CHAPTER 4

USERS OF TRADITIONAL HEALTH CARE

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 affecting the population in general as well as the therapeutic efficacy of the available services.

However, one of the problems affecting the recognition and effective deployment of traditional health practices by the modern medical practitioners is the different concept of disease causation that are so 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 an prejudice. Traditional systems have always been with the people and the concept of disease causation in the general population bears much resemblance to 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 supresses the other as is the tendency with the modern system in many countries which tends to look down upon traditional healing systems.

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 belong[1]. 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 chapter 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 the extent to which people use the services provided by traditional healers.

Methodology

Details of the methodology have been outline in chapter 2.

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 sign and sysmptoms by those interviewed and not based on standardized procedures it was not possible to classify them according to the International classfication of diseases. For example, all diseases producing fever as their main symptom were placed in one group, those producing predominantly gastrointestinal sysmptoms 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 Tanzania's most frequent cause of admissions to hospitals and OPD attendances[3], and the ranking was found to compare rather well with only minor differences (Table 4.1.). Fevers, respiratory diseases and gastrointestinal disorders were found to rank high on the lists. 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 4.1

COMPARISON OF THE TOP TEN DISEASES FOR TANZANIA AND THE TOP TEN DISEASE GROUPS FOR THE TWO STUDY REGIONS. IRINGA AND ARUSH

	TANZANIA		IRINGA		ARUSHA	
Cause of OPD Attendance and % of all attendances	Cause for admission & % all admissions		Diseases group and % of all diseases		Diseases group & % of all diseases	
1. Malaria (all forms)	12.97	Deliveries and Pregnacy Complications	16.2	Fevers	31.1	Fever	3?
2. Symptoms and ill defined conditions	8.02	Malaria (all forms)	9.0	Gastrointestinal disorders	20.3	Respiratory disease	??
3. Gastroenteritis	6.77	Pneumonias	8.4	Head and mind disorders	13.6	Head and mind disorders	12
4. Ulcers	6.35	Gastrointe- stinal dis	7.1	Repiratory diseases	11.6	Gastrointe- stinal dis.	10
5. Other diseases of the digestive system	6.33	Measles	4.8	Bites	5.5	Bites	?
6. Other diseases of the Respiratoty systm	6.72	Parasites	2.4	Trauma	4.2	Trauma	?
7. Nutritional deficiencies	5.25	Respiratory dis. other than pneumonia	2.2	Obstetrical and Gynae- cological Disorders	2.2	Skin diseases	1
8. Accidents. poisoning & Violence	4.85	Iron Deficiency Anaemias	1.9	Leprosy	2.1	Dental dis.	?
9. Bronchitis	4.44	Trauma	1.4	Skin disease	1.7	Obstetrical & Gynaecological dis.	
10. Pneumonias	3.65	Tuberculosis	1.4	Dental diseases	1.5	Leprosy	

Table 4.2

DISTRIBUTION OF THE SICK HOUSEHOLD MEMBERS IN IRINGA BY TOP TEN DISEASE CATEGORY AND AGE

Disease Category	A G E	I N		Y E A R S				
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Fevers	274 (37.1)	100 (35.1)	35 (23.3)	34 (35.4)	9 (23.7)	7 (25.9)	10 (32.3)	2 (11.1)
Gastro Int. Dis.	162 (21.9)	50 (17.5)	29 (19.3)	16 (16.7)	14 (36.8)	6 (22.2)	2 (6.5)	3 (16.7)
Head & Mind. Dis.	77 (10.4)	78 (27.4)	47 (31.3)	20 (20.8)	4 (10.5)	1 (3.7)	7 (22.6)	2 (11.1)
Respiratory	108 (14.6)	31 (10.9)	7 (4.7)	6 (6.3)	3 (6.3)	7 (25.9)	4 (12.9)	3 (16.7)
Bites	22 (3.0)	19 (6.7)	8 (5.3)	6 (6.3)	6 (15.8)	2 (7.4)	3 (9.7)	5 (27.8)
Trauma	25 (3.4)	2 (0.7)	5 (3.3)	6 (6.3)	1 (2.6)	1 (3.7)	0 (0.0)	2 (11.1)
Obs.& Gynae. Dis.	2 (0.3)	2 (0.7)	15 (10.0)	8 (8.3)	0 (0.0)	2 (7.4)	0 (0.0)	0 (0.0)
Leprosy	30 (4.1)	1 (0.4)	0 (0.0)	0 (0.0)	0 (0.0)	1 (3.7)	2 (6.5)	1 (5.6)
Skin diseases	19 (2.6)	1 (0.4)	4 (2.7)	0 (0.0)	1 (2.6)	0 (0.0)	3 (9.7)	0 (0.0)
Dental 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)
	739(100)	285(100)	150(9907)	96(100.2)	38(100.1)	27(99.9)	31(99.9)	18(100.2)

Table 4.3

DISTRIBUTION OF THE SICK HOUSEHOLD MEMBERS IN ARUSHA BY TOP TEN DISEASE CATEGORY AND AGE

Disease Category	AGE	IN	YEARS					
	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70·
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Fever	320 (47.0	29 (43.3)	95 (38.0)	74 (45.4)	34 (26.6)	23 (31.1)	19 (31.1)	23 (33.3)
Gastro Int. Dis.	89 (13.1)	38 (12.8)	25 (10.0)	17 (10.4)	18 (14.1)	6 (8.1)	2 (3.3)	4 (5.8)
Head & Mind Dis.	50 (7.3)	63 (21.1)	40 (19.6)	16 (9.6)	19 (14.8)	10 (13.5)	9 (14.8)	6 (11.6)
Respiratory Dis.	134 (19.7)	36 (12.8)	35 (14.0)	34 (20.9)	28 (21.9)	18 (24.3)	17 (27.9)	20 (29.0)
Bites	12 (1.8)	10 (3.4)	20 (8.0)	14 (8.6)	21 (16.4	5 (20.3)	12 (19.7)	11 (15.9)
Trauma	20 (2.9)	7 (2.3)	7 (2.8)	2 (1.2)	5 (3.9)	0 (0.0)	2 (3.3)	2 (2.9)
Obs. & Gyane. dis.	1 (0.1)	1 (0.3)	13 (5.2)	5 (3.1)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Leprosy	11 (1.6)	1 (0.3)	2 (0.8)	1 (0.6)	2 (1.6)	1 (1.4)	0 (0.0)	1 (1.5)
Skin diseases	24 (3.5)	5 (1.7)	4 (1.6)	0 (0.0)	1(0.8)	1 (0.8)	0 (1.4)	0 (0.0)
Dental Dis. ·	20 (2.9)	6 (2.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
	681(99.9)	298(100.0)	250(100.0)	163(100.0)	128(100.0)	74(99.5)	61(101.8)	69(100.0)

Modern health care service utilization was the higher of the two forms of health care in both regions but it was higher in Arusha than in Iringa. There was some tendency for utilization to decline with age in both regions but his could be a cohort effect. Traditional Health Care service utilization being second to modern health care service was slightly higher in the older age groups, Iringa having higher utilization rates than Arusha in this age group. Utilization of both services for the same illness had the lowest frequency. Older age groups tended to utilize both services for the same illness more than the younger ones and Iringa utilized this combination of services more than Arusha.

The results also show that there is a significant difference in the health service utilization rate between Iringa and Arusha but virtually no differences between the sexes. Although utilization rates are higher for Modern than for Traditional health services, the order of utilization by disease category was quite different. Diseases like paralysis, obstetric and gynaecological disorders and unknown diseases or diseases with ill-defined symptoms ranked high in traditional healer utilization while they ranked low in modern health service utilization.

Disease outcome by age

Recovery was more among the younger age groups, improvement was almost constant throughout the age groups and chronicity, i.e. no change in the clinical manifestations was reported more frequently among the older age groups. Interestingly the group in which age was not stated had the same pattern of disease outcome for both regions (Table 4.7 and 4.8).

TABLE 4.7

DISTRIBUTION OF SICK HOUSEHOLD MEMBERS BY AGE   AND DISEASE
OUTCOME (IRINGA)

DISEASE OUTCOME

AGE	RECOVER	IMPROVE	NO CHANGE	TOTAL
0-9	481 (44.6)	416 (38.6)	181 (16.8)	1078
10-19	162 (41.5)	153 (39.2)	75 (19.2)	390
20-29	111 (38.9)	110 (38.6)	64 (22.5)	285
30-39	71 (37.6)	75 (39.7)	43 (22.8)	189
40-49	35 (35.0)	37 (37.0)	28 (28.0)	100
50-59	16 (27.1)	21 (35.6)	22 (37.3)	59
60-69	15 (23.8)	31 (49.2)	17 (27.0)	63
70+	9 (23.1)	14 (35.9)	16 (41.0)	39
Not stated	64 (29.1)	84 (38.2)	72 (32.7)	220
TOTAL	964 (39.8)	941 (38.8)	518 (21.4)	2423)

Table 4.8

DISTRIBUTION OF SICK HOUSEHOLD MEMBER BY AGE AND DISEASE
OUTCOME (ARUSHA)

DISEASE OUTCOME

AGE	RECOVER	IMPROVE	NO CHANGE	TOTAL
0-9	357 (49.9)	212 (29.6)	147 (20.5)	716
10-19	138 (42.7)	96 (29.7)	89 (27.6)	323
20-29	79 (30.4)	94 (36.2)	87 (33.5)	260
30-39	60 (33.9)	54 (30.5)	63 (35.5)	177
40-49	32 (22.7)	48 (34.0)	61 (43.3)	141
50-59	17 (21.0)	25 (30.9)	39 (48.1)	81
60-69	15 (21.1)	23 (32.4)	28 (36.8)	71
70+	14 (18.4)	34 (44.7)	28 (32.2)	76
Not stated	26 (29.9)	33 (37.9)	28 (32.2)	87
TOTAL	738 (38.2)	619 (32.0)	575 (29.8)	1932

Disease outcome by type of service utilized

All the household members in the surveyed areas who developed illness of whatever kind during the period of one months prior to the survey period were recorded. The wife of the head of the household, or the female head of household, was asked to say where treatment was sought for the illness and what the outcome was. Disease outcome was defined according to how the respondent felt was the result of treatment.

Tables 4.9 and 4.10 show that for a given method of treatment (modern, traditional or both the proportion recovering was the same for both regions. The proportion was slightly higher with modern than traditional care but the proportion reporting improvement was higher among users of traditional than of modern treatment.

On the whole as far as disease outcome is concerned the two health care systems are comparable although comparison was not made according to type of disease. The disease outcome patterns were similar for both Iringa and Arusha.

Table 4.9

DISTRIBUTION OF SICK HOUSEHOLD MEMBERS BY METHOD OF TREATMENT
AND DISEASE OUTCOME (IRINGA)

DISEASE OUTCOME

METHOD OF TREATMENT	RECOVER	IMPROVE	NO CHANGE	TOTAL
Modern	759 (44.2)	633 (36.8)	327 (19.0)	1719
Traditional	117 (35.3)	134 (40.5)	80 (24.2)	331
Both	88 (23.6)	174 (46.6)	111 (29.8)	373
TOTAL	964 (39.8)	941 (38.8)	518 (21.4)	2423

Table 4.10

DISTRIBUTION OF SICK HOUSEHOLD MEMBERS BY METHOD OF TREATMENT
AND DISEASE OUTCOME (ARUSHA)

DISEASE OUTCOME

METHOD OF TREATMENT	RECOVER	IMPROVE	NO CHANGE	TOTAL
Modern	626 (41.0)	490 (32.1)	411 (26.9)	1527
Traditional	58 (34.1)	61 (35.9)	51 (30.0)	170
Both	54 (23.0)	68 (28.9)	113 (48.1)	235
TOTAL	738 (38.2)	619 (32.0)	575 (29.8)	1932

Discussion:

Although there are many ways in which the top ten causes for admission and OPD attendance resemble the groups of diseases for Iringa and Arusha in this study there are some striking differences like those seen for obstetric and gynaecological disorders. This constitutes the commonest cause for hospital admissions but one of the least common 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 4.1 that respiratory diseases rank
high in the group of diseases for Iringa and Arusha while they
do not rank so high in the OPD 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 cause 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 since although proportional morbidity rates were used
to compare the two regions their population structures were
almost the same since the same interviewers were used in both
regions.

The results have shown that the greatest proportion (73.5%) of
the household members who developed illness during the one
month period before the interview sought health care from
modern health care services, ie. hospitals, health centres and
dispensaries. The finding is in great contrast to that of
other studies elsewhere where majority of those interviewed
would prefer to consult traditional healers rather than modern
medical services for various health problems. Of those
interviewed in an Ethiopian study 45.6% consulted traditional
healers, 32.8% consulted modern medical services and 21.6%
consulted transitional health services whenever they had
health problems[4]. The difference between our study and the
Ethiopian one is that we dealt with people who had developed
disease during the preceeding one month period while the
Ethiopian study interviewed individuals who had developed
disease in the preceeding one year period.

The reasons for such health service utilization contrast are
not clear. In Botswana which is also 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 patients[5]. However,
the experience of other workers shows that traditional curing
systems do not simply fade away when confronted with Western
Style medicine[6-10].

In a study involving high school students in Liberia the
majority of the students (ages 18-22) did not prefer the
services of traditional healers[11]. In another study in Nigeria
it was shown that educated people tend to utilize the orthodox
system while the lliterate and uneducated ones prefer the
traditional health system[12]. 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 have influenced 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 any head of household was ordinary level secondary school and even at this level only a few household heads had achieved it. Our results show that for the educational levels studied (None, low and medium), increasing levels of education did not influence health care utilization pattern. It is therefore not know if higher educational levels would influence the utilizaion pattern.

In Tanzania the level of literacy is the highest among other developing countries in Africa but is not clear how much this achievement contributed towards our findings. The limitation with our study that might have influenced our result is that the interviews were not indepth and detailed enough to obtain the true pattern of illhealth or health service utilization. The pattern of illhealth obtained seemed mostly to reflect physical types of illhealth and not the type of illhealth such as would be brought about by bad luck, devels, bewitchment and other forms of social disruption for which a tradiₜtional 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 sophiscation 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 to continue with their practices 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 tdught to treat or refer some gynaecological and obstetrical conditions in addition to attending deliveries. Disease outcome by type of service utilized was found to differ between the two categories of health systems and in those who utilized both systems for the same illness. However households tended to mention only those diseases which would most likely end in modern health care service. This type of bias would tend to exaggerate modern health care utilization and therefore its treatment outcome.

Conclusion

The pattern for the groups of diseases for Iringa and Arusha regions resembles that of the causes for admission and OPD attendances for Tanzania in general. The majority of the household members sought health care from modern health services and among the few who sought health care from traditional health systems, Iringa utilized them more frequently than Arusha. The explanations given for such utilization patterns are found to be due to differences in disease pattern and to the types of illhealth given as responses by the people, which did not represent the type of disease for which the people would normally consult

traditional healers.   Traditional health care has a lot of potential in the management of ill-health in the community. It is therefore suggested that further studies should be carried out to determine the pattern of diseases for which traditional healers are normally consulted as well as their treatment outcomes. This would then require indept interviews of key informants in the community.

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CHAPTER V

Conclusions:

Surveys have been the basic method of obtaining information from the population on health related subjects. The method is not devoid of limitations but a trade off ensures an acceptable validity of the information collected. Chapter two on methodology well elaborate the quality of the interviewers and their recruitment. Within and between observer variation was well minimized by the extensive centralized training, their participation in the pretest and subsequent questionnaire modification.

For any society the people have their own way of alleviating pain and suffering. Modern medicine could be regarded as alien to African culture. Beck (1) describes the introduction of modern medicine into the then Tanganyika as early as late 1800s. The introduction of modern medicine was initially meant to cater for the European population, and later extended to the indigenous population. While it is almost a century since its introduction of modern medicine, traditional medicine is still being practiced even in areas with easy access to modern health care services. Hence, the flourishing of traditional medicine cannot only be explained by unavailability of modern medicine.

In chapter three the opinions of the traditional healers and Traditional Birth attendants towards modern medicine are well

discussed. Some of the shortcomings of modern health workers
cited could be implying that modern health workers hold a
distinctive position supported by their sophisticated and rich
paraphenelia.

Also their practices have little room for outsiders to know
what happens during diagnosis and treatment stages. In
addition, even patients and relatives have minimal roles in
the diagnosis and treatment processes. As further suggested
these are issues the modern health workers could address
themselves to.

The traditional healers agreed that there are a number of
health problems which they cannot treat and hence would refer
them to modern health workers or institutions. They also
implied that they only refer a patient when he/she is
suffering from a disease they believe traditional medicine
would be effective or when the patient does not improve on
their traditional regimen.

While the Traditional healers admit that their ability is
limited in some cases only, they also think that modern
medicine is effective for particular diseases only. It is
therefore important to carry out indepth studies to evaluate
the traditional healers practices to be based on utilization
patterns and disease treatment outcome. It is after such
evaluation that someone can plan for effective collaboration
between traditional and modern medicine. The evaluation would

enable one know which particular health problem if any, would better be treated by traditional medicine and vice versa.

Modern health workers in this country at one time did express positive attitudes towards traditional healers, but with a contention about the efficacy of their traditional herbal preparations. It is possible that modern health workers lack adequate information about the practices of traditional medicine as a whole[2].

More than half of the TBAs were of the opinion that they cannot benefit from training in hospital environment. At the same time almost the same percentage thought that they are competent enough to practice on their own or elsewhere. However, a larger proportion accepted the opinion that TBAs can improve their knowledge and skills by learning from midwives and doctors at the hospital. This strongly suggest that collaboration is accepted by the traditional healers and TBAs. Such collaboration as could start by working together rather than subjecting them to class-room work. Referring patients to modern health care by traditional healers and probably vice versa as a step towards collaboration received minimum support in this study. There are Probably two explanations why collaboration between the two systems of health care is yet to take place. The lack of information about the success of traditional medicine puts the modern health workers in a ambivalent situation regarding referring patients as a step towards collaboration. The traditional healers are not aware of what constitutes modern health care

systems as they often see the modern health workers avoiding the practices of traditional healers. Si&nce modern medicine is institutionalized and backed by law this leaves traditional healers resigned and in an indecisive position. This therefore calls for the Government to formulate a clear policy and guidelines to guide and protect the practices of traditional healers in this country.

Due to the nature of modern medicine with its well tested means of acquiring new knowledge, storage and dissemination of information, traditional medicine has gradually become ignored. There are no means of record keeping and, information is passed from one generation to another by oral tradition. This study came up with two distinctive groups of traditional healers in acquiring the healing skills, mainly those who came into being by apprenticeship and those who came into being by what is believed to be supernatural powers. For various reasons many traditional healers do not have intentions to train anybody to take over their practices when they die. This is probably due to fears of their healing powers being eroded by the ones they train or due to other educational opportunities opening new professional avenues to the new generation. Though the literacy level amongst traditional healers has not been ascertained, it calls for efforts of encouraging all traditional healers to document keep records of all their practices as well as to train others in order to pass on the healing knowledge and skills from one generation to another. Those practices found to be of value could then be incorporated into the training curriculum of

modern health workers, as well as mean a step towards

instutionalizing traditional medicine.

A very high proportion of the household members who reported

being sick during the recall period have been in the care of

modern medicine. However during confinement for delivery,

traditional birth attendants were called in to assist with

delivery for about 60% of the cases. It is well illustrated

in chapter 3 that the importance of delivering at home is to

observe the cultural norms and practices. It is therefore

conceivable that with such deep seated cultural convictions

there is no doubt that it will take long to get them changed.

The TBAs opinions and reasons for referral suggest that those

with prolonged labour are more likely to be referred by TBAs

to modern medical facility than those with other problems of

labour for referal, while the likelihood was very low for

placenta retention. For this reason TBAs should be made to

realize the importance of the dangers associated with the

various pregnancy complications, through education, and

working together.

The level of morbidity elicited by the questionnaire did not

differ from that reported as outpatient attendances.

Education of the head of household did not influence

utilization of either health systems. However there was a

decreased utilization as age advanced but a slight increase at

older ages

The outcome of treatment seemed better for younger age groups

while it was more of improvement for the older age groups.

It can be argued that these observations could still be made

without any intervention, however the validity of this

statement needs to be tested. This further supports the afore

mentioned-recommendation that a more detailed study of the

outcomes of both treatment modalities is warranted at the

general population level, and so should the factors

influencing treatment outcome.

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