

KNOWLEDGE OF MALARIA AND SOME ASPECTS OF ITS CONTROL IN TANGA, TANZANIA

By M. Fivawo

Introduction:

Malaria is an acute or chronic infection of red blood cells caused by protozoa parasites of the genus *Plasmodium*. Among symptoms of malaria include attacks of fever, headaches, chills rigors, general malaise, joint and muscle pains, nausea, vomiting and diarrhoea.

The German Scientist, Robert Koch, reported from Western Usambara in 1898 that the native people called the disease which he was sent to study *homa ya mbu* (fever of mosquitoes), which they said was contracted after being bitten by mosquitoes of the lowlands. This clear epidemiological knowledge of the natives has not been followed up to see how the people's knowledge can be integrated into other knowledges of malaria in the effort to effectively control the disease.

One aspect of the malaria problem which has not been adequately given attention to is the behavioral one which could show the interaction processes between community members and health providers to facilitate epidemiological control. The study of the behavioral aspects of malaria in rural Muheza was done to explore and determine factors which influence people's behaviour towards malaria control in order to suggest strategies which would facilitate the development of more effective approaches to generate health programs which will improve malaria control. Studies of people's own ways of dealing with a disease can be used to facilitate acceptable control measures.

Bonde and Sambiaa people two major ethnic groups in Tanga have known malaria for as long as they have been in the area. They call the disease 'nyongo', 'homa ya mbu', as well as the latin term 'malaria' itself. Traditional healers diagnose the disease from the type of fever which is not accompanied by any cold symptoms, as well as from examining the vomitus of the patient or the colour of the patient's urine. Patients often use the traditional as well as biomedicines to treat malaria.

Malaria is today the commonest disease in Tanzania. National statistics show that malaria is the most frequent cause of hospital out patient attendances accounting for 10 — 15% attendances. It also account for 6 — 10% of hospital admissions. In hospitals, malaria death rate is estimated to be 4 — 5% and is therefore one of the top-ten killing diseases in Tanzania.

Muheza district of Tanga region is holoendemic for malaria, which means that malaria transmission goes on for more than six months in a year. The inpatient monthly records from the district hospital for 1983 for example, show peak admission of malaria patients during March, April, May, July, August, October and November. The remaining months show lower figures which does not mean improvement in the management of the disease but that parasitaemia is maintained at low levels showing no alarming malaria symptoms. Results of parasitaemia check of a

sample of 136 healthy looking individuals from Tongwe village in March 1984 showed that only 41 of them (30%) were negative for malaria parasites. Fifteen percent had high parasite levels between 201 and 1600 parasites for 200 white blood cells (see table 1). The problem of malaria is therefore still serious in spite of the numerous scientific knowledge which we have accumulated.

Methods.

300 young women were interviewed about their knowledge of malaria and malaria control using a questionnaire. The subjects for the study were of child bearing age who have participated in the malaria prophylaxis program themselves or for their small children. Ten key persons including health personel healers, brith attendants and elders in the community were also interviewed. Individual cases of disease management were studied through follow ups.

Results

Response to the questionnaire showed that respondents have very good knowledge of malaria its symptoms, cause, lethality as well as ways of protecting one self from frequent attacks, 84% of the respondents had used chloroquine prophylaxis during previous pregnancy. The knowledge which the people have about malaria is a result of both experience with the disease and health education. It is therefore not surprising that people use both the traditional and Western methods to manage the disease.

More respondents (67%) reported having experienced side effects from therapeutic use of chloroquine than those who reported side effects from prophylactic use of the drug. Attitude research shows that attitudes arise from individuals experiences. Positive experience give rise to positive attitudes about an object while negative experience indicate precaution. With regards to malaria management a high report of side effects is consistent with low level of therapeutic compliance to chloroquine. Because of experienced side effects individuals do not complete the therapeutic dosages. A discriminant analysis of compliance behaviour showed that the individuals behaviour is strongly influenced by the therapeutic experience which she/he has with chloroquine use. Twelve other factors, including knowledge and use of herbal medicine for malaria, were also found to have influence on prophylaxis use.

Herbal medicine are used both for treatment of malaria and for self protection. (Table 2). *Muarobaini*, *Mzugwa*, *Mvumbasi*, *Hozandoghoi* and other medicinal plants are often used to treat malaria alongside hospital medicines. Some of the above named medicines are known to contain medicinal compounds which do work on malaria parasites and/or mosquito. Others are still being studied for their chemical contents and biological activity. *Mvumbasi*, *Ocimum suave* for example, which is a shrub native to Tanzania, is extensively used in Muheza to repel mosquito and has some antimicrobial activity as well. The other medicinal plants which are used by the people may also contain chemicals which work on malaria.

Another important factor which is influential in the management of malaria is the community's social structure. The individual is not always dependent on other People's advices for her/his medical behaviour, but is influenced by "important others" in her behaviour particularly with regard to the

illness of her youngest child. This "important other" is often the grand mother of the child, the father, the neighbour or the nurse. In the case of Sambia people a young mother normally goes to her parents for delivery. She learns much about child health care and her own health care which are believed to be interrelated, during this time from her own mother. The grandmother is therefore a very important health educator of the young mother. The role of the grandmother goes beyond education, and she enjoys a distinguished social status within the family and in the community. Several case studies which were followed up during the research showed that a young mother seeks help or advice from elder women, in the absence of her own mother, before taking her baby to the hospital for diagnosis and treatment. This is the appropriate behaviour according to Sambia custom. However, often-times this process of consultation takes time and it becomes too late to save the baby's life. The family social structure works as an important mechanism around which malaria and other diseases are managed. The Sambia basic family social structure is seen to override all other differences of religious affiliation and educational levels.

Discussions:

There are several factors which play an influential role in malaria behaviour. Some of these have their basis on the social structure of the family and the lineage system which govern a particular society. It may be true that there are some real problems which some individuals experience from the use of chloroquine drug for treatment of malaria. Problems which are related with side effects of the drug need to be looked into seriously to make the drug more usable. Many individuals report experience of itching due to therapeutic use of chloroquine. Such side effects of the drug contributes towards non-compliance in chemotherapy which interferes with effective treatment of the malaria parasites in the patient. Of equal importance is the problem which derives from the social organization of the community. It is proper and probably necessary to start looking at how the family or community social structure for example can facilitate the management of malaria. Can elders or healers in communities be formally involved in malaria control? Could they be affiliated to the dispensary or other medical services? Community involvement in malaria control requires closer cooperation between health institutions' own experts and the community's own authority individuals. Is the medical institution willing to open its doors to such a collaborative effect for the effective management of diseases? This is one approach which is worthy considering for effective malaria control programs.

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Table I

Plant	Plant Used for Malaria	
	Number	Percent
All cases	300	100.0
Mzugwa ¹	8	2.7
Vumbasa ²	8	2.7
Hozandoghoi ³	5	17.0
Others ⁴	10	3.3
Don't know	4	1.3
No reply	259	86.3

Botanical identification:

Mzungwa, *Coleus kilimandscharica* Guerke (Lab.)
Vumbasa, *Ocimum suave* Witld. (Lab.)
Hozandoghoi, *Hyptis pectinata* Poit. (Lab.)
Plectranthus amaniensis Guerke (Lab.)
Others, *Cissus adenocaulis* Planch.,
Mwengee, *C. engleri* Gilg (Ampel.)
Mtula, *Solanum campylacanthum* Hochst.,
S. incanum L., *sobliquum* Damm.
Fivi, *Artemisia afra* Jacq. (Comp.)
Mhasha, *Veronia iodocalyx* O. Hoffm. (Comp.)
Muuka, *Microglossa densiflora* Hook. f. (Comp.)

Source: Sangai, G. R. 1963 Dictionary of Native Plant Names in the Bondei, Sambia and Zigua languages with their English and Botanical Equivalents. Mimeo, East African Herbarium, Nairobi.

The local names were collected through a questionnaire administered to a sample of women in Muheza district, there may be more plants or other than these which healers use for malaria treatment.

TRADITIONAL BELIEFS AND TREATMENT IN MEASLES

By F. H. Mrisho

Abstract

Eight hundred and fifty five adults mostly farmers with minimum education from Lindi rural district in South Tanzania were interviewed regarding knowledge, taboos and treatment of measles.

Eighty of the respondents knew the correct symptoms of measles and 50% had nursed at least one measles child. Various taboos exist, the commonest being forbidding sex between parents of a child with measles and that measles children were not to be washed or their skins oiled for fear that the rash will "submerge in the abdomen" and result in death.

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Several medicaments were identified. These included drugs for topical body application, oral preparations and eye drops. The potential hazards of these are discussed.

Introduction

Measles is a public health problem responsible for high morbidity and mortality in Tanzania^{1,2}. In all 4 health units covering the villages where this study was done, measles was the third cause of outpatient attendance in the past one year.

The Ministry of Health has made significant progress over the last decade towards child protection against measles through immunisation. Despite these efforts, measles claims about 20% of all underfives dying in villages¹ and about 10% dying in hospitals². Measles expressing itself as skin rash is recognized by many people making it an easy disease to study.

The aims of the study were to identify traditional beliefs and medicaments used in measles and the colleration of these on the high mortality associated with the disease.

Materials and Methods

The study was done in Lindi Rural District. Lindi was chosen because of paucity of health related studies from this part of Tanzania. Selected areas included villages surrounding Lindi town dispensary, Nkone Rural Health Centre and Pangaboi Rural Health Centre.

A pretested Kiswahili questionnaire was administered by 4 health workers of the above mentioned rural health centres. Prior to this the health workers, two of which were males and two females had to be trained for two days in the filling of the questionnaire.

A house to house survey was conducted and the first adult to come out of each in response to the interviewer's call was interviewed. It is of interest to note that female interviewers had equal numbers of male and female respondents while the male interviewers had predominantly male respondents.

Results

Table 1

Age and Sex Distribution of Respondents

Age in Years	Male	Female	Total	%
0 - 20	24	49	73	8.5
21 - 30	101	174	275	32.2
31 - 40	133	82	215	25.4
41 - 50	103	45	148	17.2
51 - 60	66	14	80	9.3
61 +	55	9	64	7.4
TOTAL	482	373	855	100.0

A total of 855 people were interviewed, 56.4% being males and 43.6% females. 57.6% of the respondents were in the age group of 21 — 40 years. There were more females than males in the young age groups while more males than females in the old age groups.

Table 2

Education Status of Respondents

Education	n	%
Primary School	523	61.2
No formal education	242	28.3
Adult education	68	7.9
Quran classes	22	2.6
Total	855	100.0

All people interviewed were below primary school education with 28.3% having no formal education at all.

Table 3

Occupation Status of Respondents

Occupation	n	%
Farmer	615	71.6
Fisherman	51	5.9
Palm wine tapper	34	4.0
Government employee	25	2.9
Others	92	11.8
Total	855	100.0

Majority of the people (71%) were farmers, and only 3% of the people were government employees.

Table 4

Knowledge regarding measles diseases by age

Age in Years	Correct description	Incorrect description	Total number
	n	%	n
≤20 - 20	25	47.17	28
21 - 30	245	84.78	44
31 - 40	192	90.14	21
41 - 50	208	95.41	10
51 - 60	45	78.95	12
61 +	25	100.00	0
			TOTAL
			855

740 people (86.5%) gave a correct description of measles, while 115 (13.5%) either stated that they did not know the signs of measles or they gave the wrong description. The symptoms given were rash, fever, red eyes, diarrhoea and cough in that order of frequency. Any-body citing two or more of these symptoms, one of them being rash was counted to have correctly identified measles.

The trend shows an increase in knowledge about measles as one grows older, exception being the age group 51 — 60 which was predominantly male.

In the survey it was found that 404 children had measles and 58 of these died. This gives a case fatality rate of 6.7%. It was also found that 420 parents (48.6%) had never nursed a child with measles.

There were several taboos associated with measles. These included:-

1. abstinence of sexual intercourse in a household nursing a measles case seen in 209 of the respondents accounting for 27.6% of them,

2. avoidance of bathing the child with measles or of anointing the child seen in 21.8% and 14.0% of the respondents. 110 of the respondents (14.5%) believed in hiding the child away from relatives or some sort of an isolation. Other taboos included clearing the house of items like simsim seeds and oil, lime fruits and charms associated with witchcraft. This was seen in 132 of the respondents accounting for 17.4% of the cases. 36 respondents (4.7%) talked of several other taboos.

Absence of florid rash was considered to be one of the most feared course of the disease. Underdeveloped rash was associated with an increased mortality rate since it was believed under those circumstances the rash would remain in the abdomen, hence the avoidance of bathing or anointing the child with oil. Among the other taboos included were:-

- (a) Avoidance of consumption of hot meals, cassava leaves and overnight kept left overs in the affected child.
- (b) Leaving suitcases open in the room where the sick child was being nursed.
- (c) Keeping the child away from pregnant women or bereaved individuals,
- (d) avoidance of injections.
- (e) Avoidance of supine posture lest the eyes would be affected and lead to blindness.

About a half of the interviewed people gave health unit treatment as a preferred option when one has a measles child. It is of interest to note though that of the ones opting for hospital, one third preferred to try traditional medicines first before taking their children to the hospital. Table 5 shows the various traditional concoctions and medicaments used.

Table 5
Traditional Treatment given to children with measles

Medicine	n	%
1. "Mtamba" (sap, bark or leaves) for washing, drinking, or application to eyes	170	56.1
2. Baobab seeds pounded given to drink and application to body	36	11.9
3. Uncooked pounded groundnuts for drinking and application to body	34	11.2
4. "Mtumbati-bonde" bark and leaves for application to body and for drinking	19	6.3
5. Soil from an ant hill for body application	16	5.3
6. Others	28	9.2
TOTAL	303	100

The sap of Mtamba tree or its bark and leaves was the commonest used remedy for measles. The sap of Mtamba is applied to the eyes to prevent blindness and the boiled extract is taken orally to induce diarrhoea an event that is desirable because it "flushes the rash away from the intes-

tines". The expected effects of the baobab seeds, groundnuts and "Mtumbati-bonde" are not clear to the author. Soil from an anthill is applied to the body to "build the body". Other medicaments used include the sap of the "Mtariiba" tree, "Mtema-mbichi", "Mti-Kongo", guava leaves, "Mtandasa" tree taken orally. Also in use were ashes mixed in water and human urine. The later is used as eye drops to protect against blindness.

Discussion

The study has shown that measles is a recognisable disease with more than 80% of the people knowing the important signs of fever, rash, diarrhoea and cough.

About half the study population is made up of people who have nursed a measles child, and 6.7% of them having lost a child through measles.

Various taboos have been identified. A taboo regarding parents not having sex being the most commonly cited. This is a behavioural change which the author has failed to find an explanation for. It is however, a taboo which is harmless.

The remaining taboos involving the child such as not washing or anointing the child with oil cited by 35.8% of the people may have had influence on health. Measles disease is accompanied by fever, washing the child is one method or lowering the body temperature, that apart, the sick child need to be kept clean, more so since the child may also be having diarrhoea and vomiting which would soil the child and its clothing.

Isolation of a child with measles where feasible is important in limiting transmission of the disease.

It is known that immunisation against measles may result in a child getting measles of less severity in comparison to that of a non-immunized child. In such cases the rash may not be pronounced and if this is seen as dangerous by parents, it may jeopardise the immunisation programme.

Traditional medicines used includes a variety of extracts from trees like "Mtamba", "Mtumbati" and others. Some of the treatment involved applying to the eyes the saps from such plants. While the author is not in position to know the botanical names of these plants and or harmful chemicals in the content, potentially there is a risk of trauma and or introduction of infection in the eyes. Some of the post-measles blindness has been attributed to use of similar plant preparations or use of urine from cows or human as seen in this area of Lindi.

Induction of diarrhoea by drinking some of the preparations may lead to uncontrolled dehydration and death. The use of groundnuts or baobab seeds made into drinks is commendable, since these are nutritious foods.

In summary, the taboos though interesting are not seen to pose health risks while some of the traditional medicaments in use may be potentially hazardous.

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THE PATTERN OF ILLNESS AND THE UTILIZATION OF AVAILABLE HEALTH SERVICES IN TWO REGIONS OF TANZANIA

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Introduction

In order to officially recognize and effectively deploy the services of traditional healers, it is necessary to collect data on baseline utilization rates of the available health services. It is also imperative to have some knowledge of the pattern of diseases generally affecting the population as well as the therapeutic efficacy of the available services.

One of the problems affecting the recognition and effective deployment of traditional health practices by the modern medical practitioners however, is the different concept of disease causation that is strongly held by these two sides. Furthermore, the diagnostic and treatment methods of disease also differ greatly between the two groups. The only way of bringing the two systems together is by the people accepting and utilizing them without prejudice. Traditional systems have always been with the people and the concept of disease causation in the general population bears much resemblance of that held by traditional healers because of their closeness and cultural integration in the community. Modern systems however, have not been so close to the people in many of the developing countries because of the expenses involved and the inadequacy of the facilities for the majority of the people. This should make traditional systems more popular than modern systems if no system suppresses

the other as is the tendency with the modern system in many countries.

In Tanzania there is no policy regarding traditional medical practice except that the law does not prohibit or prevent the *bona fide* practice of systems of therapeutics according to native methods by persons recognized by the community in which they belong¹. Traditional healers are therefore acceptable as health providers by the people because modern health facilities do not adequately cover the entire country. It has been estimated that about 75% of the country population is living within a radius of 10 kilometers of a modern health facility. But the need and demand for health services has not been adequately assessed in this country because of lack of appropriate studies and inadequate disease reporting mechanisms. This paper reports some of the findings of a study which attempted to determine the pattern of illness and people's utilization of available health services in order to shed light into extent to which people use the services provided by traditional healers.

Materials and Methods

Two regions in Tanzania were selected for the study, one to the North of the country, Arusha, and the other to the South, Iringa. The two regions were taken to represent the socio-cultural aspects of the respective north and south extremes of the country. Arusha region is placed to the north east with an area of about 44,000 sq. km. and a population of 926, 223 from the 1978 population census². The inhabitants are engaged in both pastoral and agricultural life. Iringa regions on the other hand is to the south with an area of about 40,000 sq. km. and a population of 925,044, the majority of whom are engaged in agriculture.

A list of villages was obtained from each region and a random sample of 50 villages was taken from each. In each village one ten-cell leader was randomly selected and all the households (usually 10 but could be more) under his jurisdiction were studied. The heads of these households were asked about members of their households who developed illness during the month preceding the interview. They were also asked to state the type of illness, where it was treated and the outcome of such treatment. In addition they were asked about diseases which they considered best treated by traditional healers.

Results

The actual diseases developed by household members and the hypothetical ones best treated by traditional healers were so many and varied that it became necessary to categorize them into 28 groups of related diseases. Since the diseases were mostly descriptions of signs and symptoms by those interviewed and not based on standardized procedures it was not possible to classify them according to the scientific method of disease classification. For example, all diseases producing fever as their main symptom, were placed in one group, those producing predominantly gastrointestinal symptoms in another, and so on. Diseases like measles, leprosy and asthma which seemed well known to those interviewed were given the same names. Diseases producing ill defined symptoms were placed in one category.

A list of the top ten group of diseases according to the descriptions of the heads of households for Arusha and Iringa was then compiled and compared with that for Tan-

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zania's most frequent cause of admissions to hospitals and out-patient attendances³. The ranking was found to compare rather well with only minor differences as shown. fevers, respiratory diseases and gastrointestinal disorders were found to rank high on the lists.

Table 2 shows that relatively, Iringa region had more gastrointestinal disorders, more obstetric and gynaecological disorders and more leprosy than Arusha which had a higher relative frequency of respiratory diseases and fevers.

Table 3 and 4 show disease pattern as seen in Iringa and Arusha respectively. The tables clearly show that the pattern in these two regions is similar. Some differences however do exist. For example respiratory diseases in Arusha have the lowest frequency in the age group 10 - 19 years where else in Iringa it is lowest in the 20 - 29 year age group. In Arusha Obstetric and Gynaecological disorders show the highest frequency in the age group 20 - 29 while in Iringa in the 30 - 39 year age group. Table 5 shows that 73.5% of all the sick consulted modern health services while 11.6% consulted traditional health services. It can also be seen that 6.2% of the sick did not consult any health services.

In table 6 and 7 the educational status of the heads of households is categorised. The first category comprises of those who had never had any form of formal education, the second those who had either attained adult literacy education or primary IV education, and the third, those who had either attained primary VII or secondary school form IV education. The results show that the level of education of the head of household did not influence the utilization.

Figure 1 - 3 show the differences in utilization by age and place. Modern health service utilization was the highest in both regions but it was higher in Arusha than Iringa. There was some tendency for utilization to decline with age in both regions but this could be a cohort effect.

Traditional health service utilization was slightly higher in the older age groups, Iringa having higher utilization rates than Arusha. Older age groups tended to utilize both services more than the younger ones and Iringa utilized both services more than Arusha.

Figure 4 shows that there is a significant difference in the health service utilization rates between Iringa and Arusha but virtually no difference between the sexes.

Figure 5 and 6 show utilization rates by disease category and place. Although utilization rates are higher for modern than for traditional health services the order of utilization by disease category is quite different. Diseases like paralysis, obstetrics and gynaecological conditions and unknown diseases ranked high in traditional healer utilization while they ranked low in modern health service utilization.

Discussion

Although there are many ways in which the top ten causes for admission and out-patient attendance resemble the groups of diseases for Iringa and Arusha, there are some striking differences like those seen for obstetrics and gynaecological disorders. This forms the first cause for hospital admissions but one of the last conditions causing illhealth in the community. This can be explained by the fact that most deliveries taking place in hospitals are probably normal and not considered to be a cause for illhealth by the community.

It can be seen from Table 1 that respiratory diseases rank high in the group of diseases for Iringa and Arusha while they

do not rank so high in the out-patient attendances. If pneumonias, bronchitis and other diseases of the respiratory system are combined, this would rank respiratory diseases higher on the list. Similarly, on the list of causes for admission to hospitals respiratory diseases would rank second if tuberculosis, pneumonias and respiratory diseases other than pneumonias were combined.

The differences in disease pattern between the two regions reflect true differences in the magnitude of these disease groups. This is so because in spite of using proportional morbidity rates for comparison of the two regions, their population structures were very similar and the interviewers used in both regions were the same.

The results have shown that 73.5% of the household members who developed illness during the one month period before the interview sought health care from modern medical services. This finding is in great contrast to that of other studies elsewhere where the majority of those interviewed would prefer to consult traditional healers rather than modern medical services for various health problems. Of those interviewed in Ethiopia, 45.6% consulted traditional healers, 32.8% consulted modern medical services and 21.6% consulted traditional health services⁴. The difference between our study and the Ethiopian study is that while we dealt with people who had developed disease during the preceding one month period, the Ethiopian study interviewed individuals who had developed in the preceding one year period. The reasons for such health service utilization contrast are not clear. In Botswana which is at about the same stage of development as Tanzania, traditional healing is reported to be a declining profession. One of the reasons for such a decline is the development of the scientific health care which tends to make the traditional healer lose his credibility and deprive him of his former prestige and patients⁵. However, the experience of other workers show that traditional curing systems do not simply fade away when confronted with western and style medicine⁶⁻¹⁰.

In a study involving high school students in Liberia majority of students aged 18 - 22 years did not prefer the services of traditional healers¹¹. In another study in Nigeria it was shown that educated people tend to utilize the orthodox system while the illiterates prefer the traditional health system¹². Our study did not enquire about the educational status of each of the individuals who had developed illness but only that of the head of the households in which the sick individuals lived. It is not known how much his educational status would influence utilization by other members of the household but it is known that the head of the household is normally a very powerful decision maker in the African culture. The highest educational level achieved by heads of households was ordinary level secondary school, which was actually attained by very few household heads. Our results show that for the educational levels studied increasing levels of education did not influence utilization pattern. It is however, not known whether higher educational levels would influence the utilization pattern.

In Tanzania the level of literacy is the highest among other developing countries in Africa. It is however not clear how much this achievement has contributed to our findings. Another limitation in our study was that the interviewers were not detailed enough to obtain the true pattern of illhealth and health service utilization. The pattern of illhealth obtained seemed mostly to reflect physical types of illhealth and not the types of illhealth such as would be brought about

THE PATTERN OF ILLNESS

Table 1

Comparison of the ten top Disease for Tanzania and the two study regiois

Outpatient attendance	TANZANIA		IRINGA		ARUSHA	
	%	Admissstons	%	Conditions	%	Conditions
1. Malaria	12.97	Deliveries and Pregnancy complications	16.2	Fevers Gastrointestinal disorders	31.10	Fevers Respiratory disease
2. Symptoms and ill defined conditions	8.02	Malaria	9.0	Head and mind disorders	20.3	Head & mind disorders
3. Gastroenteritis	6.77	Pneumonias	8.4	Respiratory diseases	13.6	Gastrointestinal disorders
4. Ulcers	6.35	Gastrointestinal disorders	7.1	Bites	11.6	Gastrointestinal disorders
5. Other disease of the digestive system	6.33	Measles	4.8	Trauma	5.5	Bites
6. Other disease of the Respiratory system	6.72	Parasites	2.4	Obstetrical & Ganae-cological disorders	4.2	Trauma
7. Nutritional deficiencies	5.25	Respiratory disease other than pneumonia	2.2	Leprosy	2.2	Skin diseases
8. Accidents, poisoning and Violence	4.85	Iron Deficiency anaemias	1.9	Skin disease	2.1	Dental disorders
9. Bronchitis	4.44	Trauma	1.4	Dental disease	1.7	Obstetrical and Gynae-cological disorders
10. Pneumonias	3.65	Tuberculosis	1.4		1.5	Leprosy

Table 2
Disease Distribution of Sick Household Members by Age and Sex

	ARUSHA											
	IRINGA											
	MALE		FEMALE		TOTAL		MALE		FEMALE		TOTAL	
N	%	n	%	n	%	n	%	n	%	n	%	
1. Fevers	388	37.2	348	30.7	378	44.6	369	38.3				
2. Gastrointestinal Disorders	220	22.8	242	21.3	90	10.6	116	12.0				
3. Head & Mind Disorders	129	13.4	180	15.9	115	13.6	127	13.2				
4. Respiratory Diseases	113	11.7	152	13.4	141	16.6	196	20.3				
5. Bites	51	5.3	74	6.5	56	6.6	78	8.1				
6. Trauma	32	3.3	27	2.4	24	2.8	20	2.1				
7. Obstetrics/Gynaecology Disorders	0	0.0	50	4.4	0	0.0	21	2.2				
8. Leprosy	19	2.0	29	2.6	11	1.3	9	0.9				
9. Skin Diseases	22	2.3	16	1.4	19	2.2	16	1.7				
10. Dental Diseases	19	2.0	16	1.4	14	1.7	12	1.2				
TOTAL	963	100.0	1134	100.0	848	100.8	964	100.0				

Table 3
Disease Distribution of Sick Iringa Household Members by Age

Disease	AGE IN YEARS															
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+	n	%	n	%				
Fevers	274	37.1	100	35.1	35	23.3	9	12.7	7	19.4	10	33.3	2	@8.7	0	0.0
Gastrointestinal Diseases	162	21.9	50	17.5	29	19.3	16	22.5	14	38.9	6	20.0	2	8.7	3	18.8
Head & Mind Disorders	77	10.4	78	27.4	47	31.3	20	28.2	4	11.1	1	3.3	7	30.4	2	12.5
Respiratory Disorders	108	14.6	31	10.9	7	4.7	6	8.5	3	8.3	7	23.3	4	17.4	3	18.8
Bites	22	3.0	19	6.7	8	5.3	6	8.5	6	16.7	2	6.7	3	13.0	5	31.3
Trauma	25	3.4	2	0.7	5	3.30	6	8.5	1	2.8	1	3.3	0	0.0	2	12.5
Obstetrics/Gyane.	2	0.3	2	0.7	15	10.0	8	11.3	0	0.0	2	6.7	0	0.0	0	0.0
Disorders	30	4.1	1	0.4	0	0.0	0	0.0	0	0.0	1	3.3	2	8.7	1	6.3
Leprosy	19	2.6	1	0.4	4	2.7	0	0.0	1	2.8	0	0.0	3	13.0	0	0.0
Skin diseases	20	2.7	1	0.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Dental diseases	739	100.0	285	100.0	150	99.7	71	100.2	36	100.1	30	99.9	23	99.9	16	100.2

Table 4

Disease Distribution of sick Arusha Household Members by Age

Disease	AGE IN YEARS													
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+	n	%	n	%	n	%
Fevers	320	29	95	74	34	23	19	23	23	31.1	19	31.1	23	33.3
Gastrointestinal disorders	89	38	25	17	18	6	2	4	4	8.1	2	3.3	4	5.8
Head & Mind Disorders	50	63	40	16	19	10	9	8	8	13.5	9	14.8	8	11.6
Respiratory diseases	134	38	35	34	28	18	17	20	20	20.9	17	27.9	20	29.0
Bites	12	10	20	14	21	5	12	11	11	8.6	12	19.7	11	15.9
Trauma	20	7	7	2	5	0	2	2	2	1.2	0	0.0	2	2.9
Obstetrics/Gynaec.	1	1	13	5	0	0	0	0	0	0.0	0	0.0	0	0.0
Disorders	11	1	2	1	2	1	0	1	1	0.6	1	1.4	1	1.5
Leprosy	24	5	4	0	1	1	0	0	0	0.0	1	1.4	0	0.0
Skin diseases	20	6	0	0	0	0	0	0	0	0.0	0	0.0	0	0.0
Dental diseases	20	2.9	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	681	298	250	163	128	74	61	69	100.0	100.1	100.1	100.1	100.0	100.0

by bad luck, devils, bewitchment and other forms of social disruption for which a traditional healer is normally consulted. This may be the reason for such low utilization for traditional healers in our study.

Modern health services are costly compared to traditional health services mainly due to the sophistication of the facilities used. Governments are therefore unable to afford this type of service for the majority of its people. For this reason traditional healers should be encouraged after careful assessment of their therapeutic procedures to see which are not likely to be harmful and therefore to be deployed. Traditional birth attendants for example, can be taught to treat or refer some gynaecological and obstetrical conditions in addition to attending deliveries.

In summary of the pattern of diseases in Iringa and Arusha regions resembles that of the causes for admission and out-patient attendances in Tanzania in general. The majority of the household members sought health care from traditional health system, Iringa utilized them more than Arusha. The explanations given for such utilization pattern are found to be due to differences in disease pattern and to the types of illhealth for which people normally consult traditional healers. It is therefore, suggested that further studies should be carried out to determine the pattern of diseases for which traditional healers are normally consulted. This would require detailed interviews of key informants in the community.

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THE IMPACT OF TRADITIONAL HEALTH BELIEFS AND PRACTICES ON HEALTH CARE UTILIZATION PATTERNS

By J.K. Nguma

Abstract

This paper argues that traditional health beliefs and practices greatly influence peoples' decisions to seek health care and the nature of health care sought. Long after the introduction of Western medicine in developing countries, traditional healers continue to have a key role in the provision of health care among many communities. It is proposed that in the efforts to ensure "health for all by the year 2000", health planners in the developing countries should examine the role of traditional healers and explore possibilities of integrating them in the health care delivery system.

Introduction

The discovering of the "germ theory" in Europe in the 19th century laid a great foundation for what is now known as "Western Medicine". Armed with the "germ theory" Western medicine gained ground and the new medicinal profession that ensured started to claim monopoly in health care delivery over traditional homeopathic and herbal healers. These new developments set off some competitions for patients between physicians trained in the new scientific medicine and the traditional healers¹. These competitions have been and still are part and parcel of health care deliveries in both developed and underdeveloped countries.

This paper argues that even with the introduction of new Western medicine in a developing countries, the health care provided by traditional healers is still widely used due to the influence of traditional health beliefs. It is proposed that in the efforts to ensure "health for all by the year 2000", developing countries should not lose sight of the key role played by traditional healers in the provision of health care and that possibilities of integrating these practitioners into the official health care system should be explored.

Traditional Beliefs About Disease Causation

Traditionally, health care responsibilities in most developing countries (Asia, Africa, South America and Latin America) are placed upon the patient's family and his kin. Usually when an individual falls sick, the family members get together and embark on the search for causes of such sickness and its eventual treatment. This exercise is simple since the culture of each community has specific belief about disease causation, and the family's role in the diagnosis process is to identify the kind of etiological pattern the symptoms appear to follow.

Various studies have addressed the subject of disease causation or disease etiology^{2,3,4,5}. Clements² classified disease etiologies into three patterns according to peoples' beliefs. Foster⁵, on the other hand, classifies belief about disease causation into two categories. Both authors appear to

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be talking about the same thing, despite the differences in their classifications.

For example, Foster⁵ identified two general traditional disease etiologies. The first one is what he called personalistic etiologies. These are diseases believed to be caused by an active, (purposeful, intervention of an agent who may be human (a witch or sorcerer), non human (a ghost, an ancestor, an evil spirit etc.), or supernatural forces (a deity or other powerful being). Clements seems to have made two classifications out of personalistic etiologies. The first one consists of those diseases believed to be caused by supernatural agent. Here, a person may be stricken sick through the anger of gods for having broken some cultural taboos. Any other member of the victim's family breaking such taboos may also contribute to the same fate. The second category consists of those diseases believed to be caused by what he termed "contagious magic". In this pattern, a sorcerer or a witch obtains some part of the intended victims's body (e.g. hair, nail clippings, excrements or other articles such as clothing) and subject it to proper magical procedure which then strikes the victim sick.

Foster's second classification comprises naturalistic etiologies. In this category, diseases are believed to be caused by natural forces or conditions such as cold, heat, winds, dampness and, above all, by upset in the balance of the basic body elements. This classification parallels Clement's² category of diseases believed to be caused by what he termed "external material agents". Both Clements and Foster concur in this classification which pretty much resembles the western "germ theory" of disease causation.

Given the diversities existing in various communities, one has to admit that classifying all the beliefs about disease causality into two or three categories as seen above is an overgeneralization. Table 1 illustrates some of the diversities in the beliefs about disease causation observed in just a few of East African tribes. Although there appears to be some similarities in the beliefs about disease causation among these tribes, there are still some outstanding differences. Some tribes tend to attribute disease causation to multiple causes (e.g. Sebei, Toro, Sukuma and Nyamwezi) while others stick to only a few (e.g. Gogo and Kavirondo). Indeed much as one may question the methodology through which this information was obtained (e.g. it is hard to believe that the Kikuyu overlook the natural causes of disease causation). The important point here is that these classifications are always necessary to assist the patient and his family in the diagnosis process before appropriate health care is sought.

Table 1

Most Common Causes of Disease as Seen by Twelve East African Tribal Medical Systems

TRIBES	Ancestor Spirits	Broken Rules	Contagion	Evil Eye
Kavirondo	x	x		x
Kikuyu	x	x		x
Nyamwezi	x	x	x	
Sukuma	x	x	x	
Baganda	x	x	x	
Hadza		x		
Swahili	x			
Sebei	x	x		x
Toro	x		x	
Bakonjo	x	x	x	
Digo	x	x	x	x
Gogo	x			

CAUSES

Evil Spirit	God	Heredity	Natural Causes	Vague Evil Forces	Witch-craft
				x	x
	x	x			x
	x	x			x
x			x		x
x	x		x		
		x	x	x	x
x	x	x	x		x
					x
	x		x		x
					x

Adopted from Weisz⁶

Treatment Methodologies

Although therapeutic processes appear to differ from one community to another, they all tend to follow similar patterns. For example, when a patient falls ill, the family and his kinsmen get together to diagnose and seek appropriate treatment of his illness. In the diagnosis, process, the patient and his family go through the symptoms trying to place them in an appropriate class. Whether the family places the symptoms into either the naturalistic or personalistic class of disease causation (see figure 1) depends on the nature of the disease or similar ones. Once this is done, appropriate home remedies are applied.

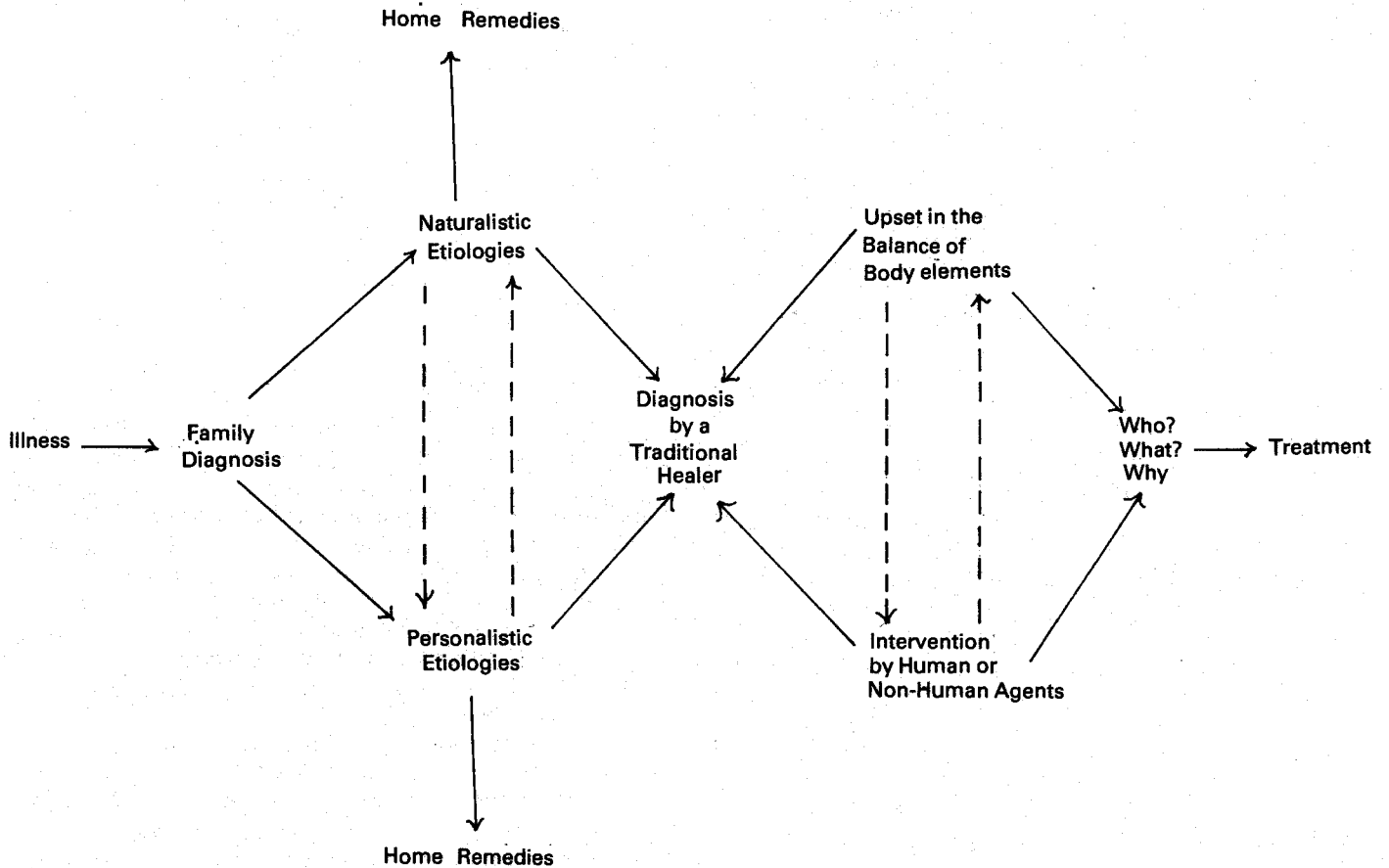
It is important to note that the two classes of disease etiologies are not mutually exclusive. For instance, based on the symptoms, the family may first diagnose the disease as having been caused by naturalistic forces and proceed to administer various home remedies that may range from herbal extracts, roots concoctions or some drugs purchased from nearby retail shop. If the symptoms persists, the family may rediagnose the disease and this time look into personalistic forces. Besides using appropriate home remedies and various herbs and roots concoctions, sacrifices aimed at appeasing ancestors or other spiritual beings may be added. With other symptoms, the family diagnosis may start with personalistic etiologies and proceed to administer the appropriate remedies, only to turn to naturalistic etiologies later following evaluation of the response to treatment. If the symptoms persist after trying various home remedies meant for naturalistic and personalistic etiologies, further diagnosis is sought from traditional healers.

Furthermore, the type of traditional healer selected depends highly on the perceptions of the family members of the possible nature of disease manifested by the symptoms. In most situations, the diagnosis made by traditional healer also tends to fall into either of the two classes of disease etiology (i.e. naturalistic and personalistic). Once the disease causation has been placed in either of these categories, the patient and his family together with the traditional healer then embark on a joint therapeutic exercise.

The nature of cures sought by the patient and his family are influenced not only by their beliefs about disease causation or etiologies but also depends on their understanding of the "levels" of disease causality. It is this very aspect that has been lacking or given less attention by the providers of modern health care services, consequently, turning away a lot of patients from such services.

FIGURE 1

Disease Diagnosis and Treatment Model in Traditional Communities



Literature on ethnomedicine suggests that people tend to share a theory that disease is just an instrument used to harm an individual and thus, there ought to be someone using this instrument to achieve such end⁵. This theory is elaborated by the identification of levels of disease causality. First there is a level that looks at the "who" or the "being" responsible for disease causation. Here, ghosts, witches and other supernatural beings are believed to be the prime beings responsible for disease causation. However, such beings use certain instruments to harm the intended victim. This leads to the second level which examines "what" or the "instrument" used to bring about harm on the individual. Like in the modern medicine, the role of traditional healer is to give the disease a name. Finally, there is a third level which attempts to answer the question "why" or the motives that such "being" may have in inflicting the particular harm or disease upon the individual. The traditional healer and patients' family try to address all these questions and coming up with some satisfactory answers for everybody.

Thus, if the disease happened to be a result of naturalistic etiologies, the patient and his family, together with the traditional healer look back into what transpired before the onset of the symptoms. If, for example, they find out that the individual had engaged in activities that may have upset his body equilibrium then, it answers the question "who" or what "being" is responsible for the illness, and in this case it will be the patient himself. There on, the procedure is simple since the traditional healer merely prescribe local medica-

tions that can either be obtained from the traditional healer himself or a herbalist.

If the symptoms persist after administration of these medications they either go back to see the healer or seek further treatment from other local specialists in the disease. It is to be noted here that the diagnosis by the traditional healer may either concur with that already made by the family members or differ from it. Just like in the case of family diagnosis, the two classes under which the traditional healer is likely to place his diagnosis are not mutually exclusive. Some disease may present symptoms that may be classified under naturalistic etiologies or simply an upset in the balance of body elements but on examining the levels of disease causality the traditional healer may find the root causes of the disease in the intervention by human or non-human agents and vice versa. Some traditional healers often try medications aimed at curing disease classified under naturalistic and personalistic etiologies and when the symptoms persists, advise the patient to see some other traditional healers or modern medical practitioners. Traditional healers specialized in symptomatic treatment for example, tend to use a variety of therapeutic procedure ranging from herbs, cupping, concoctions to message.

Given the variety of therapies these practitioners provide, it is common to find a good number of people in our communities relying solely on them as a source of health care. Even at places where modern health services are accessible, such people turn to the clinics only after they have

administered a variety of home remedies and at times use both services simultaneously.

Personalist etiologies with multiple levels of causation require more sophisticated therapies. Logically, such disease require the shaman with supernatural and/or magical skills or other traditional healers who then address the main concerns of the patient and his family. In the majority of cases the patient and his family are more concerned not with the "instrument" or the immediate cause of illness but rather with "who" and "why". However, even here, one finds some variations in what the individuals are more interested to know. For example, Jansen⁷ had this to say about the Xhosa: "They are less interested to know: *How* did it happen? rather than *Who* is responsible". On the other hand Imperato⁸ had a different observation among the Bambara: "In general, they want to know *why* they are ill and not *how* they got ill".

Once the "who", the "what" and the "why" of disease causation are known, the individual is advised accordingly to seek appropriate treatment for the immediate problem. Treatment modalities as seen in figure 1 vary, but highly depend on the beliefs of disease causation.

For example, diseases believed to be caused by a sorcerer or a witch may be treated by a traditional healer who first of all identifies the "being" involved and then treat the immediate problem. At times, he may go as far as providing the patient with protective medicines against similar harm in the future. Illness diagnosed as having been brought about by supernatural agency on the other hand may be cured through processes which usually require some sacrifices. The exercise involves manipulation of various symbols germane to patient's culture during such sacrifices.

Doctor — Patient Relationship

The discussions in the foregoing two sections paint a picture of what happens once an individual falls ill, the diagnosis made and the nature of medical therapy sought once the disease is placed in its appropriate classification.

Indeed, what is striking is that even now in the 20th century, when the western health services are accessible to many people, still, peoples' beliefs about disease causation appear to be a prime factor in their decisions to seek health care and the nature of health care they seek. In the Tanzanian situation, the past experience indicates that accessibility to modern health care services has been the major reason for low or non utilization of such services. Today, there is at least one clinic in the nearby if not in every village. Yet, a good number of our people are still stuck up with traditional healers and only go to the clinic as a last resort after trying various traditional cures.

Quite often, the argument has been that these people are lacking in health education and thus do not understand the effectiveness of the services provided by modern medicine. Even more seriously, it is alleged that they are too hung up in their traditional health beliefs and practices. Much as one may not object to the role of health education in human attitude and behaviour change, one would hesitate to assume that such changes can be achieved overnight. Further, and understanding and perhaps an appreciation of modern health services in itself is not enough to attract people to seek such services.

For example, the organization of modern health services and the manner in which such services are provided leaves a lot to be desired. As mentioned earlier, the key interest of the patient and his family in the therapeutic process is not

merely to cure the illness but to have a broad understanding of "who" is responsible for such illness and "why". Traditional healers are very much aware of such expectations and do all their best to provide such information to their clients in a plain and understandable language. As for modern health care services, the existing imbalance in the doctor — patient ratio in most developing countries, make it difficult for doctors to spend as much time with each patient to address all the burning concerns the patients may have. This shortcoming, when coupled with other inconveniences experienced by patients such as long walks from their home to the clinic, the long queues they have to go through before they finally see the physician, not to mention other extreme situations where they may not get any medication even after seeing the physician, makes future decisions for clinic attendance unpalatable. To date, in place where there is good accessibility to modern health services such as in towns and cities, there are still people who choose traditional healers over modern physicians.

The decision to seek modern health services becomes even more difficult when there are possibilities of the patient being hospitalized. Hospitalization is an anxiety arising experience not only for the patient but also for the family members and relatives. To start with, the patient is isolated from his family and kinship members, and attended by unfamiliar faces, a situation which makes him feel betrayed by his kinsmen. Secondly, the family members are not involved in the diagnosis and treatment of the patient which makes them less helpful to the patient during the recovery process after discharge from hospital. Thirdly, the patient himself is not provided with adequate information (if any) about his diases and at times he is not informed about what is being done to him and why. It is common therefore, for a patient to find himself surrounded by a number of health providers who only talk *about* him and not *to him*. This in no doubt makes the patient alienated, demoralized and anxious.⁹

The relaxed atmosphere and personal interest traditional healers take in the patient's total life-style, his relationships with others, his gender, as well as his moral and spiritual convictions, enhances patient's pride and feeling of self-worth.

Conclusion

The long history of traditional healers is too informative to be ignored. Although ineffective in some disease, the kind of care the tradition healers have been providing has earned them a lot of popularity. There is no doubt that modern health providers have a lot to learn from these practitioners and vice versa. While the traditional health beliefs and practices cherished by their clients constitute the prime factor for the success of traditional healers, the emphasis these healers place on the doctor — patient relationship and their awareness of the role of cultural and emotional aspects on physical disorders appears to have a great contribution towards their popularity.

The reality to be reckoned with here is that the traditional healers have been, and will still be working alongside the modern physician, treating more or less the same clients. It is critical therefore, for the health planners to examine the various activities of traditional healers so as to determine the kind of contributions they will have in the primary health care program. As it has been suggested by others¹⁰ health planners should determine the numbers and location of these

practitioners, the diagnostic and therapeutic methods they employ, as well as their role in their respective communities. Based on this information, those practitioners who will be deemed as suitable for integration into the official health care system will further be assessed to determine the kind of orientation they have had, if any, and what type of training they may need to improve their services.

Given their already accepted role in their respective communities, the provision of basic orientation to these practitioners together with adequate supervision will greatly enhance the general health care provision in their communities. Further, with adequate orientation, traditional healers can be used to spearhead some of the basic health programs in our communities such as sanitation, immunization, nutrition and child survival and development.

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Dr. B. Sibanda and Dr. T.E.C. Harvey on Collaboration of Allopathic Orthodox Medical Practice with Traditional Healing Methods in Zimbabwe.

Zimbabwe is one African country where specific moves have been made towards the intergration of modern and traditional medicine. One such move is the establishment in Bulawayo of the Zimbabwe Traditional and Medical Clinic.

The conference was attended by a delegation of two persons Dr. Sibanda and Dr. Harvey from the Zimbabwe Traditional and Medical Clinic who had the opportunity to brief the participants about the centre and its activities.

Zimbabwe Traditional and Medical Clinic offers both traditional and modern medical care. A patient coming to the Centre has the option of choosing between the two forms of medical care which are available under one roof. Besides the initial choice which the patient can make the practitioners of one form of medical practice may refer the patient to practitioners of the other form of medical practice.

In her presentation Dr. Sibanda made the point that the clinic allows not only for treating illnesses with which people present but also for identifying and dealing with any social-psychological factors associated with such illnesses. Practitioners at the Centre strive to treat the whole person and not only that part of the body which is diseased. Their joint practice and medicines in effect deal not only with the physical or biological diseases but also with the mental, spiritual and social aspects of the disease situation.

Dr. Harvey, himself a modern medical doctor, reported that he sends to traditional healers patients that he cannot cure. Many of these tend to have psychosomatic disorders. He claimed that the approach used by traditional healers in dealing with such disorders is much more dynamic, that tranquillisers are not used, and that an explanation as to why a disorder is present is offered in terms which the sufferers understand. Furthermore traditional healers may prescribe ablation, prayers and rituals besides performing some form of hypnotherapy as well as giving herbal concoction to drink, including for-bidding the sufferers to do certain things. All this the patients understand and fits in with the background to their social and cultural life. He contrasts this to the approach of modern doctors who in their ignorance often claim that what the traditional healers practice is black magic, voodoo rites or witchcraft. Dr. Harvey admitted however that not all traditional healers are of the same calibre as the one he has worked with and come to trust. He also indicated that psychosomatic disorders are not the only types of illnesses which he refers to traditional healers.

Address of Dr. Stephen Moses, Regional Representative for Eastern and Southern Africa, Health Sciences Division, IDRC, to the International Conference on Traditional Medicine, Arusha, 6 - 8 October, 1986.

The involvement of the International Development Research Centre (IDRC), Canada, in supporting research in the field of traditional medicine began in the early 1970s in Zaire. Research was conducted by the "Department de 1 "Enseignement superieur et de la Recherche scientifique" of the Republic of Zaire, and resulted in a publication entitled "Traditional Medicine in Zaire: President and Potential Contribution to the Health Services" (IDRC-137e). This work was followed by research projects on traditional medicine and traditional birth attendants in Egypt, Ecuador, Nepal, Thailand and the Philippines. Currently, research in this field is being sponsored by IDRC in the Philippines, Sudan, Tanzania, Kenya and Zimbabwe. Thus IDRC has been part of the

Dr. B. Sibanda and Dr. T.E.C. Harvey,
Zimbabwe Traditional and Medical Clinic,
Bulawayo.

Dr. S. Moses,
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process which has led traditional medicine as a legitimate, and indeed crucial, element in primary health care.

I am very pleased that IDRC has had the opportunity to be involved in this important conference on traditional medicine, and that I have been able to attend. I would like to congratulate Mr. Mshiu and his colleagues in the Traditional Medicine Research Unit of the University of Dar es Salaam for their superb organizational work and their initiative in putting the conference together.

I would also like to congratulate the investigators from the University of Dar es Salaam on the quality of their research, with respect to both the IDRC-supported project on traditional medicine and other studies conducted by scientists in the Department of Behavioural Science, Community Medicine, Epidemiology and Biostatistics, and other departments. Participants from outside Tanzania have in addition made extremely important contributions regarding issues in traditional medicine globally, and in particular in Kenya, Uganda, Zimbabwe, Nigeria and Zaire.

The many papers presented at the conference have been interesting, provocative and controversial. Extremely important concepts have been introduced and discussed. Perhaps more questions have been raised than answers provided but this is not, I feel, a cause for concern. Debate on traditional medicine internationally, and particularly in Africa, is still in its early stages, and if we subscribe to Murray Last's analysis, will continue for some time, perhaps well beyond the year 2,000. Much work remains to be done, but I think you will all agree that much has already been accomplished.

Although in a sense this conference marks the end of three years of research in Tanzania, I see it as signifying a beginning more than an ending. In the first instance, I expect that several publications will emerge from the Tanzanian research, in both local and international fora. In addition, the Proceedings of this Conference will likely be published as a special issue of the *Tanzania Medical Journal*. It is clear, however, that more research is needed, and the issues identified so clearly by Dr. Akerele in his paper must be addressed over the coming years. IDRC, the World Health Organization, and many other international agencies, governments, academic institutions, and non-governmental agencies will assist in this process.

In the final analysis, however, it is of course action which is required, and we know that the link between research and action can be problematic. The people in this room will be involved in making that link, and working with colleagues, with traditional practitioners, and with communities to this end. The real challenge in the years ahead, then, is to "make it happen," i.e., to ensure that traditional medicine occupies its rightful place in the delivery of health services and in the improvement of the health and well-being of people, which is the chief concern of us all. Thank you very much, Mr. Chairman, for allowing me this opportunity to address the conference.

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