Integrating African traditional health knowledge and practices into health sciences curricula in higher education: an *imbizo* approach

Mabitja Moeta*, Ramadimetja Shirley Mogale, Siyabulela Eric Mgolozeli, Mmamphamo Miriam Moagi & Varshika Pema-Bhana

University of Pretoria, South Africa

*Correspondence to: mabitjam@gmail.com

ABSTRACT

Traditional health knowledge and practices remain primary source of health services for most African communities. Despite this, the training of health professionals in South African higher education institutions remains underpinned on western medicine-based paradigms. Adversely perpetuating the health disparities and widening the gap between health professionals and African health service users. This paper describes views of African traditional knowledge holders, traditional health practitioners, health sciences academics and nursing students on how African traditional health and practices can be integrated into health sciences curricula. In this qualitative study, we purposively selected a panel of experts as participants and collected data in a discussion forum. From discussions, prominent ideas that stood out include transformation starts from within, barriers to co-existence of African and biomedical health systems and strategies to facilitate integration. This venture revealed that successful integration of African traditional health knowledge and practices into existing nursing curricula requires a concerted effort from all stakeholders in transforming and recognising the value of African traditional medicine. Lessons learnt from adopting an *imbizo* approach include improved collaboration and levelling of power differentials. We recommend that more studies on decolonisation within the African context adopt this methodology to ascertain and strengthen its viability.

Keywords: *imbizo*, transformation, decolonisation, traditional health, indigenous knowledge system, health sciences.

Introduction and background

Health sciences curricula in most African universities remain fragmented and fail to incorporate traditional health knowledge and practices of indigenous African people (Mswazie & Mudyahoto, 2013). Training of health care providers in biomedical model appears biased and does not consider values and practices of patients from different cultural and belief systems (Chitindingu, George & Gow, 2014). A critical analysis of worldviews informing most health sciences curricula in higher education institutions portrays a biomedical training model that is monolithic, hospital centred, disease oriented and that which perpetuates power imbalances, and inevitably affecting patient health outcomes (Innocent, 2016; Moshabela, Zuma & Gaede, 2016). Biomedical practitioners have reportedly scolded patients for consulting with Traditional Health Practitioners (THPs) (Krah, de Kruijf & Ragno, 2018). Thus, the biomedical model of healthcare seems to be non-inclusive and culturally ignorant of African traditional health knowledge and practices and consistently does not acknowledge and recognise African paradigms. Feeling marginalised, African patients are often reluctant to seek health services from facilities (Kleinsinger, 2010) and may withhold important information during consultations, which may be critical to their treatment regimen.

The inability to integrate African Traditional health knowledge and practices into the biomedical healthcare system is evidently due to lack of knowledge among biomedical practitioners about traditional medicine and its procedures (Nemutandani, Hendricks & Mulaudzi, 2016). Successful integration would require curricular reformation to ensure that health sciences students in higher education institutions are trained on paradigms that recognise African traditional health knowledge and practices. However, universities in South Africa lag behind in this regard and are still hesitant to integrate alternative methods of care into their curricula completely (Chitindingu et al., 2014). Biomedical practitioners seem to have been indoctrinated into accepting that the only endorsed and permissible system of healthcare is the biomedical system (van Rooyen, Pretorius, Tembani & ten Ham, 2015). Opportunities for cooperating with alternative providers such as THPs are overlooked and tabooed (Busia & Kasilo, 2010) resulting in a lack of trust between biomedical practitioners and THPs, further alienating the two parallel healthcare systems (Abdullahi, 2011). That said, Nkosi and Sibiya (2018) indicated that some biomedical practitioners are willing to work with THPs.

Political, economic and social factors have also affected health sciences institutions in South Africa. These institutions have not been spared from the spurt of protests and demands for decolonised curricula (Pillay, 2015). Oelofsen (2015), state that a decolonised and transformed health sciences curriculum should consider diversified worldviews. The inclusion of such diverse views will influence the science of teaching and the process of learning, enabling learners to provide holistic health services for the diverse needs of the communities they serve (Laird, 2014). Consultative processes with relevant stakeholders are therefore required to ensure inclusivity and representation (Moshabela et al., 2016). This paper in response to the status quo highlights the possibilities and opportunities for collaboration as well as knowledge exchange among health services providers.

Context and nature of health professional training

Recently, universities in South Africa experienced socio-political eruptions with students and activist groups calling for decolonisation of higher education curricula. The calls are linked to students' discontent with western methods inherent in university teaching and learning paradigms (Constandius, Nell, Alexander, Blackie, Malgas, Setati & Mckay, 2018). Many education institutions have been at loggerheads in responding to calls for decolonisation and transformation (Badat, 2016), and seem to have contrasting views when attempting to conceptualise the concepts. Of particular concern are critical questions regarding what should be decolonised, who should be transformed and how the process should unfold (Sayed, Motala & Hoffman, 2017).

Historically the training of nurses in South Africa has not included the alternative modalities of care, especially those commonly used among indigenous African populations. Therefore, most nurses are often unwilling or unsure how to manage patients who have been to THPs (Mokgobi, 2014:04). Due to the lack of knowledge and awareness among nurses on ATHKPs, more often than not the use of traditional medicine goes unnoticed or not even interrogated during health assessments of patients (Kelak, Cheah & Safii, 2018). The results are often unfavourable for patients due to the potential counter effects arising from the new treatment interventions in the biomedical system. THPs are often indicted in instances where there are adverse health outcomes for patients who seek medical care in health facilities after having sought help from such THPs (Scott, 2003:87). These points to a dire need for preparation of nurses in order for them to be aware of traditional health prescriptions for such patients and where possible, collaborate with THPs.

Studies have been conducted on how to integrate traditional health and practices into modern healthcare systems (Chitindingu et al., 2014; Mokgobi, 2013). However, there is a paucity of literature reporting stakeholder conversations between THPs, traditional indigenous knowledge holders, academics, students and professional organisations, using collaborative platforms such as *imbizo*. Scholars have suggested how the process of integration should be implemented but fail to interrogate the possible existing misconceptions regarding curriculum transformation and decolonisation among policy makers. Most of the recommendations in literature about integration are biased towards western methodologies of validating the knowledge and practices of African indigenous people (Innocent, 2016).

Our Process

This qualitative study followed the principles of participatory research designs by using *imbizo* (Baloyi, 2017). '*Imbizo'* in Nguni means a gathering of the subjects of the king (Mabelebele, 2006). It is an important meeting called by leaders to discuss community related issues collectively and directly with people (Pahad & Esterhuyse, 2002). *Imbizo* is a relevant tool to generate data given its participatory dimension, robustness and thoroughness (Mathangu, 2010; Baloyi 2017). This indigenous method of generating knowledge and collecting data reduces power differentials between participants and researchers.

The project was conducted in the Gauteng Province of South Africa. Gauteng province has seven universities offering health sciences education and training for health professionals. Four of seven universities are located in the City of Tshwane and three other from the Johannesburg area. Participants included THPs, African indigenous knowledge holders, biomedical practitioners, academics and students in health sciences. Five experts and two student leaders were purposively selected to participate as panellists in the *imbizo*. Panellists were selected based on their expertise and scholarly involvement in Indigenous Knowledge Systems (IKS). In addition, public nursing colleges and professional bodies such as the South African Nursing Council and Democratic Nursing Organization of South Africa were represented as part of the audience.

Researchers selected an *imbizo* as a method of engaging all stakeholders to facilitate a discussion on how African traditional health knowledge and practices should be integrated into health sciences curricula. Panellists were welcomed and allowed to introduce themselves. A facilitator introduced the topic and the central question that directed the entire *imbizo*; '*how can the African Traditional Health Knowledge and practices be integrated into health sciences curricula in higher education*?'. Panellists were given opportunities to respond to questions

from the audience. The discussion lasted for 2 hours and all the deliberations of the *imbizo* were audio-recorded for later transcription. During the discussion, a scriber used a flipchart to take notes and summarise ideas. Thereafter, the facilitator and participants followed thematic analysis steps as illustrated by Braun and Clarke (2006) to analyse data. This method was deemed appropriate due to its flexibility in accounting for all epistemological and theoretical perspectives (Maguire & Delahunt, 2017). All participants read the scribed notes to verify and clarify statements. The second step involved generating initial codes, that all participants agreed upon for each element or written statement.

Deliberations of the Imbizo

Six panellists with an interest in African traditional health knowledge and practices participated in the *imbizo*. Other invitees, including experts in health and professional organisations, participated as part of the audience. Thematic analysis of the data from the *imbizo* revealed three issues: transformation starts from within, barriers to co-existence of African and biomedical health systems as well as strategies to facilitate integration.

Transformation starts from within

Transformation within individuals and institutions emerged as an important starting point. Transformation in higher education institutions (HEIs) is a contentious issue in many previously colonised countries regardless of geographical location (Kerr, 2014; Shariffuddin, Razali & Ghani 2017). The integration of African traditional health knowledge and practices into health science education had to start from within. Participants reported that existing educational and health care institutions had to transform to facilitate the seamless integration of African traditional health knowledge and practices into health sciences curricula. Transformation is a complex process that should start within individuals. One has to go through a journey of reflection and self-introspection in order to change. The changed landscape and recent dialogues on transformation has prompted individuals to think about their spaces within the essence of existence of human kind. The following quote from the discussion summarise this view:

> *"The process of finding who we are is the first state of transformation. I will call it state of sanity because we are not normal. We need to come to our senses. We need to come to normality before we talk of transformation. Transformation need to start from who we are"* (P1)

In South Africa, the new democratic government has committed to transforming higher education through legislation and by mobilising resources to ensure that previously disadvantaged groups gain access to universities (Badat 2010). Universities as public organisations are required to improve the quality of education and support efforts for increasing relevance and improving their global competitiveness (Affandy & Prima 2013). It is not surprising that transformation is strongly emphasised across many spheres as an important step in the integration process. However, transformation will not be possible until individuals can openly discuss issues related to colonisation, apartheid and racism and their long-term effects on indigenous inhabitants of the African continent. In the discussions, concerns were also raised in this regard:

> "*How do we discover ourselves when people don't want us to discuss the past like: apartheid, colonisation and the likes"* (P2)

Transformation demands honest reflection to enable the accurate mapping of colonisation and to identify barriers and enablers to such a process. An important factor in transformation is finding one's own identity in terms of culture, language and indigenous practices within the immediate environment. Identity formation is concerned with how the individual relates to his or her community and the willingness to accept the way of life as practiced in their social grouping (Erikson, 1968; Richards, 2014). Having a collective identity and sense of belonging brings about social cohesion within a group and consequently respect for one's cultural and traditional practices (Oster, Grier, Lightning, Mayan and Toth, 2014). One example of marginalisation is that private medical funding agencies and medical aid schemes do not acknowledge or include THPs in their list of service providers. Although In some countries, progress in this regard has been reported. Therefore affecting the transformative agenda requires introspection within each individual, especially on own prejudices and stereotypes about race, culture and subjugation as highlighted in this quote.

> *"The beginning of our transformation must take effect from colonisation. We need to find a way of centering ourselves in Africa as [Africans]"* (P4)

Transformation within institutions must be facilitated through a systematic and structural overhaul. Although the universities in South Africa are no longer structured along racial lines, the culture and practices within HEIs still perpetuates the inequalities and domination as seen during the colonial era (Reddy, 2004). Despite the introduction of a National Plan for Higher

Education in 2001, to restructure and consolidate the landscape in higher education, fragmentation still exists as evidenced by the lack of integration and recognition for African indigenous knowledge systems and practices (Ramrathan, 2016). Transformation within institutions will not be possible until difficult questions are asked about the perceived identities of individuals and of higher education institutions. The mechanisms to address institutional transformation in higher education should respect human rights, social equity and justice (Badat, 2010). This view was also shared during discussions:

Barriers to co-existence of African and Biomedical health systems

Participants identified barriers that hinder the integration of African traditional and biomedical health systems. Some of these barriers are based on myths and perceptions about African traditional health and its practices. Studies indicated that traditional health is still not formerly recognised globally, South Africa included (Lambert, Leonard, Mungai, Ominde-Ogaja, Gatheru, Mirangi, Owara, Herbst, Ramana, Lemierej, 2011; Nemutandani et al, 2016). The lack of recognition persists despite international appeals, which were made amongst others by the World Health Organisation (WHO, 2013). The stigmatisation of African practices was worsened by the promulgation of the Witchcraft Suppression Act of 1957 as amended. The Act stereotyped and restricted the performance of any health activity and labelled these as witchcraft (Abdullah 2011; Hassim et al, 2007). Individuals started consulting THPs at night (Mokgobi 2012). In post-apartheid South Africa, several measures such as the promulgation of Traditional Health Practitioners Act (Act No 22 of 2007) were introduced to address the lack of recognition of African traditional health knowledge and practices. However, more still has to be done to change attitudes and mind-sets about traditional health and its healing principles as highlighted by one participant.

> *"Traditional medicine is still associated with 'ubuthakathi' (witchcraft). This is a serious problem because now our people don't think we can help them like doctors can"* (P2)

Heterogeneity as a confounding factor

It was evident that despite intentions to integrate African traditional health knowledge and practices with western systems of health care, the diversity within the South African context remains a challenge. Countries such as China and India, which were previously under cataclysm of colonialism, have been able to integrate traditional Chinese medicine and

Ayurveda respectively into their health system (Lam & Sun, 2013, Rudra, et al., 2017). Hence the integration of African traditional health knowledge and practices and biomedical system has the potential to strengthen the health system in South Africa (Vadigi 2017). Lack of recognition cascades to the evident marginalisation and stigmatisation of African traditional health knowledge and practices (Abdullah 2011; Hassim, Heywood & Berger 2007). Although steps towards the official recognition of THPs and eventually the integration of both systems of healthcare, there is no policy on how and under what conditions collaboration will take place (Nemutandani et al 2016). As a result, THPs are not recognised as equal partners with biomedical practitioners. Some health care practitioners, especially psychiatric nurses and psychiatrists, have more positive opinions of traditional healing and are of the view that traditional healing is safe (Magobi 2014). Traditional healing has also been seen as a primary health care system, which is effective in treating conditions such as schizophrenia and epilepsy.

> *"We need to understand the current philosophy of the curriculum, which says there is only one way; it says it is only though modern medicine. It has its own way of thinking and practising and whereas if we want to move we need to consider others"* (P3)

A study conducted in Limpopo Province, South Africa, on health care practitioners' opinions about traditional healing, concluded that physicians and general nurses had less positive opinions about traditional healing than psychiatric nurses and psychiatrists (Magobi, 2014). This may imply that physicians and general nurses are less willing to work with THPs, thus the lack of recognition. The findings were in line with findings by Robertson (2006) where THPs reported that biomedical practitioners frequently do not recognise their healing skills. Based on observations that community members are consulting THPs and that communities and certain health practitioners find traditional health care acceptable and effective (Peltzer and Mngqundaniso, 2008; Zuma, Wight, Rochat & Moshabela, 2016), the inclusion of traditional healing into the mainstream primary healthcare system is recommended.

Opposition of IKS research paradigms

Serious concerns exists regarding the lack of recognition for African indigenous methods for conducting research. This project emphasised that legitimising the knowledge and practices of African indigenous origin using western methodologies can be misleading. However, despite marginalisation and labelling of AIK, opportunities exist to move towards AIK research paradigms in health science education. Africa's worldview is embedded in the spirit of *Ubuntu*

focusing on wholeness, communism and harmony among the African people (Owusu-Ansah and Mji, 2012). According to Owusu-Ansah and Mji (2012) knowledge or science, and its methods of investigation, cannot be divorced from a people's history, cultural context and worldview. As far as African health practices are concerned, African people continue to use these health practices wherever they are located (Osuji, 2014). It would seem necessary from this premise, to encourage dialogue among African scholars in particular on how African research paradigms can inform knowledge creation within a tightly contested scientific scenery. Similar concern was raised by a member of the audience, who commented on the challenges associated with research processes in higher education institutions by stating that:

> *"We need to stand to develop our own story and not in the European way of describing methods. Our research committee are also difficult. We have plenty of scholars who will say this methodology is not scientific. Scholars must not only consume western knowledge but we need to be generators of knowledge."* (P5)

There also seem to be some deliberate undermining of African scholars by journals and publishers, who are reluctant to recognise scholarly work from such academics. Scholars in AIK continue to research and have scholarly interest in Africa and its peoples from the two distinctive dialectical perspectives (Bankole, 2006). The first dialogue being from an etic perspective where scholars, not only Africans, are researching Africa from an external point of view (Bankole, 2006). This perspective has a catch 22, since it results in the painting of Africa with persistent negativity (Bankole, 2006) by some scholars. The second dialogue focuses on scholarship reclaiming and rewriting Africa anew (Mogale, 2018). In this emic scholarship, scholars such as Du Bois, Diop and Mphahlele and many more, were on a mission to produce scientific evidence on Africa by Africans. However, most of this evidence was banned on the continent and not related to health science education, but can still be used to inform scholarship in this area. Recently and closer to home, researchers and scholars such as Mulaudzi (2007) in nursing, Nemutandani (2016) in public health, are among the ground breakers in exploring Africa and African phenomena in relation to health.

Strategies to facilitate integration

South Africa, as a nation in transition, is attempting to come to terms with its past, through changes in social, educational, political, economic, and cultural transformation (Bakwesegha, 2007). South Africa has been at the forefront of championing the African Renaissance, with African leaders like former President, Thabo Mbeki, believing that development of South

Africa, as a nation should be re-aligned to their tradition, history and culture (Bakwesegha, 2007). Therefore facilitating integration will promote equal and active participation among all stakeholders thereby resulting in knowledge exchange. As the strategies will respond to the needs of diverse populations especially in countries like South Africa. Seehawer (2018) cites a case of challenge in implementing the existing policies in place for encouraging integration. Integration can be facilitated by opening the healthcare facilities to the neighbourhood and make it a place for meeting and co-existence of different health care providers. Through collaboration of the two world-views, peaceful existence and championing will be possible.

According to Kaya and Seleti (2014), the higher education system in South Africa is academically distant from developmental challenges of local African communities. This is partly due to the holistic, community-based nature and approach of IKS to education and knowledge production, which is somehow contradictory to principles of modern science. Within the higher education sector in South Africa different understandings of transformation in institutions of higher learning has been demonstrated with no change in the society, hence the outcry for decolonisation (Fomunyam, 2017:6797). Decolonisation of higher education institutions' curriculum in South Africa has become a buzzword (Fomunyam, 2017:6797). However, it remains to be seen how each institution plans to approach the issues involved in the transformation agenda. Especially given the diverse nature of the South African higher education landscape as quoted below:

> *"The challenge that we have is that African traditional knowledge system is attached to people of different cultures. The work view in Venda is different from work view in Lesotho. We need harmonisation of the views."* (P5)

Strengthen the parallel coexistence of the two systems of healthcare

As noted in this project, both systems of health care exist and operate within different contexts but for the same purpose. Therefore, both should be equally supported and strengthened to ensure that the health needs of patients are not addressed from one viewpoint. The concept co-existence has a focus on inter group relations and is evident across different relationships. Co-existence is built on mutual trust, respect and recognition (Izueke, Okoli & Nzekwe 2014). Respecting the co-existence of the two systems, there is potential for positive equality, interdependence and recognition of the two systems. Through co-existence, there is enormous promotion of sustainable development where anxiety and problem that characterise the

relationship are resolved (Izueke, Okoli & Nzekwe, 2014). In order to respect and recognise co-existence in training of health care professionals there should be a harmonious relationship between the context and the content of the curricular. An example is given by Seehawer (2018) where classroom teaching is taken outside to the garden to teach about soil as it was not a topic for classroom setting. Jacobs (2015) found the need to utilise student-centered strategies, which allow the learner to explore similarities and differences between Indigenous Knowledge Systems and Western science concepts in order to allow the learner to use critical thinking and not merely accept the scientifically accepted notions of concepts. From the discussions in this project, it was evident that one viewpoint on health does not suffice and may not strengthen the coexistence. The comment below supports the inclusion and acknowledgement of coexistence:

> *"We need to explore beyond only one source of knowledge if we really want to move forward."* (P3)

Leadership and Championing for IKS

The *imbizo* recognised that for integration to be possible, the push and advocacy should start at government departments. One participant further alluded that the integration process will require commitment and support in terms of resources. There seem to be some level of disillusion at different levels of management across the board including politicians, government officials, higher education lawmakers and managers. The challenge for IKS is that even African leaders seemingly do not belief in the potential this system possess.

> *"It is important to have a champion who will lead the process of ensuring that African traditional knowledge system are parts and parcels of the modern health care system. First and foremost there is a need for a strong political statement. There has to be a leader who is going to commit to this agenda. There should also be mobilisation of resources to support this agenda".* (P3)

Championing is about integrating African traditional health and knowledge into health sciences curricular as part of deconstructing power inequities with the aim of identifying probable strategies to overcome such barriers (Burnette & Billiot, 2015). The champions and leaders for integration need firstly to analyse the historical context of decolonisation in order to harmonise the African and mainstream/Western context (Burnette & Billiot, 2015). A recommended

approach is for continuous advocacy and dialogue with policy makers and politicians (Seehawer, 2018).

Lesson-learned

A few lessons were learnt in this study, in particular from the methodological approach adopted for the study, to the value of collaborative partnership in unpacking a rather contentious issue of integrating the different systems of health care. Conducting research using traditional methods often creates power differentials where participants' voices are often silent. In our study, the *imbizo* approach was preferred and utilised as this method adopts similar principles to those of participatory transformative research. The key element in participatory transformative research is the collective nature of engagements to get solutions that are culturally acceptable to the participants (Higginbottom and Liamputtong, 2015). In our current study, we adopted an *imbizo* approach to facilitate discussions and to reach consensus on the integration of the different health systems. An *imbizo*, as an engagement platform, provides a platform for all the stakeholders to engage at the same level and evens the power variances (Baloyi, 2017).

Having participants from different institutions, representing varied interests was the basic tenet behind opting for an *imbizo*. It is important to note that this current study is part of a larger National Research Fund funded project on capacity building of allopathic health care professionals by traditional healthcare practitioners, traditional leaders and birth attendants. Therefore, most participants have been contributing to other similar discussions for some time. The ideology behind the *imbizo* in the context of our current study was to ensure that none of the participants is viewed as objects and have an important contribution to make to the discussion. Adopting participatory approach brought together participants from different spheres of life and systems of health care. Within the South African context, government departments frequently use *imbizos* formerly by to bring attention to important and partisan issues affecting communities (Netshitomboni 2007). Participation in the *imbizo* resulted in empowerment for participants subsequent the discussions and facilitated the exchange of knowledge that took place. In our approach to the study, we aimed to challenge the research status quo, where traditional methods are utilised and academics are seen as the legitimate creators of scientific knowledge. *Imbizo* has been successfully used as an instrument to effect social change, especially on issues that are political and where contestation of ideas is likely.

Through an *imbizo*, institutions, professionals and ordinary people interact directly with those in position of power thereby coming up with ideas on how to effect social change and overcome

societal problems. The *imbizo* therefore helped in building partnerships between biomedical practitioners and THPs, as the approach was collaborative and to some extent transformative. In the quest to bring about social change, we remain optimistic that further exploration and endorsement of this *imbizo* approach to deal with matters of redress within the postcolonial era in Africa, may add value to a knowledge terrain that researchers seldom explore. It is therefore recommended that further studies be conducted adopting IKS data gathering methods such as *imbizo*, *Lekgotla* and few others to evaluate, validate and ascertain their effectiveness in bringing about social change.

Conclusion

Reforms in the education and health landscape in South Africa have triggered the long overdue dialogue among different institutions of learning. However, the process of transformation and decolonisation will not be possible, without the input and involvement of not only higher education institutions, but also from the society. Practical and realistic strategies at policy levels must also address the existing gaps in integrating the multifaceted health system. To achieve this, support is required from policy makers in ensuring the recognition and respect for African indigenous knowledge systems across all spheres of health care.

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