

**ACQUISITION, TRANSFER AND PRESERVATION OF INDIGENOUS KNOWLEDGE
BY TRADITIONAL HEALERS IN THE LIMPOPO PROVINCE OF SOUTH AFRICA**

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SUMMARY

Indigenous Knowledge (IK) is in danger of being obliterated due to a number of factors, such as the lack of interest from younger generations, low life expectancy where people die before transferring it to the next generation and it not being documented. This is due to the fact that IK, by its very nature, is generally known to have been passed on from generation to generation through oral tradition. This qualitative study utilised the organisational knowledge conversion theory to investigate the acquisition, transfer and preservation of IK by traditional healers in the Limpopo Province of South Africa with the view to develop a framework to provide understanding on how IK is acquired, transferred and preserved by traditional healers. The study adopted hermeneutic phenomenology research method and utilised snowball sampling technique to determine the population of this study which consisted of indigenous healers from the Limpopo Province. Data were collected through interviews with traditional healers, observations, as well as document analysis. Data were analysed and interpreted thematically according to the objectives of the study. The study revealed that knowledge of traditional healing is mainly acquired through observations, imitations, following orders and performing tasks practically. In addition to that, collaboration was highlighted as one of the driving forces behind effective transfer and acquisition of knowledge among healers. The major finding to this study was that ancestors are believed to be the ones preserving this knowledge of traditional healing and they pass it down to the chosen ones through dreams, visions and so on. The study concludes that traditional healers also preserved their knowledge orally and commonly shared and acquire knowledge during interactions with other healers. Furthermore, traditional healing is marginalised and not properly regulated in South Africa. It is recommended that key stakeholders should play an active role in ensuring that traditional healing is incorporated into the country's healthcare system. This way traditional healing can help reduce a heavy burden on public health sector in terms of treating patients. A further study on integrating traditional healing into mainstream healthcare system in South Africa is recommended.

Key words: knowledge management, indigenous knowledge, traditional healing, traditional healers, knowledge acquisition, knowledge transfer, knowledge preservation, Limpopo Province, South Africa.

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I'm a success today because I had friends who believed in me and I didn't have the heart to let them down - Abraham Lincoln

DEDICATIONS

This thesis is dedicated to all abo *Gogo na bo Mkhulu* ¹who are hard at work contributing to the national health system. Muhammad Ali once said “*a service to others is the rent you pay for your room here on earth*”. Continue to stand tall because you are standing on the shoulders of those who came before us.

¹ *Traditional healers*

DECLARATIONS

Student number: **32692315**

I declare that *Acquisition, Transfer and Preservation of Indigenous Knowledge by Traditional Healers in the Limpopo Province of South Africa*, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



SIGNATURE
Jan Resenga Maluleka

14/07/2017
DATE

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LIST OF ABBREVIATIONS

IFLA - *International Federation of Library Associations*

IK - *Indigenous Knowledge*

IKS - *Indigenous Knowledge Systems*

KM - *Knowledge Management*

LIS - *Library and Information Science*

MMR - *Mixed methods research*

NRF - *National Research Foundation*

SECI - *Socialization, Internalization, Externalization and Combination*

THO *Traditional Healers Organisation*

THP - *Traditional Health Practitioners*

THPCSA - *Traditional Health Practitioners Council of South Africa*

TKDL - *Traditional Knowledge Digital Library*

TRIPS - *Trade Related Aspects of Intellectual Property Rights*

UN - *United Nations*

WHO - *World Health Organization*

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CHAPTER ONE

INTRODUCTION: PUTTING THINGS INTO PERSPECTIVE

Mmetla-kgola o e lebisa wabo (It's a Setswana proverb loosely translated to "Charity begins at home".)

1.1 Introduction and background to the study

Research shows that the majority of the population in Africa consults traditional healers and depend on indigenous medical knowledge for survival, yet there is limited understanding of how this knowledge is acquired, transferred and preserved (Ijumba and Barron 2005; Denis 2006; Truter 2007). According to Poorna, Mymoon and Hariharan (2014:1240), the World Health Organization (WHO 1998) report estimated that 70% to 80% of the population in developing countries dependent on traditional medicines for their primary health care needs.

Before the arrival of the colonisers, Africans had their own indigenous institutions to deal with social, psychological and physical problems. Some of these indigenous institutions worth mentioning according to Ayittey (1991); Kaniki and Mphahlele (2002) are:

- legal institutions (dealt with disputes that arose in any family or society);
- political institutions (kingdoms existed as independent entities which resulted from conquests or voluntary submissions);
- education (well-known ones are initiation schools for boys and girls);
- health (traditional healers and the use of herbs).

These institutions used indigenous mechanisms to address problems faced by their communities (Bojuwoye 2005:316). These mechanisms were used to find conflict resolutions related to farming, cattle disputes and marriage counselling (Brock-Utne 2001). The problems were mostly dealt with during a community gathering where problems are presented, addressed and decisions taken by the community leader, chief or king in consultation with council of elders (Brock-Utne 2001). Children were taken to initiation schools where adults would sit with them for months teaching and guiding them on issues related to adulthood and ways of the behaving within the community (Ntozini and Abdullahi 2017). Experienced hunters would also teach young boys different hunting techniques which they will use to feed their families in the future.

In other tribes boys would be taught how to fight and be groomed to be part of the military so that they can be able to defend their community during attacks. To be able to function properly, these institutions always had skilled people with the necessary knowledge. This

knowledge survived for centuries through oral tradition where the experienced were transferring it from one generation to the next (Raseroka 2002:2).

One such institution, which has always been of great importance, is traditional healing. The institution was very important to its community because it was responsible for primary health care and which was key to the survival of the community. A study done by the World Health Organization (2001), recently supported by Adekannbi, Olatokun and Ajiferuke (2014:2), suggests that traditional healing is usually the first choice for primary health care by rural communities in developing countries.

There may be a number of reasons why traditional healing is the first choice for primary health care in rural communities, ranging from trust, affordability and proximity. However, Popat, Shear, Malkiewicz, Stewart, Steenkamp, Thomson and Neuman (2001:229) argue that there is a mythical, yet predominant view that herbal medicines are harmless and free of side effects because they are natural. Moodley, Sutherland and Oulanova (2008:154) opine that:

while the need to seek traditional healing is embedded in a cultural paradigm of cure seeking; the appeal for traditional healing is also based on the holistic nature of traditional approaches which seek to restore harmony and balance within the individual and between the individual and his or her environment.

Moodley et al. (2007:154) further expound that the process of traditional healing is seen as holistic as it engages the mind, body and soul of an individual, as well as their families and communities. According to Hoff (1992:182), there is a large variety of traditional healers, including the following:

- Herbalists (a person who studies herbal medicine and the healing properties of plants).
- Spiritual healers (a person who uses prayer to do the healing work).
- Ayurvedic and Unani practitioners (these are traditional medicine practitioners in the Middle East and South-Asian countries).
- Traditional midwives (traditional childbirth care providers using the knowledge gained through the traditions and practices of their own communities).
- Bone-setters (this group of healers can be called traditional physiotherapists because they deal with joint manipulation, joint dislocations, bone fractures and other bone-related problems).
- Magico-religious practitioners. Winkleman (1990:311) defines magico-religious practitioners as culturally recognised healers involved in interaction with supernatural entities or powers. Winkleman (1990) further states that it was discovered that

magico-religious healers are present in all societies and are the main healing practitioners in many societies. For this study, herbalist, diviners, traditional midwives magico-religious practitioners were targeted because they were the ones known to exist in the Limpopo province.

In the South African context, Denis (2006:312) highlights that African traditional beliefs were always widely practised in secret, mainly because of apartheid laws and the missionaries such as Congregational, Methodist, Anglican, Lutheran and Catholic, who were aggressively opposed to traditional African practices, because, according to them, these were barbaric and based on superstitions. Even with the proliferation of African Independent Churches the statuesque remained the same. Ashforth (2005:286) further argues that the South African apartheid government passed into law the Suppression of Witchcraft Act in 1957, an act of colonial legislation, which declared divination illegal, thereby theoretically making the work of traditional healers impossible.

Many traditional healers themselves regard their medical knowledge as personal property that must be kept in strict confidence, because they believe that unwarranted disclosure of such knowledge can result in the treatment losing its effectiveness (Sodi, Mudhovozi, Mashamba, Radzilani-Makatu, Takalani and Mabunda, 2011:104). This may be influenced by the fact that traditional healers mostly depend on their trade for survival, therefore, protecting their knowledge and keeping it private is of great importance to them in maintaining a healthy client base.

However, this situation has been changing over the last few decades. Sodi et al. (2011:101) are of the opinion that the work of traditional healers is currently receiving attention, particularly the role that traditional healers play in preventive, promotive, curative, rehabilitative and psychosocial care of patients. Sodi et al. (2011) goes on to explain that existing research mainly focus on how individuals become healers, as well as on how the healing process is carried out.

The study by Sodi et al. (2011) looked at how individuals become healers in the South African context, including the process of indigenous healing. Furthermore, in South Africa, an extensive project, which documented traditional medicines derived from indigenous medicinal plants, was undertaken (Truter 2007:60). This project (Traditional Medicines Programme) was carried out by a team of researchers on traditional medicines, based at the University of Cape Town. The Traditional Medicines Programme (TRAMED) was founded

on a collaborative agreement entered into by the Medical Research Council, the University of Cape Town, University of Western Cape, and several traditional healers from the province (World Health Organization 1998).

The focus by scholars in the existing literature on indigenous knowledge (IK), plus South African apartheid laws towards traditional healing, may have contributed to limited research having been done by information professionals in this area and may be the reason why there is little understanding of how indigenous medical knowledge can be acquired, transferred and preserved. This knowledge sustained South African communities for generations and it is generally known to have been acquired from careful observation of the environment in a particular context by one generation to the next (Mokgobi 2014:28, Ngulube 2002b:61).

This knowledge transfer is also known to be done by means of mentorship or initiation where the student is learning directly from the master (Sodi et al. 2011). The common danger that has always been associated with this knowledge was the death of a senior or the most experienced person before such knowledge could be passed on to the next generations. That is why there is an adage that says, “When an old man dies, it is like a library has burnt down”.

Ebermann (2012:15) is of the opinion that the creation of this kind of knowledge often goes back to the prehistory of the African communities and it is often impossible to trace its origins. This was also the case during the biblical era, as stated in the book of Luke (verse 1:1-4):

“Many have undertaken to draw up an account of the things that have been fulfilled among us, just as they were handed down to us by those who, from the first, were eyewitnesses and servants of the word. With this in mind, since I myself have carefully investigated everything from the beginning, I too decided to write an orderly account for you, most excellent Theophilus, so that you may know the certainty of the things you have been taught”.

However, this knowledge has continually been refined, enhanced and improved by the integration of new knowledge into existing knowledge according to the changes in a society's needs. This knowledge is currently facing an even bigger threat of being totally lost. It was always known that IK was local to a particular area, at times referred to as the local expertise. The free movement of people from their original places of birth to other areas has really affected this knowledge. The danger exists that knowledge that existed within particular communities is in danger of being lost because the gatekeepers to this knowledge are the

elderly. In most cases, the people who were expected to acquire this knowledge from the elders relocate to the cities and, as a result, the elders are left with no apprentices to transfer the knowledge to.

Raseroka (2002:3) explains that, without apprentices, the IK held by these gatekeepers becomes endangered and may be lost to the community, unless interventions to facilitate preservation are put in place. In other areas, this knowledge is diluted and no longer accurate, because of the influx of people from other countries, which includes people from different religions. This may result in many versions of the same piece of information.

Religion, especially Christianity, which is the most popular religion in South Africa, dealt traditional healing in South Africa a major blow over the years. Even though there are some churches, like the Zionist churches, that have similarities with indigenous religious forms, and some Christian churches, that have some level of tolerance for the traditional African religions, traditional healing is still associated with witchcraft (Denis 2006:313). Some churches openly discourage their members from consulting traditional healers, because they believe that traditional healers worship the ancestors and not God, which is seen as a sin in the Christian orthodoxy (Mokgobi 2014:24). The responses from interviews suggest that the stigma and negativity surrounding traditional healing resulted in most consultations taking place in secrecy at times during the night.

1.1.1 Theoretical framework

Babbie and Mouton (2011); De Vos, Strydom, Fouche and Delpont (2011); Neuman (2011); as well as Ngulube (2015), are all in agreement that it is important to provide a theoretical framework for a research study because it provides a mechanism for selecting and prioritizing concepts to be investigated. The theoretical framework is also important in the sense that it drives the literature review. This involves consulting with what others have said in order to come up with clear unambiguous definitions of concepts that form the basis of the study. Neuman (2011:205) goes further and define conceptualisation in qualitative research as a process of forming coherent theoretical definitions, while still trying to make sense of preliminary ideas about it. The main constructs of the current study include: knowledge acquisition, knowledge transfer and knowledge preservation by traditional healers. These constructs (knowledge acquisition, knowledge transfer and knowledge preservation) are mainly leaning towards the frameworks and models of knowledge management (KM). This is because Jain (1997) mention acquisition, transfer and preservation as some of the key components of knowledge management.

KM has been a buzzword over the past years, and a number of researchers and philosophers studied it extensively, leading to a number of models and frameworks being developed in different areas of research (see Chapter Two). This study, “Acquisition, transfer and preservation of indigenous knowledge by traditional healers in the Limpopo Province of South Africa”, is anchored mainly on the SECI model originally proposed by Nonaka in 1991 and further developed by Nonaka and Takeuchi in 1995. The *organisational knowledge conversion theory*, developed by Nonaka and Takeuchi (1995) consisted of the following four modes of knowledge conversion:

- (1) **Socialisation** (from tacit knowledge to tacit knowledge).
- (2) **Externalization** (from tacit knowledge to explicit knowledge).
- (3) **Combination** (from explicit knowledge to explicit knowledge).
- (4) **Internalization** (from explicit knowledge to tacit knowledge).

The *organisational knowledge conversion theory* views the interaction processes of tacit and explicit knowledge as an essential feature in knowledge management. As a result, the organisational conversion theory was crucial in the study because it set the basis for data collection for this study. This will be explained more in the next chapter (Chapter Two); however, it is important to note that traditional healing is not a homogenous healing system, but varies from culture to culture, from region to region, and from individual to individual (Mokgobi 2014:28). Furthermore, there may be a number of similarities in the way healers treat some illnesses, but it has never been standardised.

1.1.2 Contextual setting

This section discusses the background of the population for this study. From a variety of traditional healers who are known and are present in South Africa, this study pays particular attention on herbalists (*Inyangas*), diviners (*Sangomas*, *Prophets*), traditional midwives, as well as elders in some communities. Community elders are included in the study because they are the memory of their community and philosophers in their own communities.

According to Mokgobi (2014:29), in South Africa, researchers have identified different types of traditional healers according to different regions. In the Bapedi tribe, which is found mostly in Limpopo, traditional healers are generally called ‘Dingaka’ or ‘Mangaka’. The different types of traditional healers include diviners (‘Ngaka ya ditaola’), Sanusi (‘Sedupe’), traditional surgeons and traditional birth attendants (‘Babelegisi’). Mokgobi (2014) further notes that the diviner uses bones and the spirits of the ancestors to diagnose and prescribe medication for different physiological, psychiatric and spiritual conditions.

Truter (2007:57) also notes that traditional healers are known by different names in the different South African cultures (for example, amagqira in Xhosa, ngaka in Northern Sotho, selaoli in Southern Sotho, and mungome in Venda and Tsonga). This study will pay particular attention to the traditional healers in the Limpopo Province. These healers will mainly speak Sepedi, Tsonga and Venda, as these are the three main languages spoken in Limpopo.

The Limpopo Province in South Africa is the northernmost province in the country, lying within the great curve of the Limpopo River from which the province derived its name. The province borders the countries of Botswana to the west, Zimbabwe to the north and Mozambique to the east. The capital of Limpopo is Polokwane and it is located in the centre of the province. The province is divided in to five regions, namely: Waterberg, Capricorn, Vhembe, Mopani and Sekhukhune (Limpopo Provincial Government 2014).

Table 1.1: Comparison between different types of traditional healers, (Source: Truter 2007:58)

	Sangoma	Inyanga	Spiritual healer
Skills	<ul style="list-style-type: none"> • “Called” by spirits • Apprenticed to an expert • Medical skills acquired as an inyanga 	<ul style="list-style-type: none"> • Individual choice to become one • Apprenticed to an expert 	Trances and contact with spirits
Method of service	<ul style="list-style-type: none"> • Essentially diagnostic • Throws and reads “bones” • Divination through trance • Contact with patient not needed for diagnosis • History, symptoms and nature of problem not revealed by patients 	<ul style="list-style-type: none"> • Knowledge of symptoms and patient’s history necessary • Contact with patient necessary 	Essentially diagnostic
Nature of Service	<ul style="list-style-type: none"> • Conflict resolution • Confirms patient’s beliefs • Revelation of misfortune and illness • Recommends solution • Provides expertise and leadership 	<ul style="list-style-type: none"> • Comprehensive, curative, prophylactic, ritualistic and symbolic 	Lays on hands, prays, provides holy water and other symbols
Accessibility	Depends on grades (relatively few high grade, whilst lower grade much more accessible)	Freely accessible	Freely accessible

1.2 Problem statement

According to Creswell (2007:130), good research begins with an issue or a problem that needs to be resolved. Creswell (2007) further argues that the term *problem* may be unsuitable, as people who are unfamiliar with writing research may struggle to understand the term. Therefore, instead of calling this section the problem, it may be easier understood if we called it the need for the study.

This section is intended to give an explanation or the main reason why this study was conducted. This study investigated acquisition, transfer and management of knowledge by traditional healers in South Africa. The review of literature in the background to this study suggests that IK is in the danger of being obliterated due to a number of factors, such as the lack of interest from younger generations, low life expectancy where people die before transferring it to the next generation and it not being documented. This is due to the fact that IK, by its very nature, is generally known to have been passed on from generation to generation through oral tradition. According to Ngulube (2002:99), information professionals should be proactive in their approach to managing society's knowledge resources and should ensure that indigenous knowledge, although based on orality and oral traditions, should be managed and preserved just like other documentary materials that are grounded in western codified knowledge schemes.

Ngoepe and Setumu (2016) showed that such knowledge can be documented as in the case of their heritage projects in the Makgabeng area of Limpopo. Ngoepe and Setumu (2016) report that the Makgabeng Heritage Projects documented stories and IK ranging from origins of clans, burning of witches in the areas, rainmaking, divine bones and chieftainship. The outputs of the projects comprised of books, video recordings, CDs, family trees and collection of old family photos for the purpose of creating community archives in the future. Such a community archives can be integrated in the national archival system and thus bridging the gaps of lack of documentation on local people.

The review of literature further suggests little research is being conducted by information professionals in South Africa, especially when it comes to IKS and indigenous healing (Ngulube 2002a). The current state of IK research in the South African context, especially in the area of indigenous healing, was highlighted by Sodi *et al.* (2011) and was also discussed in the background to this study. With up to 80% of Africa's population depending on indigenous healers for health care (Denis 2006; Ijumba and Barron 2005; Truter 2007), there is clearly a need for a study on how this valuable knowledge is acquired and transferred for

preservation. In the current study, the investigator will look at the acquisition, transfer and preservation of IK in the Limpopo Province.

1.3 Purpose of the study

Creswell (2013:134) explains that a purpose statement provides the major objective or intent, or the road map to the study. Therefore, the purpose of this qualitative study was to investigate the acquisition, transfer and preservation of indigenous knowledge by traditional healers in South Africa, in order to understand how this knowledge can be preserved.

1.4 Research objectives

In view of the purpose, the study seeks to:

- assess the status of indigenous healing in Limpopo Province of South Africa.
- determine how knowledge is acquired among indigenous healers in Limpopo Province of South Africa.
- establish how knowledge is transferred among indigenous healers in Limpopo Province of South Africa.
- assess how knowledge is preserved among indigenous healers in Limpopo Province of South Africa.
- suggest a framework that explains the acquisition, transfer and preservation of knowledge by indigenous healers in South Africa.

1.5 Research questions

The study answers the following research questions:

- What is the status of indigenous healing in Limpopo Province of South Africa?
- How is knowledge acquired by indigenous healers in Limpopo Province of South Africa?
- How is knowledge transferred among indigenous healers in Limpopo Province of South Africa?
- What are the methodologies employed by indigenous healers to preserve indigenous medical knowledge?
- What framework can be suggested to explain the acquisition, transfer and preservation of indigenous knowledge by traditional healers in South Africa?

Table 01.2: Objectives, research questions and sources of data

Research objective	Research questions	Sources of data	Data collection method
To assess the status of indigenous medical knowledge in Limpopo Province of South Africa	<ul style="list-style-type: none"> What is the status of indigenous healing in Limpopo Province of South Africa? 	<p>Traditional healers</p> <p>Available documents and literature</p>	<p>Interviews</p> <p>Document analysis and literature review</p> <p>Observations</p>
To determine how knowledge is acquired among indigenous healers	<ul style="list-style-type: none"> How do traditional healers in the Limpopo Province of South Africa acquire knowledge? 	<p>Traditional healers</p> <p>Available documents and literature</p>	<p>Interviews</p> <p>Document analysis and literature review</p> <p>Observation</p>
To establish how knowledge is transferred among indigenous healers	<ul style="list-style-type: none"> How is knowledge transferred among traditional healers in Limpopo Province? 	<p>Traditional healers</p> <p>Available documents and literature</p>	<p>Interviews</p> <p>Document analysis and literature review</p> <p>Observations</p>
To assess how knowledge is preserved among indigenous healers	<ul style="list-style-type: none"> What are the methodologies employed by indigenous healers to preserve knowledge? 	<p>Traditional healers</p> <p>Available documents and literature</p>	<p>Interviews</p> <p>Document analysis and literature review</p> <p>Observations</p>
To suggest a framework that explains the acquisition, transfer and preservation of knowledge by indigenous healers in South Africa	<ul style="list-style-type: none"> What framework can be suggested to explain the acquisition, transfer and preservation process of indigenous knowledge by traditional healers in South Africa? 	<p>Available documents and literature</p> <p>Traditional healers</p>	<p>Interviews</p> <p>Observations</p>

1.6 Significance of the study

The importance of conducting studies in IKS, especially where traditional healers are involved, can never be overemphasised. According to Creswell (2003:149), the significance of the study mostly focuses on how the study will add to scholarly research and literature in the field, how it will help improve practice and why it can improve policy. Research studies must also add value and be relevant to the community at large. From the review of literature it is evident that the majority of the continent's population depends on indigenous healing for survival (Sodi et al. 2011); Truter (2007); Mokgobi (2014). In 1998, the government of South Africa charged the National Research Foundation (NRF) with 'maintenance and promotion of research to facilitate the creation of knowledge, innovation, and development in all domains of science and technology including indigenous knowledge' (Ashforth 2005:151).

This study is therefore of great importance to the people of South Africa and Africa in general. Research into indigenous knowledge was identified as one of the niche areas of research by the NRF. This makes this study very relevant to, and in line with, what the South African government promotes when it comes to research. The study also suggests a framework for the acquisition, transfer and preservation of knowledge by indigenous healers in South Africa. The study further extends and adds to the knowledge base of the IKS that currently exists, especially within the LIS profession.

1.7 Originality of the study

Originality in a doctoral study is very important and is one of the requirements for this level. According to Cryer (2006), the following are some of the factors that may determine originality in research:

- When the researcher uses new tools, techniques and procedures to address research problems.
- When the researcher explores an area that is unknown or where little research was conducted in that particular area.
- When the researcher explores a well-explored subject area, but results show unexpected and unexplored subareas in that particular field of study.
- When the researcher collects original data.
- When the research results have the potential to be published.

In meeting the originality requirement for a doctoral study, the investigator employs phenomenology as a method to an area where little research was conducted. The researcher further collects original data from the field through interviews and observations with an aim to publish the results in scientific journals.

The review of literature suggest that indigenous medical knowledge is generally known to attract the interest of researchers from the health sciences (for medicinal issues) and Law (for issues related to patents). The importance of this knowledge can never be overemphasized, and the review of literature suggests that this area has not been fully explored by information professionals who are expected to be the custodians of information. The study shed some light on how this indigenous medical knowledge is acquired, transferred to the research community and preserved, especially in the field of information science. This was addressed by using the phenomenological research method to collect original qualitative data directly from the traditional healers in Limpopo.

1.8 Literature review

Neuman (2011: 125) opines that a literature review is an essential step in doing a study because reviewing the accumulated knowledge about a question or questions being investigated is very important during the research process. Neuman (2011) further indicates that the review of literature is the best way to find out what is known about the question before you try to find the answer yourself. This will most definitely help researchers to avoid re-inventing the wheel by trying to answer questions that had been answered. Literature relating to various components of knowledge management, namely, acquisition, transfer and preservation of knowledge was reviewed. The major doctrines of the literature review were knowledge management theories and the theoretical framework guiding the study. The study also reviewed literature according to the objectives of the study, which included knowledge acquisition, transfer and preservation in general; and acquisition, transfer and preservation of indigenous knowledge, the status of indigenous healing in South Africa, framework for knowledge acquisition, transfer and preservation as well as a number of studies related to the current study (See Chapter Two for a detailed literature review).

1.9 Research design and methodology

Research methodology is an important component of a research study because it helps to highlight the broader field of discussion on methods, and the relationship between methods and theories used to conduct that particular study (Alasuutari, Bickman and Brannen 2008:82). Macmillan and Schumacher (2006:9) define research methodology as the way in which one collects and analyses data. According to Sarantakos (2013:28), social science research is guided by three basic factors, namely ontology (*nature of reality*), epistemology (*nature of knowledge*) and methodology (*approaches and methods*). This section discusses the ontology, epistemology, methodology, methods and instruments that were used to conduct this study. The topics covered include research paradigms, research approaches, research

methods, study population; sampling procedures, data collection methods and instruments, as well as data analysis and presentation to be employed by this study (refer to Chapter Three for a detailed discussion).

This is an interpretive study, which, according to Sarantakos (2013:29), guides the strategies of qualitative methodology and prescribes mostly flexible designs and qualitative methods. The units of analysis are traditional healers in different regions of the Limpopo Province of South Africa. The primary goal of this study, just like in all qualitative studies, is to describe and understand, rather than to explain human behaviour (Babbie and Mouton 2011:270).

The unit of analysis in this study consists of herbalists (*inyangas*), diviners (*sangomas*, *prophets*), as well as elders who may have knowledge of years of experience, and who may have been involved in many year of experience. South Africa had approximately 200 000 practicing traditional healers in 1995, and around 300 000 in 2005 (Denis 2006, Truter 2007). This is a qualitative study and little emphasis was paid to the numbers when drawing a sample. The study focused on indigenous healers in Limpopo. Limpopo, previously called the Northern Province, which is divided in to five regions, namely, Waterberg, Capricorn, Vhembe, Mopani and Sekhukhune. All the five regions were covered by the study. This study investigated a difficult-to-reach and specialised group of people in the community, and therefore snowball sampling was employed. The study employed interviews, observations as well as document analysis as instruments of data collection (refer to Chapter Three for detailed discussion).

1.10 Data analysis and presentation

Qualitative data analysis is concerned with transforming raw data by searching, evaluating, recognizing, coding, mapping, exploring and describing patterns, trends, themes and categories in the raw data, in order to interpret them and provide their underlying meanings (Ngulube, Mathipa and Gumbo 2015: 131). Qualitative data for this study was collected through the use of interviews, observations and document analysis. During analysis, data was organised thematically according to the main objectives of the study (refer to Chapter Three for detailed discussion).

1.11 Ethical considerations

Creswell (2007:174), argue that in both qualitative and quantitative research, the researcher faces ethical issues that surface during data collection in the field and in analysis and dissemination of reports. Welman, Kruger and Mitchell (2005:201) discuss four ethical

considerations a researcher should pay attention to: informed consent, right to privacy, protection from harm and involvement of the researcher (refer to Chapter Three for a detailed discussion).

1.12 Scope and delimitations of the study

The study seeks to investigate how indigenous knowledge is acquired, transferred and preserved by indigenous healers in Limpopo. The study was limited to the Sotho-, Tsonga- and Venda-speaking healers in the Limpopo Province. Other provinces within South Africa were excluded in the study to allow the investigator to focus on one province for an in-depth study.

1.13 Discussion of key terms and concepts

This section discusses the key terms and concepts that are relevant to this study. The terms and concepts discussed in this section are explained and expressed according to what they mean and how they are understood in this study. These concepts include: knowledge acquisition, knowledge transfer, knowledge management, indigenous knowledge, as well as indigenous healing.

1.13.1 Knowledge acquisition

Knowledge acquisition refers to knowledge activities directed at seeking and obtaining knowledge from the external sources and from the internal environment. Shanhong (2000:4) describes knowledge acquisition as the starting point of knowledge management in the sense that, for knowledge to be managed, it has to be acquired first. The review of literature suggests that knowledge can be acquired in different ways, for example, through training, conferences, seminars, workshops, buying knowledge resources, learning from experts and many more.

1.13.2 Knowledge transfer

Knowledge transfer can be defined as the process by which knowledge is transmitted to, and absorbed by, a user (Garavelli, Gorgoglione and Scozzi 2002:270). For this study, knowledge transfer will be defined as the process of moving or sharing of knowledge from one person to the other.

1.13.3 Knowledge preservation

The concept of preservation is usually used to explain a situation where one keeps something safe or protects something from harm (Dictionary.com 2017). For this study, knowledge

preservation will be defined as the protection or the keeping safe of knowledge, especially indigenous knowledge, from being lost to future generations.

1.13.4 Indigenous knowledge

Ngulube, Dube and Mhlongo (2015:148) define IK as tacit know-how that is community based, unique, complex, dynamic, eclectic, non-formal and transmitted from one generation to the next in various contexts (including cultural, ecological, economic, ethical, political, social, spiritual and technological) to support indigenous communities in solving problems and making decisions that are fundamental to their existence, survival and adaptation in their everyday direct interactions and transactions with their natural surroundings, the external world, and other worldviews and value systems in a particular geographical area.

1.13.5 Traditional healing

Indigenous or traditional healing is an umbrella term referring to native ceremonies, which promote mental and physical well-being (Moghaddam; Momper and Fong 2015). The World Health Organisation (WHO 1976), as cited by Mokgobi (2014:27), gives a broader definition of traditional medicine/healing as

the sum total of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium and which rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing” and “health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercise, applied singular or in combination, to treat, diagnose and prevent illnesses or maintain well-being.

1.14 Organisation of the thesis

This thesis consists of six chapters as follows:

Chapter 1: Introduction: putting things into perspective

This chapter provides an introduction to and background of this study. The context and location of the study – traditional healers in Limpopo are presented. A conceptual review of the relevant models to the current study is also discussed. The chapter also consists of the problem statement, purpose of the study, research objectives and questions, significance of the study, the scope and limitations, as well as the outline on how all chapters are organised.

Chapter 2: Literature review and theoretical framework

This chapter presents a review of literature as well as the theoretical underpinnings guiding the topic under investigation. The study looked at knowledge management theories, the theoretical framework guiding the study with special emphasis on the organisational knowledge conversion theory. The study further reviewed literature according to the objectives of the study, which included knowledge acquisition, transfer and preservation in general, acquisition, transfer and preservation of indigenous knowledge, the status of indigenous healing in South Africa and a number of studies related to the current study were also looked at.

Chapter 3: Research design and methodology

This chapter presents the overall plan for the study, including the research paradigm, research approach, research method, study population, sampling procedures, data collection procedures and instruments, data quality, ethical considerations as well as data analysis and presentation.

Chapter 4: Presentation of the findings

This chapter presents the data collected through interviews, observation from the field, as well as document studies in line with the objectives of the study. The data was presented according to the following main themes:

- The status of traditional healing in South Africa
- Knowledge acquisition
- Knowledge transfer
- Knowledge preservation

Chapter 5: Discussion of the findings

The chapter discusses the findings of the study according to the set objectives. The discussion was based on the data presented in Chapter Four; literature reviewed in Chapter Two, driven by the knowledge conversion theory also explained in Chapter Two. The findings were interpreted and discussed and arranged according to the main objectives of the study.

Chapter 6: Summary, conclusions and recommendations

This chapter presents a summary of each chapter, a summary of the results, conclusions, recommendations drawn from the findings, the study's implications to theory and practice and suggested areas for further research. Furthermore, a framework aimed at explaining the acquisition, transfer and preservation process of indigenous knowledge by traditional healers is presented.

1.15 Referencing style used in the thesis

Good and acceptable academic writing requires that every researcher must acknowledge all sources of information used. According to Neville (2010) citing is the practice of referring to other writers' works and ideas, which you used to support your arguments, in the text of your work, while referencing is the listing of the full bibliographic details of the publications that were cited so that the reader will know where you found the information you are writing about. Neville (2010) discusses three categories of referencing styles, including the following:

(1) Name referencing styles of referencing:

- American Psychological Association (APA)
- Modern Language Association of America (MLA)
- Chicago/Turabian
- Modern Humanities Research Association (MHRA)
- Council of Science Editors (CSE)

(2) Numerical referencing styles included the following:

- British standards
- Vancouver Style
- Institute of Electrical and Electronic Engineers (IEEE)
- Council of Science Editors (CSE)

(3) Name-date (Harvard) style of referencing

The current study uses the Harvard referencing style as recommended by the Department of Information Science, which follows the guidelines given by the School of Interdisciplinary Research and Postgraduate Studies at the University of South Africa.

1.16 Summary

This chapter provided the background of this study. The theoretical framework, problem statement, purpose of the study, research objectives, research questions, significance of the study, originality of the study, scope and limitations, as well as ethical considerations were highlighted. The discussion of key terms, as well as the organisation of the dissertation, rounds off the chapter. The next chapter discusses the literature review as guided by the objectives of the study.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Mahlaku a maswa a ema ka a matala (This is a Northern Sotho proverb literally translated to: “Newly cut branches in a kraal lean against the old ones”)

2.1 Introduction

The preceding chapter attempted to put things in to perspective by providing the background to the study, contextual and conceptual setting, theoretical framework, problem statement, research objectives and questions, justification of the study, originality of the study, research designs and methodology, ethical considerations, definition of key terms as well as referencing styles used in the study. This chapter reviews literature on the subject of the acquisition, transfer and preservation of IK by traditional healers in the Limpopo Province of South Africa.

According to Leedy and Ormrod (2010:66), the review of literature is important to a research study in the sense that it helps one to know more about the investigations and perspectives related to the topic under investigation. Leedy and Ormrod (2010) further explain that, as much as the review of literature can help one to avoid conducting a study that has already been done, it can actually offer new ideas, reveal the sources of data, show how other researchers handled methodological and design issues. It can also show how other scholars may have dealt with complex issues that may appear in that particular study. The main features of this chapter include, knowledge management and knowledge management theories, the theoretical framework guiding the study with special emphasis placed on the organisational knowledge conversion theory, knowledge acquisition, knowledge transfer, knowledge preservation, indigenous healing in South Africa as well a brief overview of some studies related to the current study.

2.2 Purpose of literature review

A literature review allows the investigator an opportunity to look at the debates and arguments by other researchers about the topic under investigation. After conducting a literature review the researcher is able to identify gaps and key areas that need to be explored further. Randolph (2009:2) is of the opinion that conducting a literature review is a means of demonstrating an author’s knowledge about a particular field of study, including vocabulary, theories, key variables and phenomena, and its methods and history, which will further inform the researcher of other influential researchers and research groups in the field. Randolph (2009) also highlights that a literature review can provide a framework for relating new findings to previous findings in the discussion section of a dissertation.

Randolph (2009) lists the following as some of the reasons why it is important to conduct a literature review. Randolph (2009) argue that the literature review can play an important role in:

- delimiting the research problem,
- seeking new lines of inquiry,
- avoiding fruitless approaches,
- gaining methodological insights,
- identifying recommendations for further research,
- seeking support for grounded theory,
- distinguishing what has been done from what needs to be done,
- discovering important variables relevant to the topic,
- synthesizing and gaining a new perspective,
- identifying relationships between ideas and practices,
- establishing the context of the topic or problem,
- rationalizing the significance of the problem,
- enhancing and acquiring the subject vocabulary,
- understanding the structure of the subject, and
- relating ideas and theory to applications.

In the current study, the review of literature assisted in identifying research approaches, methods and instruments used in conducting similar studies. This assisted the investigator in assessing and matching the results obtained against the methodologies employed to see their effectiveness. It also assisted the investigator in sharpening the research strategy for the current study and in supporting the choice of methodologies employed in the current study. The review of literature, especially the completed studies at PhD level in the field of Library and Information Science, also gave direction on the need to cite, as well as the proper referencing style that should be used.

2.3 Sources of Information

The main sources of information for the current study were journal articles, books, websites, observations and personal discussions with knowledgeable people, mainly healers in the different regions of Limpopo. Books were mostly used for definitions, background information and theoretical information that may not be available in some of the journal articles. Because of their frequency in publication, journal articles were mostly consulted as they contained the most current and relevant information to the current study. The investigator also kept abreast of the latest developments during observations, and further

attended seminars, participated in conferences and other training interventions that were relevant to the study.

2.4 Literature review road map

A literature review road map is a technique used to graphically map and visualise connections of what is written about a particular topic with an aim to identify the connections in the discussions (Ngulube 2003). Ngulube (2003) is of the view that Visual thinking or the construction of the literature review road map helps the researcher to organize, structure, and present the literature related to the study. Ngulube (2003) further highlights that the literature road map model originates from the University of Sheffield with an aim to demarcate the scholarship to be included in the literature review section of the study. For the current study, the subject headings and their links to each other are connected by directional arrows as shown in *Figure 2.1*.

To kick start the review of literature involving knowledge acquisition, transfer and preservation by traditional healers in the Limpopo Province of South Africa, the investigator found it necessary to start by giving a brief discussion on knowledge management theories, because knowledge management is very central to this study. The theoretical framework that guides this study highlights the interaction processes of tacit and explicit knowledge as essential features in knowledge management.

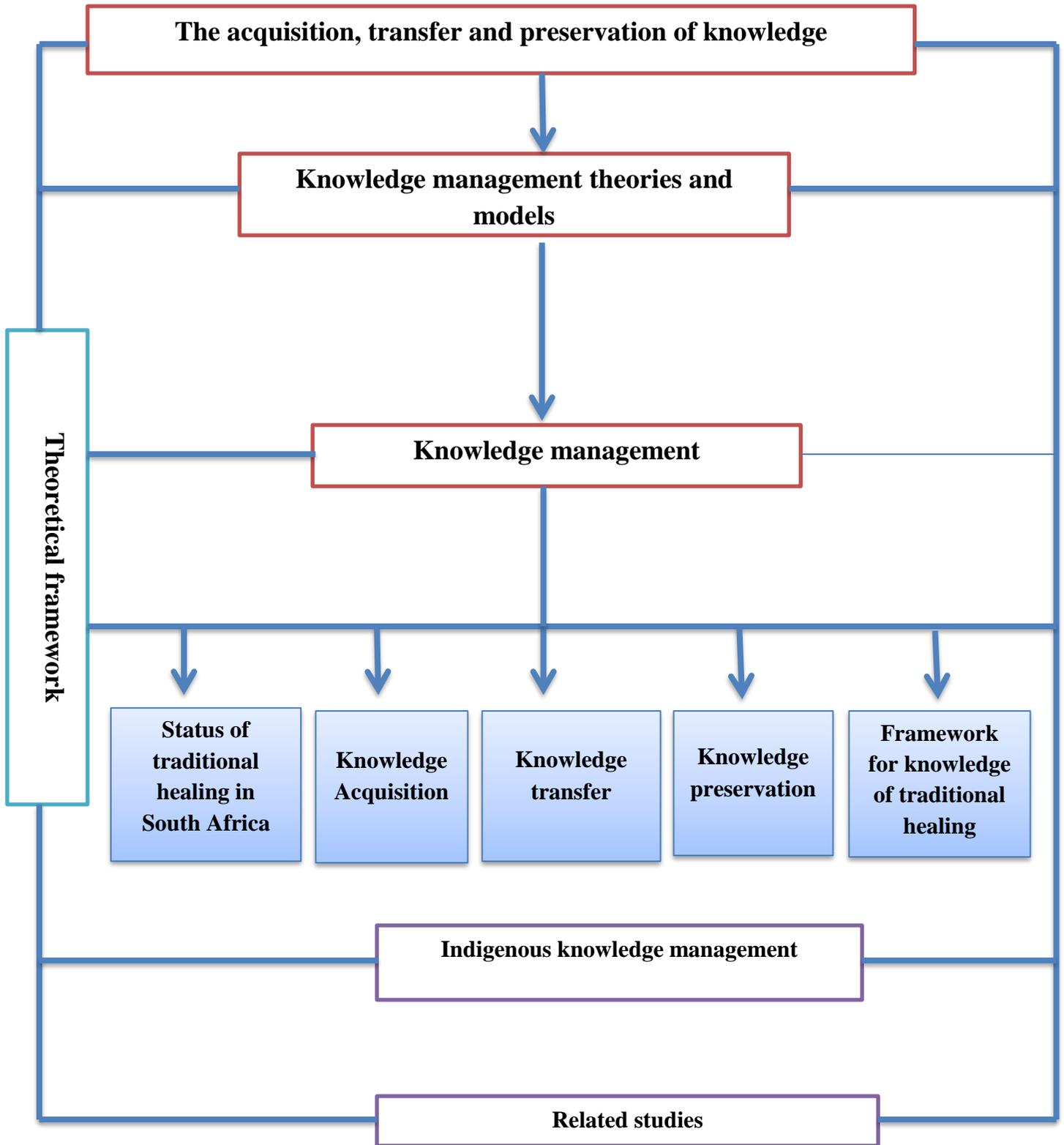


Figure 2.1: Literature review road map for the current study

2.5 Knowledge management theories and models

There are a number of knowledge management theories and models available in literature; however, in the current study the list of models by Dalkir (2005) was highlighted. That decision was motivated by the fact that the list by Dalkir (2005) provides a wider perspective on KM. The list of selected knowledge management models from Dalkir (2005:47) include: Choo (1998), Nonaka and Takeuchi (1995), Wiig (1993), von Krogh and Roos (1995), and Boisot (1998). The following is a brief discussion of the selected knowledge management models as explained by Dalkir (2005):

2.5.1 The Choo Sense-making KM Model

Choo (1998) described a model of knowledge management that stresses sense-making, knowledge creation and decision-making. The Choo KM model focuses on how information elements are selected and subsequently fed into organizational actions. Organizational action results from the concentration and absorption of information from the external environment into each successive cycle. Each phase, sense-making, knowledge creation and decision-making has an outside stimulus or trigger (See Figure 2.2). The model was not used in this study because its focus is on knowledge creation and decision making while this study is more focused on different components of knowledge management.

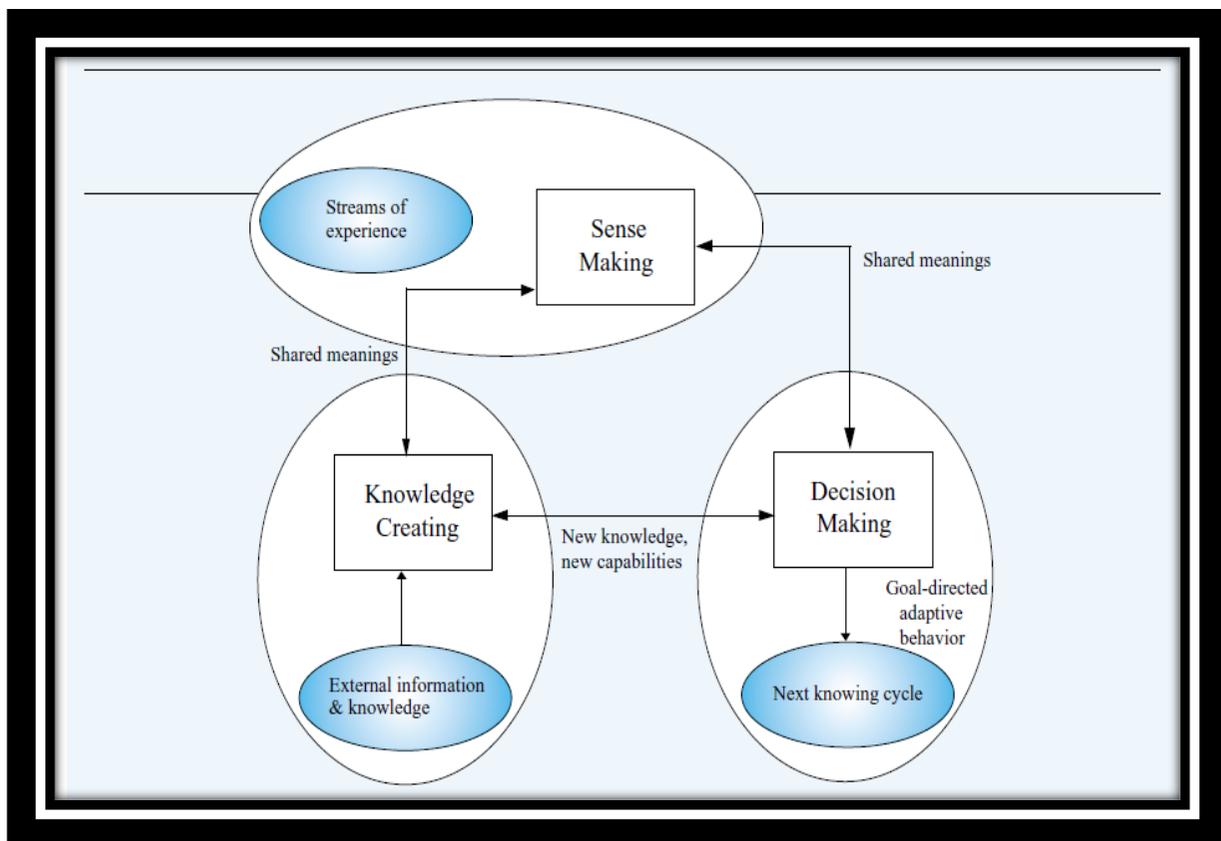


Figure 2.2: The Choo Sense-making KM Model (Source: Dalkir 2005)

2.5.2 The Von Krogh and Roos Model of Organizational Epistemology

The Von Krogh and Roos KM Model (1995) distinguish between individual knowledge and social knowledge, and they take an epistemological approach to managing organizational knowledge (Dalkir 2005). On that basis this model was not suitable for the current study and was not used. According to Von Krogh and Roos (1995:10), interpretation of organisational epistemology is a collection of perspectives, theories and concepts related to the following:

- How and why individuals within an organization come to know?
- How and why organizations, as social entities, come to know?
- What counts for knowledge of the individual and the organization?
- What are the impediments in organizational KM?

2.5.3 The Wiig Model for Building and Using Knowledge

Wiig (1993) approached his KM model with the following principle: in order for knowledge to be useful and valuable, it must be organized. Knowledge should be organized differently depending on what it will be used for. Some useful proportions to consider in Wiig's KM model include: completeness, connectedness, congruency, and perspective and purpose. *Completeness* addresses the question of how much relevant knowledge is available from a given source. *Connectedness* refers to the well-understood and well-defined relations between the different knowledge objects. A knowledge base is said to possess *congruence* when all the facts, concepts, perspectives, values, judgments, and associative and relational links between the knowledge objects are consistent. *Perspective and purpose* refer to the phenomenon through which we "know something", but often from a particular point of view or for a specific purpose. Wiig's KM model also discusses the three major forms of knowledge, namely, personal, public and shared knowledge together. The model further gives definitions of four types of knowledge, namely factual, conceptual, expectational and methodological knowledge (see Figure 2.3). The model does not touch key variables of the current study and the investigator found it to be not applicable to the current study. *Factual knowledge* deals with data and causal chains, measurements and readings. *Conceptual knowledge* involves systems, concepts and perspectives. *Expectational knowledge* concerns judgments, hypotheses and expectations held by knowers. *Methodological knowledge* deals with reasoning, strategies, decision-making methods and other techniques.

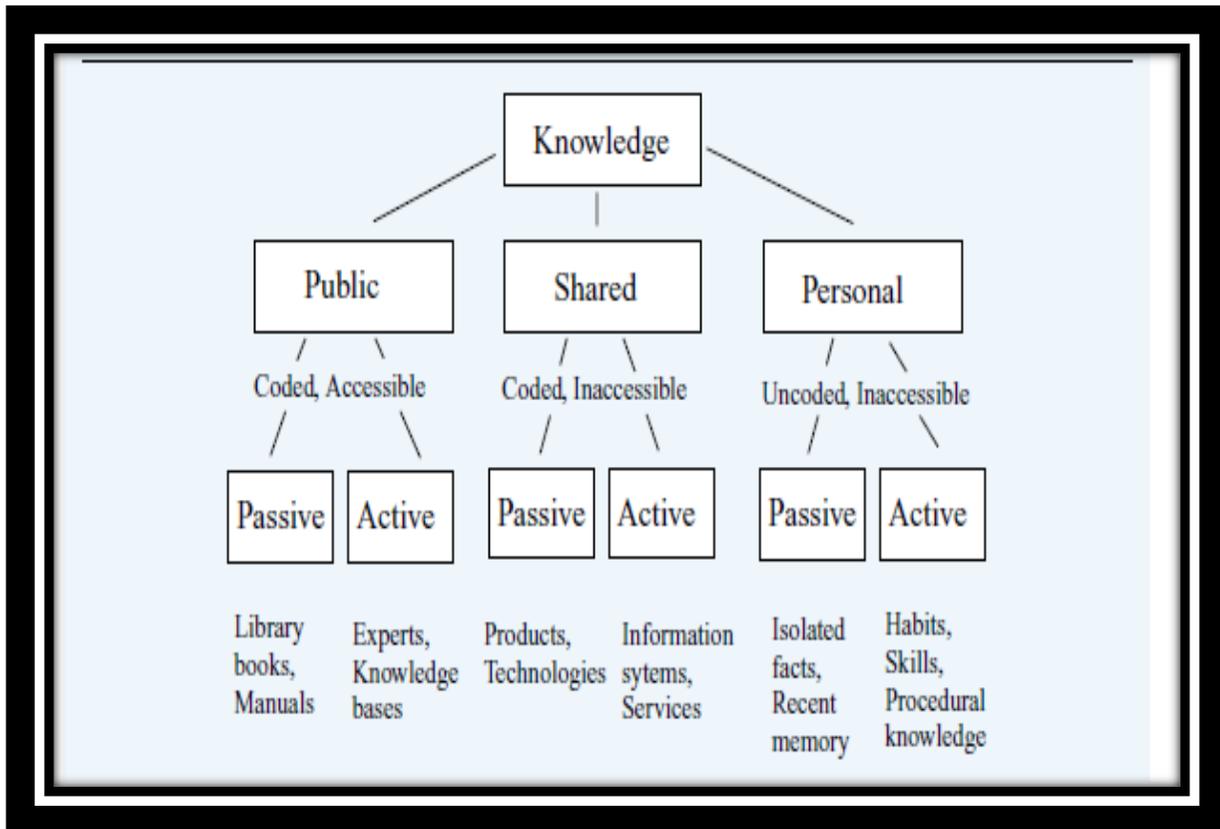


Figure 2.3: Wiig hierarchy of knowledge forms (Source: Dalkir 2005)

2.5.4 The Boisot I-Space KM Model

The *I-Space* builds on the proposition that the structuring of data facilitates its diffusion (Boisot 1995; Boisot 2004): The Boisot KM model is based on the key concept of “information good” that differs from a physical asset. Boisot distinguishes between information and data by emphasizing that information is what an observer will extract from data as a function of his or her expectations or prior knowledge. The effective movement of information goods is largely dependent on senders and receivers sharing the same coding scheme or language. A knowledge good is one that also possesses a context within which it can be interpreted. Effective knowledge sharing requires that senders and receivers share the context, as well as the coding scheme. Boisot (1998) proposes the following two key points:

1. The more easily data can be structured and converted into information, the more diffusible it becomes.
2. The less data that has been so structured requires a shared context for its diffusion, the more diffusible it becomes.

The two key points mentioned above underpin the Information Space or I-Space KM model. For this model, data is structured and understood through the processes of codification and abstraction. Codification draws distinctions and articulates boundaries between states or around objects. Abstraction treats things that are different as if they were the same (Boisot

2004). The Boisot model incorporates a theoretical foundation of social learning and serves to link together content, information and knowledge management in a very effective way. This model does not cover any of the constructs investigated in this study to that effect it was not used.

2.5.5 The Intelligent Complex Adaptive System model

The Intelligent Complex Adaptive Systems (ICAS) KM theory views the organization as an intelligent complex adaptive system. Complex adaptive systems consist of many independent agents that interact with one another locally (see Figure 2.4). The key processes in the ICAS KM model can be summarized as:

1. understanding
2. creating new ideas
3. solving problems
4. making decisions
5. taking actions to achieve desired results.

Similar to the previous models, the model did not focus on the main constructs of the current study which is knowledge acquisition, transfer and preservation.

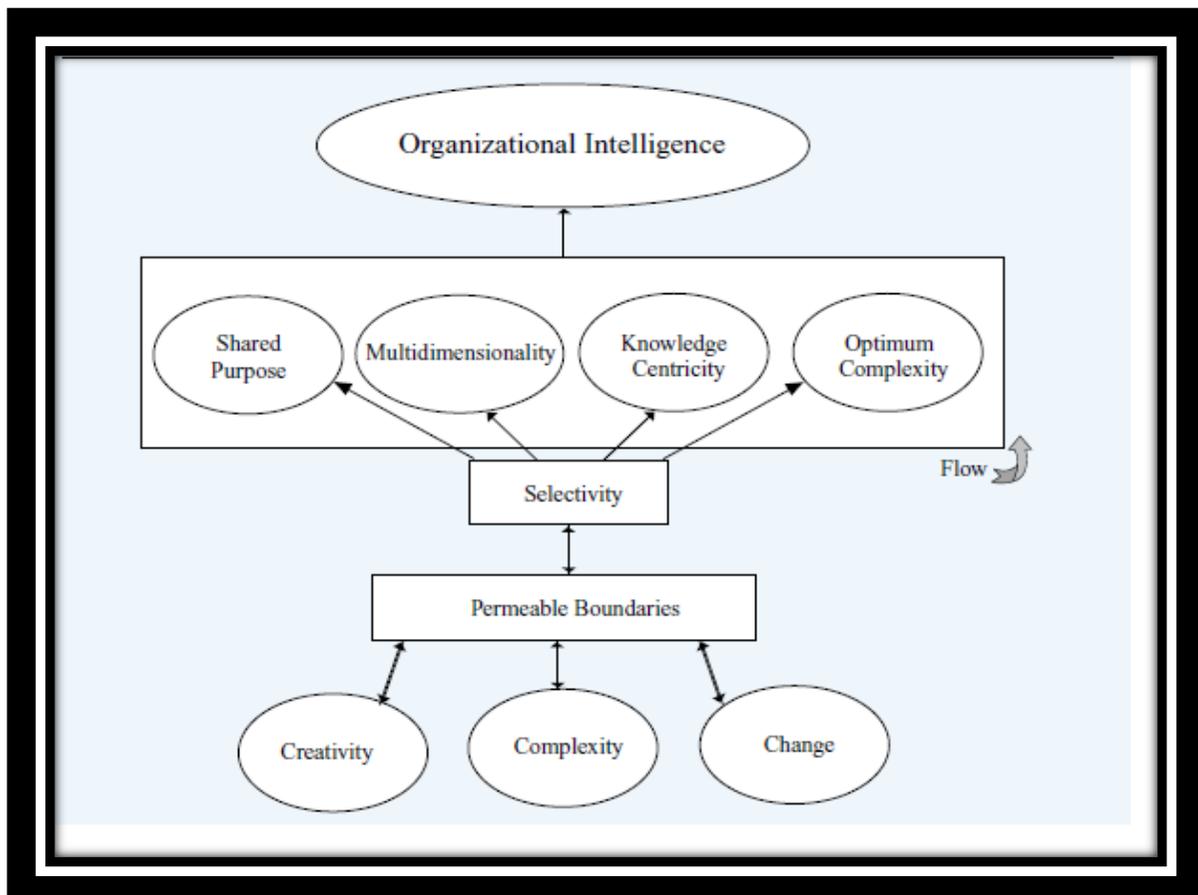


Figure 2.4: The Intelligent Complex Adaptive Systems (ICAS) KM theory (Source: Dalkir 2005)

2.5.6 Organisational knowledge conversion theory

Nonaka and Takeuchi (1995) theory of organisational knowledge conversion, which views the interaction processes of tacit and explicit knowledge as essential features in knowledge management, is very much central to this study. As discussed in the background, the organisational knowledge conversion theory identifies socialisation, internalization, externalization and combination (SECI) as the four modes of interaction that facilitate knowledge management. Even though this theory was created in the Japanese context, it can be used in the South African indigenous context because it addresses main constructs of this study, which include: acquisition, transfer and preservation of knowledge. The next section will look at this theory in detail as the theory that guided the current study.

2.6 Theoretical framework for this study

Neuman (2006) defines social theory as a system of interconnected ideas that condenses and organises knowledge about the social world. Neuman (2006:49) further argues that “*theories have an important role in research and are an essential ally for the researcher*”. Ngulube, Mathipa and Gumbo (2015: 148) reiterate that a theoretical framework is essential in research because it provides a mechanism for selecting and prioritizing variables that are to be investigated. According to Punch (2014:13), theory in research is commonly used to refer to methodological theories as well as substantive theory. Methodological theories, which will be looked at in the next chapter (Chapter Three), address the philosophy behind research methods while substantive theories address the content area of research (Punch 2014). This section discusses the substantive theory (the theory of organisational knowledge conversion by Nonaka and Takeuchi (1995)).

2.6.1 Organisational knowledge conversion theory

Logwa, Ngulube and Stilwell (2010), highlights that, the knowledge creation model, has three elements ((i.e. SECI, or Socialization, Externalization, Combination and Internalisation), *ba* and knowledge assets) which interact with each other organically and dynamically to create knowledge.

2.6.1.1 The SECI model

As highlighted in the background in the previous chapter, the organizational knowledge conversion theory identifies socialization, internalization, externalization and combination (SECI) as the four modes of interaction that facilitate knowledge management in an organization. According to Nonaka (1994:18), the proposition of the four modes of knowledge management in an organization was motivated by the assumption that knowledge

is created through conversion between tacit and explicit knowledge. Nonaka (1994:19) discusses the four major modes of knowledge conversion as follows:

Socialisation – tacit to tacit

Externalization – tacit to explicit

Combination – explicit to explicit

Internalization – explicit to tacit

2.6.1.1.1 Socialisation

Socialisation is the process of converting new tacit knowledge through shared experiences and, as explained in the discussions in the above sections, tacit knowledge by its very nature is personal and not easy to transfer or to share (Polanyi (1966); Nonaka (1994); Nonaka and Takeuchi (1995); Nonaka, Toyama and Konno (2000); Salonius and Kapyla (2013). The most popular quote by Polanyi (1966:4) says that “we can know more than we can tell”, which means that the knowledge we can share and express through language and signs is much less than what we may know as individuals. Nonaka (1994:19) makes a very important point by saying that an individual can acquire tacit knowledge without language but through apprentices who work with their mentors, and learn craftsmanship not through language but by observation, imitation and practice.

During socialization, traditional healers share personal experiences among themselves, because, as explained in the background information, the knowledge that they use on daily basis is kept in their minds. This knowledge is acquired through mentorship, initiation or from careful observation of the environment in a particular context by generation to generation (Mokgobi 2014; Sodi et al. 2011; Ngulube 2002b). Socialization enables team members to incorporate each other’s perspectives, expressing each other’s ideas in view of their experience (Anand et al. 2010:306).

Traditional healers regard their medical knowledge as a personal property that must be kept in strict confidence (Sodi et al. 2011) and this knowledge has survived for generations without being documented formally. For this knowledge to be acquired from someone, extensive personal contact is required. It is for that reason that this study aimed to determine how this type of knowledge is acquired among traditional healers in Limpopo.

2.6.1.1.2 Externalization

Externalization is the process of articulating tacit knowledge into explicit knowledge (Nonaka 1994; Nonaka and Takeuchi 1995; Nonaka, Toyama and Konno 2000). Externalization

ensures that tacit knowledge is transferred and collated into explicit knowledge, which is then easily stored in different forms and can easily be shared among individuals or groups. Externalization enables individuals to express in words, signs or in any other form, the knowledge they have created jointly through the exchange and synthesis of tacit knowledge, thus creating common understanding (Anand et al. 2010:307). Traditional healers in Limpopo can safeguard this knowledge and ensure the survival of the knowledge for future generations by externalizing their tacit knowledge, through initiation and mentoring.

When the experienced healers decide to share their experiences and skills with the trainee, then their tacit knowledge is made explicit. As already stated, traditional healers regard their medical knowledge as personal property that must be kept in strict confidence, therefore, the sharing of this knowledge usually takes place deliberately during training and it is up to the knower to decide how much information will be shared at a given time. This process is very important to knowledge acquisition and transfer, because, literature suggest that when tacit knowledge is externalised, it is possible to acquire and share this knowledge. This study investigated how traditional healers externalize and share knowledge with each other. Historically, Africans are known to have shared knowledge through oral tradition.

2.6.1.1.3 Combination

Combination is the process of creating explicit knowledge from explicit knowledge (Nonaka 1994:19). This process involves converting explicit knowledge obtained from training and combining and integrating into the existing knowledge to form new knowledge. According to Nonaka and Takeuchi (1995:67), this mode of knowledge conversion involves combining different bodies of explicit knowledge. This process encourages collaboration among individuals. Traditional healers who dealt with a particular problem may exchange ideas, share their experiences and in this way combine their ideas and experiences to create the best solutions for particular problems. The same thing can happen when experienced healers explicitly share their knowledge with their mentees during training to improve the knowledge they obtained during observations. This process is crucial for knowledge preservation because it ensures that the relevant knowledge verified by primary sources is preserved.

2.6.1.1.4 Internalization

Internalization is the process of embodying explicit knowledge into tacit knowledge (Nonaka and Takeuchi 1995:67). For knowledge that was obtained through socialization, externalization and combination to form a permanent knowledge base of an individual, it must be internalized. This means that tacit knowledge obtained during training, mentorship,

observations, collaborations, discussions, practice, and so on, should be internalized to form that particular individual's tacit knowledge base. Internalization is a very important step of knowledge preservation, especially in the African context where knowledge survived in the minds of individuals. This study aimed to assess how knowledge is preserved among indigenous healers in Limpopo.

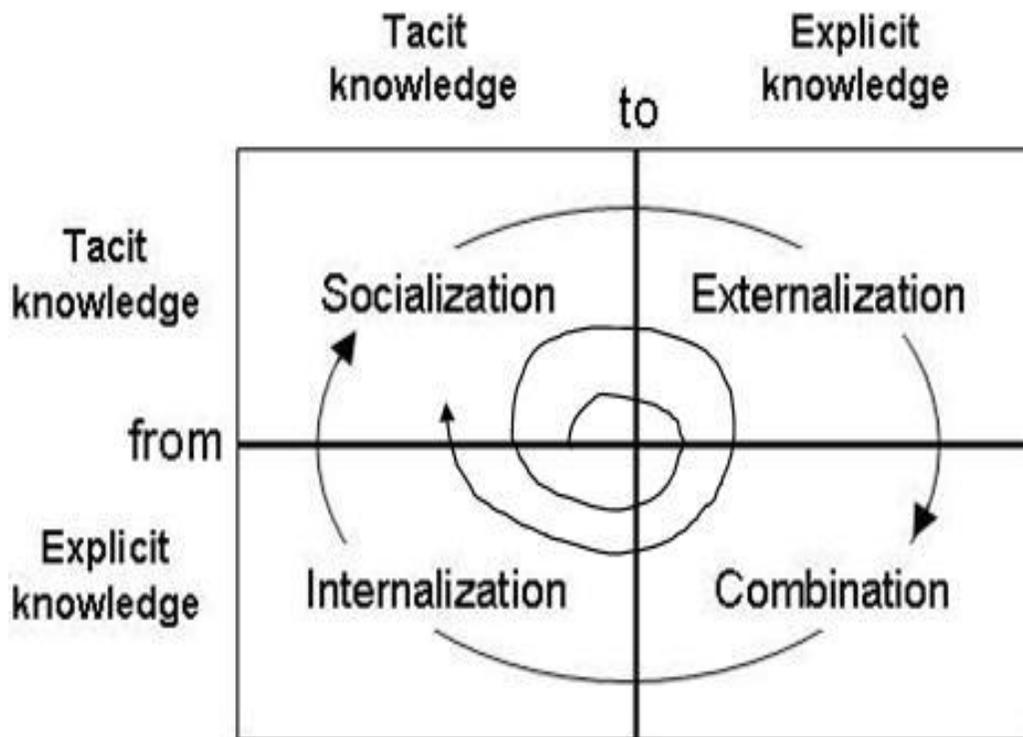


Figure 2.5: SECI model (Source Nonaka and Takeuchi 1995:71)

The interaction between tacit and explicit knowledge in organisations as explained by Nonaka, Toyama and Konno (2000:9) suggests that the creation of knowledge is a continuous process of dynamic interactions between tacit and explicit knowledge (see Figure 2.5). According to Nonaka and Takeuchi (1995:71), the content of knowledge created by each mode of knowledge conversion is naturally different; however, they interact with each other in a spiral of knowledge creation. The tacit knowledge internalized by the mentees will at some point be externalized during practice, when mentoring others or through a combination when discussing related issues with fellow young or new healers. This will in turn make sure that the process is continuous and never stop.

There are a number of scholars who explored the theory of organisational knowledge creation and, for this study, one that is worth mentioning is the extended SECI model proposed by Harmaakorpi and Melkas (2005) for regional knowledge management (Salonius and Kapyla 2013:585). In addition to the SECI model proposed by Nonaka and Takeuchi (1995) as discussed above, the extended SECI model makes mention of two extra knowledge-conversion phases, that is, potentialisation and visualisation (see Figure 2.6). This constituted

the third form of knowledge called the self-transcending knowledge (Salonius and Kapyla 2013:585).

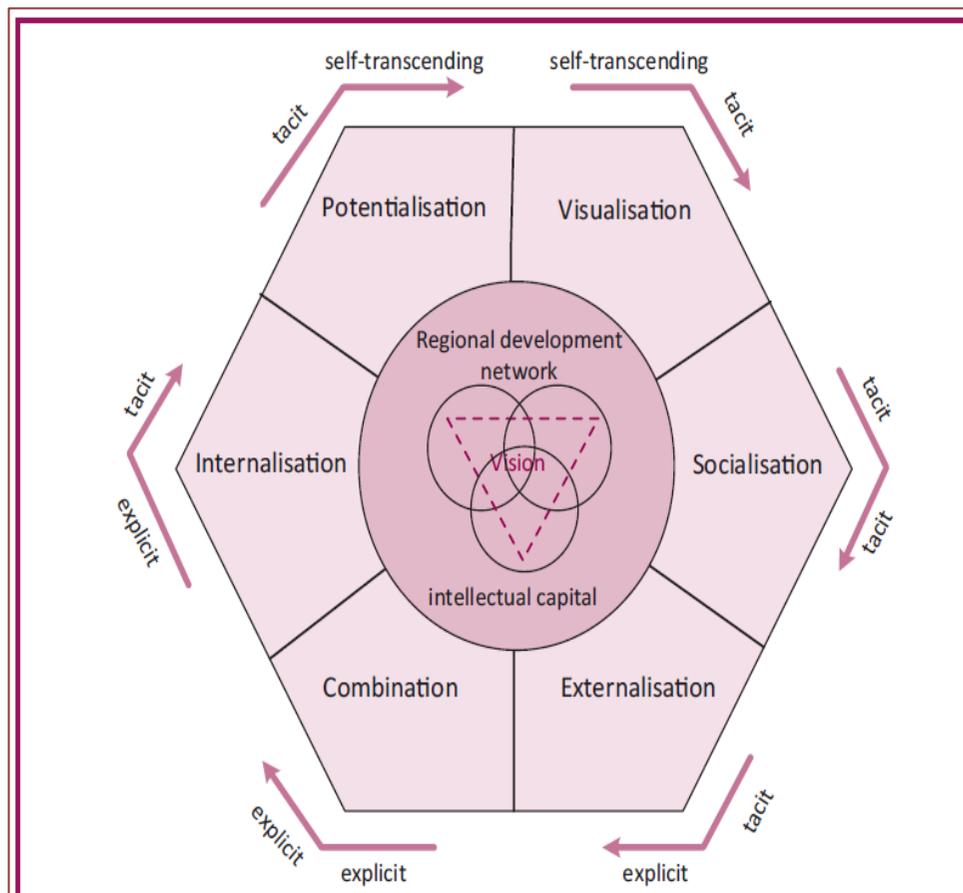


Figure 2.6 Extended SECI Model (Salonius and Kapyla, 2013:585)

2.7 Potentialisation and visualisation

Potentialisation refers to the transition from tacit to self-transcending, where tacit knowledge is disembodied and forms the basis for sensing the potential and seeing what does not yet exist (Salonius and Kapyla 2013:586). Visualisation takes place when self-transcending knowledge translates into tacit knowledge. Self-transcending knowledge is embodied in the abstract to visions, feelings and mental models (Salonius and Kapyla 2013:586). Traditional healers are known to depend on their ancestors, dreams, visions, spiritual guidance from the ancestral world for the knowledge and healing powers they possess (Sodi et al. 2011:102). For that reason, the two additional modes from the extended SECI model by Harmaakorpi and Melkas (2005) are worth mentioning in this discussion.

2.8 Types of Ba

According to Nonaka, Toyama and Konno (2000), when it comes to knowledge creation, one cannot be free from context. Nonaka, Toyama and Konno (2000) further indicate that social, cultural and historical contexts are important for individuals; as such contexts provide the

basis for one to interpret information to create meanings. This knowledge needs a physical context to be created which is regarded as *Ba*² (Nonaka, Toyama and Konno 2000). Mokgobi (2014:28) highlights that it is important to note that traditional healing is not a homogenous healing system, but varies from culture to culture, from region to region, and from individual to individual. As a result, the notions of *ba* that correspond with the SECI process are worth mentioning. The four different notions of *ba* (see Figure 2.7) that correspond with the interaction in the SECI process are as follows (Nonaka, Toyama & Konno 2000):

- **Originating *ba***
- **Dialoguing *ba***
- **Systematising *ba***
- **Exercising *ba***

2.8.1 Originating ba

The *originating ba* is defined by individual and face-to-face interactions. It is a place where individuals share experiences, feelings, emotions and mental models. It mainly offers a context for socialisation, since an individual face-to-face interaction is the only way to capture the full range of physical senses and psycho-emotional reactions, such as ease or discomfort, which are important elements in sharing tacit knowledge.

2.8.2 Dialoguing ba

The *dialoguing ba* is defined by collective and face-to-face interactions. It is the place where individuals' mental models and skills are shared, converted into common terms, and articulated as concepts. The *dialoguing ba* mainly offers a context for externalisation. Individuals' tacit knowledge is shared and articulated through dialogues amongst participants. Dialoguing *ba* is more consciously constructed than originating *ba*. Selecting individuals with the right mix of specific knowledge and capabilities is the key to managing knowledge creation in dialoguing *ba*.

2.8.3 Systematising ba

Systemising ba is defined by collective and virtual interactions. *Systemising ba* mainly offers a context for the combination of existing explicit knowledge, as explicit knowledge can be easily transmitted to a large number of people in written form. Information technology, through such things as on-line networks, groupware, documentation and databanks, offers a virtual collaborative environment for the creation of systemising *ba*

² loosely means "place" in Japanese

2.8.4 Exercising ba

Exercising ba is defined by individual and virtual interactions. It mainly offers a context for internalisation. Here, individuals embody explicit knowledge that is communicated through virtual media, such as written manuals or simulation programs. Exercising ba synthesises the transcendence and reaction through action, while dialoguing ba achieves this through thought

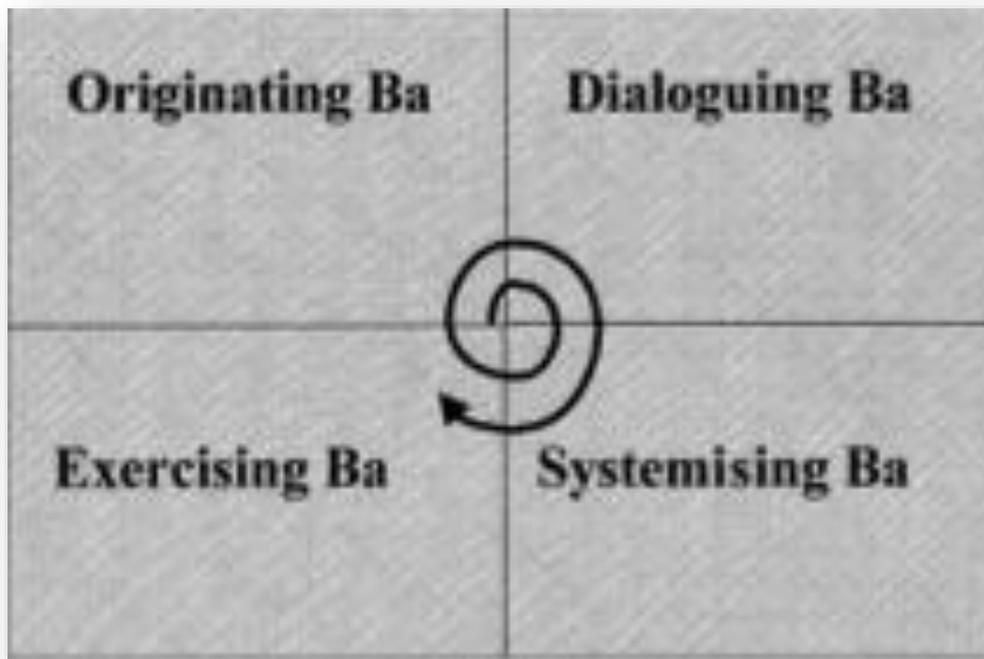


Figure 2.7: Types of Ba (Source: Nonaka, Toyama and Konno 2000)

2.9 Categories of knowledge assets

Knowledge assets are key elements that facilitate knowledge creation processes. Nonaka, Toyama and Konno (2000:20) describe knowledge assets as the inputs, outputs and moderating factors of the knowledge-creating process. Nonaka Toyama and Konno (2000) proposed the following categories of knowledge assets (see Figure 2.8):

- **Experiential knowledge assets**
- **Conceptual knowledge assets**
- **Systemic knowledge assets**
- **Routine knowledge assets**

2.9.1 Experiential knowledge assets

Experiential knowledge assets consist of the shared tacit knowledge that is built through shared hands-on experience amongst the members of the organisation, and between the members of the organisation and its customers, suppliers and affiliated firms. Skills and

know-how that are acquired and accumulated by individuals through experiences at work are examples of experiential knowledge assets. Other examples of such knowledge assets include emotional knowledge, such as care, love and trust, physical knowledge such as facial expressions and gestures, energetic knowledge such as senses of existence, enthusiasm and tension, and rhythmic knowledge such as improvisation and entrainment.

2.9.2 Conceptual knowledge assets

Conceptual knowledge assets consist of explicit knowledge articulated through images, symbols and language. They are the assets based on the concepts held by customers and members of the organisation. Brand equity, which is perceived by customers, and concepts or designs, which are perceived by the members of the organisation, are examples of conceptual knowledge assets.

2.9.3 Systemic knowledge assets

Systemic knowledge assets consist of systematised and packaged explicit knowledge, such as explicitly stated technologies, product specifications, manuals, and documented and packaged information about customers and suppliers. A characteristic of systemic knowledge assets is that they can be transferred relatively easily.

2.9.4 Routine knowledge assets

Routine knowledge assets consist of the tacit knowledge that is routinized and embedded in the actions and practices of the organisation. Know-how, organisational culture and organisational routines for carrying out the day-to-day business of the organisation are examples of routine knowledge assets. Through continuous exercises, certain patterns of thinking and action are reinforced and shared amongst organisational members. Sharing the background to and 'stories' about the company also helps members to form routine knowledge. A characteristic of routine knowledge assets is that they are practical.

<p>Experiential Knowledge Assets</p> <p>Tacit knowledge shared through common experiences</p> <ul style="list-style-type: none"> • Skills and know-how of individuals • Care, love, trust, and security • Energy, passion, and tension 	<p>Conceptual Knowledge Assets</p> <p>Explicit knowledge articulated through images, symbols, and language</p> <ul style="list-style-type: none"> • Product concepts • Design • Brand equity
<p>Routine Knowledge Assets</p> <p>Tacit knowledge routinised and embedded in actions and practices</p> <ul style="list-style-type: none"> • Know-how in daily operations • Organisational routines • Organisational culture 	<p>Systemic Knowledge Assets</p> <p>Systemised and packaged explicit knowledge</p> <ul style="list-style-type: none"> • Documents, specifications, manuals • Database • Patents and licenses

Figure 2.8: Categories of Knowledge assets (Source: Nonaka, Toyama and Konno 2000)

The preceding section discussed the importance of theories and models to research and, in particular, to the current study. A selected number of models and theories to knowledge management were highlighted. Furthermore, the theory and model that guides this study and its link to different objectives were highlighted. The next sections gives a brief overview of the concept of knowledge management, a review literature related to the objectives of the current study in order to underline the link between the theoretical framework, objectives as well as the methodological foundations that guide the study. A discussion on knowledge management as a concept is essential because knowledge acquisition, knowledge transfer and knowledge preservation are some of the basic components of knowledge management

2.10 Knowledge management

Beckman (1999) defines knowledge management as the formalization of and access to experience, knowledge and expertise to create new capabilities, enable superior performance, encourage innovation, and enhance customer value. According to Macintosh (1996), knowledge management involves the identification and analysis of available and required knowledge, and the subsequent planning and control of actions to develop knowledge assets so as to fulfil organizational objectives. Jain (2007) states that KM can be characterized as follows:

- KM involves the core process of several activities; such as creating, acquiring, capturing, sharing, using and re-using it.

- KM includes both explicit and tacit knowledge.
- KM is an ongoing activity.
- Information is the building block of KM.
- KM is action oriented or application based.
- The main drive behind KM is to improve organizational performance.

Hey (2004:9) is of the opinion that knowledge is generally personal, subjective and inherently local, and it is located within the minds of individuals, which means that it is internalized by the knower. When a person memorises something, that person has obtained that knowledge, which has a particular meaning to them. The review of literature suggests that knowledge can be broadly categorised as either explicit or tacit (Nonaka and Takeuchi 1995; Wyatt 2001). Anand, Ward and Tatikonda (2010:306) suggest that it is important to note that this classification of knowledge as either explicit or tacit is one of two prominent classifications in the knowledge management literature.

2.10.1 Tacit versus explicit knowledge

Tacit knowledge as identified by Polanyi (1966) is knowledge that is hard to encode and communicate. Polanyi (1966) stated that tacit knowledge is a form of knowledge that people carry in their minds, has been accumulated over a period of time but is very difficult to access and can be shared through casual conversations. Nonaka and Takeuchi (1995) also resonate by saying that tacit knowledge is personal, context specific and hard to formalize. This knowledge is ephemeral and transitory and “cannot be resolved into information or itemized in the manner characteristic of information” (Hey 2004:10). Dalkir (2005:8) further highlights that the *tacitness* of this type of knowledge is the property of the knower, because what is easily articulated by one person may be very difficult to externalize by another. Furthermore, explicit knowledge tends to represent the final product, whereas tacit knowledge is the know-how or all of the processes that were required to produce that final product.

Most scholars are in agreement that explicit knowledge is highly codified and is transmittable in formal, systematic language (Polanyi 1966; Nonaka and Takeuchi 1995; Boston, Dhanaraj, Lyles, Steensma and Tihanyi 2004). Furthermore, (Polanyi 1966) explains that explicit knowledge is easy to acquire and that it can be exploited quickly.

Wyatt (2001: 6) opines that explicit knowledge consists of facts, rules, relationships and policies that can be faithfully codified in paper or electronic form and shared without the need for discussion. Similarly, Hey (2004: 10) reverberates that explicit knowledge is exactly that kind of knowledge that can be encoded and is transmittable in language, once again via the

conduit metaphor. Dalkir (2005:8) also explains that explicit knowledge is usually contained within tangible or concrete media.

The difference between data, information, knowledge and wisdom, as well as the two categories of knowledge, was discussed in this section in an effort to try to explain what knowledge is and to further unpack the concept of knowledge management. The definition of KM adopted for this study is the one by Ugwu, Ekere and Ekere (2014). According to Ugwu, Ekere and Ekere (2014:32), KM is “*a process of creating, storing, sharing and re-using organizational knowledge (or know-how) to enable an organization achieve its goals and objectives*”.

Mavodza and Ngulube (2011:45) are of the view that KM originates from a variety of disciplines, and knowledge can be viewed as a valuable asset that can play a pivotal role in an organization’s performance. As highlighted in the background to the current study, the main constructs of the current study include: knowledge acquisition, knowledge transfer and knowledge preservation. From the review of literature thus far, the constructs are mainly taking the direction of frameworks and models of knowledge management. Literature suggests that the knowledge of traditional healers is known to be acquired from careful observation of the environment or through mentorship or initiation in a particular context by one generation to the next (Mokgobi 2014:28, Ngulube 2002b:61; Sodi *et al.* 2011). The next section discusses the components of knowledge management related to this study.

2.10.2 Knowledge acquisition, transfer and preservation

As explained earlier in the discussion, the main components of KM on which the current study focuses are knowledge acquisition, knowledge transfer, as well as knowledge preservation.

2.10.2.1 Knowledge acquisition

Pacharapha and Ractham (2012:725) opine that acquiring knowledge can be viewed at both organizational level and individual level. As a result, the definition of knowledge acquisition is best looked at from an organisational level and a personal level. At organizational level, knowledge acquisition can be defined as accepting knowledge from the external environment and transforming it so that it can be used by an organization and at individual level, knowledge acquisition can be accomplished by three activities, which include sourcing from organizational knowledge repositories, learning from others and learning from experiences (Pacharapha and Ractham 2012:726).

Knowledge acquisition and knowledge creation are the first steps in the process of developing knowledge (Liao, Wu, Hu and Tsui 2009). For knowledge to be acquired, willingness, attitude and the ability of a recipient to acquire and use such knowledge are crucial, and there should be a willingness to share and acquire this knowledge from both the source and the recipient (Pacharapha and Ractham 2012; Chigada and Ngulube 2015).

The review of literature suggests that organizational knowledge largely resides within individuals' memory, which means that knowledge acquisition by learning from others plays an important role in Individual Knowledge Acquisition (Ryu, Kim, Chaudhury & Rao 2005). Furthermore, Ryu et al. (2005) opine that for this type of knowledge acquisition to take place, the two parties who are involved, that is, a knowledge source and a knowledge recipient, mostly know one another and interact over time.

Nonaka and Takeuchi's theory of organisational knowledge conversion discusses knowledge acquisition and knowledge sharing in the first three modes, namely socialisation, externalization and combination. It is important to note that for information to be acquired there should be willingness to share; without knowledge sharing there will not be knowledge to be acquired. According to Cyr and Choo (2010:826), knowledge sharing is a form of social exchange that is moderated by the social value orientation of the individual and it can be seen as an exchange of a valuable resource between two parties. While the assumption in the literature is that tacit knowledge would be more effortful and costly to share than explicit knowledge, there is a general lack of empirical work that tests this assumption (Cyr and Choo 2010).

Acquisition and sharing of knowledge during socialisation (where tacit knowledge is shared) are mainly done through observations, shared experiences and imitation, to name but a few. However, it is important to note that for a successful acquisition and sharing of this tacit knowledge to take place, an opportunity for participation as well as access to knowledgeable people is necessary (Koskinen, Pihlanto and Vanharanta 2003).

During externalization, tacit knowledge is externalized, made ready and made easier to share and acquire in any given situation. When the custodians of knowledge make available and share what resides in their minds, their tacit knowledge is turned in to explicit knowledge, which is easier to share and acquire. This knowledge can be externalised in the form of books, manuals, databases, emails, letters and discussions. The acquisition of knowledge between individuals (mentor and mentee) is mostly through dialog, which can happen directly between individuals. The next section discusses knowledge transfer between individuals.

2.10.2.2 Knowledge transfer

In the background to the current study, knowledge transfer (KT) was defined as the process by which knowledge is transmitted to, and absorbed by, a user (Garavelli, Gorgoglione and Scozzi 2002:270). However, Faust (2007:1) defines KT as that part of KM, which refers to the transmission of explicit, implicit and tacit knowledge from a person or organization to one or several people. Looking at how we explained and defined knowledge sharing (KS) above, it is important to note that there is some level of overlap on the usage of both KT and KS and some similarities on how the two concepts are defined. Paulin and Suneson (2012:82) also highlight that many scholars have failed to provide a clear-cut definition for both KT and KS and at times the two concepts have been used interchangeably.

Having said that, Argote and Ingram (2000), supported by Paulin and Suneson (2012), explain that “*one common dividing line between KT and KS is related to the levels of analysis, in that KS is used more frequently by authors focusing on the individual level, while KT is used more frequently when groups, departments, organizations or even businesses are in focus*”. The current study will draw the line between the two concepts through the level of analysis. Having said that, KT in organizations can be defined as the process through which one unit (e.g. group, department or division) is affected by the experience of another (Argote and Ingram 2000:151). Sharing takes place between individuals and transfer takes place between individuals, teams, units or organizations. For this discussion, we can safely say that the transfer of knowledge occurs during the externalization mode of our knowledge-conversion theory.

Szulanski, Ringov and Jensen (2016: 306) point out that: “*through interaction, a knowledge source can articulate its own perspective and reveal implicit rules and assumptions, thereby externalizing hidden tacit knowledge that is otherwise hard to communicate, whereas knowledge recipients can gradually internalize it*”.

Moreover, interactions between organizational members can make it possible to share such tacit expertise informally and spontaneously (Malhotra and Majchrzak 2012). According to literature {Nonaka (1994); Polanyi (1966); Szulanski, Ringov and Jensen (2016: 306)} the transfer of knowledge hinges on the effective transfer of tacit knowledge. The proper handling of tacit knowledge lies at the very heart of the creation and transfer of knowledge in organizations (Szulanski, Ringov and Jensen: 2016: 306).

Tacit knowledge may be transferred through observations, imitation and practice just as explained in the previous section. It was observed that the transfer of the tacit knowledge can be done through practice, through observing and emulating a particular action, or through

learning the craft by observing the mentor then imitating and practicing until the knowledge is perfectly acquired (.Szulanski, Ringov, and Jensen 2016). Moreover, the observation of the actual performance of a practice allows engagement between the mentor and the mentee on issues that are not clear. To summarise, for tacit knowledge to be transferred through observation, there should be interaction between source and recipient, communication should be very personal, the recipient should observe the knowledge in use and the recipient should keep practicing.

Although all transfers of knowledge require some degree of effort and may experience some difficulty, some transfers experience significantly more difficulties than others, whereas some of the transfer-related problems will be diagnosed easily and resolved routinely (Szulanski, Ringov and Jensen 2016). The deliberations above suggest that tacit knowledge is not easy to transfer when compared to explicit knowledge.

Explicit knowledge can be transferred through interaction between source and recipient, personalized communication and recipient observation of the knowledge in use. Recipient practice facilitates the transfer of tacit knowledge. Explicit knowledge is contained in impersonal, standardized documents and is designed to be applicable to a wide variety of contexts and users (Nonaka 1994). As a result, the transfer methods that enable personalized communication, such as personnel transfers or informal visits, are more capable of facilitating the exchange of tacit knowledge. The main aim of the knowledge transfer process is that the recipient emerges with an identical interpretation of the message to the one that the source intended to convey (Szulanski, Ringov and Jensen 2016:305). It is, however, important to note that the transfer of information may be negatively or positively affected by different factors. Reliability of the source and ability of the recipient to absorb the knowledge are the main factors that may affect the transfer of knowledge (Argote and Ingram 2000:161).

2.10.2.3 Knowledge preservation

The concept of preservation is usually used to explain a situation where one keeps something safe or protects something from harm. One can argue that it is because of preservation that the human race has survived, adapted and adjusted over generations. It is also safe to say that people acquire and transfer knowledge with preservation in mind. Faust (2007:1) draws a good picture of the importance of knowledge preservation when he says that the loss of knowledge does not only threaten the safe and economic operation of nuclear power plants, but also has negative effects on the socio-political system of a country. In Africa, there is an age-old saying “*when an old person dies, the entire library burns*”. This sums up and shows the importance of knowledge preservation as one of the key knowledge management

components. The importance of preserving knowledge in any given situation can never be overemphasized.

Knowledge preservation, therefore, can be defined as a process for maintaining knowledge that is important to an organization's mission to store knowledge/information over time and provide the possibility of recall for future use (Mazour 2006). For this study, knowledge preservation will be defined as the process of protecting or the keeping safe knowledge (both tacit and explicit), especially indigenous knowledge, by individuals or organizations for future use.

For tacit knowledge to be preserved, it has to be acquired first. After acquisition, this knowledge is integrated to our existing knowledge base. This is what Nonaka (1994) calls combination. Knowledge obtained through training is combined with the knowledge we already have and then it is converted in to our own personal tacit knowledge. According to Nonaka and Takeuchi (1995:67), this mode of knowledge conversion involves combining different bodies of explicit knowledge. After this knowledge is integrated or combined with our existing knowledge base, it now gets to be internalized.

The conversion of the acquired explicit knowledge to tacit knowledge, i.e. internalization, occurs through a series of integrations in which individual concepts become concrete and ultimately absorbed as an integral belief or value (Faust 2007). This internalized knowledge is then preserved inside the human mind for future use. The preservation process is, however, a little different when it comes to explicit knowledge.

McMahon (2015) explains that explicit knowledge is readily codified into a tangible form, that is, documentary material (reports, analyses, memos, videos, email and databases.), that may be retained in a wide variety of media (paper, film and electronic.). It is possible to preserve this knowledge mostly by means of libraries, archives, museums and many other information-handling agencies. This knowledge started as personal, was shared through externalization and became public knowledge which, can be preserved forever. The next section discusses the theoretical foundations related to the KM discipline.

2.11 The status of indigenous healing in South Africa

In the background to the current study, Mokgobi (2014) highlighted and identified different types of traditional healers which are known to exist according to different regions of South Africa. Mokgobi (2014) cited that the Bapedi (Northern Sotho speakers) tribe calls their traditional healers *Dingaka*, Xhosas call their healers *Amagqira*, Basotho (Sotho) Sotho

speakers) *call their healers Selaoli*, Vendas and Tsongas call theirs *Mungome*. However, most South Africans generally refer them to as Sangomas (from the Zulu word *izangoma*).

South African colonial and apartheid history means that many South Africans have different views about indigenous healing because of being exposed and forced to behave in certain ways. According to Mokgobi (2014:24), many South Africans are still divided between Western and African philosophies. These divisions are mainly on issues like gender, religion, medicine, ceremonies and many other practices that are unique to Africa. This makes South Africa, which is often referred to as a rainbow nation, unique because it consists of diverse cultures and beliefs.

Historically, the use of traditional medicine in South Africa was outlawed. Ashforth (2005:286) highlights that the South African apartheid government passed into law the Suppression of Witchcraft Act in 1957, an act of colonial legislation, which declared divination to be illegal, thereby theoretically making the work of traditional healers impossible. This resulted in people associating traditional healing with witchcraft, which opinion continued over the years and the stigma is still attached to the practice today.

According to the Witchcraft Act, No. 3 of 1957, the following were offences related to the practice of witchcraft and similar practices. The act read thus:

Any person who-

- (a) imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing, or who names or indicates any other person as a wizard;*
- (b) in circumstances indicating that he professes or pretends to use any supernatural power, witchcraft, sorcery, enchantment or conjuration, imputes the cause of death of, injury or grief to, disease in, damage to or disappearance of any person or thing to any other person;*
- (c) employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard;*
- (d) professes a knowledge of witchcraft, or the use of charms, and advises any person how to bewitch, injure or damage any person or thing, or supplies any person with any pretended means of witchcraft;*
- (e) on the advice of any witchdoctor, witch-finder or other person or on the ground of any pretended knowledge of witchcraft, uses or causes to be put into operation any means or process which, in accordance with such advice or his own belief, is calculated to injure or damage any person or thing;*

- (f) for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration, or undertakes to tell fortunes, or pretends from his skill in or knowledge of any occult science to discover where and in what manner anything supposed to have been stolen or lost may be found, shall be guilty of an offence and liable on conviction-*
- (i) in the case of an offence referred to in paragraph (a) or (b) in consequence of which the person in respect of whom such offence was committed, has been killed, or where the accused has been proved to be by habit or repute a witchdoctor or witch-finder, to imprisonment for a period not exceeding 20 years;*
- (ii) in the case of any other offence referred to in the said paragraphs, to a fine or imprisonment for a period not exceeding ten years;*
- (iii) in the case of an offence referred to in paragraph (c), (d) or (e), to a fine not exceeding five hundred rand or to imprisonment for a period not exceeding five years, or to both such fine and such imprisonment;*
- (iv) in the case of an offence referred to in paragraph (f), to a fine not exceeding two hundred rand or to imprisonment for a period not exceeding two years.*

Despite all the troubles and laws, indigenous healing continued to be practised although secretly (Denis 2006:312). Denis (2006) further says that the arrival of missionaries in Africa also dealt indigenous healing a massive blow. Christian missionaries aggressively opposed African indigenous beliefs. They discredited African traditional practices, saying they were based on superstitions and equated them to evil deeds. The implication was that Africans were caught between their original, traditional practices and the Christian teachings of the missionaries. Children born during that time were affected worst because they were born in a time when their culture was eroded.

African customs continued to be practised, despite the efforts from the authorities and the Christian missionaries to wipe them out. This resulted in some level of tolerance by the Christian missionaries and the authorities. Denis (2006) indicates that Christianity and traditional African religion were transformed into a polarity, with an infinite variety of intermediary positions and multiple interactions between the two poles. This meant that Africans would attend a church service on Sunday while still practising their own rituals and visiting traditional healers.

The blended practice of traditional African religion and Christianity gave birth to Zionist churches. According to Denis (2006), by promising healing and material advantages to their members, the Zionist churches have similarities with indigenous religious forms, not in their

rituals and beliefs, which take their inspiration from the Christian doctrine, but in their very function. However, there were and still are Africans who completely left their traditional practices and purely practised Christianity and, on the other hand, other Africans rejected Christianity and remained purely with the traditional African practices (Denis 2006).

The fall of the then apartheid government brought with it many changes and had a direct influence on traditional African practices. The South African government post-apartheid recognised a person who engages in indigenous medical plants as an indigenous healer (Sodi et al. 2011:101). The South African government also passed into law the Traditional Health Practitioners (THP) Act, No. 22 of 2007, which regulates the activities of indigenous healers. The Act states that “*traditional healing means the performance of a function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine*” (Government Gazette, 2008). Traditional healers were now free to practice and were protected by law.

The purpose of the Traditional Health Practitioners Act, No. of 2007, is to establish the Interim Traditional Health Practitioners Council of South Africa; provide for the registration, training and practices of traditional health practitioners in the Republic; and serve and protect the interests of members of the public who use the services of traditional health practitioners. This Act applies to the traditional health practice in the Republic of South Africa and the traditional health practitioners and students engaged in or learning traditional health practice in the Republic of South Africa (Government Gazette 2008).

According to the Act, no person may practice as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act. Any person who wishes to register as a traditional health practitioner or a student must apply to the registrar. If the registrar is satisfied that the information and documentation submitted in support of an application for registration meet the requirements of this Act, and upon receipt of the prescribed registration fee, the registrar may issue a registration certificate authorising the applicant to practice as a traditional health practitioner within the Republic. However, there are a number of challenges in this process. As explained above, Truter (2007) indicates that training to become a traditional healer (*sangoma*) is not a personal choice but a calling bestowed by ancestors on a person who then are apprenticed to a qualified diviner for several months.

Traditionally, the experienced diviner is the one that gives the authorisation after all the teachings had been mastered and the mentee had settled his/her student fees. The government

efforts to have all traditional healers registered will prove to be difficult, because students will graduate and the communities will witness the graduation and continue using their services despite even though they are not registered in terms of the act. Traditional healers may dispute this saying they received their power from the ancestors and may not seek permission from a government office. However, there are some lawbreakers who take advantage of this loophole and are not trained healers but continued to practice traditional healing. This practice derives from the image of traditional healing.

There should be ways that accommodate the traditional healers and also allow the government to regulate the practice. The government has established the Traditional Healers Council and one of its functions is to approve minimum requirements pertaining to the education and training of traditional health practitioners, in consultation with the relevant departments, quality assessment bodies or a body of traditional health practitioners accredited by the council. However, there is no agreement between the traditional healers' council and some of the professional bodies. An example of such disengagement is the statement by the leader of the Traditional Healers Organisation (THO) Nhlavana Maseko, in 2012 when he said "Members of his organisation do not want to be integrated into the ministry of health because traditional medicine existed long before western medication was introduced in the country, instead they want to work in collaboration with it but independently (Traditional Healers Organisation 2012).

There are also other professional associations worth mentioning, which include, the Traditional Healers Organisation (THO), the African National Healers Association, Bakgaga BaMaake Dingaka Association, South African Sedibeng Dingaka Association, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Healers of South Africa, the African Dingaka Association, and the African Skilled Herbalists Association (Freeman and Motsei 1992; Kale 1995). The Traditional Healers Organisation (THO), is a non-statutory body established in 1970, which organizes about 29,000 traditional health practitioners in the country and has networks in some parts of Africa (Traditional Healers Organisation, 2011). The organisation offers training on how to treat different kinds of diseases through programmes, some of which are accredited by the Health & Welfare SETA. The African National Healers Association was founded in 1989 and is registered as a non-profit organisation in South Africa under section 21 of Act No. 61 of 1973. The details of the two associations were obtained from their websites, while some of the associations mentioned above have no active websites.

Mbatha, Street, Ngcobo and Gqaleni (2012) inform us that some provincial and local health departments in South Africa, such as the Free State, KwaZulu-Natal and North West Departments of Health, as well as the eThekweni and Ekurhuleni Municipalities, have designated traditional medicine managers. Mbatha et al (2012) further elaborate that this traditional medicine managers oversees traditional healing integration into the municipal health system and encourages two-way referrals and collaboration between clinics and THPs.

Freeman and Motsei (1992), however, warn that this collaboration may not be simply a spreading of health care but “may be a paternalistic way of making the clients of traditional healers available to western interventions”. This is because, according to Freeman and Motsei (1992), traditional healers become more involved in first-line health ‘on behalf of’ scientific medicine, so the modus operandi and the ‘culture’ of traditional healing are likely to be undermined. Mngqundanisoa and Peltzerb (2008) echoed on the same sentiments where the results of their findings suggest that traditional healers believed that western practitioners undermined their work. Freeman and Motsei (1992) gave an example of such working together which was biased to the western practitioners. It took place at the Madadeni Hospital in KwaZulu-Natal where inyangas and sangomas had regular meetings with the doctors to help patients with chronic diseases receiving their regular (**western**) medicines from the traditional healers in their district rather than making the trip to the hospital each time medication is needed. Traditional healers were merely supporting the western practitioners no mention was made of patients being sent to traditional healers for traditional medicines. Freeman and Motsei (1992), supported by Mngqundanisoa and Peltzerb (2008), argue that while the option of mutual referral of patients appears to be fair, the reality is that it favours western medicine and this is not likely to change.

Summerton (2006) reiterates this notion by pointing out that western health practitioners’ critical view of traditional medicine is based on notions which perceive traditional health practitioners as posing a danger to the health of their patients. Summerton (2006) opines that the western practitioners lack the knowledge about traditional theories of disease and health. This causes mistrust between the two sides. While some traditional healers feel undermined by the western practitioners, some western doctor’s feel that traditional healers are putting the lives of patients at risk.

In South Africa, the right to choose a health care system remains biased towards the western practice in the sense that patients consulting traditional healers may find it difficult to deal with the employer after consultation. This is caused by the level of ambiguity and

inconsistency when it comes to accepting sick notes for absenteeism issued by the traditional healers by most private and government departments (Mbatha, Street, Ngcobo and Gqaleni 2012). It should be mentioned again that traditional healers are not subsidized, and the traditional healer operates outside the formal health setting at the financial cost of the patient alone (Mbatha, Street, Ngcobo and Gqaleni 2012). This is a disadvantage to both the patient and the healer, because patients who have no money to go to the hospital may consult healers and promise to pay at a later stage, which sees the patient not benefitting from being helped by the government and the healer not being able to put food on the table.

However this may be, traditional healing is continuing to be practised in South Africa. The perception that it is only practised by uneducated, poor, rural communities proved to be incorrect. We read in the newspapers on daily basis of high-profile people such as actors, radio and television personalities who end up becoming traditional healers (Sowetan 2016). There are a number of high-profile, well-educated and well-respected people who have answered the calling and became trained as traditional healers. Even during the 2010 FIFA world cup, the world witnessed on national television when traditional healers were called to perform some rituals before the commencement of the games.

However, some religious groups discourage their members from using the services of traditional healers because they are perceived as being evil. There are also doctors who are opposed to the healing practices of traditional healers because they feel that the healers' medicines are harmful to the patients. In the midst of all those churches and doctors who are opposed to traditional healing, there is a good number of those who are gave traditional healing a chance and do not see any problem with it.

2.12 Acquisition, transfer and preservation of indigenous knowledge

The current study uses the concept *indigenous knowledge* to represent all concepts that are used to describe knowledge of traditional and indigenous communities. This is because the review of literature suggests that there is no agreement on the conceptualization of this type of knowledge as it is called differently by different scholars globally (Onyancha and Ngulube 2011:130). For that reason, in the current study, the term indigenous knowledge will be used in the place of, and to represent local knowledge, traditional knowledge, native knowledge or any other concept used to describe knowledge of traditional indigenous communities.

Indigenous knowledge played, and continues to play, an important role in sustainable development of the indigenous communities. However, this knowledge was affected by,

among other things, what Tjiek (2006) calls the “*inferiority syndrome*” where people from the third-world countries, mostly in Africa, perceive that knowledge generated by the West is superior to their own IK. The findings in a study by Poorna, Mymoon and Hariharan (2014) suggest that urgent measures are required to preserve oral knowledge as it faces a greater risk of loss and misappropriation. The global loss of IK has created an urgent need to protect and preserve it, and control its use. According to Maina (2012:14), this was one of the issues that prompted the 1993 United Nations (UN) General Assembly declaration of 1995-2004, the international decade of the world’s indigenous People and another such decade from 2005-2014.

Poorna, Mymoon and Hariharan (2014:1240) define indigenous knowledge as the knowledge which an indigenous community accumulates over generations of living, which is mostly recorded in local languages and a major portion of which has still not been recorded and remains confined to local communities. However, in the current study IK is defined as the tacit know-how that is community based, unique, complex, dynamic, eclectic, non-formal and transmitted from one generation to the next in various contexts (including cultural, ecological, economic, ethical, political, social, spiritual and technological) to support indigenous communities in solving problems and making decisions that are fundamental to their existence, survival and adaptation in their everyday direct interactions and transactions with their natural surroundings, the external world, and other worldviews and value systems in a particular geographical area (Ngulube, Dube and Mhlongo 2015:148). Chilisa (2012:99) lists the following characteristics of indigenous knowledge:

- Indigenous knowledge is cumulative and represents generations of experiences, careful observations, and trial and error experiments.
- It is dynamic with new knowledge continuously added and external knowledge added to suit local situations.
- All members of the community, that is, elders, women, men and children, have indigenous knowledge.
- The quantity and quality of indigenous knowledge that an individual possesses will vary according to age, gender, socioeconomic status, daily experiences, roles and responsibilities in the home and the community, and so on.
- Indigenous knowledge is stored in people’s memories and activities and is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, cultural community laws, local language, artefacts, forms of communication, and organisation.

- Indigenous knowledge is shared and communicated orally and by specific example and through cultural practices such as dance and rituals.

The preservation of indigenous knowledge is of great importance, more so by professionals from the library and information science (LIS) sector. Ngulube (2002) opines that information professionals need to do more to ensure that indigenous knowledge is managed and preserved like other documentary materials. This, according to Ngulube (2002), is because LIS professionals have not been at the forefront in terms of managing indigenous knowledge, in spite of the fact that indigenous knowledge is fast becoming an important resource in planning and management, yet they (LIS professionals) claim to be custodians of knowledge and information. Although the preservation of indigenous knowledge is a primary need, there are challenges that may affect this exercise which are worth mentioning.

Poorna, Mymoon and Hariharan (2014) list the following as some of the challenges faced and which may affect the preservation and protection of indigenous knowledge:

- Indigenous knowledge is created and owned collectively by the community and its use and transfer are guided by traditional laws and customs, the current Intellectual Property Rights, which are enforced in the modern world and are largely individual rights that are based on western legal and economic parameters, as well as western property law that emphasizes exclusivity and private ownership, reduces knowledge and cultural expressions to commodities that can be privately owned by an individual or a corporation.
- The corporate and multinational companies, mostly from the developed world, use IK of developing countries as a basis for their commercial products, which are then patented without sharing any benefit with the source of the IK.
- The present patent system gives the entire economic benefit to those who have only slightly altered the IK and gives nothing at all to those who developed it over generations.
- Trade Related Aspects of Intellectual Property Rights (TRIPS) obligate all signatory countries to enforce them upon their own people, including the indigenous communities that developed and held the knowledge for generations, thus restricting their free use and practice.
- Foreign patents granted over IK can greatly affect an indigenous community's cultural practices as well as control of resources that are material to practising that IK.

This study focuses specifically on how this indigenous knowledge by traditional healers is acquired and transferred for preservation among these healers. Even though there are those scholars who dispute the 80% of the population, who is said to consult traditional healers in developing countries, and who further depends on indigenous medical knowledge for survival, a number of scholars (Denis 2006, Ijumba, and Barron 2005, Moodley et al. 2007, Truter, 2007) support this claim in their studies.

The World Health Organization (WHO) report estimated that 70% to 80% of the population in developing countries such as India is dependent on traditional medicines for their primary health care needs (Poorna, Mymoon and Hariharan 2014:1240). In the South African context, the Department of Health reported that by 2005, about 70% of South Africans were consulting traditional healers (Denis 2006). The statistics may differ from province to province and from place to place. People in the cities possibly make more use of western medicine than those in the rural areas, because they have more access to hospitals than their counterparts. There is, however, a change in the demographics; in Tshwane for example, townships such as Mamelodi, Atteridgeville and Soshanguve are closer to the cities, which make more healers accessible to the city people while the government is striving to provide western medical health care to those rural communities by providing clinics to those communities. Information professionals should play a leading role in making sure that this knowledge that is in danger of being lost is preserved for future generations.

The International Federation of Library Associations (IFLA) highlighted the importance of LIS professionals becoming involved in indigenous knowledge preservation and access, and challenged libraries to take a leading role in, inter alia, collecting, preserving and disseminating indigenous knowledge; publicizing its value, contribution and importance to both indigenous and non-indigenous people; raising awareness on the protection of indigenous knowledge against misappropriation; and involving elders and communities in its production and teaching of traditional knowledge (Maina 2012:14).

In their study, "*Preservation of the Traditional Knowledge of Tribal Population in India*" Thapa and Devi (2015) evaluate the process that was initiated by the Indian Government to document the indigenous knowledge of the tribals in India. The study conducted a SWOT analysis of efforts made by the Indian Government in documenting the indigenous knowledge of tribals in India. The Indian government saw the need for and importance of developing an indigenous knowledge management system for its indigenous communities, which is aimed at documenting the knowledge heritage without jeopardizing local culture and societal practices.

There are a number of initiatives across the globe by different governments to try to preserve the knowledge of indigenous origins. There are also a number of studies that capture such activities, having said that, the one that the investigator found necessary to highlight, is the one by Poorna, Mymoon and Hariharan (2014) entitled “*Preservation and protection of traditional knowledge – diverse documentation initiatives across the globe*”. Some of the initiatives around the globe, which was designed to preserve and protect indigenous knowledge as discussed by Poorna, Mymoon and Hariharan (2014), are as follows:

- **The traditional knowledge library of India**

This library is said to host one of the largest indigenous knowledge repositories in the world. The traditional knowledge library (TKDL) project documents, in digitized format, various Indian traditional systems of medicine available in the public domain in the form of ancient and other existing literature often inaccessible to the public and rarely understood. TKDL contains information in five foreign languages for the ease of patent examiners in international patent offices and it precisely lists the time, place and medium of publication. TKDL gives defensive protection to India’s traditional medicinal knowledge.

- **Korean traditional knowledge portal**

The Korean traditional knowledge portal was compiled by the Korean intellectual property office and this database includes a vast amount of knowledge from documentation on old Korean and Chinese medicine. It also includes a wide range of articles and patent documents. The database currently contains around 350,000 entries on Korean medicine, traditional food and intangible cultural heritage. The database is available in Korean and English languages.

- **Chinese traditional medicine database system**

China is another important indigenous knowledge-holding country. The most important type of IK in China is Chinese traditional medicine, which has been derived from ancient traditions and most of which has been written down. The Traditional Chinese medicine database system was set up by the institute of information on TCM. Currently, the system consists of more than 40 categories of Chinese medicine databases, which contain 1,100,000 items. Most of these databases are available in Chinese and few in English. Traditional Chinese medicine is also present in other Asian countries such as Korea and Japan and it can be used freely in other countries. China has created a series of online databases that record information related to traditional Chinese medicine.

- **BioZulua Project of Venezuela**

The BioZulua project records data on medicinal plants and food crops of the 24 ethnic groups living in Venezuela's section of the Amazonian jungle. The database includes information on traditional indigenous medicine, traditional agricultural technologies, nutrition and conservation practices. The information is stored in a searchable database administered by the Foundation for the Development of mathematics and physical and natural sciences. The database provides genetic profiles of every plant entry and global positioning system coordinates of plant locations, and the entries are complemented with geographical references, bibliographies and digital images. The BioZulua database preserves non-codified traditional knowledge.

- **The Ulwazi programme of Durban**

The Ulwazi programme is an online indigenous knowledge database and the first of its kind in South Africa aimed at collecting and sharing indigenous knowledge and culture of local communities in the greater Durban area in English and local Zulu. This programme collects and shares indigenous knowledge such as traditional celebrations, clothing, Zulu proverbs, folk tales, spiritual herbs and traditional agricultural methods, in the form of a wiki, a website designed to enable contributions and modifications from multiple users. The Ulwazi programme operates as an integral part of local public library network that provides a framework for a digital library of IK, in which the content is created and owned by the communities themselves with the libraries playing the role of moderator and custodians of knowledge.

Indigenous people also mention spirits and ancestors as sources of their knowledge to address day-to-day challenges (Chilisa 2012:148). This is mainly because tacit knowledge is unarticulated and tied to the senses, movement skills, physical experiences, intuition or implicit rules (Jalonon 2014:1373). Indigenous people acquire and share information through storytelling, songs, poems and folklore, to name but a few (Chilisa 2012). Song and dance has always been the vehicle that carried knowledge among indigenous people across the globe over generations. The music always carried messages and dances were always part of rituals, celebrations and some form of communication with the spiritual world. Stories were always told as some form of teaching of things that have happened and how to avoid them. Most of those stories are now called myths, yet people from indigenous communities carry them in their hearts and take guidance from them. Indigenous healers also have their songs, dances and rituals they perform for a particular purpose.

However, Sodi et al. (2011:104) suggests that indigenous healers keep their knowledge very private and confidential, and they regard their knowledge as their personal property. Not everyone can easily acquire the knowledge and for the process of knowledge sharing to occur, one has to enrol as a student. This makes it difficult for most government and non-government initiatives to try to record and preserve such knowledge for future generations. Sodi et al. (2011:104) further reveals that this confidential knowledge can be shared during the training of the apprentice who has paid the training fees. This process takes time and the trainee will have to learn through observation and doing what the master is doing.

According to Sodi et al. (2011), custodians of indigenous medical knowledge are decided by the ancestors. In support of this, Truter (2007) indicates that training to become a traditional healer (*sangoma*) is not a personal choice but a calling bestowed by ancestors (usually a woman) on a person who then gets apprenticed to a qualified diviner for several months. For an individual to qualify to be trained as a healer, such individual must have a calling, which is some form of communication with the spiritual world or the ancestors. The would-be diviner is first possessed by the ancestral spirits, who make their presence known by inflicting on their host serious illnesses, which are best understood by other *sangomas* experienced in the art of divination (Bojuwoye 2005). Bojuwoye (2005) further explains that:

“one feature of the illness-experiences is excessive dreaming, which may be vague and confusing. Other symptoms are general body pains, severe headache, or general breakdown in bodily functions; sometimes there are unexplained misfortunes such as sudden loss of job, destruction of properties, or an accident that defies all possible explanations”.

In some instances, for the purposes of succession, the ancestors may decide that the aging healer should train one family member or a relative who may be selected to succeed the healer in the future (Sodi et al. 2011).

The knowledgeable healers then will take such an individual under their wing to start the mentorship process. Trainees spend a lot of time in the field of studying different plants in an effort to know their uses. According to Truter (2007), during this time, the trainees learn to throw the bones and control the trance-like states where communication with the spirits takes place. Bojuwoye (2005:8) further articulates that:

“a major feature of training is helping trainees understand and communicate with the spirit world inhabited by ancestors. This is done through altered states of consciousness, such as dreams, which trainees are helped to recognize and understand as avenues for the establishment of a link with the ancestors. The gift of possession by ancestral spirits is

usually handed from one generation to the next and therefore many would-be sangomas already can dream and recognize messages from dreams.

However, Sodi et al. (2011) cautions that the amount of knowledge acquired will depend on the competence of the mentee and the willingness to learn.

The review of literature suggest that there are a number of studies from various disciplines, ranging from nursing science, psychology, life sciences, information and media studies and law, which investigated indigenous knowledge practices. The findings were published across different journals covering different subject fields. These studies mainly employed the qualitative research approach. Data was mainly collected through the use of interviews, and a variety of sampling techniques were also employed. Traditional healers and community members were mainly the population of these studies. The qualitative data obtained was mostly analysed thematically and results mostly proved the continued use of indigenous knowledge and how important it was for different communities, especially indigenous health knowledge.

2.13 A framework for the acquisition, transfer and preservation of knowledge of traditional healing

Nonaka and Takeuchi's (1995) framework of organizational knowledge conversion which views the interaction processes of tacit and explicit knowledge is an important features in knowledge management research. The framework identifies socialization, internalization, externalization and combination (SECI) as the four modes of interaction that enable knowledge management. Central to this framework, is the conversion of one form of knowledge to the other. This framework talks about converting tacit knowledge to explicit knowledge and also further converting explicit knowledge to tacit knowledge continuously. When tacit knowledge is converted to explicit (externalization), knowledge is made available to those who might be available to learn. As explained in the previous sections, knowledge management is the process that involves among others- acquisition, transfer, and preservation of knowledge as its key components.

Understanding how knowledge of traditional healing is managed is fundamental to the current study. There is some consensus among scholars that indigenous knowledge in the third world countries especially Africa, is gradually facing extinction. As explained in the previous sections, some of the reasons why African indigenous knowledge has become endangered include but not limited to, colonialism, adoptions of foreign cultural practices and lack of interest from the new generations.

Traditional medical knowledge through the use of plants and herbs is indigenous to Africa's health care system. This practice is as old as mankind and is also used across the globe particularly in third world countries. Traditional medical knowledge is made up of the collective knowledge, skills, experiences of healers and knowledgeable people in a community. This knowledge has safe guarded the health of indigenous communities for centuries.

While some scholars define a traditional healer as someone who engages in indigenous medical practices, Sodi et al (2011) explain that a traditional healer is someone who possesses the gift of receiving spiritual guidance from the ancestral world. Sodi et al (2011) further explain that in most cases such a person is selected by the ancestors from a historical family background of healers. In South Africa, the Traditional Healers Act of 2007 states that traditional healing means the performance of a function, activity, process or service based on the traditional philosophy that includes the utilization of traditional herbs (Government gazette 2008). Similarly, the World Health Organization (1993) considers a *traditional healers as an* individuals who is recognized by his or her community as competent to provide health care service, using a range of substances and methods based on the community's social, cultural, and religious systems

In the South African context, Sodi et al (2011) explain that for one to become a healer, they must have a calling. To that effect, not everyone can wake up and decide to become a healer because according to Sodi et al (2011), a diviner is selected by the ancestors and can never self-select to become a traditional healer. It is, however, important to note that not everybody who has knowledge of herbs and traditional healing will have a calling. African indigenous communities are known to have communal knowledge which is used for different aspects of their daily lives. This knowledge is known to have always been passed down from generation to generation through oral tradition. Raseroka (2002) made reference of this type of knowledge by indicating that it survived for centuries through oral tradition where the experienced transferred what they know to the young so that the young can carry the knowledge forward. In this regard, those who might have gained knowledge of traditional healing usually come from families that have a history of traditional healers (Mokgobi 2014).

To those who have a calling, the ancestor's shows their presence by inflicting on their host serious illnesses, which are best understood by other healers experienced in the art of divination (Bojuwoye 2005, Mokgobi 2014). Bojuwoye (2005) further expounds that in addition to illnesses, the ancestors may show their presence through general body pains, severe headache, or general breakdown in bodily functions; sometimes there are unexplained misfortunes such as sudden loss of job, destruction of properties, or an accident that defies all

possible explanations. When confronted with such misfortunes, and illnesses, an experienced healer can be consulted who will in turn consult the bones to see if indeed the person has a calling. Once that is confirmed, the would-be healer will then undergo the training process under the mentorship of the experienced healer.

The other group of traditional medical knowledge carriers, who have no calling, learn about traditional healing without receiving spiritual guidance from the ancestors. Denbow and Thebe (2006) allude to these when they say that culturally those who acquired knowledge of herbs that can be used for traditional healing are called *ngaka e tshotswa* ³in Setswana. Truter (2007) further highlights that such a person possesses an extensive knowledge of curative herbs, natural treatments and medicinal mixtures of animal origin but does not receive a calling, however continues to use herbs to treat different illnesses. According to Truter (2007) this type of healers usually spends a few years as an apprentice and do not profess to have divine powers.

2.13.1 Training of traditional healers

Training of traditional healers is commonly done by much experienced healers who have the knowledge and skills to train others. Bojuwoye (2005) is of the view that training other healers is a specialty and yet another calling, in addition to simply being a healer. It is however, common to find healers who train the would-be healers while they are also, specialists in the healing of illnesses. Training of traditional healers is usually a full time thing. Those who are employed are expected to still continue with their training duties after work. According to Bojuwoye (2005) when the would-be healer accepts their calling and starts with the training, they are required to relocate to the master's home for the duration of the training. The trainee becomes an additional member of the master's home and training happens on a fulltime basis. The period of apprenticeship varies from a few months to 5 or more years.

2.13 2 Knowledge acquisition and transfer

Mokgobi (2014) is of the view that once training starts the trainees the trainee is required to live with the master and other trainees where they can constantly be observed at the same time they will be observing everything the master does and learning from that. Nonaka (1997) explain this process as socialisation where the knowledgeable person transfers experiences in the form of tacit knowledge to the trainees who will be inexperienced at the time. Bojuwoye (2005) explains that during knowledge acquisition and transfer, various exercises are

³ Someone who acquired knowledge of traditional healing but did not receive a calling

employed to evaluate the progress of trainees, until such time the master is satisfied that trainees are ready and can be able to practice on their own. Nonaka and Takeuchi (1995:63) argue that “apprentices work with their masters and learn craftsmanship not through language but through observation, imitation and practice. During this process, the following occur:

Socialization

- Senior and experienced healers share their experiences.
- The would-be healers acquire knowledge through observation, imitation, and practice.

Externalization

- Knowledge is converted into explicit concepts
- Continuous dialog among healers on traditional healing

As explained in the preceding sections, the major thing that the master does is to help the would-be healer to understand and be able to communicate with the ancestors. This is mainly because healers believe that their knowledge comes from the ancestral world. It is not everybody who has a calling who can already communicate with the ancestors, Bojuwoye (2005) alluded to this by saying that that trainees who start training without such a heritage are assisted by their master to first perform appropriate rituals and then to cultivate dreams and recognize their spirit-guides in dreams.

Other things that form a vital part of training in addition to communicating with the ancestors and dream analysis include, learning about different medicinal plants and animal extracts to use, interpreting the bones, and different illnesses and how to treat them (Mokgobi 2014). Mokgobi (2014) further highlights that certain practices that are prescribed during the training include the following:

- a trainee does not greet other people by shaking hands,
- when greeting others, especially when they meet others in the homestead, they kneel down and clap hands by placing one hand over another in an up and down fashion or sideways,
- when they meet relatives outside of the homestead, they drop a curtsy and clap hands without kneeling down,
- they would not greet strangers outside the homestead,

- a trainee does not engage in a sexual relationship with anyone else (This is called ‘*go ikilela*⁴).

Sodi et al (2011) also speak of therapeutic dances (also known as *Manchomane* or *Malopo* among Sotho and Tsonga speaking people) which are frequently done during training. During this dances, there is the beating of drums, singing (songs which sometimes carries a message about a particular aspect of healing), clapping of hands. Sodi et al (2011) are of the view that *this dance has some resemblance to a hypnotic trance that result in emotional expression and feeling of rejuvenation and hyper-suggestibility.*

2.13.3 Knowledge preservation

Nonaka and Takeuchi (1995) argue that experiences gained through socialization, externalization and combination get internalized into individuals’ tacit knowledge bases. According to Sodi et al (2011) traditional healers keep their knowledge private and regard it as their personal property. Those who are trained by the same master are likely to have similar experiences when dealing with practical issues. According to Sodi et al, ancestors has the power to withdraw the power to heal from any healer who malpractices. This means that ancestors have the power to give or take knowledge of traditional healing. After knowledge of traditional healing is acquired from the master by the mentees, the combination and Internalisation of such knowledge occurs.

Combination

Nonaka and Takeuchi (1995) state that during combination, different bodies of explicit knowledge are combined to form new knowledge. During combination the following happens in as far as traditional healers are concerned:

- Trainees systemize what they learn into a knowledge system
- Trainees align what they learnt to their existing knowledge

Internalization

Nonaka and Takeuchi (1995) are of the view that experiences gained through socialization, externalization and combination become part of the individuals tacit knowledge when they are internalized. In as far as traditional healers are concerned, it is common knowledge that their knowledge of traditional healing has been passed down from generation to generation through oral tradition. However, Nonaka and Takeuchi (1995) are of the view that

⁴ total abstinence from sexual intercourse

documenting knowledge helps individuals internalize their experiences, thus enriching their tacit knowledge. Books, articles, and all form of documented records, enable the transfer of explicit knowledge to other people, thus helping them experience the experiences of others indirectly. During internalization the following happens in as far as traditional healers are concerned:

- Trainees turn all the knowledge they gained in to their personal knowledge
- Trainees start healing patients practically
- Trainees start having their personal ways of preserving their own knowledge

As explained in the preceding sections, knowledge of traditional healing is commonly known to be preserved orally. Once the training is completed and the master is happy about the progress of the trainees, an examination is arranged. This examination usually takes place in the presence of community members (Mokgobi 2014). The examination is usually a spectacle and it is in a form of a ceremony where the trainee is assessed if he or she has learned the trade and can be allowed to graduate and therefore practice as a traditional healer (Mokgobi 2014). The period of apprenticeship varies and may vary from a few months to a number of years.

2.14 Related studies

This section looks at findings from other studies related to the current study in order to look at how those studies were conducted by other researchers. The main focus is on approaches employed, methods used, types of instruments used to collect data and the findings reached. This was done with an aim to justify and support the methodologies used in this study which are explained in Chapter Three. Even though these studies were looked at from a more global perspective to the specific, special focus was placed on those studies that focused on the traditional healing practices in South Africa, especially in the Limpopo Province.

Maher (1999) conducted a literature review on traditional aboriginal health beliefs and medical practices. One of the key issues that are worth mentioning is that the traditional health beliefs of aboriginal people are interconnected with many aspects of aboriginal life such as the land, kinship obligations and religion. Sorcery and supernatural intervention are part of the perceived reality of aboriginal life. Furthermore, traditional aboriginal medicine is widely practised in the Northern Territory of Australia, and the role of traditional healers has been formally recognised by the Territory Health Service. Traditional aboriginal medical treatment includes bush medicines, the traditional healer singing/chanting, and the utilisation of external remedies.

Ladio, Lozada and Weigandt (2007) conducted a study where a comparison of traditional wild plant knowledge between aboriginal communities inhabiting arid environments and forest environments in Patagonia was made. According to Ladio, Lozada and Weigandt (2007), in both communities, most dwellers carry out their own medical practices, but sometimes they consult what they call the *machi or yerbatera*, who is the most highly regarded medical practitioner, especially when faced with health problems that are related to the soul or supernatural factors. This was a qualitative study, which employed a random sampling technique to interview adults over the age of 20 years. The results suggest that, even though the two communities are settled in completely different environments, both populations used similar type of plants. Results further show that in both communities, medicinal species are utilized more frequently.

Maina (2012) sought to address issues related to claims that stakeholders in the traditional knowledge protection debate are making regarding the protection of this knowledge, its ownership, its control and its access. The study applied face-to-face semi-structured interviews to collect data from traditional knowledge holders and to get a grassroots and in-depth understanding of indigenous people's needs and concerns. Elders from a number of different First Nations communities in Ontario, Canada, were interviewed. The findings suggest that libraries and other information institutions need to re-examine and reconstruct themselves in ways that take into account non-western epistemologies and world-views, and develop much-needed cultural competency in order to undertake traditional knowledge custodianship.

In India, Sushila (2015) conducted a study on "Indigenous Traditional Healing Care: Belief & Practices among Tribals of South Bastar in Chhattisgarh". The study aimed at documenting the traditional knowledge of the primitive tribes of Bastar, Chhattisgarh as well as in India, with a systematic recording of the tribal knowledge. For data collection, knowledgeable people within the communities and traditional herbal healers were contacted and data was collected through interviews, observations and discussions held during field survey. The results suggested that the use of plant species as remedies is probably as ancient as humans and the knowledge of medicinal plants is still transmitted orally. There is evidence that families had derived the knowledge of home remedies from their elders, which made it clear that tribals are seeking their traditional knowledge and also want to learn and save their traditional healing culture.

Alhassan (2012) investigated indigenous knowledge acquisition and transfer among members of the Nupe Royal Music Band in Nigeria. This study has no link to traditional medical knowledge but the investigator saw it as being relevant to this study because it addresses

indigenous knowledge acquisition and transfer. According to the study, this royal music has been passed through generations by means of knowledge transfer and acquisition and aspects of this are shrouded in mystery. The main objectives of the study included: identifying types of people who are involved in the traditional Nupe royal band, finding the method used for knowledge acquisition and transfer of members of the traditional Nupe royal band, and investigating the challenges faced by the knowledge transfer and acquisition systems. The population of the study consisted of all members of the Nupe Royal band, including drummers, praise singers, trumpeters and talking drummers. For this study, a structured questionnaire was used as the data collection instrument, and the collected data was analysed using frequency count and simple percentages. The results suggested that instruments played by members of the band are dictated by family background, and that the practice is sustained within families by knowledge transfer from older to younger family members, who usually begin to learn the craft at a very early (3-10 years) age by observing and imitating elders in the family.

Adekannbi, Olatokun and Ajiferuke (2014) investigated the roles of demographic variables in the transmission and acquisition of traditional medical knowledge (TMK) in rural communities of South West Nigeria. A survey research design was adopted where three communities from each of the six states in South West Nigeria were purposely selected. The snowball technique was used in selecting Traditional Medical Practitioners (TMPs), while convenience sampling was used in selecting traditional medicine apprentices. The structured questionnaire used focused on the demographic characteristics of the TMPs and their apprentices. Three key informant interviews and two focus group discussion sessions were also conducted in each state. The quantitative data was analysed using descriptive statistics, binary logistic regression and Chi square analysis, while qualitative data was analysed thematically. The results suggested that there is a relationship between age, sex, education and TMK transmission. An enhanced level of education improved transmission, while religion reportedly hindered acquisition. Furthermore, improved access to basic and adult education and the need to stop gender discrimination is recommended to improve TMK transmission.

Anyaku, Orizu and Eneh (2015) investigated the role of medical libraries in the preservation of traditional medical knowledge (TMK). This paper recommended that as a duty to the people's collective indigenous knowledge heritage, medical libraries in Nigeria as a matter of priority, should develop inclusive policies that support collection development of TMK information resources. This study mainly draws its conclusions from the review of literature.

The results suggested that medical libraries have an important part to play in the preservation of traditional medical knowledge in Nigeria.

Mokgobi (2014) also conducted a study entitled “Understanding traditional African healing”. This study discusses the types of traditional healers, training of traditional healers and the role of traditional healers in different communities. The study reveals that the duties of healers go beyond the uses of herbs for illnesses and the findings suggest that, in addition to working with herbs and healing the sick, traditional healers are also custodians of the traditional African religion and customs, educators about culture, counsellors, social workers and psychologists.

Looking at the Southern African states, Rankopo (1996) conducted a study entitled “The influence of traditional health practices on human development: implications for human service delivery”, which looked at some of the traditional health practices still held in Botswana and the way in which they influence the behaviour of people in general. This was a qualitative study where data was gathered in a form of interview with traditional healers and personal accounts of some individuals in Botswana. The discussions centred on the strengthening and protection of children and adults, the causes of illnesses, the phenomenon of witchcraft, as well as traditional medicine and superstitions. The study concluded that traditional health care systems are very popular in developing countries and its potential should therefore be harnessed to help achieve better health standards for all.

Mngqundanisoa and Peltzerb (2008) also conducted a study entitled “Traditional Healers and Nurses: a qualitative study on their role on sexually transmitted infections including HIV and AIDS in KwaZulu-Natal, South Africa”. The study aimed at investigating the role of traditional healers in sexually transmitted infections, including HIV/AIDS and collaboration between the traditional and biomedical health care systems as seen by nurses and traditional healers. This was a qualitative study which employed the convenient sampling technique where professional nurses and traditional healers were interviewed. A semi-structured questionnaire was used to collect data. Data was analysed thematically and results suggested that professional nurses had mixed attitudes towards traditional healers, mostly negative (e.g. lacked training, used expired medicines, gave improper dosages, and kept poor or no records), but also positive, such as contributing to the management of opportunistic infections (STIs). The traditional healers also had mixed attitudes towards nurses. The traditional healers believed that nurses undermined their work (did not accept their efficacy in treatment and consequently did not refer patients). Notably, most of the traditional healers were willing to learn and refer patients to clinics and hospitals, while this was not true for the nurses.

Tshetlha (2015) probed the traditional health practitioners and some legislative issues on the issuing of medical certificates by traditional healers. Tshetlha (2015) is of the view that, despite all the powers given to the Traditional Health Practitioners Council as a professional body established by Parliament to give registered practitioners authority to issue certificates, the council does not seem to be in a position to perform this function. One of the reasons given for this problem is the fact that traditional healing seems to be impossible to regulate because practitioners cannot be subjected to objective assessment measures.

Campbell and Amin (2014) conducted a study entitled “a qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa”. The study draws on selected palliative care providers’ views and experiences to reflect on the potential benefits and possible challenges of involving traditional healers in palliative care in rural areas of South Africa. A qualitative method of photo-elicitation was employed. One-on-one discussions about the photographs taken by participants were conducted. The participants included palliative care nurses and home-based care workers who were purposively selected to provide in-depth information about their experiences as palliative caregivers in rural homes. Healthcare workers’ experiences revealed that the patients they cared for valued traditional rituals connected to illness, dying, death and bereavement. Participants suggested that traditional healers should be included in palliative care training programs as they could offer appropriate psychological, cultural and spiritual care. A challenge identified by participants was the potential of traditional healers to foster a false sense of longevity in patients facing death. The results further suggest that the inclusion of traditional healers in a palliative care team is a sensible move when one considers the influences of cultural and spiritual beliefs on the wellbeing of patients living in rural areas.

Zuma, Wight, Rochat and Moshabela (2016) looked at the role of traditional health practitioners in Rural KwaZulu-Natal, South Africa. The study explored the processes followed in becoming a traditional healer and how these processes are related to traditional health practitioners (THP) roles. A qualitative research design was adopted, using four repeat group discussions with nine THPs, as part of a larger qualitative study conducted within the HIV Treatment as Prevention trial in rural South Africa. THPs were sampled through the local THP association and snowballing techniques. Data collection approaches included photo-voice and community walks. The role identity theory and content analysis were used to explore the data following transcription and translation. The findings suggest that THPs serve roles which include, but are not limited to, being custodians of traditional African religion and customs, educators about culture, counsellors, mediators and spiritual protectors. THPs’ mode specific roles are influenced by the processes by which they become healers. However,

whichever type of healer they identified as, most THPs used similar, generic methods and practices to focus on the physical, spiritual, cultural, psychological, emotional and social elements of illness.

In the Limpopo Province, a study by Risenga, Botha and Tjallinks (2007), explored the cultural care beliefs, values and attitudes of Shangaans or Tsonga patients' and traditional healers' management strategies of hypertension in the Limpopo Province. The study aimed to describe the cultural values, beliefs and practices including taboos, rituals and religion within the world-view of the Shangaans. The study was undertaken in the Mopani region of the Greater Giyani area, with the purpose of recommending improvements to patient care in this area. A qualitative research design was used to discover meanings and describe the cultural care beliefs, values and attitudes of Shangaans in relation to hypertension. The study population consisted of hypertensive patients and traditional healers who were Shangaans. The results suggest that Shangaans have their own perceptions of high blood (Ngatileyikulu) hypertension and this is influenced by the presence of their own world views, cultural perceptions as well as their experiences in their own culture. It was further revealed that failure to recognize these beliefs, values and attitudes by nurses and other health personnel who are rendering health care might lead to many complications such as failure of Shangaans who are hypertensives to cope with the chronicity of their condition and failure to adjust to life style changes brought by the disease

Sodi et al. (2011) conducted a study entitled "Indigenous healing practices in Limpopo Province of South Africa: A qualitative study". The study investigated traditional healing practices among the Venda- and Tsonga-speaking people of Limpopo. The discussions centred on the process of becoming a traditional healer, treatments of illnesses and the notion of ethics by traditional healers. The study employed a qualitative research design and traditional healers were selected through purposive sampling. Semi-structured interviews were conducted with the participants and data was analysed thematically. The study put into perspective the ethical issues of competence, dealing with minor children and confidentiality between healers and their patients. Some of the challenges associated with collaboration between traditional healing and the Western health care system were highlighted by the traditional healers.

Bopape, Mothiba and Malema (2013) conducted a study where the indigenous practices of mothers of children admitted to the paediatric unit of a Polokwane/Mankweng Hospital complex in the Limpopo Province, South Africa, were investigated. This was a qualitative study where phenomenology as research method was employed to conduct the study. The non-probability purposive sampling method was employed to collect data from mothers of

children admitted in the paediatric unit. Data was collected using unstructured one-to-one interviews. Data were analysed using Tech's open coding approach. The results suggested that mothers of children admitted to the Polokwane/Mankweng Hospital complex do engage in indigenous practices in curing childhood illnesses whereby they take their children to the THPs before medical consultations. Furthermore, mothers also take their children to the THPs after discharge from hospital. Mothers of children admitted to the Polokwane/Mankweng Hospital complex strongly believed that some childhood illnesses such as *hlogwana*, *themo/lekone*, *makgoma*, *sekgalaka* and *sephate* can only be cured by THPs.

Another study by Rankoana (2014) entitled "Self-medication through administration of indigenous plant medicine among the Northern Sotho people of Limpopo Province, South Africa" examined factors that encourage reliance on self-medication through administration of traditional plant medicine. Data was collected through interviews with local community members and traditional health practitioners were selected purposely to participate in the study. The results suggested that self-medication is encouraged by participants' cultural orientation. Again factors such as the need to treat minor ailments, self-diagnosis, family tradition and one's responsibility to maintain good health and well-being are culturally based. Furthermore, knowledge of indigenous plant-derived medicine was noticeable among the study participants.

Semenya and Potgieter (2014) profiled the socio-cultural and traditional healing practice of Bapedi traditional healers in the Limpopo Province, South Africa. The study employed convenience sampling to identify and select two traditional healers from each of the 17 municipalities (resulting in 34 healers being used in this pilot survey) of the Limpopo Province in South Africa. Information on the social and demographic variables, and traditional healing practices of these healers was gathered from January 2013 to July 2013, using a semi-structured questionnaire, supplemented by field surveys for plant identification and collection used in the preparation of remedies. Forty eight percent of them became healers through the mentoring of another healer, while 38% acquired their traditional healing knowledge from parents and 14% from grandparents. In contrast to this, 62% of the females obtained theirs from their parents, 30% from fellow traditional healers, and 8% from grandparents. A total of 154 plant species were indicated as used by healers in the treatment of 52 health-related problems. A vast majority (89%) of these practitioners reported that prepared herbal remedies do expire, which is a temperature-dependent process. Determinations of the efficacy of remedies by most healers (67%) were via consultation with ancestors (90%). This study also found that none of the interviewees had any knowledge of provincial or national environmental legislation. The results suggest that Bapedi traditional

healers could play a leading role in both the preservation of indigenous knowledge and the primary health care sector. However, of concern is the traditional methods (via consulting ancestors) employed by most of these healers in determining efficacy of remedies, thus indicating a need for a scientific investigations to establish their safety and effectiveness. Equally, there is a need to educate traditional practitioners' regarding the significance of various conservation legislations in their traditional healing. By addressing these, the national and provincial legislators, medical fraternity as well as environmental agencies will be able to better integrate them in primary health care systems and environmental management.

Mathibela, Egan, Du Plessis and Potgieter (2015) investigated the socio-cultural profile of Bapedi traditional healers as indigenous knowledge custodians and conservation partners in the Blouberg area, Limpopo. The study was motivated by the fact that there is concern that this profession (traditional healing) is dying out, which may be detrimental to the Blouberg community and to biodiversity conservation in the area because traditional healers of Blouberg are custodians of indigenous knowledge on medicinal plants of the region. Traditional healers as well as community members were interviewed between March 2011 and July 2013 around Blouberg Mountain in the Blouberg Municipality. Furthermore, a semi-structured questionnaire was used to elucidate socio-cultural and demographic variables and healing customs of practicing healers. Attitudes to sustainable management of medicinal plants were captured. A second semi-structured questionnaire was used to gather information on community members' views of traditional healers and their practices. The results suggested that the state health care has negatively influenced the practice of traditional healing as patients now first consult government health centres before turning to traditional healers. Traditional healing has been ignored because, as an oral history, it could not be included in school curricula or government policy documents. Those traditional healers who learn to write will have the skills to document and safeguard their own knowledge. This can help to prevent the erosion of knowledge around Blouberg's medicinal plants and support the conservation of natural resources in the area. Adult learning programmes might therefore be worth implementing among healers.

Mogawane, Mothiba and Malema (2015) conducted a study to explore and describe the indigenous practices (IPs) of pregnant women at Dilokong Hospital in Limpopo. The study employed qualitative research approach and data was collected through unstructured one-on-one interviews. A verbatim recording of all interview sessions was done by using a voice recorder as well as field notes that were written to capture non-verbal cues. Data was analysed thematically and the results from the study suggested that IPs were regarded as an honourable health intervention by traditional health practitioners (THPs), families and pregnant women.

IPs such as cords around women's waists was still observed during physical examinations. However, there was a reduction of prescribed indigenous oral medication.

Rankoana, Nel, Mothibi, Mothiba, Mamogobo and Setwaba (2015) examined the indigenous knowledge systems and practices which have preventive, curative and protective properties in the Makanye community in Limpopo. This was a qualitative study where community members were purposely sampled and focus group discussions were conducted to collect data. Data was collected using the Sepedi language, which was then translated from into English and edited by experts in the Department of Translation Studies at the University of Limpopo. Data was analysed thematically where similar words and concepts were grouped together to formulate headings and subheadings to enable data interpretation. The results suggested that indigenous knowledge has a health potential, whereas many of the cultural values and practices are intentionally developed and agreed upon to maintain good health and well-being of community members. Furthermore, Indigenous knowledge used in primary health care embraces knowledge about the cause of diseases, knowledge of indigenous plant medicine administered for preventive, protective and curative care, consumption of subsistence crops, medical ethnobotanical knowledge and the use of traditional health practitioners' medicines.

2.14.1 Synthesis and evaluation of related studies

This section evaluates related studies discussed above in order to understand how where this studies are similar and how and where they differed which will give guidance to the current study. The studies reviewed above looked at how different indigenous groups used their indigenous knowledge to deal with different health problems. A qualitative approach to research was mostly preferred by researchers in this area. Interviews were the most common data collection instrument. Convenient, snowball and random sampling techniques were some of the sampling techniques used to decide the populations. All studies reviewed highlight the importance of traditional medical knowledge and how healers are important to the communities they serve.

2.15 Summary

This chapter reviewed literature relating to various components of knowledge management, namely, acquisition, transfer and preservation of knowledge. The main points of discussion in this chapter included, knowledge management theories, and the theoretical framework guiding the study with special emphasis placed on the organisational knowledge conversion theory. The study also reviewed literature according to the objectives of the study, which included knowledge acquisition, transfer and preservation in general; and acquisition, transfer

and preservation of indigenous knowledge, the status of indigenous healing in South Africa, a framework for the acquisition, transfer and preservation of knowledge and a number of studies related to the current study were also highlighted. The review of literature from studies investigating indigenous healing and medical knowledge helped in finding out what methodologies, methods and sampling procedures have been employed to conduct such studies. The next chapter describes the research design employed to conduct the current study.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Ximinta ntsengele xi tshemba nkolo (This is a Xitsonga proverb literally translated to: “He who swallows a large stone has confidence in the size of his throat”).

3.1 Introduction

The preceding chapter reviewed literature related to this study on acquisition, transfer and preservation of indigenous knowledge by traditional healers in the Limpopo Province of South Africa. The review of literature was guided by the objectives of the study driven by the organisational knowledge conversion theory. The literature suggests that a significant number of researchers investigate indigenous medical practices. These researchers stem from various disciplines including, nursing sciences, chemistry, psychology, life sciences, information and media studies, law, and many more. The reviewed studies mainly employed the qualitative research approach to conduct the investigations.

This chapter discusses the methodological theories that guide this study. Research methodology in a study is important because it helps to highlight the wider field of discussions about methods, and the relationship between methods and theories (Alasuutari, Bickman and Brannen 2008:82). Macmillan and Schumacher (2006:9) define research methodology as the way in which one collects and analyses data.

The ontology, epistemology, approach, methods, as well as instruments that were used to conduct this study are discussed in detail. The chapter further discusses issues relating to target population, sampling, data quality, ethical considerations and data analysis. According to Sarantakos (2013:28), social science research is guided by three basic factors namely ontology (*nature of reality*), epistemology (*nature of knowledge*) as well as methodology (*approaches and methods*). The roadmap for the research design and methodology for this study is presented in Figure 3.1.

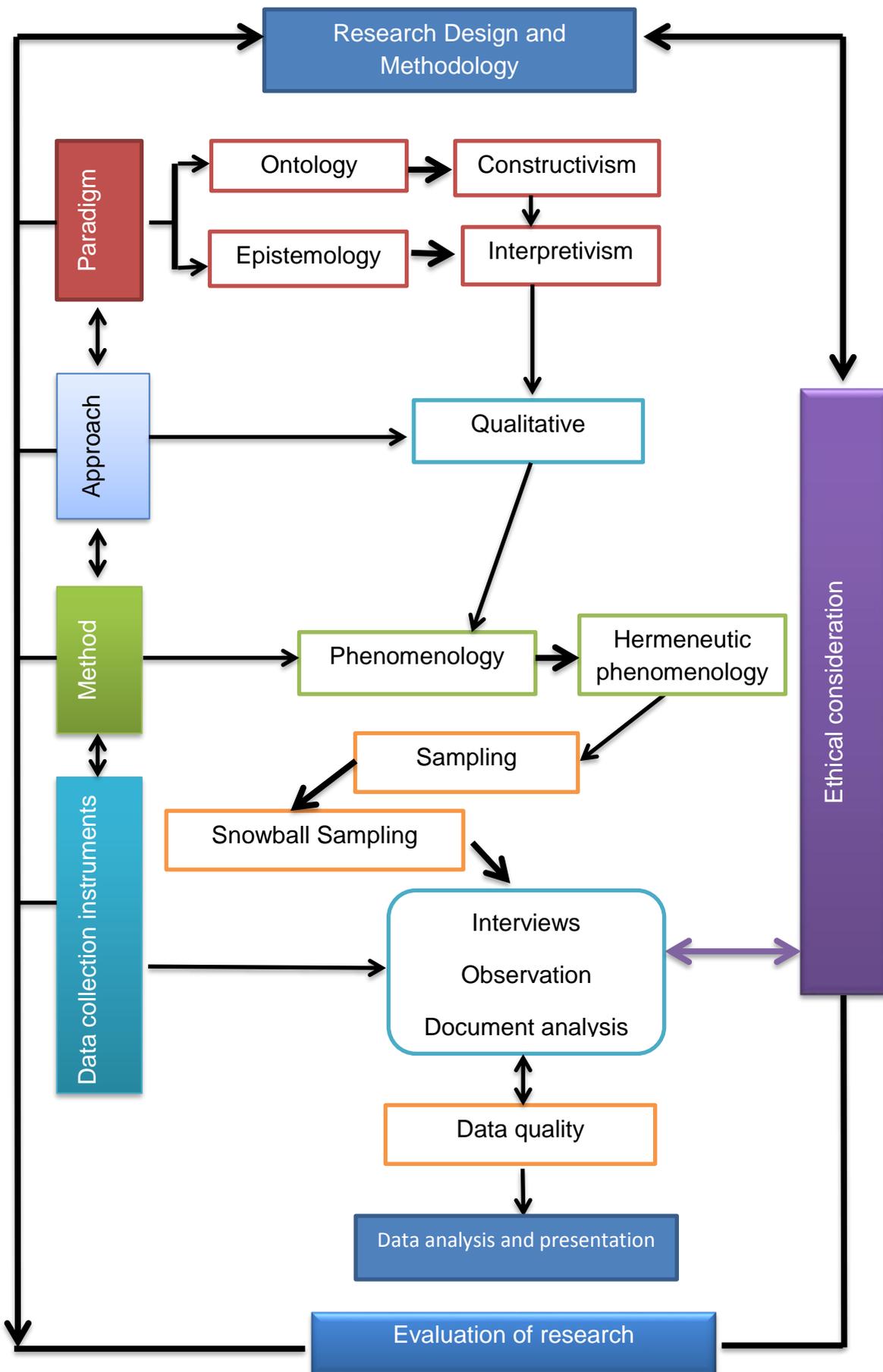


Figure 3.1: Research design and methodology road map for the current study

3.2 Methodological theories

In the preceding chapter, substantive theories guiding the study were highlighted; this chapter will look at the methodological theories or the philosophy behind the approaches and methods of inquiry that are used to conduct this study. Punch (2014) highlights that “*methods of enquiry are based on assumptions about the nature of the reality being studied, assumptions about what constitutes knowledge of this reality, and assumptions about what therefore are appropriate methods of building knowledge of this reality.*” One may ask why it is important to learn and understand these philosophical assumptions.

Neuman (2011) argue that by becoming aware of these assumptions you can better understand what underlies your choices during your research. Having said that, Neuman (2011) highlights that research methodology rests on the foundation of ontological and epistemological assumptions. Ontology deals with the nature of reality while epistemology is about how we know and view the world around us. Neuman (2011:92) defines *ontology* as an area of philosophy that asks what really is and what the fundamental categories of reality are while *epistemology* is defined as an area of philosophy concerned with the creation of knowledge.

The two basic positions within ontology are *realism* and *nominalism/constructionism* (Bryman 2012, Neuman 2011 and Sarantakos 2013). The realists assume that the real world exists independently of humans and their interpretations of it (Neuman 2011). The same author adds that, according to the realists, what you see is what you get. On the contrary, constructivists assume that humans never directly experienced reality. Creswell (2014) opine that constructivists assume that people construct their own understanding and knowledge of the world, through experiencing things and developing subjective meaning of their experiences. For the constructivists, there is no objective reality and the physical world exists but is not accessible to human endeavour (Sarantakos 2013:38). According to Sarantakos (2013), constructing reality means making accounts of the world around us and gaining impressions based on culturally defined and historically situated interpretations and personal experiences.

These ontologies informs methodologies of what research is supposed to investigate, while epistemologies informs methodologies about the nature of knowledge or where knowledge is to be sought while methodologies prepare ways to be employed by the researchers further instructing them as to where to focus the enquiry and how to recognise and extract knowledge (Sarantakos (2013:29). These assumptions constitute the essential idea of what is meant by the term paradigm in research methodology literature (Punch 2014).

3.3 Research paradigm

This section discusses the research paradigm that guided this study. A paradigm is defined by Neuman (2011) as a set of beliefs that guides the researcher in conducting a scientific study. Bryman (2012:630) defines paradigm as a cluster of beliefs and dictates that for scientists in a particular discipline influence what should be studied, how research should be done and how the results should be interpreted. Similarly, Sarantakos (2013:30) define a paradigm as a set of propositions that explain how the world is perceived. This means telling the researchers what is important, what is legitimate, and what is reasonable. According to Punch (2014:16), the main paradigm positions are positivism and constructivism. This means that realists who assume that the real world exists independently of humans and their interpretations are positivists while nominalists or constructivists whose worldview is influenced by how they interpret things and inner subjectivity interpretivists. Positivists believe that objective accounts of the world can be given, and that the function of science is to develop descriptions and explanations in the form of universal laws, while Interpretivists concentrate on the meaning people bring to the situations and behaviour (Punch 2014). Positivism is the oldest and most commonly used while interpretivism was born from the criticisms that were there against positivism. Interpretivism can be traced to the German sociologist Max Weber and the German philosopher Wilhelm Dilthey (Neuman 2011:101). The two basic positions in ontology discussed above remained for many years until the third position emerged.

The third group that emerged after the realisation that all research methods have strengths and weaknesses resulted in the third ontological position called pluralism (Ngulube 2013:11). This third force agreed with the criticism directed towards realists by constructivists and added its own criticism. According to Neuman (2011), this ontological position can be traced to the writings of Karl Marx, Sigmund Freud, Theodor Adorno, as well as Herbert Marcuse. The epistemological position of the critical social scientists is called pragmatism (Punch 2014). They criticize positivism as being narrow, antidemocratic and fail to deal with meanings of real people and their capacity to feel and think (Neuman 2011). Furthermore, the critical social scientists criticise the interpretivists of being too passive and fails to help people to see illusions around them.

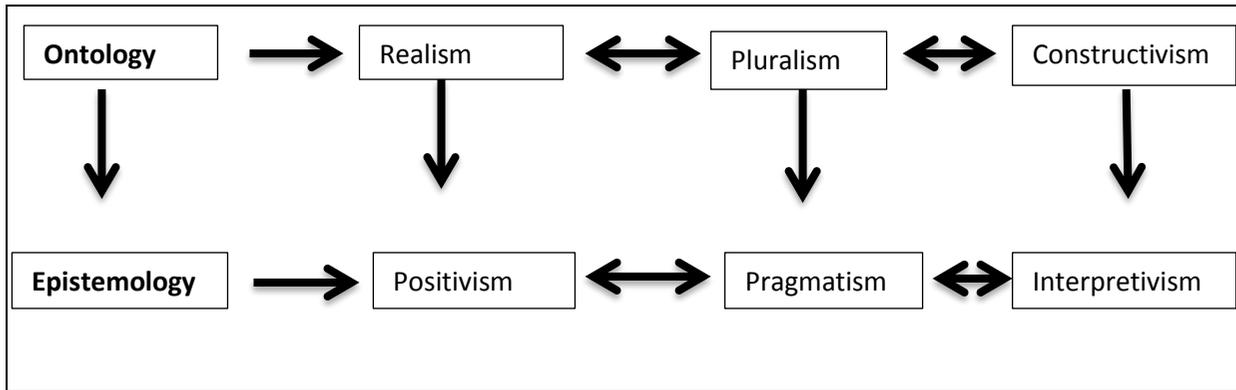


Figure 3.2: Methodological theories as discussed in this study

The current study investigated a particular human behaviour on members of the community who happen to be from a group that was previously marginalized. The investigation depended on real life accounts from the participants. This group of people was studied from their natural setting which means that nominalist ontology informs the methodologies of the type of research was done in this study. To that effect, the interpretative epistemology informs methodologies about the nature of knowledge, or where knowledge is to be sought in this study.

3.4 Research approaches

The concept research approach was adopted in this study to represent the three varieties of social science research that are sometimes referred to as methodologies, traditions or even designs. Different scholars use different terms to represent these types of social science research and there is currently no agreement among scholars as to which concept should be used. According to Sarantakos (2013) the foundations of social science involves ontology, epistemology, methodology, designs and then down to instruments of data collection. Ngulube, Mathipa and Gumbo (2015) adopted a similar approach to Sarantakos (2013), however they differ where Ngulube, Mathipa and Gumbo (2015) puts designs and approaches on the same level and further goes to talk about techniques or methods while Sarantakos (2013) calls them instruments.

Punch (2014), Neuman (2011) and to some extent Creswell (2014) talk about ontologies, epistemologies, approaches, methods then instruments. Creswell (2014:158) calls a survey a method and go on to label qualitative, quantitative and mixed methods research as approaches that provide specific direction for procedures in a research design (Creswell 2014:12).

There is no particular agreement among authorities when it comes to the use of these labels. We will try to distinguish between them by giving an analogy of making a dress. The dressmaker will begin the job with the idea of the type of dress they want to make. This will give birth to the two dimensional design of the dress (mostly on paper), which contains

everything, from the size, shape, style, and any other aspect that will contribute to the desired result. Once the design is complete, the dressmaker will then decide on things like the fabric, buttons, and any other thing that may be needed. The fabric will be cut accordingly and pieces will be put together using the approach relevant to dressmaking. The dressmaker may decide to use a sewing machine or any other instruments available for the job.

In the current study, a design is placed at the beginning and it encompasses every step that follows in the research process. It is the blue print of the research as a whole. There seem to be some level of agreement when it comes to philosophical foundations to social science research and to that effect, ontologies will be followed by epistemologies. This study will follow Creswell (2014) and Neuman (2011) and label the research process an approach. When it comes to explaining what was used to collect data we will refer to this as instruments of data collection. There is again no consensus among scholars because this to some are called, methods, while others refer to them as techniques. Refer to Figure 3.1 and Table 3.1 for a summary of approaches, methods, and instruments as discussed in this study.

3.4.1 Quantitative research

Creswell (2013) opine that quantitative research is a means for testing objective theories by examining the relationship among variables that can be measured by the use of instruments so that numbers can be generated and analysed using statistical procedures. Bryman (2012) highlights that quantitative studies aim to bring relationships between variables as a result this omit the process of interpretation that goes on in human groups. Variables are central to quantitative research. Neuman (2011) supports this by saying that in quantitative research, techniques that will produce data in the form of numbers are primarily in use. Similarly, Leedy and Ormrod (2014) view quantitative research as the type of research that try to make sense of the world through numbers.

Quantitative research does not distinguish people and social institutions from the world of nature (Bryman 2012). According to Neuman (2011) in quantitative studies, procedures are standard and replication is frequent because quantitative research is more formalised and controlled. As a result, the same principles of research are applied to all phenomena being investigated ignoring the difference between the natural world and the social world. Again in quantitative studies, emphasis is placed on measurement when collecting and analysing data. These measurements are systematically created before data is collected (Neuman 2011). Having said that, Bryman (2012) cautions that, the reliance on instruments and procedures by quantitative researchers hinders the connection between research and everyday life.

Data collection methods in quantitative research include surveys (questionnaire), structured interviews, structured observations, content analysis that seeks to quantify content in terms of pre-determined categories, and experiments. Data analysis is done by using statistics, tables, or charts (Neuman 2011). Establishing reliability and validity of measures is important to quantitative research. Another key preoccupation to quantitative research is the generalisation of the findings, which is linked to representativeness when drawing a sample for the quantitative study.

3.4.2 Qualitative research

Sarantakos (2013:36) define qualitative research as a “*procedure that operates within naturalistic, interpretive domain guided by the standards and principles of a relativist orientation, constructivist ontology and an interpretivist epistemology*”. Qualitative research approach employs qualitative methods to interpret and understand social life in order to discover meanings. Neuman (2011:175) goes a step further and say qualitative researchers document real events by recording what people say, observing specific behaviours, examining written documents and studying visual images. According to Creswell (2014:185), the following are some of the characteristics that describe a qualitative study:

- *Natural setting*: Qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study.
- *Researcher as key instrument*: Qualitative researchers collect data themselves through examining documents, observing behaviour, or interviewing participants.
- *Multiple sources of data*: Qualitative researchers typically gather multiple forms of data, such as interviews, observations, documents, and audio-visual information rather than rely on a single data source.
- *Inductive and deductive data analysis*: Qualitative researchers build their patterns, categories, and themes from bottom up by organizing the data into increasingly more abstracts units of information.
- *Participants’ meanings*: In the entire qualitative research process, the researcher keeps a focus on learning the meaning that the participants hold about the problem or issue, not the meaning that the researcher brings to the research.
- *Emergent design*: The initial plan for research cannot be tightly prescribed, and some phases of the process may change or shift after the researcher enters the field and begins to collect data.
- *Reflexivity*: In qualitative research, the enquirer reflects about how their role in the study and their personal background, culture, and experiences hold potential for

shaping their interpretations, such as the themes they advance and the meaning they ascribe to the data.

- *Holistic account*: Qualitative researchers try to develop a complex picture of the problem or issue under study.

3.4.3 Mixed methods research

Mixed methods research (MMR) which is referred to as a critical social science by Neuman (2011) is explained as one of the social science research approaches that emphasize combating surface level-level distortion, multiple levels of reality and value-based activism for human empowerment (Neuman 2011). Mixed methods research shares the fundamental aspects of both qualitative and quantitative research approaches. Punch (2014) describes MMR as the empirical research method that involves the collection and analysis of both quantitative and qualitative data. The review of literature as explained above suggests that both the positivist approach and the interpretivist approaches had strengths and weaknesses of which critics from both camps pondered on. MMR adopts both approaches supplementing each other's strengths and weaknesses. This study will however not employ the MMR technique because the nature of the study and the population type allows for a study that is mainly interpretive in nature. To that effect, the current study will employ the qualitative approach to try to understand how traditional healers in the Limpopo Province of South Africa, acquire, transfer and preserve indigenous knowledge medical knowledge.

Table 3.1: Research Paradigm, Approach and Methods as discussed in the study

Paradigm	Approach	Main features
Positivism	Quantitative	Measurements Generalisation Replication Theory testing Structured Produces hard reliable data Artificial settings Validity and reliability
Interpretivism	Qualitative	Contextual understanding Detailed descriptions Theory emergent Unstructured Produces rich deep data

		Natural settings Trustworthiness and authenticity
Pragmatism	Mixed Methods Research	Numbers versus words. Artificial versus natural.

3.4.4 Justification for the use of a qualitative approach

As indicated in Section 1.11 these study employed a qualitative approach to research to try to understand the acquisition, transfer and preservation of indigenous medical knowledge among healers. This knowledge is known to be transferred from one generation to the next through oral tradition. The review of literature suggests that the bulk of this knowledge is only known by the healers and they regard their medical knowledge as personal property that must be kept in strict confidence (Sodi et al 2011). This study investigated the healers in their natural setting, tapped in to their tacit knowledge in an effort to gain a deeper understanding of how sense of the world and how they construct their everyday lives. This meant that the research approach employed in this study was informed by the constructivist epistemology. In addition to that, the review of literature (see chapter 2) suggest that studies related to this one mainly employed qualitative research approach with interviews as the main data-collecting instrument.

The background to constructivism was given in the introductory section and it can be defined as a qualitative research enquiry with orientation towards social reality that assumes that people create and use fundamentally shape what reality is for is for them (Bryman 2008:19; Neuman 2011:102). Creswell (2013:24) agrees that in constructivism, people seek to understand the world they live and work in. According to Creswell (2014:9), the following are key features of a constructivism paradigm:

Human beings construct meanings as they engage with the world they are interpreting.

- Humans engage with their world and make sense of it based on their historical and social perspectives-we are all born in to a world of meaning bestowed upon us by our culture.
- The basic generation of meaning is always social, arising in and out of interaction with a human community.
- Qualitative researchers seek to understand the context or setting of the participants through visiting this context and gathering information personally.

- Qualitative researchers tend to use open-ended questions so that the participants can share their views.
- The process of qualitative research is largely inductive; the inquirer generates meaning from the data collected in the field.

3.5 Qualitative research methods

As explained in the preceding section, interpretive/constructive paradigms guides qualitative approaches and prescribe flexible methods and qualitative instruments (Sarantakos 2013). Creswell (2014) argue that qualitative researcher's study things in their natural settings, in an attempt to make sense of, or interpret, phenomena in terms of the meanings people bring to them. The primary goal of qualitative approach is to describe and understand rather than to explain human behaviour (Babbie and Mouton, 2011:270). Some of the main research methods that may be adopted in a qualitative study include phenomenological research; grounded theory; ethnography and case studies (see Table 2.1).

This study adopted the phenomenological research method because it investigated the lived experiences of traditional healers who share the similar experiences in their practice of traditional healing. Phenomenology has the potential to offer indigenous researchers a method from which they can investigate the real world without invalidating indigenous voices and the worldviews of the indigenous people (Ngulube and Ngulube 2017:128).

3.5.1 Phenomenology

Phenomenology as discussed in this study is a research method that is concerned with the question of how individuals make sense of the world around them and how in particular the investigator should bracket out perceptions in his or her grasp of that world (Bryman 2012). Phenomenology is a powerful way of understanding human lived experience from the participants' perspective and interpretation (Ngulube and Ngulube 2017:129). The researchers further argue that phenomenology acknowledges that the foundation of knowledge is everyday life and society as both an objective and subjective reality. The review of literature suggest that traditional healers speak a lot about spirits, dreams and their connections with the ancestral world (Mokgobi 2014), as a result, bracketing out our perceptions of the natural world, as we know it helped us encounter things as they are without prejudices and independently of any presuppositions. The population's beliefs and traditions were respected and all respondents mattered and were treated with respect.

From the review of literature we noted that phenomenological research method has similar characteristics to ethnography and narrative research especially when it comes to the unit of

analysis. However, Babbie and Mouton (2011:33) highlight that phenomenological research would support the following propositions:

- Data collection should not be confined to observable behaviour but should also include descriptions of people's intentions, meanings and reasons.
- The phenomenological tradition supports an anti-naturalist conception of objectivity that lays stress on the idea of inter-subjectivity, engagement and empathy.
- The theories are interpreted to be congruent with the common-sense concepts and interpretations of the social actors themselves.
- Phenomenology has traditionally been associated with the qualitative approach because it insists on interpretive understanding of meanings.

These characteristics supports the choice of phenomenology as a method to investigate the traditional healers in the Limpopo province

The two major types of phenomenological methods used by social scientists are hermeneutic phenomenology and empirical transcendental phenomenology (Creswell 2013). According to Ngulube and Ngulube (2017:135), hermeneutic phenomenology is interpretive while empirical transcendental phenomenology is descriptive in nature. It is however important to mention that both methods deal with experiences lived. Ngulube and Ngulube (2017) further deliberate the following characteristics of both hermeneutic phenomenology and empirical transcendental phenomenology.

3.5.1.1 Transcendental phenomenology

Transcendental phenomenologists are concerned with describing a phenomenon rather than explaining it. Studies using this method result in:

- A focus on first-person accounts of experience;
- An analysis that seeks to discern the underlying structure of experience; and
- The production of findings that describe both the universal structure (*essence*) of the experience and individual idiosyncratic meanings.

3.5.1.2 Hermeneutical phenomenology

Hermeneutic phenomenology opens up the lived experience to interpretation through language (Ngulube and Ngulube 2017). This method shift the focus from simply describing to interpreting the meaning of things as observed. The following are some of the principles of hermeneutical phenomenology (Ngulube and Ngulube 2017:137):

- i. It seek understanding of the participants; world through immersion in their world;
- ii. It make explicit, the immersion of the researcher in the hermeneutical spiral;
- iii. It maintain a constantly questioning attitude in search for misunderstandings, incomplete understandings, deeper understandings;
- iv. It engage the active participation of the participants in the research process: the implementation and interpretation;
- v. It access and make explicit participant understandings through their own modes of existence, mode of engagement while being sensitive to one's own modes of existence and of engagement and foregrounding;
- vi. It engage in the spiral task of hermeneutical interpretation along with participants;
- vii. work with participants to see which points are salient; and
- viii. view interpretive phenomenology as an interpretation of participants' interpretation

3.5.1.3 Phenomenological method selected

This study was aimed at understanding how traditional healers in the Limpopo Province acquire, transfer and preserve their knowledge for future use. To meet the objectives of the study, the investigators employed the hermeneutic phenomenology method which focuses on the understanding of experience by searching for themes rather than the search for essences as it the case with descriptive phenomenology (Ngulube and Ngulube 2017). This method goes beyond describing (common to transcendental phenomenology) by interpreting the meaning of things as they happen. When conducting hermeneutic phenomenological studies, there is an active dialogue and sharing of values, beliefs and assumptions. This method goes beyond the western methodologies that take things for granted by ignoring local context and realities (Ngulube and Ngulube 2017).

3.6 Data collection instruments

Data collection instruments for this study can be explained as tools employed to collect data during a research project. According to Ngulube, Mathipa and Gumbo (2015), the commonly used instruments to collect data are questionnaires, interviews, observation and document analysis. Usually, the research approach employed by a study influences the choice of the instruments used during research. The research instruments may either produce qualitative data or quantitative data; however Ngulube, Mathipa and Gumbo (2015) indicates that instruments may be combined to achieve triangulation whether one is using qualitative or quantitative approaches.

As indicated in the preceding section, this is a phenomenological study and phenomenology has traditionally been associated with qualitative data collection instruments and

methodologies. This is because phenomenological studies insist on interpretive understanding of meanings. To that effect, this study employed interviews, observations as well as document analysis as instruments of data collection.

3.6.1 Interviews

Interviews are the most prominent data collection tool in qualitative research because they help investigators to access people's perceptions, meanings, define situations and help construct reality (Punch 2014:144). According to Babbie and Mouton (2011:289), a qualitative interview should be flexible, interactive and continuous. Interviewing involves asking respondents or the study population questions and recording their answers. The two main types of interviews in qualitative research are the unstructured interview and the semi-structured interview (Bryman 2012:469). Structured interviews are mostly used to collect quantitative data. Within the two types of qualitative interviews mentioned above, one may use in-depth one on one-interview or focus group interviews to collect qualitative data. This study used a semi-structured interview to individually interview respondents to answer the objectives of this study. The interview guide was arranged according to the objectives and where necessary follow-up questions were asked to get the in-depth information. Questions were asked randomly depending on how and where the conversation was going.

Unstructured interviews

Unstructured interviews employ unstructured questionnaires containing a number of open-ended questions whose wording and order can be changed at will (Sarantakos 2013:278). Unstructured interviews are extremely flexible and do not limit the field of enquiry. The interviewer may choose to add other questions during the interview or even ignore some of the questions planned. Such interviews are sometimes referred to as 'discovery interviews and are more like a guided conversation than a strict structured interview.

Semi-structured interviews

Semi structured interviews contains the elements of both structured interviews and unstructured interviews. In semi-structured interview the investigator has a list of questions addressing the topics to be covered which will be used with all interviewees but mostly as a guideline because the investigator may choose to ignore some questions or even add other questions during the interview if need be (Sarantakos 2013). This interview type is also flexible and very common among qualitative researchers.

Strengths of interviews

Unstructured interviews are more flexible and questions can be adapted and changed depending on the respondents' answers. The interview allows the respondents to talk in some depth using their own words that will help the researcher to gain understanding of the interviewee's real sense and understanding of a particular situation (Sarantakos 2013). Unstructured interviews also has the potential to produce accurate information because the interviewer has the opportunity to probe for deeper understanding by asking follow up questions for clarity during the interview.

Limitations of interviews

It takes longer to conduct such interviews and analysing the data obtained can be time consuming. It is also very expensive to gather such data especially in cases where extra people may be needed to help. Again good interviewing skills are required to accomplish the task.

3.6.2 Observations

Sarantakos (2013:229) explain observations as a research instrument that entails gathering data through vision. This instrument is common to anthropologists and ethnologists but it is now gaining popularity in various areas of research. Babbie and Mouton (2011:293) notes that in qualitative research, there are usually two types of observation, namely simple or non-participant observation and participant observation. The other significant difference in observation is the extent to which it is structured and standardised. Depending on the type of research being conducted, the observation can be structured or unstructured. Structured observation has a strict design and control while unstructured observation is more flexible and no control. Unstructured observation is common in qualitative studies.

Participant observation

Participation observation is where the researcher is doing the observing and participating as a member in the group that is being observed. The common problems associated with this type of observation are that the researcher may influence the data and may find it very difficult to detach from the situation. However, the participant observer is always closest to the situation and can gain complete trust and confidence from the participant, which will improve the reliability of the data.

Non-Participant observation

During non-participant observation the observer observes from outside without taking any part. According to Sarantakos (2013:231) during non-participant observation, the investigator should be unnoticed by the members of the group being observed. The observer does not take

part and does not interfere with the activities of the group. Subjects may not realise they are being observed so that they can behave naturally.

For the current study, a non-participation unstructured observation was conducted. The entire training of the students was recorded by means of capturing images and taking notes. The investigator got an opportunity to observe the initiation of two students from the beginning to the end. Permission was granted by the mentor in consultation with the mentees for the capturing of main events during the training period. The investigator attended all the big events during the training process. Permission was granted to come in at any time to see, capture and observe the whole process.

3.6.3 Document analysis

Bryman (2012:543) stipulates that the kinds of sources upon which documents analysis is mostly done are documents such as newspaper articles, policy documents, research articles to name but a few. This can be personal or official documents depending on the type of study. Personal documents may include diaries, letters and biographies. Official documents commonly used in social science research may include government documents such as acts of parliament, policy documents, and any other official report that may be of value to the research. The current study consulted government acts, policy documents, journal articles, newspapers, healers notes, certificates, as well as websites belonging to the traditional healers and their associations.

Strengths and limitations of document studies

Sarantakos (2013:313) lists the following strengths and limitations of document studies:

Strengths

- *Retrospectivity* – documentary methods allows the researcher to study past events.
- *Quick and easy to access* – Documentary research is free of the restrictions, difficulties and problems faced during data collection from people.
- *Spontaneous* – documents are produced by the writers without being requested to do so by the researchers.
- *Convenience* – the researcher can study research questions at any time.
- *Low cost* – documentary research is cheaper to conduct when compared to other types.
- *Less time consuming* – the research requires less time when compared to other types.
- *High quality of information* – dealing with first hand original data allows production of high quality findings.

- *Possibility of re-testing* – since documents are easily accessible, replication is possible.
- *Non-reactivity* - the method itself and the act of measurement do not affect the result.

Limitations

- *Lack of representativeness* – documents are not necessarily representative of their kind and thus do not allow generalisation
- *Lacks of accessibility* – some documents are not easy to access.
- *Incomplete data* – Some documents are not complete or up to date.
- *Reliability* – The reliability of some documents is questionable.
- *Personal bias* – documents may be bias since they represent the views of their authors.

3.7 Research procedure

The previous section discussed data collection instruments employed in this study. This section will look at the research procedures followed in conducting this study. Research procedures typically include the population and how it (population) was obtained, sampling procedures, procedures employed in gathering and processing data, and data analysis. It is almost impossible to use the entire sample frame in a qualitative study. As a result, sampling decisions were made as to who will participate in this study.

3.7.1 Population and sampling

Neuman (2011:241) defines a population as the abstract idea of a large group of many cases from which a researcher draws a sample and to which results from a sample are generalized. As indicated in the background information, the population for this study will consist of herbalists (*inyanga's*), diviners (*sangomas, prophets*), as well as elders who may have knowledge of and have been involved in the healing from years of experience.

South Africa had approximately 200 000, traditional healers practicing in 1995, and around 300,000 in 2005 (Denis 2006; Truter 2007). It is however very difficult to give the exact figure when it comes to practicing healers because many are not registered with the Traditional Health Practitioners Council of South Africa (THPCSA) which is tasked with registering persons who engage in traditional health practice in South Africa (Government Gazette 2008). According to the Traditional Health Practitioners (THP) Act, No. 22 of 2007 the THPCSA is supposed to be reporting to the minister of health but there was no evidence of any link or article about the council on the website of the department of health. The researcher believes that statistical information about all registered healers should be made available on the website.

The study specifically focused on the indigenous healers in the Limpopo Province of South Africa. In defining the target population, the next section discusses the sampling procedures followed in this study.

3.7.2 Sampling

Neuman (2007:219) defines sampling as a process of having a small collection of units from a large population to allow the researcher to study the smaller group and produce accurate generalisation about the larger group. It is however important to note that generalisation is a preoccupation of quantitative research and in qualitative studies like the current study, the investigators are not obliged to ensure things like sample representativeness because results are not going to be generalised. Neuman (2006) further notes that researchers normally do sampling to save time, costs, and to produce accurate results. According to Babbie and Mouton (2011:86), “a (quantitative) sample should aim to be representative of a broader population, to include sufficient observations, to assure precision and leverage in the analysis, and to use cases that lie at the same level of analysis as the primary interface”. However, Neuman (2006:219) argues that for qualitative studies, researchers should focus less on the sample’s representativeness rather on how the sample or small collection of cases, units or activities illuminates social life. In qualitative research a non-probability sample often fits the purpose of the study (Neuman 2011:267).

3.7.2.1 Sampling procedures in qualitative research

Sarantakos (2013:181) argues that qualitative researchers employ sampling procedures that correspond to the philosophy of this type of research. The sampling procedures in qualitative research are less structured, and less strict than the techniques quantitative researchers employ. Neuman (2011) also highlights that non-probability sampling procedures that are used by qualitative researchers, do not apply the rules of probability and the researcher does not have to worry about representativeness. According to Ngulube and Ngulube (2017), fewer participants examined at a greater depth are the gold standard for phenomenological research as is the case with most qualitative methods. Neuman (2011) and Sarantakos (2013) list accidental sampling, purposive sampling, quota sampling, snowball sampling, sequential sampling, theoretical sampling as well as adaptive sampling as some of the main non-probability sampling techniques that can be used in qualitative studies.

3.7.2.1.1 Purposive sampling

Purposive sampling is a sampling technique where the researcher chooses cases that in their opinion are relevant to the study. In purposive sampling cases are rarely a representative of the population and the choice of cases is based on the judgement of the investigator.

3.7.2.1.2 Accidental sampling

Accidental sampling is a procedure that employs no strategies or techniques to choose respondents. The investigators use all cases that accidentally encounter them during data collection. It is called accidental sampling because the respondents are selected by accidents and they happen to be there when the investigator was doing the investigation.

3.7.2.1.3 Quota sampling

Quota sampling is a sampling technique where the investigator sets a proportion of respondents to be chosen from specific population groups. The researcher sets a number of cases to be selected for each category within the population to represent different dimensions of the population.

3.7.2.1.4 Snowball sampling

Snowball sampling is the sampling technique where the investigator uses any other sampling technique to select the first group of respondents and then asking them to recommend other people who meet the criteria of research and who might be willing to participate. This referral process may be continued until data saturation is reached.

3.7.2.1.5 Sequential sampling

Sequential sampling technique is a sampling technique similar to purposive sampling. The known significance difference is that sequential sampling gather cases until the amount of new information ends or when saturation is reached.

3.7.2.1.6 Theoretical sampling

Theoretical sampling is the process of data collection for generating theory. The knowledge gained from the first respondent informs the investigator who will be the next suitable respondent to interview. With these interviews, the investigator gains knowledge about the research topic

3.7.2.1.7 Adaptive sampling

Adaptive sampling is a sampling technique used for hidden populations where different sampling techniques can be used at the beginning.

Table 3.2: Sampling strategies in qualitative research, (Neuman 2011:267)

Type of Sample	Principle
<i>Convenience</i>	Get any cases in any manner that is convenient.
<i>Quota</i>	Get a pre-set number of cases in each of the several predetermined categories that will reflect the diversity of the population, using haphazard methods.
<i>Purposive</i>	Get all possible cases that fit particular criteria, using various methods.
<i>Snowball</i>	Get cases using referrals from one or few cases, then referrals from those cases and so forth.
<i>Deviant case</i>	Get cases that substantially differ from the dominant pattern (a special type of purposive sampling).
<i>Sequential</i>	Get cases until there is no additional information or new characteristics (often used with other sampling methods).
<i>Theoretical</i>	Get cases that will help reveal features that are theoretically important about a particular setting or topic.
<i>Adaptive</i>	Get cases based on multiple stages, such as snowball followed by purposive. This sample is used for hidden populations.

3.7.3 Justification of the sampling technique used

This study investigated a specialised group of people in the community. The review of literature and the observation that the investigator made is that the statistical information about the number of healers practicing in South Africa is currently not readily available. We can only talk of estimates and it may take longer and a huge effort from the government to correct that. The stigma attached to traditional healing over the years also means that not everyone may be aware of who is practicing as a traditional healer in a particular area as a result, those who worked with the healer before will be the ones likely to know. Traditional healers also regard their knowledge as personal so to gain access and trust we had to rely on those who trusted us to assure other members that we meant no harm.

Purposeful sampling and snowball sampling methods are very popular with hermeneutic phenomenology (Ngulube and Ngulube 2017). Again, with phenomenology; the focus is on selecting only those people who share the same experience of the phenomenon under investigation. With all factors considered the study led the investigators to purposefully select some respondents and further employ the snowball-sampling technique. The use of purposeful sampling and snowball sampling methods are in line with what is popularly used

in hermeneutic phenomenological research. Neuman (2007:223) defines snowball sampling as “a non-random sampling technique in which a researcher begins with one case, and then based on information about interrelationships from that case, identifies other cases, and repeats the process again and again”.

As explained, Limpopo Province is divided into five regions and the study covered all the five regions of the province. The decision to visit all regions was motivated by the fact that traditional healing is not a homogenous healing system, but varies from culture to culture, from region to region, and from individual to individual (Mokgobi 2014:28). The investigator established contacts in each region as a basis for the snowball. In some instances, a healer from Sekhukhune region referred the investigator in to the Capricorn region, which then began the data collection in that particular region.

The advantage of using snowball sampling in this regard was perfect in the sense that for one to become a healer, he/she was trained by another healer. This mentor happens to have an existing network of healers who form a certain network. Gaining access to one healer allowed the investigator to gain access to the majority of the network. Participants were interviewed and referrals requested until no new information was emerging from the participants stories.

3.8 Data quality

The quality of qualitative studies can be assessed through its trustworthiness and authenticity. Bryman (2012:389) argue that reliability and validity are most common to establishing and assessing the quality of quantitative research however, this is done through measurements and measurements are not a preoccupation to qualitative studies like the current study.

3.8.1 Trustworthiness

According to Bryman (2012:390), **trustworthiness** is made up of four criteria each having an equivalent in quantitative research:

- **Credibility** – parallels internal validity and it is about ensuring that the research is carried out in the correct way and the results are confirmed by the population to show that the investigator understood their social world. After collecting data from all the regions and analysing it, the investigator went back to some of the respondents and checked with them if the correct information was captured.
- **Transferability** – parallels external validity and it is about producing detailed accounts of the social world rather than focusing on coverage.
- **Dependability** – parallels reliability and is about keeping record of all phases of the research to establish how well proper procedures are being and have been followed

- Confirmability – parallels objectivity which is about ensuring that the researcher objective enough and has not allowed personal feelings, values or perceptions to sway the conduct of the research and the findings thereof. The responses were recorded as they are, and to check that the investigator listened to the tapes confirming that what was said is actually, what was presented in this document.

To ensure trustworthiness, the investigator collected data from credible healers who have been practicing for many years. Furthermore, a voice recorder was used to capture the interviews, and all tape recordings were saved and kept together with the field notes. In ensuring credibility of the data, the investigator used the recordings to fill in the gaps that may have been there when notes were taken. Assistant researchers who helped during data collection were consulted and together with the investigator discussed the findings to make sure everything was captured correctly. The research project enabled the investigator an opportunity to connect and network with some healers which continues to allow the investigator to have continuous discussions on issues under investigation. To confirm the collected data through interviews, the investigator triangulated the whole process by collecting additional data through observations.

3.8.2 Authenticity

According to Bryman (2012:393), authenticity in qualitative research involves the following issues:

- *Fairness* – the research should fairly represent different viewpoints of the population
- *Ontological authenticity* – the research should help the population to understand their social world better
- *Educative authenticity* – the research should teach other members to appreciate the perspectives of other members in their social world
- *Catalytic authenticity* – the research should have an influence on members to the possibility of changing their circumstances
- *Tactical authenticity* – the research should empower members to take action in their social world

To ensure authenticity, the investigator went back to some of the healers and shared with them on what was captured and allowed them to make further comments. This allowed the investigator to together with the continuous discussions that the investigator is having with some healers, gave the investigator some leverage to interpret what the traditional healers have contributed with authority. Authenticity is closely linked to credibility which was

discussed under trustworthiness in the preceding subsection, and is concerned with the correct interpretations of lived experiences of the healers.

3.9 Data analysis and presentation

In qualitative research, data is collected to describe details about people, actions, and events in their lives (Neuman 2011:507). The data collected for this study was in the form of text from document analysis, interview transcripts and audio recordings obtained during interviews as well as notes made during observation. Neuman (2011) highlights that to analyse data means systematically organising, integrating, examining while searching for patterns or themes among specific details.

According to Ngulube, Mathipa and Gumbo (2015) thematic analysis is a method for identifying themes and patterns of meaning across a dataset in relation to a research question. Thematic data analysis procedures are related to qualitative methods and are generally suited for hermeneutic (interpretive) phenomenology (Ngulube and Ngulube 2017). The following are steps in thematic data analysis that can be applied in a phenomenological study as outlined by Ngulube and Ngulube (2017):

- transcribing the interviews;
- taking note of items of interest;
- coding across the entire data;
- searching for themes;
- reviewing themes by mapping provisional themes;
- checking for relationships among themes; and
- defining and naming the themes.

In this study, interviews were conducted in Tsonga, Venda and Pedi then answers translated to English during transcribing. The investigator listened to the recorded tapes from the interviews and transcribed them from tape to paper while translating them to English. The notes taken by the research assistant during interviews were compared to the data obtained from tapes and necessary adjustments made where necessary. The data were grouped according to each theme emanating from the objectives of the study. This means that all responses addressing a particular objective were grouped together. A similar approach was taken to data collected through observation and document analysis. The data obtained from document analysis and observations were integrated and grouped thematically with the data obtained from interviews in an effort to answer the research questions.

3.10 Ethical considerations

In both qualitative and quantitative research, researchers face ethical issues that surface during data collection in the field and in analysis and dissemination of research reports (Creswell 2007:174). Welman, Kruger and Mitchell (2005:201) discuss four ethical considerations to which a researcher should pay attention to: Informed consent, right to privacy, protection from harm and involvement of the researcher. Bryman (2012:135) also highlights four main areas about ethical principles, which include:

- whether there is harm to participants;
- whether there is a lack of informed consent;
- whether there is invasion of privacy; and
- whether deception is involved.

The UNISA Policy on Research Ethics (2007:18) also explains that all studies must be conducted ethically at all times and the rights and interests of all participants must be protected at all times. The following are examples of moral principles of the research involving human participants (UNISA Policy on Research Ethics 2007: 9):

- Autonomy (research should respect the autonomy, rights and dignity of research participants);
- Beneficence (research should make a positive contribution towards the welfare of people);
- Non-maleficence (research should not cause harm to the research participants in particular or to the people in general); and
- Justice (the benefits and risks of research should be fairly distributed among people)

Therefore, in this study, an ethical clearance was obtained from the department of information science ethics review committee (see Appendix B). Each interview participant was informed as to who was conducting the research, why they were invited to participate, that participation is voluntary and are free to withdraw anytime, and that anonymity and confidentiality will be maintained at all times.

For data collected through observation, permission was granted by the mentor after consulting with the mentee. The investigator informed them that anonymity and confidentiality will be ensured and they were free to withdraw at any time. All pictures taken during observations were shown to the trainees and they had no problem with them being included in the document, however the investigator protected their identities by severing the faces on the

pictures that were used. Again names and pictures that appeared on the certificates that were analysed were hidden so that the identity of the participants was not revealed.

For document analysis, all sources consulted were acknowledged to avoid plagiarism. The ethical clearance, consent letter, standard operating procedure for research ethics risk assessment, as well as the ethics researcher's acknowledgement form are attached in the Appendices B and C.

3.11 Evaluation of research methodology

It is necessary and imperative to evaluate the procedures involved in conducting the study to outline the strengths and weakness of the study. The study used a qualitative approach and phenomenology as a method to collect qualitative data. Myers (2002) argues that the major strength of a qualitative approach is the depth to which explorations are conducted and descriptions are written. The disadvantages of qualitative research worth mentioning involve people being observed who may consciously or unconsciously change their behaviour as a result of being observed, again observations are filtered through the interpretive lens of the researcher which leaves too much room for bias (Keyton 2006:70). In addition to that, during interviews some participants may not be totally honest when it comes to some questions.

In this study, semi-structured interviews were conducted supplemented by observations and document analysis. All research methods have their strengths and weaknesses. The investigator however believes that the triangulation of data collection instruments proved useful, in enabling the investigator to collect reliable data.

There were a number of challenges faced during the interviews. Firstly, the investigator depended on referrals from one participant to the next. Participants mostly referred the investigator to participants who were not in their area because it seemed there is a lack of trust and some level of competition between healers who come from the same area. In some cases where a participant referred locally, the potential participant would refuse to participate. The problem was solved by requesting participants to travel with the investigator to the next participants to do the introductions properly.

Secondly, the interviews were conducted using the three of the local languages, that is, Venda, Tsonga and Northern Sotho. The investigator decided to make use of the research assistants who were selected according to their spoken languages. In an area where the population is predominantly Venda an assistant would be Venda speaking to help with the note taking, as well as listening to recordings and comparing notes after the transcribing of recordings. The same procedure was done in all areas of the province. During instances where

both the investigator and the assistant were not certain, the investigator phoned some of the participants to confirm some details. The biggest challenge was translating the data from the three languages in to English for the purposes of producing this research report. The investigator decided against using a professional for the translation because direct translation of the data could have resulted in the data losing its meaning. The investigator decided to use research assistants and some of the healers to help in translating the data into English. This ensured that what was documented was correct and carried the same meaning as articulated by the participants. For words that the investigator could not find their English equivalent and translation, the investigator created a footnote which tried to explain what they meant.

3.12 Summary

This chapter discussed the research design and methodology used to conduct this study. The research paradigm, approach and phenomenology as a research method and the motivation for the choice of method were explained. Data collection instruments were discussed which were motivated by the problem at hand. The population was clearly defined and the sampling strategy used was clearly explained. The chapter also looked at issues of data quality, how data analysis and presentation was done as well as how ethical issues concerning this study were considered. In chapter four a discussion of data interpretation and findings is presented. The next chapter (Four) focuses on the presentation of results obtained from interviews with traditional healers, observations as well as content analysis of the available documents.

CHAPTER FOUR

PRESENTATION OF THE FINDINGS

Hu ambuwa vhuṅanga; vhukololo a vhu ambuwi (This is a Venda proverb literally translated to: “The medicine-man who crosses into foreign territory takes his craft with him, but royal rank cannot be taken abroad.”).

4.1 Introduction

The preceding chapter looked at the research design and methodology employed to conduct this study. The chapter focused specifically on ways that were followed to answer research questions. This chapter presents the findings of the study as gathered by the investigator. The findings obtained originate from a qualitative research approach with a hermeneutic phenomenological research method employed. The chapter presents findings from the interviews, observations, as well as the document analysis. The presentation and analysis of the findings is important because it allows the investigator to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied and tested, and conclusions drawn (De Vos *et al.* 2011:249). This chapter will further help the investigator to structure the findings from interviews, observations as well as documents studies. The presentation of the results as guided by the objectives of the study were organised according to the following themes:

- The status of indigenous healing in Limpopo Province of South Africa.
- Knowledge acquisition by indigenous healers in Limpopo Province of South Africa.
- Knowledge transfer among indigenous healers in Limpopo Province of South Africa.
- Knowledge preservation among indigenous healers in Limpopo Province of South Africa.
- The acquisition, transfer and preservation of knowledge of traditional healing

4.2 Data presentation

Firstly, a semi-structured interview was used to gather data from traditional healers in the Limpopo Province. The investigator prepared an interview schedule containing questions listed according to the objectives of the study. The questions were mainly used as a guideline for the interview because they were never asked in a sequence and in most cases not all questions were asked. The flow of discussions determined which questions were asked and which ones to leave out so that there were no interruptions. The questions asked were aimed at addressing the research questions of the study. All the interviews were done at the participant's homes at the times and days determined by the participants from the sets of dates

which were given to them. The interviews were conducted between the months of September and November 2016. All interviews were conducted in Xitsonga, Pedi and Venda.

Before the actual interviews, the investigator explained to all participants the purpose of the study. The participants were informed that participation was voluntary and that they had a right to discontinue or stop the engagement at any point they feel uncomfortable during the interview. The participants were further ensured that they will remain anonymous and that confidentiality will be kept at all times. None of the healers was quoted or identified with any of the responses recorded.

In most of the interviews, permission was granted to record the conversations and in cases where permission was not given, responses were recorded manually. The manual recording of the responses interfered with the flow of events and to address the problem, the investigator made use of an assistant who took notes as deliberations unfolded. The audio-tapped recorded responses provided exact responses and opinions of the participants.

Secondly, an unstructured observation results were obtained over a period of five months, which coincided with the conducting of interviews at times. The investigator went to request for permission to do this study when one student was in the final stages of training and about to graduate with two students about to start with the training and decided to focus on the new students. The events observed were categorized according to the issues raised in the research questions of this study. The interview guide that was designed to help collect data from interviews made it possible for the investigator to recognise and record events that were addressing the objectives of the study. It is important to note that the observation data obtained were about the two students observed and is not regarded as being representative of all the healers in the province, however, interviews and the analysis of documents complemented the data.

Thirdly, the investigator looked at the available documented knowledge to help bring out the gaps and to find solutions on how this knowledge can best be preserved for future generations. The documents studied in this regard included government policy documents relating to traditional healers and traditional healing, documents in the procession of healers, newspaper stories and some research reports in the subject area of traditional healing. In this section, we focused on the status of traditional healing in South Africa, and looked at what the policy documents are saying regarding traditional healing education and training. The next section gives a bit of background about those healers who participated in this study

4.3 Background of participants

This is a qualitative study, as a result, the investigator will not be discussing issues related to the study's response rate and representativeness because the results of the study will not be generalised. Neuman (2006:219) argues that for qualitative studies, researchers should focus less on the sample's representativeness rather on how the sample or small collection of cases, units or activities illuminates social life. Qualitative studies are known to produce deep data not statistical data common to quantitative studies. The investigator visited all five regions of the Limpopo Province (Waterberg, Capricorn, Vhembe, Mopani and Sekhukhune (see Figure 4.1) to collect data. In all regions we started the interviews with the healer that we got through our contact. We then requested that particular healer to refer us to some of the people he/she had worked with. We continued the process until we were not getting any new information. The data collection process stopped when the investigator felt data saturation has been reached.

In the Mopani region six senior healers were interviewed. From the six, four were female and 2 males. One of the males was an elderly man who graduated over thirty students and had about six students undergoing training at the time. From the four females, one female had two students busy with the training and had graduated many more before.

In the Waterberg region, the investigators managed to interact with seven healers of which two were male and the other five were female. In the Sekhukhune region five female healers were interviewed. In the Capricorn region four healers were interviewed of which three were females and one was male. The last leg of interviews was done in the Vhembe region. In the Vhembe region, three males and two females were interviewed bringing the total in that region to five.

Table 4.1: A summary of interviewed participants

Region	Male	Female	Total
Mopani	2	4	6
Waterberg	2	5	7
Sekhukhune	0	5	5
Capricorn	1	3	4
Vhembe	3	2	5
Total	8	19	27

In total, 27 healers were interviewed, of the 27, 19 were female and only eight were male. A number of healers chose not to participate in the study without giving reasons, while others were not interested.



Figure 4.1 Regions of Limpopo, (Limpopo Tourism Agency 2017)

Two female trainees aged between 35 and 45 were observed in this study (see Figures 4.2). One of the trainees was employed and was going to work daily and resumed with her training in the evenings and during weekends. The other trainee was unemployed and was focussing fulltime on the training. One trainee came from the Northwest Province into Limpopo for training and the other was a resident of the Waterberg region of Limpopo. The two trainees were referred to as twins because they did their training at the same time. In traditional healing it is said that your ranking is determined by the number of years you have been practicing. If someone younger than you in terms of age trained before you, that person is

sPictures taken during observation were severed to protect the identity of the participants in order to ensure confidentiality. However, the severity of the pictures didn't make the pictures lose integrity.

your senior when it comes to the practice of traditional healing. All the healers who were trained by the same master are ranked according to their years of experience.



Figure 4.2: Healers/trainees observed. (Photographer: Researcher).

4.3.1 The status of indigenous healing in Limpopo province

There is a lot written about the status of traditional healing in South Africa, particularly post-apartheid after the Suppression of Witchcraft act of 1957 was replaced by the new traditional healer's act, which allowed healers to perform their duties, such as, the healing of patients, training other healers, being custodians of indigenous knowledge, and being the point of reference for traditional matters without any fear. The suppression of Witchcraft Act of 1957 as well as the criticism labelled by missionaries such as Congregational, Methodist, Anglican, Lutheran and Catholic towards African beliefs and religion affected and continues to affect how people treat and view the healers (Denis 2006:312); having said that, there have been significant and positive changes at government level in the democratic South Africa.

The findings from a study by Mokgobi (2014) suggest that the duties of healers go beyond the uses of herbs for illnesses. Mokgobi (2014) argues that, in addition to working with herbs and healing the sick, traditional healers are custodians of the traditional African religion and

customs, educators about culture, counsellors, social workers and psychologists. Be that as it may, Mathibela, Egan, Du Plessis and Potgieter (2015) argue that the South African government's health care has negatively influenced the practice of traditional healing as patients consult government health centres before turning to traditional healers. Some of the doctors in those hospitals discourage patients from using traditional healers for health reasons. Similarly, some of the religious leaders (mostly Christians) in the country label traditional healers as evil and consistently discourage their members to consult healers. Children grow up not understanding what traditional healing is all about and continue with the stigma that is attached to traditional healing. Children are made to believe that traditional healing is a dirty job, done by the poor and only in rural areas. On the contrary there are a number of stories which surfaced about celebrities who live in luxury, who are well educated and respected who happened to have answered the call to become healers. These stories were published in the daily newspapers and magazines that cover celebrity stories. The following are some of the celebrity stories made public by the Sowetan (2016):

- Boitumelo Thulo (*see Figure 4.3*), professionally known as "Boity", is a South African actress and TV presenter known for her role as Mpho Bogatsu on Mzansi Magic's Rockville and presenting E TV's music show, Club 808. According to the Sowetan (2016) the popular TV personality undergone a spiritual journey and has accepted an ancestral calling to become a healer.



Figure 4.3: Boitumelo Thulo (Sowetan 2016)

- Bongani Masondo (*see Figure 4.4*) is a South African actor best known for his starring role as Bafana "Prince" Shabalala in the SABC1 drama series Tshisa, from 2006-2012 and currently (2015 - as 'Babymaker' in Skeem Saam on SABC1. He graduated to be a Sangoma in 2011 at Margate in KwaZulu-Natal (Sowetan 2016).



Figure 4.4: Bongani Masondo (Sowetan 2016)

- Latoya Makhene (*see Figure 4.5*) is a South African actress, singer and TV personality. She is well known for acting in South Africa's famous soap operas, *Isidingo* and *Generations*. She also answered the call and trained as a traditional healer. According to the *Sowetan* (2016), she currently juggles her acting schedule with a small consulting business where she heals people.



Figure 4.5: Latoya Makhene (Sowetan 2016)

Treasure Tshabalala (*see Figure 4.6*) is a South African actor and radio DJ best known for his leading role as Timothy Gumede, the father of the title character, in the television sitcom *Nomzamo*, from 2006-2008. Other television series he has acted in include *Phindi*, *90 Plein Street* and *Generations*. He has also acted in the mini-series *Shaka Zulu* (1987) and the Italian made-for-TV movie *The Vulture if a Patient Bird* (1989). Treasure Tshabalala is also a trained healer.

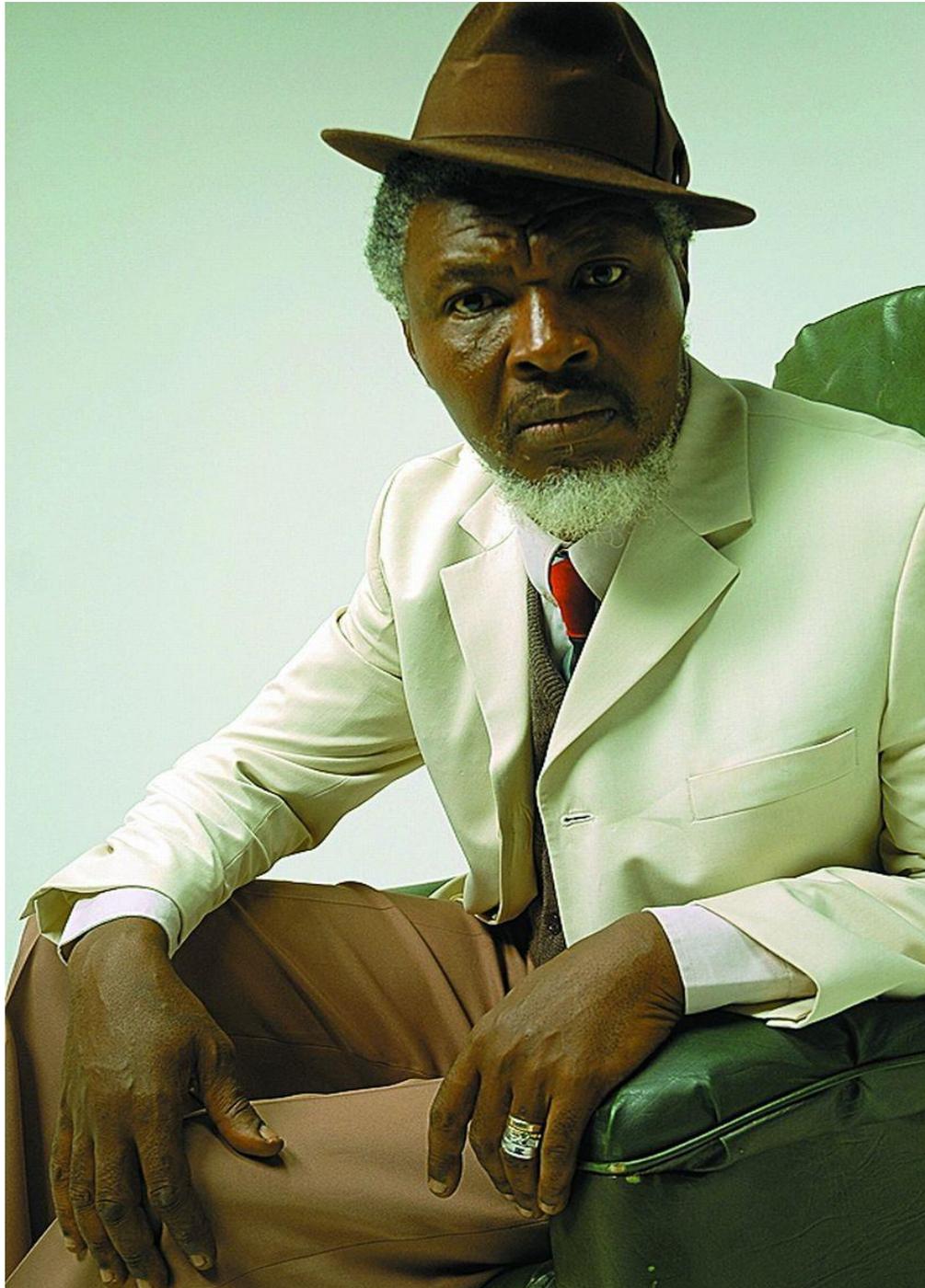


Figure 4.6: Treasure Tshabalala (Sowetan 2016)

Despite all the positive stories on traditional healing, there are still many other negative stories that are linked to traditional healing. There has been an array of media reports of traditional healers claiming to have a cure for AIDS or submitting their patients to dangerous or ineffective treatments (Richter 2003). There are also stories appearing in the news about suspected killings that are linked to healing and traditional healers where it is believed people are killed for their body parts for healing purposes.

To get an informed view on the matter the investigator went on to solicit views from healers through interviews on the status of indigenous healing in the Limpopo Province of South Africa. In cases where participants gave similar answers, only one answer was captured to avoid recording the same thing multiple times. As a start, participants were asked how they felt about their job as healers in the province. This was aimed at understanding how healers felt about their job and the state at which traditional healing is in the province. The following answers were given (see Table 4.2):

Table 4.2: How participants felt about their job as healers in the province

Participant	Response
Respondent A	<i>It is a difficult job because I have a day job and mostly do the healing part-time after hours and weekends.</i>
Respondent B	<i>Many of our children are educated and they are suffering from small things that healers can solve but they do not trust us, we are here for the people but we are not trusted.</i>
Respondent C	<i>I have patients in other neighbouring countries and it is difficult to cross the border with herbs, for that reason I am made to pay bribes to the officials</i>
Respondent D	<i>There are too many fake healers and the government is not doing anything about it because anyone can get a certificate without proof of training and this makes our job difficult.</i>
Respondent E	<i>Being a healer is risky because healers are exposed to many illnesses, they deal with sick</i>

	<i>people and never send anyone away even those without money, but the job they doing is less appreciated</i>
Respondent F	<i>I find everything about my job to be fine, everything I have this house cars and everything else, came through my work. I help the people and I never go hungry.</i>

Participants were also asked to discuss challenges they face during their traditional healing practice and the following were the answers given (see Table 4.3):

Table 4.3 Challenges faced by traditional healers during their healing practice

Participant	Response
Respondent A	<i>We normally get clients at night and at times I don't open because it might be robbers</i>
Respondent B	<i>There is no support from the government side we work on our own.</i>
Respondent C	<i>We normally get clients who are seriously sick and we help and end up not getting our money and there is no one to help us recover our money</i>
Respondent D	<i>We always heal people and expect payment when they are healed so once our job is done patients are healed we mostly don't get paid or the payment is mostly incomplete and we depend on that money to buy herbs and to feed our families.</i>
Respondent E	<i>Everything is very fine there are no problems</i>
Respondent F	<i>There are no challenges thus far</i>
Respondent G	<i>There are no challenges at all, I help the sick and ever since I left my job as a prison warden almost 40 years ago I have never gone hungry, I do the job my ancestors set me out to do and from my job I educated all my children I even have a son who has a PHD degree</i>

The investigator wanted to know whether the participants only subscribe to the ancestral beliefs or if there are other beliefs that they subscribe to as a result of how other religious leaders perceived them. The following were the answers given (see Table 4.4):

Table 4.4 How traditional healers view other beliefs

Participant	Response
Respondent A	<i>I don't have problems with churches; they however tell people we are evil.</i>
Respondent B	<i>Ancestral beliefs and churches are not too different. As healers we sometimes train people who are prophets who happen to have powers to heal but using prayer.</i>
Respondent C	<i>According to me healers and prophets are the same thing and as far as I know many healers also go to church.</i>
Respondent D	<i>There is nothing wrong with going to church as a healer but it is not all churches that can accommodate healers. There are churches that refuse the use of herbs to their members and as a healer I will never be part of that.</i>
Respondent E	<i>You can go to church as a healer as long as you seek permission from the ancestors</i>
Respondent F	<i>As a spiritual healer I work only with church people not with traditional healers because I don't use herbs and what they use, I depend on prayer</i>
Respondent G	<i>I don't have problems with other beliefs but the missionaries came into our country to destabilise us and interfere with our way of life so they are the ones who have a problem with how we live.</i>
Respondent H	<i>My sister is one of the serious people I know when it comes to praying and issues of God. I do attend when I am around during those prayer sessions. I know the bible I know how to stand in front of people and praise the lord but I know I am a healer.</i>

Healers were also asked to explain how they marketed their services. This was aimed at finding out how South Africans get to know about different healers and the services they provide under the circumstances. The following were the answers given (see Table 4.5):

Table 0

Participant	Response
Respondent A	<i>People in this area know me too well and what I am capable of, I don't need to go around showing people what I do.</i>
Respondent B	<i>Mostly patients are referred to me by those I treated before</i>
Respondent C	<i>Our clothing always tells people the type of people we are, we wear beads, and cloths that set us apart from other people and everyone will just know we healers and that's how people come to us for consultation</i>
Respondent D	<i>The ancestors decide many things when it comes to our work, we get people from faraway places that never met us before but were sent to us by their ancestors</i>
Respondent E	<i>My work does the marketing for me, I get people from places I have never been to before because of what they heard from people I helped.</i>
Respondent F	<i>People whom I helped previously tell people of the help they got from me but ancestors are the ones sending sick people to me to help. I get to help people from faraway places I have never been who just end up at my door step for help.</i>

When it comes to issues of regulating and controlling of the traditional healing practice, Tshetlha (2015:279) highlights that the Interim Traditional Health Practitioners Council (THPC) was inaugurated in February 2013, and in May 2014 the sections of the Traditional Health Practitioners Act which give it full powers came into effect. Some of the core functions of the council worth highlighting include ensuring the efficiency, safety and quality

of traditional health care services; to provide for the management and control over the registration, training and conduct of practitioners, students and specified categories in the traditional health practitioners profession.

Despite all that, the situation on the ground is somehow different. Associations with no statutory status are the ones registering the healers. The following are some of the certificates and documents the investigator managed to come across:



Figure 4.7: Natural Dingaka Herbal Medupe Association (Photographer: Researcher).



Figure 4.8: Traditional Healers Organisation (Photographer: Researcher).



Figure 4.9: African Dingaka Association ((Photographer: Researcher).



Figure 4.10: Dingaka Herbal cc (Photographer: Researcher).



Figure 4.11: Mbofho Traditional Doctors Association of Limpopo Province in South Africa (Photographer: Researcher).

The investigator then went on to ask the interview participants if they belonged to any association and the role it plays for them. The following were the main answers registered (see Table 4.6):

Table 4.6 membership to associations and the role associations play to healers

Participant	Response
Respondent A	<i>I belong to the traditional health organisation.</i>
Respondent B	<i>We belong to an association and have leaders but our leaders don't communicate anything with us.</i>
Respondent C	<i>I belong to an association and was given a certificate after undergoing training for a week on illnesses I already knew and treated before.</i>
Respondent D	<i>I am a member of an association and on my certificate it shows that I can treat only three yet I am dealing with all sorts of illnesses on a daily basis</i>
Respondent E	<i>I belong to an association and I just attended their training so that I can get my certificate and continue with my work as a healer.</i>
Respondent F	<i>I belong to an association and there is an office of traditional healers that is supposed to lead us but I have never been there.</i>
Respondent G	<i>I belong to an association the problem is every time we want something from our leaders they always want money.</i>
Respondent H	<i>I am a member of an association the problem is they prescribed very high prices for us to charge our clients which is not working because we deal with poor communities and end up ignoring them.</i>
Respondent I	<i>I am affiliated to a professional association but their offices are very far from our villages, we need offices next to where we stay because the office in Johannesburg is not helping us</i>
Respondent J	<i>I belong to the traditional health organisation, African dingaka association</i>

	<i>and was also registered by the provincial government as a healer. The associations help when there is a dispute mostly with the trainees but they also say they can help when patients are not paying after being treated but I have never used such a service before</i>
Respondent K	<i>I belong to the traditional healers association and also have a certificate for the HIV and AIDS home based care training I attended.</i>
Respondent L	<i>We pay too much affiliation fee for the traditional healers association but when you experience problems they take forever to respond or attend to you</i>
Respondent M	<i>I belong to a professional association but I don't see how they are helping even though I pay my fee every year</i>
Respondent N	<i>I belong to professional association but as a healer I am guided by my ancestors. What I do and how I conduct myself as a healer is being monitored by my ancestors, what associations need is money and as a healer it is my job to help the needy</i>
Respondent O	<i>I am not yet registered with any association but mentor mentioned to me that I need to register with an association because we need protection as healers when we face difficulties with clients like in cases where clients are not paying or maybe clients are giving us hard times or when we come across police carrying some herbs as they will need some form of identification.</i>
Respondent P	<i>Yes I belong to an association of spiritual healers and have certificates from our association.</i>
Respondent Q	<i>I was not trained as a healer I just have knowledge of herbs as a result I do not have</i>

	<i>a certificate, I usually get many herbs locally and buy those herbs that can be found in other areas because I do not have the documentation to travel with herbs.</i>
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The investigator further wanted to know if there is some level of collaboration between the western doctors and traditional healers and the following were the answers given (see Table 4.7):

Table 4.7 Collaboration between western doctors and traditional healers

Participant	Response
Respondent A	<i>We sometimes attend meetings and meet with nurses; however nurses are treating us badly.</i>
Respondent B	<i>Collaboration is one sided because we always refer patients to hospitals while they never do even though they came across illnesses they don't understand.</i>
Respondent C	<i>When we refer patients' nurses always fight with us and shout at those patients asking them why they came to us instead of going to the hospital</i>
Respondent D	<i>Hospitals will never refer patients to us; they rather stay with those patients till they die.</i>
Respondent E	<i>I had a relationship with our local hospital and we had problems when it came to issues of payment. After treating the patients the hospital just signed them off and I got nothing which was unfair to me considering that some of the herbs I use I pay a lot of money to get, while others requires that I travel long distances to other areas for me to get them which is costly</i>
Respondent F	<i>Collaboration with doctors is difficult because they undermine our practice maybe because we did not read books that they read.</i>
Respondent G	<i>When it comes to illness that I can't treat or</i>

	<i>if a patient requires water or maybe has lost a lot of blood where more blood is required I will always refer such patients to hospitals. I sometimes get patients who have some of the symptoms of HIV infection like severe weight loss and continuous coughing; I then send them to the clinic for further testing even though many refuse to go.</i>
Respondent H	<i>We want to work with the modern doctors we want the same respect, because I think we do as much if not more for the communities we live in yet our job is not recognised and we still live in poverty</i>
Respondent I	<i>After reading the bones I always know the type of illnesses the patient have and if I see it's something that is beyond me I ask them to go to the hospitals.</i>
Respondent J	<i>I never get referrals from western doctors but I always refer patients to the hospitals for sicknesses I cannot deal with.</i>
Respondent K	<i>We once had a meeting with our local hospital, we were told that they would send patients who need indigenous healing, and we were encouraged to refer patients to the hospitals if we come across issues that we do not understand.</i>
Respondent L	<i>The western doctors call us names saying we are witches they don't respect us, the bible is used to destroy African beliefs so that Africans can believe in the western way of doing things</i>
Respondent M	<i>I always refer patients to hospitals like when they need water in the body or blood that can speed up their healing because my herbs may take longer to help in such cases.</i>
Respondent N	<i>I have never received any patient from the</i>

	<i>hospital and never referred any to them before but I don't mind doing it</i>
Respondent O	<i>Western doctors have one problem, they think what they do is better than what we do. I believe that there are things that can only be treated by African healers. We do refer patients to hospitals on things we can't do like if someone wants a drip or blood transfusion but when doctors see that someone needs traditional help they never refer these people.</i>
Respondent P	<i>I currently have a patient who is at the hospital, the person came here and I was not happy with the cough they were having so I decided to send them to the hospital to check for TB before I can administer any herbs. Another one had a running tummy and I gave them herbs to stop it and send them to hospital for further checking, we get workshopped at the hospitals and are taught about HIV and TB so we normally encourage our clients to get tested however we don't have papers we can use to write those referrals to the hospitals</i>

When the interview participants were asked how the current situation in the province can be improved with regards to traditional healing in the province, the investigator got the following responses (see Table 4.8):

Table 4.8: How the situation in the province can be improved

Participant	Response
Respondent A	<i>We can be really happy if we can get the same treatment as western doctors.</i>
Respondent B	<i>Western doctors don't take us serious and we can be happy if they can show some respect towards us</i>

Respondent C	<i>Government must give us a chance, work with us because we doing all we do for our communities.</i>
Respondent D	<i>When people come to see us during working days they get punished at work because we can't give sick notes as we don't have stamps and documents to use. The government should provide us with such resources</i>
Respondent E	<i>Before anyone is granted the certificate to practice, the trainer must be present to sign the certificate to authenticate the certificate.</i>
Respondent F	<i>Missionaries came with an aim to destroy our own way of living and doing things, our healing powers come from our ancestors; our government should do more in educating our people how Africans do their things and how they survived all this years.</i>
Respondent G	<i>To get access to where important herbs are we need to pay and this makes it difficult for us. Most of our clients are poor and we normally don't collect money upfront. We deal with their problems and when they are completely healed they pay us. Such payments are mostly made in terms, many don't have cash to pay and if we are to spend too much money getting herbs our services will be expensive and everyone will suffer. We work for the nation and the government should help us get access to these herbs</i>
Respondent H	<i>Herbalists mostly Indians who sell herbs influence the increase in fake healers because anyone who is not a healer go to them, buy herbs and claim to be healers and rob people. If you are a true healer, you must go get your own herbs in the wild because you were</i>

	<i>taught.</i>
Respondent I	<i>Those who sell herbs must prove that they are trained healers, so that the correct herbs are sold to healers</i>

As a follow-up to the question on how the situation can be improved in the province, participants were asked to make some recommendations on how the situation in the province can be improved and the following answers were given (see Table 4.9):

Table 4.9: Recommendations on how the situation can be improved in the province

Participant	Response
Respondent A	<i>We need regional offices for healers where we can get help because the current situation is not working.</i>
Respondent B	<i>People are given certificates without proof they were trained, certificates must be containing a signature of the trainer so that we can know who qualified that particular person</i>
Respondent C	<i>We are made to pay R1000 for a certificate and we are told to deposit it in the bank to people we never met which means anyone can do this and all they want is money. Before a certificate is released and monies paid, people must prove that they were trained.</i>
Respondent D	<i>It is easy for anyone to practice as a healer especially foreigners because no one checks them and they end up using bad things and people's body parts which in turn is related to all traditional healers. If foreigners can't produce evidence that they are healers from their countries they must not be allowed to heal people in this country.</i>
Respondent E	<i>We heal more than three sicknesses listed on the certificates we get from the association; we want certificates that list all we do so that</i>

	<i>our clients can see and we are protected. If I am to treat a patient on an illness that does not appear on my certificate and something goes wrong I might be in trouble.</i>
Respondent F	<i>Herbs are expensive and farmers have fenced off places where we used to freely get herbs and this makes it difficult to get herbs, if we can be allowed access to such places that can help a lot.</i>
Respondent G	<i>As healers we always get a certain amount of roots or leaves from a particular tree and when we dig for roots we make sure we return the soil so that the tree can be able to grow again which will allow us to come back to it in the future, those who get these roots for commercial purposes kill the trees because they take everything and leave the tree exposed. This will deny the next generation of healers an opportunity to know these trees from the herbs.</i>
Respondent H	<i>Those without proper documentation that they are healers should be arrested when found in possession of large quantities of herbs.</i>
Respondent I	<i>People especially young ones should be taught and told that healers treat illnesses. We are not killing people. People come to us at night to get herbs hiding themselves because they are ashamed of us, we help church goers everyday yet during the day they walk past us like they are not using our herbs.</i>

4.3.2 Knowledge acquisition among healers

Ryu *et al.* (2005) opine that for knowledge acquisition to take place, the two parties who are involved, that is, a knowledge source and a knowledge recipient, must interact with one another. The knowledge of traditional healers is known to have been transferred from generation to generation through oral tradition. This knowledge is mostly residing within the knowledge bearer's individual memories. As a result, for knowledge acquisition to occur, those in need of this knowledge must learn directly from those with the knowledge.

Participants were asked what they mostly did during training. This was aimed at finding out the key elements involved during training. The following responses were given (see Table 4.10):

Table 4.10: What participants mostly did during training?

Participant	Response
Respondent A	<i>Studying of the bones.</i>
Respondent B	<i>Learning about different herbs.</i>
Respondent C	<i>Going to the wild to get different herbs in the wild so we know how they look like in the wild.</i>
Respondent D	<i>Collecting drying and grinding different herbs to take with after graduating</i>
Respondent E	<i>Participating in the healing process, my mentor demanded that I attend to the patients first before she can speak to them. After reading of the bones my mentor reads her own bones to see if we come to the same conclusion.</i>
Respondent F	<i>I was mostly grinding herbs preparing them for when I am to go home.</i>
Respondent G	<i>I trained while I was going to work so most of the things I will do after work. We planned to do things on specific days. The reading of the bones, herbs and how to treat different illnesses</i>
Respondent H	<i>We were mainly shown the basics and the rest you have to teach yourself, as a healer your ancestors leads the way. Every healer is</i>

	<i>different and the spirits that command you are the ones that should show you everything. I used to tell my master about my dreams and she told me those dreams are personal and they are meant for me, they are instructions from my ancestors.</i>
Respondent I	<i>What's most important is reading of the bones, and as mentors we teach that thoroughly.</i>

The investigator observed that learning and understanding how to read the bones (*see Figure 4.12*) is a very important part of every trainee's journey in becoming a healer. Every trainee had their own bones to use every evening when they practice. They mostly tested them amongst themselves. Sometimes the master would allow them to use their bones to help with patients before she can use her own. The bones can be regarded as the stethoscope of the traditional healing world. They are used to identify problems as well as to suggest which herbs can be administered to tackle the problem.



Figure 4.12: Trainees learning about the bones from the master (Photographer: Researcher).

Herbs are very important and form the core of traditional healing. Over the years different scholars especially in the chemistry department have laboratory tested different herbs and proven to contain different elements that heal different illnesses. A popular example in this regard being the development of the aspirin which from its origin was known to be a herbal folk medicine (Aspirin foundation 2007). Herbs are mostly taken from tree barks, roots, leaves, and even fruits. The collecting of herbs by the trainees was mostly done at the back end of their training. They visited different areas collecting specific herbs which were dried and grinded before being poured in to different containers for storage (see Figure 4.13 & Figure 4.14).



Figure 4.13: Trainees learning about different herbs (Photographer: Researcher).



Figure 4.14: Herbs dried in the sun (Photographer: Researcher).

The investigator wanted to find out how involved were that participants during their training years in the healing of patients. This was aimed at finding out how much practical work they were doing to see if participants were allowed to practically learn from the masters and if they were allowed to imitate what their masters did. The following responses were recorded (see Table 4.11):

Table 4.11: Involvement of participants in the healing of patients during training

Participant	Response
Respondent A	<i>Masters indicated that they participate in every healing process.</i>
Respondent B	<i>My mentor always gave me an opportunity to read the bones to patients before she did. I was also involved with dealing with returning patients, monitoring their progress and preparing herbs for them as shown by my mentor.</i>
Respondent C	<i>When we had patients my mentor invited me to see how the bones were read.</i>
Respondent D	<i>Every time there was a patient my mentor</i>

	<i>would call me in and ask me to use my bones to see what the problem was before she herself used hers and it was something that happened everyday by the time I was done with my training, I was very confident when it comes to the reading of the bones</i>
Respondent E	<i>We were about four students at the time I was training and it was our duty to share the responsibility of healing patients, two may read the bones with the master as the other two observe and the other two maybe requested to help prepare the herbs.</i>
Respondent F	<i>I took too long at my masters place for my training because I did not have money to pay for my fees so I ended up doing everything, I was teaching new students bones, different herbs, my master would send me to show them many things. When patients were many I would help others when my master dealt with others. For that reason I was a complete healer when I went home because there was nothing I didn't know.</i>

The investigator observed a number of times where the trainees were part of the healing process. Every time there was a client the trainees would be the ones who welcomes the client, prepares the consultation room and informs the master of the presence of clients. The investigator could not witness the actual reading of bones with the actual client and which herbs were administered because the master indicated that what she discusses with her clients is private and confidential. She however indicated that the trainees are very much involved and are always encouraged to observe how things are done. She also indicated that what once they know how she does things they will be able to start when they get home because they will get guidance from their ancestors.

4.3.3 Knowledge transfer among healers

Knowledge transfer in this study is defined as the process by which knowledge is transmitted to, and absorbed by the user (Garavelli, Gorgoglione and Scozzi 2002:270). As explained in

the background to this study, traditional healers are commonly known to possess tacit knowledge which is not documented. Having said that, the review of literature suggests that, tacit knowledge may be transferred through observations, imitation and practice. It was observed that the transfer of the tacit knowledge can be done through practice, through observing and emulating a particular action, or through learning the craft by observing the mentor then imitating and practicing until the knowledge is perfectly acquired (Szulanski, Ringov, and Jensen 2016). This is because observation allows engagement between the mentor and the mentee on issues that are not clear.

When it comes to knowledge transfer with regards to traditional healers at a government level in South Africa, the Traditional Healers' Act of 2007(Section 5 (e) to (f)) indicate that the THPC should:

- promote and develop interest in traditional health practice by encouraging research, education and training;
- promote contact between the various fields of training within traditional health practice in the Republic and to set standards for such training;
- compile and maintain a professional code of conduct for traditional health practice; and
- ensure that traditional health practice complies with universally accepted health care norms and values.

Therefore, during interviews the investigator asked the participants to share their experiences on how knowledge transfer generally occurs among indigenous healers in the Limpopo Province. The following responses were given (see Table 4.12):

Table 4.12: How knowledge transfer generally occurs among indigenous healers in the Limpopo Province

Participant	Response
Respondent A	<i>For me it all comes down to respect. Trainees must respect their master and follow all the instructions they are given at all times for them to get this knowledge.</i>
Respondent B	<i>I repeat the same actions many times for my students to clearly master what I show them, when it comes to herbs I can show them the same herb and its uses up to five times.</i>
Respondent C	<i>Trainees who are slow will require that you show them the same thing many times.</i>

Respondent D	<i>There are different kinds of healers; there are those who have the power to heal, those who have the power to train others, and that group that shines when it comes to dancing during celebrations. I am now an old man I do not do training because it is very demanding; you have to be hands on and show your students everything they need to know practically, that requires time and effort.</i>
Respondent E	<i>Students get most of what they know from their ancestors who gave them the power to heal. Those who depend only on the herbs that were shown to them during training will never grow. Students must become independent and use their maximum powers to heal the people. Traditional healing is a different and unique practice; every healer must have his or her own special herbs as shown by his or her ancestors.</i>
Respondent F	<i>When it comes to learning about herbs, we go to the wild, and are shown different trees and told to collect leaves in others, roots in some and the barks in others. After collecting all the herbs and after all the grinding is done we will spend the next few months learning what each herb does which ones to mix for some particular illnesses. From that moment, you can classify your herbs according to categories that will work for you.</i>

Senior and more experienced healers were asked how they transferred the skills and experiences they had to their trainees. This was aimed at understanding how tacit knowledge was externalised by those with knowledge and expertise. The following answers were recorded (see Table 4.13):

Table 4.13: How experienced healers transferred their skills and experiences to their trainees

Participant	Response
Respondent A	<i>This is like in a normal school; if you don't listen you will never know anything. Your attitude will determine how much you end up knowing</i>
Respondent B	<i>It mostly depends on the student and how dedicated they are. But with me we learn how to read the bones every day and involve my trainees in everything I do. I show my trainees how different herbs are prepared and for what purpose, then when there are patients I just tell them to prepare a particular herb. I also teach them how to deal with patients and how to respect their craft.</i>
Respondent C	<i>Some trainees are lazy and others show little interest, but those who are willing to learn will forever ask questions and take interest in what I do. In this job you need to look and learn, everything is practical; I show them everything and make sure they are involved.</i>
Respondent D	<i>We can all have the same herbs but use them differently because your ancestors will guide you on how and what to add to a particular herb to address certain issues. How I do things is just a guideline and trainees will have to adopt their own way of doing things as they continue in this journey.</i>
Respondent E	<i>As masters I only show them what I know from there it will all be up to their ancestors to come through for them, that is why as a healer you may have students who are more powerful than you because of their ancestors. What their ancestors tell and show them I don't have the capacity to know or control.</i>

The investigator observed that the master as the knowledge tank was always the one giving instructions, guidance and leading the way during knowledge sharing and transfer. In addition to that, former students who graduated before the two trainees constantly visited the master especially when there are events where a number of duties have to be performed. During those visits they spent a lot of time with the trainees sharing experiences, what they enjoyed and what they found hard to do. During those meetings a lot was shared between the experienced healers and the trainees. The other form of knowledge transfer which was occurring was between the inexperienced healers and the experienced healers who have been in the business for many years. During those events, the experienced healers will be working closely with the inexperienced healers showing them how certain functions are performed so that they can be able to do them independently when they start training their own students.

The investigator then asked the participants to explain the type of relationship they have with other healers, to try and determine if there is some level of working together which may promote knowledge sharing. The following were the responses given (see *Table 4.14*):

Table 4.14: knowledge sharing among healers

Participant	Response
Respondent A	<i>Working with other healers is very important.</i>
Respondent B	<i>If I come across a patient with the sickness I don't know I always consult people I work with to discuss the patient and also advice each other on which herbs to try</i>
Respondent C	<i>We share information on herbs and healing related matters.</i>
Respondent D	<i>When I get a client which I feel I don't understand the type of illness I always consults with other healers mostly seniors in our network. I also refer clients that I am struggling to help to other healers who might have dealt with the illness before.</i>
Respondent E	<i>Healers work together all the time, if I have a client and urgently need a herb that I do not have, i will simply call someone nearby to bring me the herb and help the patients because as traditional healers we don't send</i>

	<i>patients away.</i>
Respondent F	<i>There are specific herbs that you can only find in other parts of the world, we work together with healers from as far as Zimbabwe and Mozambique because they have herbs we don't have and we also have herbs that only grow in our area and we always share.</i>
Respondent G	<i>We always meet as healers at the chief's palace to discuss and share matters of traditional healing and to share some knowledge</i>
Respondent H	<i>Healers use different names to sometimes call the same herb, so when I come across a name I don't know I call people in my network to figure out the name which is common to me for that particular herb.</i>
Respondent I	<i>When one of the healers I work with comes across a bit of information in relation to what we do, we sit down and share the information to improve on what we already do.</i>

Participants were then asked to share the type of methodologies they employed to transfer knowledge and the following was what they had to say:

- *Trainees are mostly advised to observe what the experienced are doing and learn from them.*
- *We mostly tell our trainees what to do and make sure they repeat until they can do things on their own.*
- *I tell my students what to do and observe as they do to see how well they do.*
- *My master just showed me the way but I am the one who walks it through the help of the spirits, they tell me everything I need to do.*

The investigator also wanted to know how common was knowledge sharing among healers because knowledge sharing goes hand in glove with knowledge transfer. The following responses were recorded (see Table 4.15):

Table 4.15: How common is knowledge sharing among healers

Participant	Response
Respondent A	<i>Healers share information all the time.</i>
Respondent B	<i>When I come across an herb in a different area which is used for something I always come back to share with those I work closely with especially my trainees and those who were graduated by me.</i>
Respondent C	<i>You can never learn everything at the same time; some of these things come with experience and from working with other healers.</i>
Respondent D	<i>Your leaning never ends; there is always something to learn from others. As a result knowledge sharing is very common.</i>
Respondent E	<i>Healers always share information and ideas about different illnesses and how they handled them but there are healers who are secretive who don't want to show others what they using but mostly they are the ones who are left behind because as a healer there is no way you can know all herbs. As healers as we are together in the wild when one share what a particular herb is used for, the next will mention uses of another herb we come across and by the end of the day we would have discussed a lot of herbs and some of which you never knew.</i>
Respondent F	<i>Working with others is very good and will always be to your advantage because you will know of many things you didn't know, but those who are secretive are likely to know fewer herbs.</i>
Respondent G	<i>If you are not collaborating with others you may walk past different herbs not knowing what they are used for because you might</i>

	<i>never have heard about them before.</i>
Respondent H	<i>We sometimes have a traditional healer's conference organised by our leaders and in that conference we share a lot of information. At the conference there are always herbalists from faraway places selling different types of herbs. They mostly explain what each herb is and what each herb is used for which adds on the knowledge we have.</i>
Respondent I	<i>Some senior healers are just jealous especially of us young healers and never share anything with us, I mostly rely on my ancestors for guidance.</i>
Respondent J	<i>Knowledge sharing is very common but we mainly get our knowledge from the ancestors through dreams.</i>
Respondent K	<i>Knowledge sharing is very common among healers but we mostly share what is common and what is out there, if my ancestors were to come to me and instruct me what to do for a particular patient, that will never be shared with anyone because it is a special message for a particular patient. I may maybe inform my mentor and ask for guidance but only when necessary.</i>
Respondent L	<i>We work together with other healers; this is a joint venture in as much as we all have our personal things we mostly work together as Africans we invite each other when we have events like graduating of students, during those events we share a lot of information.</i>
Respondent M	<i>I share with people I work with everything I know, I don't mind telling them which herbs I use to treat particular illnesses because in this craft it all comes down to how you use the information and what your spirits are</i>

	<i>doing for you.</i>
Respondent N	<i>I show my students all the herbs I use and the ones I have used before, they also get help from the spirits it's up to them to take it to forward.</i>

The investigator wanted to find out which methods were used by senior and experienced healers to share their experiences to the new healers and the following responses materialized (see Table 4.16):

Table 4.16 Methods used by experienced healers to share their experiences

Participant	Response
Respondent A	<i>We share the same way we got the information from those who trained us.</i>
Respondent B	<i>I show them herbs then send them to another area to find the same herbs on their own.</i>
Respondent C	<i>They should do everything on their own, I just give guidance</i>
Respondent D	<i>My ancestors were mostly guiding me on things to which may come in a form of a dream, I will tell my dreams to my mentor and she will give me interpretations telling me what it means and what I should do. My students get guidance from their ancestors; my job is to help them carry out those duties</i>
Respondent E	<i>I was told to do things in a particular way and will look at how my mentor did things and try to imitate what he did. The same principle works for my students and I won't change that I will stick to it</i>
Respondent F	<i>The ancestors decide when and what you should know, they mostly give directions through dreams.</i>
Respondent G	<i>There are different levels during training, there first step is the calling of the ancestors where you take herbs and keep others under your pillow when you sleep, As soon as the</i>

	<p><i>ancestors shows their presence, you will start having dreams where you are shown different herbs, when you now ready to heal people the ancestors will show you which herbs to mix to heal a particular illness</i></p>
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4.3.4 Knowledge preservation among healers

Preservation in this study was defined as a concept used to explain a situation where one keeps something safe or protects something from harm (Dictionanry.com 2017). When we speak of preservation in this regard we will be looking at how traditional healers preserve their knowledge. It is common knowledge that traditional healers mainly use herbs to cure different illnesses and these herbs are mostly kept in huts that are cooler inside designed to keep them for longer (*see Figure 4.15*).



Figure 4.15: A hut where traditional herbs are kept (Photographer: Researcher).

To be able to use those herbs the healers have a way of knowing which herbs to use at the time. Most healers indicated that they are guided by the spirits when it comes to that function. It was observed that the trainees were using a different method. After being shown which herbs to use, they each had a note book where they wrote different herbs and their function. One of the healers was taking this exercise a step further by taking her mobile phone with when they collect herbs and taking picture of different trees from which a particular herb is collected. She indicated that once everything is captured she will use her laptop to put everything together. She further said that she plans to do this with all her herbs and the ones that she will acquire throughout her career as a healer. The other thing is that they have labels inside and on top of containers where grinded herbs are kept (*see Figure 4.16*)



Figure 4.16: Herbs inside containers with labels (Photographer: Researcher).

During interviews the investigator asked participants to share their insight on how they preserve the knowledge they gained over the years for future use. Firstly, participants were asked how they made sure that the knowledge they gained over the years was preserved and not lost to the future generations. The following were the main responses given (see Table 4.17):

Table 4.17: How healers preserve knowledge for future use

Participant	Response
Respondent A	<i>I will take someone under my wing, show him or her all the herbs I have and make sure that my knowledge is carried over to the next generations. My grandmother used to take me with her to get different herbs and at times, she will send me to the wild alone to get a particular herb, I eventually knew most of the herbs I am using today from that training</i>
Respondent B	<i>I have a young boy who already knows most of the things I do. He knows more herbs than most of the trainees you see here. I always take him with when I go to get some herbs</i>
Respondent C	<i>I will select one person I can train who will take over my job as time goes on but currently there is no one I am training because I just finished with my training about a year ago</i>
Respondent D	<i>I am forever in consultation with other healers and make sure that I use my things regularly so that I do not forget what my practice is all about.</i>
Respondent E	<i>The spirits will decide who should take over my job, currently there is no one I am teaching but the spirits will guide me on that one.</i>
Respondent F	<i>I am currently showing my daughter different herbs so that she can continue with the job. She sometimes helps people when I am not</i>

	<i>around because she has the knowledge of different herbs.</i>
Respondent G	<i>I am now 87 years and already I am teaching my child so that he does not find it difficult when I am gone. The western practices are on a mission to destroy our knowledge and cultures and you as young people who are educated do not take us serious you follow whites and cancel our things saying they are not working. When we tell people about our ancestors, they do not take us serious</i>
Respondent H	<i>It is a difficult one because the ancestors decides who should take over their job when I am gone, there is always someone who may show interest in what we do but teaching them does not guarantee the powers will be given to them. I have a son who knows a lot about my herbs but it does not mean he will take over from me, if indeed the ancestors choose him he also will get those dreams with instructions and that in it make my herbs useless to him.</i>

Participants were further asked what were the methodologies employed by traditional healers to preserve their knowledge. The following responses were given (*see Table 4.18*):

Table 4.18: Methodologies employed to preserve knowledge

Participant	Response
Respondent A	<i>Ancestors are guardians and protectors of this knowledge; they pass it to the deserving people. One will be selected to take over my job when I pass on.</i>
Respondent B	<i>This is a different type of knowledge, I have plenty of bottles where I keep my herbs (<i>see Picture 4.16</i>) but I know all of them by heart because they were shown to me and I remember all my dreams.</i>

Respondent C	<i>Most of the trainees do not have time to stay too many months and learn everything; as a result, my trainees keep record of every herb they come across. I make them write notebooks, which they can refer to when they get home.</i>
Respondent D	<i>I have a book containing the names of all the herbs that I have. I also put a piece of paper containing the herb name inside the container where the grinded herbs are kept (see Figure 4.17 & Figure 4.18). If you do not write the herb name in a book and rely only on the piece of paper inside the container alone what will you do once the herb is finished, you need to have a serious document where you keep all herbs.</i>
Respondent E	<i>When we train our students we do not stop the day they graduate, we develop a lifelong relationship, we form a network, I am their mother they are my children and I work with them all time.</i>
Respondent F	<i>Medicines in containers are heavier than others even though containers are the same so from there you easily know which herb is in which container</i>
Respondent G	<i>We write the herb name and put it inside the container so it gets easy next time we want to use the herb</i>
Respondent H	<i>Herbs look and smell different from that you can be able to separate herbs.</i>
Respondent I	<i>All the herbs in my possession are edible and I can be able to taste or smell or even differentiate them by their colours</i>



Figure 4.17: Containers prepared for grinded herbs (Photographer: Researcher).



Figure 4.18: Grinded herbs inside containers with notes (Photographer: Researcher).

4.3.5 The acquisition, transfer and preservation of knowledge of traditional healing

In trying to understand how knowledge of traditional healing is acquired, transferred and preserved, the SECI modes of interaction which discusses the conversion of one form of knowledge to the other was employed. As explained in the preceding sections, the framework identifies socialization, internalization, externalization and combination (SECI) as the four modes of interaction that enable knowledge management. In the first instance, the investigator wanted to find out how it all started, how healers became aware they have the gift of traditional healing. The following were the main responses recorded (see Table 4.19):

Table 4.19: How healers became aware they have a calling

Participant	Response
Respondent A	<i>It is a duty I was given by the ancestors so it is my duty to help people.</i>
Respondent B	<i>I started doing this job at an early age and it is all I know.</i>
Respondent C	<i>As a healer I was chosen by the ancestors</i>

	<i>and I help people, if you are chosen you have no choice but to follow orders, I am a messenger, I work for my ancestors , they take care of me and my family and make sure we have everything. Helping people and saving people’s lives is all I have been doing all this years.</i>
Respondent D	<i>I was sick and consulted a healer to determine what was wrong with me and after the reading of the bones I was told that I had a calling. The sickness was the way my ancestors were trying to get my attention.</i>
Respondent E	<i>My mother was a healer; she was a very famous healer in our region. When I was a young boy, she taught me many things that have to do with traditional healing. A few years after her death I discovered I have a calling and she wants me to take over her job. This was after I had fallen sick and went to consult to check what was wrong with me.</i>
Respondent F	<i>My journey started when would have dreams that disturbed me every night. In those dreams I would see different types of herbs. I was not taking them seriously until I developed a very serious problem with my womb. It was so painful l I couldn’t walk straight. I was in and out of the hospitals to a point where my doctor recommended an operation to get it removed. My mother decided before the operation that we should try a traditional healer to see if we can’t get another option. The healer told me I had a calling and the one thing I will deal with the most as a healer is the womb. I was a church going person and refused to hear that and returned home. A few months later my mother</i>

	<p><i>who was also a healer passed on as my illness got worse. I was defeated, I decided to accept my calling as I was very weak, a week after starting with my training things got better, I could walk and I never had a problem with the womb ever again.</i></p>
<p>Respondent G</p>	<p><i>I started by getting sick, I was sick for a very long time, and my grandmother told me she knew what my problem was because it started when I was very young. She told me I always had cloths used by traditional healers as a young boy. These cloths were always kept under my pillow when I slept at night by then I was young and didn't understand a thing. When I was 15 years I started getting strange dreams which did not make sense. I got older and started working in mines where I lasted a few years, then I moved to Johannesburg trying to find a job but every job I found I lasted only a few months. My dreams got worse and I would hear voices telling me to come back home to face my responsibilities. I came home but refused to train as a healer and I got really sick. One day my brother found me very weak and took me to the healer, the healer told me eventually the ancestors will take me because of my stubbornness. My brother then arranged that I be trained because I did not have money at all he covered money for the training</i></p>
<p>Respondent H</p>	<p><i>Before I became a healer I was always in trouble, was always fighting with people, and always having issues at work. I one day had a dream where I saw my aunt who passed on many years ago sitting on our shrine crying asking me for help. She was telling me if I</i></p>

	<p><i>help her she will help me overcome my troubles. I didn't understand what it meant at the time. I told my mom who is a healer the dream that was bothering me so much. She told me my aunt was a healer and maybe she wanted me to take over her job because her things were still there and no one was using them. I then consulted another healer who didn't know me because I didn't see myself as a healer and I got the same explanation as the one I got from my mother. I was still not convinced and one day I met a stranger, a man I have never seen before and he told me that I have a calling and all my misfortunes will never go until I do what I see in my dreams. This thing got me worried that even strangers can see things in me. After speaking to my mother for days I eventually decided to accept my calling. I did not have money at the time and I decided I will let my mother train me.</i></p>
<p>Respondent I</p>	<p><i>There was a time I would dream of an old man and a woman who were showing me cloths, and telling me I should put these cloths under my pillow. I took it easy, and one day the old man and woman told me their names in my dream and when I woke up I found my curtains open even though I remembered very well they were closed when I went to bed. The opening of curtains happened a few times, and one day I fell at work and as I was dizzy I saw that old man, he asked me why I was there because he told me where to go. I recovered and told myself it must have been because of that bad fall. I then had a dream where I was shown bones</i></p>

	<p><i>in the wild. And one day as I was collecting firewood I picked up a number of bones and I remembered my dream. I took them home and kept them. Things turned for the worse, I started getting sick, struggled with my love life, broke up with my partner and I decided to consult a healer to hear what was the cause. The healer told me they will try to heal my illness but I have a calling and my misfortunes won't stop. I consulted another healer and I got the same answer, I then decided to undergo training.</i></p>
<p>Respondent J</p>	<p><i>I started by having dreams, seeing herbs and later I got sick but never got training, I then started helping people even without training. I was very young when I dreamed of some herbs to give to my sister's child who was very sick and my sister was very much against me giving her child some herbs. The child made a full recovery even though my sister was against it. That is how it all started because I started helping a few more people and word started to spread in our village that I can help people. I was not trained by anyone and all this came naturally</i></p>
<p>Respondent K</p>	<p><i>I started by having dreams and I was told by my great grandmother that I had a calling. I was working at the time and decided to join one of the local churches hoping to get rid of this dreams. Dreams never stopped and I changed churches. One day I decided to get baptised in my new church but the night before the day of my baptism, I had a dream. In this dream I saw myself being attacked by crocodiles in the same stream where my church was doing the baptising of its</i></p>

	<p><i>members. The next day I was too I was too afraid to even go near the stream. The dreams continued but I told myself I will never do it. I then lost my job in a very strange way, I consulted to find out what really happened and I was told that my ancestors were the cost and I decided its time I gave in</i></p>
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When it comes to the trainees who were observed, it was discovered that each trainee had their own version when it comes to how their calling was shown to them and they all arrived at their master’s place under different circumstances. Trainee A, came in very sick, she could not walk. She was told she had a calling by another healer a few months earlier but decided to ignore the message. She went back home and decided to seek second opinion. Things got really worse for her to the point where she was admitted to the hospital and still could not get any better. She indicated that she was carried to her master’s place by her husband. She spent two weeks taking herbs through the steam room (*see Figure 4.19*), and regaining her strength. At that moment she decided she is going to accept her fate and start training as a healer.



Figure 4.19: A self-made steam room covered with blankets used to administer some herbs for the sick student. (Photographer: Researcher).

Trainee B had a different start to the journey of being a healer. She was bothered by dreams which she says was from someone from her father's side. Her spirits were already visiting her and showing her things before she even thought of training. She had a great grandmother who was a healer whose herbs were left unused for many years because there was no one who was given the mandate to take over.

The hut in which all that belonged to the great grandmother was left undisturbed for many years. She indicated that she always had dreams where her great grandmother was telling her to take care of her things. She ignored the message because she was kind of scared and not brave enough to go through with it. The problem got serious when she started collapsing every time she would go where there is a gathering called *manchomane* or *malopo* (traditional dance for Tsonga's and Pedi's, see Figure 4.20).

When we look at what the government say with regards to who should be regarded as a qualified healer, the Traditional Healers' Act of 2007 states that "*the Minister may, on the recommendation of the Council, prescribe the minimum qualifications to be obtained by virtue of examinations conducted by an accredited institution, educational authority or other examining authority in the Republic.*"



Figure 4.20: Manchomane gathering (Photographer: Researcher).

4.3.5.1 Training of traditional healers

The most important step in the process of becoming a healer is the actual training itself. Some scholars highlighted that training usually happens under difficult conditions in order to prepare the healer for the tough job ahead (Mokgobi 2014, Sodi et al 2011). Bojuwoye (2005) is of the view that training other healers is a specialty in addition to the knowledge of healing and dealing with herbs. That means that training of traditional healers is commonly done by much experienced healers who have the knowledge and skills to train others. To that effect, the investigator wanted to establish the criteria used by participants to select their mentors. The following were the main answers recorded:

- *I had dreams where I saw where I should go for training. I dreamt of a place I have never been to before.*

- *Your ancestors will show you who is supposed to train you. You will even see the place in your dreams. Once you get to that place you will feel it in your legs.*
- *My mother and my father were healers which they got from my grandparents and down to me.*
- *I was shown my mentor in my dreams; she was asking me when I was coming.*

According to the Traditional Healers’ Act of 2007, some of the core functions of the Traditional Health Practitioners Council with regards to the training of traditional healers include:

- *to approve minimum requirements pertaining to the education and training of traditional health practitioners in consultation with relevant departments, quality assessment bodies or a body of traditional health practitioners accredited by the council for this specific purpose.*
- *determining policy, and in accordance with policy determinations, make decisions regarding matters relating to the educational framework, fees, funding, registration procedure, code for professional conduct and ethics, disciplinary procedure and scope of traditional health practice, and*
- *control and exercise authority in respect of all matters concerning the training of persons in traditional health practice and the conduct of its members.*

The participants were further asked how long it took to complete the training. This was aimed at finding out the average time it took to complete training in order to determine if healers complete their training with all the necessary knowledge required. The following responses were recorded (*see Table 4.20*):

Table 4.20: How long it took to complete the training

Participant	Response
Respondent A	<i>It doesn't take long, it depend on whether you have money and how fast you can learn.</i>
Respondent B	<i>It takes from a few months to over a year</i>
Respondent C	<i>There is no specific time frame</i>
Respondent D	<i>It depends on the type of students you get. Some are slow and require you to spend too much time showing them while others are very fast learners</i>
Respondent E	<i>Training as a healer is not easy, it depend on a number of issues, Some people requires healing first and such instances we will have</i>

	<i>to heal the person before we start with the training, which involves calling of the ancestors, learning about different herbs and learning how to read the bones. Some trainees come ready; they can already communicate with their ancestors. Such students constantly get dreams on which herbs to collect for different illnesses. With such students training doesn't take too long</i>
Respondent F	<i>Considering everything that needs to be done, you can never take less than a year to complete the training. Many people rush the training maybe because they are working or they left children alone at home, in that case they will keep coming back to learn things from home</i>
Respondent G	<i>Many trainees rush training as soon as they feel healed they forget about learning how to heal people and all they want is to go back home.</i>
Respondent H	<i>I trained for almost two years; my planning was to go for just six months. When I was preparing myself to go home I got a dream and the person in my dream told me my training was far from over and he will tell me when it's time to go home. Indeed I continued my training until I had another dream almost a year and a half later telling me it's time to go home.</i>
Respondent I	<i>It took me about 6 months to do the whole training</i>
Respondent J	<i>It took me five months to complete my training</i>
Respondent K	<i>I took just over a year to complete my training.</i>
Respondent L	<i>I took one year training as a spiritual healer learning how to understand the spirits, since</i>

	<i>then I am being guided by the spirits on what to do.</i>
Respondent M	<i>I took only three months to complete my training because most of the things I know I got guidance from my ancestors after I had completed training.</i>
Respondent N	<i>You can't end training before you can read bones. Before you can prescribe medicines you need to read the bones so that they can guide you on which medicines to use.</i>

4.3.5.2 Knowledge acquisition and transfer

Knowledge acquisition and transfer happens when the experienced person transfers tacit knowledge to the least experienced individual who in turn will be acquiring the knowledge. The review of literature suggest that during this exercise, the senior healer plays the role of the mentor by prescribing various exercises to prepare the trainee until such time that the trainee is ready to be able to work on their own (Bojuwoye 2005). The participants were asked how masters transfer their knowledge and then he asked healers with little experience how they obtained their knowledge. This was aimed at understanding knowledge acquisition and transfer among healers. The following were the main answers recorded:

Table 4.21: How knowledge transfer happens

Participant	Response
Respondent A	<i>I was taught about herbs from an early age by my grandmother long before I became a healer</i>
Respondent B	<i>My trainees get knowledge from me and I got my knowledge from my master, they will also teach their trainees the same way.</i>
Respondent C	<i>I always went with my mentor everywhere and checking how things were done. When they collect roots of a particular tree I do the same and ask what it is used for. Despite being told what those herbs are used for, my ancestors will further give me guidance on what else I can add to that herb to treat a</i>

	<i>particular illness.</i>
Respondent D	<i>Most of the things I know came to me in my dreams through my ancestors, Even though I was shown a number of things by my mentor, my ancestors were the ones guiding me showing me the way when I get side tracked</i>
Respondent E	<i>The main contributor to the knowledge that every healer have is the ancestors themselves, anyone can learn different types of herbs and their benefits but what sets us apart is the spirits.</i>
Respondent F	<i>There are too many people with spirits but not everyone is a healer, if your spirits have no power to heal you will not help people, they are just there but with no healing powers</i>

Again, senior healers were asked to explain how they made sure trainees captured everything while newly qualified healers were asked whether they mastered everything during training. This was aimed at finding out how masters and newly qualified healers made sure that everything intended to be shared is captured. The following answers were given (see Table 4.22):

Table 4.22: How competent were healers after training

Participant	Response
Respondent A	<i>As a master I make sure they know everything more especially the bones.</i>
Respondent B	<i>I was taught a lot and I believe there is still a lot to learn.</i>
Respondent C	<i>I mastered everything I was taught in the 6 months that I attended training; there is a lot still to learn because this journey is quiet long.</i>
Respondent D	<i>I could not grasp everything and had to keep going back at times because my time was divided between healing and work. I still go back to learn about herbs that I did not have</i>

	<i>a chance to see during my training. As a healer learning never ends.</i>
Respondent E	<i>I was only shown the way and most of the things I got to do on my own because I get instructions from the spirits.</i>
Respondent F	<i>The person who trains you as a healer is only supposed to help you get in touch with your ancestors, pave the way between you and the ancestors from there you will get all the guidance from them.</i>
Respondent G	<i>Training never finishes, even when you done training you always come back to learn new things and things that you might not have learned when you undergoing training.</i>

It was observed that trainees completed their training by undergoing an examination which happened over two days where most of the family members and relatives of both trainees were present. Traditional beer made from sorghum was prepared to appease the ancestors. The master indicated that every African ritual is supposed to have traditional beer (*see Figure 4.21*) used to inform the ancestors of what is going on so they can bless the event. Goats were also slaughtered for the ancestors but only the blood was required to appease the ancestors while the meat was prepared for people to eat.



Figure 4.21: Traditional beer (Photographer: Researcher).

The first part of the examination involved slaughtering of goats and smearing of the blood over the trainees. The master indicated that the smearing of the blood is for sealing the bond between the trainees and their ancestors. From the slaughtered goats, the gall bladder was taken and used as one of the objects hidden from the trainees. The whole exercise was done in full view of the family members and the community. The trainees ran around finding all objects that were hidden from them and bringing them back to the master one after the other. The master said that, that exercise is necessary to prove that the trainees have mastered the ability to summon the spirits to help them in doing things that are beyond this physical world. After all the objects were found, trainees were given the ropes (*see Figure 4.22*) that proved that they passed the test.



Figure 4.22: Trainees earning their ropes after the first test (Photographer: Researcher).

The second part of the examination happened by the river. The master went into the river and performed some rituals which she said was to seek permission from the river spirits to use that section of the river for cleansing and introducing the trainees to the river spirits (*see Figure 4.23*). Both trainees went into the water with their master and one of her senior students to perform some rituals. Two chickens were slaughtered and thrown in to the river and other two chickens were slaughtered and roasted by the river. After the ritual trainees were covered with white sheets and were now wearing a headgear made of beads (*see Figure 4.24*) signifying their status as trained healers. Pap was cooked by the river together with the roasted chickens formed a meal to share for all who were present at the river. After the meal it was time to go home and upon arrival the new healers were welcomed by those who remained

with songs dance and ululating. The master then presented the trainees to their families (*see Figure 4.25*) who joined in the celebrations.



Figure 4.23: Trainees about to be introduced to the river spirits (Photographer: Researcher).



Figure 4.24: Trainees after being introduced to the river spirits (Photographer: Researcher).



Figure 4.25: Trainees returning home from the river (Photographer: Researcher).

4.3.5.3 Knowledge preservation

The next important step in the management of knowledge of traditional healing is the preservation phase. According to the knowledge organisation theory, preservation happens when knowledge gained over the years through practice and learning is internalised for future use. As explained in the preceding sections, each and every healer preserves their knowledge different mainly through oral tradition. The review of literature suggest that traditional healers believe that the knowledge of traditional healers is preserved by the ancestors and that it is up to the ancestors to give such knowledge to whoever they choose (Sodi et al 2011). The investigator felt that when it comes to knowledge and information, quality control is very important. Participants were asked to give an insight on how they ensured that the correct knowledge is preserved. The following were the responses recorded (*see Table 4.23*):

Table 4.23: How healers ensured that the correct knowledge is preserved

Participant	Response
Respondent A	<i>My relationship with my trainees doesn't stop after graduation, we continue working closely and that assures me that they are doing the right thing in serving the people.</i>
Respondent B	<i>When my students have many patients I always go and help and this allows me a chance to see how they do things.</i>
Respondent C	<i>When someone just finished training, they are still inexperienced and there are serious illnesses that may scare them which they never came across, but through the years of experience I might have dealt with such before and will go out there to help.</i>
Respondent D	<i>The best way to make sure students know the correct herbs is to show them the tree from which a particular herb is obtained. We take them to the wild and show them different herbs as we explain to them what those particular herbs are used for. For those trees that do not grow in our area, we buy herbs from the herbalists but as we travel to different places from time to time while</i>

	<i>treating patients, we show them the trees.</i>
Respondent E	<i>Before a trainees goes home they are requested to bring those boxes containing all the herbs that they gathered and they supposed to tell what they are and what they are used for so that we can establish which ones they might have forgotten.</i>
Respondent F	<i>Once someone performs duties on their own and starts having a healthy client base we know that our job is done, the most important thing is the fact that the ancestors will be providing guidance in the whole journey.</i>

4.4 Summary

This chapter presented data collected via interviews, observations and document analysis. Data on knowledge acquisition, transfer and preservation by traditional healers in the Limpopo Province of South Africa was presented. The results were obtained from healers in all regions of the Limpopo Province. In reporting results from interviews, observations as well as document reviews, the main objectives of the study were used as the main themes. Data obtained from the interview recordings and field notes were put together and grouped according to the main themes of the study. The actual words of interview participants were used to express ideas as they were said. Data obtained through analysis of government policy documents, healer's notebooks, certificates was mainly presented under the status of traditional healing in the Limpopo province. A summary of the key issues raised by this chapter are as follows:

4.4.1 The status of traditional healing in the Limpopo province

- Traditional healing is still being over looked in South Africa.
- Traditional healers are getting less support from the government.
- It is easy to practice as a traditional healer even without the necessary training.
- Healers depend on associations which are not recognised by government to lead them.
- Majority of traditional healers also subscribe to other religions even though their own religion is not accepted by other religions.

- Healers are willing to work with western doctors even though they feel less respected by them.

4.4.2 Knowledge acquisition

- Majority of traditional healers come from a family of healers.
- Their training started by having terrible sicknesses, misfortunes or dreams.
- Their ancestors guided them on who to turn to for training.
- Training can take from three months to over 2 years to complete.
- During training students spend most of the time learning about reading of bones, different herbs as well as practically being involved in the healing process.
- Majority of the participants indicated that training was done through mentorship and knowledge obtained orally through observations and directly learning from their masters.
- Healers were also in agreement that the knowledge they possess was acquired from their ancestors.

4.4.3 Knowledge transfer

- Knowledge transfer is mainly practical and done through repeated actions
- Trainees are shown things until they mastered them depending on their pace.
- Ancestors are the ones who transfer knowledge to the healers.
- Healers in the same network share knowledge regularly during meetings.
- Working together is very important to healers and that's when most of the knowledge transfer occurs.

4.4.4 Knowledge preservation

- Majority of the healers are currently training someone and showing them different things hoping that that person will continue doing what they do but that decision rests with the ancestors.
- Some of the healers have a modern way of preserving their knowledge. This group of healers document their knowledge and organise their herbs in ways that are working for them.

4.4.5 Understanding the management of knowledge of traditional healing

- Knowledge of traditional healing is controlled by the ancestors

- For one to get knowledge of traditional healing from the ancestors they must have a calling
- The master is responsible for training and transferring knowledge to would-be healers
- There is no standard way of preserving knowledge of traditional healing

It is clear from the data above that is a long way to go before knowledge of traditional healers can be clearly understood. The next chapter interprets the data that were presented in this chapter.

CHAPTER FIVE

INTERPRETATION AND DISCUSSION OF FINDINGS

Kgomo e tshwarwa ka dinaka, motho o tshwarwa ka mafoko (This is a Setswana proverb literally translated to: "A bull is caught by its horns and a human being is caught by his words").

5.1 Introduction

The preceding chapter analysed and presented the results of data obtained through interviews, observations and document analysis. This chapter provides the interpretation and discussion of the findings. The interpretation and discussion of the findings is very important because it allows the investigator an opportunity to indicate how the current study reinforces what is already known or how it differs from other similar studies. Neuman (2011:177) is of the view that interpreting data means to assign significant or coherent meaning. According to Kothari (2004), interpretation is highly entangled with data analysis and cannot be separated. Neuman (2011) further indicate that in qualitative studies, interpretation are started from the point of view of the people being investigated in order to find out how they see the world and define situations.

To that effect, the interpretation and discussions of the findings was based on the order in which data was presented in Chapter Four, that is, according to the research objectives, namely:

- The status of indigenous healing in Limpopo Province of South Africa
- Knowledge acquisition by indigenous healers in Limpopo Province of South Africa.
- Knowledge transfer among indigenous healers in Limpopo Province of South Africa.
- Knowledge preservation among indigenous healers in Limpopo Province of South Africa.
- The acquisition, transfer and preservation of knowledge by traditional healers in South Africa.

5.2 The status of indigenous healing in the Limpopo Province of South Africa.

The interpretations and discussions of findings concerning the status of traditional healing in the Limpopo Province of South Africa are presented according to the following sub-themes:

- Traditional healing in post-apartheid South Africa;
- Western medicine versus traditional healing;

- Regulation of traditional healing in the Limpopo Province;
- Challenges faces by traditional healers; and
- Possible solutions to challenges faced by traditional healers in Limpopo.

5.2.1 Traditional healing in post-apartheid South Africa

Denis (2006) predicted that traditional healing as one of the elements to indigenous knowledge systems in South Africa will constitute an important field for scientific research. He further indicated that, traditional African religions will occupy positions more important than ever before in public life. Contrary to the predictions by Dennis (2006) this study reveals that healers are still side-lined. They feel that they are not getting any support from the government and that they work on their own. For example, healers mentioned that they cannot provide their clients with sick notes accepted by employers in the workplace which is something that can be addressed by the government and it was not receiving attention. As a result, potential clients end up not consulting them because they cannot take time from work to consult with them. Healers also feel that the government should create an environment that will enable them to carry out their tasks because they serve their communities and they play a role in the country's health system. They serve their communities and sometimes do so without getting paid.

Traditional healers in South Africa operate in isolation, and they are not getting any support from the government side despite them playing an important role in the national health systems. They are not contributing to the country's economy because they work independently. Their contribution to the economy would be through paying tax and job creation. Collecting and preparing herbs for healing would require man power and that industry has the potential to contribute to job creation in the country in that regard

Mathibela, Egan, Du Plessis and Potgieter (2015) believe that the lack of support from the South African government towards traditional healing has negatively influenced the practice of traditional healing as patients first consult government health centres before turning to traditional healers. Mathibela et al (2015) further explain that the practice of traditional healing has been ignored because of its oral history, and it could not be included in the school curricula or government policy documents. Again the stigma attached to traditional healing by the apartheid government laws, as well as the criticism labelled by missionaries such as Congregational, Methodist, Anglican, Lutheran and Catholic towards African beliefs and religion affected and continues to affect how people treat and view the healers (Denis 2006). This was confirmed by some of the participants that they normally get their clients at night

under the cover of darkness when no one can see them because some people are ashamed of visiting healers and they prefer doing this when no one sees them. The situation puts healers at risk because people come in very sick and some end up dying there as a result staining the reputation of traditional healers.

Some of the religious leaders discourage their members from consulting traditional healers indicating that traditional healers are evil and labelling traditional healing as a dirty job done by evil people within the society. The findings however suggest that traditional healing is done by anyone regardless of social status. The stories published about well-known celebrities who answered their ancestral call are enough evidence to this. The personalities discussed are not dirty people, they are not poor, and they live glamorous lives but still deal with herbs and practice as healers.

Despite being taken for granted by other religious beliefs, and being subjected to prejudice from other religions, traditional healers stood the test of time in the Limpopo Province have no problem with other religious beliefs. It was clear from the responses that some traditional healers are church goers as well. They view their job as that similar to those of pastors who heal people using prayer. There are however some churches that do not accommodate traditional healers and expect them to quit their practice before they can be members of their church.

Traditional healers depend on herbs to treat different illnesses. The results suggest that healers are struggling to get access to many places where they can get herbs because such places are fenced off by their owners especially farmers. This forces healers to buy herbs from those who have access to the herbs. This immediately put healers on a back foot because participants indicated that they deal with people who sometimes don't have money, who mostly pay in terms after they were healed. Participants cautioned that the more money they spent on buying herbs the more expensive their services will become. The more difficult it is for the healers the more the communities who depend on these healers for their health will suffer and the country's healthcare system will be more under pressure.

Some traditional healers have a healthy client base which makes it possible for them to sustain their families, while others have a day job and continue helping people after hours and during weekends. Traditional healers are known to the majority of people in South Africa. The practice of traditional healing is constantly discussed on radios and gets coverage from different television stations. People are aware of the fact that traditional healers are there to heal sick people using traditional methods and herbs. The findings suggest that healers hardly advertise their services because people in their areas are aware of what they are capable of.

There was some consensus among respondents that new clients get to know about their services from the people they helped before. They mostly work on referrals and word of mouth. The participants however believe that their ancestors play a major role in making sure that people come to them for healing. Some participants were of the view that their clothing does the marketing for them as it displays their status as healers in the communities which set them aside from the rest of the people. One respondent said that *“our clothing always tells people the type of people we are, we wear beads, and cloths that set us apart from other people and everyone will just know we healers and that’s how people come to us for consultation”*.

It was established that traditional healers view their work as a duty assigned to them by the ancestors. Participants strongly believe that they are carrying a mandate set by their ancestors; they believe that their ancestors are doing the work through them. They are devoted to helping people and some of the participants went as far as saying helping people is all they have been doing all their lives. They indicated that despite them being there to serve the people, they are not trusted and mostly feel helpless to see children who claim to be civilised and not following traditional ways of doing things perish because of illnesses that they can heal.

5.2.2 Western medicine versus traditional healing

Mbatha, Street, Ngcobo and Gqaleni (2012) highlight that in some provinces within South Africa, the health departments have created a position of a traditional medicine manager who plays a role of overseeing collaboration and encourages two-way referrals of patients between government hospitals and traditional healers. In the Limpopo Province, there are some evidence of something being done in different regions between healers and government hospitals. Collaboration is very important in a province like Limpopo because it can be regarded as a rural province considering a number of rural communities where cultural practices such as traditional circumcision are highly practised. Collaboration between the western and the indigenous doctors can take place where western doctors do health checks to the initiates before they are sent to the mountain which will reduce a number of fatalities caused by circumcision. Initiates can only be circumcised in the hospitals in a safe environment where care is taken to reduce infections and the spreading of diseases before they are sent to the mountains to be taught what culture demands of them. However, a number of scholars warned that collaboration between western hospitals and traditional healers will be biased and will always favour the western medicine (Freeman and Motsei 1992; Mngqundanisoa and Peltzerb 2008).

The findings suggest that traditional healers feel that western medicine practitioners undermined their work, some spoke of the bad treatment they got from the nurses when they took patients to clinics. Healers mentioned that patients who are referred to hospitals after consulting healers first, were given a tough time by nurses. These nurses make it clear that they should have consulted the hospital first.

Healers however feel strongly that collaboration between western medicine and traditional medicine is necessary because there are patients who may need help from either side of the camp. The participants indicated that patients who may need to be put on a drip, who may need blood, who may need HIV testing among other illnesses are referred to hospitals, on the contrary, western medicine practitioners never refer patients to them even when they are sitting with illnesses that they do not understand or those that require traditional healing. For example, the results of the study by Bopape, Mothiba and Malema (2013), suggest that illnesses such as *hlogwana*⁶, *themo/lekone*⁷, *makgomas*, *sekgalaka*⁹ and *sephate*¹⁰ are known to be cured by traditional healers in the province. Be that as it may, hospitals never consider sending patients with such illnesses to healers, as a result, healers indicated that collaboration is one sided because they are the ones referring patients while hospitals never do any referrals.

There was some consensus among participants that the well-being of patients is of great importance and that similar to their western counterparts they had the best interest of their patients at heart; however healers felt less respected by the western doctors. They complained that some western doctors call them witches and think that what they do is better than what traditional healers do.

5.2.3 Regulation of traditional healing in the Limpopo Province

According to Tshetlha (2015), the interim Traditional Health Practitioners Council which is responsible for regulating and controlling the traditional health practice was inaugurated in February 2013. In May 2014 the sections of the Traditional Health Practitioners Act that give it full powers came into effect. The purpose of the Traditional Health Practitioners Act, No. of 2007, was to establish the Interim Traditional Health Practitioners Council of South Africa;

⁶ *Anterior fontanelle*

⁷ *retracted neck and red marks at the back of the neck*

⁸ *Some mysterious illnesses within the black communities associated with having sex with someone who did an abortion, someone whose partner died before proper cleansing was performed or attending the funeral of the mistress or lover who was with someone else.*

⁹ *Eczema*

¹⁰ *An illness in children where such children scratch themselves in the nose and fingers and also pulling their fingers*

provide for the registration, training and practices of traditional health practitioners in the Republic; and serve and protect the interests of members of the public who use the services of traditional health practitioners. This Act applies to the traditional health practice in the Republic of South Africa and the traditional health practitioners and students engaged in or learning traditional health practice in the Republic of South Africa (Government Gazette 2008).

According to the Act, no person may practice as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act. Any person who wishes to register as a traditional health practitioner or a student must apply to the registrar. The findings of the study however suggest that the council hasn't done much in carrying out its mandate. The participants were not even aware there is such an act or the existence of such a council that is meant to lead them.

Instead healers were registered by non-statutory bodies. Freeman and Motsei (1992) as well as Kale (1995) gave account of a number of associations to which traditional healers belong as: the Traditional Healers Organisation (THO), the African National Healers Association, Bakgaga BaMaake Dingaka Association, South African Sedibeng Dingaka Association, the Association of Traditional Healers of Southern Africa, the Congress of Traditional Healers of South Africa, the African Dingaka Association, and the African Skilled Herbalists Association.

These associations have their downside because healers were complaining that at times the registration is done without proper verification as to whether the healer received training or not. This was confirmed by a close analysis of the certificate presented in Section 4.3.1 of this study. The certificates only contained signatures of the association leaders and no evidence of where the certificate holder received his or her training. Respondents mentioned that what was needed was for them to deposit money into the bank for them to get their certificates. There was no evidence of an effort being made to confirm where the training was done. The investigator is of the view that, that kind of situation has the potential to open doors for bogus healers who may easily apply and get these certificates.

There are always negative reports in the media about traditional healers and it is impossible to tell whether bogus healers are behind this or not because it is impossible to differentiate between these bogus healers and the legitimate healers who received proper training at face value. As a country we are struggling to correctly tell the number of healers currently

practicing. This is because healers are scattered and registered by a number of non-statutory associations. Their numbers are not consolidated anywhere because these associations operate independently. There are also a huge number of healers who are not registered with any association who are but dealing with patients on daily basis. The THPC is mandated to consolidate the numbers and develop a database of traditional healers but that is proving to be difficult because of the current state of traditional healing in the country. Denis (2006) and Truter (2007) estimated that South Africa had approximately 200 000 practicing traditional healers in 1995, and around 300 000 in 2005. The number is expected to have risen significantly because those figures are not current and the lack of proper regulation makes it difficult to provide an up-to-date figure. According to Tshetlha (2015) the Traditional Health Practitioners Council does not seem capacitated to deliver satisfactorily on its mandate yet. One of the reasons for that being the difficulty the council is likely to face in selecting the credible practitioners from the bogus ones for registration purposes.

5.2.4 Challenges faced by traditional healers in the Limpopo Province

Denis (2006) is of the view that the dawn of the democratic South Africa created a context that is eminently favourable to the expansion of traditional African beliefs. The interviews also showed that some healers are finding their job trouble free and are happy with their job in the province. The findings however revealed that all is not smooth sailing. The following are some of the challenges faced by traditional healers on daily basis:

- Traditional healers have a safety challenge, especially female healers who mentioned that sometimes they don't open their gates at night for clients because they fear robbers. At times criminals consult them for *muti*¹¹ to use for criminal activities and they find themselves in a difficult position. In addition to that it is difficult to work long hours in to the night especially if you have a day job and are expected to report for duty the next morning.
- Healers are less supported by the government despite them playing a major role in the health of the people in the country. They are exposed to different health hazards by dealing with different illnesses at times without being paid. Because of little protection from the government healers are exploited by some government officials who demand bribes when they find them in possession of herbs or when trying to cross the border to collect herbs or to check on their clients.

¹¹ Herbs

- Traditional healers depend on the money they make from healing people to put food on the table. They mostly heal people and never get payment. They end up finding themselves in a difficult situation because their ancestors does not allow them to turn the sick people away if they come to them without money, as a result they end up treating but their families going hungry and also end up with no money to buy herbs.
- There is a serious concern among healers about the bogus healers who are practicing in the province. Many of these bogus healers are not even South Africans and they find it very easy to practice as healers in the country. The interviews revealed that it is easy to get a certificate from the non-statutory bodies offering certificates to healers, which makes it easy for these bogus healers to operate. This makes the job of genuine healers very difficult as they are painted with the same brush when something bad that was done by a bogus healer is reported.

5.2.5 Possible solutions to the challenges faced

Summerton (2006) argues that the western health practitioners' critical view of traditional medicine is based on notions which perceive traditional health practitioners as posing a danger to the health of their patients. The mind-set has to change, interviews revealed that traditional healers demand respect from their western counterparts as well as the government. According to Summerton (2006) western practitioners lack the knowledge about traditional theories of disease and health. This causes tension and stands in the way of collaboration. The department of health is also not doing enough to get traditional healing integrated in to the health system despite reports that the majority of the people in the third world countries visit healers first before going to western hospitals

The Traditional Health Practitioners Council must get its house in order and get to work so that law and order is maintained within the practice. It is very easy to get in to the practice and the sooner they start taking charge and putting control measures in place the better. The respondents feel that healers should be given permissions to have access to different places where herbs can be found and those who practice without the proper documentations and training should be stopped from selling herbs which somehow allow bogus healers an opportunity to get herbs.

The results further suggest that there should be strict measures put in place for those who sell herbs. The respondents are concerned that those who sell herbs are killing trees and negatively affecting their practice because they collect large quantities at the same time and trees never get a chance to recover as they are left exposed at times. The healers feel that there

should be regional offices where such issues can be reported and addressed. Having one centralized office in the city will not help with the domestic problems they are facing.

Mokgobi (2014) argue that traditional healers' duties go beyond the uses of herbs for illnesses; in addition to working with herbs and healing the sick, traditional healers are also custodians of the traditional African religion and customs, educators about culture, counsellors, social workers and psychologists. The respondents are of the view that children should be taught about their culture from an early age so that they can grow up knowing who they are and where they come from. This will help sustain African cultures and allow them to make an informed choice when they reach adulthood.

5.3. Knowledge acquisition

The purpose of this objective was to investigate knowledge acquisition among traditional healers in the Limpopo Province. knowledge acquisition can be defined as accepting knowledge from the external environment and transforming it so that it can be used by a particular individual (Pacharapha and Ractham 2012). According to Pacharapha and Ractham (2012:726) knowledge acquisition can be accomplished by three activities, which include sourcing from organizational knowledge repositories, learning from others and learning from experiences.

Bojuwoye (2005) argue that a major feature in the training of would-be healers is to help trainees understand and communicate with the spirit world inhabited by ancestors. This is done through altered states of consciousness, such as dreams, which trainees are helped to recognize and understand as avenues for the establishment of a link with the ancestors. The findings revealed that the trainees are first possessed by the ancestral spirits, who make their presence known by inflicting illnesses and misfortunes which can only be explained by experienced healers after reading the bones. The findings also confirm that the common method of communication between healers and their ancestors to is through dreams.

The findings suggest that healers commonly get to know about their gift of healing through dreams. This is where messages from their ancestors are delivered to them in their sleep. Furthermore, it was revealed that for one to have a calling there must have been someone in the family who was or is a healer who will pass on the knowledge to the one selected by the ancestors to continue with the job. According to Bojuwoye (2005) the gift of possession by ancestral spirits is usually handed from one generation to the next and therefore many trainees already can dream and recognize messages from dreams. After the interpretation of dreams the next stage is the actual training which is where knowledge of traditional healing is acquired.

Nonaka and Takeuchi's theory of organisational knowledge conversion places knowledge acquisition in the first three modes of the model, namely socialisation, externalization and combination. During socialisation tacit knowledge is the main type of knowledge acquired. This type of knowledge is mainly known to be acquired through mentorship, observations, collaborations, discussions, practice and imitating the knowledgeable. The findings suggest that traditional healers learn to read the bones, prepare herbs, handle patients, perform dances, and many other functions through observations and imitations. For this knowledge to be acquired extensive personal contact occurs. The findings indicate that the would-be healer is treated as the child of the master and given full attention. The trainees leave their homes and stay at their master's home for the entire training period. During this period the would-be healer will be under the wing of the mentor watching everything they do and learning how they do things.

When externalizing, the trainees are able to express the knowledge they gained over time mainly through observation and practical work. Anand et al. (2010) highlight that externalisation creates common understanding between healers about the knowledge created through the exchange and synthesis of tacit knowledge. The findings suggest that over time the master allows the would be healer to demonstrate how much knowledge they acquired by allowing them to throw the bones first when they have clients, prepare herbs for clients and do many other functions on their own. Externalization is usually followed by combination.

During combination, the healers convert explicit knowledge obtained from training and combining and integrating into the existing knowledge which they may have acquired at an early age, or maybe they got from their ancestors to form new knowledge. The findings suggest that traditional healers share a lot during their gatherings. They mostly deliberate on issues surrounding healing of patients and how they addressed certain things, at times sharing information on a particular herb which might not be known in the area. During those deliberations healers would acquire the knowledge and combine it to their existing knowledge which gives rise to new knowledge.

5.3.1 Duration of training

Chigada and Ngulube (2015) are of the view that for knowledge to be acquired, willingness, attitude and the ability of a recipient to acquire and use such knowledge are crucial. The process of acquiring this knowledge by the trainees can take from three months to a number of years depending on a number of issues. The results suggest that the amount of time it takes for the would-be healer to complete training depend on how fast they can learn and if they have all the resources required to complete training. In addition to that, those who are

naturally fast learners don't take too long to understand things and those who are slow will require more time. The results also suggest that most trainees begin their training while not in good health so their masters first has to heal their illnesses caused by their ancestors before the actual training commences and that may have implications on how long they take to complete the training.

5.3.2 Methodologies employed to acquire knowledge

Ryu, Kim, Chaudhury and Rao (2005) argue that because tacit knowledge resides within individuals' memory, knowledge acquisition by learning from others plays an important role in individual knowledge acquisition. The findings suggest that the methodologies mostly employed by trainees to acquire knowledge included: observations, practically doing things, imitations, following orders from the ancestors, and constantly shadowing their masters. The findings further suggest that even though the drumming and dancing occur almost every day, trainees spend most of their time collecting and grinding herbs, learning how to read the bones and also participating in the practical healing of patients until they fully acquire the necessary knowledge.

5.4 Knowledge transfer

This objective investigated how knowledge is transferred among traditional healers in Limpopo Province. Knowledge transfer refers to the transmission of explicit, implicit and tacit knowledge from a person or organization to another person or several other people. When it comes to tacit knowledge, Szulanski, Ringov and Jensen (2016) are of the view that through interaction, a knowledge source can articulate its own perspective and reveal implicit rules and assumptions, thereby externalizing hidden tacit knowledge that is otherwise hard to communicate, whereas knowledge recipients can gradually internalize it". The interaction between the trainees and masters make it possible to share and transfer such tacit knowledge informally and spontaneously.

Explicit knowledge can be transferred through interaction between source and recipient, personalized communication or the recipient's observation of the knowledge in use. According to Nonaka (1994) explicit knowledge is contained in impersonal, standardized documents and is designed to be applicable to a wide variety of contexts and users. The findings suggest that explicit knowledge transfer among healers mostly occurred during gatherings and informal visits they constantly have.

At the policy level, the Traditional Healers' Act of 2007 indicate that the THPC should promote contact between various fields of training within the traditional health practice in

South Africa and to set standards for such training. This is meant to entice interaction between traditional healers and various stake holders at different levels which in turn has the potential to promote knowledge sharing and knowledge transfer. The findings however suggest that even though there is some interaction between healers and some stake holders in other areas, such interaction is minimal and healers mostly operate on their own in their own networks.

5.4.1 Knowledge transfer among healers in Limpopo

This section provides interpretations and discussions of findings concerning knowledge transfer among indigenous healers of the Limpopo Province. Just as with knowledge acquisition, the attitude of the intended knowledge recipient has a major role to play in the whole process. The findings suggest that experienced healers prefer teaching and transferring their knowledge to trainees who are respectful and can follow instructions. The process of transferring knowledge requires patience as well from the knowledge bearer and at times, the masters are required to show the same thing repeatedly.

The findings further suggest that the knowledge transfer process will depend on the powers of those particular trainees. Trainees are gifted differently and their ancestors will influence the type of knowledge transferred to them. The masters believe that training as a healer works the same way as a normal school or university. Dedicated students get to get the most out of their masters while those with the wrong attitude end up knowing very little. The master's duty is to show the trainee the path and the ancestors will take over and help them walk the path. Even though it is common for knowledge of herbs and issues around traditional healing to be transferred to the would-be healers at an early age, the ancestors play a major role in deciding when and what the trainee should learn.

The findings revealed that trainees constantly get visits from experienced healers who graduated before them to share with them what they know. During those visits those who graduated spend a lot of time with the trainees sharing experiences. The transfer of knowledge also occurs between experienced healers every time there is a meeting or a gathering of some sort. During these interactions, tacit knowledge is mostly transferred because such discussions are personal. The transfer of explicit knowledge was evident when trainees exchanged notes; labelled herbs, and different recipes for different concoctions.

5.4.2 Collaboration among healers

Collaboration in this regard entails the working together of healers to achieve common goals. According to Katz and Martin (1997), one of the significant benefits of collaboration is the

effective transfer of knowledge. The study findings reveal that collaboration among healers is very common. Healers consult each other when confronted with illnesses or situations they are struggling to deal with on their own that allows some level of interaction where knowledge is transferred among the participants.

Herbs that healers use are mostly found in trees that grow in different areas. Some of these trees can only be found in specific parts of the country. To that effect, healers have developed their own networks where there is some level of working together. There are herbs that are known to grow only in mountainous areas and healers who live in areas without the mountains will get help from those in those areas and return the favour by sharing knowledge of herbs that grow in their area. It is more of a give and take situation.

In some communities, when there is a problem that affect the entire community like draught, the king usually summons all the healers to come to the palace to discuss the problem. That allows healers an opportunity to get their heads together and seek the solutions together. The whole process encourages knowledge transfer and sharing. Having said that, Sodi et al. (2011:104) suggest that indigenous healers keep their knowledge very private and confidential, and they regard their knowledge as their personal property. However, the study findings suggest that the sharing of this knowledge is common among those who are part of the network and have earned the rights to become healers. This was highlighted by Sodi et al. (2011) when it was argued that confidential knowledge can be shared during the training of the apprentice who has paid the training fees. There are however some healers especially young healers who feel that their mentors became jealous of their powers and sabotaged their training and never shared relevant knowledge to them.

5.4.3 Methodologies employed to transfer knowledge

The findings suggest that the methodologies employed to acquire knowledge discussed in section 5.3.2 also applies to knowledge transfer because they allow engagement between the mentor and the mentee on issues that are not clear. The findings reveal that in addition to the methodologies discussed in section 5.3.2 healers mentioned continuous learning and the contribution of their ancestors as key methodologies employed to transfer knowledge.

5.5 Knowledge preservation

This objective investigated how traditional healers preserve their knowledge for future use. Knowledge preservation was defined in this study as the process of protecting or the keeping safe knowledge (both tacit and explicit), especially indigenous knowledge, by individuals or organizations for future use. Knowledge of traditional healing by its very nature is generally

known to have been passed on from generation to generation through oral tradition. Raseroka (2002) is of the view that this knowledge survived for centuries because of families transferring it from generation to generation.

Knowledge of traditional healing survived in the minds of those who had it until such time they passed it to the deserving recipients. This means that this knowledge is mainly tacit in nature. According to Poorna, Mymoon and Hariharan (2014) urgent measures are required to preserve oral knowledge as it faces a greater risk of loss and misappropriation. Ngulube (2002) also argue that indigenous knowledge, although based on orality and oral traditions, should be managed and preserved just like other documentary materials that are grounded in western codified knowledge schemes.

Tacit knowledge resides in the minds of people and for it to be preserved; it has to be acquired first. After acquisition, traditional healers integrate this knowledge to their existing knowledge base. This is what Nonaka (1994) calls combination. Knowledge obtained through training is combined with the knowledge that was transferred to healers while they were still young to form their own personal tacit knowledge. After this knowledge is integrated or combined with our existing knowledge base, it now gets to be internalized.

The internalized knowledge is then preserved inside the human mind for future use. The preservation process is, however, a little different when it comes to explicit knowledge. According to McMahon (2015) explicit knowledge is readily codified into a tangible form, that is, documentary material that may be retained in a wide variety of media. This knowledge is easy to preserve in places like libraries, archives, museums or any other information-handling agencies.

5.5.1 Knowledge preservation by healers in Limpopo

From the onset it is important to highlight that, healers are known to keep their herbs inside rondavels constructed from mortar which consist of soil and cow dung with the use of specialised grass to complete the roof. These round shaped huts are cooler inside especially during hot African summer weathers. From a conservation point of view, these huts are perfect for preserving the herbs for longer. Healers in the Limpopo Province also kept their herbs in such huts. In other instances, the hut that keeps the herbs has been in use for a number of generations with only the roof being renovated over time.

When it comes to the actual preservation of the knowledge that they use for medicinal purposes, Ngoepe and Setumu (2016) proved that such knowledge could be documented. In

their heritage projects in the Makgabeng area of Limpopo, Ngoepe and Setumu (2016) documented stories and IK ranging from origins of clans, burning of witches in the areas, rainmaking, divine bones and chieftainship. The findings also revealed that healers were in agreement that the preservation of their knowledge is very important.

Healers highlighted that it is important that they take someone within the family and keep them under their wing, share all their experiences to ensure that their knowledge is carried over to the next generations. However, they cautioned that, it is not guaranteed that the ancestors will choose that particular person to take over from them as they may decide on someone else. While others have already started the job of teaching someone in the family, others have left that task to the ancestors because they believe that the power of healing is controlled by the ancestors.

5.5.2 Methodologies employed to preserve knowledge

The findings reveal that there are different methodologies employed by healers to externalise their knowledge for preservation. The study revealed that the older healers still prefer the old tried and tested way of preserving their knowledge by depending on their memories to know and handle different herbs. The current generation of healers have access to books, most have gone to modern schools, and they have different ways of preserve their knowledge.

The findings suggest that some healers are documenting their knowledge. After collecting and grinding the herbs, healers recorded a piece of paper with the herb name and placed it inside the container together with the herb. This exercise came in handy especially in situations where containers are the same or where the herbs were grinded by someone else and another does preparing of medicines for patients. This method allows people to know what is in the containers and such herbs can be used even in the absence of the healer.

Almost similar to having names of herbs inside the container, other healers use labels to identify their herbs. Healers attach labels to the containers and write the herb name on the label outside the container. This method works the same way as the method discussed but saves a lot of time and is more convenient. Instead of opening every container to find a particular herb, the healer will simply read the labels and collect the correct herb.

The findings also suggest that a notebook is used to record full details of the herbs so that it can supplements the methodologies mentioned above. This book contains all the names of the herbs and their uses. There is no standard way of recording these herbs in that particular book. Some healers organised herbs according to their functions, that is, herbs that are used on children are grouped together and those that are used for sexual problems are grouped

together so on and so on. These books are written by hand and each individual is responsible for their own book. Healers will continue updating this book every time they come across new information. The writing of these notebooks was sometimes motivated by the fact that some of the trainees cannot afford to attend training for many months because of job commitments and family responsibilities, as a result such healers keep record of everything they are taught so that they can refer when they get home.

The findings also suggest that some healers believe that it is the responsibility of the ancestors to preserve knowledge of traditional healing. They believe that the ancestors keep the knowledge safe until they identify someone deserving so that they can pass it on to. This crop of healers is against the documenting of this knowledge. They indicated that they knew everything by heart because it was shown to them in their dreams and they still that picture of their dream in their heads. They mostly identify their herbs through smell, taste, weight and their colour.

The investigation also came across a healer who was using a different and somehow advanced method of documenting their knowledge. The healer had labels on all the herbs and also kept a book with all the names. In addition to that, the healer took pictures of all the trees that she got all the herbs and matched each herb against the tree. The healer was in the process of transferring all the data in to her laptop. The investigator found this very fascinating. This will method will allow the healer to preserve complete knowledge. It will be very beneficial for teaching because trainees can be shown a picture of a tree after being told about the herb and its benefits. This also suggests that over time modern technologies may be used in the Limpopo Province to preserve knowledge.

5.6 The acquisition, transfer and preservation of knowledge of traditional healing

The purpose of this objective was to apply the knowledge conversion theory to the knowledge of traditional healing in order to understand how knowledge of traditional healing can be acquired, transferred and preserved. Nonaka and Takeuchi's (1995) framework of organizational knowledge conversion discusses the interaction processes of tacit and explicit knowledge which is regarded as an important features in knowledge management research. The framework identifies socialization, internalization, externalization and combination (SECI) as the four modes of interaction between tacit and explicit knowledge.

The review of literature suggests that for one to become a healer, they must have a calling (Sodi et al 2011). This means that, that particular person must have been selected by the ancestors to be trained as a healer. Those who are selected by the ancestors have contact with

the spiritual world and can communicate with the ancestors (Sodi et al 2011). This means that becoming a healer is not by choice. There are however those who have come to learn about traditional healing and have knowledge of the herbs but are without a calling. This group of healers has knowledge of herbs and how to treat different illnesses but never underwent training. Truter (2007) is of the view that such a person possesses an extensive knowledge of curative herbs, natural treatments and medicinal mixtures of animal origin but does not receive a calling, however continues to use herbs to treat different illnesses

To those who have a calling, the ancestor's shows their presence by inflicting on their host serious illnesses, which are best understood by other healers experienced in the art of divination (Bojuwoye 2005, Mokgobi 2014). Bojuwoye (2005) further expounds that in addition to illnesses, the ancestors may show their presence through general body pains, severe headache, or general breakdown in bodily functions; sometimes there are unexplained misfortunes such as sudden loss of job, destruction of properties, or an accident that defies all possible explanations. When confronted with such misfortunes, and illnesses, an experienced healer can be consulted who will in turn consult the bones to see if indeed the person has a calling. Once that is confirmed, the would-be healer will then undergo the training process under the mentorship of the experienced healer.

The other group of traditional medical knowledge carriers, who have no calling, learn about traditional healing without receiving spiritual guidance from the ancestors. Denbow and Thebe (2006) allude to these when they say that culturally those who acquired knowledge of herbs that can be used for traditional healing are called *ngaka e tshotswa* in Setswana. According to Truter (2007) this type of healers usually spends a few years as an apprentice and do not profess to have divine powers.

The training of those with a calling and those without a calling is slightly different but with a lot of overlaps. They are both trained by an experienced healer who may specialise in training other healers. The healer who specialises in training other healers is referred to as the master in the current study. The training is commonly known to be a fulltime thing and the trainee is expected to stay at the master's place for the duration of the training. Bojuwoye (2005) confirms this by saying that when the would-be healer accepts their calling and starts with the training, they are required to relocate to the master's home for the duration of the training. Those who are employed and having day jobs are expected to continue with their training duties after work.

Different from those with a calling, the would-be healers without a calling are commonly known to be a family member or someone chosen by the experienced healer to share the

knowledge of traditional healing with. This person has little pressure of learning and at times they might not be aware. The interviews suggest that some healers select one trusted family member who will be shown everything they do and at times given tasks to during the healing process. One of the respondents had a young boy as an apprentice. The investigator was told that the boy will take over from the master when he grows up. The boy has an opportunity to learn everything he needs to know over many years of growing up.

During the acquisition and transfer of this knowledge, various exercises are employed to evaluate the progress of trainees, until such time the master is satisfied that trainees are ready and can be able to practice on their own (Bojuwoye 2005). Nonaka and Takeuchi (1995) argue that “*apprentices work with their masters and learn craftsmanship not through language but through observation, imitation and practice.* As explained in the preceding section, trainees are required stay with the master on a fulltime basis so that they can shadow the master, observe everything and learn from what the master does. Nonaka (1994) explain this process as socialisation where the knowledgeable person transfers experiences in the form of tacit knowledge to the trainees who will be inexperienced at the time.

During knowledge acquisition and transfer, the master helps the would-be healer with a calling to understand and be able to communicate with the ancestors. This encompasses dream analysis, learning about different medicinal plants and animal extracts to use, interpreting the bones, and different illnesses and how to treat them. Bojuwoye (2005) is of the view that there are trainees who start training before they could master the ability of speaking to the ancestors. Such trainees get assisted by the master by performing appropriate rituals and then to cultivate dreams so that they can recognize their dreams when their spirits guides them.

Sodi et al (2011) also speak of therapeutic dances (also known as *manchomane* or *malopo* among Sotho and Tsonga speaking people) which are frequently done during training. During this dances, there is the beating of drums, singing (songs which sometimes carries a message about a particular aspect of healing), clapping of hands. Sodi et al (2011) is of the view that *this dance has some resemblance to a hypnotic trance that result in emotional expression and feeling of rejuvenation and hyper-suggestibility.*

Determining whether the trainees have acquired the necessary knowledge to become healers an examination is conducted. The examination is designed to test whether the trainees have mastered the ability to summon the spirits to help them in doing things that are beyond this physical world. This examination happens over two days and it is performed openly in front of the community to prove that the trainee is capable. After proving that they are capable of

communicating with the spirits, the trainees are taken to the river for cleansing and introduction to the river spirits to seal their bond with the spirits and to graduate as healers. Even though the examination seems to be mainly focused on the capability of the trainees to engage with the spirits, the findings suggest that healers are also tested on how well they know their herbs and other functions like the reading of bones. This mainly happens when they practically treat patients and when they busy collecting herbs. During those times, the master will be asking questions in between to see whether the trainee remembers the functions of each herb. The trainees are also made to bring all their collected herbs before they pack for home and to see if they can identify them by telling the master what each herb is and what its uses are.

Poorna, Mymoon and Hariharan (2014) agree that indigenous knowledge is oral in nature and it faces a greater risk of being misinterpreted and eventually being lost. As a result, the investigator wanted to know how traditional healers ensure that the correct knowledge is preserved. The findings revealed that despite the ancestors being the custodians of this knowledge, healers have a number of ways of ensuring that the knowledge preserved is correct and of high quality.

The study revealed that in order to ensure quality the would-be healers are expected to practically do things on their own, prove that they can stand on their own feet before they graduate. They physically go to the wild and do the grinding, as well as the arrangement of herbs themselves under close supervision from their masters. Senior healers keep mentoring the newly qualified healers even after graduation. They continue working closely with them and giving a helping hand whenever needed. When newly qualified healers are faced with many clients to deal with, the senior healer will mostly go there to lend a helping hand. The findings suggest that in cases where the newly qualified healer has to do something for the first time, he or she will request the presence of the master. The mentoring continues until the new healer is confident to do everything by him or herself and has established a healthy client base.

The knowledge gained through socialization, externalization and combination get internalized into individuals' tacit knowledge bases for preservation (Nonaka and Takeuchi 1995). Traditional healers are known to keep their knowledge private and only make it available to those they decide to teach either as trainees or maybe a family member whom they want to share the knowledge with. Those who are trained by the same master are likely to have similar experiences and ways of dealing with illnesses.

Nonaka and Takeuchi (1995) are of the view that documenting knowledge helps individuals internalize their experiences, thus enriching their tacit knowledge. Books, articles, and any

other form of documented records, enable the transfer of explicit knowledge to other people, thus helping them experience the experiences of others indirectly. Knowledge of traditional healing is however commonly known to be preserved orally. The respondents however strongly believe that the ancestors are responsible for safeguarding knowledge of traditional healing.

5.7 Summary

This chapter interpreted and discussed the research findings of this study. The discussion was based on the data presented in Chapter Four; literature reviewed in Chapter Two and driven by the knowledge conversion theory also explained in Chapter Two. The reviewed literature was consulted to support or argue against the findings of this study. The findings were interpreted and discussed according to the objectives as presented in Chapter One of this study.

It can be argued that even though there are laws and policies passed by the government in relation to traditional healing, traditional healing in South Africa is still being over looked. This practice is still being left unregulated, unsupported and not fully recognised within the South African health care system. In addition to that, traditional healers are faced with safety challenges such as working at night because of the stigma attached to their job; they are at risk of contracting different illnesses because of being exposed to different illnesses; they are struggling to make ends meet because they provide a service before asking for payment, at times they end up not being paid and they have no mechanisms in place to claim their money. Their profession is being exploited by bogus healers who find it very easy to practice in South Africa.

There was consensus among healers that the ancestors play a significant role during knowledge acquisition. The knowledge gained by healers during training was mainly acquired through observations, imitations, following orders and performing tasks practically. It can be argued that the acquisition and transfer of knowledge mainly depend on the attitude of the intended knowledge recipient. Collaboration was highlighted as one of vehicles for effective transfer of knowledge. Finally, there seems to be a change in how knowledge of traditional healing is being preserved. The older generation of healers still prefers the old oral tradition while the current crop of younger healers are adapting to the changes and others even embracing technology through the use of computers to record and preserve what they were taught.

The next chapter provides conclusions, summary and recommendations on the acquisition, transfer and preservation of indigenous knowledge by the traditional healers in the Limpopo Province. The chapter also proposes a framework that will help in the preservation of this knowledge.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECCOMENDATIONS

“If you talk to a man in a language he understands, that goes to his head but if you talk to him in his language, that goes to his heart” - Nelson Mandela

6.1 Introduction

The preceding chapter provided the interpretation and discussion of data presented in Chapter Four. This chapter provides a summary of the findings, conclusions and recommendations of the study based on the data presented and interpreted in Chapter Four and Chapter Five, as well as the literature review in Chapter Two. Williamson and Bow (2000) supported by Kalusopa (2011:263) suggests that when writing conclusions and recommendations the following factors should be considered:

- conclusions and recommendations should clearly be related to findings;
- the researcher should not over-conclude, which means that unwarranted conclusions and generalisations need to be avoided; and
- all research questions should be answered.

The chapter further proposes a framework that maps the process of knowledge acquisition, transfer and preservation by healers. It is hoped that such a framework will increase understanding to different stakeholders and the community at large how this knowledge is handled so it is not lost to the future generations. The chapter was structured to include the following: a summary of the findings, conclusions according to the objectives of the study, recommendations, proposed framework and suggestions for further research. This is presented according to the objectives of the study.

The purpose of this study was to investigate the acquisition, transfer and preservation of indigenous knowledge by traditional healers in South Africa, in order to understand how this knowledge can be preserved. In order to fulfil the purpose of the study, the following research objectives guided the study:

- Assess the status of indigenous healing in Limpopo Province of South Africa.
- Determine how knowledge is acquired among indigenous healers in Limpopo Province of South Africa.
- Establish how knowledge is transferred among indigenous healers in Limpopo Province of South Africa.
- Assess how knowledge is preserved among indigenous healers in Limpopo Province of South Africa.

- Suggest a framework that explains the acquisition, transfer and preservation of knowledge by indigenous healers in South Africa.

6.2 Summary of the findings

The summary of the findings is presented according to the objectives of the study

6.2.1 The status of indigenous healing in Limpopo Province of South Africa

Traditional healers play a very important role in the country's health care system. Despite attempts by the apartheid government and other religious beliefs to destroy traditional healing, the practice stood the test of time. The review of literature suggests that the majority of third world countries including Africans rely on traditional healers for their primary health care. Despite all the reports and research done by different scholars on the role of traditional healing in the South African health sector, traditional healing remains marginalised in South Africa.

It is clear from the discussion that traditional healers are getting little support from the government. Even though the government legislated and activated the Traditional Health Practitioners Act in 2007 which was followed by the establishment of the Traditional Health Practitioners Council (THPC) in 2013, not much progress is being made with regards to having healers in the national health sector and also with the regulation of the traditional healing practice. The THPC which has the status of a professional regulatory body and the powers to regulate the traditional health practice does not seem to be in a position to perform most of its functions. One of the reasons the THPC is failing to perform as highlighted by Tshetlha (2015) is the difficulty the council face in selecting the credible practitioners from the bogus ones for registration purposes. There are a number of associations giving out certificates without proper checks, as a result proving who is credible and who is not will be an impossible task.

To that effect, traditional healing remains exposed to exploitation by fraudsters because it is easy to practice as a healer in the country without being monitored. There are many associations operating independently offering certificates for a fee to traditional healers at times without properly establishing whether proper training was done or not. It is also easy for these bogus healers to get herbs because there are too many shops selling herbs open to anyone. This can only be avoided if there is some form of collaboration among all stakeholders.

The results indicate that there is very little collaboration going on between western and traditional doctors. Both camps have the same mandate and are striving to ensure that the people of South Africa get better health care. A positive collaboration was an agreement signed between the South African department of health and the Congress of Traditional Leaders of South Africa (Contralesa) whereby western doctors would help traditional initiation schools with pre-circumcision screening, circumcision and after-care (Brand South Africa 2014). This was aimed at reducing deaths and injuries suffered by initiates at the traditional initiation schools. Richter (2003) is of the view that 'Western' doctors are different from the traditional doctors mainly because the former look at 'material causation' to understand and treat an illness; while the latter generally looks towards the 'spirits or ancestors to cure illnesses.

The results however suggest that the relationship between western doctors and traditional healers in South Africa is biased and only favours the western doctors. There are sicknesses that can be referred to the traditional healers by the western doctors but most of the western doctors seem to be against working together with traditional healers. They discourage patients from seeing healers. Healers have shown willingness to collaborate with western doctors and are constantly referring patients to the hospitals.

The results also indicate that traditional healers are not supported from the government side. They work independently using their own resources to render a service to the people of South Africa. They are playing an active role and are contributing to the national health systems even though they are not supported. They operate in isolation and are not contributing to the country's economy.

6.2.2 How knowledge is acquired among indigenous healers in Limpopo.

The results indicate that traditional healing mainly runs in the family. Majority of traditional healers come from a family where some members of the family are healers or there was a healer in the family at some point in life. The decision on who should be a healer lies with the ancestors and they usually make their presence felt by inflicting sicknesses and misfortunes which will be explained by an experienced healer.

Training as a traditional healer can take from three to over 2 year depending on the trainee's competence and whether they have resources to complete the training. During training the trainees or mostly learn about reading the bones, about different herbs and their uses as well as practically dealing with the sick people. The trainees mainly acquire knowledge through

observations, practically doing things, imitations, following orders from the ancestors, and constantly shadowing their masters.

6.2.3 How knowledge is transferred among indigenous healers in Limpopo

The interaction between healers makes it possible to share and transfer tacit and explicit knowledge informally and spontaneously. Knowledge transfer among healers is mainly practical and done through repeated actions. Different associations also organise gatherings where discussions are held and the process of knowledge transfer takes place. Ancestors are explained to be the main contributor of knowledge among traditional healers. Traditional healers have established networks and such networks allow for knowledge to be transferred so that it can survive from one generation to the next.

Knowledge transfer occurs during formal discussions, observations, meetings, during imitations, from the ancestors and continuously learning from others over the years. Collaboration is the main contributing factor to effective knowledge transfer among traditional healers in the Limpopo Province of South Africa.

6.2.4 How knowledge is preserved among indigenous healers in Limpopo

Knowledge of traditional healing by its very nature is generally known to have been passed on from generation to generation through oral tradition. To that effect, some scholars feel that this knowledge is running the risk of being lost to future generations (Denis 2006, Ngulube 2002a). Results, however, indicate that healers are training someone within the family with the hope that, that person will be chosen by the ancestors to take over from them.

Even though healers indicate that ancestors are the ones who preserve the knowledge of traditional healing, the current produce of traditional healers is also using different methods of preserving this knowledge. Many have gone to school and have access to books, can read and write and that allows them to document their knowledge. Some healers record the herb name on a piece of paper and place it inside the container together with the herb. This method allows people to know what is in the containers and such knowledge can be used even when the healer is not available. Other healers use labels attached to containers with the name on the outside which allows people to know what is inside.

Other healers make use of notebooks to record all their herbs, their uses, which ones get to be combined with which to treat different illnesses. Each healer records his or her herbs and refers to this knowledge when there is a need. Some healers make use of smart phones to capture images of different herbs and electronically store it in their computers.

6.2.5 The acquisition, transfer and preservation of knowledge by indigenous healers in South Africa

Nonaka and Takeuchi's (1995) framework of organizational knowledge conversion is known to be an important features in knowledge management research. The framework identifies socialization, internalization, externalization and combination (SECI) as the four modes of interaction between tacit and explicit knowledge. Research shows that an estimated 70% to 80% of the population in developing countries depend on traditional healing for their primary health care needs yet there is limited understanding on how the knowledge of traditional healing is acquired, transferred and preserved (Ijumba and Barron 2005; Denis 2006; Truter 2007; Poorna, Mymoon and Hariharan 2014).

The results of the study, suggest that healers attain knowledge of traditional healing from their ancestors. The results further suggest that experienced healers or masters are the ones responsible for mentoring would-be healers. Nonaka and Takeuchi (1995) argue that *“apprentices work with their masters and learn craftsmanship not through language but through observation, imitation and practice.* The acquisition and transfer of knowledge of traditional healing happens during socialization and externalization. This is where the knowledgeable person transfers experiences in the form of tacit knowledge to the trainees who will be inexperienced at the time (Nonaka 1994). Determining whether the trainees have acquired the necessary knowledge to become healers an examination is conducted. The examination is designed to test whether the trainees have mastered the ability to summon the spirits to help them in doing things that are beyond this physical world.

The knowledge gained through socialization, externalization and combination get internalized into individuals' tacit knowledge bases for preservation (Nonaka and Takeuchi 1995). Traditional healers preserve their knowledge differently and according to their individual preferences. Nonaka and Takeuchi (1995) are of the view that documenting knowledge helps individuals internalize their experiences, thus enriching their tacit knowledge. The results suggest that healers strongly believe that the ancestors are responsible for safeguarding knowledge of traditional healing.

6.3 Conclusions

This section provides conclusions to the study Based on the completed investigations. The conclusions of the investigations are organised according to the objectives of the study. In addition to that, a proposed framework is presented and discussed in section 6.6 of this study.

6.3.1 The status of traditional healing in the Limpopo

Most of the people in developing countries including South Africa dependent on traditional medicines for their primary health care needs. However, the findings indicate that traditional healing is marginalised and healers are not getting enough support from the government. Traditional healing is not properly regulated which allowed anyone to practice as a healer without question as a result a lot of bad things are happening which paint a black picture towards the practice. Despite constant negative media reports, traditional healers serve their communities and they sometimes do that without compensation.

6.3.2 Knowledge acquisition by traditional healers in Limpopo

The study established that knowledge acquisition happens formally during training and informally when one or some of the family members are taught about traditional healings by a healer in the family. The latter happens when the healer decides to pass knowledge of traditional healing to someone in the family with the hope that, that particular person will take over from them at a later stage. Secondly acquisition happens formally when one has a calling and consults an experienced healer for training. In this case, the person will on top of the training received from the experienced healer/master, get guidance from the ancestors which mostly happens through dreams.

Knowledge of traditional healers is mostly kept in the mind which is mostly acquired during socialization. During socialisation tacit knowledge is the main type of knowledge acquired. The study established that this type of knowledge is mainly acquired through mentorship, observations, collaborations, discussions, practice, imitating the master. The study also revealed that the knowledge of traditional healing is mainly acquired from the ancestors.

6.3.3 Knowledge transfer by traditional healers in Limpopo

The interactions between healers make it possible for knowledge to be transferred from one individual to the other. In addition to the tacit knowledge that is transferred during training, the study established that collaboration which encourages knowledge transfer is very common among healers. Healers share and transfer knowledge informally and spontaneously during externalisation. During externalization, healer's tacit knowledge is externalized, made ready and made easier to share and acquire. The more experienced healers share what resides in their minds, and at the same time turning their tacit knowledge in to explicit knowledge, which is easier to share and acquire.

The study established that knowledge transfer happens during observations, collaborations, observations, formal and informal discussions, meetings between healers and when there are events like the trainee's examinations as well as the *manchomane* or *malopo*¹²gatherings.

6.3.4 Knowledge preservation by traditional healers in Limpopo

A number of studies have shown that indigenous knowledge is in the danger of being obliterated due to factors such as such as the lack of interest from younger generations, low life expectancy where people die before transferring their knowledge to the next generation. By its nature IK is known to have been passed on from generation to generation through oral tradition which was a means to preserve such knowledge.

Ngoepe and Setumu (2016) proved that indigenous knowledge can be documented with their heritage projects in the Makgabeng area of Limpopo where they documented stories and IK ranging from origins of clans, burning of witches in the areas, rainmaking, divine bones and chieftainship. This study also established that despite healers anonymously mentioning that knowledge of traditional healing is preserved by the ancestors; they also used other ways to preserve this knowledge. The study has established that the current generation of healers can read and write and that allowed them to use books, laptop computers and other ways to document knowledge of traditional healing. To that effect, the study concludes that even though the bulk of knowledge of traditional healing is still preserved orally, some of it is slowly being documented for preservation

6.3.5 The acquisition, transfer and preservation of knowledge by indigenous healers in South Africa

The review of literature has shown that despite traditional healing being central to the health care systems of many third world countries, there is little understanding on how this knowledge is acquired, transferred and preserved. From the evidence gathered this study concludes that healers attain knowledge of traditional healing from their ancestors. For one to be able to communicate with the ancestors, they must have a calling which will allow them access to the knowledge of traditional healing through the ancestors. The experienced healers are the ones responsible for mentoring the would-be healers with the guidance of the ancestors. The acquisition and transfer of knowledge of traditional healing happens during socialization and externalization, while the knowledge gained through socialization, externalization and combination get internalized for preservation. This knowledge can be preserved through documentation or orally depending on the healers preferred method. The

¹²*Traditional dance for Tsonga's and Pedi's*

was some consensus among healers that the ancestors are responsible for safeguarding knowledge of traditional healing

6.4 Recommendations

This section makes recommendations to address issues identified during the study. The recommendations address each of the research objectives of the study.

6.4.1 The status of traditional healing in Limpopo

The study established that traditional healing is very important especially to third world countries and continues to play a role in relieving the pressure off the countries government health resources. With that in mind, the following recommendations are made:

- The government must take an active role in ensuring that healers are formally incorporated into the country's healthcare system which will benefit both the healers and the communities they serve. Healers are exposed to different kind of illness with limited resources, the government need to intervene to protect healers from such illnesses and the process ensuring the sick get to be treated under good conditions. The government can intervene by providing safety equipment's such as gloves to help protect these healers.
- The policies passed by government on traditional healing need to be implemented and enforced. Traditional healing is harbouring criminals and those who continue to do bad things sheltering behind it as those in power are unable to carrying out mandates given to them. Traditional healing needs to be regulated to eliminate the current exploitation it is facing from those with dubious intentions.
- Community leaders should play an active role in educating the youth about African practices and how important it is to preserve these practices. The damage done through political and religious interference will never be undone but all is not lost.
- Some provincial and local health departments in South Africa, such as the Free State, KwaZulu-Natal and North West Departments of Health, as well as the eThekweni and Ekurhuleni Municipalities, have designated traditional medicine managers (Mbatha, Street, Ngcobo and Gqaleni 2012). These traditional medicine managers oversee that traditional healing is integrated on into the municipal health system and encourages two-way referrals and collaboration between clinics and THPs. This study recommends that the Limpopo local governments learn and adopt such practices from other local governments in the country.

6.4.2 Knowledge acquisition and transfer by traditional healers in Limpopo

The study has established that the Traditional Health Practitioners Council is supposed to be responsible for the training of traditional health practitioners, educational framework, fees, funding, registration procedure, code for professional conduct and ethics, disciplinary procedure and scope of traditional health practice in consultation with bodies of traditional health practitioners accredited by the Council. Considering a huge number of unaccredited associations already training and registering healers, it is recommended that the council work on getting some of the associations accredited so that the knowledge and experience they have over the traditional health practice can be used by the council.

Traditional healing is very different from formal university education and it will be unjust to subject it to the same measures operating in colleges and universities. The study established that the minister of health has the power to determine the minimum qualifications for healers to be obtained by virtue of examinations conducted by an accredited institution, educational authority or the examining authority on the recommendation of the council. The study has established that traditional healers are examined in their own way and the experienced healers are the ones who decide if the trainee has passed the exam. It is recommended that the council should have a database of healers who are eligible to train new healers who will make recommendations to the council to give those they trained licences to operate as healers'. It will be very difficult for the council or one particular institution to oversee all examinations of healers taking place in the country. The model used to qualify car drivers can be used to qualify traditional healers as well. There are a lot of similarities on how drivers qualify for their licences as well as how healers get to be trained. The drivers get to practice on their own at their chosen time using a driving school of their choice. The transport department commonly come in during the testing. Every driver is expected to undergo a test where they supposed to prove their driving skills to a traffic official. Depending on what happened on the day, the traffic official can decide to award the licence which can be used and accepted nationally.

Similarly the Traditional Health Practitioners Council can have a number of offices in different regions for that purpose. Those masters who are satisfied that their trainees are ready for examination can inform their local office which can send an expert to oversee the whole process of testing. The trainees can be awarded certificate immediately after the examination was conducted and this will allow the trainee to be in the national database and the database will remain up to date. This will indeed require a lot of effort and there should be systems in place to deal with the whole process.

6.4.3 Knowledge preservation by traditional healers in Limpopo

The study established that indigenous knowledge including knowledge of traditional healing is facing extinction, unless interventions to facilitate preservation are put in place. There is an extensive project underway, documenting traditional medicines derived from indigenous medicinal plants carried out by a team of researchers on traditional medicines, based at the University of Cape Town. The Traditional Medicines Programme (TRAMED) is founded on a collaborative agreement entered into by the Medical Research Council, the University of Cape Town, University of Western Cape, and several traditional healers (World Health Organization 1998). In October 2013 the then deputy minister of health Dr Gwen Ramokgopa gave a report at the launch of the World Health Organisation Traditional Medicine Strategy 2014 to 2023 in China that the Traditional Medicine programme is, among other objectives, there to ensure patients safety and discourage the dangerous, ineffective traditional remedies and treatments (South African Government 2013). Furthermore, the programme supports and promotes those medicinal products that are of good quality, safe and effective. It is recommended that a similar programme must be initiated in Limpopo. Traditional medicines are called differently in different languages and different areas. All medicines relevant to Limpopo Province, with the languages spoken in the province need to be documented for preservation.

Indigenous knowledge is created and owned collectively by the communities (Chilisa 2012), and its use and transfer are guided by traditional laws and customs, the current Intellectual Property Rights, which are enforced in the modern world and are largely individual rights that are based on western legal and economic parameters, as well as western property law that emphasizes exclusivity and private ownership, reduces knowledge and cultural expressions to commodities that can be privately owned by an individual or a corporation.

The corporate and multinational companies use some of the herbs traditionally known to have been used by traditional healers for their commercial products, which are then patented and blocking healers from using them and also not sharing any benefits of these products with the original sources of knowledge. It is recommended that the government do more to protect healers in this regard because such practices are interfering with the local knowledge base when it comes to traditional healing. Such practices can affect indigenous community's cultural practices as well as control of resources that form the basis of knowledge of traditional healing.

6.5 Proposed framework

Ngulube, Mathipa and Gumbo (2015) are of the view that a framework is supposed to show the relationship between concepts and their impact on a phenomenon being investigated. Similar to that, Babbie and Mouton (2011); De Vos, Strydom, Fouche and Delport (2011); and Neuman (2011) earlier indicated that one of the importance of a theoretical framework is its ability to provide a mechanism for selecting and prioritizing concepts to be investigated.

Suggesting a framework that may be used to explain the acquisition, transfer and preservation process of indigenous knowledge by traditional healers was one of the key objectives of this study. The proposed framework (see Figure 6.1) is based on the findings of this study presented in Chapter Four and Five, as well as the review of literature as discussed in Chapter Two of this study. The framework centres on Nonaka and Takeuchi's (1995) theory of organisational knowledge conversion, which explains the interaction processes of tacit and explicit knowledge. Even though this theory was created in the Japanese context, it was found to be relevant to the South African context especially in the process of managing traditional medical knowledge. This is because the four modes of knowledge management explain how more knowledge is created through conversion between tacit and explicit knowledge.

It is hoped that the proposed framework will help explain how knowledge of traditional healing is managed in order to increase the limited understanding observed when it comes to how knowledge of traditional healing is acquired, transferred and preserved. The study also established that there is limited research being conducted by information professionals in South Africa in the IK subject area. It is hoped that this framework will induce some interest towards information professionals and increase research productivity in this area.

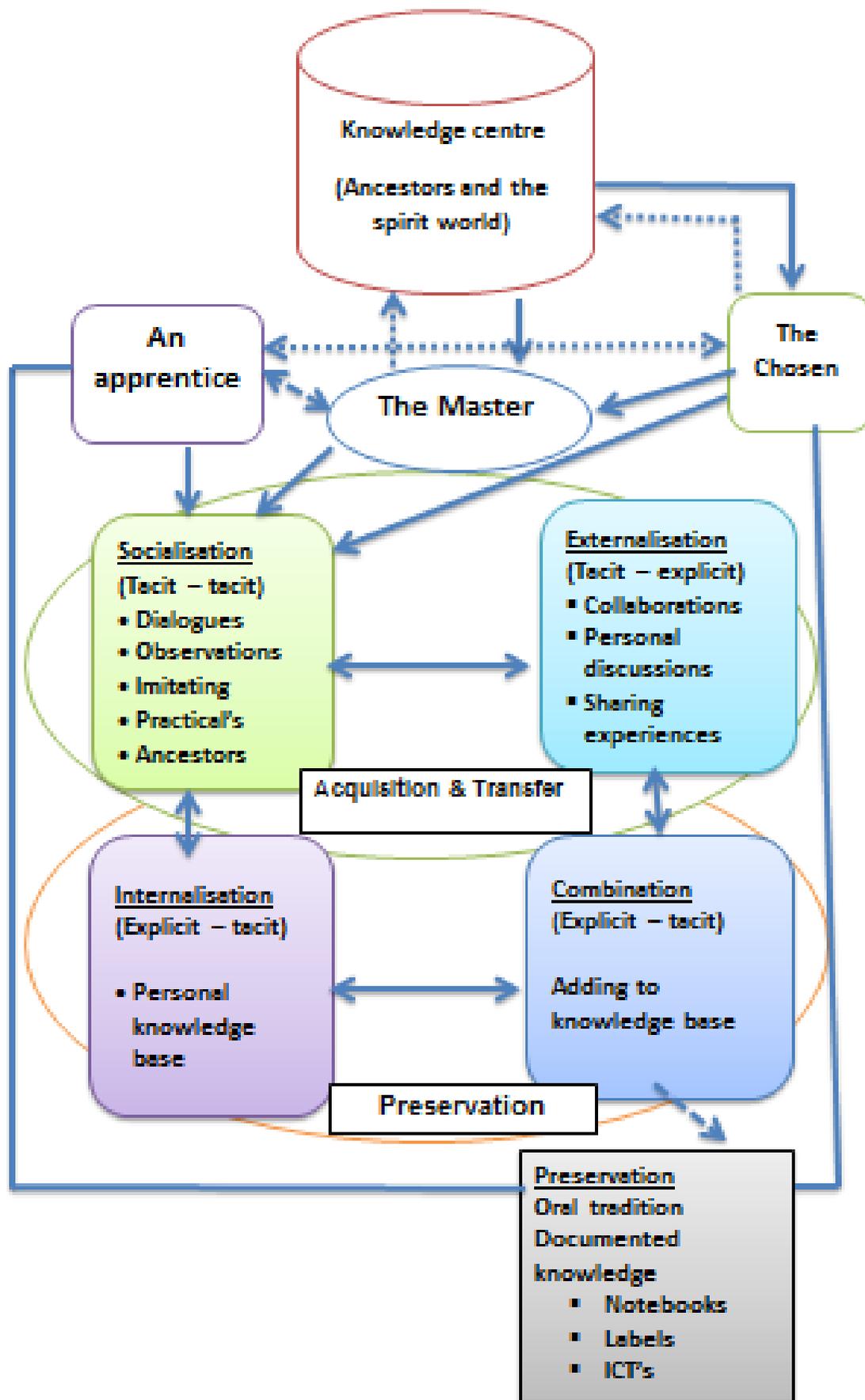


Figure 6.1: Proposed framework for the acquisition, transfer and preservation of traditional medical knowledge

The framework points the link factors that attempt to create an understanding of how knowledge of traditional healing is acquired, transferred and preserved. The factors include the spirit world (Where knowledge of traditional healing is controlled); the chosen (Someone who has a calling to become a healer); an apprentice (Someone who is being trained by the experienced healer); the master (The experienced healer with the skills to train other healers); acquisition and transfer (Socialization and externalization); preservation (internalization and combination). These factors are linked to each other using arrows to show the relationship between them to form a cohesive framework. The factors are described as follows:

a) The spiritual world

This study, as well as a study by Sodi et al. (2011) established that traditional healers depend on their ancestors for the spiritual guidance. The same was highlighted by Chilisa (2012) who mentioned that indigenous people are of the view that spirits and ancestors are a source of their knowledge to address day-to-day challenges. The study established that knowledge of traditional healing is controlled by the ancestors from the spirit or the ancestral world. Traditional healers depend on their ancestors who communicate with them through dreams, visions to provide them with knowledge and healing powers. To become a healer is not a personal choice. Those who went on to become healers indicated that it was a calling bestowed by ancestors on them. The study further established that ancestors will also show the potential healer who will train them and the place they will receive their training. The study established that healers use bones and the spirits of the ancestors to diagnose and prescribe medication for different physiological, psychiatric and spiritual conditions (Mokgobi 2014). The spirits are also responsible for guiding and monitoring how the healers conduct themselves.

b) The Chosen one

This is the individual who has a calling to become a healer. For an individual to qualify to be trained as a healer, such individual must have a calling. A calling is some form of communication with the spiritual world or the ancestors. The would-be diviner is first possessed by the ancestral spirits. The spirits will usually visit the would-be diviner through dreams and visions. The chosen one usually gets to know they have a calling after visiting an experienced healer who will read the bones and tell them about their gift.

In other instances, the ancestors make their presence known by inflicting on their chosen one serious illness, which are best understood by other experienced healers. Bojuwoye (2005), explained that one feature of the illness-experiences is excessive dreaming, which may be

vague and confusing and other symptoms are general body pains, severe headache, or general breakdown in bodily functions; sometimes there are unexplained misfortunes such as sudden loss of job, destruction of properties, or an accident that defies all possible explanations”.

Sodi *et al.* (2011) also indicated that, at times, for the purposes of succession, the ancestors may decide that the aging healer should train one family member or a relative who may be selected to succeed the healer in the future. Bojuwoye (2005:8) further articulates that “a major feature of training is helping trainees understand and communicate with the spirit world inhabited by ancestors. The study established that healers strongly believe that if you are chosen and stubborn to answer the calling, the ancestors may eventually take your life.

What is important to highlight is the fact that the chosen one has some form of link to the ancestral world and receive communication from the ancestors through dreams and can at times communicate with the ancestors and ask for clarity on some of the dreams that are not clear. In addition to the knowledge obtained through training, the chosen one also get knowledge directly from the ancestors that might not be known by the person who trains them or the master.

c) An apprentice

An apprentice in this regard can be explained as someone who learns the art of traditional healing from an experienced healer. In this case there is no involvement of the ancestors. An experienced healer may decide to show someone within the family everything they do in relation to traditional healing. This is mostly done with the hope that that particular person will take over from them. When the training starts, the apprentice has no calling whatsoever. To that effect, the apprentice has no contact with the ancestors and the spirit world.

It is, however, important to note that if it happens that the ancestors decides to give healing powers to the apprentice, then he or she will have contact with the spirit world in addition to the knowledge gained over the years. This means that training in this case will mainly focus on the spiritual side of things. It is important to note that even though the apprentice might end up without a calling, he or she would have acquired knowledge of traditional healing which may be preserved for future use.

d) The master

The master in this case is an experienced healer who has been practising for a significant number of years. This healer is usually experienced enough to access advice and guidance

from the ancestors, can interpret dreams, and can also throw bones to solve complex problems. The master is usually contacted by would-be healers to get clarity on dreams they might be having and strange sicknesses they suffering from. Through years of experience, the master will tell if the person has a calling or not. The master is usually the driving force of knowledge acquisition, transfer and preservation by traditional healers.

e) Acquisition and transfer

Liao, Wu, Hu and Tsui (2009) are of the view that Knowledge acquisition and knowledge creation are the first steps in the process of developing knowledge. For healers to acquire knowledge of traditional healing, willingness, attitude and the ability of trainees to acquire and use such knowledge are crucial. The theory of organisational knowledge conversion discusses knowledge acquisition and knowledge transfer in the socialisation, externalization modes of knowledge creation. In this framework depicted on Figure 6.1, acquisition and transfer of knowledge on traditional healing happen through . . .

(i) Socialisation

The acquisition and sharing of knowledge during socialisation (where tacit knowledge is shared) are mainly done through observations, shared experiences and imitations and practically doing things. Traditional healers attend training full time and are expected to shadow their master at all times. They practically become an additional member of the master's house because they will stay at the master's house for the duration of the training without going home. This allows trainees to be socially connected to the master and at all times get to tap in to the master's tacit knowledge. There will constantly be discussions and conversations in relation to traditional healing which will encourage knowledge transfer. In addition to that, healers who collaborate with the master visits regularly in order to help with the training and to see to it that there is progress.

(ii) Externalization

During externalization, tacit knowledge residing in the minds of experienced healers is externalized, and made ready and easier to acquire and transfer. When the custodians of knowledge make available and share what resides in their minds, their tacit knowledge is turned in to explicit knowledge. This usually happens when experiences are shared, during formal and informal discussions or when there are collaborative projects that healers are working on.

f) Preservation

For this study, Knowledge preservation was defined as a process of protecting or the keeping safe knowledge (both tacit and explicit), especially indigenous knowledge, by traditional healers. Raseroka (2002) is of the view that without apprentices, the IK held by experienced healers becomes endangered and may be lost to the future. The theory of organisational knowledge conversion discusses knowledge preservation in the combination and internalisation modes.

(i) Internalisation

When explicit knowledge is acquired, internalised and converted in to tacit knowledge, it becomes ready to be preserved permanently inside the individuals mind. The knowledge acquired by healers during discussions and engagements with other healers get internalised to form their own personal knowledge base. Faust (2007) highlights that, the internalisation process occurs through a series of integrations in which individual concepts become concrete and ultimately absorbed as an integral belief or value. Internalisation in this regard is the process where healers preserve the knowledge they gained inside their minds for future use. It mainly involves the preservation of tacit knowledge.

(ii) Combination

Combination occurs when traditional healers combine knowledge obtained through training with the existing knowledge. In most cases trainees attend training with some knowledge of what is expected of them. The training they will receive helps them to plug some of the knowledge gaps they might have to create a higher level of knowledge. According to Nonaka and Takeuchi (1995), this mode of knowledge conversion involves combining different bodies of explicit knowledge. Healers preserve this type of knowledge differently. Others choose to store it in their mind and transfer it orally, while others have gone the route of documenting the knowledge.

6.6 Implication for theory, policy and practice

Research findings must in some way be connected to what people already know, write about or believe in relation to the topic in question (Leedy and Ormord 2014). The findings of this study may go a long way in influencing policy and practice. Indigenous practices in South Africa and Africa as a whole have for long being marginalized. Politically, in South Africa, traditional healing was theoretically impossible to do because it was illegal in the past to practice as a healer. Religiously, other religious beliefs especially Christianity, did a lot of

damage to the African belief systems including traditional healing. Africans were made to discontinue their own beliefs and to adopt foreign beliefs which were imposed on them.

Traditional healing faces extinction because of a lack of interest from the up and coming generations. The negativity and stigma attached to traditional healing potentially drives the youth away. The young African children grow up not knowing who they are and where they come from because of the little understanding that they have on the African belief system. The study therefore aims to improve understanding on how knowledge of traditional healing is acquired, transferred and preserved.

The International Federation of Library Associations (IFLA) highlighted the importance of LIS professionals becoming involved in indigenous knowledge preservation and access, and challenged libraries to take a leading role in, inter alia, collecting, preserving and disseminating indigenous knowledge; publicizing its value, contribution and importance to both indigenous and non-indigenous people; raising awareness on the protection of indigenous knowledge against misappropriation; and involving elders and communities in its production and teaching of traditional knowledge (Maina 2012). The study therefore adds to the existing theoretical and conceptual issues that form the on-going dialogue on the preservation of indigenous knowledge in South Africa.

Research into indigenous knowledge was identified as one of the niche areas of research by the NRF. LIS professionals claim to be the custodians of knowledge and information yet they have not been at the forefront in terms of managing indigenous knowledge (Ngulube 2002a). The study therefore extends and adds to the knowledge base of the IKS that currently exists, especially within the LIS profession.

The study also presented a framework for the acquisition, transfer and preservation of knowledge by indigenous healers in South Africa. It is hoped that the framework will help in increasing understanding on how knowledge of traditional healing is managed. If recommendations made in this study are taken in to consideration, they could help the practice of traditional healing to get the respect it deserves. The government has put in place policy documents but there is a lack of action.

6.7 Suggestions for further research

The current study established that LIS professionals who are supposed to be the custodians of knowledge have not been at the forefront in terms of managing indigenous knowledge. This is

despite the fact that indigenous knowledge is fast becoming an important resource in planning and management. The study was delimited to Sotho-, Tsonga- and Venda-speaking healers at the Limpopo Province of South Africa. The current study therefore brings a number of issues that would require further research. As with any research study, it is not possible to study everything, as a result the following suggestions for further investigations are made:

- This study mainly used healers to solicit data and did not include leaders from different associations of traditional healers, the leadership of the Traditional Health Practitioners Council and the representatives from the South African department of health. This was not possible due to the delimitations as explained in Chapter one. In view of the above, it is recommended that further studies investigating the status of traditional healing in South Africa, should include the above mentioned key stakeholders to obtain data for the investigation. This will give a clear picture on the status of traditional healing in the South African health sector. This will allow the investigator to draw conclusions on issues from all cites of the equation.
- The delimitations of the study also indicate that the study was limited to traditional healers from the Limpopo Province of South Africa. The study established that traditional healers create their own networks where knowledge transfer and sharing occurs. These networks are believed to be the reason why healers in the province are doing things the same even though coming from the same regions. The regions are close to one another and that makes it easy for one to have networks in all regions which then create common knowledge. It is recommended that a bigger study where healers from all provinces are investigated. The recommended study will be able to give clarity if there are similarities and differences on how Knowledge is acquired, transferred and preserved across different cultures and provinces.
- The study used phenomenology as a method to collect qualitative data, which is known to have a weakness of obtaining data that is bias or responses that are not genuine during interviews. Even though an effort was made to limit the bias by triangulating data collection instruments, perhaps a study conducted by someone who has a calling or is being tenured by an experienced healer can produce the best results from using participatory observation of the entire training.
- The study also established that some healers were adopting and using ICT's to document their knowledge. As indicated in the findings of this study, those who are chosen to practice as traditional healers may come from any level of the community. The chosen may be poor or wealthy; uneducated or educated; from rural or urban communities and so on. That perhaps indicate that there is quiet a significant number of healers who have access to ICT's and have went on to adopt this ICT's for their

daily use in traditional healing. A further investigation of ICT's adopted by healers and their use is suggested.

- The study established that at the government level traditional healing is not get enough attention and is regarded is being there to complement the National Health Systems which are mainly western. The current study therefore suggests a further investigation on how traditional healing can be fully integrated into the national health system.

LIST OF REFERENCES

- Adekannbi, J, Olatokun, WM & Ajiferuke, I. 2014. Predictors of traditional medical knowledge transmission and acquisition in South West Nigeria. *Information Development*. Available at: <http://idv.sagepub.com/content/early/2014/12/09/0266666914561534.full.pdf+html>, (Accessed: 12 December 2014).
- Anand, G, Ward, PT & Tatikonda, MV. 2010. Role of explicit and tacit knowledge in Six Sigma projects: An empirical examination of differential project success. *Journal of Operations Management*, 28: 303–315.
- Anyaku, EN, Orizu, E & Eneh, E. 2015. Collection and Preservation of Traditional Medical Knowledge: Roles for Medical Libraries in Nigeria. *Journal of Library and Information Sciences*, 3(1): 33-43.
- Argote, L & Ingram, P. 2000. Knowledge transfer: a basis for competitive advantage in firms, *Organizational Behavior and Human Decision Processes*, 82 (2000), 150-169.
- Alasuutari, P, Bickman, L & Brannen, J. 2008. *The sage handbook of social research methods*. London: Sage.
- Ashforth, A. 2005. *Witchcraft, violence, and democracy in South Africa*. London: University of Chicago Press.
- Aspirin foundation. 2017. *Aspirin timeline*. Available at: <http://www.aspirin-foundation.com/history-of-aspirin/aspirin-timeline/> (Accessed: 12 July 2017).
- Ayittey, GBN. 1991. *Indigenous African institutions*. New York: Transnational Publishers.
- Babbie, ER & Mouton, J. 2011. *The practice of social research*. Cape Town: Oxford University Press.
- Beckman, TJ. 1999. The current state of knowledge management. In: J Liebowitz (ed.). *The knowledge management handbook*, pp 1-19, New York: CRC Press.
- Boisot, M. 1995. *Information space: a framework for learning in organizations, institutions, and culture*. New York: Routledge.
- Boisot, M. 1998. *Knowledge assets: securing competitive advantages in the information economy*. New York: Oxford University Press

- Boisot, M. 2004. *Exploring the information space: a strategic perspective on information systems*. Available at: <http://www.uoc.edu/in3/dt/20415/index.html> (Accessed: 15 June 2016).
- Bojuwoye, O. 2005. Traditional healing practices in Southern Africa: ancestral spirits, ritual ceremonies, and holistic healing. In: R Moodley & W West (eds.). *Integrating Traditional Healing Practices into Counselling and Psychotherapy*, edited by University of South Africa: Sage. 61-71.
- Bopape, MA, Mothiba, TM & Malema, RN. 2013. Indigenous practices of Traditional Health Practitioners (THPs) methods by mothers of children admitted to the Polokwane/Mankweng hospital complex, Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, March (Supplement 1), 147-158.
- Boston, MA. Dhanaraj, C, Lyles, MA, Steensma, HK & Tihanyi, L. 2004. Managing tacit and explicit knowledge transfer in IJVs: the role of relational embeddedness and the impact on performance. *Journal of International Business Studies*, 35: 428-442.
- Brock-Utne, B. 2001. Indigenous conflict resolution in Africa. A draft presented to the weekend seminar on indigenous solutions to conflicts held at the University of Oslo, Institute of Educational Research February 23-24, 2001. pp. 1-16. Available at: <http://www.africavenir.com/publications/occasional-papers/BrockUtneTradConflictResolution.pdf> (Accessed: 25 January 2016).
- Brand South Africa. 2014. Ensuring boys' safety during traditional initiations. Available: <https://www.brandsouthafrica.com/governance/health-services/circumcision-230614> (Accessed: 19 January 2017).
- Bryman, A. 2008. *Social research methods*. New York: Oxford University Press.
- Bryman, A. 2012. *Social research methods*. New York: Oxford University Press.
- Campbell, LM & Amin, NN. 2014. A qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa. The international electronic journal of rural and remote health research, education practice and policy. Available: <http://www.rrh.org.au> (Accessed 19 January 2017).
- Chigada, J & Ngulube, P. 2015, Knowledge management practices at selected banks in South Africa. *South African Journal of Information Management* 17(1).

- Chilisa, B. 2012. *Indigenous research methodologies*. California: Sage publications.
- Choo, C. 1998. *The knowing organization*. New York: Oxford University Press.
- Creswell, JW. 2007. *Qualitative inquiry and research design: choosing among five approaches*. 2nd ed., Thousand Oaks: Sage.
- Creswell, JW. 2013. *Qualitative inquiry and research design: choosing among five approaches*. 3rd ed., Thousand Oaks: Sage.
- Creswell, JW. 2014. *Research design: qualitative, quantitative, and mixed methods approaches*. Thousand Oaks: Sage.
- Cryer, P. 2006. *Research student's guide to success*. Maidenhead: McGraw-Hill/ Open University.
- Cyr, S & Choo, CW. 2010. The individual and social dynamics of knowledge sharing: an exploratory study. *Journal of Documentation*, 66(6): 824 – 846.
- Dalkir, M. 2005. *Knowledge management in theory and practice*. Butterworth-Heinemann: Elsevier.
- De Vos, AS, Strydom, H, Fouche, CB & Delport, CSL. 2011. *Research at grass roots: for the social sciences and human service professions*. 4th ed., Pretoria: Van Schaik.
- Denbow, J & Thebe, PC. 2006. *Culture and customs of Botswana*. London: Greenwood press.
- Denis, P. 2006. The rise of traditional African religion in post-apartheid South Africa. *Missionalia* 34(2/3): 310–323.
- Dictionary.com. 2017. *Preservation*. Available at: <http://www.dictionary.com/browse/preservation> (Accessed 11 July 2017).
- Ebermann, P. 2012. *Patents as protection traditional medical knowledge*. Cambridge: Intersentia Publishing.
- Faust, B. 2007. *Implementation of tacit knowledge preservation and transfer methods*. Available at: <http://www.fraserhealth.ca/media/Implementation-of-Tacit-Knowledge-Presevation-and-Transfer-Methods.pdf> (Accessed 23 May 2016).
- Freeman M & Motsei, M. 1992. Planning health care in South Africa-is there a role for Traditional Healers? *Social Science and Medicine* 32(11):1183-1190.

- Garavelli; AC, Gorgoglione, M & Scozzi, B. 2002. Managing knowledge transfer by knowledge technologies. *Technovation* 22: 269–279.
- Government Gazette. 2008. *See* Parliament of South Africa.
- Harmaakorpi, V & Melkas, H. 2005. Knowledge management in regional innovation networks: The case of Lahti, Finland. *European planning studies*, 13(5):641-659.
- Hey J. 2004. The data, information, knowledge, wisdom chain: the Metaphorical link. Available at: <http://www.dataschemata.com/uploads/7/4/8/7/7487334/dikwchain.pdf>
Date accessed: 2016/05/04.
- Hoff, W. 1992. Traditional healers and community health. *World Health Forum*, 13:182-187.
- Ijumba, P & Barron, P. 2005. *South African health review*, Health System Trust. Available at: <http://www.hst.org.za/publications/south-african-health-review-2005> (Accessed: 24 June 2015).
- Jain, P. 2007. An empirical study of knowledge management in academic libraries in East and Southern Africa. *Library Review* 56(5): 377-392.
- Jalonen, H. 2014. Social media and emotions in organizational knowledge creation. *Proceedings of the 2014 Federated Conference on Computer Science and Information Systems. WARSAW*, pp: 1371-1379.
- Kale, R. 1995. Traditional healers in South Africa: a parallel health care system. *British media journal*, 310:1182-1185.
- Kalusopa T. 2011. *Developing an e-records readiness framework for labour organisations in Botswana*. PHD Thesis. Pretoria, University of South Africa.
- Kaniki, AM & Mphahlele, MEK. 2002. Indigenous knowledge for the benefit of all: can knowledge management principles be used effectively? *SCECSAL 2002 (From Africa to the world- the globalisation of indigenous knowledge systems*, Pretoria: The library and Information Association of South Africa.
- Katz, JS & Martin, BR. 1997. *What is research collaboration?* Available at: http://www.sussex.ac.uk/Users/sylvank/pubs/Res_col9.pdf (Accessed: 06 December 2016).
- Keyton, J. 2006. *Case studies for organizational communication: Understanding communication processes*. 2nd ed, Los Angeles: Roxbury.

- Koskinen, KU, Pihlanto, P & Vanharanta, H. 2003. Tacit knowledge acquisition and sharing in a project work context. *International Journal of Project Management*, 21:281–290.
- Kothari, C R. 2004. *Research methodology: methods and techniques*. 2nd rev. ed. New Delhi: New Age International
- Ladio, A, Lozada, M & Weigandt, M. 2007. Comparison of traditional wild plant knowledge between aboriginal communities inhabiting arid and forest environments in Patagonia, Argentina. *Journal of Arid Environments* 69: 695-715.
- Leedy, PD & Ormrod, JE. 2010. *Practical research: planning and design*. 9th ed., New Jersey: Pearson education, Inc.
- Liao, S, Wu, C, Hu, D & Tsui, K. 2010. Relationships between knowledge acquisition, absorptive capacity, and innovation capability: an empirical study on Taiwan's financial and manufacturing industries, *Journal of Information Science*, 36(1):19-35.
- Limpopo Provincial Government. 2014. Limpopo. Available at: http://www.limpopo.gov.za/index.php?option=com_content&view=article&id=6&Itemid=11 (Accessed: 17 June 2016).
- Limpopo Tourism Agency. 2017. *Limpopo regions*. Available at: <http://www.golimpopo.com/regions> (Assessed: 24 February 2017).
- Logwa, ET, Ngulube P & Stilwell, C. 2010. Understanding indigenous knowledge: bridging the knowledge gap through a knowledge creation model for agricultural development. *South African Journal of Information Management*, 12(1):436-438.
- Macintosh A. 1996. *Position paper on knowledge asset management*. Artificial Intelligence Applications Institute University of Edinburgh, Scotland.
- Maher, P. 1999. A review of traditional aboriginal health beliefs. *Australian Journal of Rural Health*, 7:229-236.
- Maina, CK. 2012. Traditional knowledge management and preservation: Intersections with Library and Information Science. *The International Information & Library Review*, 44: 13-27.
- Malhotra, A & Majchrzak, A. 2012. How virtual teams use their virtual workspace to coordinate knowledge. *ACM Transactions on Management Information Systems*, 3(1): 1-14.
- Mathibela, MK, Egan, BA, Du Plessis HJ & Potgieter, MJ. 2015. Socio-cultural profile of Bapedi traditional healers as indigenous knowledge custodians and conservation

- partners in the Blouberg area, Limpopo Province, South Africa. *Journal of Ethnobiology and Ethnomedicine*, 11:49.
- Mavodza, J & Ngulube, P. 2011. Exploring the use of knowledge management practices in an academic library in a changing information environment. *South African Journal of Libraries and Information Science*, 77(1):15-25.
- Mazour, T. 2006. Knowledge preservation and transfer: issues and terminology. In: *Proceedings of School of Nuclear Knowledge Management*, September 18-22, 2006.
- Mbatha, N, Street, AR, Ngcobo, M & Gqaleni, N. 2012. Sick certificates issued by South African Traditional Health Practitioners: current legislation, challenges and the way forward. *South African Medical Journal*, 102(3):129-131. Available at: <<http://www.samj.org.za/index.php/samj/article/view/5295/3909>> (Accessed: 13 June 2016).
- McMahon, K. 2015. Knowledge preservation for repository systems, paper presented to the *ANS International High Level Radioactive Waste Management Conference April 13 - 16, 2015*, Charleston, South Carolina.
- Mngqundanisoa, N & Peltzerb, K. 2008. Traditional healers and nurses: a qualitative study on their role on sexually transmitted infections including HIV and aids in KwaZulu-Natal, South Africa.
- Mogawane, MA, Mothiba, TM & Malema, RN. 2015. Indigenous practices of pregnant women at Dilokong Hospital in Limpopo Province, South Africa. *Curationis*, 38(2).
- Moghaddam, JF, Momper, SL & Fong, TW. 2015. Crystalizing the role of traditional healing in an urban Native American health centre. *Community Mental Health Journal*, 51:305-314.
- Mokgobi, MG. 2014. Understanding traditional African healing. *African Journal for Physical, Health Education, Recreation and Dance (AJPHERD) Supplement 2 (September)*, 24-34.
- Moodley, R, Sutherland, P & Oulanova, O. 2008. Traditional healing, the body and mind in psychotherapy. *Counselling Psychology Quarterly*, 21(2): 153-165.
- Myers, M D. 2002. *Qualitative research in information systems: A reader*. London: Sage

- Neuman, WL .2006. *Social research methods: qualitative and quantitative approaches*. 6th ed., Boston: Allyn and Bacon.
- Neuman, WL. 2011. *Social research methods: qualitative and quantitative approaches*. 7th ed., Boston: Allyn and Bacon.
- Neville, C. 2010. *The complete guide to referencing and avoiding plagiarism*. 2nd ed., Bergshire: Open University Press.
- Ngoepe, M & Setumu, T. 2016. Converting oral narratives into written literature: lessons learnt from heritage projects undertaken in the Makgabeng area, Limpopo, South Africa. *Mousaion* 34(3): 15-30.
- Ngulube, P. 2002a. Managing and preserving indigenous knowledge in the knowledge management era: challenges and opportunities for information professionals. *Information Development*, 18(2): 95-101.
- Ngulube, P. 2002b. Strategies for managing and preserving indigenous knowledge in the management era, *SCECSAL 2002 (From Africa to the world – the globalisation of indigenous knowledge systems)*, Pretoria: The library and Information Association of South Africa.
- Ngulube, P. 2003. *Preservation and access to public records and archives in South Africa*. PhD Thesis (Information Studies). Pietermaritzburg: University of Natal.
- Ngulube, P. 2013. Blending Qualitative and Quantitative Research Methods in Library and Information Science in Sub-Saharan Africa. *ESARBICA Journal: Journal of the Eastern and Southern Africa Regional Branch of the International Council on Archives*, 32: 10-25.
- Ngulube P, Mathipa, ER & Gumbo, MT. 2015. Theoretical and conceptual framework in the social sciences. In: Mathipa ER, Gumbo MT(eds.) *Addressing Research Challenges: Making headway in developing researchers*. Mosala-MASEDI Publishers & Booksellers cc: Noordyk, :43–66.
- Ngulube, P, Dube L & Mhlongo, M. 2015. Towards a cartography of indigenous knowledge systems in library and information science training and education in Anglophone Eastern and Southern Africa. *Indilinga – African Journal of Indigenous Knowledge Systems*, 14 (2):145-168.
- Ngulube, P & Ngulube, B. 2017. Application and contribution of hermeneutic and eidetic phenomenology to indigenous knowledge systems research. In: P. Ngulube (ed.).

Handbook of research on theoretical perspectives on indigenous knowledge systems in developing countries. IGI Global. 128 – 150.

Nonaka, I. 1994. A Dynamic Theory of Organizational Knowledge Creation. *Organization Science*, 5(1):14-37.

Nonaka, I & Takeuchi, H. 1995. *The knowledge-creating company*. Oxford University Press, New York.

Nonaka, I, Toyama, R & Konno, N. 2000. SECI, Ba and leadership: a unified model of dynamic knowledge creation. *Long Range Planning* 33:5-34.

Onyancha, OB & Ngulube, P. 2011. What's in a name? Using informetric techniques to conceptualize the knowledge of traditional and indigenous communities. *INDILINGA – African journal of indigenous knowledge systems*, 10(2):129-152.

Pacharapha, T & Ractham, VV. 2012. Knowledge acquisition: the roles of perceived value of knowledge content and source. *Journal of Knowledge Management*, 16(5): 724-739.

Parliament of South Africa. 2005. Witchcraft Suppression Act, No. 3 of 1957. Available at: <http://www.justice.gov.za/legislation/acts/1957-003.pdf> (Accessed: 10 June 2016).

Paulin, D & Suneson, K. 2012. Knowledge transfer, knowledge sharing and knowledge barriers – Three blurry terms in KM” *The Electronic Journal of Knowledge Management*, 10(1):81-91.

Polanyi, M.1966. *The tacit dimension*. London: Routledge.

Poorna, R, Mymoon, M & Hariharan, A. 2014. Preservation and protection of traditional knowledge – diverse documentation initiatives across the globe. *Current Science*, 107(8):1240-1246.

Popat A, Shear, NH, Malkiewicz, I, Stewart, MJ, Steenkamp V, Thomson, S & Neuman, MG. 2001. The toxicity of *Callilepis laureola*, a South African traditional herbal medicine. *Clinical Biochemistry* 34 (2001) 229-236.

Punch, K. 2014. *Introduction to social research: quantitative & qualitative approaches*. Los Angeles, California: Sage.

Randolph, J. 2009. A Guide to writing the dissertation literature review. *Practical assessment, research & evaluation*, 14(13). Available at: <http://pareonline.net/getvn.asp?v=14&n=13> (Assessed: 06 November 2015).

- Rankoana, SA. 2014. Self-medication through administration of indigenous plant medicine among the Northern Sotho people of Limpopo Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, October (Supplement 1:2), 494-501.
- Rankoana, SA, Nel, K, Mothibi, K, Mothiba, TM, Mamogobo, P & Setwaba, M. 2015. The use of indigenous knowledge in primary health care: A case study of Makanye community in Limpopo Province. *South Africa. African Journal for Physical, Health Education, Recreation and Dance, Supplement 1:2 (October)*, 272-278.
- Rankopo, MJ. 1996. The influence of traditional health practices on human development: implications for human service delivery. In: H Normann, I Synaman & M Cohen (eds.). *Indigenous knowledge and its uses in Southern Africa*. Pretoria: Human Science Research Council. 13-27.
- Raseroka, HK. 2002. From Africa to the world – the globalisation of indigenous knowledge systems: setting the scene, *SCECSAL 2002 (From Africa to the world- the globalisation of indigenous knowledge systems)*, Pretoria: The library and Information Association of South Africa.
- Risenga, PR, Botha, A & Tjallinks, JE. 2007. Shangaan patients and traditional healers' management strategies of hypertension in Limpopo Province. *Curationis* 30(2): 4-11
- Ritcher, M. 2003. Traditional medicines and traditional healers in South Africa: a *discussion paper prepared for the Treatment Action Campaign and AIDS Law Project*. Available at: http://www.hst.org.za/uploads/files/TAC_Law_Proj.pdf (Accessed 22 February 2017).
- Ryu, C, Kim, YJ, Chaudhury, A & Rao, HR. 2005. Knowledge acquisition via three learning processes in enterprise information portals: learning-by-investment, learning-by-doing, and learning-from-others. *MIS Quarterly* 29(2): 245-278.
- Salonius, H & Kapyla, J. 2013. Exploring the requirements of regional knowledge-based management. *Journal of Knowledge Management*, 17(4):583-597.
- Sarantakos, S. 2013. *Social research*. 4th ed., Palgrave Macmillan.
- Shanhong, T. 2000. *Knowledge management in libraries in the 21st century*. Available at: <http://www.ifla.org/IV/ifla66/papers/057-110e.htm> (Accessed 04 March 2015).

- Semenya, SS & Potgieter, M. 2014. Bapedi traditional healers in the Limpopo Province, South Africa: their socio-cultural profile and traditional healing practice. *Journal of Ethnobiology and Ethnomedicine*, 10(4).
- Sodi, T, Mudhovozi, P, Mashamba, T, Radzilani-Makatu, M, Takalani J & Mabunda, J. 2011. Indigenous healing practices in Limpopo Province of South Africa: a qualitative study. *International Journal of Health Promotion and Education*, 49(3): 101-110.
- South African Government. 2013. *Deputy Minister Gwen Ramokgopa reports on progress made on Traditional Medicine programme*. Available at: <http://www.gov.za/deputy-minister-gwen-ramokgopa-reports-progress-made-traditional-medicine-programme> (Accessed 20 February 2017).
- Sowetan. 2016. *Celebs who have answered their ancestral calling*. Available at: <http://www.sowetanlive.co.za/entertainment/2016/06/13/celebs-who-have-answered-their-ancestral-calling-photos> (Accessed: 16 November 2016).
- Summerton, JV. 2006. Western health practitioners' view about African traditional health practitioner's treatment and care of people living with HIV/AIDS. *Curationis*, 29(3):15-23.
- Sushila, DM. 2015. Indigenous traditional healing care: belief & practices among Tribals of South Bastar in Chhattisgarh. *IOSR Journal of Humanities and Social Science*, 20(1):49-54.
- Szulanski, G, Ringov, D & Jensen, RJ. 2016. Overcoming stickiness: how the timing of knowledge transfer methods affects transfer difficulty. *Organization Science* 27(2):304-322.
- University of South Africa. 2007. *Policy on research ethics*. Available at: http://www.unisa.ac.za/cmsys/staff/contents/departments/res_policies/docs/ResearchEthicsPolicy_apprvCounc_21Sept07.pdf (Accessed: 16 April 2013).
- Thapa, N, & Devi, S. 2015. Preservation of the traditional knowledge of Tribal population in India. The Government Initiatives. *4th International Symposium on Emerging Trends and Technologies in Libraries and Information Services (ETTLIS)*, January 6- 8, 2015: 99-103.
- Tjiek, LT. 2006. Desa Informasi: the role of digital libraries in the preservation and dissemination of indigenous knowledge, *International Information & Library Review*, 38(3):123-131.

- Traditional Healers Organisation. 2012. *Traditional healers say no to integration*. Available: <http://tho-news.blogspot.co.za/2012/11/traditional-healers-say-no-to.html> (Accessed: 13 June 2016).
- Truter, I. 2007. African traditional healers: cultural and religious beliefs intertwined in a holistic way. *SA Pharmaceutical Journal*. (September):56-60.
- Ugwu, C, Ekere JN & Ekere,FC. 2014. Knowledge processes for successful application of knowledge management in university libraries in Nigeria. *International journal of library and information science*, 3(1):32-48.
- Von Krogh, G, & Roos, J. 1995. *Organizational epistemology*. New York: St. Martin's Press.
- Wyatt, CJ. 2001. Management of explicit and tacit knowledge. *Journal of the Royal Society of Medicine*, 94:6-9.
- Welman, C, Kruger, S & Mitchell, B. 2005. *Research methodology*. Cape Town: Oxford University Press.
- Wiig, K. 1993. *Knowledge management foundations: thinking about thinking. How people and organizations create, represent and use knowledge*. Arlington, TX: Schema Press.
- Williamson, K & Bow, A. 2000. Analysis of quantitative and qualitative dat. In: K Williamson (ed.). *Research methods for students and professionals: information management and systems*. Wagga Wagga New South Wales, Charles Stuart University. 267-285.
- Winkleman, MJ. 1990. Shamans and other magico-religious healers: a cross-cultural study of their origins, nature, and social transformations. *Ethos*, 18(3): 308-352.
- World Health Organization. 1976. *African Traditional Medicine: African Technical Report Series No 1*. Congo Brazaville: WHO Regional Office for Africa.
- World Health Organization. 1998. *Regulatory situation of herbal medicines: a worldwide review*. Geneva.
- Thembelihle Zuma, T, Wight, D, Rochat, T & Moshabela, M. 2016. The role of traditional health practitioners in Rural KwaZulu-Natal, South Africa: generic or mode specific? *BMC Complementary and Alternative Medicine*, 16(1):304

APPENDICES

APPENDIX A: INTERVIEW GUIDE

**ACQUISITION, TRANSFER AND PRESERVATION OF INDIGENOUS
KNOWLEDGE BY TRADITIONAL HEALERS IN THE LIMPOPO PROVINCE OF
SOUTH AFRICA**

Section A: General Information

1. Gender

Male Female

2. Age

15 – 20 21 – 30 31 – 40 41 – 50 51 and above

3. Are you a qualified healer?

Yes

No

I am a student

Other(specify) -----

-----.

4. For how many years have you been using the knowledge of traditional healing?

0 – 2 3 – 5 6 – 10 11 – 15 16 and more

5. How many students have you graduated?

0 3 – 5 6 – 10 11-15 16 and more

Section B: The status of indigenous healing in the of Limpopo province of South Africa

5. How do you find your job as a traditional healer in the Province?

6. What challenges did you face during your time as a traditional healer?

7. Do you only subscribe to the ancestral beliefs or there are there other beliefs you subscribe to?

8. How do you market your services?

9. Do you belong to a professional association?

If yes (specify)

If No (Please explain why)

10. What is your take on collaboration between western doctors and traditional healers?

11. Have you referred patients to the hospital before?

Yes

No

If yes, why did you refer the patient?

If No explain why not:

12. Have you ever received patients referred to you from the hospital?

Yes

No

If yes, did you get to know why they were referred to you?

13. Are you willing to work with western medical practitioners in dealing with health issues in the province?

Yes

No

Please explain:

14. What is current situation concerning traditional healing in the province?

15. What do you think can be done to improve or enhance the situation for the better?

16. What else would you like to add?

Section C: Knowledge acquisition among indigenous healers in the Limpopo province of South Africa.

17. How did you become a healer?

18. How and why did you select your mentor?

19. How long did it take you to complete your training?

20. What were you mostly doing during training?

21. Did you master everything that was shown to you? Please explain

22. How involved were you during the healing of patients while you were a student?

23. What are the methods used to share experiences during training?

24. What more can you add with regards to how you acquired knowledge of traditional healing?

Section D: Knowledge transfer among indigenous healers in the Limpopo province of South Africa.

25. How do you transfer skills and knowledge of traditional healing to your trainees?

26. How was the knowledge of traditional healing transferred to you?

27. What is the nature of your relationship with other healers?

28. What are the methodologies employed to transfer knowledge among healers?

29. How common is knowledge sharing among traditional healers?

30. What more can you add concerning knowledge transfer among healers?

Section E: Knowledge preservation among indigenous healers in the Limpopo province of South Africa.

31. How do you make sure that the knowledge you gained over the years is preserved for future use?

32. What are the methodologies employed to preserve this knowledge by healers?

33. How do you ensure that the correct knowledge is preserved?

34. What more can you add with regards to knowledge preservation by healers?

Thank you for your time and generosity in helping with this project.

APPENDIX B: ETHICAL CLEARANCE

DEPARTMENT OF INFORMATION SCIENCE RESEARCH ETHICS REVIEW COMMITTEE

Date: 22 July 2016

Dear Mr Maluleka,

Decision: Ethics Approval

Ref #: [2016_IS32692315_040]

Name of applicant: Mr JR
Maluleka

Student #:32692315

Name: Mr JR Maluleka, P.O. Box 392 Unisa 0003, maluljr@unisa.ac.za, 072 4066855

Supervisor: Prof M Ngoepe, Department of Information Science, Unisa, 012 4296360

Co-supervisor: Prof P Ngulube, School of Interdisciplinary Research and Postgraduate Studies, Unisa, 012 429 3832.

Proposal: Acquisition, Transfer and Preservation of Indigenous Knowledge by Traditional Healers in the Limpopo Province of South Africa

Qualification: Postgraduate PhD degree

Thank you for the application for research ethics clearance by the Department of Information Science Research Ethics Review Committee for the above mentioned research. Final approval is granted for the duration of the project.

For full approval: *The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Department of Information Science, RERC on 22 July 2016.*

The proposed research may now commence with the proviso that:

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Department of Information Science Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

Note:

The reference number [2016_IS32692315_40] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Department of Information Science RERC.

Kind regards,



Prof GV Jiyane

Department of Information Science

012 429 6057

APPENDIX C: INFORMED CONSENT

CONSENT TO PARTICIPATE IN INTERVIEW

ACQUISITION, TRANSFER AND PRESERVATION OF INDIGENOUS KNOWLEDGE BY TRADITIONAL HEALERS IN THE LIMPOPO PROVINCE OF SOUTH AFRICA

Dear Prospective Participant

My name is Maluleka Jan Resenga and I am doing research with Mpho Ngoepe and Patrick Ngulube, professors in the Department of Information Science towards a doctoral degree at the University of South Africa. We are inviting you to participate in a study entitled Acquisition, Transfer and Preservation of Indigenous Knowledge by Traditional Healers in the Limpopo Province of South Africa.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this qualitative study is to investigate the acquisition, transfer and preservation of indigenous knowledge by traditional healers in South Africa, in order to understand how this knowledge can be managed

WHY AM I BEING INVITED TO PARTICIPATE?

You were selected as a possible participant in this study because you are regarded as one of the custodians of this knowledge. Fellow colleagues in the province who worked with you previously referred us to you. We will be interviewing approximately 50 healers and students across all regions in the province.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

This is a semi-structured interview where open-ended questions will be asked to you to try and answer our research questions. Your experience and knowledge as the targeted participant in this study will help answer research questions for this study. We would like to record this interview so that we can use it for reference while proceeding with this study. We will not record this interview without your permission. If you do grant permission for this conversation to be recorded, you have the right to revoke recording permission and/or end the interview at any time. The interview will take around 45 minutes of your time. We may come back for a follow-up interview within three months if the exercise is not complete.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is no potential harm or discomfort foreseen for participating in this study. The researchers will ensure that no potential harm may occur to the study participants.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Explain the extent, if necessary, to which confidentiality of information will be maintained.

You have the right to insist that your name will not be recorded anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings.

Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

The researcher will store hard copies of your answers for a period of five years in a locked cupboard/filing cabinet in a secured place for future research or academic purposes; electronic information will be stored on a password-protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will then be shredded and electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the Research Ethics Review Committee of the [identify the relevant ERC], Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

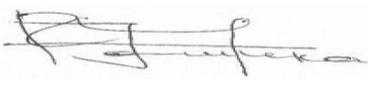
If you would like to be informed of the final research findings, please contact Jan Maluleka on 0124296004 or maluljr@unisa.ac.za.

Should you require any further information or want to contact the researcher about any aspect of this study, please contact Jan Maluleka on 0124296004 or via email on maluljr@unisa.ac.za or maluljrm@gmail.com.

Should you have concerns about the way in which the research has been conducted, you may contact Prof Mpho Ngoepe on 0124296360 or via email at ngoepms@unisa.ac.za alternatively; contact the research ethics chairperson of the department of Information Science Prof Veli Jiyane on 0124296057 or via email at Jiyangv@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.



Maluleka Jan Resenga

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I had a chance to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the Interview.

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

Participant Name & Surname (Please print)

Participant Signature.....Date.....

Researcher's Name & Surname..... (Please print)

Researcher's signature.....Date.....



Government Gazette

REPUBLIC OF SOUTH AFRICA

Vol. 511 Cape Town

10 January 2008

No. 30660

THE PRESIDENCY

No. 42

10 January 2008

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:—

No. 22 of 2007: Traditional Health Practitioners Act, 2007.



AIDS HELPLINE: 0800-123-22 Prevention is the cure

No. 30660

GOVERNMENT GAZETTE, 10 JANUARY 2008

Act No.:22, 2007

TRADITIONAL HEALTH PRACTITIONERS ACT, 2007

ACT

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

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

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CHAPTER I

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Definitions

1. In this Act, unless the context indicates otherwise
"accredited institution" means an institution, approved by the Council, which

certifies that a person or body has the required capacity to perform the functions within the sphere of the National Quality Framework contemplated in the South African Qualifications Authority Act, 1995 (Act No. 58 of 1995);

6 No. 30660

GOVERNMENT GAZETTE, 10 JANUARY 2008

Act No.11, 2007

TRADITIONAL HEALTH PRACTITIONERS ACT, 2007

"Council" means the Imerim Traditional Health Practitioners Council of South Africa established by section 4;

"Department of Health" means the national Department of Health;

"diviner" means a person who engages in traditional health practice and is registered as diviner under this Act;

"health establishment" means any public or private institution, facility, agency, building or place or part thereof, whether organised for profit or not, that is operated or designed to provide health services;

"health services" includes inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventative health services;

"herbalist" means a person who engages in traditional health practice and is registered a herbalist under this Act;

"member" means a member of the Council and includes a member of a committee of the Council;

"Minister" means the Minister responsible for the national Department of Health;

"prescribed" means prescribed by regulation;

"register" means a register contemplated in section 19(I)(c);

"registrar" means the registrar of the Council appointed in terms of section 18;

"rule" means a rule made under section 40 or 48;

"speciality", in relation to any of the categories, includes any particular sphere of extensive knowledge and skill in which a traditional health practitioner specialises;

"student" means a person training to be a traditional health practitioner;

"this Act" includes any regulation, rule, proclamation or order issued or made thereunder;

"traditional birth attendant" means a person who engages in traditional health practice and is registered as a traditional birth attendant under this Act;

"traditional health practice" means the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object-

(a) the maintenance or restoration of physical or mental health or function; or

(b) the diagnosis, treatment or prevention of a physical or mental illness; or

(c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or

(d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death,

but excludes the professional activities of a person practising any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based on traditional philosophy;

"traditional health practitioner" means a person registered under this Act in one or more of the categories of traditional health practitioners;

"traditional medicine" means an object or substance used in traditional health practice for-

(a) the diagnosis, treatment or prevention of a physical or mental illness; or

(b) any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings,

but does not include a dependence-producing or dangerous substance or drug;

"traditional philosophy" means indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice;

"traditional surgeon" means a person registered as a traditional surgeon under this Act;

"traditional tutor" means a person registered under any of the prescribed categories of traditional health practice who has been accredited by the Council to teach traditional health practice or any aspect thereof;

"unprofessional conduct" means any act or omission which is improper or disgraceful or dishonourable or unworthy of the traditional health profession. 5

Purpose of Act

2. The purpose of this Act is to—
- (a) establish the Interim Traditional Health Practitioners Council of South Africa;
 - (b) provide for the registration, training and practices of traditional health practitioners in the Republic; and 10
 - (c) serve and protect the interests of members of the public who use the services of traditional health practitioners.

Application of Act

3. This Act applies to—
- (a) traditional health practice in the Republic; and 15
 - (b) traditional health practitioners and students engaged in or learning traditional health practice in the Republic.

CHAPTER 2

ESTABLISHMENT AND GOVERNANCE OF INTERIM TRADITIONAL HEALTH PRACTITIONERS COUNCIL OF SOUTH AFRICA 20

Establishment of Interim Traditional Health Practitioners Council

4. (1) A juristic person to be known as the Interim Traditional Health Practitioners Council of South Africa is hereby established.

(2) The registrar must convene the first meeting of the Council within three months of the commencement of this Act. 25

(3) The term of office for the Council is three years, but the Minister may, in order to facilitate the implementation of, or development of amendments to, this Act, extend the term of office of the Council for a further period of not more than 24 months.

Objects of Council

5. The objects of the Council are to— 30
- (a) promote public health awareness;
 - (b) ensure the quality of health services within the traditional health practice;
 - (c) protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners;
 - (d) promote and maintain appropriate ethical and professional standards required 35 from traditional health practitioners;
 - (e) promote and develop interest in traditional health practice by encouraging research, education and training;
 - (f) promote contact between the various fields of training within traditional health practice in the Republic and to set standards for such training; 40
 - (g) compile and maintain a professional code of conduct for traditional health practice; and
 - (h) ensure that traditional health practice complies with universally accepted health care norms and values.

Functions of Council

6. (1) The Council may-

- (a) make enquiries and conduct investigations into complaints and allegations concerning the conduct of registered traditional health practitioners; 5
- (b) issue guidelines concerning traditional health practice; 5
- (c) hire, purchase or otherwise acquire any movable property or proprietary right, accept and administer any trust or donations and lease or dispose of property so acquired, but may only acquire or dispose of immovable property with the approval of the Minister, granted with the agreement of the Minister of Finance; 10
- (d) make rules on matters necessary or expedient for the proper implementation of this Act; 10
- (e) consider any matter affecting the registration of traditional health practitioners and make representations or take other action in connection therewith; 15
- (f) in writing and on such conditions as the Council may determine, delegate or assign any power or duty of the Council to any committee or a member of any committee, but such delegation or assignment does not divest the Council of the responsibility or accountability concerning the performance of the function involved; 15
- (g) cause copies of the registers or of supplementary lists containing amendments to the relevant registers, to be printed and published; 20
- (h) require from a registered traditional health practitioner such information as is necessary to enable the Council to carry out its functions effectively; 25
- (i) approve minimum requirements pertaining to the education and training of traditional health practitioners in consultation with relevant departments, quality assessment bodies or a body of traditional health practitioners accredited by the Council for this specific purpose; 25
- (j) appoint such persons as the Council considers necessary to assist the Council in performance of its functions; and 30
- (k) generally do all such things as are necessary to enable the Council to perform its functions in terms of this Act. 30

(2) The Council must

- (a) in the interests of the public, promote and regulate, liaison between traditional health practitioners and other health professionals registered under any law; 35
- (b) implement health policies determined by the Minister concerning traditional health practice; 35
- (c) advise the Minister on any matter falling within the scope of this Act, including the health needs of the people of South Africa, and the traditional health practice, and on matters of democracy, transparency, equity, accessibility and community involvement affecting the occupation of traditional health practice; 40
- (d) communicate to the Minister information of public importance acquired by the Council in the course of the performance of its functions under this Act; 45
- (e) consult and liaise with relevant authorities on matters that affect traditional health practitioners and involve traditional health practice; 45
- (f) in consultation with the Minister, determine policy, and in accordance with policy determinations, make decisions regarding matters relating to the educational framework, fees, funding, registration procedure, code for professional conduct and ethics, disciplinary procedure and scope of traditional health practice; 50
- (g) control and exercise authority in respect of all matters concerning the training of persons in traditional health practice and the conduct of its members; 50
- (h) in consultation with the Minister, control and regulate traditional health practice; 55
- (i) establish registers for the various categories of traditional health practitioners; 55

- (j) registered persons who engage in traditional health practice in accordance with the prescribed requirements for registration;
- (k) in such circumstances as may be prescribed, or where authorised by this Act, remove a person's name from the register or, 'must' upon payment of the prescribed fee, restore a person's name to the register; 5
- (f) obtain from any registered traditional health practitioner payment of the prescribed fee;
- (m) in such circumstances as may be prescribed, suspend or cancel any traditional health practitioner's registration; and
- (n) publish information regarding the objects and functions of the Council and its operations and the rights that any member of the public has under this Act. 10

Constitution of Council

7. The Council consists of a maximum of 22 members, appointed by the Minister in the prescribed manner, of whom-

- (a) one must be a traditional health practitioner appointed as the chairperson of the Council by the Minister; 15
- (b) one is the vice-chairperson of the Council and is elected by the members of the Council from amongst their number;
- (c) nine must be traditional health practitioners, one from each province, of whom each must have been in practice for not less than five years; 20
- (d) one must be an employee in the service of the Department of Health;
- (e) one must be appointed on account of his or her knowledge of the law;
- (f) one must be a medical practitioner who is a member of the Health Professions Council of South Africa;
- (g) one must be a pharmacist who is a member of the South African Pharmacy Council; 25
- (h) three must be community representatives; and
- (i) one must be a representative from each category of traditional health practitioners defined in this Act.

Vacation of office and filling of vacancies 30

8. (1) A member of the Council must vacate his or her office if-

- (a) he or she ceases to be a South African citizen;
- (b) he or she is diagnosed as having a mental illness or becomes a mental health care user as defined in section 1 of the Mental Health Care Act, 2002 (Act No. 17 of 2002); 35
- (c) he or she has been convicted of an offence and sentenced to imprisonment without the option of a fine, whether or not such sentence has been suspended;
- (d) he or she is disqualified in terms of any law from practising as a traditional health practitioner;
- (e) he or she ceases to hold the necessary qualification for his or her designation or appointment; 40
- (f) he or she tenders his or her resignation, in writing, to the Minister;
- (g) he or she is absent from two consecutive meetings of the Council without the leave of the Council;
- (h) his or her estate is sequestrated or he or she has entered into a composition with his or her creditors; 45
- (i) he or she becomes impaired to the extent that he or she is unable to carry out his or her duties as a member of the Council;
- (j) the Minister, in the public interest or on grounds of misconduct, incapacity or incompetence, terminates his or her membership; or 50
- (k) the period for which the member was appointed has expired and his or her appointment is not renewed by the Minister.

(2) If a member of the Council dies or vacates his or her office before the expiration of his or her term of office, the Minister must appoint another person to fill the vacancy for the remainder of the period of the term of office for which such member was appointed. 55

Disqualification as member of Council

9. A person may not be appointed as a member of the Council if he or she-
- (a) is not a South African citizen;
 - (b) has been convicted of an offence in respect of which he or she was sentenced to imprisonment without the option of a fine; 5
 - (c) has been found guilty of unprofessional conduct under this Act;
 - (d) has been diagnosed as having a mental illness or is a mental health care user as defined in section 1 of the Mental Health Care Act, 2002 (Act No. 17 of 2002);
 - (e) is an unrehabilitated insolvent or has entered into a composition with his or her creditors; 10
 - (f) is disqualified in terms of any law, from practising as a traditional health practitioner; or
 - (g) is, at the time of his or her appointment, or was, during the preceding 12 months
 - (i) a member of the National Assembly, any provincial legislative body, National Council of Provinces or any municipal council; or 15
 - (ii) an office bearer or employee of any party, organisation or body of a political nature.

Chairperson and vice-chairperson

10. (1) The chairperson and vice-chairperson hold office for the duration of the term of office for which they have been appointed by the Minister to the Council. 20
- (2) In the absence of the chairperson of the Council or if the chairperson is for any reason unable to act as chairperson, the vice-chairperson must perform the functions of the chairperson.
- (3) If both the chairperson and the vice-chairperson are absent from any meeting, the members present must elect one of their number to preside at that meeting and, until the chairperson or vice-chairperson resumes duty, to perform all the functions of the chairperson. 25
- (4) If the office of the chairperson becomes vacant, the Minister must appoint a person from among the remaining members of the Council. or any other person, in terms of section 7(a) and the person so appointed holds office for the unexpired portion of the period for which his or her predecessor was appointed. 30
- (5) If the office of the vice-chairperson becomes vacant, the members of the Council must, at the first meeting thereafter or as soon as it may be convenient, elect from among their number a new vice-chairperson and that member holds office for the unexpired portion of the period for which his or her predecessor was elected. 35
- (6) If a chairperson vacates his or her office without terminating his or her membership of the Council, the Minister must appoint a new chairperson from amongst the members of the Council.

Meetings of Council 40

11. (1) The registrar must, in consultation with the chairperson, convene the meetings of the Council.
- (2) The Council must meet at least twice annually to conduct its business and hold such additional meetings as it may determine.
- (3) A special meeting of the Council- 45
- (a) may be convened by the chairperson at any time;
 - (b) must be convened by the chairperson at such place and on such date as he or she may determine within 30 days of receipt by him or her of a written request by the Minister or of a written request signed by at least six of the members: 50
- Provided that such written request must state clearly the purpose for which the meeting is to be convened.

Quorum and procedure at meeting

12. (I) A quorum for any meeting of the Council is 12 persons.
- (2) Subject to subsection (6), each member has one vote on a question before the Council.
- (3) Any decision by the Council must be taken by a majority vote at a meeting of the Council at which a quorum is present. 5
- (4) Notwithstanding anything to the contrary in this Act, the majority of members of the Council or any of its committees, is one half of the total number of the members present plus one.
- (5) Only members of the Council have voting rights. 10
- (6) A decision by the majority of the members of the Council present at any meeting constitutes the decision of the Council: Provided that in the event of an equality of votes, the member presiding has a casting vote in addition to a deliberative vote.
- (7) A decision taken by the Council or an act performed under the authority of the Council is not invalid merely by reason of- 15
- (a) an interim vacancy in the Council; or
 - (b) the fact that a person who is not entitled to sit as a member of the Council, sat as a member at the time when the decision was taken or the act was authorised by the required majority of members present at the time and entitled to sit as members. 20

Executive committee of Council

- 13.(I) There is an executive committee of the Council consisting of not more than eight members, being-
- (a) the chairperson;
 - (b) the vice-chairperson; 25
 - (c) three members appointed in terms of section 7(c);
 - (d) a member appointed in terms of section 7(d);
 - (e) a member appointed in terms of section 7(e); and
 - (f) a member appointed in terms of section 7(g).
- (2) The three members of the executive committee, contemplated in paragraph (c) of subsection (I) must be elected by the members of the Council. 30

Other committees of Council

- 14.(I) Subject to subsection (3), the Council may establish such other committees, including disciplinary committees, as it considers necessary, consisting of such a number of persons as the Council may determine, including at least one member of the Council who must be the chairperson of such committee. 35
- (2) The Council may, subject to subsection (3), delegate to any committee contemplated in subsection (1), or to any member of that committee, such of its powers as it may from time to time determine, but the Council is not divested of any power so delegated. 40
- (3) Notwithstanding subsection (I), the Council may establish *ad hoc* disciplinary appeal committees consisting of-
- (a) as chairperson, either a retired judge, a retired senior magistrate or an attorney with a minimum of 10 years of experience;
 - (b) not more than two registered traditional health practitioners; and 45
 - (c) a member of the Council appointed under section 7(h).
- (4) A disciplinary appeal committee contemplated in subsection (3) has the power to vary, confirm or set aside a finding of a disciplinary committee established under subsection (1) or to refer the matter back to the relevant disciplinary committee with such instructions as it thinks fit. 50
- (5) A decision by a disciplinary committee, unless appealed against, is of force and effect from the date determined by that committee.
- (6) Where a matter has been considered by a disciplinary appeal committee, the decision of the disciplinary appeal committee, unless appealed against in a court of law, is of force and effect from the date determined by that committee. 55

Remuneration of members of Council and committees

15. The members of the Council and members of the committees of the Council must be paid the remuneration and allowances determined by the Minister, in consultation with the Minister of Finance.

Funds of Council 5

16. (1) The funds of the Council consist of-
- (a) money appropriated by Parliament;
 - (b) fees raised by the registrar in the performance of his or her functions under this Act;
 - (c) penalties contemplated in sections 34, 38 and 43; and 10
 - (d) any other fees contemplated in this Act.

(2) The Council must utilise its funds to defray expenses incurred by the Council and the office of the registrar in the performance of their functions.

(3) The Council must, with the concurrence of the Minister and the Minister of Finance, open an account with an institution registered as a bank in terms of the Banks Act, 1990 (Act No. 94 of 1990), and deposit therein all money received under subsection (1). 15

(4) The Council may, with the approval of the Minister and the Minister of Finance, invest any money deposited under subsection (3), which is not required for immediate use, with an approved institution.

(5) Any surplus which at the close of the Council's financial year stands to the credit of the Council must be carried forward to the next financial year as a credit in the account of the Council. 20

(6) The Council may establish and operate a reserve fund and deposit therein such amounts as it considers necessary or expedient.

Accounting officer 25

17. The registrar is the accounting officer of the Council and must ensure that-
- (a) proper records of all financial transactions, assets and liabilities of the Council and the registrar are kept;
 - (b) as soon as is practicable, but not later than four months after the end of each financial year, annual financial statements in respect of the financial year in question are prepared and submitted to the Council and the Minister for approval; 30
 - (c) the financial affairs of the Council and the office of the registrar comply with the Public Finance Management Act, 1999 (Act No. 1 of 1999).

CHAPTER 3 35

REGISTRAR, STAFF OF REGISTRAR AND REGISTRATION PROCEDURES

Appointment of registrar

18. (1) The Minister, after consultation with the Council-
- (a) must appoint a registrar; and
 - (b) may dismiss such person. 40

(2) The appointment of the registrar is subject to the conclusion of a written performance agreement entered into by the Minister and that person.

Functions of registrar

19. (1) The registrar-
- (a) is the secretary and accounting officer of the Council; 45
 - (b) must perform the functions assigned to him or her in terms of this Act by the Council;
 - (c) must keep registers-
 - (i) in which he or she enters the names of traditional health practitioners and students; 50

- (ii) in which he or she on instruction of the Council, enters the name, physical address, qualifications, date of initial registration and any other particulars, determined by the Council, including the category or speciality of the person so registered;
 - (iii) from which he or she must remove the names of deceased registered persons or other persons whose names must be removed in the prescribed manner; 5
 - (iv) in which he or she must update, from time to time, the relevant particulars of the person so registered.
- (2) (a) The registrar may, in writing, and on such conditions as he or she determines, delegate or assign any power or duty to any staff member, unless the Minister prohibits a specific delegation or assignment. 10
- (b) A delegation or assignment made under paragraph (a) does **not**-
- (i) divest the registrar of the responsibility or accountability concerning the performance of the function involved; 15
 - (ii) prohibit the performance of the function involved by the registrar.
- (c) A delegation or assignment made under paragraph (a) may be withdrawn. but such withdrawal does not affect any right which may have accrued to a person as a result of the function performed before the delegation or assignment was withdrawn.

Staff of registrar 20

20. (1) Subject to the written instructions of the Council, the registrar may appoint such members of staff as are necessary to perform the work arising from or connected with the Council's functions.

(2) The terms and conditions of service of staff of the registrar are determined by the Council and approved by the Minister, in consultation with the Minister of Finance. 25

(3) The Council may, with the approval of the Minister, in consultation with the Minister of Finance, establish, manage and administer any pension fund for the benefit of the staff of the registrar.

Application for registration to practise

21. (1) No person may practise as a traditional health practitioner within the Republic unless he or she is registered in terms of this Act. 30

(2)(a) Any person who wishes to register as a traditional health practitioner or a student must apply to the registrar.

(b) An application contemplated in paragraph (a) must be accompanied **by**-

- (i) proof that the applicant is a South African citizen; 35
- (ii) character references by people not related to the applicant;
- (iii) proof of the applicant's qualifications;
- (iv) the prescribed registration fee; and
- (v) any further information relating to the application that the Council may consider necessary. 40

(3) If the registrar is satisfied that the information and documentation submitted in support of an application for registration meet the requirements of this Act and upon receipt of the prescribed registration fee, the registrar must issue a registration certificate authorising the applicant to practise as a traditional health practitioner within the

(4) If the registrar is not satisfied that the information and documentation submitted in support of an application for registration meet the requirements of this Act, he or she may refuse to issue a registration certificate to the applicant, but must, if so required by the applicant, submit the application to the Council for a decision.

(5) The registrar must only register a traditional health practitioner if the registrar is satisfied that the person applying for registration is suitably qualified to be a traditional health practitioner or if the Council is so satisfied. 50

(6) Any entry which is proved to the satisfaction of the Council to have been made in error or through misrepresentation or in circumstances not authorised by this Act must be removed from the register **and-**

- (a) a record of the reason for every such removal must be made in the register;
- (b) the person in respect of whom such removal has been made must be notified thereof in the manner contemplated in section 23(2); and 5
- (c) any certificate issued in respect of such registration is deemed to have been cancelled as from the date on which notice has so been given.

Qualifications for registration

22. (1) The Minister may, on the recommendation of the Council, prescribe the minimum qualifications to be obtained by virtue of examinations conducted by an accredited institution, educational authority or other examining authority in the Republic. 10

(2) Any qualification contemplated in subsection (1), obtained on its own or conjointly with any other qualification, entitles a holder thereof to registration in terms of this Act if he or she has, before or in connection with or after the acquisition of the qualification in question, complied with the prescribed conditions or requirements. 15

Removal from and restoration of name to register

23. (1) The registrar must, on instruction from the Council, remove from the relevant register the name of any person- 20

- (a) who has died;
- (b) who has ceased to be a citizen of the Republic and has permanently left the Republic;
- (c) who has been absent from the Republic for a continuous period of more than three years; 25
- (d) who has failed to pay any relevant prescribed fee;
- (e) who has failed to notify the registrar of any change in residential or postal address or the address of his or her practice within six months after any such change;
- (f) who has requested that his or her name be removed from the register, in which case such practitioner may be required to lodge with the registrar an affidavit or affirmation to the effect that no disciplinary or criminal proceedings are pending or are likely to be instituted against him or her; 30
- (g) who has been found guilty of improper or disgraceful conduct in terms of this Act; 35
- (h) whose name has been removed from the register, record or roll of any education and training institution or other body from which he or she received the qualification by virtue of which he or she was registered;
- (i) who has been registered through error or fraud;
- (j) who has failed to furnish the registrar, within a period to be determined by the Council, with such information as the registrar may require under this Act; 40
- (k) whose registration is proved to the satisfaction of the Council to have been made in error or through fraudulent misrepresentation or concealment of material facts or information or in circumstances not authorised by this Act; or
- (l) who, after an assessment was made in the manner contemplated in section 41, has been found to be mentally impaired. 45

(2) The registrar must give notice of the removal of a person's name from the register in terms of paragraph (b) up to and including paragraph (l) of subsection (1) by registered mail addressed to such person at the address of such person as it appears in the register. 50

(3) From the date on which the notice contemplated in subsection (2) was given-

- (a) any registration certificate issued under this Act to the person concerned is considered to have been cancelled; and

- (b) a person whose name has been removed from the register must cease to practise as a traditional health practitioner and is precluded from performing any act which he or she, in his or her capacity as a registered person, was entitled to perform,

until such time as his or her name is restored to the register. 5

(4) The registrar must restore the name of a person whose name has in terms of this section been removed from the register if the person concerned-

- (a) applies on the prescribed form for restoration of his or her name to the registrar;
- (b) pays the prescribed fee, if any; 10
- (c) complies with such other requirements as the Council may, from time to time, determine; and
- (d) is otherwise eligible for registration.

Issue of duplicate registration certificate, certificate of status and extract from register or certificate 15

24.(1) The registrar may, on application by a registered traditional health practitioner, issue a duplicate certificate of registration if the applicant-

- (a) provides proof of his or her identity to the satisfaction of the registrar;
- (b) provides an affidavit in which he or she confirms that the certificate of registration has been lost or destroyed; and 20
- (c) pays the prescribed fee determined by the Council.

(2) The registrar may, upon payment of the prescribed fee, issue to any registered person a certificate of status containing-

- (a) particulars of such person's registration; and
- (b) a statement to the effect that- 25
- (i) the said person is not disqualified from practising his or her occupation; and
- (ii) no disciplinary steps are pending against him or her in terms of this Act.

(3) The registrar may issue a certified extract from the register or a certificate contemplated in subsection (2) under his or her hand to any person upon payment of the prescribed fee. 30

(4) A certificate may be issued subject to certain conditions imposed by the Council and such conditions must be indicated on the certificate.

Custody and publication of registers

25. The registers must be kept at the office of the registrar, and the Council may, at intervals determined by it, cause to be printed and published copies of the registers or 35 supplementary lists showing additions, removals, amendments or revisions effected since the last publication of such copies of the complete registers.

Register as proof

26. (1) A copy of the most recent published issue of a register or any supplementary list contemplated in section 25, and certified by the registrar, is *prima facie* proof in all 40 legal proceedings of the facts therein recorded and the absence of the name of any person from such copy is proof, unless there is credible evidence to the contrary, that such person is not registered in terms of this Act.

(2) For the purposes of subsection (1) a certified extract or a certificate contemplated in section 24(3) bearing a date subsequent to the date of publication of the register or 45 supplementary list contemplated in subsection (1) is "credible evidence to the contrary".

(3) If the registrar issues a certificate, dated later than the date of publication of the register or supplementary list contemplated in subsection (1), to the effect that a practitioner's name has been removed from the register since the date of publication of the register or supplementary list and has not been restored thereto, that certificate is 50 proof, in the absence of credible evidence to the contrary, that such person is not registered in terms of the provisions of this Act.

(4) A certificate of registration is proof of registration for a period of one year after its date only and thereafter an annual practising certificate issued upon payment of the prescribed annual fee and upon the submission of such information as may be required by the Council to enable it to keep accurate statistics on human resources in the health field, is proof of registration in the absence of credible evidence to the contrary. 5

Right of appeal

27.(1) Any person who is aggrieved by a decision of the registrar may lodge an appeal to the Council within 30 days from date of that decision.

(2) Any person who is aggrieved by a decision of the Council may appeal to the appropriate High Court against such decision. 10

Conditions relating to continuing education

28. The Council may from time to time make rules which prescribe-

- (a) conditions relating to continuing education and training to be undergone by persons registered in terms of this Act in order to retain such registration;
- (b) the nature and extent of continuing education and training to be undergone by persons registered in terms of this Act; and 15
- (c) the criteria for recognition by the Council of continuing education and training courses and of education institutions offering such courses.

CHAPTER 4

DISCIPLINARY INQUIRIES AND INVESTIGATIONS BY COUNCIL 20

Laying of complaints

29. (1) Any person may lay a complaint with the Council about the way in which he or she was treated by a registered health practitioner or student.

(2) In laying a complaint, the person contemplated in subsection (1) must follow the prescribed procedure. 25

Inquiries into charges of misconduct

30. (1) Notwithstanding anything to the contrary in this Act, the Council may institute an inquiry into any complaint, allegation or charge of unprofessional conduct against any person registered in terms of this Act and, on finding such person guilty of such conduct, to impose any of the penalties contemplated in section 34: Provided that in the case of a complaint, charge or allegation which forms or is likely to form the subject of a criminal case in a court of law, the Council may postpone the holding of an inquiry until such case has been concluded. 30

(2) If the Council is in doubt as to whether any inquiry should be held in connection with a complaint, charge or allegation, it may, in connection with the allegation, charge or complaint in question, consult with or seek further information from any person, including the person against whom the allegation, charge or complaint has been lodged. 35

Manner in which certain investigations may be instituted

31. (1) The registrar may, with the approval of the chairperson of the Council, appoint a member of the Council as the investigating officer for the purposes of this section. 40

(2) Notwithstanding subsection (1), the registrar may, with the approval of the chairperson of the Council and on such conditions as the Council determines, appoint any person who is not a member of the Council and not in the full-time employment of the Council as the investigating officer for a particular investigation or to assist the investigating officer contemplated in subsection (1) with a particular investigation. 45

(3) A person appointed in terms of subsection (2) has the same powers and duties regarding the investigation as the investigating officer contemplated in subsection (1).

- (4)(a) The registrar must issue to the person appointed under subsection (1) or (2), as the case may be, a certificate to the effect that he or she has so been appointed, and, in the case of a person appointed for or to assist with, a particular investigation, that he or she has so been appointed for such investigation.
- (b) The person so appointed must on demand produce such certificate. 5
- (5) The registrar may institute an investigation-
- (a) into an alleged contravention of, or failure to comply with, this Act;
- (b) to determine if a specific provision of this Act applies to a particular registered person;
- (c) into a charge, complaint or allegation of improper or disgraceful conduct by a 10 registered person; or
- (d) into the affairs or conduct of a registered person, if any person files a complaint with the registrar, supported by an affidavit setting out the allegations contained in such complaint.
- Entering and search of premises, attachment and removal of documents 15
32. (1) An investigating officer contemplated in section 31(1) or (2) may, with the approval of the Council and without an entry or search warrant, enter and search any premises, other than a private dwelling, to carry out an investigation contemplated in section 31(5) if-
- (a) a person who is competent to do so, consents to such entry, search or seizure: 20
or
- (b) the investigating officer, on reasonable grounds, believes-
- (i) that a warrant would be issued to him or her if he or she were to apply for that warrant; and
- (ii) the delay in obtaining that warrant would defeat the purpose of the entry. 25
- (2) An entry and search under this section must be executed by day, unless the execution thereof by night is justifiable and necessary.
- (3) An investigating officer must identify himself or herself to any person concerned during entry or search.
- (4) During the search of the premises, or at any other time, an investigating officer 0
may-
- (a) request any person found on the premises to immediately, or at a time and place determined by the investigating officer-
- (i) produce any book, record, document or thing which relates to, or which 5
on reasonable grounds is believed to relate to, the matter under investigation, and which is or was on the premises or in the possession or custody or under control of that person or his or her employee or agent;
- (ii) furnish such explanations as may be required in respect of any such book, record, document or thing;
- (b) request from any person who has or is suspected on reasonable grounds of 40
having in his or her possession or custody or under his or her control any book, record, document or thing relating to the matter which is being investigated, to produce it immediately or at a time and place determined by the investigating officer, for examination of such book, record, document or thing, or to make 45
extracts or copies from such book or document, and may further request that person to furnish such explanations as are required in respect of any entry in that book or document.
- (5) A person who carries out an investigation in terms of this section-
- (a) must preserve secrecy in respect of any facts which come to his or her notice 50
in the performance of his or her functions; and
- (b) may not disclose any such fact to any person except to the registrar, or to the chairperson, or any other member of the Council, or to the public prosecutor concerned in the case of an offence in terms of this or any other Act, or by order of a court.
- (6) Notwithstanding subsection (5), no personal particulars regarding a patient may 55
be disclosed to any person except in terms of a court order or with the consent of the presiding officer at an inquiry contemplated in this Act.

(7) The court order contemplated in subsection (6) must be executed as if it were a judgment in a civil case in a magistrate's court.

(8) Any person who-

- (a) refuses or neglects to produce any book, record, document or thing to a person authorised under this section; 5
- (b) hinders or obstructs the investigating officer in the exercise of his or her powers or in the performance of his or her duties;
- (c) pretends that he or she is an investigating officer; or
- (d) contravenes a provision of subsection (5) or (6),

is guilty of an offence and liable on conviction- 10

- (i) in the case of a contravention contemplated in paragraph (a), (b) or (c), to a fine or to imprisonment for a period not exceeding six months or 10 both a fine and such imprisonment; or
- (ii) in the case of a contravention contemplated in paragraph (d), to a fine or to imprisonment for a period not exceeding two years or to both a fine and such imprisonment. 15

(9) This section does not preclude any other authority that is otherwise authorised from instituting an investigation into any alleged contravention of, or failure to comply with, any provision of this Act.

Report by investigating officer' 20

33. (1) The investigating officer responsible for an investigation under this Act must compile a report of the investigation and submit that report to the registrar.

(2) If the report contemplated in subsection (1) reveals evidence of improper or disgraceful conduct contemplated in this Act and no complaint, charge or allegation regarding such conduct has been made for the purpose of an inquiry in terms of section 30, such report is deemed to be a complaint made for the purpose of an inquiry and the registrar must serve a copy thereof on the registered person concerned. 25

(3) If the report contemplated in subsection (1) reveals evidence which, in the opinion of the chairperson of the Council, makes it desirable that an inquiry on the grounds of an apparent impairment of the complainant's rights be instituted, the registrar must serve a copy thereof on the registered person concerned. 10

(4) If the report contemplated in subsection (1) does not reveal evidence of unprofessional conduct contemplated in this Act, the registrar must serve a copy thereof on the registered person concerned.

(5) To the extent that the report contemplated in subsection (1) contains statements of witnesses which would have been admissible as evidence at an inquiry into impairment of rights or into complaints, charges or allegations of unprofessional conduct, section 213 of the Criminal Procedure Act, 1977 (Act No. 51 of 1977), applies with the necessary changes in respect of those statements at such an inquiry. 35

Procedure at inquiry and relevant matters 40

34. (1) A person registered under this Act who, after an inquiry held by the Council, is found guilty of improper or disgraceful conduct, or conduct which, when regard is had to such person's profession, is improper or disgraceful, is liable to one or more of the following penalties:

- (a) A caution or a reprimand or both; 45
- (b) suspension for a specified period from practising or performing acts pertaining to his or her profession;
- (c) removal of his or her name from the register;
- (d) a prescribed fine;
- (e) a period of compulsory community service determined by the Council; 50
- (f) the payment of the costs of the proceedings; or
- (g) restitution of any money paid by the complainant to the registered practitioner.

(2) If an appeal is lodged against a penalty of removal of a registered practitioner's name from the register or suspension from practice, such penalty remains effective until the appeal is heard. 55

- (3) The Council may, subject to such conditions as it determines-
- (a) terminate any suspension under subsection (I) before the expiry of the specified period; or
 - (b) on payment of the prescribed fee, restore to the register any name which has been removed therefrom. 5
- (4) In respect of inquiry proceedings contemplated in section 30, the Council must-
- (a) give notice of that inquiry to the person who is the subject of the inquiry;
 - (b) give an opportunity to that person to either represent himself or herself or to obtain legal representation at the inquiry proceedings;
 - (c) afford that person an opportunity to state his or her case in response to the allegations. 10
- (5) The Council may, at any inquiry proceedings contemplated in section 30-
- (a) take evidence under oath or affirmation;
 - (b) on the direction of either the registrar or the chairperson of the Council, as the case may be, summon witnesses to give evidence at such proceedings; 15
 - (c) require the production of any book, record, document or thing;
 - (d) through either the chairperson of the Council or the presiding officer at the inquiry, as the case may be, administer an oath to any witness or accept an affirmation from such witness; or
 - (e) examine any book, record, document or thing which any witness was required to produce at the proceedings. 20
- (6) A summons to appear before the Council as a witness or to produce to it any book, record, document or thing must be-
- (a) as nearly as practicable, in the prescribed form;
 - (b) signed by the chairperson of the Council or the registrar, as the case may be: 25
- and
- (c) served either by registered letter sent through the post or in the same manner as it would have been served if it had been a subpoena issued by a magistrate's court. 30
- (7) Any person who, having been summoned-
- (a) refuses, or without sufficient cause fails, to attend and give evidence relevant to the inquiry at the time and place specified in the summons;
 - (b) refuses to take the oath or to make an affirmation when required to do so by the chairperson of the Council or the presiding officer, as the case may be, at the inquiry; or 35
 - (c) refuses or fails without sufficient cause to produce any book, record, document or thing which he or she has in terms of the summons been required to produce,
- is guilty of an offence and on conviction liable to any sentence which may be imposed on a witness subpoenaed to give evidence in a civil trial in the High Court who is convicted of a similar offence: Provided that every person so summoned is entitled to all the privileges to which a witness subpoenaed to give evidence before a provincial division of the High Court is entitled. 40
- (8) The chairperson of the Council may appoint a person with adequate experience in the administration of justice to be present as an assessor at an inquiry and to advise the Council or the disciplinary committee, as the case may be, on matters of law, procedure or evidence. 45
- (9) If a person registered in terms of this Act (in this section referred to as the accused) is alleged to be guilty of unprofessional conduct and the Council on reasonable grounds is of the opinion that it must impose a fine determined by the Minister in consultation with the Minister of Justice by notice in the Gazette on conviction after an inquiry contemplated in terms of section 30 was held, the Council may issue a summons in the manner prescribed on which an endorsement is made by the Council that the accused may admit that he or she is guilty of the said conduct and that he or she may pay the fine stipulated without appearing at the said inquiry. 50 55

(10) Where a summons as contemplated in subsection (9) is issued against an accused in terms of this Act, the accused may, without appearing at an inquiry in terms of section 30, admit to his or her guilt in respect of the conduct referred to in subsection (I) by paying the stipulated fine (in this section referred to as the admission of guilt fine) to the Council before a date specified in the summons. 5

(I) Any penalty imposed under this section, excluding an admission of guilt fine, must be paid to the Council within 14 days after such imposition.

(12) The imposition of a penalty has the effect of a civil judgment of the magistrate's court of the district in which the inquiry contemplated in section 30 took place.

(13) The Minister may, on the recommendation of the Council, amend the amount mentioned in subsection (9) by notice in the *Gazette*. 10

Postponement of imposition of penalty and suspension of penalty or part thereof

35. (I) Where a person has been found guilty of any conduct contemplated in section 30, the Council may-

(a) postpone the imposition of a penalty for such period and on such conditions as it determines; or 15

(b) impose any penalty contemplated in section 34(1)(b), (c) or (d), but order the execution of such penalty or any part thereof to be suspended for such period and on such conditions as it determines.

(2) If, at the end of the period for which the imposition of a penalty has been postponed in terms of subsection (I)(a), the Council is satisfied that the practitioner concerned has observed all the relevant conditions, the Council must inform such practitioner that the penalty contemplated in section 34 will not be imposed upon him or her. 20

(3) If the execution of the penalty or any part thereof has been suspended in terms of subsection (I)(b) and the Council is satisfied that the practitioner concerned has observed all the relevant conditions throughout the period of suspension, the Council must inform that practitioner that the penalty contemplated in section 34 will not be executed. 25

(4) If the execution of a penalty or any part thereof has been suspended in terms of subsection (I)(b) and the practitioner concerned fails to comply with one or more of the conditions of suspension, the Council must put such penalty or part thereof into operation unless the practitioner satisfies the Council that the failure to comply with the conditions concerned was due to circumstances beyond his or her control. 30

Effect or suspension or removal from register 35

36. A person who has been suspended or whose name has been removed from the register in terms of section 34 is disqualified from carrying on his or her profession and his or her registration certificate is deemed to be cancelled until the period of suspension has expired or until his or her name has been restored to the register by the Council.

Cognisance by Council or conduct under certain circumstances 40

37. (I) A registered person who--

(a) has been convicted of any offence by a court of law; and

(b) where the Council is of the opinion that such offence constitutes unprofessional conduct as contemplated in section 30,

may be dealt with by the Council in terms of this Chapter and is liable on conviction to one or more of the penalties contemplated in section 34: Provided that, before imposition of any penalty, such person must be afforded an opportunity to address the Council in extenuation of the conduct in question. 45

(2) Whenever in the course of any proceedings before any court of law it appears to the court that there is *prima facie* proof of unprofessional conduct on the part of a person registered in terms of this Act, the court must direct that a copy of the record of such proceedings, or such portion thereof as is material to the issue, be transmitted to the Council. 50

Penalty for false evidence

38. A person who gives false evidence on oath or affirmation at any inquiry held in terms of this Act, knowing such evidence to be false, is guilty of an offence and liable on conviction to the penalties which a court may impose for the crime of perjury.

Limitation of liability

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39. Neither the Council nor any member, officer or employee thereof is liable for any act done in good faith under this Act.

Rules relating to offences

40. (1) The Council must make rules specifying the acts or omissions in respect of which the Council may take disciplinary steps in terms of this Act: Provided that the powers of the Council to make inquiries into and deal with any complaint, charge or allegation contemplated in this Act are not limited to the acts or omissions so specified. 10

(2) No rule made in terms of subsection (1) or any amendment or withdrawal thereof is of force and effect until such rule is approved by the Minister and published in the *Gazette*.

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Inquiries in respect of mentally impaired registered persons

41. The Council may hold an inquiry in the prescribed manner in respect of a person registered in terms of this Act who appears to be mentally impaired and if that person is found on assessment to be impaired, the Council may-

- (a) impose prescribed conditions relating to the registration of that person; or 20
- (b) suspend or remove such person from practice.

CHAPTERS

GENERAL AND SUPPLEMENTARY PROVISIONS

Fees charged by registered persons

42. (1) Every person registered under this Act must before rendering any traditional health services inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he or she intends to charge for such services. 25

(2) Any traditional health practitioner who in respect of any traditional health services rendered by him or her claims payment from any person (in this section referred to as the patient), must, subject to the provisions of the Medical Schemes Act, 1998 (Act No. 131 of 1998), where applicable, furnish the patient with a detailed account within a reasonable period. 30

(3)(a) The patient may, within three months after receipt of the account contemplated in subsection (2), apply in writing to the Council for a determination of the amount which, in the opinion of the Council, should have been charged for the services to which the account relates. 35

(b) The Council must, as soon as possible after receipt of the application, determine the said amount and notify the traditional health practitioner and the patient, in writing, of the amount so determined. 40

(c) Before the Council determines an amount, it must afford the practitioner concerned an opportunity to submit to the Council, in writing, the relevant factors to be considered by the Council in support of the amount charged.

(4) The Minister may, after consultation with the Council, prescribe the procedure which the Council must follow in disposing of an application under subsection (3). 45

(5) The Council may, from time to time, determine and publish the fees used by the Council as the norm for the determination of amounts contemplated in subsection (3).

(6)(a) A claim for payment, which is the subject of an application contemplated in subsection (3) and of which notice has been given by the Council or the patient to the traditional health practitioner concerned, is not recoverable until a determination has been made in terms of subsection (3).

(b) Only the amount so determined is payable and if the patient has paid to the traditional health practitioner concerned an amount exceeding the amount so determined, the traditional health practitioner must repay the patient the amount by which that payment exceeds the amount so determined. 5

(7) This section does not divest the Council of any of its functions in terms of this Act with regard to acts or omissions in respect of which it may take disciplinary steps. 10

(8) For the purposes of this section "fee" includes payment in kind.

False representations, false entries in register and impersonation

43. (1) A person is guilty of an offence if he or she--

(a) by means of a false representation procures or attempts to procure for himself or herself or any other person, registration or any certificate or decision referred to in this Act; 15

(b) makes or causes to be made any unauthorised entry or alteration in or removal from a register, certified copy thereof, or extract therefrom or any certificate issued under this Act;

(c) wilfully destroys, damages or renders illegible any entry in the register or, without the permission of the holder thereof, any certificate issued under this Act; 20

(d) forges or, knowing it to be forged, uses any document purporting to be a certificate issued under this Act;

(e) impersonates any person registered in terms of this Act; or 25

(j) supplies or offers to supply to any person not registered under this Act or any other law, an instrument or appliance which can be used, or is claimed to be effective, for the purpose of diagnosing, treating or preventing physical or mental defects, illnesses or deficiencies, whilst knowing that such instrument or appliance will be used by such unregistered person for the purpose of performing for gain an act which such unregistered person is in terms of this Act or any other law prohibited from performing for gain. 30

(2) A person found guilty of an offence contemplated in subsection (1) is liable on conviction to a fine or to a period of imprisonment or to both a fine and a period of imprisonment. 35

Limitations in respect of unregistered persons

44. (1) No remuneration is recoverable in respect of any act which relates to the profession of a traditional health practitioner if such an act is performed by a person who is not authorised under this Act to perform such act for gain.

(2) No person other than a person registered in terms of this Act, and holding the necessary qualifications, is eligible for or entitled to hold any appointment to any establishment, institution, body, organisation or association, whether public or private, if such appointment involves the performance of any act which an unregistered person, in terms of this Act, may not perform for gain: Provided that nothing in this subsection precludes the training of traditional health practitioners or students under the supervision of a suitably qualified traditional health practitioner, or the employment in any hospital or similar institution of any person undergoing training with a view to registration in terms of this Act, under the supervision of a suitably qualified traditional health practitioner or other health professional. 45

Investigation of matters relating to teaching or training of certain classes of persons

45. (1) Despite any law to the contrary, a person who is authorised by the Council, in writing, to investigate any matter relating to the teaching or training of any person or class of persons undergoing such teaching or training for the purpose of qualifying 5 themselves for practising the profession to which this Act applies, may, in the manner contemplated in section 32(1) for the purpose of making such investigation, enter any institution or premises utilised in the teaching or training of any such person or class of persons.

(2) A person who prevents a person authorised in terms of subsection (1) from 10 entering any institution or premises contemplated in that subsection, or who hinders that person from pursuing his or her investigation, is guilty of an offence and liable on conviction to a fine or to a period of imprisonment or to both a fine and a period of imprisonment.

Exemptions 15

46. (1) The Minister may, after consultation with the Council, by notice in the *Gazette* exempt any juristic person or class of juristic persons specified in the notice, either generally or subject to such conditions as may be specified in the notice, from the operation of this Act, so as to enable such juristic person to practise as a traditional health practitioner, 20 subject to the registration of such juristic person under this Act.

(2) Any reference in this Act or any other law to a person registered in terms of this Act to practise as a traditional health practitioner or to a partner or partnership in relation to such registered person, is deemed to include a reference to a juristic person contemplated in subsection (1) or to a member of such a juristic person, as the case may 25 be, unless the context indicates otherwise.

(3) The Minister may, after consultation with the Council, at any time by notice in the *Gazette* amend or repeal any notice issued under subsection (1).

Regulations

47. (1) The Minister may, after consultation with the Council, make regulations relating 30 to--

- (a) the appointment of members of the Council;
- (b) (i) the registration by the Council of students in any prescribed category of traditional health practice undergoing education or training at any accredited training institution or educational authority or with any 35 traditional tutor, the fees payable in respect of such registration and the removal by the Council from the register in question of the names of such students;
- (ii) the minimum standards of education and training required of students as a condition precedent to registration; 40
- (iii) the duration of the educational programme to be followed by student<; at an educational or training institution or with a traditional tutor;
- (iv) the minimum requirements of the curricula and the minimum standards of education or examinations which must be maintained at every educational or training institution or by every traditional tutor offering 45 training in traditional health practice, in order to secure registration and recognition of the qualifications obtained under this Act;
- (c) (i) the minimum age and standards of general education required of a candidate for examination for a certificate entitling the holder thereof to 50 registration in terms of this Act;
- (ii) the courses of study and the training required for examinations;
- (iii) institutions at which, or persons with whom, educational courses or training may be undertaken and any other requirements relating to such study or training; 55
- (iv) the registration by the Council of persons undertaking educational courses or undergoing training and the fees payable in respect of such registration;
- (v) the fees payable by candidates for examinations;

- (vi) the appointment and remuneration of examiners for examinations;
- (vii) any matter incidental to examinations or the issue of certificates by the Council;
- (viii) the nature and duration of the practical training to be completed by persons before they may be registered; 5
- (ix) the nature and duration of the training to be completed by a person who has obtained a qualification as a traditional health practitioner but who is not yet registered as such, before he or she may be registered as such;
- (d) the conditions under which a registered person may practise as a traditional health practitioner or practise in any category of traditional health practice; 10
- (') (i) the registration of students of traditional health practice, including the recording of particulars relating to their training and proof of the fulfilment of the requirements thereof;
- (ii) the health establishments or () [her institutions, if any, at which or the persons with whom such training may be undertaken; 15
- (iii) any other matter incidental to the registration or training of students;
- (j) (i) the registration of the categories of registered persons, which includes diviners, herbalists, traditional birth attendants and traditional surgeons; 20
- (ii) the registration of specialities;
- (iii) the requirements to be satisfied, including the experience to be obtained, the nature and duration of the training to be undergone and the qualifications or additional qualifications required from a person before any category or speciality may be registered; 25
- (iv) the circumstances under which any applicant for the registration of any category or speciality may be exempted from any of such requirements;
- (v) conditions in respect of the practices of persons whose categories or specialities have been registered, including conditions restricting the practice of any such person to the category or speciality registered in his or her name; 30
- (g) the conduct of an inquiry contemplated in section 30, including-
 - (i) the manner in which complaints or charges brought against a registered person must be lodged;
 - (ii) the method of summoning an accused person and the penalties for failure or refusal on the part of any such person to attend or for obstructing or interrupting the proceedings; 35
 - (iii) the continuation of a disciplinary inquiry, after a plea has been lodged, by the committee conducting the inquiry, should one or more members of the committee be unable to continue to serve: Provided that at least two of the original members of the committee must be available to continue with the inquiry; 40
 - (iv) the procedure to be followed to lodge an appeal with an appeal committee and the time within which an appeal may be lodged;
 - (v) any other matter relating to the conduct of such an inquiry or appeal; 45
- (h) (i) inquiries contemplated in section 41 relating to students or persons registered under this Act who appear to be mentally impaired;
- (ii) the assessment of the condition of mentally impaired persons;
- (iii) the conditions to be imposed on mentally impaired person's registration or practice; 50
- (iv) the suspension or removal from practice of mentally impaired persons;
- (v) the revocation of any of the imposed conditions, or of suspension or removal from practice;
- (vi) acts of unprofessional conduct committed before or during assessment or investigation of mentally impaired persons. 55
- (i) the procedure which the Council must follow in disposing of an application brought under section 42(3);

- (j) traditional medicines in order to protect the public and to ensure safety of administration or application;
- (k) standards of traditional health practice in order to ensure that practices are not detrimental to the health of patients or the general public;
- (l) scopes of practice of the various categories of traditional health practitioners; 5
- (m) any disease contemplated in section 49(1)(g) to be terminal; and
- (n) generally any matter which it is necessary to prescribe in order to effect the smooth implementation of this Act and the transition of traditional health practice from an unregulated to a regulated occupation.
- (2) The provisions of any regulation made under paragraph (e) or (f) of subsection (1) relating to fees payable under section 23(4) may vary according to the reason for the removal of a person's name from the register and the period during which it was so removed. 10
- (3) Any regulation made under this section may prescribe penalties for any contravention thereof or failure to comply therewith. 15
- (4) The Minister must, not less than three months before any regulation is made under subsection (1)--
- (a) publish the regulation in the *Gazette* together with a notice declaring his or her intention to make such regulation; and
- (b) invite interested persons to comment thereon or to make representations with regard thereto. 20
- (5) Subsection (4) does not apply in respect of--
- (a) any regulation which has been amended by the Minister in consequence of representations received by him or her as a result of the notice published in terms of subsection (4); and 25
- (b) any regulation in respect of which the Council advises the Minister that the public interest requires it to be made without delay.

Rules

48. (1) The Council may make rules relating to--
- (a) the conduct of the business and the procedure at meetings of the Council and committees of the Council and the manner in which minutes of such meetings must be kept; 30
- (b) the manner in which--
- (i) contracts must be entered into on behalf of the Council;
- (ii) the accounts of the Council must be kept; and 35
- (iii) money accruing to the Council must be disposed of;
- (c) the allowances which may be paid to members of the Council or to members of committees of the Council;
- (d) the duties and the conditions of service of the registrar and other officers appointed under this Act; 40
- (e) any fees other than prescribed fees payable in terms of this Act;
- (f) the various registers to be kept under this Act, the certificates which may be issued under this Act and the manner in which alterations may be effected in such registers;
- (g) the forms to be completed and the documents to be submitted by an applicant for purposes of registration or re-issuance to the register; 45
- (h) the returns and information to be furnished by a person registered under this Act;
- (i) any other matter which must or may be promulgated as rules under this Act.
- (2) The Council must, not less than three months before any rule is made under this Act--
- (a) publish such rule in the *Gazette* together with a notice declaring the Council's intention to make such rule; and
- (b) invite interested persons to comment thereon or to make representations with regard thereto. 55

Offences

- 49.(1) A person who is not registered as a traditional health practitioner or as a student in terms of this Act is guilty of an offence if he or she-
- (a) for gain practises as a traditional health practitioner, whether or not purporting to be registered; 5
 - (b) for gain-
 - (i) physically examines any person;
 - (ii) performs any act of diagnosing, treating or preventing any physical defect, illness or deficiency in respect of any person;
 - (iii) advises any person on his or her physical or mental state; 10
 - (iv) by reason of information provided by any person or obtained from such person in any manner whatsoever-
 - (aa) diagnoses such person's physical or mental state;
 - (bb) advises such person on his or her physical or mental state;
 - (cc) supplies or sells to or prescribes for such person any traditional 15
medicine or treatment;
 - (v) prescribes or provides any traditional medicine, substance or thing; or
 - (vi) performs any other act specially pertaining to the profession;
 - (c) except in accordance with any other law, performs any act having as its object- 20
 - (i) the diagnosis, treatment or prevention of any physical defect, illness or deficiency in any person; and
 - (ii) obtaining by virtue of the performance of such act, either for himself or herself or for any other person, any benefit by way of deriving profit from the sale or disposal of any traditional medicine, food or substance or 25
by way of any donation or gift or by way of providing accommodation, or obtaining, either for himself or herself or for any other person, any gain whatsoever;
 - (d) pretends, or holds himself or herself out, to be a traditional health practitioner or student (whether or not purporting to be registered), of whatever 30
description, of physical defects, illnesses or deficiencies;
 - (e) uses the name of traditional health practitioner, student, healer or doctor or any name, title, description or symbol indicating, or calculated to lead persons to infer, that he or she is the holder of any qualification as a traditional health practitioner or of any other qualification enabling him or her to diagnose, treat 35
or prevent physical defects, illnesses or deficiencies, or that he or she is registered under this Act as a traditional health practitioner or a student;
 - (f) except in accordance with any other law, by words, conduct or demeanour holds himself or herself out to be able, qualified or competent to diagnose, treat or prevent physical defects, illnesses or deficiencies or to prescribe or 40
supply any traditional medicine, substance or thing in respect of such defects, illnesses or deficiencies; or
 - (g) (i) diagnoses, treats or offers to treat, or prescribes treatment or any cure for, 45
cancer, HIV and AIDS or any other prescribed terminal disease;
 - (ii) holds himself or herself out to be able to treat or cure cancer, HIV and AIDS or any other prescribed terminal disease or to prescribe treatment therefor; or
 - (iii) holds out that any article, compound, traditional medicine or apparatus is or may be of value for the alleviation, curing or treatment of cancer, HIV 50
and AIDS or any other prescribed terminal disease.
- (2) For the purposes of subsection (1) "cancer" includes all neoplasms, irrespective of their origin, including lymphoma and leukaemia,
- (3) A person who is not registered as a traditional health practitioner, is guilty of an offence if he or she- 55

- (a) pretends to be so registered in respect of such occupation; or
 (b) uses any name declared by regulation to be a name which may not be used. (4) A person found guilty of an offence in terms of this section is liable on conviction to a fine or to imprisonment for a period not exceeding 12 months or to both a fine and such imprisonment 5
- (5) This section does not apply to a medical practitioner or dentist contemplated in the Health Professions Act, 1974 (Act No. 56 of 1974).

Payment of annual fees

50. (1) The Minister may, on the recommendation of the Council, by notice in the *Gazette* prescribe a fee to be paid annually to the Council by the registered persons 10 concerned: Provided that in prescribing such fee the Minister on advice by the Council may differentiate between persons according to whether they have been registered before or after a date specified in the notice and may vary the amount of such fee according to whether it is paid before or after a specific date.

(2) If a person who is liable to pay any annual fee prescribed in terms of subsection 15 (1), fails or refuses to pay such fee within the period specified in the notice in question, the Council may recover payment of such fee by action in a competent court.

(3) If a person's name has been removed from the register in terms of this Act he or she must pay the outstanding annual fee before his or her name may be restored to the register. 20

(4) The Council may, by resolution, in writing, exempt for an indefinite or definite period any registered person specified in the resolution from payment of any annual fee prescribed in terms of subsection (1).

Transitional provisions

51. No person is subject to legal or disciplinary action or to any penalty contemplated 25 in this Act for engaging in traditional health practice during the period of one year following the date of commencement of this Act without being registered to do so.

Short title and commencement

52. This Act is called the Traditional Health Practitioners Act, 2007, and comes into operation on a date determined by the President by proclamation in the *Gazette*. 30