

**AN ANALYSIS OF UTILIZATION OF TRADITIONAL MEDICINE  
IN KADUNA STATE, NIGERIA**

**BY**

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**ZARIA, NIGERIA**

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## DECLARATION

I declare that the work in this dissertation entitled, ‘An Analysis of Utilization of Traditional Medicine in Kaduna State, Nigeria’ has been performed by me in the Department of Sociology, Ahmadu Bello University, Zaria. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other Institution.

Jacob Shekari Kura GANDU  
Name of Student

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## CERTIFICATION

This dissertation entitled AN ANALYSIS OF UTILIZATION OF TRADITIONAL MEDICINE IN KADUNA STATE, NIGERIA BY JACOB SHEKARI KURA GANDU meets the regulations governing the award of the degree of Doctor of Philosophy (Ph.D) of the Ahmadu Bello University, and is approved for its' contribution to knowledge and literary presentation.

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## **LIST OF ABBREVIATIONS**

CAM	-	Alternative and Complementary Medicine
FGD	-	Focus Group Discussion
HIV/AIDS	-	Human immunodeficiency virus/acquired immunodeficiency syndrome
IDI	-	In-depth Interviews
LGA	-	Local Government Area
LFN	-	Law of the Federal Republic of Nigeria
MM	-	Modern Medicine
MHCPs	-	Mental Health Care Providers
NEEDS	-	National Economic Empowerment and Development Strategy
NAFDAC	-	National Agency for Food and Drug Administration and Control
NPC	-	National Population Commission
NGOs	-	Non-Governmental Organisations
SAP	-	Structural Adjustment Programme
STIs	-	Sexually Transmitted Infections
TBS	-	Traditional Bone Setting
TBA <sub>s</sub>	-	Traditional Birth Attendants
TM	-	Traditional Medicine
THs	-	Traditional Healers
TOPs	-	Traditional Orthopedic Practitioners
TMPC	-	Traditional Medicine Practice Council
TMPs	-	Traditional Medical Practitioners
UNAIDS	-	United Nations Programme on HIV/AIDS
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
WHO	-	World Health Organization



## Abstract

Individuals all over the world continue to utilize traditional medical care, despite the increased availability of modern medicine. However, there is very little understanding of why this is so. In recent years, there has been a steady erosion of faith in the ability of modern medicine to provide for all of society's health care needs. According to World Health Organization (WHO), a vast majority of people in Africa have turned their attention to Traditional Medicine for their primary health care needs because of the challenges of modern health services. Many factors contribute to people's inclination to see a traditional healer rather than a modern medical professional ranging from wide aspects of socio-demographics variables. Documentation of Traditional Medicine (TM) utilization is insufficient and most studies conducted so far are limited and focused on comparing traditional healers and modern medical doctors. Whereas findings of studies on why this trend persists remain little understood, there is dearth of data from research on utilization of Traditional Medicine in Kaduna State. To enhance the understanding of utilization of Traditional Medicine in Kaduna State, the following objectives were examined: services provided by traditional medical practitioners (TMPs); type of diseases that TMPs treats, the socio-cultural and economic factors influencing utilization of Traditional Medicine; and the socio-demographic characteristics of those who patronize Traditional Medicine. A Marxist political economy perspective was used to explain the increasing patronage and utilization of traditional medicine in this work. To achieve the objectives of the research, a multi stage sampling method was applied such that both quantitative and qualitative methods of data collection were used. A total of 1,242 respondents were sampled for the survey, twelve FGDs were conducted, 93 clients of traditional healers, 57 traditional healers, 18 key informants, and seven modern health personnel were interviewed for this study. Findings indicate that income constraints are associated with patronage and utilization of traditional medicine. The users reported high levels of satisfaction that are attributable to procedural factors. Findings of the study suggest that traditional health practitioners are consulted for 29 different types of health issues by clients from diverse socio-demographic backgrounds in Kaduna State. The study reveals that 96 percent of respondents reported having ever utilized Traditional Medicine for a health issue. Malaria/Typhoid were the most (33.9%) sought treatment. The study revealed that bone setting and mental healing were considered the most satisfactorily treated. This study established that home delivery services by traditional healers partly account for high patronage and utilization of Traditional Medicine. Specifically, the study found that Traditional Medicine promotes health care through its curative, preventive, promotional and rehabilitative services using various therapeutic herbs to improve the quality of people's health. Significantly the services of TMPS are filling the unmet gap left by modern health care in the state. It is recommended that traditional medicine should be incorporated into the Primary Health Care (PHC) system because of its efficacy and affordability. For this to be effective, government should establish modalities to control the activities of practitioners of Traditional Medicine. This can be achieved when government's health policies make provision for setting up of traditional medical board and educational institutions to train people in the field of traditional medicine. Moreover, if practitioners of traditional and modern medicine (MM) come together in small groups to share knowledge and expertise, they can do better in partnership.

# CHAPTER ONE

## INTRODUCTION

### 1.0 Background to the Study

It is given that Traditional Medicine has gained increased patronage in the world over (Rainer, 2013). This study examines the utilisation of Traditional Medicine (TM) in Kaduna State of Nigeria. For those health seekers who patronise or utilize the traditional healthcare services in Kaduna State, the study examines the factors and types of health challenges that influence their decisions.. By studying the utilisation of traditional healthcare services in Kaduna State, this study provides important but rare data on the intricacies associated with its practice. Also the study unveils the challenges that emanate from the regulatory means set by the Kaduna State Government to check this informal form of medical practice and protocol in the State. The objective is to also generate data that could contribute in speaking to appropriate measures and standards that could be put in place to ensure quality and safety of Traditional Medicine practices in the State. The study also provides the baseline data for researchers for further investigations to determine the trend of utilisation and challenges faced by Traditional Medicine users in the State.

Traditional medical care services are usually provided by practitioners who are popularly referred to as Traditional Healers (THs). THs are health care providers or practitioners who typically have little or no formal or modern medical ‘training’ from recognised medical institutions but are recognised as ‘Traditional Doctors’ by local communities (Agbor and Naidoo, 2011).

To become a Traditional Healer, those on apprenticeship are required to acquire the skills necessary for the job. Training of would be Traditional Healers, though informal, comes in different forms and context. For instance, one of the training comes in the form of health promotion guided through food taboos in which lay down rules are developed to guide the dietary practices of people (Colding and Folke, 1997). Most teaching is done on the job while working as a learner. Through such trainings, the apprentice learns their job in exchange for continuing labour for an agreed period of time after which he or she is expected to acquire the skills to be on his/her own. This can simply be described as “on the job training”. This training aspect of the African Traditional Medicine prepares practitioners to be responsible, accommodating, hardworking, good listeners as well as having a sense of pride in themselves, their tradition, culture and society.

For the purpose of this study, Traditional Medicine is seen as the sum total of knowledge, skills, and practices based on indigenous theories, beliefs, and experiences passed on to present generation by preceding generations for the need of maintaining good public health, health care prevention, local health care diagnostic services and the treatment of illnesses affecting people. The sum total of the Traditional Medicine approach is therefore contextualised in the traditions of every culture which has been passed on from generation to generation. Traditional health care, therefore, connotes all health care services or medical practices that are indigenous or therapies that are non-western or non modern. In popular parlance, Traditional Medicine or traditional health care practices are conventionally regarded as non western health care practices or protocols. In this study, Traditional health care practices and Traditional Medicine is

therefore used interchangeably. The World Health Organization (WHO, 2002:1) defines Traditional Medicine as “the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to various indigenous cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses”.

Traditional Medicine therapies include medication which in some cases may involve the application of herbs, animal parts and/or minerals and other substances. Traditional Medicine therapies that involve non-medication or substances are usually done mainly without the use of medication. This is seen in the healing practices like acupuncture, needles used; manual therapies and spiritual therapies that are associated with warding off of evil spirits. Also, message and casting out of evil spirit.

Nations and local communities all over the world have evolved different versions of traditional medical practices for generations, and found such practices to be valuable, reasonable and still depend on them for their health care needs. Many of these nations have their own indigenous forms of health care such as yoga in India, acupuncture in China, and Native American dream catchers, amongst the indigenous population of North America (WHO, 2002a). Due to the sustainability, utility value and relevance of TM among local communities all over the world, individuals continue to utilise Traditional Medicine. This reality is partly and primarily responsible for why Traditional Medicine has continued to be complementary sources of health care to modern medical practices.

According to Rainer (2013:1), about half of the population of Latin America uses Traditional Medicine as primary health care. WHO (2003b) estimates that in Chile, about 71% of the population use Traditional Medicine. In the same study, 40% of people in Colombia and about 80% in the African continent were said to have utilised Traditional Medicine. Similarly, WHO (2011) estimated that between 70% and 95% of people in the developing countries utilized Traditional Medicine. This report went further to state that even people in developed countries utilize Traditional Medicine in one form or the other. Wassie, Aragie, Taye, and Mekonnen, (2015:1) describe in graphic details the increasing and growing global significance of Traditional Medicine in both the developing and developed world thus:

The widespread use of TM has resulted in traditional health care becoming a lucrative, multinational business. Billions of US dollars are spent annually on traditional medicine in many developed countries. For example, in 2012, 32 billion dollars were spent in the United States of America on dietary supplements, an amount expected to increase to 60 billion dollars in 2021. The World Health Organization estimates that the global market of traditional medicine is approximately US \$83 billion annually. Traditional medicines also contribute to the development of pharmaceutical treatments. As much as one-third to one-half of pharmaceutical drugs was originally derived from plants. Some prominent examples including digitalis, morphine, quinine, and vinca alkaloids were obtained from plant sources.

The foregoing significance and evidence of the global use and utilisation of Traditional Medicine further validates the earlier Alma-Ata Declaration of 1978 on Primary Health Care, which recognises the role of Traditional Medicine and its practitioners for attaining health for all (WHO, 1978). The declaration urges member countries to include Traditional Medical Practitioners (TMP's) who are duly trained to work as a health team and to respond to the expressed needs of the community.

Non-western medicine that has wide spread use and utilisation, is known in different countries by different names. For example, in the countries of Asia such as India, medicine is generally referred to as “Indian system of medicine”; it is indigenous to the Indian subcontinent and is a mix of six different forms of medicine currently designated with an acronym called AYUSH which stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (Samal, 2016: 91). In the case of China, it is referred to as *Acupuncture*; in North America, it is popularly referred to as Complementary and Alternative Medicine, Chiropractic, Homeopathy, (Robinson and Zhang, 2011; Abodunrin, Omojasola, Rojuginboka, 2011). In Nigeria, it is referred to as “Traditional or herbal Medicines” (Awodele, Amagon, Wannang, & Aguiyi, 2014; Moreira et al. 2014). Others refer to it as “Magic medicine”, (Abbott, 2014, Raphael: 2011), and “Alternative Therapies in Health and Medicine” (Barrett, Kiefer, & Rabago: 1999),

A number of factors which are responsible for the widespread use of Traditional Medicine have also prompted the sudden concern and need to study the rate of utilisation of Traditional Medicine across the world. For instance, Dada, Yunusa and Giwa (2011) established that Traditional Medicine enjoys high patronage and confidence from the communities where it exists because of its relevance to health issues. Abdullahi (2011:119) shares this view and went further to posit that “Traditional Medicine is more accessible, readily available and affordable than modern drugs and therefore enjoy higher patronages from people”. Other reasons adduced for increase in the utilisation of Traditional Medicine rests on the fact that modern medical care is increasingly becoming expensive and out of the reach of majority of the population particularly in the rural areas

of developing societies. Closely related to the foregoing is the fact that Traditional Healers are also known to charge based on ability to pay and terms of payment are flexible. This runs contrary to modern health system and facilities who will always insist on cash payment before treatment (Nxumalo, Alaba, Harris, Cherisch, Goodge, 2011).

Related factors include the fact that a number of Traditional Medicines are important and possess effective therapeutic regimens in the management of a wide spectrum of diseases some of which may not be effectively managed using Modern Medicine. According to Mander, Ntuli, Diederichs, and Mavundla (2007:190) that among South African black population, Traditional Medicine “is thought to be desirable and necessary for treating a range of health problems that Modern Medicine does not treat adequately”. In Nigeria, effective medicinal plants in the management of a range of diseases have been adequately documented (Blench and Dendo 2006; Ogunshe, Lawal and Iheakanwa 2008) including those used for the treatment of opportunistic infections associated with HIV/AIDS. These yet to be proved claims, as reported by Kajuna (2009) has led researchers in Nigeria and other countries to conduct further research on Traditional Medicine used for the treatment of malaria, HIV/AIDS, diabetes, sickle-cell anaemia, and hypertension in order to assess their safety and objective therapeutic efficacy.

## **1.1 Statement of the Research Problem**

Scholarly studies on Traditional Medicine patronage and utilisation such as Oluwabamide (2007); Fakeye, et al., (2009) and Lucas (2010) revealed that Traditional Medicine is assuming greater importance in both primary and secondary levels of health care for individuals and communities in the developing world. An earlier study conducted by WHO (2003a) suggests that compared to Modern Medicine, Traditional Medicine seemed to enjoy a wider acceptability among the people as an estimated 80% of Africans

use it when they needed primary health care. Specifically, in Nigeria, Owumi and Taiwo (2012) aver that the Nigerian Primary Health Care is catering for less than 20% of potential patients, while Traditional Medicine caters for between 70 and 80 percent of various categories of Nigerians for the prevention, diagnosis and treatment of social, mental and physical ailments. Given the foregoing reality, the place of Traditional Medicine in health care in Nigeria and Kaduna State in particular requires a detailed investigation to ascertain the rate and extent of utilization by potential clients. This traditional health care has suffered relative neglect not only by Nigeria's national development planning architecture over the years, but by the nation's health care system development policies.

The expanding and growing significance of Traditional Medicine has been reported in many literatures. For instance, Abdullahi (2011:118) observes "that Traditional Medicine continues to be the first port of call for rural communities health care in Nigeria". Buttressing the significance of Traditional Medicine in Nigeria's health care system, Omoruan, Bamidele, & Phillips (2009:108) reveal that "about 55% of the total population in Nigeria lives in the rural areas, where modern health care services are inadequate and inaccessible". In cases where modern health care facilities exist, most of them are understaffed, poorly maintained, undersupplied and the few available health care personnel execute their duties with limited operational facilities and resources. To further compound the problem, the patient-doctor ratio which is 1:4000 in Nigeria is very high compared to WHO standard of 1:600 (Alagboso, 2015). The few available modern health care facilities are over stretched to such extent that it is common to find patients waiting overnight in the hospital premises or may arrive hours before the day's work begins to be at the head of the queue in search of care. The problem is such that even after spending many hours on the queue, patients seeking for modern medical care do not always get the chance of being attended to as many return home without receiving the



treatment they seek. Therefore, such clients are left with no alternative but Traditional Medicine. Despite all these contributions, Traditional Medicine is poorly documented with practices that are difficult to transpose from one individual to another.

This study is driven by the need for social science to expand its research scope to document the cultural and socio-economic profile of Kaduna State residents who utilise the services of Traditional Medicine as well as understanding the complex political economy challenges existing in the modern health care system that push them to seek health care from traditional sources. The patient's cultural perception, acceptability, perceived efficacy, affordability, accessibility and psychological comfort and which are the underlying logic of their preferences for Traditional Medicine is buttressed in this work. It is imperative because one study (Birhan, Giday, & Teklehaymanot, 2011) shows that Modern Medical Practitioners seem to know have little knowledge about patient's cultural perspective to illness. This study also examines the various forms of traditional medical services available to the people of the State.

It is the identification of the forgoing existing gaps in the literature and our knowledge on the relevance and role played by Traditional Medicine to the overall health care architecture in Nigeria; that this study seeks to fill the gaps by providing reputable knowledge on Traditional Medicine utilisation in Kaduna State. It is in that vein that this study critically explores and analyses the utilisation of Traditional Medicine and ascertained its contributions to general health care system and architecture in Kaduna State.

## **1.2 Research Questions**

This study provides answers to the following questions:

1. What are the medical health services provided by Traditional Medical Practitioners in Kaduna State?;
2. For which health problems do clients mostly seek Traditional Medicine in Kaduna State?;

3. What are the socio cultural and economic factors influencing patronage and utilisation of Traditional Medicine by health care seeking patients in Kaduna State?;
4. What are the socio-economic profiles of clients who patronise traditional health care services in Kaduna State?; and
5. To what extent does Kaduna State Government regulate the practices of Traditional Medical Practitioners in the State?

### **1.3 Aim and Objectives of the Study**

The aim of this study is to examine the patronage and utilisation of Traditional Medicine by citizens of Kaduna State. This broad aim translates to the following specific objectives:

1. To determine the type of medical health services provided by Traditional Health Practitioners in Kaduna State;
2. To determine the health problems and challenges for which Traditional Medical Services are sought by health care seeking citizens in Kaduna State;
3. To examine the socio cultural and economic factors influencing utilisation of Traditional Medicine by patients in Kaduna State.
4. To investigate and analyse the socio-economic profiles of clients who patronise Traditional Medicine in Kaduna State?
5. To identify the extent to which Kaduna State Government's regulatory mechanism for the practice of Traditional Medicine is safe.

### **1.4 Significance of the Study**

The significance of this study is located squarely on the increasing role that Traditional Medicine is playing in the lives of millions of people in developing economies. At the threshold of the 21<sup>st</sup> century, it was reported that in Africa, up to 80% of the population rely on herbal medicine for primary health care (WHO, 2002a) either because they were convinced that this type of treatment was pure“natural” and then “risk-free”; or as an addition to treatment for a chronic, debilitating or incurable disease (WHO, 2001a and Adesina, 2007). In Ghana, Mali, Nigeria and Zambia, the first line of treatment for 60% of children with high fever resulting from malaria is associated with the use of herbal medicine at home (Darko, 2009; Okigbo and Mmekka, 2006; WHO, 2003a; WHO, 2003b). In their study of the choice of traditional or modern treatment in West Burkina-Faso (Carpentier et al., 1995) discover an increasing demand for Traditional Medicine in the case of rheumatic and neurological complaints. Roberts (2001) found that about 70% of the Ghanaian population depended primarily on traditional medicine. In South Africa, about 27 million citizens, mainly Africans use Traditional Medicine to treat various kinds of ailments (Lekotjolo, 2009).

This study has generated increased knowledge and added to literature in the academic field about Traditional Medicine. The study portrays the contributions of traditional health care and creates awareness of the limitations of modern health care in Nigeria. It further expands knowledge on the importance and use of traditional health care in Nigeria’s health care system. Increased knowledge about traditional health care can foster ways to exploit health care delivery. Specifically, it is most useful to the Nigeria’s Ministry of Health, which is directly responsible for the provision of public

health services delivery in terms of policy formulation, monitoring and evaluation, resource mobilisation and regulation of delivery health services.

Given the fact that modern health care system in Nigeria has not been able to cater for all the health needs of the majority of Nigerians, this study becomes very significant because it addresses the relevance of Traditional Medicine in the overall health care system of the country. The most significance of this study is its attempt to analyse and synthesise the extent to which health care seeking citizens perceive and utilise Traditional Medicine in Kaduna State of Nigeria. This study also investigates the social and economic factors influencing the utilisation of Traditional Medicine. This new knowledge derives from the study can be used to guide future research intervention designs and review existing health care systems and policies with the objective of improving health care delivery and development in Nigeria.

Therefore, the justification for the study is that social scientists and other relevant stakeholders who are interested or involved in promoting alternative health care services and to bring about change in peoples' attitudes to Traditional Medicine will find this work useful. After all, an understanding of the intricacies and the need to standardise the practice of Traditional Medicine is a pre-requisite for Nigeria's evolving the health care architecture. Therefore, this study will not only provide valuable information on the extent to which Traditional Medicine is patronised and utilised by health care seeking citizens in Kaduna State; the type of medical health services provided by traditional health practitioners; investigate and analyse the perspectives as well as the socio-economic profiles of clients who patronise traditional health care services; determine the

health problems and challenges for which traditional medical services are sought by health care seekers; as well as identify the extent to which Kaduna State Government's regulatory mechanism for the practice of Traditional Medicine is effective.

Although there is a stereotypical and common sense apprehension against alternative medical practices in general and Traditional Medicine in particular, it is significant that in the aftermath of the excruciating negative effects of Structural Adjustment Programme (SAP) and other ongoing litany of liberal policies on the health sector in developing countries, this study shifts attention to the relevance or otherwise of Traditional Medicine by focusing of Traditional Medicine in Kaduna State. Analysis of clientele of Traditional Medicine, Traditional Healers, the volume of patronage of the general public, utilisation and perceptions of Traditional Medicine and assessment of government regulatory policies using recently collected data is most likely to provide the needed insights into the place and role of Traditional Medicine in Nigeria health care system. A study of this nature will go a long way to stimulate further research in developing a holistic framework for understanding the significance of Traditional Medicine to health issues in Nigeria.

### **1.5 Scope of the Study**

This study examines the extent of patronage and utilisation of Traditional Medicine as a medical health care system by citizens of Kaduna State. Specifically, the study focuses on the services provided by traditional healers and how they have contributed to the medical needs of the citizens of Kaduna State. The study also focuses on the profiles of clients who patronise Traditional Medicine in the State. In addition, the

study examines the types of health conditions in which Traditional Medicine is sought. This study excludes healers who use laboratory, chemical and biological test methods to evaluate the efficacy of herbal medicine, but basically the testimonies of Traditional Medicine clients, and the perceptions or socio-cultural beliefs and practices related to their use. It also does not encompass spiritual treatments, but the physical and material aspects of herbal medicine. The study covers the three Senatorial Zones of Kaduna State: Southern, Central and Northern.

In all, this chapter concludes that the significance of a research on Traditional Medicine and its role in the overall health care system has gone beyond its healing capacity but understanding the political economy that drive health seekers to patronise it. Therefore, the thrust of the study is seen by crafting out the drivers that influenced the researcher to delve into the ramifications surrounding the social and economic problems that pushed Nigerians to utilise traditional healthcare services in Kaduna State. It provides both the context and exposes the reader to understand the background responsible for the expanding and growing significance of Traditional Medicine by raising pertinent research questions and objectives. As the preliminary part of the study, this chapter acknowledges that the relative failure of modern health care system to cater for all the health needs of majority of Nigerians, seem to push increasing number of people to patronize Traditional Medicine. This chapter also partly explains why the social scientists and other relevant stakeholders who are interested or involved in promoting alternative health care system need to investigate the social and economic variables that can best explain these emerging phenomena in the health care system in emerging economies.

## **CHAPTER TWO**

### **LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

#### **2.0 Introduction**

This chapter reviews existing literature on Traditional Medicine. The objective of reviewing relevant literature is to provide insight on the subject matter under investigation. Issues/themes covered in the empirical review of literature includes, the services provided by traditional healers; the socio-economic profiles of clients who patronise traditional health practitioners; the health challenges for which traditional medical services are sought; and the role played by government regulatory agencies in traditional health care.

Apart from reviewing relevant conceptual and empirical literature, this chapter also presents the theoretical framework on the Political Economy of Traditional Medicine. The theoretical underpinning of this study which is based on Marxist Political Economy analyses the social and economic contradictions that push more people into utilising Traditional Medicine and less in utilising Modern Medical Services because of the high cost of accessing the latter.

## **2.1 Traditional Medicine: An Overview**

Prior to the advent of Modern Medicine in most Sub-Saharan African countries, traditional medical practices which include the use of herbs/plants and other products from plants and animal parts as well as spiritual procedures, were the main remedies for nearly all kinds of ailments (Mahomoodally, 2013). Despite the increase in the use of Modern Medicine in African countries at the threshold of the 21<sup>st</sup> century, the use of Traditional Medicine is also witnessing huge patronage as more Africans continue to rely on it for their health care needs. Adjei (2013: 2) corroborates this view in his words:

...another factor that validates the relevance of herbal medicine is that herbs remain the foundation for a large amount of commercial medications used today for treatment of heart disease, blood pressure regulation, pain remedies, asthma and other health problems...For instance, Artemisinin which is extracted from the Chinese herbal wormwood plant *Artemisia annua* is the basis of more effective antimalarial drugs... Herbal medicines are being used increasingly as dietary supplements to fight or prevent common maladies like cancer, heart disease and depression. The public and herbal medicine community is extolling the miraculous medical benefits of the ginkgo biloba, St. John's wort, moringa, sunflower seed, black cohosh and many other herbs...In spite of all these prospects, herbal medicine remains poorly integrated into the current health care structure of Ghana.



The term “healthcare” varies in meaning depending on the context it is used. Conventionally, it is an important determinant in promoting the general physical and mental health and well-being of people (WHO, 2010). Health can therefore be conceived to mean a state of complete physical, mental, and social well-being and not just the absence of disease and sickness or frailty (WHO, 1946). In political terms, health (well-being) of a people can be conceptualised in terms of what governments do and neglect to do about the world of medical care (Marmor, 2013). Sociologically, three major perspectives offer different types of explanations, but together they provide us with a more comprehensive understanding of health care. First, while Functionalism emphasises that good health and effective medical care are essential for a society’s ability to function; the Political Economy of Health emphasises the extent of inequality in accessing the quality of health and health-care delivery for citizens of a given society or economy (Weitz, 2013). The political economy explains how social and economic variables that impede the ease of access to modern medical services which in turn pushes people to utilise traditional medical alternatives (Gandu, 1992). The Symbolic Inter-actionist Approach emphasises that health and illness are *social constructions*.

For the purpose of this study, health care refers to the maintenance or restoration of physical health, mental health and social well-being. This can be achieved through prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairment in human beings. Utilisation is seen as the act of making use of health care services provided by TMP or self-applied for therapeutic or healing purposes

Traditional Medicine is used to describe a variety of indigenous health care practices employed by people including the prevalence of a wider belief system that

encompasses the triune nature of man that may come in the form of physical expression and, could manifest in mental as well as spiritual forms (Hucks and Tracy, 2013). In general terms, both at the diagnostic and treatment levels, the operational platform of Traditional Medicine tends to focus on the whole condition of the individual patient or health seeker, rather than on the particular ailment or disease in question (WHO, 2002). This in part explains why Bratman (1997) and Patwardhan (2005) suggest that unlike modern medical health care practice, Traditional Medicine whose central focus is more on healing does not fall within the realm of bio-medicine. Their position is attested by Bodeker (2005) that in North America and Western Europe, Traditional Medicine is referred to as Complementary and Alternative Medicine (CAM).

Informed that Traditional Medicine is therapeutically conceived to be the sum total of health practices, measures, ingredients and procedures given to present generations from years past which has enabled human beings of all cultures to fight disease, to lessen pains due to ill health and to provide treatment (WHO, 1978). Traditional Medical system is a health care practice since man's civilization protecting and restoring human health before the coming of Modern Medicine. Plants of Medicinal values are the main drivers of Traditional Medicine and also the earliest known-health-care products to mankind.

In view of the diverse nature of Traditional Medicine as an all encompassing therapeutically health care system; several definitions and conceptions have been advanced by scholars. While Helwig (2005:374) classifies "Traditional Medicine as a holistic discipline involving indigenous herbalism and indigenous spirituality, typically involving diviners, midwives, bone setters and herbalist". Abdullahi (2011:1) refers to

traditional medicine as “ethno-medicine, folk medicine, native healing, and alternative medicine”. He considers it as the oldest form of health care system that has stood the test of time. His use of the term “folk medicine” connotes health practices arising from superstition and cultural beliefs, while “ethno-medicine” stands for the health practice by a specific indigenous people.

Diversity in the classification and definition of Traditional Medicine indicates that developments have taken place without a clear standard body of medical thought and practice to the system. This implies the need for a standard and accepted definition that would serve as a working tool for the various definitions of Traditional Medicine (Aamir, 2014). Bognar (1998:76) is of the view that Traditional Medicine is an “alternative treatment because it represents continued hope in quest for survival”. However, whether alternative or complementary, Traditional Medicine, or *Ayush*, all refer to a variety of medical practices that can be bound together in what Patwardhan (2005:31) describes as “logic of reductio-ad-absurdum, defined by criteria of absence from the mainframe of what has come to be known as modern medicine”. In a similar vein, Dawkins (2003:58) submits that "there is no alternative medicine; there is only medicine that works and medicine that does not work". To agree to this assertion, is to infer that if any medicine is to be an alternative to another, Modern Medicine would be more appropriate because it is an off-shoot of Traditional Medicine. According to Stepan (1985:281), “Traditional Medicine is interpreted in a broad sense to include inter alia medicine, practices of alternative medicine and practices of traditional healers” because of its diverse dimensions WHO (1976:3) formulates a more all-embracing definition of Traditional Medicine as: “The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observations handed down from generation to generation, whether verbally or in writing”. The foregoing definition by the WHO suggests that some concepts and practices of Traditional Medicine obtainable from Africa have been taken into account. Therefore, this study sees Traditional Medicine as encompassing the diverse health approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercise applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illnesses in humans.

Any person endowed with the knowledge and skills to provide the health needs of a community but has not attended any form of formal modern training can be referred to

as a traditional healer. As part of their services, traditional healers prescribe medicines that are prepared using animal parts, herbs, water, alcohol, roots, leaves and tree barks available in their immediate natural environment. These services are covered in the World Health Organisation (1976:4) definition which states that a traditional healer is:

A person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.

The foregoing definition incorporates certain components of traditional healers yet some aspects of it have tended to be non-specific in nature. For instance, its inclusion of ‘witch-doctors’, diviners, seers, or spiritualists would seem to suggest that scientific research into such areas of Traditional Medicine would be very difficult or almost impossible because those are not amenable to any of the human senses, hence they cannot be scientifically studied and recorded (Sofowora, 2008).

In the African context and African reality, ‘witch-doctors’, diviners, seers, or spiritualists are part and parcel of integral components of the practice of Traditional Medicine. Diagnosis in Traditional Medicine involves a systematic quest for answers to the genesis of a particular ailment to determine who or what cause it, and why (Ngubane, 1977). The answers come from the cosmological beliefs of the people (Onwuanibe, 1979). Diagnosis is reached either through spiritual revelations, physical observation past, personal or family history. In circumstances where divination is needed, diagnosis may come in the form of combination of observation, patient self diagnosis, understanding the direction of a small metal ring movement which is hung on a thread. In addition, cowries direction points, broken pieces of metals and wood thrown randomly on

the ground or mat fall, observe the marks left on sand by an animal entice with food and unfamiliar footprints. Interpretation and understanding of signs or words made by possessed persons in trance, and water gazing in which the diviner communicates with the right spirit whose image he sees reflected in a pot, calabash or water (Iddrisu, 2017). The preparation and administration of Traditional Medicine is based on indigenous methods whereby treatment is prescribed, usually consisting of herbal remedies that are considered to have healing abilities and spiritual effects (Onwuanibe, 1979).

The art and science of traditional medical practices in Africa include ritual sacrifice to mollify the ancestors, ritual and magical strengthening of people and possessions, steaming, purification (like ritual washing, or the use of emetics or purgatives), sniffing of substances, cults or cultic practices, wearing of charms, and body piercing among others (Truter, 2007). Scarifications, blood-letting, circumcision and cupping or drawing of blood are the commonest surgical procedures performed by African traditional healers and these are sometimes performed in the presence of other people. The letting of blood is sometimes used as a way of casting out the illness. If the cause of the sickness is perceived to be bewitchment, a number of cultic practices or rituals may be performed in order to cast out the spell including the inducing of vomiting, enemas, blood-letting, whistling or elaborate rituals such as animal sacrifices. In Traditional African Medicine, the main objective of occultic practices and or rituals is to reinstate stability and harmony in terms of the beliefs and values of an established culture. These rituals lessen patients' worry and serve to alleviate feelings of guilt. End of the rituals often has a calming effect on the patient. A large part of the African traditional healer's practice is also devoted to counseling individuals (Truter, 2007).

Karim, Zigubu-Page, Arendse (1994:12) indicate that a variety of treatment methods are used in the administration of herbal medications including:

sucking of hot medicated liquid from fingertips, inhalation of powdered medicine in its dry form as snuff, rubbing of powdered medication into incisions, steaming or use of a vapour-bath, use of enemas for stomach complaints, use of fomenting treatment for aching feet, burning of incense which is said to appease the ancestors, use of an amulet manufactured from animal skin to ward off evil spirits.

These culture-bound conditions of spirit possession, sorcery, ancestral wrath, neglect of cultural rites or practices and defilement (Truter, 2007) are thought not to respond to modern medicine and must be treated by traditional healers.

In some cases, patients have been reported to use Traditional Medicine simultaneously with Modern Modern (Abdullahi, 2011). Wolffers (1990:14) states that “the wisdom behind combining modern and alternative approaches rest on the fact that the patients are seeking for what they need from the right source, and only absence or unaffordable desired of medical facilities can frustrate the choice”. Combining modern and alternative approaches in some African countries popularly referred to as “shopping treatment” (Freeman and Motsei, 1992:1185) is the interchangeable, consecutive or even concurrent use of both for the same ailment. Boonzaier (1985:237) states that patients attempt to get “the best of both worlds” and are absolutely happy to exchange freely between traditional and modern treatment. This wavering between the two systems of health care for treatment makes it difficult to determine the more effective one. Nevertheless, it would be of interest to know some of the health conditions that make patients to use the two types of treatments simultaneously in the succeeding parts of the chapter.

## **2.2 Health Care Services Provided by Traditional Health Practitioners**

Traditional healers are very ingenious and continue to play a key role in public health and in many spheres of people's lives especially in Nigeria and other developing economies where patients' population to physician ratio is high. The role of traditional healers cannot be over emphasised because of the enormous contributions they make in the health care delivery system. Apart from being 'medical knowledge storehouses' (Agbor and Naidoo 2011), they equally serve the important role of being educators on traditional culture, cosmology, spirituality, counselors, social workers, psychotherapists and custodians of indigenous knowledge/science (Mills, Cooper and Kanfer, 2005; Mokgobi, 2014).

Further more, King and Homsy (1997:221) note that "traditional health practitioners provide client-centered and personalised health care that is tailored to meeting the needs and expectations of their patients and paying special respect to social and spiritual matters". Even though Traditional Medical Practitioners may be regarded as unconventional, unorganised and unofficial by modern health care practitioners, the reality on ground shows that they have continued to play an important role in the health care delivery and their mode of operation is unique. In a study of Ethno-pharmacological use of plants in Ghana, Wodah and Asare (2012:807) found that 'traditional healers possess rich knowledge on medicinal plants and therapeutic activities'. However, Edwards (2011) observes that there are many coverts that healers are not ready to reveal to anyone. This is done to protect their rich cultural values from people who may use it illegally. According to UNAIDS (2006), 80-85 percent of Black South Africans utilise the services of Traditional Medical Practitioners in both rural and

urban areas for various kinds of ailments. The healers are the main custodian of this rich cultural aspect of health care for which Africans have always patronised (van der Geest, 1992). In the circumstances surrounding the expansion of modern medical practitioners and practice in Africa, traditional healers are still popular and relevant (Oluwabamide, 2007; Mensah and Gyasi, 2012).

In addition, herbalists, traditional orthopedic practitioners (TOPs), traditional birth attendants (TBAs), poison healers (PHs), spiritual therapists (STs), mental health care providers (MHCPs), healers specialized in eye, pediatric conditions, skin diseases among others are some of the specialty areas as described by scholars like Last and Chavunduka, (1986), Karim et al., (1994), Ogunbodede, (1999); Patwardhan (2005), Oluwabamide (2007) and Truter (2007). Even though each category has its own distinctive features and functions, these may often overlap so that borders become unclear because some healers treat two or more diseases.

Healthcare services provided by traditional healers are better appreciated when viewed in cases of emergencies like child birth, the onset of violent mental disorder, fracture, snake bites and so on. These usually occur in situation, where there is no Modern Medicine and only Traditional Medicine is available. Given the import of the foregoing and its relevance to this study, it is important to review the notable services provided by Traditional Medicine healers.

### **2.2.1 Traditional Birth Attendants (TBAs)**

The World Health Organization (1976:7) defines a traditional birth attendant (TBAs) as any “person who assists the mother at childbirth and who initially acquired her



skills delivering babies by herself or by working with other birth attendants”. In northern Nigeria where Islamic religious practice is predominant, most TBAs are females. But in Christian dominated parts of Northern Nigeria and other regions of Nigeria, both males and females are involved as TBAs. In child birth, the place of delivery is one of the determinants of maternal and child morbidity. It is noted, that there is a shortage of modern skilled birth attendants and the few ones available are unevenly distributed geographically (United Nations Children’s Fund, 2001). Therefore, TBAs continue to fill in the gap left by the modern birth attendants (Oshonwoh, Nwakuwo and Ekiyor, 2014). Most child deliveries in rural communities in Nigeria and African countries are usually conducted by TBAs. However, TBAs also exist in urban areas rendering their services as required (Tomedi et al., 2015). TBAs continued attendance at home deliveries suggests, however their potential in influencing maternal and neonatal outcomes (Falle et al., 2009).

TBAs occupy a prominent position in Nigeria. Between 60 and 85 per cent of births in the country are conducted by them, especially in the rural communities (Adesina, 2011). The preference for TBAs to skilled birth attendants (SBA) has been documented in Nigeria. Prata and Ejembi (2012:1288) found that of the 1,875 women enrolled in a community-based program to improve delivery outcomes in Zaria, Nigeria, 95% of who delivered at home, only 7% was attended by a skilled attendant. Doctor and Findley et al. (2012), in a survey of 6,882 married women in northern Nigeria, discover that only 26% of the women surveyed had received any antenatal care, 13% delivered in a modern medical facility attended by skilled birth attendant, and 86% gave birth at home under unskilled care. In a cross-sectional survey of health facilities in Shagamu Local

Government Area in Ogun State Nigeria, Adelaja (2011) observes that 67% of the 300 women studied delivered at home, and the majority assisted by unskilled attendants.

Empirical and normative evidences suggest high patronage of TBAs (Owens, 2011). They are usually the first point of call during pregnancies and at delivery. They command a high respect (Verney,2015) because they are familiar with the culture, show friendliness and empathy, low cost services, trust, are highly credible (Bergstrom and Goodburn, 2001) and usually have the backing of the traditional and religious institutions. In Onicha Community, Ebonyi State, most services are still provided by the TBAs (Ojua, Bisong, & Ishor, 2013). Ellis (1996) noted that some TBAs provide ANC to pregnant women prior to delivery and post natal care after delivery. They act as midwives, give advice and perform rituals associated with pregnancy and childbirth. They know how to diagnose pregnancy, confirm it and determine the position of the growing foetus. In addition, they perform the duty of massaging of the mother and see to the prescribed disposal of the placenta, give advice on post-partum, cord care and advise the mother on the nutritional and health benefits of exclusive breast feeding (Ellis, 1996 and Omoseyindemi, 2006). A few TBAs provide birth control medicines and advice, while others are consulted in cases of infertility in men and women (Chavunduka, 1994).

### **2.2.2 Traditional Bone Setters (TBS)**

Traditional bone setting (TBS) constitutes another important health care service provided by traditional health practitioners in Nigeria. TBS involves the manipulation of sprains, dislocations and fractures through the use of splints, massaging, and salves. This is similar to modern orthopedics practices. Indigenous traditional bone setting is an area where traditional medical practice has made spectacular development in terms of effectiveness in treating dislocations and fractures. Some medical researchers have attested to the positive contributions and competence of TBS. For instance, Singh and Bindra (2013) point out that a highly remarkable degree of expertise and skill is involved in the medical practice of TBS, especially as there are no radiological aids employed in their practice. Oyebola (1980) is impressed by the fame the traditional bone setter (TBS) enjoyed in their locality as patients abscond from modern hospitals to receive treatment from TBS.

In a study conducted by Bassey, Aquaisua, Edagha; Peters & Bassey (2011) in the South-South Geo-political Zone of Nigeria on the practice of traditional bone setting it is

discovered that there are several bone setting practices reported in the literature that are either equivalent to or better than modern practice. Hemmila et al. (2002) in a study on long term effectiveness of bone setting, light exercise therapy and physiotherapy for prolonged back pain in an observer blinded, randomized clinical trial in 132 patients as compared to standard physiotherapy sessions, concluded that traditional bone setting seemed more effective than exercise or physiotherapy on back pain and disability, even one year after therapy. Treatment for fracture of forearm bones in adult is generally accepted is open reduction and plate fixation has equally been reported. For instance, Shang, Gu, and Dong (1987) tried the Chinese method of bone separator pads and splint immobilisation in 2,221 forearm fractures as of then. They found that the method was not only simple, economical and effective but also eliminated delayed union or non-union. In another observation, Fang, Wu and Shang (1996) used paper roll spreaders and wooden splints in 147 patients with forearm fractures. They conclude that by preserving interosseous membrane, manipulative reduction is greatly simplified and that simple wooden splints were found to be much more effective and satisfactory than plaster of paris for immobilization of fractures of shafts of both forearm bones. The technique is easier, affordable and much more comfortable for children. The cast bracing of modern hospital is similar to some of the ‘bamboo’ bandaging pattern of traditional bone healers (Sarmiento and Lata, 2006).

In Nigeria, traditional bone-setters provide treatment for between 70 and 90 percent of the fracture care in many communities (Omololu, Ogunlade, and Gopaldsani, 2008). Abang et al. (2016) studied reason for patronage of traditional bone-setters and their continuing popularity in Calabar, Nigeria. Their study reveals that the educational level of respondents did not seem to influence the patronage of and belief in bonesetters’ skills. TBS offer cheaper and utilise allegedly faster healing methods, fear of heavy plaster of paris bandages by the hospital, prolonged periods of immobilization and

amputation influenced people to visit the TBS. In some cases, unconcerned attitudes of modern hospitals staff, pursuance by relatives, neighbors and TBS supporters, easily accessible and offering home treatment led clients to TBS. Re-iterating further, a study conducted by Onuminya, (2004) revealed that bone-setters command great respect for their expertise in treating fractures in various parts of the country and the outcome of the practice is good for closed fractures of the shaft of the humerus, ulna, radius and tibia.

Ogunlusi et al. (2007) in a prospective study on why patients patronise TBS, involving twenty-nine patients who were presented at orthopedic outpatient clinic after attending TBS centers, it is revealed that the duration of management at the TBS centre was as long as 18 months in a patient with closed femoral shaft fracture. Fractures and dislocations were managed by using the typical simple splint made of bamboo, rattan cane and palm leaf axis knitted together to form a mat which was wrapped around the fracture site tightly along with the herbal. The study also reveals that 72.4% of the patients attended TBS as they wanted cheaper and quicker services than the modern orthopedic treatment. The study also shows that many of the patients wanted quicker services for their acute problems and to return to work early. Fear of amputation is the reason of patronage in 7% of patients. The complications of the TBS treatment were nonunion and malunion which accounted for 96.5%.

Olaolorun, Oladiran, and Adeniran, (2001:635), posit that “there is a widespread belief in Nigeria that traditional bone-setters are better at the treatment of fractures than modern orthopedists which make patients patronise TBS”. Omololu, Ogunlade, Alonge (2002:2392) also submit that people living in remote rural areas believe that “those who have fractures once referred to a Teaching Hospital, amputation is unavoidable”. Another reason is the fear of the application of *Plaster of Paris* (POP) which is too heavy, delay healing and may lead to bad limb (Agarwal and Agarwal, 2010).

In a study conducted by Nwachukwu, Okwesili, Harris and Katze (2011) on traditional bone-setters and contemporary orthopaedic fracture care in the developing nations. It is discovered that the developments made in indigenous bone-setting are effective and affordable. The study also observes that the result of traditional bone-setting practice is good for closed fractures of the shaft of the humerus, ulna, radius and tibia, but

poor for peri-articular and open fractures which should be referred to the nearest hospital. A study by Onyemaechi, Lasebikan, Elachi, Popoola, Oluwadiya (2015) on patronage of traditional bone-setters in Makurdi, North-Central Nigeria discovers that 48% of patients with broken bones after passing through the services of modern medical doctors eventually end up with traditional bone-setters. Yet, another study by Onuminya, Onabowale, Obekpa and Ihezue (1999) on traditional bone-setter's gangrene in Nigeria showed that clients still prefer traditional bone-setting because of quick attention and faster mending of fracture. By implication it means TBSs are filling a void created by the dearth of modern orthopedists. Moreover, the TBSs are primarily located in rural areas where they care for underserved communities.

In a paper review on Traditional Medicine, Egharevba, Ibrahim, Kassam and Kunle, (2015:126) observe that "bone setters are capable of arresting the deterioration of gangrenous limb that would normally require amputation". Similarly, Udosen, Otei, and Onuba, (2006:172) posit that "there is widespread belief in the society that TBS are better at fracture treatment than modern practice". Fang et al. (1996), conclude that simple wooden splints are found to be much more effective and satisfactory than plaster of Paris for immobilisation of fractures of shafts of both forearm bones. It is therefore incumbent on the social science world researching on traditional medical practice not to ignore utility and scientific value of this level of non-modern health care services. While bone-setting has a long tradition, the safety and efficacy of traditional methods need to be continuously evaluated to avoid traditional bone setter's errors and failures (OlaOlorun, 2001). Occasional occurrence of errors and failures which seem to drive opposition to the practice should not overshadow the benefits derived from traditional bone setting (TBS).

This is because while occasional failures of bone setting procedures have been reported, leading to a bad reputation of the providers, such few cases should not form the basis for wide and wild criticism of bonesetters on the grounds that they use, none western and irrational methods. Chowdhury, Khandker, Ahsan and Mostafa (2011) in their prospective study to analyse complications of fracture treatment by TBS and factors predisposing to complications in Dinajpur district of Bangladesh concluded that out of 120 patients, 16.7% had a fracture union in acceptable position with near to normal range of movement at different joints whereas 83.8% had complications in the form of malunion (77%), delayed union (6.8%), nonunion (13.5%), gangrene (1.5%), compartment syndrome (2.7%), extensive blister formation and cellulites (20.3%), Volkmann's ischemic contracture (3.4%) and rest had stiffness of elbow and shoulder.

Hag and Hag (2010), in their study on complications of fractures treated by traditional bone setters in Khartoum, Sudan reported compartment syndrome (14.3%), osteomyelitis (8.6%), and restriction of movement (11.4%), Volkmann's contracture (5.7%) and gangrene (8.6%) which ended in amputation to be the complications of bone setting. Besides these complications, there is a great demand for TBS services, so much that some patients elect to leave modern hospitals in favour of treatment by a TBS for reasons mentioned earlier.

Overall, providers of orthopedic care in the rural areas of the developing world have widely recognised the contributions of traditional bone setters. Their practices do not require any formal education or a certificate to set bones. The acceptance or non-acceptance of such practices is solely defined by societal norms. However, a scientifically-trained general health practitioner can effectively treat common orthopedic and trauma conditions. In the face of infrastructural improvements, use of non-medical healthcare providers in rural clinic settings has been advocated as a viable low cost alternative (Mock, 1993).

### **2.2.3 Traditional African Treatment and Rehabilitation of Mental Patients**

Traditional mental healers specialise, mainly in the treatment of mental disorders. The Traditional mental healers are known to play an important role in the treatment of mental health problems and that these traditional psychiatrists are important resource in the provision of primary mental health services (WHO, 1990). Ehab, Nor, and Mohammad (2012) examine the treatment outcome of psychotic disorders by traditional healers in central Sudan of 129 in-patients. Their study reveal that traditional mental healers provide an important force in the treatment of psychiatric disorders. Similarly, Ovuga, Boardman, and Oluka, (1999) found in Uganda that most clients who had

experienced emotional problems were given adequate treatment by traditional healers. Majority felt that their personal problems were treated successfully because of the healers' vast knowledge and long experiences in treating psycho-social problems in their communities.

Traditional African treatment and rehabilitation of people with mental disorders usually take long periods. According to Oluwabamide (2007:85) "the management of the patient is determined and dictated by the nature of the mental derangement". Thus, a careful study of patients' situations needs to be done before any treatment is begun. Lunatics are usually restrained if violent by chaining to heavy objects such as wood or stone. Those diagnosed as being possessed by demons, are usually caned believing that will make the spirit go away from the afflicted. Thereafter, such patients are given herbal hypnotics or highly sedative herbal potions to restrain them (Sofowora, 2008).

#### **2.2.4 Herbalist**

The World Health Organisation (2002) regards the herbalist as an ordinary person who has acquired extensive knowledge of medicinal plant use, and who does not, typically, possess occult powers. They are usually male, and are often selected and mentored by an established practitioner (Gumede, 1990). Herbalists are in most cases seen and perceived by their immediate communities as powerful and knowledgeable group in health and social matters. Herbal medicines constitute the main component of Traditional Medicine, which have been used for thousands of years for health care promotion, curative and rehabilitative properties and in the prevention of illnesses (Obafemi 2012; Etobe, et al., 2013). In some cases, established herbal remedies used traditionally and have become modern medicines through drug development. Such is the case with Digoxin, morphine, colchicine, and artemisinin. People rely on herbal therapy

because of its application and man's experience from generation to generation. At present, the use of herbal medicinal plants for health products is increasing worldwide.

Out of herbalist knowledge of pharmacopeias, many modern drugs have been made. It is established that the practice of herbalist mirrors the early stages of modern and present medical practices because the most frequently used plants by herbalists are known to have beneficial chemical and medical properties (Ihekwoaba, Okwor, & Ugwuanyi, 2014). From the knowledge of herbalists, public and modern medicine/pharmacy is said to extol the miraculous medical benefits of plants like *ginkgo biloba*, *St. John's wort*, *moringa*, *sunflower seed*, *black cohosh* and many other herbs for treatment of different ailments (Okigbo and Mmekaka, 2006). Similarly, while plant medicines like vincristine and vinblastine amongst others have been extracted from the *rose periwinkle* and used to treat childhood leukemia and hodgkin's disease, *reser pine* extracted from the African or Indian *Rauwolfia* are used in tranquillizers; herbal medicine *Artemenia annua* is also used for the treatment of malaria, as well as St John's wort which is used for the management of mild to moderate depression (Patwardhan, 2005 and Adesina, 2014). In a similar vein, artemisinin which is extracted from the Chinese herbal wormwood plant *Artemisia annua* is the basis of more effective antimalarial drugs (Okigbo and Mmekaka, 2006; WHO, 2008).

In Nigeria, the National Institute for Pharmaceutical Research and Development (NIPRD) has reported to have developed traditional medicinal products from medicinal and food plants for sickle cell disorder called *NIPRISAN* (Wambebe et al. 2001). Other herbal medicines for the treatment of sickle-cell anemia have been developed by Esoma Herbal Research Institute and Neimeth based in Abuja, Nigeria. Published data indicate



significant clinical efficacy as majority of patients are protected from medical crises, and this will enable them to go back to their normal duties after administering herbal medicine (Wambebe, et al. 2001). Nikiema, et al. (2009), Simpure et al. (2003) and Kajuna et al. (2009) carry out test after administration of the traditional medicines to people living with HIV/AIDS for the management of opportunistic infections, and found a decrease in viral load, increase in CD 4 (cluster of differentiation 4) and CD 8 counts, weight gain, a regain in energy and appetite, improvement of overall clinical conditions and quality of life. Similarly the development of Herb 25 successfully provided an anti-malarial herb for the treatment of malaria by a research team (Ahmadu Bello University: 2012).

To ascertain the safety and to erase doubt in the use of herbs by traditional healers in Nigeria, some herbal formulations have passed the initial phyto-chemical analysis and safety test by the National Agency for Food and Drug Administration and Control (NAFDAC) and have been found to be safe for human use (see Appendix VIII). Examples of such formulation include: *Nd* Flusher Herbal Powder, *ND* Pala Herbal Powder and *Nd* Powercin Booster Herbal Powder (Ndubisi, 2011). Despite these findings, concerns are constantly being raised by policy-makers, modern health professionals and researchers on the efficacy, quality, reliability and safety of herbal medicine (WHO, 2001; WHO, 2002a; WHO, 2004, Baidoo, 2009). Much of these studies centre on safety, quality and reliability with less attention paid to the clients involved in the field that is the users.

The act of drug safety is popularly known as 'Pharmacovigilance'. This has been a major concern of modern science on herbal medicine. WHO (2004: 9) defines

'Pharmacovigilance' to mean "the science and activities relating to the detection, assessment, understanding and prevention of adverse effects of drugs or any other possible drug-related problems". These include "herbals; traditional and complementary medicines; blood products; biological; medical devices; vaccines". Other issues relevance to the above definition as explain by WHO (2004:9) include:

Substandard medicines, medication errors, lack of efficacy reports; use of medicines for indications that are not approved and for which there is inadequate scientific basis. case reports of acute and chronic poisoning; assessment of drug-related mortality; abuse and misuse of medicines; adverse interactions of medicines with chemicals, other medicines and food.

The overall specific aims of pharmacovigilance include the desire by WHO to among others " improve patient care and safety in relation to the use of medicines and all medical and paramedical interventions; improve public health and safety in relation to the use of medicines; contribute to the assessment of benefit, harm, effectiveness and risk of medicines, encouraging their safe, rational and more effective (including cost-effective) use"; and "promote understanding, education and clinical training in pharmacovigilance and its effective communication to the public".

The climatic and topographic conditions of Nigeria offer different vegetations, which influence the growth and thriving of various herbs for use by herbalists to treat various ailments. Studies by scholars such as Kondo (1990); Oluwabamide (2007) and Faleyimu and Akinyemi, (2010) on indigenous medical knowledge in African societies records that a significant proportion of Africans utilise animal parts and plants for treating diseases, preventing others and promoting some aspects of health. A study by Abubakar et al., (2007:625) on the practice of Traditional Medicine for treatment of cancers and inflammation in Northern Nigeria revealed that "more than 95% of

traditional medical preparations are of plant origin unlike modern medical drugs. Those who use traditional medicine value these plant materials because they are available and can be prepared easily and used within the ambit of primary health care”. By implication herbalists services are seen to increase availability and accessibility to cost-effective treatment of commonly encountered health problems with herbal remedies.

### **2.2.5 Diviners and Faith Healers**

Diviners constitute another category of healers who provide alternative health care services. Diviners are generally regarded as experts who consult the spirit world to identify the cause of the disease/ailment or to find out whether there is an unremitted or violation of norms/taboo by the sick or by their relations. This category of healers diagnose illness and explain the social and spiritual origins using divination objects (Karim et al., 1994). It is also a way to access information that is normally beyond the reach of the rational mind. Diviners derive their knowledge from a communication of spiritual forces, such as the ancestors, spirits and deities (Olupona 2004:103–104). Omonzejele (2008:122) argues that “because of the revealing powers of divination, it is usually the first step in African traditional medicine”.

According to Gumede (1990), diviners identify the origin and reason and recommend appropriate spiritual remedy for the affliction through spiritual means (Jolles and Jolles, 2000). Generally speaking, diviners perceive themselves as agents of the gods and ancestors through whom clients can find divine answers to their health challenges and predicaments. Contributing to the debate on the utility value of diviners in the provision of traditional medicine in African context, Azongo and Abubakari (2014) assert that diviners are basically custodians of the spiritual means by which people can find out the causes of diseases and the course of action for the cure of such diseases. The claim is

that the professional duty of diviners to their clients is to determine the cause of their health challenges and to proffer the remedies.

In Western Medicine and health care system, caring for the patient's body only seems to be largely its concern. But this thrust that is associated with modern medicine is not acceptable by most communities in Sub-Saharan Africa as some TMP scholars hold that diseases, accidents and or bad luck are sometimes believed to have spiritual components in man's life and best handled by traditional health practitioners (Staugard, 1985:91 and Abbott, et al., 2011). In a similar vein, Dada et al (2011) submit that many communities in Nigeria believe that sicknesses and afflictions usually have spiritual components which need to be treated traditionally by spiritual intervention. Some of these scholars attribute most illnesses, diseases, personal and communal catastrophes, accidents and deaths to sorcery and evil machinations of enemies, gods and ghosts. This is evidenced in the work of Adefolaju, (2011) where he notes that the services of traditional healers must be consulted because of the belief that they are vast in treating psychological and spiritual components of diseases before the physical components can be treated by MM. For instance, Lambo's (1978) survey of African students in British Universities, establishes that majority of them firmly believe that their emotional problems originate in the evil machinations of enemies. These are diverse forms of misfortunes that need to be appropriately categorised. Some of them need to be excluded from the field of medicine; yet traditional healers claim to have medical remedies for them, hence, the medicalisation of fortunes and misfortunes in Traditional Medicine. The objects of protection are the individual, his property, the family and the community (Chalmers 1990:10). For example, protective medicines are sprinkled in the yard to

protect family compounds as well as family members from witchcraft and evil spirits (Gumede, 1990).

Medicalising of luck and bad luck requires, users of traditional medicine to apply amulets, bracelets, charms and necklaces containing power to protect them from ailments and other unfavorable occurrences around them (Staugard 1985:91). Examples are good luck charms, love potions, charms to make one's business prosper, charms or potions to guarantee successful growth of crops, charms or potions to win the love of an unwilling woman/man, charms or potions to ward off evil spirits, charms or potions to win an election or when gambling, attracting customers to a shop, passing examinations, to nullify both old and new types of hazards, and charms or potions to keep one's job. Court cases have shown that human flesh may be used as medicine or charm to obtain favorable ruling (Chavunduka, 1994; Simpson, 1994).

Faith-based healing is a form of health care service that is most often provided by traditional religious healers, Christian as well as Muslims clerics in Africa. They use the power of suggestion, prayer and faith in God to promote healing. They appeal to God to change a person's physical or mental condition for the better (Cockerham, 1992). Village (2005:98) defined faith healing "as the ritualistic practice of prayers and gestures (such as laying of hands on the afflicted)". The claims are that the act of laying of hands is an outward sign that calls for divine spiritual intervention against evil forces that are responsible for causing the disease in the first place. This practice is common with traditional religious clerics as well as some Christian and Muslim clerics. According to Azongo and Abubakari (2014:1004) faith healing is "a divine gift of dealing with ill-health. It is required that mendicants believe in the divine power that they will be healed". Evidence is noted of a divine gift of Ze Arigo a psychic surgeon who practiced psychic surgery with his simple kitchen knife (Fuller, 1974).

In modern Sub-Saharan African societies, most faith-based healers tend to come from the Christian and Islamic faith than from traditional religious healers. Both the Christian and Islamic clerics who engage in faith based healing tend to rely heavily on their respective scriptures for the justification of such healings. While the Christians rely on the Holy Bible and the Muslims rely on the Holy Koran to draw, justify as well as routinise the faith-based healing powers (Erinosho, 2006). Ill-health and other

misfortunes which defy scientific and traditional treatments are attributed to spiritual forces directed by either witches, wizards, sorcerers, evil spirits or angered ancestors (Ojua and Omono, 2012; Obot, 2012). The popular notion is that people do not just suffer illness by chance; rather, all illnesses are believed to originate or cause by one or more supernatural agents. The roles of viruses, bacteria and parasites are either seen as secondary or chance/opportunistic factors that play auxiliary roles in exacerbating illnesses in humans.

Research on faith-based healings has shown that religion and spirituality are associated positively with better health and psychological wellbeing (Koenig, 2004; Pargament, Koenig, Tarakeshwar, Hahn, 2004; Puchalski, et al. 2009). Koenig et al (1997) argues that religious commitment has the tendency to improved stress control by offering better coping mechanisms, richer social support and strengthen personal values and worldview. Strawbridge (1997) suggest that individuals who are more disposed to the role of religion and faith-based healings have the tendency to engage in regular spiritual practices to live longer than those who are less religious and spiritual. Yates, Chalmer, St James, Follansbee, McKegney (1981:125) observes that those “who are spiritually faithful tend to have a more positive outlook and a better quality of life”. Consequently, Yates et al (1981) submit that patients with advanced cancer who found comfort from their religious and spiritual beliefs were more satisfied with their lives, were happier, and had less pain than other treatments sought elsewhere. This shows that faith healing is related to the ability to enjoy life even in the midst of symptoms, including pain. This also suggests that faith-based healing is an important clinical component of curative medicine.

Faith-based healing is sometimes favoured because its doctrinal philosophy seems to integrate both Christian and African traditional beliefs. Faith-based healing tends to interpret sickness in terms of the patient's world-view and perception. The faith-based healing sessions can therefore comprise vigorous displays of emotions in rhythmic movements, dances or consumption of some prepared substances of any form. The offending forces from whatever sources are commanded to come out of the victim. Faith-based healing seems to be in line with most cultures in Africa.

### **2.2.6 Traditional Surgeons**

Traditional surgery is another form of medical service provided by Traditional African Medicine. Some of these practices are rooted in the tradition of African and religious belief. Traditional surgical operations vary across cultural groups in Nigeria and other African economies and societies. Some of the traditional surgeries include the making of tribal marks on the face or body of the client. In some cases, Traditional surgical operations carried out on both male and female in the form of circumcision, removal of whitlows, cutting of the uvula (Uvulectomy), draining of pus in abscesses and so on. The cutting of the uvula is widely practiced in both rural and urban settings. It is believed that uvulectomy can protect the patient from infection of the pharynx and the respiratory system (Adesina, 2011). In surgery, traditional medical practitioners in Africa are adepts in the performance of intricate operation to remove bullets and poisonous arrows from wounded traditional fighters. They are operated on the belly to extricate noxious tissues which caused unnecessary disturbances and stitched together by technical application of pieces of calabash on the operated part while the sore gradually heals

(Akpomuvie, 2014). Traditional surgeons in Northern Nigeria and other West African societies specialised in cutting-off the upper end of the throat flap (epiglottis), for the treatment of many illnesses (Adesina, 2011). This is a clear indication that if adequate research is carried out in the country, most of the Traditional surgeons will become experts in their field. Adequate training of traditional surgeons can enhance their productivity; improve the medical and health status of the people.

### **2.3 Health Issues for Traditional Medical Interventions**

Traditional healers in Africa are consulted for a wide range of physical, psychological and social issues, including promotions at place of work, passing examination, winning a soccer game by a team, getting pregnant or discouraging one's spouse from being unfaithful (Vontress, 1991). Other health challenges and conditions for which people seek medical treatment from traditional healers include infertility, epilepsy, cancer, fracture, toothache, fever, headache, diabetes, asthma (Campbell 1998 and Ogunbodede 1996), *degedege* otherwise known as "convulsions" in rural Tanzania (Makundi, Malebo, Mhame, Kitua, and Warsam, 2006; Kretchy et al. 2014), hypertension (Okubadejo, 2007; Hwang et al. 2014) and various medical and spiritual circumstances (Awad and Al-Shaye, 2014; Faith et al. 2013; Gyasi et al. 2013).

Child birth in the rural areas of Africa is mostly conducted by Traditional Birth Attendants (WHO, 2001). For example in a study of health care practices of pregnant women in Cape Town Jewkes et al., (1998) found that 60% of South African women use herbal medicines during pregnancy. In their survey of 577 pregnant women attending their first antenatal visit at King Edward VIII hospital in Durban; South Africa, revealed widespread use of herbal medications. One of the reasons for this high usage of herb was attributed to parents/relatives (69.8%) and traditional birth attendants/herbalists (22.6%) who felt that the herbs are relevant to their health and pregnancy.



Similarly, a study of twenty three local healers in Chiawa rural area of Zambia, Ndubani and Hojer (1999) reveals that in the treatment of Sexually Transmitted Infections (STIs) male patients tended to prefer traditional healers because they believe it is more effective than modern medicine. In a community survey of Northern Province of South Africa, Pelzer (2003) notes that among rural adult of those who reported to have had STIs in the previous 12 months, 36% had consulted traditional healers for treatment. In Nigeria, most of those living in rural communities rely on TM for the treatment of STDs and other related illnesses (Bakare, 2005). The common STDs treated are gonorrhoea, Syphilis, Urethritis, Vaginal Candidiasis and Chlamydia (Bakare, 2005). The facts presented above show that traditional medicine and traditional healers have become a good alternative and they complement the formal health system, thus slowing down the spread of the disease in the areas affected.

Apart from natural causes, supernatural and preternatural factors are also perceived as causes of illness and can be remedied only by traditional healers intervention. It is the belief of many Nigerians that witches cause sickness by charming the victim. Owumi (1993) in his study of the Okpe people of Delta State, Nigeria, found that the belief in witchcraft is well entrenched in their culture. They believe that the *Edjele* (witchdoctor) is the only source of resolving witchcraft related health problems. They also believe that other categories of healers like *Oboh* (ordinary doctor) can only resolve problems which are naturally caused. Perception of the cause of illness, especially the supernatural often leads to the consulting witchdoctors and spiritual healing churches.

The contributions of Traditional Medicine to health care have also been demonstrated in some studies conducted in Nigeria, for instance, on the treatment of STIs in the Niger Delta Region in Nigeria. Ajibesin, Bala and Umoh (2011) found that the leaves of *palisota hirsute* are used to treat gonorrhoea successfully. In another study by Anani, Hudson, De Souza and Akpagana (2000) on rationalising the ethno-medicinal use of *palista hiseta*, reported significant activity of the methanol extract of the plant against bacteria such as *Eschenchia Coli* and viruses including herpes simplex one of the causative agents of STDs. In validating the traditional use of *A.conyzoides* against STDs,

Ogunshe, Lawal and Iheakanwa (2008) reported that the ethanol extract of the leaves shows an inhibitory effect against strains of vaginal *lactobacillus* and *candida* species associated with *Candida Vaginitis*. Similarly, the bark of *Magnifera Indica* is said to be effective in treating syphilis.

Other studies in Africa and North America have shown that up to 75% of people living with HIV/AIDS use herbal medicine alone or in combination with other medicines for various symptoms or conditions (WHO, 2003b). Herbal medicines have been identified (Peters, Immananagha, Essien, Ekott, 2004) as often used as primary treatment for HIV/AIDS and for HIV-related problems including dermatological disorders, nausea, depression, insomnia, and weakness. Although, most traditional herbal medicines have not been well-researched, poorly regulated, may contain adulterated products, and may produce adverse effects, but are still appreciated by most people in developing countries. With this wide acceptance, there is a need for the involvement of research institutes and other bodies to authenticate the safety of these herbs.

#### **2.4 The Socio Cultural and Economic Factors Influencing Patronage and Utilization of TM by Health Care-Seekers**

The practice of Traditional Medicine is a means of livelihood for some individuals, organisations and governments as there are various marketing strategies employed to warrant patronage. Adjei (2013:2) point out that:

Indeed, various researchers have found that herbal medicine is effective, more readily available, affordable, culturally acceptable, and is consistently being argued as an easily accessible health care system that can aid and complement government's efforts at ensuring quality and

equitable health care... In some rural communities, herbal medicine is the only form of health care that is available, affordable and accessible. Indeed, herbal medicine has demonstrated efficacy in the areas of chronic and psychic ills, boils, tuberculosis, asthma, infertility, hernia, hypertension, diabetes and malaria, where modern medicine has either failed to produce equally good results or has simply ignored the need for systematic attention and research.

The annual global market for herbal medicine is growing steadily at a rate of 15% to 25% and stands at over US\$60 billion (WHO, 2003a; 2003b; 2002a; 2000b). Annual revenues for herbal medicine in Western Europe reached US\$ 5 billion in 2003-2004 and in China, sales of herbal products totaled US\$ 14 billion in 2005 (WHO, 2008). Herbal medicine revenue in Brazil was US\$ 160 million in 2007 (WHO, 2008). In Australia, the estimated national expenditure on alternative medicines and alternative practitioners is close to A\$1000 million per annum, of which A\$621 million is spent on alternative medicines (Kamboj, 2000). Nigeria can as well benefit from the world market if the abundant herbal resources are fully utilised.

Affordability in terms of cost-involvement in treatment of an ailment has been identified as one of the reasons for high patronage of Traditional Medicine. In their study, Ogunlusi, Okem and Oginni (2007) established that most people visit traditional bone setters because they provide cheaper and quicker services than modern medicine. Lower fees, easier accessible, quicker service, less competition, cultural settings, including incantations and concoction, pressure from friends and families are also identified by Dada et al. (2011) as some of the reasons for the high patronage of traditional bone-setters in Nigeria. The flexibility in payment plan; makes the traditional system more attractive.

Realising that some modern drugs come from herbs have influence the patronage and utilization of TM. For example the UNESCO (2013) noted that 30% of modern medicines are derived directly or indirectly from medicinal plants used by traditional practitioners. Examples of these medicines are analgesics (aspirin); anti-cancer medicines (vincristine and vinblastine); anti-hypertensive agents (reserpine) anti-malarial (quinine, artesimin) among others (WHO, 2008 and Paulo, Kofi, and Ossy, 2010). This has generated a number of research institutes like the Ahmadu Bello University, Zaria, and Pharmaceutical Research and Development of Nigeria (NIPRD) are conducting research on Traditional Medicines for the treatment of malaria, HIV/AIDs, diabetes, sickle-cell anemia, and hypertension in order to produce evidence on their safety, efficacy, and quality. The idea of reflecting back to centuries-old-knowledge of herbal medicines used in treating or palliating numerous illnesses by these organisations gave way for patronage of TM. In Africa Traditional Medicine is perceived to be effective by various communities because it is embedded in the belief and culture (Teklehaymanot and Giday, 2010).

The belief that diseases and accidents have spiritual components and need to be treated as such partly accounts for patronage of TM. For instance, Dada et al, (2011) document that many communities in Nigeria believe that sicknesses and afflictions usually have spiritual aspects and should be treated traditionally by spiritual intervention. This is evidenced in the work of Adefolaju, (2011:102) where he observes that services of traditional medical practitioners are relied upon by people because of the belief that they are vast in treating physical illnesses as well as psychological and spiritual comfort.

Putting culture first, Ossey, Paulo and Kofi, (2010) observe that treatment regimens are provided through tradition and cultural philosophy citing norms, taboos, tradition and culture, as the pillars of clinical practice of Traditional Medicine. Thus, the philosophy requires a traditional health practitioner to provide health services under a "humanity-first" consideration and not for material gain. He or she must be a person of high standing in the community, open and available to serve others when they need health care services (Paulo et al. 2010). Studies by Ogunlusi, Okem and Oginni (2007), Dada et al (2011) and Owumi, Taiwo and Olorunnisola, (2013) discover that lower fees, easy access, quick service, cultural belief, utilisation of incantations and concoction, pressure from friends and families are major reasons for the patronage of Traditional Medicine. On cultural grounds, Chris and Kwarja (2011) argue that lesser fees charged by practitioners has a strong conviction and belief that the spirits will desert the treatment centres and make the medicine powerless, and in some cases, make the practitioners go mad or die when monetary rewards become the primary drive.

## **2.5 Socio-Demographic Characteristics of Traditional Healers Clients**

The enjoyment of the highest attainable standard of health is the fundamental right of every human being without distinction of race, religion, political belief, economic or social condition (Thoa, Thanh, Chuc, and Lindholm 2013; United Nations [UN], 2000; WHO, 1948). The social class and demographic situation of people may have direct influence on their treatment and/or health-seeking behaviour. Demographic factors of age and sex impact on utilization of Traditional Medicine. Children are found to be important clients of Traditional Modern Practitioners in rural Nigeria and Ethiopia (Kroeger, 1983). In sub-Saharan Africa and several other

developing countries women consulted Traditional Medical Practitioners most. Traditional medicine is basically rooted in the rural economies of developing countries where less knowledge about Modern Medicine exists. Worldwide, the political, economic and social structures among communities determine who gets what, where and how (Stock, 1985; Buor, 2008a). In agreement with other studies Ahmed et al. (1999) found that the majority of those seeking the help of Traditional Medical Practitioners are women. Unlike other studies (Berhane, Gossaye, Emmelin, Hogberg 2001), this study reveals that also young and educated participants in this urban area consulted Traditional Medical Practitioners.

The different categories of people who patronise Traditional Medicine demonstrate its popularity across social categories in Nigeria. Evidence from a study by Owumi, Taiwo and Olorunnisola (2013) in Ibadan North Local Government Area of Oyo State reveals that the clients of the service of Traditional Medicine cut across all strata of Ibadan residents. In addition, other studies have shown similar pattern (Chuma et al. 2012; Osamor and Owumi, 2010). Several studies in Ghana indicate that most patrons of traditional medicines are predominantly females and non-literates rather than males and literates (Fosu, 1981; Buor, 1993 and Darko, 2009). These agree with Birhan, Giday and Teklehaymanot's (2011) findings in Addis Ababa that females, individuals with middle class-income level and those with education visit traditional healers' clinics more frequently than the rest of informants. Low income earners have been mentioned as the beneficiaries of traditional healers' clinics (Giday, Teklehaymanot, Animut, and Mekonnen 2007).

It is not unexpected that women have been found to use Traditional Medicine more than men because they tend to be more introspective and concerned about health issues, with greater health awareness than their male counterparts (Mechanic, 1992). In most cases, it translates into higher level of herbal medicine use (Votova, 2003; Kelner and Wellman, 1997). It can be argued that females form a greater percentage of the poor in developing countries like Nigeria, Ghana, Ethiopia and also predominantly live in rural areas where the use of herbal medicine is greater. However, Bereda (2002) in his study on ‘traditional healing as a health care delivery system in a multi-cultural society reveals that males utilised Traditional Medicine more than females. Similarly, black consumers of traditional medicine were more than other racial groups. The study also found that 80 percent of the participants had a higher education and they consume Traditional Medicine. Therefore, the need for utilisation of Traditional Medicine could never be biased because of high educational status.

The religious background of an individual may also influence the type of treatment he/she seeks. According to Mensah (2008), some Christians consider Traditional Healers to be associated with fetishes and superstition practices which are against their religious beliefs. Moslems avoid certain traditional remedies including palm wine and animal parts which they consider to be spiritually unclean for consumption. On the contrary, a study conducted by Ejima (2014) on traditional bone setting in Kogi State Nigeria found that religion was not a barrier to the patronage of traditional bone setter.

In Nigeria, Traditional Medicine contributes to health care even to urban areas that are considered to be well served with modern healthcare facilities such as Lagos, Kaduna, Kano, Ibadan and Enugu (Dada, Yinusa and Giwa, 2011). For instance, Sani and

Ayodel, (2015) in their study of traditional bone setters and fracture care in Eketi town establish that 67.2 percent of the respondents had utilised TBS. Also Olaolorun, Oladiran, and Adeniran, (2001) in their study of complications of fractures treatment by traditional bone setters in Ibadan South Western Nigeria revealed that eighty-five percent of patients who presented with femoral fractures to an Orthopaedic Hospital had been to traditional bonesetters (TBS) prior to going to the hospital. In Lagos, herbal medicines were reportedly used by 259 (66.8%) respondents (Oreagba, Oshikoya, and Amachree, 2011). Similarly, other studies have documented high patronage of traditional medicine in both urban and rural areas for instance the work of Areo (2014) on Traditional Medicine practice in Osun State Nigeria and Ojua et al (2013) on the theoretical overview and socio-cultural implications of urban dwellers patronage of trado-medical homes and services in Nigeria. These studies signify the contribution of Traditional Medicine. to both rural and urban population in Nigeria.

## **2.6 Criticism against Traditional Medicine**

Despite the apparent positive contributions of Traditional Medicine to health care, there have been contrary opinions on the utility value of herbal medicine by proponents of modern health care system which perceives traditional medical practices as comparatively inferior. Some of the principal criticisms include its lack of scientific and verifiable based evidence and effectiveness, absence of set rules and standards, and none existence of formalised training. It is on the basis of such claims that Traditional health practice is dismissed as customs rather than an effective form of health care (Helman, 2007).



It has also been noted that some traditional healers exaggerate claims of the potency of their medicaments for clients to patronise them (Wilkinson, 2013; Worley, 2016). They present anecdotal experiences of patients they had successfully treated as a point of reference. Osborne (2007) notes that some of the practitioners made exaggerate claims in public advertisements via print and electronic media. In some cases, practitioners tend to attach fake proofs which lack scientific effectiveness, thus making it difficult to distinguish the genuine from false claims.

Akinleye (2008) corroborates this when he identifies some of the drawbacks of Traditional Medicine as ‘incorrect diagnoses’, ‘imprecise dosage’, low hygiene standards, secrecy about healing methods and the absence of written records about the patients. Thus, a Modern Medical biased practitioner considers the methods of traditional medical knowledge as primitive and backward (Elujoba, Odeleye, Ogunyemi, 2005). These are similar to imperialists’ views which considered African diviners as Witch Doctors and declared them illegal (DeJong 1991 and Sofowora, 1993). The Christian Missionaries and colonial administrators believe that native medical practices are pagan, superstitious and evil and have to be replaced by modern medicine (Onwuanibe, 1979). During this time, attempts are also made to control the sale of herbal medicines (Helwig, 2005). These are challenges of Traditional Medical practices in the hand of Modern Medical Practitioners.

Traditional Medicine is perceived as harmful because they have not been subjected to modern pharmaceutical assessment. Kew et al. (1993) opine that most herbal products on the market have not been subjected to modern scrutiny to demonstrate their safety and effectiveness because some of them contain traces of mercury, lead, arsenic and corticoids. For instance, in a study of childhood blindness in Nigeria, Harris and

Cullinan (1994) found that 25% of this disease in Nigeria and India are associated with the use of traditional eye medicines.

To demonstrate the efficacy of TM Alonge, Dongo, Nottidge, Omololu and Ogunlade (2004) argue that Traditional Bone Setting (TBS) practices are not scientifically based and cause a lot of complications which may lead to loss of limbs or death leading to the bad reputation of TBS providers (Agarwal and Agarwal 2010). In many situations, the bone-setter practices his/her skills in sepsis prone conditions. Thus, they have been widely criticized by modern medical practitioners for their use of ‘irrational’ methods. Oginni (1992) for instance, found a high failure rate of 66.7% among patients of traditional bone-setting treatment in Nigeria. However, the question remains how this calculation is done and among which categories of bone-setters the study was conducted.

The traditional bandaging method of applying splints directly to skin has often been mocked by modern practitioners as nothing more than the *traditional tourniquet fracture* splint (Oniminya et al. 2000). Warren (1974); Tijssen (1979), and Ventevogel (1996) argue that a traditional bone-setter is a lay practitioner of joint manipulation. Similarly, Samuel (2007) opines that bone-setters are seen as unqualified practitioners who take up practice of healing without having had any formal training in accepted medical procedure. Findings from a study conducted by Udosen, Otei, and Onuba (2006) in Calabar confirm that all the practitioners have little or no formal education. TBS services are mostly family practice, and training is by apprenticeship. The arts and skills of such services are kept strictly by oral tradition and transmitted to upcoming generations of family members (Ogunlusi, et al., 2007).

Despite the foregoing criticism against Traditional Medicine, it is still relevant as noted by Abbott (2011) on medical students' attitudes toward complementary, alternative and integrative medicine in the United States, 74 percent of its medical students believe that despite these odds, modern medicine would benefit from incorporating alternative medicine as part of its discipline. Thus, Bishaw (1990) has reported changing attitudes of Modern Medical Practitioners on traditional herbal medicine, such that many major health organizations around the world now view traditional healing methods as a viable alternative to overall accessibility and utilization of health care by majority of people who ordinarily are not able to pay for the cost of modern medical and health care services (Samal (2016), Uwakwe (et al. 2015), Wassie (et al. 2015), Moreira (et al. 2014), Ihekwoaba (et al. 2014), Adjei, (2013), Robinson and Zhang (2011), WHO (2004) WHO (1993).

## **2.7 Nigeria's National Regulatory Policy on the Practice of Traditional Medicine**

In his preface on history of public health Rosen (1958:17) asserts that "the protection and promotion of the health and welfare of its citizens is considered to be one of the most important functions of the modern state. This function is the embodiment of a public policy based on political, economic, social and ethical consideration". Article 25 of the 2 Universal Declaration of Human Rights (UDHR) further explicates that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, medical care and the right to security in the event of sickness, debility and disability" (UN, 1948; WHO, 2003). As an essential element for human existence the right to good health care is therefore a major responsibility of the government.

World Health Organization (2001:29) reported that the informal interaction between the Government and Traditional Medicine practitioners can be traced back to the 19th century. Formal legislation of promoting Traditional Medicine dates to 1966 when the Ministry of Health authorised the University of Ibadan to conduct research into the medicinal properties of local herbs. Since then attempts have been made to promote traditional medicine throughout the 1970s in the form of conferences and training programmes. In the 1980s, policies were established to accredit and register traditional medicine practitioners and regulate the practice of traditional medicine. In 1984, the Federal Ministry of Health established the National investigative Committee on traditional and alternative medicine. A committee to research and develop traditional and complementary/alternative medicine was formed by the Federal Ministry of Science and Technology in 1988.

The national regulatory policy on Traditional Medicine in Nigeria (Federal Republic of Nigeria: 2007: 1) admits that the “Nigerian State has shown interest through various resolutions, commissions and other initiatives at the Federal, State and Local Government (grassroots) level, and has also shown an appreciation for the role, which Traditional Medicine plays in health care delivery in the country”. It also concedes that “despite the rapid expansion of conventional medicine in the last three decade and the rapid increase in its human resources, a majority of Nigerians still utilise Traditional Medicine”, and submits that “available evidence indicates that some herbal remedies and traditional therapeutic regimen are effective and affordable”. The National Regulatory Policy on Traditional Medicine then became futuristic thus:

These observations notwithstanding, Nigerians are continually being exposed to potential hazards from the use of traditional medicines, which should therefore be regulated. In view of the fact that many users administer to themselves both traditional and conventional medicines concomitantly; the potential hazards of this habit should not be underestimated and needs to be addressed. The goal of the National Health Policy is to harness all available resources for health care delivery. It is envisaged that Traditional Medicine would constitute one of the veritable means of promoting Health for all by the Year 2010 and beyond as enunciated in the National Health Policy. This will be in line with the Declaration of the Heads of State and Government of African Union Member States that the period of 2001 to 2010 be the Decade for African Traditional Medicine (Federal Republic of Nigeria: 2007: 2).

The objectives of Nigeria's national Traditional Medicine policy include the desire to “develop and facilitate the use of Traditional Medicine in Nigeria in the official health care system; harness the potential and economic benefits of traditional medicine practice to accomplish the provisions of the National Economic Empowerment and Development Strategy (NEEDS) and; establish a country-specific institutional framework for traditional medicine” (Federal Republic of Nigeria: 2007: 2). It captures the vision of Traditional Medicine in the country in the following way thus:

To see the practice of traditional medicine in Nigeria become a respected mode of treatment, preserving our cultural heritage with respectable practitioners and providers, delivering quality healthcare to all Nigerians, and a situation in which the economic potentials of traditional medicine are also actualized to the benefit of all. The establishment of a situation whereby both conventional and traditional medicine practitioners legally and freely render their services in parallel but in clear understanding of each other and in close collaboration at all levels of healthcare delivery system and providing the chance for the patient to make an informed choice (Federal Republic of Nigeria: 2007: 2-3).

The mission of Nigeria's national Traditional Medicine policy is “to create an enabling environment for the development of Traditional Medicine for national health system development and economic benefits” and, the expected outcome of the policy, “is to see both the traditional and conventional health care delivery systems empowered to

deliver good quality health care to Nigerians and to derive economic benefits”. According to the national policy on Traditional Medicine, its health-related goals include the drive “to promote the appropriate use of Traditional Medicine; incorporate Traditional Medicine into the national health care delivery system; reduce the use of foreign currency for the importation of unnecessary medicines and to promote the exportation of manufactured traditional medicines; provide jobs in the area of conservation, cultivation, and harvesting of medicinal plants; produce traditional medicines locally at the industrial scale; and build up capacity in all areas of traditional medicine development (e.g. agro forestry manufacturing, distribution and marketing (Federal Republic of Nigeria: 2007: 3).

The national policy on Traditional Medicine also commits itself to the establishment of legislative and regulatory instruments to provide for the setting up of Traditional Medicine Practitioners’ Council, Boards and Committees through appropriate legislation at the Federal, State, and Local government levels respectively. Such a Council shall be “responsible for the registration of traditional medicine practitioners and all matters pertaining to their practice and welfare through the Boards and Committee” as well as setting up codes of ethics for the practice of TM in the country (Federal Republic of Nigeria: 2007: 5).

Close to over ten years since the formulation of the national policy on Traditional Medicine little practical steps have been put in place by the Federal Government as well as some states and local governments to realise the objectives for which the policy was formulated in the first place. Yet, the use and utilisation of Traditional Medicine in the

country is witnessing rapid increase nation-wide (Uwakwe, et al., 2015, Ihekwoaba et al., 2014, Abodunrin, et al., 2011, Raphael, 2011).

Since then, the National Agency for Food and Drug Administration and Control (NAFDAC) which was established by decree No. 15 1993 (LFN, 2004f) has been the agency with the authority to regulate and control all kinds of foods, drinks and drugs and to ensure standard among others. By provision of the NAFDAC Act, the Agency is saddled with responsibilities that also cut across various activities of Traditional Medicine practitioners. Therefore, NAFDAC is conscious of its regulatory role regarding the activities of the nation's traditional medical practitioners and actively regulates products of traditional medicine in matters of registration, labeling, advertisement, sale and distribution of herbal drugs and extracts. Essentially, therefore, the most active and aware regulatory body for the control of traditional medicine in Nigeria is NAFDAC.

The foregoing analyses make it clear that, except with regard to some specific areas of practice, there are no formal legal requirements for registration before one can practice Traditional Medicine in Nigeria; and that the requirement of registration may have more to do with the product than the practitioner (LFN, 2004g). For the purpose of regulation and ensuring compliance with provisions of the law three regulatory authorities have been instated to enforce compliance they are; State Commissioner for Health, Any Authorized Officer and Advisory Committee on Traditional Medicine.

## **2.8 Theoretical Perspectives**

This section which addresses the theoretical framework of the study examines the Political Economy of Traditional Medicine in Africa which emphasis is on the structure

of the society and the Behavioural Models of Health Service Utilization by Andersen and Newman (1973). The objective of adopting these theories is to understand the social, economic and behavioural context that explains the increasing patronage and utilisation of Traditional Medicine by members of the public.

The Political Economy of Traditional Medicine is akin to the generic Marxist political economic theory on health care. The perspective attempts to understand health related issues within the context of the class and imperialist relations inherent in the capital world-system. The Political economy assumes that resources are allocated not on the basis of relative efficiency or merit—but according to power. The proponents perceived of unequal distribution of resources, wealth and power. This theory believes that the economic power structure or the economic system of any society cannot be divorced from the nature of its healthcare delivery. The Marxian theoretical perspective perceives contradictions within socio-economic relations that drives those at the lower socio-economic ladder of society towards patronising alternative medicine because of cost. This perspective emphasizes the role of economic power (Jessop, 2014), economic system and living conditions which shape people's health, health service delivery, affordability and accessibility to health care services. The political economy theoretical framework provides a valuable background in which to consider the socio-economic and political determinants of health care.

Modern Medicine, which is the favoured medical system is seen portraying the interest of the capitalist group in the way health facilities and services are distributed. The facilities and services are highly uneven and whose availability varies from different groups in the society. (Edwin, Clearly, English and Molyneux, 2016). These uneven distribution and the economic challenges are preventing many people from enjoying what they would have wished for. For instance, some people who live in rural and slums in urban areas are of low economic status. This category of people finds it difficult to pay for modern medical care turn to Traditional Medicine which is available and affordable on a large scale as the better option. In contrast, modern medical practice is materialistic in nature which is guided strictly by Structural Adjustment market strategy of out of pocket payment before service is provided. Most people who can afford modern medical care are those with sound economic background and these people on a greater scale live in first class residential areas.



In this study, Marx's perspective is useful in understanding and explaining the high patronage and utilisation of Traditional Medicine because the health care system of Nigeria mirrors the society's class structure. This structure is seen through control over health institutions, stratification of health practitioners, and limited occupational mobility into health professions. Health policy recommendations reflect the interest of the aristocrats and the ruling class groups. The state's intervention in health care generally protects the capitalist economic system and the private sector. Medical ideology helps maintain class structure and patterns of domination.

Prior to the colonial conquest, Nigerians had a health care system (Traditional Medicine) that was self-serving (Taiwo, 1993). This kind of medicine served their needs reasonably well (Alubo, 1995). During colonial period, modern health resources were established and distributed by the colonial Governments to promote colonial goal of political, economic ambition and pacification at the same time discrediting the existing Traditional Medicine (Alubo, 2001). When on board, the Nigerian ruling class continues to accord official recognition to the kind of medical care introduced by the European to protect their interests. The laws and policies that emanate from the state reflect the interest of the dominant ruling class, to the detriment of the teeming masses (Trueman, 2015). This class owns the pharmaceutical industries, contractors of medical facilities and best medical schools for their children and would not like any policy that goes against their economic interest. Thus, profits derived from such business ventures are used to maintain their power in the state. This explains why Traditional Medicine is not officially recognised and healers are not licensed to practice despite the pressure put on the government by both traditional healers and their clients. For fear of reaction by citizen they did not banned or criminalized Traditional Medicine but merely tolerating it, but meanwhile thwarting its effort to grow and highly discouraged its use.

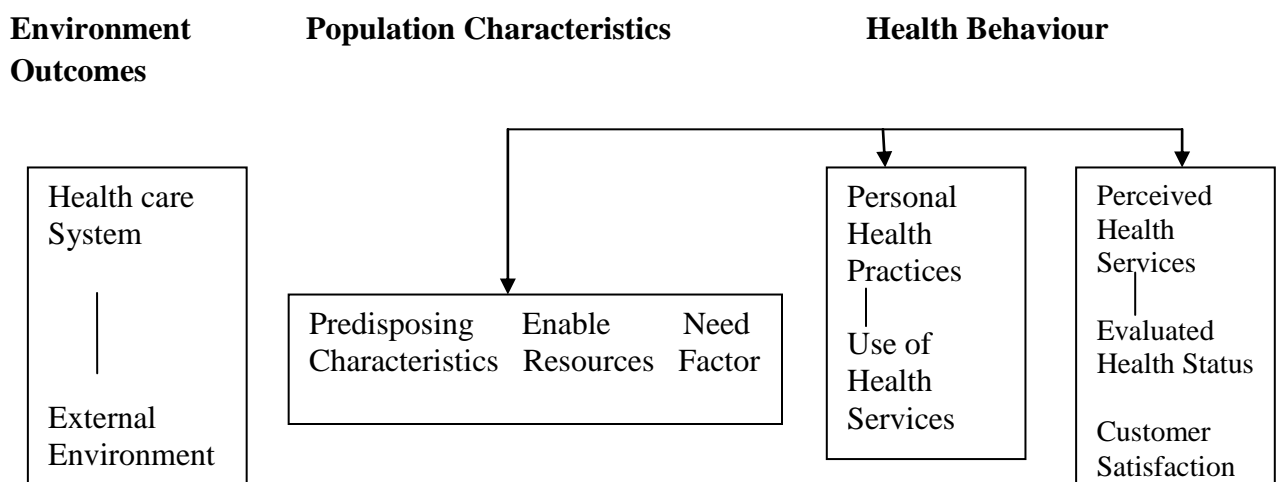
While the forgoing explains preference of modern medicine over traditional medicine by the Nigerian state, it also explains why the contribution of traditional health care is relatively ignored by national health care policies in the country. Relevance of the Political economy of traditional medicine to this study would be better appreciated when we place traditional medicine vis-à-vis in comparative terms with modern medicine. For instance, Olaolorun et al., (2001) while calculating the difference in the charges made by traditional bonesetters and orthopedic hospitals in South West Nigeria established a 4-fold difference in the charges between traditional and modern medicine. A traditional bonesetter is said to charged N3, 385 (\$30) on average, modern hospitals charges an average of N12, 500 (\$130) for a simple fracture. It is such comparatively high charges by modern medicine that Omololu et al., (2002) identify as the prohibitive cost that drives potential health seekers away from modern care in a hospital setting. It follows that the high cost of Modern Medicine and drugs to treat and manage diseases seem to be felt by poor households, middle and low income earners, especially in Kaduna State. Gandu (1992) study established that at no time was this phenomenal reality expressed than in the aftermath of the introduction of Structural Adjustment Programme (SAP) in 1986. One of the social and economic costs of SAP on the health sector was the difficulties experienced by the urban poor to pay for health care services. This resulted in a sharp increase in the patronage of Traditional Medicine.

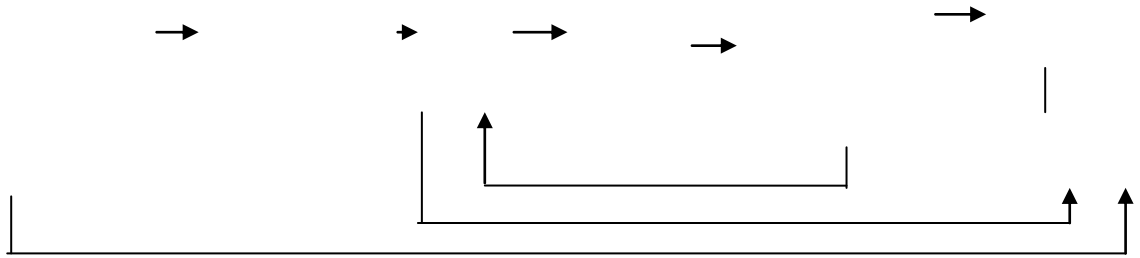
The Behavioural Models of Health Service Utilisation evolved from the health belief model introduced in 1950s which was letter modified by Andersen and Newman, 1973. The Behavioural Model of Health Services Utilization developed by Andersen and Newman, 1973) is built on the premises of the conditions that either facilitate or impede

utilization of health services. The model has four components, including environment, population characteristics, health behaviour, and health outcomes (Andersen, 1995).

The behavioural model of health services utilization is adopted in this work to complement the political economy of health perspectives. Andersen and Newman (1973) framework for understanding health services utilisation takes into account societal and individual determinants of health service utilisation. The societal determinants include the norms about the health care system and the external environment. The individual determinants include predisposing characteristics, enabling resources and need actors. The societal determinants are shown to affect the individual determinants both directly and through the health service system which have been vividly explained by the political economy of health. The health services used by individuals are influenced by different individuals' determinants. Essentially, the behavioural model suggests that individual's access and use of health services is a function of three determinants, namely predisposing characteristics, enabling resources and need factors (Andersen and Newman, 1973). The model, thus, assumes that a sequence of conditions contribute to the type of level of health service a person uses. The use of a health service then depends on the predisposition of the individual to use services, his ability to secure the services, and his illness level (Andersen and Newman, 1973).

**Figure. 2.1: The Behavioural Model of Health Services Utilisation**





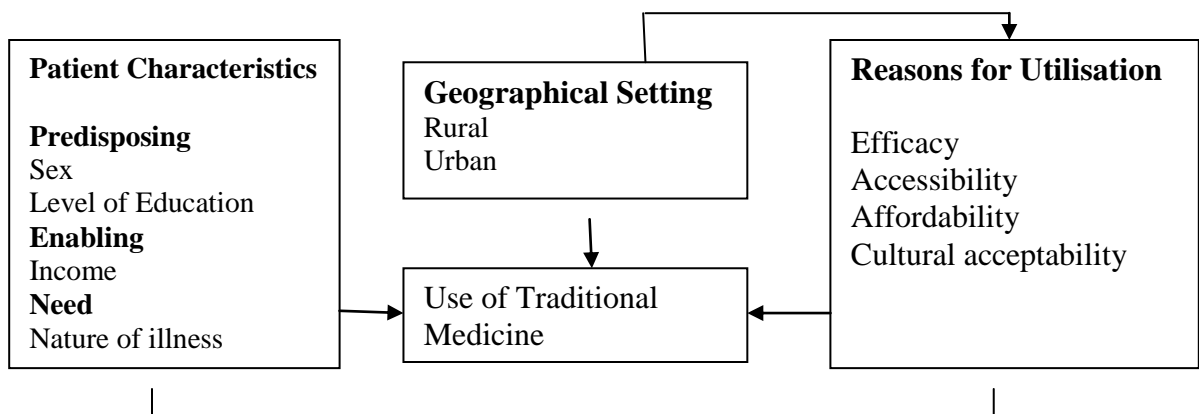
**Source: Andersen and Newman (1973)**

According to Andersen (1995), individuals are predisposed to use health services depending upon their socio-cultural characteristics that exist prior to the illness, such as demographics that is, age and sex, social structure, which include, education, occupation, ethnicity, social networks, social interactions and culture, and health beliefs that is, attitudes, values, and knowledge that people have concerning and towards the health care system. The social structure variables mirror the location (status) of the individual in his society as measured by characteristics such as education and occupation of the family head (Andersen and Newman, 1973). These characteristics predict what the lifestyle of the individual may be, and they point to the physical as well as social environment of the individual and associated behaviour patterns which may be related to the use of health services.

With regard to the attitude or beliefs about health care, it is believed that what an individual thinks about health may ultimately influence health and illness behaviour (Andersen and Newman, 1973). Health beliefs are not considered to be direct reasons for using health services but affect one's inclination toward use of health services. For example, individuals who strongly believe in the efficacy of herbal remedies might seek the services of a traditional medical practitioner more often than individuals with less faith in the results of herbal treatment. Therefore, factors that are associated with patient's utilisation of traditional health care services like herbal care, home health care, and community's service among others play vital role in Traditional Medicine utilisation. The models explored preliminary as a template for prevention and the delivery of services that address health risk behaviours.

Bearing in mind that other variables such as the geographical setting, efficacy, affordability, cultural acceptability need to be known to find out any possible emerging trends in the study communities a later developed model from the behavioural model gives a clearer picture for the utilization of Traditional Medicine as shown in Figure 2.2.

**Figure 2.2 Modified Behavioural Model on Utilization of Traditional Medicine.**



**Source: Adapted from Andersen and Newman (1973)**

The model depicts the use of Traditional Medicine at the centre, which depend on other factors. The predisposing characteristics, enabling resources, need factors, Geographical setting, efficacy, accessibility and cultural acceptability. The model shows that patient characteristics influence the level of use of Traditional medicine. The

characteristics include, predisposing, enabling resources and need factors. Predisposing characteristics are sex and level of education of the patient. Enable resources is the income of the patient and the need factors include the nature of the illness. Furthermore, the Geographical setting of a people determines their level of use of Traditional Medicine. This includes rural and urban settings. Besides, the use of Traditional Medicine depends on its efficacy, accessibility, affordability and cultural acceptability.

However, the emphasis of the model is centered on Modern Medicines use, while disregarding Traditional Medical use. Modern Medical Care is always considered to be the 'suitable standard' in accessing health care (Sato, 2012d). The model therefore, did not mirror the important role that Traditional Medical system plays in developing economies (WHO, 2010). Its attention is on Modern Medical Practice while neglecting the ways to improve Traditional Medical Care as a suitable alternative and/or complementary system to national health delivery system

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Location of the Study**

The location of the study is Kaduna State which is situated in the Southern part of the High Plains of Northern Nigeria. It lies between parallels 9°03'N, and 11°32'N, and extends from the upper River Mariga on 6°05'E to 8°48'E on the foot slopes of the scarp of Jos Plateau. The total land area of the state is 46,053km<sup>2</sup> which is about 5% of the total land area of Nigeria (Kaduna State Ministry of Economic Planning, 2013). To the South-west, the State shares border with the Federal Capital Territory, Abuja, Nassarawa State to its South, Bauchi and Plateau States to the East, Niger to the West, while Zamfara,

Katsina and Kano States take up its Northern boundaries positioning it as a communication and economic hub (State Ministry of Economic Planning, 2013).

Kaduna State population is estimated as 6.4 million people spread across 23 Local Government Areas (LGAs) and 255 political wards, according to the National Population Commission (NPC) (2006). The actual field research is conducted in two selected Local Government Areas (LGAs) from each of the three Senatorial Zones of the State, totalling six LGAs in all. The decision to spread this study across the three Senatorial Zones is primarily influenced by the presence of Traditional Medical Practitioners at different rural locations in Kaduna State. One major thing that is constant in Kaduna State is that major modern health care facilities and hospitals are largely urban based. These health care facilities include the General Hospital, Kafanchan, located in the Southern Senatorial Zone; Barau Dikko Hospital, Gwamna Awan Hospital, Yusuf Dantsoho Hospital, General Hospital, Tudun Wada and General Hospital, Sabon Tasha, all located in Kaduna Central Senatorial Zone. There are also four Federal Hospitals in this zone: Army Reference Hospital (44 Hospital), Federal Neuro-psychiatric Hospital, National Eye Centre, and Ear and Throat (E and T) Hospital. In the Northern Senatorial Zone, Zaria is the largest town. The largest State Hospitals are Gambo Sawaba and Sabon Gari (Limi) General Hospitals. The Federal Hospitals in this zone include: National Tuberculosis and Leprosy Training Centre, Sayi Zaria, and the Ahmadu Bello University Teaching Hospital, Shika.

In all, Kaduna State has 739 Primary Health Care Facilities, 29 Secondary Health Care Facilities, five Tertiary Hospitals, 656 Private Health Care Facilities and 2,500 registered patent medicine shops (Kaduna State Ministry of Health, 2009). Each of the



three Senatorial Zones has Primary Health Care Clinics, private clinics/hospitals, patent medicine stores including faith and spiritual healing centres. There are also eight tertiary institutions of learning and four post-basic health-training programmes for human resources development for the Healthcare Services. These facilities are largely urban based. While there are Traditional Medical homes/shops in urban areas of Kaduna State, such facilities are rare. Given that modern health care facilities are not common in rural areas of Kaduna State, the field work of the study focused on both urban and rural areas as the target population, particularly rural areas where modern health facilities are less available and accessible to the citizens. This study, therefore, argues that there is the need to shift attention away from the clients of Modern Medical Healthcare services to those of Traditional Medicine with a view to understanding the contributions of the latter to healthcare in the study area.

In a State of over 6.4 million people, only 2,723 health personnel are available and are disproportionately distributed. This gives a low population ratio of 1:2350. Excluding those in the private sector, faith based and Federal institutions, Kaduna State Government has only 180 Medical Doctors, 213 Pharmacists including Technicians, 91 Laboratory Scientists, 14 X-ray Radiographers and Technicians, 2520 registered Nurses and 120 health support officers making a total of 3138 modern health personnel in the State service (Kaduna State Ministry of Health, March 2010). This number of health personnel and the available health facilities are inadequate to handle the health challenges of the over six million people. This suggests that a significant number of citizens has to seek alternative medicine.

The predominant occupations of the people of Kaduna State include: farming, trading, cattle rearing and government work. Traders, artisans and civil servants are predominant in Kaduna town which has a large number of ministries and private companies' headquarters. Subsistence agriculture is the dominant occupation of those living in rural areas. Kaduna State is the most ethnically and culturally diverse state in the north-west geopolitical zone. The poverty level has increased from 67% to 95% between 2001 and 2013 (Aliyu, 2013).

### **3.2 Population of the Study**

In order to collect data capable of providing answers to the research questions of the study, the target populations comprises selected traditional healers, adults (18 years above) clients of THs or adults who have ever used the services of traditional healers in the study community, relatives of those who patronise or have ever patronised the services of traditional healers, community leaders, youth leaders, representatives of religious organisations and officials of the State Ministry of Health.

### **3.3 Sampling Procedure**

To determine how Traditional Medicine is perceived and utilised by health care seeking citizens of Kaduna State, a multi-stage cluster sampling technique was used because of the wide geographical spread of the population and the social heterogeneous nature of the State. The essence is to have a good representation of the entire population.

#### **3.3.1 Selection of Respondents for the Survey**

For fair representation, a multistage cluster sampling technique is used in this research. The first stage involves taking on all the three existing Senatorial Zones, Kaduna South, Kaduna North and Kaduna Central as clusters. The second stage involves selecting

two LGAs, predominantly rural from each cluster through simple random sampling technique. A Hat and Draw method of randomisation is used in selecting the LGAs. Names of LGAs were written on pieces of papers, folded and mixed thoroughly in a hat, shaken and picked one after the other. The names of the LGAs picked are selected for the study. The following LGAs are selected: Soba and Kudan in the Northern Senatorial Zone, Giwa and Kajuru in the Central Senatorial Zone, Zongon Kataf and Kachia in the Southern Senatorial Zone. This gives a total of six LGAs (See Appendix VII).

The third stage is the selection of Wards. Using the same simple random sampling procedure the following Wards are selected: Kwaturu in Kachia LGA, Gidan Jatau in Zangon Kataf LGA, Kasuwan Magani in Kajuru LGA, Maigana in Soba LGA, Hunkuyi in Kudan LGA and Giwa in Giwa LGA, giving, a total of six wards (See Appendix VII). Furthermore, purposive sampling is used to select larger communities based on many households and population sizes. The communities selected are: Abet in Gidan Jatau Ward, Kwaturu in Kwaturu Ward, Kasuwan Magani in Kasuwan Magani Ward, Giwa in Giwa Ward, Hunkuyi in Hunkuyi Ward and Tudun Saibu in Maigana Ward. By so doing, the selected study units within the zones fairly represent each of the three Senatorial Zones of the State. For urban areas, one large town is purposively selected from each zone to make a total of three. The towns selected are Zaria, Kaduna and Kafanchan. The rationale for this is that the socio cultural practice of health care services of the people in the rural areas is likely to be different from what obtains in the towns. Large towns are distinguished from the small towns in terms of the population size, types of occupation, social organisation and the availability of social amenities such as electricity, roads, schools, well equipped hospitals, pipe borne water, railway stations and other services.

The adoption of this criteria is to ensure easy access to respondents, research participants as well as informants with the objective of obtaining representativeness for both the quantitative and qualitative data.

To select the respondents from rural and urban communities, attention is restricted only to adults (18 years and above) that had lived in an area for at least five years. For the purpose of convenience, 110 respondents are selected each from the six communities and 220 respondents each from the urban areas. To select the respondents in each community, five existing administrative units (referred to as *Ungwa* in Hausa) are identified with the assistance of the community heads (village head). In each *ungwa*, eleven large households (compound families) are purposively selected since there are no records to show house numbering. Households constitute the basic units of inquiry because the respondents come from there. Fifty five (55) households are selected from each rural community giving a total of three hundred and thirty (330) households selected for the survey from the six rural communities. This comprises of 110 households in the South, 110 households in Central and 110 households in the North Senatorial Zones of the State.

In the large towns, two major streets are purposively selected because of the large population size. The criterium used for the selection is based on the already existing criteria of centrality, business/ administrative area, and other religious clustering. The major streets selected are: Gaskiya Road, Tudun Wada, in Zaria LGA with 158 households, and Main Street, Ungwan Maigado in Sabon Gari Zaria with 159 households. In Kaduna, Kachia Road at Sabon Tasha with 171 households, and Abeokuta Street/Maiduguri Road by Constitution Road with 159 households are selected. In

Kafanchan, Kagoro/Ungwan Rimi Road with 157 households, and Takau Road with 151 households, are also selected. A total of 955 houses are identified, with an average of 159 households per street. Within each chosen study area, selection of participants for the survey is done systematically by selecting every 3<sup>rd</sup> house along a street on both sides of the road after the first houses on either side of the street are selected first. Fifty five (55) households from each street are selected. In all, one hundred and ten households are selected from each large town (Kaduna, Zaria and Kafanchan) giving a total of three hundred and thirty (330) households for the administration of the questionnaire.

In a selected household an adult male, preferably the household head and any adult female are selected to respond to the questions. There are no restrictions placed on the participants on the basis of gender, language and religion. The sample is demographically diverse. Hence, in the absence of any of these respondents, the next person in the order of age, seniority or authority, is selected. If structure persons selected are unwilling (since it is voluntary) the researcher goes on to the next eligible house-hold to seek for a willing participant. The preference for adults is to ensure that the respondents are assumed to be knowledgeable and could make informed decisions by themselves, and contribute meaningfully and effectively to the study.

A household in this study consists of a person or group of related or unrelated persons who live together in the same housing unit, share same housekeeping and acknowledge one person (usually an adult) as its head. In a compound housing unit where a group of households live only one household was studied to represent all the units. To avoid issues of possible double-counting of persons. Practical rules followed were:

### Criteria Exclusion

- i. Exclude sampling of public buildings, e.g.: hotels, boarding houses, hostels, jails, military barracks or nursing homes and so on. (these would be excluded by default anyway given the household selection process whereby researchers must look for 'the most common type of housing' as a starting point); and
- ii. Exclude the 'floating population' (those who are not settled permanently).
- iii. Exclude foreign nationals without citizenship.

### Inclusion Criteria:

- iv. Include all those who have been residing in the household for at least the past six consecutive months (apart from children below 18 years).

### **3.3.2 Selection of Informants for the Qualitative Data**

For the qualitative data, information is sought from traditional healers, clients of traditional healers, modern medical personnel, community's leaders and some key informants in the community. Clients of traditional healers, community leaders, modern health personnel and some key informants were purposively selected. Purposive sampling is a type of non probability sampling in which the units to be observed are selected on the basis of the researcher's judgment about which ones will be the most useful or representative. It is a technique used to select a sample on the basis of knowledge of a population, its elements, and the purpose of the study (Vogt, 1999). The rationale for this method is to concentrate on people with particular characteristics who will better be able to assist with the relevant information for the study.

Fifty seven (57) Traditional Medical Practitioners were selected using snowball sampling technique. This decision was not to seek representativeness, but to have in-depth information from Traditional Healers of different social background. The fifty seven Traditional Medical Practitioners are specialists in bone-setting, mental health, faith healing, traditional surgeon, maternal and child care and herbal practitioners as shown in Table 3.1.

**Table 3.1 Place of Residence and Type of traditional Medical Practitioner**

Location of interview	<u>Type of traditional Medical Practitioner</u>							
	Bone setters No.	Mental healers No.	TBAs No.	Herbalists No.	Faith Healers No.	Traditional Surgeons No.	Bori No.	Total No.
Kaduna	1	1	1	7	2	-	1	13
Kafanchan	-	-	1	3	1	-	-	5
Zaria	2	1	1	7	2	1	-	14
Kwaturu	2	1	1	1	-	-	-	5
Kasuwan Magani	1	1	1	1	-	-	-	4
Gidan Jatau	1	1	1	1	-	-	-	4
Giwa	-	-	1	3	-	-	-	4
Hunkuyi	-	-	1	3	-	1	-	5
Maigana	1	-	1	1	-	-	-	3
<b>Total</b>	<b>8</b>	<b>5</b>	<b>9</b>	<b>27</b>	<b>5</b>	<b>2</b>	<b>1</b>	<b>57</b>

**Source: Field Survey 2017**

These categories of healers are identified to practice the art of TM in their various communities. Seven (7) modern health practitioners, who have worked for at least for five years or more in different area of specialisation were purposively selected for

interview because they can explain better in their areas of specialisation. In the Southern Senatorial Zone, a Medical Doctor and one Nurse were selected. In the Central Senatorial Zone a Psychiatric Doctor, a Psychiatric Nurse, and a General Nurse are selected. In the Northern Senatorial Zone, an Orthopedic Doctor and one General Nurse are selected. Their views on the role of Traditional Medicine in health care are the main foci.

From each selected community, one community leader (A Village head) is interviewed. The leaders are selected by virtue of their position as custodian of the community; who should know the healers and their medical expertise in the community where they live. On the basis of this requirement most of them volunteered to take part in the interviews. The community leaders also recommended other opinion or religious leaders who were similarly interviewed. In each of the nine communities where the study was located, two informants participated in the interviews. Thus a total numbers of eighteen participants took part in the in-depth interviews conducted in the nine different communities. The clients of the Traditional Medicine are also interviewed. Their selection is based on their presence at the Traditional Medical clinics identified in the community selected for the study. Eighty one (81) clients of Traditional Medicine who are undergoing treatment at the time of the study were interviewed. As for the mental patients, the relations served as proxies for the sick relatives where necessary. Twelve women who are delivered of their babies by Traditional Birth Attendants are interviewed. Nine discharged former patients of traditional healers who have been successfully treated for various ailments by traditional healers are also interviewed. A Director of Pharmaceutical Services, in the Ministry of Health, Kaduna State is also interviewed.

### **3.4 Method of Data Collection**



Data for the study are generated through quantitative and qualitative data collection instruments/techniques. The quantitative data are collected through survey instrument, namely: structured questionnaire; whereas the qualitative data are elicited through Focus Group Discussions (FGDs) and In-depth Interviews (IDIs).

### **3.4.1 Quantitative Data Instruments**

The quantitative instrument is structured questionnaire which is administered in interview form. Questionnaire administration takes place as a general survey among adults in randomly selected households in the study communities. The questionnaire treats in relative detail, the variables related to the problems and objectives of the study. To guarantee some kind of flexibility in the view data collection, two kinds of schedule items are used namely pre-coded (fixed alternative) or close-ended and open ended questions. Fixed alternative items required respondents to choose among two or more alternatives. This provided the opportunity of comparing the uniformity or otherwise of response. On the other hand, the open-ended items or questions, which did not impose restrictions on the content and manner of respondents' answers, provided the opportunity to probe into the depth of the responses. Moreover, open-ended items enabled the researcher to clarify any misunderstanding by probing to detect ambiguity and respondents' lack of knowledge. Furthermore, because open-ended questions encourage cooperation and can build rapport, it helped to estimate respondents' true intentions, beliefs and attitudes. On the whole, the decision to use questionnaire was to gather data from a large number of people about their views on traditional medicine (Appendix D). The main areas covered in the questionnaire are on socio-demographic backgrounds; patronage and utilization of Traditional Medicine; types of ailment for which treatment is

sought; reason for patronising Traditional Medicine; services provided by traditional health providers; perceived relevance of indigenous health services to health needs of the clients in terms of treatment effectiveness, affordability and availability. The questionnaire is self-administered by the literate respondents while the items are read to the non-literates and their responses recorded accordingly. All together, 1320 questionnaire are distributed and 1242 (94.1%) are retrieved. Prior to the administration of the questionnaire, nine research assistants are trained on the basic skills and techniques as well as providing them with detailed information on the meaning and requirements of each question contained in the questionnaire and how respondents were expected to fill the questionnaire. Four of the research assistants are graduates of Political Science, Geography, Language Arts and Creative Arts respectively. However, four of the field assistants are National Certificate of Education (NCE) and an HND holder in business administration.

### **3.4.2 Qualitative Data Collection Instruments**

The qualitative data collection instruments are Focus Group Discussions (FGDs) and In-Depth Interview (IDI) guides. The FGDs are held with adult male and female of the study communities. The goals of these FGDs are to collect data on the perceptions and views of participants on utilisation of Traditional Medicine to ascertain the prospect of change in behaviour based on their responses. FGD is used in this study because of its ability to provide insights into complex patterns of utilising Traditional Medicine in the face of approved mainstream health care (modern medicine). Information captured from the FGDs enriched and also complement the data obtained from the questionnaires.

A total of twelve FGDs are conducted for the study; four FGDs in each of the Senatorial Zones of the State. Six FGDs came from urban areas, while the other six were conducted in rural areas. The groups are formed to be fairly homogeneous with respect to residence (rural or urban) and sex so as to minimise inhibition in the flow of the discussions. Each FGD comprised seven or eight discussants. Participants were chosen in a non-probabilistic random fashion from various communities or settlements to ensure a broad range of experiences within each group. Focus group discussions were led by trained indigenous moderators and note-takers (males and females depending on the sex of the group), who were trained by the researcher on Focus Group Methodology. All the moderators and note takers are university undergraduates of humanity-based disciplines. They are however closely supervised by the researcher. As a prelude to the discussion, the moderator provides a general introduction to the study and the the importance of the specific session. Anonymity and confidentiality are assured, and permission from the discussants is (with explanation) sought for the use of tape recorder. The interview guide used for the FGDs is attached as Appendix IX.

Furthermore, sixty five in-depth interviews (IDI) are carried with professionals on various fields of health care, one hundred and two clients of traditional healers and eighteen community leaders. The IDI is served as tools to gather in-depth and firsthand information about the perception and utilisation of Traditional Medicine. In-depth interview guide which consisted of topic guides to ensure that important issues is prepared by the researcher for each of the categories, that is, traditional healers, clients of Traditional Medicine, community leaders and government officials (Appendices II-VI). The interview technique is tailored to these groups of interviewees because they are

knowledgeable or experienced enough to provide information about Traditional Medicine. The interview guides contain statements and probe questions which are tailored in accordance with the objectives of this study. Those willing are interviewed in their premises or place of practices. Interviews are either conducted in the English language or Hausa. The interviews are audio-taped, and later transcribed verbatim and then read several times to check for accuracy.

Observation is done during the field work to check for nonverbal expression of feelings, determine who interacts with whom, grasp how traditional healers communicate with their clients, practice environment, number of clients visiting the healer at the time of interview and check for how much time is spent on various activities. The method provided useful understanding of how traditional health products are processed, packed, stored, displayed, distributed, and marketed in both urban and rural settings. The observable actions are written either in a jotter or in a pictorial form (Plate 1-10).

### **3.5 Data Analysis**

The data collected through survey method are processed using the Statistical Package for Social Sciences (SPSS) version 21 and Microsoft Excel 2007 software. The software is used to aid the analysis of quantitative data, after they are arranged, coded and edited. Coding is the process of translating verbal data into categories or numerical form, where necessary. Two types of analytical techniques are employed in the analysis of the quantitative data in order to achieve the stated objectives of the research they are, the Univariate and Bi-variate analysis with the level of significance at 0.05.

The univariate analysis involved the use of descriptive statistics such as frequency counts and percentages to describe the background characteristics of the respondents, the distribution of their perceptions of Traditional Medicine. The focus of the background characteristics data is on the numerical description of the age, educational level, religion, income, gender and ethnicity. Bivariate analysis involve cross tabulation and the use of Chi-square ( $X^2$ ) statistic to indicate the differences across categories.

The data collected through FGDs and IDIs are first of all transcribed and translated and sorted according to the research objectives using content analysis. In all, the transcriptions are then reviewed and relevant quotations that captured the themes and ideas being expressed in each question are noted and compiled. Since the discussion covers the same topics in more or less the same order, the research report provided a balance between the direct quotations of the participants and the summarisation of their discussions to form the topic of analysis. The results and information gathered from the focus group discussions and interviews are used to add strength to the results of the quantitative data analyzed.

### **3.6 Challenges Faced in the Study**

There are difficulties in generating data from traditional health practitioners on the rate of patronage and background characteristics of their clients because none of them kept written records on their clients. Modern Practitioners were simply reluctant to give classified information for the research on the basis that their records are confidential. In addition, it was difficult to meet the survey residents in their houses because most of them went to work early. Also, there was the problem of understanding the questions,

since many respondents have little education. These challenges stand the chance of affecting the quality of information of this work.

However, measures taken to overcome these problems include assuring the respondents that information provided would be treated confidentially. The participants were encouraged to re-call their experiences on some of the issues under review. The researcher also went to the communities very early in the morning or in the evening to overcome the problem of not meeting respondents at home. Questions were translated for respondents in the local language especially Hausa since it is the most common language spoken in the State. The responses were translated in English by the researcher. Thus the above limitations have no adverse effects on the results of this study.

### **3.7 Ethical Issues**

Appropriate ethical steps such as informed consent voluntary participation, maintenance of confidentiality, adequate briefings before the commencement of data collection were followed/observed. The respondents were treated with due respect to maintain their integrity and human rights. Every respondent was informed that participation is voluntary and they are free to ask for clarification or withdraw consent whenever they so wished. The participants were re-assured that all information would be treated anonymously and confidentially. The researcher complies with the application procedures of the research permit from the Department of Sociology, Ahmadu Bello University, Zaria and was given a Letter of Introduction. Similarly, permission to conduct the study was sought and obtained from the State Ministry of

Health and the National Psychiatric Hospital, Kaduna to conduct a research with the staff and clients of the hospital.

## **CHAPTER FOUR**

### **DATA PRESENTATION AND ANALYSIS**

#### **4.1 Introduction**

This chapter is the analysis of data. It consists of five broad sections. The first section presents data on the socio-demographic characteristics of the respondents. The second section examines the services provided by traditional medical practitioners. The third section looks at the health challenges for which traditional medical services are sought. The fourth section examines the socio cultural and economic factors influencing patronage and utilisation of Traditional Medicine. The fifth section presents information on socio-economic profile of Clients who patronise Traditional Medical Practitioners and

section six looks at government position on Traditional Medicine services in Kaduna State.

#### 4.1.2 Socio-demographic Characteristics of the Study Sample

Data are collected on the age, sex, marital status, religion, ethnic group, education, income, educational attainment and occupation of the respondents. The socio-demographic background information gathered provided useful insights on the 1,242 respondents who participated in the survey. The socio-demographic characteristics are shown in Table 4.1

**Table 4.1 Socio-demographic characteristics of the respondents**

Variables	N= 1242 Frequency (F)	Percentage (%)
<b>Sex:</b>		
Male	661	53.2
Female	581	46.8
<b>Age:</b>		
< 25	271	21.8
26-40	661	53.2
Above 40	310	25.0
<b>Marital status:</b>		
Married	825	66.4
Single	347	27.9
Divorce	46	3.7
Others	24	1.9
<b>Ethnic identity:</b>		
Southern Kaduna state Indigenes	469	37.8
Hausa/Fulani	427	34.4
Yoruba	89	7.2
Igbo	89	7.2
Other Northern Nigerian ethnic Groups	81	6.5
Other Southern Nigerian ethnic Groups	87	7.0
<b>Religious Affiliation:</b>		
Christianity	663	53.4
Islam	549	44.2



	Traditional	30	2.4
<b>Education:</b>			
	No formal education	189	15.2
	Primary	293	23.6
	Secondary	347	27.9
	Tertiary	297	23.9
	Others	116	9.3
<b>Monthly income in Naira:</b>			
	≤ 19,000	633	51.0
	20,000-39,000	395	31.8
	40,000 and above	214	17.2
<b>Occupation:</b>			
	Civil Servant	269	21.6
	Farming	375	30.2
	Artisan	178	14.3
	Business/trading	322	26.0
	Home maker/Unemployed	98	7.9
<b>Source: Field survey, 2017</b>			
		<b>where F= Frequency</b>	<b>%= percentage</b>

Table 4.1, fifty three percent (53.2%) of the respondents are males and 46.8 percent are females. The higher proportion of males may be because there are more males in the study sample and in some communities women are not allowed to talk to other people without the permission of their husbands. The proportion of respondents aged 26-40 years who took part in the study are young adults 53.2 percent whereas those aged 40 years or more is 25 percent. The average age of the respondents is 34 years. In terms of religion, those who professed Christian faith dominated (53.4 %) followed by Islam (44.2%) and only 2.4 percent respondents say that they practice their respective traditional religions. Basically, Islam and Christianity are the two dominant religious groups in the study area. Religious affiliation is an important variable in the choice of treatment from any source of health care services because it directs the behavior of an individual on the kind of treatment an individual should go for.

There are many ethnic groups in Kaduna State, but for easy analysis the respondents are categorised according to some cultural traits observed during the survey. The data on ethnic group displayed on Table 4.1 show that the ethnic groups of Southern

Kaduna State constitute (37.8%), and Hausa/Fulani (34.4%) are major ethno-cultural groups captured in the study. Several other ethnic groups are identified under the broad categorisation such as Idoma, Igala, Ibibio, Effik and many others. The distribution of respondents according to their marital status presented in Table 4.1 shows that 66.4 percent of the respondents are married, 27.9 percent were single, divorce 3.7 percent and other 1.9 percent. The educational attainment of respondents as shown in Table 4.1 shows that majority (75.4%) have formal education with secondary education as the most attained level 27.9%, followed by 23.9% tertiary education and 23.6 percent primary school. Distribution according to average income per month demonstrates that majority (51.0%) of the respondents earned N19,000 or less per month. This suggests they are within the national minimum wage N18,000. Similarly, the data reveal that majority of the respondents are engaged in one occupation or the other with the exception of 17.2 percent who are either or home makers or unemployed. Table 4.1 shows that 21.6 percent of the respondents are civil servants, followed by artisans (14.3%), business/trading (26.0%) and farming (30.2%).

#### **4.1.3 Socio-Demographic Characteristics of the Interviewed Respondents**

The first category in our target population constituted the traditional healers. This category of our study population include bone setters, traditional mental healers, traditional birth attendants (TBA), faith healers, herbalists, traditional surgeons, and *bori* (See Table 3.1). In terms of the educational profile of Traditional Healers in Kaduna State, this study reveals that majority did not have formal education. For instance, among the eight bone setters interviewed, the sources of the medical knowledge and practice of this category of Traditional Healers are mostly inherited from on-the-job-training from either their parents or grandparents. In the case of the nine TBAs, the study indicates that majority of them are middle-aged women who acquired their skills and sought knowledge from older women (relatives or neighbours) during their youth. With continue practice they are able to strengthened and improve their skills and knowledge through the years.

The implication of this finding is that this category did not also have formal educational training. For the 27 herbalists only two had attempted junior secondary school which they did not finished. All others in this category had no formal education. Most of them (21) acquired the profession from either their parents or grandparents while the remaining 6 herbalists learnt the job as apprentice from their masters. Faith healers two are Muslims and the other three are Christians. The faith healers had acquired some education in the areas of their religious believe. As for the traditional surgeons, they inherited the profession from their parents.

The traditional healing profession in Kaduna State is dominated (44) by male as against (13) female traditional healers. The average age of the healers was 41 years and had practice for more than 10 years. Healers entered the profession at the young age of between 17 and 22 years old. More than half of the healers are elderly (that is, over 45 years of age). In general, more than half (32) of the traditional healers interviewed reside in large towns of Kaduna State (Kaduna, Zaria and Kafanchan). This indicates a shift from rural to large towns where the business is lucrative due to large population of people in the towns.

In terms of educational profile, the study found that the highest educational qualification attained by some community' leaders is secondary school while the least is primary school. For the stakeholders all have acquired tertiary education either from a university or polytechnic. Nine youth leaders participated in this study and the study found that majority of them had acquired a secondary school education. The average age of the community leaders interviewed is fifty years and has occupied the position for more than five years. Most of them are engaged in farming as an occupation with the exception of community leaders in township who took farming on part time basis. The ages of youth leaders ranges between twenty five and thirty five years. Most youth leaders are involved in different occupations for example farming, artisan work and teaching.

#### 4.2. Health Care Services Provided by Traditional Health Practitioners

This section presents an analysis on the health care services provided by the traditional medical practitioners in Kaduna State. Cataloguing the main health care services and their respective providers is a vital step in the direction of understanding the utilisation of Traditional Medicine in Kaduna State. First, the services under survey responses are catalogued based on the broad health care design of the State which includes: curative, preventive, promotive and rehabilitative. The respondents' views on the broad types of health care services are presented in table 4.2

**Table 4.2 Types of services obtained from traditional healers**

Type of Service	Area of Residence				Total
	Urban		Rural		
	F	%	F	%	
Curative	327	55.7	375	62.0	702
Preventive	55	9.4	90	14.9	145
Promotion	90	15.3	26	4.3	116
Rehabilitation	115	19.6	114	18.8	229
<b>Total</b>	<b>587</b>	<b>100.0</b>	<b>605</b>	<b>100.0</b>	<b>1192</b>

**Source: Field Survey, 2017**

F=frequency, %=percentage

The data in Table 4.2 show that the curative service is the most frequently sought recorded in both rural (62.0 percent) and urban (55.7 percent) areas. However, promotion services accounted 15.3 percent in urban whereas 4.3 percent in rural areas. The result suggests that respondents surveyed patronise Traditional Health Practitioners for curative

services. The implication of this finding is that traditional healers' services are cherished in both rural and urban areas of the State.

Secondly, the study reveals that the broad services are achieved through specific services in their various communities. Discussion with Traditional Medical Practitioners', clients and communities' leaders during the interview on specific services provided by the healers in their communities are presented thus:

#### **4.2.1 Bone-Setters**

In this category, healers specialised in bone-setting and other bone abnormality. In terms of type of care TBS provide, aside fracture, sprain and dislocation, other bone abnormalities like bow legs and K-leg were treated. These are cases which are challenges to modern orthopedic practitioners and TBS provides continued care for patients who had earlier been to the hospital. The continuous utilisation of traditional bone setters by patients with bone problems implies either dissatisfaction with service received from modern orthopedic hospitals or belief in the efficacy of the practice of traditional bone-setters.

Expatriating on the services of TBS, a bone-setter in Kwaturu, Kachia LGA says:

My services are all about putting in place of bone fracture, joint dislocations and to some level bone abnormalities using traditional method. I massage to set the bone and apply tradition ointment made from herbs and rubbed on the affected area. Fracture is a broken bone at a flat location, while joint dislocation is the veering-off at the joints of human skeleton. In practicing my profession I have realized that joint dislocation stand to be healed faster than fracture because it takes three weeks to have a joint heal while a fracture takes four or more weeks depending on the level of the injury (A male bone setter in Kwaturu).

The above statement shows that bone setters are valuable asset in meeting the needs of people with bone challenges in their respective communities.

Affirming on the quality of the services provided by TBS, a 31 year male-TBS' client who suffers from compound fractures at Kwaturu, Kachia LGA. He states:

I had an accident on a motorcycle and had fractures in two places on my left leg. I was taken to the hospital, they treated the physical injuries sustained and were preparing me for referral to another hospital. I over-heard them saying they will refer me for possible amputation, but my family and I objected to their decision and opted for traditional bone setting.....We went for traditional bone setting and to my surprise it did not take us long when I had my leg fixed. You can see for yourself that I am using the leg perfectly well. Baba, the bone setter has saved many lives. I met three patients in Baba's home, six others came later, making a total of ten but by God's grace the first three were all healed successfully and have been discharged. Some will be discharged soon...in few days I know Baba will discharge me.

The above statement demonstrates that TBS serves as viable alternative to amputation at the orthopedic hospitals because they often record faster healing of fracture than at modern orthopedic facilities.

The practice of providing health care for patients in their homes by TBS referred to in this dissertation as 'home care delivery' is a commendable dimension of accessibility of health care service for communities. Explaining 'home delivery service' further, a 69 year old male traditional bone-setter in Zaria observes that:

Clients are brought to me at home but many invite me to treat their cases in their own home. For instance I was invited by one of highly influential person in the country to treat his ward whom orthopedic doctors had failed to cure. The location of the fracture was at a delicate position that is in between the legs I successfully treated the case. Since, I do not keep records of my clients; it is difficult to tell you the number of cases I treat in a year. But in a week I may have two or more cases to treat, but it all depends on prevailing situations around the community (A bone setter in Zaria)

It is clear from the above statement that TBS provide home services to some clients whose illnesses seem to defy the abilities of modern medical personnel

The mode of treatment by all the TBS is direct contact with the affected part of the body. Diagnosis by all the TBS interviewed was by observation, palpation of the surface of the fracture part and applying little pressure on the affected part. The fractured bone is set raw without the use of any pain relief (anesthetics). When the bone is set the herbal cream is applied on the area. After reduction and embalming, the affected part is splinted to immobilise the limb. All the TBS in the study areas acknowledged that splints are removed every three or four days depending on the degree of injury to check for faults in the setting of the bone. If the setting is found to be in place, warm water would be applied to the injured part, the herbal cream is then applied and the splint is again retied to the injured part. It takes 6-7 weeks of complete limb immobilisation to heal followed by another 6-7 weeks period of rehabilitation before return to normal function. During the second period, patients are gradually mobilised and the bonesetter continues to massage and wrap up the part weekly while also counseling the patient on some training exercise. This procedure by the TBS gives credit to the service rendered to their communities.

Findings reveal that all the bone-setters interviewed have no formal training in fracture care. The elder bonesetter learned the craft from another bone-setter and passed the skill to their children or apprentice along the line. This assertion is evidenced in the statement by a female bone-setter in Zaria who explains her own situation as follows:

I specialized in bone setting. I have been in this profession for more than thirty years. I inherited the skill from my parents. I work on dislocations and fractures; I straighten k-leg and bow legs. Many have left modern hospitals to seek treatment from me. I have treated a large number of cases in the past 30 years, but have not recorded the exact number. I use herbs, skill and knowledge in my treatment method. However, I have challenges like any other profession, for instance, bone setting is normally considered a male job but here I am a female, setting bones but lack crutches, patient accommodations and wheel chairs to move patients at the point of need (Bone setter, Zaria).

Two issues are central to the above statement: one has to do with type of care rendered to patients and the other the challenges experienced by the practitioners. On the issue of challenges, gender barrier and inadequate infrastructure are identified. Generally, females are associated with the practice of Traditional Birth Attendance and use of herbs in treating childhood diseases. Some of the male FGD participants considered female participation in a traditionally male dominated practice of bone-setting, as a deviation from gender roles and may experience the challenge of being accepted in the profession. They also acknowledged inadequate infrastructure in the home of traditional bone setters where they practice their art of healing. Inadequate equipment limits capability to effectively render quality services to clients.

In TBS homes across the three Senatorial Zones, 51 bone patients were interviewed and 246 respondents of those ever treated by TBS. Some of the major reasons given for choice of TBS include: a) Fear of inserting foreign objects in the body; b) Faith in the expertise healing powers of the bonesetter; c) Convenience and availability of traditional bone-setting; d) High cost of modern hospital setting; e) Acquaintance with bone-setter practice and insufficient knowledge about orthopedic centers. One of the bone-setters explains that she counsels her patients and their families to avoid Orthopedic centers because many of those who use such facilities “return with missing legs or arms or with foreign objects in their bodies”

On the average, the number of clients received per month by a TBS in the study area is fifteen (15). This position is evidenced from the statement by a female bone-setter in Zaria who says:

With the increase in the number of vehicles, motor cycles and tri-cycles on our roads many cases of fractures and dislocations are brought to us on daily basis. In a month I treat between 17 and 20 cases. I do not keep records but it may be more than that.



This statement demonstrates that a considerable number of clients patronise bone-setters in a month. It is evident that part of TBS services is decongestion of the number of fracture patients in the modern orthopedic sections in the modern health facilities in Kaduna State.

It is obvious from the above discussion that TBAs have been contributing a lot to health care in Kaduna State. For instance, the bone setters have treated patients with bone fractures and dislocations based on the testimonies of those who have been treated and those still on treatments (the 51 bone patients) in the study area. This suggests a reduction in the number of orthopedic patients in the hospitals and Government expenditure. This is not to say they have succeeded in treating all cases. The study notes one case fracture poorly handled by a traditional bone-setter which led to amputation of the leg in the hospital.

#### **4.2.2 Traditional Birth Attendants (TBAs)**

The practitioners in this category take up cases of maternal health and child birth. Their assignment is primarily to contribute to the good of mothers and babies in the community. Nine traditional birth attendants participated in this study, all of them are females as it seems to be, a female dominated practice. Findings reveal that the nine TBAs interviewed attend to most child deliveries in their respective communities, and provide postnatal care to mothers following delivery. In postnatal care, they administer a warm water bath for the mother and a warm bath for the baby for a period of time, both in the morning and in the evening for all days. The choice of morning and evening is based on the belief that if the mother and baby bath after sunset, it may attract some bad omen to the baby and mother. The TBA also play a role in coordinating post-natal procedures

caring for the umbilical stump, and teaching the mother how to feed the new baby. One important aspect expressed by the TBAs is on feeding the baby. A TBA in Abet observes:

After conducting the delivery I instruct the new mothers in the art of feeding. Specifically, babies who are reluctant to feed normally, usually at the age of three months I advise the mother to lay the baby on her laps, block the nostril with the left hand while using her right hand to pour the pap into the mouth of the baby via her left palm. The baby struggles to breathe and forced to swallow the pap in the effort to gasp for air.

The statement shows that mothers are taught about infant feeding practices to ensure proper nutrition for their babies. It is believed by the rural communities which the study took place that any infant not fed in this manner runs a risk of malnourishment. However, the method of force feeding exposed the baby to risk of suffocating which may lead to death.

The clients built good impression of the TBA which make them to prefer the TBA for subsequent deliveries over modern medicine. This seems to be the general opinion of most FGD participants in the rural areas. A rural-based female participant gave further insights and summed up the discussants on TBAs which express to be the general view of other FGDs:

In all, I have given birth to four children, three deliveries were conducted by a TBA and one was in the hospital. To be frank, the sanitary condition in the hospital is very good, but the cost of delivery is high for people like me. They always demand for soap, dettol, razor blade and some money. In the case of TBA anything that you can offer they will accept. On some occasions they do not collect anything. However, the sanitary condition cannot be compared to the hospital, but I was more comfortable with the TBAs services than the hospitals, because the reception given in the hospital was less cordial than the TBAs who will sit by your side and give you all the possible encouragement until you deliver (TBA client from Hunkuyi).

The above statements indicate that some mothers are comfortable to deliver their babies at home with the helps of TBAs than in the hospital. This suggests that ‘home delivery service’ help to meet the immediate need of a woman in labour better than the hospitals thereby saves lives of mothers and babies.

The experienced and skilled TBAs with good knowledge of traditional herbs and skills in their midwifery practices believe in their effectiveness. The quote below by a female Traditional Birth Attendant from Giwa illustrates this fact:

I have been in the practice of delivering children for more than twenty years. People know me very well in Giwa because of my work. My mother and grandmother were traditional birth attendants and the skill was passed to me. In the course of this work, I have delivered more than a hundred babies and I have not recorded any maternal death. I administer different types of herbs to pregnant women but that depends on the stage of the pregnancy and the type of problem presented. I advise pregnant women on the types of food to eat and how to take care of themselves and the baby after delivery. ... I have conducted several deliveries successfully that were considered complicated by the village health workers (Traditional birth attendant, Giwa town).

This statement demonstrates the level of proficiency, confidence and acceptability of the services of TBAs at the community level.

The study reveals that some women receive antenatal care from modern health facilities but turn to TBAs for delivery. The reason given by a 37 year old woman in Kasuwan Magani is that:

Our community is a rural place, the few health workers available are not competent enough to take child delivery, not always available, they complain of lack of equipment whenever we go for antenatal. They demand for money for services they render. Also, the distance to the bigger hospitals in town is far and one may not have enough money for transport fare and for the hospital’s services. In this situation, one is left with no option than to use what is available, that is, the traditional birth attendants because attendant at maternal health have been proving very efficient.

Reiterating more on this, a 42 year old house wife from Giwa explains further:

My first and second deliveries were conducted by TBAs. My husband at that time did not complain about money for the welfare of the children after deliveries but on my third delivery which was in the hospital as soon as we returned home he started complaining bitterly that he had spent all his money in the hospital so there is no money to give for the baby welfare. So my last two deliveries I resorted to utilise the services of the TBAs and amazingly he provided money needed for the babies in all the separate deliveries.

The statements affirms the assertion that there are pit falls in modern health care in Kaduna State such as, unqualified/under staff of health personnel, lack of health facilities and high cost involve for seeking for health services. This suggests that the TBAs are filling the gaps left by modern health care services. Furthermore, when women need financial support from their husbands after baby's delivery, may choose TBAs so that they get the money they need. On the contrary, women with some level of formal education are not likely to implore the services of a TBA. For instance, a 38 year old secondary school teacher from Kwaturu says:

I cannot imagine myself bowing to a TBA with all the health talks in the hospital, books I have read about pregnancy and child delivery and my level of education as a graduate of education. Most likely complication may arise during delivery and the TBA may not be able to handle it which means one may suffer a lot or can even lead to death.

It is clear from the above statement that women with some high of education and relatively high income are less likely to access the services of TBA.

With shortage of modern skilled health workers for service delivery, Traditional Birth Attendants (TBAs) remain the best option in ensuring the provision of adequate maternal and child health care services in the study area. Thus, experienced traditional birth attendants can effectively reduce maternal and neonatal and infant death. To some

extent, they also teach their clients about the importance of personal hygiene and nutrition.

#### **4.2.3 Traditional Psychiatrists**

This category treats patients with mental disorder. This study reveals that the healers believe in the supernatural causes and cures of diseases. It is noted that healers in this category apply divination for diagnoses, use incantation and herbs for treatment. The major concern of the healers in this group is to drive away the evil spirits that are considered responsible for the mental illness and to destroy the evil spirits responsible for the mental derailment of their patients.

Traditional psychiatrists believe that mental disorder has cultural association, that is, when one violets the norms of the society. Thus explain their clients' actions and major experiences in the milieu of relationships with the ancestors, or of bewitchment. Their explanation is spontaneous rather than intuitive experience or physiological dysfunction. Describing how people are attacked by evil spirits (*Iskoki*, in Hausa), a 62 year old traditional psychiatrist from Zaria who takes part in the IDI opines:

Evil spirits usually come out at midday or midnight. They live under baobab trees, hills and in forests. They could be directed by witches, wizards, sorcerers, or angered ancestors to an individual. The spirits are known to bite/cut/beat/burn individuals who offend them and can inflict mental illness to such offenders. The signs presented by victims are mostly mental disturbance, and some anti-social behavior. When patients with mental problem are brought to us if it is caused by *Jinn* we apply our knowledge and skills by asking the Jinn to leave the person.....in some cases we have to appease the spirit. If it is just mere mental disturbance we counsel and administer herbs....by God's grace the person will get better.

The opinion expressed by this informant largely reveals the popular notion (belief) that people do not just suffer mental illness by chance; but that mental illness originates primarily from supernatural causes through the evil machination of fellow human beings (Adefolaju, 2011) that can only be treated traditionally. Sharing a similar view is a 53 year old traditional psychiatrist from Kasuwan Magani that:

Generally, people are exposed to many dangers. For instance, evil attacks by sorcerers and witches. When we notice has been attacked by evil spirits (*Iskoki*) we burn incense, apply our skill and knowledge and some herbal mixture to drive away the evil spirits that have taken possession of the mental faculty of our patients. The evil spirits (*Iskoki*) do not like the incense we apply, so when they smell it, they move out but later try to come back that is why we keep some of the patients for some weeks to observe them until we are sure that they are completely healed...we do a lot more for our patients and their relations because the source of this evil spirit may not be known to them. I have treated many patients without keeping records. I am concern with treatment outcome and not records. You can see for yourself the number of patients that are in the rooms. Feel free to talk to them or their relatives.

It is evident from this statement that illnesses are attributed to evil spirits and the measures used by these healers involve some form of exorcisms and spraying scent to repel the spirits and restore the patients' reasoning capacities. This is consistent with the thinking of many people that herbal medicine is generally implored to cure disturbed physiological processes in order to return to a stable equilibrium rather than meet diseases head on.

A 42 year old mental health specialist from Kwaturu ward (Tagged Alhaji Boyi Mai Bulala) states that he uses canes and chains in his treatment regimen. In his words:

We usually restrain mental patients from becoming aggressive by chaining them with iron-chain or by fastening them down with wooden shackles. Violent disorders patients, particularly those who are considered demon possessed, are usually beaten to compliance and then given herbs to calm them. I was trained by my father and right from my training period till date we have been able to restore

the health of many patients. In a year we treat not less than fifty patients successfully.

The statement demonstrates a pattern of diagnosis and treatment of psychological problem which differs from the modern medical approach. However, even though they attempt to serve the people's needs, this form of treatment is not humane and lacks the compassionate care that is required from a healer. This healing practice is characterised by battering and bodily harm with adverse implications on the patients' health. This is one of the negative practices of traditional healing that needs to be addressed. Confirming the issue of flogging a 45 year old man and a relation of a mental patient from Kwaturu says:

....the wounds seen on the body of my ward (the mental patient) resulted from flogging he received from the healer. It was after the flogging that he calmed down and was not misbehaving nor talking irrationally.... The wounds are nothing compared to the mental problem, we try as much as possible to keep the wounds clean to avoid infection. In fact we use honey and herb's powder to treat the wounds. I am satisfied with the treatment and very soon he will be discharged.

The statement indicates a kind of humiliation faced by patients in the name of treatment.

Findings reveal that the services rendered by the traditional mental health practitioners in their various communities are appreciated. The view of a community leader in Kasuwan Magani confirms this:

In my opinion, Alhaji (The healer) is doing very well in this community. I have seen people that came from far and near with mental problems and he successful treated them.

Participants in some FGDs also acknowledge the good services of traditional mental healers of treating cases attributed to *Iskoki* (spirits) and cover anything affecting one's mental balance, including schizophrenia, drug addiction, alcoholism, epilepsy, hysteria and other psychic somatic conditions, which are generally attributed to cause by

*Iskoki* (spirits). Other cases in which *Iskoki* may be involved include eclampsia, stroke and poliomyelitis (El-Nafaty and Omotara, 1998). The term *Iskoki* refers to powerful forces that live in an invisible human world and perceived to be behind many health problems afflicting people. The common forms of affliction seen for treatment in the field typically involve hysteric conditions among young people, usually between the age of 20 and 35 years. For instance in one of the FGD session, in Central Senatorial Zone, a 60 year old man stated that:

Evil spirits, sorcery and witch-craft can inflict mental illness and other ailments on people. Illnesses caused by evil spirits and witch-craft can best be treated by traditional healers. The traditional psychiatrist in our community has been doing great works in treating those inflicted by evil spirit. Many who come for treatment for mental disorders have expressed satisfaction with the treatment received.

The statement shows that traditional healers are providing valuable mental health service. Most traditional psychiatric healers in the Southern Senatorial Zone are non indigenes. They are mostly Fulani settlers who are patronised by the indigenes. However, other people in faraway places like Bauchi, Taraba and Benue hear about them and come as clients. This finding is not surprising because the Fulani men move from one geographical location to another in search of pasture for their cattle. They are familiar with the pharmacopeia of the forest hence are seen as knowledgeable about medicinal herbs.

#### **4.2.4 Herbalists**

Herbalists are the most common type of healers found in this study and approximately, 93 percent are male. They use herbal materials, herbal preparation from plants as active ingredients for their medicine. Herbalists are usually recognized for the treatment of specific ailments. Some of the ailments as reported during the FGDs include:



shortness of breathing, illnesses related to digestive system, STDs, urinary tract infections body and abdominal pains among others. Mostly, herbalists use plants of medicinal value but sometime apply animal parts and minerals for their healing. They are good in preventive and prophylactic treatments. Some herbalist specialised in the treatment of only one disease and become well-known specialist on that disease other are general practitioners. One of the major services provide by herbalists is the application of herbs to renew or restore body function and stimulating the healing process by boosting the immune system. Expressing his opinion on the matter during one of the interviews a 35 year old male herbalist in Kasuwan Magani says:

Every village you go in the state you will find at least two or more herbalists using herbs to threat different types of illnesses either physical or spiritual illnesses. Even in the urban areas, you see many herbalists at the parks, some even have treatment centre where they administer herbs to treat their patients. These herbs come in liquid, powder and other forms.

While some herbalists invoke spirits to strengthen the healing power of their medicinal herbs others solely depend on the natural potency of herbs. The former incorporates religious acts such as rituals in their diagnosis and consultations while the latter do not connect their practice to divine or religious connotations. The study shows that the non-spiritual herbalists are the group that relates their work to modern practitioners. The herbalist specialises in the use of herbs and other medicinal preparations for treating diseases even the ones that defy modern drugs. The herbalist has a widespread knowledge of medicinal herbs, natural treatments and medicinal mixtures from plants and animal origin. An urban-based male herbalist and currently the Secretary of Traditional Medical Association, Zaria Local Government Area provides insight into his association's contribution to modern medicine:

Many from the hospitals and in the universities have come to me and some of our members requesting to know more about the herbs we use in treating some ailments for instance, malaria, stomachache etc. Again, we have herbs that are bitter which are used for treatment of some ailments. These medical doctors have come to get these herbs and compare with their modern drugs. Well we use to tell them what we can and reserve

others to our selves because they never come back to tell us what they have done with our herbs only to hear from the media that they have found a drug that cure one type of ailment or the other.

The statement is an indication that some modern drugs may be derived from herbs since scientist from universities research institutes and hospitals visit herbalists to acquire the knowledge of herbs used in their treatment regimen. However, the herbalists whose herb's knowledge is acquired to make some of these modern drugs are never acknowledged as the providers of the raw materials.

Interviews with the herbalists suggest that many inherited their arts from their parents or grandparents. Twenty three herbalists said they inherited that profession from parents or grandparents, while four said they learnt through apprenticeship. A 57 year old herbalist in Abet said:

Since I was a young child, my father started teaching me and now I am above fifty and still practicing. The profession runs in my family, my father taught me the various herbs as he was taught by his father. I am conversant with different herbs which I use to treat various types of illnesses among children and adults for instance stomachache, ear problem and scorpion sting. Those I have treated often refer others to me as a result many people come from several villages for treatment. I cannot at this point say this is the number of people I have treated I do not keep records but I can say I have treated many people since I started this profession. However this is not to say I can treat every kind of sickness, any sickness that is not the type I treat I will tell the person to look for someone who can help them (Herbalist, Abet).

This statement suggests that the herbalists have a good knowledge of their natural environment which includes the ability to select and use certain plants for their nutritional value and for medication. The statement further indicates that traditional healers are not jack of all trade as they handle illnesses they specialise in and make referral in cases they cannot manage.

The findings reveal that majority of the herbalists interviewed lack a special room for inpatients, rather consulting their clients as outpatient. However, it is observed that majority of the outpatients are received, in the herbalists' homes or market points where they dispensed their services to clients. Findings reveal that among the herbalists there is a group that can be described as itinerant, who render their services either at street corners or moving from house to house or displaying their herbs at the market square on market days. They sell plants, animal, insect parts and mineral substances used in making herbal preparations use for treatment of variety of ailments. Their services benefit both sellers and purchasers. Interview with herbalists confirm that some of them were advertising cures for a wide range of ailments for instance erectile dysfunction, bareness, piles, boils, infertility and so on. A 33 year itinerant herbalist while peddling his wares in Zaria says:

I display my herbs at the major markets, busy streets and in front of mosques. I also tell the public where they can locate me and my phone contact. I sell medicines for various illnesses. I enlighten people about the various illnesses such as diabetes, hypertension, arthritis and the cure the herbs can offer for these illnesses. In addition I have herbs for other illnesses that bother people be it children or adults. On daily basis I serve not less than twenty clients with various health challenges (Herbalist in Zaria)

A similar pattern is adopted by another itinerant herbalist in Kaduna town:

I take these herbs to various places for people to have access to. I prescribe and sell to those who demand certain herbs. I am not boasting but I have full assurance in all the herbs I display here. If a client test positive to typhoid this herb will deal with it. If the person failed to heal then it is not typhoid. All of my clients have testified to being healed. I also give medicine for men and women diseases, erectile dysfunctions, bareness and children illnesses. (medicinal herb seller in Kaduna).

The position of these two informants is not peculiar to them as it reflects the views of most itinerant herbalists in both rural and urban areas of the study. The efficacy

of their claims is based on verbal report from their clients. Although these herbalists seem to be treating diverse illnesses yet do not have area of specialisation. Consequently, there is high tendency for infiltration of quacks into the practice. Participants in the FGDs are divided in opinion about the itinerant herbalists some appreciate their services as a means of meeting health challenges while others are skeptical about their services because of uncertainty of whom they are and the herbs they sell. Infiltration of quacks into the profession is possible because of economy recession. Quacking can be a threat to health and wellbeing of the people as harmful substances can be administered by quacks leading to ill health and in the worst case disability and death.

In-depth Interview with some of the traditional healers who live in the urban areas shows that some of them collaborate with modern medical practitioners for diagnoses before treating their patients. The practitioners in this group usually request their clients to visit modern medical laboratories for diagnosis to ascertain the nature of the ailment before coming to them for herbal medication. For example, those illnesses that have to do with infections, high blood pressure or diabetes. Some educated traditional healers have acquired some little knowledge or out of inquisitiveness are observed to have some modern medical testing equipment such as sphygmometer, Blood Pressure Apparatus and glucometer to examine their clients before commencing herbal treatment. Findings show that these traditional healers have not gone to any medical school but because of they relate well with some health practitioners hence acquired some little knowledge of handling these equipments. A participant during an interview session affirms that:

People often think that traditional healers are engaged in trial and error. To overcome this challenge so as to provide services that will meet the health needs of our patients, clients are always advised to have themselves tested in the hospital before and after treatment. We do this in order to prove the effectiveness in the health care of our people who think that we are just out to make money...we depend on what the client was told in the hospital. (Baba Otta at Kaduna Branch).

To further buttress this point, a 33 year male healer from Zaria states that:

To ensure that we give the right treatment to our clients, we advise them to have tests carried out in medical laboratory to confirm the type of illness. The technicians usually tell them the type of illness seen which they will report back to us before commencing our treatment. This will ensure effective treatment. (Mr. Hunter at Zaria Branch).

The statements demonstrate that the practitioners are synthesising some aspects of modern health care diagnosis into traditional medicine. This practice demonstrates that traditional health practitioners are making attempt to address the challenge of improper diagnosis/guesswork before treatment commences because this has often used as arguments to downgrade the practice of traditional health practitioners. An urban based 41 year old herbalist from Kaduna says:

This is a new age where technology has brought improvement in so many areas including health; we too need to work in line with new technology. To build confidence of our clients, we allowed them to use modern technology to identify what is wrong with them because the technology can only identify not treating; therefore we use our herbs to treat the ailment. By adopting this method it reduces the way modern health workers and other educated people regard us with contempt

The statement above demonstrates the awareness of the effectiveness of modern health equipment by the traditional healers. But collaboration between traditional and modern health practitioners at official level is required to effectively execute the primary health objectives set by WHO.

#### **4.2.5 Faith Healers**

This category of healers uses prayers, holy water and holy books for their healing. The healers in this group consist of pastors, imams and other learned members of both the Christian and Islamic faiths. The supernatural has a significant role in the health care administration of the healers in this category. From the diagnosis to the treatment of illness,

spirits are invoked to help heal the sick person. This is a modern form of divination where diviners have crept into the major religious organisations under the guise of monotheistic faith healing to perform their practice because the faithful of the monotheistic faith are not permitted to patronise them as diviners. Findings reveal that services rendered by Christian faith healing include cases of frequent deaths, bad dreams, protracted illnesses, sleeplessness, mental disorders, poverty, demonic attacks, delays in marriage and bearing children. Treatment mode is observed to be by prayer followed by transmission of prophetic messages, to the client, fasting, holy oil/water and words assurance.

The Christian faith healers believe in the power of prayer. They apply Holy water and Holy oil which are blessed by the 'pastors'. When the holy water or oil is administered to the person possessed by the evil spirit will be set free. A 37 year old Pastor in Kaduna states that:

There is power from God in what you see us doing. The application of anointing oil or holy water is to symbolize the presence of the Almighty through such a channel. The most important issue is the faith of an individual. People have been set free from various demonic oppressions, the sick have been healed and those with fertility problems have been blessed with children (Faith healer in Kaduna).

The healing system of the Islamic faith is influenced by the interpretation of Islamic texts concerning the divinely ordained relationship between Allah, mankind, diseases and cure of the sick. An Islamic faith healer (Malam) said this in an interview:

Passages from the Holy Quran are often recited as there is supernatural power in the Quran as Allah sent cure to human kind for every disease. There are natural ingredients prescribed in the Quran that can cure sicknesses. The treatment offered, differed according to the depending on the type of illness that supplicants present it could be physical, mental or spiritual. Almighty Allah has sent cure for each ailment (Quranic Mallam in Kaduna).

These statements imply that faith healing is perceived as a remedy for all diseases and other life challenges. Also, this pattern of healing which includes the use of medium such as supplication, water, incense and other substances to demonstrate power to heal and deliver.

On the contrary not everybody who goes for spiritual healing gets healed. This point is made clear by a 42 year old female informant in Kaduna:

My neighbour has visited three or four pastors for her health problem but the situation has not changed because she still feels the same. She is currently visiting a modern medical doctor in one of the hospitals in Kaduna.

Participants at the FGDs indicate that the introduction of Christianity, Islam and other organised religions, the practice of Nigerian traditional diviners have diminished because it is against the faith of the monotheistic religions. The work of traditional Nigerian diviners is seen by these religions especially Islam and Christianity as fetish. It is not only the religions organisations that have limited the practice of traditional diviners as expressed by a male participant during one of the FGDs in Kaduna town:

....the introduction of ultra-modern and highly-equipped hospitals, like general Hospital Kafanchan, Barau Dikko specialist Hospital Kaduna and Ahmadu Bello University Teaching Hospital Zaria. There appears to be a visible or physical explanation to causes of diseases. In addition, modernity also tends to give a logical explanation to every occurrence in society. Thus, the logical manner the traditional diviners follow to diagnose diseases and prescribe medicine has become less popular. The lay can see some of the problems on X-ray, Ultra Sound to perform fits like identifying the broken bone under the skin or reveal the sex of baby in the womb and how it is lying there.

#### **4.2.6 Traditional Surgeons**

This category popularly refers to as *Wanzama* in Hausa. They are highly respected in the society. They specialise in one or more of the services they render, for

example: hair cut, tribal marks, abdominal scarification, blood cupping and both male and female circumcision. Apart from the normal activities of a barber, they are also regarded as traditional surgeon because of the surgery they perform when indicated. The findings reveal that the most popular traditional surgeons are those who go around villages seasonally with their circumcision bags to circumcise groups of young boys especially in the cool season. The practice is common in the rural areas of northern Senatorial Zone of Kaduna State. They also perform incisions on boils, abscesses and sometimes the removal of uvular and unwanted growth tissues, particularly those on limbs. Explaining further on this a 67 year old traditional surgeon (Wanzami) from Hunkuyi bears his mind:

... I move about or when invited by neighbouring communities (because I am getting old and cannot be effective like when I was younger) to perform circumcision, tribal marks on children and cupping and incision on boils in adult. I do not charge any money on the services rendered. Some appreciate our services in kind or in cash others do not have we still accept verbal appreciation...throughout my practice I have not recorded any death or harm. The number of children and adult that I have rendered my services to are too many to remember since I do not keep any record of them. My training started at an early age and most of it was done informally, since it was regarded as an intra familial matter. I followed my grandfather who was a *Wanzam* carrying his surgical tool-kits seeing what he was doing and he started engaging me by holding a blade to shave the heads of male children in his presence.

Providing further explanation on the services of traditional surgeon a 59 year old male *Wanzami* from Zaria, using his knife on the face of a baby on the seventh day of birth to give tribal marks as symbol of identity of the lineage the baby was born into:

As a custodian of the traditional culture of the people, I am vested with the role of giving identity to each child born in the community. I use sharp blade and make incision on the face and abdomen. The abdomen marks are performed to drain the 'black blood' from the abdomen of the child. Some herbs are applied immediately afterward. Also, this is believed to prevent certain abdominal conditions and ensures that the child will grow properly. Blood cupping, literally means horn (*Kaho*) involve the use of the sharp end of a cow's horn with a small hole made at



the thinner end. I use sharp blade to make incisions on the area of the body being treated. At least six to nine tiny but deep incisions are made. The wider end of the *Kaho* is placed over the incision, tightly covering the entire area. Secondly, I proceed to suck through the small hole of the *kaho* to drain the unwanted blood. Cupping gives relief for the following conditions; dizziness, swelling caused by injury or malignancy, general body pain, essential practice for those over the age of forty. (traditional surgeon from Zaria).

The horn (*kaho*) method has been used for blood-letting and is regarded as an effective treatment for rheumatism as well as other morbid condition of the blood. The Wanzamai are the custodians of this traditional health practice, and it is their duty to see that the significant ailments and conditions listed above are treated or prevented among the people of their communities. However, the instruments use in performing the surgery are not sterile in this situation clients are at risk of contracting HIV/AIDS. As a simple remedy, it is of critical importance that the Wanzamai be educated and trained to sterilise their tools before carrying out any procedure of such kind.

The findings reveal that the treatment of male circumcision after cutting of prepuce is not strictly adhered to the application of traditional herbs, parents will choose to embark on modern treatment for the wound. Investigating further, on why tradition to modern it was revealed that the modern antibiotics applied heal faster and that not all the modern health personnel can perform child circumcision.

#### **4.2.7 Diviners (Yan Bori)**

The practice of *Bori* is one form of divination reveals in this study. *Bori* involves trances, exorcism and other supernatural practices in healing of ailments and other social problems in the northern part of Nigeria particularly among the Hausa ethnic group. The practice is being discouraged by Islam and Christianity. Finding reveals that the *Bori* practice is characterised by the worship of *Iskoki* or spirits described as supernatural

spirits, as the deities to secure medicine to cure sickness. Explaining further on *Bori*, a 67 year old *Bori* practitioner in Kaduna says:

The *bori* practitioner believes that the Jinn possess all the powers possessed by Allah. They believe that these spirits give or withhold health, offspring, rain and bountiful harvest, peace and security and all forms of powers and fortunes and can unleash wrath in the form of epidemics on their adherents if and when they misbehave against them. The spirits are perceived to lie behind many health problems particularly infertility, miscarriages, death in infants and small children and suspended pregnancy among others. The practitioner under the influence of *bori* spirit is able to diagnosed the sickness and guides the practitioner on what type of herbs to administer to a patient. Many have reported being healed by *yan bori*.

*Bori* is practiced principally for the cure of ailments on individuals or communities. Emphasising the healing ability of *Bori*, a community leader in Kaduna makes the point:

This practice takes place for various reasons and at various times such as during specific seasons, festivities and wedding, naming or other ceremonies with *yan Bori* that is, those possessed with the spirits performing abnormal or supernatural feats when they are possessed by the spirits, following provocations by specific music or panegyrics supernatural. It is believed that the spirits possess the power human beings lack. People can therefore go through them to obtain cure for any ailment. It is believed here that the Jinn can inflict epilepsy, barrenness and other ailments in the humans so when consulted the *Dan bori* or *yar bori* your problem can be solved.

He further states that:

There are many quack traditional healers in the society today because they make claims of what is not true. Years back every medicine man was famous in the area of specialization and there was no doubt about its efficacy. A healer is always sure of the efficacy of his medicine. Some traditional healers are after money thus making the system to lose its credibility.

The statement demonstrates that the health needs of the people are met but with caution because many charlatans with unreliable services have infiltrate the profession.

#### **4.4. Health Challenges for Seeking Traditional Medical Services**

A traditional medical practitioner's meaning or identification of a common disease may not be same with that of a modern medical practitioner because Traditional Medical Practitioners approaches to diagnosis and classification differ significantly from Modern Medical Practitioners. Respondents in this study are asked to indicate the type of illness they have sought treatment from a traditional healer in the past two years. Table 4.3 identifies 23 most common illnesses for which Traditional medicine is sought for.

**Table 4.3** Types of Illnesses Traditional Medicine was Sought for by the Respondents in the three senatorial Zones of Kaduna State

Health Challenge	Central Senatorial Zone		Northern Senatorial Zone		Southern Senatorial Zone		Total
	F	%	F	%	F	%	
Malaria/Typhoid	139	34.6	135	33.0	130	34.1	<b>404</b>
Fracture/Dislocation	86	21.4	78	19.0	82	21.5	<b>246</b>
Stomachache/ constipation	30	7.5	29	7.1	24	6.3	<b>83</b>
STIs/Toilet infections	20	5.0	25	6.1	19	5.0	<b>64</b>
Hypertension/stroke	14	3.5	20	4.9	16	4.2	<b>50</b>
Arthritis	16	4.0	15	3.6	14	3.7	<b>45</b>
Headache	15	3.7	13	3.2	12	3.2	<b>40</b>
Pile	9	2.2	10	2.4	8	2.1	<b>27</b>
Ulcer	5	1.2	7	1.7	6	1.6	<b>18</b>
Mental problem	6	1.5	6	1.4	5	1.3	<b>17</b>
Backache	5	1.2	4	1.0	5	1.3	<b>14</b>
Toothache	5	1.2	4	1.0	5	1.3	<b>14</b>
Eye problem	4	1.0	4	1.0	3	0.8	<b>11</b>
Skin disease	2	0.5	4	1.0	4	4.0	<b>10</b>
Asthma	3	0.7	4	1.0	3	0.8	<b>10</b>
Diabetes	4	1.0	2	0.5	3	0.8	<b>9</b>
Jaundice	1	0.2	4	1.0	4	4.0	<b>9</b>
Infertility	3	0.7	4	1.0	1	0.3	<b>8</b>
Spiritual attacks	3	0.7	2	0.5	2	0.5	<b>7</b>
Cough/Sore throat	1	0.2	3	0.7	3	0.8	<b>7</b>
Epilepsy	3	0.7	3	0.7	1	0.3	<b>7</b>
Bedwetting	1	0.2	1	0.2	2	0.5	<b>4</b>

Others	26	6.5	33	8.1	29	7.6	<b>88</b>
<b>Total</b>	<b>401</b>	<b>100.0</b>	<b>410</b>	<b>100.0</b>	<b>381</b>	<b>100.0</b>	<b>1192</b>

**Source: Field Survey, 2017**

Table 4.3 shows the distribution of respondents according to the most common type of diseases Traditional Medicine was sought for. The data indicate that Traditional Medicine treatments are mostly sought for illnesses caused by a microbe that is malaria/typhoid (34.6%, 33.0% and 34.1%) across the Zones. The findings also agree with the study on the utilisation of traditional herbal medicine in Wassa Amenfi West District of Ghana by Adjei (2013) whereby malaria/typhoid ranked one of the most common diseases treated by herbal medicine. This finding suggests that TM is playing a significant role in the treatment of malaria/typhoid fever which has been identified as endemic in African countries by WHO (2013). Illnesses associated with the musculoskeletal system as 20.6% sought treatment for fracture and dislocation. Corroborating this with the number of clients (51) observed in traditional healers' homes is for bone setting. This high number for both survey and qualitative data indicate the contributions Traditional Medicine is making in decongesting the hospitals. Bone injuries have been associated with growing dependence on motor cycles (*Okada Riders*) by urban and rural dwellers which often result in motor cycle accidents.

Other health conditions identified during the interview sessions which are not mentioned in the survey include snake bites and scorpion stings, cancer (called *Ciwon daji* in Hausa), whitlow, boils and earache. It is interesting to note that mental disorders constituted 0.9% of respondents in the survey but during IDI, 17 clients are observed in the traditional healers' homes. The implication is that, many did not want to mention certain ailments in the survey such as mental disorder, sexually transmitted diseases and

so on. because of the stigma associated with them but in the interview session clients were physically seen and can give humble opinion. This suggests that clients of Traditional Medicine can disclose certain ailments but can equally be reluctant to disclose others particularly chronic diseases like dementia, Cystic fibrosis, Epilepsy, HIV; psychological disorder or social disruption disease of reproductive systems like Gonorrhoea, Syphilis, Chlamydia, and diseases that are slow to respond to treatment or believed to be evil manipulation in origin. For instance, a 61 year old community leader from Kwaturu ward explains further on patients' reluctance to disclose their ailment to people thus:

The society is full of evil people. Some may show empathy to a sick person and some may not. Instead of showing pity they will rather discriminate and stigmatize the person depending on the nature of the ailment. Enemies will rejoice seeing their rival in anguish that is why some chose to keep their sickness a secret.

#### 4.4.1 The Outcomes of Using Traditional Medicine

Issues in relation to the outcome for those who had ever used the services of Traditional Medicine for different types of health conditions are highlighted by the study participants. Feelings and experiences with traditional healing of most common illness further validate the contribution of Traditional Medicine to health care. The responses obtain from the patients treatment experiences of some illnesses are presented in Table 4.4

**Table 4.4 Patients Experiences with Traditional Medicine Treatment**

Type of Illness	Treatment Outcome						Total
	Completely Healed		Partially Healed		Cannot say		
	F	%	F	%	F	%	
Malaria/Typhoid Fever	207	51.2	137	33.9	60	14.9	404
Fracture/Dislocation	143	58.1	103	41.9	-	-	246

Stomachache/Constipation	29	34.9	54	65.1	-	-	83
STIs/Toilet Infections	50	50.0	23	46.0	2	4.0	50

**Source: Field Survey, 2017**

The result in Table 4.4 indicates that a large proportion of respondents for fever (51.2 percent), fracture (58.1 percent) and STIs (50 percent) who are treated by THs were completely healed. However, 65.1 percent reported partially healed for stomachache. This finding suggests that as many as sought treatments from traditional health practitioners are healed from the ailment the treatment was sought for. For instance, a 41 year old woman, a TH patient’s wife in Kafanchan said:

My husband was hit with stroke for over ten years, after several visits to the modern hospitals. Glory to God it took the intervention of this traditional healer to enable him to do what he could not do before. Now, he can walk freely (Client’s wife of a herbalist, in Kafanchan).

On whether respondents who have ever sought treatment from a traditional healer are satisfied with the outcome of the treatment, the result of most frequent ailments is represented in Table 4.5.

**Table 4.5 Types of Illness and Respondents Satisfaction with Traditional Medicine**

Type of Illness	Satisfaction with Traditional Healer’s Treatment						
	Yes		No		Uncertain		Total
	F	%	F	%	F	%	
Malaria/Typhoid Fever	198	49.0	66	16.3	140	34.7	404
Fracture/Dislocation	211	85.8	35	14.2	-		146
Stomachache/Constipation	26	31.3	43	51.8	14	16.9	83
STIs/Toilet Infections	25	50.0	23	46.0	2	4.0	50

**Source: Field Survey, 2017**

It is observed from Table 4.5 that significant proportion of the respondents note satisfaction through the treatment of traditional healers. The high satisfaction of

Traditional Medicine in treating various ailments could explain part of high utilisation of Traditional Medicine.

Most participants during the FGDs perceived Traditional Medicine to be satisfied and safe in treating various diseases. This is reflected in the following statement made by one of the participants, a 40 year old client of Traditional Medicine in Giwa:

Plenty drugs are in circulation these days for malaria and typhoid treatment especially in rural areas. I bought a fake drug when I had malaria in the village from one of these drug stores; it almost killed me after taking it. Since then I decided to go for herbal remedies any time I am ill. ...Our forefathers lived and depended on the traditional medicine for their health. It is God's gift and natural; they lived longer than our generation, because we rely so much on modern medicine which is chemically produced. As far as I am concerned modern medicine is more risky to take than traditional medicine, it can kill very fast. What are commonly used to prepare traditional medicine are natural things like Aloe Vera, mango leaves or the barks of some trees (Client of herbalist in Giwa).

Another participant, a 45 year old youth leader in Kasuwan Magani posits that medicine which is natural without man-made chemical guarantee safety when used. He, however, expresses grief on the negative effects of chemical induced products like insecticides and fertilizer:

Spraying of our rooms with chemicals to derive away insects like mosquitoes and the application of fertilizer for better yields all have side effects on our bodies when compare to natural products to treat similar issues.

Efficacy is an aspect that continues to be an issue of concern in traditional health practice. A patient is more likely to use Traditional Medicine for his health if the efficacy is certain regardless of income, education status and nature of disease. The data obtained from respondents who had ever sought treatment from traditional healer on efficacy of most frequent ailment is presented in Table 4.6



**Table 4.6 Types of Illnesses and Efficacy of Traditional Healing**

Type of Illness	Efficacy of traditional Healer's Treatment							
	Very Good		Good		Poor		Total	
	F	%	F	%	F	%	F	%
Malaria/Typhoid Fever	86	21.3	234	57.9	84	20.8	404	100
Fracture/Dislocation	97	39.4	126	51.3	23	9.3	246	100
Stomachache/Constipation	13	15.7	41	49.4	29	34.9	83	100
STIs/Toilet Infections	2	4.0	23	46.0	25	50.0	50	100

**Source: Field Survey, 2017** $X^2 = 807.90$ ,  $df = 63$ ,  $p < 0.05$  Significant

Findings in Table 4.6 show that Traditional Medicine is effective particularly in treating illness like malaria, typhoid, fracture and to some extent Stomachache/Constipation. On the rating scale, majority of respondents assess the efficacy of Traditional Medicine as “Good” (57.9%) across different types of illnesses. This finding is consistent with other studies in both developing and developed countries (Sen et al., 2011; Mensah and Gyasi, 2012; Gyasi 2014 and Hwang et al., 2014). With such evidence about effectiveness of Traditional Medicine from those that have accessed it, one would have thought that Traditional Medicine is really contributing to people’s health care.

Popularity of Traditional Medicine in treating specific ailment and its efficacy is revealed through experiences of others. One of the participants a 37 year old male during the interview session:

I had an infection and I use modern medicine as prescribed by the doctor but there was no improvement...I resorted to taking traditional medicine that is, the ‘ultimate flusher’ a traditional herb (remedy for staphylococcus) I am feeling very okay now. However, I was cautioned by the healer to avoid sex with multiple partners. (Clients of a Herbalist in Zaria).

Supporting this view is a 40 years male participant that:

My problem has been typhoid, Ciprotabs was prescribed to me in the hospital but the disease goes and come back. Since I visited this herbalist, he gave me some herbs and for the past six months I have not experience typhoid. I am here to get the same medicine for my uncle who was diagnosed with typhoid (Client of a herbal practitioner in Kaduna).

Reiterating the efficacy of Traditional Medicine, a 50 year old trader from Kafanchan observes:

I am convinced that there are a lot of traditional medicines that would work well for many diseases both communicable and non-communicable ones like hypertension, diabetes, cancers,...and many others. But I think most these herbal medicines are overshadowed by modern drugs. Most people don't know much of them because they are ignorant of them. I am a living witness of those that have been treated perfectly with traditional medicine like asthma, hypertension, STDs, fracture and even skin disease.

Most of the statements cited above suggest that Traditional Medicine is very effective in its treatment and people would prefer Traditional Medicine for such ailments than Modern Medicine because they have seen it works on them and others.

#### **4.5. Socio-Cultural and Economic Factors Influencing Utilization of Traditional Medicine**

There are several reasons why patients choose to use Traditional Medicine. Participants in this study are asked to mention the reasons why they patronise Traditional Medicine. Respondents indicated different perceptions and beliefs about Traditional Medicine which in one way or the other influenced their patronage. Some of the reasons are referred to the perceived restricted access, disadvantages and dissatisfaction with modern health care services whilst other reasons suggested beliefs and positive aspects, advantages and/or benefits of Traditional Medicine.

Although medical fields are divided and labeled as modern and traditional medicine, culture play a key role and well-known by the people and may thus influence people's perspective on what belongs to 'our culture' and the other culture and where to seek healthcare (Wreford 2005). Cultural affinity between traditional healers and their clients was a strong reason for utilisation and patronage of healers in Kaduna State. Table 4.7 presents respondents' perceptions on cultural affinity to Traditional Medicine.

**Table 4.7 Ethnicity and Cultural Affinity of Traditional Medicine**

Ethnic Group	Cultural affinity							
	Agree		Undecided		Disagree		Total	
	F	%	F	%	F	%	F	%
Ethnic groups in Southern								
Kaduna	445	95.1	4	.8	19	4.0	468	100
Hausa/Fulani	407	95.8	3	.7	15	3.5	425	100
Igbo	57	79.2	2	2.8	13	18.0	72	100
Yoruba	59	79.7	1	1.4	14	18.9	74	100
Other Northern Nigerian ethnic Groups	56	76.7	1	1.4	16	21.9	73	100
Other Southern Nigerian ethnic Groups	65	81.3	1	1.3	14	17.5	80	100
<b>Total</b>	<b>1089</b>	<b>91.4</b>	<b>12</b>	<b>1.0</b>	<b>91</b>	<b>7.6</b>	<b>1192</b>	<b>100</b>
<b>Source: Field Survey, 2017</b>	$X^2 = 811.46, df = 5, p < 0.05$						Significant	

Table 4.7 reveals that 91.4 percent of the respondents across all the ethnic groups agree that cultural affinity is one of the main reasons for patronising Traditional Medicine. Within ethnic groups the Southern Kaduna and Hausa Fulani have the most (95.1% and 95.8%) popular opinion of cultural affinity Traditional Medicine utilisation. It can also be seen from the Table that 7.6 percent of the respondents did not agree that this factor is a reason for patronizing Traditional Medicine. It can therefore be deduced from this finding that most respondents might be interested to and use Traditional

Medicine because they believed that Traditional Medicinal practices are part of their culture. The cultural values and traditions of people determine their consciousness which in turn influences their health-seeking behaviour.

On why they think that traditional medical healing is accepted by their communities, most participants in Kwaturu, Kafanchan, Kasuwan Magani, Giwa, Zaria and Hunkuyi said that traditional healing is “part of their culture and that traditional healers are readily available”; “ people in the community are taught about Traditional Medicine, and to believe in traditional healing efficacy”; “in many cases, people hold the belief that their illnesses are caused by witchcraft or sorcery and therefore traditional healers are the first port of call”; “traditional healing works for them”. Sharing the same view some participants who took part in the interview conducted in the study area emphasised how they cherish their cultural value. One of the participants a 47 year old relative of a mental patient says:

Hospital medicine has distanced us from our culture and custom such that certain illnesses cannot be cured by them because they don't have the knowledge about them so patients will suffer more in their hands. I brought my brother here because he has a spiritual attack. I tried the modern doctors but they failed. I turned to traditional medicine and now my brother is getting better (a relative of mental patient at Kasuwan Magani).

The statement demonstrates the strong belief that patients have in Traditional Medicine as the last resort when other alternatives failed.

Literature has shown (Omonzejele, 2008) that practitioners of Traditional Medicine share same culture, hold similar view of health and illness and conception of the human organ with their patients thus form the basis of utilising Traditional Medicine by clients. Some participants believed that some sickness/illness like emotional disturbance, spirit possessed among others do not desire going to the modern health facilities because they may be spiritual attacks. Other respondents also said that there are

minor diseases/illness such as wounds or fatigue after a day's activities that may be cured with herbs without wasting money and time to go to the hospital. It is observed in the field that some rural communities soaked assorted roots called "*Jiko*" in Hausa which is drunk before and after the day's activities. The significance of *Jiko* is to enhance energy.

Some participants during the interview sessions perceived spiritual illness as a reason to seek traditional medical care. Some believed that sickness like mental and physical illnesses are not just ordinary they are caused by spirits, by enemies, disobedience of ancestors. Respondents elucidated that spiritual illnesses can only be treated and undo through spiritual means by traditional healers. This observation by a 50 year old man from Giwa explains further:

I would not waste my time going to the hospital for modern health personnel to treat my spiritual problems. I know they cannot do it because spiritual illness is beyond their scope. Their major concern is illnesses that are physically or tested using their equipment but cannot handle the spiritual components which cannot be tested. The herbalists, spiritualist and diviners are always the right people for such spiritual problems. They can read, see and reveal things that are hidden from human eyes. (A client of TM from Giwa)

Another male respondent from Kasuwan Magani explains further that:

It is clear, that traditional healers treat patients by experience and in ways which cannot be explained by modern sciences. They can predict the future. This is why they are capable of curing certain diseases such as epilepsy and mental disorders which are difficult for modern drugs to do. (A 65 year old man from Kasuwan Magani)

It can be deduced from the above statements that lack of such cultural affiliation between modern practitioners and their clients is often blamed for poor relationship by clients and thus dissatisfaction of modern health personnel. It is clear from the statements that Traditional Medicine is doing that which cannot be done by modern health practitioners that is cultural aspects of health and illness.

Accessibility is another reason which persistently came up from quantitative and qualitative aspects of this study. Accessibility in this work is considered in relationship to physical parameter that is how distance influences health service use. Respondents express their opinions in comparison to modern health care facilities. The views of respondents on accessibility are presented in Table 4.8

**Table 4.8 Place of Residence and Respondents' Perceptions of Accessibility of Traditional Medicine**

Place of Residence	Perception on Accessibility						Total	
	Easily Accessible		Uncertain		Not Easily Accessible		F	%
	F	%	F	%	F	%		
Urban	219	38.7	245	43.3	102	18.0	<b>566</b>	<b>100</b>
Rural	390	62.3	233	37.2	3	4.5	<b>636</b>	<b>100</b>
<b>Total</b>	<b>609</b>	<b>51.1</b>	<b>478</b>	<b>40.1</b>	<b>105</b>	<b>8.8</b>	<b>1192</b>	<b>100</b>

Source: Field Survey, 2017

$\chi^2 = 140$ ,  $df=2$ ,  $p < 0.05$  Significant

Table 4.8 indicates that a higher proportion of rural dwellers (62.3percent) opines that Traditional Medicine is very accessible than their urban counterpart (38.7 percent). Also, 18.0 percent of the urban respondents show that Traditional Medicine is not readily accessible. However, only 4.5 percent of the rural respondents indicate that accessible is not the reason for utilization of Traditional Medicine. It is, therefore, evident from the result in Table 4.8 that a good proportion (51.1%) of respondents opined that accessibility is a motivating factor for relying on TM. It implies that people utilise Traditional Medicine because it is easy to get to.

Participants in the FGDs similarly confirmed availability of Traditional Medicine knowledge of herbs which are available in their locality, thus, help in treating malaria

fever, stomach pain, snake bites, scorpion stings and harm by other reptiles. Most families in rural areas have folk knowledge of medicinal herbs and go to traditional healers (Renown TH) for ailments they cannot handle. The view of a community leader at Abet lends credence to this during the interviews. He says:

In our community every member of the family even a small child knows one leaf or root that can be used to treat one ailment or the other. The medicine and the healers are just around us People seek the help of notable healers only when the family or home remedy is not successful.

The study reveals that the distance from some of the rural communities of study to the hospitals are long enough to influence the type of health facilities to utilise. Clients from Kwaturu, Abet and Kasuwan Magani rural areas have to travel for more than 20 kilometers on foot or motor cycle to get to the nearest hospitals. In addition, the roads connecting the rural areas and the modern hospitals are in very bad shapes. The few drivers and motor cyclists who use such roads charge high prices for the trips. Participants during the IDIs pointed out that the proximity of traditional healers, and the congenial attitudes of traditional healers towards clients are factors responsible for preference of traditional medicines. Some participants also pointed to the poor human relations of modern health practitioners, the cumbersome process before seeing a modern doctor in the hospital and long waiting period. A 37 year male client of Traditional Medicine shares this:

The distance from this village to general hospital Kafanchan is far. Also, one may queue up for more than two hours before seeing a doctor. None of these challenges is encountered if one visits the traditional healer in the village as we can visit or see them anytime. We don't waste time to see them (A client of traditional healer in Abet).

Supporting this position a male traditional medical practitioner in Zaria says:

The medicinal plants we use are found in our surroundings, we do not need to import them, and nature has made them available unlike modern drugs. Some of the plants are seasonal, nonetheless we harvest and preserve them when in seasons. So it is rare to run out of herbs to treat illness (Traditional Healer in Zaria).

The statements above illustrate that people in the State will continue to patronise Traditional Medicine in as much as it is the most available option for them.

This outcome is congruent with some studies which reports that patients continue to utilise Traditional Medicine partly because healers are nearer and have good relationships with their clients (Peltzer et al., 2009; Vickers et al., 2006). In addition, some of the herbalists are very easy to reach because their places of practice include market, their homes and motor park where people can easily get to them. Sometimes they move around the communities to make their services accessible and available to clients.

Many participants in the FGDs mention that personal knowledge of what use traditional health care is all about makes it easier to get to when compare to modern health care. They note that, folk knowledge of medicinal plants is an added advantage to access herbalists and herbs in their environment whenever needed, especially when there is no other alternative. Specifically, participants mention that there is always herbalist in the neighborhood who is specialised in one ailment or the other and is ready and willing to assist when needs arises at no cost.

Affordability is another factor influencing the use of Traditional Medicine. Affordability in this study is seen in terms of economic parameter, that is, how financial limitations influence health care use. Most respondents indicated that they are low income earners, who live below the minimum monthly salary and poverty is noted to be a



strong barrier to health care utilisation. The views of the respondents on affordability are presented in Table 4.9:

**Table 4.9 Respondents Perceptions of Affordability of Traditional Medicine and Monthly Income of Traditional Medicine**

Monthly Income	Perception on Affordability						Total	
	Affordable		Uncertain		Not Affordable		F	%
	F	%	F	%	F	%	F	%
≤#19,000	359	57.0	60	9.5	211	33.5	<b>630</b>	<b>100</b>
20,000-39,000	191	48.8	23	5.8	178	45.4	<b>392</b>	<b>100</b>
40,000	55	32.3	8	4.7	107	63.0	<b>170</b>	<b>100</b>
<b>Total</b>	<b>605</b>	<b>50.8</b>	<b>91</b>	<b>7.6</b>	<b>496</b>	<b>41.6</b>	<b>1192</b>	<b>100</b>
<b>Source: Field Survey, 2017</b>		$X^2 = 52.35, df = 4, p < 0.05$ Significant						

The result in Table 4.9 reveals that 57.0 percent of respondents earn #19,000 or less income report that income is a reason for utilising Traditional Medicine while 63.0 percent of the respondents of income #40,000 or more disagree. Most clients of traditional practitioners and community leaders pointed out that TM is affordable. These findings agree with other studies like Ogunlusi, et al., (2007), Dada et al., (2011) and Omololu et al., (2002) on patronage of Traditional Medicine in Nigeria.

Among the explanations given for relative affordability of Traditional Medicine in this study include; relatively low cost of herbal products, naturally grown medicinal plants in their environment, payment in kind or by installment and high cost of hospital services. A 37 year old youth leader (male) who is also a client of traditional healer in Zaria aptly described the influence of affordability on patronage of Traditional Medicine as follows:

Traditional medicine is cheaper and available all the time, even the nicely packaged herbal medicines in the drug stores cost much less than the hospital ones. The herbal medicine meant for treating STIs like syphilis, herpes and gonorrhoea is less

expensive than the modern drugs. For instance, I paid more than N5, 000 for my treatment with the modern doctor but was not heal... Meanwhile I visited a herbal store, the healer gave me the “ultimate flusher” a herb mixure (remedy for staphylococcus) which cost less than 1,500 and I am feeling much better now (A client of an herbal practitioner in Zaria).

Added to this, a mental patient’s relative from Kasuwan Magani narrates his experience in the treatment of their ward saying:

When the illness of this our son started we took him to a modern hospital. The doctor examined him and said that the treatment will cost about N150,000, we cried out ‘we can’t afford it’. Because we do not have that amount and we cannot afford to pay such. The doctor finally agreed to give us some prescriptions to buy until when we are ready. The charge for the drugs he prescribed was too costly so we decided to come here for the traditional medicine and by the grace of God he is much better (A relative of a mental patient from Kasuwan Magani).

These statements presuppose that most poor people entirely rely on TM as an alternative remedy to the high cost of modern medicine. The implication of this is that the patient would have remained untreated if there were no Traditional Medicine

Beyond high cost of Modern Medicine most (70%) participants argues that every day, there is a long waiting period in the modern hospital to see a doctor and in addition some modern health personnel are harsh to clients, which may add stress to the already anxious patient.

Acceptability is another determinant factor why patients patronise Traditional Medicine. The acceptability component shows respondents conceptualization of illness is in accordance to their health beliefs, thus indicating possible causes and cures which may differ from that offered by modern medicines. This view is supported by many literature (Kleinman, 1980, Twumasi, 1979b), respondents perception on acceptability of Traditional Medicine is presented in Table 4.10.

**Table 4.10 Place of Residence and Respondents Perception on Acceptability of Traditional Medicine**

Place of Residence	Perception on Acceptability							
	Acceptable		Uncertain		Not Acceptable		Total	
	F	%	F	%	F	%	F	%
<b>Urban</b>	294	51.9	170	30.0	102	18.0	<b>566</b>	<b>100</b>
<b>Rural</b>	411	65.6	181	28.9	34	5.4	<b>626</b>	<b>100</b>
<b>Total</b>	<b>705</b>	<b>59.1</b>	<b>351</b>	<b>29.5</b>	<b>136</b>	<b>11.4</b>	<b>1192</b>	<b>100</b>

**Source: Field Survey, 2017**

$X^2 = 50.7$ ,  $df = 2$ ,  $p < 0.05$  Significant

As can be seen in Table 4.10 a higher proportion of the respondents (59.1%) reported that Traditional Medicine is more acceptable. The result also indicates that rural respondents (65.6 percent) agree that Traditional Medicine is very acceptable than Urban 51.9 percent. The implication of this finding is that individuals who do not accept Traditional Medicine are on the whole less likely to utilise it. Individuals who agree that Traditional Medicine is acceptable are more likely to utilise Traditional Medicine than modern medicine.

The perceived delay development, disadvantages and discontent with modern health care services, the long usage of herbal medicine by forefathers, conformity to cultural beliefs, and public confidence or high patronage by communities are among the explanations given as reasons for the popularity of Traditional Medicine during the FGDs and in-depth interviews. The quotes below capture most opinions of the participants: A 48 year old male relative of a mental patient at Kasuwa Magani says:

Traditional medicine is what I am used to. This is because I was brought up in a rural area and herbal medicine is my major source of health. So it has become part of our lives. It works for me and can easily access it. (A relation of mentally ill patient at Kasuwa Magani).

Corroborating this statement by a 51 year old female client of the herbalist says:

I am someone who keeps to my culture and traditional medicine is part of our life. Our forefathers survived with traditional medicine. I cannot stop patronizing traditional medicine, it is a major remedy for me and my family whenever we are ill because everything about it is natural no chemical attached to it like what people get in the hospitals (Client of a herbal practitioner in Zaria).

The statements above demonstrate that respondents are satisfied psychologically with the use of Traditional Medicine because they perceive the system to be part of their socio-cultural heredity. This is in line with the study by Peltzer et al., (2006) on an HIV/AIDS/STI/TB intervention with Traditional Healers in South Africa.

On the contrary the opinions of modern health personnel are divided concerning acceptability of Traditional Medicine. The nurses appreciated the role of traditional medical personnel in treating some health conditions while the medical doctors saw nothing good in that medicine because Traditional Medicine practices lack scientific evidence. For instance a psychiatrist in Kaduna states:

Except if the traditional healers work is subjected to scientific proof, I disagree with what they are doing because most of those treated by them end up here with us in the hospital.

The implication of this statement is that they hold negative attitude towards traditional health practitioners. It shows that they do not look at the social relation implications as much as the Traditional healers. In all, it appears that modern doctors do not see anything good in the traditional healing knowledge.

Persistently occurring during the interview with clients of Traditional Medicine and community leaders is the cordial relationship of Traditional Healers to their clients. During the interviews, one participant had these to say:

Traditional healers always have time for their clients that come to them. Some can even make them forget about their sickness or pains by encouraging and assuring

them of good treatment before they even apply the medicine. For instance some will say “my son or my friend do not worry everything will be OK” (A 37 year old man, client of TM from Kwaturu)

Personal knowledge of the healers’ ability to treat certain kinds of illness is another factor that makes patients to patronise Traditional Medicine. Attesting to this, a relative of a mental patient at Kwaturu says:

We came here because of our personal knowledge of the healer on treating people with similar conditions. There is great improvement since we came to him. We thank God (A relative of a mentally ill patient at Kwaturu).

This position is corroborated by a 38 year old female participant:

I live in this area and have seen many people with serious fractures that were treated successfully by this TBS woman. So I came to her, because her work speaks for her (A female patient of Saraya (Mama Tumba) clinic in Zaria).

The views expressed by the participants indicate that community members know the therapeutic skills of the traditional medical practitioners because they live and work among them unlike those of modern medical practitioners who live and work far away from them. For example, a traditional birth attendant can patiently attend to a woman in labour even if the woman in labour does not adhere to instructions given to her. A 45 year old house wife from Giwa attests to this when she says:

I had three of my children delivered by a TBA and one in the hospital....but I was more comfortable with the TBA than the modern midwives do in the hospital because the TBA did not insult or embarrass me as the midwife did. The midwife were rude and lukewarm to me and other clients that went there for delivery. (A 45 year old woman at Giwa)

The statements reaffirm the commitment of traditional healers to their duties and the needs of their clients.

The lukewarm attitude portrayed by Modern Medical Practitioners usually creates dissatisfaction with the services they render to their clients. A 35 year male client of Traditional Medicine in Zaria, said:

The last time I went to the hospital when I had serious body pains, I waited on a long queue for more than two hours, when I finally saw the doctor, the consultation lasted less than five minutes. While he was asking me of what the problem was, he was already writing the prescriptions. After taking these drugs, I did not get better. So I decided to visit a traditional healer who attended to me kindly. (Client of a traditional healer in Zaria).

This statement indicates that clients are dissatisfied with modern medicine because of long waiting time and inadequate examination. This is contrary to TMPs who will pay more attention to the client.

Most practitioners interviewed are found to sustain warm, friendly and comforting smiles to their clients, relatives and visitors unlike the hostility seen in the modern hospitals. The cordial rapport created by traditional healer with his clients is a motivating factor for the success in their treatment that is, a client is obliged to whatever the healer says. The statement by a herbalist in Kafanchan captures the opinions of most traditional medical practitioners who participated in the study. He says:

When patients come to me I welcome them very well and make them feel comfortable in my house. I offer them food and water to drink. In the process of my treatment I usually ask them about their ailments and explain what I will do and what is expected of them. Sometimes we crack jokes.....(A Herbalist in Kafanchan).

Corroborating this statement by a Traditional Health Practitioner in Zaria, explains the acceptance of Traditional Medicine by communities when he says:

I treat my clients kindly because they are part of me. This is evidenced in the number of patronage we receive every day from various categories of patients, the

rich and poor, educated and uneducated, people from rural and urban areas. On the average two clients visit me in a week (Traditional bone setter, Zaria).

Efficacy is another factor for choosing herbal medicine as the first port of call for many patients. The perception of efficacy in relationship with the actual health seeking practices of participants, seem to indicate a high level of local confidence surrounding the practices of traditional healers. Table 4.11 presents the views of respondents on the efficacy of Traditional Medicine.

**Table 4.11 Respondent’s Assessment of Efficacy of Traditional Medicine by Sex**

Sex	Assessment of the Efficacy							
	Effective		Undecided		Not Effective		Total	
	F	%	F	%	F	%	F	%
Male	475	75.1	46	7.3	111	17.6	<b>632</b>	<b>100</b>
Female	473	84.5	51	9.1	36	6.4	<b>560</b>	<b>100</b>
<b>Total</b>	<b>948</b>	<b>79.5</b>	<b>97</b>	<b>8.1</b>	<b>147</b>	<b>12.4</b>	<b>1192</b>	<b>100</b>

**Source: Field Survey, 2017**  $X^2 = 34.28$ ,  $df = 2$ ,  $p < 0.05$  Significant

The result in Table 4.11 reveals that more (84.5 percent) female than male (75.1 percent) respondents opines that TM is efficacious while 12.4 percent of both sexes disagree. But a few respondents are undecided. A similar scenario is also reported during the interview session, where majority of the participants, perceived Traditional Medicine as efficacious. The views of the following participants capture the view of the majority on the opinions. One of the key informants from Abet says:

Traditional medicine is more efficacious than modern medicine, because there are some diseases like fracture, STI, hypertension, diabetes, rheumatism which traditional medicine treats effectively. If such illnesses are taken to the hospital, they will either have you amputated in the case of fracture and with long list of drugs to take which sometimes leads to other problems or even death. Many

people rely on traditional medicine for treatment, except cases we know they cannot handle successfully like surgery to remove growth in the abdomen (a community leader at Abet)

The assertion of efficacy of Traditional Medicine is supported by a 31 year male fracture patient from Kwaturu during the IDI. He explains that:

When I had an accident, one part of my legs was neither turning nor moving, the people around started saying 'I got a fractured on my leg', I did not make any move to go to the hospital because I know there is an expert in traditional bone setting here who can fix my leg better than in the hospital. So I was brought here by my family and I am 14 days here and by the grace of God much better (client of traditional bone setter from Yabung (Kwaturu)).

Reiterating further on this, a 41 year male patient of a bone setter in Zaria explained the efficacy of Traditional Medicine as follows:

I had a motor cycle accident and visited many hospitals but there was no improvement after spending much money, I decided to go for traditional bone setter and now we have spent 8 weeks here and I am much better because I can sit up by myself without support. Her work is very effective compared to what I saw in the hospitals I visited (A client of bone setter, Zaria).

The statements imply that efficacy is one of the major contributing factors for increasing popularity and patronage of Traditional Medicine in Kaduna State. Added to that the statements show that Traditional Medicine is efficacious in handling some ailments like fracture problems. The effectiveness of Traditional Medicine has validated its contributions to health care of many patrons.

Moreover, during the IDI three clients of TBS indicate that they absconded from the modern hospital for TBS services because they believe they would be eventually amputated or wrapped with Plaster of Paris (POP) and take long duration before healing. It shows they lack confidence in the performance of modern orthopedic in handling their



bone problems. These are salient issues which patients rarely disclosed to their medical personnel when in the hospital.

Traditional Medicine is found to be efficacious in treating various ailments as presented by a 55 year old community leader from Kaduna who says:

I use traditional medications for ulcer, high blood pressure and other needs and found it meeting my health conditions but my children who were born in Kaduna are not in support of it. They see TM as concoction that is harmful to the body. But I used to tell them that I gave them traditional herbs when they were babies to treat various kinds of ailments that affected them then (a male in Kaduna).

This statement indicates efficacy of Traditional Medicine by those who believe in it. Some people may see its utility others may not. For instance, during one of the interview sessions a 25 year male participant from Kaduna clarified the significance of one's belief in healing system. He explains why he does not patronise traditional healers as follows:

I am not against traditional medicine. It is just not my way. That's just that. Because everybody has his or her own little road they have to pass through in life and that's not my way and not because of any other reason, but because I know it is not my choice.....everyone has a certain belief in certain things. One man's meat is another man's poison. We are all different (a 25 year male participant in Kaduna).

The statement indicates different perception of Traditional Medicine by a youth born in an urban area because of their exposure to modern health facilities which differs significantly from those born in rural areas with few modern health facilities.

Similarly an IDI with a modern medical practitioner reveals that he is skeptic and doubtful of some claims made by traditional medical practitioners. He says that some Traditional Medical Practitioners claimed beyond what they can do. He cites an example of a young man whose hand have to be amputated because of the bad management he received from a traditional bone-setter. There are traditional healers not fit to practicing

the art mostly seen at the local lorry parks, market places where all kinds of herbs and mixtures are sold to unwary clients who bear the brunt when medication failed.

The traditional healers are asked how they knew their treatments were effective. Majority of them said that they determined treatment outcome effectiveness based on report from their patients. They were optimistic about their healing methods to be equally or more efficacious than modern medicines. They maintain that because their medicine works that is why people patronise them.

Sources or information concerning Traditional Medicine services and practitioners is another factor which continues to be mentioned during the FGDs as the basis for patronising the traditional healers. Some of the sources mentioned include mass media, friends, relatives and close associates, testimonies of people who have patronised Traditional Medicine services and knowledge from folk medicine. The results revealed that some traditional health practitioners have resorted to more aggressive marketing drives in both the print and electronic media to make their products and practices known to the public. The utilisation of mass media channels such as television, radio and FM stations, and news magazines as opposed to the traditional verbal advertisements ensures wider audience awareness and promote patronage of their products and services. Evidence of the strategies adopted by these healers to achieve patronage include: distribution of handbills (Plate 1-10) buying of airtime to sponsor programmes that are of interest to members of the general public for instance, drama, football, and so on. They also organize herbal trade fairs to showcase their products as explains by 31 year old male healer in Zaria:

We have to make ourselves and our services known to those that need our help through the media such as news papers, radio, and herbal fairs (A representative of Baba Otta Herbal Point Zaria).

Corroborating this statement by the chairman organising committee for 2018 Trado medical fair in Kaduna, he says:

It is necessary for us to do this in order to show the world that traditional medicine is the best option in treating so many health challenges despite the opposition we are facing from the modern medical practitioners. My colleagues and I treat different types of ailments effectively. You can see people in different stands with various health challenges seeking for solution.

Results of such print and electronic advertisements are evidence from clients with some kind of education during the interview sessions. It is revealed that participants who can read and write are exposed to newspapers, magazines, news and advertisements on the radio and television stations about Traditional Medicine. These have helped in broadening their knowledge of traditional medical practices that have been proven effective in treating certain illnesses. This is evident from some participants who have attained tertiary level of education during the interview sessions. The evidence from a 37 year male client of a bone-setter in Zaria demonstrates this:

Here with me is a radio. I listen to radio programs quite often, including advertisement of traditional medicine which has promoted my thought about traditional medicine. Also, I read books and magazines on health issues especially nature and health columns in magazines and newspapers. I am a graduate of political science with four years of work experience. (A 37 year client of bone setter, Zaria)

Explaining further, a female client of the bone-setter said:

I am a National Certificate of Education (NCE) holder I buy national newspapers to read the health column especially issues on complementary medicine and traditional medicine. These gives me an understanding of the efficacy of natural

products provided to us by God. I understand that if we use God's given material carefully we will live long like our fore fathers. (A female client of TBS in Zaria)

The statements show that those with some level of education choose to patronise Traditional Medicine based on the information they get through mass media or other people. However, some participants in the study disagreed with 'the-hearsay' in the radios and newspapers. A 44 year old male participant in one of the FGDs in Zaria who had an encounter with Traditional Medicine:

The claims made by some of the media are false and misleading because I had a swollen stomach some years ago and was advised by relations based on what we heard from the radio to go for traditional medicine because it was effective in treating such ailment. I nearly died when I took the herbs given. I decided to see a doctor in the hospital who did some test and prescribed drugs for me and since then I have not experienced such an illness. I don't think I will go in for any traditional herbs and will never advise anyone to go for it.

The statement shows that information about Traditional Medicine is not limited to mass media but could also come from people but the kind of information through mass media could be misleading because they are after money. The statement further demonstrates that some educated people are not yet convinced of the safety and efficacy of traditional herbs.

Findings reveal that the practitioners that have gone far on improvement in the preparation of herbal medicine, through the use of some modern health practices procedure of consultation with clients and aggressive marketing through the mass media are mostly done by the educated healers and those that have obtained more than just a basic education.

On safety, there is a general notion to believe that herbal medicines are safe and are more useful than harmful. Persistently recurring in both the qualitative and

quantitative studies is the issue of safety and harmfulness of Traditional Medicine. Table 4.12 presents the views of respondents about the safety of Traditional Medicine.

**Table 4.12 Respondents Views on Safety of Traditional Medicine**

<b>Safety</b>	<b>Frequency (f)</b>	<b>Percentage (%)</b>
Safe	638	53.5
Uncertain	457	38.3
Not Safe	97	8.2
<b>Total</b>	<b>1192</b>	<b>100.0</b>

**Source: Field Survey, 2017**

The result in Table 4.12 reveals that a preponderance of the respondents (53.5%) maintained the idea that use of Traditional Medicine is less harmful compare to the use of modern drugs. However, only 8.2 percent of the respondents think that Traditional Medicine is not safe. Corroborating this with the information from the discussants and informants who took part in the FGDs and IDIs conducted showed that clients of Traditional Medicine saw no harm in using traditional herbs. Most of them felt that herbal products which are natural do not cause risk like modern drugs. Many participants also felt that herbal medicines work softly and gradually in comparison with modern medicines which are full of chemical and less powerful but harmful to the body. This was reflected in the following quotes;

A forty year client of a Traditional Healer in Kaduna states as follows:

These herbs we are using are pure natural products. These natural products are free from chemicals unlike the pharmaceutical drugs. The chemicals used in the modern drugs are dangerous to the body their effects could be short or have long, long-term on the body. I distaste hospital drugs because I don't want to put chemicals into my body.... I go for herbs when I am ill because they are safe (A client of TM from Sabon Tasha Kaduna)

Expressing a similar view a 41 year female client of Traditional Medical Practitioner say:

I prefer herbal preparations because they work well on our bodies. It has no restraining measures we're free to take as much as we can. Let me show you an example, you know that vegetables and all leaves we take as salad are herbal medicines?. You can take any quantity of them at any time but will cause no problem for you ....vegetables and leaves like, onions, cabbage, carrots, lettuce, pawpaw, moringa leaves .they are all harmless. They even provide enough blood for the body and helps indigestion in the body (A client of TM from Kafanchan)

The statements above demonstrate willingness to continue utilising Traditional Medicine because of perceived safety by clients. The implication of these statements is that clients are not aware or ignorant about natural substances in plants that could be dangerous to human health.

Evidence in this study, suggested that the long history of human utilisation of herbal medicines confirm their safety and maintaining of society's health. On the issue of traditional and modern medicine, many participants saw no problems in taking traditional alongside modern medicines. During the interview, some informants observed that they are skeptical about taking herbal medicines at the same time as modern ones. One of the community leaders says:

Patients on traditional medication always go for modern medicine when it causes problems and similarly if hospital's medicine failed traditional herbs come to mind as an option. (Community leader in Tudun Tsaidu)

The implication of this is that those who use modern medicine are much more likely than non-users to believe that herbal medicines are harmful and vice versa.

Most participants in the FGDs conducted in the three Senatorial Zones maintain that unlike modern drugs that have counterfeits, Traditional Medicine is hardly ever adulterated and it is natural and has less side effects. This forms the basis of dissatisfaction with modern medicine by participants in the FGDs. At its natural form,

herbs use for treatment of some ailments have revealed significant contribution to health care of people rather than harm as indicated in most modern drugs (*side effects*). A middle age woman (A young adult) who participated in one of the FGDs sessions from Hunkuyi states that:

Natural things are without chemical and therefore warrant safety but when such herbs are grown or produced with chemical in it may turn to different thing. Herbs grown around the compound are chemically induced which cause side effects but if they are harvested at its natural setting they are very free from contamination and very effective for the purpose meant for.

To ensure safety of patients herbs are carefully prepared in such a way they may not affect the clients as narrated by a 33 year old male traditional healer from Kafanchan who stated that:

We administer our herbs using the available natural resources for example mixing herbs with liquid such as water, porridge, as smoke, rub, by means of nose the plant parts are steamed or burned and the smoke/steam inhaled. The prepared remedies are applied by either a patient or healer on the affected body part/s.

The statement shows that administration of herbs in this manner is to reduce any side effect. The statement also points out the similarity of method in treating ailments with the modern hospital and many have testified being healed by such application. This suggests Traditional Medicine is not competing with Modern Medicine but is complementing in the areas that its services cannot be reached. Reiterating further on natural aspect of Traditional Medicine a community leader from Giwa says:

Herbs prepared by herbalists are natural and our people appreciate natural herbs than synthetic drugs because some of them have expired and can harm the body rather than healing. People get relief from catarrh when they inhale the steam of some herbs prepared by herbalist. Similarly, herbs for stomachache prepared by herbalists are found to work well, they are accessible and less costly.

The statement indicates that users are contented with the role traditional healers are playing in handling health matters without much adverse effect in the society as such accounted for Traditional Medicine patronage and utilisation. As part of ensuring safety, a 42 year male traditional medical practitioner from Kaduna states as follows:

As part of my healing practices I always advise my clients to maintain proper hygiene in their homes and to boil or use clean water for herbs that involve soaking with water.

This statement demonstrates that traditional healers are health educators when it comes to health matters. They are custodian of environmental health awareness.

Majority of the FGD discussants state that some people patronise Traditional Healers not on health grounds but for protection against evil spirit, evil eye and bad luck. Amulets, hair style and eye make-up such as antimony or kohl (*tauzali*) are used for protection against malevolence people. Furthermore, some medicines are used as charms against an enemy. Cultural ritual and scarification are commonly employed in diseases prevention. These aspects of Traditional Medicine are considered to have spiritual and social dimensions. A 51 year female herbalist in Kaduna during the interview session explains further on this:

Many people come to me from different socio economic and demographic backgrounds to get medicine to enhance their well being and good luck (*sa'a or farin jinni*), for protection against enemies, evil forces, and witches. Many that patronize my services have come back to appreciate me. (Herbalist - Kaduna)

The statement shows that clients visit Traditional Healers for health conditions; success in life, enhancement of social wellbeing and for protection against what they think will affect their health immediately or later. This is just like immunisation or vaccination against some diseases where hindrances to optimal physical and social wellbeing are perceived as diseases.

#### **4.6 Socio-Demographic Characteristics of Traditional Healers Clients**



One of the objectives of this study is to find out the socio-demographic characteristics of respondents who had utilised the services of traditional healers. The responses obtain indicate that 96 percent of the respondents had sought the services of traditional healers while four percent constituting the minority had never (Appendix XI). This finding confirms the literature on high patronage of traditional medicine in Nigeria (Lucas, 2010; Fakeye, et al. 2009 and Oluwabamide, 2007). The results of the Chi test identified sex, age, and income, among other socio-economic variables, found to be significant ( $p < 0.05$ ).

When examined separately by sex, it is found that Traditional Medicine was highly patronised by males and females, the prevalence of Traditional Medicine utilisation varied from male to female in the study areas. Table 4.13 shows the distribution of the respondents by sex.

**Table 4.13 Gender and Traditional Medicine Utilisation**

<b>Traditional Medicine Utilisation by Gender</b>					
<b>Gender</b>	<b>TM User</b>		<b>TM Non User</b>		<b>Total</b>
	<b>F</b>	<b>%</b>	<b>F</b>	<b>%</b>	
<b>Male</b>	632	95.6	29	4.4	<b>661</b>
<b>Female</b>	560	96.4	21	3.6	<b>581</b>
<b>Total</b>	<b>1192</b>	<b>96.0</b>	<b>50</b>	<b>4.0</b>	<b>1242</b>

**Source: Field Survey, 2017**

$X^2 = 59.271$ ,  $df = 1$ ,  $p < 0.05$  Significant

When examined within the group, Table 4.13 reveals that a higher proportion of females (96.4%) than males (95.6%) are found to have utilised Traditional Medicine. This difference may be as a result of the delicateness and other health-related challenges peculiar to females. This is obvious in some studies (Buor, 2008a; Ahmed et al. 1999),

where used of herbal products and other traditional medical therapies are found to increase among pregnant women. This study reveals that Traditional Medicine is used in diverse health challenges peculiar to pregnant women like nausea, anxiety, stress, depression, backache, labour induction, headaches, migraine, urinary tract problems among others. This is congruent with the study of Gaffney and Smith, (2004) on South Australian obstetricians and midwives attitude's towards the use of complementary and alternative medicines (CAM) during pregnancy. This is because of the popular belief among women that Traditional Medicine is more natural and thus safe to use in pregnancy and child birth. Other studies equally identified personal beliefs to influence females have utilisation of Traditional Medicine (Stock, 1985; Lasker, 1981). A non-parametric test of difference is performed to determine the association between sex and use of Traditional Medicine (Table 4.13). The results show a significant relationship between sex and use of Traditional Medicine.

When examined separately, the educational attainment of respondents helps to reveal whether respondents' choice of a particular health care system is influenced by their level of education. The result obtained is presented in Table 4.14

**Table 4.14 Level of Educational Attainment and Utilization of Traditional Medicine**

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**Ever Utilized Traditional Medicine**

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Education	TM User		TM Non User	
	F	%	F	%
No formal	185	97.9	4	2.1
Primary	286	97.6	7	2.4
Secondary	336	96.8	11	3.2
Tertiary	276	92.9	21	7.1
Others	109	93.9	7	6.1
<b>Total</b>	<b>1192</b>	<b>96.0</b>	<b>50</b>	<b>4.0</b>

**Source: Field Survey, 2017**

$X^2 = 8.891, df= 4 \quad p < 0.05 \quad \text{Not Significant}$

The data in Table 4.14 clearly demonstrate persistent decrease in patronage as the level of education moved higher. The result in the table shows that no formal (97.9 percent) and primary (97.6 percent) tend to utilise Traditional Medicine than Secondary (96.8 percent) and tertiary (92.9 percent). Thus, the effect of education is mixed, as results show those with a little or ‘no education’ have a slightly higher propensity to utilise Traditional Medicine, but those with the higher types of education appear to use less. It became clear that the need for utilisation of traditional healing could never be biased because of one’s educational attainment. It is believed that those with low level of education are low income earners and cannot afford the high cost of modern medicine. They depend so much on Traditional Medicine because of its comparative low cost, coupled with its efficacy. The trend supports the popular view that those who have not undergone schooling tend to patronize Traditional Medicine more than those with some level of educational attainment.

However, findings from the visit to Traditional Medical Practitioners show that majority of patients found in TBS homes had attended secondary school or a higher level of education. In fact traditional bone setting is patronised by people from different level of education. Expressing his opinion on this, a 63 year old community leader in Kaduna bears his mind:

I am a university graduate with M.sc degree in Economics but when my wife had an accident on a motor cycle and got a fracture on her right leg, I personally took her to the traditional bone setter because of his experience in handling this type of cases. I did not take her to the hospital because it could have taken her several months to get well, but with the TBS she was able to walk after a few months. Precisely four months. But on the other side I cannot imagine myself or taking my relation to a herbalist to treat a kidney problem. Certainly there are health conditions that I cannot consent to traditional medicine.

He continues;

Some 'educated' people in the society patronize traditional medicine even more than modern medicine for one reason or the other but would not admit that they use it. They utilize traditional medicine secretly because of their level of education or status in the community. (A community leader in Kaduna)

This view demonstrates that patronising Traditional Medicine is not peculiar to less educated people but also those with some forms of education do but shyly. It also shows the popularity of Traditional Medicine in treating some ailment and the efficacy perceived through experiences of others. The concealment of the patronage of traditional healers by 'educated' persons can be explained in two dimensions, first the colonial master perception of Traditional Medicine as superstitious, witchcraft and mainly for poor people (Hassim et al., 2010, Sofowora, 2008). With this notion some of those who are properly indoctrinated into colonial mentality do not want people to see or know that they seek help from Traditional Healers. In the second dimension, the monotheistic religions forbid patronising traditional healers especially the diviners and soothsayers. Therefore, the religious faithful choose to see them secretly for fear of being sanctioned.

Response from the field indicates that, though a larger proportion of the people go for one form of health care or the other. This however, depends on how much they earn accessibility to health facilities, type of medical facility, tastes and preferences. These factors have greater influence on respondents' choice of medication. Income levels seem

inevitably to influence to a large extent the type of medical facility respondents' use. The income level and Traditional Medical utilisation is presented in Table 4.15.

**Table 4.15 Income level and Utilization of Traditional Medicine**

Monthly Income in Naira	TM User		TM Non User		Total	
	F	%	F	%	F	%
≤ 19,000	630	52.9	3	6.0	633	100
20,000-39,000	392	32.9	3	6.0	395	100
40,000 and above	170	14.3	44	88.0	214	100
<b>Total</b>	<b>1192</b>	<b>96.0</b>	<b>50</b>	<b>4.0</b>	<b>1242</b>	<b>100</b>

**Source: Field Survey, 2017**       $X^2 = 183.007$ ,  $df = 2$ ,  $p < 0.05$       Significant

It can be seen from the data in Table 4.15 Traditional Medicine utilisation was higher (52.9 percent) for low income earners (≤ # 19, 000) compared to their contemporaries whose income levels are high 32.9 and 14.3 percent respectively. The data indicate that the higher one's income level, the less their use of Traditional Medicine. The data suggest that low income tends to influence decision to patronize the services of traditional healers as indicated by other scholars like Omotoso (2010), Adjei (2013), and Areo (2014). In circumstances where people are not able to generate enough money from their business enterprise, they are most likely to utilise Traditional Medicine. This shows that Modern Medicine is more costly than Traditional Medicine. This is similar with earlier studies assessing the income and general economic status and use of Traditional Medicine (Dahilig et al, 2012; Al-Windi, 2004) in Philippines and Swedish respectively.

A greater proportion of discussants who took part in the FGDs indicated that people go for one form of health care or the other based on how much they earn, other factors like accessibility, type of medical facility and tastes and preferences also had a greater influence on clients choice of medication. Income levels, certainly, determine to a great extent the type of medical facility client's use.

Shading more light on low income can influence the utilisation of Traditional Medicine, a 58 year TBS client in Kwaturu states

I am a poor farmer and satisfied to be here because the little money I have can be accepted here for my treatment.

A female relative of a mental patient in Kasuwan Magani explains further:

I do not have enough money to go to the big hospital and not sure whether my needs will be met if I go there, but thank God there is much improvement since I brought him here. I am a widow. I rely solely on farming and assistance from God fearing people.

The two statements describe how low income influences the patronage of Traditional Medicine.

However, during the interview some high income participants were among the patrons of TM. One of the main reason given was the efficacy of Traditional Medicine and failure of modern medicine to cure their illnesses. For instance, the explanation of a 36 year old military officer, a client of a bone-setter in Zaria confirms this. He says:

I was taken to the hospital first when I had this fracture but decided to go for the traditional bone setting not because of money, because I have the money to settle my bill but could not just stay in the hospital when I observed the procedures they were taking will make me to stay in the hospital for a long time. I opted out to this

place and I am very happy because there is much improvement when compared to the hospital (A client of traditional bone setter in Zaria).

This statement entails that higher income does not hinder patronage of TM rather other reasons such as belief of efficacy in the treatment regimen of Traditional Medicine.

It is observed from the Table in appendix XI that the type of occupation engaged in by the respondent show a significant association with Traditional Medicine utilisation. A higher proportion of farmers (31.1%) and traders (26.0%) utilised the services of Traditional Medicine than respondents who were civil servants (21.3%). This finding agrees with a study by Elkins et al., (2005) who reported that the frequency of use of Traditional Medicine was dominantly and significantly higher amongst self-employed who are widespread and engaged in numerous economic activities. It could be argue that the low level of education and the higher rate of exposure to various sales' points of Traditional Medicine such as, vendors and peddlers in every nook and corners of streets, open market places and within mobile buses in the State account for the higher patronage. On the contrary, this finding is not in agreement with the studies carried out by Dahilig and Salenga, (2012) in Philippines and Aziz and Tey, (2009) in Malaysia. The two studies report that there is no significant association between Traditional Medicine use and the nature of occupation of clients.

Some participants who took part in the interviews confirm the wide spread use of Traditional Medicine among artisans. According to a 32 year old motor mechanic in Zaria:

... these herb mixtures will boost my energy and at the same time cleanse my system. It helps me to do my work better. Peddlers of Traditional Medicine usually come around to sell their herbs to us here (An automobile mechanic in Zaria).

Another participant, a 33year old healer in Zaria:

I display my herbs at the major markets, busy streets and in front of mosques. I also tell the public where they can locate me and my phone contact. I sell different medicines for various illnesses. I enlighten people about the various illnesses such as diabetes, hypertension, arthritis and the cure the herbs can offer concerning these illnesses. In addition I have herbs for other illnesses that bother people be it children or adult ...people that access my services are mostly those engaged in hand work. (Herbalist in Zaria)

The data on age categories (appendix XI) show that larger percentage of respondents who had ever sought traditional treatment is between the age of 26 and 40 which suggests that Traditional Medicine serve people of different groups thus covering a very wide range of health care for different age categories in the society. The chi-square ( $X^2$ ) results show significant ( $p < 0.05$ ) association, indicating that there is a significant relationship between age and patronage of Traditional Medicine.

Patronage of TM has no social or geographical boundaries. The study reveal that Traditional Medicine is utilised by all ethnic groups in Kaduna State. For instance, a Yoruba male traditional health practitioner aged 55 years, who participated in the in-depth-interview in Kaduna says:

I am a Yoruba man and I have been attending to various people, some are my language people, some Hausa, Igbo, Idoma, people from this State and even Niger Delta. This is to show that people from different ethnic groups in Nigeria patronize me (A traditional medical practitioner, Kaduna).

This statement is supported by a 63 year old female bone setter in Zaria:

I am a bone-setter an indigene of Bornu State. People from different tribes and languages come to me for treatment, I do not have a record of my patients but most tribes in Nigeria had patronized my services at one time or the other. As you can see, there are men, women and children currently on admission and they are



from different ethnic groups. For example I have Hausa, Fulani, Yoruba, Surubu, Kagoma and Benue. (A bone setter, Zaria).

These statements indicate the patronage of Traditional Medicine, irrespective of cultural origin of the practitioner and client. Because people from different ethnic backgrounds and gender across the various States in Nigeria patronise Traditional Medicine. This finding is not unexpected, it agrees with the work of Twumasi (2005) on medical systems in Ghana, where tribes, cultures and indigenous people of nations utilize the services of Traditional Medicine. Similarly, different ethnic groups in Nigeria have found most of these medical practices reliable and affordable and can patronise any healer that is most accessible to them and proves to be effective for their health care needs. It is observed that the dominant ethnic group patronizes the healer who is nearer to them than other ethnic groups because of proximity. This observation is confirmed by a 57 year old traditional healer from Kaduna North Local Government Area, who says:

... Hausa/Fulani and Muslim, particularly patronize my services more than other ethnic groups, perhaps because I am a Muslim and Hausa by tribe. Also where I am located I am surrounded by my tribe's people than any other tribe. But a few from other tribes patronize my herbs (A general traditional medical practitioner)

This statement demonstrates that proximity and recognition of the fame of traditional healers by community members including other ethnic groups in that environment attracts clients.

Place of residence is a determining factor in the use of Traditional Medicine. Table 4.16 presents the results of ever sought treatment from a traditional healer.

Table 4.16 Respondents place of residence and Ever Utilized TM

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**Ever Utilized Traditional Medicine**

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Place residence	Ever Used TM		Never used TM		Total
	F	%	F	%	
<b>Central Ssenatorial Zone</b>					
Rural areas (Giwa and K/magani)	204	97.1	6	2.9	<b>210</b>
Urban (Kaduna)	195	95.1	10	4.9	<b>205</b>
<b>Southern Senatorial Zone</b>					
Rural areas (Kwaturu and Abet)	199	95.7	9	4.3	<b>208</b>
Urban (Kafanchan)	193	94.6	11	5.4	<b>204</b>
<b>Northern Senatorial Zone</b>					
Rural areas (Hunkuyi and T/Tsaibu)	202	97.1	6	2.9	<b>208</b>
Urban (Zaria)	199	96.1	8	3.9	<b>207</b>
<b>Total</b>	<b>1192</b>	<b>100</b>	<b>50</b>	<b>100</b>	<b>1242</b>
<b>Source: Field Survey, 2017</b>		$X^2=260.48$ , $df=1$ , $P < 0.05$ Significant			

It can be seen in Table 4.16 that there is a little variation across rural and urban divide regarding use of TM. The results reveal that more (50.8%) rural residents of central, Southern and Northern Senatorial Zones utilised Traditional Medicine than their counterparts (49.2%) in the urban areas in absolute terms. This marginal difference in utilisation of Traditional Healers between rural and urban residents as shown in Table 4.16 might be due to large differences in socio-economic position of the individuals and communities between the two geographical settings. Political forces in the distribution of health care facilities remain a strong determinant accounting for this utilisation pattern.

Discussants during the FGD sessions generally agree that distribution of modern health facilities are usually tilted against the rural communities. They point out that non-availability of health care facilities and personnel in the rural communities make people

in such rural setting to utilize TM for ailments that can be best handle by modern medicine. Even where a few facilities are provided, patients would have to travel a long distance or pay more to a motorcycle rider to reach the nearest health facility. Furthermore, environmental conditions in rural areas favour the use of Traditional Medicine, for instance, easy access to the various botanical based products. Other reasons given include, health status, health beliefs and cultural. This phenomenal diversity contributes to the differential utilisation of health care resources. A female discussant from Abet a farmer summed up the issue thus:

We thank God that culture has provided us with knowledge of healing and those specialized in the art of traditional medicine, otherwise one would not be talking now. The local government clinic here has nothing to talk about; it is more or less an empty building with no health workers and facilities. The community has been deceived several times by those in authority with laudable promises of equipping the clinic but nothing seems to happen. For proper attention when one is seriously sick to go to Kafanchan General Hospital. The issue is how to get there because people do not have enough money to transport themselves to the hospital. People are just poor farmers without any reasonable income. The best option is to rely on our traditional healers.

This opinion expressed by the discussant shows that many rural dwellers utilise Traditional Medicine for their health care as they cannot afford the services of Modern Medicine because of the distance and non availability of facilities in their communities.

Informants who participated in the IDI in the rural areas also showed that modern health services are better found in urban than rural areas. Some informants stated that if there are serious sickness that involve surgery they have to move to the town where they have their relation working in order to acquire such medical attention.

When examined separately, religious affiliation seems to have no influence in the utilisation of Traditional Medicine. Table 4.17 shows the distribution of respondents by type of religion.

**Table 4.17 Religious Affiliations and Ever Utilised Traditional Medicine**

<b>Ever Utilised Traditional Medicine</b>					
<b>Religious Affiliation</b>	<b>Ever Utilised TM</b>		<b>Never Utilised TM</b>		<b>Total</b>
	<b>Freq</b>	<b>%</b>	<b>freq.</b>	<b>%</b>	
Christianity	636	95.9	27	4.1	663
Islam	529	96.3	20	3.6	549
Traditional	27	90.0	3	10.0	30
<b>Total</b>	<b>1192</b>	<b>96.0</b>	<b>50</b>	<b>4.0</b>	<b>1243</b>

**Source: Field Survey, 2017**  $X^2=109.60, df=2, P < 0.05$  Significant,

In terms of religion, Table 4.17 shows that although Traditional Medicine was highly patronised by all the three religious groups, the prevalence of utilisation varied from one group to another in the study area. Table 4.17 presents the distribution of Traditional Medicine use by religious affiliation of the respondents. Slightly, more Muslim (96.3%) than Christians (95.9%) and Traditional (90%) faithful are found to utilise Traditional Medicine. The implication of this behaviour is that given the religions: Christianity, Islam and traditional, one would expect traditional religion to have recorded a hundred percent utilisation. Unlike Christianity and Islam there is no restriction on the choice of traditional health care by traditional religion. Thus, whether Christians, Muslims or Traditional believers, faith is important in choice of treatment from any source.

However, some of the FGD discussants agreed that religion does not prohibit utilising TM except where rituals related to the gods of the land are practiced particularly Islam and Christian religions. However, traditional religion has no restriction on contacting the gods for healing. To some of the participants, it is a matter of faith in God

because he is the provider of all things so one is free to use whatever thing God has provided for man’s well-being. A 46 year Muslim farmer from Hunkunyi who participate in the FGD session says:

Our religious books talk about sickness and even made provision for treatment. The treatments are not from Whiteman’s medicine but from nature, that is plants and animal parts found in the environment. People in this community use Traditional Medicine so much partly because religion does not prohibit them from using it.

The opinion held by this discussant demonstrates that some people go for Traditional Medicine because religion allows its use.

Respondents in the study were further asked to indicate the number of times they used TM in past 24 months prior to the survey. The result is presented in Table 4.18:

**Table 4.18 Number of Times Patrons Used Traditional Medicine in past 24 months  
By Residence**

Number of Times	Residence				Total	
	Urban		Rural			
	Freq.	%	Freq.	%	Freq.	%
Once	150	26.5	170	27.2	320	25.8
Twice	301	53.2	320	51.1	621	50.0

Thrice	115	20.3	136	21.7	251	20.2
<b>Total</b>	<b>566</b>	<b>100.0</b>	<b>626</b>	<b>100.0</b>	<b>1192</b>	<b>100.0</b>

**Source: Field Survey, 2017**  $X^2=0.55, df=2, P <0.05$  Not Significant,

Table 4.18 reveals that 25.8 percent of the respondents mentioned they had used Traditional Medicine at least once during the period for both rural and urban areas. Most (50%) have used Traditional Medicine or accessed the services of Traditional Medical Practitioners for twice or more times during the period. This provides ample evidence that Traditional Medicine is frequently used in the study area.

#### **4.7 Government Regulation of Traditional and Modern Medicine**

Despite the existence of traditional medicine for many centuries and its extensive use during the last decades, Nigeria Traditional Medicine has not yet received official recognition in the main stream of health care. Due to the influences of colonialism and imperialism in the postcolonial era, western medical practices are still dominant in all parts of the country. After the independence in 1960 modern medicine is adopted as the mainstream health service. Acknowledging the role of Traditional Medicine to health care is an important political topic which needs to go with the formulation of a state or national policy on traditional medical practice. The formulation of appropriate regulatory and legal frameworks, for controlling the practice, practitioners and traditional medicinal products will in many ways improve the primary health care of the country.

Explaining in general terms the reasons for poor management of health resources, poor health care services, unequal distribution and inability to meet stated health goals

which have created a gap for the activities of Traditional Medicine, a 55 year old community leader in Kaduna who participated in the study observes that:

Politically the Kaduna State commitment to health care development, at the Local Government level is not encouraging. The State government has come up with a number of policies and laws aimed at reforming the health services, nonetheless some crucial ones are yet to be operationalised with a whole lot of suffering from implementation problems. In this case, the state needs a strong political commitment, developing an adequate regulatory frame work that include herbal medicine, good governance, transparency and accountability, implementation, management as well as monitoring, evaluation and research.

The statement clearly demonstrates that the State government has not properly implemented its policy on this aspect of health matters. It also, indicates poor coordination and lack of effective health leadership. The community leader further reiterates that:

..... no appropriate financial plans for research at the state and the Local Government levels. Health funding is low, unpredictable and untimely. Funding of health care is nothing to talk about because out-of pocket expenditure remains the dominant method of financing health care in the State. There is an inequity distribution of health facilities and personnel. Shortages of drugs and equipment stand as the major challenge at Primary Health Centre level. There are gaps in the quantity, quality and mix of health care personnel. Services at this level are disjointed, not integrated and essentially narrow down to clinical-based interventions. There are no appropriate referral systems because the health management information system is poorly developed and it excludes the private and traditional sectors. Community participation is poor and the state public private partnership policy is yet to become fully operational.

This explanation implies poor health financing and improper coordination of the available health care services. People who fall sick will definitely go for an alternative medicine because of the prevailing situation. Such a choice falls on traditional medicine, the only alternative available to most of them.

The study reveals that the Kaduna State Government policy thrusts on health care include: delivery of priority health services, management and development of health resources, stewardship, fiduciary and health management and consumer/client participation and demand issues (Kaduna State Ministry of Health 2010). But all these policy statements are basically on modern health perspectives ignoring the contribution that Traditional Medicine can make. Non- recognition of the services of Traditional Medicine in the regulatory programme of the health care system, where majority of over six million citizens obtain health services is an indicator of not meeting the health reform programmes/health policy as scheduled.

Findings reveal that the government of Kaduna State has a draft bill to creating the Traditional and Herbal Medicine Care (THMC) Board to accelerate the development of traditional medical care (Appendix X). The objectives of the bill are; (a) to encourage scientific research on and development of traditional medicine; (b) to promote and advocate the use of traditional medicine; (c) to develop and coordinate skills training; (d) standard guidelines and codes of ethical practice; and (e) formulate policies to strengthen the role of Traditional Medicine and to promote traditional health care. This bill is yet to receive appropriate discussion by the Kaduna State House of Assembly. The implication of the yet to be passed bill nonetheless means that the Kaduna State government is aware of the importance of Traditional Medicine but is very slow in its approach to implementing it.

Discussion with a representative of the Kaduna State Ministry of Health reveals that despite the increased use of herbal medicines, there are demands by the Ministry for herbal medicinal products to be scientifically proven. Thus, traditional medical practitioners are required to submit their products to the Pharmaceutical Department of the Ministry of Health for screening and testing to check the toxicity level of their products before they are certified as safe and efficacious enough for public use. Findings



reveal that there is no proper machinery put in place for the screening and test requirements for the traditional herbs. For instance, no officer that is directly responsible in coordinating the activities of Traditional Medical Practitioners to ensure submission for screening of their products. However, traditional medical practitioners have a different standard of testing the efficacy of herbal medicines that is, testimonies from clients which can prove the efficacy of their services. Explaining further on this a traditional medical practitioner in Kafanchan said:

We do not have modern technology to test the effectiveness of our herbs. We rely on our clients who usually come back to appreciate us that the herb really worked. If we can get a little training on how to handle some of the modern equipment the health service of the State in general would improve greatly.

This statement implies that the laboratory test for TMPs to know about the effectiveness of their treatment is the ‘verbal feedback’ they received from their clients and other community members.

With modernisation effort, the government obliges that traditional practices and products be aligned to the control and testing of traditional medicines by modern health care standards. Thus the representative of the Ministry of Health opines that:

People may be primarily interested in preserving indigenous medical knowledge such that it would be difficult to have total control of their activities. They may be unwilling to disclose their Knowledge to the medical scientist for screening for general use. However, efforts are being made to address the issue by collaborating with Research Institutes.

This statement reflects the cultural importance attached to Traditional Medicine which is not just curing a disease but an indigenous knowledge as a legacy from generation to generation before biomedicine came into being, and may not wish to disclose to the modern medical system which may use Traditional Medicine knowledge to make money.

**CHAPTER FIVE**  
**DISCUSSION OF FINDINGS**

**5.1 Discussion of Key Findings**

The discussion of key findings in this study is categorised into sections based on the specific objectives of this study. The primary focus of this study is to provide insights on the utilisation of traditional medicine for health care and to examine the social, economic and cultural forces motivating the continual practice of this medical system in Kaduna State. The study found that Traditional Medicine plays an important role in health care in Kaduna State.

The study found that a large proportion of the sample had used Traditional Medicine. Specifically, the study revealed that 96 percent of the 1,242 respondents surveyed had utilised Traditional Medicine. This study like many studies conducted in different parts of Nigeria (Oluwabamide, 2007; Fakeye, et al., 2009; Abdullahi, 2011; Adesina, 2013; Owumi, et al., 2013) confirmed high patronage of Traditional Medicine. Similarly, the presence of many clients in traditional medical practitioners' homes during the IDIs also confirmed the high patronage among participants. This attests to the high demand for traditional medicine (Dada et al., 2011 and Studdert et al., 1998). Traditional Medicine Practitioners are readily available in Kaduna State with a very high ratio of Traditional Healers to the general population of users of their services compared to the relatively small ratio of Modern-trained Medical Practitioners to the general population of 1: 34,000 (KMOH, 2010). There are thus more Traditional Healers to treat citizen than Modern Medical Practitioners.

Health care is designed to promote good health and well being of the citizens of the State and Traditional Medicine is found to achieve this design through its preventive, curative, promotion and rehabilitative services it renders to individuals health in the population (Obafemi, 2012; Etobe, et al. 2013). The study found that services provided

by Traditional Medical Practitioners in Kaduna State are content in this health care design such that, curative services (58.1%), preventive services (12.1%), promotion services (9.7%) and rehabilitation service (20.0%) are prevalent among the practitioners. Specifically, the study revealed that their services are well appreciated under the areas of therapeutic practices, like traditional bone-setters (traditional orthopedist), where they attend to 15 patients on average per month; traditional birth attendants (traditional midwifery), where most baby deliveries in the rural areas are assisted by TBAs; traditional mental healers (traditional psychiatrist); faith healers, herbalists, traditional surgeons and diviners. Traditional healers in all the categories are found to play very important role of health care in only communities where they live. The study revealed that all the Traditional Medical Practitioners' clients interviewed acknowledged being cured or greatly improved in their health conditions. These imply efficacy of Traditional Medical services. This finding is consistent with the trend observed in other studies (Ogunbodede, 1999; Patwardhan (2005); Truter (2007), Oluwabamide (2007 and Adesina, 2014) on traditional health practitioners' services in Africa, which showed that each category of traditional healer is specialized in one or more areas of health care.

The application of therapeutic herbs in their treatment regimen is shown to reduce mortality, morbidity and disability in this study. Traditional healers provide treatment for illness that the scope of biomedicine does not cover especially the psychological and other culture bound syndromes such as spirit possession, sorcery, ancestral wrath, omission/violation of cultural rites and defilement, and provide home based care for their clients. Therefore, traditional healers have a role to play in building the health system in Nigeria since many believe in their art of healing. By virtue of their roles as physician,

counselor, psychiatrist among others, traditional healers are important and valuable assets in health care delivery particularly in rural areas where such beliefs predominate, thereby filling the void created by too few modern health personnel.

As noted in this study, traditional medical practitioners treat many types of illnesses presented to them. The study reveals that treatments were sought for many types of illnesses in which Malaria/Typhoid being the most (34%) sought treatment. This finding is corroborated with the study of Usifoh and Udezi's (2013) on the patronage and use of complementary and alternative medicine in Enugu; the study identified malaria and typhoid as the highest infection treated with traditional medicine. The findings of this study is consistent with other studies in Africa where the first line of treatment for 60% of children with high fever resulting from presumed malaria is the use of herbal medicine (WHO, 2003a,b; Okigbo and Mmekka; 2006; Darko, 2009). This study also, confirms the trend in Nigeria where 50% of illness episode is due to fever (malaria) (FMOH, 1998). A similar trend was found in Ghana (Gyasi 2014; Adjei (2013). The study also revealed that treatment of fracture/dislocation carries 20.6 percent of the surveyed respondents corroborating with the IDI a large proportion of clients interviewed were patients of TBS in this study. Similarly, the patronage of traditional bone setters in Nigeria, have been attested to by Olaolorun et al. (2001) and Omolola, et al. (2008) who assert that traditional bone-setters provide from 70-90% of the fracture care in many communities. This implies that the traditional bone-setting centres are carrying a burden which is rarely done by the modern health facilities. The diversity of ailments treated by traditional health practitioners gives a picture that Traditional Medical Practitioners provide the first line of health care for many people particularly those in rural areas in Kaduna State. The

study suggests that with this array of ailments treated by Traditional Medical Practitioners in the study area Traditional Medicine is fulfilling the role propose by WHO in the 1978 at the Alma Ata declaration of PHC, which states that:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Findings from the FGDs and IDIs (page 109 and 110) revealed that diseases that are directly associated with the mind such as psychological disturbance and illnesses believed to cause by evil spirits are proven to be effectively treated by Traditional Medicine. Healers in their treatment methods of these ailments adopt a holistic approach in delivering their services. They do this by incorporating aspects of spiritual, social, psychological, and environmental factors which are rarely done in Modern Medicine. Traditional Medical Practitioners are easily approachable and accessible, for clients to lay their health complaints.

As part of health challenges presented to Traditional Medical Practitioners which is rarely discussed by clients was application of protection 'gargets'. The study discovers that some participants are wearing charms, amulets, application of kohl, hand girdles and waist for protection against diseases, witchcraft, bad and good luck. This finding is consistent with the literature (Chavunduka 1994:79) on what African do for protection

against incoming diseases and enemies. Some of the medicine are prepared and incised in the skin of the client to serve as immunisation against snake bites, evil machination of enemies and other as desired. The study further reveals that there is a strong belief that only Traditional Healers can handle such desires or treatments as applicable.

The study reveals a high prevalence (96.0%) of Traditional Medicine usage among respondents. This trend is however akin to results from various studies in Africa including the rate of 84.7 percent reported by Onyiatat et al (2011) in Enugu, Nigeria and the 80 percent observed in Morocco (Eddouks et al, 2002). This finding support current documented evidence that TM use is common among individuals with various medical and spiritual conditions (Awad and Al-Shaye, 2014; Hwang et al, 2014; Kretchy et al, 2014; Faith et al, 2013; Gyasi et al, 2013). When compared to other studies in some countries, it is more than the 51.3 percent reported among HIV patients in South Africa (Peltzer et al., 2008) and 31 percent among Finnish parents in Finland (Hameen-Anttila et al, 2011).

The study reveals that Traditional Medicine has high use prevalence among different ethnic groups in the state ranging from 90.8% to 97.4%. This agrees with the study conducted by Owumi et al., (2013) on utilisation of traditional bone-setters in the treatment of bone fracture in Ibadan North Local Government of Oyo State where they found that patronage of Traditional Medicine cuts across various ethnic groups. The study also agrees with the work of Twumasi (2005) on medical systems in Ghana found that tribes, cultures and indigenous people of nations throughout the world have evolved system of Traditional Medicine for generations to handle health matters and Nigeria is included. Each ethnic group has its own ethos which regulates health seeking behavior of its members. Essentially traditional healing is linked to the wide belief systems about illness and health which often remain integral to peoples' lives. Therefore, different ethnic groups in Nigeria have found most of these medical practices valuable and affordable and in fact patronise any healer that is nearest and proves to be effective for their health care needs. The study, therefore, suggests that the norms and values embedded in the socio-cultural and belief system of most ethnic groups, which regulate health seeking behavior, might be partly responsible for the high patronage of Traditional Medicine among respondents. The study argues that the belief system is fundamental but

the thrust of the matter is that patients health needs are met and that accounts for their loyalty for Traditional Medicine.

On gender perspective, the study shows that females (96.4%) utilize Traditional Medicine than males (95.6%) respectively). The difference is not high enough to generalise among the population and to make any meaningful predictions it shows that there is no significant difference between males and females in the use of Traditional Medicine. This finding is similar to other studies (Osamor and Owumi, 2010; Birhan, et al. 2011 and Chuma et al. 2012) which report no significant differences in use of Traditional Medicine between males and females. It is, however, not in agreement with other studies such as Hughes et al. (2013) and Aydin et al. (2008) which establish differences in the use rate of Traditional Medicine between males and females. Individual beliefs is one the factors for utilisation of Traditional Medicine by females as cited in other studies (Stock, 1985; Lasker, 1981). However, the study suggests that Traditional Medicine is serving the health needs of both males and females.

This study is also of the view that young-adult aged 26-40 years (54.2%) patronises Traditional Medicine more than other age categories. The result is not surprising because age 26-40 years is a socioeconomically active age group and ready to try every aspect of life to make them healthy in the process of their job performance and could use Traditional Medicine to enhance their ability to work. Findings reveal that people of different age categories patronise Traditional Medicine practitioners because the practitioners deal with arrays of ailments that affect different age groups.

The study, however, found that there is no much difference between educational level and use of Traditional Medicine. The result reveals that 97.9 percent of respondents with no formal education patronised Traditional Medicine and 95.6% of respondents with



formal education did. This is in line with Buor's (1993) assertion, that people with little education patronise Traditional Medicine more than those with higher education. The result is consistent with the popular view that those with formal education are less likely to patronise traditional healing practices to prefer modern medical facilities (Buor, 1993 and Effiong and Ebong, 2009), because they are more likely to imbibe new knowledge and technologies. However, this study differs from other studies done in California (Leung et al. 2001), Israel (Arye et al. 2009), and Ethiopia (Birhan, et al. 2011) which indicate that female with higher income and high education patronise Traditional Medicine more than their male counterpart. Most likely, people of various levels of education have different mindsets concerning the use of Traditional Medicine. This ranges from disappointment with modern medicine to an informed knowledge of which type of medical facilities to patronise. Interestingly, finding from the FGDs and IDIs indicate a variant on fracture care for which most participants of fracture interviewed have attended higher education. This can be explained in two possible ways: first efficacy of TBS treatment, which takes a short time to heal and secondly fear of amputation in the orthopedic hospitals.

The study further reveals that income levels, could determine to a large extent the type of medical facility use. For instance, it is noted that 52.9 percent of those who had sought help from THPs are from low income categories, while 32.9 percent and 14.3 percent and from middle and high income respectively. Majority of informants who took part in the IDIs conducted similarly established that their low income status militating against seeking modern medicine when the ailments is believed to best handle by Modern Medicine. This finding is consonant with previous studies assessing the income and general economic status and use of traditional medicines (Dahilig et al., 2012; Al-Windi, 2004), who reported in their studies that low income earners patronise Traditional Medicine than a high income group. It therefore becomes very clear from the findings that low income earners are not economically strong enough to utilise Modern Medicine which is comparably more expensive.

The study found that a higher proportion of rural dwellers (50.8%) utilise Traditional Medicine than the urban dwellers (49.2%) the result is statistically not significant. This finding supports other studies that have reported statistically significant differences in Traditional Medicine utilisation between rural and urban residents (Godfrey et al. 2012; van der Hoeven et al. 2012; Adams et al., 2011a; Mike, 2011 and Andrews et al. 2010). Adams et al. (2011a) find in Australian Longitudinal Study that women who consulted a practitioner varied by place of residence where 28 percent of the research sample resided in the urban areas, 32 percent resided in rural areas whilst 30 percent resided in remote areas. It has been reported (Adesina, 2011) most baby deliveries in rural Nigeria are done by TBAs. This marginal difference in utilisation of

Traditional Medicine between rural and urban residents might be subject to large differences in socio-economic standing of the individuals and communities between the two geographical settings. Political force remains a strong determinant accounting for this utilisation pattern particularly, in the developing countries. The distribution of modern health facility provision is usually tilted against the rural communities.

Regarding religion, the study shows that both Christians (53.4%) and Muslims (44.2%) utilise Traditional Medicine indicating that Traditional Medicine contributes to health care of people from different faiths. Although, some Christians considered traditional healers to be associated with fetishes and superstition, which are against their religious beliefs and would not patronise Traditional Medicine in whatever way. Nevertheless, some patronise Traditional Medicine despite the faiths they practice because they believe that most healers do not apply secrecy and spirit consultation in their practices which Christianity and Islamic faiths forbid. In the same vein, remedies that are alcohol-based and religiously prohibited animal parts are prohibited by Christians and Muslims, irrespective of their efficacy.

The study establishes that motivation to seek treatment from Traditional Healer fell into one or two broad categories that are the “drive” factor and the “drag”. The ‘drive’ factors are the perceived bottlenecks, disadvantages and dissatisfaction with modern medicine health care services while the ‘drag’ factors connote beliefs and perceptions as regards the positive aspects, advantages and/or benefits of Traditional Medicine. The study reveals that affordable services (48.7%), accessible services (49.0%), efficacy (76.3%), cultural affinity (92.7%) and personal knowledge of the healers’ ability to treat the illness were the ‘drag’ factors. The high response on efficacy in this study is similar to the study done in Trinidad (Clement, et al., 2007) where efficacy of traditional medicine was the reason for choosing herbal medicine as the first line of health care option. This is also similar to other studies in both developing and developed countries (Hwang et al., 2014; Gyasi 2014; Sen et al., 2011). The ‘drive’ factors are presented during the IDIs in this study to include prevalence of counterfeit drugs, while herbs are safe and natural and dissatisfaction with modern medical services in terms of physical distance, cost, time and other intervening obstacles such as attitude of modern health personnel, long waiting time before consultation amongst others. These reasons, support the views captured in the literature for instance, belief in healers vast knowledge to treat the illness (Adefolaju, 2011), dissatisfaction with modern medicine (Fakeye, Adisa and Musa, 2009), efficacy (Birhan, Giday, and Teklehaymanot, 2011), accessibility and cost (Ogunlusi et al., 2007). Nigeria is particularly prone to fake drugs which are widespread in rural areas where the monitoring of drug stores by NAFDAC is limited. The consequences of consuming fake drugs include therapeutic failure, drug resistance and sometimes fatality. Therefore, people go for alternative treatment to avoid the consequences of consuming fake drugs.

Furthermore, the study found that common conception that modern medicine which is scientifically based is more reliable, safer and more effective is faulted by some participants that some modern drugs previously considered to be harmless are frequently withdrawn from the market for causing severe side effects and even fatalities. Recently in Nigeria the NAFDAC (2005) banned the use of Novalgin (a potent analgesic and antipyretic) because of severe side effects that led to the death of children. Even though Traditional Medicine is acknowledged for the management of various diseases, like other studies conducted in Africa (Kevi et al., 2008 and Sofowora, 1993) this study confirms the undocumented practice of Traditional Medicine in Kaduna State. As such, the utilisation of Traditional Medicine continues to rely on undocumented testimonies of patients spread through social networks and other electronic media.

This study reveals that the Kaduna State Government's emphasis is on modern medicine, its health policies and laws are on modern health practice. Traditional medical practice is tolerated and there is no law or policy controlling it, yet more than 90% of the participants have ever or are utilizing it. Thus, the Government is lagging in its regulatory role. This is evidenced by the lack of adequate supervision and control of the activities of the traditional health practitioners in Kaduna State. In the face of poverty and unemployment the traditional medical sector is opened to the challenges of infiltration by different kind of practitioners. The implication is that so many lives will be affected by fake herbs from charlatan healers that is, lost of lives and most likely deformation of body. This is particularly found in urban areas where these quack healers enjoy anonymity. In this context, the healers are compelled to depend on self-made claims, which may have little or no practical backing. Some Traditional Medicine practitioners give unproven testimonies of people whom they claim to have previously healed. They more often than not make exaggerated claims on a wide range of health conditions that they could handle.

Although, the traditional healers fill the void created by inadequate modern health infrastructure, yet their contributions to health care is not documented or taken into account. Given the current economic challenges and the concomitant unemployment, there is a marked increase in the number of unproven claims of traditional healers. Consequently, their services may become deterrence to health care delivery if there is a continuous neglect of the sector by the government. This study suggests that the unregulated medicine (TM) to be made relevant by regulating the activities of TMPs like the MM in order to obtain maximum utility and quality of health care.

Kaduna State Government can emulate what the Lagos State Government has done concerning the regulation of traditional healing. Lagos State has passed the Traditional Medicine Bill that recognises traditional healers (Ajai, 1990). In 1980 the Lagos State Government established a Traditional Medicine Board to regulate the practice of traditional healing (Ajai, 1990). The members of the Board are largely traditional medical practitioners.

The main functions of the Board according to Ajai (1990) include:

- to prepare the criteria for registration and to maintain a register of all traditional practitioners;
- to formulate plans for the development of traditional clinics, health centres and hospitals;
- to standardise training in traditional medicine and define the types of medical services to be
- rendered; and
- to set up a code of conduct and thus regulate the practice of traditional healers.

The basic premise of the argument of this study is that Traditional Medicine practice in Kaduna State, however, faces greater challenges in the hands of government officials and modern medical practitioners who disregard their contributions. Yet the citizens still utilise Traditional Medicine for their health care. The action of the government and modern doctors is not surprising because it is a carry-over from the colonial government who wanted to deracinate traditional medical practice for their own medical system to flourish and therefore described the former as nothing more than witchcraft and fetish. The Nigerians who took over from colonial master that is, the Nigerian elite, political leaders and associates regardless of their cultural background, was not better as the western propaganda had been instilled to doubt the historical and quality of the indigenous health care system. This is manifested in the Nigeria government's reluctance to accord Traditional Medicine its proper position in the healthcare system. As a matter of fact, Traditional Medicine is practiced in Nigeria today without enabling national legislation that will regulates its practice as obtained in many parts of the world (Stepan, 1985; WHO 2011). However Kaduna State is yet to established Traditional Medicine boards/agencies to monitor the activities of its practitioners.

Finally, deducing from the discussion of findings, the political economy of health stance is made clear the dominance of capitalist interest in the health care system of Nigeria which mirrors the society's class structure through control over modern health institutions, stratification of health practitioners, unequal distribution of modern health facilities and limited occupational mobility into modern health professions. Monopoly capital is manifested in the growth of medical centers, financial penetration by large

pharmaceutical firms, and the private medical centres which are not affordable and accessible by the rural people but by the aristocrat and the ruling class. Therefore, these categories of people will not support any policy that will compete against their interest. This image portrayed by these capitalists in the health sector of Nigeria explains the non recognition of the contributions of Traditional Medicine.

Regarding utilisation of traditional medicine among communities in Kaduna State Andersen's model is pictured to gives direction to this study in addressing gaps in the literature such that, predisposing susceptible factors captured behaviors that are theoretically antecedent to illness, such as education, ethnicity, age, gender, and relationship status. The need factors beam how an individual views his own health and evaluated need is assessed by a health care provider. The enabling factor is seen in the process of obtaining care, which include having a primary care provider, geographic region, and community size. For this analysis, Traditional Medicine is considered a proxy measure of health care utilization because it implies that the individual had an interaction with the health care system. Andersen's model of health service use provided guidance and context for variable selection and interpretation of the findings.

## **CHAPTER SIX**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **6.1 Summary of Findings**

Traditional Medicine is highly utilised in the study prefecture. 96 percent of the 1242 respondents interviewed reportedly use Traditional Medicine. With regard to the first objective, which is TMPs services are content in the health care design of the State. These services are achieved through their therapeutic practices in the areas of specialisation such as bone setting, mental disorders, maternal health and child delivery, herbalism, traditional surgeries, faith healing and divination services. The study reveals that traditional healers promote health using various therapeutic herbs, which helps to reduce, morbidity, disability and mortality. The study further reveals that the services provided by Traditional Medical Practitioners are helping to build the health system in Nigeria where the needs are great and the resources are inadequate. They are the custodian of culture physicians, counselors, psychiatrists among others. The study reveals Traditional Medical Practitioners have important and valuable roles in health care delivery by increasing health coverage to people especially in rural areas; filling the void created by shortage of modern health personnel; provides medicinal knowledge of herbs and herbal cures to research institutes and interested pharmacologists; healers offer counseling services as a form of therapy and provide home based care for clients (Mobile health care).

The study reveals that treatment is sought for twenty nine types of illnesses. Malaria/Typhoid being the most (33.9%) sought treatment, it is an illness associated with microbe infections. Two ailments were reported in this study to be reasonably treated well if not better than modern medicine that is, bone setting and mental healing. A high proportion of respondents in both the survey (246) and IDI (93) reported utilising TBS. Mental disorder recorded low (0.5%) in the survey responses. However, a large proportion of mental cases are recorded in the traditional mental homes (19) during visit for the interview sessions. The stigma associated with mental disorder (*mahaukachi*) is thought to account for low response, but in the healers' home their physical presence is noted. This implies that traditional healers of mental illness are also helping to reduce the number of mental disorder problems in the society. In general, the diversity of ailments treated by traditional health practitioners as reveals in this study are indication that they



provide the first line of health care for many people particularly those in rural areas in Kaduna State.

It is revealed in study, that patronage of Traditional Medicine cuts across all socio economic strata of the study area. Between 90.8 and 97.4 percent of the respondents use Traditional Medicine. The study therefore, suggests that the norms and values embedded in the socio-cultural and belief system of most culture or ethnic groups, which regulates health seeking behaviour, is responsible for the patronage of Traditional Medicine among respondents. A higher proportion of female (96.4%) than males (95.6%) utilize Traditional Medicine. The difference is not enough to be generalised among the population and to make any predictions. However, the study suggests that Traditional Medicine is serving the health needs of both males and females. The study revealed that the young-adult aged 26-40 years (54.2%) patronises Traditional Medicine more than other age categories. The study reveals that income inevitably; determines to a large extent the type of medical facility respondents' use. For example, 52.9 percent of the respondents who had sought help from Traditional Medical Practitioners are from low income category. Their low income status prohibits them accessing Modern Medicine even when it is observed that the ailments is found to be best handle by Modern Medicine. Occupation, Place of residence and religion tend to influence patronage of Traditional Medicine. The study therefore suggest that patrons of Traditional Medicine with less education low income patronise Traditional Medicine more because they are not economically strong to access Modern Medicine. The study notes that rural residents patronized Traditional Medicine more (50.8%) than urban dwellers (49.2%). Two main reasons are feasible to this variation, first, large differences in socio-economic position of the individuals and communities between the rural and urban areas. Secondly, urban areas are usually favoured in terms of distribution of modern health facility as against the rural communities. Thus, the study suggests that Traditional Medicine is playing a substantial role in health care delivery for the low income earners in the rural area when they are ill.

On specific terms, the research has established that utilisation of Traditional Medicine across all socio-economic levels is on its highest point for many reasons. Some of the reasons are connected to the bottlenecks, disadvantages and dissatisfaction with modern health care services whilst other reasons suggested beliefs and perceptions as regards the positive aspects, advantages and/or benefits of Traditional Medicine. The practice of Traditional Medicine is perceived to be entrenched and enshrined in the sociocultural milieus of the people. Therefore, this cultural affinity between traditional healers and their clients was a strong reason for utilisation and support of involvement of healers in health care delivery in Kaduna State. Other accompany reasons include, accessibility (49.0 %), affordability (48.7%), acceptability (56.8%), attitude of TH

(59.1%), safety (51.4%) and efficacy (76.3%). In all, the findings reveal that clients of Traditional Medicine services acknowledged satisfaction of Traditional Medicine Practitioners services to their health. This implies that Traditional Medicine is really contributing to health care of the citizens in the State.

The study reveals that the traditional medical practice is tolerated and there is no law or policy regulating the activities of the practitioners of Traditional Medicine. The study reveals that the Kaduna State Government is lagging in its regulatory role. This is evidenced by the lack of adequate supervision and control of the activities of the traditional health practitioners in Kaduna State. Findings reveal that the democratic government of Kaduna State has a draft bill to creating the Traditional and Herbal Medicine Care (THMC) Board to accelerate the development of traditional medical care. This bill is yet to receive appropriate discussion by the Kaduna State House of Assembly. The implication of the yet to be passed bill nonetheless means that the Kaduna State Government is aware of the importance of Traditional Medicine but is very slow in its approach to pass the bill.

### **6.3 Conclusion**

The study investigated the patronage and utilisation of Traditional Medicine in Kaduna State. The study is particularly undertaken against the background that previous studies had made valuable suggestions to explore the sociological and contextual dimensions of the patronage and utilisation of the long time and traditional method to health care. Like many other studies this study found that Traditional Medicine is

efficacious, more readily available, affordable, culturally acceptable, and consistently an easily accessible health care system that can support and complement government's efforts at ensuring quality and equitable health care. In most rural communities, Traditional Medicine is the only form of health care that is available, affordable and accessible.

Many of the previous studies applied a quantitative approach separately in utilisation studies which rarely bring out the desired outcomes looking at the intricacies of the innate variables. The qualitative data in this study present a unique value of complementing, validating and providing a better understanding of quantitative discoveries. Therefore, the study has filled gaps in literature as regards motivation factors and predictors of Traditional Medicine utilisation among service users in Kaduna State Nigeria. The findings have validated the objectives set for the study.

The study has provided empirical evidence to refute and to agree with some arguments that Traditional Medicine is largely used by females, rural dwellers and the less educated. The study concludes that the decision to use Traditional Medicine is greatly influenced by people's socio-cultural background, socio-economic status, their health beliefs, attitudes to Traditional Medicine with regards to belief in efficacy, safety of use and attitudes of Traditional Medical Practitioners.

The study also shows that increase in patronage of Traditional Medicine has significantly increased health care coverage by filling the gaps not covered by modern medicine. Services provided by TMPs have increased the economic well-being of members of the communities. Given the necessary direction and support, Traditional Medicine could be a formidable force in health care delivery in Kaduna State. Therefore, necessary recognition must be given to traditional health practitioners and their practices so as to encourage them to put in more effort in health care in the State.

One other contribution of this research is the provision of a conceptual model for studies on empirical relationship between Traditional Medicine patronage and the various

demographic, socio-economic and the biopsychosocial variables. Based on the emerged model, it should be noted that as long as majority of Nigerians rely on Traditional Medicine for their primary health care needs, despite its neglect by the political class, it is important to consider documenting the Traditional Medical Practitioners' practices in all health issues.

#### **6.4 Recommendations**

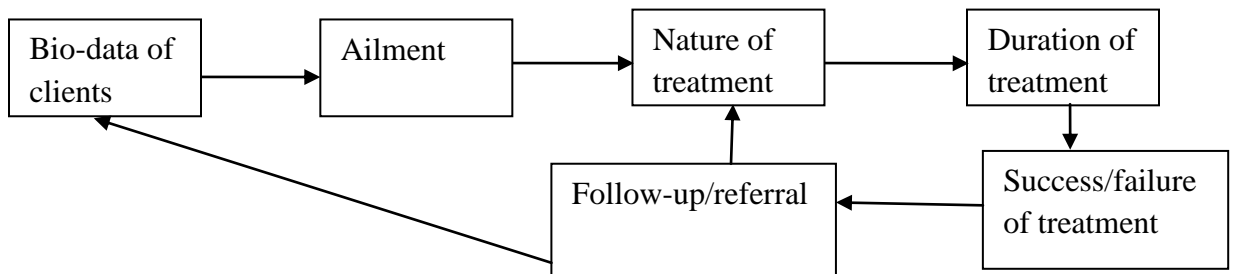
Based on the findings of this study, it is recommended that the following measures be taken to improve quality, access and utilisation of traditional medical services in the study area:

1. The study realises that main ailments handle by Traditional Healers, include: bone problems, malaria/typhoid, stomachache, baby birth and hypertension particularly in rural areas. Therefore, it is obvious that exclusive reliance on one particular health practice cannot assuage the health needs of the people. The most funded medical system is hardly accessible to the majority of Kaduna State citizens due to poverty and lack of infrastructures. We recommend that the practitioners should be strengthen and make to work side by side with Modern Medicine particularly in rural areas.
2. Considering the high prevalence of utilisation of Traditional Medicine alongside Modern Medicine this study recommends that the Ministry of Health to incorporate Traditional Medicine and implement policies and regulations governing intellectual property rights and the sharing of rewards derived from traditional medicine. Hence, a legal framework for professional health care practice among traditional health practitioners needs to be put in place as a mechanism to guard against malpractices and enhance fair play.

3. It is recommended that research institutions like the Universities in Kaduna State should conduct researches on traditional herbs use by traditional healers to recommend which aspects should be incorporated in the main stream health care in the State. Engaging science in traditional medicine preparation is not to replace the role of traditional healers but to promote their knowledge by introducing facilities like laboratories to test the efficacy of the herbal medicine. Healers of relevant and useful herbs should be recognised by the authority concern.
4. The study discovers that Traditional Medicine clients, claimed to have been cured of ailments by herbal medicine such as fracture, mental illness, sexually transmitted infections, diabetes and hypertension. Therefore, we recommend that clinical trial should be established to confirm such claims by their local governments through the Kaduna State Ministry of Health to enable them to practice their art in local government areas. Traditional birth attendants, bone-setters, mental health therapists and others should be registered following recommendations by their community. Herbalists, like conventional doctors, should be subjected to annual inspection and renewal of registration certificates by the appropriate authorities to ensure standard. The advantages of statutory regulation of traditional healer are enormous as risk of harm for clients will be reduced and misconduct by healers will be easily detected thus, protecting the healers and the clients. It is advocated here that professionalisation of Traditional Medicine should be ensured via statutory regulation.
5. As herbal medicine is the first line of contact for rural people when they require medical care, it is imperative for government to take immediate steps to introduce the use of traditional medicine to supplement PHC. It implies, that the Kaduna state House of Assembly should as a matter of necessity sign into law, the regulation and recognition of

the practice and use of traditional medicine. For Kaduna State to function well in health care there should be a standard of care to apply equally to all practitioners. Therefore, Kaduna State Government should set a standard health care regulatory framework that cuts across both boards for modern and traditional medical practitioners.

- Findings show that most Traditional Medicine practitioners inherited or had their skills handed over to them through oral traditions or other means without written record, therefore, there is tendency of losing some aspects of the skills or herbs. A simple training is required on how to keep record of their practice. In this respect, the researcher proposes a simple model to help the healers, government, researchers and nongovernmental organisations to assess their contributions to health care.



**Figure 6.1 Documentary model for traditional healers**

## 6.5 Suggestions for Further Research

- This research was limited to exploring the views of traditional healers and clients on utilisation of Traditional Medicine in Kaduna State. A more comprehensive study that involves modern health care practitioners' views on utilisation of Traditional Medicine in Kaduna State is imperatively recommended. Possible benefits of such a study could yield

many important results, as government policy (being influenced by this outcome) could begin to reflect such comprehensive provision of health care.

2. A longitudinal study following Traditional Medicine clients who claim to have been cured of some ailments by herbal medicine such as mental illness, sexually transmitted diseases, diabetes and hypertension is important if comparative clinical data can be obtained for claim of herbal cure. This is important in helping to identify new ways to improve and modify the standards of herbal medicine.

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## APPENDIX I

### QUESTIONNAIRE ON UTILIZATION OF TRADITIONAL MEDICINE IN KADUNA STATE

Dear respondent,

This questionnaire is designed to collect information on utilization of traditional medicine in Kaduna State. This exercise is purely academic and so any information supplied would be used strictly for the purpose that is being designed for. The information you provide will be treated confidentially and will be use only for the purpose of research; neither will any attempt be made to disclose the identity. To guarantee your confidentiality, do not write your name anywhere on the questionnaire.

Thank you for your cooperation.

Jacob Gandu

**Town of interview**.....

**Please tick or fill in the blank space as required**

1. What is your sex? (a) Male [ ] (b) Female [ ]
2. How old are you now (completed years)? .....Years

3. What is your marital status? (a) Single [ ] (b) Married [ ] (c) Divorce [ ]  
(d) Others .....
4. What is your occupation?.....
5. What is your highest level of educational attainment? (a) No formal education [ ]  
(b) Primary school [ ] (c) Secondary school [ ] (d) Tertiary [ ] Others  
(specify).....
6. What is your religion? (a) Christianity [ ](b) Islam [ ](c) Nigeria Traditional  
religion [ ] (d) Others (Specify).....
7. What is your ethnic group? .....
8. What is your estimated income per month in Naira (a) below 20,000 [ ] (b)  
20,000-39,000 [ ](c) 40,000 or more
9. Do you have any traditional medical practitioners in your community? (a) Yes [ ]  
(b) No [ ]
10. Name the type of traditional medical practitioner you have in your community?  
.....
11. How often do you use traditional medicines? (a) Daily [ ] (b) Weekly [ ] (c)  
Monthly [ ] (d) Yearly [ ] (e) When need arise [ ]
12. How many times you used TM or consulted traditional healer in last three times  
you were sick? (a) None [ ] (b) Once [ ] (c) Two times [ ] (d) Three time [ ]

**For each of the statements in questions 13-18, kindly indicate to what extent would you agree or disagree with the reasons why people patronize traditional medical practitioners instead of modern medical practitioners. (A=Agree, UN=Uncertain, D =Disagree, MM=Modern Medicine, TM=Traditional Medicine)**

	<b>Statement</b>	<b>A</b>	<b>UN</b>	<b>D</b>
13.	It is because traditional practitioners are nearer than modern medicine practitioners?			
14.	It is because traditional practitioners' services are cheaper than MM?			
15.	It is because traditional medicine is more efficacious than MM?			
16.	It is because traditional medicine is in line with the culture of my people?			
17.	It is because the attitude of traditional practitioners is more welcoming than modern practitioners?			
18.	It because traditional medicine is less harmful than modern medicine?			

19. Have you ever sought for treatment from a traditional healer? (a) Yes [ ] (b) No [ ]

20. If ever, please outline the type of illness for which you sought treatment in the past 2 years.....
21. What was the outcome of the treatment? (a). Completely healed from the health condition [ ] (b) Partially relieved from the health condition [ ] (c) cannot say [ ]
22. How would you rate the efficacy/efficiency of traditional herbal medicines? (a) Poor [ ] (b) Good [ ] (c) Very good [ ]
23. Did you have any side-effect from the treatment? (a) Yes [ ] (b) No [ ]
24. How would you rate the safety of use of traditional medicines? (a) Poor [ ] (b) Good [ ] (c) Very Good [ ]
25. How do you rate the attitude/of TMPs towards their clients?  
(a) Poor [ ] (b) Good [ ] (c) Very Good [ ]
26. What is your level of comfort when accessing traditional health care (during the use of TM or consulting TMP)? (a) Poor [ ] (b) Good [ ] (c) Very Good [ ]
27. State the type of health services in order of importance generally provided by Traditional healers in your community.....
28. Name at least three main diseases that traditional healers can effectively treat in your community  
a).....b).....c).....d).....
29. Have you ever visited a traditional medical practitioner but had reason(s) to go to a modern medical practitioner for the same illness? (a)Yes [ ] (b) No [ ]
30. If ever for which illness? .....
31. State the reason(s) for your action.....  
.....
32. Were you satisfied with the treatment outcome of the modern medical service?  
Yes [ ] No [ ]
33. Have you ever visited a modern health care practitioner but later went to a traditional medical practitioner for the same illness? (a)Yes [ ] (b) No [ ]
34. If ever for which illness .....
35. What was/were the main reason(s) for your action .....  
.....  
.....



36. Were you satisfied with the treatment outcome of the traditional medical services?  
Yes [ ] No [ ]
37. Do some traditional healers combine traditional medicine with modern medicine?  
(a) Yes [ ] (b) No [ ]
38. Are there some harmful practices involved in traditional medicine? (a)Yes [ ] (b) No [ ] (c) Uncertain [ ]
39. If yes, please mention these harmful practices a).....  
b).....c).....d).....e).....  
f).....
40. Which of the following most discourages you from going to traditional medicine?  
(a) Bad taste [ ] (b) Unhygienic Preparation [ ] (c)Poor Packaging [ ] (d) Non specific Dosage [ ] (e) Application [ ] (f) others (specify) .....
41. What do you think should be done to the traditional medical practitioners on the harmful practices?  
(a) Educate them on the harmful practices [ ] (b) Stop them from practice [ ] (c) other specify.....
42. Have your relations ever been ill in the past two years? (a) Yes [ ] (b) No [ ]
43. If yes mention the type of ailment/s.....
44. Where did you take him/her/them to? (a) Traditional healer [ ] (b) modern medical practitioner [ ] (c) traditional healer then to modern practitioner [ ] (d) modern practitioner then to traditional practitioner [ ] (f) Prayer session [ ](c)I don't Know [ ]
45. Indicate if you were satisfied with the treatment outcome? (a) Yes [ ] (b) No [ ] (c) Not certain [ ]
46. Would you support referral from traditional medical practitioners to modern medical practitioners? (a) Yes [ ] (b) No [ ] (c) I don't Know [ ]
47. Would you support referral from modern medical practitioners to traditional medical practitioners? (a) Yes [ ] (b) No [ ] (c) I don't Know [ ]
48. If yes, for which disease name at least three  
a).....(b).....(c).....(d).....
49. Would you utilize traditional medicine if incorporated in the nation main health stream? (a) Yes [ ] b) NO [ ]

50. Give reasons for your answer in question 49.....

51. Please feel free to express your personal views on the contributions of traditional medicine to health care in your community  
 .....  
 .....

52. Tick (√) the diseases best treated by the medical system below:

Disease	Medical System that Best Prevent/or Treats Health Issue			
	Modern Medicine	Traditional Med.	Islam Faith	Christian Faith
Measles				
Whooping cough				
Mental illness				
Miscarriage by women				
Cancer				
Snake bite				
Tuberculosis				
HIV/AIDS				
Meningitis				
Fracture/dislocation				
Body swelling				
Stomach ache				
Deafness				
Blindness				
Infertility				
Typhoid				
Diabetes				
Hypertension				
Malaria				
STIs				
Tooth ache				
Ulcer				
Asthma				
Arthritis				

**Thank you**

## APPENDIX II

### IN DEPTH INTERVIEW GUIDE FOR CLIENTS OF TRADITIONAL PRACTITIONER

**Bio Data:** Age, Sex, Ethnic group, Occupation, Religion, Highest level of formal education and Location of interview

1. Client experiences in patronizing traditional medical practitioner.

Explain why you came to this place and not the other for treatment?

**Probe for:**

- **Nature of illness** that made you to visit a traditional medicine practitioner with respect to fever, typhoid, diabetes, hypertension, cholera, cancer, bone fracture, sexually transmitted infections (STIs), scorpion bite, snake bite etc.
  
- **Accessibility**(nearness, easily reach and seen, etc),
- **Affordability** (cost eg cheap to pay, relief treatment, assistance, cost of drugs, fees etc etc),
- **Acceptability** (freely discuss problems, listen to you any time, good relationship etc),
- **Efficacy**( duration of treatment to get better)
- **Recommended**–if so, by whom e.g. friends/relatives/colleagues/practitioners/advert.
- **Cultural and supernatural** beliefs are responsible for patronage
- **Religious implications**

2. As a user of traditional medicine can you explain some of your experiences of patronizing TM?

**Probe for:** General Experiences / Use and Benefits:

-Regard for t/medicines: important or unimportant, essential, or not

-What do you expect from them?

- Used it before
- Tried other things and failed
- Hygiene matters

3. Which of the two forms of medicine (Modern and Traditional) medicines do you consider more effective?

**Probe for:**

- Nature of your ailment is it good for modern medicine?
- Nature of your ailment is it good for traditional medicine?
- Consultation and diagnosing the illness
- Ever use TM and other people you know would use MM
- Utilization of both TM and MM at the same time
- Would you advocate simultaneous application of TM and MM?

4. What will you say about the contributions of your traditional healer to health care?

- Prevention and treatment of disease
- Satisfied with the treatment?
- Health information about new diseases
- Notification of outbreak of any disease.

5. Would you support Government position to recognize TM as MM? **Probe for:** training, paying TMPs as modern health practitioners etc

### APPENDIX III

#### IN-DEPTH INTERVIEW GUIDE FOR PRACTITIONERS of TM and MM

Place of interview.....  
Sex.....  
Age.....  
Years of experience.....  
Type of training acquire/ area of specialization.....

1. What is the average number of clients that come for treatment?

**Probe for:**

- No of client patronage per day/week
- Male, female, age, Socio-economic status, Christian/Muslim, educated/uneducated, rural/urban, ethnic group etc
- Common health problems sort for among male, female, salary earners, non salary earners, business people with respect to the field of specialization.
- Time taken to see a patient
- Number of patients you can handle in a day

2. Have you ever had an encounter with a traditional/modern health practitioner?

**Probe for:**

- Exposure to traditional/modern healers in your medical career
- Ever utilized the services of TM/MM
- Experiences of clients from TM before MM or vice versa
- Referrals from traditional healers/MM
- Measures traditional medical practitioners take when their own method of treatment fails: nothing, give advice to visit modern health care service, attempt other medications/ provide additional dose, Refer to other traditional healers

3. What are the services do you render to people in your community?

**Probe for:**

- Curative services
- Preventive services
- Promotional services
- Counseling services
- Rehabilitation
- Views on accessibility/affordability emphasis will be on cost and proximity
- Client-patient relationship emphasis will focus on duration of consultation with patient, empathy, attitude towards patient
- Efficacy of practice emphasis will be on diagnosis of illness, treatment procedures, duration of treatment and health advices
- Ability to handle certain illnesses/disease
- Satisfaction with care in terms of hygiene condition of environment and outcome of care
- Cultural relevance including beliefs, taboo etc.
- Ever requested by government or any organization to submit your herbs for assessment? If so what did you do?
- Referrals from traditional healers/MM

4. Can you explain some of the ways your practice is contributing to health care of clients?

**Probe for:**

- Apart from prevention and cure are there other assistance you give to your clients?
- Food and balance diet
- Spiritual protection
- Accident, Promotion, Business success etc
- Preparations involve any secrecy?
- Disclosure of preparation
- Training, poverty, unemployment, affordable health care etc

5. Would you like to work with traditional/modern medicine in your area of specialization?

**Probe for:**

- Comfortability of working together?
- Whether practitioners will acknowledge contributions.
- What area of traditional would it be feasible to work together?
- Challenges to face by merging the two medical system?

6. What is the Government role on TM and MM?

**Probe for:**

- Aware of any government regulation to encourage the practice of traditional health care practices.
  - Do you receive any form of encouragement from the government? eg training, fund and material
7. Do you have a professional association?
- Probe for:**
- Belong to an association
  - Name of association, Local, sState or National
  - If no association why?
  - Benefit of association

## APPENDIX IV

### IN DEPTH INTERVIEW GUIDE FOR COMMUNITY LEADERS

1. Socio demographic characteristics: Age, sex, Religious, Ethnic group, educational level, Occupation; social status Number of Age, ethnic group,

Place of interview.....

2. It is common to find traditional healers in almost every community; do you have such in your area?

**Probe for:**

- Type of TMPs found in the community
  - Perception of traditional and modern medicine
  - Nature of illness that influence visiting traditional medicine and modern practitioner
  - Types of ailments commonly visiting traditional healers
  - Ailment/s most effectively handled by traditional healers?
  - Barrier to use of traditional medicine e.g. Convenience, affordability, efficiency, accessibility, good taste, preparation, packaging, dosage, application.
  - Aspects of traditional medicine and modern medicine that collaboration can be made
  - Aware of any government regulation to encourage the contribution of TM
- .
3. As a community leader are you aware of the type of people that patronise traditional healer?

**Probe for:**

- Social status
- Occupation

- Education
- Marital Status
- Sex

4. What are the common ailments reported to traditional healers?

**Probe:**

- Nature of the ailment
- Duration of treatment
- Number of visit
- Satisfied with the treatment outcome
- Poverty
- Religious belief

5. What are the types of health care services given by traditional healers in your community?

**Probe:**

- Curative
- Preventive
- Protective
- Rehabilitative
- Other contributions

6. Harmful practices of traditional medicine

**Probe:**

- Dosage
- Hygienic environment
- Packaging
- Application
- Failure of medication to work

7. Ways traditional medicine can be improved to serve the needs of the population to a better degree

8. Traditional Medical Association in the community

Prob. for: Role play if any If not why?

9. Do you have modern health facilities in your community?

**Probe for**

- Type
- Personnel
- Facilities in place
- Services

10. Who conduct women delivery in your community?



Probe for:

- Hospital
- Home
- Traditional birth attendants

11. What are the major challenges TMPs encounters in rendering their services?

- Inadequate capital for running their services
- Modern health workers do not value their services
- Lack of training to suit modern time
- Medicinal plants have been destroyed
- Refusal to carry instructions by client

## APPENDIX V

### IDI GUIDE FOR COMMISSIONER MOH KADUNA STATE

1. What is the role the Government is playing on Traditional Health Care in Kaduna State?

**Probe for:**

- Registered under a board to protect practices of the practitioners.
- Training of Traditional medical practitioners on health issues.
- Regulatory frame work.
- Scientific testing TM before use in the hospital.
  - Document/s
- Agencies/research council etc

2. Traditional medical practice is as old as the society, is the Government of Kaduna State aware of the existence of indigenous health practitioners?

**Probe for:**

- Number of traditional healers in the state
- What the government is doing about the large number of traditional healers

3. How can the various categories of healers best be accommodated in the proposed statutory regulation?

## APPENDIX VI

### In-depth Interview (IDI) Schedule with people who at one time utilized traditional medicine

#### A. IN DEPTH INTERVIEW GUIDE

1. Place, Sex, Age, Education, Marital status, Religion, Tribe, Income, Main Occupation

2. At the time you were sick where did you first go for treatment?

**Probe:**

- Socio-demographic background
- Type of illness-first point of treatment
- Type of traditional healer visited

3. Under what condition do you patronize traditional medicine?

**Probe:**

- When fund are limited
- Nearness, effectiveness/efficiency
- Failure of MM
- Availability
- Acceptability
- What was the outcome of your visit?

4. What type of ailments traditional medicine is very effective in treating?

**Probe:**

- Curative, Preventive and promotion/training
- Type of ailment- malaria, typhoid, fracture, HBP, pile, SDT, mental, ulcer, infertility, asthma, diabetes, skin infections etc.
- Disease that is most effectively handle by traditional healers

5. Did you experience any side effects at the time of your treatment with TM?

**Probe:**

- Dosage
- Measurement
- Environment
- Duration

6. Can you freely discuss some of the contribution traditional medicine is making to health care?

**Probe for:**

- Restoration of health
- Source of income
- Hospital congestion reduction
- Modern medicine

7. How do you think traditional medicine can be improved to serve the needs of the population to a better degree?

**B. In-depth Interview for Women at child delivery**

1. Age .....  
Ethnic group.....  
Educational background.....  
Religion.....

2. Have you ever given birth to a child?

**Probe:**

- Number of times ever given birth
- Where it took place
- Who take the delivery

3. Women like their baby delivery in certain places

Probe:

- Number of time delivered at home/hospital
- Reason
- Who assisted in the delivery
- Satisfaction

4. What was your experience from pregnancy to delivery time?

Probe:

- TBA involvement (nature of their involvement)
- Type of services received
- Attitude of TBA/health personnel

5. Would you prefer to have your child delivered by a TBA?

Probe: Reasons?

- Availability
- Affordability
- Acceptability

6. Categories of pregnant women that patronize TBA

Probe: low income, education level, culture bound etc

7. TBA's contribute to the health need of women/children in the community

Probe: areas of contribution, problems etc

## APPENDIX VII

### WARDS IN THE LOCAL GOVERNMENT SAMPLE

<b>Wards in Zangon Kataf</b>		
1. <b>Gidan Jatau</b>	5. Madakiya	9. Zongo Urban
2. Gora	6. Ungwan Gaya	10. Zonkwa
3. Kamuru Ikulu	7. Ungwan Rimi	11. Zongon
4. Kamanton	8. Zaman Dabo	
<b>Wards in Kachia LGA</b>		
1 Agunu	5. Gidan Tagwai	9. Bishini
2. Awon	6. <b>Kwaturu</b>	10. Kachi Urban
3. Dokwa	7. Ankwa	11. Sabon Sarki
4. Gumel	8. Katari	12. Kurmin Musa
<b>Wards in Kajuru LGA</b>		
1 Kajuru	5. Afogo	9. Idon
2. Tantatu	6. <b>Kasuwan Magani</b>	10. Maro
3. Buda	7. Kallah	
4. Kufana	8. Rimau	
<b>Wards in Kudan LGA</b>		
1. Kudan	5. Zabi	9. K/Kwali (N)
2. <b>Hunkuyi</b>	6. Doka	10. K/Kwali (S)
3. Sabon Gari Kunkuyi	7. Likoro	
4. Garu	8. Taban Sani	
<b>Wards in Giwa LGA</b>		
1 <b>Giwa</b>	5. Yakawada	9. Panhauya
2. Kakangi	6. Idasu	10. Galadimawa
3. Shika	7. Kidandan	11. Gangara
4. Danmahawayi	8. Kadage	
<b>Wards in Soba LGA</b>		
1 <b>Maigana</b>	5. Richifa	9. Soba
2. Kinkiba	6. Gamagira	10. Garu gwanki
3. Gimba	7. Danwata	11. Rahama
4. Kwassallo	8. Turawa	

## APPENDIX VIII

### NAFDAC LIST OF REGISTERED HERBAL PRODUCTS

ODUCT NAME	ACTIVE INGREDIENTS	MANUFACTURER	REGISTRATION NUMBER
BEFIT HERBAL	SHUDDHA SHULAJEET 50MG, ASWAGGANDHA 50MG, SATAVARI 50MG E.T.C	BOSCH AND BRAWN HERBALS R-8/287,RAJ NAGAR,GHAZIABAD 201002 INDIA	04-3609L
BENABIOTIC HERBAL ANTIBIOTIC 200M		PHARACHEM INDUSTRIAL LTD. ESTATE ILUPEJU LAGOS	04-3615L
HOLISTA HERBAL ANTI- ULCER 200ML	VEMONIA AMYGDALINA 3.0MG, SECURINEGA VIRUSA 3.2MG, RORIPA MADGASCARIENS 2.5MG,E.T.C	PHARACHEM INDUSTRIAL LTD. ESTATE ILUPEJU LAGOS	04-3614L
MANIX HERBAL 2 X 10'S	DIOSCOREA BULBIFERA 207MG,SESAMUM INDICUM 99MG, ASPARAGUS RACEMOSUS 42MG,E.T.C	WOCKHARDT LIMITED MUMBAI,INDIA	04-3610L
T.ANGELICA HERBAL 750ML	DOUNDAKE ROOT 5.56G, CASSIA ACUTIFOLIA LEAF 1.50G, KALI NITRAS 0.11G/150ML	HERBALINE NIG LTD MILE 14, ONUGABA,NIKE EMENE, ENUGU	04-3954L
SYNERGIN ANTI BACTERIA HERBAL X 150	XYLOPIA ACTHROPICA 80MG, UVAMIA CHANAC 70MG,EUPHORBIA LATERIFLORA 55MG, ANONA SENEGALENSIS 55MG, TETRAPLEURA TETRAPTERA 30MG, AGERANTUM CONYZOIDES 20NG,COSTUMATER 15MG, PIPER GUINEESE 15MG	SAME AS APPLICANT	04-3678L
PERKING HERBAL ACTIVE CHINESE HEAT BALM	CINNAMON OIL 3% W/W, LEMON GRASS OIL 7.5% W/W, NILGRIRI OIL 5% W/W, CLOVE OIL 1% W/W ETC.	MEYER HEALTHCARE PVT LTD. 10D, 2ND PHASE PEENYA IND. AREA BANGALORE, 560058,INDIA	04-3955L
WOMEN AFFAIRS HERBAL TONIC 500ML	SACHARUM OFFICINALUM, SPONDIAS MOMBIUM, SIDA RHOMBIFOLIA, MUSA PARADISIACAL, WATER, SYRUP	SAME AS APPLICANT	04-5450L
BOOSTER N HERBAL TONIC 1L	ZINGIBER OFFICINAL, PIPER OFFICNARIUM, PIPER GUINEENSE, CITRUS LIMONA, PINEAPPLE	SAME AS APPLICANT	04-5607L

	EMULSION		
RANONG HERBAL GREEN TEA	MULBERRY GREEN TEA	MULBERRY GREEN TEA LTD. 42/3 SOL 1 SHINNAKATE, BANGKOK, THAILAND	04-5611L
SUPREME HERBAL MIXTURE 200ML	ALSOTNIA CONGENSIS, MARKAMIA TMENTOSA, OPUTIA SPP, DANIELLA OLIVERI, EUGENIA AROMATICA, OLAX SUBSCORPIODISA, BUTYROSPERMUM, CAMEL.	DOAJIS & CO 2 ADENIJI APATA HOUSE NEAR FED. AIRPORT AUTHORITY, IBADAN. MR	04-5805L
FUNMILAYO CHILDREN HERBAL MIXTURE	ALLIUM ASCALONICUM, CHRYSOPHYLLUM ALBIDUM, STROPHANTHUS INSIPIDUS, PSEUDOCEDRELA KOTSCHYYI, NICOTIANA RUSTICA	DOAJIS & CO 2 ADENIJI APATA HOUSE NEAR FED. AIRPORT AUTHORITY, IBADAN.	04-5804L
DR. ALADDIN'S 7 KEYS HERBAL MIXTURE (RENEWAL)	ALLIUM SATIVUM, XYLOPIA AROMATICA, TETRAPLEURA TETRAPTERA, FICUS CARICA, NAUCLEA LATIFOLIA, STERCULIA URENS, COMBRETUM MISRANTUM	SAME AS APPLICANT	04-1986L
GNLD MASCULINE HERBAL COMPLEX TABS (RENEWAL)	SERENOA SERRULATA, AVENA SATIVA, APIUM GRAVEOLENS, TURNERA DIFFUSA, ACHILLEA MULLEFOLIUM	LABORATORY PODEX INDUSTRIE 34/46 VENUE DU VIEUX ST. DENIS, PARIS,	04-3194L
SUPER B HERBAL BLOOD MIXTURE	ENTANDROPHAMA UTILE, ANACARDUM OCCIDENTALIS, SACCHARUM OFFICINALUM	SAME AS APPLICANT	04-5162L
SUPER B SEVEN HERBAL MIXTUR	AQUEOUS EXTRACT OF ANACARDIUM OCCIDENTALIS AND SACCHARUM OFFICINALE	SAME AS APPLICANT	04-5163L
ULAR HERBAL CAPSULES	CIMIFUGA REEMOSA, LANURUS CARDIACEA, CRATEGUS OXYANCANTHA, DIOSCOREA VILLOSA L.	SAME AS APPLICANT	04-5158L
ABALERIA HERBAL ANTI- MALARIA	CAESALPINA BONDOC 750MG, CALOTROPIS PROCERA 975MG ETC.	PHARCHEM INDUSTRIES LTD. PLOT J INDUSTRIAL EST., ILUPEJU LAGOS.	04-3529L
GNLD HERBAL RESPIRATORY FORMULA	HERBAL EXTRACT BLEND 301MG	LABORATORIRE OPODEX INDUSTRIES BP 3292393 VILLENEUVE LA	04-3075L

		GARENNE FRANCE	
HERBI SEPT HERBAL	PHILIPPINENSIS 26.6% W/W, SHOREA ROBUSTA 3.4% W/W	CADILA PHARMA LTD., 244 GHODASAR AHMEDABAD 380050, INDIA.	04-2543L
HOLISA HERBAL ANTI- ULCER 200ML	VERMONIA AMYGDALINA 3MG, SECURINEGIA VIRUSA 3.2MG, RORIPA MADGASCARIENS 2.5MG ETC	PHARMACHEM INDUSTRIAL LTD.ILUPEJU LAGOS	04-3614LS
JOBELYN HERBAL PREPARATION	PARQUENTINA NIGRESCIN 200MG SORGHUM BICOLOUR 150MG HARUNGANA MADAGAS CARIENSIS 87.5MG	PHARCHEM IND. LTD. PLOT J IND. ESTATE ILUPEJU LAGOS	04-2738L
LIVASET HERBAL TONIC	EXTRACT 680MG PHYLLANTUS ECLIPTA ALBA 600MG PURNANANAVA 350MG KALMEGH 160MG	SYNCOM FORMULATIONS INDIA LTD 2ND FLOOR TAGORE CENTRE, DANA BATAR 13-14 RNYMARG INDORE,INDIA	04-2818L
PEKING HERBAL ACTIVE CHINESE HEAT BALM	CINNAMON OIL 3% W/W LEMON GRASS OIL 7.5%W/W NILGIRI OIL 5%W/W CLOVE OIL 1%W/W ETC.	MEYER HEALTHCARE PVT LIMITED, 10D, 2ND PHASE PEENYA IND. AREA BANGALORE, 560058, INDIA.	04-3955L
PHYSOGEN HERBAL SUPPLEMENT	BITTER COLA 1.5G, BITTER NCOLA 1.5G	NEIMETH INT'L PHARMA PLC, 1 HENRY CARR STR., IKEJA, LAGOS.	04-2505L
STOMACH COMFORT	CALCIUM 550MG HERBAL BLEND 330MG ALGINIC ACID CARICA PAPAYA	NATURES SUNSHINE PDTs 75E 1700 SOUTH PROVO UTAH-84606 USA	04-3028L
DAMIANA GINSENG HERBAL FORMULA	DAMIANA LEAVES,FO-TI ROOT,GOTU KOLA (STAM, LEAF) E.T.C	NATURE'S WAY PRODUCT INC. SPRINGVILLE UTTAH.U.S.A	04-3244L
EX- STRESS HERBAL FORMULA	PROPRIETARY BLEND 860MG, SCULLCAP, WOOD BETONY<1% E.T.C	NATURE'S WAY PRODUCT INC. SPRINGVILLE UTTAH.U.S.A	04-3243L
FEMININE HERBAL COMPLEX	DIOSCOREA VILLOSA, SALVIA OFFICINALIS, HYPERICUM PERFORATUM E.T.C	OPODEX S.A. 34/46 AVENUE DU VIEUX CHEMIN DE ST. DENIS PARIS, FRANCE.	04-3240L
MEBO HERBAL	B-SITOSTEROL 0.25%	GULF PHARM. IND. LTD BIG DAGA EST, C RAS AL KHAIMAH UNITED ARAB EMIRATES (U.A.E)	04-3241L
NATURE'S WAY HERBAL SLIM	PROPRIETARY BLEND 1.88G CHICKWEED (STEM, LEAF), SAFFLOWER (FLOWER) ETC.	NATURE'S WAY PRODUCTS INC. SPRINGVILLE UTAH	04-3196L



		84663 U.S.A	
NATURE'S WAY YUCCA AR HERBAL	PROPRIETARY BLEND 850MG. YUCCA (ROOT) WILD YAM (ROOT) ETC.	NATURE'S WAY PRODUCTS INC. SPRINGVILLE UTAH 84663 U.S.A	04-3197L
T. ANGELICA HERBAL TONIC 750ML	DOUNDAKE ROOT 5.56G, CASSIA ACUTIFOLIA LEAF 1.50G, KALLI NITRES 0.11G/150ML	HERBALINE NIGERIA LIMITED, MILE 14, ONUGABA MIKE EMENE, ENUGU.	04-3954L
BLOOD SUGAR WITH GYMNEMA EXTRACT HERBAL FORMULAR	VITAMIN A1505IU, CHROMIUM 300MCG E.T.C	NATURE'S WAY PRODUCT INC. SPRINGVILLE UTTAH.U.S.A	04-3242L
DAMIANA GINSENG HERBAL FORMULA	DAMIANA LEAVES,FO-TI ROOT,GOTU KOLA (STAM, LEAF) E.T.C	NATURE'S WAY PRODUCT INC. SPRINGVILLE UTTAH.U.S.A	04-3244L

## APPENDIX IX

### FOCUS GROUP DISCUSSION GUIDE

1. Do you have traditional healers in your town?

**Probe for:**

- Type of traditional healers
- An indigene or a settler
- Length of practice of the practitioner/s
- Services in the community, curative, preventive, promotion etc
- Challenges of traditional health practitioners

2. Reasons people patronize traditional healers even with the availability of modern health care?

**Probe for:**

- Nature of illness that made people to patronize traditional healers
- Affordability, accessibility, acceptability, efficacy etc
- Cultural dimension
- Categories of people that patronize traditional healers

3. Can you explain some of the people's experiences with traditional medicine?

**Probe for:**

- Advantages and disadvantages of using traditional medicine
- Used before
- Hygienic aspect of traditional healers home and their herbs
- Ever used before and it works or have not tried it at all

4. Which of the two forms of medicine (Modern and Traditional) medicines do you consider more effective?

**Probe for:**

- Nature of the ailment that is good for modern medicine?
- Nature of the ailment that is good for traditional medicine?
- Consultation and diagnosing the illness
- Ever use TM and other people you know would use MM
- Utilization of both TM and MM at the same time
- Would you advocate simultaneous application of TM and MM?
- Harmful practice of TM- dosage, packaging, hygiene, fail to work

## **APPENDIX X**

### **DRAFT BILL FOR KADUNA STATE HOUSE OF ASSEMBLY**

#### **A BILL CREATING THE TRADITIONAL AND HERBAL MEDICINE CARE (THMC) BOARD TO ACCELERATE THE DEVELOPMENT OF TRADITIONAL MEDICAL CARE IN KADUNA STATE NIGERIA**

*Be it enacted by the Kaduna State House of Assembly*

SECTION 1, Title – this Act shall be known as the “Traditional and herbal Medicine bill (THMB) of 2008”

### **ARTICLE 1**

#### **GUIDING PRINCIPLES**

SEC.2. Declaration of Policy.- It is hereby declare that the policy of the state is to improve the quality and delivery of health care service to the Citizens of Kaduna State through the development of traditional and herbal medicine health care and its integration health care delivery system. It shall also be the policy of the state to seek a legally workable basis by which indigenous societies would own their knowledge of traditional medicine. when such knowledge is used by outsiders, the indigenous societies can require the permitted users to knowledge its source and can demand a share of any financial return that may come from its authorized commercial use.

SEC.3. Objectives.- of this bill are as follows:

- (a).To encourage scientific research on and develop traditional and alternative health care systems that have direct impact on public health care;
- (b) To promote and advocate the use of traditional, alternative, preventive and curative health care modalities that have been proven safe, effective, cost and consistent with government standard on medical practice;
- (c) To develop and coordinate skills training courses for various forms of traditional and alternative health care modalities;
- (d)To formulate standards, guidelines and codes of ethical practice appropriate for the practice of traditional and alternative health care as well as in the manufacture, quality control and marketing of different traditional and alternative health care materials, natural and organic products, for approval and adoption by the appropriate government agencies;

(e) To formulate policies for the production of indigenous and natural health resources and technology from unwarranted exploitation, for approval and adoption by the appropriate government agencies;

(f) To formulate policies to strengthen the role of traditional and alternative health care delivery system;

(g) To promote traditional and alternative health care in international and national conventions, seminars and meetings in coordination with the Kaduna state Ministry of Tourism, and other tourism related agencies as well as non-government organizations and local government units.

## **ARTICLE II DEFINITION OF TERMS**

SEC.4. Definition Terms.- As used in this bill, the following terms shall means:

(a) "Traditional and herbal health care" - the sum total of knowledge, skill and practices on health care utilized in cultural practices of local communities, other than embodied in modern/Orthodox medicine, used in the prevention, diagnosis and elimination of physical or mental disorder.

(b) "Traditional medicine" - the sum total of knowledge, skills and practice of health care, not necessarily explicable in the context of modern, scientific philosophical framework, but recognized by the people to help maintain and improve their health towards the wholeness of their being the community and society, and their interrelation based on culture, history, heritage, and consciousness.

(c) "Modern/Orthodox medicine" - the discipline of medical care advocating therapy with remedies that produce effect differing from those of the disease treated. It may also be referred to as "allopath," "western medicine," "regular medicine," "conventional medicine," "mainstream medicine, or cosmopolitan medicine."

(d) "Alternative health care" - other forms of non-allopathic, occasionally non-indigenous or imported healing methods, though not necessarily practiced for centuries nor handed down from one generation to another. Some alternative health care modalities include acupuncture, massage and nutritional therapy, and other similar methods.

(e) "Herbal medicines" - finished, labeled, medicinal products that contain as active ingredient/s overground or underground party/s of plant or other material or combination thereof, whether in the crude state or as plant preparations. Plant material includes juices, gums, fats, oils, and other substances of this nature. Herbal medicines, however, may contain excipients in addition to the active ingredient(s). medicines containing plant material(s) combined with chemical-defined active combined with chemically-defined

active substances, increasing chemically-defined, isolated constituents of plants, are not considered to be herbal medicine.

(f) “Natural product”-this includes anything from plant, animal or of mineral origin and is found spontaneously in nature whether or not they are tended by man. It also refers to foods that have been prepared from grains, vegetables, fruits, nuts, meats, fish, eggs, honey, raw milk and the like, without the use or addition of additives, preservatives, artificial colors and flavors, or manufactured chemicals of any sort after harvest or slaughter.

(g) “Manufacture healers”- any and all operations involved in the production, including preparation, propagation, processing, formulating, filling, packing, repacking, altering, ornamenting, finishing, or otherwise changing the container, wrapper, or labeling of a consumer product in the furtherance of the distribution of the same from the original place of manufacture to the person who makes the final delivery or sale to the ultimate consumer.

(h) “Traditional healers”- the relatively old, highly respected people with a profound knowledge of traditional remedies.

(i) “Intellectual property rights”- is the legal basis by which the indigenous communities exercise their rights to have access to, protect, control over their cultural knowledge and product, including but not limited to, traditional medicines, and the right to receive compensation for it.

### **ARTICLE III**

#### **THE KADUNA STATE BOARD FOR TRADITIONAL MEDICINE IN HERBAL CARE PRACTICES AND CONTROL**

SEC. 5. Kaduna State Board for traditional Medicine and herbal Care Practice and Control. There is hereby established a body corporate to be known as the Kaduna State Board for Traditional Medicine and Herbal Care Practice and Control, hereinafter referred to as the Board. The Board shall be attached to the Kaduna State Ministry of Health. Its principal office shall be in The Ministry, but it may established other branches or offices elsewhere in Kaduna State as may be necessary or proper for the accomplishment of its purpose and objectives.

SEC.6. Powers and Functions.- In furtherance of its purposes and Objectives, the board shall have the following powers and functions:

a. To formulate a code of ethics and standards for the practice of traditional and alternative health care modalities for approval and adoption by the Ministry of Health and other relevant government agencies;

- b. To formulate policies that would create public awareness through educational activities, conventions seminars, conferences, and the like by focusing on promotion of healthy living for preventing diseases, thereby uplifting the health care industry;
- c. To formulate standard and guide lines for the manufacture, marketing and quality control of different traditional and alternative health care materials and products and this will consist of those guidelines as approved by the National agency for Food and Drug Administration and Control (NAFDAC);
- d. To serve as the coordinating center of the State net work of traditional and alternative health care practice located in different regions of the State;
- e. To acquire or obtain from any governmental authority whether national or local, foreign or domestic, or from any person, corporation partnership, association or other entity, such charters, franchises, licenses, rights, privileges, assistance, financial or otherwise, and concessions as are conducive to and necessary and proper for the attainment of its purposes and objectives;
- f. To organize and develop continuing training programs for physician, nurses, pharmacists, physical therapists and other professional health workers and students, as well as scientists research managers and extension workers in the field of traditional and alternative health care;
- g. To plan and carry out research and development activities in the areas of traditional and alternative health care, and its ultimate integration into national health care delivery system;
- h. To verify, package and transfer economically viable technologies in the field of traditional and alternative health care, giving emphasis on the social engineering aspects necessary for group endeavor;
- i. To provide the data base or policy formulation that will stimulate and sustain production, marketing and consumption of traditional and alternative health care products;
- j. To adopt and use corporate seal;
- k. To sue and be sued in its corporate name;
- l. To adopt its by-laws and promulgate such rules and regulates as may be necessary or proper to implement this bill, and to amend or repeal the same from time to time;
- m. To borrow, raise or obtain funds, or to enter into any financial or credit arrangement in order to

SEC. 9 powers, Functions and duties of the Board Chairman. The Chairman shall have the following powers, functions and duties;

- i To exercise overall supervision and direction over the implementation of all programs of the board, and to supervise and direct the management, operation and administration of the board,
- ii. To implement and enforce policies, decision, orders, rules and regulations adopted by the Board;
- iii. To submit to the Board an annual budget and such supplement budget as may be necessary for its consideration and approval;
- iv. To exercise such other powers and functions and perform such other duties as may be authorized or assigned by the Board.

#### **ARTICLE IV**

##### **PROMOTION OF TRADITIONAL AND ALTERNATIVE HEALTH CARE**

SEC. 10. Traditional and Alternative Health Care Advocacy- The Board shall promulgate a statewide campaign to boost support for the realization of the objectives of this bill. It shall encourage the participation of non-government organizations in traditional and alternative health care and health-related projects. The board shall also formulate and implement a research program on the indigenous traditional health practices performed by “traditional healers” using scientific research methodologies.

SEC. 11. Standards for the Manufacture, Marketing and Quality control of Traditional Medicine- The Board, in collaboration with NAFDAC, shall formulate standards guidelines for the manufacture, quality control and marketing of different traditional and alternative health care materials and products.

SEC. 12. Incentives for Manufacturers of Traditional and Alternative Health care products like herbal medicinal plants shall enjoy such exemptions, deductions and other tax incentives as may be provided for under any relevant investment Code of the State, as amended.

#### **ARTICLE V**

##### **TRANSITORY PROVISIONS**

SEC. 13. Appointment of Board Members-. Within Thirty (30) days from the date of effectivity of the bill, the Governor of Kaduna State shall appoint members as well as the Chairman of the Board.

## **ARTICLE VI**

### **MISCELLANEOUS PROVISIONS**

SEC. 14. Implementation Rules and Regulations- Within thirty (30) days from the completion of their appointments, the Board shall convene and, I collaboration with the Ministry of Health, formulate the rules and regulations necessary for the implementation of this Bill. Said rules and regulations shall take effect upon publication in a newspaper of general circulation.

SEC. 15. Repealing Clause- All laws, decrees, executive orders, and other laws including their implementing rules and regulations inconsistent with the provisions of this are hereby amended, repealed or modified accordingly.

SEC. Separability Clause- If any provision of bill is declared unconstitutional or invalid, other provision thereof which are not affected thereby shall continue in full force and effect.

SEC. 16. Effective- This Bill shall take effect fifteen (15) following its publication in the Official gazette or in at least two (2) newspapers of general circulation.

## **APPENDIX XI**

**Table 4.13 Socio-Demographic Characteristics of Traditional Healers Clients**

<b>Variables</b>	<b>Total No. of</b>	<b>Traditional medicine Utilization</b>
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	respondents (1242)		TM Users 1192 (96.0 %)		Non TM Users 50(4.0%)		X <sup>2</sup> value	df	P- value	Remark
	f	%	f	%	f	%				
<b>Gender:</b>										
Male	661	53.2	632	53.0	29	58.0	59.271	1	<0.05	Significant
Female	581	46.8	560	47.0	21	42.0				
<b>Age</b>										
< 25	271	21.8	246	20.6	25	50.0	158,628	2	<0.05	Significant
26-40	661	53.2	646	54.2	15	30.0				
Above 40	310	25.0	300	25.2	10	3.3				
<b>Marital status</b>										
Single	347	27.9	347	29.1	0	0.0	121.902	3	<0.05	Significant
Married	825	66.4	794	66.6	31	62.0				
Divorce	46	3.7	31	2.6	15	30.0				
Others	24	1.9	20	1.7	4	0.3				
<b>Religious Affiliation</b>										
Christianity	663	53.4	636	53.3	27	54.0	109.606	2	<0.05	Significant
Islam	549	44.2	529	44.4	20	40.0				
Traditional	30	2.4	27	2.3	3	6.0				
<b>Education:</b>										
No formal	189	15.2	185	15.5	4	8.0	8.8916	4	<0.05	Not Significant
Primary	293	23.6	286	24.0	7	14.0				
Secondary	347	27.9	336	28.2	11	22.0				
Tertiary	297	23.9	276	23.2	21	42.0				
Others	116	9.3	109	9.1	7	14.0				
<b>Monthly income in Naira</b>										
≤ 19,000	633	51.0	630	52.9	3	6.0	183.007	2	<0.05	significant
20,000-39,000	395	31.8	392	32.9	3	6.0				
40,000 and above	214	17.2	170	14.3	44	88.0				
<b>Occupation:</b>										
Civil Servant	269	21.6	254	21.3	15	50.0	597.145	14	<0.05	Significant
Farming	375	30.2	371	31.1	4	0.8				
Artisan	178	14.3	167	14.0	11	22.0				
Business/trading	322	26.0	309	26.0	13	26.0				
home maker/Unemployed	98	7.9	91	07.6	7	14.0				

Source: Field Survey, 2016 F= frequency, %=percentage, df= degree of freedom