

TYPES OF MENTAL ILLNESS MANAGED BY TRADITIONAL HEALERS IN KENYA

A MONOGRAPH OF AFRICA MENTAL HEALTH FOUNDATION

Principal Investigators (PI)

Prof. David Ndetei

Co- Principal Investigators (CO-PI)

Dr. Lincoln Khasakhala

MBChB, MSc Clinical Psychology, (Nairobi), Kenya
Research Officer, Africa Mental Health Foundation

Contact:

Prof. David M. Ndetei
University of Nairobi

Director, Africa Mental Health Foundation
AIC Building, Suite 4, Ralph Bunche Road
P.O. Box 48423-00100

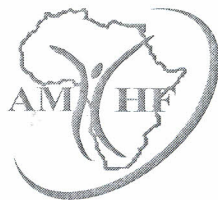
Nairobi Kenya

AFRICA MENTAL HEALTH FOUNDATION (AMHF), 2009

P.O. Box 48423-00100, Nairobi, Kenya

E-mail: dmndetei@uonbi.ac.ke; dmndetei@amhf.or.ke

Website: <http://www.africamentalhealthfoundation.org>



University of NAIROBI Library



0380524 9

UNIVERSITY OF NAIROBI LIBRARY
P. O. Box 30197
NAIROBI

UNIVERSITY OF NAIROBI
MEDICAL LIBRARY

Table of Contents

ACRONYMS.....	ii
EXECUTIVE SUMMARY	iv
INTRODUCTION	1
Traditional Medicine Therapies.....	2
Rationale	3
Study Questions	3
OBJECTIVES.....	4
STUDY DESIGN AND METHODOLOGY.....	4
Ethical considerations	8
RESULTS	10
RESULTS OF THE IN-DEPTH INTERVIEW OF THE PATIENTS OF THE TRADITIONAL HEALERS	14
SUMMARY OF FOCUS GROUP DISCUSSIONS AND INDEPTH INTERVIEWS WITH THE TRADITIONAL HEALERS	15
TYPES OF DISORDERS SEEN BY THE TRADITIONAL HEALERS.....	17
OTHER IMPORTANT FINDINGS OF THE STUDY DRAWN FROM THE INDEPTH INTERVIEWS OF BOTH THE TRADITIONAL HEALERS AND THE PATIENTS.....	21
DISCUSSION	25
CONCLUSION.....	27
POLICY RECOMMENDATIONS	28
REFERENCES	30

EXECUTIVE SUMMARY

BACKGROUND

Traditional healing has been practised by many cultures in Kenya and for many years. It is an accepted mode of treatment in different cultures. The traditional healers are consulted even today and provide treatment to many people for various physical illnesses. They are also consulted for mental illnesses. In many of our communities, before the individuals go for treatment in the health centres for mental disorders, they will have tried the traditional healer first or continue to see the traditional healer as they continue with hospital based medication. The fact that mental illness is given cultural interpretation in the African setting in most cases gives the basis of seeing the traditional healers. These healers therefore probably manage a wide spectrum of mental illnesses that is hitherto scarcely reported.

OBJECTIVES

General Objective: To document the various types of mental illness seen and treated by the traditional healers.

Specific Objectives

- 1) To determine the validity of the mental disorder diagnoses made by the traditional healers
- 2) To document the treatment modalities for mental illness offered by the traditional healers
- 3) To document the knowledge, attitudes and practice in regard to intellectual property by the traditional healers in Kenya

DESIGN, SETTING AND PARTICIPANTS

STUDY DESIGN: Cross sectional

SETTINGS: Kibera, Kawangware and Kangemi

PARTICIPANTS: Traditional healers residing in the areas of study and patients of the traditional healers.

METHOD

The study was carried out in three informal settlements in Nairobi; Kibera, Kawangware and Kangemi. Nairobi is home to almost all the tribes of the country, thus it has a national representation. Snowballing method was used until the required number of traditional healers representing the various communities in Kenya was reached. In-depth interview was done with each traditional healer. An in-depth interview with each patient of the traditional healer was done and later administered the MINIPLUS to them to counter check the diagnoses arrived at by the traditional healers. The research assistants who were non clinicians from both public and private universities in Nairobi were trained in a central place in Nairobi on the objectives of the study, ethical considerations and in particular confidentiality and informed consent. They were also trained on the research instruments.

Clearance to carry out the study was sought from Kenyatta National Hospital Ethics Research Committee and permission for community entry was also sought from Ministry of Science and Technology and the community leadership.

Participation in the study was completely voluntary on the traditional healers and also on the part of their patients, with the right to withdraw participation from the study at any stage and without any repercussions from the research team.

All traditional healers residing in the areas of study and who agreed to participate in the study and patients of the traditional healers who signed the consent were interviewed.

Data was collected using self developed questions for socio-demographic and in-depth interviews, and MINIPLUS for adults and quantitative analysis was done using SPSS.

RESULTS

PATIENTS OF THE TRADITIONAL HEALERS

Socio-demographic Profile

The study enrolled 305 adult patients of the traditional healers. These patients were above 18 years. Male patients were 50 (16.4%) while female patients were 255 (83.6%). The range in age of the patients was between 18 years and over 60 years.

Of the 302 patients who responded to the marital status question, 111 (36.4%) were single, 157 (51.5%) were married, 29 (9.5%) were divorced/separated while 5 (1.6%) were widowed.

Patients had attained different levels of education. Twelve (3.9%) had not attended any school, 159 (52.1%) had reached primary level, 112 (36.7%) had reached high school level while 22 (7.2) had gone up to middle level college.

Mini Plus results

Of the respondents, 33.99% said they lost their ability to respond to things that previously gave them pleasure, or cheered them up while 66.01% of the respondents said they did not lose their ability to respond to things that previously gave them pleasure.

Further, 94.08% of the respondents did not think they would have been better off dead or wished they were dead. However, 5.92% of the respondents said they thought they were better off dead or wished they were dead.

A small percentage of 19.08% of the respondents said they had experienced or witnessed or had to deal with an extremely traumatic experience while 80.92% of the respondents said they had never experienced or witnessed or had to deal with an extremely traumatic experience.

A proportion of 89.22% of the respondents did not have psychotic disorders where they believed that people were spying on them or that someone was plotting against them or trying to hurt them while 10.78% of the respondents believed that people were spying on them or that someone was plotting against them or trying to hurt them.

Only 24.67% of the respondents said they were worried excessively or had been anxious about several things of the day to day life at work, home or in their close circle over past 6 months. A proportion of 75.33% of the respondents said they were not excessively worried.

A small percentage of only 5.92% of the respondents said they were fearful or embarrassed being watched, being the focus of attention or fearful of being humiliated while in public or in social situations. The other 94.08% of the respondents said they were not fearful or embarrassed while in public or in social situations.

Almost all of the respondents, 96.7%, said they had not been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive, or distressing in the past month with only 3.3% who said they had been bothered by such recurrent thoughts in the past month.

Only 7.26% of the respondents said they had experienced a period of time when they were “up”, or “high” or so full of energy that other people thought they were not their usual self while 92.72 % of the respondents said they had never experienced such a period.

Out of all the respondents, it was only 8.17% who said they felt anxious or particularly uneasy in situations where escape would have been difficult and where help might not have been available in case of panic attacks whereas the majority, 91.83% said they did not feel anxious or uneasy in such situations.

TRADITIONAL HEALERS

Socio-demographic Profile

A total of 59 traditional healers were enrolled in the study from the three study sites of Kangemi - 16 (27%), Kawangware - 21 (36%) and Kibera - 22 (37%).

They comprised of 33 (57%) males and 25 (43%) females. One traditional healer did not indicate the gender.

For those who could remember their ages, the age ranged between 18 years, for the youngest, and 70 years, for the oldest. These ranges were as follows: less than 20 years, 1; 21-30 years, 3; 31-40 years, 10; 41-50 years, 27; 51- 60 years, 7; while 61-70 year olds were 7.

Majority of the traditional healers had reached primary school level.

INTRODUCTION

According to WHO³, traditional medicine is the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses. Traditional medicine has been practised in many parts of the world for many years before the onset of modern/western medicine. Traditional medicine therapies include use of medication which can be from herbs or from animal parts and non medication therapies which are varied in different parts of the world for example, divination and psychotherapies practised widely in Africa.

Traditional medicine is widely used for different types of illnesses, both physical and psychiatric, as it is affordable and accessible to poor people in developing countries. In Africa for example, up to 80% of the population depends on traditional medicines in order to meet their healthcare needs.³

Traditional healers are an important source of psychiatric support in many parts of the world, including Africa. They offer a parallel system of belief to conventional medicine regarding the origins, and hence the appropriate treatment of mental health problems.⁵ This was recognized in Kenya by Dr Otsyula, who reported in 1973⁶ that patients went to hospital only to look for the cure of their illness, whereas they went to see traditional doctors for both the cure and also to find out the cause of their illness. The application of diagnosis and treatment methods is largely influenced by the culture and beliefs dominant in a particular community to the extent that they may be ineffective when applied in a different context⁴.

Research statistics from Kenya and Uganda suggest that 25–40% of all people seeking medical care at primary health level have problems purely related to mental health and another 25–40% have a combination of both mental health problems and physical problems.⁷ At the same time the distribution of modern medicine personnel is uneven,

with most being found in the urban centre as opposed to the rural areas with few being found in informal settlements. This was found by Ndetei especially in relation to mental health.⁸ Traditional healers are the first professional contacted for mental illness in many parts of Africa.^{9, 10} This is because they are sufficient in numbers in the communities; are accepted; do home visits, do not stigmatise mental illness, are often consulted and have been demonstrated to see many people with mental disorders;¹¹ are willing to learn and also are willing to collaborate with hospital based health professionals for the holistic approach in the management of patients.^{8, 11} They are enshrined in the minds of the people, are respected in their community, are often its opinion leaders and are first respondents in case of an emergency⁵

Traditional Medicine Therapies

Herbs: Many traditional healers use herbs; and a wide range of herbs is used for treatment purposes. An example of a plant with psychiatric medicinal properties and has been used for treating severe psychotic conditions going back to 1925¹² is *Rauwolfia*, which is rich in reserpine. This plant is found as an ornamental plant in many parts of Kenya and Tanzania, especially around the Mt Kilimanjaro area, where it also grows in the wild. It is known for the treatment of 'madness', by which is meant psychosis, regardless of the cause or type

Psychotherapy: The practice of psychotherapy and behavioural therapy is so very much advanced in traditional practice in East Africa that these therapies, as practised in the West are not a match to what happens in traditional Africa. This is illustrated by a statement by Rappoport & Dent (1979)¹³ who noted that psychotherapy as practiced in Tanzania was as effective if not more effective than psychotherapy as practiced in the West. The same observation was made by Ndetei⁵

Surgical: A classic example of a traditional surgical intervention is craniotomy as practised by the Kisii and Turkana peoples of Kenya for the treatment of psychosis, related to diseases thought to be located inside the skull.¹² This is, however, not practised today.

Spiritual therapy: Spiritual therapy attempts to bring peace and harmony between the living and the spiritual world, especially spirits of the ancestors, which are believed to live on after death and continue to influence events in the living world

Rationale

With the informal settlement having most of its population living with less than a dollar a day, the residents might not give health issues and especially mental illness a priority when allocating the money. The lack of priority on allocation of funds for mental health is shown from the government level where only 1% of annual health budget is spent on mental health. At the same time, in Kenya there is a shortage of psychiatrists, the ratio being approximately 1:500000.¹⁷ Many of these psychiatrists operate private clinics and their charges are out of reach for the people in the informal settlements. Government hospitals also practise cost sharing and this could discourage many people from going there unless it is a matter of life and death. There is ample scientific evidence from Kenya and elsewhere that traditional healers are easily accessible, affordable and accepted by the communities and are highly consulted including for mental illnesses.^{6,13,18-22} However there has not been a systematic study on the kind of psychiatric conditions they diagnose and how they treat them. We intended to gather this information with a view towards informing policy about their practices and if the methods of treatments were unique with respect to other practices, then patenting, hence protecting their intellectual property.

Study Questions

1. Are traditional healers in Kibera, Kangemi and Kawangware consulted by people suffering from mental illnesses?
2. Do consulted traditional healers treat mental illnesses and are they able to identify the different types of mental disorders?
3. How do the traditional healers identify the types of mental illnesses that they treat and how valid are the identified mental illnesses according to DSM IV?

OBJECTIVES

1. To document various types of mental illness seen and treated by traditional healers.
2. To determine validity of mental disorder diagnoses made by traditional healers
3. To document treatment modalities for mental illness offered by traditional healers
4. To document knowledge, attitudes and practice with regard to intellectual property by traditional healers in Kenya

STUDY DESIGN AND METHODOLOGY

a) Study Design: Cross sectional.

b) Study Area Description

The study was carried out in Nairobi, the capital city of Kenya. The reason for picking Nairobi was that as the capital city, it is home to almost all the tribes of the country. Thus it has a national representation. Three informal settlements in Nairobi were picked, Kibera, Kawangware and Kangemi. It was noted that the distribution of modern medicine personnel is uneven, with most being found in the urban centre as opposed to the rural areas and few being found in the informal settlements. This was found by Ndetei especially in relation to mental health.⁸ The three study sites are informal settlements and the income of the residents does not enable them to seek psychiatric services from private doctors who, in most cases, are not found in the informal settlements. These are also areas where Africa Mental Health Foundation already has other study projects.

Kibera is situated in Nairobi's Southwestern peri-urban zone approximately seven kilometres from the Nairobi City Centre. Kibera as a whole is an informal settlement comprising of ten villages covering approximately 250 hectares of land with an estimated population of about 200000 people. It is made up of 10 villages which are; Lindi, Kisumu Ndogo, Soweto, Makina, Kianda, Mashimoni, Siranga, Gatuikira, Laini Saba and the newly founded Raila village. The villages are densely populated with 95% of the residents living below poverty line. Most of them are working in the industrial area of the

city as casual labourers with an average income of Kshs 45/= per day. The average family of 7 occupies a small room of 10 by 10 feet. There are no street lights. Most of the houses are made of mud and roofed with either corrugated iron sheets or covered with polythene papers. Administratively, Kibera is in Langata District.

Kangemi is a cosmopolitan area found in the western part of Nairobi; about 10 minutes drive from the heart of the city. It is in Westland constituency. The Kangemi informal settlement is located in Kangemi location, Westlands Division which is found in the western district of the city of Nairobi in Kenya. The informal settlement is divided into 12 'villages', each with a village head. The village heads are invaluable associates and confidantes of the location chief (the local government administrator) and work very closely with him/her and the three assistant chiefs. Kangemi is an established settlement rather than a typical urban slum. Many people living here are long time residents, offspring of long time residents or their close relatives. Other residents are people who have migrated from rural areas to set up temporary homes here. Majority of the residents of this area live below the poverty line on less than US\$1 a day and can barely afford basic necessities. Kangemi Health centre and Gichagi Dispensary serve as the primary government health care delivery clinics. Private medical clinics, some of which are owned by individuals, are distributed across the settlement area. A few are operated by non-governmental organizations, community-based organizations and faith-based organizations. Personnel running these clinics however have no mental health training; meaning they cannot effectively manage and follow-up cases of mental illness.

Kawangware is a mixture of formal and informal settlement. It is in Dagoretti Constituency. The slum has a population of over 100000 people. It is situated approximately 12 km in the western outskirts of Nairobi Central Business District. This informal settlement is associated with poor living conditions, no access to piped water, sewage system and it is characterized by shanties, overcrowding, and high rate of crimes due to unemployment. The residents work as low-income labourers and house helps in the neighbouring affluent areas of Lavington.

c) Inclusion criteria

1. All traditional healers residing in the areas of study and who agreed to participate in the study
2. Patients of the traditional healers who signed the consent.

d) Sampling Method

Using the help of community health workers, all the traditional healers from the different tribes living in the three study sites were identified. If a tribe had more than two traditional healers, the names of the traditional healers were written on separate papers and then two names were randomly picked to represent that particular tribe. The traditional healers were requested to identify their patients who, in their own opinion had mental illness and were at that time treating the patients for the same. The patients were adults (18+ years). For each traditional healer the names of the patients were written on ballot papers from which five were randomly picked. However the traditional healers could only identify very few patients who had mental illnesses. This made the investigators ask them to give them their patients with physical illnesses. This was due to the fact that physical and mental illnesses do occur together and the mental illness is missed out during diagnosis.

e) Training procedures

The research assistants were trained by the PI on: (a) the consenting process, (b) administration of the MINI PLUS and (c) how to conduct in depth interviews with traditional healers and their patients.

f) Recruitment and consenting procedures

Recruitment took the following procedures:

(a) Making contact with traditional healers

- 1) We sought community entry through (a) the Medical officers of health of the following Districts: Dagoretti, Langata and Westlands (b) the chief and village elders.

- 2) The community health workers in each site then invited the traditional healers to a meeting in a central place in each study site, where the PI explained the nature of the study including all ethical considerations and in particular their right not to participate and also their right to withdrawal the consent any time in the course of the study.
- 3) Each traditional healer was then given a copy of the consent explanation for reading. The PI took the traditional healers through the consent explanation, explaining every section. *Those who agreed to participate in the study then signed the consent form.*
- 4) Date for the focus group discussion was made.
- 5) After the focus group discussion, appointments were made with each of the traditional healer to visit them in their practices for in-depth interviews and availing their patients.

Interviewing the traditional healers at their practices then followed.

(b) Interview with the patients

Once the patient was picked as explained above, the community health worker took the research assistant to the home of the patient. The research assistant then explained the nature of the study to both the care giver and the patient for their respective informed consent for the participation of the patient. Those who agreed to participate were then interviewed by the research assistants using the study instruments.

g) Quality assurance procedures

The research assistants were non-clinicians from both public and private universities in Nairobi. They were trained in a central place in Nairobi on the objectives of the study, ethical considerations and in particular confidentiality and informed consent. They were also trained on the research instruments.

The research assistants were not to make any interpretation of the data, they were only to recording the responses to specific questions which they were not allowed to alter or modify. They were trained in two phases: (a) theoretical (b) practical.

On daily and on site basis, every questionnaire was scrutinised by the field coordinator for observance of ethical issues, consistency, and satisfactory completion. Each

questionnaire was then assigned a code and any identifier removed. They were then transported to the data entry point at AMHF where double entry and comparison were done using the SPSS 16.

h) Data collection Instruments

All the instruments used were translated into Kiswahili.

(1) Social demographic for both traditional healers and the patient - described above

(2) In depth interviews for both traditional healers and the patients - described above

MINI PLUS for the patients: The MINI-International Neuropsychiatric Interview (MINI - Plus) is a structured diagnostic interview, which was developed by Sheen *et al* in 1998 to assess the diagnoses of psychiatric conditions according to DSM-IV and ICD-10 criteria. It takes 20-30 minutes to complete it and assess 23 disorders. It has high validity and reliability.²⁴

Ethical considerations

Clearance to carry out the study was sought from Kenyatta National Hospital Ethics Review Committee and permission for community entry was also sought from Ministry of science and Technology and the community leadership.

Consent explanation was done to two groups; the traditional healers and their patients and family or legal care providers.

Informed Consent

Whereas all the information on the study was to be provided, the participation in the study was completely voluntary for the traditional healers and also on the part of their patients, with the right to withdraw participation from the study at any stage and without any repercussions from the research team.

Confidentiality

The personal details were replaced by an anonymous number which was a personal code. Any personal details were kept in a locker under key at Africa Mental Health Foundation (AMHF) Headquarters and only accessible to the PI who was the only person with the

key to the locker. This was to ensure that nobody would be able to identify traditional healers or their patients.

Benefits

The benefit to the traditional healers would be information on patenting, benefit sharing and intellectual property.

The patients too would benefit in that if they were found to have psychiatric disorders they would be advised to visit the nearest health centre for further evaluation or go to Mathari Hospital. They would then make a choice whether to continue with their traditional healer or take up the referral or both.

The information would also enable the policy makers to know the best way to positively engage with traditional medicine.

Risks

There were no invasive procedures to both the traditional healers and their patients. No biological samples were taken from either. However the traditional healer feared that he/she may be exposing their ways of treatment. However, this was safeguarded by the assurance that details of what they did were not being discussed with anybody else.

The risk to the patients was the emotional pain of talking about their mental states. However, the talking was to trained research assistants who had been trained on the skills of listening, being empathic and maintenance of confidentiality.

This study therefore took the approach of do no harm, maximize on benefits.

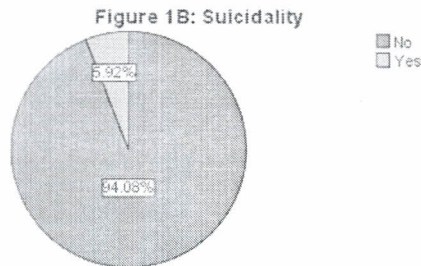
Participants were not paid for participating in the study. However a maximum of one hour of patients' time and of the traditional healers' time at their own homes caused inconvenience to them. This was appreciated through a token gift of a bar of soap. However, any expenses incurred relating to the study was paid for.

RESULTS

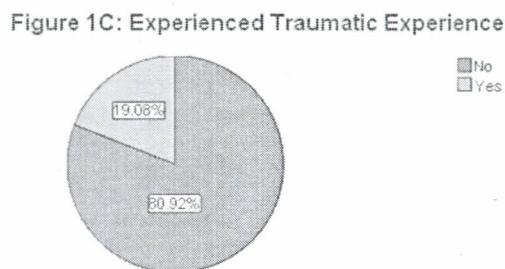
PATIENTS OF TRADITIONAL HEALERS:



A proportion of 33.99% of the respondents said they lost their ability to respond to things that previously gave them pleasure, or cheered them up while 66.01% of the respondents said they did not lose their ability to respond to things that previously gave them pleasure as in figure 1A above.

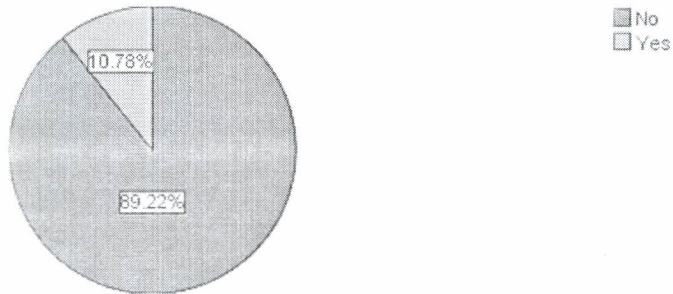


From figure 1B, almost all of the respondents (94.08%) did not think they would have been better off dead or wish they were dead. However, 5.92% of the respondents said they thought they were better off dead or wished they were dead.



A small percentage of the respondents said they had experienced or witnessed or had to deal with an extremely traumatic experience with 19.08% while 80.92% of the respondents said they had never experienced or witnessed or had to deal with an extremely traumatic experience as in figure 1c above.

Figure 1D: Psychotic Disorders



As in figure 1D, 89.22% of the respondents did not have psychotic disorders where they believed that people were spying on them or that someone was plotting against them or trying to hurt them while 10.78% of the respondents believed that people were spying on them or that someone was plotting against them or trying to hurt them.

Figure 1E: Generalised Anxiety Disorder



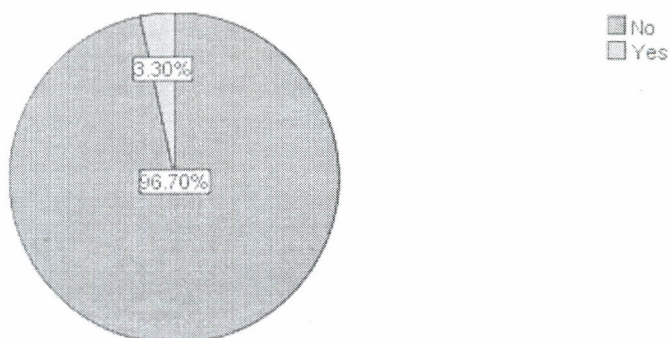
From Figure 1E, it is only 24.67% of the respondents who said they were worried excessively or had been anxious about several things of the day to day life at work, home or in their close circle over past 6 months. A proportion of 75.33% of the respondents said they were not excessively worried.

Figure 1F: Social Phobia



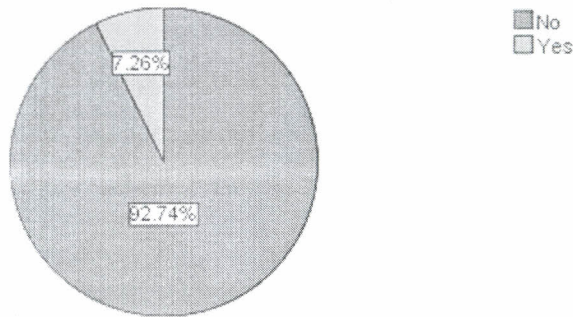
As in figure 1F, a small percentage of only 5.92% of the respondents said they were fearful or embarrassed being watched, being the focus of attention or fearful of being humiliated while in public or in social situations. The other 94.08% of the respondents said they were not fearful or embarrassed while in public or in social situations.

Figure 1G: Obsessive Compulsive Disorder



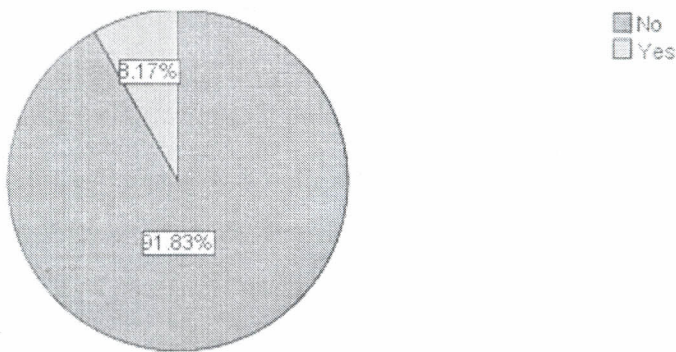
Almost all of the respondents with 96.7% said they had not been bothered by recurrent thoughts, impulses or images that were unwanted, distasteful, inappropriate, intrusive, or distressing in the past month with only 3.3% who said they had been bothered by such recurrent thoughts in the past month as in figure 1G.

Figure 1H: Bipolar 1 Disorder



As in Figure 1H, 7.26% of the respondents said they had experienced a period of time when they were “up”, or “high” or so full of energy that other people thought they were not their usual self while 92.72% of the respondents said they had never experienced such a period.

Figure 1I: Agoraphobia



Out of all the respondents, it was only 8.17% who said they felt anxious or particularly uneasy in situations where escape would have been difficult and where help might not have been available in case of panic attack whereas the majority, 91.83% said they did not feel anxious or uneasy in such situations as demonstrated in Figure 1H above.

RESULTS OF THE IN-DEPTH INTERVIEW OF THE PATIENTS OF THE TRADITIONAL HEALERS

A total number of the 305 patients enrolled in the study. Of the 304 patients who indicated their gender, males were 50 (16%) while females were 254 (84%).

Level of education: Most of the patients reached primary school, with others reaching secondary level and a few having been to colleges. None had reached university.

Only 15 patients said that they were not satisfied with the traditional healer. The rest said that they were.

Asked what made them decide to start going to the traditional healer, almost all the patients said that they used to visit the hospital but they were not getting well. This was with regard to all diseases.

Only less than 20 patients combined traditional medicine with modern medicine. Some of the patients who combined the two claimed that they only took pain killers when they had sudden headaches, while others said that they went to hospital for investigations then told the traditional healer who treated them while one or two said that they went to the hospitals when they had money.

Many patients stuck to one traditional healer. Those who consulted another traditional healer claimed that they did so when they were not getting well or when they moved upcountry and got sick and so they consulted the nearest traditional healer.

The payment to the traditional healer was both in cash and in kind. Some combined both cash and kind. It was also reported that many could pay in instalment with those without anything being treated free of charge. It was also noted that patients could pay when they got well.

Asked whether the traditional healer were more affordable compared to the hospitals many patients responded 'yes', depending on where one was seeking treatment. A number responded that though the traditional healers were expensive, the fact that they got well did not matter. Some also said that in the hospitals all they got were panadols. Also those who felt that the traditional healers were expensive said that they could pay in instalments.

On the question of accessibility of the traditional healers almost everybody said that they were easily accessible with some making home visits. However it was noted that it was

difficult to get a true traditional healer. When they travelled to look for their herbs, they could take a while.

SUMMARY OF FOCUS GROUP DISCUSSIONS AND INDEPTH INTERVIEWS WITH THE TRADITIONAL HEALERS

Three focus group discussions were held, one in each study site. The groups consisted of 8 persons; 4 males and 4 females. They had no problem in sitting and talking together as they said it was not the first time they had discussed issues together. They then responded as follows:

- Asked whether they had been trained, they all said that they had been. Majority were trained by their grandparents and parents while the rest were trained by other traditional healers.
- On the types of patients that went to consult them in terms of age, gender, socioeconomic, tribe, educational levels and religion, they said that all types of people went to consult them.
- Asked about the types of diseases that they treated, they all said that they treated many types which included:
 - Diabetes
 - Male and female reproductive health problems
 - Asthma
 - Sexually transmitted infections
 - Witchcraft
 - Allergy
 - Depression
 - Anxiety
 - Madness
 - Alcohol abuse
 - Epilepsy
 - All sorts of aches including tooth ache

156538/ron

- Children's disease etc
 - Some women acted as traditional birth attendants
- Very few specialized in a particular type of disease.
- All treated using herbs which they said that they got from Ngong Hills and the neighbouring countries, particularly those from Kawangware who went to the neighbouring Uganda and Tanzania.
- Asked on how they prepared their medications, they said that it depended on the type of medication but boiling was the standard method of preparing them. Others used to crush the herbs.
- Asked whether their practices were registered, many said 'no'. Various reasons for not registering were given which included:
 - Lack of finance
 - Not attending a seminar to help them on the knowledge of registration
- On the issue of patenting, all of them said that their methods were not patented. The reasons given were that they were not aware of the process and would like to learn more about it and how to go about it. They requested to be taught about it.
- When asked whether they referred their patients to the hospitals, almost all said that they did and especially if they treated and the person did not get well and needed further tests. One said that he referred to a senior traditional healer. However they complained that though they referred their patients to medical facilities, the medical doctors never reciprocated by sending patients to them (TRs) and yet there were conditions that could only be treated by the traditional healers.
- Asked how they compared their charges with those of hospitals, they all said that they were cheaper.

- They said that they were paid both in kind and cash depending on the person's ability.
- Asked whether they combined modern methods of treatment with traditional ones, they said 'no'.

TYPES OF DISORDERS SEEN BY THE TRADITIONAL HEALERS

The traditional healers see a number of disorders, from the conventional physical, mental and neuropsychiatric disorders to those that can only be interpreted from the cultural perspective, for example spirit possession and witchcraft.

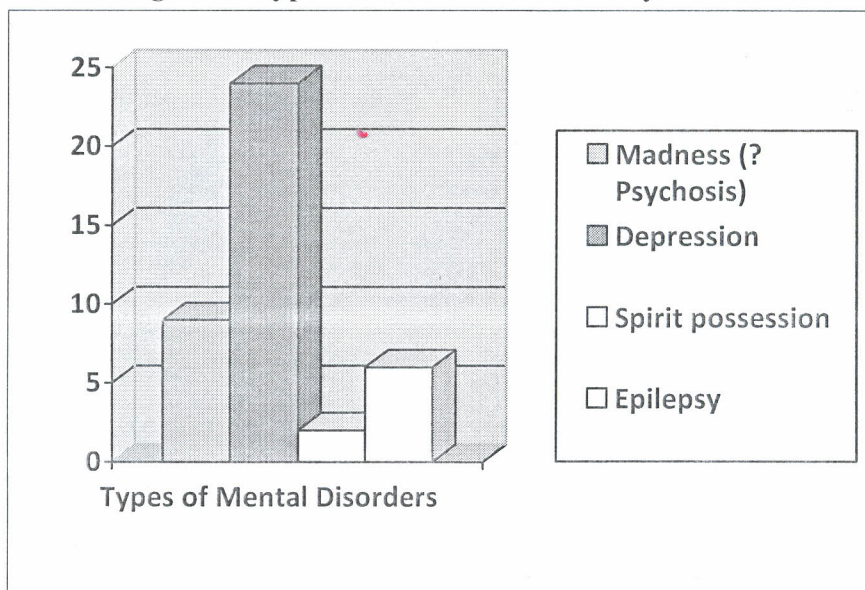
Objective 1: To document the various types of mental illness seen and treated by the traditional healers.

A total of 296 patients responded to the question on the type of diagnoses given by the traditional healers (TH). Table 1 and Figure 1 show that traditional healers recognised broad categories of mental and neuropsychiatric illnesses and had generic names for these conditions.

Table 1: Types of mental illness seen by the TH

Types of mental illness seen by the TH	Frequencies	percentages
Madness/psychosis	9	3.04%
Depression	24	8.108%
Spirit possession	2	0.6756
Epilepsy	6	2.02

Figure 1: Types of mental illness seen by the TH



A total of 17 (5.7%) patients were described as having been victims of witchcraft christened *kutupiwa*. However it was not clear whether this was a diagnosis on its own or the cause of the illness whether physical or mental.

Objective 2: To determine the validity of the mental illness diagnoses made by the traditional healers against internationally recognised instruments

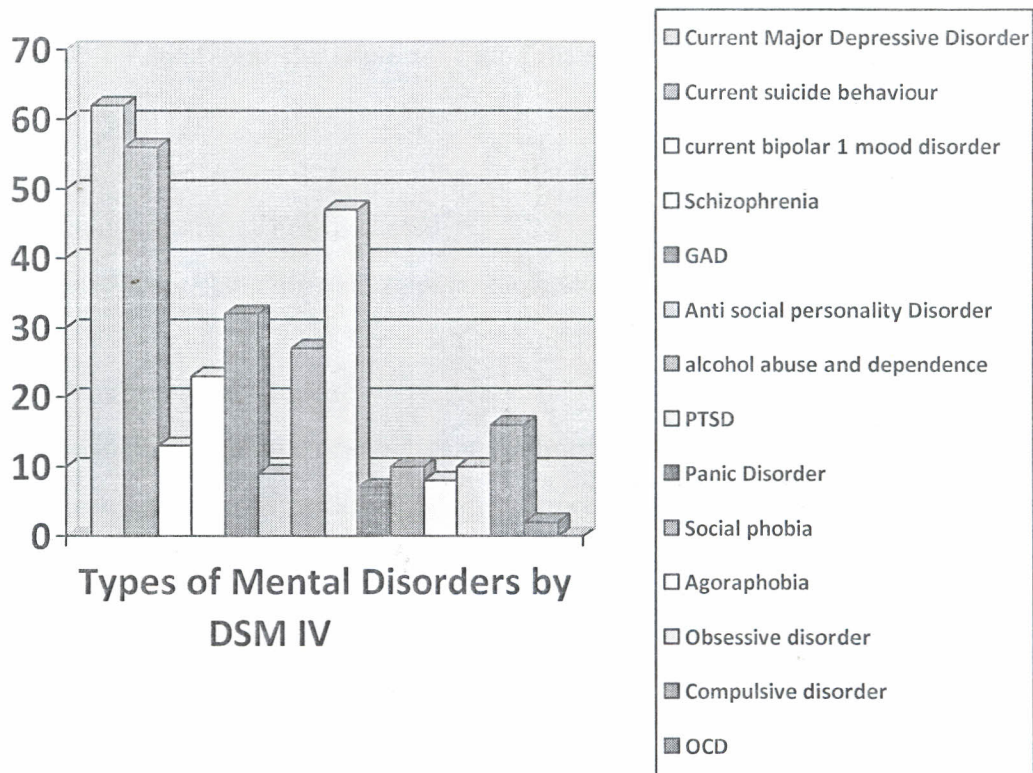
305 patients completed the MINI PLUS to be able to find out the types of mental illness that they were suffering from. The following DSM IV disorders were identified. However note that DSM IV does not pick epilepsy.

Table 2: Types of mental illness by the MINI PLUS

Types of mental illness by the MINI PLUS	Frequencies	percentages
Current Major Depressive Disorder	62	20.3
Current suicide behaviour	56	18.4
current bipolar 1 mood disorder	13	4.3
Schizophrenia	23	7.5

GAD	32	10.5
Anti social personality Disorder	9	3.0
alcohol abuse and dependence	27	8.9
PTSD	47	15.4
Panic Disorder	7	2.3
Social phobia	10	3.3
Agoraphobia	8	2.6
Obsessive disorder	10	3.3
Compulsive disorder	16	5.2
OCD	2	.7

Figure2: Types of mental illness diagnosed with MINI PLUS



Of the patients diagnosed by the TH as having depression and madness/psychosis the MINI PLUS correctly identified them as having those mental illnesses. Many patients had co-morbid mental illnesses. However, from the above results of the MINI PLUS (figure 2), it is clear that many patients with psychosis (christened madness - “kuruka kichwa” by the TH) and depression were missed/ misdiagnosed by the TH. A number of explanations can be put forward:

1. Those who had been diagnosed as having been bewitched were not given any type of mental illness
2. Many of these patients were presenting to the THs with physical illnesses. It is known that a number of physical diseases concurrently occurred with mental illnesses.
3. However the most plausible explanation is that they did not have the appropriate knowledge on how to diagnose those conditions; a familiar story amongst general doctors in general hospital facilities.²⁵

Objective 3: To document the treatment modalities for mental illness offered by the traditional healers.

The TH used different methods for treating mental illnesses depending on the severity of the disease and the cause. These included:

- Counselling - being the most popular method of treatment
- Use of different types of herbs which could be taken orally, others for washing while others were inhaled.
- Combining herbal treatment with counselling.
- Consulting the spirit world including the ancestors who then gave instructions on how the patient should be treated.
- Other TH would move to the patient’s home to help him/her remove certain items which the TH claimed had been used to bewitch the patient.

Objective 4: To Document the Knowledge, Attitudes and Practices Regarding Intellectual Property by the Traditional Healers in Kenya

The TH had little if any knowledge on intellectual property. However during the capacity building on this particular area it became clear that they were wary of researchers who wanted to find out about their methods of treatment. This was because they reported that those who had gone to them especially for the treatment of HIV/AIDS only used their findings to advance themselves (stole their methods of treatments) but never acknowledged the TH. They (researchers) *got rich* from the TH's *sweat*. They did not want to take any of their information to any government body. They said that others would use them. They preferred to protect and retain this information within their families by passing it down orally and through ancestral instructions to specific members of the family.

OTHER IMPORTANT FINDINGS OF THE STUDY DRAWN FROM THE INDEPTH INTERVIEWS OF BOTH THE TRADITIONAL HEALERS AND THE PATIENTS

Why people seek help from traditional healers

All the patients were asked why they sought help from the traditional healers and yet there were government health centres near them. Their responses were:

- Many reported that they would not get well despite visiting the hospital. This was common irrespective of the disease.
- They also said that the traditional healers had more time for them and talked to them in a kind manner as opposed to the hospital settings.
- Others said that the health centres did not have medicine and all they got were *pain killers*.
- The fact that the traditional healer could let them pay later was a major attraction to the patient. No traditional healer sent the patient away due to lack of money.
- The traditional healers' services were not necessarily less expensive than health facilities for example, payment by chicken which would have a market value of 500Kshs as opposed to 20 Kshs user fee at a health centre. However the fact that

one could pay in instalment and in kind made the people visit them (flexibility in mode of payment).

- However, of more significance was that pre payment was not a condition for treatment as there was allowance for payment after one got better and there was fear of spiritual punishment or recurrence of the illness should one fail to honour their oral undertaking to pay.
- TH also operated a waiver system strictly on the ability to pay. If the TH sent a patient away on the basis of genuine inability to pay, the TH would be punished by their spiritual mentors.

Satisfaction with traditional healers' services

Only 15 patients said that they were not satisfied with the traditional healers' services. The rest said that they were satisfied.

Combining traditional healing and modern medicine

Less than 20 patients combined traditional medicine with modern medicine. Some of the patients who combined the two claimed that they only took pain killers when they had sudden headaches, while others said that they went to hospital for investigations then told the traditional healer who then treated them while two said that they went to the hospitals when they had money.

Moving from one TH to another

Many patients stuck to one traditional healer. Those who consulted another traditional healer claimed that they did so when they were not getting well or when they moved upcountry and got sick; and so they consulted the nearest traditional healer.

How patients paid the TH

The payment to the traditional healer was both in cash and kind. Some combined both cash and kind. It was also reported that many could pay in instalment with those without anything being treated free of charge. It was also noted that patients could pay when they got well.

Comparing the affordability of the TH to that of health facilities

Asked whether the traditional healers were more affordable compared to the hospitals, many patients responded 'yes', but depending on where one was seeking treatment. A number responded that though the traditional healers were expensive, the fact that they got well did not matter. Also, those who felt that the traditional healers were expensive said that they could pay in instalments.

Accessibility of the TH

On the question of accessibility of the traditional healers almost everybody said that they were easily accessible with some making home visits. When they travelled to look for their herbs, they could take a while.

The training of the traditional healers

Most of the traditional healers said that they inherited their treatment methods from their grandparents or parents who trained them from the time they were young. Few were trained by prominent traditional healers.

How traditional healers made a diagnosis

Asked on how they got to know that the patient had a mental illness, various responses were given which included:

- Examining the patient
- Observing his/her behaviour and mode of talking
- Getting the history of the patient
- Some traditional healers used the mirror to arrive at a diagnosis (spiritual 'imaging')
- Others prayed to get revelations from spirits (divination)
- Some beat a drum to get revelation (*kupiga ramli*)

Whether the TH referred their patients to hospital facilities

Many THs refer their patients to other more experienced THs but if the patient is not getting well they send them to hospitals for more tests. They also said that they always encouraged the AIDS patients on ARVs to continue with their medications. A few claimed that they can cure HIV/AIDS. They also said that though they referred their patients to the hospitals, the doctors did not reciprocate. They felt that the doctors did not recognise them.

DISCUSSION

Of the patients diagnosed by the TH as having depression and madness/psychosis the MINI PLUS correctly identified them as having those mental illnesses. Many patients had co-morbid mental illnesses. However, from the above results of the MINI PLUS, it was clear that many patients' with mental disorders were missed/ misdiagnosed by the TH. A number of explanations can be put forward:

1. Those that had been diagnosed as having been bewitched were not given any type of mental illness.
2. Many of these patients were presenting to the THs with physical illnesses. It is known that a number of physical diseases occur concurrently with mental illnesses.
3. However the most plausible explanation is that they did not have the appropriate knowledge on how to diagnose those conditions; a familiar story amongst general doctors in general hospital facilities.²⁵

The patients given the diagnosis of thinking too much were probably having depression. In the African context there was no word for depression from the focus group discussions, many traditional healers mentioned that for them depression was not known "but thinking too much" was common. These findings were similar to those found in South Africa.²⁹

The traditional healers' services were not necessarily less expensive than health facilities for example, payment by chicken which would have a market value of 500 Kenya shillings (6.25USD) as opposed to 20 Kenya shillings (25UScents) user fee at a health centre. However the fact that one could pay in instalment and in kind made the people visit them (flexibility in mode of payment). However of more significance was that pre payment was not a condition for treatment as there was allowance for payment after one got better and there was fear of spiritual punishment or recurrence of the illness should one fail to honour their oral undertaking to pay. The fact that the traditional healer could let them pay later was a major attraction to the patients. No traditional healer sent the patient away due to lack of money. Traditional healers also operated a waiver system strictly on the ability to pay. If the TH sent a patient away on the basis of genuine inability to pay, the TH would be punished by their spiritual mentors.

The finding that many patients had visited the health centres before visiting the traditional healers was also similar to findings in Uganda ²⁷. Most patients sought treatment from traditional healers once they felt that health centres were not offering adequate treatment for them. Probably, many also felt that they would be able to discern the cause of disease from traditional healers, a benefit that according to the patients, health centres did not provide.

Many traditional healers had inherited the skill from their parents or grand parents. This is a common phenomenon as is reported by Nwoko. ³⁰ The skill therefore tends to run in families, thereby a privilege of selected families.

The failure to recognize the traditional healers' role in the provision of medical care in the community is not unique in Kenya. It is a similar story in Zimbabwe where many people still seek help from them, both the poor and the rich, because of their varied explanation of the cause of disease. ³¹

Some of the practices carried out by the traditional healers while making diagnoses are similar to those done by the western trained doctors, for example history taking. The traditional healers also said that they gave their medication depending on the age of the patient. This is a common practice with western trained doctors

CONCLUSION

1. Traditional healers are consulted by members of the community for various illnesses including mental illnesses.
2. Traditional healers recognise mental illnesses though in a limited way leading to misdiagnosis, under-diagnosis and at best minimal proper diagnosis.
3. Traditional healers are extensively patronised and have a large clientele and therefore cannot be ignored. Instead they should be engaged constructively to promote better understanding of mental illnesses, their diagnoses and the possible referrals while at the same time discouraging harmful practices.
4. Traditional healers offer counselling and psychotherapy and in particular psychoanalytic therapy though based on traditional beliefs and practices. These are models in current practice in western countries where they have the time and the resources but are hardly practised in health facilities for lack of time and expertise.
5. To ensure safety of the treatment modalities where herbs are used for treatment by the traditional healers, education on having their herbs tested by a recognised body in Kenya, for example KEMRI is important. However, this must be accompanied by full proof assurance that their intellectual knowledge will be safeguarded.
6. The traditional healers get their medication from plants in local forests and even neighbouring countries hence the need for environmental conservation.
7. Traditional healers are not averse to cooperation with health facilities and therefore are willing to collaborate and in fact refer patients. This may aid in creating a channel of increased referrals if they were empowered through constructive and positive engagement and supportive supervision through continuous education on the various psychiatric disorders and their manifestations. The current negative, dismissive and condescending attitudes of western medicine to traditional and 'alternative' medicine are not only counterproductive but in the long run it is the citizens who suffer. Indeed it can be argued that western medicine is the alternative medicine as it is a newcomer.

However, these back and forth accusations and counter accusations do not help the patients.

POLICY RECOMMENDATIONS

The following policy recommendations were made and presented:

1. Recognise the existence of the traditional healers and their large clientele. These clients are Kenyans crying for help and they go where they think they can get help unless they are given an alternative.
2. Empower the traditional healers on how to recognize the different types of mental illnesses. This can include showing them how to use simple tests which can be translated into their mother tongues. They will therefore be able to screen at their level and in the process increase referrals and improve on the mental health information system.
3. Strengthen their skills on interventional methods that do not require the use of drugs. This would include individual therapy, family therapy and group therapy as they use counselling to treat certain types of mental illnesses. Therapies have been shown to be effective even when practised by lay people. This would go a long way in ensuring the safety of the patients from getting certain herbs which could have serious side effects and also ensure that human rights observance in relation to practices that may be harmful to the patients.
4. Empower them on when and where to refer. This can only be possible if they are recognised and appreciated rather than being shut out. The referred patients if they still want to see their traditional healer can go for psycho-social support thus complementing the management of the patient on aspects that the health facility based personnel do not have the skills or the human and time resources to deliver.
5. The traditional healers outnumber psychiatrists (and even the other doctors), as they are there in plenty. If embraced, mental health will be taken from the health centres to the grassroot level – household level. This has been a recommendation for the African Region²⁶

6. Part of the collaboration between traditional healers and health facility based practitioners would be psychosocial support in relation to adherence to medicine for not only mental disorders but also physical conditions such as HIV/AIDS and TB. This trend is common for example in South Africa relating to other diseases.
7. The traditional healers should be sensitised on the need for taking their herbs for testing. This will ensure that their patients get the correct dose.
8. Through the department of Culture and the Traditional Healers Association, the traditional healers need to be encouraged to register so that they are recognised. This helps to eliminate the quacks.

REFERENCES

1. Commission on Intellectual Property Rights. Integrating intellectual rights property and development policy. London: September 2002.
2. Gupta Anil "Rewarding Traditional Knowledge and contemporary creativity: The role of Intellectual property protection " (<http://www.cid.harvard.edu/cidiharvard/edn/biotech/eventes/anil-gupta-paper.htm>).
3. World Health Organization. Traditional Medicine Strategy 2002–2005. Geneva: 2002
4. Kibet A N. Indigenous Knowledge, Alternative Medicine and Intellectual Property Rights Concerns in Kenya. December 2005.
5. Ndetei DM. Traditional healers in East Africa. *Int Psychiatry* 2007; 4 (4): 85-86.
6. Otsyula W. Native and Western healing: the dilemma of East African psychiatry. *Journal of Nervous and Mental Disease* 1973; 156: 297–299.
7. Ndetei DM, Muhanji J. The prevalence and clinical presentation of psychiatric illness in a rural setting in Kenya. *British Journal of Psychiatry* 1979; 135: 269–272.
8. Ndetei DM, Khasakhala LI, Kingori J, Oginga A, Raja S. The Complementary Role of Traditional and Faith Healers and Potential Liaisons with Western-Style Mental Health Services in Kenya. Available online at www.utsouthwestern.edu/psychiatryandfreedom
9. Abiodun O. Pathways to Mental Health Care in Nigeria. *Psychiatric Services* 1995; 46 (8): 823 – 26
10. Ngoma M, Prince M, Mann A. Common Mental Disorders among Those Attending Primary Health Clinics and Traditional Healers in Urban Tanzania. *British Journal of Psychiatry* 2003; 183 (4): 349 – 55
11. Ndetei DM, Khasakhala L, Oginga A. Traditional and Faith Healers' Practices in Kangemi Informal Settlement, Nairobi, Kenya. Africa Mental Health Foundation and BasicNeeds UK in Kenya. 2008.
12. Ndetei DM. Psychiatric phenomenology across countries: constitutional, cultural, or environmental? *Acta Psychiatr Scand Suppl* 1988; 344: 33-44.

13. Rappoport H, Dent PL. An analysis of contemporary East Africa folk psychotherapy. *British Journal of Medical Psychology* 1979; 52: 49–54.
14. Dutfield G. The public and private Domains Intellectual Property Rights in Traditional Ecological knowledge. 2000 March: [[http://www.oiprc.ox.ac.uk/EJWP099 htm](http://www.oiprc.ox.ac.uk/EJWP099.htm)].
15. Kuyek D. Intellectual Protection Rights: Ultimate Control of Agricult R&D in Asia. 2001 March: [[http://www.grain.org/briefings/2id = 35](http://www.grain.org/briefings/2id=35)]
16. Commission on Intellectual Property Rights. Integrating Intellectual Property Rights and Development Policy. London: 2002 September.
17. Ndeti DM, Ongecha FA, Mutiso V, Kuria M, Khasakhala LI, Kokonya DA. The challenges of human resources in mental health in Kenya. *South Afr Psychiatry Rev* 2007; 10: 33-6.
18. Ndeti DM. Psychiatry in Kenya, yesterday
19. Adewuya A, Makanjuola R. Preferred Treatment for Mental Illness among Southwestern Nigerians. *Psychiatr Serv* 2009 January; 60:121-124.
20. Sorsdahl K, Stein DJ, Grimsrud A, Seedat S, Flisher AJ, Williams, et al. Traditional Healers in the Treatment of Common Mental Disorders in South Africa. *The Journal of Nervous and Mental Disease* 2009 June; 197 (6): 434-441
21. Abbo C, Ekblad S, Waako P, Okello E, Muhwezi W, Musisi S. Psychological distress and associated factors among the attendees of traditional healing practices in Jinja and Iganga districts, Eastern Uganda: a cross-sectional study. *Int J Ment Health Syst* 2008; 2: 16.
22. Ovuga E, Boardman J, Oluka EGAO. Traditional healers and mental illness in Uganda. *Psychiatric Bulletin* 1999; 23: 276-279.
23. World Health Organization. Global burden of disease in 2002: Data sources, Methods and results. Geneva: 2004.
24. Sheehan DV, Lecrubier YS, Sheehan KH, Amorim PJJ, Weiller E, Hergueta T, et al. The Mini-International Neuropsychiatric Interview (M.I.N.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *J Clin Psychiatry* 1998; 59 (20):22-33.

156538/row

25. Ndeti DM, Khasakhala L, Kuria M, Mutiso V, Ongecha FA, Kokonya D, The Prevalence of Mental Disorders in Adults in Different Level General Medical Facilities in Kenya: A Cross-Sectional Study. *Annals of General Psychiatry* 2009, 8:1.
26. Hanlon C, Wondimagegn D, Alem A. Lessons Learned in Developing Community Mental Health Care in Africa. *World Psychiatry* 2010;9: 185-189