Review Article
Volume 11:4, 2023

Journal of Health Education Research & Development

ISSN: 2380-5439 Open Access

Understanding Indigenous Practices in Epilepsy Management from a Theoretical Perspective

Ngonidzashe Mutanana[1*], Maria Tsvere[2] and Manase Kudzai Chiweshe[3]

[1]*Department of Child Sensitive Social Policies, Women's University in Africa, Harare, Zimbabwe*

[2]*Department of Child Sensitive Social Policies, Chinhoyi University of Technology, Harare, Zimbabwe*

[3]*Department of Sociology, University of Zimbabwe, Harare, Zimbabwe*

Abstract

The main objective of this paper was to evaluate theories that support indigenous practices of epilepsy management in Africa. The authors reviewed literature related to the following theories; the Health Belief Model (HBM), the agency approach, the Technological Acceptance Model (TAM) and the sustainable livelihoods theories. The authors concluded that these theories help to understand why some individuals in Africa opt to use traditional medicines when western medicines are available at hospital centres. For instance, the behaviour of an individual is determined by a number of health threats and beliefs that he/she possesses about his/her well-being as well as the effectiveness and outcomes of particular behaviours or actions. The capability or ability of that same individual is affected by his or her cognitive belief structure that is formulated through his or her experiences and perceptions that are held by the society. The acceptance and the increasing utilisation of indigenous technological innovations in the health care sector are not only crucial, but are beneficial to both the healthcare professionals and patients during their diagnosis and the treatment processes. Culture plays many roles in the sustainable framework. As such, these theories assist in understanding the knowledge gap that exists on traditional medicines in epilepsy management.

Keywords: Indigenous practices • Health belief model • Agency approach • Technological acceptance model • Sustainable livelihood approach

Introduction

This paper provides a nuanced evaluation of theories that can be used in understanding management of epilepsy in Africa by professional counsellors, social workers, psychologists and many other people who want to understand the behaviour of people with epilepsy. Whilst the subject of epilepsy has been heavily contested in the last decades, insignificant attention has been devoted to examining health seeking behaviours of people living with epilepsy in developing countries. This paper will help to understand their behaviour and to this end the authors evaluate the following theories; the Health Belief Model (HBM), the human agency approach, the Technological Acceptance Model (TAM) and the sustainable livelihoods approach [1].

The Health Belief Model (HBM), as a cognitive model posits that the behaviour of an individual can be determined by a number of health threats or beliefs that he/she may possess about his or her well-being and the effectiveness or outcomes of particular behaviours or actions. The underlying concept of the original HBM is that the health behaviour is determined by one's beliefs and the perceptions that he or she has about that disease and strategies which are available in order to decrease its occurrence. For instance, some people with epilepsy believe that epilepsy is caused by evil spirits and strategies available in some non-western countries to manage the condition are traditional. In other words, the personal perception is influenced by some intrapersonal factors that affect the health behaviour. There are four perceptions that serve as the main constructs of the HBM and these are perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers [2].

Literature Review

The Health Belief Model (HBM)

With perceived severity, Janz Becker, Glanz Rimer and Viswanath agree it is a subjective assessment about the severity of a health problem and its potential consequences. The HBM has proposed that people who perceive the health problem to be serious are likely to be engaged in behaviours which prevent a health problem from

***Address for Correspondence:** *Ngonidzashe Mutanana, Department of Child Sensitive Social Policies, Women's University in Africa, Harare, Zimbabwe; E-mail: ngonidzashemtnn31@gmail.com*

Copyright: *© 2023 Mutanana N, et al. This is an open-access article distributed under the terms of the creative commons attribution license which permits unrestricted use, distribution and reproduction in any medium, provided the original author and source are credited.*

Received: 05 August, 2019, Manuscript No. JBHE-23-103272; **Editor assigned:** 08 August, 2019, Pre QC No. P-103272; **Reviewed:** 22 August, 2019, QC No. Q-103272; **Revised:** 30 June, 2023, Manuscript No. R-103272; **Published:** 28 July, 2023, DOI: 10.37421/2380-5439.2023.11.100086

occurring or may try to reduce its severity. For instance, people may perceive epilepsy to be a serious health problem because it interferes with their daily social roles and work. Consequently, they are forced to engage in behaviours that prevent this health problem from occurring or they reduce its severity [3].

Janz Becker, Glanz Rimer and Viswanath argue that perceived susceptibility refers to subjective assessment of risk of developing a health problem. The HBM predicts people who perceive to be susceptible to particular health problems may engage in behaviours which reduce the risk of developing such health problems. On the contrary, those who have low perceived susceptibility may deny that they are at risk of contracting a particular health problem. For instance in epilepsy, if a family perceive a high risk of developing the epidemic, it is likely to engage in behaviours that decrease the risk of developing the health problem [4].

There are also perceived benefits that promote people with epilepsy to be engaged in health seeking behaviours. As highlighted by, Glanz, Rimer and Viswanath, these health related behaviours are normally influenced with perceived benefits after taking action. Perceived benefits are also described by Glanz, Rimer and Viswanath one's assessment about the efficacy of engagement in a certain health-promoting behaviour in order to decrease that risk of the health problem. For example, a person who believes that anti-epilepsy drugs will help to improve his/her condition is likely to take that medication unlike a person who believes they are not useful at all. Similarly, one who believes in traditional doctors will make use of them regardless of the objective facts by medical doctors regarding the effectiveness of the traditional practices in epilepsy management [5].

Finally, we have perceived barriers, described by Glanz, Rimer and Viswanath as health-related behaviours which are a function of perceived barriers in taking action. This is a one's subjective assessment about obstacles to behaviour change. A person with epilepsy may perceive a health condition as threatening believing that particular action will help to effectively reduce the threat, but barriers may prevent engagement in health-promoting behaviours. For instance, medical doctors may suggest brain surgery for an individual with epilepsy. Perceived side effects associated with medical procedure like danger, expenses and inconvenience may be a barrier to this health seeking behavior [6].

A stimulus, better known as a cue to action is also of paramount importance in triggering necessary engagements in any health-promoting behaviour. Janz and Becker and Carpenter these cues may be either internal or external. Physiological cues such as pain or symptoms are examples of an internal cue to action. An individual with epilepsy may have symptoms of a mentally disturbed person, or may be suffering from some internal physiological pain after the convulsions. This may drive the individual or fellow family members in support to seek medication, which may be either traditional or western. External cues on the other hand include information from the media, close others or health care providers and these may promote an individual to get engaged in a certain health-related behavior. For instance, the media in Zimbabwe is awash with the spiritual papa movement with Prophet Makandiwa and Prophet Magaya being on the forefront. The media may trigger an individual with epilepsy to be engaged in traditional practices of epilepsy management because of this media. Family members, in particular the elders may also influence an individual to get help from traditional doctors [7].

From this analysis, it can be observed that the HBM is a suitable theory in understanding why Africans opt for indigenous practices in epilepsy management. As highlighted by Carpenter and Rosenstock, Stretcher and Becker HBM has been used towards the development of effective interventions in changing health-related behaviours that are targeting various aspects of key constructs. Interventions based on HBM try to increase the perceived severity and susceptibility of health conditions such as epilepsy by providing education on the prevalence and incidence of the disease as well as individualised risk and information about the consequences associated with the diseases, such as financial, social and medical consequences.

The human agency framework

In social science, agency is described as a capacity for individuals to act independently and to make their own free choices. Metcalfe, Eich and Castel posit that one's agency is an implication of one's independent ability or capability to act. The capability or the ability is affected by an individual's cognitive belief structure that is formulated through his or her experiences and the perceptions that are held by an individual and the society. Bandura described human agency as a human's capability to exert influence over functioning and the course of events by an individual's actions. Bandura (ibid) also suggest that it is through cognitive self-guidance that human beings may visualise futures which act on the present. Human beings construct, evaluate or modify alternative courses of action to gain valued outcomes and override environmental influences. Bandura thus concludes that human agency is an agent means which influence intentionally on one's functioning and life circumstances [8].

Perhaps an example of an individual with epilepsy will help to grasp this definition. This individual has a wide variety of choices for epilepsy treatment. He/she can visit the hospital, non-governmental organisations such as epilepsy support foundation Zimbabwe or any nearest clinic to get treatment in the form of psychological counselling and anti-epilepsy medication. The same individual can also visit a traditional doctor to get treatment in the form of herbs and spiritual treatment.

Epilepsy, described as a mental condition by the western, is attributed to spirituality in African traditional practices. Many people in African countries, Zimbabweans included believe in African traditional practices and have consequently resorted to traditional and spiritual medicines. To this end, several studies have demonstrated that people with epilepsy make use of traditional and spiritual medicines as treatment for epilepsy. The indigenous healer or the diviner occupy a central place in communities' participation in life events, including epilepsy. In some cases, studies have suggested an inter-play between western medication and traditional medication. For instance, Asadi-Pooya, Saburi agree that traditional medicines may be used to complement western medication. To this end, it would appear the majority is neglecting western medication. This is evidenced by epilepsy support foundation Zimbabwe which claims that about 86% of people who are living with epilepsy are still not receiving anti-epilepsy medication. This is in spite of the media reports that have supported western medication ahead of indigenous medicines [9].

To explain this conception, Bandura argue people are the contributors to their life circumstances. Bandura (ibid) insists people create social systems which will in turn organise and influence their lives. Throughout history epilepsy has been perceived to be a mysterious and supernatural disorder. Studies have also indicated that a widely held notion about epilepsy in Africa is that epilepsy is caused by evil spirits and witchcraft. Mutanana and Mutara also argue that many communities in Zimbabwe still believe that epilepsy results from witchcraft or possession by evil spirits. These are the social systems that are organising and influencing people with epilepsy. Human agency is thus a cognitive self-guidance which human beings can use in order to visualise the future that act on the present. Bandura strongly believes it is through cognitive self-regulation that human beings are able to create a visualised future that act on the present. Human beings are able to construct, evaluate and to also modify alternative courses of action to secure valued outcomes. This explains the problem of interplay between western medications and traditional practices of epilepsy management in some reported in some studies [10].

According to Bandura a social cognitive theory has adopted an agentic perspective on human development, change and adaptation. Bandura (ibid) insists that to be an agent is to influence intentionally on an individual's functioning and their life circumstances. What it means is that personal influence is part of the causal structure. This theory, it would appear, is also trying to explain the behaviour of an individual with epilepsy. The government of Zimbabwe offers free medication and psycho-social support at hospital centers, but according to statistics provided by epilepsy support foundation in Zimbabwe 86% of people who are living with epilepsy are still not receiving anti-epilepsy medication. The presumption earlier was that the government is not resourced enough to take care of people with epilepsy and to solve this problem non-governmental organisations such as epilepsy support foundation Zimbabwe were introduced to help with medication, counselling and social services but this development has not yielded any positive results. A possible cause of this problem could be that the reaction to epilepsy in Zimbabwe is shaped by traditional indigenous beliefs and traditional treatment. According to, Bandura, as human beings they are self-regulating, self-organising, self-reflecting and they contribute to their life circumstances. They don't need medical doctors or the media to advise them on the disadvantages of indigenous medicines because they created the social systems which is now organising and influencing them [11].

The Technology Acceptance Model (TAM)

Davies in Ziyu proposed this theory, the Technology Acceptance Model (TAM) in order to explain and predict behaviours of people towards technological innovations, particularly the acceptance of users towards information technology systems. Fishbein and Ajzen supported by Ziyu report the technological acceptance model to be originally an extension of the Theory Reasoned Action (TRA). TRA was a psychological theory that explain an individual's actions by identifying the causal connections between various components of life such as attitudes, beliefs, intentions and the behaviours.

However, with TAM, unlike TRA there are two primary variables; independent and dependent variables. Independent variable includes Perceived Usefulness (PU) and the Perceived Ease of Use (PEOU).

The dependant variable is the attitude towards using (AT). The perceived usefulness is defined by Davis as the degree to which a person believes in using a particular system that would enhance his/her performance. Davies also defines perceived ease of use as the degree to which people believe using a particular system would be free of effort.

Epilepsy support foundation Zimbabwe, for instance has indicated that about 86% of people living with epilepsy are not on anti-epilepsy medication in Zimbabwe. This has been attributed to the fact that many people with epilepsy who live in developing countries have limited access to health care facilities. In this context, it is widely assumed that traditional and spiritual medicine, being easily accessible, plays an important role in treating people with epilepsy. This could be attributed to the perceived usefulness by users, who may be having a feeling that that these traditional medicines are quite useful in enhancing their performance. This can also be attributed to the Perceived Ease of Use (PEOU) described by Davies as the degree to which people with epilepsy believe in this system would free of effort [12].

Davies further theorised that the actual information usage as being determined by behavioural intentions and these intentions were jointly determined by the user's attitudes towards these systems and perceived usefulness. Studies have also highlighted that a widely held notion about epilepsy in African countries is that epilepsy is caused by evil spirits and witchcraft Carod-Artal and Vazquez-Cabrera. Mutanana and Mutara also argue that many communities in Zimbabwe still believe that epilepsy results from witchcraft or possession by evil spirits. There is also a grave social stigma attached to epilepsy with some people believing that it is a contagious disease (epilepsy support foundation). Thus Mpofu is of the opinion that traditional healers and prophets (faith healers) are crucial at community level and they are the first port of call and often the last resort.

Ward argues that the Information and Technology (IT) was proposed within the healthcare because of a variety of reasons that includes benefiting and improving patient care. It also enhances patient care. Ward also argues that technology acceptance model focus on factors and decision processes which are undertaken by an individual as he or she goes through any decision to accept or use a technology, for instance; indigenous technologies in management of epilepsy in Zimbabwe. The perceived usefulness as well as the perceived ease of use is viewed as key determinants in one's choice for the right treatment. Many studies have placed much emphasis on the attitude and the social factors on a person's behavioural intention. For instance, if these traditional practices are not recognised as part of medication for people with epilepsy, they will continue to live in severe social isolation and discrimination. This will hinder their development psychologically, medically, educationally and economically. They continue to die prematurely because they are depending on these traditional modes of epilepsy treatment to sustain their livelihoods [13].

Gucin and Berk have suggested that the acceptance and the increasing utilisation of technological innovations in the health care sector are not only crucial, but they are beneficial to both the healthcare professionals and patients during their diagnosis and the treatment processes. These authors seem to be supportive of modern technologies of epilepsy treatment

because they strongly feel these are helpful in managing the condition of people with epilepsy. However, Gucin and Berkin agree that there are influencing factors that may differ for both health care professionals and their patients. They observed that perceived ease of use may be affected by personal norms and the perceived control beliefs. Gucin and Berkin believe suspicions of confidentiality and privacy are some of the influencing factors for refusing technology usage among patients. As such, these factors must be considered when one is designing intervention programs in order to enhance technology acceptance among people with epilepsy.

Sustainable livelihoods theory

Collier argues that when one is doing his or her development work, an essential factor is to ensure that the state is in a position to secure the support of those development activities. Petersen and Pedersen agree with Collier and further suggest that if the state is unable or uninterested in creating resources which support different development activities, then there is a little chance of activities to continue. In this paper, it will be argued that the government of Zimbabwe should support the development of indigenous practices in sustainable management of epilepsy in Zimbabwe. The authors therefore agree with several researchers who have advocated for sustainable livelihoods in developing countries such as Zimbabwe [14].

According to the sustainable livelihood approach was inspired by the work of one Robert Chambers in the 1980's and was further developed by Chambers, Conway and others during the 1990's. This framework as a tool in development work, highlights how to understand, describe and to analyse main factors that affect livelihoods of local people, such as people with epilepsy in Zimbabwe. DFID describes sustainable livelihood as a livelihood that is comprised of capabilities, assets which includes material and social resources and activities that are required as a means of living. A livelihood is thus sustainable because it copes with and also recovers from the shocks and stresses maintaining and enhancing capabilities and assets, while at the same time not undermining the natural resource base.

Chambers and Conway have posited that the sustainable livelihoods theory is a way of understanding livelihoods of local people, for instance people with epilepsy in Zimbabwe. The approach was found to be suitable in this presentation because it places people with epilepsy and traditional medicines at the centre of development agenda. This approach also draws its influence from, Chambers and Conway who have suggested that a livelihood is comprised of assets, capabilities and activities that are required as a means of living. These researchers believed a livelihood was sustainable if it coped with and recovered from stress and shocks. A sustainable livelihood is also understood to be a provider of livelihood for the future generation. The approach is people centred; it is holistic and dynamic in nature. The theory also provides a framework for analysing indigenous practices in sustainable management of epilepsy in community development [15].

Petersen and Pedersen argue that this framework describes what development that is dedicated to reduction of poverty should be focused on in order to create the livelihoods for the local, such as people with epilepsy. The first basic principle identified Petersen and Pedersen is that the development work has to focus on the people. The paper is focusing on people with epilepsy and the community, the majority of who are poor. What it means is that we need to focus on what matters to people with epilepsy and as individuals or communities differ in their cultures and how this affects the way in which they understand epilepsy treatment. Another principle by Petersen and Pedersen is that the poor themselves must be key actors in identifying important aspects of their own livelihoods. The community knows what matters to itself, as such the government, community based organisations and non-governmental organisations who handle issues of people with epilepsy must value the priorities of people with epilepsy instead of assuming their own values and ideas as good or better. Chambers and Conway also argue that it is a principle for donors such as epilepsy support foundation to be process facilitators that help people with epilepsy to be aware of their priorities and to analyse their own surroundings for resources such as traditional medicines. What it means is that participation and partnership between the community and service providers becomes essential factors in development of indigenous practices of epilepsy management. People with epilepsy are empowered instead of being dependant on the outside world for epilepsy management all the time.

DFID supported by Petersen and Pedersen identify transforming structure and process component that includes institutions, policies and organisations that frame livelihoods for the poor. These are found at all levels, from the household to the international level. Chambers and Conway also explain that these processes and structures are the ones that determine and access that human beings have different kind of assets, thus the importance cannot be over emphasised. Some examples of these processes include international agreements, laws and ownership rights to secure rights of people. Structures might be in existence within ministries, self-help groups in local community and banks that give credit. What it shows is that these indigenous practices need to be supported with laws and international agreements to secure the rights of African people who are suffering from epilepsy [16].

Chambers and Conway claim livelihood outcomes are achievements of people's strategies of livelihood. Outcomes are described by the local people themselves, in this case, people with epilepsy since they include more than the income. Petersen and Pedersen believes for outsiders it is difficult to understand what the people are seeking and why because people are often influenced by values, norms and culture. In this study, the insiders, who happen to be people with epilepsy or people who have interacted with people with epilepsy may be influenced with their culture, norms and values. What does this show?

Krantiz claims the description of the sustainable framework shows that it is a systematic and holistic way of describing factors which affect livelihoods of poor people, such as people with epilepsy. This framework is an attempt to understand poverty as a multifaceted concept which covers more than just economic growth. Petersen and Pedersen suggest that these factors have an impact on how people take advantage of the economic opportunities, combine assets and what livelihoods can create. Description of these different factors also show how important it is to include those that are poor, because they are the ones who have the knowledge about the content associated with each factor and how these factors affect each other in negative or positive ways. To this end, it can be noted that this framework emphasises that other

aspects are important, such as social status, health and natural resources [17].

Petersen and Pedersen posit that culture plays many roles in the sustainable framework, thus influencing different components in the process as well as the interaction between them. A thorough understanding of culture becomes essential in the sustainable framework in order for the framework to be effective. As highlighted by Daskon and Binns, culture is frequently ignored in the Eurocentric strategies, yet it seen as both an inhibitor and a facilitator in development. From a psychological point of view, Heine argues that the central aspect of studying culture revolves around understanding a dialectic relationship between an individual and culture. Triandis defines culture as shared attitudes, categorisations, beliefs, expectations, roles, norms, self-definitions, values and other such elements of subjective culture that are found among people whose interaction are facilitated by shared language, geographic region and historical period.

This definition gives an insight into some processes through which culture may influence individuals with epilepsy in the management of the epidemic. It is through socialisation that culture specifies a way of living which has been proven in the past. Rothbaum et al. argues culture thus provides patterns of living which include attitudes, norms and beliefs that form the basis for people with epilepsy, from which these people construct perceptions of themselves and of their life in general. This has been reflected in the sustainable framework through the way it focuses on people as well as what matters to them. As shown in this definition, what matters to people is influenced by their culture. Culture is thus seen as a fundamental of understanding the components of the sustainable framework, which is from the vulnerability context right through to the different capitals in the livelihood outcome. For the people with epilepsy that the study intend to help, the components are viewed from a specific cultural stand because culture influences the individual's perception of wrong or right, personal resources, his/her possibilities and the environmental resources.

Petersen and Pedersen suggests that being aware of the local culture as well as what it means for people that are to be empowered through the sustainable framework have got a positive impact on how one views components in the framework, thus have a positive impact on the livelihood outcome. Petersen and Pedersen posit that the most obvious impact is related to capitals or livelihood assets. As discussed in the human capital, the capital is essential in order to benefit other capitals. Further, culture plays an important role in influencing knowledge and skills that an individual is socialized with. From this analysis, it can be clearly seen that human capital is valuable for people with epilepsy and vary tremendously according to location. Recognising the knowledge and skills that traditional doctors have, this framework is supposed to assist and provide an opportunity for them to be the experts and also to use what it is they value as the starting point of securing sustainable livelihoods for people with epilepsy. Petersen and Pedersen thus claims the framework does not only benefit recognition of culture as part of the transforming process which determines access people have to assets, but it also views culture as a resource for people within this framework [18].

Discussion

Analysis of theories that support indigenous practices of epilepsy management

Based on the discussions above, the authors find the following theories to be suitable in understanding indigenous practices of epilepsy management; Health Belief Model (HBM), the agency approach, Technological Acceptance Model (TAM) and sustainable livelihood theory. These theories help to justify why some people opt for indigenous practices of epilepsy management. They also justify why they opt for those practices and finally help to manage the knowledge gap currently in existence on indigenous practices of epilepsy management. Below is a diagrammatic presentation of these theories (Figure 1).

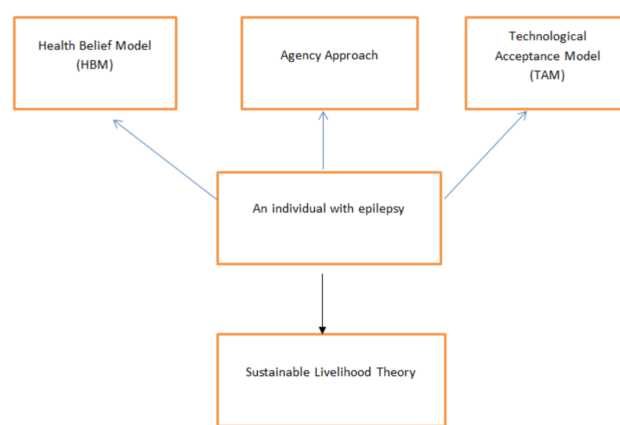

Figure 1. A diagram showing various approaches that can influence an individual with epilepsy.

At the centre is an individual with epilepsy. He/she she has various choices of treatment; western medication or traditional medicines in the form of spiritual healing and traditional herbs. These theories; Health Belief Model (HBM), agency approach and Technological Acceptance Model (TAM) are trying to explain factors that influence an individual's choice. The sustainable livelihood theory clearly spells out the need to develop these theories in order to ensure sustainable management of epilepsy.

The Health Belief Model (HBM), described Sharma and Romas as a psychological model which attempts to predict and explain health behaviors is a cognitive model. The behaviour of an individual is determined by a number of health threats and beliefs that he/she possesses about his/her well-being as well as the effectiveness and outcomes of particular behaviours or actions. The underlying concept of the HBM is that health behaviour is determined by individual beliefs and perceptions about the disease and strategies that are available to decrease its occurrence. For instance, some people with epilepsy believe that epilepsy is caused by evil spirits and strategies available in some to manage the condition are traditional. In other words, personal perception is influenced by some intrapersonal factors that affect the health behavior [19].

Similarly, the agency has been described as the capacity for individuals to act independently as well as to make their own free choices. Metcalfe, Eich and Castel suggests that one's agency implies one's independent ability or capability to act on one's will.

The capability or ability is affected by one's cognitive belief structure formulated through one's experiences and perceptions that are held by the individual and the society. Bandura described human agency as the human capability to exert influence over one's functioning as well as the course of events by one's actions. Human beings construct, evaluate or modify alternative courses of action in order to gain valued outcomes and to override environmental influences. Human agency is thus an agent means that influences one's intentionality on functioning and life circumstances.

Just like HBM and agency theory, Davies explains that the Technology Acceptance Model (TAM) helps to predict the behaviour of people towards a technological innovation, particularly the acceptance of users towards information technology. This theory is a psychological theory which explains people's actions by identifying causal connections between the various components of life such as attitudes, beliefs, intentions and the behaviours.

The sustainable livelihood theory also helps to understand different choices of epilepsy management by individuals with epilepsy. It goes further to understand, describe and analyse the main factors which affect livelihoods of local people, such as people with epilepsy in Zimbabwe. DFID describes sustainable livelihood as the livelihood which is comprised of the capabilities, assets that include material and social resources as well as activities that are required as a means of living. A livelihood is thus sustainable when it copes with and also recovers from shocks and stresses maintaining and enhancing capabilities and assets, while at the same time not undermining the natural resource base. This framework has also concluded that the subject of culture on sustainable development of epilepsy management is indeed a complex matter. A thorough understanding of culture and how it influences individuals and various components of the sustainable framework must be made. Research studies cannot ignore cultural resources or cultural differences in sustainable management of epilepsy in Zimbabwe. Petersen and Pedersen further recommend researchers to draw upon the resources of culture for development of projects, such as epilepsy management.

Conclusion

Based on these discussions, the authors concluded that the HBM, agency approach, TAM and sustainable development theories help to understand why some individuals opt to use traditional medicines when western medicines are available at hospital centres because of the following reasons:

- The behaviour of an individual is determined by a number of health threats and beliefs that he/she possesses about his/her well-being as well as the effectiveness and outcomes of particular behaviours or actions.
- The belief structure formulated through one's experiences and perceptions that are held by the individual and the society.
- The acceptance and the increasing utilisation of technological innovations in the health care sector are not only crucial, but they are beneficial to both the healthcare professionals and patients during their diagnosis and the treatment processes.
- Culture plays many roles in the sustainable framework.

These theories also assist in understanding the knowledge gap that exists on traditional medicines in epilepsy management.

References

1. Asadi, Pooya, Ali A and Mehrdad E. "Perception and Use of Complementary and Alternative Medicine among Children and Adults with Epilepsy: The Importance of the Decision Makers." *Acta Medica Iranica* 52 (2014): 153-157.
2. Bandura, Albert. "Self-Efficacy: Toward a Unifying Theory of Behavioral Change." *Psychol Rev* 84 (1977): 191.
3. Bandura, Albert. "An Agentic Perspective on Positive Psychology." *Positive Psychol* (2008): 167-196.
4. Bandura, Albert. "Social Cognitive Theory: An Agentic Perspective." *Annual Rev Psychol* 52 (2001): 1-26.
5. Birbeck, Gretchen L. "Seizures in Rural Zambia." *Epilepsia* 41 (2000): 277-281.
6. FJ, Carod Artal and Domenech PEM. "Treatment of Epilepsy among the Guarine (Palenque) Tribes." *Neurologia* 10 (1995): 394-395.
7. Carod-Artal, Francisco J and Carolina BVC. "An Anthropological Study about Epilepsy in Native Tribes from Central and South America." *Epilepsia* 48 (2007): 886-893.
8. Daskon, Chandima and Tony B. "Culture, Tradition and Sustainable Rural Livelihoods: Exploring the Culture Development Interface in Kandy, Sri Lanka." *Comm Dev J* 45 (2010): 494-517.
9. Davis, Fred D. "Perceived Usefulness, Perceived Ease of Use and User Acceptance of Information Technology." *MIS Quarter* 13 (1989): 319-340.
10. Diop, Amadou Gallo, Hanneke MdB, Custodia M and Leonid P. "The Global Campaign against Epilepsy in Africa." *Acta Tropica* 87 (2003): 149-159.
11. Janz, Nancy K and Marshall HB. "The Health Belief Model: A Decade Later." *Health Edu Quarter* 11 (1984): 1-47.
12. Mohammed, Inaam N and Haydar EB. "Traditional and Spiritual Medicine among Sudanese Children with Epilepsy." *Sudanese J Paediatr* 13 (2013): 31.
13. Chitiyo, Morgan, George C, Jonathan C and Victoria O, et al. "Understanding the Causes and Management of Problem Behaviour in Zimbabwean Schools: Teacher Perceptions." *Int J Inclusive Edu* 18 (2014): 1091-1106.
14. Mpofu, Elias. "Rehabilitation an International Perspective: A Zimbabwean Experience." *Disability Rehab* 23 (2001): 481-489.
15. Munthali, Alister, Stine HB, Lisbet G, Yusman K and Benedicte I, et al. "Seeking Care for Epilepsy and Its Impacts on Households in a Rural District in Southern Malawi." *African J Disabil* 2 (2013): 1-8.
16. Wu, Mao-Ying and Philip LP. "Host Tourism Aspirations as a Point of Departure for the Sustainable Livelihoods Approach." *J Sustain Tour* 22 (2014): 440-460.
17. Rosenstock, Irwin M. "Historical Origins of the Health Belief Model." *Health Edu Monograph* 2 (1974): 328-335.
18. Shizha, Edward and John C. "Health and Wellness in Southern Africa: Incorporating Indigenous and Western Healing Practices." *Int J Psychol Counsel* 3 (2011): 167-175.
19. Watts, Anne E. "The Natural History of Untreated Epilepsy a Rural Community In Africa." *Epilepsia* 33 (1992): 464-468.

How to cite this article: Mutanana, Ngonidzashe, Maria Tsvere and Manase Kudzai Chiweshe. "Understanding Indigenous Practices in Epilepsy Management from a Theoretical Perspective." *J Health Edu Res Dev* 11 (2023): 100086.