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TRADITIONAL MENTAL HEALTH PRACTITIONERS IN KWARA STATE, NIGERIA

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ABSTRACT

Objectives: To assess the knowledge, practice and attitude of traditional mental health practitioners (TMHPs) in four Local Government Areas (LGAs) in Kwara State, Nigeria, on mental health care; to organise training sessions aimed at improving their knowledge base, practice and; to evaluate such training after allowing for a period of practice.

Study design/intervention: Pre-training evaluation phase: TMHPs were assessed in the area of knowledge, attitude and practice of mental health, with the use of a questionnaire. They were then trained in the concepts of normality and abnormality, types of mental illness, treatment of mental illness including follow up, after-care, relapse prevention, other primary preventive measures, and some introductory talks on some sub-specialties of psychiatry, for example, child psychiatry, old age psychiatry, forensic psychiatry, drug and alcohol abuse and; after a free-practice period of two months, the TMHPs were again re-assessed for the impact of the training.

Results: Pre-intervention phase: TMHPs could easily recognise most symptoms of mental illness except undue sadness. The TMHPs also expressed strong belief in the supernatural factor as a cause of mental illness. Some of them beat their patients for therapeutic reasons and; Post-intervention phase: there was a widening of the sense of recognition of TMHPs of important mental symptoms such as undue sadness, social withdrawal and elation. There was a better understanding of the aetiological concepts of mental illness. There was also a reduction in the habit of beating their patients as a form of treatment.

Conclusions: The use of information, education and communication intervention techniques could lead to more positive and less hazardous forms of practice among TMHPs and; The high level of cooperation achieved in this study would indicate a bright chance for future collaborative activities between orthodox and traditional healthcare providers.

INTRODUCTION

For over two decades, the main target for health care delivery world wide has been 'Health for All' by the year 2000 A.D.(1). The pivot of achieving this is through Primary Health Care (PHC)(1,2). In Nigeria, although a lot of progress has been recorded in the delivery of health care at the PHC level, a major limitation has been the unwillingness of western-trained practitioners to work in the rural areas where more than 70% of the population reside. Psychiatric service delivery is further hampered by the dearth of orthodox personnel. TMHPs have therefore filled in the gap and played a major role in caring for the mentally ill in the community. They are highly patronised because they are more evenly distributed and close to the people. They also tend to have a good understanding of the family and socio-cultural systems. Furthermore, they share the same belief system with the people in terms of causation and possible management strategies for common mental disorders(3,4). However, TMHPs have been criticised for their use of chains and shackles to restrain aggressive or

agitated patients, a practice which has often led to serious complications such as wound sepsis and loss of function in the affected limb(4-7).

In recent past, there has been a renewed interest in fostering better working relationship between orthodox mental health practitioners (OMHPs) and TMHPs. In this regard, interested orthodox researchers have undertaken studies aimed at facilitating a better understanding of the practice of traditional medicine in general, and traditional mental health practice in particular(4-9). However, none of the studies on traditional mental health practice in Nigeria had involved training sessions between the two groups and an evaluation of the impact of such training. This report, presents the findings of a systematic study aimed at evaluating the impact of specific interactive (intervention) sessions with TMHPs in four LGAs of Kwara State, Nigeria.

It is hoped that this study will highlight the impact of training on the practice of TMHPs and provide a possible reference point on which future evaluation studies on TMHPs could be based.

MATERIALS AND METHODS

The study was conducted in four phases. The first two phases (pre-training evaluation and training) took place between October 1998 and March 1999. These were followed by a free practice period lasting two months (March to May 1999). The fourth phase (post training practice evaluation) was conducted over a six-month period (May- October 1999).

Community penetration: The authors first approached the Kwara Medical Herbalists Association (KMHA) and explained the aims and objectives to the key officers. We were struck by their warm and welcoming attitude. The officers in turn arranged a meeting of the entire membership during, which the study was introduced to them. The authors were later taken round the selected LGAs on familiarisation tour by the Secretary of KMHA. Further, the Secretary accompanied the researchers to the study sites throughout the period of study. In spite of these helpful gestures, the authors still experienced a lot of difficulties with some TMHPs who were suspicious of the aim of the study. Another problem had to do with some TMHPs who were requesting for unrealistic amounts of financial incentive.

Pre-training evaluation: This was done with the use of a questionnaire designed by the authors, which sought information on socio-demographic variables, and data on the knowledge, attitude, and practice of the TMHPs (Appendix A). Focus group discussions were also conducted with each group of TMHPs trained, in order to obtain in-depth information on the various topics of interest.

Training: Following the pre-training evaluation, all consenting TMHPs in each LGA participated in a training programme which comprised the following modules: introduction and explanation on aims and objectives of study; concept of normality and abnormality; types of mental illness; treatment of mental illness including follow-up; after-care, relapse prevention, other primary preventive measures, and some introductory talks on some sub-specialties including child psychiatry, old age psychiatry, forensic psychiatry, drug and alcohol abuse.

Free practice period: During this phase, participating TMHPs were allowed a two-month period of free practice during which they were expected to put into practice the knowledge they acquired during the training period.

Post-training/practice evaluation: There was considerable difficulty in recruiting TMHPs into this phase of the study. Only 27 of the original 43 TMHPs, participated in this phase. One reason for this situation was that some of the TMHPs invited were suspicious of the motive behind the study, despite adequate explanation and reassurance by their leaders. Another reason for the attrition was that some TMHPs again, as in the pre-training and training phases, insisted on adequate (although unrealistic) financial compensation for their time and contribution to the study.

During this phase, the same questionnaire used for the pre-training evaluation was administered to the TMHPs who participated in the pre-training evaluation. In addition, focus group discussions were held with TMHPs in three of the LGAs to discuss issues relating to their experiences during the evaluation (pre- and post- training) and the free practice period.

RESULTS

Socio-demographic data: Generally, the respondents interviewed in the pre- and post-intervention periods were fairly similar in their socio-demographic characteristics (Table 1).

Pre-intervention: Forty three traditional mental health practitioners (TMHPs) were interviewed. Their ages ranged from 22 years to 80 years with a mean of 50 ± 15.5 years. Thirty-eight (88.4%) were males, while five (11.6%) were females. Forty two (97.7%) were Moslems, while one (2.3%) was a Christian Thirty two (74.4%) of the TMHPs were primarily traditional practitioners of mental health, five (11.6%) were farmers, three (7.0%) were artisans, while the remaining three respondents comprised a student, a trader and a civil servant.

Post-intervention: Twenty seven TMHPs were interviewed. Their ages ranged from 22 years to 80 years with a mean of 51 ± 14.4 years. Twenty three (85.2%) were males, while four (14.8%) were females. All the TMHPs were Moslems. The primary occupation of the majority of the respondents 23 (85.2%) was the traditional mental health practice, one (3.7%) was a farmer, one (3.7%) was a trader while the remaining two (7.4%) did not properly indicate their primary occupation.

Symptom recognition by TMHPs: Majority of TMHPs could easily identify the following as symptoms of mental illness at the evaluation phase: laughing to self (93%), talking to self (93%), social withdrawal (79%), talking out of context (100%), deteriorating personal hygiene (81%), elation (79.1%) and sensation (83.7%). It was noted that only a relatively lower percentage recognised undue sadness (67.4%) as a symptom of mental illness (Table 2).

Table 1

Comparison of socio-demographic data pre- and post-intervention

	Pre-intervention n = 43 (%)	Post-intervention n = 27 (%)
Age (years)		
Range	22-80	22-80
Mean	50.2	51.0
SD	15.5	14.4
Sex		
Male	38 (88.4)	23 (85.2)
Female	5 (11.6)	4 (14.8)
Primary occupation		
TMHP	32 (74.4)	23 (85.2)
Farming	5 (11.6)	1 (3.7)
Trading	1 (2.3)	1 (3.7)
Civil servant	1 (2.3)	Nil
Student	1 (3.7)	Nil
Others	3 (7.0)	-
Inconsistent	-	2 (7.4)
Education		
No formal education	20 (46.5)	13 (48.1)
Primary	16 (37.3)	6 (22.2)
Secondary	2 (4.7)	2 (7.4)
Tertiary	5 (11.6)	9 (33.3)

Table 2

Symptoms recognition by TMHPs pre- and post-intervention

	Pre-intervention n = 43 (%)	Post-intervention n = 27 (%)
Laugh to self		
Yes	40 (93)	27 (100)
No	3 (7)	–
Talk to self		
Yes	40 (93)	27 (100)
No	3 (7)	–
Withdrawn		
Yes	34 (79)	26 (96 ^a)
No	9 (21)	1 (4)
Talks out of context		
Yes	43 (100)	27 (100)
No	–	–
Deteriorating personal hygiene		
Yes	35 (81)	26 (96)
No	8 (19)	1 (4)
Undue sadness		
Yes	29 (67.4)	25 (92.6 ^a)
No	14 (32.6)	2 (7.4)
Undue happiness		
Yes	34 (79.1)	27 (100 ^a)
No	9 (20.9)	–
Crawling sensation		
Yes	36 (83.7)	26 (96)
No	7 (16.3)	1 (3.7)

^ap<0.05

At the post-intervention phase, higher percentages of the TMHPs could recognise all the symptoms listed, but the differences were only significant for social withdrawal (Yates's corrected $\chi^2=2.74$; $p<0.05$), undue sadness (Yates's corrected $\chi^2=4.6$; $p<0.05$), and elation (Yates's corrected $\chi^2=4.7$; $p<0.05$).

Aetiological factors to mental illness: Table 3 shows that at the pre-intervention phase, a high percentage of TMHPs recognised genetics (81.4%), cannabis abuse (100%), cocaine abuse (95.3%), 'curse' (95.3%) as important aetiological factors to mental illness. The percentages of positive responses on these factors at the post-intervention phase were generally comparable to those obtained at the pre-intervention phase. However, a lower percentage (88.9%) was recorded for 'curse' as an aetiological factor at the post-intervention phase, compared with the 95% obtained at the pre-intervention phase. The difference was not statistically significant.

Classification of mental illness: At the pre-intervention phase, the following categories of mental illness were mentioned by the percentages (in brackets) of TMHPs: chronic psychosis (93%), mental retardation (72.1%), epilepsy (72.1%), neurosis (93%), acute psychosis (79.1%) and psychosis of the elderly (76.7%) (Table 4). At the post-intervention phase, an increased percentage of TMHPs mentioned all the categories. However, the increases were significant only for mental retardation (Yates's corrected $\chi^2=7.24$; Fisher's exact 2-tailed test <0.01), epilepsy (Yates's corrected $\chi^2=7.24$; Fisher's exact 2-tailed test <0.01) and acute psychosis (Yates's corrected $\chi^2=4.75$; Fisher's exact 2-tailed test <0.05).

Table 3

Aetiological factors to mental illness as mentioned by TMHPs

	Pre-intervention n = 43 (%)	Post-intervention n = 27 (%)
Genetic		
Yes	35 (81.4)	24 (88.9)
No	8 (18.6)	3 (11.1)
Cannabis		
Yes	43 (100)	27 (100)
No	–	–
Cocaine		
Yes	41 (95.3)	27 (100)
No	2 (4.7)	–
Curse		
Yes	41 (95.3)	24 (88.9)
No	2 (4.7)	3 (11.1)
Infection		
Yes	27 (62.8)	21 (77.8)
No	16 (7.2)	6 (22.2)

Table 4

Classification of mental illness by TMHPs

	Pre-intervention n = 43 (%)	Post-intervention n = 27 (%)
Chronic psychosis		
Yes	40 (93)	27 (100)
No	3 (7)	–
Mental retardation		
Yes	31 (72.1)	27 (100 ^b)
No	12 (27.9)	–
Epilepsy		
Yes	31 (72.1)	27 (100)
No	12 (27.9)	–
Neurosis		
Yes	40 (93)	26 (96.3)
No	3 (7)	1 (3.7)
Acute psychosis		
Yes	34 (79.1)	27 (100 ^a)
No	9 (20.9)	–
Psychosis of the elderly		
Yes	33 (76.7)	27 (100 ^b)
No	10 (23.3)	–

^ap<0.05; ^bp<0.01

Attitude of TMHPs to the mentally ill: Table 5 shows the pre- and post-intervention responses (Yes or No) of TMHPs to questions aimed at assessing their attitudes to mentally ill. At the pre-intervention phase, the following, positive responses were obtained: mentally ill patients should be shown love (97.7%), should be treated at the outskirts of the city/village (44.2%), should be allowed to work (100%) and should be allowed to continue schooling (97.7%). At the post-intervention phase, a significant increase in the percentage of TMHPs who said patients should not be sent out of the community was noted (Yates's corrected $\chi^2=7.24$; $df=1$; Fisher's exact 2-tailed test <0.01).

With regard to the issue of beating of patients, participants at the post-intervention FGD claimed they no

longer beat their patients, which was an improvement on the statements made by respondents at the pre-intervention FGD. The following quotes from the FGDs indicate this observation:

Pre-intervention: "A mentally ill patient is beaten not as a form of treatment, but as a means of forcefully making him/her comply with treatment, for example, herbs or even to force him to eat. When a cane is used as part of treatment modality for a mentally ill patient, the cane must have been soaked in traditional medicaments. It is not an ordinary cane."

Post-intervention: "I no longer, beat my patients. Instead of beating, I persuade them. This method even seems to work better than beating."

Attitude of TMHPs to orthodox mental health practitioners (OMHPs): At the pre-intervention phase, majority of the TMHPs claimed they would attend seminars aimed at improving their skills (95.3%), and would collaborate with OMHPs (93%). At the post-intervention phase, an increased percentage of TMHPs said they would attend seminars aimed at improving, their skills (96.3%) and would collaborate with OMHPs (96.3%). These increases were however, not statistically significant.

Table 5

Attitude of TMHPs to the mentally ill

	Pre-intervention n=43 (%)	Post-intervention n=27 (%)
Patient should be shown love		
Yes	42 (97.7)	27 (100)
No	1 (2.3)	-
Patient should not be sent out of the community		
Yes	31 (72.1)	27 (100 ^a)
No	12 (27.9)	-
Patient should be treated at the outskirts of the city		
Yes	19 (44.2)	9 (3.3)
No	24 (55.8)	17 (63.3)
Patient should be beaten		
Yes	10 (23.3)	7 (25.9)
No	33 (76.7)	20 (74.1)
Rehabilitation		
Yes	38 (88.4)	26 (96.3)
No	5 (11.6)	1 (3.7)
Can marry		
Yes	43 (100)	26 (96.3)
No	-	1 (3.7)
Can work		
Yes	43 (100)	26 (96.3)
No	-	1 (3.7)
Can go to school		
Yes	42 (97.7)	27 (100)
No	1 (2.3)	-

^ap<0.01

Table 6

Modality of treatment

	Pre-intervention n=43 (%)	Post-intervention n=27 (%)
Herbs		
Yes	43 (100)	-
No	27 (100)	-
Incantations		
Yes	33 (76.7)	22 (81.5)
No	10 (23.3)	5 (18.5)
Beating		
Yes	3 (7)	-
No	40 (93)	27 (100)
Occupational therapy		
Yes	15 (34.9)	19 (70.4 ^b)
No	28 (65.1)	8 (29.6)
Use of modern drugs		
Yes	2 (4.7)	-
No	40 (93)	27 (100)
Sacrifice		
Yes	30 (69.8)	25 (92.6)
No	13 (30.2)	2 (7.4)
D/K	1 (2.3)	-
Scarification marks		
Yes	30 (69.8)	23 (85.2)
No	13 (30.2)	4 (14.8)
Counselling		
Yes	38 (88.4)	24 (88.9)
No	5 (11.6)	3 (11.1)

Modalities of treatment: Table 6 shows the treatment modalities used by TMHPs as follows: herbs (100%), incantations (76.7%), beating (7%), occupational therapy (34.9%), 'modern drugs' (4.7%), sacrifice (69.8%), scarification marks (69.8%), counselling (88.4%). At the pre-intervention phase, three (7%) claimed they beat their patients, while post-intervention, none claimed to beat his patients. This is corroborated by the FGD findings as earlier highlighted. At the pre-intervention phase two (4.7%) claimed they use modern drugs to treat mental illness but post-intervention, none of them claimed to use modern drugs. The percentages of TMHPs who claimed to make scarification marks on their patients and counsel them, were comparable both pre- and post-intervention. With regard to the use of occupational therapy as an adjunct in treatment, a statistically significant increase in the percentage of TMHPs employing this modality was noticed post-intervention ($\chi^2=7.0$; $df=1$; $p<0.05$).

Referral and follow up: Table 7 shows the attitude of TMHPs to referral and follow-up. At the pre-intervention phase, 27 (62.8%) claimed to refer their patients to other TMHPs, while six (14%) claimed they refer to OMHPs. At the post intervention phase, it was noticed that an increased percentage (81.5%) of TMHPs, albeit not statistically significant, claimed they refer patients to other TMHPs. There was a slight decrease in the number of TMHPs who claimed they refer patients to OMHPs at the post-intervention phase.

Table 7

Referral and follow-up

	Pre-intervention n=43 (%)	Post-intervention n=27 (%)
Referral to TMHPs		
Yes	27 (62.8)	22 (81.5)
No	12 (27.9)	2 (7.4)
D/K	4 (9.3)	3 (11.1)
Referral to OMHPs		
Yes	6 (14)	5 (18.5)
No	33 (76.7)	19 (70.4)
D/K	4 (9.3)	3 (11.1)
Regular follow-up		
Yes	25 (58.1)	24 (88.9 ^a)
No	18 (41.9)	3 (11.1)

a p<0.05

Of the 43 TMHPs studied at the pre-intervention phase, 25 (58.1%) claimed they practice regular follow-up, while 18 (41.9%) did not. Following intervention, there was a statistically significant increase in the percentage (88.9%) of TMHPs who claimed they practice regular follow up ($\chi^2=6.1$; $p<0.05$).

DISCUSSION

The study suffered from a few limitations. First, the number of TMHPs investigated was small (forty three) in the evaluation phase, and further reduced to twenty seven in the post-intervention phase. This could be explained by the limited funds available, which meant a restriction of the study to only four LGAs. Secondly, it was not possible to verify the claims regarding issues like follow up at the post-intervention phase. Third, because the TMHPs do not keep records, it was difficult to authenticate their verbal claims as regards some of the issues raised during the study. Fourth, some of the TMHPs invited were suspicious of the motive behind the study, despite adequate explanation and reassurance by their leaders. Lastly, some TMHPs insisted on adequate (although unrealistic) financial compensation for their time and contribution to the study. More time and resources will therefore, be needed to improve on these limitations in future similar studies. In spite of these limitations, this would appear to be the first evaluation study conducted with TMHPs in Nigeria.

In this study, most TMHPs were able to recognise the obvious (common) symptoms of mental illness such as talking to self, laughing to self, and deteriorating personal hygiene. A relatively fewer percentage of the TMHPs were able to recognise subtle but important symptoms like undue sadness. The difficulty in recognising symptoms of depression among Africans is not peculiar to TMHPs, but has previously been reported among OMHPs(10,11). One of the reasons adduced for this findings is: perhaps, that Africans do not generally verbalise their depressive symptoms as much as Caucasians do. A second reason is that a depressed patient usually keeps to himself/herself and does not constitute much problems to others. The

chances of such a diagnosis being, missed may therefore be higher compared to conditions in which verbal and physical disruption, aggression, and violence are key features. The symptoms of depression may also be missed in view of the self-limiting, nature of the disorder. All these reasons do not, however, add up to the fact that depression is uncommon in the African setting. Indeed, studies have shown that depressive disorders are as common in Africa, as among Caucasians, although the pattern of presentations may be coloured by cultural variability(12,13).

Following the lectures on symptom recognition delivered to TMHPs during the intervention phase of this study, statistically significant improvement in the recognition of depressive symptoms (social withdrawal, undue sadness) was noticed at the evaluation stage. It would appear therefore that TMHPs could respond positively to new information on different aspects of mental health, including symptom recognition. This method of knowledge transfer is therefore recommended as a way of assisting, TMHPs to improve on their practice.

The belief that 'curse' is a major factor in the aetiology of mental illness was expressed by a large number of TMHPs in this study. This is an important observation, as it determines, to a large extent, the treatment modalities employed by TMHPs. The type of treatment usually prescribed is to appease the gods through the offering of sacrifice. Once the latter is completed TMHPs believe that such illnesses would disappear. It is for this reason that majority of TMHPs do not consider it necessary to follow up their patients. It therefore becomes imperative to assist TMHPs to widen their concept of aetiology using the biopsychosocial model. This will make it possible for them to appreciate the fact that 'curse', as a form of suggestibility, could explain only a small fragment of psychiatric symptomatology. The authors introduced the latter concept at the intervention phase of this study. It is noteworthy that, post-intervention, the percentage of TMHPs who believed in curse as an aetiological factor in mental illness reduced. Although the difference was not significant, this could have been due largely to the small sample size.

A large majority of TMHPs involved in this study recognised the abuse of cannabis and cocaine as possible causes of mental illness. Some of them also claimed to specialise in the treatment of drug-dependent persons. This finding would suggest that TMHPs could be incorporated into the governmental drug abuse control activities, both in terms of primary prevention and treatment of drug-dependent persons. However, there is a need to carry out further in-depth studies on the TMHPs' concept and practice of drug abuse management, before such incorporation could be possible.

Collaboration between TMHPs and OMHPs has been a major debate issue(15). In order to have a meaningful collaboration, it will be relevant for both types of practitioners to understand their principles of practice. A possible way of doing this is by organising seminars for

TMHPs. In this study, majority of TMHPs signified their intention to attend seminars aimed at improving their skills. At such fora, TMHPs could be better equipped to carry out preventive (information, education and communication) or IEC activities on mental health-related issues, treat and rehabilitate the mentally ill.

As total prevention of the occurrence of mental illness is virtually impossible, more emphasis is generally placed on early identification and prompt treatment and rehabilitation of the mentally ill. One method of rehabilitation is through the practice of occupational therapy (OT), which assists the patients to sustain their occupational skills or develop new ones. Through OT activities (playing of indoor games such as *ludo*, *ayo*, *draughts*), patients are able to interact with, and learn new behavioural skills from other patients, and sometimes from the care staff. Patients' progress in treatment can also be monitored through their performance at OT activities. However, only 35% of TMHPs claimed they engage in any form of OT at the pre-intervention phase. Following intervention, there was a statistically significant increase of upto 70% of TMHPs who claimed they practice OT. The commonest form of OT offered to patients by TMHPs was farming, or involving them in herbal preparations. This study therefore revealed the poor development of OT as a major setback in traditional mental health practice. The government, non-governmental organizations, and funding agencies could assist TMHPs in developing this aspect of their practice through regular training workshops and seminars. They could also be supported with procurement of relevant equipment, and encouraged to develop simple, cost-effective, community-based and culturally relevant OT programmes.

The practice of beating mentally ill patients as part of treatment by TMHPs seems to have been a long time practice (4-6). The practice also seems to have found root in *Yoruba* culture as evidenced by an adage that says *egba ni ogun were* (caning is an effective treatment for the mentally ill). It is noteworthy that the reasons given by TMHPs for beating a mentally ill patient are varied. Beating of clients could be a means of enforcing compliance with medication and feeding, or as a treatment modality on its own. This method of treatment is however, not without some disadvantages. Most of the patients so beaten develop wounds, which often become septic before the patient is referred to the hospital. This practice is not humane and should be discouraged through effective education. It is therefore, encouraging to note that after intervention, the percentage of TMHPs who claim they beat their patients reduced significantly. This finding would suggest that the IEC method should be a useful tool of checking the practice of beating patients by TMHPs.

In orthodox psychiatric practice, follow up is one of the powerful tools used in monitoring mental stability of the treated patient, and for early identification of relapse in a patient. Early identification and prompt treatment will save cost (time and money) to patient, relatives, health workers and the nation. The importance of follow-up can therefore not be overemphasised. The concept of follow up

is based on the premise that mental illness can recur if the factors that led to its onset recur. In traditional mental health practice, cases are not usually considered potentially recurrent once sacrifice and final rite have been done. The patient is generally considered to have been totally cured. This is probably what informs the TMHPs attitude of not following up their patients. Indeed, to some TMHPs, recurrence portrays failure and lack of competence. In this study therefore, it was noteworthy that at the evaluation phase, more TMHPs significantly reported that they follow-up their patients

CONCLUSION

Despite the limitations earlier highlighted, this study has demonstrated that the use of information, education and communication intervention techniques could lead to changes in attitude, belief and practice of TMHPs. This is evidenced by our findings of significant improvement, post-intervention, in the following areas of their practice: a widening of their sense of recognition of important mental symptoms such as undue sadness, social withdrawal and elation; a better understanding of the aetiological concepts of mental illness; the reduction in the habit of beating their patients as a form of treatment and; the greater adoption of the standard practices of OT and follow-up.

It is noteworthy that the majority of TMHPs embraced this pilot project with enthusiasm. They claimed they have benefited tremendously from their interaction with us, and would be quite willing to participate in any of such future activities. If this observation could be projected to their larger bodies and associations, it would then mean that there is currently a better chance of conducting collaborative activities between orthodox and traditional healthcare practitioners in general, and those in mental health field in particular.

Appendix A

Evaluation of traditional mental health practitioners in four LGAs of Kwara State

(Practitioners' Questionnaire)

Socio-demographic data

1. Age (years)
2. Sex: (i) Male (ii) Female
3. Religion (i) Islam (ii) Christianity (iii) Traditionalist
4. Primary Occupation (i) Farming (ii) Trading (iii) civil servants (iv) Others
5. Level of education: (i) Nil (ii) Primary (iii) Secondary (iv) Tertiary
6. Location of clinic: Town L.G.A:
7. Place of origin: Town L.G.A:

Knowledge of traditional mental health practitioners on mental health

8. How will you describe a person with mental illness?
 - (i) A person who laughs to self
 - (ii) A person who talks to self
 - (iii) A person who is socially withdraw
 - (iv) A person who talks out of context
 - (v) A person with deteriorating personal hygiene
 - (vi) A person who is unduly sad, has reduced activity and lost interest in activities.

- (vii) A person who is excessively happy, hyperactive and feels unduly important
- (viii) A person with crawling sensation in the body/head
- (ix) Other (specify)
9. What factor could predispose to mental illness?
- (i) Genetic (v) Infections
- (ii) Indian Hemp (vi) Cocaine
- (iii) Heroine (vii) Others
- (iv) Curses/Punishment from gods
10. What types of mental illness do you know:
- (i) Chronic psychosis (Were)
- (ii) Mental retardation (Danidani)
- (iii) Epilepsy with behavioural disorder (Were Ipa)
- (iv) Neurosis (Aluro, Afota, Gbohngbohun, Ode Ori)
- (v) Acute psychosis (Asinwin)
- (vi) Psychosis of old age (Were Agba)
- (vii) Others (specify)
25. If yes, what do you do?
- (i) Refer to other traditional healer
- (ii) Refer to orthodox practitioners
- (iii) Continue to try
- (iv) Others (specify)
26. What do you do for your patients when they are discharged?
- (i) Advice regular follow-up
- (ii) Follow-up not necessary

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11. What does a mentally ill person need? Please tick as appropriate.
- (i) Love and care
- (ii) Treatment
- (iii) Should not be sent out of the community
- (iv) Should be treated at the outskirts of the community
- (v) Should be beaten until well
- (vi) Rehabilitation
- (vii) Others (specify)
12. What advice will you give to a mentally ill person who has been treated and well?
- Please tick as appropriate.
- (i) Should marry (iii) Should go to school
- (ii) Should work again (iv) Others specify
13. Will you be interested in attending a seminar on mental health practice organised by government or her agencies?
- (i) Yes (ii) No (iii) Don't know
14. What is your feeling towards orthodox practitioners?
- (i) Cannot work with them
- (ii) Can work with them
- (iii) Can share knowledge with them
- (iv) Cannot share knowledge with them
15. If (i) give reason
16. If (ii) give reasons:
- Practice of traditional mental health*
17. Did you receive any formal training (i) Yes (ii) No
18. How were you trained?
19. Who trained you? (i) Parent/relative (ii) Other traditional healers
20. For how long were you trained?
- (i) >3 years (ii) 3-5 years (iii) 6-8 years
- (iv) 9-11 years (v) > 11 years
21. How do you treat your patients?
- (i) Herbs (vii) Charms
- (ii) Incantations (viii) Sacrifice
- (iii) Koranic Verses (ix) Biblical Verses
- (iv) Beating (x) Scarifications
- (v) Occupational therapy (xi) Counselling
- (vi) Modern drugs
22. Do you treat all forms of mental illnesses? (i) Yes (ii) No
23. If No what forms don't you treat (Refer to question 10):
24. Do you sometimes come across difficult cases you cannot treat (i) Yes (ii) No
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