

FOLK MEDICINE AMONG THE KAMBARI OF NIGER STATE

By

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NOVEMBER, 2006

DECLARATION

I hereby declare that this thesis entitled “Folk Medicine among the Kambari of Niger State” has been written by me as my personal research work. It has never been presented in the same form in any previous application for same degree. Sources of information other than mine are duly acknowledged.

Saleh Ngaski Garba
November, 2006

CERTIFICATION

This thesis entitled “Folk Medicine among the Kambari of Niger State” by Saleh Ngaski Garba meets the regulations governing the award of the degree of Master of Science (M.Sc) of Ahmadu Bello University Zaria, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to my late father, Mal. Usman Wakili and my mother, Malama Fatima Usman. It is also dedicated to my late friend, Abubakar Mohammed Chidawa who participated in the data collection but did not live to see the successful completion of this work.

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Abstract

The purpose of this study is to describe Kambari folk medicine. The research was conducted in Kambari dominated Magama Local Government Area, Niger State. Nasko, Salka and Magaman – Daji communities were selected for the study. Seventy nine (79) households were selected in Nasko, 78 in Salka and 74 in Magaman–Daji by first enumerating the Kambari households at each site after which a systematic random sampling was conducted. In all, a total of 231 household heads responded to the questionnaire. Thirteen traditional healers (five in Nasko and four each in Salka and Magaman – Daji) were included in the study. An in-depth interview was conducted with each of them on diseases they treat and the outcomes of the treatments. They had been practicing traditional medicine for an average of 19 years.

The household heads belong in three religious groups; Islam (48.9%), Christianity (28.2%) and Kambari Traditional Religion (22.9%). Fifty one percent (51%) of them had formal education, ranging from primary to tertiary levels. Sixty three percent (63%) of the respondents believe that illnesses are caused by supernatural factors. They use traditional medicines for treatment. Thirty nine percent (39%) reported that they use only modern

medicines for treatment. Male adults in the households constitute a form of medical team for sick members of their extended family. They consult in diagnosing and treating the ailments. Elderly women provide gynaecological and paediatric services to younger females and children in their respective households.

The study reveals a medical pluralism among the Kambari. A cumulative 76% of the household heads either use traditional and or combine it with modern medicines for treating household members. Mothers in 66.2% of the households deliver their babies at home, taken by traditional birth attendants. The rest deliver at modern health facilities. There is a high prevalence of chronic ailments with 55% of the households having one or more members suffering from either leprosy, infertility, crippling deformity, epilepsy, vesico vaginal fistula or blindness. The ailments worsened and became intractable due to ineffective treatment using traditional medicines at onset.

While 38.5% of the traditional healers work full time, 61.5% combine traditional medical practice with other occupations. They have designated places in their homes for treating patients. All the four female healers specialize in gynaecology and paediatrics. About 69% of all healers believe that illnesses are solely caused by supernatural factors. Eight traditional

healers revealed having informal professional relationship with the modern health practitioners and often referred clients to them. Most healers claim success in treatment. Only two reported the deaths of patients in their care which were attributed to non-compliance with treatment schedules. Domestic/bush animals, specified clothing materials and money are accepted and paid instalmentally by compound heads for treatments.

The findings show that level of educational attainment, age and place of residence influence the choice of forms of treatment sought by the Kambari. Those who have lower education tend to patronize traditional medicine which is less effective in treating some diseases. It is recommended that the Kambari should have more access to schools. Mass enlightenment campaign on modern health services should be embarked upon while proper machinery should be put in place to make such health services available, accessible and affordable.

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CHAPTER ONE

INTRODUCTION

Long before the discovery and development of modern scientific medicine, traditional healing methods had been in use and are still being used today in every culture (Logan, 1981). The resulting traditional health beliefs and practices are referred to as folk medicine. According to Coe (1978), folk medicine is the medicine of the people that consist of medical beliefs and practices which are in principle, available to all members of a society without reference to those responsible for its existence or specialized training of the practitioners. Folk medicine represents the institutionalized aspects of the medical pattern being more or less integrated with other cultural patterns.

Foster and Anderson (1978) describe folk medicine as being magico-religious practices which utilize a few rational elements. They further explained that this concept involves all those beliefs and practices about health that are founded in tradition and are generally accepted uncritically by the people. These practices have been going on from one generation to another largely because things have always been done that way. Lieban (1977) described folk medicine as the indigenous medical features that are not explicitly derived from the conceptual framework of modern medicine but which influence the utilization of modern medicine by the people. He referred to it as “ethnomedicine”, “popular health culture”, and the people’s health practices” and further explained that there is what he also referred to as the “professional health culture”. Lieban (1977) described what he called the popular health system as the unspecialized lay practitioners, laymen in traditional medicine and specialists such as non-career practitioners of homeopathic medicine. The professional health culture on the other hand refers to the institutions, roles values and knowledge of highly trained practitioners of indigenous medical systems of South-Asia as well as the practitioners of cosmopolitan scientific medicine which include the folk healers. This category combines the modern concepts with those of traditional civilizations.

Coe (1978: 157), describe folk medicine as the un-institutionalized aspect of the medical cultural pattern which is integrated with other cultural pattern. He explained that folk beliefs are part of the oral tradition passed from parents to children, from older generations to the young and tend to persist overtime. He further stated that.

Folk medicine represents in parts, a set of traditional health beliefs and remedies which have been passed down from generation to generation.

The practices of medicine takes place within a social system that defines the roles the participants may take, specifies the kinds of behaviour appropriate to those roles and provides the sets of values and orientations for the participants. Saunders and Hewes (1969) explained that the practices of medicine is a social activity between two or more socially conditioned human beings whose outcome of interaction is a function of the attitudes values, cognition's and expectations of the participants.

Folk medicine is also concerned about what people consider as illness and what is considered to be the cause(s) of the illness (Hufford, 1997). Illness is therefore, a product of the peoples' shared beliefs about the causes of diseases and the explanations for the incidence and course of illness. This is embodied in the health beliefs and practices of the people. Illness as an inevitable factor in most social groups, disrupts the social, psychological and biological functioning of the sick person and the significant others.

The medicine man, the priest, the herbalist and the magician undertake in various ways to bring relief to the sick. The sick person is an active participant in the process or treatment for illnesses and together with the relations of the sick decides what should be done about the illness. Most cultures have among their patterns, a body of beliefs and practices centering on the recognition and treatment of illness. Foster and Anderson (1978: 70) stated that:

Folk medicine exists in all cultural and sub cultural groups. In the United States of America, there are as many folk medicines as there are ethnic groups because, the Afro-Americans, the Puerto – Ricans, the Cubans, the Chinese – American, the Italian – Americans and the Spanish – Americans all have their own medical beliefs and practices.

Treatment seeking behaviour is determined by the assessment of symptoms as indicative of an illness and the belief about the causes of the illnesses. Thus, symptoms that are accepted as evidence of illness in one society may be ignored in another. According to Mechanic (1978), the nature of symptoms and the beliefs about the causes are the most powerful factors influencing the definition of illness and the search for cure. Medical beliefs and practices are generally consistent with the prevailing cultural values of a particular society. Twumasi (1975) stated that the diagnosis of

illness by the traditional healers in Ghana is deeply embedded in the whole magico-religious systems of the society. He explained that the medicine man performs acts which give the person inspiration and restoration of confidence.

Causes of diseases are classified differently by different authors. Morley and Wallis (1978), classify the causes of diseases in the non-western world into two broad categories; the personalistic causative factors and the naturalistic causative factors. For the personalistically perceived cases, illness is believed to be caused by the active and purposeful intervention of an agent who may be a supernatural being (a deity or a god), a non-human being (such as a ghost ancestor, or evil spirit) or a human being (a witch or a sorcerer). This belief considers the sick person as a victim to whom the illness had been directed for reasons that concerns him alone and whose treatments must be sought from spiritual healers, diviners, herbalists e.t.c.

In the naturalistic cause, illnesses are said to occur due to observable cause whether or not the relationship established between cause and effect is correct. This belief conforms to the equilibrium model which explains that health prevails when the insensate elements in the body; the heat, the cold, the humour e.t.c. are in balance appropriate to the age and condition of the individual in his natural and social environment. The belief holds that illness results when this equilibrium is disturbed (i.e disequilibrium). This disequilibrium can be corrected through the use of herbs and other special preparations. According to Morley and Wallis (1978), the personalistic and naturalistic systems of disease causation are not mutually exclusive because, people who invoke personalistic causes in explaining illness usually recognize some natural causes and vice versa. In spite of the overlap between the personalistic and naturalistic beliefs, many people seem to be committed to one or the other.

Swantz (1970) reported that the Zaramo ethnic group of Tanzania believe that the causes of illness and misfortune include strained social relationships and that treatment require a form of ritual healing through the communal participation of all involved in the conflict, the significant others and the community at large. Kunitz and Levy (1981) in a study of the Navajos of United States of America, an ethnic group from Mexico, found that the Navajos believe that diseases among them are caused by “Soul loss”, spirit possession”, “wizardry”, “breach of taboo” and “witch craft”. The Navajo believe that “soul” or “wind” as it is often called enters and attaches itself lightly to the body soon after birth until oldage when it becomes loosely attached. At death, the soul leaves the body and becomes a ghost. It

is the ghost of those who die while the soul is well attached that are believed to be potent causes of illness.

‘Wizardry’ according to the Navajo beliefs is a special form of witchcraft in which a disease causing agent is injected into the body of a victim while ‘spirit intrusion or possession’ involves the displacement of the wind-soul by the spirit of a dangerous being most often a supernatural being. “Breach of taboo” is the most frequently reported kind of diagnosis among the Navajos where it is believed that the commission of prohibited acts like sibling incest and other forms of taboo can cause illness. In the case of witchcraft, the Navajos believe that the means of working of the witch is by touching the victim with a powder made from corpse’s flesh. Sorcery is closely associated with witchcraft and sorcerers participate in the ceremonials performed by the witches.

In Africa, the traditional medical system consists of different beliefs and practices that vary from culture to culture. In a study of the medical system of the Gimi ethnic group of Guinea, Glick (1977) reported that the Gimi belief system divides illnesses into “severe” and “peculiar” illnesses. In Gimi beliefs, “severe” illnesses are insidious, tenacious and violent in nature and are caused by human antagonists through “poison sorcery” and “demonic beings”. The “peculiar illnesses” in the belief of the Gimi include deformity, destructive lesions and insanity which are believed to be caused by non-human antagonists such as Ghosts and Weird beings. For the two categories of illnesses, Glick reported that the Gimi people use herbs, rituals and modern methods for treatment. Harwood (1971) explained that among the Safwa people of Tanzania, illness is believed to be caused fundamentally by a disruption in the social relationships of a group to which the sick person belongs. Deng (1971) reported that the Dinka ethnic group of Sudan believes that illnesses are caused by discord among people. Their treatment patterns according to him include the use of herbs, divination and modern methods of treatment.

It is pertinent to mention that the role of spiritual healers and magicians in the treatment of illnesses are very important in Africa because of lack of modern health care facilities in many societies. Some of the methods such as the use of herbs and spiritual healers have some scientifically proved therapeutic and psychological functions. The importance of traditional medical practices in the treatment of illnesses had been observed and adopted by the World Health Organization (W.H.O.). This observation was made by the W.H.O. African Regional Director in a speech delivered at the Heads of States Summit of the Organization of

African Unity (O.A.U.) held in Lusaka-Zambia in June, 2001. He stated that:-

Traditional medicine has been with us since time immemorial, the majority of our population mostly rural and the few urban dwellers use it. It is incumbent on us Africans to be proud of our own and the WHO will continue to encourage and support research in traditional medical practices with a view to further developing its potential in the prevention, cure and management of priority diseases such as malaria, hypertension, sickle cell anaemia, tuberculosis, HIV/AIDS and other infectious diseases. (Samba, 2001: 1).

In Nigeria, traditional medical beliefs and practices play very important functions in health care delivery system because certain illnesses are considered to be caused by supernatural and mystical factors. The treatment for these illnesses is often considered to be beyond orthodox medicine (MacLean, 1976). The existing beliefs and practices determine the kinds of treatment to be sought. In some traditional societies, modern health care centres established by governments, individuals and private organizations are avoided and in their place, the services of traditional medicine men, spiritualists and faith healing are sought (Erinosho, 2005).

While acknowledging the health contributions of some traditional medical beliefs and practices in effectively dealing with some psychosomatic illnesses, it is pertinent to note that certain illnesses that would have been effectively cured by scientific medicine get worse in the process of seeking ineffective traditional remedies for such ailments. In some cultural groups, the non-utilization of modern health services is mainly on account of resistance to the westernization/modernization process – (Erinosho, 1981). This is most likely to be the case for the Kambari among whom resistance to modernization has resulted in the vicious circle of dearth of modern social services within their reach.

1.1 The Persistence of Traditional Social Institutions among the Kambari

The Kambari is one of the four major ethnic groups in Niger State. The other three are the Nupe, the Gwari (Gbagyi) and the Hausa/Fulani. The Kambari are found in the Kontagora Emirate in the northern part of Niger State. They are the most numerous ethnic group in Magama, Agwara, Rijau, and Mashegu Local Government Areas of the state. They are in addition found in Kontagora and Mariga Local Government Areas. The Kambaris form between 75 and 80% of the

total population of Magama Local Government Area (Central Administration, Magama Local Government, 2002).

The Kambaris are patrilineal. The oldest male is the head of the lineage. He has real control over the members of the household. They place high value on marriage to the extent that the choice of a spouse, formal proposal and the arrangements for the marriage ceremony is the sole responsibility of the family head. Majority of the Kambaris are polygynous. Marriage among the Kambari is of traditional relevance and is usually contracted by the ‘capture’ of a prospective bride usually carried out by the groom and his friends.

The traditional Kambari religion is the “Magiro cult. The Magiro is a Kambari god for whom an annual ceremony of sacrifices with local beer (*Burkutu*), dogs, goats and chickens are made to appease and thank him for successful harvest, good health and prosperity. In the events of outbreaks of epidemics like cholera, meningitis and whooping cough, certain rituals are conducted to appease the “Magiro” and seek for health for the entire members of the communities. In addition, the “Magiro” is consulted through the head of the shrine in cases of illnesses believed to be caused by sorcery or witchcraft. The Kambari belief system is gradually changing due to the influence of Islam, Christianity and western education. There is usually a leader of the shrine who, together with his council members oversees the activities of the Magiro. Every traditional Kambari settlement has its own Magiro shrine which is worshipped and consulted in times of natural disasters such as drought, flood, epidemics, mysterious illnesses and when taboos are violated. The Magiro is also an agent of social control. The leader of the shrine is called “Ganau”.

The Kambaris believe in the existence of the Supreme One God but see the “Magiro” as the representative of God on earth. The adherents of ‘Magiro religion’ see the Magiro as god and addresses it as such. They refer to the Magiro for solutions to all problems encountered by them in life. The main occupations of the Kambaris are farming, animal husbandry, hunting, fishing, blacksmithing and crafts. They mostly live in rural areas and majority of them are non-literate. In a typical Kambari family, feeding, accommodation, health care and other social services are the responsibilities of the husband/father in a nuclear family while in an extended family, the leader of the family who is usually the oldest male ensures that these basic needs are provided to the family members. The head of the family takes decision on issues like where the family lives, what they eat, and what treatment to administer in the event of illness. Among the Kambaris, an

illness affecting a member of the family is seen as affecting all the members of the family. This has great effect on the health seeking behaviour of the sick and significant others because the sick does not decide what type of treatment to be administered on him and where to go for treatment. In addition, the resources of the entire family are used in securing treatment for the sick member of the family. Everybody is involved in the decision making and subsequent treatment of the sick.

The Kambari lineage is patrilineal in organization. Authority is so much centralized in the lineage that the heads of nuclear families require the permission of the household heads on personal issues like migration, taking another wife, embracing Islam/Christianity and sending children to school. These days the heads of nuclear families are only required to notify the household heads on plans to migrate, send children to school, take another wife, profess new faith and take up modern jobs in towns and cities. This type of freedom is said to be the result of modernization and individualized farming where the head of the nuclear family uses his personal resources to finance his projects. Of particular importance is the fact that in the traditional Kambari setting, the head of a nuclear family living in an extended family does not decide independently on issues relating to his health or that of his wives and children. He therefore, only reports to the head of the household about every illness affecting him or his immediate family. The head of the household will then decide what form of treatment to be administered after consultations with other male household members.

1.2 Governmental Social Services Available to the Kambari

The Kambaris are left behind in the modernization process. The areas they occupy are deficient in basic social infrastructures like potable water, schools, health services, good road network and communication services. The dearth of these reinforces their resorting to traditional medicine in the event of illnesses. The Kambari speaking areas of Niger State are poorly supplied with safe water for consumption and domestic activities. Majority of Kambari people get their water from streams, wells and a few functional boreholes constructed by the defunct Directorate of Foods, Roads and Rural Infrastructures (DFRRI), the Local Government, UNICEF and other agencies. The 2002 annual departmental report of the Works and Housing Department of the Magama Local Government Area, where 75%-80% of the population are Kambari, indicated that out of a total number of 107 boreholes in its four districts, only 57 are functional. Tap water is only

available in the four District Headquarters, out of which only that of Nasko, the Local Government headquarter has regular supply with occasional seizure as a result of power failure. Generally, water supply in the Local Government Area is poor, especially during the dry season when most of the wells and streams are dry.

1.2.1 Education

Availability of schools and the total enrolment in them are important indicators of the level of literacy of the people. There are no records of the literacy rates of the Kambari people but the general view is that majority of the Kambaris, especially the women, are non-literate. In Magama Local Government Area, there are only four co-education secondary schools, one each in the four district headquarters of Nasko, Ibeto, Salka and Auna. There are 69 primary schools in the Local Government Area whose total enrolment record is not available in the Local Government Education Authority (L.E.A.) office. Among the four districts, the Salka District has the highest level of literacy which is traced to the influence of Christianity because majority of their indigenes belong to the Christian faith.

1.2.2 Health Care Services

The Kambari speaking areas are lagging in the availability of modern health care facilities. The Magama Local Government Area has one Government Rural Hospital located at Auna. There are three Basic Health Centres; one each located in Ibeto, Salka and Nasko. There is one National Programme on Immunization (NPI) office located at Nasko, an Health office located at Nasko, the Local Government Headquarter and 53 dispensaries spread all over the Local Government Area. Most of these health care facilities are non-functional due to lack of equipment and qualified staff. The roof tops of some of the dispensaries and health centres have been destroyed by wind.

Health care personnel are inadequate in the Local Government Area. There is only one qualified medical doctor under the services of the State Ministry of Health residing at the Rural Hospital Auna, seven midwives with only two in the services of the Local Government, with only three nurses employed by the Local Government, four Community Health Officers (C.H.O.) and 49 Community Health Extension Workers (CHEW). There are

three private clinics owned by medical doctors who are not resident in the areas where the clinics are located.

1.2.3 Transport Services

Transportation is an important factor in the provision of health care services as means of transport determines the utilization of health care facilities by those far away. Most parts of Magama Local Government are not motorable especially during the rainy season. At present, only the roads linking the four district headquarters are tarred and motorable throughout the year. Most villages in which the health care facilities are not available are cut off from the district headquarters where the health facilities are located during the rainy season by flooded rivers. The means of transport in some areas include motorcycles, bicycles, donkeys, camels, bulls and by foot in areas not easily accessible to four wheel vehicles. The combined effects of poor supply of potable water, poor level of literacy, inadequate health care facilities and poor transport systems are partly responsible for communicable and non-communicable diseases, poor utilization of health care facilities and the health seeking behaviour of the Kambari.

1.3 Statement of the Problem

In pluralistic medical systems, health seeking behaviour depends on the medical beliefs of the sick and their significant others. According to Landy (1977), in modern societies, natural causes of diseases are considered and treatment is in most cases sought at the available orthodox health institutions. In the traditional societies where the causes of illnesses are considered to be personalistic and supernatural, indigenous medicine tends to be preferred on account of the spiritual healers', witch doctors' and diviners' perceived abilities to obliterate the supernatural forces perceived to be responsible for the illness.

The year 2000 annual report of the Niger State Ministry of Health emphasized that the occurrence of communicable and non-communicable diseases are increasing among the Kambari communities. According to the report, diseases of high prevalence include malaria, tetanus, malnutrition, tuberculosis, gastroenteritis, measles, bleeding and anaemia in pregnancy. The presentation of the diseases at health centres were reported to be delayed. The ensuing complications seen include anaemia, crippling deformities of the limbs as a result of guinea worm, blindness and deafness. Maternal and child morbidity and mortality are high. The report showed a 5-8% annual increase in maternal mortality in the area between 1999 and

2001. Of the number of cases recorded in the area, 29.7% were malaria, 17% measles, 9.1% tetanus, 15% malnutrition, 11% maternal conditions, 10.4% diarrhoeal diseases while 1.5% and 6.5% were for guinea worm and surgical / other conditions. The 2001 annual report of the health offices as compiled by the zonal Epidemiological and Disease Control Unit, Kontagora, indicated low hospital / clinic attendance by the people in the Kambari speaking areas. Since majority of the people residing in the area are members of the Kambari ethnic group, it is obvious that they are more affected by these problems.

This study is therefore intended to seek answers to the following questions: What are the Kambari beliefs about the common illnesses affecting them? What are the traditional preventive and curative remedies for these illnesses? To what extent are these traditional remedies currently applied? In what circumstances is one health system preferred to the other? Which among the traditional and modern remedies is more often patronized by the Kambari? What are the consequences of the peoples' beliefs and practices on their health?

1.4 Objectives of the Study

The broad objective of this study is to describe Kambari folk medicine. The study will also identify the impact of folk medicine on the health of the people. Against these broad objectives, the following specific objectives are proposed:-

1. To describe Kambari folk medicine.
2. To identify the health seeking behaviour of the Kambaris.
3. To describe the activities of the Kambari traditional healers.
4. To identify the consequences of Kambari health beliefs and practices on their health.

1.5 Significance of the Study

Knowledge of the indigenous medical beliefs and practices of the people is important in the planning of health care programmes and the delivery of modern health care services for the people by the government. The study will identify appropriate strategies of providing health education

for the people that will make the Kambari appreciate and utilize modern health services. This will ensure that the Kambari seek modern treatment for diseases like malaria, measles, malnutrition, diarrhoeal diseases, anaemia in pregnancy, bleeding in pregnancy tetanus and guinea worm that often affect. They believe that these are caused by witchcraft, sorcery and spirit and mostly seek treatment from the traditional healers. A drastic reduction in work days lost due to these diseases will make the Kambari people more productive in their respective communities. The findings will also serve as a major step in the promotion of health of the people, prevention of diseases and reduction in maternal and child morbidity and mortality.

1.6 Delimitation of the Study

The study is delimited to the identification and description of medical beliefs and practices among the Kambaris of Niger State. The study was carried out in the northern part of Niger State where the Kambari are located. It also looked at their health belief system, health seeking behaviour, available health care resources and how their health care resources will be improved. The study also identified the consequences of the health beliefs and practices to the people.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Beliefs about the Causes of Diseases

Beliefs about disease causation differ from culture to culture (Lynch, 1969). According to Morley and Wallis (1978), the causes of disease in many cultures are perceived as either natural or supernatural. The supernatural beliefs attribute the origin of the diseases to extra-sensory forces, malevolent agents or acts which are not directly observable. These include witchcraft, sorcery, spirit or demon intrusion, evil eye e.t.c. The natural causes of diseases are those based wholly on observed cause-effect relationships e.g. when one sustains a fracture on falling from a height. In the supernatural causes, Swantz (1978) and Coe (1978) stated that sorcery is a frequently suspected cause of illness and misfortune. Foster and Anderson (1978) are of the view that illnesses are caused by agents who in some way bring their powers to bear against victims and such agents may be human, superhuman or non –human.

In a study of traditional Ibo ideas about diseases and their treatment, Ezeabasili (1971) found that there is a strong belief that illnesses are caused by natural, preternatural and mystical factors. The study established that very often, a sickness is believed to be caused by all the three causes. For example, when an Ibo falls sick, he/she first tries the general patent medicine he/she knows. If there is no improvement, he/she goes to the doctor and if it fails, he rationalizes by blaming, the spirits, witches, sorcerers .et.c.

In some instances, there is no concept of accidents in mishaps that result in injuries (Foster and Anderson 1978). For instance, among the Igalas, illnesses are believed to be manipulated and sent to afflict victims through supernatural agents. Boston (1971) explained that the Igalas believe that a snake bite is caused by sorcery. The snake is manipulated by the malevolent person and sent to attack the victim. In some cultures, it is believed that injuries sustained in falling from a tree or automobile crash are caused by witchcraft (Warren, 1975). Describing the Idoma illness behaviour, Armstrong (1971) explained that the Idoma people do not believe in the “germ theory” of diseases. Instead, they have what he called the “moral theory” of diseases in which illnesses are attributed to moral lapses on the part of the sick.

Explaining disease causality, Landy (1977) and Honigsmann (1973) concluded that the belief that illness is a punishment for wrong doing is widespread in human society and that the attribution of illness to misconduct may have been a very early form of social control in the development of human society. Coe (1978) explained that in most traditional societies, many diseases are seen as manifestations of supernatural powers, thus, causal explanations in these societies take on the magico – religious dimensions. Describing the belief system about the causes of diseases among the Italian – Americans, Ragucci (1981) explained that their belief system centres both on the natural and supernatural. The natural causes include heredity, contamination and exposure to certain substances while the supernatural causes include the “evil eye” (*Molocchio*) and curse (*Castiga*) by God and evil people.

Erinosho (2005) is of the view that the general belief among Nigerians is that illness can be caused by any one of three factors; natural, preternatural and mystical. According to him, the natural causes are connected with bad diet, insect bites, bad odours, defective blood in people and other things not connected with gods, fairies and spirits. The preternatural explanation is related to the belief in witchcraft, where the onset of illness is attributed to the evil machinations of an enemy. In the mystical factor, there is the belief that cosmic forces can cause illness. For example, the Maguzawa believes that the appearance of a new moon in the sky may induce mental illness. There are beliefs that ancestors are reputed to cause unrest of the mind among people who fail to carry out necessary rituals or violate certain taboos. Erinosho (2005) concludes that despite the recognition of all these factors, in virtually all Nigerian cultures, the belief in witchcraft as the ultimate explanation for the onset of illness are strongly embraced. For example most Nigerian cultures imbibe the belief that a sorcerer, wizard and other malevolent fellow human beings can remotely direct a snake to bite a victim.

2.2 Sources of Health Care Services and Illness Behaviour

Illness behaviour refers to the ways in which symptoms of illnesses are perceived, evaluated and acted upon. Mechanic (1978) explained that cultural context defines the conditions that are recognized as illness, the

causes to be attributed to them and the persons who have legitimate authority to assess, define and treat such conditions. He further explained that many studies about illness behaviour across ethnic groups have shown that cultural and social factors play important roles in patterning illness behaviour. According to him, these factors have great influence on the concepts of disease and illness, patterns of utilization of health care services and home treatments provided for the sick.

According to Harwood (1981) health beliefs and practices consist of a wide range of knowledge and activities that include techniques for health promotion, standards for recognizing and evaluating symptoms, assessment of the seriousness of various conditions and information about the forms and sources of treatment. These involve how the treatment is obtained and strict adherence to treatment instructions. Quite often, certain factors such as cultural background, level of education, financial status, gender, age and level of acculturation greatly influence the illness behaviour of some individuals (Logan and Dawkins 1986, Alakija 2000).

The health systems of most groups, however simple the culture is, can be broken down into at least two major categories; the 'disease theory' and the 'health care system' (Foster and Anderson, 1978). According to them, a disease theory system embraces, beliefs about the nature of health, the cause

of illness, the remedies and other techniques used by the healers for the treatment of illnesses. A health care system on the other hand is concerned with (1) the knowledge about disease and how it is applied to assist the sick and (2) how the sick are cared for. The health care system involves the interaction of a number of people, minimally the sick and the curer. Fromer (1979) explained that a health care system often reflects the logical and philosophical characteristics of the disease causality system of the people, because the disease causality system dictates many of the decisions that are made and the actions taken by the sick and his significant others. This means that where illness is considered to be as a result of the supernatural causes, treatments are sought from the magicians and other forms of traditional healers.

Rosengren (1980) emphasized that ethnic background has great influence on the peoples' concept of disease and illness in three ways:

1. Ethnic groups exhibit varying degrees of knowledge about categories of diseases.
2. Ethnic groups also differ in the ways in which symptoms are classified into illness categories.

3. Ethnicity has been shown to correlate with conceptions about the causes of disease and illness and therefore where treatments are sought.

These determine the health system of all societies. Logan and Dawkins (1986) described ethnicity and culture as being relevant to health and the health care process because ethnic groups vary both within and across groups with respect to their lifestyles, health beliefs and practices and the use of health care facilities. According to them, ethnic groups also vary in term of morbidity and mortality for different diseases. Fromer (1979) stated that familiarity with ethnic cultures present in the community is essential for the effective provision of health services because according to her, the beliefs and values of a group have a great influence on their illness behaviour. For instance in a study about the traditional Ibo ideas about disease and its treatment, Ezeabasili (1971) reported that for most of the illnesses, the Ibo will first visit a patent medicine store before seeing a medical officer after which he will attribute the illness to spirits, witches or sorcerers and then visit the indigenous healer if the patent medicine and the medical officer fail to provide effective treatment.

2.3 Folk Treatment of Illnesses

Inspite of the presence of modern medicine, folk medicine has continued to thrive. Harwood (1981) reported that in many advanced countries of the world, folk medicine is still being practiced. He explained that the blacks, the Puerto – Ricans, the Chinese, the Spanish-Americans and other immigrants in the U.S.A. still practice folk medicine along side modern medicine. Dennis (1975) in a study about the traditional healers in Liberia, reported that folk healers are engaged in treating virtually the same illnesses as the western medical practitioners.

Mechanic (1978: 95) stated that:

Folk healers often use diagnostic model that logically may not be too different from the diagnostic models used by the

modern medical practitioners. The sick may complain of subjective feelings of distress and the healer observes the evidences of deviation from implicit norms of functioning. The healers underlying theory may be that such manifest symptoms are consequence of spiritual failings on the part of the sick or a result of possession by evil spirits, and may thus attempt to treat the sick by helping to adjust his spiritual state by exorcising the spirits.

Paul (1969) explained that in folk medicine, some local population often divides afflictions into two classes; those that respond to folk methods of treatment and those amenable to scientific treatment. However, the dividing line may shift from one culture to another. For instance in a study about the traditional healers of Botswana in a changing society, Ulin (1975) reported that several alternatives for health care are available to the residents based on their beliefs about the type of illness affecting them. These are the official clinics and hospitals on one hand, and then the faith healers and the traditional healers on the other hand. She further explained that individuals and families select where they go for treatment based on the illness affecting them. These are the official clinics and hospitals on one hand, and then the faith healers and the traditional healers on the other hand. She further explained that individuals and families select where they go for treatment based on the illness afflicting them.

Morley and Wallis (1978) and Coe (1978) reported that in the vast range of traditional medical systems, there are many beliefs and practices that contain elements of techno-empirical knowledge such as the use of medicinal plants to treat diseases, avoidance of certain noxious food substances, parasite control and incest taboo. They explained further that some of the plants used by the herbalists are found to be pharmacologically effective. It is pertinent to note that in many societies, there are medical practices that require knowledge of the human anatomy and some considerable degree of technical skills that are empirically acceptable. These include bone setting, acupuncture, enemas, and inhalations. Other skills include ligation, use of hotsprings, massage, isolation and confinement of the sick, special exercises to improve strength and endurance with certain family psychotherapy which reduces tension and psychological stress.

Some scholars have emphasized the magico-religious approach in the treatment of illness. Honigmann (1973) reported that the scope of every medical system should be in line with the medical features of the society it

serves and that the treatment system should be a vast subject that must include the magico-religious and scientific procedures. Ru-shu (1988) reported in a study about acupuncture and moxibustion in China that the procedures require the knowledge of anatomy which is inherent in Chinese traditional medicine. He explained that acupuncture is still being used both traditionally and scientifically as new modern scientific techniques of acupuncture such as electro puncture therapy, low frequency electric therapy and point laser radiation have been developed and introduced into the modern medicine of the Chinese. Coe (1978) is of the view that the reason for the use of magic in the treatment of the sick is that most of the time, sick people recover whether treated or not. However there is the tendency to attribute recovery to the remedy resorted to. In this way, the magical remedies are proved to be efficacious by users. This belief makes the magical practices to have a great deal of psychotherapeutic value although, some of the treatments are empirically efficacious by western standard.

In most societies, different systems of treating illnesses are utilized by the people. Ragucci (1981) reported that among the Italian – Americans, treatment of illnesses are sought from traditional healers especially from women that have divine powers, from modern medical facilities and at home. Gould-Martin and Ngin (1981) reported that among the Chinese – Americans there are numerous Chinese traditional medical practitioners in major towns and cities of the United State of America attending to the health needs of the Chinese. They reported that in a street census of New York City's China town carried out in 1975, there were 20 herbalists, 5 acupuncturists, 7 bone setters, 2 herbal shops without herbalists and 19 associated businesses that sold herbs. The study revealed that these health practitioners are usually consulted after a decision has been taken in the family. This empirical finding illustrates the “transplant” of medical systems by migrants to other lands to suit the medical beliefs and needs of the migrants as dictated by their cultures. In a similar study by Logan and Dawkins (1986), the non-white ethnic groups (Bahamians, Haitians, Puerto-Ricans, and Afro-Americans) of the United States of America were found to be using both their own folk and the scientific medical systems in their treatment patterns.

Cosminsky and Scrimshaw (1980) in a study about medical pluralism in a Guatemalan Plantation settlement reported that residents use pluralistic healthcare system where self treatment through the use of herbs, the use of spiritual healers, home remedies, folk practitioners, lay pharmacists, cosmopolitan medial resources and patent medicines singularly,

interchangeably or simultaneously. They stated that although certain folk illnesses such as the 'evil eye' and fallen frontanelle are thought to be cured only by folk curers, this does not preclude the use of modern medicine to treat the symptoms. In other cases, the symptoms are treated with modern medicine while the cause of the illness is dealt with through a folk specialist. The pluralistic behaviour is pragmatic, often based on trial and error, perceived effectiveness, uncertainty of illness causation and expectation of quick results. For example, if a child has diarrhoea, it could be 'evil eye', so, the child is taken to a folk curer, but, if the baby still has diarrhoea, then may be the cause was not the 'evil eye', but some other factors, so, he is taken to another health care facility for treatment. These findings are similar to the report by Coe (1978) who explained that in the city, one can find faith healers, quacks, patent medicines, home remedies and lay explanations for the causes of illnesses which determine the health seeking behaviour in combination with the quest for modern methods of disease treatments. According to him, the choice may be due to the belief system of the people, economic factors, high expectations for quick results and the pluralistic practices of some of the healers who sometimes use combination treatment or their clients.

The considerations given to the cultural beliefs, practices, family structure and the values attached to these by the people also influence their choice of the treatment patterns when they fall sick. Twumasi (1978) in a study on the health system among the Asante of Ghana, reported that the diagnosis of illness is deeply embedded in the magico-religious system of the people. The medicine man performs acts which give the sick inspiration and restoration of confidence. The weight of the community, its religion, myths, history and the spirit enters into the therapy. He explained that the medicine man does not differentiate between illness of the physical and the psychological in origin. Twumasi explained that the person who is ill recognizes that he is ill and explains such to the significant others. The family elders then take decision and relieve the sick of his role and this is reinforced by the medicine man when the case gets to him. In the treatment, the sick may be denied rest so as to deny the 'demons' rest. The 'demons' are frightened away through the use of terrifying masks, grimaces, noises, dances and sometimes the 'demons' are smoked out by unbearable smell and fumigations. If the demons are too strong, then they must be appeased with sacrifices and precious gifts. Twumasi (1975), further explained that the main issue in the treatment is 'psychotherapy' where the sick persons faith and the medicine man's personality are very important.

Maclean (1976) in a study on some aspects of sickness behaviour among the Yoruba of Nigeria reported that four medical systems exist in the Yoruba community. These are the traditional Yoruba Medicine, modern medicine, Hausa medicine and faith healings. She explained that among the Yoruba, there is a belief about three things. These are the belief about the Yoruba oracle of divination called the “*Ifa* cult”, the belief about the priest of the oracle referred to as the “*Babalawo*” and the belief in the Yoruba herbalist called the “*Onishegun*”. According to her, both the “*Babalawo*” and the “*Onishegun*” have to undergo a long period of apprenticeship, learning the efficacy and appropriate use of a large number of herbal and other constituents of medicines and in the case of the “*Babalawo*”, committing to heart a lengthy sequence of verses connected with the worship and manipulation of the “*Ifa*”. Maclean revealed that Yoruba women often take care of their sick children. She stated that individuals first recognize sickness and speak out, the relations react and decisions are taken about the type of treatments to be sought. Morley and Wallis (1978) in a study about choices of treatment among the Yoruba conducted in Ibadan, reported that 71% of the households studied agreed that they use traditional remedies either sometimes or always. In the same study, 60% of secondary school pupils most of whose parents were enlightened reported occasional use of remedies in their families. Of the Yoruba mothers studied, a good number reported the existence of “*Abiku*” children, and the existence of medicines for conception, miscarriage, successful labour and for the inducement of lactation in older women. There was a general response about the popularity of folk medicine and that Yoruba medicine is concerned with the identification of all manner of disturbances in an individual’s pattern of existence and interpretation of its supplicants, the frustrations of their fragile hopes and expectations as well as the failure of their physical health.

Last (1976) in a study on illness behaviour in a non-Muslim Hausa (Maguzawa) community, reported that individuals usually decide if they are sick as no one wants to claim magical powers by proclaiming someone sick and that women and children are often the ones that fall sick. He explained that the Maguzawa perceived health as a personal matter and that the sick woman only mentions it to her husband or another enquiring woman. According to Last, husbands, mothers-in-law and close kins occasionally suggest spirit attack, soul attack, sorcery and witchcraft as the factors responsible for the illness of a member of the family. He explained that except for the illness classified as sexually transmitted the sick is not blamed for his illness and that wound sustained while cultivating the farmland is

believed to be caused by an angry spirit. The report explained that herbs are often used for treatment of illnesses and that traditional herbalists do not touch the sick except the bone setters, because speech is believed to be as powerful as touch.

Warren (1975), in a study conducted in Ghana on the Bono traditional healers reported that the majority of the Techiman–Bono people prepare and use their own herbal mixtures for the treatment of illnesses. He explained that when their own treatments fail, they consult a number of non-professional herbalists and priests. The study revealed that many Bono herbalists and spiritualists attend to the sick in designated places outside their houses on specified days and that some of the herbalists travel to near by villages on market days to attend to the sick. The choice of treatment among the Bono people whether modern or traditional is said to be based on the proximity of the health care facility to the people.

From the reviewed literature, it could be seen that illness behaviour varies across and even within cultures. Saunders and Hewes (1969) explained that most cultures have among their elements and patterns, a body of beliefs and practices centering on the recognition and treatment of illness. Some of these beliefs and practices have positive effects while others have negative consequences on the health of the people. These beliefs and practices greatly influence the provision of health care services and programmes to the people.

2.4 Theoretical Framework

This study, on folk medicine among the Kambari of Niger State is based on ethnomedicine which is a subset of the ethnomethodological theoretical perspective. According to Foster and Anderson (1978), ethnomedicine is the product of indigenous cultural development, beliefs and practices relating to diseases and their treatment in a community. Haralambos (1980) define ethnomethodology as the study of the methods used by people. It is regarded as a phenomenological approach which is concerned with examining the methods and procedures employed by members of a society to construct, account for and give meaning to their social world. The ethnomethodologists are concerned with how members of society go about the task of seeking, describing and explaining social order in the world in which they live.

Ethnomedicine is an offshoot of medical anthropology in non-western medical systems. From their early field research, anthropologists have gathered data on the medical beliefs and practices of the people they studied in the same way and for the same reason that they have gathered data on all other aspects of culture. Anthropologists reported that indigenous medical systems are social institutions to be studied in the same way as other social institutions and that indigenous medical practices are rational actions when viewed in the light of prevailing beliefs about causes of diseases (Fromer 1979, Foster and Anderson 1978). They also opined that religion, magic and medicine are always intimately linked together so that one can only be studied in terms of the others. Anthropologists see ethnomedicine as the study of non-western medicine and made it a part of their speciality. Folk medicine exists in all cultures and societies. Every culture has ways of maintaining the health of its people and curbing disease or alleviating the suffering of the sick ones. Folk medicine refers to the traditional medical beliefs, indigenous theories of diseases and medical practices of the people. The study will be undertaken within the ethnomedical theoretical framework.

The implication of using this theoretical framework is that the health beliefs and practices of the Kambari people will be identified and described. The ways in which these beliefs determine the perceptions of illness and what to do to remedy the illness are the key issues of the study. The study will also identify and explain ways of promoting those beliefs and practices that have positive impact on the health of the people while those with negative consequences will be identified with a view to correcting them.

As a social reality, health is viewed by the Kambari as an important aspect of their social life. The Kambari sees illnesses as afflictions caused by natural and supernatural factors. The sick is not blamed for falling sick because he/she is seen to be a victim of forces stronger than his/her strength. Assistance is therefore rendered to the sick by all members of the household. In, addition, the sick is normally exempted from his/her usual role and provided with quality medical care often from the traditional sources and

occasionally from modern services. There is a collective responsibility in the process of health seeking for the sick.

In Kambari folk medicine, religion, magic and medicine are linked. The health beliefs and practices have some religious and magical explanations. Similarly, treatments for illnesses are sought from religious, magical and other traditional medical sources based on the peoples' beliefs about the causes of illnesses.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Research Design

This study is aimed at describing in a systematic manner, the characteristics, features and facts about Kambari ethno-nosology and therapeutic systems. The study is interested in describing the illness and health behaviours and medical practices among the Kambari.

3.2 Location of the Study

This study was carried out in Niger State. The state shares boundaries with Kebbi, Kwara, Kogi, FCT, Kaduna States and the Benin Republic. Niger State has a population of about 2.5 million people made up of different ethnic groups. The four major ethnic groups are the Nupe, the Gwari, the Hausa/Fulani and the Kambari. Other ethnic groups in the state include the Kamuku, Pangu, Dukkawa, Dakarkari, Kadara, Koro, Yoruba, Ibo, Bussa and other ethnic groups. Majority of the people are farmers, residing in the rural areas.

The specific location of the study is Magama Local Government Area, between 75% and 80% of whose population is constituted by the Kambari. Magama Local Government Area was created in 1991. It shares boundaries with Kontagora, Rijau, Agwara, Mashegu and Borgu Local Government Areas of Niger State and Ngaski Local Government Area of Kebbi State. The 1991 census estimated the total population of Magama Local Government Area at 134,390 people spread over four districts. These districts are Ibelu, Salka, Auna and Nasko; the Local Government headquarters. Magama Local Government is considered among the Kambaris as their headquarter because majority of the Kambaris trace their origins to villages in the Local Government. The Kambaris of Magama Local Government Area will therefore adequately represent the Kambari ethnic group.

Specifically, three locations were selected for the study. These are Nasko, which is the Local Government Headquarter, Salka, and Magaman-Daji ward. As the Local Government Headquarters, Nasko was selected because all the districts and wards have some of their people resident there. In addition, Nasko has some basic social amenities such as health centre, tap water, schools and good road network which may have influence on the health beliefs and practices of the people. The Kambaris in Nasko are also said to be predominantly Muslims.

Salka was selected because it has the largest concentration of Kambari households in the Local Government Area. Salka also has the highest number of the Kambaris with formal education [Local Government Education Authority Nasko, 1998]. In addition, majority of the Kambaris in Salka are Christians some of whom have been exposed to modernization before independence due to their early contact with the white missionaries and western education.

Magaman-Daji ward is the most backward ward in the Local Government. It is the farthest from Nasko and it is not close to any town or Local Government headquarters. There is poor road network and few primary schools. There is no government or private health centre at the time of this study. There are three dispensaries in the ward located about 7-10 kilometers apart most of whose staff do not reside in their stations. There are few people with formal education and majority of the Kambaris in the area adhere to the Kambari religion [magiro]. The closest health centre to the people is located in Ibeto, about 25 kilometers away. In addition, the river Magaman-Daji makes access to the villages very difficult during the rainy season. The selection of this area provides adequate information for the comparison of the illness behaviour, health beliefs and health practices of the Kambari between those residents in the rural areas and those in semi-urban areas, between the followers of the three religions and across levels of formal educational attainment.

3.3 Sample Size and Sampling Technique

A total of two hundred and thirty one [231] household heads were selected for the study. In Nasko, a total of seventy nine [79] household heads were selected by first enumerating the Kambari households after which a systematic random sampling was carried out. In Salka, seventy eight [78] households were also selected through the systematic random sampling after enumerating the households owned by members of the Kambari ethnic group. Seventy four [74] Kambari households in Magaman-Daji were selected using a similar method. In all the 231 households, only the household heads and in their absence, their representatives were interviewed for the survey. A household refers to the occupants of a house or place of residence who may either be members of a nuclear or extended family. A household head refers to the person controlling and coordinating the affairs of a household as recognized by the members of the household.

The socio-demographic characteristics of the household heads with regards to age, gender, marital status, number of wives and number of children are presented in this section. Other key socio-demographic characteristics are the type of family, religious affiliation, educational attainment and occupation. In terms of age, most of the household heads were aged 31-50 years as presented in Table 3.1.

Table 3.1 Age Composition of the Household Heads

Age (in years)	Frequency	Percentage
18-30	29	12.6
31-50	144	62.3
51-70	46	19.9
71-90	10	4.3
91 and above	2	0.9
Total	231	100

Mean age – 45 years

Source: Field survey, 2004

Table 3.1 shows that 62.3% of the household heads were aged 31-50 years. About 5.2% of the household heads were aged 71 years and above. This indicates that majority of the Kambari household heads were young and in their active productive stages which make them prepared for the challenges of the leadership in their households.

The study also revealed that the Kambaris practice three main religions; Islam, Christianity and the Kambari Traditional Religion (magiro). Results of the field survey showed that 113 (48.9%) of the respondents practice Islam, 53 (22.9%) are Christians while 65 (28.1%) are followers of the traditional religion in which members worship the Magiro.

The sex distribution of the household heads in the study shows that 205 (88.7%) were males while 26[11.3] were females. Among the male household heads, 193 (83.5%) were married, 7(3.4%) were widowers and 5(2.4%) were divorced. All the widowers were aged 70 years and above most of whose dependents were grandchildren who lost their parents and those whose children are females married to people within and outside their places of residence. There were 19(73.1%) widows and 7(26.9) divorced females making up the 26 females in the study.

A cumulative proportion of 86.1% of the male household heads are polygynous as presented in Table 3.2

Table 3.2 Male Respondents' Number of Wives.

Number of wives	Frequency	Percentage
a. Not married	12	5.8
b. One wife	27	13.9
c. Two wives	72	37.3
d. Three wives	36	18.7
e. Four wives	21	10.9
More than four wives	37	19.2
Total	205	100

As shown in Table 3.2, most of the household heads (37.3%) had two wives while about 5.8% of them were not married at the time of the field survey. This indicates that majority of the Kambaris are polygynous.

In terms of the number of children in the households, about 26.8% of the household heads indicated that there were 6-10 children in their households while another 36.8% reported that there were between 11and 25 children in their households. Only about 26.4% of the household heads had 5 or less number of children in their households. This indicates that there are high fertility and fecundity rates amongst the Kambari.

From the 231 households studied, there were 143[61.9%] compound families, 62[26.8%] were nuclear families while 26{11.3%} were single

parent families with widows, widowers and divorced women heading the households.

. This indicated that majority of the Kambaris have maintained the traditional compound type of families. Similarly, a significant proportion of them had retained farming as their main occupation as shown in Table 3.3

Table 3.3 Occupations of the Respondents

Occupation	Frequency	Percentage
a. Farming	105	45.5
b. Civil service	62	26.8
c. Trading/Business	50	21.6
d. Artisan	14	6.1
Total	231	100

Source: Field survey, 2004.

It is seen in Table 3.3 that farming is the most common occupation of the household heads in which about 45.5% indicated farming as their only occupation. Other occupations of the household heads are civil service, trading/business and artisanship. However, all the respondents that indicated engaging in occupations other than farming claimed that they also farmed as a secondary occupation.

With regards to formal educational attainment, it was found that about one third of the respondents had no formal education as shown in Table 3.4

Table 3.4 Respondents Highest Level of Formal Educational Attainment

Level of education		Frequency	Percentage
1	No formal education	69	30.0
2	Qur'anic education	24	10.4
3	Adult education	19	8.2

4	Primary education	27	11.7
5	Secondary education	46	19.9
6	Diploma	25	10.8
7	NCE	16	6.9
8	First degree and above	5	2.2
	Total	231	100

Source: Field survey, 2004.

From Table 3.4, it can be seen that a combined total of 112 (48.5%) of the respondents i.e. including those who had adult and Qur'anic education had no formal education at the time of the study while majority of those with formal education were holders of either primary or secondary school certificates. This has affected greatly the peoples' acceptance of modernization because they were not well informed about modern health services and peoples' participation in promotive and preventive health care services such as proper nutrition, basic hygiene, family planning, prompt treatment of illnesses and immunization against some diseases. The implication of this is that majority of the Kambari have continued with their traditional ways of life including the health beliefs and practices which ultimately have negative impact on their health.

In addition to the household heads, thirteen [13] traditional healers resident in the selected communities were purposively selected and interviewed using a prepared in-depth interview schedule. All together, five [5] traditional healers were interviewed in Salka, four[4] in Nasko, and another four[4] in Magaman-Daji to make a total of thirteen[13] traditional healers that were interviewed. This distribution of respondents ensured good representation and provided the information required for the study.

The traditional healers' key socio-demographic characteristics specifically, age, religion, sex, occupation and highest level of educational attainment is presented in Table 3.5.

Table 3.5 Socio-demographic Characteristics of the Kambari Traditional Healers

	CHARACTERISTICS	FREQUENCY	PERCENTAGE
A	Age		
	31-50 years	5	38.5
	51-70 years	4	30.8
	71-90 years	2	15.4
	91-110 years	2	15.4
	Mean age=62.1 years	N =13	Total=100
B	Sex		
	Males	9	69.2
	Females	4	30.8
C	Religion		
	Islam	5	38.5
	Christianity	3	23.0
	Traditional	5	38.5
D	Educational		

	Attainment		
	No formal education	11	84.6
	Primary education	2	15.4
	Total	N=13	100

In Table 3.5, the modal age of the traditional healers is 31 - 50 years. Their mean age is 62 years. This shows that most of the traditional healers are young, active, and strong enough to undertake the art of healing. There were more males than females amongst the traditional healers which indicate the situation of male dominance among the Kambari. Table 3.5 also shows that there is equal number of Muslim and Traditional religions' worshippers among the traditional healers in the study while the others are Christians. As shown in the table, 8(61.5%) traditional healers combine the traditional medical practice with farming as occupation while 5(38.5%) indicated only the traditional medical practice as their occupation. This shows that more than one third of the healers are into full time traditional medical practice. Also presented in Table 3.5 is the respondents' highest level of formal educational attainment. Most of the respondents 11 (84.6%) indicated that they had no formal education while 2(15.4%) had only primary education as the highest educational qualification obtained. This indicates that most the Kambari traditional healers had no formal education.

3.4 Methods of Data Collection

Data was collected using the questionnaire and an in-depth interview schedule for the household heads and the traditional healers respectively. Items contained in the questionnaire for the household heads elicited responses on beliefs about illnesses, causes of illnesses, most frequently occurring illnesses, and the illness behaviour of the Kambari. Other responses elicited include the methods of treatment for the illnesses, information on sources of treatment available to the respondents and members of their households as well as the people's acceptance of the modern health care services.

3.5 Techniques of Data Analysis

To analyze the data collected for this study, descriptive statistical measures such as percentages were used. Other statistical measures used

include the chi-square and test of levels of significance to identify the relationship between the socio-demographic characteristics of the respondents and variables such as health beliefs, sources of treatment for illnesses and accessibility to sources of treatment. These measures facilitated accurate identification, description and explanation of the health beliefs and practices as well as the illness behaviour of the Kambari.

CHAPTER FOUR

HEALTH BELIEFS AND PRACTICES OF THE KAMBARI

HOUSEHOLD HEADS

4.1 Health Beliefs and Practices among the Household Heads

This section presents the health beliefs and practices among the household heads. The questions asked were on what they perceived as the causes of illnesses, the most frequently occurring illnesses and where treatments for such illnesses are usually sought. A significant proportion of the household heads (62.8%) believed that illnesses are caused by the supernatural factors as presented in Table 4.1.

Table 4.1 Respondents' Beliefs about the Causes of Illnesses

Perceived causes of illnesses	Frequency	Percentage
a. Change in weather	17	7.4
b. Bad Food/water	60	26.0
c. Witchcraft	13	5.6
d. Poisoning	5	2.2
e. Spirits	9	3.9
f. All of the above	101	43.7
g. Others (germs, accidents)	26	11.3
Total	231	100

Source: Field survey, 2004.

Table 4.1 reveals that a combination of 43.7% of the respondents believe that change in weather, food/water taken, witchcraft, poisoning and spirits are the causes of one form or the other of illnesses among them. Some of the respondents who indicated one of the mentioned factors as the single cause of illnesses explained the identified factor as the leading one, working together with ancillary causes. A good illustration of this belief is the assertion by most of the respondents that accidents occur in various forms as directed by the witches, spirits or sorcerers that have engineered them, inflicting whatever form of harm that has been designed for the victims by the perpetrator.

The respondents' views about the most frequently occurring illnesses amongst their people were sought so as to ascertain what they consider as illness and what form(s) of illnesses are commonly found within their environments. Responses in terms of most frequently occurring illnesses indicated that malaria fever, diarrhea/ vomiting and malnutrition are the most frequently occurring illnesses as presented in Table 4.2

Table 4.2 The Most Frequently Occurring Illnesses In Respondents' Families

Illnesses	Frequency	Percentage
a. Malaria	86	37.2
b. Typhoid	18	7.8
c. Malnutrition	24	10.4
d. Pneumonia/asthma/cough	18	7.8
e. Diarrhea and vomiting	35	15.1
f. Dysentery / haemorrhoid (pile)	26	11.3
g. Appendicitis / hernia	16	6.9
h. Epilepsy/mental illness	8	3.5
Total	231	100

Source: Field survey, 2004.

From Table 4.2, it can be seen that some of the respondents (37.2%) indicated malaria as the most frequently occurring illness while diarrhea/vomiting (15.1%) and malnutrition (10.4%) are the next most frequently occurring illnesses amongst the people as indicated by the respondents. This is typical of the tropical areas and especially in Africa where malaria, malnutrition and communicable diseases are endemic. The respondents also indicated that typhoid fever, respiratory tract infections like pneumonia, dysentery/haemorrhoid, appendicitis/hernia, epilepsy and mental illness are increasingly recurring and affecting more people than in the past. Although some of the illnesses like asthma, haemorrhoid, epilepsy and mental illnesses are either chronic, intractable or recurring, they are considered to be most frequently occurring. Their presence is endemic to the family. The perennial presence of a non-abating illness makes the household heads perceive it as the most frequently occurring. Measles and epilepsy were said to be occurring most frequently during the harmattan season because the spirit agents causing them come along with the harmattan wind.

The Kambari belief also links some illnesses to certain episodes such as being attacked by a witch, the consumption of inappropriate foods such as unripe fruits or food poisoned by enemies through spells and other forms of sorcery. The other perceived causes of the illnesses presented in Table 4.1 include being attacked by evil spirits and exposure to germs. The belief about sorcery (*sammo*) as a cause of illness is very strong among the Kambaris. They believe that a rival can attack an enemy by sending a mysterious poisoned needle into the body of the victim and cause various forms of chronic illnesses, permanent deformities or death. This mysterious needle is often claimed to be removed from the body of the victims by the traditional healers through either counter spells, the use of herbs or rituals. For instance, a victim of snake bite perceived to have been caused by an enemy is directed by the priest of the magiro (*Ganau*) to sacrifice a black goat after conducting some rituals before some herbs were given for medication. The rituals and the sacrifice were said to be carried out to neutralize the perceived powers of the enemy while the herbs were to neutralize the effects of the snake venom.

As a practice, several treatment regimes are provided for the sick members of a Kambari household. About 40.7% of the household heads indicated that they combine both the traditional and the modern methods of treatment when a member of the family is ill as presented in Table 4.3

Table 4.3 The Usual Medical Systems Consulted For Treating Illnesses Amongst Members of Ones Household.

Methods of treatment	Frequency	Percentage
a. Traditional treatment	71	30.7%
b. Traditional and modern	94	40.7%
c. Modern treatment	66	28.6%
Total	231	100

Source: Field survey, 2004.

Those that indicated the use of combination of treatment methods are observed to be mostly among those that had some form of western education. This is a result of the prevailing westernization which is fast gaining ground in the Kambari culture. As presented in Table 4.3, it can also

be seen that 71 (30.7%) respondents indicated the use of traditional methods of treatment. For people in this category, the services of the herbalists, diviners, the magiro priests and some Islamic scholars (*mallams*) are sought in various combinations as the patients and their relations deem fit. For it is common for faithfuls of other religions usually to visit and obtain medical or spiritual help from religious leaders other than theirs. For instance, some Christians explained that occasionally, they often contact their priests to pray for them and members of their households when illnesses occurred. They categorically stated that these prayers were combined with either the traditional or modern methods of treatment or both. The third form of treatment presented in the Table (4.3) is the modern method which was indicated by 66 (28.6%) of respondents. This method includes treatments obtained from patent medicine stores, clinics and hospitals. The respondents also explained that sometimes some health workers in the community treat them in their houses. In such cases, the health worker concerned is paid for the services rendered. Both the government and private employees usually render this type of service unofficially. Some of the factors that influence the choice of treatment method include accessibility to the service, age of both the sick and the household head, the types of illness and the perceived causes of the illness.

When household heads were requested to mention recurring illnesses affecting their household members that they diagnose by themselves as household heads, a cumulative proportion of 63.6% stated malaria, skin diseases, diseases of the eye, diarrhea and vomiting. These are presented in Table 4.4

Table 4.4 Recurring Illnesses Usually Diagnosed by the Household Heads

Illnesses	Frequency	Percentage
a. Malaria fever(<i>usudawu</i>)	69	29.9
b. Eye diseases/skin diseases	30	12.9
c. Ulcer/abdominal pain	17	7.4
d. Diarrhoea and vomiting	48	20.8
e. Haemorrhoid(<i>dankanoma</i>)/dysentery	39	16.9

f. Asthma/pneumonia(<i>makambu</i>)	9	3.9
g. Epilepsy(<i>farfadiya</i>)/mental illness(<i>ujaru</i>)	7	3.0
h. All of the above	12	5.2
Total	231	100

Source: Field survey, 2004.

As presented in Table 4.4, malaria, diarrhea, vomiting, and haemorrhoid/dysentery are the illnesses most commonly diagnosed by the household heads. It is significant to note that 12 (5.2%) respondents indicated that they usually diagnose all the illnesses listed in Table 4.4. The respondents explained that all the Kambari household heads are normally required to diagnose and treat some illnesses affecting their household members. All the household heads claimed to know and administer one or more herbal remedies. A 70 year old household head explained that a Kambari household head is required to identify and treat certain illnesses in his household before seeking help from the traditional healers because according to him, Kambari medicine is part of the culture. Some of the remedies were shown the researcher. These herbal preparations are kept for the use of the family members and neighbours especially in times of emergency. The respondents also admitted that if the household head is not skillful in the art of diagnoses, a more knowledgeable neighbour is contacted for assistance after which a specialist may be contacted if there is no improvement in the condition.

About 50.7% of the household heads reported that they usually apply only traditional treatments like herbs and rituals to treat a sick member of the household as presented in Table 4.5

Table 4.5 Home Treatment Provided by Household Heads

Method of treatment	Frequency	Percentage
Traditional (herbs, rituals, incantations)	117	50.7

Modern (home, patent medicines)	56	24.2
Traditional and modern (combined)	58	25.1
Total	231	100

Source: Field Survey, 2004.

Table 4.5 also reveals that other forms of treatment applied by the household heads are modern treatment (24.2%) in the form of self medication or obtained from chemists. They also use a combination of both the traditional and modern methods which is often in the form of modern drugs obtained from hawkers and patent medicine stores usually administered concurrently with herbs, rituals or incantations. In all, 75.8% of the household heads apply one form of traditional treatment or the other at home when illness affects a member of the household. The respondents unanimously agreed that the choice of treatment depends on the type of illness affecting a person because every illness has a perceived cause which determines the type of treatment to be applied. Table 4.6 presents some of the sources of treatment available to the household members as indicated by the respondents.

Table 4.6 Where Treatments are Sourced by the Household Members

Sources of treatment	Frequency	Percentage
Home treatment	27	11.7
Traditional healers	19	8.2
Chemist (patent medicine store)	15	6.5
Hospitals/clinics	27	11.7
Home and chemists	33	14.3
Traditional healers and chemists	21	9.1
Traditional healers and hospitals	19	8.2
Home and traditional healers	33	14.3
Home, hospitals, traditional healers and chemists	37	16
Total	231	100

Source: Field survey, 2004.

From Table 4.6, it can also be seen that a cumulative 55.6% of the respondents indicated that household members source treatment from the traditional healers when illnesses occur while others indicated other sources like chemists, hospitals and clinics. One source is either being used at a time or a combination of two or more sources are being used at the same time. It is also seen that 27 (11.7%) respondents indicated that they source treatment at home alone. The treatment is provided by either the household heads or someone given that responsibility in the house. In all, the Kambari make use of more than one source of treatment commencing with home remedies before seeking help elsewhere.

4.2 Home Diagnosis of Illnesses, Decision Making Processes and Treatment Seeking

For illnesses in children, 61.0% of the household heads revealed that the mothers usually first notice and complain about illness episodes affecting the child as shown in Table 4.7

Table 4.7 People that First Notice Illness affecting Children in the Household

Person(s)	Frequency	Percentage
The mother	141	61.0
The father	23	10.0
Both the mother and father	32	13.9
The household head	12	5.2
The oldest female in the house	19	8.2
The father and the household head	4	1.7
Total	231	100

Source: Field survey, 2004.

The mothers usually first notice and initiate the process of help seeking for a sick child because children are closer to the mothers than any other person in the household. Other categories of persons that first notice illnesses affecting children are the father, the household head, the oldest female in the house and a combination of the fathers and mothers. The respondents explained that when the mothers are able to identify that a child is sick, they commence treatment with herbal preparation or sometimes with medicines obtained from the chemist. Young mothers also consult the oldest and usually the most experienced female in the household. In an extended family, the older woman consulted is expected to confirm sickness and provide treatment or report to the household head. However, in a nuclear family, the mother complains directly to her husband who decides whether or not help will be sought outside the house. The household heads explained

that where there is cooperation among the heads of the nuclear families in a compound family, the compound head decides where the child should be treated and pays the bill. A significant proportion of the house hold heads (45.5%) revealed that the household heads usually initiate the process of help seeking for a sick adult member of the household. This is presented in Table 4.8.

Table 4.8 The Persons who Initiate the Process of Help-seeking for Sick Member of Household.

The Initiators of Help Seeking	Frequency	Percentage
The sick adult	29	12.6
The household head	79	34.2
The father of the sick	67	29.0
The mother of the sick	11	4.8
The household head and father (combined)	21	9.1
The father and mother (combined)	19	8.2
All of the above	5	2.2
Total	231	100

Source: Field survey, 2004.

The initiators of help seeking as seen in Table 8 include the father and mother of the sick. Where the household head initiates the process of help seeking, it is usually done by either calling for a family meeting of usually the male adults or by contacting a specialist for medical assistance

without necessarily, informing any member of the household. Sometimes, the household head may initiate help seeking by preparing home remedies for the sick. Most of the respondents explained that a sick adult member of the household is required to inform the household head or any elder in the household before seeking for any outside help. The explanation given was that if the household head is informed, he will provide moral and financial support for the sick. The usual actions taken are shown in Table 4.9

Table 4.9 Usual Actions taken by the Household Heads for Sick Member

	Help seeking activities	Frequency	Percentage
1	Call a household meeting	117	50.6
2	Prepare home treatment	86	37.2
3	Invite a traditional healer	59	25.5
4	Take the sick to the traditional healer	54	23.4
5	Take the sick to the hospital	43	18.6

Source: Field survey, 2004.

Other activities involved in the process of help seeking for a sick member of the household include preparing home treatment which is usually in the form of herbs or modern drugs obtained from the chemists and inviting a traditional healer. Sometimes the sick is taken to the clinic/hospital. The respondents revealed that some of the actions are either taken in stages or concurrently. For instance, majority revealed that actions such as preparing home treatment, inviting a traditional healer, taking the sick to the traditional healer and taking the sick to the hospital are done in stages depending on the sick person's response to a particular action taken. The respondents explained that actions such as calling a meeting of the household and preparing home treatment are almost always being carried out simultaneously as according to them, before meetings are called, home treatments are commenced. Majority explained that the hospital is often the last resort because home treatments and traditional healers must have been explored before taking the sick to the hospital.

Most of the respondents stated that even when the sick is taken to the hospital for modern treatment, traditional medicine continues to be used to complement the modern method. This indicates an entrenched medical pluralism. The belief in the traditional healers' ability to neutralize the supernatural aspect of the cause of the illness is indispensable. The modern version of the treatment is to effectively remove the natural cause of the illness. The respondents also revealed that help seeking for a sick member of the household is primarily the responsibility of the household head and secondarily, a collective responsibility of all the adults in the household.

4.3 Payment for the Treatment of Sick Members of the Household

This section discusses how money required to effect payment for treatment of a sick member of the household is sourced. In this regard, 94% of the household heads revealed that the household head is responsible for settling the bills in a compound family with joint ownership of resources. However, 89.4% of the household heads also indicated that the father of the sick child is usually required to settle the bills especially if the compound family is not engaged in joint production/ownership of resources. This is despite the fact that the household head culturally determines where treatment is sought. The other sources of fund for payments in respect of treatment(s) received by the sick include the mother of the sick (if a child).

It was explained that other members of the household such as the grand parents of a sick child, the uncles and other close relations usually assist in settling the bills only when the resources of the household are jointly owned as in joint farming or when the father of the sick child is unable to pay. Where resources are jointly owned, payment is effected directly from the joint resources by the household head.

In a nuclear family, the father normally pays but the mothers sometimes willingly contribute especially when the father is not able to pay the entire bill. The respondents unanimously agreed that mothers are not normally expected to pay for the treatments of their children. If the father is dead, the paternal relations are required to pay. This is an outcome of the Kambari patrilineal system of family organization in which children "belong" to the fathers who are required to provide for the children's upbringing.

Husbands were identified as being normatively responsible for payment for the treatment of their wives. However, in exceptional circumstances, the sick wife or her natal family may pay for her treatment.

Where the wife and her husband belong in a compound family, the household head normally pays from the joint resources if the husband fails to. It was emphasized that neither the wife nor her natal family are required to contribute for the payment as this is a sign of weakness on the part of the husband and his family. However, it was also stated that the wife or her natal family can settle the bills in a situation where the husband and his relations are unable to settle the bill. In such cases, the amount involved is culturally regarded as a loan which the husband is required to pay back. In situations where the illness is chronic and requires a lot of resources for the treatment, the woman's natal family may contribute but this is culturally seen as assistance and not a responsibility. The male adult normally pays for the treatment of members of his household. However, if he is not able to pay, his paternal and maternal relations assist in the payment.

In a compound family, the family heads are usually responsible for payment for the treatment of a sick member of the household. This practice includes payment for a sick wife and children of a member of the compound family especially where the family is engaged in joint ownership of resources. Where the sickness is involving a male adult member of a compound family engaged in joint production and ownership, treatment fees are settled by the household head from the common resources.

Generally, the respondents explained that unlike in the case of the modern medical treatment where money is used for payment, items such as farm produce and domestic animals are normally accepted by the Kambari traditional healers. Some of the items are used as sacrifice to appease the gods or to drive away the evils or neutralize the spells cast. The items commonly used for payment and sacrifice include goats, chickens, honey, farm produce, manually woven cloths and bush animals such as antelopes. Payments can be deferred to harvest or other more convenient periods if the payment cannot be made in the course of treatment. One of the Kambari medical ethics is for the client to pay after cure has been achieved. This however, precludes the provision of victims and other materials for sacrifice which are used for medication.

4.4 Factors Influencing the Health Beliefs and Practices of the Kambari

In this section, the factors influencing the beliefs and practices of the Kambari relating to health are discussed. The findings revealed that socio-demographic factors such as the age, religion, level of educational

attainment and place of residence affect the beliefs and practices of the people.

The findings show that age has no significant influence on beliefs about the causes of illnesses among the people because most of the respondents (74%) across all age groups believe in the supernatural causes of illnesses as shown in Table 4.10

Table 4.10 Ages and Belief about Causes of Illnesses

Age	Beliefs about Causes of illness			
	A Natural	B Supernatural	Combination of A and B	Total (N)
18-30 years	9 (31.0%)	9 (31.0%)	11 (37.9%)	29
31-50 years	41 (28.5%)	39 (27.1%)	64 (44.4%)	144
51 years and above	10 (17.2%)	22 (37.9%)	26 (44.8%)	58
Total	60	70	101	231

$X^2 = 4.25$, $df=4$, Not significant at 0.05 level, $p>0.05$, $n=231$

Table 4.10 also reveals that the belief about the combined effects of the natural and supernatural causes of illnesses is held across the age groups as indicated by a proportion of 101 (43.7%) household heads. For example, irrespective of the age, some of the respondents who believe in the combined natural and supernatural causes explained that diseases like snake bite, meningitis, epilepsy, mental illness and tuberculosis, though, with known natural causes like germs, snake bite, accidents and the use of hard drugs are the direct effects of sorcery (sammo), poisoning (guba) and witchcraft. When asked about the general causes of illness, a 33 year old household head exclaimed that:

God loves everybody He creates, therefore, He cannot send suffering to His creature through illnesses. It is the enemies, the wicked and the witches that send sickness to their victims through illnesses.

Also, about 26% of the household heads across the age groups indicated that illnesses are solely caused by natural causes like germs, snake bite, bad food and contaminated water. The most frequently identified supernatural factors responsible for illnesses, are sorcery, witchcraft, and spirits.

Apparent natural causes according to most of the older household heads, are precipitated by the supernatural causes most especially sorcery in which the perceived enemy uses magical power to send a mysterious poisonous needle to for instance, cause a snake bite and illnesses like osteomyelitis. This explains the peoples' choice of a combination of traditional and modern treatments for illnesses.

The findings also indicated that the household heads' formal educational background influence their belief about the causes of illnesses. The relationship between formal educational background and belief about the causes of illnesses among the people is presented in Table 4.11.

Table 4.11 Level of Education and Perceived Causes of Illnesses

Level of education	Causes of illness			
	A Natural	B Supernatural	A and B Combined	Total (N)
No formal education	20 (17.9%)	45(40.2%)	47(42%)	112
Primary and secondary education	24(32.9%)	17(23.3%)	32(43.8%)	73
Tertiary education	16(34.8%)	8(17.4%)	22(47.8%)	46
Total	60	70	101	231

$X^2=13.1$, df = 4, significant at 0.05 level, $p<0.05$, $n=231$

Table 4.11 shows that a significant proportion of respondents across all educational categories (42%-48%) believe that illness is caused by the combination of both natural and supernatural factors. However, the table also reveals that those who have any form of formal education (33%-35%) attribute illnesses to natural causes in contrast to only 18% that do not have

formal education that hold similar belief. On the other hand, 40.2% of those who do not have formal education attributed illnesses primarily to supernatural causes such as sorcery, witchcraft and poisoning in contrast to only 17% of those who have tertiary level of education and 23.3% that have lower level of education that attributed illness to natural causes.

From the data in Table 4.11 it can be deduced that those who attain higher levels of education tend to shed off beliefs in supernatural factors as causes of illnesses. However, the findings also reveal that the Kambaris' upholding of cultural beliefs is strong because the majority of the respondents irrespective of their levels of education still attribute illnesses to a combination of natural and supernatural factors. The implication of this finding is that the household heads with formal education are likely to attribute illnesses to their actual causes and seek treatment for the sick members of the households from the modern sources.

In terms of level of formal educational attainment and sources of treatment utilized by the people, the findings reveal that 35% of the respondents that source treatment from the traditional medical services are not formally educated. The findings are shown in Table 4.12.

Table 4.12 Level of Education and Sources of Treatment

Level of education	Sources of treatment			
	Traditional	Modern	Pluralistic(Combined)	Total (N)
No formal education	39(34.8%)	19(17%)	54(48.2%)	112
Primary and secondary education	13(17.8%)	24(32.9%)	36(49.3%)	73
Tertiary education	7(15.2%)	19{41.3%)	20(43.5%)	46
Total	59	62	110	231

$X^2=16.36$, $df = 4$, significant at 0.05 level, $p<0.05$, $n=231$

Table 4.12 shows that 44-49% of the household heads across the levels of formal educational attainment combine the traditional and modern sources of treatment. However, there are more people among those with no tertiary level of education (41.3%) that source treatment from modern sources of treatment than there are among those with no formal education (17%) while 33% of those with primary/secondary also source treatment from modern health services like patent medicine stores, clinics and hospitals. The explanation for this is the tendency for the people to use the traditional sources of treatment when illnesses occur. Also, the findings indicate that people with formal education tended to source treatment from modern health care facilities.

There is no significant relationship between the age of the household heads and the sources of treatment. The findings show that about 41.4% of the household heads aged 18-30 years source treatment from modern health care facilities like hospitals, clinics and patent medicines stores as against 22.4% of those aged 51-70 years. The findings are presented in Table 4.13.

Table 4.13 Age and Sources of treatment

Age	Source(s) of treatment			
	Traditional method	Modern method	Pluralistic (combined)	Total (N)
18-30 years	7(24.1%)	12(41.4%)	10(34.5%)	29
31-50 years	33(22.9%)	37(25.7%)	74(51.4%)	144
51-70 years	19(32.8%)	13(22.4%)	26(44.8%)	58

Total	59	62	110	231
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$\chi^2=5.93$, df = 4, Not significant at 0.05 level, $p>0.05$, n=231

Table 4.13 also shows that a proportion of the respondents aged 18-30 years (34.5%) combine both the traditional methods such as home treatment using herbs, treatment from the traditional healers as well as utilizing modern methods. For instance, a 28 year old household head explained that when his 2 year old daughter developed febrile convulsion, she was taken to the clinic for fast relief of the fever and the convulsion after which she was taken to the traditional healer to ward off the evil spirits. Another reason is that the healers are greater in number and more accessible to the sick than the modern medical practitioners.

The findings also indicate that irrespective of the age of the household heads, 34.5-51.4% usually combines both the traditional and modern sources of treatment when illness occurs. However, while most of the younger household heads (41.4%) tended to source treatment from the modern services, the older (44.8%) mostly utilize the services of both the traditional and modern sources. Majority of the middle aged household heads (51.4%) usually combine the two sources for treatment. The use of combined sources of treatment is hinged on the belief that modern medicine does not successfully treat supernaturally caused diseases. Asked why combining the traditional and modern methods of treatment, a household head answered:

A'ah, don't you know that the modern medicine only reduces the severity of an illness? I have to take the traditional medicines for total cure.

The influence of religious belief on the sources of treatment utilized by the households is presented in Table 4.14

Table 4.14: Religion and Sources of Treatment

Religion	Sources of treatment			
	Traditional	Modern	Pluralistic (combined)	Total (N)
Islam	23(20.4%)	46(40.7%)	44(38.9%)	113

Christianity	14(26.4%)	8(15.1%)	31(58.5%)	53
Traditional	22(33.8%)	8(12.3%)	35(53.9%)	65
Total	59	62	110	231

$\chi^2 = 5.93$, df = 4, Not significant at 0.05 level, $P > 0.05$, n = 231

As shown in table 4.14, there is a significant difference between religion and source of treatment of illnesses. While a significant proportion of Muslims (41%) restrict their sources of treatment to modern sources such as the patent medicine stores, hospitals and clinics, the Christians (59%) and the traditional worshipers (54%) seek treatment from both the traditional and the modern sources simultaneously. The sources include traditional and modern where the household members utilize the services of home treatments, traditional healers, chemists, hospitals and clinics. As shown in Table 4.14, members of the traditional religion utilize the traditional sources of treatment more than the Muslims and the Christians although, majority of the traditionalists are pluralistic in their search for remedies.

These findings suggest that modernization is gradually gaining ground among the Kambaris as seen by their use of both traditional and modern methods of treatment of illnesses. Respondents (across religion) claimed that they use modern medicines for fast relief of symptoms of illnesses and apply traditional methods for total cure especially for fever, diarrhea and skin diseases.

Since modern health care facilities are not evenly distributed among the people of the area, the relationship between the place of residence and the source of treatment was also investigated and presented in Table 4.15.

Table 4.15: Place of Residence and Source of Treatment

Village/town residence	of	Sources of treatment			
		Traditional	Modern	Pluralistic (combined)	Total (N)

Nasko	31(43.7%)	20(30.3%)	28(29.8%)	79
Salka	12(16.9%)	35(53.0%)	31(33.0%)	78
Magaman Daji	28(39.4%)	11(16.7%)	35(37.2%)	74
Total	71	66	94	231

$\chi^2=21.74$, df = 4, significant at 0.05 level, $p<0.05$, $n=231$

As seen in Table 4.15, higher proportions of respondents in Nasko and Magaman-Daji (39.4-43.7%) use the traditional sources of treatment when illnesses occur than those in Salka (17%). However, Salka residents (53%) are the major utilizers of modern sources of treatment like the clinics, hospitals and the patent medicines' stores while the Magaman-Daji residents (17%) are the least in this direction.

The finding in Table 4.15 reveals that people resident in Magaman-Daji (a rural area) and Nasko (Local Government Area Headquarters) seek for treatments from traditional sources more than those in Salka. This could be a result of the dearth of modern health care services and persistence of traditional life styles. Nasko, though a Local Government headquarter, is not as large as Salka and has fewer people who have formal education than in Salka. In addition, there are more private and government owned modern health care facilities like dispensaries, clinics, and patent medicines stores in Salka than in Nasko and Magaman-Daji combined. This is therefore, responsible for the people's utilization of the traditional sources of treatment in Nasko and Magaman-Daji. As reported by the Magama Local Government Education Authority, (1994) Salka, is a Christian dominated settlement and has more formally educated people who were also in contact with missionaries. As for Magaman Daji, it is typically a rural settlement with few patent medicine stores, 3 primary schools and four dispensaries in the entire ward. Majority of the people have no access to modern amenities such as schools, clinics and road. This is responsible for their insistence on traditional practices including sourcing treatment from the traditional healers. Another explanation is that the Kambaris may be very conscious of their cultural practices which include the use of traditional methods of treatment. Reluctant to give up the Kambari medicine, they combine it with the modern. However, the study reveals that the people with no formal

education tend to rely more on traditional methods of treatment than the modern. Presented in Table 4.16 is the relationship between the formal educational attainment of the respondents and home treatment available to them.

Table 4.16 Respondents Level of Education and Home Treatment Most Utilized

Level of education	Medicine used in Home treatment			
	Traditional	Modern	Combined traditional and modern	Total (N)
No formal education	51(45.5%)	7(6.3%)	54(48.2%)	112
Primary and Secondary	22(30.1%)	12(16.4%)	39(53.4%)	73
Tertiary	7(15.2%)	15(32.6%)	24(52.2%)	46
Total	80 (34.6%)	34 (14.7%)	117 (50.7%)	231 (100%)

$\chi^2 = 22.81$, $df=4$, Significant at 0.05 level, $p<0.05$, $n=231$

Most respondents across the levels of educational attainment (48-52%), utilized both the traditional and modern medicine for the treatment of illnesses at home. Table (4.16) reveals that in all the three educational groups, most of the households access combined modern and traditional methods in home treatment. While the most traditional forms are herbs and traditional rituals, modern treatments are accessed from patent medicines stores. It is in form of self prescription especially amongst those with formal education and prescriptions from unskilled patent medicine vendors especially for the non-literates. For instance, most of the literate respondents claimed that they usually obtain medicines such as Phensic, Indocid, Cough Syrup, Eye drops, Ampicillin, Chloroquine and Procold whenever they have pains, cough, fever, or catarrh. These drugs according to them are combined with the necessary herbal preparations for treatment. The finding indicates

that the higher the formal educational attainment the more the tendency to utilize modern forms of treatment at home.

4.5 The Implications of Kambari Beliefs and Practices on the Peoples' Health.

The study has revealed a high prevalence of chronic diseases and disabilities amongst the people which is partly due to the peoples' health beliefs and practices. A total of 126 (54.5%) of the respondents reported that some members of their households were suffering from such chronic illnesses and deformities like leprosy, infertility, VVF, blindness and mental illness as presented in Table 4. 17.

Table 4.17 Chronic Illnesses/ Deformities Reported among Household Members

Illnesses / Deformities	Frequency	Percentage
a. Leprosy	29	23.0
b. Blindness	36	28.6

c. Crippling deformity	11	8.7
d. Epilepsy	14	11.1
e. Mental sickness	14	11.1
f. Infertility	23	18.3
g. Vesico Vaginal Fistula	8	6.3

As shown in Table 4.17, blindness, leprosy and infertility have the highest frequency rate amongst the chronic illnesses and deformities in the area with blindness having as high as 29% occurrence rate in the area. The belief that factors such as sorcery, poisoning, spirits, and witchcraft are responsible for diseases like measles, conjunctivitis and leprosy made them seek help from the traditional healers, the only competent healers for such ailments. In some situations, herbal preparations are applied into the eyes for the treatment of conjunctivitis most of which could be contaminated and poisonous to the eyes. The remedies could in this case be harmful and likely to be responsible for the high rate of blindness among the people.

Infertility suffered by women could be associated with the traditional treatment of sexually transmitted diseases like gonorrhoea and pelvic inflammatory diseases [PID] which are the common causes of blockage of the fallopian tubes and subsequent infertility in the developing countries. These illnesses that are common causes of infertility can only be effectively treated by the modern health care system. Treatment of the diseases by traditional healers is likely to be ineffective and allows the diseases to precipitate infertility (Bennett and Brown, 1993:84-88). The belief that mental illnesses are caused by spirits, sorcery, poisoning and witchcraft is partly contribute to the prevalence of the illness among the Kambari because the real causes like drug abuse, head injuries and some psycho-social factors are not considered as causes.

Vesico vaginal fistula (VVF) was another problem mentioned by the household heads as present in some households. This health problem is caused by factors like prolonged labour which is promoted by the cultural practices and the activities of the traditional birth attendants in which women in labour are kept at home for several days. Asked about the normal duration of labour, a TBA explained that a woman can spend about three to

four days before delivering especially when bewitched. This perceived “normal” duration is long enough to cause the development of VVF.

The respondents were requested to state whether the sufferers of the chronic illnesses and deformities ever received treatments. Ninety percent of the household heads said that they did. Table 4.18 presents the types of treatments the victims received.

Table 4.18 Type of Treatment Received by Patients of Chronic Illnesses (eg. VVF, mental illness, epilepsy, leprosy etc)

Treatment Methods	Frequency	Percentage
a. Modern Treatment in Hospitals/Clinics	39	31.0
b. Modern Self Treatment From Chemists	13	10.3
c. Traditional Self Treatment At Home	8	6.3
d. Traditional Treatment From Specialists	52	41.3
e. Combination of modern and traditional treatment	14	11.1
Total	126	100

A large proportion of the respondents (41%) had been treated by traditional healers. Some household heads said that the sick received treatment from modern health care services like hospitals, clinics, and other specialized modern health institutions for the diseases. The household heads in this category were mostly young and formally educated. Other household heads reported that their members received treatments at home from either modern sources such as the patent medicine stores [chemists] or the traditional sources like herbal preparations, rituals and incantations. It was also shown that some respondents (11.1%) who were mostly resident in places that had clinics and patent medicine stores claimed combining both the traditional and modern methods of treatments indicating a blend between tradition and modernism among the people.

Household heads whose charges had not received treatments from any sources stated several hindrances like lack of money, no known cure for

the illness and refusal of treatment by the sick. However, some of the household heads explained that some affected people especially the adults, had resorted to self-medication mostly with traditional medicine, without contacting any member of the household.

The use of traditional methods of treatments for the identified illnesses could largely be responsible for the occurrence and severity of the illnesses. Scientific studies have shown that illnesses like leprosy, infertility and mental disorders only respond to certain modern treatments. The pharmacologically active substances may not be available in adequate quantity in traditional herbal medical preparations for the effective treatment of the diseases. Therefore, traditional treatments usually worsen the already bad state of health. This usually increases the virulence, chronicity, spread and mortality associated with the diseases. The traditional belief that illnesses are due to sorcery, witchcraft, spirits and poisoning is another reason for the belief that some illnesses have no cure.

The claim that the household's money has been exhausted on treatment is the result of poverty and possibly a rationalization for reluctance to spend large sums of money and time for treating diseases like mental illnesses and leprosy both of which require protracted duration of treatment. Withdrawal of financial assistance for the treatment was responsible for the incomplete treatment received by the sick which led to the severity of the illness, increase spread of communicable diseases, as well as increase morbidity and mortality associated with the illnesses.

The claim that the sick refused treatment as a reason for lack of treatment was due to failure on the part of the care givers to realize that the sick needed to be persuaded and encouraged to receive treatment especially in chronic illnesses where long term treatment is required. The consequence of the actions was that people with treatable chronic illnesses like leprosy and infertility were not treated.

Maternal and child health seeking behaviour was considered an important indicator in the health practices of the people and in the quality of health care services provided. The household heads were requested to provide information on antenatal care, child bearing, and childhood immunization for members of their households. Most of the elderly and non-formally educated household heads [60.6%] claimed that the women in their households did not go to any clinic/hospital for antenatal care while only 91[39.4%] of the respondents particularly those resident in the semi-urban settlements and the formally educated indicated that the women in their

households attended antenatal clinics. Failure to attend the antenatal clinics could lead to inability to detect pregnancy complications like anaemia, pre-eclampsia, and intra-uterine foetal death. Also, failure to assess the pelvis and foetal positioning lead to obstructed labour, breach presentation during delivery and maternal deaths. Those whose wives did not attend clinics for ante natal care express unawareness that pregnant women were required to go for antenatal care or complained about lack of money for the bills to be paid during the antenatal visits. However, others especially the elderly household heads, those in remote villages and the non- formally educated stated that the traditional healers/birth attendants attended to the women when they were pregnant.

Another factor in maternal and child health is where women deliver their babies. In this regard, the household heads were requested to state where women in the households delivered their babies. Seventy one percent of the respondents said that their women delivered either at home (66%) or at the TBAs place (15%).

They explained that culturally, the woman was expected to deliver her baby at home usually under the supervision of an old woman who had attained menopause. The services of a professional traditional birth attendant were sought only when there was no experienced woman at home or if the oldest woman of the household suggested that the traditional birth attendant be called. This usually occurs when there is problem with the progress of labour like in prolonged labour and breach presentation of the baby.

Some respondents explained that the women delivered their babies in the hospitals/clinics. Most of these categories of respondents were observed to have some formal education while the few non-formally educated in this category were resident in areas with modern clinics. Poverty and cultural practices influenced the choice of where the women delivered their babies. Other places where the women were reported to deliver their babies are religious homes and the traditional birth attendants' [TBA's] homes. The respondents however, explained that the religious homes and the TBAs homes are only used when there is prolonged labour. The woman in this case was taken to a place where the suspected witchcraft and sorcery activities cannot interfere with child birth. These places according to the respondents with this belief include the special treatment places (i.e. the folk hospitals), the shrine and the houses of some of the traditional healers.

The household heads' acceptance of childhood immunization differed between the formally educated and the non-formally educated. For instance,

while 152[65.8%] household heads stated that their children were immunized, 79[34.2%] revealed that their children did not receive any form of immunization. Those whose children were not immunized argued that a child who had taken a special herbal preparation [*Dauri*] at childhood does not require any immunization to have protection against diseases.

CHAPTER FIVE

THE KAMBARI TRADITIONAL HEALERS

5.1 INTRODUCTION

Between 65% and 75% of the Kambari households patronize traditional medicines either as a sole means of treatment or in combination with the modern medical system when illnesses occur. The study therefore, investigated the activities of Kambari traditional healers with a view to identifying their mode of operation. This chapter discusses the Kambari traditional healers' provision of health care services to the people. Information provided includes their mode of training, specialization, the services rendered and methods of payment for the services. In addition, the relationship between traditional healers, modern health practitioners and modern services as explained by the traditional healers is presented in this section. A total of 13 traditional healers were identified and interviewed.

5.2 Skill Acquisition, Specialties and Length of Practice

Questions such as how did you become a traditional healer? What form of traditional treatment[s] do you provide? and for how long have you been practicing this art of treating the sick, were posed to the traditional healers.

Eleven (84.6%) of the healers had inherited the practice from their parents. For the other two, one had received the message to treat the sick from a spirit while the other had been trained by someone. All the female respondents said that they were trained by their parents (either the father or the mother). The male respondents explained that their fathers started by sending them to collect some herbs from the bush for their clients. Later, they were informed about the uses of the herbs they were collecting. After some years (between three and five years), the parents started inviting them to attend their consultations. An informant narrated his case thus:

Initially, my father would send me to collect some herbs for him in the bush, but I was not interested then. So, I often returned to inform him that I either did not get the particular herb in the bush or that I forgot the description of the herb. My father used to be very annoyed and then often sent me back to collect the herbs after repeating the description. I gradually picked interest, often attending the consulting sessions, after which he started sending clients to me for treatment. From then on I started receiving my own clients most of whom were not able to see my father due to his tight schedules. I however, occasionally consulted him about some clients for advice and proper handling.

According to him this went on for 17 years before the death of his father after which he took over the responsibility of attending to all clients. Some of the healers explained that their parents asked them to accompany them (parents) for collecting the herbs and other materials for treatment. The parents used to instruct them to prepare the herbs for the clients when they were told the use of each herb.

The respondent who claimed that he received divine message to undertake the treatment of the sick explained thus:

I was sleeping one night when I dreamt that an unknown old man was directing me to go to a forest about 5km away from our village which I ignored. Three days latter, the same old man appeared in another dream urging me to go to the same place to collect an undisclosed message which I also ignored. But this time the dreams became a source of worry to me. The third dream came about seven months later. This time with a directive that I should go within three days failing which I should have myself to blame. The directive came from a man dressed in all black attire with a white material covering the face in the dream. I became so sick the following day that I could not get out of bed due to severe pains in my knee joints and headache. I narrated the story to my father (who was not a traditional healer). I was treated for the sickness with herbs and a sacrifice with a black chicken by my father who latter directed me to go to the forest as instructed in my dreams. At the forest, I met a very short man with his hands almost touching the ground while standing. The man was sitting on an ant hill with his eyebrows covering his eyeballs. The man directed me to turn back and pick one out of three pots placed on a stone. The pot contained a black talisman, three cowries, three dry leaves, an egg and a bark of a tree. I was directed to cook and eat the egg while the other contents of the pot were to be boiled and the decoction used for bathing. From then on I started healing the sick because whenever I slept, I would be told about the next sets of ailments that clients will complain of and their treatments in dreams. The patients eventually call and complain as described in the dreams. This has been going on for the past 21 years. The short man was a spirit sent to me by God for the benefit of humanity.

One of the healers said that he received training from a neighbor who was a close friend to his late father. The training had lasted for three years during which he was collecting and preparing herbs for the master. Thereafter, he was told about the uses of the herbs he had been collecting. He attended the consulting sessions for one and a half years after which he was asked to consult and treat clients under the supervision of his master for six months. Thereafter he was allowed to practice independently. This suggests that some rigorous training takes place among the Kambari traditional healers.

Some of the healers who learnt the art from both their parents and others explained that their parents started the training but died before they completed training. They went to their late parents teachers/ mentors to complete the training. This shows that a form of cooperation exists among

the traditional healers who are also promoting some form of continuity of traditional practice in lineages. The researcher observed that there was no formalized course structure for the learning process. The length of training was not also specified for those that inherited the art from their parents. The training was for as long as their parents lived. Only one respondent said that he had a gregarious formal graduation ceremony. Others had private graduation. They were directed to sacrifice a goat and to throw part of the meat into a specified river. The remaining part of the meat was distributed to different categories of people like children, leprosy patients and women that had attained menopause. The meat was quietly delivered to them in their homes. He was also directed to give out items like chicken and guinea corn to specified categories of people like the lepers or barren women. Some of the sacrifices performed were considered confidential and not disclosed to the researcher. This implies two types of graduation ceremonies, that is, public and gregarious; and private supplications and sacrifices, with emphasis on donations to the poor.

The traditional healers were requested to state the length of time they had been traditional medical practitioners. The mean year of experience is 19 years. More details are presented in Table 5.1

Table 5.1 Traditional Healers' Years of Experience in Practice

Years	Frequency	Percentage
1-10	4	30.8
11-20	5	38.5
21-30	1	7.7
31-40	2	15.3
41-50	1	7.7
Total	13	100

Mean years of experience =19 years

Table 5.2 reveals that the modal years of practice is between 11 and 20 years while 30.7% of the respondents had between 20 and 50 years of practice. Most of them had more than 10 years experience which shows that they had adequate experience in the art of healing.

The study revealed that there is some form of specialization among the traditional healers as presented in Table 5.2 in which the respondents are categorized as herbalists, spiritualists, diviners, and as specialists in particular form of illness such as bone setting.

Table 5.2 Traditional Healers' Categories/Specialization

	Category	Frequency	Percentage
A	General Herbalists	6	46.1
B	Herbalists/Spiritualists	4	30.8
C	Specialists (e.g TBAs, Bone Setters)	3	23.1
	Total	13	100

The general herbalists who constitute the largest groups specialized in using herbs to treat various diseases. They indicated having remedies for HIV/AIDS, mental illness and epilepsy and treat all forms of spiritual illnesses. As a respondent succinctly put it

Is there any sickness that the herbs cannot cure? The white man is only wasting his time saying that some diseases don't have cure.

Some traditional healers that specialized in the treatment of particular forms of illnesses such as bone setting, treatment of mental illness, treatment of infertility, and treatment of childhood problems. It is noteworthy that all the categories of healers mentioned used herbs for treatment and that all the female traditional healers claimed that they usually treat illnesses affecting children, provide antenatal care and treat gynaecological patients.

A traditional healer who said that he used herbs to treat spirit induced illnesses explained that he specialized in the treatment of illnesses caused by sorcery and witchcraft. He had learnt the art from his father, after whose

death he went to learn from his late fathers' friend; a popular herbalist based in Douala, Cameroon. The trip took him four months during which he learnt how to identify a witch at first sight and also learnt how to uncover planned witchcraft activities and sorcery. He also reported that some prescriptions are revealed to him in dreams. Another traditional healer; the "Magajin Magiro", a priest of the Magiro cult had been in practice for about 50 years. He explained that he specializes in treating illness caused by spirits, witchcraft and sorcery.

He had acquired power from the "Magiro" the Kambari god. The magiro form of treatment involves the use of herbs, incantations and sacrifices of chickens and goats.

5.3 Traditional Healers' Perceived Causes of Illnesses

The traditional healers were requested to state, what they believed caused illnesses. They unanimously stated factors like sorcery, witchcraft, poisoning, spirits, bad food/water and change in weather. One of the healers emphasized that:

Even the white people are victims of these factors but because they don't use herbs and offer sacrifices, their illnesses keep recurring.

Two other respondents added that there are some germs that could be responsible for some illnesses but these germs are normally the agents of witchcraft, sorcery, and spirits. According to them, the spirits and their brothers, the witches and sorcerers have powers which they misuse for wickedness. These powers are being temporarily released to the germs to afflict perceived enemies who in most cases are innocent. They explained that the modern medicines only attack the germs which they know too well, leaving the witch and the spirits to continue inflicting discomfort on victims. That is why illnesses treated with the modern medicine recur. Another traditional healer observed diseases such as mental illnesses, epilepsy, leprosy, infertility, tuberculosis, and some skin diseases are hereditary having been inflicted on victims ancestors by spirits or sorcerers.

Sorcery is considered a potent source of illness. The traditional healers believe that some possess the power to harm others. Food and water are common causes of minor ailments like diarrhea, abdominal pain, hemorrhoid, vomiting, and wasting or stunting in children. Majority of the traditional healers including all the females amongst them stated that the

breast milk which is usually contaminated by the evil spirits and the witches is a major source of illness to the child. They reported that once the breast milk is contaminated by the evil spirits and the witches, it becomes poisonous to the child. Nine (69.3%) of the traditional healers explained that diseases like mental illnesses, epilepsy, leprosy, diarrhea, malnutrition, and deviant behaviors like stealing and prostitution can be inherited from the mother through the consumption of breast milk contaminated by the evil spirits, the witches, or sorcerers. All the traditional healers expressed the belief that change in weather is always accompanied by different evil spirits, hence, different diseases in different weather conditions.

5.4 Illnesses Suffered by the People

The traditional healers were asked to mention the complaints usually brought to them by the people in the areas where they are practicing. Illnesses like infertility, breast diseases, abdominal pains, hernia, headache, febrile convulsions, malaria, measles, and meningitis were mentioned in various combinations. Other illnesses stated include prolonged labour, gonorrhoea, epilepsy, diarrhea, cancer [*ciwon daji*], rheumatism, menstrual pains and mental problems. Some respondents stated typhoid fever, cataract, appendicitis, haemorrhoid, and blindness. These illnesses are attributed to sorcery, witchcraft, poisoning, bad food/water, spirits, and change in weather. The healers noted that some of the illnesses occur seasonally because the spirits and witches release the afflictions when there are changes in weather. A traditional healer who had a primary school leaving certificate explained that malnutrition is one of the common diseases suffered by children in the area. He linked the disease to poor feeding and partly to the evil spirits and witchcraft that prevent the affected children's bodies from making use of food eaten.

5.5 Venues for Consultations and Treatment

The Kambari traditional healers usually consult and treat the sick in specific places. The choice of place of treatment depends on factors like type of illness, the perceived causes of illness, severity of illness, the traditional healers' specialization and the relationship between the traditional healer and the sick.

Eleven (84.6%) of traditional healers stated that the sick is normally taken to the healer's house for consultation and treatment because the spirits

of healing live in the healers' houses or shrine in the vicinity of the healers' residence and therefore more accessible. In addition, they explained that compliance with treatment schedules are guaranteed when treatment sessions are conducted at the healer's residence. However, most of the respondents who expressed this view explained that if the illness is not severe and if the sick is resident in the same community as the traditional healer, ambulatory care could be provided. The traditional head of the community is also usually granted a privilege to be treated in his place of residence because the spirits normally recognize the ruler and accord him respect. This is however, predicated on sacrifices to appease the healing spirit and the payment of higher fees than those who come to stay at the healers'.

Relations usually prepare food for the sick and assist in ensuring compliance with treatment instructions. The Magajin Magiro revealed that the sick is usually brought to his house for consultation after which he/she is taken to the shrine for treatment which include an offering of sacrifice. If the sick requires special care, he/she is admitted in a place near the shrine. The inpatient facility which was shown to the researcher consists of five round huts with a wide open space in the centre. There were fifteen patients with an average of three per hut that was only big enough to accommodate two people. These huts were shared with the relations of the sick without considerations for the type of diseases the patients were suffering from. The clients were being treated by three men who were introduced as the children of the priest who were also undergoing their training as the future priests of the magiro shrine. There were eggs, chickens and goats at the place, some of which were slaughtered for sacrifice. Some people were seen talking irrationally and were described as apprehended witches confessing their witchcraft activities after consuming a specially prepared concoction [*Ruwan magiro*]. According to the priest, witchcraft/sorcery penitents are usually given antidotes after their confessions on payment of prescribed fees of money, goats and chickens for sacrifice. He added that failure to pay the specified items by the apprehended witches and wizards, they would develop mental illnesses.

The female traditional birth attendants are mainly concerned with child birth which in most cases takes place at the residence of the woman in labour. The fourth category of traditional healers indicated that consultation and treatment of the sick are normally carried out at the healer's house, the residence of the sick and at a special treatment place depending on the type and severity of the illness and the category of the healer. It was noted that

those who have special treatment places are specialists in treating mental illness, bone setting, and the spiritualists such as the Magiro priest.

5.6 Payment for Treatments

All the traditional healers explained that they charge fees on sliding scale. They take into account financial strength of the sick and their relations and the severity of the illness. They observed that mental illness, epilepsy, infertility, leprosy, chronic cough, suspected witchcraft attack, sorcery induced diseases and impotence, usually attract higher charges than fever, headache, abdominal pain, diarrhea, typhoid fever, cancer[ciwon daji]. Minor illnesses like diarrhea, vomiting and body weakness are often treated free. Payments are usually made instalmentally with the initial payment normally made before treatment is commenced. Subsequent payments may be delayed for months or years depending on the financial status of the client's family. A traditional healer asked the researcher thus:

Is health not better than anything in life? Is the knowledge for treatment not from God? How can you insist on payment from a person that does not have? All human beings are not financially equal.

This mode of payment is favourable to the poor members of the society. It is also good in times of emergency where prompt treatment may be required. The traditional healers noted that there were very few cases of defaulting in the payment of loans because the people are aware that failure would lead to severe calamities inflicted by the spirits of healing. Defaulters could be afflicted by more serious illnesses or even the death of family members.

Items like money, domestic animals such as goats, sheep, cows, chickens, farm produce and cowries are usually accepted for payment. According to them, cowries, chickens, and goats are used for sacrifice to appease the gods and to send away the evil spirits, the witches, and the sorcerers. Most of the aged traditional healers explained that in the past, money was not accepted as payment in the treatment. Only farm produce were accepted because in their views, the art of healing is a service to God and to humanity. However, money is now the main mode of payment for most traditional healers' services which has made treatment less affordable to the poor members of the community.

5.7 Professional Relationship between Traditional Healers and Modern Health Care Providers

For the much needed integration of the traditional and modern medicine being advocated by the World Health Organization to be achieved, there is a need for mutual understanding between the two medical systems. To this end, the researcher attempted to identify whether or not there is a form of cooperation between the traditional and the modern medical practitioners. Eight of the 13 traditional healers revealed that there is informal professional relationship between them and modern health care providers in their respective communities. They said that, they usually refer clients to modern health institutions and that clients were also referred to them from the modern services. The categories of clients referred to them by the modern health care providers are those suspected to be suffering from witchcraft/sorcery attacks and spiritual illnesses. They explained that the modern healthcare providers that usually refer clients to them are mostly the Kambaris and members of other ethnic groups resident in the area.

Two traditional healers said that they meet with modern health care practitioners in their communities to discuss treatment of categories of clients that each medical system should handle and when clients are to be referred to a particular medical system. The traditional healers stated that the meetings were not regular and that it depended on the staff in-charge of the modern clinic which are mostly dispensaries because some of the staff discourages such meetings. They concluded that most of the resolutions at the meetings are not implemented. The meetings according to them had not taken place for the past 5-7 years. Some of the traditional healers stated that they used to have a two way referral system between them and the modern medical practitioners. They indicated that patients with health conditions like dehydration, anaemia, patients who needed intravenous infusion and wounds that require dressing are usually referred to the clinics/hospitals. After the initial treatment in hospitals/ clinics, the patients return to the traditional healers for “total cure” which modern medicine does not provide. Illnesses like convulsion, epilepsy, mental illness, fracture, witchcraft and sorcery attacks, cancer, infertility, typhoid fever, and breast problems were identified as those referred to them from the clinics for treatment. Three traditional birth attendants claimed that cases of prolonged labour are usually referred to the clinics especially when surgery is suspected to be the solution. The rest claimed that labour cases do not require referral to the clinics because according to them, every woman is required to deliver her

child without surgery and that when the witchcraft or sorcery responsible for the problem are eliminated, the woman would deliver her child without difficulties.

However, five traditional healers explained that there was no professional cooperation between them and the modern medical practitioners. They stated lack of respect for them by modern health practitioners as the main reason. One traditional healer claimed that he was not aware that they needed to relate in anyway with the modern practitioners. According to him, “the modern medical practitioners do not believe in what we believe, so, how can we cooperate?”

5.8 Self Extolment for Successful Treatment by the Traditional Healers

The Kambari traditional healers recounted successes and self-satisfaction with treatments that they provide for the sick. Although, there were no records relating the number of clients attended to, the number of clients successfully treated and discharged and deaths of clients in the course of treatment, they explained that the treatments they provided over the years have been successful. When the issue of clients’ death was raised, most of them denied ever recording the death of clients in their care. In this regard, only two traditional healers reported cases of death. They were very averse to the discussion of the deaths of patients in their care. All they did was deny such deaths after which they kept mute to any probing. A traditional healer almost terminated the interview session when the question about deaths was posed.

He angrily remarked:

How can somebody that receives treatment from me die? No death has been recorded since my father was alive. The person can only die of something else but not after coming in contact with me. “*Sai dai in kwana ya kare*” [unless the person is destined to die at the time of death]. I cannot remember any case of death for the past 30 years of my practice.

The Magajin Magiro however, revealed that some deaths were recorded in his 50 years of practice but that he cannot remember the actual number and that the deaths of ambulatory patients were never reported to him. He however explained that the deaths occurred due to non-compliance with treatment instructions or reporting late for treatment. He stated that because his charges are a little higher than those of the other traditional healers, and because of religious differences, some patients come to him after the

illnesses have become worse. He complained that the Muslim and Christian Kambaris report to him for treatment only after unsuccessful trials at other sources of treatment. A traditional birth attendant also reported the death of one woman in Parturition in her care.

In conclusion, it can be seen from the findings that the Kambari traditional healers share the same belief system about health and illness with the people. This is partly responsible for their patronage by the people. However, some of their services are inimical to the health of the people. Most of their activities are not rationally explained. Some of the treatments are secretive which is likely due to fear of punitive measures by the government. In particular, the lack of formal professional co-operation between them and the modern health care providers is partly responsible for some morbidity and mortality in their communities of practice.

5.9 Consequences of the Activities of the Traditional Healers on the Health of the People

Although the use of traditional medicine is popular among the Kambari, it often has some negative consequences for their health. High failure rates of treatments exist due to the inefficacy of some traditional medicines. However, the perceived divine favour bestowed on traditional medical practitioners make patients and relations believe the healers' verdict religiously. They fail to look for alternative health care. For example, a middle aged man with a severely swollen knee and obvious signs of anaemia was seen at the clinic of a traditional healer. Asked for how long the client had been there, the traditional healer said four months. He explained that the sick was a victim of an evil spirit for which he had received message to exorcize and that the sick is aware that the spirit from his body can only be exorcised by the healer. This claim was confirmed by the sick who expressed confidence in the ability of the healer to treat him of the illness.

Another disturbing aspect of the activities of the traditional healers is the practice of keeping patients suffering from different illnesses in the same rooms and huts during treatment. For instance, in one of the treatment centres visited, four clients were seen in the same room. One of the patients had symptoms of tuberculosis like loss of weight, coughing and looking

anemic while another had a swollen knee joint which resembled a typical case of osteomyelitis. The other two were diagnosed by the traditional healer to be having haemorrhoid (*Dankanoma*) and ulcer. The implication of this type of patient combination is that the other three patients could contract tuberculosis from the other room mate.

It is evident from the findings that some of the traditional healers do not refer clients to the modern health facilities for treatment. This was the case with the earlier mentioned case study of the client who had swollen knee joint that was kept by the traditional healer who claimed to have received divine message to treat the sick. Their refusal to refer the sick for proper treatment even when it is obvious that there was no improvement could worsen the already bad health situations in the area as indicated by the findings of this study. This could lead to increase morbidity and mortality among the Kambaris. Also, other serious illnesses could be allowed to deteriorate to unmanageable states before they are either taken away by the relations of the sick or allowed to die in the hands of the healers.

CHAPTER SIX

SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

6.1 Summary of the Findings

The mean age of the household heads is 45 years while that of the traditional healers is 62 years. About 88.7% of the household heads are males while 11.3% are females. The study reveals that 83.5% of the male household heads are married, 3.0% are widowers and 2.4% are divorced. The findings shows that 73.1% of the female household heads are widows and 26.9% are divorced. It was seen that 80.9% of the household heads are polygynous and about 61.9% maintain the traditional compound family structure. Majority of the household heads (45.5%) are farmers. The study revealed that 48.5% of the household heads had no formal education. It is seen that 48.9% are Muslims, 22.9% are Christians while 28.1% are followers of the traditional religion (i.e. the magiro).

The findings show that 62.9% of the household heads believe in the supernatural causes of illnesses. Malaria, typhoid fever, malnutrition, diarrhea/ vomiting, haemorrhoid, dysentery and respiratory infections are the most frequently occurring illnesses amongst the people. It is observed that about 39.0% of the respondents combine both the traditional and modern medicines for the treatment of illnesses among the people, 34.2% utilize the modern medicine and 26.8% utilize only the traditional medicine for the treatment of illnesses. The findings revealed that all the household heads usually diagnose and treat certain illnesses affecting members of their households. The majority (50.7%), usually apply traditional methods of treatment like herbs, rituals and incantations for treating the sick at home. The main sources of home treatment are herbs, patent medicine stores, and the traditional healers who also use herbs and rituals to treat the sick.

Majority of the household heads (61.0%) indicated that the mothers are the first to notice illnesses affecting their children while the household heads (34.2%). The fathers of the sick and sometimes the sick adults (12.6%) usually initiate the process of help seeking for the sick member of the household. Actions taken by the initiators include calling a household meeting (50.6%), preparing home treatment (37.2%), taking the sick to the traditional healer (23.4%) and taking the sick to the hospital (18.6%). Fathers of the sick (89.4%) usually pay for the treatment of the sick. Others that are involved in the payment are the mothers of the sick (44.5%) and the

household heads (27.8%). Husbands normally pay for the treatment of their sick wives.

For the traditional healers, 38.5% each are faithfuls of Islam and traditional religion while 23.0% are Christians. Eleven (84.6%) of traditional healers did not receive any form of formal education while 15.4% had primary education. The findings revealed that 38.5% of the traditional healers are in full time practice. Eighty five percent of them had inherited the art from their parents while only one each had received informal training and divine message to treat the sick respectively. Six of the traditional healers are general practitioners while the remaining specialize in illnesses like infertility, mental illnesses, fracture and cancer. Nine traditional healers had been in practice for 11-50 years. They share the same health beliefs with the clients about illnesses being caused by the supernatural factors. The traditional healers explained that health problems like infertility, diseases of the breast, measles, malaria, typhoid fever, haemorrhoid, diarrhea, respiratory tract infections and sexually transmitted diseases are the most frequently occurring illnesses among the Kambaris. Most of the traditional healers treat the sick in their homes while a few admit the sick in a special treatment place outside the healers' family residence. Payments for treatments are usually on sliding scale basis and are usually made instalmentally by the male members of the patrilineage. Domestic/bush animals, farm produce and money are used for payment.

Eight of the traditional healers revealed that there is an occasional two way referral system and informal meetings between them and the modern medical practitioners in their communities. This implies that the modern healers recognize the folk medicine and it is a positive indication for the planned integration of the two health systems.

It is also clear that the peoples' persistence on traditional health beliefs and practices is responsible for certain chronic illnesses like leprosy, infertility, blindness, vesico vaginal fistula and some crippling deformity. The findings also show that the incidence of some communicable and mal-nutritional diseases is on the increase in the communities.

6.2 Discussion of Findings

The study shows that majority of the respondents believe in the supernatural causes of diseases like change in weather, witchcraft, poisoning, spirits, and sorcery. However, some of the respondents believe in the natural causes like the consumption of contaminated food/water, contact

with germs and accidents. It was also observed that some accidents are associated with sorcery and witchcraft.

The findings conform to the findings of Ezeabasili (1971), Boston (1971) and Mitchell (1997), which variously identified that amongst the Ibo and the Igala ethnic groups of Nigeria and the Afro-Americans respectively, illnesses are believed to be caused by the natural and the supernatural causes. Also, Erinoshio (1981), reported that among many Nigerians, illnesses are believed to be due to natural and supernatural factors. These imply that treatment for illnesses are sought from the traditional sources. This study shows that diseases like malaria, typhoid fever, malnutrition, respiratory tract infections, diarrhea, dysentery, haemorrhoid, and hernias are the most frequently occurring illnesses among the Kambari. This indicates that the people are most frequently affected by communicable and nutritional deficiency diseases. However, most of these are attributed to sorcery, witchcraft, and change in weather.

Majority of the respondents combine both the modern and the traditional methods of treatment when illnesses occur. There are similarities between these findings and that of Cosminsky and Scrimshaw (1980) and Bensoussan et al., (1998) whose studies in Guatemala and China respectively, revealed the use of a combination of herbs and modern drugs in the treatment of illnesses among the people. The findings are also supported by the assertion of the W. H. O. (2003), that in Africa, about 80% of the population uses the traditional medicines for primary health care. It was observed that all the household heads usually diagnose some illnesses affecting members of their household and provide home treatments before resorting to others for help. Illnesses usually diagnosed by the respondents include all the most frequently occurring ones like malaria, measles, typhoid fever, and pneumonia. The study revealed that home treatments provided include herbs, rituals and patent medicines which are often combined. All the respondents reported the use of herbs at one time or the other either as single remedies or in combination with the modern sources of treatment.

Majority of households start treatment for illnesses at home using herbs and drugs from patent medicine stores while few members seek treatments from the clinics and hospitals. There are similarities between these findings and the assertions of Paulanka and Purnel (1998) who reported that more than 80% of the Indians rely on herbal remedies and the patent medicines as the principal means of preventing and curing illnesses. Although, the process of help seeking for the sick is usually initiated by the household heads, the sick adult normally begin by self prescription which

could be a combination of both the traditional and the modern medicines before complaining to the household head. The activities involved include calling a meeting of the male adults in the household to discuss the illness and what is to be done, preparing a home treatment for the sick using herbs and inviting a traditional healer to attend to the sick. Other activities involved are taking the sick to the traditional healer or the hospital. The findings also reveal the persistence of collective responsibility of male adult members in seeking medical help for sick members of households. This finding agrees with that of Wellman (2000) whose study in the United Kingdom and United States on who helps when one is sick revealed that the rural ethnics tend to rely on the family network in deciding where to go to for treatment when illness occur.

Most of the respondents indicated that payment for the treatment of the sick child is mainly undertaken by the father. Other people responsible for the payment are the mothers of the sick and household heads who may not necessarily be the father of the child. The findings show that payment for the treatment of a sick wife is normally undertaken by the husband and occasionally by the household heads. In situations where either the husband or the compound head is unable to pay, the sick wife or her natal family pays. A sick adult male usually settles his treatment bills. However, household heads of joint families may also pay. Payments are made with items like farm produce, honey, goats, chickens and dogs, and some specially recommended game animals like antelopes. Money is accepted for payment. Payments are usually made installmentally, with the first installment paid at the commencement of treatment. These practices make health care available and affordable to everybody in the community.

Socio-demographic attributes like age of the respondents, religious affiliation, level of formal educational attainment and place of residence have significant influence on the sources of treatment. For example, the respondents' level of formal educational attainment has significant influence on the choice of treatment because, household heads with secondary school certificates utilize the modern health services than those with no formal education. These findings are in line with the statements of Fugh-Berman (1997) that the use of folk medicine and other alternative medicines is influenced by the level of education, age, and distance from the mainstream health services.

Majority of the traditional healers inherited the skills from their parents while a few had either received divine message to treat the sick or had been trained by some one in the art of healing. The assertion of

Chipfakacha (1997) that most of the traditional healers have inherited the art of healing is similar to the findings. Similarly, the earlier observation of the researcher that there is no formal training for the traditional healers is justified by the findings. In addition, there is similarity between the findings and the statement of Marbella et al (1998) that the traditional healers mostly learn treatment methods from their parents. The findings show that the traditional healers have been in practice for 11-50 years. The explanation to this is that most of the traditional healers usually begin learning the art concurrently with the practice as soon as their parents introduced them into it. This is responsible for the long years of experience indicated by the traditional healers.

Another important finding is the fact that there is a form of specialization among the traditional healers. There are those who combine the use of herbs with other spiritual incantations, animal products and divination in the treatment of sick, while others specialize in the treatment of specific health problems like bone setting, infertility, epilepsy, and mental illnesses. It is observed from the findings that all the female traditional healers specialize in the treatment of illnesses affecting women and children. Women are believed to have higher knowledge about the health problems affecting women and children in the traditional communities. The study shows that all the traditional healers share the same beliefs which mostly attribute illness to supernatural factors. To this extent, the household heads and other older members of the households have some basic knowledge about illnesses and common treatments obtainable to them. This aspect of the tradition implies learning through observation/practice. The finding is similar to Turkey's Ministry of Culture and Tourism (2002) which stated that folk medicine lives amongst the people as part of their culture in which information about illnesses are shared by others in the society.

Another finding in the study is that consultation and treatment of the sick often take place in the homes of the traditional healers and other special places provided for treatment sessions by the traditional healers. According to 93.7% of the traditional healers, the use of place for consultation and treatment depend on the healers' specialization, the severity of illness, relationship between the traditional healer and the sick and the social status of the sick in the community. For instance, community heads may be treated in their residence. This indicates some elements of flexibility in the provision of professional medical services. However, most of the traditional healers reported that consultations and treatment sessions normally take place at the residence of the healer or any place designed for such by the

healer. The findings agree with Lazar and O'Connor (1997) who observed that most traditional healers apply treatments in their own homes while others treat the patients in places considered as 'folk hospitals'.

The female heads of the households normally pay for the treatment of the sick under their care often assisted by their natal families and the paternal relations of the sick. Medium of payment include items like cowries, goats chickens, farm produce, honey, game animals and money. This indicates the people's persistence on traditional practices and strict adherence to the cultural norms despite the advent of modernization in the area.

The study also shows that there is no formal mutual relationship and co-operation between the traditional healers and the modern health care providers in the area, although clients that require blood transfusion, wound dressing and intravenous infusion are sometimes referred to modern health services by traditional healers. This is usually based on personal relationships between the practitioners of the two services in the area. This supports the findings of Chipfakacha (1997) who reported lack of co-operation between the traditional healers and the scientific medical personnel in Botswana. John et al (2002) reported that poor relationship between the traditional healers and the modern health care personnel especially in the area of referrals is a serious health problem which they claimed is mainly caused by ignorance, undue rivalry, the attitudes of the health personnel and the peoples' general beliefs about health and illness. However, this is in contrast with the much taunted need for the integration of the traditional medicine into the modern medicine. W.H.O. (2003) stated that over one third of the population in the developing countries lack access to essential medicines hence, the provision of safe and effective traditional/complementary alternative medicine therapies could become a critical tool towards increasing access to health care.

The findings reveal that 92.3% of the traditional healers showed aversion to discussing deaths of clients in their care and denied recording any death of a client receiving treatments from them. A possible reason for unwillingness to reveal deaths recorded is the fear that government could resort punitive measures like the closure of premises and court actions against the traditional healers. There is also the possibility of loss of clients. However, healers who admitted deaths of clients attributed the deaths to non-compliance with the healers' treatment schedules and instructions. There are similarities between these findings and the statement of Lin (1998) that in folk medicine, the death of the client in the course of treatment does

not mean that the method of treatment is unsuitable but that the patient failed to comply with instructions for treatment.

The findings shows that as a consequence of Kambari's health beliefs and practices, chronic illnesses and deformities like leprosy, blindness, crippling deformities, vesico vaginal fistula, infertility and mental illness are present in various combinations in 55% of the households. The findings show that communicable and nutritionally related diseases are the most frequently occurring illnesses among the people which are often treated at home using herbs and self prescribed modern drugs obtained from the patent medicine stores or itinerant vendors. This high prevalence of treatable chronic diseases in the community is due to failure to apply effective treatment at the onset of the problems.

The finding shows that most women (66.2%) in the households deliver their babies to the hands of the traditional birth attendants. This is partly responsible for the maternal and child morbidity and mortality as well as complications like vesico vaginal fistula, obstructed labour, retained placenta, eclampsia, as well as pre-partum and postpartum haemorrhage. The traditional birth attendants are often reluctant to refer patients to modern health facilities for treatment. When they refer, it is often inconvenient for the people to comply due to poverty and problems of transportation. It is evident from this study that both the people and the traditional healers share the same belief system about the causes of illnesses, methods of treatment and the predicaments of poor access to modern health services. These contribute to high prevalence of chronic illnesses like leprosy, infertility, blindness, vesico vaginal fistula, mental illness and crippling deformities.

6.3 Conclusion

This study reveals that the Kambaris still hold to their traditional health beliefs and practices. A good proportion (47.6%) utilizes both traditional and modern medicines. These impacts negatively on the health of the people as evidenced by the fact most of the chronic ailments and deformities are due to reliance on non-effective traditional treatments and the non-application of the more efficacious modern medicine for such ailments. Judging from the findings of the study, it can be concluded that the activities of the traditional healers who are mostly not formally educated have serious consequences on the health of the people. In addition, the strain in the relationship between some of the traditional and the modern health care

providers and the non-integration of the traditional medical practice into the mainstream health services is impacting negatively on the health of the people. It is therefore evident that lack of modern health facilities and the tenacious holding to Kambari traditional health beliefs and practices are detrimental to the health of the people.

6.4 Recommendations

To discourage harmful traditional health beliefs and practices that hinder the utilization of modern health care facilities, the following recommendations are made;

1. The Kambari should be encouraged to send their children to acquire formal /western education through the provision of free and compulsory primary and secondary education.
2. Mass enlightenment campaigns should be embarked upon on the dangers of some traditional health beliefs and practices and the extolling the efficacy of modern systems of treatment.
3. Potable water should be provided to reduce the prevalence of water borne diseases like typhoid fever and diarrheal diseases.
4. The government should formulate national policy and regulation for proper utilization of traditional and alternative medicine among the Kambari in particular.
5. The government should work out a policy towards the integration of the traditional with the modern health care systems as recommended by the W.H.O. In addition, the practice of collective responsibility in dealing with illnesses affecting members of the household should be encouraged among the people.
6. The government should step up the current immunization programme so as to reduce the incidence and prevalence of the immunizeable diseases in the area considering the high prevalence of communicable diseases like measles, meningitis, and tuberculosis.

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APPENDIX I

DEPARTMENT OF SOCIOLOGY AHMADU BELLO UNIVERSITY, ZARIA

QUESTIONNAIRE ON “FOLK MEDICINE AMONG THE KAMBARI OF NIGER STATE”

Dear Sir/Madam,

I am carrying out a research on Folk Medicine amongst the Kambari Ethnic Group of Niger State. This research is intended to provide information about health and health seeking behaviour of the Kambari people. The information is required in order to improve the health care services for the people. Your sincere and truthful response is required for the success of this research.s

Anonymity is guaranteed, therefore, your name is not required.

Thank you for your co-operation.

A. PERSONAL/FAMILY DATA

1. Age.....
2. Religion:
 - (a) Islam (b) Christianity (c) Traditional
 - (d) Others (specify)
3. Sex: (a) Male (b) Female

4. Marital Status:
 - (a) Single (b) Married (c) Divorced
 - (d) Widow/widower (e) Others (Specify).....
5. If married Male, how many wives do you have?
 - (a) One (b) Two (c) Three (d) Four
 - (e) More than four (specify)
6. Number of children.....
7. Type of family: (a) Nuclear (b) Compound
8. Village/Town of Residence
9. Occupation:
 - (a) Farming (b) Civil servant (c) Trade/Business
 - (d) Artisan (specify)
 - (e) Others (specify)
10. Educational attainment:
 - (a) No formal education (b) Primary education
 - (c) Secondary education (d) Diploma
 - (e) NCE (f) First degree
 - (g) Higher degree (specify)

B. DISEASES, ILLNESS AND THEIR CAUSES

11. Which of the following do you believe cause illness among the Kambari?

(Tick as many as applicable)

- (a) Change in weather (b) Bad food (c) Bad water
(d) Poisoning (e) Spirits (f) Misunderstanding between
people (g) Witchcraft (g) Others specify).....

12. Name the most frequently occurring illnesses among members of your household. (Stating their Kambari or Hausa names, causes, and what you use in their treatment as provided in the spaces provided below.

A Illness (English name)	B Kambari or Hausa	C Causes	D Treatment
i.			
ii.			
iii.			
iv.			
v.			
vi.			
vii.			
viii.			
ix.			
x.			
xi.			

13. State how many members of your household suffered from any of the diseases listed in question 12 above in the past few years?

Disease	Number of Sufferers
i.	
ii.	
iii.	
iv.	
v.	
vi.	
vii.	

14. Mention some of the disease(s) or illness(es) that the household member(s) suffered from in the past two years and where they sought treatment.

Diseases/illnesses Hausa/Kambari Name	Source of Treatment				
	Home	Traditional healer	Chemist	Hospital	Combination (specify)
ii.					
iii.					
iv.					
v.					
vi.					
vii.					

15. Are there mentally ill people in this community?
 - (a) Yes (b) No
16. If yes, how many do you know of in this community?
 - (a) 1 – 3 (b) 4 – 6 (c) 7 and above
17. What made them mentally sick?
 - i.
 - ii.
 - iii.
 - iv.
 - v.
18. Has any mentally sick Kambari person ever been successfully treated?
 - (a) Yes (b) No
19. If Yes, where was he/she treated?
 - (a) At home using herbs (b) At a traditional healer's place
 - (c) At a modern hospital/clinic (d) At a religious home
 - (e) Using a combination of treatment (specify).....
20. Are there mentally sick Kambari currently receiving treatment?
 - (a) Yes (b) No

21. If yes, what medical system are they applying in the treatment?
- (a) The use of herbs (b) Taken to a specialist for the treatment of mental illness
 - (c) Traditional rituals (d) Modern hospitals/clinic
 - (e) Combination of treatments (specify)
 - (f) Others (specify)
22. If there are mentally sick Kambari who are not receiving treatment, why are they not receiving treatment? (Tick as many as applicable)
- (a) The mentally sick refused treatment
 - (b) The illness has no cure or treatment.
 - (c) The family has no money to pay for the treatment.
 - (d) The treatment is expensive
 - (e) There are no specialists to handle the case.
 - (f) Others (specify)

SECTION C: ILLNESS BEHAVIOUR OF THE KAMBARI

23. Who often first notices illness episode affecting adult members of your household?
- (a) The sick person (b) The household head

- (c) The oldest female member of the household
 - (d) Others (specify)
24. Who often first notices illness episode affecting children in your household?
- (a) The mother of the sick children (b) The father of the sick child
 - (c) The oldest female in the household (d) The head of the household
 - (e) Others (specify)
25. Who initiates the process of help seeking?
- (a) The sick person (b) The household head
 - (c) The father of the sick (d) The mother of the sick
 - (e) Others (specify)
26. What does the person(s) that initiates the process of help seeking do?
(Tick as many as applicable)
- (a) Call the household members for a meeting
 - (b) Prepare home treatment for the sick
 - (c) Invite the traditional healer to see the sick
 - (d) Take the sick to the traditional healer
 - (e) Take the sick to the modern hospital/clinic
 - (f) Others (specify)

27. As a household head, please tell me the illness (es) that you usually diagnose and treat among members of your household by your self.

Illness(es)	Treatment(s)
i.	
ii.	
iii.	
iv.	
v.	
vi.	
vii.	

28. Do members of your household go to traditional healers for treatment?

(a) Yes (b) No

29. If yes, state the three most important reasons why you go to the traditional healers (Tick 3 reasons)

- (a) We believe their treatment is effective.
- (b) We do not like the modern health services
- (c) Modern hospitals/clinics' treatments are not available in our community.
- (d) Modern hospitals/clinics' treatments are expensive.
- (e) Because of the poor attitudes of the hospitals/clinics' staff.
- (f) Modern hospitals/clinics do not treat all illnesses successfully.
- (g) Others (specify)

30. What are the usual outcome(s) of the traditional methods of treatments for your household?
- (a) The sick gets better
 - (b) Sickness usually worsen
 - (c) Condition do not improve
 - (d) Some cases are usually referred to the modern hospital/clinics.
 - (e) The sick person often dies.
 - (f) Others (specify)
31. What type of home treatments is available to members of your household? (Tick as many as applicable)
- (a) Herbs
 - (b) Traditional rituals
 - (c) Patent medicines
 - (d) Others (specify)
32. Are other members of the family allowed to decide what form of home treatment to be used when some one is sick?
- (a) Yes
 - (b) No
33. If yes, who? (Tick as many as applicable)
- (a) Other elders of the household
 - (b) Someone given that responsibility in the household
 - (c) Members of the household at a meeting
 - (d) Others (specify)

34. Can a sick adult member of the household decide the cause(s) of his/her illness? (a) Yes (b) No
35. If yes, why? (Tick as many as applicable)
- (a) Every adult member of the household is aware of the causes of diseases.
 - (b) The sick adult knows what is disturbing him.
 - (c) Others (specify)
36. If No, why?
- (a) He/She does not know anything about illness
 - (b) According to the customs, she/he has no right to decide
 - (c) Others (specify)
37. Does the sick member of the household decide where he/she go to for treatment? (a) Yes (b) No
38. If Yes, Why? (Tick as many as applicable)
- (a) The sick is aware of the medical systems available for treatment.
 - (b) He is free to decide for himself as an adult.
 - (c) He uses his money for the treatment.
 - (d) Others (specify)

39. Who usually pay(s) for the treatment of a sick wife of a member of the household (Tick as many as applicable).
- (a) The husband (b) The sick housewife. (c) The head of the household. (e) The sick woman's natal family
- (f) Others (specify)
40. Who pays for the treatment of a sick child in the household? (Tick as many as applicable).
- (a) Father of the sick child (b) Mother of the sick child
- (c) Head of the household (d) From the resources of the household (e) Others (specify)
41. Which of the following diseases/illnesses is any member of your household suffering from? (a) Leprosy (b) Blindness
- (c) Crippling deformity (d) Epilepsy (e) Mental sickness
- (f) Infertility (g) Vesico Vaginal Fistula?
42. If any in question 40, is/are the individual(s) currently receiving treatment? (a) Yes (b) No

43. If yes, what type of treatment is he/she receiving?

Disease(s)	Modern treatment	Traditional treatment	Modern self treatment	Traditional self treatment	Others (specify
a.					
b.					
c.					
d.					

44. Why do you choose the method of treatment mentioned above?

- (a) We believe it is the best for the illness
- (b) There are no alternatives available
- (c) It is not expensive for us
- (d) It is readily available
- (e) Others (specify)

45. If No, why is he/she not undergoing treatment?

- (a) We believe that there is no cure for the disease.
- (b) The patient had refused treatment.
- (c) We are tired of spending money for the treatment
- (d) We do not have money for continuation of treatment
- (e) Others (specify)

46. Do the wives of members of your household go to the

modern clinics/hospitals when they are pregnant? (a) Yes (b)No

47. If yes, for how many pregnancies has each wife gone?

Wife	Number of Pregnancies	Number of pregnancies that attended clinics	Number that did not attend
A			
.....			
B			
.....			
C.			
.....			
D.			
.....			
E.			
.....			
F.			
.....			
g.			

48. If No, why? (Tick as many as applicable)

- (a) There are no modern hospitals/clinics in our community.
- (b) We do not know that they need to go there.
- (c) We do not have money for the visits.
- (d) The traditional healers attend to them during pregnancies.
- (e) Others (specify)

49. Where do wives of members of your household usually deliver

- their babies? (a) At home (b) Modern hospitals/clinics
- (c) Traditional birth attendants usually conduct the delivery
- (d) Religious home (e) Others (specify)

50. Are members of the household aware of the child spacing
(family planning) programme? (a) Yes (b) No
51. If yes, are members of your household implementing any of
the messages? (a) Yes (b) No
52. If Yes, which of the methods?
(a) Pills (b) Safe period (c) IUCD (d) Injectables
(e) Condom (f) Abstinence during breast feeding
(g) Traditional method (specify)
53. If No, why are you not implementing the message?
(a) We want to have as many children as possible
(b) Our culture forbids it (c) Our religion forbids it
(d) Others (specify)
54. Are you aware of the National Immunization Programme?
(a) Yes (b) No
55. If yes, do you take your children for immunization?
(a) Yes (b) No

APPENDIX II

INDEPTH INTERVIEW GUIDE FOR KAMBARI TRADITIONAL HEALERS ON “FOLK MEDICINE AMONG THE KAMBARI OF NIGER STATE”

A. PERSONAL/FAMILY DATA

1. Age:
.....
2. Religion (a) Islam (b) Christianity (c) Traditional
(d) Others (Specify)
3. Sex: (a) Male (b) Female
4. Marital Status: (a) Single (b) Married (c)
Divorced
(d) Widow/Widower (e) Others (Specify).....
5. Type of family: (a) Nuclear (b) Compound
6. Village/Town of Residence
7. Educational attainment:
(a) No formal Education (b) Primary Education
(c) Secondary Education (d) Tertiary/Higher education

8. Occupation:
 - (a) Farming (b) Civil Servant (c) Trade/Business
 - (d) Artisan (specify).....
 - (e) Others (Specify).....
9. Number of wives:
10. For how long have you been practicing this art of treating the sick?
.....
11. What form of traditional treatment(s) do you practice?
 - (a) Herbal treatment (b) Spiritual healing
 - (c) Divination (d) Special treatment
(specify).....
12. How did you become a traditional healer?
 - (a) I inherited the art from my parents.
 - (b) I receive divine message to undertake the treatment of the sick.
 - (c) I received training from some one
 - (d) I was appointed to do so by the community
 - (e) I am blessed with the skill from childhood
 - (f) Others (specify)

13. Please tell me more about how you (were) trained for the job
irrespective of how you became a healer.....

.....

14. For how long did you receive the training?.....

15. Where do you treat patients?

(a) The sick is brought to my house

(b) I usually attend to the sick in his/her place of residence

(c) The sick is taken to a special treatment place.

(d) Others(specify).....

16. What type of illnesses/diseases do you usually treat?

.....

17. What in your opinion causes the diseases you usually treat?

Diseases	Causes
i.	
ii.	
iii.	
iv.	
v.	
vi.	
vii.	

18. How do the sick pay for the services?.....
19. With what do the sick pay for the services?
.....
20. Is there any relationship in practice between you and the modern health care services?
(a) Yes (b) No
21. If yes, what type of relationship do you have?
(a) They use to refer some patients to me
(b) I usually refer some patients to the hospitals
(c) We usually meet to share ideas.
(d) Others (specify)
22. If No, why?
23. If you do refer some patients to modern Hospitals, which categories of patients do you refer.....
24. If they do refer patients to you what type of patients do they usually refer to you?.....
25. In your opinion, what can be done to improve the relationship between your type of health care system and the modern health care facilities?
.....

APPENDIX III

MAP OF NIGER STATE SHOWING LOCATIONS OF THE STUDY

