	**NO**	
I agree that the information I provide may be used anonymously by other researchers following this study.	**YES**	**NO**	

..... (signature)

..... (name of participant)

..... (date)