



Durham E-Theses

An Auto-Ethnographical Study of Integration of Kanuri Traditional Health Practices into the Borno State Health Care System

El-Yakub, Kaka

How to cite:

El-Yakub, Kaka (2009) *An Auto-Ethnographical Study of Integration of Kanuri Traditional Health Practices into the Borno State Health Care System*, Durham theses, Durham University. Available at Durham E-Theses Online: <http://etheses.dur.ac.uk/171/>

Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in Durham E-Theses
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full Durham E-Theses policy](#) for further details.

Academic Support Office, Durham University, University Office, Old Elvet, Durham DH1 3HP
e-mail: e-theses.admin@dur.ac.uk Tel: +44 0191 334 6107
<http://etheses.dur.ac.uk>

**AN AUTO-ETHNOGRAPHIC STUDY OF
INTEGRATION OF KANURI TRADITIONAL
HEALTH PRACTICES INTO THE BORNO
STATE HEALTH CARE SYSTEM**

by

Hajja Kaka El-Yakub

**a thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
School of Applied Social Sciences
Durham University
November 2009**

**Supervisors:
Prof. David Byrne and Dr Andrew Russell**

Contents

Declaration		i
Abstract		ii
Acknowledgements		iii
Dedication		v
Chapter One	Introduction	1
Chapter Two	Borno State and Kanuri Society: The Context of Social Change	27
Chapter Three	Methods	51
Chapter Four	The Formal Healthcare Delivery System in Nigeria and in Borno State	73
Chapter Five	Traditional Healthcare in Borno State	97
Chapter Six	Traditional and Biomedical Healthcare Practices in Their Social Context in Borno and Beyond	128
Chapter Seven	Views of Biomedical Professionals on Some of the Kanuri Traditional Health Practices	159
Chapter Eight	Views of Lay People and Traditional Practitioners on Some of the Kanuri Traditional Health Practices	178
Chapter Nine	Conclusion and Recommendations	192
Appendix I	Rites of Passage	202
Appendix II	The Formal Organization of Healthcare in Borno State	215
Appendix III	Interview Schedule/Questionnaire Design	221
Bibliography		224

DECLARATION

The copyright of this thesis rests with the author. No quotation from it should be published in any format, including electronic and the Internet, without the author's prior written consent. All information derived from this thesis must be acknowledged appropriately.

Hajja Kaka El-Yakub

ABSTRACT

AN AUTO-ETHNOGRAPHIC STUDY OF INTEGRATION OF KANURI TRADITIONAL HEALTH PRACTICES INTO THE BORNO STATE HEALTH CARE SYSTEM

Hajja Kaka A. El-Yakub, November 2009

There are many forms of traditional health practices in Nigeria, many of which are at odds or conflict with orthodox western biomedical practices. Yet they are highly patronized, especially by rural dwellers who make up about 80 percent of the country's population.

The objective of this thesis is to consider the traditional health practices of the Kanuri people of Borno, NE Nigeria, and the extent to which they may harm and endanger the lives of people especially mothers and children. The context of the study is the high rates of maternal and infant mortality in the state. I occupy a dual role as both an upholder of the traditions of the Kanuri people (including their health traditions) and a public health professional. The dissonance and paradox inherent in this dual role is illustrated with first-hand examples throughout the thesis. It gave me the motivation to undertake this piece of research with a view to reducing the rhetorical gap between theory and practice which pertains in the state in regard to integrating the two systems, the co-existence and integration of which is promoted by the health policy of the country as a whole.

Formal ethnographic research was conducted during a five year period from 1999 to 2005. The philosophy of reflexivity was adopted, drawing on my earlier experiences in an auto-ethnographic manner. Data triangulation was employed due to the complex nature of the research. Focus group discussions, interviews and questionnaire administration were employed with different categories of research subjects – traditional and orthodox health workers, urban and rural mothers.

The results show that western-trained health professionals in the state stand between their own culture, which is of course changing, and the global professional identities they have acquired through professional development and training. At the same time the traditional healers can no longer operate in a context separate from official western-based systems which co-exist with the traditional practices and are widely known to the general public in Borno. Historically, the systems have been in opposition. Now there is supposed to be collaboration and overlap.

ACKNOWLEDGEMENTS

I am indebted to the Almighty Allah for making me what I am today, so also to my parents Ahmed and Habiba Khadi, especially to my mother who took the pains of staying with my children any time I travelled to England for the programme. She did not survive to see its completion.

I must thank sincerely the Borno State government and Governor Dr Ali Modu Sheriff, and his wife Mrs Fatima Ali Sheriff, for giving me both moral and financial support that contributed greatly to the success of the programme.

I acknowledge with gratitude my supervisors Professor David Byrne in the School of Applied Social Sciences and Dr Andrew Russell of the Department of Anthropology, both at Durham University, England. I have been inspired by their encouragement, giving of expert technical advice as well as showing keen interest towards the success of this ethnography. I am short of words to express my gratitude to both of them who, in spite of their tight schedules, were able to give me attention as desired.

I acknowledge with thanks the concern of Sarah Dawson, without whose help the programme would not have taken off and matured. She assisted in no small way from the beginning until the maturation of the programme. Also in this category Mrs Yabawa Wobi highly deserves my appreciation as her assistance contributed to the maturation of the programme in a big way.

My special acknowledgement goes to Professor B.A. Omotara (who is my mentor) whose encouragement motivated my academic pursuit to this level.

I should be ungrateful if I did not acknowledge with gratitude M. Iargema Bukar who assisted in the collection and collation of the triangulated data and Baba Gana Allamin who assisted in the packaging. And to the following people who participated as respondents – Fati Alkali, M. Aja Zannah Yerima, M. Bukar, Dr Alphous, Dr Gajere, Mrs Ashe Barde, Hajja Kanumbu Kachalla, Bawa Gana Tijani, Ya Mali Baba Shehu, Zara Maaji, Baa Wanzama and others too numerous to mention and those who wish to remain anonymous even at the point of acknowledgement.

Lastly but by no means least are the members of my family, friends and well-wishers who are too numerous to mention individually but include the following:

My husband Alhaji Mohammed El-Yakub, my daughter Fatima, niece Fati, sons Yakub and Ahmed, Mustafa Shehu and Yafati my house help.

Among my friends, the Bukar Wobis highly deserve my acknowledgement for their assistance at the beginning of the programme.

I must thank Ms M.K. McCarthy whose encouragement gave me some sense of belonging in a faraway home. Her encouragement contributed in no small way in making the programme a success.

I also thank with gratitude Yagan Jibrin my niece, whose concern has given me a sense of belonging in faraway England and to Fariba and family for the nice lunches at weekends in Durham that bridged my nostalgis for home and home foods.

I thank the Honourable Commissioner of Health Dr. Asabe V. Bashir and all my Director colleagues in the Ministry of Health, Borno State, for the cooperation and understanding.

I am sincerely grateful to Dr. Alhavi Bulama Mali Gubio without whose assistance and intervention the programme could have been a failure when he was the Permanent Secretary for Scholarships, and to Alhaji Maina Wadai the Secretary of Scholarships. And lastly but by no means the least to Dr Antia Bassy who took the pains of editing this thesis in spite of the tight schedules of his work. My PhD examiners, Dr. Dorothy Hannis and Dr. Gina Porter, commented on an earlier version and made inestimably useful suggestions for its improvement. Any errors and omissions remain my own.

DEDICATION

To my mother and father

Hajja Habiba and M. Ahmed Khadi

CHAPTER ONE

INTRODUCTION

1.0 INTRODUCTION

Paradoxically I am in a situation of dialectics, not of materialism as Marx puts it, but rather a paradox of roles. My role as horn to the traditional royal family of the *Mainin Kinandi* of Borno comes with the expectation that I will preserve Kanuri culture. At the opposite end, the expectation that comes with my technical professional role as a highly trained Nurse, Midwife, Midwife tutor, Health and Social Worker, and Public and Health Administrator requires that I uphold proper biomedical standards. These simultaneous roles create a dilemma, given the opposition between the two. Sometimes I feel I am a deviant when I fail to get the two opposite ends to meet in the middle. Dialectics, whether of materialism or roles, is chaotic. What a paradox!

The issue of the relationship between traditional health practices and bio-medical health care systems is one that is very relevant in Nigeria. The country has two systems of health care, namely, the western orthodox type that came with colonialism in 1900, and the traditional African type (which is as old as African tradition) that was well established before colonialism. This thesis investigates the relationship and interactions between the two at

both the personal and public levels in Borno State in North Eastern Nigeria, with a focus on ascertaining areas of compatibility and promoting integration of the two systems.

The western orthodox (biomedical) health care system is based on a three-tier system of Primary, Secondary and Tertiary healthcare delivery. It is supported by a policy document entitled 'The National Health Policy and Strategy to Achieve Health for All Nigerians' (1988). The policy document has its backing from the constitution of the Federal Republic of Nigeria. According to the policy:

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

(Federal Ministry of Health 1988: 7)

Although the policy, with its focus on Primary Health Care (PHC), has been in place since the mid-1980s, the health care situation in Nigeria still leaves a lot to be desired. Nigeria's overall health system performance was ranked 187 out of the 191 member states by the World Health Organisation (WHO 1991), while most of the country's disease burden is due to preventable diseases; poverty is a major cause of these problems. The Maternal Mortality Rate (MMR) of about 1:7 is one of the highest in the world (Borno State Statistical Year Book 2000: 20). Several other health status indicators, like the morbidity of

children under five years of age, are higher than average for Sub-Saharan Africa. However, the accuracy of the data on which these statistics are based is hard to judge since only recorded cases are used. Many cases go unrecorded, especially in rural areas where a high percentage of people in the country live. Coupled with the uneven distribution of modern health facilities between and within rural and urban settings, consumers have no option but to engage in affordable and accessible health-seeking behaviour, which partly accounts for the exodus to traditional healers. The Minister of Health of the Federal Republic of Nigeria, in an address during the 46th National Council on Health, made similar observations which are discussed in more detail in Chapter 4.

The traditional system of health care delivery is based on traditional practices by traditional care-givers within their domains. The practitioners and practices vary a great deal within the country. In Borno State, practitioners like *wanzama* (local barber), *kelagotama* (a person who treats *kelayekero* (falling of head)), *suromuwoma* (traditional birth attendant), *kawugotama* (person who treats prolapsed uterus), *gau* (herbalist), *kaskima* (soothsayer), *karwina* (local hunter), *safima* (magician), *shilashiwoltama* (bonesetter), and *mallam* (Islamic scholar) are commonly seen practising. They carry out procedures such as *kangadegenata* (blood cupping), *dawugota* (uvulectomy), and *berikaro* (tribal marks), among others. Some of these practices are strongly rooted in the Islamic religion (Chapter 6), while others are based on traditions established before the introduction of Islam in the 14th century.

The World Health Organization (WHO) defines traditional medicine as follows:

Traditional medicine is the sum total of knowledge and practice, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental and social imbalance and relying extensively on experience and observation handed down from generation to generation, whether verbally or in writing.

(AFRO Technical Report Series 1976: 3-4)

In spite of the fact that biomedical practices and traditional practices are dissimilar, people use both. There is simultaneous use as people pursue different kinds of treatment at the same time (Janzen 1978: 37), a practice which is referred to as “shot gun therapy” in Africa (Igun 1988: 52). In Borno State for example, the “hierarchy of resort” (Pool and Gleissler 2005: 44) is that people tend initially to self-medicate at home and use biomedicine for illnesses that are believed to be of natural cause while they resort to traditional medicine particularly for chronic conditions that are believed to originate in supernatural causes. “A mother in a village can buy a tablet for her child – if she has money – rather than engaging in a ritual governed by her mother in-law or putting herself at the mercy of a powerful government doctor” (Illich 1976: 8). The dual use is partly attributable to the gross underfunding of the western biomedical system, which, as a result, does not penetrate into the rural areas where 80 percent of the population dwell. However, the affluent and the middle class in the urban areas who can afford to seek health care from the orthodox practitioners also seek health care from traditional practitioners. Interestingly, biomedical health professionals may refer patients to the traditional practitioners in some instances, for example when patients are observed to have certain psychological problems.

There is a real conflict between western medical models as embodied in empirical knowledge and the WHO initiative that encourages the integration of traditional medicine

into modern medical practice; this issue will be considered further in chapter six. The WHO, using the report of the Basic Health Services Scheme (BHSS), initiated the integration of traditional medicine by Member States in the World Health Assembly (WHA) in 1987. It further called for the integration of traditional medicine into the modern practice when the Member States returned to their countries. Nigeria took into consideration the report of the BHSS in which the unequal distribution and lack of accessibility to modern health facilities was a real issue, as well as the WHO directive during the WHA. As a Member State who attended the WHA in 1987, Nigeria considered the issue in its inaugural health policy document of 1988 by encouraging the integration of traditional medicine into the modern practices while discouraging those traditional practices that may be regarded as harmful (Federal Ministry of Health 1988: 13).

The WHO does not seek to replace the traditional health system with modern biomedicine, or vice versa, but rather is interested in the integration of both systems. However, harmful nature of some of the practices used by some of the traditional healers makes such integration problematic. For example, uvulectomy (one of the practices discussed in this thesis) is prevalent in Kanuri society and leads to great difficulties because of the harm it causes. On the other hand, even scientifically oriented bio-medical practice is not without its problems. For example, there is the issue of fake and counterfeit drugs, and the erratic supplies of pharmaceuticals (as mentioned by the health Minister and detailed in chapter four). The attitude of lay people in Borno to the possible iatrogenic effects of modern medicines has parallels to those described by Jitsukawa (1997: 177) regarding hormonal contraceptives in Japan.

1.1 BETWEEN TWO WORLDS: THE INTEGRATION OF TRADITIONAL AND MODERN MEDICINE AT A PERSONAL LEVEL

The current study is motivated by the conflicting roles my personal circumstances compel me to play, as documented in the epitaph at the beginning of this chapter and described further below. The *Mainin Kinandi* of Borno is the second in command of the Kanuri royal leadership (I explain my role as horn to the traditional royal family in this chapter because it will give better insight into the conflicting positions I occupy). All male children born to the family of the *Mainin Kinandi* are given the prefix *Maina* at the prefix to their first names while daughters are prefixed *mairam*. The *Mairamaa* (plural for *mairam*) have a very strong role in preserving the Kanuri culture. That may be the reason why only the male children of the family were normally given the opportunity to have western education beyond the basic level. I was lucky to be born to one of the *Mainaa* who was highly educated in both the western and Islamic systems and to a mother who was well educated in Islamic and basic western education. I believe that gave me the opportunity to pursue a western as well as Quranic education, despite the fact that most female offspring of such royals were not normally sent to western schools beyond the basis primary level at the time I successfully finished both my primary and secondary schooling.

Though often in contradiction, I have worked hard to ensure the preservation of Kanuri culture in areas where there are no conflicts with my professional ethics training. In my opinion and that of others, this made me a horn (a potent symbol of protection, defence

and/or struggle in Kanuri culture) as I become a role model and ambassador for my family in various aspects of life. I have been identified as a high achieving woman in the State, have acquired many awards both professionally and otherwise, and above all carry the traditional Kanuri title of the *Ya sudani* of Borno. This historical title is given to the senior wife of the *Aji Sudani* of Borno, the leader and representative of the Shuwa – Arabs in the Borno Emirate Council (see Chapter 2).

The *Mainin Kinandi* literally means the king number two. The position of the *Mainin Kinandi* is chief judge and was first introduced by Mai Idris Alloma in 1571 when selected from the royal maiaa (royal chiefs) to serve as second in command (see Chapter2). The *Mainin Kinandi* is second in command in the Borno Emirate Council, the leader of the King makers as well as *khadi* (judge in the Islamic Sharia Court). According to protocol, his sitting position is always on the right side of His Royal Highness, the *Shehu* of Borno. The family is entitled to thirty-three people (only male members) with the title of *Shettima* (the learned person who is a principal actor in assisting the *Mainin Kinandi* on judicial matters). Other royal *Mais* in the Borno Emirate Council are entitled to only three positions for the title of the *Shettima*. That means that every male member of the *Mainin Kinandi* royal family has a chance of becoming a *Mainin Kinandi* and/ or *Shettima* provided he has excelled and become a learned person. Formerly, excellence was measured only in terms of *Quranic* and *hadith* knowledge but now it is acceptable to have a western education also.

The *Mainin Kinandi* family members are expected to preserve and uphold the Kanuri culture. ‘Kanuri culture’ mainly involves traditional rites of passage, dress (including

hairstyles), and traditional health practices. This expectation applies regardless of whether that person is traditionally (*Quranic* and *hadith*) or western educated, their age, or their gender. Details of the rites of passage the *Mainin Kinandi* are expected to uphold are provided in Appendix II, and details about the traditional Kanuri health practices are described in Chapter 5.

Unfortunately, I lost my father in the early part of my secondary school years. After completion of my secondary education, both my mother and I encountered a conflict in preserving the Kanuri culture, as family members (specifically my paternal uncles and aunts) wanted me to terminate my education at that level and marry. Luckily my mother was very supportive and secured my admission into the school of nursing in 1976. It was here that I started observing the conflict of roles, especially between western medical practices and Kanuri traditional health practices. Fortunately, I became recognized as an achiever (Gadzama, 1997: 26) in the family because of how I handled my professional and traditional roles. However, I was faced with philosophical questions expressed in the paradox at the start of this chapter, and the search for a resolution to this paradox is the driving force of this thesis. Paradoxes are important factors in uncovering the existence of problems and hence the beginning of the search for solutions. A paradox arises “. . . when a set of apparently incontrovertible premises gives unacceptable or contrary conclusions. To solve a paradox will involve either showing that the reasoning is erroneous or that an apparently unacceptable conclusion can in fact be tolerated” (Oxford Dictionary of Philosophy 1994: 276). Thus, in considering a paradox I am a step forward in addressing problems I have observed. Two examples of vignettes and accounts of other experiences in the personal/professional realm

will make these clearer. In the first, I was primarily a person in a non-professional role; in the second, I was in a professional role with personal implications.

1.1.1 A Personal/Professional Vignette

In 1983, I was a Nursing Sister at the Eye Hospital in Maiduguri, Borno State, Nigeria. The following event took place in December of that year. My uncle is the *Mainin Kinandi* of Borno which, as we have seen, means he is the second in the hierarchy of the traditional dynasty of Borno State. As he had done since I entered the School of Nursing, my uncle solicited my opinion on a health problem he was having, specifically an eye problem. From the complaints and the physical assessment I did before advising him to go to the hospital for treatment, I observed that my uncle had a cataract – a condition that is corrected by surgery. I assured him that I would accompany him to the Eye Hospital the following day.

At the Eye Hospital, the physician had several investigations done. All test results indicated my uncle was an appropriate case for surgery, with the exception of his blood pressure which went up during the afternoon. This meant that the cataract extraction had to be deferred until his blood pressure stabilised in order for surgery to be safely performed. Sometime in the interim he developed a significant systemic problem that warranted major surgery. When his blood pressure was controlled, we were all happy (i.e. members of his “therapy managing group” (Janzen 1978: 4) – the members of his family as well as the

medical and surgical teams involved in his care). However, the priority had shifted from the extraction of the cataract to major abdominal surgery.

When we got everything ready for surgery, the physician observed during physical examination that my uncle looked pale and that his appearance did not tally with the result of the previous laboratory investigation in terms of his haemoglobin level. The doctor therefore ordered another haemoglobin test, and the result read 9 grams as compared to the 14.6 grams of the previous test. The doctor therefore interviewed my uncle to ascertain whether he had had a physical haemorrhage of any type in the interim. My uncle said there was no haemorrhage of whatever type experienced by him during the period under review. Members of the therapy managing group (myself included) had also not observed any haemorrhage in the interim. I felt I was becoming part of my uncle's therapy managing group in a potentially awkward way since I was neither what is described in the literature as the 'lay' nor the 'professional' part of the group, but was instead a representative of both. The physician then deferred the scheduled date of surgery and asked us to choose between getting donors for blood transfusion or waiting long enough for my uncle's haemoglobin to be built up by iron supplements. However, he advised that the latter might be perilous because of the uncertainty of his condition, which might present us with an emergency.

Having been a keen observer of Kanuri traditional health practices since the onset of my technical professional training, I felt there might be something there – a practice – that would explain the reduction in my uncle's very good haemoglobin level from 14.6 grams to 9 grams, without any physiological or pathological clinical evidence. For the next five days I

kept raising questions in my mind as to what might have been the cause of the shift in his haemoglobin level. Through in-depth discussions with my uncle's wives, palace associates, servants and my uncle himself, I came to know that my uncle had had the *Wanzama* (local barber) conduct the traditional Kanuri health practice of *Kangadigenata* (blood cupping) on him. The practice was regarded as so normal that nobody had related it to the haemorrhage queried by the doctor in his earlier interview. Was this health practice, which is presumed to remove 'bad blood', not harmful given that it brought about a reduction in haemoglobin, an essential factor in healthy living and a necessary precursor to a successful western medical operation? What a paradox!

1.1.2 A Professional/Personal Vignette

My second example of a paradox encountered is with Proctor & Gamble, an international firm with its head office in Hungary and branch offices in Lebanon, the U.K., the U.S. and Nigeria. The Nigerian branch office is based in Ibadan, the capital of Oyo State . In 1999, salesmen of Proctor & Gamble went round Maiduguri distributing their Always sanitary pad to students of secondary schools and some higher education institutions in the State. The Principals of the schools involved told us that that most of those who used the free samples distributed developed rashes, itching and vaginal discharges. Based on these observations, the religious bodies in the state staged a campaign against the use of the product in churches and mosques. The Principals collected and burnt the unused free pads from the students while in the University of Maiduguri, the students organized themselves and got the items destroyed. As a female Director in the Ministry of Health in my state and

Patron to two organizations (The Federation of Muslim Women of Nigeria (FOMWAN) and the Gamboru Women's Development Association on the Discouragement of Harmful Traditional Practices), I was brought to the forefront of the Always sanitary pad issue in Nigeria which ended up becoming an international cause celebre.

In 2001, a HIV/AIDS positive woman came to my office carrying in her hand the free samples of the Always sanitary pad distributed by Proctor & Gamble. She stated (and I quote her): "I am a diagnosed case of AIDS. I have been tested in the General Hospital, Maiduguri and was told that I contacted the disease through the use of the 'Always pad'. Please help me *Hajja* or else ...". Knowing how sensitive the issue is, I sat her down and counseled her with emphasis on how HIV/AIDS is contracted. I made it clear to her that the possibility of contracting the disease through a sanitary pad was very slim but I asked her to go to where the investigation she claimed was done and bring the notes along with her results for me before anything could be done. I advised her to see the HIV/AIDS programme officer of the Ministry of Health for expert counseling.

Exactly two weeks after that encounter, the President of FOMWAN Borno State Branch also came into my office with the free samples and narrated how the samples had caused lots of problems to the persons who had used them. She felt that since she was a female director in the Ministry of Education and I was a female director in the Ministry of Health as well as the health advisor of FOMWAN, the two of us could proffer solutions in a more formal way with the government machinery at our disposal. I saw the wisdom in pursuing the case through the Ministry of Health but the authorities then advised us to put it

through the Ministry of Women's Affairs & Social Development since it was a women's issue. We then went and saw the Permanent Secretary Ministry of Women's Affairs & Social Development. The issue was discussed, as was the need to build inter-sector collaboration with the women's Non-Governmental Organizations (NGOs). It was decided that obtaining the views of the NGO's on the issue before including it on the government agenda was imperative. The broad objectives were discussed at the insistence of Her Excellency, the wife of the Executive Governor Hajja Hadiza Malah Kachallah, who then invited a group of women for breaking of fast during Ramadan, including NGO leaders, Directors and women occupying high government offices. We solicited their co-operation in informing the rest of the members of their associations and groups before we called for a general meeting on the issue. Samples of the Always pad were circulated to members to see by the FOMWAN President.

It was discovered that most of the women who got earlier information via the media had made up their minds not to use any type of sanitary pad. Many thought of going back to the use of rags as pads. That situation caused me significant concern and expanded my quest for the discouragement of harmful traditional practices. Luckily, some three weeks later, the Advisor on Women's Affairs to the President of the Federal Republic of Nigeria, Chief Titilayo Ajanaku, came down to Borno State as part of her visit to the North East Region of Nigeria. She came to hear about women's problems with a view to proffering solutions. Being the Advisor to the President on women's affairs, all women in the state were mobilized and a good forum was developed where NGO's, government and political groups came

together in a collaborative manner. The Always sanitary pad issue was identified as a top priority to be addressed.

The women unanimously choose me to present the case, which I did in earnest. Because of the sensitivity of the case, the Advisor, immediately after going back to her office at Abuja, took up the case by briefing His Excellency the President and wrote to the National Research Institute attaching the free samples of the Always sanitary pad that we presented to her at Maiduguri for urgent investigation and results. The result of the investigation proved to be HIV/AIDS negative but culture growth showed *Staphylococcus Aureus*- bacterium that causes infection and sexually transmitted disease (STD). When the Nigerian press got the information about the complaint, they made inflammatory headlines portraying the Always sanitary pad as being HIV positive (e.g. Ezereonwu 2001), hence the use of the pad being capable of transmitting HIV/AIDS. That created public outrage leading to chaos in some parts of the country. Proctor & Gamble, however, was quick to react by sending their Group Managing Director from the Hungarian Head Office and the quality control Manager from the United Kingdom to Nigeria.

The Advisor to the President on Women's Affairs called a press conference at her Abuja office. The President of FOMWAN Borno State branch and the President of the National Council of Women Societies, Borno State and I were in attendance. The Advisor, the representatives of Proctor & Gamble and the three of us from Borno State faced the media representatives from about twenty media houses. The Advisor led the discussion by saying that we were not 'witch hunting' anybody but rather fighting for the cause of women

based on what had happened in our community following the distribution of free samples by Proctor & Gamble. She said that she initially did not want to give audience before the results of the investigation that was being conducted by the Research Institute were completed. However, the workers of the Institute were on strike and the fact that the National Agency for Food Drugs Administration and Control (NAFDAC) had given the firm clearance on the absence of HIV made the need to open up discussion to address the problem of the staphylococcus aureus imperative. In my own opinion, I blamed the press for sensationalizing the issue prematurely. The President of FOMWAN, Borno felt the firm had caused serious damage to the majority of the women who used the Always sanitary pad that was distributed freely. The President of the National Council of Women Societies was of the view that the firm aimed to destroy the womenfolk of Borno State deliberately by the distribution of the infected samples.

The Group Managing Director of Proctor & Gamble advanced some reasons for distribution of the free samples as a promotional exercise of their firm. However, he accepted the observations I made, which were as follows:

- That no information on the active substance of the product was made available;
- That no information directing the withdrawal of the product in case of symptoms, such as itching, was included;
- That only a few women overseas were sampled and used for the pilot test;
- That no permission was sought from the Ministries of Education and Health before the distribution of the free samples to the students;

- That repackaging was done in the country, Nigeria, which is not in line with Total Quality Management (TQM) principles;
- That public education was not undertaken using appropriate media before the new samples were introduced ‘through the back door’.

The representatives of Proctor & Gamble agreed to consider all of the above points in addition to translating the information concerning directions for use into Hausa, English, Ibo, and Yoruba. The representatives of Proctor & Gamble from Lebanon, the U.K. and Ibadan, Nigeria came to Maiduguri, Borno State requesting that we write a proposal for public education, but this visit ended in deadlock because the laboratory results were still pending. When the results were released, Proctor & Gamble mounted a campaign on the negative HIV issue, ignoring the issue of *Staphylococcus aureus* which was found to be positive. Staphylococcus is a bacterium that is almost as bad as the HIV in causing infection, especially when introduced to the female reproductive organs where it can cause sexually transmitted diseases (STD) and even infertility in severe cases.

The Gamboru Women’s Development Association on the Discouragement of Harmful Traditional Practices made some bold steps in counseling most of the women who hitherto decided to go back to the use of rags instead of the modern sanitary pads available in the market. Those who were already infected by the use of the Always free sample that was distributed by Proctor & Gamble were advised to seek medical treatment. One woman who was divorced by her husband because of the itching she got from the free infected sample

was reconciled with her husband by convincing the husband that it was not caused by an STD as he had believed earlier.

As a result of the Always pad fiasco, I undertook to set up an NGO to act as a meeting point for those with a concern for women's issues, with the goal of promoting partnership with universities both within and outside Borno State, and even outside the country. The organization, Research into Culture and Reproductive Health for Sustainable Human Development, is registered with an office in Maiduguri, the Borno State capital. The organization is research-oriented and its broad objective is to reduce predominant health-related problems with particular reference to women and children, especially those residing in rural areas. The main areas of focus are basic literacy and numeracy, basic human rights, basic health services and ethnographic research and advocacy with capacity building.

1.1.3 Reflections: Between Two Cultures?

As an academic, my thoughts are focused on what I term my paradox, which concerns the conflict between traditional health practices with its related problems on one side, and the modern medical system which can solve numerous health concerns but which also involves iatrogenic problems on the other side. The conflicting roles I play are paradoxical in the sense that I am a professional biomedical health practitioner, but also a royal and a custodian of Kanuri cultural practices which biomedicine labels as harmful. This paradox not only exposes the conflicts between traditional and biomedical practices but also portrays the conflicts that exist for a highly trained individual who is also from a

traditional background. This situation raises questions about value judgements, ethics, culture and change, all of which are crucial to this study.

It is important to consider the attributes and reasoning of the people especially in dealing with a traditional community like Borno State when promoting changes to traditional practices, especially where such change is presumed to be in direct conflict with traditional values and practices. The approach must be appropriate for the time, social class, moral beliefs and the culture of Borno State. Culture is the embodiment of a group's way of life, the totality of their experiences in their environment. Culture therefore includes all learned behaviour such as language, attitudes and skills as well as the value systems and ethical judgments that underlie them, and the particular material items that people use. Every individual in a society learns how to express his needs and feelings in a way that other members of the society can understand and accept. Also, every society has its own particular forms of customary behaviour, its own distinctive culture. Culture influences behaviour, mode of adaptation, mental stress, health and disease. The following excerpts summarise and refine the definition of culture as it relates to this study. Helman (1994: 2-3) suggests that "man is a social animal organised into groups that regulate and perpetuate themselves and it is man's experience as a member of a society which shapes his view of the world". He reviews the variety of definitions of culture provided by anthropologists, the most famous being Tylor's definition (1871) which sees culture as "that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society". Keesing (1981) stresses the ideational aspect of culture. That is, cultures are comprised of "systems of

shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings live”. Based on the above two definitions, Helman gives a useful summary:

From these definitions one can see that culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual. To some extent culture can be seen as an inherited ‘lens’ through which the individual perceives and understands the world that he inhabits and learns how to live within it. Growing up within any society is a form of enculturation whereby the individual slowly acquires the cultural ‘lens’ of that society. Without such a shared perception of the world, both the cohesion and continuity of any human group is impossible.

(Helman, 1994: 2-3)

The central foci of the above summary of culture are an individual’s sense of belonging to a particular group, environment, and specific period (generation), as well as enculturation and acquisition of the cultural lens by individuals. These may be very difficult to synchronize especially at the global level. It is therefore not out of place to consider gradual change when promoting shifts in cultural practice and perception. However, we as philosophical thinkers must not forget Karl Marx’s opinion on change wherein “the philosophers have interpreted the world in various ways, but the task is to alter it” (Russell 1946: 707). My understanding of Marx’s view is that the real world is full of complex activities ranging from so-called normal activities to complex ones as interpreted by the philosophers. I am therefore optimistic that change is not only inevitable but is necessary for reducing gaps between the two modes of practice inherent in the above paradox. The types of change I portray and aspire to are gradual, slow and peaceful ones,

such as those we see today in Borno involving language, educational patterns and health-seeking behaviours. However, even gradual changes may have a profound effect, as suggested by Byrne (1998: 14):

Changes do not occur in a linear fashion. In reality, as opposed to mathematical models, the crucial dimension along which changes occur is time. In non-linear systems small changes in casual elements over time do not necessarily produce small changes in other particular aspects of the system, or in the characteristics of the system as a whole. Either or both may change very much indeed, and, moreover, they may change in ways which do not involve just one possible outcome.

(Byrne 1998: 14)

As a philosophical thinker, professional and lay significant other, my struggle is to combine my professional and cultural positions and identities and create an integrated whole. I have faced lots of challenges throughout my life and this thesis attempts to address them in an overt manner. One way I think both my professional and Kanuri peers see me as deviant is in my resolve to bring the two cultures (traditional and professional) together in relation to the various health practices under consideration.

1.2 OBJECTIVES OF THE THESIS

In this thesis, therefore, I study the co-existence of western biomedicine and traditional Kanuri health practices in Borno State, Nigeria, with a focus on the following areas:

1. Ascertaining areas of compatibility (as determined by beneficial effects) between traditional and modern biomedical health care.
2. Determining the prospects and problems (as viewed by practitioners) for integrating both forms of health care.
3. Identifying how the populace simultaneously interacts with both traditional and modern health care systems.
4. Providing recommendations for future integration strategies.

This chapter has introduced the modern and traditional forms of health care, and described the conflicting roles the researcher has to play, as a professional Nurse and as a Royal custodian of cultural practices which biomedicine labels as harmful.

1.3 THE STRUCTURE OF THE THESIS

1.3.1

The purpose of this introductory chapter has been to introduce the thesis and provide a brief summary of all the chapters. I have recognized and described the issue of my dual status as a researcher and as a member of the traditional Kanuri elite, which is an instance of the paradox which will be dealt with in detail in Chapter 3. As a Kanuri woman seeking to reconcile my two divergent roles, I have sought to develop solutions for integrating western biomedicine and traditional Kanuri health practices so that the two can co-exist in a meaningful way and help remedy existing inequalities in health care.

1.3.2

Chapter two provides a description of the study site, Borno State of Nigeria, with an emphasis on Kanuri society, including both a historical perspective on Kanuri society as well as a contemporary perspective that considers the cultural changes that have occurred as a result of urbanization. Geographical, historical, ethnic, governmental, educational and economic issues, as well as information on the infrastructure of health care, serve to contextualise the study. I present an account of the history and origin of the state from the Kanuri Empire to present day Borno in this chapter to demonstrate the long and rich history of Kanuri culture and society. Many people in the community place great importance on preserving this heritage and expect royals such as myself to be guardians of it.

1.3.3

Chapter three deals with the research methodologies used to gather materials for this study, including exploratory and triangulated information gathering, auto-ethnography, review of official documents, and interviews and focus group discussions with biomedical health professionals, traditional health practitioners and urban and rural mothers. The interview schedule/questionnaire was designed by me as there was no existing standard tool available for that purpose and was used for all categories of respondents.

1.3.4

Chapter four further contextualises the study by describing the organization of formal health care in the study site, Borno State of Nigeria. Providing contextual information concerning this formal organization is necessary since the emphasis of the study is on traditional health care and its possible integration into the modern health care system in the state. The Ministry of Health is the umbrella organization dealing with health policies and programmes in the health sector. The chapter is rhetorical in that, although the Nigerian Health Policy makes a provision for the integration of traditional health practices into the modern health system, the Borno State Ministry of Health has yet to establish a Traditional Medicine Board, which is the first level in the movement towards positive integration.

1.3.5

Chapter five presents information on traditional health care practices. This chapter is largely based on my personal knowledge and life experiences which I present as a catalogue of traditional health knowledge, including specific areas such as sex and areas of specialization. Though the list I present is not exhaustive, providing an outline of the main health practices and the respective practitioners involved, it goes some way towards providing a possible basis for the integration of the traditional into the modern health system in a complex environment where both systems are utilized by the populace simultaneously. It also attests to the significant variety of health practices that exist. From the descriptions presented, some practices appear to be clearly harmful; some are of little appreciable value in a biomedical sense, while others appear to be beneficial. In order to make any useful attempt

at integrating the orthodox and traditional practices, contrary to what Thomas (1928) and Mackie (1997) both suggest about relativity, I would argue that there must be a clear understanding of what is harmful and what is beneficial about both practices.

1.3.6

Chapter six analyses the relationship between traditional and biomedical health care systems in light of both local and national situations in Nigeria and elsewhere in Africa. It is a common practice that both traditional and biomedical practices exist simultaneously, allowing people to select their preferred mode of treatment. The chapter also examines how the populace in the study area interacts with both traditional and biomedical health care. This includes a discussion of the practice of medical pluralism, where patterns, motivations and circumstances for using both methods are explored. With regard to interaction between the two, the family is identified as forming the first level of care and acting as the therapy managing group through the provision of support and advice on various treatment options. The choice of treatment modes is informed by tradition, and therefore traditional healers are still frequently utilized. African traditional health practitioners or healers are labelled in a variety of ways, such as herbalist, native doctor, witch doctor, and other terms.

Approximately eighty to ninety percent of the population continues to utilise this type of treatment in our communities. Given this reality, coupled with the recognition that some traditional practices cause significant health problems, the WHO in 1978 declared Primary Health Care as a strategy to achieve health for all by the year 2000 and further called for the need to integrate the two systems (WHO 1979). I argue that these traditional healers can be

especially useful in areas underserved by modern medical facilities. The Nigerian government has remained lackadaisical about the policy on the integration of the two systems despite the efforts of the WHO which have included litigation, registration, and training, as well as community-based research.

In order to achieve the successful integration of the two models, there is the need to examine areas of commonality so that points of compatibility may be identified. The purpose of this study is to review the two methods and to identify a preferred mode of treatment. Following Galli (1978: 6), this study argues that a successful health care programme must be informed by an understanding of community factors, individual perceptions and attitudes toward health. Both Islamic and African traditions greatly influence the traditional health practices, especially among the Kanuri, because some of the traditional practices are derived from the *Quran* or *Hadith* (such as blood cupping (*Kangadigenata*)). However, such influence, somewhat paradoxically, is not without conflict.

1.3.7

Chapter seven presents and analyses the results of my own research into the views of the biomedical professionals, including the Kanuri and Non-Kanuri midwives, and the Kanuri and non- Kanuri medical doctors. In order to gain better insight into the issue of integration of traditional and orthodox medical care, I felt it was necessary to obtain the views of the two groups of professionals on the traditional practitioners in terms of preferred

mode of treatment, effectiveness of treatment, harmful practices, ways of reducing maternal and infant mortalities, and means of integrating the two systems. The chapter reports on a total of four focus group discussions.

1.3.8

Chapter eight reports on focus group discussions conducted with traditional healers and urban and rural mothers. I also include information gathered during an in-depth interview I conducted with a traditional bonesetter.

1.3.9

Chapter nine summarises the whole thesis and its central contention that some Kanuri traditional health practices are harmful while others are beneficial. The establishment of a Traditional Medicine Board and integration of Kanuri traditional health practices into the Borno State healthcare system are seen as necessary for the development and improvement of health service utilization in the State.

CHAPTER TWO

BORNO STATE AND KANURI SOCIETY: THE CONTEXT OF SOCIAL CHANGE

2.0 INTRODUCTION

In this chapter, I set the scene for the consideration of traditional Kanuri health practices by presenting the geographic and demographic context of Borno State, the people and languages spoken, its history, and the traditional rites of passage of the Kanuri people who live there. Some of the latter are described in more detail in Appendix I; they are now largely idealized rather than realized due to the rapid amounts of social change caused by education, technological development, population growth, urbanization and globalization, issues which this chapter considers. These changes have contributed to the perpetuation of the traditional forms of health care in a situation of medical pluralism, as I discuss in Chapter six.

2.1 GEOGRAPHY AND POPULATION

According to the information on geography and population in the Borno State Executive Diary (2000: 1-6), Borno State lies in the north eastern part of Nigeria between latitudes 10 degrees: 02 'N and 13 degrees: 04'N and longitude 11 degrees: 04'E and 14 degrees: 04'E. It is the largest state in the Nigerian Federation in terms of landmass, covering an area of 69,436 Km². Its neighbours within the country are Bauchi to the south-west, Yobe to the west and Adamawa to the south. Occupying the greater part of the Chad

Basin, Borno shares borders with other countries: Cameroon to the east, Chad to the north – east and the Republic of Niger to the north.

The climate is hot and dry for a great part of the year, but milder in the southern part of the State. The rainy or wet period varies from north to south due to the influence of climatic factors such as rain-bearing winds and topography. The rainy season is usually from June to September in the north, while it lasts from May to October in the south. The relative humidity ranges from 48 to 49 percent and evaporation of 203 mm per year. The major vegetation zones are the Sahel in the north with severe desert encroachment covering most of the Chad Basin areas, and the Sudan Savannah in the south which consists of scrubby vegetation interspersed with tall woodlands. Water is scarce in the Sahel, but better in the Sudan Savannah of the south.

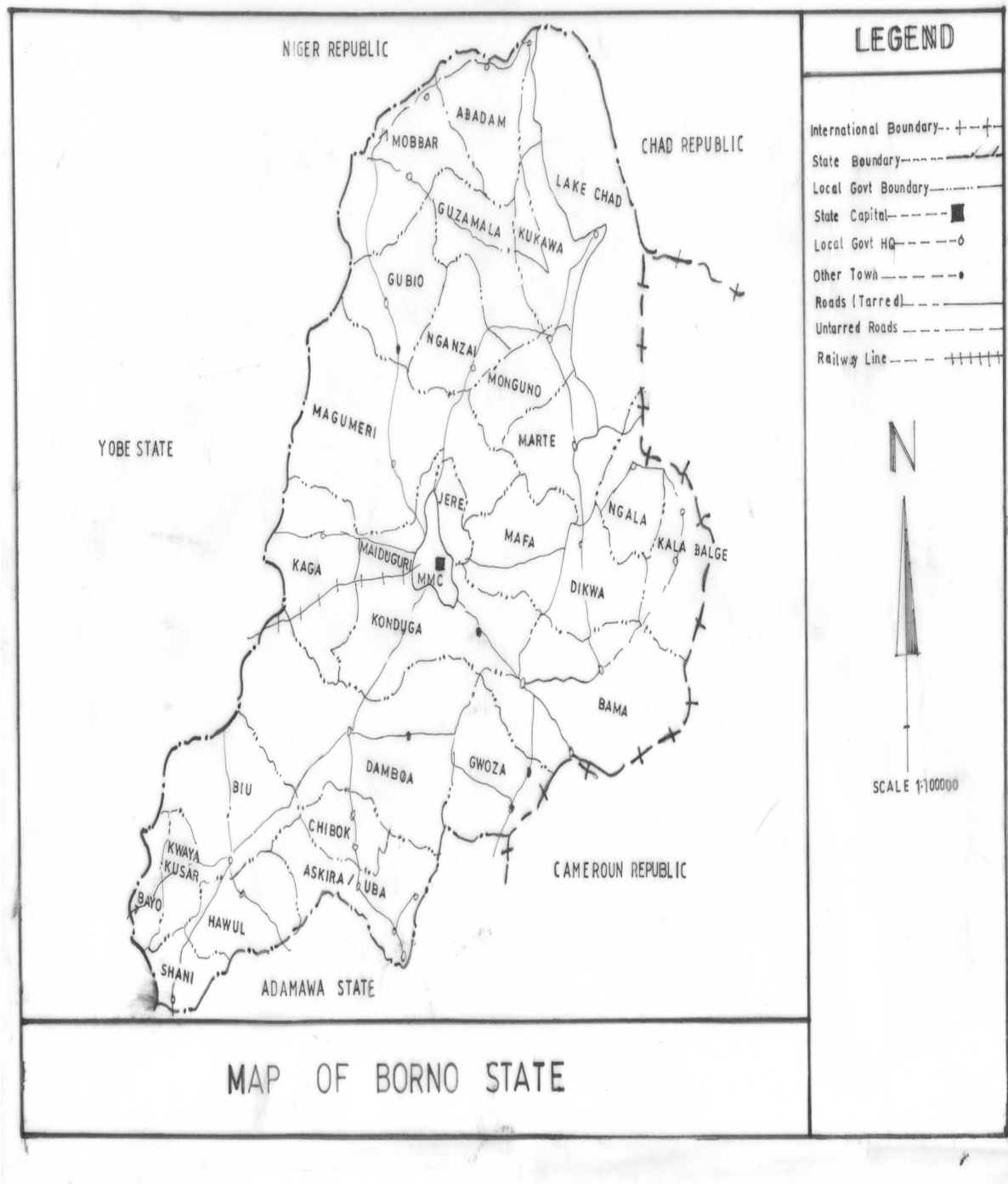


Figure 2.1: Map of Borno State

(Source: Ministry of Land and Survey, 2000)

Table 2.1: Local Government Areas and Population Figures

S/No	Local Govt. Area	1991	1997	1998	1999
1.	Maiduguri	653,401	771,149	792,741	841,938
2.	*Jere	-	-	-	-
3.	Bama	195,377	230,586	237,042	243,680
4.	Gwoza	145,868	172,155	176,975	181,931
5.	Damboa	137,824	162,661	167,216	171,898
6.	*Chibok	-	-	-	-
7.	Konduga	131,650	155,374	159,724	164,197
8.	Kukawa	131,393	155,071	159,413	163,877
9.	*Guzamala	-	-	-	-
10.	Ngala	130,972	154,574	158,902	163,351
11.	*Kala-Balge	-	-	-	-
12.	Askira-Uba	123,334	145,560	149,636	153,826
13.	*Mobbar	-	-	-	-
14.	Abadam	111,514	131,610	135,295	139,083
15.	Biu	109,253	128,941	132,551	136,263
16.	Hawul	86,964	102,636	105,570	108,464
17.	Kwaya Kusar	83,087	98,060	100,506	103,628
18.	*Bayo	-	-	-	-

19.	Dikwa	75,760	89,413	91,917	94,490
20.	Monguno	68,510	80,856	83,120	85,447
21.	Shani	66,264	78,205	80,395	82,646
22.	Marte	56,907	70,703	72,683	74,718
23.	Magumeri	53,068	62,631	64,385	66,187
24.	Kaga	51,971	61,337	63,054	64,820
25.	Mafa	45,436	53,624	55,125	56,669
26.	Gubio	43,589	51,444	52,884	54,365
27.	Nganzai	30,861	36,422	37,442	38,490
	TOTAL	2,533,003	2,993,012	3,076,576	3,189,968

* Data not available, as the Local Government Areas in question are recent creations in 1999.

Jere is created from Maiduguri, Chibok from Damboa, Guzamala from Kukawa, Abadam from Mobbar and Bayo from Kwaya Kusar.

SOURCE:

- 1) Federal Republic of Nigeria Official Gazette Lagos, No. 25, Vol.1
- 2). Projection (estimate) by the State Directorate of Statistics, Department of Budget and Planning, Governor's Office, Maiduguri.

Groundnut and maize are grown across the vegetation areas in most of the Local Government Areas. Tomatoes, long pepper, onions, wheat and millet that yield well in the Sahel Savannah are common in the Northern part of the State, although dry-season farming boosts the production of crops like long pepper and onions in this zone. Other crops like maize, rice, short pepper and cotton yield well in the Sudan Savannah and are common in the southern areas.

The total population according to the 1991 census was 2, 533,033 with a population density of 38 inhabitants per square kilometer. The projected population for the year 2000 was 3,189,968, while according to the National Population Commission, given an annual growth rate of 2.83%, the current population is 3,500,000 people. The population structure according to the 1991 census shows that there were 1,335,844 people in the 0 – 19 age group, representing about 52.6 percent of the total population. People aged 20 – 69 made up 1,143,878 (45.1 percent) of the population, while there were 56,281 in the 70 – 85 age group representing 2.2 percent. The male population was 1,296,111 which was 58,033 higher than the female population of 1, 239,892 individuals.

2.2 PEOPLE AND LANGUAGES

Borno State is pluralistic in ethnic composition with about thirty languages represented, many of which are autochthonous. Twenty-six of these languages are classified as Chadic by linguists, while Kanuri (the largest language and ethnic group) is classified as Saharan. Nineteen out of the twenty-seven local government areas are Kanuri-speaking (see

figure 2.2). Arabic is only spoken by the Shuwa-Arabs. Fulfulde is also spoken in parts of the State. Kanuri is also spoken in some other States in the country as well as in other African countries. For example, there are Kanuris in the Yobe and Nasarawa States of Nigeria and in the African countries of Niger, Cameroun, Chad, and the Sudan. The second largest ethnic group is the Babur-Bura, with its home in the Biu emirate in the southern part of the state. The Babur-Bura have a lot in common with the Kanuri. However, although their kingship traditions of today appear to be similar, the different regalia and ceremonies suggest independent origins.

Gwaza includes a conglomerate of languages and is a mixture of all ethnicities, with a number of languages and cultural traditions shared with the people of Cameroun. Their major languages are Clavda, Johode, Mandara and Waha. The Marghi language of the Askira –Uba emirate is divided into dialects grouped mainly under the North and South *Marghi*. Like Gwoza, Uba emirate is also a place of mixed ethnicity. The main language of the Shani Emirate is *Tera*. The Shani record a long list of capable leaders.

Kanuris have different types of dress for the two sexes and for different occasions. The dresses for adult Kanuri men and women are three pieces, which for men includes the *kulwua*, *gemajea*, and *yangea zawaa*, while the dress for women includes *fatellea*, *gemajea*, and *zanekelayea*. Boys and girls normally wear *dankikia* and *yangea*, and *gemajea*, *fatellea* respectively.

The hair style for adult men involves a completely shaved head, while for boys before puberty, the hair style is referred to as *koyo*. *Koyo* is done by shaving some of the hair while leaving some parts designed in a particular way. Each Kanuri family has a style representing the identity of the family. *Koyo* is equally done on baby girls until age three when plaiting of the front (*fuwukelaye*) and middle (*dawukelaye*) part of the hair is introduced. Plaiting of the back (*budikelaye*) part is done when the girl reaches puberty, a hair style that is referred to as *kelayakke* which literally means ‘three heads’ because of the way that the hair is demarcated at the front, middle and back. Women maintain the *kelayakke* hair style when they are newlywed until one year after marriage, when the hair style is ceremonially changed to either *kelagoto* or *keshangalti* (hair styles for mature women).

2.3 LIVELIHOODS IN BORNO

Borno State is essentially an agrarian society and most of the people residing in the rural areas are peasant farmers. Most of its industries are dormant, although the State government is making efforts to progress into an agro-industrial economy. This effort aims to promote economic diversification, create employment opportunities, generate income and promote sustainable economic growth. To achieve these ends, the following dormant industries are being resuscitated: Borno Wire & Nail Industry, NETAL Tannery & Shoe Factory, Borno Livestock Company, Ash Plant, Maiduguri International Hotel, Borno Express Transport, and other companies. The Borno Investment Company was established for the development of commerce and industry in the State.

Tourism is based on the rich traditions, cultural heritage, impressive history and natural resources of Borno. The State is named the “Home of Peace”, and is endowed with some attractive recreation and tourism spots such as Lake Alau, Sanda Kyarimi Zoo, Borno State Museum, the Gwoza Hills, Sambisa Game Reserve, Lake Tilla, Rabeh’s Fort, The Jaffy Hills, the Shehu’s Palace, Lake Chad Sanctuary, and the Tombs of First Four Shehus of Kukawa. Durbar and *menwara* festivals are great festivals of the State. The Durbar is usually organized to mark important occasions and Sallah festivals, and is characterized by royal horsemen, drummers, dancers and gorgeous horses and trumpeters led by the Shehu, seconded by the *Mainin Kinandi* and followed by the Emirs, district heads and other traditional rulers. A few of the *Abbaa* (Shehu’s sons or male blood cousins), *Nanaa* (Shehu’s daughters or female blood cousins), *Mainaa* (*Mainin Kinandi*’s sons or male blood cousins) and *Mairam* (*Mainin Kinandi*’s daughters or blood cousins) lead the horsemen on foot. The *menwara* festival is celebrated annually by the *Tera* people of Shani LGA. It offers an opportunity for the emir of Shani to consult his people on matters of unity, peace, security and progress.

2.4 HISTORY

Borno is one of the oldest extant empires in the world. Its founder, Mai Umme Jilmi, who reigned from 1088 to 1097, popularly referred to it as the first Kanuri Empire, with the capital Njimi at Kanem in Chad. The empire has survived into the 21st century. Borno became the melting pot of several peoples (from which the Kanuri emerged as the dominant group) because of its strategic geographical setting.

Onwubiko (1967: 33-40) discusses the details of the history of the Kanuri empires. According to him, Mai Dunoma I, son of Mai Umme Jilmi, took over the mantle of leadership from his father and expanded the empire. He reigned from 1097 – 1150. He was a devoted Muslim and made three pilgrimages to Mecca. Mai Dunoma II, who reigned from 1221 – 1259, continued his predecessor's policy of territorial expansion. He established a system of decentralized government with delegated powers. The *Mai* (King) was at the helm, with full authority over twelve advisors who controlled state policy. The state was divided into four provinces each under a provincial governor. Governorships of the provinces were in the hands of the royal with *Magira* (queen mother) and *Gumsu* (*Mai*'s first wife) exerting a certain degree of influence on state matters.

Taxes were collected on the products of the peasants. It was a feudal society, with aristocrats at the top and slaves at the bottom. The *Mai* was able to acquire a large number of horses through trade and is said to have commanded about 100,000 horsemen. The empire's location in a desert and semi-desert area, with the attendant issues of scarcity of and competition for natural resources, created many problems. Furthermore, the new system of transferring the post of provincial Governors to the sons of the royal family brought competition among the princes. This in turn led to threat from the *Bulala*, (who came from the north- Niger) which forced the *Safewa* dynasty (dynasty of the *Mai*) to migrate southwards in the 13th century. Subsequently, the attacks from the *Bulala* and Sao intensified during the reign of Mai Daud (1366 – 1376), who was driven from the capital Kanem and

subsequently killed. He was succeeded by Mai Umar ibn Idris (1384), who transferred the capital to Borno.

The founder of the second Kanuri Empire was Mai Ali Ghali who reigned between 1472 and 1504. He built a new capital at Ngazargamu and restored power and stability through the reformation of the government. In addition, he raised a strong royal army, improved the economy of the new state through trans-Saharan trade and got Borno on the Portuguese maps of Africa in the 15th century. Mai Ali Ghali's son, Mai Idris Katakarmabi, succeeded him and reigned from 1504 – 1526. He defeated the Bulala, reoccupied the old capital of Njimi, and made Kanem a province of the Borno Empire.

The greatest of the Mais was Mai Idris Alooma who reigned between 1571 – 1603 when Borno reached the apogee of its power and prosperity. He first expanded and unified the empire. He improved the economy by efficient collection and equitable utilization of taxes and trade with Kano, Cairo, Tripoli and Tunis. He imported firearms from Tripoli and is recorded as having been the first to use firearms in Western Sudan. He modified the administration by appointing counselors and divided their labour among different offices. Each of them was appointed for life and their authority was exercised over their specific territories. Governors chosen from humble royal and slave families carried out the actual administration of the province. *Magira* (the King's Mother), *Mogoram* (the King's eldest sister) and the *Gumsu* also exercised strong influence on the administration. The Shehu's son is named with *Abba* at the prefix of his first name (collectively *Abbaa*), while the daughter is named with *Nana* at the prefix of her first name (collectively *Nanaa*). Mai Idris Alooma also

established a proper judicial system based on Sharia law enforced by the *Khadis*. The *Mainin Kinandi*, or chief judge, was chosen from the royal *Maiaa* who also served as second in command. The twenty-eight *shettima* (learned persons) of Borno are chosen only from the *Mainin Kinandi*'s descendants.

Mai Idris Alooma found time to go on pilgrimage to Mecca where he got the idea of a Cultural Revolution of the state. He pursued vigorously the policy of Islamisation of Borno for peace keeping; it is from this time that the name 'Home of Peace' for Borno originates. He built many mosques and hostels for Borno pilgrims in Mecca, in addition to schools in Borno. In oral traditions, it is stated that he settled in Sudan on his way to Mecca for pilgrimage and introduced some of the Kanuri customs there. He left some of his Kanuri followers in Sudan where they remain to this day. Similarly, he came with some Sudanese people to Borno and these Sudanese are settled in Borno. He appointed a leader of the Sudanese (Shuwa Arabs) as *Aji Sudan* of Borno and to date the *Aji Sudani* of Borno are the representatives of the Shuwa Arabs in the Borno Emirate Council. When he died in 1603 (like his counterpart Queen Elizabeth I of England who died in the same year), Mai Idris Alooma left a strong, united empire with an efficient system of administration that lasted until the 19th century. After the death of Mai Idris Alooma, incompetent hands ruled the empire. In addition, the long period of peace during the reign of Alooma and of some of his successors weakened the army so much that it could no longer perform well. For instance, in 1637 to 1694 when Mai Ali reigned, he capitulated in the face of Tuareg attacks.

By the beginning of the 19th century, Borno was so weak that it was easily overrun by the Dan Fodio Jihad. The empire rose again in the same century under Mohammed El-Kanemi. The empire remained strong and peaceful with minor disputes from other tribes, especially the Fulani that had come under the control of El-Kanemi since 1830. El-Kanemi died in 1837 and was succeeded by his son, Umar, who reduced the power of the *Maia* (kings). That led to persistent crises and a further weakening of the empire.

Rabeh Faterralla conquered Borno in 1893 by burning Kukawa. He then established a new capital at Dikwa. He was defeated and killed by the French, and the British were then able to take Borno quite easily in 1900 during their colonization of Nigeria. The ancient Borno kingdom was divided among Britain, France and Germany. The British put the descendants of the El-Kanemi on the throne, and they have occupied the throne ever since. The new order of the El-Kanemi dynasty saw the Shehu of Borno (Shehu Sanda Kura) on top, *Mainin Kinandi* as second in command, *Waziri* as the secretary, *kaigama* as war head, *shettima* as learned person in the Quran, *laari* as judge and *maaji* as treasurer. Subsequently, “Shehu Sanda Kura, who was enthroned by the British, was on the throne for only one year before died. He was succeeded by Shehu Abubakar Garbai El-Kanemi (from 1902 to 1922), Shehu Sanda Kura (from 1922-1937), and Shehu Sanda Kyarimi Ibn Ibrahim (from 1937 to 1967)” (Ngamdu 2002: 36). He was succeeded by Shehu Umar Garbai Ibn Bukar who reigned for only six years from 1968 to 1974. The successor of the latter is the incumbent Shehu of Borno, Dr. Mustafa Ibn Umar El-Kanemi, who came to the throne in 1974.

In a Kanuri history text titled ‘Gargam Bornobe Nwawo Rabiben (1900 – 2003)’ with the literal meaning “History of Borno after Rabe from 1900 – 2003”, Ngamdu (2002: 31-34) enumerates the list of leaders of Borno in the categories of Shehu, Military and civilian administrators or governors with the dates when they reigned or governed. He observes a change from the traditional system when the regional government gained power over the traditional institutions, especially in the north.

Table 2.3 All leaders of Borno since 1901 to the present

NAMES	YEARS	MAI	SHEHU	MILITARY GOVERNOR	CIVILIAN GOVERNOR
Shehu Sanda Kura	1901-1902		Shehu		
Shehu Abubakar Garbai El-Kanemi	1902-1922		Shehu		
Shehu Sanda Kura	1922-1937		Shehu		
Shehu Sanda Kyarimi Ibn. Ibrahim	1967-1974		Shehu		
Shehu Umar Garbai Ibn. Bukar	1967-1974		Shehu		
Shehu Mustafa Ibn Umar El-Kanemi	1974-Date		Shehu		
Maj. Gen. Musa Usman	May – Sep.72			Military	
Lt. Col. Mohammed Buhari	Aug75-Mar 76			Military	
Gr. Capt. Mustapha Amin	Apr 76-July 78			Military	
Col. Babatunde Idiagbon	July78-Sept.79			Military	
Alhaji Mohammed Goni	Oct.79-Sept.83				Civilian

Alhaji Asheikh Jarma	Oct.83-Dec.83				Civilian
Maj. Gen. Abubakar Waziri	Jan.86-Aug.85			Military	
Lt. Col. A. Aminu	Jan. 86-Aug.88			Military	
Col. Abdu One Mohammed	Jul 90-June 90			Military	
Col. Mohd Lawan Maina	Jan. 90- Jun90			Military	
Lt. Col. Buba Marwa	June90-Jan.92			Military	
Alhaji Maina Maji Lawan	Jan.92-Nov.93				Civilian
Grp. Capt. Ibrahim Dada	Dec. 93-sep.96			Military	
Col. V. A. Ozodinobi	Sep.96-Feb.97			Military	
Lt.Col. Augustine Aniebo	Feb.97-Aug.98			Military	
Wing Comd. L.N. Haruna	Aug98-May 99			Military	
Dr. Alh. Mala Kachallah	May99-May 03				Civilian
Dr (Sen) Ali Modu Sheriff	May03-date				Civilian

2.5 BRITISH OCCUPATION OF NORTHERN NIGERIA – BORNO

Crowder (1977: 143-151) discusses British Colonial rule. He explains how the colonial masters, after demarcating Nigeria, brought the people together and ruled through the philosophy of association (i.e. Nigerians maintaining their culture in all facets of life) under two regions, initially the Northern and Southern protectorates. The country was later divided into four regions, the Western, Southern, Eastern and Northern regions, for administrative reasons. The four regions were further divided into provinces. Indirect rule was used in the Northern part of Nigeria, which was referred to as the Northern Protectorate whose capital was initially at Zengeru but later moved to Kaduna. The head of the Northern Protectorate was the Governor General Frederick Lugard. Goldie, an influential

administrator and businessman, desired to expand his trade in Northern Nigeria; this led to the exclusion of the French and the introduction of a policy of indirect rule, which was ultimately extended to the whole country by Lugard. A British protectorate was declared in 1900 with Lugard as the high commissioner. The area was only British on paper, however, so Lugard had to conquer it with his small force as the northern emirates did not combine to resist him. Though he was able to take Borno easily, he was then faced with the problem of how to govern the region. He either had to discard some of the areas or keep them. Due to the small numbers of people he had to help him, he decided to keep the emirates and their traditional rulers, thus beginning the policy of indirect rule. In leaving intact the government of the Muslim North, Lugard also had to respect the Islamic religion. It was impossible to rule northern Nigeria in any way other than through the traditional rulers because of the vast area and the few British officers approved to join Lugard.

Under indirect rule, the traditional system of government was maintained but with the rulers being advised by the British officials – the resident and district officials. The traditional ruler was installed in office by the British and could be deposed by them. The traditional ruler no longer controlled the unoccupied land, as this became the property of the British crown. The emir was directed to help the British in the construction of roads, bridges and telegraphs in his emirate. He continued to have a private police force for his orders and he received the protection of the British government who promised not to interfere in the Islamic religion. This situation has been cited as a primary cause of the large gap between the North and South in terms of access to western education (Alkali and Usman 1983: 56). Missionaries were not allowed to enter unless specifically invited by traditional rulers, even

though Lugard himself was in favour of their presence. Native courts were established as well as introduction of direct taxation, and grades of chiefs were formally recognized in the Native Authority and they were given fixed salaries. These chiefs were directed to stay with their local subjects instead of staying far away in the capital, a practice which had caused inefficiency in local administration before Lugard gained power.

The Northern Nigerian system involved few structures and practices likely to influence the culture and traditions of the north. Lugard was allowed to bring missionary education to the north but there were no major changes until the 1930's when Donald Cameron insisted that the emirs must travel in order to gain experience and developed the idea that the educated should get places in the administration. However, the traditional political and religious leaders still retained considerable power up to and after independence.

Colonial administration came into being in Borno State with the deputy lieutenant Governor at the head. His residence was built in the outskirts of Maiduguri (Yerwa) and the area was named the Government Residential Area (GRA). The houses of the senior government officials in the GRA are still occupied by the senior government officials in this neo-colonial era. People who stay in the GRA and especially in the government residential quarters are regarded as English people but with black skin. The virgin lands around the area were purchased by rich business tycoons who built their residential houses there. The Christian cemetery within the GRA was specifically established for the use of the white colonial masters, and it continues to be used by the Christian elites in burying the remains of their dead (Masta 1983: 7).

Although the power structure allowed traditional rule to continue, the powers of the traditional rulers were reduced as the colonial masters controlled and implemented the budget through the local authority (Ajayi 1974: 48). In central Borno province, primary schools were built through the efforts of the colonial administration, as were hospitals, dispensaries and clinics. Missionaries also contributed to the building of missionary schools and hospitals. In terms of trade, the colonial administration in Borno introduced railways and telephones, and vitalized groundnut farming in the State. Additionally, the administration built an oil mill for the production of groundnut oil in Maiduguri. Groundnut was also exported to Britain for use in making chocolates and margarines, which were then imported back to Nigeria and sold. Big trading companies were established in Maiduguri, such as the United African Company (UAC), Perterson and Zakariyas (PZ), John Holt (JH), and banks like Barclays Bank, Standard Bank and the United Bank for Africa (UBA).

When independence was gained in 1960, the country was administered under three regions, which were later expanded into four. Twelve states were created during the military administration of Retired General Yakubu Gowon in 1968, with Maiduguri as the capital of what was then the North Eastern State. With the later creation of five more states out of the North Eastern State in 1992, Maiduguri again became the capital of Borno State.

The preceding historical information makes it clear that Borno State has been exposed to the challenges of political change, social change and urbanization. Colonialism had influenced changes in the state with respect to administration, infrastructural development,

trade, education and health care. The effects of colonialism and indirect rule on colonial-era Borno are varied, as Lugard was able to administer a vast area with only a small number of political officers. He also streamlined local systems of administration, justice and taxation. The traditional institutions of emirs and councils, native courts, native prisons, and native treasuries became models for southern Nigeria and other parts of Africa, such as Tanganyika. Although development has been slow, Maiduguri has become an urban capital and globalization has affected development throughout the state (Anene and Brown 1966: 78).

2.6 SOCIAL CHANGE, DEVELOPMENT AND URBANIZATION IN THE CONTEXT OF GLOBALIZATION

Change is not only inevitable, but is also a necessary concomitant for the development of society. The Kanuri society is a dynamic one, and has experienced elements of social transformation with respect to cultural traditions caused by education, population growth, technological changes, modern health care, NGO support, and the effects of mass media. All of these changes have led to the urbanization of the State capital and, to a lesser extent, the local government headquarters. There is thus a clear impact of globalization on the state in an era where the entire world is referred to as one “global village” (Cohen and Kennedy 2000: 16). Globalization is facilitated by ease of communication that comes with telephones, computer networks and television. All the changes described above are far more evident in urban than in rural areas.

Globalization and technological advancements are not without problems, and as a member of the global community, Borno has experienced both the positive and negative aspects of these changes. On the positive side, Borno State has witnessed many developments in terms of infrastructure, education, health care, agriculture, and transportation since the beginning of colonialism. But imperialism can be “creative or destructive, [and] for better or for worse has destroyed traditional institutions” (Mastanduno 2008: 3). Traditional health practices in Borno have not diminished in influence, and their ongoing practice may be attributable to particular problems associated with the provision of modern health facilities, good road networks, access to water, support from NGO’s, and other imbalances between rural and urban areas that have produced tension. For example, Borno State has general hospitals, primary and tertiary schools, water, and transportation systems in all the local government headquarters. There is also support from international agencies and NGO’s brought about by passionate individuals who think globally while acting locally (Roadman 1998: 12). Traditional health practices are neglected in spite of their ongoing patronage, especially by the inhabitants of rural areas where the practices are most common, as they are not on the priority list of either the international agencies or NGO’s that give support to the state. The Nigerian Policy Document on traditional medicine is therefore rhetoric rather than reality, as will be discussed in chapter four.

Rural-urban drift remains continuously high, as most of the young population tends to leave their villages and come to either the state capital or the local government headquarters. This migration leads to high unemployment rates and numerous associated problems. The process of urbanization is particularly evident in Maiduguri, and to a lesser extent in the

twenty-seven local government headquarters in the State. For instance, the state capital Maiduguri, which is also the largest town in the state, has a population of about 462,763 according to the 1991 census. Because of rapid urbanization, the wealthy area is surrounded by seas of poverty leading to social vices ranging from delinquency to drug addiction, alcoholism, armed robbery, unwanted pregnancy, abortion, street children, HIV/AIDS, and ritual killings. Most of these problems are also evident in the industrial cities in the West as well as other colonial cities in Africa (Cohen and Kennedy 2000: 265). The global economic recession is also a problem as the dollar is controlling the whole world. The inflation in prices of all raw materials is due to the capitalist nature of the economy with western imperialism at its peak. Nevertheless, globalization has its positive impact, such as rapid improvements in environmental cleanliness due to increases in modern infrastructure in the urban areas, improvements in communication and technology, and improvements in education, health and agriculture. Similarly, some benefits are obtained from the protectorate approach among imperialists, since richer countries do lend support towards preventing some of the problems that might otherwise land on their doorstep, including the global challenge of HIV/AIDS, green belt preservation, prevention of wars to reduce migrations, and emergency communication responses at the global level such as the recent information sent out globally by the U.S government on the prevalence of the Swine Flu virus.

2.7 CONCLUSION

Borno is a plural society composed of many ethnic groups, with the Kanuri as the largest and most dominant ethnic group. It is one of the oldest empires known to mankind,

founded by Mai Umme Jilmi who reigned from 1088 – 1097 and who established the first Kanuri Empire. Since that time, Borno has been ruled and administered by many leaders ranging from ancient Mais, Shehus, and colonial administrations to the present day civilian administrations.

This chapter has described the Kanuri people who form the greatest part of the Borno Empire and their distinctive traditional culture. For further information, a description of Kanuri rites of passage is provided in Appendix I. Some aspects of Borno culture and society have been transformed by development, social change, urbanization and globalization following the British occupation of Northern Nigeria. Education, health care, agriculture and infrastructural development have seen great advances, while the traditional health system remains underdeveloped. Urbanization is most evident in the state capital, Maiduguri, and the LGA headquarters. Also evident are the social vices that accompany urbanization, including drug addiction, juvenile delinquency, alcoholism, armed robbery, unwanted pregnancy, and other social problems.

In conclusion, Borno remains a strongly traditional society with a strong traditional culture while also experiencing massive change caused by globalization, including exposure to the western biomedical health system. The Kanuri society of Borno has greatly transformed in terms of its people and language, due largely to social change, development and urbanization in the context of western imperialism and globalization. This is the cause and context for the current situation of medical pluralism in the state, in which both traditional and modern biomedical health care systems are patronized. The potential for the

integration of these two systems is the subject of my research, and the methods for this research are described in the following chapter.

CHAPTER THREE

METHODS

3.0 INTRODUCTION

This is a multi-method study using focus groups, interviews with key informants, documents and self-reference auto-ethnography. This combination of methods was intended to give the fullest possible picture of the integration of traditional health practices into the western biomedical system as understood by health professionals, traditional healers, and potential patients. Furthermore, this broad methodology allowed me to address how the administration of health care in Borno State relates to the traditional healers. The study is primarily qualitative with a small quantitative element. The multi-method research design combines “an umbrella of techniques” (Burgess 1984) typical of field research.

The study began as an auto-ethnography that includes ethnographic observations drawn from my own experience. I combined the auto-ethnographic portion with a review of relevant documents, a small quantitative survey, interviews, and focus groups with a representative sample. Additionally, I gathered general views on how to better integrate traditional health practices into the modern biomedical system. This multitude of methods allowed for proper triangulation of data collection techniques, which I describe in greater detail in the following section.

3.1 TRIANGULATION

Given the diversity of respondents included in the present study, incorporating different methodologies and triangulating results was essential. Several forms of triangulation were undertaken, including the following:

- 1) Data triangulation. This considers concepts of time, space and person. Data were collected at different times, in different places and different local health zones, and from different categories of respondents.
- 2) Investigator triangulation. This form of triangulation involves the inclusion of multiple observers. In my study, I utilized additional research aides, both to assist with the amount of work involved as well as to provide male research aides to help with note taking where male respondents were involved.
- 3) Methodological triangulation. This approach combines multiple research methods to maximize the accuracy and robustness of the data collected, and to compensate for intra-method disparities.

The inherent difficulties involved in a broad ethnographic study such as this have been described by other social scientists. For example, Nigel Gilbert discusses the complexities of such work, noting that “it is however rather more difficult to give a toolkit for this kind of work because the data materials are so various. . .” (Gilbert 1993: 199). Furthermore, “despite the large number of published studies, it is surprising that little attention has been paid to assessing the validity and reliability of seasonal effects and generalizability” (Sauerborn 2000: 118). The most appropriate way to overcome the

weakness of any one method “is to combine the method with others, quantitative or qualitative, and to look for consistency or lack thereof using a technique called triangulation” (Khan and Manderson 1992: 56-66).

3.2 SAMPLING AND SELECTION OF FOCUS GROUP PARTICIPANTS AND INTERVIEWEES

My sample combined opportunistic sampling with theoretical sampling to obtain a broad range of views and opinions which were representative of key stakeholders in the different zones. Theoretical sampling is a term used mainly in relation to grounded theory to refer to sampling carried out so that emerging theoretical considerations guide the selection of cases and/or research participants. Theoretical sampling is supposed to continue until a point of theoretical saturation is reached, which can be defined as “the point when emerging concepts have been fully explored and no new insights are being generated” (Bryman 2001: 508). The sample for this study included a wide range of health care professionals, mothers from both rural and urban areas, and traditional healers.

The following samples of respondents were drawn from three of the six health zones (Maiduguri Metropolitan, Damasak and Biu). These zones were selected in order to include an appropriate combination of urban and rural areas and a cross-section of the health zones.

The categories included:

- Non-Kanuri Doctors
- Non-Kanuri Nurse/Midwives

- Kanuri Doctors
- Kanuri Nurse-Midwives
- Mothers from Urban and Rural Areas
- Traditional Health Practitioners/Healers/Traditional Birth Attendants (TBAs)

Reliability, validity and design efficiency were considered in selecting the respondents for questionnaires, and the participants for interviews and focus groups. Reliability is defined as the extent to which an instrument measures consistently what it is designed to measure each time it is used. Validity is defined as the extent to which an instrument takes precise and accurate measurements. Concepts of validity, especially in ethnographic studies, are not static, and are subject to change due to the dynamic nature of the social world (Johnson 1976: 253).

For my study, reliability is achieved by utilizing multiple methods, each complementing the other such that any trained researcher could produce findings similar to those presented here. Additionally, the study design acknowledges the role of insider bias given my position as a member of the educated elite and as a member of the royal family. In order to overcome limitations caused by insider bias, I have included multiple methodologies, a broad group of informants, data collection in multiple geographic locations, and employed a number of research assistants who have contributed to data collection. The validity of this study has been achieved by conducting detailed focus group discussions and in-depth interviews in order to collect the most accurate and thorough data possible. I have

also provided detailed records of all data collected, and described the specific analytical methods used.

By the first quarter of 2001, field work was started in earnest. I started by traveling to all the nineteen Local Government Areas in the state in order to encourage participation in my research programme and to explore the issue of representativeness, since my earlier opportunistic and theoretical sample of six health zones had been reduced to three. I chose to reduce my focus to the three health zones because the first, Maiduguri Metropolitan, is an urban zone where Kanuri culture most sharply contrasts with western and global values and practices, and because the other two are representative of Kanuri rural societies. The following itinerary was followed:

- Borno North:
 - Abadam and Mobbar
 - Magumeri, Gubio, and Guzamala
 - Nganzai, Monguno, and Kukawa
 - Marte

- Borno Central:
 - MMC, Jere, Kaga, Mafa, Dikwa, Ngala, Kala Balge Konduga and Bama

- Borno South:
 - Damboa – Baale

In each of the Local Government Areas, the Local Government Council members, the traditional institutions comprised of the traditional rulers and health practitioners, the staff of the general hospitals, and women development officers were contacted and the purpose of my research was explained to them in detail. I recruited participants to attend a focus group discussion in the state capital on a subsequent date. I engaged in a similar process of explanation and recruitment for the mothers and other health care professionals as well. I also encouraged men to allow their wives, who were invited to participate, to attend. The traditional institutions, which included traditional rulers and traditional health practitioners, were likewise informed of the importance of responding to the planned questionnaires, as well as the importance of attending focus group discussions and face-to-face interviews.

3.3 ETHNOGRAPHY AND AUTO-ETHNOGRAPHY

3.3.1 General Method

According to the Blackwell Dictionary of Sociology, “ethnography is a descriptive account of social life and culture in a particular social system based on detailed observations of what people actually do” (Johnson 2000: 111). Based on specific observations, ethnography is a well-explained account of social and cultural organization within a particular system. This is a research method often associated with anthropological studies of tribal societies. It is also used by sociologists, frequently in relation to groups, associations and communities that form part of wider and more complex societies such as ethnic groups, hospitals, neighborhoods, urban groups, or religious groups. Ethnography seeks to

understand the social behaviour of people living in their natural settings. Hammersley (1992) further describes the process of conducting ethnography, noting that

as a set of methods ethnography is not far removed from the sort of approach that we all use in everyday life to make sense of our surroundings. It is less specialized and technical in character than approaches like the experiment or the social survey, though all social research methods have their historical origins in the ways in which human beings have always gained information about their world.

(Hammersley 1992: 2)

Auto-ethnography is a specific form of ethnographic research, which involves a form of writing and research that relates the person to the cultural, fixing self within a social context (Holt 2003). Auto-ethnographies are texts that are usually written in the first person and feature emotion, dialogue and personal consciousness.

3.3.2 Issues of Reflexivity in the Conduct of the Research: My Status as an Indigenous Ethnographer

Both ethnography and auto-ethnography emphasize the three key elements of self, culture and the research process. The latter form also includes an analytical or objective personal account, about the self (writer) as part of a group or culture, a description of conflict of culture, an opportunity to explain differences from within a particular context, and always an attempt to explain self to other. Auto-ethnography allows a researcher to remain in a naturalistic setting, therefore offering particular insights since “proper ethnographic work can be accomplished only by remaining in as close contact with the ‘natives’ as possible” (Malinowski 1961: 6-7).

It is true that ethnographic research as a qualitative method has been criticized as an “all-comers province in the sense that it lacks scientific principles” (Igbinosun 1992 22). However, I feel that ethnographic research offers a vital form of analysis for understanding health sector reform. Social systems are dynamic and constantly changing, and detailed understanding is best achieved by people who, like me, have remained with their local communities. My status as a “native” offered certain strengths and insights into the cultural issues I explored, as noted by Malinowski above and by Anderson, who stated that “as ethnographers, anthropologists on familiar terrain will achieve a greater understanding than elsewhere, because they do not have to surmount linguistic and cultural barriers” (Anderson 1992: 101).

However, despite the relative lack of linguistic and cultural barriers I experienced while conducting this ethnography, I was faced with the problem of navigating conflicting roles within the culture since I am a member of the educated elite, a woman, an administrator, and a member of the royal family. I found a need to practice non-judgment and to maintain an awareness of cultural relativity in my work. I operated with an awareness of insider bias and the nature of my conflicting roles, as I was involved in two health systems, one considered orthodox and one unorthodox. These conflicting roles and systems form the crux of a paradox that I explore in this ethnography. I approached this ethnographic work as a Kanuri speaker and tradition bearer, a member of the Kanuri elite, and also as a very senior health professional. I reflected on how this influenced my own perceptions, as well as the ways in which other people responded to me. I was faced with the duality of

being perceived as a powerful individual based on my position as a member of the elite and from a royal background, while simultaneously being seen as occupying a less dominant social position based on my gender. As I will discuss in later chapters, several of the focus groups reveal how women are considered less powerful than men in this social context. In focus groups with doctors, gender was less at issue and while I was aware of the role of gender, I do not feel it greatly affected what the doctors chose to share with me.

All of these issues concerning competing roles and social perceptions relate to the concept of insider bias, which has both advantages and disadvantages when conducting ethnography. In my case, the advantages included being able to use existing networks and contacts within the traditional institutions, including the traditional and religious leaders and the local health councilors, and gaining access to a much wider cross-section of people than might otherwise have been available to me. On the other hand, the disadvantages related to my position and gender include the way I was perceived by the informants in this study; it is impossible to know the extent to which my informants were truthful in the perceptions and opinions they shared with me or whether they were telling me the things they thought I wanted to hear.

I selected a sample that included a wide range of health professionals (doctors, Kanuri doctors, midwives, and Kanuri midwives), mothers from both urban and rural settings, and traditional healers. I needed to apply my non-judgmental stance to traditional practices which I earlier considered 'harmful' without considering their time and place, the ingredients of proper ethnography and auto-ethnography. Such considerations are essential, since both

society and the natural environment are dynamic and ever-changing. What was harmless in the last generation might be extremely harmful today. For example, traditional tribal marks (*berikaro/dawukirikaro*) can predispose one to contract the killer disease HIV/AIDS in this generation (time) and/or especially in rural areas (place).

My unique position as a member of the traditional royal family and as a very senior biomedical professional involved a certain amount of cognitive dissonance for me as I dealt with the paradox of being expected to uphold both modern and traditional practices. Given this unique position, my aim has been to expand upon these experiences based on phenomenology, i.e. the sensibility of my lived world (Johnson 2000) as well as my own life course. This project grew out of my own real life experiences, and not simply as the result of a PhD programme. Throughout my childhood and schooling, and through my working life, I have lived in a social world where traditional and modern biomedical practices are being used by the people in my immediate community, and I stand in a position of tension between the two systems.

3.4 FOCUS GROUPS

3.4.1 General Method

Focus groups enable researchers to conduct group interviews that focus on in-depth exploration of a particular topic or theme. Both individual and group viewpoints are examined, and general group consensus about specific ideas is recorded. Use of focus group

discussions is a qualitative method with an empirical component, involving deliberately organized social events that encourage collective interaction among participants.

The benefit of using focus groups as opposed to alternative methodologies, as described by Morgan (1998), is that focus groups enable researchers to capture respondents' attitudes, beliefs, feelings, reactions, and experiences which are only revealed through social interaction with other participants and cannot be adequately captured by observation, individual interviews, questionnaires, or surveys. Focus groups also provide researchers with multiple perspectives on a single topic, and produce a large amount of information in a shorter period of time compared to individual interviews. Similarly, whereas direct observation necessarily involves waiting for key events to occur, focus groups allow researchers to produce a deliberately organized forum for the articulation of key themes and ideas. On the other hand, focus groups can be problematic when power differences exist among respondents or where issues of language, culture, or other sensitive topics are discussed.

The purpose and advantages of focus groups have been described by Bryman, who defined focus groups as “a form of group interview in which there are several participants (in addition to the moderator/facilitators)” (2001: 337). According to his definition, focus groups involve moderators engaging multiple participants on a clearly defined topic, with an emphasis on intra-group interaction and the collective construction of meaning. Focus groups can take two forms, either involving a group interview where multiple respondents

discuss a variety of topics or focus interviews where people known to have been involved in a particular situation are interviewed about specific experiences.

Use of focus groups constitutes one of the best methods for eliciting more in-depth and diversified information compared to other methods. An ideal group consists of between eight and fifteen discussants. Focus groups necessarily involve social interaction, and therefore groups must be assembled carefully. It is extremely important to select diverse participants for each focus group. Information from the different categories of respondents should be taped, transcribed, cross-examined, and analyzed.

3.4.2 My Own Use of Focus Groups

Eight categories of respondents were involved in focus group discussion (FGD) and one in an in-depth interview. The categories included: Kanuri midwives, non-Kanuri midwives, Kanuri doctors, non-Kanuri doctors, traditional healers, TBAs, urban mothers, rural mothers and a bone setter. They were asked specific questions about whether they saw particular practices as harmful or beneficial. They were also asked whether, on a personal level, if any of their family members was afflicted with certain conditions they would utilize traditional medicine or not. They were further questioned about the advantages and disadvantages of traditional practices, the benefits and harms involved, and the relative cost of such practices.

In addition, broader questions were posed about how traditional healing practices can be integrated into the modern health care system, and what particular strategies can be employed to successfully achieve such integration. As a health professional, the issue of maternal and infant mortality is particularly important to me, especially given that my state is one of the areas with the worst rates in Nigeria. The high infant mortality rates may be attributable to *dowugota* (uvulectomy) among infants, which leads to mortality at a rate of approximately 800/100,000. I therefore also included questions about how to reduce the high maternal and infant mortality rates.

Focus group discussions with eight categories of respondents were held at multiple time points and in different venues. The discussions were audio-taped and later transcribed by me. I employed field researchers who assisted during the discussion and took notes. Discussions ranged from 3- 6 hours depending on the topic of discussion and on the membership of the group. As time went on and more focus groups were conducted, the timing improved and focus group discussions were reduced to approximately 20-50 minutes. Themes were identified which captured the views of each category of respondents. Information on some of the Kanuri traditional health practices were sought through FGD via a questionnaire I designed given that there was no standard tool for that purpose before the commencement of my study. The respondents were selected within the sampled health zones of the state and the data collection was completed within the stipulated period.

Focus group discussion with a mixed group of traditional healers and a traditional birth attendant (TBA) was conducted on the 3rd of February, 2001. The discussion was

conducted in Hausa, as respondents selected from the sampled Kanuri-speaking LGAs were not solely Kanuris but had three Hausa-speaking traditional healers who had been settled in the area for about three decades. The discussion was conducted in the UNFPA training room of the School of Midwifery, Maiduguri. The discussion was mediated by me and took a far longer time than anticipated because the power relations between various traditional practitioners, depending on their area of specialization and their gender, affected the discussion in spite of my attempts to effectively mediate the conversation. I observed that the traditional practitioners who engage in surgical interventions like the *wanzama* and *Kelagotama* were more independent and vocal in the presentation of their opinions, and did not request permission to speak by signalling to fellow practitioners as some of the other practitioners did. Side discussions were also observed between practitioners from other groups seeking to know precisely what response should be given. Interesting events occurred during the focus group discussions. For instance, the TBA who was the only woman in the group had to take permission from the *Wanzama* or *Gau* before she voiced her opinion and I recalled that air time was whisked by the *Wanzama* and *Gau* on two occasions. Without my intervention as mediator of the discussion, her opinion would not have been heard. This power dynamic among the respondents necessitated my selection of two homogenous groups of traditional healers and TBAs respectively for subsequent focus groups, and those groups held at later dates were completed successfully.

Traditional birth attendants (TBAs) were selected from the sampled areas and were invited for the discussion which was held in the same venue as above on the 20th of February, 2002. Although there was a non-Kanuri TBA in the group, the discussion was conducted in

Kanuri as all of the respondents spoke Kanuri fluently. The same applied to the traditional healers as again not all of the respondents were Kanuri, but all were able to speak Kanuri fluently. The discussion lasted for approximately one and a half hours.

Themes adopted for the Kanuri TBAs included: perceptions of Kanuri TBAs of Kanuri Health Practices, preferred mode of treatment, advantages and disadvantages of Kanuri traditional health practices, strategies for easy co-existence between traditional and orthodox health practitioners, strategies for reducing maternal and infant mortality in Kanuri communities of Borno State, and recommendation for the improvement of Traditional Health practices. The themes adopted for the Kanuri Traditional Health Practitioners were the same as above except for the final point, where the traditional health practitioners were asked about recommendations for the improvement of health care. The focus group discussion with the traditional healers was conducted in the UNFPA training room of the School of Midwifery in the afternoon. Respondents included *Wanzama, Kelagotama, Shilashiwoltama, Suromowoma, Kawugotama, Kaskima, Gau, and Karwina*. The discussion lasted for one hour and forty minutes.

Focus group discussion with the Kanuri Nurse/Midwives was completed on the 5th of July, 2001. The discussion was conducted in Kanuri. The sample was selected from the same Local Government Areas, but included different maternity units where the nurse/midwife in charge was Kanuri. Ten registered Nurse/Midwives in charge of maternity units were invited for the focus group discussion and eight accepted the invitation. The focus group discussion lasted approximately three hours, and I acted as mediator while a field

officer took notes. The discussion was audio-taped, and later transcribed by me. The discussion was held in Yerwa Maternity Clinic in downtown Maiduguri.

Focus group discussion for the urban mothers was conducted in Kanuri at my house. My house was selected as an appropriate venue because most of the women are full-time housewives and holding the discussion in a more official environment might have hindered their willingness to share their views. Furthermore, most of the men had prepared their wives to participate in the discussion in a home environment. Of the ten urban women who were invited, nine accepted the invitation and eight ultimately participated in the discussion.

The focus group discussion with rural mothers took place on September 2nd, 2001, in the Jajeri area of Maiduguri Metropolis. Jajeri was chosen because it is an urban area resembling a rural setting. I wanted to encourage the free sharing of ideas among participants by not taking them to a location that was in conflict with their normal environment. Of the fifteen rural mothers invited, thirteen accepted the invitation and eight participated in the discussion. During the post-focus group discussion, the list of harmful practices compiled by the urban mothers was presented to the rural mothers. All items on the list were well-known to the rural mothers. The discussion lasted for two hours.

The themes expressed by the urban mothers included the perception urban women had on Kanuri traditional health practices, preferred mode of treatment, treatment preference for a specific ailment/condition, advantages and disadvantages of various treatments, strategies for co-existence between orthodox and traditional medicine, and strategies for

reducing maternal and infant mortality in the Kanuri community of Borno State. The same themes were adopted for the rural women, with an additional theme involving strategies for the improvement of traditional health practices by rural mothers.

Doctors in charge of the General Hospitals in the sampled areas were invited for a focus group discussion. Eight doctors were invited to participate, and all eight accepted the invitation. Out of this group, two were non-Borno indigene from Southern Nigeria, and both were Christian. The other six participants were Muslim, and one was born and raised in Borno State and was Kanuri-speaking, although this focus group was conducted in English. One group member was female, and participated freely among her male counterparts. This discussion was held on the 15th of February, 2002 at the UNFPA training room of the School of Midwifery. The discussion was audio-taped and lasted for one hour and forty-six minutes.

A sample of Kanuri doctors who were Principal Medical Doctors in charge of General Hospitals was selected, and eight participated in the discussion in the same venue as above on the 17th of February, 2002. There were seven males and one female, and all were Muslim. The transcripts show that the female Kanuri doctor spoke well and more informatively than her male counterparts. The discussion lasted for one hour and thirty five minutes.

A discussion with non-Kanuri Nurse-Midwives was conducted on the 20th of February, 2002 in UNFPA training room of the School of Midwifery, Maiduguri. The Nurse/Midwives were invited from the selected areas, and eight Nurse/Midwives in charge of

maternity units participated in the discussion. They were all female, five were Muslim and three were Christian. All spoke Kanuri reasonably well. The discussion lasted for about one and a half hours.

3.5 INTERVIEWS

3.5.1 General Method

The Oxford Advanced Learners' Dictionary defines an interview as a "meeting between two people to discuss important matters usually rather formally" (1998: 963). Interviews take place between the interviewer, who is typically the researcher, and the interviewee, who is the respondent. Gibbs (1993) has described the advantages of this method, noting that interviews are easy for researchers to control compared to focus groups, where individuals interact with each other in a collective format in order to reach a group consensus. According to Gibbs, individual interviews are designed to "obtain attitudes, beliefs, and feelings" (1993: 2-4). Interviews are more flexible than other methods since they entail extended periods of participant observation, making interviews particularly appropriate for the collection of qualitative data.

The inclusion of life history interviews in this study was appropriate given the exploratory nature of the study, in which I aimed to explore attitudes, beliefs, and feelings, as well as reflecting on my own inner experiences as they relate to the topic of this study. The

nature of this project required the use of diversified methods, where interviewing techniques were tailored to particular groups of respondents as appropriate.

3.5.2 My Own Use of Interview

My initial interview was conducted in-person with a traditional health practitioner on the 3rd of February, 2001. I initially planned to have a focus group discussion, but it became clear that a face-to-face interview with the traditional bone setter was more appropriate. I was assisted in the interview by a trained field researcher who took notes. The interview was audio-taped, and later transcribed by me.

I also conducted an in-depth interview with the Kanuri *Shilashiwoltama* on the 22nd of February, 2002. The interview was conducted in the house of the traditional practitioner in the Mafoni area of Maiduguri Metropolis, one of the sampled areas. The interview was conducted in Kanuri by me, audio-taped and transcribed.

3.6 DOCUMENTS

3.6.1 General Method

Documents are official papers such as newspapers, magazines, books or other sources that convey factual information or evidence. Personal documents can include diaries, letters, or autobiographies. Indeed, “the term ‘documents’ covers a very wide range of different

sources, and a wide range of different documentary sources can be used in qualitative research” (Bryman 2001: 369). The four sets of criteria for assessing the quality of documents, as described by Scott, are as follows: “Authenticity: Is the evidence genuine and of unquestionable origin? Credibility: Is the evidence free from error and distortion, and representative? Is the evidence typical of its kind, and, if not, is the extent of its un-typicality known? Is the evidence clear and comprehensible?” (Scott 1990: 6).

There are multiple approaches to the interpretation of documents. However, the most typical approaches include qualitative content analysis, hermeneutics, and semiotics. Qualitative content analysis involves eliciting clear themes from the material. These themes are systematically examined, coded, and subsequently analyzed using reflexivity and grounded theory. Hermeneutics involves understanding the context in which the document was produced, and determining the purpose of the writing and the perspective of the author. Semiotics involves the analysis of symbols, and is popularly referred to as the science of signs.

3.6.2 My Own Use of Documents

Multiple document sources were included in the present study in order to generate detailed contextual data on Borno State and its health care system, as well as the development of Nigerian and WHO policies pertaining to the relationship between traditional and western-based health care practices. An extensive library search for all relevant books, journals, periodicals, and post-graduate theses was conducted in both England and Nigeria.

This study also reviewed government circulars, position papers, and workshop and conference materials. The traditional healers and some lay people were consulted when oral accounts of traditional practices affecting the health of women and children were sought. A thorough search was conducted on each of the following topics:

- Understanding the social context of health, including the relationship between culture, health and illness, as well as gradual changes in the social context of health
- Evolution of health services in Nigeria and Borno State during both the colonial era from 1900-1960 and during the post-colonial period
- The historical and contemporary perspectives on the health policy of the Federal Republic of Nigeria (FRN) and traditional health care as advocated by the World Health Organization (WHO)
- Traditional society, traditional institutions and traditional health practices that affect public health and quality of life in Borno State
- Changes in epidemiologic patterns, global health challenges, and Nigerian health sector reform.

3.7 CONCLUSION

This research initially grew from an auto-ethnography, which led to my desire to conduct focus groups with additional informants. I subsequently conducted interviews to explore in more detail the themes which emerged from the focus group discussions. It became clear that information gathered in focus groups and individual interviews needed to be understood within the social context in which it occurred, so I also gathered and reviewed

documents that helped define administrative structures and the relationship of such structures to traditional practices. These materials included documents produced by the Nigerian government, Borno State, and the WHO. Ultimately, this thesis combined my own personal experience with focus groups and individual interviews involving clinical practitioners, traditional healers, and urban and rural health users, with related and contextualizing information provided by additional documents.

CHAPTER FOUR
THE FORMAL HEALTHCARE DELIVERY SYSTEM IN NIGERIA
AND IN BORNO STATE

4.0 INTRODUCTION

In this chapter, I describe the development of biomedical healthcare and health professional education in Nigeria and the current state of formal health care organization and delivery in Borno State. To do so, I first establish the context and present a brief historical account of the development of formal health care in Nigeria in general and in Borno in particular.

The provision of health services began much earlier than the formal training of health professionals in Nigeria, beginning as far back as 1900 when the country was colonized. Colonialism was not only economically oriented, but had social and cultural aims as well. The development plans adopted during the pre-independence era were largely conceived by the colonial expatriates, and post-independence plans did not deviate substantially from the ideas already in place. The BHSS (Basic Health Services Scheme) became the general plan for health policy in the country, addressing some of the health problems relevant to Nigeria. While the document outlined a well-designed and flexible health policy, numerous issues arose in Borno State related to the actual implementation of these policies in practice.

The Ministry of Health oversees the formal organization of health care in Borno State. It is organized with the Honorable Commissioner of Health at the apex, the Permanent

Secretary as the accounting officer, and the Secretary of Health as deputy to the Permanent Secretary. There are eight directorates in the ministry, each headed by a director with specific responsibilities, although at times the directors work in collaboration with each other (see Appendix II).

The realities of health care in Nigeria and in Borno are reflected in its health statistics. Nigeria's overall performance was ranked 187 out of 191 member States by the WHO. In Borno, the situation is nearly identical, in spite of the fact that the region is influenced by economic, educational, geopolitical, technological and social inputs and developments, and that foreign international agencies as well as the World Bank offer their support. Borno's current maternal mortality rate (MMR) is 1.7, one of the worst rates in the country. The manner in which health policies are implemented in the Borno State Ministry of Health is problematic, and there are significant holes in the ability of the Ministry to address key health issues facing the people of Borno State. One such hole is the complete lack of a Traditional Medicine Board. No such board exists because the Directorate of Medical Services, assigned with supervising the establishment of a Traditional Medicine Board, opposes the use of traditional medicine. Borno State is currently the only state in all of Nigeria that operates without the guidance and oversight of a Traditional Medicine Board.

4.1 THE DEVELOPMENT OF HEALTH CARE AND PROFESSIONAL EDUCATION IN NIGERIA

Early explorers from Portugal, Scotland and England introduced medical services which were meant for them. They were accompanied by their own doctors, and services were designed to meet their own health needs rather than those of indigenous Nigerians. Towards the end of the 19th and early 20th century, few African doctors had formal qualifications. The first African who qualified as a doctor was a Sierra Leonean named John Macaulay Wilson (Adeloye 1977). The first Nigerian doctors recorded in history were James Africanas Beale-Horton and Williams Broughton-Dalles, who graduated from St. Andrew's University, Scotland in 1859 after studying in Fourah Bay College of Sierra Leone. Other Nigerian doctors mentioned in historical accounts included Dr. Nathaniel King who came to Lagos, Nigeria and joined the service in 1876 and died in 1885. Others were Lumpkia, Oguntola Sapara, W.A. Cole and Curtia Adeniyi-Jones. The doctors whose names appeared in the medical directory as far back as 1893 were Obadiah Johnson, Leigh-Sodipo, and Prince Orisadipe. The so-called African doctors were segregated and discriminated against, and were paid lower salaries than even their most junior white colleagues. No black doctor was ever put in a position of authority over a white doctor or a white nursing sister. The black doctors were always superseded by a cadre of junior white doctors, and these discriminatory practices caused very few blacks to choose medicine as a profession at that time. In fact, the system was most likely designed to discourage black people from seeking medical training, since medicine was regarded as a superior profession fit solely for Europeans.

The Nigerian medical service emerged from the Army's health service which was organized for the frontier force of West Africa. The first hospital in Nigeria was established

in 1863, mainly for attending to sick military personnel in Lagos. More hospitals were built in Nigeria, with the general hospitals being classified as either European or African. One of the earliest hospitals was built in 1905 at Itu Jebba. Others that followed were St. Margaret's Hospital in Calabar, Lokoja, Zungeru, Zaria and what is referred to as Bush Hospitals in Abakaliki, Afipko, Akwoga, Ogoja, Owerri, Ikom and Ikot Ekpene. More hospitals were built in Abeokuta and Calabar before the beginning of the 20th century. Massey Street Dispensary, the Mental Asylum and Leprosarium in Yaba were also established in the early 20th century. In the North, the Kano Nursing Home was opened in 1905, with hospitals built in Kaduna, Zungeru and Offa.

Paralleling the models developed in Europe in the field of public health, a separate Sanitary Department was created and medical officers of health were deployed. They were the ones who introduced anti-malaria campaigns by rolling and spraying pools and buildings and encouraging mosquito proofing of houses (Shehu 1978: 9). The colonial administration then created administrative units comprised of three regions of North, East and West with their Ministries of Health and the Native Authorities. Missionaries continued to arrive in Nigeria and some of them prominently influenced the medical education of a few individuals. For example, Dr. Walter Miller took Barau Dikko to England in 1932, and Dikko later qualified and became the first Northern Nigerian doctor. Dr. Miller also contributed to the development of the Wusasa Hospital in Zaria, which was used for the practical training of nurses and midwives in the country.

Both government and mission hospitals were continuously built. At the outbreak of the First World War in 1914, there were hospitals in Lagos, Calabar, Ibadan, Onitsha, Sapale and Ilesha in the Southern part of the country. In the North, there were small hospitals in Kaduna, Lokoja, Kano, Zungeru, Wusasa, Maiduguri, Offa, Sokoto and Bauchi. Between the two World Wars (1919 – 1939), more government hospitals were built in Lagos, Enugu, Jos, Aba, Mubi, Ijebu –Ode, Oshogbo and elsewhere. The Native Authorities also built their own hospitals during that period. Dr. I.L. Oluwole, who graduated from Glasgow in 1918, was appointed in 1935. Hospitals built by the colonial government included the Nursing Home Maiduguri (specifically for use by the colonial whites within the Maiduguri Government Residential Area (GRA)) and the General Hospital within the township. Others were built by the missionaries, such as the Molai Leprosarium in Maiduguri, and General Hospitals in Lassa and Marama. In addition to hospitals, the Shehu Garbai Primary School was built in 1970 within the GRA for the children of the post-colonial elites, mostly white expatriates.

4.1.1 Medical Education in Nigeria

The West African Medical Council was launched in 1927. In 1935, Dr. C. A. Ajose became the first Nigerian to earn a post-graduate degree in public health. The first formal training programme for medical personnel began providing training for medical assistants in 1930 at the Yaba Medical Training College. There were also a number of auxiliary training schools for dispensary assistants and attendants. More medical schools were established in the states of the federation, with attendant teaching hospitals for the practical training requirements of the medical students. The first institution for the training of medical doctors

in Nigeria was the University College Hospital (UCH) at Ibadan, established in 1957. Thereafter, many medical schools were opened as part of the Universities and Teaching Hospitals in the country for the training of medical students. There are currently about 16,000 qualified medical doctors who are practicing in Nigeria. This figure excludes those who were trained abroad and are practicing there. In Maiduguri, the University of Maiduguri Teaching Hospital (UMTH) was commissioned in 1979. The University Medical College was established for the training of medical students in 1978, and the first cohort of 21 medical doctors graduated in 1983. The institution has produced over 1,000 medical doctors and the number of students in the college is now more than 700.

4.1.2 Nursing Education in Nigeria

With the arrival of the colonial masters, some Nigerians were sent abroad and were trained and registered as nurses in England. Nursing training in Nigeria did not begin until the establishment of the UCH in 1957. Nursing training subsequently grew, as more university colleges and faculties of medicine were established throughout the country. Initially, the nursing curriculum was limited to the certificate level but later was upgraded to offer diploma levels at some institutions. Currently, the schools of nursing in the country offer certificates which run for three years while the university colleges offer a degree that runs for four years. The certificate of nursing programme in Maiduguri was created in 1970, and in 1973 the School of Midwifery was established mainly for the training of midwives. It was upgraded for the offering of post-graduate midwifery training in 1982. In 2000, the University of Maiduguri introduced the BSc Nursing programme in its Department of

Medical Sciences. Psychiatric Nursing at the diploma level was established at the Neuropsychiatry Hospital in Maiduguri. Diploma-level training in post-operative care nursing was also introduced in 2007.

4.1.3 Health Services Provision

With the integration of the Army medical service with the colonial government during the colonial era, the government offered to treat local civil servants and their relatives, and eventually offered care to the local population living close to government stations. As the colonial medical service developed it remained obliged to provide free medical treatment to the Army and the colonial service officers. Thus medical treatment, which the government initially provided only to its own officials, was made available to the local population merely as an incidental service. Various religious bodies and private agencies also established hospitals, dispensaries and maternity centres in different parts of the country.

The action of the British government to provide health care to its members first may be attributable to self –protection, given that Africa was then seen as a hostile environment referred to as ‘the white man’s grave’. Additionally, colonialism was not seen solely in terms of economics, but also in terms of social and cultural conquest. During the colonial period, Africa was dominated by Europeans for the trading of slaves. The Europeans made their first contact with the Nigerian indigenous population in the 1850’s for commercial reasons, motivated by the highly lucrative slave trade. The proprietors of the slave trade instituted some forms of medical care facilities for their staff and the slaves on board the

slave ships. The slave traders never ventured into the hinterlands from where the slaves were taken (HERFON 2007: 3). Therefore, the medical personnel who provided health services were practising only on board ships meant for slave trading. In fact, “the first practising doctors were medical missionaries who settled in the 1850s as ship surgeons, medically qualified botanists and explorers who sailed into several Nigerian ports and navigated several large rivers from the 17th Century onwards” (Schram 1966: 20).

The very first attempt at anticipatory developmental planning of health services in Nigeria took place in 1946 as part of an overall ten-year plan. The plan was designed to promote development and welfare covering all aspects of government activities from 1946 to 1956. Since Nigeria was still a colonial territory, the proponents of this plan were mainly expatriate officials. The plan included 24 major schemes designed to extend the works of existing government departments, but it was not a fully integrated development plan. The schemes were neither properly co-ordinated nor were they related to any overall economic target. Nevertheless, it was a modest, realistic, well thought-out plan for its time and purpose, and it served as the basis for subsequent health plans. Once the country gained independence in 1960, health policies were established either as an approach to a specific health problem or enshrined into the National Development Plans.

The second National Development Plan of 1970 – 1974 identified some deficiencies in need of correction. The new plan emphasised curative rather than preventive health services, which was the predominant health problem facing the country. The plan was largely based on colonial ideas, however, since the independence granted by Britain was

primarily a “flag bearing one” (Fanon 1967: 83). That simply meant that all decisions or plans that were projected were based on British ideology and then applied to the Nigerian experience (Jinadu 1980: 83). That may be due to the fact that the majority of the country’s top decision makers who shaped the development plans had some form of British orientation, either through formal western education or long term civil service (Crowder 1977: 199).

A deliberate attempt was made to produce a comprehensive health plan for the country with the creation of a Third National Development Plan from 1975 - 1980. When it was observed that huge sums of money were being invested into health without improving health outcomes for the Nigerian population, the Basic Health Services Scheme (BHSS) was adopted. A committee comprised of Nigerian health experts and representatives of the WHO was assembled, and committee members went around the country to ascertain the state of the health of the nation. That was the first time a feasibility survey was conducted prior to designing a plan related to health services in the country. Key health-related issues were identified, including the development of manpower for health services, the provision of comprehensive health care services based on the Basic Health Services Scheme, disease control, efficient utilisation of health services, essential research, and health planning and management. The committee’s findings focused on lack of accessible roads to the rural communities, lack of potable drinking water, and uneven distribution of modern health facilities between the rural and urban areas. Only 25 percent of Nigerians had access to modern medical facilities, while 85 percent of the population resided in rural areas. Of those living in rural areas, 90 percent were presumed to be illiterate, and given the lack of access to health facilities, traditional health practices remained predominant. Approximately 98

percent of births in these areas were attended by traditional birth attendants. Despite the committee's findings that there were significant problems associated with traditional medicine and a marked need to improve its practice, the issue was largely neglected and experts placed more emphasis on other health-related issues.

Faced with facts on lack of access to medical facilities in rural areas, combined with information on the relative neglect of traditional medicine, a change of attitude toward traditional healers occurred within the WHO. This shift created a strong desire to promote the integration of traditional medicine into modern medical practices based on the WHO's observations that use of traditional medicine was growing and that there were official and commercial interests in the use of traditional remedies. The World Health Assembly adopted a resolution for the integration of traditional medicine in 1977, and many developing nations including Nigeria subsequently took action for the development of policies and programmes for the integration of the traditional medicine into the national and primary health care systems. Subsequently, in 1978 the International Conference on Primary Health Care (PHC) was held in Alma-Ata sponsored by the WHO and UNICEF (the United Nations Children's Fund). This conference passed additional resolutions to implement its strategy of attaining 'Health for all by the year 2000'. "These resolutions promote the incorporation of useful elements of traditional medicine (TM), as well as its practitioners, into national health systems" (Haymen and Ramesh 1994: 65). As a result, there has been a "recent shift among international donors and in many national policies in support of incorporating traditional medicine into the dominant modern/western health care programmes" (Akerere 1987: 181). There are practical and philosophical reasons for the increasing popularity of traditional

medicine, which include economic crises and political disruptions affecting developing countries. These have often led to severe shortages of certain modern drugs that are often imported, thereby forcing more people to use traditional medicine out of necessity, regardless of government policy.

More recently, the Fourth National Development Plan addressed the issue of adoption of a health policy in line with the Alma-Ata Declaration of Health for All. In 1988, the Nigerian government produced its “National Health Policy and Strategy to Achieve Health for All Nigerians”. This National Health Policy is based on the national philosophy of social justice and equity. A health system based on primary health care has been identified as the primary means of achieving this national health goal. The document emphasizes community involvement and mobilization, and also addresses the issue of integration of traditional health practices with modern medical practices. It acknowledges that traditional medicine is widely used, but also notes that there is no one uniform system of traditional medicine in the country. Rather, there are wide variations, with each variant being strongly bound to the local culture and beliefs. The policy calls for local health authorities, where applicable, to seek the collaboration of traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning, and immunization. It also calls for traditional health practitioners to be trained to improve their skills and to ensure that they cooperate in making use of the referral system in dealing with high-risk patients. The national government also aims to better understand the traditional health practices and to support research activities to evaluate them. The policy states that practices

and technologies of proven value should be encouraged and adopted into the health care system while those that are proved harmful to the health of the people should be discouraged.

4.2 THE LEVELS OF HEALTH CARE TODAY

The National Health Care System was organized around three levels of care: primary, secondary and tertiary. These levels correspond to the local, state and national governments, respectively, with a referral process built into the system at every stage.

4.2.1 Primary Health Care

The Primary level of health care provides general health services, including preventive, curative, promotive and rehabilitative services, to the population and serves as an entry point into the health care system. The provision of care at this level is largely the responsibility of local governments with the support of the State Ministries of Health and within the overall national health policy. Private medical practitioners also provide health care at this level.

4.2.2 Secondary Health Care System

The Secondary health care level provides specialised services to patients referred from the Primary level through out-patient and in-patient services of hospitals for general medical, surgical, paediatric and community health services. It also serves as the

administrative headquarters, supervising health care activities of the peripheral units.

Secondary health care is available at the district, divisional and zonal levels of the state.

Adequate supportive services such as laboratories, diagnostics, blood banks, rehabilitation services and physiotherapy are provided.

4.2.3 Tertiary Health Care

Tertiary health care, which consists of highly specialised services, is provided by teaching hospitals which administer care for specific diseases and conditions, such as orthopaedics, ophthalmology, psychiatry, maternity and paediatrics. Care is taken to ensure that these services are evenly distributed geographically. Appropriate supporting services have been incorporated into the development of these tertiary facilities to provide effective referral services. Selected centres are encouraged to develop special expertise in the use of advanced modern technology, thereby serving as a resource for evaluating and adopting these new developments in the context of local needs and opportunities.

4.3 THE REALITY OF HEALTH CARE IN NIGERIA AND IN BORNO STATE

4.3.1 The Reality at the Federal Level

Nigeria's health system continues to perform poorly, being ranked 187 out of 191 member states by the WHO. Most of the country's disease burden is due to preventable diseases, and poverty is a major cause of these problems. The maternal mortality rate is one

of the highest in the world. Other health status indicators, such as adult mortality and mortality of children under age five, are higher than average for sub-Saharan Africa. There is a limited capacity for policy formulation, implementation, monitoring and evaluation at all levels. There is no health act describing the national health system and defining the health functions of the three tiers of government, and partnership between the public and private sector is non-existent or ineffective. In the area of health service delivery and quality of care, programmes targeting specific illnesses such as HIV/AIDS, TB, malaria and other areas like reproductive health are currently being implemented within a weak health system and have had little impact. A very high proportion of primary health care (PHC) facilities serve only 5-10 percent of their potential patient load due to consumers' loss of confidence, among other causes. The secondary health facilities are in poor condition, while diagnostic and investigative equipment in tertiary health institutions are outdated. Furthermore, the referral system between various types of facilities is non-functional and ineffective. Coupled with the uneven distribution of modern health facilities between and within rural and urban areas, consumers have no option but to make use of affordable and accessible health services such as those offered by traditional healers.

The Minister of Health of the Federal Republic of Nigeria, in an address to the 46th National Council on Health, noted that counterfeit, sub-standard, adulterated and unregistered drugs are prevalent, while erratic supplies and availability of drugs and other materials abound throughout the country. On health financing, the scenario is even more dismal given that public expenditure on health is less than \$5 per capita, compared to the \$34 recommended internationally by the WHO. Private expenditure is estimated to cover 70

percent of the total health expenditure, with most of it coming from out-of-pocket expenditures. There is no broad based health financing strategy to support the large numbers of people living in endemic poverty.

4.3.2 The Reality in Borno State

The Health Care System of Borno State is based on the national system, and interacts with both the national health system above and the local health systems below it. In Borno today, medicine operates within the structure of a capitalist society, and therefore mainly exploits health and illness for profit. Private ownership of health care facilities has made the price of high-quality care extremely costly. As a result, health care is based on ability to pay, and those with resources are able to obtain better health services while those without resources are excluded. This has caused a widening gulf between two socially-stratified classes. Furthermore, those doctors who are the private owners of health care facilities tend to hire other health professionals at a rate that is not commensurate with the services they provide.

The Borno State Health Care System operates within the supra-system of the World's Global Village through support from international agencies like the United Nations Fund for Population Activities (UNFPA), the World Bank (WB), Rotary Club International, Global 2000, and other similar organisations. It also interfaces with sub-systems, whose influence directly affects the quality of output in the healthcare system. These sub-systems include the economic, educational, geopolitical, technological and sociocultural systems. Economically,

Borno is a poor state whose budgetary allocation to health care expenditures is not adequate to provide quality health care for its citizens. In the education sector, Borno State is ranked as one of the most educationally disadvantaged states in Nigeria, with 70% of the population living in rural areas, of whom 90% are illiterate. The number of years required to obtain a medical education is also prohibitive, both to the individual and to the government, which invests money in medical training. In most instances, once health personnel are trained they prefer living in areas where working conditions and remuneration are better, leading qualified health care workers to leave the very areas most in need of their services. The lingering effects of colonisation are still evident, and the political atmosphere remains unstable and at times requires military intervention. Borno also remains a technologically disadvantaged state, where health care equipment is outdated and inadequate. Finally, the sociocultural environment involves strong religious and cultural traditions with a history of peaceful coexistence among different tribes. In spite of this cultural history, however, there remains no traditional medicine board to govern long-standing traditional health practices. The reasons why no such board has been created are discussed below.

4.3.3 Local Government

As discussed previously, there are 27 Local Government Areas (LGA's) in Borno State. Of these, 24 have general hospitals while the remaining three are in the process of completing hospitals. All of the hospitals are under state control. The local government takes charge of the primary health centres, dispensaries, health clinics and posts, as well as private health practitioners and traditional health practitioners. At the local level, healthcare

is governed by the Primary Healthcare Coordinator, who oversees the technical aspects of health services, while an elected Councillor of Health is responsible for the administrative aspect of health services.

4.4 THE ABSENCE OF TRADITIONAL MEDICINE BOARD IN BORNO STATE

It seems curious that Borno State, which is second only to China as one of the oldest traditional empires in the world, does not have a traditional medicine board in place. In addition to its antiquity, Borno has maintained its traditions and cultures in many areas, including the traditional titles and positions within the kingdom, as well as its longstanding traditions related to traditional healing. The fact remains, however, that no traditional medicine board has been established to date.

The reason for the absence of a traditional medicine board in Borno State may be traced to the Civil Service Reform of 1988, which advocated for the professionalization of the civil service. The reform directed all ministries to have three mandatory directorates of Planning, Research and Statistics, Administration and Supplies, and Finance and Accounts with not more than five professional directorates. Health was singled out as a unique sector in the sense that 'health planning' is a professional role which must be governed by a qualified public health planner. Unfortunately, in Borno State there was no single individual with that qualification to head the directorate and as a result a medical doctor who was the director hospital services was appointed head of the directorate. Since medical doctors are often uncomfortable working with other types of professionals, including traditional healers,

the medical doctors leading the directorate ended up marginalizing all other constituents when the Nigerian Health Policy was implemented.

The National Health Policy assigns responsibility for supervising and coordinating the activities and issues related to traditional medicine to the Director of Primary Health Care in each state. However, in Borno relatively few funded programmes are handled by this department. Ironically, the Medical Services Department, which is populated by those generally opposed to the practice of traditional medicine, is the department assigned to create and organize a traditional medicine board in Borno. This would serve as the highest ranking administrative body responsible for overseeing traditional medicine in the state. Because of this oversight in assigning an inappropriate department to implement and supervise a traditional medicine board, Borno is the only state out of Nigeria's thirty-six states that remains without such a board.

Another factor involved in the absence of a traditional medicine board may relate to the attitudes of the traditional healers themselves. They are typically hesitant to open up their practices for review based on the fear that they may ultimately lose their jobs. They also lack the ability to form unions or establish NGO's to implement organized and uniform strategies for the integration of modern and traditional medicine. Additionally, those who use traditional medicine the most are the least likely to influence policy related to its practice. Three-quarters of the population of Borno reside in rural areas, and there is a marked lack of access to modern health facilities for these people compared to those living in urban areas. However, while those residents of Borno State who live in rural areas are the most likely to

obtain treatment from traditional healers, they are poorly equipped to advocate for the establishment of a traditional medicine board. A large percentage of the rural populace is illiterate, and therefore significantly less able to advocate for changes in government policy pertaining to traditional medicine. Finally, those in a position to actually influence government policy are also responsible for the failure to establish a traditional medicine board in Borno. Those who represent the elites and the traditional institutions with adequate power to directly influence health policy, those who constitute the managerial team both at the middle and operational level, and those who are the consumers of health care in the state all contribute to the absence of the board by failing to acknowledge that a very high percentage of people do patronize traditional healers in Borno. They refuse to recognize that the use of traditional medicine can be advantageous in the face of an over-stretched, under-funded and often inaccessible modern health system, particularly for the rural communities who constitute the majority of Borno's population.

I was appointed the Director of Health Planning, Research and Statistics at the State Borno Ministry of Health in 1996. My priorities were to institutionalize health systems research and establish evidence-based planning and policies. Since I was both a representative and leader of my people and a western-trained health professional, I found myself in a paradoxical role. In this position, I assumed that integration of traditional medicine into the modern medical system, as advocated by the WHO, might be a welcome solution to the health challenges facing Borno State. However, in order to achieve such integration, the discrepancies between the primary health care and medical directorates needed to be addressed. That was and still remains a significant challenge, given that the

functional misfit was deliberately created by those who opposed the practice of traditional medicine. At this point in time, the misfit is deeply rooted and has been 'as constant as the northern star' for an extended period of time.

4.5 BORNO AND YOBE STATES OF NIGERIA AND TRADITIONAL MEDICINE – A COMPARATIVE APPROACH

A comparison of the role of traditional medicine within the modern healthcare system in Yobe State and Borno State is useful for illustrating the important implications of government policy related to traditional medicine for actual health outcomes. Yobe State was created out of the present Borno State in 1991. It consists of twenty-two LGA's, and shares a border with Borno State to the north. Like Borno State, Yobe State has multiple tribes with Kanuri and Bade being the principal languages spoken. Although younger than Borno, Yobe State established a traditional medicine board in 2002. The board is comprised of ten members who are drawn from all walks of life, including the traditional healers, traditional rulers and the civil society. A retired civil servant and traditional title holder with the Yobe Emirate Council was appointed as the chairman of the board, and a practicing nurse serves as the board's executive secretary. The board emphasises advocacy, training related to the improvement of health outcomes through use of preventive care, and discouragement of harmful traditional health practices. The board advised the traditional healers to establish a union in the form of an NGO, which was created in 2001. The patron of the NGO is a traditional leader who is also a nurse, and the NGO has received a corporate registration.

The group has been successful in its activities through financial support from the government as well as from larger NGO's.

Important health research presented by the Yobe State Governor in 2006 revealed that the health status of Yobe State had improved since the inception of the traditional medicine board. This outcome was attributed to a "bottom up" approach which emphasized the role of traditional healers in preventing and reducing disease burden in partnership with the government and other organizations. The MMR in Yobe is 1.5 per 1000, compared to 1.7 per 1000 in Borno State (Borno State Statistical Year Book 2007: 96). The significant difference in MMR between the two states may be attributable to the presence and absence, respectively, of a traditional medicine board which serves as a means of actively incorporating traditional medical practices into the health care system in ways which can be beneficial.

I recall that when Yobe State got their Traditional Medicine Board, I was trying to argue that we should assign the task of setting up a similar board in Borno to a more appropriate department. The Director of Medical Services proceeded to present falsified research results which claimed that "the pilot study was done on the training of traditional birth attendants, and the research result showed that too much money was spent on training yet the health situation of the State did not improve". I responded by posing a question as to "what were we (health professionals) doing when the MMR of our State rose as high as 1.7 per 1000 births? Does it mean that government did not spend enough on the training of

medical doctors, nurses and other healthcare providers? In my opinion, if there is any profession that the government spends too much money on, it is the medical profession”.

An attempt was made in 2003 to establish a traditional medicine board in Borno State, but the proposal outlined a plan for board membership which was not properly appropriate or realistic. For instance, the proposed board chairman was the Director of Medical Services of the Ministry of Health, and a pharmacist was the proposed Executive Secretary. Other members would have been drawn from the directorates of the Ministry of Health as well as other professional associations. In my opinion, this proposal was ill-conceived. The Director of Medical Services would have been an unrealistic board director, since not only is he extremely busy with administrative and professional duties, but as a doctor he also would be viewed as solely biomedical in orientation, unlike nurses who are viewed as biomedical but also holistic. By virtue of their training and indoctrination, nurses give much more consideration to issues related to traditional medicine, and would be better suited to govern a traditional medicine board. Additionally, the proposal failed to get input from relevant experts, and was therefore entirely incomplete. This may have resulted from the fact that the department that was supposed to write the proposal and outline all policy guidelines was not involved in the proposal at all.

4.6 CONCLUSION

This chapter has outlined how healthcare and health professional education in Nigeria has developed from the early influence of Portuguese, Scottish and English explorers and their colonial successors.. Recognizing the potential role of traditional healers in providing

services essential to the health care of a country's populace, the WHO adopted a policy which encouraged the integration of traditional medicine into modern health care practices. In Nigeria, the document outlining the national health policy clearly addresses the integration of traditional medicine into the healthcare system and places the responsibility for doing so on the Directorate of Primary Health Care at both the federal and state level. However, in Borno State, that responsibility was assigned to the Directorate of Medical Services, which opposes the use of traditional medicine. As a result, out of the thirty-six states in Nigeria, Borno State remains the only one without a traditional medicine board. The absence of a traditional medicine board has significant implications for the health status of Borno. In contrast to Yobe State, whose traditional medicine board is active and successful, Borno's health statistics are comparatively poor. It appears that the incorporation of traditional medicine into formal state health policy can be advantageous, especially when modern health services are over-stretched and under-funded. This is even more relevant to rural areas, where there is little access to modern healthcare facilities. However, it is also true that some traditional health practices are harmful and have negative implications for health, which I discussed previously as part of the 'paradox' in which I find myself. A policy of discouraging harmful health practices while encouraging and improving beneficial practices would go a long way towards the integration of traditional and modern health services and the establishment of a traditional medicine board in Borno.

Although this chapter has described the evolution of the modern healthcare system in Borno, it will become apparent that this system cannot be adequately considered in isolation from the traditional healthcare system which many of its patients also use. While in Yobe

State use of the dual healthcare systems simultaneously is a recognized part of state health policy, in Borno State no such integrated approach currently exists. I explore traditional healthcare in Borno, and its relationship with modern biomedicine, in greater detail in the following chapters.

CHAPTER FIVE

TRADITIONAL HEALTHCARE IN BORNO STATE

5.0 INTRODUCTION

This chapter explores the practices and practitioners of Kanuri traditional health care delivery, as well as their selection and training, and describes the variation and overlapping roles that exist in the traditional healthcare system of Borno State. It presents information on traditional health care practices, and catalogues these practices based on the type of practitioner, what services they perform, and the relevance of each type of care for wider Kanuri culture. Other information about each practitioner includes their sex, areas of specialization, standard remuneration, and their relative status in society. Although the list is not exhaustive, cataloguing the main health practices and their respective practitioners is an important step towards integrating traditional medicine into the modern healthcare system in a complex social environment where both systems are utilised simultaneously. This description stems from both my traditional and professional experiences. As explained in chapter one, I am expected both to preserve the Kanuri culture and to uphold professional ethics as a healthcare practitioner. Sometimes, these expectations are at polar opposites from one other.

My perspective explores Kanuri health practices as a form of indigenous knowledge (IK). IK is defined as the facts that ‘natives’ understand through information, education or experience, and includes those areas in which people become skilled in things that naturally

belong to them (Sillitoe 1998: 223). This includes health-related behaviours and practices, which are regarded as a form of traditional or local knowledge. This perspective offers a useful paradigm for approaching Kanuri traditional health practices. Although traditional knowledge is not sufficiently recognised by many intellectuals, it is understood to include the beliefs, values and practices that distinguish one community from another. The health sector reform agenda of Nigeria emphasises the importance of traditional health practices in accordance with WHO policy. Recognising and enhancing traditional health knowledge is important for increasing public health throughout the country. Traditional indigenous healing employs a holistic approach, and therefore has significant contributions to make especially to psychological and psychiatric cases. However, it is important to acknowledge that other aspects of traditional medicine can be harmful. I consider both positive and negative aspects of traditional medicine through the use of personal vignettes that are interspersed throughout the chapter.

As well as concern over the safety of its practices, western biomedical health professionals may regard traditional health knowledge as permanent and unchanging and therefore without room for improvement. However, the reality is that the traditional health practitioners are continually evolving and absorb, influence, compete with, and merge with outside influences remarkably well (Osborne 1976). In some cases, it is the children of traditional health practitioners who are now practicing biomedical health professionals. For example, there are surgeons whose fathers are or were *Wanzama*, midwives whose mothers were TBAs, and a host of other practitioners whose parents are or were either *Shilashiwoltama*, *Mallam Gau*, *Kaskima*, or other types of practitioners. Moreover, there is a

shared professional identity between some of the traditional health practitioners and the western biomedical health professionals. This factor may potentially make practitioners more amenable towards the integration of traditional and modern health care practices. The views of the formal professionals on their relationships with their indigenous counterparts are presented in Chapter seven, while those of traditional health practitioners are presented in Chapter eight.

5.1 A CATALOGUE OF PRACTITIONERS AND PRACTICES

The catalogue of practitioners I shall present begins with the *Wanzama* (local barbers). The *Wanzama* are highly respected in the society and are organised under a traditional title of the *Zannah Dambusuma* of Borno. Barbering is entirely a male occupation and runs strictly in the family. Though a *Wanzama* enjoys no fixed remuneration, he handles the following important traditional health practices: *Dawugota* (uvulectomy), *Berikaro/Dawukirikaro* (tribal marks and abdominal scarification), *Kangadigenata* (blood cupping), *tadakaja* (male circumcision), *keskayo* (giving of herbs), *Shilakolte* (correction of dislocation), *kannukasargenata* (surgical treatment for convulsions from high fever), *kokotulowu* (surgical treatment for malnourished children), *Nareduto* (suturing of deep cuts), and *Lambagenata* (surgical treatment for abdominal distension).

Other traditional health practitioners include the *Kelagotama* who deal with lifting of the head, and *Shilashiwoltama* who are responsible for correcting dislocations as well as bonesetting. Both are unisex occupations and do not run in the family. *Kawugotama* (person who corrects cases of prolapsed uterus), *Safima* (magician), *Gau* (herbalist), *Karwina* a (local

hunter who practices magic as well as giving of herbs), *Kaskima* (soothsayer) and *Kermallam* (Islamically learned person) are mainly male occupations and also do not run within families. *Kawugota* is mainly a feminine enterprise, and *Suromuwoma* (traditional birth attendant) who attend *suromuwo* (childbirth) is strictly a female occupation which mainly runs in the family.

The following list catalogues all the recognised traditional health care practitioners among the *Kanuri* in Borno State today. Most of them are likely to be found in every *Kanuri* community.

Wanzama	(Local barber)
kelagotama	(Person who lifts fallen head)
suromuwoma	(Traditional birth attendant)
Kawugotama	(Woman who corrects prolapsed uterus)
Safima	(Magician)
Gau	(Herbalist)
Kaskima	(Soothsayer)
Karwina	(Local hunter)
Mallam	(Quranic learned person)
Shilashiwoltama	(Traditional bonesetter)

5.2 WANZAMA (BARBERS)

Apart from the normal activities of a barber, *Wanzama* are also regarded as traditional surgeons because of the surgical role they play in the Kanuri society. The most popular traditional surgeons are those who go around villages seasonally to circumcise groups of young boys and girls who are approximately at the age of marriage. They also perform “incisions on boils, abscesses and sometimes the removal of unwanted growth tissues, particularly those on limbs” (Igun 1988: 131).

The factors affecting the selection of *Wanzama* amongst the Kanuri are that the individual be male, and that he is close to his parent or guardian (who may be the uncle). Training starts at an early age and most of it is done informally, since it is regarded as an intrafamilial matter. Leadership responsibility is first placed on a child who is being trained as a *Wanzama* when he is circumcised along with other children. He is expected to play the role of the monitor in the circumcision camp, with the responsibility for reporting errant boys especially during the time when they are healed but have not yet been discharged to return home, since the *Fugu* (leader of the *Wanzamaa*) spends less time with the children at that time than he does when the wounds have not yet healed.

The practical training for the *Wanzama* is introduced at the age of ten by allowing the child to hold a blade and shave the heads of male children, which is done in the presence of elders. Introduction of the trainee to the other practices depends on the individual’s willingness, as well as on the ability of the trainee as judged by his mentors. There is no universally accepted standard for the training of the *Wanzama*. Although *Wanzama* enjoy no fixed remuneration, they handle the following important traditional health practices:

<i>Dawugota</i>	(uvulectomy)
<i>Berikaro/Dawukirikaro</i>	(tribal marks/abdominal sacrifice)
<i>Kangadigenata</i>	(blood cupping)
<i>Tadakaja</i>	(male circumcision)
<i>Shilashiwolta/Shilakolte</i>	(bonesetting/correction of dislocation)
<i>Konnukasargenata</i>	(surgical treatment for convulsions from high fever in children)
<i>Kokotulowu</i>	(surgical treatment for malnourished children)
<i>Nareduto</i>	(suturing of deep cuts)
<i>Lambagenata</i>	(surgical treatment for abdominal distension)

5.2.1 *Dawugota* (uvulectomy)

As a matter of tradition, all children born to Kanuri families must have their uvula removed on the day of their naming ceremony. Otherwise, it is believed that they will fail to thrive, experiencing growth retardation leading to death. It is a strong cultural health practice of the Kanuri people to have a baby's uvula removed on the seventh day of life, likewise for all older children or adults whose uvula are inflamed, with sickness manifesting as severe headache, pain, difficulty swallowing, and loss of appetite. *Dawugota* is usually done surgically by the *Wanzama*. The *Wanzama* are thus seen as playing a life-saving role, ensuring healthy growth and normal development of children.

In the case of a newborn, the baby is brought out into the midst of the crowd on the day of the naming ceremony, which typically takes place on the seventh day of life, to the *Wanzama* who usually works with the baby's aunts to perform the removal. The baby is placed on a towel on the ground, and his or her mouth is opened and the left index finger of the *Wanzama* is used as a gag while he puts a curved blade down the baby's throat and removes the uvula. Some salty warm water mixed with local herbs is placed in the mouth of the baby. The *Wanzama* then advises the mother to breastfeed the baby adequately, since warm milk hastens the healing of the wound. For older children and adults, a local mouth gag is used to keep the mouth opened during uvulectomy. Several individuals are needed to holding the patient down, especially for older patients who struggle out of fear of the *Wanzama's* blade.

The Kanuri beliefs surrounding uvulectomy are polar opposite to conventional biomedical belief and practice. From a biomedical perspective, the uvula is one of the reticular endothelial cells which serves as an important part of the body's defense system and confers resistance to infection. From this perspective, it is unfortunate that this important organ is removed from the throat of the baby by the *Wanzama*. A particularly distressing experience of *dawugota* motivated me to think of an empirical solution to the paradox which I observed between the two systems. I vividly recall one morning of early 1980 when a family who had had their first baby invited everyone in the local area to attend the naming ceremony. It is the traditional belief that all the rites should be handled by the new baby's paternal grandparents. However, the father of the baby was of the view that the uvula of his baby should not be removed because of the lesson he had learned from a neighbour whose

baby died after undergoing the traditional practice. In the morning of the naming ceremony, although he was not culturally allowed to make any decisions or participate in the rites, he summoned up the courage to make his feelings known. He met all the requirements for services provided by the *Wanzama* (both in cash and in kind) but discharged him without performing the services.

After the ceremony, which included eating and giving a name to the baby, he left to his business place content with the thought that he had protected his child from a part of this rite of passage that concerned him deeply. Unfortunately, the baby's paternal grandfather felt alienated by his son's actions, and disregarded his son's decision. He re-invited the *Wanzama* to perform the services he had earlier been paid by the baby's father to provide. The *Wanzama* came and removed the uvula, but tragically the baby died barely an hour after the uvula was removed. Obviously, the father of the baby could not take the barber to court for murder because the case would implicate his own father. He therefore had no option but to be a prisoner of his own culture.

5.2.2 *Berikaro/Dawukirikaro* (tribal marks on the face and abdomen, respectively)

Berikaro is an incision made by the *Wanzama* using his knife on the face of a baby on the seventh day of life. This is referred to as a tribal mark (*Kanuri beri laarra*).

Dawukirikaro is the mark done on the abdomen of the baby, which is also done on the seventh day. As in *Dawugota*, the baby is brought out into the mist of the crowd on the day of the naming ceremony and placed on the ground. The *Wanzama* uses his sharp blade and

makes incisions on the face and abdomen. A total of nine incisions are made on the face while twelve are made on the abdomen. Some herbs are applied immediately afterward. The *Wanzamaa*, as custodians of the traditional culture of the Kanuri people, are vested with the roles of giving identity to each Kanuri child born in the community. Tribal marks on the face are a symbol of identity of the Kanuri people. The *Dawukirikaro* is performed in order to drain the 'black blood' from the abdomen of the child. This is believed to prevent certain abdominal conditions and ensures that the child will grow properly. If *Berikaro* and *Dawukirikaro* were done following proper antiseptic and aseptic principles, there would be no problem. However, as currently performed, one can easily imagine the dangers caused by the procedure because of the risk of contracting new diseases like HIV/AIDS. As a simple remedy, it is of critical importance that the *Wanzamaa* become educated and trained to sterilise their tools before carrying out any procedure of such kind.

5.2.3 *Kangadigenata* (blood cupping)

The word *Kangadi* literally means horn, and this practice involves the use of the sharp end of a cow's horn with a small hole made at the thin end. The *Wanzama* carries out the *Kangadigenata* procedure in two phases. First, the *Wanzama* uses his blade and makes incisions on the area of the body being treated. At least six to nine tiny but deep incisions are made. The wider end of the *Kangadi* is placed over the incision, tightly covering the entire area. Second, the *Wanzama* proceeds to suck through the small hole of the *Kangadi* to drain the unwanted blood. *Kangadigenata* is indicated for the following conditions:

- Dizziness after delivery
- Swelling caused by injury or malignancy

- General body pain
- As a routine practice for those over the age of forty
- Removal of black blood in generally unhealthy individuals

The *Wanzamaa* are the custodians of this traditional health practice, and it is their duty to see that the significant ailments and conditions listed above are treated or prevented among the people of their communities.

5.2.4 *Tadakaja* (male circumcision)

The act of *Tadakaja* involves cutting the prepuce of the male genital organ by the *Wanzama* using his blade. After bathing the boy thoroughly with soap and water, the *Wanzama* prays before pulling the prepuce and cutting it. He then applies herbs to control the bleeding, and uses local sticks and threads (which are clean) to support the organ. The boy is instructed to stay with his legs spread wide to prevent injury to the wound. Following the procedure, the *Wanzama* nurses the boy closely.

5.2.5 *Shilashiwolta/Shilakolte* (bone setting/correction of dislocation)

This treatment focuses particularly on bone setting and dislocations in the upper and lower limbs. Some *Wanzamaa*, but not all, engage in the traditional *Shilashiwolta* (bone setting) where there are no *Shilashiwoltama* (traditional bone setter) or *Shilakoltema* (one who can correct dislocation) available in close proximity. The level of expertise of some of

the *Wanzamaa* can therefore be attributed to the frequency with which they handle such cases. All cases of joint dislocation, involving either the upper or lower limbs, are corrected by the *Wanzama* through manipulation. Often times, the relatives of the patient assist him in the procedure, especially in cases that require the use of force to keep the patient calm in spite of severe pain (no pain relievers are used). The positioning of the patient depends on where the dislocation is, but in most cases patients are lying down when they receive this treatment. In effect, the role of the *Wanzama* in these cases provides orthopaedic services to the people in the community, especially in emergency situations where biomedical experts are not accessible. The *Wanzama* also have the role of diagnosing fractures and making referrals to the *Shilashiwoltama* and or *Shulakoltema*.

5.2.6 *Konnukasargenata* (surgical treatment for convulsions from high fever)

Konnukasargenata refers to the treatment of convulsion from high fever in children known as *kulongu*. In such cases, the *Wanzama* uses a stick of guinea corn called *kangale* and lights it on fire and places it directly on the forehead of the convulsed child. The stick is kept in position for five minutes or until the fire has burnt the area deeply and the child struggles, cries, or passes stool.

5.2.7 *Kokotulowu* (surgical treatment for malnourished children)

The word *Koko* means “frog”, and the condition called *Koko* is a disease that occurs only in children younger than two years of age. It is believed that if the mother jumps

over a live frog during pregnancy, the *Koko* condition (which involves the accumulation of white tissue in the inner cheek of the baby) will affect the baby, preventing it from thriving until the *Koko* is removed by the *wanzama*. The *Wanzama*, with the assistance of the baby's mother, lies the baby down on a flat surface, forces the mouth open and inserts a mouth gag. The *Wanzama* then uses his sharp blade and removes the *Koko* from the mouth of the baby. He then instructs the baby to be fed with warm fluid and to be given a warm salt and water mouth wash.

5.2.8 *Nareduto* (suturing of deep cuts)

Nareduto refers to the suturing of torn tissue on any part of the body and/or a tear of the perineum during childbirth. The *Wanzama* uses an instrument called a *tongu* with thread to suture the part of the body that is torn. He uses different sizes of *tongu* for different types of injury in different places on the body. He gets the assistance of the members of the family in holding the patient in position during the procedure because of the pain involved, especially as no form of anaesthesia is utilised. In this capacity, the *Wanzama* provides critical care in emergency situations.

5.2.9 *Lambagenata* (surgical treatment for abdominal distension)

The procedure is the same as that described for *Konnukasargenata* (above), except that a larger stick is used for *Lambagenata* which is performed on the abdomen, and is usually done for older children and adults.

5.3 *KELAGOTAMA* (PERSON WHO LIFTS FALLEN HEAD)

Kelagotama are traditional health practitioners, who can be men or women, who are trained in treating a condition known as *kelayekero*, which translates to ‘falling of the head’. This is a condition in which the parietal and frontal fontanelles are depressed downwards either in adults or children. The symptoms include severe headache, blurred vision, anorexia, halitosis, vomiting, high temperature and/or general malaise. The treatment is known as *kelagota*, which involves returning the depressed fontanelles to their normal position. In mild cases, the patient is asked to sit up and the *Kelagotama* sits behind him holding the head of the patient firmly. The traditional practitioner massages the head of the patient very firmly. He then massages the head in a circular movement until he is well satisfied that the depressed fontanelle has been restored to its normal position. In serious cases of depressed fontanelles, the *Kelagotama* asks the patient to open his mouth while a mouth gag is used to keep it wide open. Then the *Kelagotama* puts his or her index finger directly into the throat area and applies pressure upwards until fresh blood or pus, or a mixture of both, is removed. After the procedure, health education is given by the *Kelagotama* on how to prevent a recurrence. Patients are advised to rigorously avoid jerky movements and not to lift heavy objects. *Kelagota* is also indicated for individuals who fall from a great height, irrespective of whether the fall has caused depressed fontanelles, and is also conducted for individuals suffering from any general sickness of unknown origin. The Kanuris traditionally believe that *Kelayekero* is a very serious illness with severe consequences, and therefore are quick to seek treatment from the *Kelagotama*.

5.4 SUROMUWOMA (TRADITIONAL BIRTH ATTENDANT)

Suromuwuma is a traditional birth attendant whose training is typically passed from mother to daughter. *Suromuwo* refers to delivering babies by the traditional birth attendants. The traditional birth attendant is expected to provide antenatal care and to attend to deliveries in the community (Harrison 1973: 14-22). The *suromuwoma* also treats minor cases of *kawuyekero* (prolapsed uterus) before making referral to the *kawugotama* for more serious cases, which is discussed below.

Deliveries attended by traditional birth attendants can range from normal deliveries to complicated or abnormal ones. In normal cases, the traditional birth attendant positions the labouring woman on a local stool (*buwur*) and conducts the delivery. The woman (mother) is expected not to complain of pain. Any source of ventilation in the room is blocked and a fire is lit within the room since it is believed that sweating by the expecting mother facilitates a faster delivery. In difficult cases where delivery is complicated by some obstruction of the baby or the placenta, a very hot dried ground pepper is put into the fire and the mother is left alone in the unventilated room to breathe in the fumes of the pepper, which promotes coughing. It is believed that the internal force generated by the coughing assists in expelling the baby or placenta. In cases where the foetus has died in-utero, the traditional birth attendant removes the foetal remains using her bare hands after applying a traditional lubricant called *kowulu*.

Following birth, the placenta is usually buried within the premises of the house and whenever the mother eats, small portions of her food are placed with the placenta.

Traditional beliefs hold that if this practice is not followed, both mother and baby will suffer from illness. If there is any dizziness following delivery, the traditional birth attendant refers the case to the *wanzama*, who comes to use the *Kangadi* (instrument for blood cupping) to remove the black blood that is believed to be causing the dizziness.

The traditional birth attendant is expected to attend all deliveries in the community, and to provide antenatal care to mothers following birth. Furthermore, she is expected to administer a hot water bath for the mother and a warm bath for the baby for a period of forty days, both in the morning and in the evening before sunset. It is believed that if the bathing of mother and baby is done after sunset, the baby will become blind. The traditional birth attendant is also expected to play a role in coordinating post-natal procedures like *Berikaro*, *Dawukirikaro*, *Dawugota*, caring for the umbilical stump, and teaching *Tadatafta* after forty days of the baby's life.

5.4.1 Vignette on the birth practices of a TBA in *suromuwo*

I was in Jere town in Borno State about ten years ago for a professional assignment when I received a request to talk to the sister in charge of the Maternity Clinic to encourage her to allow one woman in labour to be taken to a TBA. I gave fair hearing both to the midwife and the client's family members, who were overseeing her care. Interestingly, the midwife confided in me that she would have advised them to go to the TBA if the woman had not already been admitted. The midwife stated that she frequently referred women to traditional birth attendants on an informal basis. Her stated reason for doing so was that she

knew the local TBA safely delivered many difficult and complicated cases using traditional approaches. The midwife's attempts to learn the TBA's techniques had been unsuccessful, however. This last point surprised me, and I requested an audience with that TBA. Fortunately for me, the TBA was attending a difficult labour at that time, and what I witnessed was unbelievable. The TBA administered some herbal mixture to the patient, who I learned had been labouring for five days. I observed that she appeared to be in distress, because her mouth was extremely dry and she displayed other symptoms that would have sent her to the operating theatre immediately. Instead, to my surprise, within five minutes of administering this herbal mixture and reading some verses from the Quran, the TBA was able to facilitate a safe delivery. The baby was blue but when the TBA placed three drops of a liquid mixture into its mouth, the contents of which she concealed. Within three minutes of receiving the drops the baby, who had appeared so weak, let out a healthy cry.

In my quest to learn more about the secrets of the TBA, I sought out the midwives I had taught in the 1980's. Out of the 124 midwives I talked to, 49 are daughters of TBAs, while 12 were raised by TBAs who had never had biological children themselves. Interestingly, all of them responded that what the TBA recited from the Holy Quran would have been *Ayat Khursiyu*, a verse for safety that literally means "chair". As a Muslim, I agreed with them as I too have recited that particular verse on receiving deliveries when I was a full-time practising midwife in the hospital. I was told that the same verse was written on a slate and washed with water, and that water was the mixture that was dropped into the baby's mouth. One of my greatest breakthroughs occurred when I returned to the TBA, and after talking with her for a long time she finally revealed that the information I had obtained

was correct and that it should be used for my own purposes only. She told me that if I have faith in the practice, it will be successful every time.

5.4.2 *Tadatafta* (Forced Feeding of the Baby or Infant)

Tadatafta is the force-feeding of an infant beginning forty days after birth and lasting until two years of age, at which time the child is introduced to the family's table food. Every childbearing mother is taught to practise this with her babies. The *Suromuwuma* (the TBA that conducted the mother's delivery) initially instructs young mothers in the practice of *Tadatafta*, and the eldest woman in each neighbourhood also teaches every young mother about traditional infant feeding practices, particularly when babies are about three months old. The process of *Tadatafta* involves laying the baby on the mother's lap, with its two nostrils blocked by the mother's left hand. The mother uses her right hand to pour the pap into the mouth of the baby. Since the baby's nostrils are blocked, it struggles to breathe and therefore quickly swallows all of the pap in order to gasp for air (Gazali 1996: 11). Mothers are taught that this practice is essential for ensuring proper growth of their babies. The Kanuris believe that any infant not fed in this manner runs a risk of malnourishment.

5.4.2.1 Personal vignette on *Tadatafta* (forced feeding)

The following account of *Tadatafta* probably represents the most emotional experience I had during the completion of my student nursing. In 1977, I was attached to the paediatrics ward for practical clinical experience as a junior student (my first clinical

experience in paediatrics). I was on my way to the hospital mosque to say my two o'clock prayer when I heard a baby crying. From the sound of the cry it was evident that the procedure of *Tadatafta* (forced feeding) was taking place. I went to the corner where the crying was coming from, which was a space set aside for patient's relatives. Suddenly, I saw one of the patient's relatives feeding a baby forcefully who did not know that the baby was out of breath and was really struggling hard to get enough oxygen. The baby coughed for a while and then became blue. I immediately advised the mother and took the baby from her and rushed to the paediatrics emergency unit for resuscitation. Unfortunately, the baby died. These events happened in less than forty minutes.

Forced feeding was not warranted in that circumstance. I learned from the other relatives that they had seen the baby readily accepting food using a cup and spoon. However, the mother felt the baby was not receiving adequate nourishment through this method, and therefore decided to engage in force feeding the baby. In my opinion, the act of forced feeding is an indirect invitation of death by mothers to their babies. From time immemorial, mothers have no doubt witnessed at least one such negative outcome occurring for someone they know. The most painful thing as a healthcare professional was my inability to discourage the harmful practice of forced feeding. A philosophical question I pondered was whether, if that baby had survived and grown to adulthood, she too would have engaged in force feeding her own infants. Would I possibly have died had my mother chosen to force feed me? Would historically significant figures, such as Margaret Thatcher, Indira Gandhi, or other world leaders have also ended up with the same fate had their mothers practiced forced feeding?

5.5 KAWUGOTAMA (WOMAN WHO SPECIALIZES IN THE CORRECTION OF PROLAPSED UTERUS)

A *Kawugotama* is the person who specialises in *Kawugota* (the correction of prolapsed uterus). A prolapsed uterus is believed to occur during or after pregnancy. It may also occur when a woman lifts a heavy weight, whether or not she is of childbearing age. The procedure is performed by the *Kawugotama* who is always a woman. The traditional birth attendant also treats minor cases of prolapsed uterus (*kowuyekero*) (Igun 1988:132), but refers more complicated cases to the *Kawugotama*. The *Kawugotama* lubricates her right hand either with groundnut oil or cow butter and lubricates it further with dry okra soaked in water (*kawulu*). She then inserts the whole of her right hand into the vagina and lifts and/or rotates the uterus into place. In case of subsequent prolapsed uterus, a piece of rag is packed and left in position for a period of one to two weeks, at which time it is removed. The woman is asked to have adequate rest until she is completely healed, which occurs when the uterus is no longer prolapsed. The *Kawugotama* treats all cases of prolapsed uterus in the community. *Kawugota* is regarded as an essential procedure since it is assumed to happen in all women of childbearing age that are exposed to the rigours of lifting heavy objects or strenuous domestic chores. As a nurse-midwife, I have seen many cases of prolapsed uterus treated by a *Kawugotama* and in most instances, the mothers are likely to end up with an infection. One case that stands out in my mind was that of a middle-aged relative whose prolapsed uterus was worked upon by the *Wanzama*. This led to bleeding and the eventual

death of the woman. I thought this outcome was tragic, especially because the woman was the mother of nine children.

5.6 SAFIMA (MAGICIAN)

Safi is a form of magic that has to do with imaginary mysterious powers that make people see what may or may not actually be true. For example, one may “see” a man cutting himself with sharp objects with no effect on his skin, while in reality he may actually be using a piece of wood. In some instances, it may be that due to the protective powers of charms and other occult sources, the sharp object may actually fail to penetrate the skin. Additionally, some *safi* change objects into shapes or forms other than what they actually are, like making a white paper morph into a currency note, turning a piece of stick into a snake, or changing human beings into animal form and back to human form.

Traditional beliefs hold that *safima* (magicians) can give proactive protection to people from being harmed by enemies. Sometimes they make adversaries disappear mysteriously when people are attacked or faced with clear danger. Their magic formulations vary depending on the nature of protection required, but generally involve herbs used for bathing, drinking, or for wearing in amulets (*warfi*), necklaces (*laya*), or waistbands (*guru*). Some of these remedies confer protection on their own, while others are triggered by specific actions. For example, some formulations take effect as soon as the person becomes angry. In other cases, the *laya*, *guru* or *warfi* must be moved backward, upward, or to the side in order to become effective. Certain conditions must be followed when *Safi* is used.

Individuals are advised not to eat certain foods or drink from certain containers on specific days, or they are advised not to engage in certain activities on certain days. These conditions must be carefully followed in order for the charms to remain effective. The conditions are inherently superstitious, and are therefore regarded as *haram* (a forbidden act) in Islam.

The role of the *safima* is that of a security guard. In Kanuri culture, the *safima* serves the purpose of providing protection and defence against unforeseen external attacks. The *safi* also has the capacity to protect others by giving them charms to defend themselves from physical attack or to make them disappear into thin air.

5.7 GAU (HERBALIST)

The herbalists known as *Gau* are general herbal practitioners who have a vast knowledge of disease causes, prevention, and treatment, although they practice without a licence. The *Gau* can be either male or female, and anyone who has an interest can become an herbalist, though few cases of father-to-son or mother-to-daughter transmission of knowledge have been recorded. The *Gau* prescribes and administers medicines to cure, prevent and protect against wizards, thugs, and thieves, and also administers medicine for the mentally retarded (*Karuwama*). The herbalist's approach is secretive, and is done in such a way that the information on the combination of what herbs form treatment for specific ailment is not revealed to others. The *Gau* gives herbs to be taken orally and/or to be used in a bath. The herbs are dissolved in water for a number of hours as prescribed by the *Gau*, ranging from one to seventy-two hours. Clients of the *Gau* have to adhere to many

conditions for the prescription to be effective, just like with the *Safi* procedures. In addition, clients are normally advised not to attack others physically or spiritually, as such actions will bounce back on them, in some instances leading to death. They are therefore advised to act only in self-defence.

5.7.1 *Karuwayebakta* (Affliction by Evil Spirits or Mental Illness)

Karuwa refers to evil spirits that cannot be seen by normal human beings. It is believed that evil spirits come out at midday and midnight, and are found under baobab trees. Similarly, the spirits are known to bite individuals who run into them and cause mental problems in their victims. The signs presented by victims are mostly mental disturbance, paralysis of limbs, and some anti-social behaviour (cf. Wheaton 1980: 7). *Karuwa* is an evil spirit while *bakta* is an affliction. The number of cases that are attributed to *karuwa* is increasing and covers anything affecting one's mental balance, including schizophrenia, drug addiction, alcoholism, epilepsy, hysteria and other somatic conditions, is regarded as *karuwa*. Other cases in which *karuwayebakta* may be involved include eclampsia (El-Nafaty and Omotara, 1998), stroke and poliomyelitis. The common forms of affliction seen for treatment nowadays typically involve hysteric conditions among young females, usually ranging in age from those leaving secondary school to new university entrants. For afflicted patients, the traditional healer, usually an occultist makes some incantations which only the heart can comprehend. In most cases, the mentally disturbed are kept by the *Gau* in his domain for the entire period of treatment. Sometimes grasses are burnt in a fire, creating fumes for the patient to inhale, though most of these are harmful to the human system.

Among the Kanuri, a professional handling *karuwayebakta* is a consultant on medicines for diseases and on protection from spiritual and physical attacks, and on treatment for the mentally retarded. *Karuwayebakta* is viewed as extremely serious, leading to severe health problems and/or disability. The role of the *Gau* is to provide treatments to such victims in society. The Kanuris believe that *karuwayabakta* cannot be treated by modern conventional medicine, similar to the beliefs regarding *shimkiri* (jaundice) described below. Other practitioners such as the *Kaskima* and *Mallam* may also play a role in the treatment of *karuwayebakta*. *Karuwayebakta* thus demonstrates overlap between different types of traditional practitioners and the conditions they treat, but the *Gau* is definitely the principal healer.

5.7.2 *Shimkiri* (Jaundice)

Shimkiri (jaundice) involves yellow discolouration of the eyes and mucous membranes, and is associated with fever, general body pain and headache. *Shimkiri* is common, and the Kanuri people believe that it cannot be treated at the hospital by biomedical doctors. Therefore, a patient exclusively seeks out traditional medicine for the treatment of jaundice, which is provided by the *gau* (herbalist) who is invited to the patient's home. There are both herbal and surgical remedies for *shimkiri*. Initially, the *Gau* dispenses herbal remedies orally, but in some severe cases patients may also be referred to the *Wanzama* who make incisions on the joints of the body.

Both the herbal and surgical remedies can potentially cause harm to patients, due to their toxicity and trauma respectively. A case in point is that of a middle aged man in my neighbourhood who was taken against medical advice from the hospital to his house and was given a traditional herb that led to severe vomiting and subsequently death on the third day. His death was tragic, and occurred just before he was to enroll at the university for a master's degree in agricultural engineering.

5.8 KASKIMA (SOOTHSAYER)

Kaskima is usually referred to as 'the god of those who are in a hurry' (*Ala kam azallataye*). *Kaskima*, simply put, is the person who conducts *kaski* (soothsaying). This generally involves predicting what will happen in the future, particularly regarding topics such as wealth, health, sources of sickness, and prospects for successful marriage. Most of the clients who solicit the services of a soothsayer are women of all ages and backgrounds. However, *Kaskima* are also utilised by important businessmen and politicians. The *Kaskima's* procedures involve incantations, slaughtering black goats, chickens or puppies, or the divinatory use of footprints on white mats. The success of the soothsaying depends on having a strong belief in the activity of the *Kaskima*, and strict compliance with the conditions that preserve his powers and charms. The moment a client harbours doubt, or complains of the service being *haram* (prohibited) or *halal* (acceptable) under Islam, or does not adhere to stated rules (pertaining to travelling on certain days, eating certain foods or acting in certain ways as prescribed by the *Kaskima*), the service becomes ineffective. The practice is generally regarded as an alternative to the modern approach to problem-solving in business and in health care. In most cases, the predictions turn out to be true for believers,

thus helping clients avoid dangers, solve problems, and gain protection. However, the practice is regarded as *haram* (forbidden) in the teachings of the Islamic religion.

5.8.1 Vignette on Professional Identity Between the *Kaskima* and the Psychiatrist on *Karuwayebakta* as an Example of a Non-Harmful Traditional Health Practice

In 2000, I encountered a girl who was in my daughter's cohort entering into university to read for a Bachelor of Science degree. Before she could gain admission to the university, she was exposed to the rigors of all sorts of psychological problems as most of her peers were married. The few that were not married had suitors and fiancées. Instead, she was planning to finish at least her first degree before getting married. That dream was disrupted by her parents, who became worried about her lack of a suitor (*bulusu*) at an age where she was supposed to have had suitors. Indeed, she was beautiful and was from a cultured family that is highly respected (*Burzumgata*). Her father therefore gave her a deadline within which to produce a suitor, or else he would proceed with an arranged marriage for her. It is common for very rich old men from other northern states in Nigeria to come down and seek wives in Borno, as women in Borno State are known for their good manners, good cooking abilities, and *harrak* (seductive perfumes). This ultimatum from her father caused the young woman to begin displaying antisocial behaviour, largely due to lack of sleep caused by nights spent worrying about how to find a suitor within the stipulated period of time. She was able to find a fellow student from her university who was one year ahead of her, but unfortunately he could not bring his *raaki* (gift for intention of marriage) as his parents were not ready for his marriage at that time. Finally, the deadline passed, and the

father now responded to the interest of one very rich old man, who was in fact older than him, to marry his daughter. There was significant division in the household, as the mother did not want to hurt her daughter and wished for more time to be given for her daughter to find a suitable person. The situation was also especially problematic for the daughter, as it is not considered acceptable for a female to ask the hand of a man in marriage. Instead, she was forced to wait for some “Mr. Right” to make the first move. The mother now had no other option than to go the *kasmima* to seek guidance on whether there was any option other than to allow her daughter to be married to the old man. At the same time, the daughter was starting to have hallucinations for several days which turned into a full-blown case of hysteria. She ceased going to the university, and neither ate nor drank. I recall that when I went to greet her, her fist was firmly clenched and I was told by her mother that it had been like that for three days.

Consultation with the *Kaskima* revealed that the daughter was inflicted by three black evil spirits, one in the university, another in an area where they sell firewood near their house, and a third and worst evil spirit who was not clearly identified. The treatment for the two known spirits, according to the *kaskima*, was the slaughtering of a black sheep and a goat, as well as a white cow. For the third and worst spirit, he advised the parents to take their daughter to the psychiatric hospital where treatment could be given to unclench her fists. After several days, the daughter showed signs of improvement, as her fists were unclenched and she was able to communicate. The *kaskima* asked the parents to allow her to eat and sleep well, and said that he would repeat the *kaski* that night and would call the following day to interview their daughter before telling them the final result of his *kaski*.

The following day the *kaskima* came, and he met the daughter who was fresh after a good night's sleep and a good meal. His interview focused on the marriage issue, and he asked the daughter whether she preferred to be married before finishing her university education, to be married to the old rich man or for her father to extend the deadline for her to find a suitor. He emphasized that her star had indicated that whether she would get well from the *karuwa* or suffer forever depended on the truth of her response to his questions. The daughter indicated that she wished to complete her university education before thinking of marriage, and that was what she had continually wished for in her life. The *kaskima* discharged the daughter and invited the parents in to present to them his results. He removed one white paper in his bag and handed it to the mother. He then requested for a fire to be made and he put some herbs onto the fire and asked the mother to direct the white paper to meet the resistance of the smoke of the herbs from the fire. After two minutes, a clear Arabic inscription appeared on the paper stating that their daughter should not be married to the old man if they wanted her psychiatric condition to improve, and that she should be kept away from marriage talks for at least four years. Images also appeared on the paper, depicting three cows, three sheep, three goats and twelve chickens meant for slaughtering and sacrificing over a period of time. The *kaskima* went to the psychiatric hospital and asked the doctor to advise the parents to allow their daughter to go back to the university.

Since this time, the daughter went for her Youth Service Corps Programme, the psychiatric doctor took his gift for intention of marriage (*raaki*) to her, and their marriage was arranged for September 2009. It is impossible to know whether the matchmaking that

resulted from the *kaskima's* services was done deliberately or whether it occurred coincidentally!

5.9 KARWINA (LOCAL HUNTER)

The *Karwina* is a general practitioner who possesses all the powers of the *Safi* and *Gau*. He also has the power to catch all the wild animals, reptiles and dangerous insects in the forest. In addition to the procedures used by the *Safi* and *Gau*, the *Karwina* goes out to the forest to kill wild animals like lions, elephants, and hyenas. The flesh and fat of these animals is required for the treatment of certain ailments in the community. The *Karwina* also trap and kill wild animals that enter into townships or villages to cause destruction of farm lands/crops and/or kill people and domesticated animals. They are experienced marksmen as well as sharpshooters who are highly skilled and can protect themselves against on-coming shots. Within Kanuri society, the *Karwina* also act as herbalists and security consultants. This is an important service to the community since it is common for wild animals to break into villages and cause destruction. Every village has a *Karwina* who acts as the defence officer in the face of invasion or attack by animals and humans.

5.10 SHILASHIWOLTAMA (TRADITIONAL BONESETTER)

The *Shilashiwoltama* is a person who specialises in traditional bone setting. *Shilashiwolta* refers to the setting of a bone by the traditional bone setter. Practitioners may differ in the procedures they use to set bones. Some use incantations coupled with physical manipulation of the bone in the patient, while others perform bone setting without actually being in the presence of the patient. In such instances, the *Shilashiwoltama* manipulates a stick, roughly the size of the fractured area, which is used as a proxy and is believed to set

the bone immediately. Others actually set the bone manually, using sticks to align and immobilise the bone, which is then tied with a rope. In cases where the femur or leg is broken, a nine-inch block is used to keep the fractured area in place. No anaesthesia is used during the procedure, even though it can be quite painful. Some *Shilashiwoltamaso* (plural for *Shilashiwoltama*) do refer the patient to the hospital for pain relief treatment and, interestingly, nowadays some of them refer their patients to the hospital for x-rays and even antibiotics. The *Shilashiwoltama* may also inform the patient on when he will untie the fractured area for inspection in order to monitor the extent of healing after a specific period of time. He recommends that the patient consume foods rich in protein, and recommends unprocessed millet for adults and older children and increased breast milk for infants. The *Shilashiwoltamaso* act as orthopaedic surgeons in the community, which is an important role given the number of cases of bone fracture which do occur in the Kanuri community.

5.11 *KERMALLAM* (PRACTICE OF *MALLAM*, A QURANIC EXPERT)

The *Mallam* is a person learned in Islam who has deep knowledge of the Holy Quran and the entire teachings and practices of Islam. He has the ability to impart his knowledge to others, and also prays for them. These services are collectively called *Kermallam*. The *Mallam* derives his wisdom and powers to give preventive and/or curative care from the knowledge of the holy book (cf. Wall 1988: 232-233). Most practitioners are men, but there are a few practising women, too. The *Mallam* is a natural teacher in the Kanuri community. Every individual is expected to acquire a Quranic education by attending the *Moramji* to study the Quran and the teachings and practices of Islam. A patient or client may consult a *Mallam* with a specific concern, and the *Mallam* then diagnoses the problem through *Rakaa*

(special prayers for diagnosis). The *Mallam* pray by reciting the Holy Quran, in whole or in part, to the patient or client (*tayeda*). He may also write portions of the Holy Quran on a wooden slate which is washed off with water, which the patient or client then drinks. The *Mallam* acts as teacher and consultant, with the power to diagnose problems and prescribe appropriate treatment.

From the preceding catalogue, it is clear that there are variations and overlapping roles among and between the traditional healers and their practices. For instance, the *wanzama*, who is the surgeon, dispenses herbs similar to the *Gau*, and also is involved with bone setting and some aspects of *Kermallam*. Similarly, the *Suromuwuma* also practices *Kawugota*, *Kermallam*, and the administration of herbs, which are the principal roles of the *Kawugotama*, *Mallam*, and *Gau*, respectively. The *Karwina*, *Safima* and *Kaskima* also practice in similar ways, and there are conflicting roles related to the application of magic in their practices.

5.12 CONCLUSION

This chapter has described the practices and practitioners involved in traditional health care among the Kanuri of Borno State. These practitioners are likely to be found in every Kanuri community. The list of practices is conceivably even longer, but the above description gives an idea of the range of topics encompassed by traditional medicine, ranging from herbal remedies to magico-religious healing. Clearly, there are practices that appear to be harmful while others are indeed beneficial. Any attempt designed to integrate biomedical

care with traditional healing must be based on a clear understanding of the relative degree of harm and benefit inherent in each system of medicine (Anderson 1992).

I personally have mixed feelings on some of the traditional Kanuri health practices and practitioners. I recognize that some of the practices are quite beneficial to individuals and to the collective, and are commonly used and considered effective. However, while I appreciate the importance of this indigenous knowledge, the harm involved in some of the practices needs to be fully examined and such practices discouraged. The only way to achieve this goal is to bridge the gap between the traditional and modern health care practitioners. There are common identities between the two groups, and in fact many of the biomedical professionals are the children of parents who are or were traditional healers. There is also an informal working relationship that operates between the two groups of practitioners. Integration is necessary because, whether the traditional practices are harmful or beneficial, traditional medicine is widely accepted by both rural and urban populations in contemporary Borno State. Enhancing the health status of the people of Borno depends on integrating the traditional system into modern medical services. Strategies for achieving this integration are the subject of the following chapter.

CHAPTER SIX

TRADITIONAL AND BIOMEDICAL HEALTHCARE PRACTICES IN THEIR SOCIAL CONTEXT IN BORNO AND BEYOND

6.0 INTRODUCTION

This chapter explores the bases for a relationship between the traditional and biomedical health care systems. The chapter highlights various relevant perspectives, including those of both the WHO and researchers in African medical sociology and anthropology, and it reviews areas of compatibility and divergence of the two systems of medicine. The chapter begins by looking at definitions of health and the concept of medical pluralism, since there is indeed more than one health care system operating in Borno State, Nigeria. The chapter reviews evidence that all efforts toward integration must necessarily involve indigenous practitioners, western-trained healthcare professionals, government agencies and policy-making bodies, as well as healthcare consumers. Therefore, the chapter proceeds with a discussion of traditional and modern medicine at various levels, including the policy level, the practitioner level, and the user level. At each level, it is evident that the health-seeking behaviour of the populace must be understood in relation to the nature and type of health care available, as well as cultural considerations and beliefs informing concepts of health and illness. The chapter concludes with an overview of the role religion plays in the health care practices prevalent in Borno State.

6.1 DEFINITIONS OF HEALTH

Understanding how health is defined and perceived can provide a helpful foundation for the discussion of health issues and health-related behaviours. Igun (1988:17) has defined health as a social construct composed of two dimensions, the functional level and the prognosis. Others employ a continuum perspective on the definition of health. At one end of the continuum, a range of problems exist where non-social clues are sufficiently strong that no social explanation is needed. Moving away from this end of the continuum, social causes take on increasing importance, culminating in the opposite end of the continuum where there exist extremely variable concepts of health within and among societies (Twaddle 1974: 30). Parsons (1951: 24) defines health as “the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized.”

The “ defines health as a complete state of physical, social or mental wellbeing, not defined merely by the absence of disease or infirmity”. Igun (1988: 15) argues that the definition espoused by the WHO is inappropriate on several levels. First, a state of complete physical, mental and social wellbeing does not exist anywhere in the world. By this definition, there would be no healthy people, but in practical terms it is clear that there are millions of healthy people in the world. Second, the WHO definition does not provide a standard for evaluating health status in everyday life, so has little practical utility.

In describing health-seeking behaviours, Igun (1988) separates behaviours into two categories: those which are preventive, including the actions people take in order to avoid

becoming sick, and those which are curative, involving the actions people take to treat an illness.

6.2 MEDICAL PLURALISM

Medical pluralism denotes the coexistence of multiple systems of medicine, such as traditional, modern, and folk systems. Pluralism provides individuals with multiple choices and options, and allows access to various levels and types of care (Akerle 1984). In general, people access both traditional and orthodox medicine, sometimes as complementary therapies and sometimes as therapies that exist in stark opposition to one another. Igun (1988: 15) explains such an approach, which he terms 'shotgun therapy', by acknowledging that people simultaneously use all modes of healing that are available to them.

The introduction of western biomedicine has involved significant changes to the pluralistic nature of medicine, however. Although traditional medicine has flourished when accessed privately, once western science and western-oriented medical care were introduced in the 19th century they came to dominate and control other health-related institutions. As a result, traditional and modern medicine have not been easily organized into a single system. Instead, they act as parallel but often unrelated treatment options, both of which are utilized by the people of Africa. For those suffering from illness, both systems are seen as equally legitimate. Therefore, the state of medical care throughout much of Africa is truly pluralistic, with regard to both treatment options as well as explanations for what factors cause a

particular disease. For example, both germ theory and supernatural forces are used to explain illness in Africa, regardless of one's level of education (Igun 1988: 70).

6.3 TRADITIONAL AND BIOMEDICAL HEALTHCARE PRACTICES: POLICY LEVEL

The WHO has made specific attempts to address problems related to health care delivery in developing and poor countries, especially for the large segments of the population living in rural areas for whom traditional healers are the sole source of health care available. In 1978, the WHO called for the adoption of the PHC strategy by its member states. Included in this strategy was an emphasis on the promotion and development of traditional medicine. This action initiated a tremendous interest in the role of traditional medicine within healthcare systems in the developing world. Furthermore, the WHO policy has called into question whether the integration of traditional and scientific medicine is possible. At the present time, "Nigeria has been involved in this debate, although the government has remained lackadaisical about a clear national policy on the matter" (Offiong 1999: 126).

The first attempt to integrate traditional and modern medicine was made in 1977. Since that time, the World Health Assembly and member countries in the developing world have undertaken significant efforts to create policies and programmes that promote successful integration. The 'Health for All by the Year 2000' resolution promoted the incorporation of useful elements of traditional medicine into western biomedical practice, and encouraged its positive attributes while discouraging overtly harmful practices. Although this policy represented meaningful progress, its actual implementation was

considerably more complicated. Member countries such as Nigeria largely failed to achieve successful integration because of lack of political will amongst the elite classes, and because of the attitudes of modern health professionals who generally supported modern medicine exclusively and held negative views about traditional medicine and traditional practitioners. However, several factors have subsequently contributed to an increased willingness to support traditional medicine and to incorporate it into national policy. These factors include:

1. Indigenous health care resources (traditional practices, remedies, and the practitioners themselves) are increasingly being brought under the purview of formal health services.
2. The severe shortages of certain imported drugs in many developing countries, due to various political and economic crises, which force an increasing proportion of the population to use traditional medicine (WHO 1985).
3. The scarcity or total lack of resources for making modern medicine available in all areas, in spite of the desire to do so by many government bodies.
4. The recognition that comprehensive PHC provides a strong foundation for full use of human and material resources in a given community, thereby strengthening indigenous culture, knowledge, practices, resources and technologies and contributing to the sustainability of local and regional development (WHO 1979).

There are four possible approaches by which government entities can choose to address the use of traditional medicine. These approaches are considered elastic and broadly defined, and there is some degree of overlap between them. However, they designate very different methods for dealing with traditional medicine. The four approaches are as follows:

1. The state can completely prohibit traditional medicine via restrictive legislation, with modern medicine recognized as the only legal form of healthcare.
2. The state can formally tolerate traditional medicine and decline to interfere in the practice of traditional healers.
3. The state can formally recognize and regulate traditional medicine, requiring that traditional medicine be practiced only after completion of training, registration and licensing.
4. The state can choose to formally recognize and officially sanction the integration of traditional medicine into the formal healthcare system.

According to the WHO, several African countries now consider the concept of integration a reality that may be fully achieved in the near future. Such efforts are still evolving, and few countries have taken concrete steps to integrate traditional and modern medicine on a national scale. However, the WHO has established certain guiding principles to assist with ongoing efforts to integrate the two and emphasizes that government commitment to traditional medicine, one which views it as a viable and important component of healthcare delivery, is crucial to successful integration. The WHO's guidelines include a number of specific actions, such as: the creation of legislation supporting integration of traditional medicine into the existing healthcare system at the institutional and community level; engaging in pilot projects and establishing ongoing funding for research and documentation of traditional medical practices and use of medicinal plants; formalizing the registration of traditional practitioners; establishing an Institute of Traditional Medicine which can provide training of traditional healers; supporting the full integration of the two

systems of medicine at all levels of healthcare delivery; granting equal status to the practitioners of the two systems; and providing training for community PHC workers in both traditional and modern medicine.

These WHO guidelines particularly emphasize the importance of research for effectively integrating traditional medicine into PHC services. Specifically, research into the theories, practices, and materials involved in traditional medicine is considered essential. Basic studies should focus on selected PHC facilities where traditional healers and modern medical personnel work together. Pilot projects are required to demonstrate the process involved in such collaboration, the feasibility of integration, and the implications for health and professional outcomes. As a result of such research efforts, successful projects can be identified, replicated and generalized to other areas. Additional research should also focus on comparative studies of traditional medicine, modern medicine, and a combination of traditional and modern medicine. Both qualitative studies and epidemiological research can be used to evaluate the impact of integration on the surrounding community. Furthermore, education, training, and professional development efforts are necessary to promote and expand integration of traditional medicine into the PHC setting.

Currently, existing research does document some of the benefits of successful integration. Pearce (1981) presents the arguments of both radical and conservative scholars in favour of successful integration, even though their specific proposals for accomplishing such integration often differ. The benefits of integration that are frequently cited include the ability of traditional medicine to serve communities where western medical services are

lacking or non-existent, especially since the cost of creating modern health facilities on a national scale is seen as prohibitive. Additionally, many feel that less expensive indigenous facilities could be merged with the modern hospital system to produce a nationwide network of services. Furthermore, indigenous medicine has particular value and can be readily accessed by the majority since it is congruent with the culture and beliefs of the populace. Indeed, local healers often have particular insights into the psychology and cultural values of the people, and such insights should be used to the benefit of the healthcare system.

In contemporary Nigeria, modern healthcare involves the use of sophisticated and expensive technologies which are not workable for those living in rural areas, who do not have the resources to create or access these forms of modern care. In these rural areas in particular, there are strong traditions which inform beliefs and understandings related to health and illness. These communities require locally available, readily accessible methods for the prevention and treatment of disease which are acceptable to the people, rather than those methods created in a foreign context and at times inappropriately imposed on diverse communities. The concern of the Nigerian government is to ensure health for all Nigerians. Nationally, the attitude of the people is shifting toward an emphasis on modern treatment methods, while other Nigerians feel that modifications to traditional medical practices are acceptable and do not detrimentally affect the traditions and customs of the people.

Since the 1960s the issue of integration has remained problematic in Nigeria. There are a number of TM associations: the Nigerian Association of Medical Herbalists, the Nigeria Union of Medical Herbal Practitioners, the Nigerian Association of Traditional Medical

practitioners. Officially, these groups are only given informal recognition. However, no official restructuring of either system occurred to develop an integrated system. Besides the research into the chemical component of African plants and local herbal mixtures, the Federal Ministry of Health in April, 1979 organized a seminar on Traditional Medicine and after the two-day conference various recommendations were adopted. These included:

1. That a Traditional Medicine Conference of Nigeria (TMCN) be set up to help control the practice of indigenous medicine;
2. That hospital wards specifically for the practice of indigenous medicine be created alongside western medical practices;
3. That a National Research Institute be created, and the Committee on Traditional Medicine in the Federal Ministry of Health include registered herbalists.

To enhance training and research on indigenous medicine, traditional medical centers have been set up in some Nigerian states (e.g. Lagos, Edo, Imo, Anambra and Plateau). Several agencies and individuals continue to advocate for integration. For example, the President of the Lagos State Branch of the Nigerian Association for Trado-Medicalism advocates for the use of herbal medications in place of synthetic drugs introduced by western nations, which he believes to be dangerous. He also advocates that western trained physicians should work with herbalists to continue developing herbal remedies.

6.4 TRADITIONAL AND BIOMEDICAL HEALTH CARE PRACTICES: PRACTITIONER LEVEL

Any attempts to integrate traditional and modern medicine must adequately address the respective needs, roles, and practices of the two types of medical providers. A number of studies have been conducted to examine the relationship between traditional healers and modern healthcare practitioners, and to consider options for integrating the two systems of medicine. For example, Ademuwagun (1979: 155) has suggested that, since most professional health workers have limited knowledge of the cultural factors likely to promote or inhibit health, they would do well to consider working in partnership with native doctors. However, the psychiatrist Asuni (1981: 176) has argued that many practitioners feel that not enough is known about indigenous practices to warrant an integration programme. He cited the example of Yoruba leaders, who have little knowledge in the areas of surgery, ophthalmology, neurology or pathology. He also suggested that integration would be complicated by the problems encountered by traditional healers in adjusting to social changes brought about by integration.

In order to address the relationship between biomedical professionals and their indigenous counterparts, Pearce (1981) conducted a research project regarding western trained healthcare practitioners in Nigeria, and found them predominantly negative with regard to the following questions:

- how do modern healthcare practitioners feel about working with their indigenous counterparts?

- to what extent have they made use of (informally) indigenous therapeutic practices?
- in what areas do they believe that western models or practices can learn from traditional medicine?

From the opposite direction, in a paper presented at the 7th International Conference on Social Science and Medicine, Odebiyi (1981: 12) argued that there is interest in integration among traditional health practitioners in Nigeria. Odebiyi's research found that 61.1% of respondents indicated their willingness or desire to integrate the two systems. However, only 34% of respondents supported the operation of joint clinics, although 63.7% felt that the separate development of the two medical systems was a good idea. Many felt western-trained physicians could learn and benefit from indigenous medicine. Out of the 86 respondents, 26 preferred integration in the areas of psychiatric/mental health practices. 31 preferred integration in the areas of herbal/pharmaceutical remedies, 9 supported integrated efforts involving supernatural healing, and 4 preferred integration of orthopedics/bonesetting. From these responses, it is clear that traditional practitioners were not advocating wholesale integration, but were quite specific in their ideas about which areas of traditional medicine it would be worthwhile.

Akpede et al. (2001:91-98) examined the treatment of diarrhoeal illness in both systems of medicine, including how diarrhoeal management practices are perceived by traditional healers. The study found that the national programme to control diarrhoeal disease initiated in Nigeria in 1986, designed to enhance home management of diarrhoea, has not been fully adopted by all practitioners. He therefore argued that traditional healers should

be trained to effectively promote use of oral rehydration therapy (ORT), and should be encouraged to assist their patients in implementing home management practices.

The role of traditional practitioners in modern healthcare was also examined by Njodi et al. (1998: 301-307). They examined traditional beliefs and traditional health practices of the Bade and Kanuri people in Yobe State, Nigeria from 1996 to 1997. Their survey investigated people's attitudes and perceptions of health and preferred treatment methods, especially in relation to diarrhoeal illness. Their study found that diarrhoeal illness is diagnosed by traditional healers based on mothers' reports and complaints, that there is some degree of specialization among traditional healers in the management of specific types of diarrhoeal illness, and that breastfeeding was perceived by both ethnic groups to cause diarrhoea. Healers in both groups believed that the treatments they administered would effectively stop the occurrence of diarrhoea. The authors concluded that traditional healers in the region do contribute to the home management of diarrhoea, although their perceptions and practices need to be improved and enhanced in order to ensure more successful treatment.

The example of Yobe State illustrates a successful model of utilizing traditional healers within the modern medical system. For example, they were successful in incorporating traditional healers during important national health campaigns, including national immunization programs. As a result, fewer cases of vaccine rejection were observed in Yobe compared to similar immunization campaigns in Borno. Similarly, fewer cases of the wild polio virus have been reported in Yobe compared to Borno, which has seen a

number of polio cases even though the disease is supposed to have been eradicated globally by now. There is also evidence that the Yobe State Traditional Medicine Board involves traditional healers in the local communities as part of public awareness campaigns, such as the campaign devoted to fighting HIV/AIDS. However, the success of HIV/AIDS campaigns in Yobe may be attributable to lower numbers of infected people living in the state compared to Borno. Borno shares a border with three countries, which can contribute to increased disease burden, whereas Yobe shares a border with only one country.

6.4.1 Evidence of Compatibility and Overlapping Professional Identities

Among the practitioners of traditional and modern medicine, there is often doubt about the prospects for successful integration. However, it must be recognized that the two forms of practice do not make for completely strange bedfellows. First, there exists a significant degree of overlap in the professional identities of traditional and modern healthcare practitioners. A large proportion of western-trained healthcare professionals are the children or grandchildren of traditional healers; this is especially evident among modern midwives, who are frequently the descendants of traditional birth attendants. Second, there are instances where patients may benefit from receiving a combination of traditional and modern services. For instance, it is common practice for traditional bonesetters to place their patients on conventional analgesics. Less commonly, they may also refer patients to hospital for antibiotics and/or tetanus toxoid (TT) injections. On very rare occasions, biomedical professionals do seek the advice or assistance of a *Shilashiwoltama*. Especially for psychological health concerns, it is common for both modern and traditional healers to

collaborate with regard to treatment options. During circumcision, many *Wanzama* now refer their patients to modern facilities to obtain penicillin injections or oral ampicillin capsules.

The Aro experiment of 1954 has been well documented by Lambo (Lambo 1979:7). This experiment was based on two major ideas. First is the community based treatment system was needed in psychiatry and (secondly) patients were required to live in villages and their kinfolk accompanied them to assist with their care. The second idea entailed the notion that collaboration with indigenous leaders would be highly therapeutic under the supervision of the clinical staff. These practitioners helped in the day to day treatment procedures. The initial success of this experiment encouraged others to collaborate with indigenous psychiatrists. While Dr Lambo, a younger brother to Professor Lambo in 1964 showed that he did not “advocate extensive training of traditional healers”, he and others oppose the setting up of institutes for traditional medicine as found in Mainland China and India, but he is in support of collaboration.

The ‘shot-gun’ method of healthcare delivery described by Igun (1988) is particularly evident in some healthcare settings, where patients are allowed to receive traditional treatments in a modern context. For example, in the Aro Hospital, patients are treated with both traditional and modern modes of care. Likewise, I have observed several settings in Maiduguri, including the General Hospital, the Nursing Home, and the Gamboru Psychiatric Hospital, where relatives act as therapy managing groups for patients and bring traditional remedies with them to deliver to the patient. Most commonly, these remedies include Quranic verses written on slates and washed with water to produce a tincture which is then consumed by the patient, or may include herbal medicines and prayers for healing.

There are also a number of cases in which biomedical professionals sought the advice of traditional healers before beginning treatment within the western medical system. For example, when a medical professional was invited to present a paper on uvulectomy to the Inter-Africa Committee State Chapter at what was then the Gongola State Workshop on Training and Campaign on Traditional Health Practices Affecting Women and Children, he had no option but to seek the assistance of a traditional barber who cooperated with him. In a statement that clearly illustrates overlapping professional identities between a biomedical doctor and a traditional barber, the medical professional described his experience as follows:

When I was requested to present a talk on traditional uvulectomy, I was very uncomfortable for several reasons, but principally because I felt asking an orthodox medical practitioner to talk on traditional medical practices is a paradox. My discomfort should therefore be understood, as it is not always easy acting as a sheep in wolf skin. In order to enable me to approach the subject therefore, I had to modify the topic to what it is, because this will, at least, allow me find out the facts about traditional uvulectomy and the fallacies thereof, vis-a-vis my medical background. The facts about traditional uvulectomy can of course be found only from their practitioners and recipients. But such a fact cannot be total, given the degree of expected suspicion that will arise from an orthodox medical practitioner asking questions from sources that are supposed to be a family secret, which should be carefully guarded. Nonetheless, with the cooperation of Mallam Isa Musa (a traditional barber) otherwise known as *Wanzami*, who has practiced uvulectomy for over 20 years, and the wealthy experience of Baba Njidda *Wanzami*, whose practice spans over 40 years, I was able to summon courage to talk to this August gathering about the basic facts of traditional uvulectomy. (Nuhu 1991: 18)

6.5 TRADITIONAL AND BIOMEDICAL HEALTHCARE PRACTICES: USER LEVEL

The integration of traditional and biomedical practices does not take place in a vacuum. Beliefs and attitudes of lay people, as these affect their health seeking behavior, must also be taken into account.

In a study of the health-seeking behaviour of rural Nigerians, Omotara (2000) provided the following description:

Health seeking behavior is said to be influenced to a large extent by perception and knowledge of causes of diseases and illness. Five final-year medical students examined the health-seeking behaviour of the rural dwellers in the North of Nigeria. This they did by designing an open-ended questionnaire which sought information on the types of health care system used by the people, which of them were found to be most effective, and the reason for choosing a particular health care system. The study was conducted over six week period in which they were resident in the area. They reported that a majority (58.5%) use western medical care, 12.5% use both western and traditional, while 28.7% use traditional medical care.

A majority (72.7%) found western medical care most effective and therefore prefer it to traditional medical care. They also prefer it to traditional care for both communicable and non-communicable diseases. This exercise was able to demonstrate to students the overwhelming responsibility that was ahead of them after qualifying as a medical doctor. The fact that people in rural areas, despite their deep-seated traditional and cultural beliefs, have come to fully accept western medical care would make them appreciate their profession more. Some of the problem they faced during this exercise was: transportation, and lack of confidence in the students by the villagers. These problems helped the students to appreciate inherent problems in community-based research.

Omotara (2000: 170-171)

Lessons learned from diarrhoeal management efforts in northeastern Nigeria also reveal information on health-seeking behaviour. Diarrhoeal management provides a good

example of the need to appreciate the broader socio-economic context in which integration of traditional and biomedical health practices could take place. These efforts began in 1995 with the a focus on oral rehydration therapy (ORT) to reduce morbidity and mortality related to diarrhoeal illnesses. Although awareness of ORT is high, studies have shown its use rate is low, child caretakers incorrectly prepare SSS and use it only briefly, and some lack an understanding of the function of ORT. Discrepancies between the recommended use of ORT and its actual implementation may be due to conflict between public health policies and cultural norms, perceptions and practices. Therefore, the need to understand local culture is essential in improving the home management of diarrhoea.

Issues related to effective use of ORT have been documented in several studies. Research conducted by Akpede and Omotara (1996: 54-60) indicated that lack of continuous reinforcement of the appropriate composition of the salt-sugar solution (SSS) and knowledge of its use created a significant hindrance in the effect treatment and management of diarrhea and underscored the need for frequent oversight of training quality related to the preparation and administration of SSS. They sought to shift the emphasis on ORT promotion to simply raising awareness of the appropriate use of ORT among the Kanuri and Bura ethnic groups of Borno state. The results of their study revealed that 73.1% of mothers in the 258 Kanuri households they included, and 84.2% of mothers in 260 Bura households, were aware of SSS. They ultimately recommended that chemists, patent medicine stores, and traditional healers should all be targeted with education campaigns promoting ORT, especially since these categories served as healthcare providers in both urban and rural areas.

In a similar study on intercultural variation in the perception and treatment of diarrhoeal illness in northeastern Nigeria, Akpede and Omotara (1994: 118-123) examined how the WHO/CDD and the National Control of Diarrhoeal Disease Programme (NCDD) sought to reduce diarrhoea-related morbidity and mortality through home management practices. Their study focused on areas of conflict between programme recommendations and traditional perceptions of diarrhoea, and argued that home management practices are influenced by numerous factors including perception of diarrhoeal illness, attitude, situational factors, time, and treatment choice. Their research included focus group discussions to identify common types of illness affecting children under the age of five, with an emphasis on diarrhoea. As a result of the focus groups, they concluded that the Kanuris and Buras differ in their perceptions and in their treatment practices. Kanuris typically classified diarrhoea based on perceived causes, and formal treatment was only sought after home remedies had failed, or when either a husband or mother-in-law made a decision to seek additional help from traditional healers, *Mallams*, chemists, pharmacies, dispensaries, clinics or hospitals. Buras, on the other hand, listed causes of diarrhoea that had no clear classification or categorization. Their treatment practices and help-seeking behaviour included an initial trial of home remedies, followed by attendance at a hospital or clinic. When formal medical treatment failed, Buras would eventually return to herbal remedies, such as the use of *harba* (rubbing yam or cassava boiled with the bark on the baby directly, or used as a drink). Use of SSS was sought after other remedies had failed. As a result of the information obtained in focus groups, the authors concluded that differences between Kanuris and Buras contributed to intercultural variations in the perception and treatment of diarrhoea, and that such differences necessitated the formulation of culturally specific

messages about home management of diarrhoeal illness. Since both groups were found to seek treatment in hospitals, they argued that the healthcare system should attempt to provide information and education about home management practices, including proper food, personal and environmental hygiene. They also suggested that traditional medical practices should be modified through health education, such as encouraging traditional healers to prescribe ORT instead of herbs for home management.

Akpede et al (1995) also examined the use of ORT as a strategy for home management of diarrhoea in northeastern Nigeria. They suggested that use of ORT reduces burden on healthcare facilities and improves health outcomes. Understanding what factors mothers use to evaluate the severity of their child's symptoms can provide insight into the factors affecting choice of treatment, including use of ORT. In a separate study of how mothers interpret symptoms, Igene et al. (1992) asked Kanuri and Bura mothers to describe features of diarrhoeal illness in children under five, and score each feature as serious or dangerous. He found cultural variation in perception of symptoms based on demographic factors, perception of ORT, and help-seeking practices. The Kanuris regarded diarrhoea as serious when it lasted for more than two days and when home management failed. Buras regarded it as serious when diarrhoea was frequent, when fever was present, or when associated with weakness or the inability of the child to play normally. In such instances, formal medical treatment was sought. The author suggested that there is a need to mix broad public health campaigns with group-specific messages due to the significant differences observed among the two groups, especially with regard to education and utilization of health facilities in rural and urban areas. He further called for health education programmes for

mothers and other caregivers about the dangers of diarrhoea, and the benefits of proper treatment for reducing the risk of subsequent illness.

Another study by Akpede et al. (1997: 231-240) investigated knowledge about and ability to properly prepare SSS in northeastern Nigeria. Their study took place one year after the 1996 launch of the ORT programme, and found that 20% of mothers had already forgotten how to prepare SSS and 14% lacked the materials required to do so. All of the respondents, including both Kanuris and Buras, had heard about ORT and SSS. However, the Kanuris mainly obtained information through public demonstrations while the Buras heard about ORT and SSS at formal health facilities and churches. ORT and SSS were well-accepted by both ethnic groups, although rural Kanuris were unlikely to use the remedy without the advice of healthcare workers. In general, Kanuris had little knowledge about the purpose of ORT and SSS whereas the Buras (both urban and rural) understood the purpose of ORT and SSS since they were instructed at healthcare facilities. The study concluded that efforts to promote awareness of ORT must change so that an emphasis is placed on educating people about the use of ORT, appropriate use, and ability to properly prepare the solution.

In addition to research on treatment choices and health-seeking behaviour related to diarrhoeal illness, other studies have examined similar topics related to maternal morbidity and mortality. This area of research is especially timely and relevant since the World Bank has identified maternal mortality as the number one health issue facing young adult women in the developing world, noting that it accounts for 18% of total disease burden in such areas. Significantly, a number of maternal deaths stem from medical causes (from obstructed

labour, anemia, sepsis, abortion, etc.) as well as from socio-cultural practices common to certain ethnic groups. In Borno, eclampsia is the second cause of maternal mortality, and a majority of patients who suffer from eclampsia come from rural areas.

El-Nafaty and Omotara (1998: 20-25) investigated the perceived causes of eclampsia in four ethnic groups in Borno state. The study aimed to highlight the perceived causes of eclampsia among the Kanuri, Shuwa, Babur and Marghi. It also aimed to determine how these perceptions contribute to mortality and morbidity in the state. Among the perceived causes of eclampsia were evil spirits, witches and wizards, the killing of antelopes by the Shuwa tribes, hereditary factors, and malnutrition. The Kanuri and Shuwa emphasized the role of evil spirits and poor nutrition, while the Babur and Marghi emphasized the negative effects of early marriage. Misconceptions about the aetiology of eclampsia led to the use of traditional medicine, including the inhalation of smoke meant to drive out evil spirits. The consequences of this practice can include aspiration, airway obstruction, and death. Medicinal treatments also put patients at risk for toxicity, brain damage, puerperal psychosis, neurological disorders, and other complications. The authors concluded that the culture of the four major ethnic groups required systematic change in information and social behaviours in order to effect positive changes in women's reproductive health. Additionally, they felt that the relationship between men and women should be made clearer in order to enhance decisions pertaining to family affairs.

In order to address other facets of female reproductive health, Idris and Omotara (1996: 239-241) conducted a study on planned homebirths in Maiduguri, Nigeria. According

to them, maternity services in most sub-Saharan countries are inadequate. Furthermore, epidemiological data on maternal health is scarce and where it is available, it is largely drawn from hospital-based samples and is therefore not representative of the community since only elite members of society or those with especially complicated cases seek treatment at a hospital. The purpose of their study was to evaluate the safety of homebirths among healthy, low-obstetric risk women attending a regular antenatal clinic in Maiduguri, and to recommend any necessary changes to support improvements in maternal health. 80% of their sample had a successful homebirth attended by a TBA. However, 3% required hospitalization after the birth due to postpartum eclampsia, puerperal sepsis, or postpartum hemorrhage. 20% required transfer to the hospital because of complications during labour. In their study, there were eight recorded prenatal deaths, six of which occurred among those who required hospital delivery; the other two were macerated stillbirths. Their study concluded that homebirth was generally safe and reliable for low-risk patients. However, they also indicated that regular antenatal care is necessary in order to identify those who require hospital delivery and to treat minor disorders during pregnancy. The authors found that complications observed among those patients requiring hospital delivery may have been due to low educational levels (80% of the women sampled had no formal education). They also noted that poor economic status motivated the choice to have a homebirth.

An important factor which significantly affects health-seeking behaviour is the family unit. The family plays an important role in health-related behaviour, acting as a therapy-managing group which discusses a patient's illness and gives advice about treatment options, including where treatment should be sought. Collectively, the family usually reaches an

agreement about the diagnosis and nature of the problem, makes decisions about lay referrals, provides moral and material support to the patient, and follows the patient to the various treatment providers selected, ultimately deciding on whether to continue treatment or not (Igun 1988: 55). In this context, the “decisions and actions involving dyads of sufferers and kinsmen, sufferers and specialist, and kinsmen and specialist, indicate that therapeutic action is usually motivated by diagnostic agreement based on shared information, worked out in the setting of structural congruence” (Janzen 1978: 3).

Like the family unit, tradition also plays a significant role in moulding the behaviour of individuals and groups since tradition includes the opinions, beliefs, and customs that are handed from one generation to another. Often patients make their treatment choice in accordance with their traditional culture, leading to either good or bad health-related choices. Various health-seeking behaviours that are informed by culture and tradition may ultimately involve harm. These “harmful traditional practices are traditionally and culturally based which transcends from one generation to the other and bears a harmful infliction to the human body. In most cases the harm caused is irreversible” (El-Yakub 1997: 38-44).

Padanu et al. (1988) investigated the role of traditional medicine in healthcare delivery in the Song LGA of Gongola (now Adamawa) State of Nigeria. The study examined the past and present role of traditional medicine as well as the types of traditional medical practices commonly patronized by the people in the LGA. The objectives of their study were to define illness behaviour in Song, to investigate what role traditional medicine

played in the LGA, and to advise the government on how to effect meaningful changes in the community congruent with cultural beliefs and practices. The authors hypothesized that, based on the antiquity of traditional medicine in that cultural context, the people of Song LGA would have a marked preference for traditional medicine over modern biomedical care. The study found that people attributed chronic illnesses to a variety of causes, including heredity, broken cultural rules, acts of God, and other supernatural forces. Acute illnesses, however, were thought to be caused by contagious infection, drug addiction, alcoholism, or unhygienic living conditions. In spite of their cultural orientation, most of those interviewed in the study chose modern medicine for treatment, but preferred traditional medicine for illnesses believed to be caused by supernatural powers like evil spirits, acts of God, or witchcraft.

In Africa generally, and Nigeria and Borno in particular, most harmful traditional practices are suffered by women. This is connected to their physical nature as well as the value placed on women in Nigerian society. The fact is that “harmful traditional practices affecting the life of men, women and children are various, but women being the carriers of a high percentage of the day-to-day problems, especially of child bearing and rearing, suffer most of the inflictions. More so, women are anatomically and physiologically prone to these inflictions by virtue of their society’s value on them” (Delano 1990: 67).

There is a link between some traditional health practices and the high maternal mortality rates in northern Nigeria. In fact, “northern Nigeria has a maternal mortality ratio greater than 1000 deaths per 100,000 live births and serious maternal morbidity, for example

vesico-vaginal fistula, is also common” (Renne 1997: 164). However, there are relatively few cases of vesico-vaginal fistula (known as the ‘Gishiri cut’) in Borno compared to Zaria, where Renne’s study was conducted. The lower rate in Borno may be due to the fact that the Gishiri cut is not practiced by Kanuris. The Zaria study further indicated that “among the most important factors contributing to this topical situation are an Islamic culture that undervalues women, a perceived social need for women’s reproductive capacities to be under strict male control, and the practice of purdah (wife seclusion), which restricts women’s access to medical care” (Renne 1997: 165).

Other negative health outcomes experienced by women were documented in an ethnographic study conducted by Platte (1998), a German anthropologist who was fluent in Kanuri and who lived and conducted her fieldwork in Musene (a typical rural village in Borno). In that study, a traditional birth attendant reported that one of the major problems involved in complications during childbirth happens when the laboring mother becomes unconscious. The TBAs also reported that they never attempt to cut the vagina, as done in other parts of the world. Instead, they apply salt to stretch and soften the tissue. Other treatments employed during labour included the application of onions and infusions of herbal solutions. Platte further reported that there were cases of early marriage that involved obstructed labour, that harmful health practices resulted because there were inadequate facilities to deal with obstetric emergencies in the clinics, and that there was universal female illiteracy as well as a political culture marked by corruption and inefficiency. According to her report, these factors have resulted in Musene having one of the worst records of female reproductive health in the world. Unlike Zaria, however,

Platte's research in Musene indicated that, although purdah was considered by many, none of the women were subjected to it and they all attended ante natal clinic. Such discrepancies support the theory that an accurate ethnographic assessment can only be produced when one stays with the local people to understand their language, terms and appreciate their culture before attempting to determine exactly how and why they behave the way they do (Glaser and Strauss 1967; Gilbert 1993: 168).

There was some agreement between the findings of the Musene study and the Zaria study, however. Identified variables affecting maternal health included age of marriage, harmful traditional health beliefs and practices, inadequate facilities to deal with obstetric emergencies, and a deteriorating economy. The Zaria study reported that menarche usually coincides with age of marriage, usually between the ages of twelve to thirteen. However, some elderly women reported that the usual age of marriage is six months after menarche, although data showed that most were married before that time as there was no clear marriage law. It can be argued that literacy levels in Borno are negatively affected by the fact that women marry at a time when they should have instead begun their secondary education.

The Musene study also uncovered certain harmful traditional practices and negative attitudes during pregnancy, such as food taboos involving avoidance of eggs and not having the evening meal. Such practices are detrimental to both mother and baby since avoiding foods rich in protein, a nutrient essential to pregnant mothers and foetuses, can result in nutritional deficiency. Furthermore, activities that are known to involve obstetric risk, such as carrying heavy loads, sleeping on one's belly, and engaging in sexual intercourse early in

pregnancy, were reported to be culturally acceptable. All of these may be categorized as harmful traditional practices. Furthermore, the Musene study also revealed that the women prefer traditional childbirth practices at home (*Suromuwo*) compared to going to a modern health facility, even though for other conditions they prefer to seek modern medical treatment rather than that of a traditional healer.

In cases of obstetric emergencies, the results of the Musene study validates the finding that in other areas of northern Nigeria, only 35% of the population had access to medical treatment. Modern medical care is particularly important for urgent gynecological conditions, because effective traditional medicine does not seem to exist in that field (Platte 1998: 53). This reinforces the idea that geographic factors motivate health-seeking behaviours, since geography affects variables such as proximity to health facilities, availability of roads to access such facilities, and availability of transport, all of which are major determinants of health-seeking behaviour. These factors are all relevant to Musene, which is located in a rural area that lacks an access road, market or motor park, and is situated in the far northeastern portion of Nigeria. From Musene, it would take approximately four hours in a four-wheel drive vehicle to reach the nearest hospital.

6.6 TRADITIONAL HEALTHCARE PRACTICES: THE ROLE OF RELIGION

There are a number of religious influences, both African and Islamic, which underlie the traditional healthcare practices of the Kanuri people in Borno state. For example, blood cupping (*Kangadigenata*) is validated by the Hadith, which states that it is desirable for

Muslims to have blood cupping done periodically. In his book *Healing with the Medicine of the Prophet*, Imam Ibn Quyim Al-Jauriziyah (2003) writes extensively on the subject of blood cupping. Ibn Majah narrated in one of the Hadith, specifically on blood cupping, that the Prophet said, “during the night of Israa (the overnight journey from Mecca to Jerusalem and then to the heavens), every company (of angels) that I passed by would say, ‘O Muhammad! Order your nation to use cupping.’ ” It is also narrated in the Sahihan that the Prophet was cupped by Abu Taybah. The Prophet paid him for that service and then said “cupping is among your best remedies.” The prophet disliked cupping the cavity of the nape of the neck because it reduces the memory power of the brain. The prophet further prescribed cupping to be done on the seventeenth, nineteenth or twenty-first day of the month, “so that the septic blood does not cause death to one of you.” There is therefore a clear linkage between *Kangadigenata*, as practiced by the Kanuris of Borno State who are entirely Muslim, and Islamic influence.

In addition to blood cupping, the Prophet Mohammed comments on several other practices, for example discouraging uvulectomy, and advocating for the treatment of *Karuwayebakta* and other conditions through Islamic prayers. There are two types of prayers in Islam: the five daily prayers, which are obligatory for all Muslims, and *duah* which is used as a remedy for challenges or problems. As narrated by Ai-Buhari in one of the Hadith, the Prophet said that “there is cure in three substances, a drink of honey, a slash with a knife used for cupping and cauterizing by fire. I forbid my Nation from cauterizing by fire.” From this passage, it can be deduced that drinking honey and practicing blood cupping are prescribed to Muslims as Islamic forms of treatment for various diseases and conditions.

With respect to the Prophet's guidance on treating tonsillitis and administering oral medication, it was narrated in Sahihan that the Prophet said, "cupping and marine costus (aloe) are among your best remedies; and do not torture your children by pressing their uvula to cure tonsillitis." It was also narrated in the Sunan and the Musnad (by Imam Ahmad) that Jabir said,

The messenger of Allah came to Aisha and saw a boy with a bleeding nose and said, 'What is this?' They said, he is suffering from tonsillitis, or a headache.' He said, "Woe unto you! Do not kill your children. Let the mother whose child is suffering from tonsillitis or headache scrub Indian costus (aloe) with water and then administer it to the child through the nose.' When Aisha ordered that the prescription be followed, the boy was cured.

The prophet discouraged physical tampering with the uvula as a way of treating children because of the harm it involves. This represents an interesting conflict between Islam and traditional health practices, since *dawugota* and *kelagota* are common traditional health practices of the Kanuri people who are predominantly Muslim.

The role of religion in determining healthcare practices is particularly complicated in the area of contraception. At the Federation of Muslim Women's Association of Nigeria (FOMWAN) in September 1994, women expressed their own interpretations of the Quran related to use of contraceptives. One woman, a medical doctor, noted that there are certain topics (including contraceptives) on which the Quran is silent. She was unable to find any passages where family planning or use of contraceptives were expressly prohibited. Their use, she concluded, is therefore subject to interpretation. For her, Quranic passages that enjoin husbands to protect the health of their wives and children mean that family planning is not designed to limit births but rather to ensure the ability to successfully raise existing

children. From this perspective, the use of contraceptives is neither blasphemous nor anti-Islamic if married partners agree to use them. The doctor concluded her remarks by observing that, if Allah does not agree with this perspective, no matter what humans may plan Allah will determine what will come to pass. This particular interpretation of contraception comes from a thorough knowledge of the Quran made by a literate Muslim Hausa woman.

There are additional aspects of the Quran which are used to guide women in their decisions about family planning. Several are thought to encourage or permit some forms of family planning. For instance, “married Muslim women attending adult Islamic education classes may be encouraged to practice *azal* (withdrawal) because it is specifically mentioned in religious texts” (Sobo and Russell 1997: 128). However, those who oppose any form of fertility control or contraceptive use argue that only Allah can make such life and death decisions (Renne 1997: 172). Furthermore, strict religious leaders like the Mallam of Borno argue that since modern contraceptives are not literally mentioned in the Quran, their use is prohibited. He has stated:

It’s always good for people to stick to their understanding of what Islamic law is saying or what the prophet said. Now, the prophet showed a lot of things. First of all, He didn’t talk these things coming, these tablets, condoms, and so on and so forth and then if He approved, there were many things which He pointed to that they will come but He didn’t give to these things coming. . . But in this case he did not pinpoint. And even the pills and the condom they also have their own dangers and problems, so certainly the Prophet wouldn’t have recommended them.

6.7 CONCLUSION

Culture is seen to play a great role in determining the healthcare norms for the population, even when such norms produce negative health outcomes. For example, TBAs are held in high esteem and their treatment is preferred over hospital deliveries, particularly if it is the first delivery for the family. However, alongside this culturally-informed choice of birth attendants is the unacceptably high rate of maternal mortality among women in the region. It seems that the practice that is acceptable to the majority is the very one that is claiming the life of mothers. What a paradox! Perhaps the paradox can be more effectively addressed by acknowledging the need to bring the two systems of medicine together, benefiting from the strengths of both systems and from the ability of one system to compensate for the weaknesses of the other, particularly those of traditional medicine. It is obvious that traditional medicine has a part to play in the healthcare delivery system of Borno. The people of Borno, particularly the Kanuris, remain very traditional in their cultural beliefs and practices. A strategy for integrating the two systems is essential to the health of the populace, especially since the people simultaneously access both traditional and modern medical care. In Nigeria, and in Borno particularly, the two systems of healthcare interact in a complementary manner, and each impacts the health status of the people. In my opinion, they are opposite sides of the same coin. Yet the paradox reflected in my own life experience and in my professional role as a participant observer will not go away. It is time to move on to my own empirical research into the attitudes and beliefs of the different groups of people relevant to my attempts at its resolution.

CHAPTER SEVEN

VIEWS OF BIOMEDICAL PROFESSIONALS ON SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES

7.0 INTRODUCTION

This chapter reports on the views of the biomedical health practitioners on some of the traditional health practices. The chapter represents a significant step toward integrating the two systems, and it could be utilized in policy-making and planning. Currently, there is very little research being done on traditional medicine, and none is being conducted in Borno specifically. The situation represents a potential opportunity, as the biomedical system does not reject traditional medicine across the board but rather views traditional medicine, for the most part, as largely acceptable. However, biomedical professionals trained in the west are very negative about integrating traditional practices into modern medicine, particularly because some are seen as especially harmful.

I conducted focus group discussions (FGD) with biomedical practitioners using a questionnaire that I designed for this purpose, since no standard tool existed prior to the commencement of my study. The professionals who participated in the discussions were selected within the sampled health zones of the state, representing Borno North, Central and Southern Zonal Health Areas, as well as the nineteen Kanuri-speaking LGAs in the state. Detailed information on the fieldwork methods employed is included in chapter 3. The discussions were conducted in English and Kanuri as appropriate, and the sample was drawn

from maternity units in the above LGAs where the head of the unit was Kanuri. Ten registered nurse-midwives in charge of maternity units were invited for the FGD and eight accepted the invitation.

The professional respondents include midwives (Kanuri and non-Kanuri) and medical doctors (Kanuri and non-Kanuri). The medical doctors were Principal Medical Officers in charge of general hospitals, while the midwives were in charge of maternity units in the general hospitals in Borno. This resulted in four categories of respondents, including Kanuri midwives, non-Kanuri midwives, Kanuri doctors and non-Kanuri doctors. These categories were included in order to portray a wide range of views and opinions. Given the auto-ethnographic nature of this work, I also recognized that it was important to involve both those professions who have a wealth of practical experience, as I do, as well as those who have trained and practice within their local communities. This balanced approach ensures that all aspects of the issue are adequately represented.

7.1 RESPONSES OF THE BIOMEDICAL HEALTH PROFESSIONALS REGARDING SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES

The biomedical professionals were asked about traditional health practices including lifting of the head (*kelagota*), uvulectomy (*dawugota*), tribal marks(*berikaro*), child birth (*suromuwo*), correction of prolapsed uterus (*kawugota*), forced feeding (*tadatafta*), jaundice (*shimkiri*), traditional bone setting (*shilashiwolta*) and affliction by evil spirits

(*karuwayebakta*). In each case I first recap on the practice itself, as well as any harm involved, before presenting the responses from the FGDs to each form of treatment.

7. 1.1 *Kelagota*

The traditional practice for dealing with falling of the head (*kelayekero*) is called lifting of head (*kelagota*). Fallen head is a condition characterized by persistent headache, vomiting and an inability to look up. When a combination of these symptoms are observed, the patient is taken to the traditional *kelagotama* who confirms the diagnosis. The native *kelagotama* detects the condition by asking the patient to look up, and assesses the patient's forehead and checks for an unusual smell in the nose. The treatment is performed either by massaging the nape of the neck or by putting a finger into the patient's throat and lifting upward on the inner gums. The treatment may also involve bloodletting or removal of pus. The act of examining the depressed fontanelles that are associated with headache in children and the treatments performed by the *Kelagotama* can have serious negative implications. The act of putting fingers into the mouth to press the soft palate, as done by the *kelagotama*, can often lead to puncturing the soft palate which is "harmful" and may result in bleeding, infection and even death.

7.1.2 *Dawugota*

The removal of the uvula by traditional healers is carried out as routine preventive care to ensure against growth retardation in children, and is performed on adults for curative purposes. The removal is done by the *wanzama* who uses a sharp, curved knife. It is done

between the seventh to the fortieth day following a baby's birth, although it can be done anytime in older children and adults. Following the procedure, the patient is advised to drink hot salt water drink for the first twenty-four to thirty-two hours after the removal. The cutting of the uvula is mostly done with dirty or contaminated instruments which may cause infection or severe bleeding which may result in haemorrhage and death. The procedure is very harmful, and there were several cases of death known to have been caused by uvulectomy.

7.1.3 *Berikaro/Dawukirikaro*

Tribal marks are performed by the local barber using his knife. The procedure is done on the day of a baby's naming ceremony, which is always the seventh day after birth. The Kanuris have nine marks, given for identification and as a mark of beauty. Some get the marks done on the abdomen (*dawukirikaro*) for the prevention of abdominal colic in children and other abdominal disorders in adult life. Although Kanuris believe that the procedure removes black blood, the presence of which can harm the body, it is also true that the use of a contaminated blade may cause infection, and excessive bleeding can lead to anaemia, resulting in significant complications.

7.1.4 *Suromuwo*

This traditional childbirth attendant, the *suromuwoma*, is often an elderly woman in the community who performs deliveries at home. *Suromuwomas* usually keep a labouring

woman on the traditional stool known as a *buwur*. The care they provide can take many forms, from dispensing herbs to reading from the Holy Quran. Some of these *suromowumas* are experienced in predicting labour and delivery times. If well trained, they are able to conduct normal deliveries at home, but in cases of complicated labour and especially when there are high-risks cases, their practice may be harmful. There are some cases of recorded complications and death caused by their actions.

7.1.5 *Kawugota*

Kawugota involves the correction of a prolapsed uterus or any other prolapsed female reproductive organ. The prolapse is diagnosed when a woman complains of persistent backache or vulva pain after labour, especially following prolonged labour. Treatment is done by the *kawugotama* who specialises in correction of uterine prolapsed. The procedure varies and often involves a process of trial and error. The *kawugotama* usually puts cotton wool inside the vagina, lifts the cervix with it, and turns the woman upside down for a couple of minutes. There are harmful implications to this practice. Turning a patient upside down may cause discomfort, and placing unsterilised cotton inside the vagina may damage soft tissue in the female reproductive tract, leading to infection, vesico-vaginal fistula (VVF), or recto-vaginal fistula (RVF).

7.1.6 *Tadatafta*

Force feeding of infants is primarily carried out by mothers. If the mother is inexperienced in the practice of forced feeding, the *suromuwoma* teaches her how to do it. *Tadatafta* involves laying the baby upside down on the mother's lap and blocking the nostrils, while pouring the pap into the baby's mouth. The baby has to gulp the pap in order to clear its mouth to breathe. This practice is normative in Kanuri culture, especially among rural families. Sometimes it is adopted when there is insufficient breast milk, or when a baby has a poor appetite caused by illness. Others choose to overfeed their infants in order to make them sleep longer periods, so that the mother will have enough time to carry out her domestic work. The act of forced feeding may result in suffocation because the nose is blocked, and the child has to struggle for oxygen while swallowing food, leading to choking and even death. Cases of death from this procedure have been documented. The practice is very harmful, and should be eliminated.

7.1.7 *Karuwayebakta*

The treatment provided by *kermallam* is regarded as effective because of its spiritual and psychological approach.

7.2 RESULTS OF FGD WITH THE KANURI MIDWIVES

Kanuri nurse-midwives perceived several of the Kanuri traditional health practices described above to be very harmful and a cause of infection. Blood cupping (*kangadigenata*) and correction of fallen head (*kelayekero*) were cited as harmful because of the use of an

unsterilised blade by the local barber (*wanzama*), and by the lack of antiseptic procedures used by the *kelagotama* in cases of fallen head, both of which may expose patients to contracting diseases like HIV/AIDS. The same concerns were expressed for uvulectomy (*dawugota*), which the respondents perceived as very harmful since the uvula naturally helps prevent infection and is therefore very important to the health of a child. The traditional practices related to forced feeding (*tadatafta*), tribal marks, and uvulectomy were felt to be totally unacceptable. One respondent reported an instance in which a child lost her voice following uvulectomy, and another commented on the severe risk of infection caused by many of these traditional practices. Tribal marks on the face and abdomen, uvulectomy, and bloodletting are all done without sterilization of implements, and the resulting risk of infection meant that there was no possible advantage to receiving traditional as opposed to modern medical care for these ailments. Treatment of jaundice (*shimkiri*), correction of prolapsed uterus (*kawugota*), bone setting (*shilashiwolta*), child birth (*suromuwo*), and *karuwayebakta* were perceived to be harmful as well, although one respondent felt that *suromuwo* could be beneficial in cases of normal labour. The respondents preferred that all of these conditions be treated in the hospital whenever possible. *Berikaro/dawukirikaro* was not perceived as harmful as long as antiseptic techniques were used and prevention of HIV/AIDS was ensured. The Kanuri nurse-midwives also felt that bonesetters could serve an important function and could possibly be used in consultation for the treatment of fracture. However, such consultation was only felt to be appropriate in cases of fracture where there was no open wound, and bone setting by a traditional healer was primarily useful only in a rural setting where modern health facilities were unavailable. However, one respondent noted that bonesetters are sometimes capable of treating complex fractures, and cited an

instance in which her mother suffered a serious fracture which could not be fixed in the hospital. Upon receiving treatment from a traditional bonesetter, her fracture was healed.

It is clear from the above points that the overriding concern about traditional healing techniques involved noncompliance with antiseptic practices. However, the respondent whose mother had received treatment from a traditional bonesetter is an example of someone advocating some traditional healthcare practices when treatment provided by the modern health care system failed. The Kanuri nurse-midwives advocated a strategy for the coexistence of the traditional and modern systems based on the creation of government workshops designed to foster a good working relationship between the two groups of practitioners. They particularly recommended workshops that could teach *Wanzama* (traditional barbers) proper skills and reveal the relative advantages and disadvantages of their practices. They advised soliciting the state government to establish standard guidelines for the operation of the workshops. Overall, the Kanuri nurse-midwives made several key recommendations for the improvement of traditional healthcare practices. These included giving incentives of various sorts to traditional practitioners to participate in an integrated health care delivery system, creating awareness about the implications of their practices, and organizing periodic training opportunities. Additionally, they recommended that the media be used to educate people about the use of traditional medicine, and that the government should provide guidelines about how traditional healers should operate so as not to cause harm to patients. Finally, they felt that the government should encourage traditional healers to form cooperatives.

The Kanuri nurse-midwives also discussed strategies to reduce maternal and infant mortality among the Kanuri. They cited a need to empower primary health facilities, since these serve as the entry point for the entire healthcare system. Furthermore, they felt that emphasis should be placed on community mobilization, extensive public health education, discouragement of early marriage and other practices harmful to health, as well as encouragement of home visits, personal hygiene, routine immunization, good nutrition, proper antenatal care and hospital-based deliveries.

7.3 RESULTS OF FGD WITH NON-KANURI MIDWIVES

All the non-Kanuri midwives who participated in the FGD were able to identify at least four Kanuri traditional health practices and one participant was familiar with six. Out of the fourteen practices discussed during the focus group, *dawugota* was the most frequently mentioned and was familiar to all of the participants. *Kawugota*, *kelayekero* and *shilashiwolta* were also mentioned frequently, while the other traditional practices were not discussed frequently. The general perception of the non-Kanuri midwives was that *dawugota* (uvulectomy) was the most harmful traditional treatment. One participant revealed a very personal experience with this practice, stating: “I hate to see it done because I lost my child to it. It is very bad and may Allah forbid all bad things including *dawugota*.” The participant considers those who practice *dawugota* to be ‘butchers of human beings’, and another participant said that she was aware of a ‘lovely boy’ who died following the procedure only two days prior to the FGD.

Other traditional practices were also perceived by the non-Kanuri midwives as harmful. They noted that *kangadigenata* (blood cupping) often fails to provide adequate treatment, and the patient is left with complications which may eventually lead to death. Similarly, the participants felt that *kawugota* (correction of prolapsed uterus) is likely to result in death in most cases. One participant shared a personal experience with this practice. Following the birth of her eighth child and subsequent *kawugota* treatment, she lost her ability to walk and the baby began walking before the mother herself was able to regain her ability to walk. *Kelayekero* (correction of fallen head) was also cited as a harmful practice. One participant attributed the death of her mother to this practice, and another participant claimed to have had a very negative experience with this practice but declined to disclose the specific details. However, she did state that she hates to hear about the practice being done and felt that it should be banned. *Tadatafta* (forced feeding) was also considered very harmful because it so often causes severe choking in the child and may result in death. One participant noted that “in fact, anything forced is bad, and only heartless mothers [engage in *tadatafta*]”. Finally, *shimkiri* was viewed as a harmful practice even though participants recognized the inability of orthodox medicine to effectively treat jaundice. Participants noted that *shimkiri* often results in excessive vomiting.

The non-Kanuri midwives did cite several benefits from certain traditional practices. They felt that *suromurwo* (traditional child birth) is good for rural women because of the lack of access to modern medical care in rural areas. However, they felt that TBAs are limited in their ability to handle complicated cases, and these cases should always be referred to the nearest health centre. They also suggested that TBAs be trained on basic antiseptic

techniques. *Karuwayebakta* (affliction by evil spirits/mental illness) was also perceived as beneficial because the disease was viewed as spiritual in nature, rather than physiological. Therefore *Mallams* were seen as the only ones capable of handling this condition since the healing involved was ultimately “something beyond human knowledge”. Several traditional practices were cited as beneficial, but with more mixed views about their safety presented by the group. *Berikaro/dawukirikaro* (tribal cutting) was considered beneficial because it serves to preserve Kanuri culture, but the participants noted that antiseptic techniques need to be properly observed, and one participant cautioned about the potential for transmission of HIV. Another participant felt that she would not choose to have this procedure performed on her children or grandchildren. Similarly, *shilashiwolta* (bone setting) was viewed as a positive practice that should be encouraged when there was no tearing, although use of pain killers was recommended. However, other participants perceived it as harmful and noted that the practice varies considerably from one individual to another. One participant stated that her cousin had lost an arm to this practice.

The non-Kanuri midwives discussed their preferred mode of treatment for each of the conditions related to the traditional practices. They preferred use of orthodox medicine for *kangadigenata*, *suromuwo* and *shimkiri*, traditional healing practices for *berikaro/dawukirikaro* (provided that antiseptic techniques were followed), and a combination of orthodox and traditional healing for *kelagota*, *Shilashilashiwolta* and *Karuawyebakta*. *Tadatafta* and *dawugota* were regarded as entirely harmful, and the participants felt that these practices should not take place under any circumstances.

The participants in this FGD cited many disadvantages associated with traditional Kanuri health practices compared to modern biomedicine. They stated that many of the practices predispose patients to anaemia, severe infections including HIV/AIDS, and that complications could lead to lack of rest, mental illness, and even death. Specifically, they felt that *kangadigenata* (blood cupping) causes excessive bleeding and creates a risk of anemia, leaves a big scar, causes infection, and may expose patients to HIV. Likewise, they indicated that *Kelagota* can complicate headaches, cause infection, excessive bleeding, and damages the brain, leading often to madness or death. They reiterated their firm opposition to the practices of *dawugota* and *tadatafta*. They pointed out that *dawugota* can cause excessive bleeding, injury to the soft tissue of the mouth and throat, and may cause a baby to lose its voice and/or bleed to death. They felt that the severe risks involved in *tadatafta* included choking and suffocation, which may lead to the instant death of the baby. Participants also felt that forced feeding was entirely unnecessary, and that hospitals are able to offer alternative feeding arrangements, such as use of intravenous fluid, for any infants requiring nutritional support. *Berikaro/dawukirikaro* received more mixed reviews. Participants felt that it has the potential to cause accident, injury, infection, swollen scar tissue and itching, but did note some benefit to its role in preserving Kanuri culture. *Suromuwo* was also felt to involve potential benefits, although this practice was not without its own risks. Participants felt that it was beneficial for patients who were healthy or who lived in areas where modern health facilities were not available, and they noted some benefit associated with the fact that mothers did not need to leave the home for all of the traditional rites to be performed. However, they felt that *suromuwo* was not appropriate for complicated cases, and that a *suroma* needed to be extremely aware of her own limits in handling such

cases. They also stated that the traditional practice involves visitors who prevent the mother from getting adequate rest, and may lead to the death of mother and/or baby.

The non-Kanuri midwives discussed some strategies for integrating traditional medicine into modern medical practice. They suggested that training should be provided to traditional practitioners in order to educate them on modern treatment techniques, give them information on the proper use of herbal medicine, and inform them about preventing infection and other complications. They especially emphasized the need for such training among TBAs, since they are the most accessible to people living in rural areas. Other strategies discussed included the creation of a traditional health board, establishing standards and qualifications for traditional healers in order to keep “quacks” from harming patients, and giving legal backing to traditional healers so that they can operate under the supervision of medical doctors in their field. They suggested using the traditional bonesetters as a pilot for this work. Overall, they were in favour of traditional healers being employed by and integrated into the modern system.

The strategy for reduction of infant and maternal mortality advocated by the non-Kanuri midwives involved empowerment of primary health care providers, and discouragement of harmful traditional practices that negatively impact mothers and children. They also indicated the need to immunize all children, improve health education through widespread distribution of health-related information. They favoured education and training of traditional healers on the dangers associated with their practices, and on understanding the limits of their competence beyond which they should refer patients on to biomedical facilities.

7.4 RESULTS OF FGD WITH KANURI MEDICAL DOCTORS

The Kanuri medical doctors were familiar with and able to describe the various traditional Kanuri health practices. *Kelagota* was described as the most harmful of the traditional surgical interventions. One participant described his personal experience with this procedure, stating that it had been extremely uncomfortable. He said:

The irony of the whole thing was, I do not know if the person that did it on me is just dirty or not. The thumb fingernail was so long and it looks so hardened and dirty. So later I had to regurgitate, gargling my mouth with salt and water because of the injury inflicted on me.

The Kanuri doctors also felt that the *Wanzamas* who perform *Dawugota* are considered to be black wizards with supernatural powers. When *Dawugota* is performed, the cut uvula may or may not be presented to the patient. When it is presented, it assures the parents that the uvula has been removed. However, if it is not presented, the parents do not ask for fear of terrible consequences. *Berikaro* means facial tribal marks while *Dawukirikaro* means stomach scarification. This is done because it is believed that it aids the healing process of the umbilical cord. It is believed that there is a collection of blood in that area which needs to be drained. Distinction was made between the two scarifications with *Berikaro* being unique to the Kanuri in terms of the number and position on the face. Traditional birth attendants are said to use charms and dried flowers, which are considered harmful. However, they are perceived to be very relevant in the Primary Health Care setting and need to be re-trained to be more efficient, especially in aseptic techniques related to cord care.

7.5 RESULT OF FGD WITH NON-KANURI MEDICAL DOCTORS

The non-Kanuri medical doctors were able to mention and describe many of the Kanuri traditional health practices. Similar to other FGDs, the participants in this focus group felt that *dawugota* is extremely harmful, is likely to cause infection and other complications, and should be discouraged. They also noted that the uvula has an important physiological function and should not be removed. Likewise, they felt that *tadatafta* (forced feeding) is without any potential benefit, and advocated for the discontinuation of this practice. With regard to other aspects of traditional health medicine, the non-Kanuri doctors considered both risks and benefits associated with the traditional practices. They felt that *shimkiri*, the traditional treatment for jaundice, was not advisable, since the remedy has a toxic effect on the liver, the very organ involved in jaundice, and may therefore actually aggravate the condition. However, they felt that this treatment, when done with caution, could be useful when biomedical treatment for jaundice fails. The doctors were not necessarily opposed to the use of *berikaro/dawukirikaro* (tribal marks) because these marks impart cultural identity, but did note that there is potential for infection that could be serious. The participants were also not opposed to the practice of traditional birth attendants, recognizing that they serve an important function in providing health care, especially in rural areas. However, they also recognized that TBAs need to receive proper training in order to deliver safe, high-quality care. Traditional bone setting was viewed as generally acceptable by one of the respondents, who stated:

I saw a case where a patient's leg was slated for amputation but the relatives took him against medical advice. The same case was treated by the *Shilashiwoltama* and now that person is perfect with his leg. I could vividly recall when I was small I had a fracture and though my parents were educated, they never took me to the hospital. A traditional bonesetter treated me. I therefore don't see anything bad in traditional bone setting.

The non-Kanuri Medical Doctors discussed strategies for reducing the harmful effects of traditional health practices. They suggested embarking on a large-scale public health campaign targeted at mothers (Kanuri and non-Kanuri), traditional healers (Kanuri and non-Kanuri), and the entire Kanuri population. They also advocated for the general improvement of health care delivery and for enhanced cooperation between biomedical and traditional practitioners.

7.6 CONCLUSION

The general view expressed throughout the different focus groups was that most, if not all, the traditional practices were harmful in some way. The medical professionals felt that the conditions involved in these practices are better treated in a hospital setting, although some felt that traditional healing techniques could be helpful when used with caution. Most notably, they were in favour of traditional techniques where long-term, continued care is required, such as for psychological disorders like schizophrenia or when irreversible damage from conditions such as stroke occurred. Some of the medical professionals felt that traditional practices could be improved by enhancing the beneficial aspects of traditional medicine while removing the harmful aspects. However, all four categories of respondents indicated that they were mostly uninterested in seeking traditional treatments because of their enormous disadvantages and potential to cause significant harm, including bleeding, injury, pain, infection, and deformities either during or following the procedure. They therefore felt that the disadvantages of the traditional practices outweighed the benefits, although they

could envision potential improvements in traditional techniques that might remedy some of the disadvantages. Improvements in traditional care were felt to be especially important for those in rural areas, for whom modern facilities are not accessible or affordable. Therefore, they were firmly in support of integrating traditional practices into the modern healthcare system, particularly in the traditional settings of rural Borno where cultural traditions are respected and accepted.

The Kanuri doctors viewed *Kangadigenata Kelayekero*, *Dawugota*, *Kawugota*, *Tadatafta Shimkiri Shilashowolta* and *karuwayebakta* as harmful while *Berikaro* and *suromuwo* were viewed as beneficial. However, the non-Kanuri doctors viewed *Suromowu* and *Shilashiwolta* as positive while the rest were considered negative. Interestingly, there was no significant difference between the views expressed by the Kanuri doctors and those of the non-Kanuri doctors. The Kanuri midwives considered *Berikaro* (tribal marks) and *Suromowu* to be beneficial practices, while all the rest were seen as harmful. By contrast, the non-Kanuri midwives viewed *Suromowu* and *Shilashiwolta* as good traditional health practices while the rest of the practices were seen as detrimental.

Similar to what I have experienced in my paradoxical role, these health professionals all saw the wisdom of improving traditional healthcare, even in the face of western scientific training and modern healthcare practices. In their view, the strategies required to incorporate traditional medicine into the modern system included the establishment of a good working relationship with the traditional healers, and organising workshops or conferences aimed at differentiating between harmful and beneficial traditional practices so that the former can be

eliminated while the latter can be encouraged. They also recommended that traditional healers be employed in the civil service and adequately remunerated. Finally, they felt that it would be important to offer integrated health services in village communities that would enable traditional practitioners to work side-by-side with modern healthcare professionals.

The focus group discussions also produced some recommendations for reducing the high rate of maternal and infant mortality in Borno State. The medical professionals suggested empowering primary health care providers, encouraging proper antenatal care, undertaking public health campaigns to educate the populace on living a healthy lifestyle, and dispensing information to mothers about their health and that of their children. They also were inclined to discourage those traditional health practices which were harmful, and encourage those that were beneficial. They felt that where traditional birth attendants were practicing, they should be encouraged to support hospital-based deliveries for complicated cases. In general, these professionals were in full support of incorporating traditional medicine into the modern healthcare system as has been done in other parts of the world. They advocated the formation of a traditional health board, noting that out of the entire Nigerian Federation, only Borno State lacks such a board. They recommended that the board be provided with adequate funding, and that it be involved in training traditional healers in areas such as cleanliness, sterilization, infection control and disease prevention. They felt that traditional healers should be allowed to practice within the hospitals in the LGAs where they would be able to work under the supervision of modern medical professionals.

This chapter has documented the views of four categories of health professionals on the traditional health practices common in Borno State. Contrary to expectations, these groups were not entirely opposed to traditional health practices, but rather encouraged integration of the two particularly in rural areas where access to biomedical services is limited. The views of the traditional practitioners themselves, and users of health services, are presented in the following chapter.

CHAPTER EIGHT

VIEWS OF LAY PEOPLE AND TRADITIONAL PRACTITIONERS ON SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES

8.0 INTRODUCTION

This chapter reports on the views of several categories of traditional healers, including traditional birth attendants, urban mothers, rural mothers, and a traditional Kanuri bonesetter. Views on the Kanuri traditional health practices were obtained through FGDs and an in-depth interview using a questionnaire. The respondents were selected within the sampled health zones of the state, which were the same as the ones from which the health professionals were drawn, and the data were collected during the same two-year period. All of the discussions were conducted in Kanuri, with the exception of the discussion with the traditional healer which was conducted in Hausa. The discussions were facilitated by me while a field officer I trained assisted in taking notes. The in-depth interview was conducted and recorded by me.

8.1 RESULTS OF KANURI TRADITIONAL HEALTH PRACTITIONERS ON KANURI TRADITIONAL HEALTH PRACTICES IN FGD

The Kanuri traditional health practitioners viewed all of the traditional health practices as beneficial. They noted specific advantages of the various forms of treatment,

including the ability of *kangadigenata* to drain body fluids, relieve swelling and reduce discomfort. Similarly, they pointed out that *kelayekero* tends to relieve severe headache, *kawugota* allows for the repositioning of female reproductive organs, and *tadatafta* can be helpful for babies who are not getting adequate nutrition due to illness. Overall, they saw traditional practices as helpful, cheap and effective, and able to successfully relieve pain, treat headache, or stop excessive vomiting. They described *berikaro* as imparting a sense of cultural belonging and beautifying one's face, and *shilashiwalta* as useful in setting broken bones.

The traditional health practitioners saw no disadvantages associated with traditional medicine. They preferred the use of traditional remedies for all conditions, because each ailment was addressed by a practitioner who specialized in treating that condition. They also criticized the English-based system for its ignorance of things like *dawugota*, and felt that the hospitals were best suited to those assimilated into English culture who are referred to as *nasara kamsullumbe* (literally meaning 'a white man with black skin').

In order to incorporate traditional medicine into the modern medical system, the Kanuri traditional health practitioners suggested that the government integrate traditional practices into hospital-based settings, that the government organize conferences to train healers on the safe dispensing of drugs, and that the government provide incentives to the traditional healers to participate in the larger health system. They also felt that it was important for the traditional healers to organize and communicate with the government as a unified collective in order to get the government to listen to their views. Furthermore, they

felt that the government should subsidize the cost of healthcare services, and should utilize traditional healers to increase community awareness about health and bring healthcare ‘to the doorsteps of the people’. They advocated the employment of traditional practitioners in the hospitals, and recommended educating the healers about modern techniques and methods in order to greatly improve health services.

The Kanuri traditional healthcare practitioners also made some recommendations for the reduction of maternal and infant mortality. These included the provision of high-quality traditional care with enhanced training of traditional healers, especially TBAs. They also called for the distribution of adequate nutrition to mothers and children, and improvement of the economy in general. They suggested that mothers should observe all traditional customs and practices during pregnancy, delivery, and lactation, and that they should patronize traditional healers whenever necessary. Above all, mothers should be advised to ‘pray for the best’.

8.2 RESULTS OF KANURI TRADITIONAL BIRTH ATTENDANTS ON SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES IN FGD

The Kanuri TBAs perceived virtually all aspects of traditional medicine as positive, citing *kangadigenata*, *kelayekero*, *berikaro*, *suromuwo*, *kawugota*, *shilashiwolta* and *Karuwayebakta* as particularly beneficial. The TBAs preferred traditional treatments for all the conditions discussed, and felt that traditional practices were cheaper, more accessible, more convenient, highly effective, and in accordance with their cultural identities and

preferences. The only disadvantages they discussed involved *tadatafta* and *shimkiri*. The TBAs felt that both of these practices were generally appropriate and could be useful, but that they did entail a certain risk of harm. *Tadatafta* was potentially harmful to infants, and *shimkiri* involved a risk of death due to severe vomiting caused by oral intake of bitter herbs.

The TBAs made several recommendations for the improvement of traditional health practices. First, they suggested that the government provide more funds for traditional healers. They also wished to see the government taking the use of traditional medicine more seriously, especially by fostering understanding between the traditional and biomedical practitioners. They also advocated that traditional healers should be empowered so that they could practice with safety, and felt that the healers should ‘pray very hard’ for their own improvement. The TBAs felt that in order for traditional and modern medicine to effectively coexist, the government needed to formally recognize traditional medicine, provide a salary to traditional healers on par with their counterparts in modern medical practices, allow them to practice in modern medical facilities, and to enhance training for traditional healers.

The TBAs discussed strategies for reducing maternal and infant mortality in the Kanuri communities of Borno State. Specific points considered included a recommendation that TBAs pray and work hard in support of maternal health, that adequate food be provided to mothers, and that the government unite the efforts of traditional and modern healthcare practitioners and allow the work of each to complement the other. Additionally, the TBAs felt that women should be taught to understand what is good for them during pregnancy, and any operations or harmful traditional practices performed on pregnant women should be

discouraged. They suggested, too, that the government set aside funds specifically devoted to the reduction of high mortality rates within Kanuri communities. Finally, the TBAs indicated that prayers performed by *Mallams* were very important.

8.3 VIEW OF THE TRADITIONAL BONE-SETTER IN AN INTERVIEW

The traditional bonesetter who took part in this interview was an elderly man who had been in practice for forty years. He is well-versed and extremely knowledgeable in traditional bone setting techniques, and inherited his knowledge and skills in this area from his father. He described his method of diagnosing fracture, and stated that a fracture is identified by putting pressure on the affected area, manipulating it, and listening for a characteristic sound produced by a disconnected bone. For fractures that have broken the skin, the bonesetter's treatment involves manipulating the broken bones to fit the two edges back together, after which he applies *santrum* (charcoal) to the wound to dry it out and expedite healing. Additionally, he noted that some bonesetters use chicken and/or ostrich fat and skin in cases where a patient's skin has been severely damaged. After applying these treatments, the broken bone is immobilized with wooden sticks tied together using clean rags as bandages.

The bonesetter also elaborated on different methods of diagnosis depending on whether a shin bone or femur is involved. Since a femur is covered with more flesh than a shin bone, a fractured femur must be handled even more carefully in order to prevent serious

harm. When treating a broken femur, he described how two strong men typically hold a patient's entire body down, pulling steadily while the bonesetter sets and immobilizes the fractured area. About six nine-inch blocks are used to support the femur bone after the bone is immobilized with sticks and tied with rags. The bonesetter also noted that it can be "harmful" to shake the bones at any stage of the setting. In a situation where the fractured area experiences swelling resulting from being tightly tied, the bonesetter loosens the bindings and reties them in such a way that blood is able to flow freely to the area. Following treatment for a broken bone, the bonesetter recommends that all patients consume meat and chicken. Furthermore, he felt that a procaine penicillin injection decreases healing time. He believed that if treatments were handled properly, all patients have a 100 percent chance of healing from a broken bone.

The bonesetter also described how reassessment of a fractured bone may be necessary, and further described circumstances in which referral to another healer is warranted. He felt that reassessment was necessary if a patient moved a lot after the bone was set and tied in place, or when the tying or manipulation were not initially done properly. Referrals were made to other traditional bonesetters in some instances. Fractures that did not heal properly could be rebroken and set again by the healer who had initially treated a patient, or the case might be referred to another healer for subsequent treatment.

8.4 RESULTS OF URBAN WOMEN ON SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES IN FGD

The urban women in this FGD had more mixed views on the relative safety of, and benefits associated with, various traditional practices. They viewed *berikaro*, *suromuwo* and *karuwayebakta* as very beneficial, but felt that *kelayekero* and *shilashiwolta* involved both benefit and harm to patients. The women felt that *kangadigenata*, *dawugota*, *kawugota*, *tadatafat* and *shimkiri* were harmful practices. The group cited certain benefits of traditional medicine, including the cheaper cost of treatments and ease of access to traditional healers. They also discussed the fact that some conditions are only recognized in a traditional context and therefore can only be treated by traditional healers. However, they recognized key disadvantages, as well. Some treatments were seen as harmful, such as *Dawugota*, and some were felt not to be particularly effective. The women viewed the traditional healers as operating on a trial-and-error basis. Overall, these women preferred both traditional and modern medicine for all of the conditions discussed. Their preferred mode of treatment involved seeking out a hospital, nearby chemist, or traditional healer depending on the condition involved or where a husband indicated that treatment should be received.

In discussing strategies for the integration of traditional and modern medicine, the urban women thought that the government should offer training to traditional healthcare practitioners, and identify ‘best practices’ among traditional healers to be used as complimentary care alongside modern medical care. In particular, *suromuwo* and *shilashiwolta* were suggested as being appropriate for integrated care. They also suggested that the media become involved in integration efforts by promoting traditional medicine through drama. They wished to see indigenous traditional healers coming together and presenting a model for the integration and co-existence of traditional and modern medicine to

the government. They suggested that passage of a bill aimed at improving traditional medicine and promoting acceptance of traditional healers would serve to prevent fraudulent traditional healers from practicing on patients. Furthermore, they felt that NAFDAC (the National Agency for Food and Drug Administration and Control) should be responsible for overseeing and controlling all medicines. They suggested that the government provide funding for research on traditional medicine, and that it set aside funds for traditional medicine like it has for poverty alleviation and enhancing primary education. Finally, the urban women felt that women should form an advocacy group to address issues related to traditional medicine.

The urban women made many recommendations for the reduction of maternal and infant mortality in the Kanuri communities of Borno State. They advocated traditional family planning methods in accordance with Kanuri culture, which involve fathers arranging for their wives to give birth in turn as scheduled and at their choice. They also felt that mothers should be better educated on eating a balanced diet, while fathers should take responsibility for providing food to their wives and family. Women should be encouraged to attend antenatal clinics, and environmental strategies aimed at mosquito control should be made a top priority. Finally, the participants recommended that women should form NGO's designed to address harmful maternal health practices. They felt that the government should involve more women in management and policy making, especially in areas related to health, education, justice and women's affairs.

8.5 RESULTS OF RURAL MOTHERS ON SOME OF THE KANURI TRADITIONAL HEALTH PRACTICES IN FGD

The rural mothers viewed many of the Kanuri traditional health practices as very beneficial, including *kangadigenata*, *kelayekero*, *suromuwo*, *kawugota*, *shimkiri*, and *karuwayebakta* and *shilashowalta*. However, they felt that *tadatafta* is a harmful practice, as is *dawugota* which can cause serious infection. One participant revealed that she had lost her child to *dawugota*, and another participant knew of three children who had died following the procedure. Yet another participant had undergone this treatment herself and characterized it as “a painful experience”. Despite some potential harm, the rural mothers felt that traditional medicine was desirable because it is readily available, effective, inexpensive, and has few side effects. These women saw few disadvantages to traditional medicine as long as herbs were taken as instructed. Although one participant reported that her preferred mode of treatment depended on the nature of the condition, overall the rural mothers preferred traditional treatments for their healthcare. They felt that none of the conditions discussed could be treated adequately in a hospital, that the cost of modern care was prohibitive, and that modern treatments could not offer a quality of care that is comparable to traditional medicine. There was some disagreement about this, however, with some participants stating that traditional forms of treatment are always superior while others indicated that they might go to a hospital for certain conditions.

The strategies for the improvement of traditional health practices, as outlined by the rural mothers, included employing traditional healers in hospitals and clinics and providing

proper remuneration for their services. They also suggested that the government instruct traditional healers in hygienic practices, and provide updated training in the use of herbs. These women also felt that the integration of traditional and modern medicine required government allowances paid to traditional healers, regulations allowing traditional healers to sell their herbs freely, and regulatory agencies to test herbs for efficacy and safety, and general support for traditional practitioners coupled with discouragement of any harmful practices. They also advocated enhanced public education related to the importance of traditional health practices.

In order to reduce mortality rates, the rural women suggested discouraging early weaning and encouraging proper hygiene and nutrition. They also recommended discouraging closely spaced births (*comcomi*), and encouraging the proper use of traditional herbs in accordance with instructions and in the appropriate dose. Finally, they felt that children should be protected from harmful objects and that high-quality food should be given to mothers and children.

8.6 CONCLUSION

All of the respondents were of the view that the traditional practices are beneficial, with the exception of one respondent who felt that *tadatafta* may be harmful. They indicated a preference for receiving treatment from traditional healers rather than going to the hospital, particularly because many of the practices are unknown in the hospital setting and also because some hospital practices were believed to make conditions worse and possibly result

in death. Another advantage associated with traditional medicine was that each ailment has a traditional specialist, whose treatments are much less expensive and generally “better” than hospital-based care. They further suggested that English people are not even familiar with all of the traditional forms of care, such as *dawugota*, and felt that hospitals were primarily appropriate for the *nasara kamsullumbe* (literally, a black person with an English orientation, usually referring to western-educated people who emulate English culture and lifestyle). They therefore felt that traditional medicine was the best approach to treating all of the conditions discussed.

In discussing the relative advantages and disadvantages of traditional forms of healthcare, the respondents pointed out the advantage of having traditional care delivered in a patient’s own home, especially when financial resources are limited. They argued that it costs less to be treated by a traditional healer than by a doctor in a hospital, where almost all of one’s monthly income might be spent on a single examination, even without the purchase of medicine. They valued the ability to receive traditional care locally, without having to travel long distances, and also noted the benefit of being able to obtain traditional care without spending an entire day waiting in a queue. Furthermore, they felt that language barriers with hospital staff often prevented the effective delivery of care, since hospital staff often speak “*jili*” (any language spoken other than Kanuri, Shuwa-Arab, Fulani and English). These respondents also felt that traditional medicine involves no disadvantages. In their opinion, it is cheap, effective, relieves pain, and effectively treats headache and severe vomiting. The use of *berikaro* provides a sense of belonging, *kawugota* achieves proper placement of all female pelvic organs, and *shilashiwolta* permanently sets broken bones.

The strategies required for the incorporation of traditional methods of healing into the national healthcare system, as enumerated by the respondents, involved recognition by the government that traditional healers provide an important service to the community and provide added manpower to an underfunded modern medical system. They believed that the government should employ traditional healers and remunerate them properly, as is done for medical doctors. They expressed an urgent desire to create a traditional medicine board within the Ministry of Health in Borno State, similar to the boards currently operating in other parts of the country. They also supported the organization of conferences to train traditional healthcare practitioners on how to dispense drugs safely. Their general desire was that the government, biomedical professionals, and traditional healers all come together, achieve mutual respect and understanding, and engage in effective collaboration.

The traditional healers, including the TBA's, considered all of the traditional health practices to be beneficial. There were no significant differences in the views expressed by the different categories of the traditional healers. There were, however, significant differences in the views of the urban and rural mothers. The rural mothers viewed all of the traditional health practices mentioned as beneficial, similar to the traditional healers and the TBAs. The urban mothers viewed all of the traditional practices as negative, with the exception of *kelagota*, *suromowu*, *shilashiwolta* and *karuwayebakta*. The difference may be attributable to the fact that the traditional healers view modern medicine as only meant for the *nasara kasullumbe*. These individuals regard modern medicine as alien, inaccessible, costly and less effective than the traditional medicine. The rural mothers have views that are

similar to the traditional healers, perhaps because traditional medicine is the only method that is readily available to them in the rural areas.

Table 3: Analysis of focus group discussions by category of respondent and treatment

	KANURI DOCTORS	NON-KANURI DOCTORS	KANURI MIDWIVES	NON-KANURI MIDWIVES	MALE TRADITIONAL HEALERS	TBA'S	URBAN MOTHERS
Kagadi genata	Bad	Bad	Bad	Bad	Good	Good	Bad
Kela yekero/gota	Bad	Bad	Bad	Bad	Good	Good	Good
Dawu gota	Bad	Bad	Bad	Bad	Good	Good	Bad
Beri/Dawu kiri karo	Good	Bad	Good	Bad	Good	Good	Bad
Suromowu	Good	Good	Good	Good	Good	Good	Good
Kawu gota	Bad	Bad	Bad	Bad	Good	Good	Bad
Tada tafta	Bad	Bad	Bad	Bad	Good	Good	Bad
Shimkiri	Bad	Bad	Bad	Bad	Good	Good	Bad
Shila shiwolta	Bad	Good	Bad	Good	Good	Good	Good
Karuwaye bakta	Bad	Bad	bad	Bad	Good	Good	Good

Note: The above table is derived from the FGDs held with those providing either modern or traditional health care services, as well as the consumers of both forms of treatment.

CHAPTER NINE

CONCLUSION AND RECOMMENDATIONS

9.0 INTRODUCTION

This thesis has studied the co-existence of western biomedicine and traditional Kanuri health practices in Borno State, Nigeria vis-a-vis the imbalance in the distribution of both types of health facilities in the region. The project examined areas of compatibility between traditional and biomedical healthcare, and explored prospects and problems inherent in the integration of the two systems, as viewed by traditional and modern practitioners and their clients. The thesis also addressed how the population utilise and interact with both systems simultaneously, and recommends possible strategies for developing each form of care while also effectively integrating the two. This project has presented Borno as a case study of a larger problem, namely the difficulty encountered in any society where western and traditional healthcare practices coexist, especially in areas where access to western medicine is severely limited. In Borno, even those who are able to gain access to modern medical care are still exposed to traditional practices because such practices represent traditional and firmly entrenched cultural values, and because they find traditional practices effective.

In the course of conducting this research, I have dealt with several key issues, beginning with the position of the WHO recommending full integration of traditional and modern medicine. As I have described, this process has been exceptionally difficult even in areas where it might have been predicted to be smooth, such as Borno State. In Borno, the

indigenous elites still are expected to uphold cultural traditions, including those related to health and healing. Furthermore, one would have imagined that the relative peacefulness and stability of Borno might have lent itself to more seamless cooperation between and integration of traditional and modern practices. However, as I have demonstrated, the pervasive ideology and even individual personalities of western biomedical professionals and policy makers has acted as a formidable barrier to successful integration.

The second key issue that is woven throughout this thesis is the issue of assessing harm and benefit when evaluating any form of healthcare. Regardless of how one might view integration, the nature of the various practices and their associated outcomes must be considered. Some traditional practices are beneficial, or perhaps at least not harmful, and especially in rural areas, some forms of traditional medicine are essential. For example, traditional birth attendants perform a valuable service and are in reality the only birth attendants available to most women living in rural areas. However, other forms of traditional medicine are exceptionally harmful and may even be fatal in some instances. My research has been able to document some of the views of representatives of both the traditional and modern systems. I have considered these views at the institutional level, among different groups of practitioners and their constituents, and also within my personal life experience. This auto-ethnographic component of my work uses my own paradoxical role as a member of the royal family and an educated biomedical professional to illustrate the inherent conflicts, both cultural and professional, which accompany attempts to develop and integrate health care services in Borno State. In this capacity, I have had to balance dual expectations, those

that accompany my royal Kanuri background and those that are attached to my training as a biomedical professional.

This thesis on healthcare practices has been informed by the social sciences, but it is not intended to contribute towards theoretical developments in the social sciences. I do offer a critique of the WHO's wholesale support of integration based on my personal experience of witnessing the detrimental effects of some of these traditional practices, which I hope is a useful contribution. However, my primary focus is on shaping healthcare policy and implementing such policies at the grassroots level in Borno State. I hope to assist with identifying strategies for the integration of traditional and modern medicine, and I wish to do so in a way that is agreeable to all involved.

9.1 SUMMARY

The objective of this thesis was to explore the interface between traditional and modern healthcare delivery in an African context using the existing situation in Borno State, Nigeria. Traditional medicine is an old, extremely established part of African culture, while modern biomedical care is relatively recent and dates to colonization in the early 20th century. The contemporary healthcare system in Nigeria is based on a three-tiered system, with primary, secondary, and tertiary healthcare delivery instituted throughout the country as outlined in the 'National Health Policy and Strategy to Achieve Health for All Nigerians'. The policy is based on the concept of primary healthcare as declared in Alma Ata in

September 1978, though it was not fully adopted in Nigeria until 1985. Despite the adoption of this policy more than twenty years ago, the Nigerian health system continues to perform far below expectations on a number of health indices, There is a limited capacity for policy formulation, implementation, monitoring and evaluation at all levels of the healthcare system. Furthermore, there is no health act describing the national health system and clearly defining the health functions of the three tiers, and partnership between the public and private sectors is virtually non-existent. The inequalities in the distribution of healthcare facilities between rural and urban areas further aggravates current public health challenges.

Approximately 30 percent of healthcare facilities are located in rural areas where about 70 to 80 percent of the population resides, while 70 percent of the facilities are located in the urban areas where less than 30 percent of the population is located. Gross under-funding in the health sector has been a recurring factor in successive government administrations.

Currently, less than \$5 is allocated to healthcare per capita, falling far short of the recommended \$34. This situation has left the healthcare sector in a weak and ineffective position. The lack of accessibility and affordability of modern healthcare facilities has left consumers with no choice but to patronize traditional healers, who constitute the only available alternative to modern medical care which exists for the majority of the population.

The WHO defines traditional medicine as “the sum total of knowledge and practice, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental and social imbalance and relying extensively on experience and observation handed down from generation to generation, whether verbally or in writing” (WHO 1979). Traditional health practitioners vary greatly within the country. In Borno State, which is located in the

far northeast of the country, practitioners such as *Wanzama, Kelagotama, Suromuwoma, Kawugotama, Gau, Kaskima, Karwina, Safima, Shilashiwoltama* and *Mallam* are common. Their practices are specialized and most often rooted in Islamic faith. During the course of my growing up, I watched with keen interest the development of the two systems and their struggle for relevance in the face of a rapidly developing civilization. Even though I developed an interest in modern biomedicine, and eventually pursued a career as a nurse-midwife, my interest in traditional healthcare was sustained by virtue of my cultural heritage and my position as a descendant of one of the traditional title holders in the Kanuri dynasty. I found myself in constant conflict over these two discrepant roles which needed to be reconciled. My need to resolve this conflict using a systematic and scientifically-informed approach became a pressing challenge which I felt deserved immediate attention because of the significant consequences associated with both forms of care. As an insider, I was able to observe the advantages and disadvantages of both systems. Many personal experiences raised questions in my mind about cultural traditions, value judgments, and ethical considerations. As I sought to reconcile my conflicting roles over the years, I searched for a solution which would enable western biomedicine and traditional Kanuri health practices to successfully co-exist, thereby ameliorating existing inequalities in access to healthcare.

Among the traditional Kanuri healthcare practitioners that I have considered in this thesis are *wanzama, Kelagotama, Karwina, Suromuwoma, Mallam, Kaskifita, Safima, Kawogotama, Shilashiwoltama, and Gau*. These traditional healers often have no formal training and derive their skills from knowledge handed down from preceding generations. Some of their methods are crude, and the results of their practices can be disastrous or even

fatal. The fact that traditional medicine confers considerable benefit to the populace while also involving significant risk and negative outcomes reinforces the need to integrate traditional medicine with modern healthcare in order to enhance the safety and efficacy of some of the traditional practices. This thesis provides a multivocal assessment of which traditional practices are harmful and which are beneficial, and offers some recommendations related to specific practices that are relevant to policy formulation in this area. Based on firsthand experiences as well as my research in this area, I conclude that traditional Kanuri practices such as *dawugota*, *kelagota*, and *kawugota* are harmful and should be prohibited. Others, like *suromuwo*, *shilashiwolta*, and *karuwayebakta* are beneficial, and the skills of these practitioners should be enhanced and their practices encouraged. In Chapter 6, we have seen how Islam and the African tradition have great influence on traditional health practice especially of Kanuri people of Borno State, Nigeria, in the sense that most of the practices are derived directly or indirectly from the Quran or *Hadith*. For example *kangadigenata* (blood cupping) is discussed in detail in the *Hadith*, including the procedure based on healthy living though Islam opposed some practices e.g. *dawugota* (uvulectomy) which does not contribute to healthy living but rather constitutes harm.

Given that a large percentage of the population, particularly those living in rural Nigeria, still receives the vast majority of its healthcare services from traditional healers, the need to successfully integrate traditional and modern medicine is an issue which remains timely and relevant. Furthermore, political and economic hardship forces many in Nigeria to utilise both methods of healthcare simultaneously. This situation is not limited to Nigeria, but is common to other underdeveloped areas in Africa. In spite of this context, however, the

Nigerian government has been lackadaisical in undertaking efforts towards integration, failing to develop a policy which promotes the incorporation of useful elements of each system into healthcare services. Considerable work remains in order to achieve goals outlined by the WHO which include promoting research, evaluating herbal remedies, and regulating traditional practices.

In Nigeria, previous attempts have been made to combine the two systems of medicine, as reported by Lambo (1979). Ongoing attempts to combine the two systems culminated in the establishment of numerous organizations, such as the Nigerian Association of Medical Herbalists and the Nigerian Union of Medical Herbal Practitioners, although such groups were not legally recognised. However, the Traditional Medical Conference of Nigeria was created to help control the practice of indigenous medicine. It recommended the establishment of hospital wards devoted to traditional medicine alongside modern medicine, and the inclusion of a registered herbalist on the committee on traditional medicine within the Federal Ministry of Health. Some states in Nigeria have followed suit, organising their own traditional medicine boards. Only Borno State currently lacks this type of board.

Considerable debate continues on how best to integrate traditional and modern healing techniques. I am a strong proponent of the integration of both systems, even though I am acutely aware of differences between them. These differences are not irreconcilable. Traditional healers are quite useful, especially in rural areas which are still underserved by modern medical facilities. I fully support the WHO initiative as a welcome innovation in healthcare practice. However, in spite of this view, I feel that caution must be taken in order

to ensure that a model of integrated medicine does not allow mediocrity to flourish or hazardous practices to continue. Numerous dangers do exist within traditional medicine as currently practiced, including use of unsterilized knives in local surgeries, and lack of quantified dosages in the remedies used by traditional herbalists. These and other carefully identified problems must be fully addressed before any meaningful and sustained integration can successfully occur. I believe that an appropriate starting point involves examining commonalities between the two systems and identifying areas of compatibility. This can begin with common ties in terms of professional identity, since many biomedical doctors are the children of traditional healers and many nurse-midwives are the daughters of traditional birth attendants. Many situations exist in which the two groups could combine their skills to address particular health problems. In my professional career I have observed situations where the two systems coexisted to the benefit of the patient. For example, during a complicated birth a TBA was able to ‘rescue’ the situation and ensure a safe delivery. Similarly, I have had experiences with traditional bonesetters who prescribed mild analgesics for their patients, and some who even refer their patients for a tetanus injection in order to prevent fatal infection. Likewise, I have known *wanzama* who are fully informed on risk of infection and refer their patients to the hospital for injections of penicillin following circumcision. I also believe that the field of mental health is well-suited to complementary modes of treatment, and have observed patients families bringing traditional healers into the hospital to supplement available biomedical services. This view is reinforced by my experience with the psychological disorder of a member of my daughter’s cohort, which I described in Chapter 5. In this case, use of both a modern psychiatrist and a *Kaskima* (traditional healer) was essential to facilitating a successful outcome for all involved.

9.2 RECOMMENDATIONS

Although biomedical healthcare and traditional medicine are fundamentally different in their approach and practice, in reality most people utilise both systems. The successful integration of the two systems depends upon identifying areas of compatibility, such as those discussed above, and properly evaluating the relative merits and problems associated with each form of healthcare. I offer several specific recommendations related to developing healthcare services in Borno State and integrating traditional and modern medicine:

- There is a need for the government of Borno State to create a traditional health board without delay. The Ministry of Health in Borno State should follow the examples of other Nigerian states and assign responsibility for oversight of traditional medicine to the Directorate of Primary Care where it rightly belongs, rather than to the Directorate of Medical Services which opposes traditional medicine outright.
- Non-governmental organizations whose focus is on issues related to traditional healing should unite and publicly demand the integration of the two systems. They should submit legislation to the Borno State House of Assembly which will help prevent incompetent or fraudulent healers from practicing traditional medicine, and which will promote the acceptance of positive and beneficial traditional health practices. These organizations should bring together the traditional medical

practitioners and encourage them to present a model for the development and integration of the two systems.

- The government should employ traditional healers under the supervision of modern health professionals in designated hospitals and primary health centres. The government should educate health professionals on the benefits and harms associated with traditional medicine, and should advocate for its integration into modern medicine.
- An increase in the budgetary allocation to healthcare spending is needed in general, and specific funds to support maternal and child health should be made available. Traditional birth attendants in particular should receive training on antiseptic techniques. Furthermore, the government should create a fund to provide professional education and training through workshops and hospitals, and should provide financial support for the integration of traditional medicine into the modern healthcare system.
- There is a dire need for additional research into traditional healthcare practices. This should initially involve an inventory of existing traditional practices, followed by more specific research on individual practices, their efficacy, appropriate use of herbal remedies, potential side effects, and avenues for improvement of traditional practices. Research-focused NGO's and universities both within and outside the state and the country should collaborate and develop partnerships to achieve these goals.
- There is a serious need to involve the media in promoting mass support for the integration of traditional and modern medicine.

APPENDIX I

rites of passage

The rites of passage of the Borno people are one way in which their distinctive cultural identity is maintained. Many of these rites of passage involve traditional healing and are therefore relevant to the subject of this thesis. What follows are rites of passages in an ideal situation.

Bollo Nelefaye

With the safe delivery of a new baby into the family, the women in the immediate family, neighbors who are close associates, and friends and relatives will divide roles and carry out the following activities: pound 4-8Kg of millet or rice, mix it with sugar, and make it into a pastry (*Bollo*); roast chickens; and distribute the cake and the roasted chickens to the neighbors and children.

Jiji

The activities involved in the *jiji* (celebrating the sex of the baby) are the same as above except that *jiji* is carried out from the third to fourth day after a baby's birth. The sex of the baby is not made public before the naming day, and *Jiji* is the accepted way of informing the community of the sex of the baby. An odd day indicates a male child while an even day is used for females. Thus, the roasted chickens and *bollo* are distributed on the third or fifth day for a male baby or on the fourth or sixth day for a female baby.

Su (Naming Ceremony)

Su is conducted on the morning of the seventh day of a baby's life. It is always considered a happy and festive occasion in which the mother and baby are showered with gifts by parents, sisters, friends and members of the extended families, as well as colleagues and associates.

The naming ceremony is either held at home or in a mosque. The former situation involves people gathering at the house to grace the occasion, while the latter is done following the early morning prayers in the mosque where the father of the child normally prays.

Pre-Naming Ceremony Activities

When a child is born, the mother is exempted from any kind of work at home until after the fortieth day; with subsequent deliveries, she is free of work for only seven days. All her domestic chores are done by friends, relatives and associates. On the eve of the naming ceremony, most of the friends, relatives and associates spend the night cooking a variety of dishes in preparation for the naming ceremony in the morning.

The father makes sure that he has a healthy ram for the naming ceremony. The responsibility of the father in the evening is to call the prayer in Arabic three times into the ear of the baby. This is an obligatory part of the naming ceremony. Other important responsibilities of his are the issuing of an invitation to attend the ceremony to friends, relatives and associates both far and near.

The Naming Day

In the early morning of the naming day, mats are spread in and outside the house for women and men, respectively. Among those attending are praise singers who, though not invited, are usually present to praise people and get money from them.

Prayers will be said, after which the learned *ulama* is invited to slaughter the ram by calling the new name given to the baby silently. The praise singers and some of the *ulama* then ask for the new name given to the baby to be presented for public consumption. If the child is named after an individual who happens to be present, the praise-singer collects money for the announcement from that person. If the child is named after someone who has died, that person's children, friends or associates pay the money. The slaughtered ram is divided into portions of meat and given out raw in alms to the needy.

The cooked varieties of dishes are shared amongst the guests. Very important persons do not usually eat in a public gathering like this, and therefore dishes are sent to their houses. After eating, the men disperse with the exception of the *Wanzama* who stays to carry out the *dawugota* (uvulectomy) and *berikaro/dawukirikaro* (tribal marks), and most of the women stay until dark.

Male Circumcision

This is the cutting or removal of the foreskin of the male organ. Although it can be medically recommended in few cases, it is regarded as primarily religious in Kanuri culture.

Though it can be done at an earlier age, the recommended age in Islam is seven. The *wanzama* performs the circumcision.

The first stage is the invitation of the *Wanzama*. Whenever a parent or guardian intends to circumcise his child or children, he draws the attention of his *Wanzama*. The circumcision can either involve invitees and ceremonies, or it can be done quietly. The *Wanzama* is informed of the type preferred.

In case of circumcision with invitees, at least three days are required by both the parents and *Wanzama* for the preparation. The parents make sure that there is enough food (ram and/or cow) and drinks for the invited guests, while the *Wanzama* invites his assistants and drummers (if the parents require drummers). The mother organizes the cooking and serving of guests on the day of the circumcision. The father provides the *wanzama* with raw materials for the erection of the stand where the circumcision takes place. It is the responsibility of the *Wanzama* to erect the stand depending on the number of boys to be circumcised, as they will be staying there from the day of the circumcision until they are healed, which usually takes about three weeks.

The *Wanzamaa* (plural for *wanzama*), some of the invited guests, and all the children to be circumcised and their friends must be present at the dinner on the eve of the circumcision. Interestingly, the *Wanzamaa* will only eat after the father pays them to eat, but there is no fixed amount. The skin, head and legs of the slaughtered ram are given to the leader of the *Wanzama* (a man known as the *Fugu*). After the dinner, a *mangum* (an instrument with

celestial sound, used only for circumcision) is blown and drumming until bedtime may follow.

On the day of the circumcision, the *wanzama* invites the fraternal uncle of the child to take the child to the *ngushi* (hut) for the preparation of the circumcision. When this is done, the *Wanzama* hides the blades from the view of the child. Thereafter he takes the child on his legs and asks one of his male assistants to hold the child in order to avoid shaking. The *Wanzamas* says some words of prayer and cuts the foreskin and orders for the blowing of the *magnum* to indicate a successful circumcision. The women inside then respond by ululation (*wurwuli*) and celebration by dancing to the drums that follow the *mangum*.

Whenever there is a successful circumcision, it is mandatory for the mother of the child to provide the *Wanzama* and his assistants a dish of cooked food, soup porridge and two packets of sugar. In addition, she gives them money, and requests them to eat and drink the food and porridge. The father provides a tray full of corn, a set of male traditional gowns comprised of a big top dress (*kulwu*), inner dress (*gemaje*) and trouser (*yange*), and some amount of money. The *Fugu* and his assistants then go to the mother and her associates to collect gifts, ranging from materials, jewelry, and electronics to raw cash. Material gifts are for them, while cash gifts are set aside for the up-keep of the circumcised children until their discharge after two weeks. Finally, the mother is invited by the *Fugu* who informs her of the success. The mother then provides the *Fugu* and his team materials, a tray full of corn, and a dish full of *bolombo* (local peanut cakes). The items, cash and *bolombo* are put together and distributed hierarchically according to the following procedure. The *Fugu* takes the largest

share, followed by the *Grema* who is the second in command, and so on. The cash is given to the representative (*wakil*) of the *fugu* for the purpose of house-keeping, while *bolombo* is distributed equally amongst all of them.

Zuwuu

This is the graduation ceremony associated with training in the memorization of the holy Quran. West Africa made its contact with Islam in the 8th century. Like elsewhere in the Islamic World, Quranic graduation is a happy and highly respected occasion in Borno State. The criteria for graduation are the complete recitation and/or writing of the sixty verses of the holy Quran from memory.

On the eve of the graduation, ram, rice and other essential foodstuffs are provided by the parents or guardians of the graduates to the house of the *Mallam*. The wife of the *Mallam* and her associates cook food in large quantities on the day of the graduation, usually on Wednesdays. New dresses for the *Mallam* and graduates are also provided. Invitation, usually verbal, is given to the people by announcing in mosques, *Mgoromji*, house to house, etc.

The occasion starts on the eve of the ceremony where the recitation is rehearsed throughout the night. This is the reason Wednesday is chosen, as Thursdays and Fridays are work-free days in the Islamic world. Memorization starts as early as eight o'clock depending on the number of graduating students. There are also students from other *mogoramjis* that come and listen to the recitation and see how it is rehearsed for their future preparation.

On the morning of the graduation, the *Mallam* slaughters the ram and hands it over to his wife to prepare the meal for the invited people who are expected at two o'clock in the afternoon. Some portion of the meat is given raw as *sadakat* (alms).

The graduating students get the area cleaned, spread mats and carpets before they have their bath and put on their new clothes. They then come with their wooden slates, called *Allo* (a kind of wooden board on which a portion of what they recite is written). The invited guests also come with their *Allo*. The session, known as *Darasu*, then starts. *Darasu* is where all the *Mallamaa* (plural for mallam) will read the *Allo* (slate). Usually, individuals take turns within the whole group, but there are situations where the number of invitees is so large that people are divided into various sub-groups. This is done in order to complete the session before dark.

The graduating students read their *Allo* finally after reading all others. *Sadakat*, in which sweets, biscuits, kola nuts and cash are distributed, follows. After that, the graduates are led into the house where their mothers, sisters, aunts, and friends shower them with gifts ranging from clothes, shoes, cash, to a wife or husband, piece of land, house, etc. The ceremony comes to a close with dinner for invited guests.

Marriage Ceremony

Marriage is the coming together of a man and woman, and is regarded as *Sunnah* (not compulsory). In spite of it being not compulsory, it is regarded as a respectful thing that makes the man responsible, while making the woman respected.

There are three types of marriage: for love, family intermarriage (*bawan rawangana/awanan awakurangana*), and free gift. Parties are classified as follows: divorcee, widowed, first timer, and dry marriage (solemnizing without going to the husband's house). Other classifications include: *fatoro nyabe* (marriage of a sister to her sister's husband when one's sister dies), *njimsuri* (where the freshly married female got divorced within the first few months of the first marriage); and *chir* (where a woman is bought by a master without solemnizing). Note that these categorizations are all based on the status of the females rather than the males. Early marriage is very common among the Kanuri, but the practice is rapidly declining, even in rural areas where it was predominant.

With the exception of a few cases of arranged or forced marriages, if a man decides to marry, arrangement is made for him and the female to meet and assess each other. The man then sends gifts (*ra'aki*) to his would-be wife through her family. Thereafter, a date for the marriage can be fixed or a date for the fixing of the date can be agreed upon (*ferokoro*).

Solemnization days are usually Thursdays for Islamic-oriented people and businessmen, while Saturdays are preferred by civil servants. Invitation cards are sent out a week prior to the day of the solemnization. As the parents both for the bride and groom send out their invitation cards, the friends of the bride will go out for picking of *karimbo* (tropical African

tree) leaves and thorns (*karimbonamte*) and placing of the *karimbo* leaves on the forehead of the groom's friends by the bride's friends *karimbobaktaa*, while the groom and friends will meet on the proceedings of the marriage.

In the case of a Saturday wedding, the previous Tuesday is the *nalle* (henna) day when the family of the bridegroom now sends gifts of clothes, perfume, shoes, bags, cosmetics, bag of henna, etc. to the bride through her family. These arrangements are the sole responsibility of the aunts of the bride and bridegroom. In return, the bride's aunts give a sack of rice, soap, small room carpet, and big dishes.

Thursday, *nyaa* (pasta made from wheat flour, rice and honey) is cooked at the house of the bride; the bridegroom's family sends the raw material for cooking the *nyaa*, while sweets and soft drinks are distributed to those women who do the cooking.

Friday morning, *dela boota* (literally, 'call the jackal') is done by the women folk. A big calabash is filled with water; a small calabash is placed on the water face down. The women then use sticks in beating the smaller calabash placed on the water as a drum. It produces a peculiar sound which is followed by songs for about two hours in the morning. The same is repeated in the evening and the water is kept to bathe the bride the following day when she will be dressed to be taken to her husband's house.

Friday evening is the *ushe ushe* evening when the man's friends, associates and relatives escort the bridegroom to the bride's house among drums. The bride's family, relatives and

associates receive them with cheers among drummers. The drummers are called in groups, and display their talents for some number of minutes depending on the number of groups. The bride and bridegroom come forward dancing while the loved ones paste money onto their forehead. The money belongs to the drummers at the end of the *ushe ushe*. The bride's family provides soft drinks and snacks, as the occasion is more of a cocktail affair. The *ushe ushe* usually lasts for no more than three to four hours.

The *ushe ushe* is followed by the *kawe* (words of advice by praise singer) for the bride if it is her first marriage. This is the advice given to the bride on how she goes about responding to the challenges of married life in general. This is done until daybreak. In case of the bridegroom, he returns from the *ushe ushe* with his entourage to his house. There, *sale*, that is giving of advice (if he is marrying for the first time), takes place until daybreak.

The actual ceremony of solemnization is done anytime from 6:30 to 10:00 a.m. depending on the time agreed upon by both families, which must be indicated in the invitations given out the previous Saturday. Invited guests gather at both the house of the bride and that of the groom. The family of the bridegroom moves en masse, together with friends, associates, praise singers, etc. to the house of the bride. The *Fatihah* (solemnization) is done after payment of the *Sadawu* (bride price). *Sadawu* may have been arranged previously. The representatives (*lowori*) of both the bride and bridegroom are identified, and they stand in as the witnesses for their bride and groom. The *Mallam* now solemnizes the marriage in accordance with Islamic teaching. The groom's family distributes Kola nuts, sweets and money. They then come to the bridegroom's house to carry out the rest of the formalities.

Very important people take their leave after prayers for peace are said, while food meant for them is sent to their houses individually. Other guests stay put and eat amidst drumming and praise-singing, before the gifts are taken to the bride's house.

The *kellatulta* (washing of the bride's hair) is done in the morning after the solemnization among *dunu* (peculiar drums and songs) by the paternal aunts of the bride while the hair is plaited (*kelakerta*) to *kelayakke* (three heads) style by the *duwuramma* (hair dresser) who is given kola nuts, clothes and skirt for her service. The three heads style is especially for unmarried girls and newlywed young girls who are changed to *kelashangalti* or *kelagoto* during the naming ceremony of her first baby or after one year of her marriage (whichever that comes first). The hair plaiting is then followed by the *kawulu genata* (traditional rite of giving gifts to the bride by her parents, relatives, etc). Drumming and singing continue. *Bujingenata* (sitting the bride on a mat) and *kowuwulu genata* (traditional rite of giving gifts to the bride by her parents, relatives, etc.) are done in the evening after the previously described 'call the jackal' (*dellabowuta*).

Meanwhile, at the house of the bride, the males disperse after eating and drinking the local soft drink. Close relatives and friends stay behind to assist in receiving the groom's gifts. Food is sent to the homes of the very important personalities, as they do not eat in public. The male group takes the *fafarei* (gifts, ranging from clothes, carpet, shoes, caps, Quran, rosary, special Kanuri snacks in big dishes, etc.) from the bride's parents to the house of the groom before his own gifts are brought to the bride.

The gifts from the groom are brought usually in the afternoon. Gifts ranging from a bed, bedding, chairs, refrigerators, kitchen utensils and equipment, etc. are given to the bride by her parents and relatives. Some female relatives of the bride go along with these items to the groom's home, to set things up before the bride is taken at dark. The friends and relatives of the groom come to the house of the bride after dark and carry their bride away. Friends and relatives of the bride follow them while a few stay with them until the seventh day (*turur*) when gifts of skirts and cosmetics are given by the groom to friends and relatives of the bride who stayed. After the *turur*, an elderly woman is left to stay with the family until the fortieth day (*fidiowu*), after which the bride and groom are finally left alone. Gifts are also given to the women who stayed until the *fidiowu*.

Funeral Rites (Shitera)

Whenever a person is reported dead, urgent measures to ensure successful burial with or without the deceased's relatives is paramount. The body is bathed and dressed in accordance to the Islamic rites. The bathing is done by close relatives of the same sex. This gender rule also applies to children though is not strictly adhered to.

The dead body is removed from the *ganger* (coffin) in front of the grave and put into the grave directly by a team of people. The deceased is buried and prayers are said by the graveside before departure. After burial, people return to the home of the deceased. The family and relatives stay for a week receiving sympathizers. On the third day, *sadakat* and prayers are made, as well on the seventh day, the fortieth day, and after the first year. The loved ones visit the grave any time but people usually fix Fridays for convenience. Prayers

are however a continuous process. Some do travel to the Makkah specifically to pray for forgiveness of the soul of the departed, but this is not compulsory.

APPENDIX II

THE FORMAL ORGANIZATION OF HEALTHCARE IN BORNO STATE

The Ministry of Health is the main branch of the state government charged with the healthcare of the people of Borno State. The Ministry supervises hospitals under the Hospitals Management Board, and implements the health policies established by the government. The responsibilities of the Ministry of Health encompass all aspects of health care including the following: policy formulation; planning health care services across the state; construction of and providing equipment for health facilities; training healthcare providers such as nurses, doctors, community health workers, and public health workers; carrying out essential health research; and attaining the preventive, promotive, curative and rehabilitative health goals of the government, in collaboration with international external agencies. These overall functions are facilitated by the Hospitals Management Board, which is responsible for the day-to-day operations of the thirty-six hospitals in the state, the six zonal health offices that supervise the twenty-seven Local Government Area health offices, and the Schools of Nursing, Midwifery and Health Technology, all located in Maiduguri. The ministry has a total staff of one thousand and eighty nine (1089) on its payroll. Out of this, seven hundred and thirty seven (737) are conventional staff, three hundred and twenty seven (327) are students of the Schools of Nursing, Midwifery, Health Technology and Medicine, with twenty-five (25) newly appointed medical students who have not yet begun their course or received their stipend.

The Ministry of Health is headed by an apolitical head, the Honourable Commissioner for Health, as well as the Permanent Secretary (who is the accounting officer) deputized by the Secretary for Health under whom the eight directors of Health Planning, Research and Statistics, Administration and Supplies, Finance and Accounts, Food, Drug Administration, Nursing Services, Primary Health Care, Disease Control and International Health, and Medical Services operate. The directors carry out activities in accordance with the schedules assigned to them based on their professional expertise.

Directorate of Planning, Research and Statistics

The Directorate of Planning, Research and Statistics is charged with the responsibility for developing plans, capital budgets, and staff salaries of the Ministry of Health, as well as execution, monitoring and evaluation of capital projects. The Directorate also collects, collates and processes health statistics, as well as manages the Ministry's Health Management Information System (HMIS), which includes all of the Ministry's records and information resources. The department has executed numerous projects and programmes, including the construction of many hospitals and primary health centers across the state, the development of an HIV/AIDS framework, training of top- and middle-tier staff on computer use and compilation of vital statistics, and the projection of the annual budget.

Directorate of Administration and Supplies

The Directorate of Administration and Supplies is vested with the responsibility for human resources development and management. This involves staff appointment, promotion, transfers, training, welfare and discipline, as well as general maintenance of

offices and stores. The Directorate has successfully facilitated the employment of newly qualified medical students into the system. The department has, in conjunction with the Department of Health Planning, trained top-level managers on computer application and usage, as well as facilitated state government sponsorship of a PhD student on part-time overseas training.

Directorate of Finance and Accounts

The Directorate of Finance and Accounts is responsible for all the financial transactions of the Ministry. This includes payments of salaries, other staff entitlements, and capital projects. The department is also responsible for keeping all financial records, and prepares the recurrent expenditures of the Ministry in conjunction with the Department of Health Planning.

Directorate of Food and Drug Administration

The Directorate of Food and Drug Administration is responsible for the procurement of drugs for the Drug Revolving Fund (DRF) Scheme. It is also responsible for registration, monitoring and inspection of private pharmaceutical and patent medicines. It coordinates the training of pharmacists and pharmacists' assistants. The department also serves as the Secretariat of the Committee on Fake and Counterfeit Drugs. In fulfillment of its mandate, the department has successfully inspected medicine stores and pharmaceutical chemists as well as conducted regular monitoring of fake and counterfeit drugs in the society.

Directorate of Nursing Services

This department coordinates all nursing services in the state, including training and re-training of nurses, including student nurses and midwives. In liaison with the Nursing and Midwifery Council of Nigeria, it registers all qualified nurses into the Council and also monitors the activities of nurses and midwives to curtail malpractice.

Directorate of Primary Health Care

The Directorate of Primary Health Care is charged with the responsibility of Health Education, Family Health Services (including United Nations Fund for Population Activities (UNFPA) support), managing infrastructural facilities in the Local Government Areas, training traditional birth attendants, and coordinating maternal and child health care services. The directorate also is responsible for several programmes, including the Integrated Management of Childhood Illnesses, Women's Health Development Programme, and Oral Re-Hydration Therapy. It oversees the elimination of health hazards (including harmful traditional practices), the provision of vaccines for routine preventive care at the health clinics in the Local Government Areas, the coordination of national immunization days, the campaigns against six serious diseases, the polio eradication campaign in the state, and the coordination of school health services and school health technology. The department has successfully carried out the National Immunization Exercise in the state, and has liaised with multi-lateral organizations such as UNFPA, WHO, and UNICEF.

Directorate of Disease Control and International Health

This department is responsible for the control of diseases by pursuing specific disease control programmes, including water and sanitation programmes as well as control programmes for the following conditions: HIV/AIDS, malaria, Guinea worm, meningitis, Schistosomiasis, and Onchocerciasis. Some of these programmes receive the financial support of international agencies, although counterpart funding from the state is required in each case. Other functions of the department include the procurement of vaccines and drugs in order to control the various community-based diseases, such as measles, meningitis, and cholera. It is also responsible for international health issues, including border health, issuance of international certificates to travelers, and pilgrimage medical care. Finally, the department is responsible for supervising environmental health, occupational health, sanitation and hygiene. These supervisory functions are carried out in collaboration with the Local Government Health Departments and the Sanitation Court. It also includes the coordination of the functions of the six zonal offices of the MMC, Monguno, Dikwa, Bama, Biu, and Damask.

Amongst the achievements of the directorate are the bulk purchase of drugs and vaccinations for over two million people against cerebro-spinal meningitis (CSM) and yellow fever. The directorate, in liaison with the DHPRS, has also distributed about 20 million treated bed nets in line with the Roll Back Malaria (RBM) objectives. The directorate also vaccinates intending pilgrims to Mecca against yellow fever and provides yellow cards accordingly. Advocacy workshops on the SARS disease were also conducted by the department to raise public awareness about the disease during the time of the SARS scare.

Directorate of Medical Services

The Directorate of Medical Services is responsible for the procurement of medical equipment (both new and old) for the state's health institutions, and co-ordinates the training of medical staff including doctors, laboratory scientists, ophthalmologists, and other healthcare professionals. Other functions of the department include the inspection and licensing of private medical establishments (excluding pharmaceutical and patent medicine stores), coordinating Baby Friendly Hospital initiatives, and acting as a representative of the Nigerian Medical Council and the Traditional Medicine Board. The directorate has successfully monitored private health establishments, and also facilitated the 2006 World AIDS Day celebration.

APPENDIX III

INTERVIEW SCHEDULE / QUESTIONNAIRE DESIGN

What is your occupation and position? _____

What are the traditional health practices of the Kanuri people of Borno State, Nigeria? Please list as many as you can. _____

How and why are the following practices carried out: Kangadi genata, Kela yekero/gota, Dawu gota, Beri karo/Dawukiri karo, Suro muwu, Kawu gota, Tada Tafta, Shim kiri, Shila Shiwolta and Karuwaye Bakta? _____

What are your views on how the practices are carried out in term of whether they may or may not be harmful? _____

If any member of your family happens to have any of these conditions, do you resort to traditional healers? _____

If yes to the above, why? _____

If no, why not? _____

Identify which conditions in the above 1 – 10 list can best be treated by orthodox methods.

Identify which ones can best be treated by traditional healers. _____

What are the advantages and disadvantages of these traditional practices as compared to modern health practices? _____

What are the strategies required for the easy co existence of the traditional health practices in the health care system? _____

How can maternal and infant mortality be reduced within the Kanuri communities of Borno State, Nigeria? _____

What are your general recommendations for the improvement of the traditional practices so that traditional way of healing co exists with the modern medical practices?

BIBLIOGRAPHY

Adeloye, A. (1977) (ed.) *Nigerian Pioneers of Modern Medicine: Selected Writings*. Ibadan: Ibadan University Press.

Ademuwagun, Z. (1979). "The Relevance of Yoruba Medicine Men in Public Health Practice." In Z Ademuwagun (ed.) *African Therapeutic Systems*. Waltham, MA: Crossroads Press.

African Regional Office of the WHO (1976) *African Traditional Medicine*. Report of the Regional Expert Committee, Technical Report Series No.1. Brazzaville (Congo): WHO.

Ajayi, J.F.A (1974). *A Thousand Years of West African History*. Ibadan: Ibadan University Press/Nelson.

Akerele, O. (1983). "Which Way for Traditional Medicine?" *World Health Organization*, 3-4.

Akerele, O. (1984). "WHO's traditional medicine programme: progress and prospectives." *WHO Chronicle* 38 (2): 76-81.

Akerele, O. (1987). "The best of both worlds: bringing traditional medicine up to date." *Social Science and Medicine* 24(2): 177-181.

Akpede, G.O. and B.A. Omotara (1994). "Inter-Cultural Variations in Diarrhoea Perceptions and Treatment Practices in North-Eastern Nigeria." 5th Proceedings of the AFCODD. Maiduguri: University of Maiduguri Press, pp. 118 – 123.

Akpede, G.O. and B.A. Omotara (1996). "Defining New Strategies for the Promotion of Oral Dehydration Therapy: Lessons from Field Surveys of Diarrhoea Management in North – Eastern Nigeria." *The Nigeria Medical Practitioner* 31(4): 54-60.

Akpede, G.O., B.A. Omotara and W. Gazali (1995) "Severity signs of childhood diarrhoea in north eastern Nigeria." *Journal of the Royal Society for the Promotion of Health*, 115(3): 164-74.

Akpede, G.O., B.A. Omotara, G.D. Webb and J.O. Igene (1997). "Caretakers' Knowledge and Preparation Abilities of Salt-Sugar Solution in North-Eastern Nigeria." *Journal of Diarrhoeal Disease Research*, 15(4): 232-240.

Akpede, G.O., J.O. Igene and B.A. Omatara (2001). "Perceptions of and Management Practices for Diarrhoeal Diseases by Traditional Healers in North Eastern Nigeria." *Journal of Health, Population and Nutrition* 19(2): 91-98.

Alkali, M.N. and Usman, Y.B (1983). *Studies in the History of Pre-Colonial Borno*. Zaria: Gaskiya NNPC.

Anderson, P. (1998). "Confidentiality and Consent in Qualitative Research." *British Sociological Association Network*, 69: 6-7.

Anderson, R. (1992). "The Efficacy of Ethnomedicine: Research Methods in Trouble". In M. Nichter (ed.) *Anthropological Approaches to the Study of Ethnomedicine*. Reading: Gordon and Breach Science.

Anene, J.C. and Brown, G.N. (1966). *Africa in the 19th and 20th Centuries*. Ibadan: Ibadan University Press/Nelson.

Asuni, T. (1981). "Health and Society: Modern Medicine and Traditional Medicine." In Z. Ademuwagun (ed.) *African Therapeutic Systems*. Waltham, MA: Crossroads Press.

Bodeker, A.U.G. (1994). "Traditional Health Knowledge and Public Policy." *Nature and Resource*, 30(2): 5-16.

Borno State Executive Diary (2000). *Brief on Borno State*. Maiduguri: Ministry of HomeAffairs and Culture.

Borno State Ministry of Health (2003). *Functions of the Eight Directorates*. Maiduguri: Director of Health Planning, Research and Statistics, Ministry of Health.

Borno State Statistical Year Book (2000). Maiduguri: Borno State Department of Statistics and Information.

Borno State Statistical Year Book (2007). Maiduguri: Borno State Department of Statistics and Information.

Bryman, A. (2001). *Social Research Methods*. Oxford: Oxford University Press.

Burgess, R.G. (1984). *In the Field*. London: Allen & Unwin.

Byrne, D.S. (1998) *Complexity Theory and the Social Sciences: an Introduction*. London: Routledge.

Cohen, R. and Kennedy, P. (2000). *Global Sociology*. London: Palgrave Macmillan.

Cohen, R. (1967). *The Kanuri of Borno*. New York: Holt, Rinehart and Winson.

Crowder, M. (1977). *West Africa: An Introduction to its History*. London: Longman.

Delano, E. (1990). *A Guide to Family Planning*. Ibadan: Spectrum Books

.

El-Nafaty, A.U. and B.A. Omotara (1998). *Percieved Causes of Eclampsia in Four Ethnic Groups in Borno State, Nigeria*. Maiduguri: University of Maiduguri Press.

El-Yakub, K.A, (1997). *Traditional Health Practices Affecting the Female Female Reproductive Health: Being a Paper presented on Launching of Community Health Reproductive Services in Borno State*. Maiduguri: Alpha Prints.

Ezereonwu. J. (2001). "AIDS Scare over American Firm's Free Sanitary Pads to Students." *The Guardian*, February 21.

Fanon, F. (1967). *Black Skin, White Masks*. New York: Grove Press.

Federal Ministry of Health (1988) *The National Health Policy and Strategy to Achieve Health for All Nigerians*. Lagos: Federal Ministry of Health.

Frankenberg, R, (1974). "Functionalism and After: Theory and Development in the Social Sciences Applied to the Health Field." *International Journal of Health Services* 4 (3): 411-27.

Gadzama, E. (1997) (ed.) *Who is Who Among Women in the North-East*. Maiduguri: Nasarawa Publishing.

Galli, N. (1978). *Foundation and Principles of Health Education*. New York: Holt, Rinehart & Winston.

Gazali, W.A, (1996). Baseline Survey of Socio–Cultural Factors Affecting Attitude and Behavior of the Kanuri of Borno and Yobe States of Nigeria. Lagos: UNFPA (Unpublished MS).

Gibbs, N. (1993). Why use Focus Groups and other methods. *Social Research Updates*, 19: Guildford: University of Surrey.

Gilbert, N. (1993). *Researching Social Life*. London: Sage.

Glaser, B.G. and A.L. Strauss (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Hammersley, M. (1992). *Reading Ethnographic Research: a Critical Guide*. London: Longman.

Hammersley, M. (2000). *Reading Ethnographic Research, 2nd Edition*. London: Longman.

Harrison, I. H. (1973). “Traditional Healers: A Neglected Source of Health”. *Proceedings of the International Symposium on Traditional Medical Therapy*. Lagos University of Lagos Press.

Haymen, B. and Ramesh, A. (1994). "Traditional Medicine: Its Extent and Potential for Incorporation into Modern National Health Systems". In: D.R. Philips and Y. Verhasselt (eds.), *Health and Development*. London: Routledge.

Helman. C.G. (1994). *Culture, Health and Illness, 3rd Ed.* Boston: Elsevier..

HERFON (Health Reform Foundation of Nigeria) (2006) *Nigerian Health Review 2006*.
Ibadan: Kenbim Press.

HERFON (Health Reform Foundation of Nigeria) (2007) *Nigerian Health Review 2007*.
Ibadan: Kenbim Press.

Holt, N.L. (2003). "Representation, Litigation and Auto-ethnography: An Ethnographic Writing Story". *International Journal of Qualitative Methods*, 2(1): 18-28.

Idris, A. and Omotara, B.A. (1996). "Planned Homebirth in Maiduguri, Nigeria." *Journal of Obstetrics and Gynaecology* 16 (4): 239-241.

Igbinosun, P.E. (1992). *Selection of Key Research Issues and Topics and Formulating Appropriate Research Questions*. Ibadan: University of Ibadan Press.

Igene, J.O., Akpede, G.O., Omotara, B.A. and Webb, G.D. (1992). Comparative study of the perception and treatment of diarrhea among the Kanuris and Buras of Borno State, North Eastern Nigeria. Applied Diarrheal Disease Research Project Grant #129.

Igun, A.U. (1988). *Medical Sociology: An Introduction*. St. Helier, Channel Islands: Shanason C.I. Ltd.

Illich, I. (1976). *Limits to Medicine, Medical Nemesis: The Expropriation of Health*. Harmondsworth: Penguin.

Imam Ibn Quyim Al-Jauriziyah (2003). *Healing with the Medicine of the Prophet, (2nd ed.)*. Riyadh: Darussalam.

Janzen, J. (1978). *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press.

Jinadu, L, A. (1980). *FANON: In Search of African Revolution*. Enugu Fourth Dimension Publishing Co. Ltd.

Jitsukawa, M. (1997). "In Accordance with Nature: What Japanese Women Mean by Being in Control. *Anthropology and Medicine* 4 (2): 177-210.

Johnson, A.G. (2000). *The Blackwell Dictionary of Sociology: A Users Guide to Sociological Language, 2nd Edition*. Oxford: Blackwell.

Johnson, J.M. (1976). *Doing Field Research*. New York: Free Press.

Keesing, R.M. (1981). *Cultural Anthropology: A Contemporary Perspective*. New York: Holt, Rinehart & Winston.

Khan, M.E. and Manderson, L. (1992). "The Use of Focus Groups in Social and Behavioural Research: Some Methodological Issues". *World Health Statistics Quarterly* 44: 145-149.

Kirk, J. and Miller, M.L. (1986). *Reliability and Validity in Qualitative Research*. NewburyPark, CA: Sage.

Kleinman, A. (1980). *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Lambo, J. (1979). Evaluation of the Scope of Traditional Medicine. Paper presented at WHO Workshop on the Promotion of Traditional Medicine, Lagos.

Mackie, J.I. (1997). *Ethics: Inventing Right and Wrong*. Harmondsworth: Penguin Books.

Malinowski, B. (1961). *Argonauts of the Western Pacific*. New York: E.P. Dutton & Co.

Marriot.M. (1955). “Western Medicine in a Village of Northern India.” In: B.D. Paul (Ed.), *Health, Culture and Community: Case Studies of Public Reactions in Health Programmes*. New York: Russell Sage Foundation.

Masta, A.T.S. (1983). Brief on Maiduguri, Yerwa Town. *Annals of Borno*,1.

Mastanduno, M. (2008), Imperialism, *Microsoft Encarta 2008*, <http://encarta.msn.com>. Accessed 24th March 2009.

Mechanic, D. (1978). *Medical Sociology (2nd ed.)*. New York: Free Press.

Ministry of Land and Survey (2000). Map of Borno State. Maiduguri Maiduguri Printing Press.

Morgan, D.L. (1998). “Practical Strategies for Combining Qualitative and Quantitative Methods: Applications for Health Research.” *Qualitative Health Research* 8: 362-76.

Ngamdu, A.M. (2002). *Gargam Bornobe Ngawo Rabiben (1900 – 2003)*. Maiduguri: Mintar Printing Press.

Nisbert, R.A. (1969). *Social Change and History*. New York: New York University Press.

Njodi, I.A., D.W. Bwala and B.A. Omotara (1998), Traditional Beliefs and Health Treatment Practices Among the Bade and Kanuri people of Yobe State of Nigeria. *Annals of Borno* 13/14 (1996-97): 301-307.

Nuhu, I.M. (1991). Traditional Uvulectomy: Facts and Fallacies. *Health Magazine of the Inter-Africa Committee (IAC), Nigeria on Harmful Traditional Practices* 1 (2). Lagos, Nigeria.

Odebiyi, A. (1981). "Integrating Traditional and Orthodox Medicine in Nigeria: the traditional healer's perception". Paper presented at 7th International Conference on Social Science and Medicine, Leeuwenhorst, Netherlands, June 22-26.

Offiong, D.A. (1999). "Traditional Healers in the Nigerian Health Care Delivery System and the Debate Over Integrating Traditional and Scientific Medicine". *Anthropological Quarterly*, 72(3): 118-30.

Okara, G. (1967). "Piano and Drums" In *West African Verse: An Anthology*. Chosen and Annotated by Donatus I. Nwoga. Lagos: Academy Press.

Omotara, B.A. (2000). "Medical Education in Nigeria." In H. Schmidt, J. Magzoub, G. Feletti, Z. Nooman & P. Vluggen (eds) *Handbook of Community-Based Education: Theory and Practices*: Maastricht: Network Publications.

Onwubiko, K.B.C. (1967). *History of West Africa A.D. 1000 – 1800*. Jurong, Singapore: Africana Educational Publishers, in Association with FEP International.

Osborne, O. (1976). “Anthropology and Nursing: Some Common Traditions and Interests.” In: P.J. Brink (Ed.), *Transcultural Nursing: A Book of Readings*. Englewood Cliffs, NJ: Prentice Hall.

Oxford Advanced Learners’ Dictionary (1998). Oxford: Oxford University Press.

Oxford Dictionary of Philosophy (1994). “Paradox”. Oxford: Oxford University Press.

Oyebola, D.D.O. (1981). “Professional Associations, Ethics and Discipline Among Yoruba Traditional Healers in Nigeria.” *Social Science and Medicine* 15B: 87-92.

Padanu, M.K.O., B.O. Olowokure, U. Birmah, Y. Takwoingi (1988). Traditional Medicine in Health Care Delivery System in Gongola State: The Case of Song Local Government Area. *Annals of Borno*, 5: 160-169.

Parsons, T. (1951). *The Social System*. London: Routledge and Kegan Paul.

Patrick, D.I., W.J. Bush and M.M. Chen (1973). “Towards an Operational Definition of Health.” *Journal of Health and Social Behaviour* 14: 6-23.

Pearce, T.O. (1981). "Integrating Western Orthodox and Indigenous Medicine, Professional Interests and Attitudes among University Trained Nigerian Physicians". *Social Science and Medicine*, 16(18): 1611-7.

Pool, R. and Geissler, W. (2005). *Medical Anthropology: Understanding Public Health*. Maidenhead: Open University Press.

Platte, E. (1998). *Problems of Pregnancy and Childbirth in the Rural Areas of North Eastern Nigeria, the case of Musene*. Unpublished PhD Thesis, Frankfurt University:

Renne, P.E. (1997). "The Meaning of Contraceptive Choice and Constraint for Hausa Women in a Northern Nigerian Town." *Anthropology and Medicine* 4 (2): 159-175.

Roadman, K.A. (1998). "Think Globally, Punish Locally: Nonstate Actors, Multinational Corporations, and Human Rights Sanctions." *Ethics and International Affairs* 12: 19-41.

Rodney, W. (1976). *How Europe Underdeveloped Africa*. Dar es Salaam: Tanzania Publishing House.

Russell, B. (1946). *History of Western Philosophy*. London: Routledge.

Sauerborn, R. (2000). "Non-Routine Data Collection Methods". In T. Lippeveld, R. Sauerborn and C. Bodart (eds). *Design and Implementation of Health Information Systems*. Geneva: WHO.

Schram, R. (1966). *Development of Nigerian Health Services, 1460 – 1960*. Thesis for an MD accepted by Cambridge University, UK, under the title 'A Brief History of Public Health in Nigeria. (Published by the University of Ibadan Press in 1971 under the title 'A History of the Nigerian Health Services)

Scott, J. (1990). *A Matter of Record*. Cambridge: Polity.

Shakespeare, W. (1959). *Julius Caesar*. Longman Group Limited London

Shehu, U. (1978). The Problems and Prospects of Improving the Health Status of the People – Paper presented at the seminar on Public Health Planning in Borno State Maiduguri, 1978. University of Maiduguri Press

Sillitoe, P. (1998). "The Development of Indigenous Knowledge: A New Applied Anthropology." *Current Anthropology* 39 (2): 223-52.

Sobo, E.J. and Russell, A. (1997). "Contraception Today: Ethnographic Lessons" *Anthropology and Medicine*, 4 (2): 125-30.

Thomas W.I. (1928). *The Child in America: Behaviour Problems and Programmes*. New York: Knopf.

Twaddle, A.C. (1974). "The Concept of Health Status." *Social Science and Medicine* 8(1): 29-38.

Tylor, E.B. (1871). *Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Art and Custom*. London: John Murray.

Wall, L.L. (1988). *Hausa Medicine: Illness and Well-Being in a West African Culture*. Durham: Duke University Press.

Wheaton, B. (1980). The Sociogenesis of Psychological Disorder: An Attributional Theory. *Journal of Health and Social Behaviour* 21 (2): 100-24.

WHO (1979) *Formulating Strategies for Health for All by the Year 2000: Guiding Principles and Essential Issues*. Geneva: WHO.

WHO (1985) *Report of the conclusion on approaches for policy development for traditional health practitioners including traditional birth attendants*. NUR/TRM/85-1, WHO Regional Office for South-East Asia, New Delhi.

WHO (1991), *The Public/Private Mix in National Health Systems and the Role of Ministries of Health- Report of a meeting held in Mexico, July 20-26, 1991*. Geneva: WHO (Division of Strengthening of Health Services).