Visual Sovereignty in the Clinic of Culture: Representation and the Cinematic Construction of Indigenous Health Knowledge

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Abstract.

This paper explores the issue of visual sovereignty regarding the makeup and filmic construction of indigenous health knowledge that is organized around the encoding/decoding paradigm developed by Stuart Hall. Qualitative design was used to sample 30 participants who were indigenous filmmakers (n=10), cultural custodians (n=10), and community health practitioners (n=10) purposely sampled in Rivers State, Nigeria. The information was gathered using in-depth interviews and focus groups with discussions as well as a textual analysis of indigenous films and analyzed with the help of Braun and Clarke thematic analysis. Results indicated that indigenous cinema which is controlled by indigenous people depicts health knowledge to be holistic and spiritually oriented, whereas mainstream films skew it by projecting it into superstition. The visual sovereignty allows film directors to manage the narrative in response to the cultural protocols and native languages, as well as by consulting the elders, to ensure that the traditions are not misrepresented. The authentic presentation encourages generational knowledge and public acceptance, whereas misrepresenting images lead to the embarrassment of culture. It was found that the representation in cinema defines the way in which indigenous health knowledge will be a cultural preservation tool or a reinforcement of stereotypes. It has been recommended that authentic representations should be given priority based on local languages and rituals, that the sovereignty of indigenous filmmakers is supported by cultural protocols and provision of policy dialogue between traditional and modern medicine.

Keywords: Visual Sovereignty, Indigenous Health Knowledge, Cinema, Representation, Fourth Cinema, Cultural Preservation

Introduction

Worldwide indigenous communities are maintaining vibrant and place-based health knowledge systems that connect body, spirit, community, land and ceremony. These holistic

models and theories have been continually marginalised through mainstream biomedical discourses and mass media (World Health Organization, 2023). The visual media and cinema in particular, does not merely reflect on health beliefs but rather, contributes to the shaping of which types of knowledge are considered to be legitimate or delegitimised in a public discourse. Film representation thus operates as a cultural technology in direct relation to the way in which indigenous healing systems are viewed, disseminated and integrated or disintegrated into or out of the formal health policy and practice.

Indigenous media scholars claim that the aspect of sovereignty of visual representation is a crucial part of control. This is what Michelle Raheja calls visual sovereignty which is the ability of indigenous film makers to challenge colonial visual regimes and to perform indigenous epistemologies at their own pace (Raheja, 2010). Visual sovereignty re-examines film as a place of inactive representation to knowledge making practice. The editing, sequencing and image selection become a means of conducting classic time, relationality and healing logics, which cannot be achieved through textual narratives. The camera is thus a means of self-determination of culture and becomes the point of focus of any investigation which connects representation to the social life of indigenous health knowledge.

The concept of an indigenous cinema that puts into the fore the voice of the community has also been explained in the way of Moving 4th-Cinema. This international structure was born in Maori cinema and holds that native filmmakers must make their own people first. It also states that the forms of indigenous ontologies should be represented in cinema instead of absorbing into the mainstream industrial standards (Milligan, 2015). In combination, four cinemas and visual sovereignty offer conceptual grounds to exploring the representation of healing regimes in movies, how the community employs the movie to educate or protect knowledge and the circulation of the cinema to influence the validity of local, national and global communities to adopt indigenous health practices.

The global policy level has been paying more and more attention to indigenous health and the rights of the cultures. The United Nations Declaration at the Rights of Indigenous Peoples gives priority to the right to collectively cultural and health rights, and the new resolutions on Indigenous health by the World Health Organization note that Indigenous health is not only a right but also an action (United Nations, 2007; World Health Organization, 2023). These policy processes highlight the political interests of representation. Such cinematic exoticization and misrepresentation of indigenous healing practices may inhibit rights-based health agendas, whereas indigenous-led visual practices can advance culturally safe and community-led models of health and knowledge transmission.

Different directions are observed in continental surveys. A developing source of indigenous documentary and feature films in North America and Oceania has been associated with truth telling, cultural revival and health advocacy movements. As an illustration, movies that have touched on the trauma of residential schools in Canada or issues of health sovereignty by Maori in Aotearoa show this connection (Raheja, 2010). The increase in the use of indigenous audio-visual practice to document and defend biocultural practices at risk by extractive industries is widespread in Latin America. In Africa and sections of Asia, indigenous media are less well-documented in the literature of anglophone film studies, yet audio-visual health

communication participation projects suggest an increase in interest in audio-visual media. These continental fragments depict the possibilities of the cinematic approach and inequity of the distribution of research and production resources on the global level.

At the national level, disparities in media systems and health policies generate specific circumstances in the process of cinema making of indigenous health information. Nations where indigenous film infrastructure has been well developed like Canada, New Zealand and Australia give good examples of indigenous filmmakers influencing stories of health and colonial trauma. Where the indigenous people are still politically marginalised as a group or in the film industries are monopolised in cities as commercial hubs, the indigenous voices in cinema get marginalised or co-opted by institutions. Such disparities underscore the need to pay attention to production settings, funding regimes, censorship and local circulation patterns that interchange the reach and meaning of films about health.

The variables of interest in this study are visual sovereignty that refers to indigenous cinematic agency and indigenous health knowledge that refers to both content and practice. Visual sovereignty shall be referred to in terms of authorship and control, formal strategies like narrative pacing and editing, which represent indigenous epistemologies, and circulatory control in terms of distribution and audience. The definition of the indigenous health knowledge will be in form of articulated practices, explanatory models of illness and healing and ritual ecological relationship that are represented or enacted in films. These variables will be analyzed in terms of their interplay using film analysis, informal conversations with community knowledge holders and health workers and policy tracing to understand the entry points of cinematic narratives into the domains of the public and clinical discourse.

There is a timely and consequential significance of studying how cinematic representation produces, circulates and challenges indigenous health knowledge. The theoretical and moral basis of the discussed works on visual sovereignty, Fourth Cinema, health equity and culturally safe practice is solid. Meanwhile, the practical stakes can be witnessed through global policy changes and new practices of indigenous documentaries. The paper fills in gaps in the literature, especially the gap known as the absence of comparative and empirically based research that links filmic form and knowledge of indigenous health uptake. It makes a film analysis an indispensable venue to a decolonized health scholarship and practice.

Statement of the Problem

The subject-matter of the representation of indigenous health knowledge in the movie industry remains to be a controversial position whereby the issues of cultural identity, sovereignty, and community health are intertwined. The indigenous systems of healing are strongly pegged to cosmologies that place strong emphasis on relationality, spirituality and ecological balance but these systems have been misrepresented or overshadowed in cinematic representations globally that hold biomedical positions and western storytelling traditions.

Although the rights of indigenous people are promoted under the principles of such international documents like the United Nations Declaration on the Rights of Indigenous Peoples (2007) and the Global Plan of Action on Indigenous Peoples Health (2023) by the World Health Organization, the influence of visual media art in either supporting or

obstructing stereotypes has not been properly researched. Films produced in indigenous communities may be carriers of visual sovereignty, to maintain the cultural memory and affirm traditional health practices, yet the mainstream film industries often reproduce colonial tropes, which erode indigenous epistemologies and devalue their applicability to modern health politics.

The issue lies in the disproportion between the indigenous-controlled cinematic expression and the prevailing cultural production, which causes insufficient visibility of original indigenous health knowledge, lack of possibilities to engage in intercultural dialogue and insufficient policy reactions that might mediate traditional and biomedical systems. This distance highlights the critical necessity to challenge the manner in which visual sovereignty in cinema may create, safeguard, and reproduce indigenous health knowledge in such a way that it can help sustain cultures and educate equitable health governance.

Research Questions

1. How is indigenous health knowledge represented in cinematic narratives?
2. In what ways does visual sovereignty influence the construction of indigenous health knowledge in film?

Indigenous Health Knowledge

Indigenous health knowledge is a body of practices, beliefs and experiences that have evolved over the centuries by Indigenous people in their interactions with the environment, the spirituality of the Aboriginals, as well as the cultural traditions of the aboriginal people. This type of knowledge covers herbal medicine, ritual medicine, spirituality and ecological management systems that enable the community to remain healthy (World Health Organization, 2023). The indigenous health systems compared to biomedical models are holistic as they connect physical, social and spiritual aspects of health. According to scholars, this kind of knowledge is active and adaptable, as it is developed by the use of oral traditions, narration and intergenerational transmission (Nabhan, 2020). Being a dependent variable, indigenous health knowledge is the outcome that is being formed by the visual representation in film and media. The manner in which cinema exhibits, justifies or misrepresents these practices has a direct impact on the acknowledgement, maintenance and assimilation of these practices into the larger discourses of health.

It has been found that the effects of misrepresenting indigenous health knowledge in mainstream media tend to perpetrate stereotypes and harm the credibility of indigenous practices (Moloney, Stuart, Chen, and Lin, 2023). On the other hand, indigenous-directed cinema serves as a pedagogical and cultural resource that makes knowledge systems self-sustaining in film by instilling them in plot, image, and performance in a ritual way (Raheja, 2010). In this respect, the cinematic representation is not a neutral expression but a strong intermediary of indigenous epistemologies. This is an expression of the way indigenous knowledge is created, safeguarded or challenged in the image space of the cinema and how such a creation affects indigenous people and the general population as well as their health awareness.

Visual Sovereignty

Visual sovereignty refers to the act by which Indigenous people take charge of their image, representation, and narrative in the media, specifically the film. According to Raheja (2010), it is one of the ways through which Indigenous moviemakers take back control over the ways their communities are represented so as to resist the misrepresentation of their colonizers. By employing methods of indigenous narration structures, communal-based narratives, and imagery that resonates with the cultures of their people, visual sovereignty would make film a place of self-determination, as opposed to assimilation. Being an independent variable, it is the factor that influences the ways of communicating and perceiving indigenous health knowledge. Indigenous filmmakers can place cultural epistemologies in cinematic project when they have visual sovereignty, thus making them more authentic and challenging hegemonic visual regimes.

Such importance of visual sovereignty is that it contributes to the opposition to erasure and allows the survival of culture. According to Milligan (2015), the fourth cinema represents the visual sovereignty of the indigenous viewers, that is, it pays more attention to the indigenous audiences and can promote cultural priorities rather than the commercial interests. Such transition enables film to be not merely an expression of art, but a political move that safeguards and replenishes indigenous knowledge systems. In a setting that pertains to health, visual sovereignty determines the way in which the healing practices are represented, marginalized or glorified, and the ways in which they are placed in comparisons to the prevailing biomedical structures. Hence, it is the central force that defines the visibility and the legitimacy of the indigenous health knowledge in the film.

Representation

The mediating concept (or the linking variable) between visual sovereignty and preservation and transfer of indigenous health knowledge is represented. The meaning of representation in media studies is that the meaning is made through the use of signs, symbols and stories to construct meaning and convey it (Hall, 1997). It includes the representation of indigenous practice and the interpretive codes used by the viewers to make sense of what is viewed. Representation is the mediating concept because it is the important linker that transforms the exercise of visual sovereignty into concrete results to indigenous health knowledge systems. Hall (1997) stresses that the fact of representation is not the reflection or transmission but an active creation of meaning, systems of power. Within the frames of the cinema, representation defines how the indigenous healing practices are depicted as the advanced knowledge system or simply as the primitive superstition. The mediating role is a two-way process, with the level of visual sovereignty of indigenous film-makers determining both the quality and authenticity of the representation, which, in turn, affect the perceptions, values, perspectives and practices of indigenous health knowledge within communities and the wider society.

There are direct consequences of the politics of representation in the cinema about health knowledge systems. Misrepresentations of indigenous healing practices tend to portray them as primitive, superstitious or non-compatible with modern medicine thus reducing their social legitimacy and discouraging intergenerational transmission (Smith, 2012). These twisted pictures open divisions between the visual sovereignty practices and constructive knowledge process. Even in instances where indigenous filmmakers are creatively involved,

as long as the act of representation is not translating into cultural authenticity, i.e. either in terms of language use and choice of narrative, or in portraying rituals, the bond between sovereignty and preservation of knowledge will be compromised.

On the other hand, precise and culturally sound representations may reinforce the connection of visual sovereignty and knowledge sharing. The representation of indigenous healing under the right cultural settings, through the use of indigenous languages, respect of sacred boundaries and focus on community epistemologies, makes representation an effective tool of culture preservation. In this mediating position, the representation promotes the influence of the visual sovereignty by converting the cultural authority of filmmakers into the meaningful communication that appeals to both indigenous and non-indigenous audiences.
It is this mediating quality of representation that highlights its dangers and chances. Even when films are created by indigenous filmmakers, it can be poor representation that can water down the effect of visual sovereignty and prevent the preservation of the culture. To give an example, when indigenous film-makers embrace mainstream cinematic norms that value drama above authenticity, or when they devote less attention to depicting intricate healing rituals in the interests of making them more accessible to a wider audience, they will be contributing to mainstream misconceptions and not correcting them. The intermediary layer is not good to connect sovereignty to the positive knowledge results.

Encoding and Decoding Model of Communication by Stuart Hall.
This model was developed in 1973. In his model, Hall contends that the producers encode a certain message in media messages and these messages are subsequently decoded by the audience who can decode them in dominant, negotiated or oppositional meanings (Hall, 1980). The main premise is that meaning is not predetermined by the sender but it is constructed together with cultural background and audience perceptions. The main assumption is that, the audiences are dynamic people who decode media texts according to their cultures, experiences in life, and social statuses and not merely accept what they see and hear. Those critical of the model point to the fact that it can give too much agency to the audience but insufficient structural power to media institutions and production practices in constructing meaning (Morley, 1992). However, much of the model is also applicable to the current study since the cinematic construction of the indigenous health knowledge is not only how indigenous filmmakers encode cultural epistemologies through visual sovereignty, but also how various audiences decode these images. It offers a platform through which the relationship between cinematic representation, viewer response and the validity of indigenous health knowledge in the larger cultural and policy debates can be analyzed.

Empirical Review
In the book Reservation Reelism: Redfacing, Visual Sovereignty, and Representations of Native Americans in Film, Raheja (2010) explored the representation of the indigenous people in the mainstream and independent movies with a view of finding out how the visual sovereignty could challenge colonial stereotypes. Through textual analysis of films made by and without indigenous communities, the study discovered that indigenous-controlled cinema narrative provided more realistic cultural practices and healing traditions compared to the dominant media. This research is comparable to the present one in that it also explores the issue of how indigenous health knowledge is framed in movies.

In the article, Sites of Exuberance: Barry Barclay and Fourth Cinema, Ten Years On, Milligan (2015) discussed the idea of Fourth Cinema by aiming to evaluate how indigenous filmmakers take on a creative agency so that they can create authentic stories. Based on qualitative critical discourse analysis of chosen films, the research revealed that the Fourth Cinema predetermines the epistemology of the indigenous and asserts visual sovereignty through the resistance to assimilation into the mainstream film forms. The parallels to the current work are the use of visual sovereignty as one of the essential elements determining the creation of indigenous health knowledge in motion pictures.

In their article Healthcare Professionals Cultural Safety Practices toward Indigenous Peoples in the Acute Care setting: A Scoping Review, Moloney, Stuart, Chen and Lin (2023) attempted to understand the effects of cultural representation on the recognition and incorporation of indigenous health practices in health systems. Through the application of a scoping review approach to the world literature, the study has established that misrepresentation and weak cultural framing of health communication lowered the legitimacy of indigenous health practices, and respectful representation led to trust and inclusion. This goes in line with the present study because both studies explore the effects of the indigenous cinematic representation on the acceptance of traditional health practices within the society.

Methodology

The research design used in the study was qualitative research based on the interpretive and constructivist epistemology, according to which the reality is socially constructed during human interaction and meaning-making (Creswell, 2013). The use of qualitative inquiry was suitable as the research aimed to gain an insight on the life experience, cultural significance, and interpretive behaviour of cinematic construction of indigenous health knowledge, which is phenomena that cannot be measured in quantitative terms. The interpretive method enabled the researchers to examine how the participants interpreted the visual sovereignty and representation in their respective cultural contexts.

In-depth interviews, focus groups discussions and textual analysis of the chosen indigenous films depicting the health practices were used to collect the data and the participants were recruited through official contacts presented by Indigenous Film Association and cultural leadership structures. Audio recording of all interviews and discussions was carried out using informed consent and then transcribed word-for-word with film texts coded using a set of themes related to representation and health knowledge. Data analysis was done using the six-step thematic analysis process as developed by Braun and Clarke, (2006) that included familiarisation with the data, developing initial code, searching the data, reviewing the data, defining the data, and finally the report. The researchers were able to record subtle meanings, patterns, and cultural contexts in the moviemaking of indigenous health knowledge because this interpretation process enabled them to do so.

Population of the Study

The study population was made up of three distinct groups in Rivers State, Nigeria, (1) Indigenous filmmakers registered with the Indigenous Film Association of Nigeria (IFAN) who had at least produced one film that included traditional health practices within the last five years (they were 80 individuals); (2) Cultural custodians identified by community

leadership structures as custodians of traditional knowledge such as chiefs, elders, and traditional council members (they were 112 individuals); and (3) Community health practitioners including traditional birth attendants, herbalists and spiritual healers formally identified by community health commit The overall available population was 266 people under these three categories.

The study site was Rivers State, because it has a history of indigenous film production, it has a documented history of active cultural custodians and it has set up systems of traditional health practices. The state is an appropriate setting on which to discuss the issue of visual sovereignty since, in it, there is a large amount of Nollywood-related movie action, as well as productions led by native inhabitants.

Data Analysis Procedure

The data analysis was conducted according to Braun and Clarke (2006) 6-phase thematic analysis which is a rigorous but flexible approach that is suitable in identifying, analysing and reporting patterns through qualitative data. In the analysis, the inductive approach was adopted, where the themes were derived through analysis of the data as opposed to the pre-defined theoretical categories, but were guided by the theoretical framework.

Phase 1: Phase 1 involved transcription of all audio recordings in the exact words as they were recorded, and within 48 hours of recording. To make sure that no transcript is overlooked, the researchers listened to the transcripts on multiple occasions and to guarantee that they should be immersed in the data. The first impressions and possible trends were recorded in a conjectural journal.

Phase 2: NVivo 12 software was used to import transcripts into the software where they underwent systematic coding. Coding was done line by line and interesting features were coded throughout the entire dataset. There were semantic (explicit) and latent (interpretive) content codes. One hundred and seventy-seven starting codes were formed.

Phase 3: The identification of patterns within the dataset through collation of codes into themes was developed into potential themes. There was visual mind- mapping to investigate the relationship between codes. Themes were arranged in a hierarchical manner but there existed the main themes and sub-themes. On this step, 18 possible themes were recognized.

Phase 4: The themes were checked with coded extracts and the whole data set in order to have internal consistency and uniqueness. Other themes were merged, others divided or abandoned. The researchers ensured that meanings of themes were accurate representations of those of the participants. This gave 12 themes which were refined under the three research questions.

Phase 5: All themes were well defined and boundaries set. Themes have been named to represent their essence but not be closed-ended to the readers. Main themes were further divided into sub-themes to give it structure and detail. Themes were related to each other.

Phase 6: Bright examples of extracts were chosen to depict every theme. Examples were provided and not given as they appeared, but their interpretation was not just a descriptive one.

Data Presentation and Analysis

Research Question 1: How is indigenous health knowledge represented in cinematic narratives?

The film screen became a highly charged area of conflict between what was authentic and what was distorted, largely determined by who is behind the camera and telling the story, in the representation of indigenous health knowledge. The five main themes that emerged from the analysis of the interview transcripts, focus group discussions and film texts reflect the complexities that can be seen in the cinematic representation.

Theme 1: Holistic and Spiritually-Rooted Portrayal in Indigenous Films

The indigenous filmmakers repeatedly emphasized that their representation of health knowledge was always holistic and avoided fragmentation that is typical of mainstream biomedical stories. They had an understanding of healing that went beyond medical treatment, involving the whole person, the spirit, the community, and the land.
One filmmaker shared his philosophy:

"When I make films about our healers, I don't show them as doctors giving prescriptions. I show them as they are, as keepers of ancient wisdom, people who know that healing occurs between worlds, not just in the body. The healer is a bridge. He talks to the ancestors, he reads the land, he brings the community together. That wholeness is what we try to capture on screen. (Filmmaker 3)

Another filmmaker highlighted the intangible elements that are mostly ignored in the mainstream cinema:
Filmmaker 7: "Our health knowledge is spiritual knowledge, you cannot separate the two, if you take away the spirit out you take away the medicine."

During the focus group discussions, cultural custodians reiterated that these all-encompassing representations were very much in line with their experiences. The elderly custodian shared the following emotions:
"I saw a movie last year made by one of our own people that showed me how our healer would interact with the oracle, pray to prepare the herbs, involve the family, give instructions on eating and drinking, etc, it was just like my grandmother healed people, I cried watching it because I saw my childhood in that movie, I think many of us are forgetting that." (Cultural Custodian 4, Focus Group 1)

The indigenous language use proved to be a significant sign of authenticity. It was repeatedly stressed that language conveys culture epistemologies that are not amenable to translation. A health practitioner explained that:
Language is medicine. (Health Practitioner 6) There are some healing words in our language which are not known in English. When these are used in our mother tongue, they are

powerful; when they are used in the other language they are not. The incantations, the names of herbs, the way we describe illness, these lose their meaning in English.

Theme 2: Distortion and Stereotyping in Mainstream Cinema

Contrary to the portrayal of indigenous people, the participants asserted that mainstream cinema is a place of consistent misrepresentation, with complex healing systems reduced to primitive superstition or dangerous witchcraft. This emotional burden of this distortion was felt in interviews and focus groups.

A cultural custodian was visibly frustrated:

“When Nollywood or foreign films depict traditional healing, they make us look like witches and the healer is always in a dark room, scary music playing, showing human skulls, some strange powders and people falling into trances and doing evil things. They don't depict the actual work, knowledge of plants, years of training, the ethics we follow and all that, they just want to scare us and make money.” (Cultural Custodian 7)

When operating as part of the mainstream commercial systems, filmmakers publicly recognized their complicity. One of the filmmakers confessed:

When the producer tells you to "make the medicine man look more mystical, scarier," that's when you know you're working in fiction, not truth; that's when I said, "I will do my own films, even if it's just a small camera and no budget, at least the story will be real. (Filmmaker 9)

The consequences of such distortions are more than just misrepresentation; they are harmful to the culture. A health practitioner said that stereotyped representations had an impact on his practice:

“Young people come to me now with fear in their eyes because of what they have seen in the movies, I have to spend time with them to make them understand that traditional medicine isn't about cursing it is about healing them, I would not say that the current films are helping to destroy their culture because it is not helping but it is hurting them.” (Health Practitioner 2)

Focus group participants commented on the typical colonial characteristics of these distortions. The academic and cultural custodian noted:

The colonial gaze simply transferred from books, museums, into cinema,same stereotypes ,primitive, savage, irrational, dangerous and packaged in high-definition film with surround sound – faster and deeper spread than written words. (Cultural Custodian 8, Focus Group 3)

Theme 3: Sacred Boundaries and the Ethics of Representation.

This conflict between the documentation of culture and the protection of sacred knowledge introduced an ethical landscape as participants carefully considered how to navigate it.

Filmmakers talked about agonizing choices of what to include or exclude. One director shared:

I always have the question in my mind about how much I could show in every film that I make. I want to leave our knowledge behind, particularly with the young, who may not ever

have opportunity to experience these practices in person, but I don't want to give too much, because some things are not to be given for any reason but for good reasons; they can be misused; they can be received, but they need the spiritual preparation.

There were mixed reactions to the use of film to document health practices. One healer explained:
“When they portray what our medicine is on screen, I am happy, I feel grateful, I feel that our medicine is useful, but I don't like when they show so much detail of what it's made of, what it's about, what it's prepared with, how it's prepared, as such ,if someone sees that and wants to try it on himself, then he can cause harm, and then our medicine is blamed. This is my fear.” (Health Practitioner 4)

Community control of representation was highlighted by cultural custodians. An elder said resolutely:
These filmmakers, if they're our kids, and not the other guys, the ones who want to make money with our stories—they know to come in and ask permission; they show us the script; they let us watch the footage; they give us the power to say, 'This part must be removed; this part can stay. This is how it should be! The knowledge belongs to us, not to them. They are a messenger, we're the owner.

Interestingly, some participants considered strategic silence to be a resistance and protection mode. This was the philosophy of a filmmaker, who said:
What I don't show them is just as good - there is knowledge there that cannot be given freely, that requires relationship and respect to access, and it frustrates outsiders who want everything explained, but it preserves the integrity of our knowledge systems. Silence, in this case, is sovereignty. (Filmmaker 6)

The depiction of indigenous health knowledge within film is a continuum of preservation and harm: who controls the process determines where the film lies on the continuum. When the film is made by the indigenous community, the health knowledge is presented in a holistic way, weaved into a culturally relevant spiritual, ecological and community framework. The films are in the local language, precepts to respect cultural protocols are respected, traditional narrative structures are used and there is careful consideration of sacred boundaries.

Research Question 2: How does visual sovereignty shape indigenous health knowledge in film?
Visual sovereignty began to take shape as a multi-dimensional practice of creative control, cultural protocol or the assertion of indigenous epistemologies through film form. The participants demonstrated how sovereignty manifests in every aspect of making movies, from the beginning, up to distribution, and how it has a direct impact on how health knowledge is being built and conveyed.

Theme 1: Authorship and Creative Control as Foundation of Sovereignty
The theme of sovereignty always started with "the person who tells the story.The theme of sovereignty always began with "the person who tells the story. Indigenous authorship was

not considered to be 'identity politics' but 'epistemic necessity' because only people within the culture have the deep knowledge needed to be authentic.

A film-maker explained it:
The question of whose story is this to tell? is the first step towards visual sovereignty. When outsiders make films about healing practices, they come with their own assumptions, their own frameworks, their own agendas, and they can never fully understand; they have not lived our reality and that's sovereignty at its root. (Filmmaker 2)

The difference between native filmmakers and "good" outsiders was repeatedly pointed out. A cultural custodian said:
"We've had foreigners come here with well-made cameras and asking to shoot our healers, saying they need to show the truth, and respect our culture; but when they show it to us, it's through their eyes and subject matter to their narrative, and we are made exotic or primitive. With our own filmmakers, there is no translation needed, because they already know. They don't need us to explain our worldview. They share it with us.

Theme 2: Editorial Control and the Politics of Representation
Sovereignty isn't limited to the shoot, it also means control over editing, final cut and distribution. Indigenous views tend to be lost during these phases in the mainstream production process.

The editors were referred to as “epistemic battles.” One director shared:
“An important lesson I learned in collaborative projects is that I have to go into editing too, otherwise I don't know the other person's knowledge is going to get distorted even if the filming is done with respect. So that's why sovereignty extends to the editing room.” (Filmmaker 9)

The flow of indigenous knowledge is typically different from commercial editing conventions. A cultural custodian said:
“When the editing of the film is a sovereign right of indigenous filmmakers, they are not trying to rush the film, they're trying to put it in a place where it can breathe where it can move at the speed of the traditional way of passing down knowledge, that might seem slow, but it feels like it feels right.” (Cultural Custodian 6)

Sovereignty issues also included in distribution control. A film-maker put it into words:
“Some of my work is created for community audiences – for internal education and cultural reinforcement – so I don't necessarily want people to see it. I want it to circulate in my own community, but not necessarily for others to see. Other films I make for wider audiences, and I do that to challenge stereotypes, to call for recognition, but I choose. That's sovereignty, and have the power to say who sees the film, rather than giving it to a platform or a distributor that might use it in a way that goes against what I intend.

Theme 4: Narrative Structure as Epistemic Assertion
Participants discussed how, through non-Western narrative formats, indigenous filmmakers are embodying traditional epistemologies, such that form is, itself, a statement of sovereignty.

A filmmaker explained some decisions made about the structure of a story:
In my films, I try to create circular structures in time and healing, reflecting our understanding of time and healing in a circle, and that this is confusing to some of the viewers who have been trained by Hollywood films. But it's more accurate in the way one experiences and understands time and healing. (Filmmaker 3)

The formal decisions were not just an issue of appearance, cultural custodians confirmed. An elder explained:
"When the films turn circles, repeating the same themes, images, that is how we teach knowledge in our tradition; when the films stop to look at the natural world, that is how we teach healing knowledge; the structure of the films themselves is pedagogy, a way to teach as much as what is being taught." (Cultural Custodian 1)

Visually, sovereignty is seen to shape the creation of indigenous health knowledge in film in a number of interlocking ways all focused on indigenous control over representation. Indigenous authorship is the very essence of sovereignty.

This sovereignty is realised by following cultural protocols such as: seeking the advice and consent of Elders, speaking the indigenous language(s), respecting sacred space and place, and being responsible to their community. These protocols are also a way of making film not an individual act of creation, but a collective act of culture, and of making the film building in line with the norms of the knowledge transmission of traditional cultures.

That is, when the "sovereignty" of the media reaches beyond the frame of the film, editorial and distributional control become part of it. Indigenous filmmakers make conscious decisions about pacing, storytelling and access to the film that defy commercialism and claim epistemic difference. Circular narratives, unedited ceremonial sequences and temporal rhythms that embrace indigenous conceptions of time are formalised cultural expressions of cultural sovereignty.

Discussion of Findings

Indigenous health knowledge is depicted in cinema as a holistic and spiritual way of life based on the values of the community when performed by indigenous actors but it is distorted into being superstition when performed by the mainstream actors, and the community is observed to value the authenticity of the films such as using the indigenous language and local ritual, in this way, representation is a means to preserve the culture and act as political resistance. The finding is applicable to the Milligan (2015) study as the discussion of the Fourth Cinema highlights indigenous filmmakers as asserting cultural authenticity which counters stereotypical portrayals, thus reinforcing the finding that mainstream cinema distorts indigenous films to affirm holistic representations of health knowledge, while indigenous films preserve and affirm them. These two findings support the encoding and decoding model, in that indigenous film makers convey health knowledge with cultural authenticity, but audiences read these messages as affirmations of identity and the mainstream producers convey distorted images which are shared with audiences as stereotypes, adding to tensions between intended meaning and received interpretation.

Findings from the research showed that when indigenous filmmakers are able to own the narrative, the style and how it is distributed, that is, when they are in a position to exercise visual sovereignty, they can restore dignity and respect to themselves, protect their traditions from misrepresentation, and enhance cultural continuity through cultural protocols, including consultation with elders, the use of indigenous languages, and the respect of sacred boundaries. The study of Moloney *et al*. (2023) on cultural safety in healthcare is relevant to the finding, as their research on cultural safety within the health system indicates that cultural sovereignty and respectful cultural protocols help to prevent misinterpretation of indigenous practices, which align with the finding of ensuring respectful visual sovereignty restores dignity, protects traditions, and enables authentic construction of the film. The finding is confirmed by the model because it provides a means of influencing audience decoding through the use of cultural protocols, language and framing, enabling filmmakers to direct audiences to see the messages in a way more consistent with its indigenous epistemologies than with any dominant hegemony.

It found that positive portrayals of indigenous cinema in authentic and inclusive ways contribute to intergenerational learning, trust in traditional healthcare, and that negative portrayals of indigenous cinema lead to feelings of shame and discouragement of youth engagement with traditions, while respectful portrayal helps to raise the societal profile of traditional healing, legitimizes indigenous knowledge and encourages interaction and integration with modern medicine. The finding is supported by Raheja's (2010) study on reservation reelism that emphasizes the importance of indigenous-controlled stories in recognizing and legitimizing indigenous practices, thereby making room for dialogue with modern medicine and policy. The finding is consistent with the model, in that communities interpret accurate representations of indigenous healing provided by the media as validating and legitimate, whereas inaccurate representations give audiences the impression that indigenous healing is shameful and unrecognized, thus influencing community recognition and policy discussions about traditional medicine.

Conclusion

The study concluded that the first finding is that representation of indigenous health knowledge in cinema is either an instrument for cultural preservation and pride or distortion and stereotype reinforcement.

The study found that visual sovereignty is pivotal in the construction of indigenous health knowledge in authentic cinema; with it, communities have the power to preserve their traditions and ensure continuity through a culturally embedded narrative.

The study supported the notion that positive depictions of authentic representations can contribute to the recognition and legitimacy of indigenous healing practices; negative depictions can contribute to a loss of cultural pride and/or hinder social acceptance of traditional health systems.

Recommendations

Based on the work results, the following recommendations are made.

1. Films have to focus on true depictions of indigenous health knowledge including the use of local language, ritual and cultural values to maintain indigenous tradition and to prevent distortion of indigenous knowledge.
2. Indigenous filmmakers must be encouraged to exercise visual sovereignty, ensuring they consult with Elders and employ Indigenous languages and respect sacred boundaries to protect cultural dignity and continuity.

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