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TRADITIONAL HEALERS IN NIGERIA: PERCEPTION OF CAUSE, TREATMENT AND REFERRAL PRACTICES FOR SEVERE MALARIA

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Summary. Malaria remains one of the main causes of mortality among young children in sub-Saharan Africa. In Nigeria traditional healers play an important role in health care delivery and the majority of the population depend on them for most of their ailments. The aim of this study was to investigate the perceptions of traditional healers regarding causes, symptoms, treatment of uncomplicated malaria and referral practices for severe malaria with a view to developing appropriate intervention strategies aimed at improving referral practices for severe malaria. A qualitative study was carried out in Ugwango-Nike, a rural community in south-east Nigeria, which included in-depth interviews with 23 traditional healers. The traditional healers believed that the treatment of severe malaria, especially convulsions, with herbal remedies was very effective. Some traditional healers were familiar with the signs and symptoms of malaria, but malaria was perceived as an environmentally related disease caused by heat from the scorching sun. The majority of traditional healers believed that convulsions are inherited from parents, while a minority attributed them to evil spirits. Most (16/23) will not refer cases to a health facility because they believe in the efficacy of their herbal remedies. The few that did refer did so after several stages of traditional treatment, which resulted in long delays of about two weeks before appropriate treatment was received. The fact that traditional healers are important providers of treatment for severe malaria, especially convulsions, underlines the need to enlist their support in efforts to improve referral practices for severe malaria.

Introduction

Malaria is a highly prevalent disease in the tropics. It threatens about 40% of the world’s population, underlining the health and welfare of families, endangering the survival of children, debilitating the active population and straining already scarce resources.
resonence by its excessive public health cost, low productivity in those affected and impaired growth in children (WHO, 1993).

About 90% of all malaria deaths in the world today occur in Africa, south of the Sahara. An estimated one million people in Africa die from malaria each year and most of these are children under five years old (WHO, 2002).

In Nigeria, malaria is endemic throughout the country and more than 90% of the population live in areas with stable malaria. Malaria is one of Nigeria’s leading causes of morbidity and mortality with a prevalence rate of 919/100,000. It is responsible for 35% of infant mortality and 30% of childhood mortality. Malaria accounts for 50% of outpatient consultations/visits and between 15% and 31-3% of hospital admissions. Of the four species of Plasmodium infective to man, all except Plasmodium vivax are found in Nigeria with Plasmodium falciparum accounting for about 80% of cases (WHO, 2003a).

Several studies have reported that traditional healers are frequently consulted because the symptoms associated with severe malaria are commonly thought to be related to supernatural causes and hospital treatment is often considered to be not only ineffective but also dangerous (Hieger, 1994; Mwasana et al., 1995; Wünisch et al., 1996). This results in long delays between initial symptoms and admissions.

The major factors that determine the choice of care for malaria treatment are cost of treatment (Okonsodo et al., 1992; White, 1998), availability of health facilities (Kanolezi and Makaikwa, 1992), level of awareness and cultural beliefs (Mwasana et al., 1995). In some cases certain illnesses are seen as amenable to treatment by modern practitioners while others are considered best treated by traditional methods (McComb, 1996). In a previous study conducted in Nigeria an utilization of different types of health care systems, it was noted that traditional healers were the most utilized (Adenwagun, 1997). Traditional medical services were found to be cheaper than orthodox medical services and were readily accessible and acceptable (Adenwagun, 1997).

Prompt and effective treatment of all children with malaria is a critical element of malaria control. People who become ill with the disease need prompt and effective treatment to prevent the development of severe manifestations and death (WHO, 2003a). This underlines the need for research to ascertain traditional healers’ recognition of malaria symptoms, causes, treatment and referral practices for severe malaria for an effective intervention planning and implementation programme.

This paper presents results of a larger study designed to ascertain caretakers’ and health care providers’ recognition of malaria symptoms, causes, treatment and referral practices for severe malaria in a rural community in north-east Nigeria. This is with a view to designing appropriate intervention strategies to promote early and appropriate treatment of mild malaria in young children with prompt referral of severe cases.

Methods

The study area and population

The study was conducted in Nike in the Enugu-East local government area. This is a rural area situated about 20 km east of Enugu, the capital of Enugu State,
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Nigeria, Enugu is located between latitude 5° 55' and 7° 10' north, longitude 6° 50' and 7° 55' east. The population is mainly Christian, ethnically Igbo and most are farmers and petty traders. The vegetation is a mixture of forest and savannah types. Rainfall is seasonal and occurs between the months of March and October. There are no good roads, no pipe-borne water supply and no electricity. Malaria is hyperendemic in these communities. Uwagogo-Nike, one of the four autonomous communities in Nike, was randomly selected as the study area. It is made up of ten villages and has a population of about 9224 of whom 1748 (18.5%) are children under five years old (project census). It has one primary school and one secondary school. There is a primary health centre and a comprehensive health centre (cottage hospitals) in the same village.

Ethical issues

Ethical approval was sought and obtained from the Ethical Committee of the University of Nigeria Teaching Hospital, Enugu (UNTII). The research objectives and methods were explained to individual respondents and verbal informed consent was obtained from the study participants before the research instruments were administered. Confidentiality was maintained by only allowing information to be accessible to members of the research team.

Study design

The study was undertaken in all the villages between November 2001 and April 2002. Traditional healers were identified and listed with the help of the traditional community healer, who was also a traditional healer, and the village chiefs. The location of those who treat malaria and convictions was then mapped out, using a hand-drawn map. In-depth interviews (IDI) using an IDI guide were used to elicit information from traditional healers on their perception of causes, symptoms, treatment of malaria and convictions and on referral practices for severe malaria. The research objectives and methods were explained to them and informed oral consent was obtained before administration of the research instrument. The interviews were conducted in the evenings by two community health nurses trained by a social scientist. Each session lasted about 45 minutes.

The research instrument was pre-tested for appropriateness, clarity and ambiguity and the study instrument modified accordingly. Proceedings were recorded with the aid of tape recorders. The recorded proceedings were transcribed and analysed manually by content analysis.

Results

They were a total of 34 traditional healers of which 34 were specialists in the treatment of fever and convictions. Others included housekeepers, and specialists in the treatment of snakebites, psychiatric problems, sexually transmitted diseases and other illnesses. The specialists comprised of ten females and 24 male healers; altogether ten female and thirteen male traditional healers were interviewed. The first traditional
healer interviewed was chosen by a simple random sampling method, and sub-
sequently the nearest was visited. The interview was conducted until no new
information was gathered. This agreement was from 30 to 70 years with a mean of 51
years. The majority (14/23) had no formal education: 6/23 had primary and 3/23
secondary education. Most practiced healing as an adjunct to another occupation,
mainly farming.

The traditional healers knew locally as Dlibhe were mainly herbalists, with
one spiritualist who also treated malaria with herbs. These herbalists had no formal
health training and the most common way (21/23) of acquiring their healing skills was
by having it passed on to them by their fathers; this was referred to locally as Oma
tatula (inherited from father). One traditional healer stated that:

1 inherited it from my great-grandfather, it comes from hand to hand, we do not buy it.

A less common (2/23) way to become a healer was to have a vision in a dream.
As explained by a male traditional healer:

The god of our land told me to come and start this healing and since then I have been doing it.

Local perception of causes and recognition of malaria and contam tant:

For the majority of traditional healers, the common illnesses suffered by children
under five years old were considered to be malaria, known as Iba (14/23, 60%),
followed by convulsions (2/23, 34.8%), referred to locally as the ebube (literally
meaning something that pulls), fever, known locally as Akwukwu i.e. 'hot body', and
stomach ache, which were each mentioned by 2/23 (30.4%) respondents. Also included
was the local akele odukani which was reported by 22/23 (91.7%) of the respondents
and refers to the passage of greenish/frequent stools by children.

Two types of Iba were described by traditional healers: Iba akwuka, which is 'normal'
Iba, and Iba eche na anyan, which is 'yellow' Iba and causes yellowish discoloration
of the eyes and is regarded as the serious variety.

Among the indicated causes of malaria as mentioned by the traditional healers,
sunburn highest (18/23), followed by the eating of oily food (14/23). Others include
rain, hard work and, in the same proportions (3/23). However, an
unbalanced diet and Iba were also mentioned by one traditional healer as a cause of
malaria. One male traditional healer in an IC interview remarked that:

Too much sun causes Iba. I am a healer that stays under the sun for long and it causes the
Too much oil, two catch fish hard also causes this.

On the mode of transmission, some of the traditional healers said that sharing
the same cup will cause malaria:

... how it is transmitted is that if you use the same cup with someone who has Iba the disease
will stick where you will be infected.

On the cause of convulsions, most traditional healers responded that:

The Ondish healthcare is from the blood, that is why it does not occur in every child. It is from
the blood of the father and mother.

Some also believe convulsions to be due to evil spirits. A responding male
traditional healer, who was also a spiritualist, pointed out that:

...
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... the one that comes jingling, the Ochichi, is the one that we make sacrifice to the gods.

The symptoms indicated by traditional healers as being associated with malaria are, in descending order of magnitude: fever 9/23 (39%), loss of appetite 8/23 (34.8%), headache 6/23 (26.1%), weakness 6/23 (26.1%), dark yellow urine 3/23 (13%), and restlessness and vomiting, which were each reported by 3/23 (4.4%) of the respondents. The symptoms of severe malaria in decreasing order of proportion are: yellowish discolouration of the eyes 21/23 (91.3%), convulsions 7/23 (30.4%), high fever 6/23 (26.1%), dark yellow urine, headache and extreme weakness, which were each mentioned by 3/23 (13%) of traditional healers, while excessive vomiting, pale bowels, dryness of skin and loss of appetite were reported by 1/23 (4.4%) respondents.

In describing the symptoms of convulsions a female traditional healer stated that ‘the child will start to jerk and the eyes will be rolling up’.

Treatment practices

The treatment of mild malaria by traditional healers is with herbs. A female traditional healer in an IDU pointed out:

... that I will go and get the herbs and boil it, I will give some to the child to drink with a small spoon, those three a day, then I will give some to be worn on the body. There is another one which I will grind with Ogiri (ground spina) and use (pepper). This the child will lick.

The duration of the treatment is for three to four days.

All the traditional healers affirmed that they treat convulsions by giving different kinds of herbs. Some boil the herbs and allow the sick child to inhale the vapour from boiling herbs; others dry the herbs, grind them and mix them with a solvent. This is summed up by the following statement:

... once they bring the child, I will go to the bush and bring some herbs and mix it with ‘nde abu’ (green turmeric) powder and apply on the whole body. I will put some in the mouth, under the eyes and ears. The child will immediately move and go to sitting. If the body is cold, I will make fire and put the child’s legs near the fire. Another thing we do is to make an incision beside the eye, on the hands and feet then square some herbs into it.

The popular belief is that convulsions start with abdominal upset, which is a result of ‘dirty stomach’. The herbs are therefore interred into the anus to induce diarrhoea, which ‘cleans out the stomach’ to make the child feel better. Commenting on this a traditional healer remarked:

I will use one finger to insert the herbs into the anus to induce the child to stool. Once he goes to toilet, he will feel better and I know my job is fulfilled.

For those who believe convulsions to be due to evil spirits, their treatment involved offering a sacrifice to the gods. This belief would explain the treatment given by an old respondent who stated that:

... for convulsions there are seeds I will put in the fire, then put the child near the fire. The burning seeds will bring out very bad odour which will chase away the evil spirits.

Some traditional healers consult the oracles to find the cause of convulsions.

The time a child is allowed to take the herbs ranges from one to three weeks depending on how severe the illness is and how the child is responding to the treatment. When asked about the duration of treatment a traditional healer remarked:
It is usual the illness stops which takes about three weeks for severe malaria and a total malaria it takes less than three weeks.

From the responses on their treatment of convulsions, it is clear that they believe that their method of treatment is very effective.

Refractory practices

Most 16/23 (69.6%) traditional healers will not refer a case to a health facility. Of these 4/23 (17.4%) claimed they refer to their colleagues if the patient is not getting better while 13/23 (56.5%) will not refer to anybody. Those who will not refer were made up of ten males and six females. 13/23 had no formal education, 20/23 had primary education, and the majority were aged between 50 and 70 years. One healer responded by saying:

I don’t refer because my herbs always cure them. If the child is not responding to the initial herbs, I will look for another cure, which must work. Look, my own is still.

Another traditional healer exclaimed:

God, there is no body I give my herbs that did not recover.

However, some 7/23 (30.4%) claimed they refer to a health facility if the child is not improving.

Preventive measures

Most traditional healers believe that malaria can be prevented by avoiding too much sun and freshly food and by taking their herbs regularly. They also claimed that since too much work leads to malaria, not working too hard would prevent it.

One traditional healer stated that malaria can be prevented ‘by avoiding the use of the same cup used by someone who had malaria to drink water’. Yet another one noted that malaria cannot be prevented since it is hereditary. He summed it up by saying:

You know malaria is in born specially for Africans. There is no way you can prevent it, when it comes you start taking herbs.

However, most claimed that convulsions can be prevented by giving herbs and by making scarifications on the eyes, hands and feet when a child is born.

Discussion

Malaria is recognized by traditional healers as a distinct disease known as lfa. However, two types of malaria are recognized: lfa niki, the ‘normal’ variety, is viewed as a common illness compatible with mild malaria, and the ‘yellow’ variety, lfa enche me amu, which causes yellowish discoloration of the eyes, is the severe form. Yellowish discoloration of the eyes, presumed to be jaundice, is the most popular symptom used for identification of severe malaria. This differs from the clinical definition of severe malaria (WHO, 2004), which includes jaundice among other important symptoms, and as such it will be difficult for traditional healers to
recognize those life threatening symptoms of severe malaria requiring prompt referral to a health facility.

In this study only 13% of those interviewed mentioned mosquitoes as a cause of malaria; instead, malaria is perceived by the majority as being due to heat from the scouring sun. This poor level of understanding of the cause of the disease was also observed in a Tanzanian study which reported that concepts of causation were different from those of Western medical knowledge (Gesler et al., 1995a). The implication is that this poor knowledge of the mosquito-malaria link may have an adverse effect on malaria control efforts. Obviously, if mosquitoes are not connected to malaria transmission, the need to prevent mosquito bites using bednets cannot be properly appreciated (WHO, 2003b). However, a study conducted in Ghana showed that the understanding of an association between mosquitoes and malaria did not predict bednet usage and that the primary reason for bednet usage was avoidance of the nuisance of mosquito bites and not necessarily to prevent malaria (Agypong & Manderston, 1999).

Traditional healers had reasonable knowledge about the signs and symptoms of malaria as it is defined by Western medicine and this may contribute positively to control efforts. The symptoms associated with malaria were quite varied and ranged from fever, loss of appetite, weakness, headache, dark yellow urine to vomiting and restlessness. A high recognition rate of malaria symptoms has also been reported in Tanzania (Gesler et al., 1995a), and this may be attributed to the fact that the study community had been exposed to some educational activities which took place about five years ago, with the distribution of insecticide-treated nets to those who were willing to pay. The traditional treatment of malaria, as reported in this study, included bathing with herbs, which may have the same effect as that of a sponge bath used to lower a child's body temperature and may therefore be regarded as being beneficial. Having said this, further study is needed to investigate the effect of the herbal remedies that are given orally. Traditional healers are not usually consulted for mild illnesses. The relatively minimal use of traditional healers for treatment of malaria was noted in previous studies in Nigeria (Obereander & Ekeredan, 2000) and in other studies elsewhere (Agypong, 1990; Espino, 1992). This may be attributed to the fact that people already know how to treat malaria with traditional or Western medicines. The implication is that they are not important providers of treatment for mild febrile illnesses in this setting.

The odida, i.e. convulsions, is the second most common presentation of severe illness and from the description given it is compatible with the illness condition referred to as degedge, a term used to describe severe malaria in many parts of Kenya and Tanzania (Mwenesu et al., 1995; Mwavamba et al., 1996; Winch et al., 1996).

On the cause of the odida, most traditional healers are of the belief that it is inherited and this would explain why it does not occur in every child. Some also believe convulsions to be due to evil spirits. In Africa it is a common belief that convulsions are of spiritual origin and therefore treated from that point of view (Mwenesu et al., 1995; Winch et al., 1996). There was no perceived relationship between malaria and convulsions, so mild and severe malaria are regarded as distinct conditions with different local terms, etiological factors, symptoms and treatment.
Past studies have shown that severe manifestations requiring treatment by traditional healers are often associated with supernatural causes. It has been suggested that when symptoms change abruptly or when treatment does not provide the expected results, supplicants of witchcraft or spirits can emerge. The reinterpretation of illness from 'natural' to witchcraft or spirit causes can mark the turning point for moving from biomedical to traditional health care providers (Moore & Ribera, 1998).

The majority of people who resort to traditional healers if the illness gets worse, since complications such as convulsions are perceived to be managed better by them (Mweusi, 1993). The most popular method of treatment for severe malaria is the administration of herbal remedies, which in this study they all agreed was very effective. The practice of making incisions on a convulsing child is dangerous. The sloughers associated with using unsterilized instruments for making an incision cannot be over-emphasized; they range from tetanus infection to the transmission of Hepatitis B and HIV infection. There is also the risk of burns when a child's legs are placed near a fire. None of the healers would treat severe malaria with compound medicines. Similar findings were observed in the Tanzanian study, where in addition to herbal treatment, chicken blood was applied topically (Makumbi et al., 1996). This study found that local remedies, some containing dangerous components, were sometimes used. Udu aka, i.e. palm kernel oil, which is popular, could cause chemical conjunctivitis when applied to the eyes, which may lead to blindness. Use of dangerous components was also reported in the western part of Nigeria where cow urine is used (Ramakrishna et al., 1983-89). This results in considerable delay in referral to a health facility, as was also found in coastal Tanzania (Makumbi et al., 1996).

Although traditional healers are not the main source of treatment for mild malaria illness, they are the key practitioners in the treatment of severe malaria, as shown in this and other studies (Birger, 1994; Mweusi et al., 1995; Wambe et al., 1996; Makumbi et al., 1996). They also change their treatment from health facilities and are therefore economically more accessible (Addo-Amaquaye, 1977). Traditional healers were found both in the central and peripheral areas of the study community, so they are the group with the greatest potential to improve access to care. In Nigeria, the traditional healing system plays an important role in health care delivery and about 70% of the population depend on traditional healers for most of their ailments. The findings of this study show that the majority of traditional healers would not refer cases to a health facility because they believed in the efficacy of their herbal remedies. Some did refer cases that did not respond to their treatment to either a health facility or another traditional healer. However, this frequently occurred late, after several stages of traditional herbal remedies that always take more than 1 week, thereby resulting in long delays before appropriate treatment is received. Differing results were obtained in Tanzania where almost all traditional healers would refer patients to a hospital or dispensary when their own treatment failed or when they knew the patient would be better treated in a health facility (Cleland et al., 1995).

A study in the Gambia showed that a delay in seeking treatments is an important factor in mortality from malaria. The mean duration of symptoms in children who died from malaria was only 2.8 days (Greenwood et al., 1987).
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Conclusion

The fact that traditional healers are seen as specialists in the treatment of severe disease, especially convulsions, suggests that they are in a position to have an impact on malaria-related morbidity and mortality. It will now be for us to seek the support of traditional healers in efforts to improve referral practices for treatment of severe malaria. The potential for successful collaboration with traditional healers in public health interventions has been demonstrated in several African countries (Warren et al., 1982; Green et al., 1993, 1995).

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