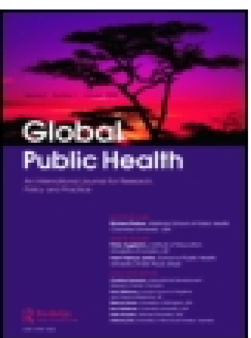

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God, Church water and spirituality: Perspectives on health and healing in Soweto, South Africa

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ABSTRACT
Faith, belief, and religion can powerfully shape how people live with and heal from illness. Engaging in religious practices, from gathering for services to reading the holy texts and engaging in private prayer, can serve as a critical way of coping or building resilience amidst everyday social, moral, and medical challenges. In this article, we investigate why, what, and how people living with chronic illness in an urban South African township prioritise healing practices of the Church over the Clinic. We conducted 88 in-depth qualitative interviews to understand how people think about health, chronic illness, and healing. Most people described complex socio-spiritual beliefs and practices that many prioritised or practiced apart from biomedical care. This included religious practices, such as prayer and drinking church water, as well as one's spirituality, which was an essential way in which people found healing. Recognising how socio-spiritual practice fosters healing and wellness is critical for thinking about health and healing for Soweto residents.

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Healing; church water; god; spirituality; South Africa

Background

> "I never used to drink anything from the doctor. All I'd drink was the tea and water provided by the church." – a Grandmother in Soweto

Faith, belief, and religion can powerfully shape how people live with and heal from illness. This is true within Christian traditions, which is a focus of this study, as well as among many others (Anderson, 2003; Eves, 2010; Garrity, 2000; Hardin, 2016). Engaging in religious practices, from gathering for services to reading the bible and engaging in private prayer, can serve as a critical way of coping or building resilience amidst everyday social, moral, and medical challenges (Kim et al., 2019; Roger & Hatala, 2018). Putting trust in religious practice as a source of healing, alongside biomedical modes of care for mental and physical illness is one form of medical pluralism (WHO, 2013). In this article, we investigate why people living with chronic illness in an urban South African township prioritise healing practices of the Church over the Clinic.

Medical pluralism is widespread, including in South Africa (Legare & Gelman, 2008). Some influential South African leaders have made sound arguments for the integration of biomedical and non-medical, or traditional healing systems, despite the fact that these divergent ways of thinking and caring for people often are fragmented and disconnected from one another (Leclerc-Madlala et al., 2016; Moshabela et al., 2016). Yet, an inherent frame conflict exists, where

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biomedicine promotes what is thought of as 'culture-free representations of disease' that are seen to be neutral and scientific, while alternative providers are constantly criticised for investing in and profiting from social and spiritual dimensions of healing (see Moshabela et al., 2016). The South African case is complex because of the breadth of culture, language, race, ethnicity, and religion that shape a diverse population, posing challenges for the country's health system (Leclerc-Madlala et al., 2016). Moshabela et al. (2016) suggest that 'medical pluralism results in delays in reaching appropriate biomedical services, high medical costs, and toxicity from traditional medicines' (p. 84). Instead of two disparate ways of healing, Parkin (2013) suggests that medical pluralism involves several healing traditions that coexist in a region, with mutual borrowing of ideas, styles, and practices between them, and by implication more differentiated strategies adopted by patients in search of cure (see Parkin, 2013, p. 125). Understanding how people perceive and engage in multiple modes of healing provides a fuller picture of what and who people trust and follow in their everyday healing and care practices, especially for chronic disease. This can require social, spiritual, and practical investments of individuals and families.

Beliefs in the causes of illnesses drive many people to seek care from 'alternative' sources, or non-medical care. We use alternative medicine or care to refer to different modes of healing that depend on knowledge bases distinct from biomedicine like using herbs, liquids, or prayers for healing (Kleinman et al., 1978). Some may seek alternative care in part because people often perceive illness through a religious or cultural lens, such as identifying punishment from a deity or a god (Eves, 2010), a nonhuman being, such as a ghost, ancestor, or evil spirit, or a witch or sorcerer as the cause or complicator of illness (Ibeneme et al., 2017). The Abron people of Ivory Coast, for example, believe that people sicken and die because some power has acted against them (Alland, 1970). The Akan communities in Ghana believe that one could become sick through invocation curses in the name of the river deity, Antoa, upon an unknown offender (White, 2015). Others, including people from India and China, believe in a naturalistic system – where illnesses are caused by imbalances of natural causes, such as heat or cold or sometimes strong emotions (Erickson, 2016). In part because of people's beliefs that illnesses come from the social or spiritual world, many people also put trust in cures that are social or spiritually linked, such as using traditional herbs, incantation, prayers, or soothsaying (Ibeneme et al., 2017).

Some South Africans reject biomedicine because of historical aggressions from clinics or systems that prioritise biomedical care and treat people as patients as opposed to people, dissociating the personal or spiritual aspects of an individual from their care (Coovadia et al., 2009). Mistrust therefore serves as a motivator for why people seek care from alternative providers. In South Africa trust in institutions such as public hospitals can be rocky – in part because of historical discrimination from apartheid as well as persistent systemic failures, such as long waiting times, drug stock outs (see Audet et al., 2017; Bosire et al., 2021; Coovadia et al., 2009; Mashabela, 2017), and oppressive power dynamics between patients and clinicians (Bosire et al., 2020a). Many other examples come from colonial legacies of oppression and current aggressions through large-scale testing on or exploiting people who are living with infectious diseases (such as tuberculosis); in some cases, this causes mistrust of development projects (see Eves, 2012; Packard, 1989;Tilley, 2016; Yahya, 2007). For example, Tocco (2014) observed how Muslim patients in Northern Nigeria were suspicious of the massive intervention and funding from PEPFAR and the United Nations Global Fund to Fight AIDS, Tuberculosis and Malaria (UNGFAMT); many distrusted these international actors rolling out large-scale antiretrovirals (ART) programmes in part because people did not understand who they were and what they were doing there. Many did not believe ART could improve the lives of people living with HIV; instead, many preferred Islamic prophetic medicine, with treatment consisting of reciting passages from the Quran, as opposed to international programmes that were not culturally acceptable or locally relevant for how people perceived both their illness and healing (Tocco, 2014).

Other religious practices and rituals such as reading the bible, praying, going to church, and water rituals are common forms of healing used within Christian traditions (Roger & Hatala,

2018; Romeo et al., 2015). For example, Samoan Christians perceived biomedicine to be limited or incapable of addressing a patient's subjective experiences, such as stress and anger, or curing metabolic disorders such as diabetes (Hardin, 2016). Instead, the Samoans believed in church healing which required first learning to develop faith and depend on the Divine in order to change health practices and secure effective healing (Hardin, 2016, p. 112). Water rituals are particularly common symbols used in worship such as for baptism, foot-washing services, cleansing, and healing (Romeo et al., 2015). In many contexts, the use of water is symbolically used to clean off 'dirt' or 'pollution' from the body – where dirt/pollution is roughly defined as something that causes social dis-order or dis-harmony. For instance, Mary Douglas in her book 'Purity and Danger' (1966), defines dirt as 'matter out of place', she goes on, 'Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements' (p. 36). In this case, she argues that 'Ritual recognises the potency of disorder [… .] and expects to find powers and truths which cannot be reached by conscious effort' (p. 95). In this way, it marginalises anything that is not religious or pure, suggesting that only those practices and beliefs on a spiritual path may bring about healing.

In South Africa, more people live with HIV than in any part of the world, and increasingly these individuals face colliding metabolic conditions, like hypertension and type 2 diabetes, as well as a well-established psychological burden (Oni et al., 2015). People rely on public health care systems for diagnosis, treatment, and care (Fusheini et al., 2017), but rarely rely exclusively on this care for one or more of these conditions, often seeking herbs from traditional healers or fostering mental health with religious practice (Burman, 2019; Mashabela, 2017). In Soweto, many people engage radical acceptance and, although they trust in medical care as a source of healing, engaging in private prayer, prayer groups in the homes of churchgoers, and spiritual healing fostered resilience amidst adversity, such as a severe health threat like breast cancer (Kim et al., 2019).

In this article, we investigate how people engage in self-care of their physical bodies through spiritual and religious practice, such as prayers, trusting in God, water rituals, and spirituality, and how such practices influence the ways in which people then conceptualise their illness and healing in Soweto, South Africa. Although biomedical practice dominates much of what we know about how people think about and heal from illness in this context, we argue that people think about health and healing through socio-spiritual frames that inform how they care for themselves and others in their lives, such as family and community members. Many people rely on biomedical therapies and routine primary health care to manage chronic illnesses such as HIV and Type 2 diabetes; however, in many cases people care for their illness beyond the narrow medical paradigms to achieve healing on their own terms.

Methods

Study context

This article draws from a subset of 88 people (29 men and 59 women) recruited from a large disease surveillance cohort in Soweto, a prominent peri-urban area on the southwest of Johannesburg, South Africa. Soweto is characterised by a wealth of ethnic diversity and integrated linguistic and cultural nuance reflected in the families who have resided there for generations. Soweto, like much of South Africa, has its own unique cultural milieu, with families often speaking one or more languages, from isiZulu, Setswana, Sesotho, isiXhosa and Xitsonga, mixed with English and Afrikaans, and is relatively wealthy compared with other 'townships' – reflecting its history as a conglomerate of six racially segregated urban areas. With a history of resistance and prominent political organising during the anti-apartheid movement (Zuern, 2011), Soweto continues to be a unique area where residents tend to live there for long. Yet, as in many other contexts in South Africa, a history of systemic racism, intensified by apartheid has created structural vulnerability, which have led to social and economic inequalities (Coovadia et al., 2009). Concurrently, rapid

development in contexts like Soweto are visible in the shopping malls, industry, transport, grocers, and restaurants that have opened in the past two decades, leading to more obesogenic environments (Moodley et al., 2015), where people are moving less, eating fewer meals at home (and often fattier foods), and experiencing more stress and pressure from the cost of food and labour expectations (Wrottesley et al., 2019). This has promoted an escalation of metabolic conditions like hypertension and diabetes (Micklesfield et al., 2013), which now co-exist with multiple other chronic conditions like HIV and mental illness (Coovadia et al., 2009). With complex and often syndemic medical conditions, compounded by historical mistrust of biomedicine, many people seek care apart from formal public hospital or clinical settings, and finding healing with personal and collective religious practice is normalised.

Study design and sampling

This ethnographic study was nested within a larger study of community-level surveillance of health and diseases in Soweto. For the larger study, we had two field teams (with two research assistants each) conducting interviews with Soweto residents that were 25 years and older (n=957). These interviews involved questions on socio-demographics, stress and coping, adverse childhood experiences, social coping and cohesion, medical histories, and anthropometrics. For this project, we recruited people from this larger community sample who had no illness (n=47) and those who had diabetes and a comorbidity, including hypertension, depression, or infection, mostly HIV (n=41).

Data collection

People from the community sample were invited to participate in a lengthier life history narrative, lasting for about 45–120 min. Most interviews were a combination of languages, including isiZulu, Sesotho, isiXhosa, Setswana and English. Two multilingual primary interviewers completed these interviews using an open-ended interview guide which was designed to capture study participants' life histories, with a focus on early childhood, family, community, education, social dynamics, illness, social support, care-seeking, and medical and alternative care. These interviews were conducted at a research unit affiliated with the University of the Witwatersrand in Soweto. Interviews were conducted from May 2019 to June 2020. All interviews were audio-recorded, and interviewers wrote extensive field notes to describe major themes that emerged from the interviews. Study participants were compensated 150 ZAR (US$ 12) for transportation costs. This research project was approved by the University of the Witwatersrand Human Research Ethics Committee (Clearance number M180544).

Data analysis

Data from all interviews were transcribed verbatim; audio from vernacular languages were transcribed and translated into English, while maintaining consistency with their original meaning. We used an inductive method that involved reading and rereading transcripts and field notes while comparing the two to ensure no data was misinterpreted. The study team designed a codebook based on this inductive analysis, which included 30 main codes with many sub-codes. These codes were well defined and collectively agreed upon, reflected in the interview guide, field note, select transcripts, and in-depth discussion; each code was identified, defined, applied, revised, and discussed among a team of five core members of the research team. We administered the codes to each transcript using Dedoose (a qualitative analysis software), with the first author as the primary coder and two secondary coders reviewing and applying codes to each transcript.

This manuscript emerged through grounded theory, as we read through the field notes, transcripts, and discussed the data collectively. We then re-examined the codes around medical and

alternative care-seeking and care-provision. These codes include personal faith as healing, God as a healer, faith healers, medication/treatment given by the church, traditional healers and herbs. We worked from the literature and previous ethnographic and in-depth narrative research the team has collected alone and together in order to write up each theme category broadly. We then used axial coding to describe a more nuanced analysis of sub-codes, which are delineated in the results section by subheadings. Axial analysis of these major themes provided a deeper understanding of the complexities around why and how people care for themselves and others.

Results

Forty-seven participants had no comorbidity (53%), fifteen had comorbid diabetes, hypertension and low stress (17%), nineteen had comorbid diabetes, hypertension and high stress (22%), and seven had diabetes and infections (including HIV) (8%). Most participants with no comorbidity revealed that they rarely attended hospitals; they only sought medical care when they were very sick. In most cases, these participants relied on self medication including using over the counter pain killers (such as Panadol, Grand pa) and readily available natural herbs. Moreover, participants with comorbidity who reported low stress coped well with the demands of managing their conditions, and most switched care between medical and alternative care providers. In contrast, many participants with comorbidity and high stress reported that they struggled to cope with their illnesses, relying on God for healing, and church and family members for social support. In addition, some participants from this group revealed distrust in hospitals and healthcare providers. Those participants with diabetes who reported HIV revealed that they constantly engaged with the healthcare system: although indicated trust towards public primary clinics in Soweto, they complained about the poor quality of clinical services, which drove them to seek care from alternative providers.

Below, we present the key emerging themes from this study. First, we discuss people's perspectives, beliefs and meanings of health and sickness. Second, we present the alternative practices – how people use the church and both personal and collective notions of spirituality or God, to heal. Seeking care in these ways – from God, church, and personal spirituality – was influenced by people's belief system, family members, friends or one's community. Lastly, we discuss how alternative care impacted on individuals' health seeking behaviour, health, and overall well-being.

God, pain and the meaning of health and illness

Many participants revealed a close relationship with God, faith healers, and medication provided by church for healing and general well being. One participant said: '*Without believing in God, there is nothing that you can do.*' Both men and women revealed that they consulted different alternative care providers. However, more women than men revealed that they trusted in God as a healer.

Health was described using different isiZulu (a commonly spoken language in Soweto) words; '*inhlalakahle*' which was translated as 'being well'; '*impilo*' translated as 'life' and '*ukuphila*' which meant 'to live'. Health was also described as being energetic and capable of doing different activities – participants used the phrase '*ukuba flexi*' which loosely translated to mean 'being flexible' and '*ukuba namandla*' which meant 'having strength' or physically capable of doing things including self-care – eating well, exercising, taking medication; and being mentally stable. One participant said: '*I would say health is based on how well you are looking after yourself and whether you eat food that is healthy for your body.*' Health was also conceptualised as the body being at 'balance'-insinuating a positive equilibrium; '*Health is when I feel my body is strong and having energy, and not having any pains, it's just being balanced.*'

Illness or sickness was largely described in IsiZulu as '*ukugula*', meaning having somatic pain (including in the head, feet, back or different body joints). One elderly woman said: '*I have pains every day, 24 h. It feels like you're being pricked by needles; the whole body from the toes right up*

to the head.' Similar sentiments were echoed by another male participant who said: '*Sickness is when you feel pain in your head or having pain in the chest and your stomach.*' Here people described illness as a heavy burden, commonly felt in the head then moving to the rest of the body. Others described this feeling as a kind of 'frequent tiredness' or 'fatigue' or 'being weak': '*when you wake up with a feeling of frail in your body*', and this hindered individuals from doing routine activities or leading a normal lifestyle.

Despite the different ways of framing health and illness, God was often at the centre of people's ideas about health, sicknesses, and death. There was a common belief amongst all participants that God determined what happened to people's lives; '*I believe that everything that happens in your life is the will of God; he is the one that takes away sickness from your life so that you can live a good life*'. In this context, trusting in God's healing power was one way that participants accepted their illnesses, expressed hope for recovery from their illnesses and generally coped with the challenges that they faced. God was also described as a supreme being and one who had control over people's lives; '*God is the almighty, he knows my life better, just like the chef knows his pots. So, I accept what I have and leave it to God.*' In this context, individuals understood the chronic issues that they had, and perceived that they needed to develop an interdependent relationship with God by surrendering all their troubles to God in order to attain healing. Many participants without comorbidity viewed their good health as God's favour on their life, while those with comorbidities believed that their healing could only come from God as he is the one who created them.

Participants with comorbid conditions provided various perceptions of the causes of their illnesses, many of which extended beyond clinical explanations like food intake and weight. Almost half of the participants believed that illnesses were linked to cultural or spiritual causes – such as bad spirits, curses, bad luck or being bewitched, and that only spiritual interventions and prayers would heal a person. A middle aged woman with comorbidity and high stress said: '*God didn't bring sickness to the world, if you're ill, you need to chase that sickness away from your body. You must pray.*' In this context, participants believed that people became sick as a result of disturbance of social relationships with their neighbours, ancestors or God, and illness was a form of punishment. Therefore, people needed to consult with God through prayers to 'expel' diseases away from their bodies and be healed as exemplified by one participant: '*I was not born with diabetes, so I must fight against it, I must pray to God to help me.*'

Yet, although many believed that God could heal their illnesses, they also pointed out that death was God's will – arguing that if someone died, there was nothing that could be done to control death. As such, participants tried to make sense of their life amidst chronic diseases, including the meaning of death.

> … even if a person can die, I will weep at that time and then tell myself that if God did not want to take that person, he would still be alive, and so it was time for that person to die.

In this way, individuals were able to explain the reasons behind death, and this helped them cope with the deaths of loved ones.

Prayers, trusting in God and healing

More than half of our interlocutors (n=58) described different religious practices such as going to church, reading the bible, or conducting prayers (self prayer and being prayed for by others) as key in fostering strength, hope, and meaning of life amidst chronic diseases: '*It's prayers that keep me strong, it gives me strength to push on.*' Taking part in such religious practices created a personal, intimate relationship with God. Others revealed that the church and trusting God was a collective source of healing both physically and mentally: '*I don't even feel like I'm sick, the church is healing me, and I feel okay in my body [physical] and mind.*'

Many described prayers and trusting in God as a routine practice, and the main reason why they were still alive: '*Prayer keeps me alive; I trust in God and am praying more than anything.*' Moreover, the notion of praying more or frequently emerged among many other participants and was associated with a continued commitment/connectedness to God, as a process towards healing. One participant revealed that although she had stopped praying, her illnesses forced her to go back to what she was taught to do when she was a child; praying and trusting in God: '*I now decided to follow what my mother taught me when I was a child, to pray a lot for God to heal me.*'

Although individuals were not able to attest of visible outcomes of healing, they still trusted and had faith that they were healed or will be healed; '*I do tell myself that I was not born with high blood pressure, I was not born with diabetes. I know God will heal me.*' Such sentiments also confirmed people's perceptions on causes of their illnesses (bad spirits, curses or bewitchment, as discussed above) which required socio-spiritual interventions for healing. Other participants with comorbidities revealed a need for continuous connection with God through prayer, as a way of overcoming sickness and regaining health: '*sometimes I'd feel as if I'm healed but then the symptoms would show up again, I'd pray more because, God is in control of our lives and we must keep praying to be healed.*'

In addition, many participants in this study combined praying frequently and visiting the church to release tension or stress and calm down: '*The only thing that is helping me now is church, when I leave the church service, I feel that I have offloaded some stress.*' Praying together with others in the church, and other communal church activities, were crucial in providing psycho-social support: '*I go to church to be with others, we pray to God together and support each other.*' Attending church also provided a form of communalism, and people, including the ill, interacted and comforted each other: '*The church helps a lot because at church you will hear other people talking about this illness and I will realise that I am not the only one suffering from these illnesses.*' Ultimately, many believed in being prayed for by others to improve their health: '*I'm a believer, so there's a church that I go to where I pray and ask to be prayed for and after that, I feel better.*'

Drinking church water

Many participants in this study attended the Zion Christian Church (ZCC), one of the fastest growing African Independent Churches (AICs) in South Africa. They commonly described drinking 'church water' – a liquid mixture served at church or prepared for participants to take at home – as a source of healing. Many interlocutors referred to it as 'holy water' or 'tea' (which was locally called '*indayelo*'). One woman said; '*It's indayelo [the holy water] that heals me.*' Participants reported that church water was prepared by mixing water, oil, tea and some herbs and then prayed on by a church minister, pastor or '*omama bomthandazo*' who are 'mothers/women of prayer'. These women not only prayed for the water in the church, but also visited and prayed for church community members in their homes. Drinking church or holy water is an old and common practice amongst ZCC church members, as well as many other Christians in Soweto. Yet, particularly West's (1972) studies on African independent churches in Soweto reported on the use of holy water amongst the Zionist church members for healing. He says, 'Holy water may be given to members of a congregation to heal them of something specific, or else it may be drunk to purify and protect against illness and misfortune' (p. 185), he adds that, 'The importance of holy water in healing can be seen by the fact that it was given to patients in 79% of consultations' (p. 213). Recently, in his interviews with undisclosed ZCC members in Soweto, Mashabela (2017) reported that tea and coffee were the old forms of healing; 'In the African spirituality worldview, it is critically important to use coffee and tea as they are not invented memories but practically and historically lived memories within the ZCC spirituality' (p. 6). In other words, tea and coffee were old forms of spiritual healing and has been used since the inception of the ZCC church.

Findings from our study show that church water played different roles in healing. First, it induced vomiting – and this was one way of cleansing the body. This vomiting process was called

'*ukukhipha inyongo'* which meant 'excreting gall or bile.' Here, illness or discomfort in the body was perceived to be as a result of excess build-up of gall or bile (or a lack of equilibrium in the body) which was caused by ingesting food with excess amounts of sugar and fat. Thus, vomiting up this gall or bile would relieve people of the disease within the body. One participant said: '*They call it indayelo yes they make that tea and then you drink it and induce vomiting, I like it because it cleanses my body.'*

Many people also observed changes to the physical body, or excrements as a result of *ukukhipha inyongo*. This was described by one person who said: *'I take the water to clean my blood. My urine used to smell, and it was yellow and now it is clear and doesn't smell.'* But this was not only material release; indeed, many people said church water could help in calming the body from stress or anxiety: '*When I've drunk it, I feel calm; I'm no longer in that high pressure or stress.'*

Spirituality, acceptance and coping with medical and social challenges

Participants in this study (both with and without illnesses) described how they drew their strength from spirituality – through understanding the meaning and purpose of life – including illness and health (as described above), spending time alone, meditating, connecting with God and friends, and making personal decisions about their life and self-care. Searching for meaning and purpose in life, for example, was said to draw them closer to God and enhance acceptance of their illnesses. One participant said: *'Most of the time, I have just told myself, who was supposed to get sick if I don't? So why must I stress of a disease when I am not the only one who is sick. I better accept it.'* Others demonstrated their understanding of the consequences of not-accepting their illnesses, such as 'becoming sicker', and thus decided to accept and focus on God and healing: '*I don't dwell on it [illness] a lot, if you dwell on a sickness that is when you get sicker. I accept and I know with God, I will be okay.'* Another participant said: '*If you keep stressing and thinking about problems, you're making things worse.'*

Some participants described how they spent private time – sitting quietly in private rooms or spaces, away from any distractions, as a way of attaining calmness, contemplating about their lives, meditating or connecting with God. This was said to help many in attaining inner peace which helped them to heal: *'I close myself in my room and remain silent, I meditate and think about my life. I even get irritated at the kids because I don't want noise.'* One participant described how he spends time with nature as a way of distressing: *'I'm an outdoor person so I spend my personal time out a lot; at the Zoo Lake, the Botanical Gardens; that's how I distress.'* Many others described how they connected with others as a way of healing: *'If I feel stressed, I go see other people and talk to other people; and then I feel better.'*

Spirituality was also said to be key in guiding individuals to make rational choices. One participant said: *'Knowing that in as much as I can set goals for myself, I believe in my spirit. It's my spirituality that helps me in reducing my stress and planning my life.'* Another participant related her spirituality and personal decision to adhere to medication when she said: *'My spirituality heals me; that is why I am saying that I am not able to leave my pills and put all my faith in the church.'*

In this context, spirituality emerged powerfully as a strategy that some people used to attain inner peace, accept and cope with their everyday challenges, take charge of their lives, make rational decisions in self-management and generally, it facilitated perceived health improvements in relation to chronic illness (see also, Unantenne et al., 2013). Researchers have also reported that intrinsic spirituality is positively associated with effective coping strategies, health-promoting activities, mental health and well being (Brooks et al., 2018). As such, health promotion interventions may need to include spirituality as a tool that would empower individuals managing chronic illnesses.

Switching between different health sectors

Ultimately, findings from this study show that people mixed different care systems in managing their medical and social issues. This was particularly common among participants with diabetes and HIV, and those with comorbidity and high stress. Although church healing, spirituality, or biomedicine seemed to be different, participants did not rigidly adhere to one system of care but moved between the different systems depending on the meaning and perceptions they attached to their illnesses. One participant said: *'They [doctor] said I mustn't burst the skin, but I did. I then went to see a traditional healer for treatment.'*

Moreover, the challenges experienced in accessing care from the hospitals such as drug stock out drove many to utilising alternative care (such as from church, traditional healers, or use of herbs) as exemplified by a 65-year-old man managing diabetes and hypertension and high stress: '*I went to the clinic this month and the pills were finished, the Metformin pills for diabetes were not there. I decided to use traditional medicine and church water.'* In this context, some people switched between hospital medication and alternative care:

> I've been drinking church water for a long time, sometimes, I skip the hospital medication. Other participants, revealed that they preferred alternative care to biomedical care; 'I don't like drinking pills [hospital medication] because I get help from the medication from church.

One elderly woman with comorbidity and high stress demonstrated her distrust with the hospital when she said that; 'Going to the hospital makes me think that I will not leave the hospital compound alive, because all my family members have perished here.' Thus, she preferred managing her illnesses using alternative methods.

One middle aged male participant without comorbidity said: '*I trust in the church healing. That's why I'm telling you that for me, the hospital has no place because I get the help I need from church.'* Other participants revealed that they had completely discontinued taking hospital medication because they believed and trusted in the church to heal them.

Many participants without comorbidity revealed that they did not go to the hospital, unless they were very sick: '*Personally I prefer taking over the counter meds. I don't like consulting often, it's only when I think it's serious that I'll obviously consult at the clinic.'* Participants reported that they used over the counter medications – such as Panadol, Grand Pa or Med-Lemon or some rubs that were easily accessible in spaza shops and Dischem stores to self-manage common ailments including: congested chest, flu, having a stomach-ache, headache, and somatic pain.

Discussion

This paper demonstrates the powerful role of alternative care in people's lives in Soweto, regardless of people having received any medical diagnosis. Many put trust in God, which is embodied through prayer and drinking holy water to enhance their health and promote healing. While many people engaged multiple modes of care, some explained that they stopped using medicine and seeking care from hospitals. In his studies, Mashau (2016) reported that emphasis on prayers and church healing by the church resulted in medical treatment being rejected in some churches. Elsewhere, studies have reported that religious practices and beliefs have led to individuals neglecting biomedical care for chronic diseases such as HIV/AIDS (Mattes, 2014; Tocco, 2014), or cases where parents refused their children to be vaccinated or treated at the hospital (O'Mathúna & Lang, 2008). Indeed, seeking care from alternative providers especially amongst people living with chronic diseases is a common practice in South Africa (Mokgobi, 2014; Moshabela et al., 2016), although it is unclear what people's long-term health experiences are once they abandon biomedicine altogether (Nyamongo, 2002).

People described how powerful prayer, reading the bible, and water rituals become central to people's self-care to enhance relief, strength, healing, and promoting the inner spiritual and

psychological well being (see Mashabela, 2017; Unantenne et al., 2013). Many of our participants' strong belief that they were healed or would become healed was essential for their ability to cope with and heal amidst chronic illnesses (see also, Hardin, 2016). In other words, finding psychological and spiritual balance amidst metabolic or material chaos can serve to improve chronic physical illnesses (Roger & Hatala, 2018; Unantenne et al., 2013). For example, when people described how a constant relationship with God through prayers, confiding all their fears and worries to him, they felt heard. This was significant in part because very few people felt heard or valued within the biomedical system. Harris et al. (2016) have demonstrated that patients are happier, more cooperative and effective in adhering to medical regimens, and more likely to make positive behaviour changes when they feel heard and valued in decision making pertaining to their health. Promoting health care environments where patients feel heard and understood by those caring for them has also been found to enhance collaborative decision making, address misunderstandings, relieve suffering, and improve quality of care (Gramling et al., 2016). Yet, patients too often feel silenced, ignored, and misunderstood in biomedical systems of care (Bosire, 2020b). Indeed, comments on biomedical care were rarely conveyed through trust or a deep sense of healing. In contrast, healing was definite to those who believed and trusted in God's healing powers and were committed to religious practices such as praying. This is similar to what Hardin (2016) found amongst the Samoans: 'Healing is an everyday activity for many evangelical Samoans; it requires striving for divine interdependence as a way to change health behaviours and called for continual attention' (P. 107). Robbins (2004) also argued that, Christian rituals 'both in their symbolism and their processual design are shaped by the goal of helping those who practice them to overcome the difficulties of ethical self-formation' (255). In this way, God was conceived as one who was trustworthy and reliable, while medical care was somewhat unreliable and stressful.

Church water was a central element of healing in Soweto (also see West, 1972), as it is throughout many diverse South African communities. Individuals strove to ensure that they drank church water as frequently as possible in order to be healthy and receive divine healing. In many contexts, water as a symbolic object has always played an important role in cleansing and healing (Kgatle, 2018; Romeo et al., 2015). Anderson (1999) argues that water rituals in the South African context 'represent cleansing and purification from evil, sin, sickness and ritual pollution, concepts familiar to traditional religion' (P. 305). Using holy water is a Christianity-wide ritualistic practice, embodied through baptism with water serving to purify spiritually as one is inducted into the Church. As Lebeloane and Madise (2006) describe, 'Water is perceived as a gift from the Creator. It is further understood to have life-giving and life-invigorating power if it has been blessed by either a minister of religion or a traditional healer (called *inyanga* or *ngaka*)' (p. 146). In this way, water is both Western and embodied in local ideal and practices. Anderson (2003) further explains that, 'water is mentioned in the Sepedi phrase, *meetse a thapelo*, meaning water of life, as the source of healing within the ZCC and used to purify members at their homes, funerals and other services' (p. 112). While such ways of thinking and healing are antithetical to uncommon in biomedicine (Good, 1994), understanding how critical these beliefs are for people who engage in biomedical care is essential. This is particularly important for those engaging in radical self-care, where their physician may advise strict diets, exercise routines, and medications and, by practicing non-medical healing that promotes good mental health, their clinical health measures may improve.

Spirituality was also found to play a critical role in people's lives as it enhanced closer connection with God, other social networks, promoted calmness, enhanced acceptance of illnesses and facilitated how individuals made decisions about their lives, including self-care. Coyle (2002) describes spirituality as a subjective concept whereby each person finds existential meaning, or a realm of social action where the individual's autonomous ability to choose is paramount and reflecting self reflexivity. In this way, individuals were able to shift their attention away from their social or medical suffering and relied on their spiritual resources in order to enhance their mental and emotional well being. In deed, spirituality and religiosity have been reported to provide positive emotional, mental and physical well being amongst individuals with chronic illnesses (Brooks

et al., 2018; Michaelson et al., 2019; Roger & Hatala, 2018). Yet, it is not clear how external factors such as poverty or poor living conditions influence individual's spirituality and capability to connect with others or make decisions in life. Future studies should examine in detail issues around spiritual coping and effective approaches to spiritual care for people with multiple social and medical challenges.

Thinking about where people heal is critical for studies of public health and medicine around the world. Certainly, how patients heal from a chronic metabolic condition like diabetes differs from an infectious chronic condition like HIV in Soweto; yet, how people interpret and heal with both conditions together and alone, and in doing so rectify what health and a good life means, differs across contexts. Recognising ways in which people feel heard, heal, and live well with convergent infectious and metabolic conditions – either from healing sources in the clinic, home, or church – is critical as we continue living through one of the most challenging times in modern history. COVID-19 has challenged not only how we see personal risk and responsibility but also how others perceive, care for, and promote healing among those most vulnerable among us. This certainly includes people living with chronic conditions like diabetes and HIV, those elderly whom we hold most dear (though, many marginalise or write off as dispensable), and others who depend upon routine medical care. As we become more globally connected – as the novel coronavirus has revealed in unimaginable ways – we also become increasingly disconnected as we hole away in our homes, insular internet communities, and groups that we feel connected to. With many places of spiritual healing like churches closed amidst the pandemic, and clinical spaces limited while caring for COVID-19 patients, finding solace and healing for non-COVID-19 conditions produces challenges for many people, not least an extraordinary mental burden (Kim et al., 2020). Although non-medical forms of care and healing may be hidden in people's clinical charts, these practices of self-care that go beyond biomedical reckoning of what constitutes 'self-care' to begin with (Yates-Doerr, 2015), are what will fuel communities through this time of crisis.

Conclusion

How people think about their social and spiritual lives plays a critical role in how they conceive of and seek care for illness. This is a well-known fact within anthropology and other social sciences, but still rarely in biomedicine. Recognising these critical aspects of healthy practices are important in part because they celebrate how or what individuals are doing to care for illness, especially when their management is chronic or long term. By celebrating what people are engaging in – from prayer to ritual – messages from medical providers may not only shed more positive light (as maintaining mental health is critical for anyone with a chronic illness, especially a metabolic one), but also truly improve physical outcomes. The limitation is when these ideals and practices are marginalised within caregivers who do not have training or knowledge of these practices, or of what is moral and virtuous in people's lives, which strengthen their spiritual selves on the paths to strengthen their physical bodies. Recognising these critical lenses and practices can, therefore, enhance care within or through these pluralistic healing practices.

Moreover, this study shed light on ways in which religious practices such as prayers and drinking church water are likely a source of emotional and social support in Soweto, ultimately leading to people's improved mental and physical health. However, health care providers may be unsure of how to incorporate these religious practices into patient care. Understanding the role of religion or spirituality can be integrated through frames such as cultural humility (Isaacson, 2014) for clinicians serving the multi-cultural, and spiritually pluralistic patient populations in an urban South African contexts like Soweto (Janse van Rensburg, 2014). In some ways, training clinicians to understand how religion/spirituality empowers and promotes resilience amongst people with chronic illnesses may help them to think through the benefits for mental health as well as potential positive impact on physical health. This could also be helpful in enhancing curriculum or training for medical students. In this way, integrating alternative care with biomedicine could afford patients

a more complete form of care that would synergise biological, psychological, social and spiritual approaches. This would produce a more culturally-sensitive, patient centred healthcare system.

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Availability of data and material

Data will be made available upon written request to the corresponding author detailing the intended use of data.

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References

Alland, A. Jr. (1970). *Adaptation in cultural evolution: An approach to medical anthropology*. Columbia University Press.

Anderson, A. (2003). *Healing in the Zion Christian churches of Southern Africa: Daneel's Research in Zimbabwe compared with the South African movement*. In G. Cuthbertson, H. Pretorius, & D. Robert (Eds.), *Frontiers of African Christianity: Essays in honour of Inus Daneel* (pp. 86–173). University of South Africa Press.

Anderson, A. H. (1999). The lekganyanes and prophecy in the Zion Christian Church. *Journal of Religion in Africa*, *29* (*3*), 285–312. http://doi.org/10.1163/157006699X00368

Audet, C. M., Ngobeni, S., & Wagner, R. G. (2017). Traditional healer treatment of HIV persists in the era of ART: A mixed methods study from rural South Africa. *BMC Complementary and Alternative Medicine*, *17*(1), 1–6. https://doi.org/10.1186/s12906-017-1934-6

Bosire, E. N. (2020b). Patients' experiences of comorbid HIV/AIDS and diabetes care and management in soweto, South Africa. *Qualitative Health Research*. https://doi.org/10.1177/1049732320967917

Bosire, E. N., Mendenhall, E., Norris, S. A., & Goudge, J. (2020a). Patient-centred care for patients with diabetes and HIV at a public tertiary hospital in South Africa : An ethnographic study. *International Journal of Health Policy and Management*.(x), 1–12. https://doi.org/10.34172/ijhpm.2020.65

Bosire, E. N., Norris, S. A., Goudge, J., & Mendenhall, E. (2021). Pathways to care for patients with type 2 diabetes and HIV/AIDS comorbidities in soweto, South Africa: An ethnographic study. *Global Health: Science and Practice*, 1–16. https://doi.org/10.9745/GHSP-D-20-00104

Brooks, F., Michaelson, V., King, N., Inchley, J., & Pickett, W. (2018). Spirituality as a protective health asset for young people: An international comparative analysis from three countries. *International Journal of Public Health*, *63*(3), 387–395. https://doi.org/10.1007/s00038-017-1070-6

Burman, C. J. (2019). Re-Contextualizing medical pluralism in South Africa: A research schema for indigenous decision making. *Systemic Practice and Action Research*, *32*(4), 379–402. https://doi.org/10.1007/s11213-018-9460-0

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, *374*(9692), 817–834. https://doi.org/10.1016/S0140-6736(09)60951-X

Coyle, J. (2002). Spirituality and health: Towards a framework for exploring the relationship between spirituality and health. *Journal of Advanced Nursing*, *37*(6), 589–597. https://doi.org/10.1046/j.1365-2648.2002.02133.x

Douglas, M. (1966). *Purity and Danger. An analysis of concepts of pollution and taboo*. Routledge.

Erickson, P. I. (2016). The healing lessons of ethnomedicine. In P. J. Brown & S. Closser (Eds.), *Understanding and applying medical anthropology* (3rd ed., pp. 188–196). Left Coast Press.

Eves, R. (2010). In God ' s hands ': Pentecostal christianity, morality, and illness in a melanesian society. *The Journal of the Royal Anthropological Institute*, *16*(3), 496–514. https://doi.org/10.1111/j.1467-9655.2010.01636.x

Eves, R. (2012). Resisting global AIDS knowledges: Born-again Christian narratives of the epidemic from Papua New Guinea. *Medical Anthropology: Cross Cultural Studies in Health and Illness*, *31*(1), 61–76. https://doi.org/10.1080/01459740.2011.594122

Fusheini, A., Eyes, J., & Goudge, J. (2017). The state of public hospital governance and management in a South African hospital : A case study. *International Journal of Healthcare*, *3*(2), 68. https://doi.org/10.5430/ijh.v3n2p68

Garrity, J. F. (2000). Jesus, peyote, and the holy people: Alcohol abuse and the ethos of power in navajo healing. *Medical Anthropology Quarterly*, *14*(4), 521–542. https://doi.org/10.1525/maq.2000.14.4.521

Good, B. (1994). *Medicine, rationality, and experience: An anthropological perspective*. Cambridge University Press.

Gramling, R., Stanek, S., Ladwig, S., Gajary-Coots, E., Cimino, J., Anderson, W., … Unroe, K. T. (2016). Feeling heard and understood: A patient-reported quality measure for the inpatient palliative care setting. *Journal of Pain and Symptom Management*, *51*(2), 150–154. https://doi.org/10.1016/j.jpainsymman.2015.10.018

Hardin, J. (2016). "Healing is a done deal": Temporality and metabolic healing Among evangelical Christians in Samoa. *Medical Anthropology: Cross Cultural Studies in Health and Illness*, *35*(2), 105–118. https://doi.org/10.1080/01459740.2015.1092143

Harris, B., Eyles, J., & Goudge, J. (2016). Ways of doing: Restorative practices, governmentality, and provider conduct in post-apartheid health care. *Medical Anthropology: Cross Cultural Studies in Health and Illness*, *35*(6), 572–587. https://doi.org/10.1080/01459740.2016.1173691

Ibeneme, S., Eni, G., Ezuma, A., & Fortwengel, G. (2017). Roads to health in developing countries: Understanding the intersection of culture and healing. *Current Therapeutic Research, Clinical and Experimental*, *86*, 13–18. https://doi.org/10.1016/j.curtheres.2017.03.001

Isaacson, M. (2014). Clarifying concepts: Cultural humility or competency. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing*, *30*(3), 251–258. https://doi.org/10.1016/j.profnurs.2013.09.011

Janse van Rensburg, A. (2014). South African Society of psychiatrists guidelines for the integration of spirituality in the approach to psychiatric practice. *South African Journal of Psychiatry*, *20*(4), 133–139. https://doi.org/10.4102/sajpsychiatry.v20i4.593

Kgatle, M. (2018). The practice and impact of divine healing in saint john apostolic faith mission: A missiological perspective. *Scriptura*, *117*(2), 1–11. https://doi.org/10.7833/117-1-1386

Kim, W. A., Kaiser, B., Bosire, E., Shahbazian, K., & Mendenhall, E. (2019). Idioms of resilience among cancer patients in urban South Africa: An anthropological heuristic for the study of culture and resilience. *Transcultural Psychiatry*, *56*(4), 720–747. https://doi.org/10.1177/1363461519858798

Kim, A. W., Nyengerai, T., & Mendenhall, E. (2020). Evaluating the mental health impacts of the COVID-19 pandemic: Perceived risk of COVID-19 infection and childhood trauma predict adult depressive symptoms in urban South Africa. *Psychological Medicine*, 1–13. Advance online publication. https://doi.org/10.1017/S0033291720003414.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*(2), 251–258. https://doi.org/10.7326/0003-4819-88-2-251

Lebeloane, L., & Madise, M. (2006). The use of different types of water in the Zion Christian church. *Studia Historiae Ecclesiasticae*, *XXXII*(2), 143–152.

Leclerc-Madlala, S., Green, E., & Hallin, M. (2016). Traditional healers and the "fast-track" HIV response: Is success possible without them? *African Journal of AIDS Research: AJAR*, *15*(2), 185–193. https://doi.org/10.2989/16085906.2016.1204329

Legare, C. H., & Gelman, S. A. (2008). Bewitchment, biology, or both: The co-existence of natural and supernatural explanatory frameworks across development. *Cognitive Science*, *32*(4), 607–642. https://doi.org/10.1080/03640210802066766

Mashabela, J. K. (2017). Healing in a cultural context: The role of healing as a defining character in the growth and popular faith of the Zion Christian Church. *Studia Historiae Ecclesiasticae*, *43*(3), 1–14. https://doi.org/10.25159/2412-4265/1909

Mashau, T. D. (2016). Moving to different streams of healing praxis: A reformed missionary approach of healing in the African context. *Verbum et Ecclesia*, *37*(1), 1508. https://doi.org/10.4102/ve.v37i1.1508

Mattes, D. (2014). The Blood of Jesus and CD4 counts: Dreaming, developing and navigating therapeutic options for curing HIV/AIDS in Tanzania. In R. van Dijk, H. Dilger, M. Burchardt, & T. Rasing (Eds.), *Religion and the challenges of AIDS treatment in Africa: Saving souls, prolonging lives* (pp. 169–193). Ashgate.

Michaelson, V., King, N., Inchley, J., Currie, D., Brooks, F., & Pickett, W. (2019). Domains of spirituality and their associations with positive mental health: A study of adolescents in Canada, england and scotland. *Preventive Medicine*, *125*(May), 12–18. https://doi.org/10.1016/j.ypmed.2019.04.018

Micklesfield, L. K., Lambert, E. V., Hume, D. J., Chantler, S., Pienaar, P. R., Dickie, K., Puoane, T., & Goedecke, J. H. (2013). Socio-cultural, environmental and behavioural determinants of obesity in black South African women. *Cardiovascular Journal of Africa*, *24*(9-10), 369–375. https://doi.org/10.5830/CVJA-2013-069

Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation, and Dance*, *20*(Suppl 2), 24–34. PMID: 26594664; PMCID: PMC4651463

Moodley, G., Christofides, N., Norris, S. A., Achia, T., & Hofman, K. J. (2015). Obesogenic environments: Access to and advertising of sugar-sweetened beverages in soweto, South Africa, 2013. *Preventing Chronic Disease*, *12*, 140559. https://doi.org/10.5888/pcd12.140559

Moshabela, M., Zuma, T., & Gaede, B. (2016). Bridging the gap between biomedical and traditional health practitioners in South Africa. *South African Health Review*, 83–92.

Nyamongo, I. K. (2002). Health care switching behaviour of malaria patients in a Kenyan rural community. *Social Science & Medicine*, *54*(3), 377–386. https://doi.org/10.1016/S0277-9536(01)00036-3

O'Mathúna, D. P., & Lang, K. (2008). Medicine vs. prayer: The case of Kara Neumann. *Pediatric Nursing*, *34*(5), 413–416. PMID: 19051845.

Oni, T., Youngblood, E., Boulle, A., McGrath, N., Wilkinson, R. J., & Levitt, N. S. (2015). Patterns of HIV, TB, and non-communicable disease multi-morbidity in peri-urban South Africa- a cross sectional study. *BMC Infectious Diseases*, *15*(1), 366–383. https://doi.org/10.1186/s12879-015-1101-y

Packard, R. (1989). *White plague, black labor: Tuberculosis and the political economy of health and disease in South Africa*. University of California Press. http://www.jstor.org/stable/10.1525/j.ctt1pnvdq.

Parkin, D. (2013). Medical crises and therapeutic talk. *Anthropology & Medicine*, *20*(2), 124–141. https://doi.org/10.1080/13648470.2013.805349

Robbins, J. (2004). *Becoming sinners: Christianity and moral torment in a papua new guinea society*. University of California Press.

Roger, K. S., & Hatala, A. (2018). Religion, spirituality & chronic illness: A scoping review and implications for health care practitioners. *Journal of Religion and Spirituality in Social Work*, *37*(1), 24–44. https://doi.org/10.1080/15426432.2017.1386151

Romeo, N., Gallo, O., & Tagarelli, G. (2015). From disease to holiness: Religious-based health remedies of Italian folk medicine (XIX-XX century). *Journal of Ethnobiology and Ethnomedicine*, *11*(1), https://doi.org/10.1186/s13002-015-0037-z

Tilley, H. (2016). History of medicine: Medicine, empires, and ethics in colonial Africa. *AMA Journal of Ethics*, *18*(5), 473–563. https://doi.org/10.1001/journalofethics.2016.18.7.mhst1-1607

Tocco, J. U. (2014). *Prophetic medicine, antiretrovirals, and the therapeutic economy of HIV in Northern Nigeria*. In R. van Dijk, H. Dilger, M. Burchardt, & T. Rasing (Eds.), *Religion and the challenges of AIDS treatment in Africa: Saving souls, prolonging lives* (pp. 119–145). Ashgate Publishing.

Unantenne, N., Warren, N., Canaway, R., & Mandersone, L. (2013). The strength to cope: Spirituality and faith in chronic disease. *Journal of Religion and Health*, *52*(4), 1147–1161. https://doi.org/10.1007/s10943-011-9554-9

West, M. E. (1972). *African independent churches in Soweto* [Ph.D. thesis], University of Cape Town.

White, P. (2015). The concept of diseases and health care in African traditional religion in Ghana. *HTS Teologiese Studies/Theological Studies*, *71*(3), https://doi.org/10.4102/hts.v71i3.2762

World Health Organization. (2013). *Traditional medicine strategy 2014–2023*.

Wrottesley, S. V., Bosire, E. N., Mukoma, G., Motlhatlhedi, M., Mabena, G., Barker, M., Hardy-Johnson, P., Fall, C., & Norris, S. A. (2019). Age and gender influence healthy eating and physical activity behaviours in South African adolescents and their caregivers: Transforming Adolescent Lives through Nutrition Initiative (TALENT). *Public Health Nutrition*, 1–20. Advance online publication. http://doi.org/10.1017/S1368980019002829

Yahya, M. (2007). Polio vaccines - "no thank you!" barriers to polio eradication in Northern Nigeria. *African Affairs*, *106*(423), 185–204. https://doi.org/10.1093/afraf/adm016

Yates-Doerr, E. (2015). *The weight of obesity: Hunger and global health in postwar Guatemala*. University of California Press.

Zuern, E. (2011). *The politics of necessity: Community organizing and democracy in South Africa*. University of Wisconsin Press.