

The effectiveness of indigenous knowledge in the prevention and treatment of infertility in a rural community of Limpopo Province: A social work perspective

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ABSTRACT

Background: Indigenous populations seek to attain autonomy and self-determination through the preservation, protection and revitalisation of their indigenous knowledge which has been eroded by colonization, Western culture and more recently, globalization. Indigenous knowledge systems refer to the unique, traditional, local knowledge existing within a particular environment and developed around the specific conditions of people indigenous to a particular geographical area. Sexual and Reproductive health is a state of complete physical, mental and social well-being, and not just the absence of reproductive disease or infirmity. Sexual and Reproductive health deals with the reproductive processes, functions and systems at all developmental stages of life.

Aim: The main aim of the study was to explore and describe the role of indigenous knowledge towards sexual and reproductive health and rights. The study was aimed specifically at describing indigenous methods (practices) and values used in the prevention and preservation of sexual and reproductive health. This study targeted older persons who are regarded as indigenous knowledge custodians and practitioners from a rural community in the Limpopo Province.

Methods: For the purpose of this study, contextual design, incorporating qualitative methodology, was considered appropriate and therefore, selected for exploring and describing indigenous knowledge relevant to sexual and reproductive health and rights in a rural area. The study incorporated purposive sampling in which three focus groups were conducted with older persons aged between 65 – 80 years.

Results: Sexual and reproductive health, with special reference to menstruation and fertility, have over the years been taken care of and addressed by and through application of indigenous knowledge amongst the rural people over the years. During the menstrual and mourning periods, women are allowed to have their periods uninterrupted for 7 days and 3 months respectively by men having sex.

Conclusions: Since time immemorial, African people have been successfully preventing and treating their sexual and reproductive health through indigenous knowledge successfully. Faced with the globalizing forces which promote universal approaches to knowledge and understanding, indigenous peoples have reacted by alternately seeking to re-discover ancient wisdoms as foundational directives for the future. It could be asserted that indigenous knowledge should be revisited in instances where global knowledge seems to fail to address challenges affecting people.

Keywords: Indigenous knowledge, sexual and reproductive health and rights, menstruation period, mourning period, fertility, rural area and social work

Introduction

Sexual and reproductive health and rights are the rights for all the people, regardless of age, gender and other characteristics, to make choices

regarding their own sexuality and reproduction as enshrined in the Constitution of the Republic of South Africa, Section 27 of Act 108 of 1996 as amended. They are fundamentals for socio-

economic development of the people. They include the right to access to information and services to support these choices and promote sexual and reproductive health. With the emergence of Western systems of knowledge, indigenous knowledge has been regarded as a pagan practice and therefore, relegated to the lower level. In support of this notion, Barbarin (2003:248) asserts that “. . . an erosion of traditional values create a challenging environment for development in South Africa” There is, therefore, a need not only to help bring western (global) knowledge to the indigenous people mostly in developing countries in their localities, but also to learn about indigenous knowledge (IK) from these countries, paying particular attention to the knowledge base of the poor which serves as a basis for local decision-making in health and other activities. Indigenous knowledge is embedded in community practices, institutions, relationships and rituals (World Bank, 1998).

In spite of the usefulness of indigenous knowledge to its holders, subscribers and practitioners, a large body of information has been recorded about the negative influence of indigenous knowledge (socio-cultural and religious values, practices, and customs) regarding sexual and reproductive health and rights for the survival of people in their localities (Feldman, O'Hara, Baboo, Chitalu, & Lu, 1997; Letamo & Bainame, 1997; Macdonald, 1996). For instance, the following illustrate the negativity towards socio-cultural and religious values, practices and customs. Lawoyin and Kanthula, (2010) has reported that there is a strong influence of social norms on unsafe sexual behaviour. Certain cultural and social patterns have also been shown to account for high HIV prevalence rates in developing countries. In many sub-Saharan African countries, such as South Africa, Botswana and Mozambique, it has also been documented that first sexual exposure takes place outside marriage under circumstances of low and inaccurate knowledge of sexual and reproductive health, and with very little use of family planning or other protective measures (Nare, Katz & Tolley, 1997).

Other findings indicate that, marriage is interpreted as granting men unconditional sexual access to their wives, a “right” enforced through force if necessary. Women's lower socio-economic,

political and cultural status inhibits them from making informed sexual and reproductive health choices to prevent HIV infection (Murphy & Ringheim, 2001:46-47; SAFAIDS, 2009).

This paper addresses the question of how indigenous knowledge through, traditional institutions can be used to enhance sexual and reproductive health and rights of people. There is a need to apply a culturally sensitive approach to sexual and reproductive health and rights programmes, recognizing and appreciating the valuable knowledge and the unique cultures of indigenous peoples. The understanding and promotion of sexual and reproductive rights are essential in the social work profession, not only to improve the health status of affected populations, but also to effectively advocate for social justice, protecting the rights of women, and challenging practices and policies which do not uphold basic human rights.

Social work is a helping profession, particularly with the indigent, the exploited, neglected, violated and discriminated against because of their vulnerability as highlighted by Farley, Smith and Boyle (2003). Women are more susceptible to be the victims of domestic violence, and gender-based violence due to infertility. Such victimisations might be as a result of family and community members not effectively utilising indigenous knowledge for their benefit. In such instances, social workers provide counselling. Besides that, social workers should be able to source and utilise indigenous knowledge for the benefit of their clientele. In support of this Patel (2005) argues that services should be established in collaboration with families, community, and faith-based organisations and indigenous social networks to provide care and social support with the aim of promoting well-being of the community.

Respect for cultural diversity and identity of all the communities which social workers serve is an essential part of a preventative and developmental efforts. The more indigenous communities continue to be under threat of degradation and marginalization of cultural beliefs, values, customs, practices, the more social workers need to ensure that developmental social welfare programmes not only protect these indigenous people, but learn from, value and appreciate the unique blend of

knowledge and tradition of culture and harmony with current trends that is implicit in their communities.

Background information

Indigenous people offer alternative knowledge and perspectives to address health and social ills based on their own locally developed practices of resource use (Berkes, Colding & Folke, 2000). Grenier (1998) states that previously, outsiders who were socialized and trained in the western knowledge systems (for example, social, physical, and agricultural scientists, biologists, colonial powers) ignored or maligned indigenous knowledge, depicting it as primitive, simple, static, 'not knowledge,' or folklore. This historic neglect in spite of its cause which might have been racism, ethnocentrism or modernism, with its complete faith in the scientific method; has contributed to the decline of indigenous knowledge systems, through lack of use and application. This legacy is still prevalent in instances wherein if one is confronted with a sexual or health problem, without thinking about possible indigenous intervention, one resorts to western methods of intervention. Also, in some countries, official propaganda depicts indigenous cultures and methodologies as backward or out of date and simultaneously promotes one national culture at the expense of minority cultures. Formal schooling often reinforces this negative attitude. Local people's perceptions (or misperceptions) of local species and of their own traditional systems may need to be rebuilt. Some local people and communities have lost confidence in their ability to help themselves and have become dependent on external solutions to their local problems.

Sexual and reproductive health is a pre-requisite for social, economic and human development. It is for this reason that it forms an important part of general health. The highest attainable level of health is not only a fundamental human right for all, but it is also a social and economic imperative as well because human energy and creativity are the driving forces of development. Such energy and creativity cannot be generated by sick and tired people. It is as a result of this that a healthy and active population becomes a prerequisite for social and economic development. According to Sullivan (1995: 373) women's right to health well illustrates the interrelationship and interdependence of civil,

political, economic, social, and cultural rights. Violations of a particular aspect of women's rights to health may involve violations of both civil and political rights as well as economic and social rights. Similarly, Ashworth (1993: 34) states that the issue of reproductive rights is placed in the context of civil and political rights because they are a question of autonomy or self-determination in the most sensitive and complex social and cultural reality of gender relations, rather than of health alone or in the context of environment and population debate.

In order to respond appropriately to the health needs of a community, it is important to gain an understanding of the social and cultural contexts of people's lives and to identify needs within, and in terms of, such contexts (Heggenhougen, 1991:). The social worker is in a unique and enviable position to contribute to the prevention of infertility among rural people by creating an enabling environment for them to use their indigenous knowledge where it is necessary and appropriate.

The social worker is health-oriented, conceptually and philosophically. He plays roles of a broker and/or guide, aiding the people to look for and utilize resources and ensure that a linkage is created between the person and the system that maintain health (Farley, Smith and Boyle, 2003; Lombard, 1991). Accordingly, a cultural approach in health utilizes culture as a lens through which one can gain a deeper understanding of individual and collective health behaviours and a means to formulate prevention programmes within a specific cultural context. Sexual and reproductive health is essential if people are to have a responsible, safe and sexually fulfilling lives. Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors (indigenous knowledge values, practices and customs) affect and determine whether the expression of sexuality leads to sexual health and well-being or to sexual behaviours which put people at risk or make them vulnerable to sexual and reproductive ill-health.

Then bringing the indigenous knowledge (socio-cultural approach) into sexual and reproductive health will therefore, allow for prevention efforts not to rely solely on the import of foreign and

biomedical concepts as a means of prevention, but also to utilise local knowledge for sustainable and appropriate health programmes and prevention efforts since well health is something that people have to strive for (Heggenhougen, 1991), it has to be realised through a process which begins with prevention at the local level, on distinctly local terms (Somma & Bodiang, 2003).

Aim and Objectives of the Study

The main aim of the study was to examine the effectiveness of indigenous knowledge (socio-cultural and religious norms, values, practices and customs) in shaping sexual and reproductive health and rights choices among rural community people in the Limpopo province and to delineate the roles of a social worker which are advocacy, broker, guide, social work researcher and educator.

In order to achieve the main aim of this study, the following objectives were set:

- To describe the nature of infertility and childlessness amongst people in rural communities
- To establish how infertility and childlessness can be prevented and treated using indigenous knowledge among the rural people of Limpopo Province.

Research Design and approach

Much indigenous knowledge research, such as traditional healing, protection of IK and the rights and interests of indigenous medicine, relies on social science techniques which are mainly in the form of interviews which yield qualitative rather than quantitative data. Researchers, such as Grenier (1998), Kibuka-Sebitosi (2008) and Sodi (2009) have a variety of ideas for designing and conducting a good interview. In order to obtain an understanding from the perspective of the older persons on sexual and reproductive health and rights, a qualitative, explorative, descriptive and contextual design was ideal to provide rich information from participants' perceptions and experiences within their natural setting (Babbie & Mouton, 2001). This research was explorative-descriptive which involved narrating the behaviour of participants without influencing it in any way. In other words, it was qualitative in nature, which enables its readers to gain a better insight into the

indigenous knowledge and sexual and reproductive health and to generate possibilities for future research (Durrheim, 2006; Babbie & Mouton, 2001). Individual interviews were used which De Vos (2002) asserts that they are meant to gain a detailed picture of a participant's beliefs about, or perceptions or accounts of a particular subject.

Contextual design has developed within the information systems design practice of the high technology industry. Contextual Design is a popular human-centered design method from the field of information systems design (Beyer & Holtzblatt, 1998). Contextual design practitioners herewith as social science researchers conduct focused field observations, validate or adjust their interpretations in discussion with participants (Notess, 2005). According to De Vos (2002) people's behavior becomes meaningful and understandable when placed in the context of their lives. Without a context, there is little possibility of exploring the meaning of an experience. Terre Blanche, Kelly and Durrheim (2006) contend that the meaning of creations, words, actions, and experiences can only be ascertained in relation to the context in which they occur. The principle of understanding in context has a strong influence in the development of qualitative methodologies.

The rationale for this methodology was also rooted in the attempt to discover valuable, practical and appropriate information regarding the sustainability of indigenous knowledge and the significance of this body of knowledge in relation to sexual and reproductive health and rights. It was also focused on how this IK discovery could promote its utilisation in relation to sexual and reproductive health and its relevance to developmental social welfare services.

Population and sampling

The sample was a purposefully selected group of individuals who could provide information to understand the phenomenon of indigenous knowledge in the context of infertility and childlessness. The study population was, therefore, limited to the older persons perceived as indigenous knowledge holders and practitioners from a rural community in Limpopo Province. Purposive and snow-ball sampling were used in this study. The sample was a purposefully selected

group of 10 older persons who could provide information to understand the phenomenon of sexual and reproductive health and rights. "Purposive sampling is appropriate to select unique cases that are especially informative" (Neuman, 2006:222). De Vos (2002) states that snowball is aimed at approaching a single case that is involved in the phenomenon to be investigated in order to gain information on other similar persons. The researcher approached two IK holders and practitioners whom he knew and unwittingly, they referred him to other participants as they indicated they had interacted with them on IK issues. The hope was that each one would refer the researcher to the one he or she has worked with on IK issues, particularly on issues of infertility and childlessness. This qualitative study is ultimately concerned with information richness and not representativeness (Patton, 1990 in Julie, Daniels & Adonis, 2004).

Data collection and analysis

Structured individual interviews (face-to-face) were conducted with each older persons purposefully selected and each referred the researcher to the next indigenous knowledge holder and/or practitioner. This method was selected as it provided an opportunity to minimize variations in the questions posed to the participants and to make sure that all relevant topics are covered (De Vos, 2002). Participants (indigenous knowledge holders and/or practitioners) were visited at their homes and appointments were secured with each one of them. Informed consent of participants was obtained prior to data collection. The consent form explained the purpose and nature of the study, gave assurance of anonymity, confidentiality and the right to withdraw from the study. The aim and objectives of the study were explained and they agreed by signing the consent form.

Structured individual interviews which had mainly open-ended questions based on the underlying objectives of the study, guided the interview process. The interviews were tape-recorded with the permission of the participants, transcribed and thematically analyzed. For the researcher to verify and maintain accuracy, he was guided by the viewpoint that qualitative data analysis involves bringing order, structure and meaning to the mass of information collected (De Vos, 2002). Data was analyzed thematically. Thematic analysis is a

search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). The process involves the identification of themes through "careful reading and re-reading of the data" (Rice & Ezzy, 1999:258). It is a form of pattern recognition within the data, where emerging themes become the categories for analysis.

In support of that, Terre Blanche, Durrheim and Kelly (2006:322 - 326) outline these steps as follows: Step 1 is the familiarisation and immersion (getting to know the data and engaging the data from the tape recorder, field notes and interview transcripts). In Step 2 is the inducing themes (working with themes that are easily noticeable). These themes emanate from the data relating to the research aim. Step 3 entails coding (breaking up the relevant data in understandable means). Step 4 is elaboration (getting fresh view of the data by exploring themes more closely) and Step 5 is interpretation and checking the data (the researcher provides clarification and assessment of the data).

Results and Discussion

A total of 10 older persons who are regarded as indigenous knowledge holders and practitioners were individually interviewed. Contrary to traditional knowledge of confining indigenous knowledge to women, men also have this knowledge today. It was found that with the use of indigenous knowledge, sexual and reproductive health and rights were promoted and maintained for the benefit of the good health of the society. Presentation of the results and subsequent discussions are based on the following two themes:

- **The nature of infertility and childlessness amongst people in rural communities**

One of the most important and underappreciated reproductive health problems in developing countries is the high rate of infertility and childlessness (Bergstrom, 1992; Leke et al., 1993). Infertility has a major impact on the reproductive health of men and women living in Africa (Dyer, 2008). According to Ombet, Cooke, Dyer, Serour & Devroey, (2008) more than 70 million couples suffer from infertility worldwide, the majority being residents of developing countries. They further

assert that negative consequences of childlessness are experienced to a greater degree in these countries as compared to the developed ones. Although this impact varies from region to region, it is influenced by, among others, religious, socio-cultural and legal factors. The inability to procreate is frequently considered as a personal tragedy and a curse for the couple as it impacts on the entire family as well as the local community as a whole. Negative psycho-social consequences of childlessness are common and often severe (Daar & Merali, 2002; Dyer et al., 2002a,b, 2004; Umezulike & Efetie, 2004; Dyer, 2007). Infertility, on the other hand, leads to both psychological and social hardship as childless marriages often result in divorce. These complete separations mainly ensue from extramarital relationships (de Kok, 2009).

Responding to the question of what the socio-cultural and religious norms, values, practices and customs are on the couple who are infertile in the rural community of Limpopo Province, one indigenous knowledge (IK) holder and practitioner said:

“Ku pfumala n’wana i khombo lerikulu. Loko munhu a ri hava n’wana swi fana niloko a nga zangi a va kona kumbe a nga hanyi hikuva ku hava mbewu leyi a nga ta yi siya, rixaka rero hikona ri file,” which means literally that not having children is a huge disaster. If a person does not have a child of his/her own, it is as if that person does not exist as there will not be any continuity in his/her generation.

In another interview, one IK holder and practitioner related her experiences of how socio-cultural and religious norms, values, practices and customs have impacted her childless life:

“Hi ku pfumala n’wana, va ndzi rhumele eka rikwerhu leswaku va ya vona kuri ndza veleka, loko swi nga ri tano ndzi nga ha tlheleli evukatini,” which means that not having children, they sent me back to my parents’ home so that they must see to it that I bear children, if not that, she should not return to her husband’s house.

There are instances where the husband will request the wife to allow him to marry the second or even the third wife in certain cases where there is

barrenness in the family. This was confirmed when another IK holder and practitioner stated that:

“Tatana loko a vona nkarhi wu famba ku ri hava n’wana, u ndzi komberile leswaku a teka nsati un’wana leswaku a ta n’wi velekelo vana.” which means after realising that there is a child-bearing problem, the husband has sought consent from her (the principal wife) to marry the second wife so that she can bear children for him.

The problem of infertility among the couples also involves other family members. Dyer, Abrahams, Mokoena, and Van der Spuy (2004) state that at times other family members’ reactions to infertility seemed to be based on perceived violations of social values, norms and practices. In support of that, for instance, Gerrits (1997) notes that some of her (Mozambiquan) respondents realize that infertile women feel bad when excluded, but argue that “these cultural taboos have to be respected. If the infertile women do not follow the cultural rules, they or their relatives will get serious (health) problems.” Gerrits (1997) in her study also found that it is also acknowledged by rural people that bearing children will sustain patrilineal clan.

These socio-cultural norms, values, practices and customs as well as taboos should be conformed to if recurrence of unfortunate and undesirable instances of not giving birth to children is to be avoided. In describing what socio-cultural and religious norms, values, practices and customs really are in relation to infertility and childlessness, IK holders and practitioners advanced a wide array of views. An elderly female IK holder and practitioner related her views and experiences of the issue when she said:

“Evuton’wini ku na swiyila. Loko wansati a ri emasikwini, a nga fanelangi kuri nchumu lowu a wu tirhisaka ku susa ngati liya yi humaka yi voniwa hi vanhu kumbe a cukumeta laha vanhu va nga yi vonaka. Naswona loko a ri emasikwini a nga fanelangi a etlela na wanuna hikuva swi ta sivela mbewu ya wanuna ku mila”. This loosely means that in life there are taboos. If a woman is in menstruation period, she is not supposed to expose the cloth she uses to clean up the blood and that should not be seen by people. Again, she should not have sex as that could prevent the male to procreate.

Another IK holder and practitioner indicated that:

“Wansati loko a humele hi khwiri, a nga fanelangi ku etlela na wanuna ku fikela tin’hweti ta tsevu ku ya eka lembe. Sweswo swi ta pfuna ku ri a hatla a kuma vana”. It means that when a woman is in menstrual period, she should not have sex until at least six months to a year have passed by. This custom will enable her to conceive very urgently.

Furthermore, they outlined that both men and women should respect cultural values, customs and practices which pertain to sexuality and reproduction. Results from qualitative studies conducted in other regions document similar as well as additional findings. The findings indicate that failure to adhere to cultural taboos and God’s will, are among the central causes believed to cause infertility (Feldman-Savelsberg, 1994; Sundby, 1997 & Koster-Oyekan, 1999).

- **Treatment of infertility and childlessness using indigenous knowledge among rural people**

The participants unanimously stated that infertility was treatable using indigenous knowledge. They said that there were various ways employed when marital partners get it hard to give birth to children.

- ◆ **Use of herbs**

First, they would look at the type of food the marital partners eat and if, to their way of thinking based on their experiences, it is wrong, they would prescribe the correct diet for them. Preferably, food high in nutrition (peanuts, fruits and vegetables) was recommended.

“Loko endyangwini ku nga ri na vana, hi vumbirhi bya vona, nuna na nsati hi va lunghisela mbita. Laha mbiteni ku swekiwa murhi lowu wu nga ta pfluxa ku navela ka swa masangu hi vumbirhi bya vona. Endzhaku ka tin’hweti tinharhu ku ya eka mune, u fanele ku vona swin’wana swi cicile eka wansati. Enhenhla ka sweswo, loko wanuna kumbe wansati a nwa byalwa kumbe madhleke, ku cheriwa chigwana, u ta n’wi twa a ku wanuna wa penga nakambe loko o kuma wansati, wansati u ta nkekela’. It means that if there are no children in a household, special medicinal herbs are prepared for both partners. These medicinal herbs activate their sexual prowess. After two to three months, a

woman may conceive. Furthermore, when an infertile woman or a man drinks alcoholic beverages, a certain concoction (chigwana - medicinal herbs) is poured into the drink, with the belief that he will be sexually stimulated. This is supported by Mashamba (2009) who indicated that some treatment methods include prescribing herbal medication and timing sexual intercourse to coincide with the fertility period.

- ◆ **Use of traditional and/or spiritual (faith) healing**

In case there are no positive results in terms of a woman conceiving, traditional and/or spiritual healers will be consulted. It was revealed that traditional healers will as well prescribe herbs which have to be taken at a certain period. Some people, depending on their faith; consult spiritual healers for solutions. Spiritual (faith) healers also give their spiritual injunctions which have to be followed accordingly as well.

Another participant painted a very personal and touching story of her infertility. She indicated that many doctors (medical practitioners) confirmed that she would never conceive according to their findings. She stated that after consulting the spiritual (faith) healer with her problem, she fell pregnant and gave birth to twins.

Several other studies describe the important role that herbs, medicinal drinks, amulets, cleansing rituals, spiritual and religious healers play in the prevention and treatment of infertility in Africa (Ebomoyi & Adetoro, 1990; Gerrits, 1997; Seybold, 2002). Collectively, these studies indicate that, although traditional health systems may differ in their individual context and in the beliefs upon which they are built, their overall role and structure is remarkably similar throughout the continent (Sundby, 1997). In southern Chad, infertility-related health-seeking behaviour is referred to as ‘looking for children’ and ‘doing research’ (Leonard, 2002). At the outset of this ‘research’ the cause of infertility has to be identified, often from a multitude of possibilities. Infertility secondary to social discord is managed through the traditional health system. Interventions involve reconciliation ceremonies, food offerings and ritual cleansing. In contrast, help is sought from the biomedical sector for most of the somatically expressed causes of infertility (such as

infections, worm infestation and a 'dirty' womb). Marabouts, who are healers connected with the Muslim faith, play an important role in providing infertility-related health care in the Gambia (Sundby, 1997). Interventions are usually based on medicinal drinks and amulets containing writings from the Koran. Other aspects of traditional health care involve spiritual healers, herbalists, fortune tellers and visits to sacred places. According to an anthropological study in Nigeria, infertility may be managed by a number of different traditional healers including local reproductive health specialists, herbalists and spiritual healers (Koster-Oyekan, 1999). Treatment involves sacrifices offered to deities or ancestors, various ceremonies to lift evil curses as well as powders and medicinal soaps to treat different causes of non-conception. Linked to these interventions are preventative strategies which include charms, herbs and the adherence to cultural taboos. A further preventative strategy is the avoidance of contraceptives and vaginal speculum examination as these are believed to be possible causes of infertility (Koster-Oyekan, 1999).

Implications for social service professionals (social work practice)

Striving for cultural competence comes from acknowledgment that society is rapidly becoming more diverse, and along with this growing diversity come divergent beliefs, norms, and value systems (Manoleas, 1994; Mason, Benjamin, & Lewis, 1996; Matthews, 1996; McPhatter, 1997; Ronnau, 1994; Sowers-Hoag & Sandau-Beckler, 1996). In part, striving for cultural competence is recognition of the profession's ethnocentric foundation. Social work has historical roots in England, and this cultural legacy may lead social workers to operate from a professional belief system antithetical to cultural values, norms, and beliefs of some clients (Weaver, 1998). Mason, Benjamin, & Lewis (1996) have acknowledged that Eurocentric values have dominated the sciences including the behavioural and social sciences and have been transmitted as universal cultural standards. This transformation begins to signal the unavoidable rattle between dominant perspective which is Eurocentric worldview and non-dominant cultural approach which is Afrocentric worldviews. This peculiarity frequently symbolizes a point of rasping between two systems which is the social work professionals

who is trained from Eurocentric worldview and the clientele who has a different worldview and in particular, Afrocentric worldview (Mason et al., 1996). In the past social workers and social welfare systems have imposed American middle-class norms as rigid standards for clients (Pinderhughes, 1997).

Knowledge about various cultural groups is essential for cultural competence in social work practice (Dana, Behn, & Gonwa, 1992; Manoleas, 1994; Mason et al., 1996; Matthews, 1996; Pierce & Pierce, 1996; Ronnau, 1994; Sowers-Hoag & Sandau-Beckler, 1996). Awareness of the personal and professional's own values, biases, and beliefs is important for cultural competence and relevance (Mason et al., 1996; Ronnau, 1994; Sowers-Hoag & Sandau-Beckler, 1996).

A culturally competent social worker must value diversity and understand the dynamics of differences in terms of values, practices and customs (Manoleas, 1994; Mason et al., 1996; Ronnau, 1994; Sowers-Hoag & Sandau-Beckler, 1996). Culturally competent social work practitioners go through a developmental process of shifting from using their own culture as a frame of reference for assessing the behaviours of their clients (Krajewski-Jaime, Brown, Ziefert, & Kaufman, 1996).

The participants' experience indicates that there is a need for an education on indigenous knowledge regarding infertility and childlessness, when developmental social welfare services are rendered. These services should be rendered through prevention of social ills such as domestic violence due to childlessness by using social work primary methods of casework, group work and community work, particularly community education model. It is important for developmental social welfare service providers to develop a shared philosophy, mission, vision, values and outcomes alongside indigenous knowledge. Of course, developmental social welfare service should be based on collaboration with an emphasis on reciprocity and equity. Increasingly, however, a new way has been to focus on the interface between indigenous knowledge and modern knowledge systems, such as sexual and reproductive health and rights, to generate new insights, built from two

systems. The interface approach recognizes the distinctiveness of different knowledge systems, but sees opportunities for employing aspects of both so that dual benefits can be realized and indigenous worldviews can be matched with contemporary realities. The emergence of new, complex social and health concerns demands that the public health field strengthens its capacity to respond by acknowledging both bodies of knowledge: indigenous knowledge and western knowledge. The social work profession, with its longstanding involvement in public health and emphasis on ecological approaches, has been a partner in many trans-disciplinary community-based efforts.

Conclusions

This article has discussed the African worldview (indigenous knowledge application) as the basis for practice in the helping professions, with particular reference to social work practice. The article has pointed out socio-cultural values, norms, practices, beliefs and customs that a helping professional should take into account when dealing with African clients. The main thrust in this discourse has been African socio-cultural beliefs inform the behaviour of African clients, particularly when Africans face health and psycho-social challenges that life presents to them. Helping professionals should know African socio-cultural beliefs in order to appreciate what informs the behaviours of African clients (Thabede, 2008).

Understanding the motivations and constraints of all indigenous knowledge holders and practitioners as well as social workers involved in the sexual and reproductive health and rights service provision, provides a foundation for effective collaboration planning. This allows for the identification of the diversity of strengths and weaknesses that could influence the strength of the collaboration and makes it possible to focus on the strengths and to minimise the weaknesses. Understanding the diversity of the context of each of the different partners is crucial to the sustainability of the sexual and reproductive health and rights services as it prevents misunderstandings and ensures a supportive environment. In support of that, Williams (1997:14) state that "If we care about families and children, we have an ethical imperative to make culture and cultural competence central to everything we do".

The data collected are a useful indication of concerns and successes of those who are involved in the developmental social welfare services focusing on sexual and reproductive health and rights and it is envisaged that these will generate possible hypotheses which could be explored in further research studies on this topic.

Contrary to claims and thinking that indigenous knowledge is inferior to Western knowledge and a hindrance to development, the existence and survival of the people in rural communities without basic amenities is a testament to the value of their indigenous knowledge as they continue to thrive with the Mother Nature. This indigenous knowledge system is dynamic in nature and belongs to a group of people who live in close contact with the natural world, allowing a co-existence between them and their environment. In rural communities in the Limpopo Province there is a reservoir of indigenous knowledge used by such communities for the benefit of their inhabitants. Most of this body of knowledge has not been documented. Myths and legends provide ethical and moral education to instil respect for people and the environment.

Health problems and health practices of rural communities have been profoundly influenced by the interplay of complex social, cultural, educational, economic and political practices. The study of health culture of rural communities belonging to the poorest strata of society is needed as it is essential to determine their access to different health services available in a social set up. Common beliefs, customs, traditions, values and practices connected to health and disease have been substantially discussed. In most rural communities, there is a wealth of indigenous knowledge associated with health beliefs. The health culture of a community does not change so easily with changes in the access to various health services (Balgir, 2004a). Hence, it is required to change the health services to conform to health culture of rural communities for optimal utilisation of health services. The indigenous knowledge of the people in rural communities is an embodiment of age-old traditions which have been passed on from generations to generations. Despite the 'greed' associated with the way in which this knowledge is jealously guarded, protected and confined to the

keeper of unique, specific knowledge, these bodies of knowledge are usually for the good and sustainability of the community and its members. Such knowledge is not meant for everyone, but only to those who are considered to be qualified to guard such knowledge with outmost wisdom and secrecy.

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