Research Note

THE INTEGRATION OF TRADITIONAL HEALERS INTO THE MAIN-STREAM OF OUR HEALTH CARE DELIVERY SERVICES: A RE-APRAISAL

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Abstract: This paper is essentially theoretical and attempts to re-appraise the issues involved in the call for the integration of traditional healers by the WHO. In order to discuss in perspective, it focusses on the Nigerian situation and demonstrates why integration represents a more viable avenue to the realization of 'Health for all by the year 2000 AD'. The paper winds up suggesting a modality for achieving this.

When the day shall dawn upon us from on high to give light to those who sit in darkness and in the shadow of death . . . Luke 1:79.

HEALTH PLANNING

Erinosho (1981) has argued that health planning for developing nations: . . . is aimed at ensuring for the average citizen in the population, access to medical care and other basic facilities which would enable him/her to attain a reasonably high health status and life long expectancy.

It is given therefore, that the efforts of health personnel will be geared towards achieving this goal. Even then, such methods as employed have however, never been divorced from the differing state ideologies and consequently, their political economy. For Unscheuld (1976), the medical system of any society has to do with the distribution of the health resources in that society. A look at the pattern of health care delivery services in the USA, and USSR will epitomise this.

THE US MODEL

The capitalistic economies of the United States and nay, of all Western World is predicated on a regulated free enterprise. Although evidences abound to show strong element of welfarism: in the United States health care delivery service is left at the whims and caprices of enterpreneurs who act as fronts to the various insurance companies that exist to fill the vacuum of the provision of health care (Anderson, 1963). Under such an arrangement, Erinosho (1981) noted that “the citizenry is at the mercy of those companies which invariably derive substantial profits from the sale of health policies”.

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THE USSR MODEL

Health care delivery services in the Socialist Soviet Union and indeed all Eastern bloc, seems to operate on the premise that building a healthy nation is contingent on having healthy citizenry. The state - as typical of this bloc - therefore, sees it as obligatory on her, to provide health needs for all her citizens. Little wonder she directly intervenes in all ramifications of the provision of health services; in order to meet this goal (Field, 1966). This therefore, explains the phenomenon of relatively low cost of sophisticated health shopping enjoyed by the people of this bloc.

THE NIGERIAN MODEL

In Nigeria, medical system is organised along Euro-america model. Orthodox medicine exists side by side with traditional medicine, even though, the latter and older is yet to be given official recognition by the government (Oyebola, 1981).

As a medical system that was borne out of colonial experience, orthodox medicine emphasizes curative rather than preventive health services: whereas, social epidemiological research reports have made it abundantly clear that by far greater proportion of the diseases prevalent in the tropical Africa are preventable. The implication of this is that reliance on orthodox medicine alone will not actualize 'health for all by the year 2000 AD'.

Orthodox medicine is founded on science and as a variable knowledge limits its explanation only to what it can empirically verify. As a practice that is guided by scientific ethics, modern medicine restricts its explanation to germ theory which explains disease causation in terms of physical or biological discontinuity resulting from such things as insect bites, bad odour, habitation in unhygienic environment and so forth (Erinosho, 1981; Oke, 1982). But while it is true to say that the reflection of scientific ethics in modern medicine is in consonant with the world view of western societies, it is right too to say it goes beyond this for the African whose explanation, in addition to taking cognisance of the physical world also incorporates the psyche realm (Oke, 1982; Erinosho, 1981; Gluckman, 1963; Armtrong, 1971; Macleans, 1971; Impareto 1975; Chilivumbo, 1976; Unschuld, 1976). This insufficiency is most noticably in the illness behaviour of Nigerians. Cases have been heard where hospitalized patients secretly have their relations bring them traditional medicine (Asuni, 1979; Osuntokun, 1975; Tory, Sunday Guardian, Feb. 10, 1986).

Other problems centre around the urban based nature of orthodox medicine which encourages the scanty number of personnel she parades to cluster around urban centres, brain drain, high cost of training paramedical personnel and that involved in purchasing neccessary equipment. The list is endless. It can be argued that it is the recognition of the flaws in the orthodox system; particularly its variant position with epidemiological reports, that have made the Federal Government of Nigeria to engage in the Expanded Programme on Immunization (EPI).

Again, while it is true to say that Nigeria has everything to going by engaging in this programme, it is relevant too to mention that analysts see it as another 'urban' project. These facts if coupled with the knowledge that over 2/3 of Nigerians live in the rural area and are ill provided with medical facilities (WHO, 1975; Ademuwagun, 1969. 1976; Olatundosun, 1975)—will better enable us to grapple with or appreciate the works of scholars who have
called for an alternative approach which favours preventive services rather than curative.

This approach is quite apt and no doubt constitutes a viable alternative to the present system. Moreso as it favours epidemiological reports stated earlier. Yet attractive as this approach may seem, it is the contention of this paper that the modalities for implementing it is fraught with numerous problems capable of making us lose sight of the very essence of health care delivery services. Indeed, as Rosett (1967), rightly observed, the difficulty is that when reforms are attempted at a deeper level “... new problems arise to replace the old”.

We contend that the physicians who undoubtedly derive great importance from the present arrangement are in all probabilities likely to unleash all the powers at their disposal including lobby by such accredited bodies as the Nigeria Medical Association (NMA) and National Association of Resident Doctors (NARD) to frustrate such moves. While this is going on, the very essence of the whole affairs will in all certainty be disrupted and eventually defeated.

THE RATIONAL WAY OUT

In the light of the foregoing, we strongly advocate that the only effective means of actualizing health for all by the year 2000 AD is to follow the directive of WHO (1978) to integrate the traditional healers into the mainstream of health care delivery services in Nigeria.

A traditional healer is defined by WHO (1977) as: ... a person who is recognised by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on social cultural and religious background as well as on the knowledge, attitudes and beliefs that are present in the community, regarding physical, mental, social well being and the causation of disease and disability.

This call for integration hardly needs substantiation. It is cheap and efficacious (WHO, 1978; Elling, 1981; Maclean, 1969; Ademuwagun, 1969; Prince, 1960; Otsyula, 1973). Eighty per cent Nigerians are already used to going to them (Oyebola, 1980; WHO, 1975; Lambo, 1966; Harrison, 1974). It adequately captivates the world view of the Africans (Ndeti, 1976; Chilivumbo, 1976), and they are available in all localities (WHO, 1975).

ANTICIPATED PROBLEMS FOR INTEGRATION

One big tragedy for integration, is the lack of unanimity among scholars on the issue of how best to go about it. For example, while some of the scholars favour the idea of the traditional healers working side by side with medical doctors in the hospital setting, others think otherwise. The main argument advanced by the former is that it will be cheaper and quicker to assimilate them that way. This stance however creates more problems than it solves. It neither takes into account the social-cultural context from which it seeks to invite the traditional healers nor takes into consideration, the present attitude of Nigerian physicians to the healers. It suffice to say for now that those social scientists who have had course to work with the medical doctors in the hospital setting have said it requires a lot of
We therefore, suggest that one way to achieve full integration and hence health for all by the year 2000 AD is for the traditional healers to remain in their present setting. This will tentatively remove the issue of standardized concepts, eliminate complexes and accommodate role conflicts like how close to get to the patients, at what stage of diagnosis should the traditional healers be called in and whether or not to make or take diagnosis jointly.

In a recent study, the researcher discovered other problems capable of frustrating this call for integration. One of such is the literacy level of the traditional healers. A total of 44% of the traditional healers fell into the stark illiterate cohort and another 44% into the semi-literate category; whose educational attainment ranked below senior secondary one. We linked this with the Universal Primary Education prevalent in the then Western region. It is therefore, doubtful if other healers in regions that did not run this programme would not rank lower.

A more fundamental problem is that of concretising the spiritual world. Science does not recognise what is cannot see. So how do we take seriously the claims by healers to be able to carry out healing arts with the aid of the supernatural? Is this a mere belief, in which case having something to do with the psychological disposition of the mind or is it realistic? Exactly to what extent can it be relied upon to yield the same result from time to time?

Other areas of problems include the purification of healers drugs, lack of accurate dosage and that of procuring a winowing machine to help sever ‘grain-healers’ from ‘chaff-healers’. We strongly believe that it is the partial recognition of some of these problems and the threat of integration to the status quo that have made some scholars and especially the modern practitioners to continue to asymmetrically or lopsidedly utilize their present access to the source of power, to pass derogatory and deprecating comments on the persons and works of the traditional healers (Daily Stetch, Monday Jan., 20, 1986; Ndeti, 1976; Oyebola, 1980; Bannerman, 1981; Torrey, 1972). Even then we have reasons to believe that these problems are not insurmountable. It took time to build those well organised Euro-america model the excellence of which the Nigerian Physician now strives to achieve, despite its high cost and ill suitability for the tropics.

**RECOMMENDATIONS**

It is our expressed view that the only way the traditional healers can be integrated and logically health to the door-step of all by the year 2000 AD, is for the Federal Government to recognise them. There is no other way out. Oke (1985) reported that 79% of his respondents were quite willing to heed WHO’s call for integration. My field experience and the work of Erinosho (1985) further served to confirm this.

2. Official recognition should be followed up by the setting of an all exclusive traditional healers board, by the Federal Government. This body should be charged with drawing up a uniform code of conduct for all registered traditional healers in the country and be given power to deal with erring members and fake healers (unregistered healers).

3. The Federal Government should then direct the various state governments to follow suit in setting up an all exclusive healers board. This board should be composed of healers from all the local government areas. Again, representation should be on equal basis.

4. The state boards should be responsible to the one at the federal level and in fact should
be seen as an organ for meeting its ends in the country.
5. The Federal Board should then direct all the state boards to register all the traditional healers in their state by their specialization. Such registration should be on local government basis.
6. Numbers three and five functions if properly executed should winnow quack healers. It should also enable us to have a proper categorization of the various branches of traditional medicine in Nigeria.
7. To disband the present multifarious traditional healers association in all the shapes and sizes and to set up state association to which all registered members must belong.
8. This body should be an arm of the Federal body which should have a Federal Secretariat.
9. The State bodies should have final say in the prosecution of quacks and erring members, but offenders should be allowed to appeal to the Federal level, should they feel dissatisfied with the judgements. Such rights however should not be extended to quacks—or registered members. We recommend that the quacks and dismissed practitioners should only practice at the risk of being prosecuted.
10. The Federal Government should assist the Federal healers' Board to set up a pharmacological research body to determine both the medicinal potency and the chemical components of herbs.
11. In this bid, the assistance of the various states should be enlisted.
12. Based on the above, the pharmacological body should come up with a classification of the list of traditional drugs in Nigeria.
13. To device effective ways of disseminating the results of such efforts at standardization of herbs. The above if conscientiously executed should standardize our drugs and by so doing take care of the issue of over doze and that of the purity or refinement of healers’ drugs.
14. To tackle the problem of low literacy rate by organizing symposia debates and seminars in which members will be schedule to talk; not necessarily in English, and for adequate coverage to be given to such gatherings.
15. To further encourage healers by empowering the Board to recruit and train for a maximum of two years, school certificate holders who will act as interpreters to healers in their various local governments secretariat if need be and/or translate in native dialect and broadcast the activities.
16. The Government can help to reduce to level, the blases of medical practitioner by allowing Erinosho (1981) to persuade her into inculcating in the curricula of medical education in Nigeria, knowledge of the “ubiquitous social cultural factors which underlie the contigencies of medical care in tropical Africa”.

Erinosho's suggestion if adopted will help the physicians to understand and better cope with the illness behaviour of Africans. It will help the doctors to know that Africa is still a face to face society where relationships with kins and neighbours matter a lot. This will play down on their present tendency towards impersonal services. This is the key to the haven patients find in the homes of the traditional practitioner (Oke, 1982; Erinosho, 1981).

Furthermore, implementing Erinosho's recommendation will as said before, correct the present attitudes of physicians to healers. This will set off a chain of reactions like reducing complexes, resolving numerous role conflicts like the issue of how close to get one's patients; foster accommodative atmosphere that will eventually culminate in the working side by side of the traditional healers and the medical doctors in the hospital setting.
When this happens we cannot but agree that a new dawn has arrived. The common man will wax stronger in health and Nigeria will thrive. We have no doubt whatsoever that such an ideal state of a nation's health can be achieved if we integrate our traditional healers into the 'midstream' of our health care delivery services. The time to start is now.

**DISCUSSION**

A search for a viable alternative in the corridors of the medical systems of Euro-america and the USSR can not guarantee health for all by the year 2000. Today, Nigeria operates the Euro-america model. But it is too riddled with insufficiently syndrome to be relied upon. Today 80% of Nigerians live in the villeges and are ill provided with medical facilities.

Therefore, a model which will be accommodated by the operators of the present system will be best adopted in the interest of our continued existence. This model calls for the integration of the traditional healers into the 'midstream' of our health care delivery services. This seemly new model is not new. In China and USSR traditional healers work side by side with the medical doctors, and are doing quite well (Prince, 1964; Maclean, 1966). Perhaps it is the perfection of such wedlocks, coupled with epidemiological reports and insufficiency syndrome that made Maclean and Bannermann (1982), Ademuwagun (1969), WHO (1973) to recommend this integration "dose" to ailing third world countries. A trillion voices cannot be wrong. A healthy nation is contingent on healthy citizenry.

Here I rest my oar!

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