



## Role of Traditional Healers in the Treatment and Referral of Common Childhood Diseases in Selected Rural Communities in The Gambia

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### Abstract

**Introduction:** Childhood illnesses cause high morbidity and mortality in The Gambia. Effective case management of these diseases is hampered by poor access to existing biomedical services, as well as by a lack of trained manpower in the government health sector. Many villages in The Gambia however, have access to alternative sources of health care including pharmacies, informal drug sellers and traditional healers.

**Aim:** The purpose of the study was to Role of Traditional Healers in the Treatment and Referral of Common Childhood Diseases in Selected Rural Communities in The Gambia

**Methods and Material:** A rapid ethnographic assessment was undertaken in six villages using in-depth interviews among a purposive sample of 38 traditional healers, 39 mothers and caregivers, 23 health workers, 10 policy makers, 6 village health workers, 6 traditional birth attendants and 6 community health nurses. In addition 12 focus group discussions were conducted with community leaders.

**Results:** The findings showed that Traditional healers were involved in multiple roles in the management of childhood diseases including providing curative (healing) services and in referring to the formal health sector. The Traditional healers were perceived to provide preventive (health advice and counselling) and also a large amount of supportive roles such as listening to mothers. These were also amongst the factors that motivated mothers to seek treatment from traditional healers. Their concepts of the causes of diseases that affect children are attributed to both social and cultural beliefs as well as, biomedical related causes.

**Conclusion:** This fusion of traditional and biomedical concepts of health care should be seen as complimentary and an important step towards formulating effective policies regarding the role and involvement of traditional healers in the formal health sector.

**Keywords:** Morbidity; Mortality; Healing; Gambia

### Introduction

Despite a number of interventions in the health sector mainly targeting women and children, maternal and infant mortality still remain high. Such a phenomenon can be attributed to factors like poor implementation of policies, poverty, illiteracy and most important low patronage of health facilities. Low patronage may also be due to socio cultural beliefs, lack of confidence by the communities in biomedical services which forces them to look for parallel forms of treatment such as traditional healer [1,2]. For ease of comprehension, the term "healers" used in the context of this thesis refers to traditional healers.

Access to health services including equity is a national goal but it will be difficult to achieve, as long as, health services continues to be imposed and controlled by the formal health policy makers. When health care services are centrally planned they are not sensitive enough to local situations and can inhibit collaboration as well as, having a better chance of being culturally inappropriate at the local level. Another issue however is that inadequate research studies to look at appropriate strategies also continue to hinder policy development. Consequently, policy and decision makers do not have information to identify problems and needs, formulate evidence-based programme design to reach sick children; whom

the existing health delivery strategies cannot reach. It is vital that the delivery of health care be based on well-designed evidence based pilot studies rather than on current or political guesswork [3-5]. As a result of the above factors in health care delivery, the community members utilize the traditional practitioners who are seen as part of them and are readily available to meet their immediate health needs. This is supported by the following research findings; According to World Health Organization (WHO), 80% of the population of most developing countries rely for their primary source of health care on traditional forms of care [6-10]. Likewise, it is reported that approximately 70% of mental health services is delivered through non-orthodox means such as religious organizations and healers [11].

In The Gambia, there is a fairly low level of access to optimal health care services, high cost of drugs and low level of coverage by existing formal health care sector, coupled with the inadequate investigation of alternative strategies to reach sick children [12]. Hence policy and decision makers do not have information to identify problems and needs, formulate evidence-based programme design to reach sick children whom the existing health delivery strategies cannot reach. The relative ratio of local healers and western-trained doctors in relation to the entire population in The Gambia is revealing. There is at least one local healer for about 300 people compared to one medical doctor for about every 10,000 people. Therefore, the majority of the people have greater access to local healers than to western health care. Local healers being an integral part of the local cultures, they are accepted as key and reliable sources of care and knowledge on diseases and illness.

In The Gambia, healers remain a popular choice for health care since they are culturally acceptable and readily available in rural communities and their system of charging for their services to children in their communities is community friendly. Healers such as Herbalists, Birth Attendants, Spiritualists, Diviners and Bone Setters have their own support systems and infrastructure already in place. Although there are many different types of healers who practice in Gambian communities, official figures and clear classification of these healers are not yet established.

Recognition of the value of healers and traditional medicine is not always accompanied by strong political and financial support. However, this is contrary to the situation in The Gambia. The political will to incorporate healers in the health development process is already in place [13,14].

In The Gambia, information regarding local healing systems is scant; however, information derived from community studies

shows that a significant section of the population consults healers and traditional medicine is widely used. These studies have demonstrated the usefulness of healers in the treatment of childhood diseases and other diseases such as infertility [15-17]. Healers remain an accepted choice for treatment of common childhood diseases as they seem more culturally accessible. However, this thesis is confronted with the fact that written sources about studies relating to healers' treatment and referral practices in The Gambia are limited. In the context of The Gambia, although healers are used in National Diseases Control Programmes but there is hardly any studies relating to how healers can be better linked to the public health framework. Lack of scientifically based evidence inhibits efforts to promote the proper use of healers in formal health sector [18]. Since a study of this nature has not been carried out before, it is therefore, imperative to make a proper attempt to study the role, nature, magnitude and contribution of healers. Secondly, to explore possible forms of collaboration between the healers and formal health sector, as these findings would contribute to knowledge.

The current national health policy made a commitment to establish partnerships with healers [14]. A policy for the formal inclusion of healers in the health delivery system is yet to be in place to make such partnership functional. There is also no legislation governing registration of healers and traditional medicine. Nevertheless, firstly, research is required to discover more about the role of healers in their communities as the initial step towards formulating effective policies regarding collaboration and partnership.

In view of this background, the study attempts to investigate the role of healers in The Gambia, in the management of common childhood diseases related to the Integrated Management of Childhood Illnesses (IMCI) strategy; with a view to exploring possible mechanisms of collaboration with the formal health sector geared towards enhancing a much effective health care delivery system.

## Materials and Methods

An exploratory research design was adopted to explore the dimensions of the role of healers or to develop or to find the relationships between healers and formal health workers.

### Study villages (Setting)

In Berending, the village map shows the availability of education institutions both formal and Arabic, as well as the distribution of healers involved in health care. This suggests that the villagers have access to both health and education services. When compared to Jarreng, there is a proliferation of the "dara" (Arabic schools) which are close to where the healers live as could be seen on the village map. The main difference between Chilla Jurunku and the other villages is that this population has no access to formal educa-

tion as it has no formal training institution but has a proliferation of Madarassa (“dara”). This could be an explanation for the large number of healers in the village. Poor access to referral services coupled with the village’s strict religious adherence to the dictates of elders and the grand marabouts makes Chilla Jurunku rather unique and different from the other villages.

In Mamutfana, it takes the villagers one hour to get to the highway on foot before getting access to transport, suggesting poor access to referral and communication services. However, it is amongst the villages with the highest concentration of healers. The village also has a number of social and development programmes and there is some degree of intersectoral collaboration among the development partners. In Nyamanarri, transportation is hardly available and the majority of the population travel by bicycle or motorcycles. Compared to Mamutfana, the village’s geographic location makes access to the nearest health facility difficult. This is, however, the only village in the study where the location of the healers cannot be easily identified from the village map.

### Study population

The population under study comprises of:

- Healers (herbalists and marabouts);
- Mothers and caretakers of children less than five years of age (any female who routinely and regularly cared for a child under the age of five years);
- Influential community elders both men and women;
- Health workers (RNs, ENs, CHNs, Public Health Officers (PHOs), VHWs, and TBAs);
- Policy makers (Staff from DOSH and collaborating agencies such as UNICEF and WHO and National Assembly Members (NAMs)).

### Sampling method

The selection of the healers involved two phases. First the DHT asked the CHN responsible for the supervision of the selected village and catchments area to provide a list of names of the available and active healers within the area of the study village irrespective of what type of illnesses the healers treat in the community. The healers were not chosen at random as they were not easily available; as a result the researcher used a purposive sampling method because the team needed to go in search of the healers in the community to identify them.

A purposive sample requires no overall sampling design that tells you how many of each type of informant is needed for the study [19]. A good reason for choosing this type of sampling was to find a sample that reflects the issues that the researcher was

interested to identify. As the research used a qualitative approach which is intended to allow in depth understanding rather than empirical generalization sampling stops when theoretical saturation is reached [20,21]. This means that no new analytical insights are forthcoming therefore the in depth interviews were conducted until no new information was being gathered.

Before the selection of the healers FGD was conducted with the influential elders in each selected study village. The influential elders were used as key informants who helped develop a list of healers who lived not more than five kilometres from the selected study village irrespective of what type of illnesses they treat. They did this through submitting to the team; names of healers whom they knew and had seen treating people in the community. These available two lists of healers provided a sample frame for the healers. The team conducted a pre-interview discussion with each identified healer to make a decision whether he or she treats common childhood illnesses such as malaria ARI, diarrhoea, measles and malnutrition before final inclusion into the study.

The sampling frame for the CHWs used the selected PHC study villages or the nearest, in the event that a CHW was not available in the study village. In-depth interviews were conducted with each CHW. In addition, the research team selected health staff from the health facilities and the staff from NGO and undertook in depth interviews with them. The village elders plus the influential community leaders were selected through the VDC and the council of elders that represented the village.

A convenience sample of ten policy makers were identified from three sources; namely six from the DOSH in The Gambia., one technical officer responsible for child health related activities at UNICEF, Banjul, office and three NAMs were identified because of their influential role in promoting and supporting community programmes in their respective constituencies.

### Criteria for selection of traditional healers

The criteria for the selection of the healers were the same but the availability of healers for final inclusion into the study varied according to village and catchments area. This variation in availability provides the explanation for the variation in the numbers of healers that participated in the study by village. All the healers included in the research met the following criteria:

- The healer did not live more than five kilometres from the study village.
- The healer was involved in the treatment of more than one of the common illnesses and was known in the community they served.

- The healer has to be a member of either one of the following tribes: Fula, Mandinka or Wolof.

### Data collection method

#### Data collection tools

In order to collect data, a set of interview guidelines was developed specifically for each of the following target groups:

- A focus group guide for elderly men and women
- A focus group guide for mothers and caretakers
- An in-depth interview guide for mothers and caretakers
- An in-depth interview guide for healers
- An in-depth interview guide for health workers and
- An in-depth interview guide for policy makers

These interview guidelines are attached as Appendix 4.

#### Selection of interviewers

The study first recruited a team of four (three interviewers plus the researcher) prior to fieldwork. The criteria for selection of interviewers took the following into account:

- Fluency in one or more of the local languages;
- Previous experience with collecting qualitative data;
- Having lived and worked in a rural setting;
- Their literacy level;
- Their age; and
- Their ethnicity.

These were important in ensuring diversity within the data collection team and minimising the effects of individual bias as well as ensuring the quality of the information collected. The interviewers worked as a team with the researcher throughout the interview process.

#### Training of the interviewers

The interview team benefited from a training period over one week immediately after the selection process. The purpose of the training is for Interviewers to guide the respondent's throughout the interview in order to obtain complete and reliable answers. Similarly the interviewer is trained to guide the respondents to appreciate the reasons for using the different interview methods.

#### Pre-testing of interview guides

The field testing took five days plus an additional three days to revise the interview guidelines. The interview guidelines were pre-tested at Macca-Farafenni (Wolof), Kubandarr (Mandinka) and Yallah Tankonjalla (Fula) villages. The pre-testing helps to en-

hance the reliability of the study as it allows the team to ensure that the guides are appropriate to assess the extent of what was intended to be measured. The same information derived from the pre-test is expected during the study phase. After the pre-testing; the team noted and made minor adjustments to the interview guidelines before starting the study.

#### In-depth interviews

In depth interviews allows the interviewee enough time to develop their own accounts of the issues important to them [21]. The reason for conducting in depth interviews with the healers in a face to face setting was because experience has shown that healers do not discuss sensitive issues such as healing practices in a group discussion. Therefore FGDs were not ideal for this particular group as this process would have gone against societal norms. This technique was used to enable the team obtain comprehensive data on the perceptions of treatment and referral practices, as well as, the current role of healers in management of common childhood diseases related to IMCI.

During the process of the interviews the team used tape recorders to record the interviews. The team also made notes during the interview. The recorded data was translated, and the raw notes rewritten and expanded upon. The researcher held meetings with the team to clarify issues regarding the information gathered as well as reviewing the methodology.

#### Focus group discussions

The literature has shown that FGDs have various advantages in health related research. These are to examine public understanding of illness and health behaviours. Secondly, it is a good technique to examine people's experiences of disease and of health services. The technique is also shown to have the potential to produce considerable information in a fairly short time [21,22]. Since the thesis aims to identify factors associated with the communities' perceptions towards child health programme activities, the FGD technique was best suited to gain insight into the perceptions of communities.

FGDs were conducted with mothers and caretakers and influential elders. The FGD with the elders is crucial as these influential elders are believed to have influence in childcare during illness episodes, in particular in decision making and use of health care providers. Influential elders are a good resource to raise awareness amongst mothers and caretakers regarding where and when to seek care. The FGD elicited information concerning prevailing cultural, family, and community practices about the common childhood illnesses such as malaria, ARI, diarrhoea, measles and malnutrition, the reasons for their utilisation of western and traditional



healthcare providers and views concerning the quality of services provided at PHC level. The influential elders also gave suggestions on how healthcare services could be improved to promote the health of children. The roles of influential elders and their involvement in supporting community programmes were explored in terms of decision-making and their perception towards the role of healers in the management of childhood illnesses. This is because the lines of power within village families also affect utilisation of medical treatment. In The Gambian culture “words” or the “advice” of elders relating to these issues are hardly challenged. Treatment can be modified or enforced according to who is most influential in that particular family. Furthermore the influential community leaders given their roles in their communities can be used to strengthen and promote the partnerships between communities and in particular healers and health facilities. Most important during the FGD with influential the participants also assisted the team identify where the healers are located.

The team selected a moderator to facilitate the FGDs and two team members took notes during the discussion. All the discussions were tape-recorded and the team obtained permission from the respondents prior to the discussions.

A sample of the mothers and caretakers that participated in the FGDs was purposely identified. The participants for the FGDs were selected by gender and age and each group had between 8 and 12 participants and the interviews were carried out in separate gender groups. This was because the perceptions and needs of groups could differ by gender. Also, interventions tend to be planned according to gender specific problems and needs. The influential men and women who participated in the FGDs were selected in consultation with the members of the VDC and the council of elders. A random sample was not appropriate, as this process would have gone against societal norms.

An FGD guide was used for the discussion. The information derived from the discussion was used to triangulate information obtained from the in depth interview.

### Ethical Considerations

Prior to commencing the study an official letter was sent to the Director of Health Services requesting permission to conduct the research study. After permission was granted, the proposal and study design were presented to the staff at the DOSH, including stakeholders, as the research study was expected to shed more light on a key priority area of the DOSH. The initial proposal was to conduct the study in two health divisions, the WD and URD. However, during the presentation the staff from DOSH suggested that the study areas should be revised as the concentration of tradi-

tional healers is highest in the NBD and CRD. With the originally proposed two divisions, the healers are more likely to be missed. The change affecting the study divisions was then communicated to my supervisor and research committee members at London School of Hygiene and Tropical Medicine.

A letter was written to all the Officers-in-Charge of the DHTs in the country to inform them of the study and full support solicited from them prior to field work. Staffs at health facilities and the community, policy makers and other stakeholders were written to and the purpose of the study explained. These letters were followed up by a sensitization and follow up visit to all DHTs. This provided an opportunity to discuss the rationale for the study and solicit the full support of the DHTs as well as other health personnel and NGOs working within each DHT prior to the field work. As the DOSH was interested in this study, staff at the DHT representing the Health Department assisted and participated fully in the selection of the study villages.

The importance of ethical considerations in conducting this research cannot be overemphasized. The purpose of the study was fully explained and informed consent was sought prior to the FGDs and in-depth interviews. Verbal consent from the healers was sought because written consent would have gone against societal norms. This was evidenced during the pre-testing of the guides. Furthermore the respondents were reassured about the confidentiality of the information collected and that it would only be used for the purposes of the study. Confidentiality has been discussed as an important principle for ethical practice (Green and Thorogood 2004). The Principal Investigator transported all the sick children as well as adults that were identified during the process of the data collection exercise to the nearest health facility to obtain treatment. The ethical clearances for this study were provided by The London School of Hygiene and Tropical Medicine and DOSH in The Gambia.

### Data processing and analysis

#### Data processing

All the face to face in-depth interviews and the FGDs were tape recorded and at the same time verbatim notes were taken and recorded in hard-cover books during these activities. After the interviews all the tapes were re-played and the discussions that ensued were translated into English, and compared with the written interview text to ensure both recorded and written interview text reflect what the participants had reported. The data collected was cross-checked for accuracy, completeness and clarity. Discrepancies between the recorded and written text were corrected. All interviews were then typed into Microsoft Word.

#### Analysis of in-depth interviews

After the in-depth interviews with the healers and the mothers were completed, the interviews were transcribed and then typed

into Microsoft Word. The word documents were then transferred into text files and imported into the Nud\*ist (Non-numerical unstructured data indexing, searching and theorizing) software programme to manage the non-numerical and unstructured data. An index tree for each of the target groups was developed using themes that were generated from the data. These themes were entered into Nud\*ist as per index tree. Using the interview text, the categories that matched a particular theme were identified, coded and grouped under each theme using the respondents own phrases. The relevant quotations that correspond to the identified themes were also extracted and presented verbatim to give the data credibility. Relevant questions to guide the analysis were then formulated, e.g. “where do mothers take their sick children for curative care and why?”(see Appendix 6).

**Analysis of FGDs**

The data collected from the FGDs with the influential elders and mothers like the in depth interviews were transcribed and com-

pared with the recorded data for accuracy and then typed into Microsoft Word. The word documents were then transferred into text files and imported into the Nud\*ist (Non-numerical unstructured data indexing, searching and theorizing) software programme. Key themes were generated from the data. Then the index tree for this target group was developed. The relevant quotations that correspond to the identified themes were also extracted and presented verbatim to give the data credibility.

**Results**

Six villages were selected for the purpose of the study. Table 1 below shows the villages, the Divisions, ease of access to the nearest health facility and the under-five mortality for each village. The six villages were selected such that each of the three major ethnic groups (the Wolof, Mandingo and Fula) was represented. The villages were all rural and are located in three out of the five administrative divisions of The Gambia.

**Table 1:** Key characteristics of the study villages.

Village	Division	Ethnicity	Distance in (km) nearest H/F	Ease of access to nearest H/F	Under-five mortality per 1000 by LGA -1990
Berending	NBD	Mandingo	4	Good	137
Kerr Amadou	NBD	Fula	4	Poor	
Chilla Jurunku	NBD	Wolof	9	Poor	
Mamutfana	CRD	Wolof	8	Good	166
Jarreng	CRD	Mandingo	7	Good	
Nyamanari	URD	Fula	9	Poor	158

According to the results from the study there is no difference amongst the three ethnic groups in The Gambia, in terms of perceptions of traditional healing practices.

All of the villages had a PHC programme, a health post, a VHW, a TBA, monthly MCH clinic services provided by the main referral health facility and healers who said they treated the common childhood diseases. All of the villages except Chilla Jurunku had a formal education institution, but only Nyamanari had a Breast Feeding Support Group.

The sampling strategy identified a total of one hundred and twenty one healers in the six villages. Each of these healers was asked if they treated the IMCI related diseases and only those who said they treated one or more of the IMCI related diseases such as malaria, ARI, diarrhoea, measles and malnutrition were then asked to participate in the study. This resulted in a total of thirty eight healers purposively identified for the study and all of whom

agreed to participate. There was a reasonably even distribution of numbers of healers amongst the villages with the least number being five in Nyamanari and the highest of eight in Mamutfana (Table 2).

In addition to healers the study participants included mothers and caretakers of children less than five years of age; all mothers between the ages of 16 and 45 years were identified in each village. Amongst this group a purposive sample of the available breast feeding mothers per village were selected for in - depth interviews. This resulted in a total of thirty nine breast feeding mothers (Table 3). There was not much variation in the distribution of the mothers per village with Mamutfana having the highest number of eight and Nyamanari the least number of five.

The health facilities serving the study villages include a hospital, NGO facilities and dispensaries (Table 4). A total of 23 Interviews were undertaken with staff at these facilities as well as with members of the DHTS that supervise these health facilities.

**Table 2:** Distribution of healers by village, type of healer, and ethnicity.

Village	Ethnic Group	Type of Healer			Total
		Herbalist	Herbalist and Marabou	Marabou	
Berending	Mandingo	3	4	0	7
Jarreng	Mandingo	4	2	0	6
Chilla Jurunku	Wolof	4	1	1	6
Mamutfana	Wolof	5	0	3	8
Kerr Amadou	Fula	6	0	0	6
Nyamanari	Fula	4	1	0	5
Total		26	8	4	38

**Table 3:** Distribution of mothers by village, average age and age range.

Village	No of Mothers	Average Age of Mothers	Age Range of Mothers
Berending	8	32 years	19-41
Kerr Amadou	7	23 years	20-34
Chilla Jurunku	6	34years	25-40
Mamutfana	6	28 years	25-42
Jarreng	6	35 years	23-48
Nyamanari	6	29 years	20-35

**Table 4:** Distribution of health staff by village and nearest health facility.

Village	Type of Health Facility	Category of Health Staff			
		Registered Nurse	Enrolled Nurse	Community Health Nurse	Public Health Officer
Berending	Major health centre			1	2
Kerr Amadou	Minor health Centre	1			
Chilla Jurunku	Dispensary				
	NGO health centre	1			
Mamutfana	Hospital	1		2	3
	Dispensary				
	NGO health centre	1			
Jarreng	Hospital	1			2
	Dispensary			1	
	NGO health centre		1		
Nyamanari	Major health centre	1		2	1
	Minor health centre	1		1	
Total		7	1	7	8

A convenient sample of ten policy makers were identified from three sources namely, The DOSH. The policymakers from this Department were identified from the office of The Director of Health Services, Participatory Health Population and Nutrition Project (PHPNP), the MCH unit, the Psychiatric Hospital, and Kudang and Basse Major Health Centres respectively. One technical officer

responsible for child health related activities from UNICEF Banjul participated because of UNICEF supportive role towards Child Health programmes in The Gambia. Three NAMs were identified purposively and they agreed to participate in the study because of their influential role in promoting and supporting community programmes at the level of their constituencies (Table 5).

**Table 5:** Distribution of Policymakers by category.

Institution	Policy Makers by Category of Staff				Total
	Medical Doctor	SRN	PHO	NAM	
Department of State for Health	1	2	1	0	4
Health Facility level	0	2	0	0	2
UNICEF	0	1	0	0	1
National Assembly Members	0	0	0	3	3
Total	1	5	1	3	10

Among the thirty eight healers in the study, three types of healers were identified based on the methods used that they reportedly elaborated on to treat patients. Firstly, those healers that reported that they worked with herbs and roots were classified as herbalists (N = 26). Secondly, those healers that reported they used both herbs and the Quran to treat were classified as both herbalist and marabou (N = 8) and the third category who reported they used the Quran to treat were classified as marabou (N = 4). This classification system also reflects the way in which the healers themselves prefer to be recognised and addressed, and accords with the way they are identified and referred to by mothers and other community members.

When the narratives were analysed they showed that the healers greatly valued being classified and addressed according to their appropriate type of healing practice. This was evident both in the way they express their role in the community and in their explanations of what type of healing they practiced. Their reputations were bound up with this type of recognition and the mothers and the communities at large identified them according to the type of healing practice they perform.

All the villages had at least three herbalists but in the two Fulla villages only one of the eleven healers was not a herbalist (she was a herbalist-marabou). In the Mandingo villages almost half of the

healers were herbalist-marabou (6/13) rather than just herbalists. In the Wolof villages there was also only one herbalist-marabou, but in these villages, unlike the Mandingo and Wolof villages there were also healers who identified themselves as just marabous. Female healers were represented in each village and thus in each of the three ethnic groups (Table 6).

Mamutfana had only one female healer (a herbalist), Berending, Kerr Amadou and Nyamanari each had two female healers (in Berending and Nyamanari, one was a herbalist and one a herbalist-marabou, while in Kerr Amadou both were herbalists). Jarreng and Chilla Jurunku both had three female healers, all herbalists. However, while eleven out of the twenty six herbalists were female, there were no female marabou and only two out of eight herbalist-marabous were female.

**Types of IMCI diseases treated by healers**

During the in depth interview healers were asked which of the IMCI related diseases they commonly treated and the data suggest that there is little variation between the different types of healers or between the different ethnic groups in terms of the IMCI related diseases they commonly treated. All except one healer (a herbalist) reported treating malaria and ARI and all but three (35/38) said they treated diarrhoea (Table 7). Fewer of the healers said they treated measles and malnutrition but still over three-quarters of the healers reported treating these diseases.



**Table 6:** Distribution of healers by gender, ethnic group and type of healing practised.

Type of healer	Gender	Ethnic group			Total
		Wolof	Mandingo	Fula	
Herbalist	Female	4	4	3	11
	Male	5	3	7	15
Herbalist and marabou	Female	0	1	1	2
	Male	1	5	0	6
Marabou	Female	0	0	0	0
	Male	4	0	0	4
Total		14	13	11	38

**Table 7:** IMCI related diseases reportedly treated by type of healer.

IMCI diseases	Type of Healer			Total (N = 38)
	Herbalist (N = 26)	Herbalist and Marabou (N = 8)	Marabou (N = 4)	
Malaria	25 (96%)	8 (100%)	4 (100%)	37 (97%)
ARI	25 (96%)	8 (100%)	4 (100%)	37 (97%)
Diarrhoea	23 (88%)	8 (100%)	4 (100%)	35 (92%)
Malnutrition	20 (77%)	7 (88%)	3 (75%)	30 (79%)
Measles	20 (77%)	6 (75%)	3 (75%)	29 (76%)
Other illnesses	12 (46%)	3 (38%)	1 (25%)	16 (42%)

In addition to the in-depth interview (without any reference period), a case study interview was conducted with each healer to explore in depth to what extent healers are currently involved in treatment and referral of common childhood diseases. The reference period for the case study was two weeks. Thirty-seven healers from the 38 healers were interviewed. One healer did not participate in the case study because he travelled and the reference period was not adequate to this healer for case study interview.

“I treat almost all diseases brought to me as I am using the true name of Allah and the right trees for the right purpose I am not specialised I treat all diseases in men and women, children young and the old” (KH5).

“All the sicknesses are attached to malaria ‘kajee’ and it is malaria that has spread to cause all these diseases I treat children suffering from all sicknesses. Among the diseases I treat are ‘Kajee’ or ‘Jarrala’ (malaria); ‘Paiso’ (yellow fever); ‘Sumaayakurango’ (pneumonia); ‘Sisidimo’ (chest pain), ‘Nigkando’ (fast breathing), ‘Konobayo’ (malaria in pregnancy); ‘Konokarakato’ (Diarrhoea); ‘Konobayoming kake-fiyoti’ (Dysentery); and ‘Kungo’ or ‘tiyo’ (Malnutrition)” (BH6).

In this study, a total of 18 FGDs were conducted. One FGD with elderly men and elderly women in each of the six selected study

village (N = 12). One FGD in each village with mothers and caregivers in the child bearing age group who did not participate in the in depth interviews (N = 6). The village elders plus the influential community leaders were selected through the VDC and the council of elders that represented the village. The main purpose of the FGD with the elders is to triangulate the information collected from the other target groups.

**Discussion**

The majority of the healers received some training and acquire their skills from their fathers through learning the Quran and the collection and preparation of the herbs. The average number of years of experience for the healers was 30 years with a range from 4 to 70 [13,23]. Apprenticeship was the main method used and their knowledge and skills are based on practical observations, carrying out physical tasks assigned to them by their tutors over a long period. Other studies have reported similar pattern of recruitment among the healers studied. All the healers felt they are part of their communities as they live with them. They see their role as very important and valued within their communities [23,24].

Discussions with the healers show that classifying them by their type of healing practice has a great impact on their status and the healers’ value if generally being addressed by the type of healing practices they perform [25]. Experience has shown that compe-

tion and jealousy do exist between the different categories of healers. Cultural norms also dictate that social interaction and acceptance within societies occur amongst elders and influential groups with similar backgrounds. It is therefore important to address issues with healers that have similar backgrounds to minimize this competition and reinforce better relationships amongst healers. For example, it might be useful to bring together healers of similar categories during health care training.

The thesis provided data on the role that healers currently play in the management of childhood illnesses that can inform policy. The findings reveal multiple roles played by traditional healers' in management of childhood illnesses as expressed by all the target groups. These included, healing, health advice counselling, providing a referral system and supportive roles such as listening to the mothers. These were also amongst the factors that motivated mothers to seek treatment from healers for sick children. Given the inadequate health personnel, inadequate logistics and poor health facilities, lack of required drugs at PHC, healers could be trained as CHWs in PHC as healers are less inclined to leave their rural communities. This will improve the accessibility of health care in rural communities as well as enhance the curative role that healers can perform.

Since healers have the capacity and serve as advisers in terms of where people can get health care to another level they should be given a more prominent role in decision making about delivery of PHC in the country. This shows that to enhance collaboration between the traditional and formal sector therefore, is an important element to provide health care in PHC.

As the majority of the healers consider themselves to have a healing role which the professional health workers fail to recognise; healers are of the opinion that professional health workers should change this attitude and encourage the healers to work side-by-side with the formal health sector. Overall it can be argued that there is the potential for collaboration between the healers and professional health workers [13,24]. However, this potential is unlikely to be realised unless opportunities for collaboration are vigorously explored and put in place.

The data show that the healers can be effective in playing a central role in providing education and an advisory role to mothers and caretakers when their children are sick [26,27]. The explanation is attributed to, not only are healers' important figures and that the mothers normally obey their words, but also, the traditional, cultural beliefs that prevail in the society towards the role of the healer is a contributory factor. At the same time, the literature review suggests that healers could be used as potential

agents to disseminate health information, as well as bridging the gap between communities and professional health workers. The findings of a study conducted in rural Zambia on traditional healers as a source of information and advice for people with sexually transmitted diseases came to a similar conclusion [28]. In contrast in Nyamanari village where there is a community programme of mothers support group fewer healers reported considering themselves as having a role in health promotion compared to the other study villages. Presumably this was due to the way the programme was introduced. It is possible that the healers were not informed about their role in the programme and were therefore not involved. In general between each ethnic group there was no significant difference between how healers understood their roles in advising mothers about preventive health care practices that are important to promoting the health of children.

Some professional health workers have expressed the fear that the role of healers in the treatment of childhood diseases relating to IMCI might be a difficult one to determine because the health workers expressed that they are not fully aware of the types of treatment that healers use. Nonetheless, they still acknowledge that healers have a curative role. For example, one of the NAMs explained to me that one healer did explain to him that the roots of "nebedaya" prevent malaria and cures "Samatinya" (Anaemia). The NAM also reported that he saw the healer on the television explain how the leaves and seeds of "nebedayo" is dried and pounded up into powder and sprinkle on the food the child feeds on. Both healers and health workers have diverse views regarding the role of the healer in the treatment of measles.

The majority of the health workers believe healers have a referral role, [24] as measles is a communicable disease. At the same time some professional health workers however, believe that healers have the herbs to treat measles and are of the view that these herbs they give to the sick children are very effective. In contrast, from the healers' perspective the health centre cannot do much about measles. In addition the professional health workers believe that when the healers receive training on what they are expected to do, i.e. in the treatment of measles, they can carry it out properly and it will be beneficial to the child at home. This suggests that the health workers have faith in the curative role of the healers. The findings from the FGDs with the elderly men and women were also similar to views from the healers. All the groups pointed out that the healers have a curative role, but they also pointed out that the healers could not treat all illnesses.

The communities, as well as, health workers and policy makers, still have faith in the services that the healers offer. The results of the study have shown that healers' perceptions towards their role

in treatment of common childhood diseases have been positive. Health promotion has been rated as essential followed by curative procedures. However, the effectiveness of their treatment will have to be explored in another study.

Although the reported roles of healers are highlighted, the effectiveness of these roles could not be measured by this study. The professional health workers have divergent views about the role of healers. However, the roles of healers could be further investigated and clearly identified to enable health workers to build up a consensus and to avoid confusion regarding the expected roles of healers. Until this could be achieved, integrating healers into the formal health services at this point in time will meet with limited success nonetheless collaboration efforts could be pursued.

When the responses from the different target groups were compared it seems there is a lot of consistency in what each group says about the others. This suggests that each group has a good idea of who the other people are, what they are doing, and why they do those things. This could be because it is a small-scale society where everyone simply knows everything about their neighbours, their responses are similar. This cultural affiliation between healers and their patients is an important factor to encourage more active role of healers in PHC suggesting healers as change agents. The sharing of cultural experience and preference of treatment enhances the efficacy of treatment. There is no difference in ethnicity concerning what the different target groups consider as the factors that motivate mothers and caretakers to take sick children to healers.

### Conclusion

In order for public health goals to be attained in Africa, healers should be active participants in the formal health care delivery system. As both modern medicine and traditional healing approaches are not perfect both systems must join forces if better outcomes are to be achieved. This is what medical syncretism aims to emphasize. That is a fusion of the two different systems because successes in both systems are partial or outcomes heterogeneous [29].

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