The contribution of indigenous medicine knowledge to the delivery of quality healthcare in Migori County, Kenya

Vol. 9 No. 2

October 2024

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Abstract

Rationale of Study – Literature has extensively discussed integrating Indigenous Medical Knowledge (IMK) systems with modern medical practices to enhance the quality of healthcare services. Many countries have also committed to incorporating IMK systems into their healthcare programs. However, in Kenya, the county governments, which bear significant responsibility for healthcare delivery, have not fully embraced IMK systems as expected by the current laws, including the Healthcare Act 2017.

Methodology – This study analyses IMK's contribution to providing quality healthcare in Kenya. It took a purely qualitative approach and was guided by a phenomenological research design.

Findings – IMK has a profound role in reducing the disease burden in Migori County, both in terms of the many diseases IMK practitioners manage and the advantages associated with IMK practices over biomedical practices.

Implications – The study, therefore, recommended that IMK practices be formally embraced as an alternative healthcare delivery system along with biomedical practices in the country.

Originality – While much has been written about IMK practices globally, no study has been conducted to correlate this to county governments in Kenya, and indeed, no empirical study has been carried out about this in Migori County.

Keywords

Alternative medicine, complementary medicine, traditional medicine, primary health care

Citation: Ouma, C.F.O., Namande, B.W. & Kinya, H. (2024). The contribution of indigenous medicine knowledge to the delivery of quality healthcare in Migori County, Kenya. *Regional Journal of Information and Knowledge Management*, 9(2),84-94.

Published by the

Regional Institute of Information and Knowledge Management

P.O. Box 24358 – 00100 – Nairobi, Kenya

1 Introduction

Saray (2001) defines Indigenous Medicine Knowledge (IMK) as the knowledge and practices employed by indigenous communities to manage diseases through diagnosis, prevention, and elimination. The knowledge generally derives from practical experiences and observations delivered across generations in given societies. Sirama (2014) stated that IMK encompasses various knowledge systems, including physiotherapy pharmacology, behaviour therapy, spiritual therapy, and surgical therapy. Before the advent of modern medicine, humanity depended entirely on this knowledge for their healthcare needs. Today, the world is witnessing a resurgence of IMK practices due to breakthroughs in IMK quality control and validation grounded on modern scientific research.

According to the World Health Organization (WHO, 2002), 80% of underdeveloped nations' population receives medical care from IMK practitioners. The organisation further predicts that more individuals will rely on IMK practices in future as a result of epidemiological shifts associated with longer life expectancies and the rise in lifestyle disorders like diabetes, cancer, and high blood pressure. UNAIDS (1998) broadens the discussion by stating that using IMK systems in healthcare delivery is essential to reaching vulnerable populations with healthcare services since they are more easily accessible, reasonably priced and more culturally acceptable than biomedical practices. To this end, the IMK practices help governments respond to the need to provide low-cost, effective, and sustainable healthcare services.

At the global stage, many declarations and initiatives have been preferred to support adopting IMK practices in quality healthcare delivery. Notable global declarations supporting the application of IMK in quality healthcare delivery include the Alma-Ata Declaration (1977) on the use of IMK in formal healthcare provision, the Chiang Mai Declaration (1988) on the preservation of medicinal plants, the Ottawa Charter for healthcare promotion, among many others. These conferences were held within the ambits of summits on healthcare strengthening, WHO meetings on primary healthcare (PHC) and the different conferences on health promotion. Taking the queue, Africa has also pronounced itself in supporting the inclusion of IMK in quality healthcare provision through different declarations, including the Ouagadougou Declaration (2000) by the World Health Committee on Africa.

Emerging from all the above, many countries have moved to mainstream IMK practices in their formal quality healthcare delivery. One notable example is India, where the

government officially supports using IMK practices in conjunction with allopathy in healthcare delivery. Guite (2015) says similar cases are observed in Asian nations, including China, Japan, Korea, and North America. Further, in Germany and France, medical professionals receive professional training in traditional medicine practices.

It is generally acknowledged that there is greater dependence on IMK systems in Africa than in any part of the world in the management of their health challenges, including grave situations of maternal health and communicable and non-communicable diseases (World Bank, 2011). As a result, many African countries have legislated issues regarding IMK systems and their application in healthcare delivery. These countries include South Africa, the Republic of Benin, Guinea, Mali, Mauritius, Swaziland, Kenya, Nigeria and Ghana (Sharad et al., 2011).

According to the Kenya National Household Survey 2019 (KNBS, 2019), 57% of Kenyans rely on IMK practitioners for their healthcare needs. This reality points directly to the gaps in the formal healthcare system associated with problems that touch on limitations on basic infrastructure, medical equipment, drugs, medical supplies, personnel, and a lack of diagnostic accuracy and adherence to clinical guidelines. These gaps can partly be filled by the country embracing IMK systems. Indeed, even the Kenyan Constitution 2010 recognises the role of indigenous knowledge and cultural expression in national development. Because of Kenya's widespread reliance on IMK practices, the country currently enjoys a pluralistic healthcare system undergirded by services provided by IMK practitioners working alongside biomedical practitioners affiliated with different hospitals. This situation is strongly supported by the Kenya Constitution of 2010, the Traditional Practices and Cultural Heritage Act of 2016 and the Kenya Health Act of 2017.

The 2010 Kenyan Constitution brought about a paradigm change in Kenyan healthcare delivery. One of the most notable reforms was the nearly complete devolution of healthcare services to the 47 counties. Under this approach, county governments are anticipated to assume complete control over healthcare services at their levels while collaborating with national governments. The services falling within the purview of county governments include the management of county health facilities and pharmacies and the promotion of primary health care, among many other functions.

In their struggles to realise their mandates about quality healthcare delivery, county governments face many teething challenges to the sector's historical achievements. These challenges are in the healthcare sector. The service disruptions are severe due to strikes,

poor system staffing, management challenges, and lack of coordination between the national and county governments (GOK, 2013). These challenges can be addressed by formally adopting IMK practices as anticipated under the Health Act 2017.

2 Problem statement

According to the Kenya Demographic and Health Survey 2022 (KNBS, 2022), county governments in Kenya have been unable to provide the expected level of quality healthcare services that the people require. In many countries, including Migori, the critical health indicators generally fall below the expected international standards and the national average. Furthermore, the counties are facing severe setbacks in basic quality healthcare parameters.

While it has been strongly recommended globally that IMK can partly be harnessed to address the above perspectives of quality healthcare challenges, as can be seen in declarations such as the Alma-Ata Declaration, Chiang Mai Declaration, the Ottawa Charter, Ouagadougou Declaration, and the Abuja Declaration, African countries are yet to embrace the requirements fully spelt out in these declarations. Indeed, even in countries like Kenya, where legal frameworks in support of IMK are robust, steps to implement the requisite policy requirements are still needed.

In Migori County, even the fundamental health policy documents, including the Health Strategic Plan and the different health-related Acts and Bills, have no IMK-related content. In reality, the county has not embraced IMK in its healthcare provision initiatives despite the many practitioners actively working with people in their communities and even receiving referrals from county health units. As a result, the county falls far behind in benefiting from the potential benefits associated with IMK practices for quality healthcare delivery. The purpose of this paper is to explore ways in which IMK practices contribute to the delivery of quality healthcare in Migori County.

3 Literature review

As a branch of Indigenous Knowledge (IK), IMK pertains to specific knowledge exclusive to a given community or society that finds application in healthcare delivery. According to Saray (2004), this type of knowledge is created by methodically analysing local conditions, trying out potential fixes, and then readjusting previously found fixes to account for altered environmental, socioeconomic, and technical circumstances. It is typically transmitted

through oral tradition or cultural customs and has been the foundation for healthcare delivery advancements for many years.

While relating the general sector indigenous knowledge to the healthcare sector, the WHO (2002) gives one of the broadest definitions of IMK as referring to the totality of knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance, and relying exclusively on practical experience and observations handed down from generation to generation, whether verbally or in writing. The widespread adoption of IMK is generally based on the belief that causes of disease are intimately related to magic, science and religion. As such, in addition to disease aetiology (causes), IMK can offer healthcare services based on explanatory models of disease, which are formed from cultural symbols, experiences and expectations associated with different types of diseases (Onu, 1996). However, beyond this, IMK practices have found widespread adoption in managing contemporary diseases.

According to Silwal (2011), indigenous knowledge of health care is not just about the treatment of diseases; it also covers indigenous knowledge about the causes of disease, which is a crucial aspect in attaining health care needs in any country since necessary treatment for diseases starts with ascertaining factors responsible for diseases and the necessary treatment. Voyce et al. (2015) contend that the knowledge of folk medicine offers immediate treatment for common diseases. Bullut et al. (2024) add that many cultural values and practices have been developed over many years and utilised in maintaining community members' excellent health and well-being.

According to Owuor (1999), health refers to not only the absence of disease but also the general state of mental, physical, and social well-being, including the environment in which people live, as well as access to nutritious food, safe water, sanitation, education and social cohesion. On the other side, the Kenya Institute of Public Policy Research and Analysis (KIPPRA, 2014) clarified that health care is a broad concept that refers to the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions. The author does not mention IMK practitioners, who are also critical players in offering healthcare services in modern society.

Three aspects of providing high-quality healthcare are examined in terms of structure, procedure, and outcome factors, according to Donabedian (1993). The physical surroundings, provider skill sets and experience, interruptions, and handoffs that occur

when giving patient care are all considered structural factors. These elements can jeopardise procedures, including patient monitoring, comfort, diagnosis, and therapy. Poor outcomes, such as staff liability, patient discontent, inefficiency, and inaccessibility from the viewpoints of patients and hospital administrators, may result from the combined influence of structural problems and process deficiencies. Conversely, high-quality technical care is defined as using medical research and technology to optimise health benefits without commensurately raising dangers. Therefore, the degree of healthcare quality pertains to the extent to which healthcare provided is expected to achieve a favourable balance of risks and benefits concerning structure, process and outcome dimensions.

Silwal (2011) argued that service quality comprises three components, which gave rise to the 3Ps model of service quality. These components were identified as physical processes (technical facilities, processes and procedures of the organisation), people's behaviour (staff behaviour and response towards patients) and professional judgment (staff efforts and judgment to improve quality of service). According to the author, organisations should strive to achieve an appropriate mix of all these components based on other contextual factors such as the need for service process customisation, labour intensity, contact and interaction between the customer and the service process.

Parasuraman et al. (1993) argued that five characteristics can be used to summarise the elements that affect an organisation's service quality. These five characteristics are tangibility, which is concerned with an organisation's physical space, tools, and staff appearance; reliability, which examines the capacity of the organisation to deliver on its promises of service consistently and accurately; responsiveness, which centres on the organisation's willingness to assist clients and offer prompt service; assurance, which is concerned with employee knowledge and demeanour and their capacity to instil confidence and trust and lastly empathy, which indicates the level of personalised attention the organisation offers to its clients.

The arguments of all the above authors provide the foundation for evaluating the quality of healthcare services in any jurisdiction. Indeed, the many healthcare challenges bedevilling the world today are anchored in the parameters mentioned above. Specifically, for counties in Kenya, these challenges have been discussed regarding staffing, infrastructure, and the quality of services available to the populace.

4 Methodology

The study was carried out in Migori County to investigate the contribution of IMK to providing quality healthcare to the residents. The study was based on an interpretivist research approach using qualitative measures. Based on the approach, the study relied on a phenomenological research design. The population under the study comprised all the IMK practitioners and their clients drawn from Migori County. Since there were no authentic population records, the researcher relied on the WHO (2002) projections that placed several people who rely on IMK practices at 80% of the people in Sub-Saharan Africa.

Given that the total population of people in Migori County stood at 1,108,950 persons (KNBS, 2019), the population of the study was 887,160 people, which is the number of those who rely on IMK for their healthcare needs. Emerging from these numbers, the study specifically targeted IMK practitioners for the study. Their numbers were arrived at based on the assertion by Gakuya et al. (2020) that the ratio of IMK doctors to their clients stands at 1:833. Based on this, the researcher targeted 1,065 IMK doctors for the study.

Further, for purposes of data triangulation, each doctor identified one of their most trusted clients to provide data to back up their knowledge claims. Using stratified and snowball sampling techniques, the study was carried out on 42 practitioners and an equal number of clients drawn across all the eight sub-counties of Migori County and spread out equally across the key specialisations amongst the IMK practices (generalists, bonesetters, midwives, circumcisers and entrepreneurs). Data was collected from all the cases using an in-depth interview method and analysed qualitatively.

5 Findings and discussion

Based on the study's objective, the contribution of IMK to quality healthcare delivery in Migori County was analysed from two perspectives: the contribution of IMK in reducing disease burden and the advantages of IMK to healthcare provision compared to biomedical practices.

5.1 Reducing disease burden

The study sought to determine the role of IMK in reducing disease burden and the diseases that IMK practitioners could treat. This was done by having the practitioners identify the diseases they can treat and further seeking confirmation from clients as to whether they could treat the diseases mentioned by their 'doctors'. Since the list could have been very long, only the ten most mentioned diseases among the practitioners and confirmed by their

clients were considered. The diseases that topped the list were skin diseases, which were mentioned 19 times; Sexually Transmitted Diseases (STDs) was mentioned 15 times; sterility, 12 times; epilepsy and stomach problems, 14 times; measles and malaria ten times; and lastly, colds, Uterine Track Diseases (UTD) and bites which were each mentioned nine times.

In terms of disease burden, the KNBS (2019) identified infant and child mortality, HIV/AIDS, malaria, upper respiratory tract infections, diarrhoea, pneumonia and skin diseases to be overwhelming in Migori County. As indicated by the data above, these IMK practitioners have contributed to dealing with many of these diseases. While many of these are treatable in hospitals, the respondents were categorical that when the diseases are associated with witchcraft, spiritual sources and contraventions of taboos, the hospitals will not treat them. The cases mentioned widely in this connection were measles, sterility, madness, epilepsy, bites and even skin diseases.

Compared to what is available in the literature, the list of diseases mentioned in the study represents a tiny fraction of diseases that IMK practitioners can manage. Yirga et al. (2012) gave a list of over 50 diseases that IMK practitioners in Northern Ethiopia, while research by Minta et al. (2018) also catalogued different medicinal plants used to treat malaria, diarrhoea, tuberculosis and asthma. Similarly, a study by Gumisiriza et al. (2021) identified 39 ailments managed by IMK practitioners in western Uganda. Many of the diseases identified by the works of these scholars were mentioned in this study.

5.2 Advantages of IMK practices over biomedical practices

At this level of analysis, the study sought to find out the advantages associated with IMK practices compared to hospital-based services by asking all respondents to explain why people would prefer the services of IMK practitioners to those offered in hospitals. Since the list could have been longer, the study settled only on the ten most mentioned advantages from the perspective of the practitioners and their clients, looking at the responses in totality. According to the findings, the advantages included quality services, which were mentioned 33 times; affordability 29 times; easy access 32 times; managing African diseases 39 times; trusted services 40 times; empathy 26 times; and minimal risks 22 times.

As is evident from the above findings, IMK practices are associated with many advantages over biomedicine. While alluding to empathy when handling patients in QHD, respondent number 10 among respondents (a midwife) narrated that:

> *"Many of my clients are uncomfortable with hospitals where they are being rough and rudely treated by the nurses. They prefer our services because we handle them with compassion and empathy."*

Looking at the available literature, the advantages associated with IMK practices touch directly on quality healthcare parameters but may be operationalised differently. According to Donabedian's theory of quality healthcare provision, services are considered quality when they are free of errors arising from compromised observation, diagnosis, and therapy standards. According to Berman et al. (2021), access as a quality parameter is a composite of other factors, such as availability, appropriateness, and affordability. Regarding affordability, it was noted that IMK practitioners are not necessarily motivated by the desire to make money. According to Interviewee number 9 among practitioners (a generalist):

> *"The people we treat are generally poor and can scarcely afford costly hospital medical services. When they come to us, we do not insist on immediate payment. The payment they make comes after they have recovered as an appreciation."*

The affordability of healthcare is a major indicator of QHD. The WHO (2002) asserted that IMK promises to provide quality healthcare, especially to the vulnerable members of society who find healthcare services less accessible due to unavailability and high cost. Regarding the quality of services, the respondents strongly believed that hospitals can treat many diseases, which they also manage but not at the same level of perfection. According to interviewee number 28 among practitioners:

> *"Hospitals cannot treat epilepsy, which they can only manage, while IMK practitioners can do it effectively. Again, 'even after people are treated in hospitals for sexually transmitted diseases, they should come to us to ensure the diseases are cleared completely from their system."*

The foregoing debate demonstrates that IMK practices are critical in reducing the disease burden in rural areas. They are usually the first point of contact with patients and offer better services than biomedical practices. As such, the need to appreciate and embrace these practices in formal healthcare programmes is long overdue, and policies to address this reality are needed.

6 Conclusion and recommendations

IMK practitioners have a special contribution to the delivery of QHC in Migori County. Their contribution was measured regarding the diseases they manage among the residents

and the advantages associated with the practices. The study established that the practitioners treat several diseases, including skin diseases, STDs, sterility, epilepsy, stomach problems, measles, malaria, colds, UTDs and bites. It was also reported that reliance on IMK practices comes with advantages different from those of biomedical practices: quality services, affordability, easy access, managing African diseases, trusted services, empathetic services, and risk-free services.

Based on the above conclusion, the study recommends formal recognition of the role played by IMK practitioners in supporting quality healthcare delivery among the residents of Migori County. Hospitals in Migori County should work with IMK practitioners to meet the county's healthcare objectives. Furthermore, requisite legislation, policies, and programmes should be implemented to formalise the arrangement.

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