SECTION 1

COLLABORATION WITH AFRICAN TRADITIONAL HEALERS FOR THE PREVENTION OF BLINDNESS
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RATIONALE: WHY WORK WITH TRADITIONAL HEALERS?

Many eye care providers and the Ministry of Health may wonder — why do we recommend collaboration with traditional healers for the prevention of blindness? In answer to this question, consider the following:

- One of the greatest impediments to reducing blindness in rural areas is the problem of access to services. Even when services are readily available many patients do not use them. Healers can be a bridge between the community and district eye care providers.
- We recognize that some healer eye care practices are damaging; collaboration could be a route to induce change. Some traditional healer practices could be beneficial (e.g. face washing) and should be encouraged.
- Marginalizing or criticizing traditional healers will not make them disappear or cease treating eye diseases. People will be consulting healers for many years to come.

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BACKGROUND INFORMATION ON TRADITIONAL HEALERS IN AFRICA

It is helpful to have some understanding of the background and training of healers even though there are many differences across the continent. Traditional medicine in Africa is a combination of ingredients, practices and procedures that enables the patient to prevent disease and brings an end to suffering. Many elderly people might be labeled as "traditional healers" since they have some knowledge of how to treat common ailments by using herbs. For complaints other than the most rudimentary, however, "real" traditional healers are consulted. We will not delve into the differences among herbalists, diviners, and other types of healers as the intent of this publication is to encourage the creation of collaborative efforts with any "type" of healer currently undertaking eye care in the community (the exception is market healers, discussed below). We use the term "traditional healer" rather than "traditional practitioner" because it is more commonly used in the literature and the field.

Traditional healers in Africa, after experiencing a divine "call" (often through a dream or traumatic illness) will undertake training from a willing healer. The duration of training varies and competence is assessed by the individual trainer. Healers commonly have assistants who are apprentices in training.

Some countries, for example, Zimbabwe, have licensing bodies for healers while others do not. Most countries have traditional healer associations although the degree of organization varies. In countries with a national traditional healer organization, collaboration can be initiated within this

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association. There are "market" healers in most towns; these tradespeople have not been the focus of most work and are not the target of this publication as they are not community based and are generally perceived to be business people rather than "true" healers. However, it should be noted that market healers have great influence in healer associations in many countries.

There are healers in almost every village in Africa; the estimated healer per population ratio is 1:350. Healers are respected by the community, partly because of their acquired knowledge, their age, their ability to provide answers and treatments that are meaningful to the community, and their position as the moral core of the community. Their moral influence is strongest among the adults and the elderly.

Diagnosis is based primarily on discussing the patient's history or through interpreting dreams, rather than on physical examination. Sorcery and witchcraft are commonly proposed etiologies. There are significant gender differences in the activities of male and female healers. While male healers treat children, women and men; female healers tend to treat primarily women and children. Some female healers also serve as traditional birth attendants.

The cost of traditional medicine is variable, depending upon the nature of the treatment, the kind of disease being treated, and the relative wealth of the client as perceived by the healer. High cost is generally associated with measures to bring good luck or to treat infertility and sexually-transmitted diseases. Treatment for eye disease is generally less expensive.

A list of suggested reading is given in Appendix C for readers who want more information on healers.

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TRADITIONAL EYE PRACTICES

Healers use a variety of products (plant, animal, etc.) to make decoctions for face washes, “fume baths” and for direct application to the eye. Scarification (tattooing) is often performed as a preventative and curative procedure. There is limited information on specific traditional eye practices or traditional eye medicines and almost no information on the traditional eye care activities of the general population. Products used vary from country to country and healer to healer. There is no inventory of traditional eye medicines nor have investigations been carried out to determine the most commonly used products, those that are particularly harmful and those that might have curative properties. As different parts of the plant (leaves, bark, roots, etc.) are used in different ways, understanding the properties of specific traditional eye medicines will be complex. The complexity is increased because traditional medicine is dynamic, changing with the cultural, political and economic environments of the setting in which healers live.

Couching, the dislocation of the lens for the treatment of cataract, deserves special mention. It is still performed in many areas of West Africa, although not by most community-based healers. Couchers are generally itinerant and there is minimal follow-up. The demand for their services reflects the lack of availability of modern cataract surgery or lack of faith in the outcome of modern cataract surgery. Couching is still practised in some places in Asia, particularly China. Specific recommendations for areas where couching is practised are given in the unit on cataract in Section 2.

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COLLABORATING WITH TRADITIONAL HEALERS

Even though there is often great respect for healers within the community, this does not exist in the biomedical community. There are many barriers to collaboration between biomedical health personnel and traditional healers which need to be recognized by both groups:

- There is a natural competition for patients and prestige.
- There is a tendency for government and non-government officials to direct training toward the work-force that is most readily supervised, namely government employees.
- Biomedical personnel are reluctant to cooperate with healers because of a genuine concern that healers practice in a way that may be harmful to patients. Biomedical personnel generally only have experiences with the "disasters", and are unaware of successes in the community.
- Biomedical personnel may believe (although often incorrectly) that traditional medical practices are illegal.
- Biomedical personnel may fear that working with healers will legitimize improper healer practices.
- Government and non-government officials usually have little or no knowledge of the actual practices of traditional healers.

Flexibility on the part of biomedical personnel, government officials and healers will be needed to help overcome these barriers and effectively involve traditional healers in primary eye care.

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Traditional healers are unique, and primary eye care messages and approaches must take into account their role and position in the community. Attitudes by many biomedical personnel must change before healthy interaction can be achieved. Specifically, biomedical personnel must:

- Respect the role that healers have in the community;
- Recognize that biomedical eye care personnel cannot solve all eye care problems;
- Be willing to empower healers;
- Be willing to learn from healers;
- Recognize that medical "quackery" exists within both biomedical and traditional medicine.

The intent behind involving traditional healers in prevention of blindness activities is not to integrate healers into national eye care programmes but to build on their existing capacities so that they can provide the best possible primary eye care within the structure of their relationship with patients and the community.

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