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A community survey of traditional medical practitioners in high density suburbs of Harare

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Z NYATHI**

SUMMARY

Traditional medical practitioners (TMP) are an important part of the health system in Zimbabwe. The objective of this study was to determine, in the study area, their numbers, sociodemographic characteristics and clinical practice. A cross sectional community survey was conducted in two high density suburbs in Harare, Zimbabwe. A sampling frame of TMP was defined by means of a three stage community census ($n = 189$). A random stratified sample ($n = 110$) was interviewed with a semi-structured interview.

Nearly half the TMP were not registered with formal organizations. Prophets were more likely to be Zimbabwean, Shona speaking, better educated, to have entered practice at a younger age, had fewer years of experience and charged less for consultations. Many TMP reported busy attendance at their clinics in the evenings or on weekends, but on average, most TMP see few patients. Few TMP specialised in physical disorders. Almost two thirds referred patients to formal

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medical services and most TMP wished to have greater collaboration with biomedical services.

INTRODUCTION

Traditional medical practitioners (TMP) play an important role in primary health care in Zimbabwe, particularly in rural areas of the country.^{1,2} They provided the only source of health care until the advent of colonial rule, and with it, biomedical health care, 100 years ago. Although many authors have reported the widespread use of TMP for health related problems in contemporary Zimbabwean society, there have been few studies on the practice of TMP in Zimbabwe, the most recent study being in the 1980s.^{1,3}

TMP can be grouped into two categories; *n'anga* (all words in italics are Shona terms), a term which includes spirit mediums and herbalists, and faith healers or prophets, who are associated with the many African Christian churches in the country. The latter use practices which syncretize traditional treatments with Christian beliefs. TMP are relatively well organized.

Shortly after independence in 1980, the Zimbabwe National Association of Traditional Healers (ZINATHA) was formed by the amalgamation of eight pre-existing organizations. Its aims were not dissimilar to those of professional bodies of biomedical practitioners.⁴ Another organisation, ZITHA (Zimbabwe Traditional Healers Association), was formed in 1991. A number of smaller and more loosely structured organizations also exist, representing particular groups of healers such as those of neighbouring countries.

An important function of these organisations is to maintain registers of TMP but, even though it is generally thought that there are over 40 000 TMP in the country,⁵ only half are registered with the largest organisation, ZINATHA.³ Although ZINATHA claims to register both prophets and *n'anga*, anecdotal evidence suggests that most prophets avoid any links with this organisation.

This study was designed to examine the characteristics of TMP and their practices in high density suburbs of Harare. The specific objectives were to determine the number of TMP in practice, to study the socio demographic characteristics of a random sample of these TMP, to estimate the size of the case load of this sample, to determine the commonest reasons for consultation, and to explore attitudes of TMP towards

collaboration with biomedical services. Throughout, it was also aimed to compare the sub-groups of prophets and *n'anga*.

MATERIALS AND METHODS

Setting.

This study was conducted during February and March 1994 in two high density suburbs of Harare (Dzivaresekwa [DV] and Mufakose [MK]), selected on the grounds that a parallel study evaluating health services usage by the communities had been conducted there.⁶ Both suburbs have moderately well defined geographical boundaries. The total population of the two suburbs was 106 792 (1992 census).

Sample.

The first source of data for the sampling frame of all TMP in the two suburbs were official registers. ZINATHA and ZITHA lists yielded 58 TMP in MK and 44 TMP in DV. Due to the informal nature of TMP registration it could not be assumed that this was an exhaustive list of local TMP. Indeed, reliance on official lists would have introduced unquantifiable bias to the sampling frame. The second stage of sample definition involved asking key informants being interviewed in the parallel study mentioned earlier to name TMP known to them in their suburb. As a final check on the completeness of the census a sample of registered healers from the original lists were approached and asked for the names of TMP they knew who practised in their suburb. This third stage did not elicit any further names. In this way a further 50 TMP were identified in MK and 37 TMP in DV. The final sampling frame consisted of 189 TMP: 58 registered TMP in MK, 44 registered TMP in DV, 50 unregistered TMP in MK and 37 in DV. Of the unregistered TMP, 35 were described by key informants as prophets. A stratified random sample was then constructed of 29 registered TMP in MK, 20 registered TMP in DV and 26 unregistered TMP together with all 35 prophets in the two suburbs (total 110). The reason for this stratification was to ensure that adequate numbers of prophets were included in the sample to allow for comparative analyses with the more numerous *n'anga*.

Instrument.

A semi-structured interview based on questionnaires used in previous studies with TMP in Zimbabwe⁷ and Botswana⁸ was designed and piloted with a group of TMP for ease of use and conceptual validity. Data was

collected by face to face interview with TMP conducted in Shona by two authors (TM and ZN). It elicited information on sociodemographic factors, clinical practice, numbers of patients seen, busiest days and times of clinics, the commonest reasons for consultations, referral patterns, areas of specialization, and attitudes towards collaboration with biomedical services. All qualitative data was recorded in Shona and subsequently translated into English to facilitate analysis. TMP were occasionally unable to give definite replies to some items; such items were considered as missing values in analysis and thus denominators occasionally differed.

Data Analysis.

Qualitative data were post coded numerically following the methodology used in studies with the Explanatory Model Interview in Harare.⁹ Interview records were reviewed, qualitative data for each item were collated and broad facets identified. For example, for the item "reasons for consultation", facets such as "aches and pains", "other somatic complaint", "spiritual complaint" were extracted and then coded. The data was analysed for the whole sample, and compared between prophets and *n'anga*, and registered and unregistered TMP. Between group comparisons were performed with X^2 tests (with a continuity correction), T tests or Kruskal-Wallis tests as appropriate. Results are presented only when they are statistically significant in two-tailed tests.

RESULTS

The field interviewers were able to interview 97 subjects (88 pc of the sample): 45 registered TMP (91 pc of the sub sample), 25 unregistered TMP (96 pc) and 27 prophets (87 pc). Thirteen TMP were either no longer residing at their given address or no longer practising in that suburb. Given that the classification of TMP by official organizations or key informants may be inaccurate, individual TMP were asked to describe whether they were *n'anga* or prophets; 72 labelled themselves as *n'anga* and 25 as prophets. References to *n'anga* or prophets in the rest of this paper will refer to the labels applied by the respondents to themselves. Twelve (25 pc) of those TMP not on official registers claimed membership, in addition to all the listed TMP. None of the listed group disclaimed membership.

Characteristics of TMP (Table I).

Key sociodemographic characteristics comparing *n'anga* and prophets are presented in Table I. In summary, the significant differences were that in comparison to *n'anga*, prophets were younger; better educated; were more likely to be Zimbabwean nationals and to have Shona as their first language; to be affiliated to the Apostolic churches; were less likely to be affiliated to a TMP association; to have fewer years' experience of practice; and to have started practice at an earlier age.

Characteristics of TMP' practice.

Both prophets and *n'anga* ran their practices in similar ways. The majority of the total sample claimed to be fulltime TMP; 12 admitted to having another job. When asked about the busiest time of the week 53 (54 pc) reported that they saw more clients at weekends. While 53 (55 pc) indicated that they saw clients seven days a week, 27 (28 pc) stated that they only consulted at weekends. When asked about the busiest time of day 41 (42 pc) indicated that they consulted more often in the evenings. More than half (54) reported that they saw more patients at the end of the month. One respondent indicated specifically that the busiest time was after payday. Most clients came from within the TMP's suburb, with residents of other suburbs, other Zimbabweans and foreign nationals being less frequent in that order. However, 11 TMP estimated that the majority of their clients came from elsewhere in Harare and nine that the majority came from outside Harare.

Although prophets described themselves as busier than *n'anga* in terms of the maximum numbers of clients they claimed to see, there was no statistically significant difference between the two groups in this regard. Both groups reported seeing a median of three or four clients daily. Prophets reported that they charged lower fees than *n'anga*; their minimum charges were lower (median minimum fees (range): prophets ZW\$0 (0-10), *n'anga* ZW\$10 (0-35); Kruskal-Wallis $H = 38.4$, $p < 0.001$) as their maximum charges (median maximum fees: prophets ZW\$0 (0 - 700), *n'anga* ZW\$100 (0 - 900); Kruskal-Wallis $H = 14.2$, $p < 0.001$).

TMP were also asked about their "diagnostic" methods. The commonest methods for both prophets and *n'anga* were trance states and dreams (62 reports) followed by the use of various objects eg. shells, calabashes or mirrors (29). While 25 *n'anga* used

Table I: Sociodemographic characteristics of *n'anga* and prophets.

Variable	Prophet	<i>N'anga</i>	Statistical comparison
Gender	62 pc	58 pc	ns
pc of males			
Age	mean 32,2 yrs sd 11,3 yrs	mean 54,5 yrs sd 11,7 yrs	F = 66 p < 0,001
Education	36 pc	3 pc	Fishers = 17,2 p < 0,001
Passed O levels			
Nationality	92 pc	61 pc	X ² = 9 p < 0,01
Zimbabwean			
First language	96 pc	63 pc	X ² = 9,2 p < 0,01
Shona			
Religion	88 pc	7 pc	X ² = 66 p < 0,001
Apostolic			
Registration with TMP organisation	16 pc	72 pc	X ² = 19 p < 0,001
Years of experience	mean 6,8 yrs sd 4,4 yrs	mean 20,6 yrs sd 16,1 yrs	K-W H = 18 p < 0,001
Age at which practice started	mean 24,1 yrs sd 10,2 yrs	mean 35 yrs sd 13,5 yrs	F = 12,5 p < 0,001

All p tests results are from two-tailed tests; ns = not significant; K-W is the Kruskal-Wallis test.

objects (35 pc), only four prophets used them (16 pc); two used a bible and one each shells and a calabash.

Problems seen.

Each respondent was asked to list the five conditions which they saw most commonly in their practice. The responses were recorded in Shona and then translated into English for qualitative examination with the aid of a TMP, two Shona field workers and an experienced Shona psychiatrist. It was felt appropriate to classify problems into a number of categories. In an earlier study, problems has been classified into "traditional", "Western", "mental" and "gynaecological" categories;¹ this classification was adapted for use in this study eg. the "Western" category was sub-divided into "non-specific physical complaints" and "specific physical problems". The largest group of complaints were non-specific physical complaints (eg. problems with the back, neck or head, often but not always pain – 119 reports), spiritual or traditional problems (111 reports), specific physical problems (eg. cough, falls, diarrhoea, sores and fits – 98 reports), and fertility problems (48 reports). Psychological disorders, childhood problems, domestic difficulties and problems associated with

pregnancy or childbirth accounted for less than 12 pc of all reported problems (51 reports).

Most TMP reported that they saw a range of problems, usually from three or four of the categories listed above. The most common non-specific complaints were related to the stomach (*mudumbu*), the head (*musoro*) or the legs and feet (*makumbo*). Common traditional problems were *mamhepo* (evil spirits), *ngozi* (avenging spirits), *zvitsikwa* and *zviposo* (witchcraft). Prophets reported traditional problems more often than *n'anga* (traditional: prophets 40 (34 pc), *n'anga* 71 (23 pc); X² = 4,74; p = 0,029). Specific physical complaints included *mabayo* ("pneumonia"), *manyoka* (diarrhoea), *maronda* (sores) and *siki* (sexually transmitted disease). The commonest term used in relation to infertility was *kuuchika*. Psychological problems were almost universally *kupenga* (madness); there was one report of *fuzo* (retardation). Childhood problems were referred to predominantly as *nhoya* ("depressed fontanelle").

Almost half the sample (39) considered themselves to have specialist expertise. This "specialist" group were most likely to claim expertise in traditional problems, infertility (both eight reports) and childhood

problems (seven reports). Only five claimed skills with specific physical problems and four expertise with *kupenga* (madness). The majority of specialist TMP (63 pc) estimated that more than half of their clients brought problems related to their area of expertise. Almost two thirds of the total sample (54) indicated that they referred clients to clinics, and "specialists" were more likely to refer (proportion referring: specialists 74 pc, non-specialists 49 pc; $X^2 = 4.9$; $p = 0.027$). Of the 90 reasons for referral given, 69 (77 pc) were physical problems; *ropa* (problems related to the blood), *manyoka* (diarrhoea). TB and AIDS accounted for half of these.

Views on collaboration.

When asked to express their views on collaboration with clinics, three quarters of the respondents gave positive responses. The commonest group of suggestions related to referrals. These included easier referrals to and from clinics and being known personally as the TMP referring the patient. Twenty three TMP commented on aspects of care.

Seventeen TMP wanted more access to and shared care of patients at clinics or in hospitals; six wanted to be able to pray with patients. Two TMP wanted hospitals built specifically for *n'anga* and two were keen to learn more about Western medicine.

DISCUSSION

No structured data has been published on the numbers and practice of traditional medical practitioners in urban Zimbabwe since the mid 1980s. This study sought to provide such information for two high density suburbs in Harare and aimed to compare the two main groups of TMP, i.e. prophets and *n'anga*. Efforts were made to delineate as complete a list of TMP as possible in the two study suburbs by use of both official registers and key informants. We were able to interview almost 90 pc of the random sample chosen for the study. A limitation of our methodology is that the interviews relied on self reported information alone; the use of participant observation was precluded due to the constraining factors of time and cost. However, some of the data collected was corroborated by a parallel community survey of health care provider usage in the same suburbs.⁶

The study suburbs are served by 58 primary care nurses and five private doctors, which represents a ratio of three TMP per biomedical practitioner. It is also

important to note that 46 pc of our final census of TMP were not registered with a TMP association. This finding is consistent with the discrepancy between registered numbers and estimates of national numbers noted above and underlines the risks of relying on official lists in studies of this nature.

These numbers hide the fact that prophets were solely represented within the unregistered part of our sample. This suggests that the attempts by ZINATHA to include prophets in their official registers has not met with significant success. The registration bias is relevant since prophets and *n'anga* constitute different groups of TMP. Prophets appear to be less diverse than *n'anga* in terms of their nationality, language, religious affiliation and "diagnostic" approach. They are also younger and better educated. Prophets enter practice at a younger age and had fewer years experience in practice at the time of the survey. Virtually all are affiliated to an African church, most commonly the Apostolic church. However, *n'anga* outnumber prophets three to one. Recent studies have shown that those attending *n'anga* are significantly older than those attending other health resources.⁶ This greater age of *n'anga* and their clients may reflect a change in health care seeking patterns, from those based on a traditional world view, favoured by an older generation of TMP who are preferred by older community members, to those rooted within contemporary syncretic Christianity and favoured by younger members of the community.

At the same time, both groups have common characteristics in their practices. The majority of TMP are full time, as reported by other authors.¹ TMP often see clients in the evenings and at weekends. In doing so, they appear to offer a practical and convenient service available at times when clients may be better able to access them. The average TMP reported seeing only a handful of patients daily. Prophets tend to charge lower fees and reported themselves as busier than *n'anga*, two findings which may be linked. These differences are corroborated by other studies in Zimbabwe and Botswana.^{6,8}

Another area of interest was the clinical aspects of TMP's practice. Most TMP are general practitioners and see a range of problems, medical and physical, traditional and social. Traditional and spiritual problems account for only a quarter of consultations. This

problem profile is similar to that reported in earlier work in Zimbabwe,^{1,3} Botswana⁸ and Kenya.¹⁰ Prophets see traditional problems and non-specific complaints more often than *n'anga*. About half of TMP claim specialist expertise, particularly with traditional or spiritual problems, infertility and childhood problems; very few claim expertise in physical problems. Perhaps reassuringly for biomedical health service providers, many TMP, especially specialists, refer some patients to clinics. The predominant reasons given for referral were physical. Thus, TMP may be adapting to changing knowledge about medicine, for example, by recognizing increasingly that some illnesses respond better to biomedicine and referring such patients accordingly.^{1,10,11} Many of those interviewed wished for closer relationships with the biomedical sector, whether through easier and more personal referral systems or through opportunities to share or transfer care between the traditional and biomedical sectors.

In conclusion, TMP are numerous, accessible at hours convenient to clients, familiar with a range of problems, aware of current health concerns and favourably disposed towards biomedical care. At a time when Zimbabwe faces a serious shortage of health manpower, we suggest that TMP remain an underused group of health workers who should be included in future national health programmes. Attempts at collaboration suggest that although there is initial mistrust, collaboration is not only possible but effective.¹² In a pilot study in Zimbabwe involving cooperation between TMP and biomedical practitioners, patients reported that they were very satisfied with being able to consult both and asked why this was not more available.¹³ However, this study did not aim to determine treatments used by TMP for disorders or the outcome of such disorders and these issues remain a source of potential conflict between biomedical and traditional practice. Further research into TMP practice and treatment approaches would be a potentially productive area for future research.

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