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The use of indigenous knowledge in primary health care: A case study of Makanye community in Limpopo Province, South Africa

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Abstract

The use of indigenous knowledge to meet primary health care needs goes back to 1978 when the World Health Assembly announced the potential use of traditional medicine and urged member states to use traditional medical practices in primary health care. The present study examined the use of indigenous knowledge for preventive, curative and protective health care. Data were collected through interactions with a sample of 100 participants. The study results provide explanations of disease, disease etiology, health implications of food and medical ethnobotanical knowledge as the indigenous knowledge systems used to maintain good health. These knowledge systems provide protective, preventive and curative care. The study recommends scientific research to explore the role of indigenous knowledge in health care among South African cultural groups in order to validate the knowledge and use it to achieve Sustainable Development Goals *to ensure healthy lives and promote well-being for all people.*

Keywords: Indigenous knowledge, primary health care, traditional medicine, rural community, sustainable development goals.

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Introduction

The use of indigenous knowledge and practices in health care were first recognised by the World Health Assembly (WHA) in 1978 when it urged the member states to utilise traditional medical practices in primary health care. Indigenous knowledge is recently regarded as an important commodity in global health development (Lama, 2000). The World Health Organisation (WHO) in the Health for All Declaration (1978) highlighted the need to include local communities, their traditions and practices in primary health care. The inclusion of local communities meant that their indigenous medical practices could be used to achieve primary health care goals because the indigenous systems of health

care and healing practices have had to meet the needs of the local communities over many centuries and continue to do so (Lama, 2000). Two major assertions were made about the potential use of traditional medicine in primary health care. Keleher (2001) asserted that to make primary health care readily accessible and acceptable in the local communities, community participation would be essential. For von Wolputte and Devisch (2002), community involvement could enable communities to deal with their health problems in the most suitable ways, and community leaders could make rational decisions concerning primary health care and ensure appropriate support for health projects.

Indigenous knowledge of health care rests on the application of traditional medicine to meet primary health care needs. Ethnomedical practices form the basis for indigenous health care systems. The practices are derived from knowledge of the uses of specific plant and animal materials (Saray, 2001) for protective, preventive and curative health care. Knowledge of indigenous plant-derived medicine is the oldest form of health care known to humans and the art of herbal healing is as ancient as human history. Traditional herbal medicine continued to play a significant role in remedial, prevention and protection of life-threatening diseases such as malaria, tuberculosis and HIV and AIDS in developing countries, though no adequate scientific evidence has been documented about the safety, quality and efficacy of the medicines (MRC, 2008).

Du Toi (1998) and Marecik (2007) attest that indigenous knowledge of health care is not only accomplished through administration of herbal medicine. Indigenous knowledge about the causes of disease is an important element that could be useful towards the achievement of primary health care needs. The knowledge provides varieties of factors responsible for disease and treatment that involves remedial, protective and preventive care. Onu (1996) adds that at community level, beliefs about the cause of disease are intimately related to magic, science and religion. In addition to disease etiology, primary health care could be enhanced by people's explanatory models of disease which are formed from cultural symbols, experiences and expectations associated with categories of disease (Patel, 1995). The models reveal sickness labelling and cultural idioms to experiences of disease and decisions for treatment. In addition to these belief systems, the indigenous dietary systems proved to have health potential. Marecik (2007) and the World Bank (2004) ascertained that traditional vegetables and fruits provide an important daily nutrient intake with respect of vitamins, calcium, iron, zinc, protein, carbohydrates and beta-carotene.

Research on indigenous medicinal plant use in South African rural areas was extensively documented with little focus on the role of indigenous knowledge and practices in the prevention and cure of disease. The present study was designed to explore the importance of indigenous knowledge in meeting primary

health care needs. The study examined the indigenous knowledge systems and practices which have preventive, curative and protective health care in Makanye community in Limpopo Province. The results of the study could be used to design community-based primary health care programmes which will draw from the local communities' indigenous knowledge systems of health care.

Methodology

Study area

The study is based on fieldwork conducted in Makanye community in Polokwane Local Municipality, Limpopo Province. The community covers the area of 4.90 km² with a population of about 9536 (1946.37 per km²). It is made up of 2256 households (460.47 per km²). Racial groups are Black African (9486), Coloureds (28), Indian/Asian (9), White (7) and other (6). The main languages spoken are *Sepedi*, which is spoken by 9314, *Xitsonga* by 72, *Tshivenda* by 50, *Setswana* by 48, English and Afrikaans by 52 community members (Polokwane Local Municipality Integrated Development Plan [IDP], 2013/2014).

Study design

A qualitative study was conducted to examine the role of indigenous knowledge to meet primary health care needs in Makanye community. The study explored the indigenous knowledge systems used to prevent, protect and cure disease through direct interactions with the participants.

Participants

The study sample was made up of 100 community members purposely sampled. The age of participants ranged from 45 to 92 years. The sex ratio of the participants was 50 % female and 50% male. Fifty three percent of participants had a high school education, 10% had graduate and post-graduate education. Thirty two percent of the participants were never employed, professionals were two and 13 were self-employed.

Collection and analysis of data

Thirteen focus group discussions were conducted. Each group was made up of 8 members. One group was made up of 4 elderly members aged between 80 and 92. The research questions were based on the indigenous methods of protective, preventive and curative health care. Three research assistants were appointed to assist with data collection and analysis. Data were translated from *Sepedi* to English and edited by experts in the Department of Translation Studies at the

host institution. Analysis of data was accomplished through content analysis. Similar words and concepts were grouped together to formulate headings and subheadings to enable data interpretation.

Trustworthiness

Trust and mutual relationships were created to allow the participants to freely express themselves in their home language; *Sepedi*. The researcher repeated the research questions at the end of the discussions to validate the data. Bias was avoided by analysis of the participants' answers to the research questions other than the researcher's own knowledge of the use of indigenous knowledge in preventive, protective and curative care of primary health care.

Ethical considerations

The participants consented to participate in the study by signing the consent form. Ethical approval was obtained from the host university ethics committee. The local authorities of Makanye community granted the research team permission to conduct the study. The real names and identities of the participants were not used to maintain anonymity and confidentiality.

Results

The role of indigenous knowledge in primary health care

The participants' responses to the questions about the cultural practices they use to prevent and cure disease provided the following:

Indigenous explanations of disease

The participants' explanations of disease were reported. There was general consensus that disease is a state of the human body disequilibrium. Disease is described as a symptom of dysfunctional body systems. It is prevented and cured in terms of how it is understood and described by the patient or his/her family members or the traditional health practitioner. These explanatory models were the basis for disease etiology described during the discussions.

Disease etiology

The responses provided during the discussions revealed the participants' knowledge about factors responsible for many of the diseases that attack community members. The participants reported that *badimo* (ancestral spirits), witches and sorcerers are the main causes of misfortunes, impotency, insanity, miscarriage and infertility as well as epilepsy and physical deformity.

Knowledge about the causes of disease is important in preventive care of primary health care. The knowledge limits susceptibility to disease as the causes of disease could be avoided to maintain a state of well-being. Diseases also could be prevented through performance of sacrifices and observance of cultural taboos.

Indigenous dietary systems

The indigenous knowledge about dietary systems has health potential. The participants reported that traditional subsistence crops, vegetables and fruits are nutritious foods and primary sources of body strength that reduces susceptibility to disease.

Traditional health practitioners

It was reported that the traditional health practitioners are the indigenous knowledge holders and sources of primary health care offered through holistic care by administration of indigenous plant-derived medicines. The medicines are administered for prevention, protection and cure of disease.

Medical ethnobotanical knowledge

The participants reported that indigenous plant species are sources of medicine prepared and administered for preventive, protective and curative care by traditional health practitioners and elderly members of the community with knowledge of plant properties and their healing potential.

Discussion

The indigenous knowledge systems used in primary health care are reported in the study. The systems are sources of preventive, protective and curative care of primary health care. Indigenous knowledge about the causes of disease is an important element in protective and preventive health care. With this knowledge people are able to avoid susceptibility to disease by avoidance of disease causing agents. Additionally, the participants are knowledgeable about the health potential of traditional subsistence crops. Lama (2000), Hall and Patrinos (2005) corroborate these findings by showing that the indigenous knowledge of health care is usually part of a wider system of knowledge about health and illness. The medical ethnobotanical knowledge reported in the study is an important element of primary health care. In the study, knowledge of the plant properties and their healing potential are important aspects of preventive and curative primary health care. Regassa (2013) supports this finding that medicinal plants play an important role to meet primary health care needs in most developing countries.

Tapan (2014), Tripathi, Shashi, Varma and Goldey (2011) show that knowledge of folk medicine offers immediate treatment of common diseases.

The use of indigenous knowledge systems to meet primary health care needs reported in the study is firmly accepted by lead development organizations such as the World Health Organisation (WHO) and the World Bank (WHO, 1996; 2003; World Bank, 2004). The WHO launched the Traditional Medicine Strategy in the Year 2000 to assist countries to develop national policies on the evaluation of traditional medical practice for the possibility of its integration into the National Health Plans. Traditional medicine, it is believed, could provide sound basis for a cheaper, accessible, and reliable health care delivery because it is culture-bound. Due to the high cost of primary health care, the WHO encouraged developing countries to redistribute functions and responsibilities with the purpose of reducing costs and increasing the efficacy and productivity in the use of traditional medicine in primary health care (WHO 2005). The World Bank (2004) recommended the use of traditional plant-derived medicines in primary health care. This increasing acceptance suggests that indigenous knowledge still plays a crucial role in meeting primary health care needs and could be incorporated into the mainstream health care to offer accessible, affordable and comprehensive health care.

Conclusion

Indigenous knowledge has a health potential. Many of the cultural values and practices are intentionally developed and ageed-upon to maintain good health and well-being of community members. Indigenous knowledge used in primary health care embraces knowledge about the cause of diseases, knowledge of indigenous plant medicine administered for preventive, protective and curative care, consumption of subsistence crops, medical ethnobotanical knowledge and the use of traditional health practitioners' medicines. The results of this study could be used to design community-based primary health care programmes which will draw from the local communities' knowledge systems of health care. The study recommends further scientific research to explore the indigenous knowledge systems reported in the study, validate the systems and adopt them to achieve Sustainable Development Goals to *ensure healthy lives and promote well-being for all people*.

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