

Traditional healers' practices and the spread of HIV/AIDS in south eastern Nigeria

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SUMMARY A 3-year (1997–1999) prospective study was carried out to evaluate the possible role of traditional healers (THs) in the spread of HIV/AIDS in south eastern Nigeria. Their patients' knowledge of HIV infection was also ascertained during the review period. Four contiguous states in south eastern Nigeria with high prevalent rates of HIV infection were chosen for the survey. Sixty-nine patients of THs were randomly selected and contacted from the patients' list of five selected THs in each state. Thus, a total of 20 THs and 69 patients formed subjects of the study.

The study involved a face-to-face interview of the subjects by trained health personnel in each state using a prepared structured questionnaire. The questionnaire elicited information on their biodata, past/present medical history, social/family history, nature and mode of treatment received or administered, and their knowledge of HIV infection, where applicable.

The results showed that there was a serious HIV/AIDS related risk inherent in the practices of Nigerian THs patronized by over 60% of the population. This was suggested by the continuous usage of unsterilized instruments and cross contamination with patients' blood and body fluid in their practices. It was further revealed that, the patients' HIV/AIDS related knowledge was poor (30%).

Basic education on HIV/AIDS must be given to all groups in Nigeria including THs, their patients and general public. The World Health Organization and other agencies involved in the fight against HIV infection should focus on the safety of THs' practices as a possible mode of transmission of HIV infection in Africa. Unless this aspect is taken seriously along with other preventive strategies already adopted, the epidemic of the disease condition may continue to spread in Africa.

Introduction

The HIV/AIDS pandemic is the most challenging public health problem confronting developing countries today¹. According to the World Health Organization (WHO), developing countries have the highest AIDS prevalence in the world². It is estimated that nearly 40 million people have so far been infected, with over 70% of them in sub-Saharan Africa^{3–4}. It probably accounts for the death of

over 20 million people in sub-Saharan Africa, orphaning about 12 million children in the process⁵. The United Nations Programme on HIV/AIDS (UNAIDS) estimates that, 15 000 new infections occur every day and 7 out of 10 new infections occur in sub-Saharan Africans⁶.

Thus, the HIV/AIDS epidemic in Africa is increasing even as the condition has peaked or is under control in the western industrialized world. In Africa, heterosexual unsafe sex is the major source of spread of HIV infection and therefore every effort to check the spread of this deadly disease in Africa has been directed at the prevention of unsafe sexual intercourse. Unfortunately, this approach is not yielding the desired results as the epidemic is increasing.

In these countries, traditional healers (THs) play a major role in providing for the healthcare needs of the people, especially in the rural areas, in the absence of modern health facilities^{7–8}. It is believed that about 60% of the population of the developing countries, including confirmed cases of HIV/AIDS, patronize these healers. This is probably because THs are cheaper and culturally more acceptable in parts of these countries. The information obtained in interviews of confirmed HIV/AIDS patients at our centre who had patronized THs suggested a probable HIV/AIDS related risk inherent in the practices of the THs.

The use of unsterilized instruments, especially the reuse of contaminated blades between patients, and the healer's contact with patient's blood and other body fluids are potential sources of spread of the infection. These and other practices put the healers and their non-HIV patients at great risk of contracting HIV/AIDS. The WHO and other agencies involved in tackling this awful disease should examine the risk posed by THs in the spread of HIV/AIDS in Africa, if the battle against the disease is to be won.

This paper seeks to highlight the possible role of THs in the spread of HIV/AIDS in south eastern Nigeria. It will also evaluate their knowledge of HIV/AIDS.

Subjects and methods

The study used interviews to obtain the required information. We used a prepared structured questionnaire, which focused on the practices of the healers and their patients' HIV/AIDS-related knowledge.

Four contiguous states of south eastern Nigeria – Rivers, Akwa Ibom, Cross River and Bayelsa – all located near the Cameroon–Nigeria border with an appreciable high rate of HIV infection, were selected for the survey. Akwa Ibom State is currently ranked second in the HIV prevalence rate in Nigeria according to a federal ministry of health survey⁹. The four states together have a population of about 10 million people.

Sampling design

Sixty-nine past/current patients of THs from the four states were randomly selected for the study. The patients were selected from the list of past/current patients of the five THs selected from each state for the survey.

Their names and addresses had been noted in the registers enabling the patients to be contacted. However, as some healers do not keep registers, the sample size was small. Thus, a total of 20 THs and 69 patients (past and current) were included in this study.

Informed consent was obtained from all the patients and the healers selected for the survey, after having had the aims of the study explained to them.

Box 1 General characteristics of those included in the study**Patients (n=69)**

Sex: Male (45); female (24)
 Age range: 15–25 (8); 26–35 (16); 36–45 (25);
 45–55 (13); >55 (7)
 Origin: Cross River (31); Bayelsa (9);
 Akwa Ibom (18); Rivers (11)
 Occupation: Civil servant (22); students
 unemployed (16); farmers (16); businessmen
 (12); fishermen (3)
 Education: Primary (19); secondary (30);
 tertiary (15)
 Residence: Semi-urban (18); urban (10); rural (5)

Traditional healers (n=20)

Sex: Male (20); female (0)
 Age: 40–50 (7); 50–60 (9); 61–70 (4)
 Education: None (20)
 Residence: Rural (20)

Interviewing methods

The interview of selected patients and THs was conducted by interviewers who spoke the local languages fluently and were conversant with the culture of the people. The interviewers were trained health personnel recruited from each of the states and were supervised by one of the authors assigned to supervise that state. Prior to the interview, a 1-day training workshop was organized to provide intensive training for all interviewers:

- how to solicit the cooperation of the healers and their patients
- how to administer questionnaires
- how to record accurately and manoeuvre the questionnaire by the interviewer.

This training session was followed by field demonstration and practice sessions with the respondents. The face-to-face personal interviewing method was used. All completed questionnaires were checked for accuracy by the field supervisor before submission to the state's supervisor who did the final checking for errors in each state.

Questionnaire

The structured questionnaire was designed to evaluate the practices of THs and how much their patients knew about

HIV/AIDS. The questionnaire was divided into the following sections:

- biodata
- educational background
- social/family history
- past medical history
- HIV/AIDS-related knowledge of patients
- nature and mode of treatment administered or received by the respondent
- treatment outcome/acceptability by patients
- safety/aseptic measures adopted by THs
- general nature of practices of the THs.

The style of questioning and wording of each question were modified after pre-testing of a draft questionnaire in the field. The answers were not restricted as the interviewer could manoeuvre certain questions.

The AIDS-related knowledge score was derived by adding the mean scores of the questionnaire which probed the patients' knowledge of HIV/AIDS and grouped them under certain variables such as (i) state of origin in Nigeria, (ii) educational level of patient, and (iii) place of residence (rural or urban). The mean score was expressed in percentages with standard deviation (SD).

Results

Box 1 shows the general characteristics of subjects included in the survey.

The 69 patients (male=45, female=24), ranging in age from 15–62 years and 20 healers (all men aged between 40–65 years) were interviewed between 1997 and 1999. Thirty-nine patients were married and 30 were either single or separated. Five had no formal education, 19 received primary school education, 30 secondary school education and 15 post-secondary (university) education. Thirty-one lived in rural areas and 28 in urban and semi-urban communities. The 20 THs interviewed had not received any formal education and resided in rural areas.

The AIDS-related knowledge of the THs' patients is shown in Table 1. Their mean scores were generally very poor in relation to certain variables, e.g. educational status, states of origin, and urban or rural residence. However, a greater number of patients were able to identify the people at risk of contracting HIV/AIDS (Figure 1).

Questionnaire results

All the 69 patients were aware of AIDS and acknowledged its existence in Nigeria. Forty-three (62%) did not

Table 1 AIDS-related knowledge score (%) of patients of traditional healers

Variables	Groups of patients	AIDS-related knowledge score (mean \pm SD)
Origin	Patients from Rivers State (11)	24 \pm 7%
	From Cross River State (31)	33 \pm 4%
	From Akwa Ibom (18)	26 \pm 5%
	From Bayelsa State (9)	21 \pm 3%
Educational level	Patients with post secondary school education (15)	38 \pm 7%
	Patients with primary and secondary school education (49)	28 \pm 3%
	Patients with no formal education (5)	19 \pm 10%
Residential area	Urban areas (28)	35 \pm 4%
	Rural areas (41)	27 \pm 4%

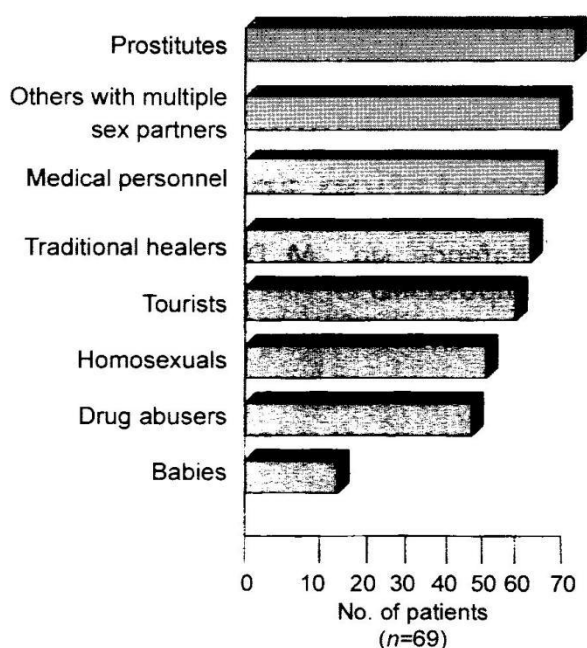


Fig. 1 Patients' evaluation of the people at risk of contracting AIDS

know that HIV was the causative organism of AIDS. They believed that AIDS was a punishment from the gods for:

- sins committed by the AIDS patients 23 (33%)
- witchcraft 21 (31%)
- adultery 17 (25%)
- insect bites 14 (20%).

Thirty-three (48%) believed that HIV/AIDS is transmitted from person to person through sitting on toilets used by someone suffering from AIDS, 29 (42%) from kissing HIV-infected persons and 7 (10%) by shaking hands with an AIDS patient.

The treatment received by 53 (77%) patients from THs involved incisions made with unsterilized blades. Herbal preparations were then rubbed into these actively bleeding skin cuts, using unprotected fingers, which were in direct contact with the patient's blood. The contaminated instruments, e.g. blades, were then cleaned with a piece of cloth [19 (28%)], and then washed with either cold [10 (15%)] or hot water [4 (6%)]. While 48 (70%) had no idea what the healers did to the contaminated blades, 20 (30%) thought the healers reused the unsterilized instruments and 24 (35%) admitted they allowed the use of a blade without first establishing the source or its sterility. However, 17 (25%) said they provided their own blades.

THs disposed of patient's body fluids/waste in various ways: nine (44%) burning them, five (25%) throwing them into a dustbin, four (20%) had thrown them into a bush and two (10%) into a source of drinking water/river. None of the THs used any protective device. However, 52 (75%) of the patients interviewed were still satisfied with the services provided by THs.

Discussion

Our study has demonstrated the risk posed by THs' practices in the spread of HIV/AIDS in south eastern Nigeria. Their mode of treatment which involved the use of unsterilized instruments, making multiple skin inci-

sions, and the direct contact of their unprotected fingers with patients' blood further confirmed the suspicion. This is coupled with the fact that these native 'surgeons' also carry out female genital mutilation, male circumcision and native 'tonsillectomy' using very crude and unsterilized instruments.

It is unfortunate that these THs who had endeavoured to fill the gap left by inadequate modern health facilities in many parts of Africa are using practices which risked spreading the disease. Patients could risk contracting HIV/AIDS from visiting the clinics of traditional healers.

The patients' level of education, knowledge of mode of transmission and extreme fear of HIV/AIDS did not positively influence the nature of their relationship with healers and did not contribute to the improvement of the safety of healers' practices. While 75% of patients accused healers of not doing anything to protect them from HIV infection, only 25% of the patients actually attempted to protect themselves by providing their own individual blades. It was therefore established that the majority of the patients were not sufficiently enlightened to fully appreciate the HIV/AIDS-related risk inherent in the practices of the THs. Even those who were aware, probably because of their respect for the THs, hardly made any safety-related demands when they visited the healers.

For the 70 million Nigerians who live in rural communities, transmission through the practices of THs may be an important additional source of spread of HIV/AIDS. In these communities, intravenous drug abuse and blood transfusion are rare. As there is no alternative to the medical services provided by THs in most rural communities and their clientele is ever increasing, HIV/AIDS-related safety precautions should be encouraged. The majority of the clients are unfortunately children, and these unsafe practices may mean that the children escape HIV infection from their mothers only to be infected by an ignorant TH¹⁰.

The social and economic impacts of HIV/AIDS are becoming issues of great concern as the pandemic continues to spread. In sub-Saharan Africa, 25 million people are HIV-positive, representing 70% of the total world number of HIV-positive patients. Worldwide, women constitute 47.6% of the total number of HIV patients – African women constitute 55.4%¹¹. This places a heavy burden on the already limited budget of families and governments. Thus, HIV/AIDS constitutes a heavy burden on individuals, the family and the nation¹².

The unavailability in Africa of the expensive drugs that have proved so effective in the Western world is only one of several reasons why this epidemic is rife and spreading in Africa. In the absence of an effective vaccine against HIV/AIDS, the most powerful weapon available to any developing country like Nigeria in the battle against AIDS is health education and information aimed at getting people (e.g. THs and their patients) to make life-saving choices by changing their behaviour styles and traditional practices¹³.

The mean AIDS-related knowledge of the patients was generally very poor (30%) in relation to certain variables such as states of origin, place of residence and educational status. Although the patients interviewed exhibited evidence of primary/secondary school (70%) and university (20%), the patients' HIV/AIDS-related knowledge was still poor. For instance, 62% did not know that HIV causes AIDS. Several factors have probably contributed to this poor knowledge: inaccessibility to the media especially for the 59% of patients who lived in rural

areas; poor coverage of HIV/AIDS-related news; and the absence of an effective, adequately funded national AIDS awareness campaign. This further suggests that patients patronizing THs were unaware of the potential risk of THs spreading the dreaded disease.

In the light of our findings, we strongly recommend that, if this disease is to be checked in Nigeria, health education officials must reach these THs. Basic education on HIV/AIDS must be given to THs, their patients and the general public.

A greater knowledge of AIDS-related risks might ultimately increase the safety of the healers' practices^{2,14}.

THs should be educated first as they will be the ones who will meet the needs of the people deprived of modern healthcare. If the efforts of the WHO and other agencies to curb the spread of HIV/AIDS is to be successful in Africa, the education of THs must be included alongside those preventive strategies already adopted.

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Buruli ulcer in the Democratic Republic of Congo: epidemiology, presentation and outcome

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Introduction

Buruli ulcer (BU) is a mycobacterial skin ulcer caused by *Mycobacterium ulcerans*, an acid-fast bacillus 3-6 µm wide¹. It is the third most common disease caused by a mycobacterium in the tropical regions - after tuberculosis and leprosy². Large ulcers, almost certainly caused by *M. ulcerans*, were described by Cook in Uganda in 1897³. The aetiological agent was first isolated and characterized in 1948 by MacCallum *et al.*⁴.

The name derives from the Buruli district of Uganda where the disease was investigated by a British group in the 1960s⁵⁻⁷. It has been reported in 27 countries in the west Pacific, Asia, the Americas and Africa⁸. The largest concentrations of patients are to be found in the central African countries of Uganda, the Democratic Republic of Congo (DRC), and in the Ivory Coast, Ghana and Benin in West Africa³. From 1923 to 1935 Dr Kleinschmidt, a missionary doctor working in North East Congo, observed skin lesions containing acid-fast bacilli⁹. The first case reported on the Congo was in an American boy living in the Kwilu region in 1950¹⁰. Nowadays, in DRC the disease is confined to two regions (the Songololo region in the province of Bas-Congo and Kasongo in the province of Kivu)¹¹. However, the disease has been reported in other areas - Kinshasa¹², Kasongo¹³⁻¹⁵.

The association of the BU and HIV infection has also been reported in DRC¹⁶⁻¹⁸. During 1965 to 1974 there were a number of reports of the disease including a study by Andersen in 1965 focusing on Kimpese near the Songololo region¹⁷, Smith in 1970¹⁸ and Meyers *et al.* in 1974⁹. Recently, however, there has been renewed interest in the disease, especially in Bas-Congo (Phanzu *et al.*; Polman and Phanzu; and Bafende *et al.*, unpublished) and the association between BU and AIDS has been reported at Kimpese¹⁹⁻²¹. Our report presents the experience of IME Kimpese Hospital in the management of BU and the setting up of a project to fight the infection in Bas-Congo.

Table 1 Site of lesions found in Buruli ulcer patients

Site of lesions	1989-1999	2002
	N=45 (%)	N=14 (%)
Face	0 (0)	1 (7)
Thorax/abdomen/back	0 (0)	2 (15)
Legs	40 (89)	10 (71)
Arms	8 (11)	8 (58)