Traditional Healers and their Provision of Mental Health Services in Cosmopolitan Informal Settlements in Nairobi, Kenya

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Traditional Healers and their Provision of Mental Health Services in Cosmopolitan Informal Settlements in Nairobi, Kenya

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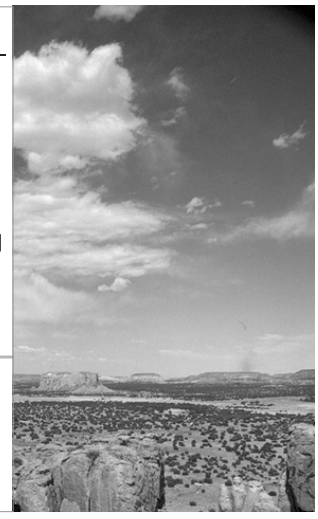

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List of Acronyms

AIDS	Acquired Immune-deficiency Syndrome
AMHF	Africa Mental Health Foundation
ATPS	Africa Technology Policy Studies Network
DSM IV	Diagnostic and Statistical Manual IV
GAD	Generalised Anxiety Disorder
HIV	Human Immunodeficiency Virus
KEMRI	Kenya Medical Research Institute
KIPI	Kenya Industrial Property Institute
MINI	Mini International Neuropsychiatric Interview
OCD	Obsessive Compulsive Disorder
PTSD	Post Traumatic Stress Disorder
TH	Traditional Healer

Abstract

Traditional healing has been practiced by many cultures in Kenya and for many years. It is an accepted mode of treatment in different cultures. Traditional healers are consulted even today and provide treatment to many people. Traditional medicine has been used by large pharmaceutical industries to produce the western type of medication and at times the traditional healers are not aware that the knowledge that they give to these firms is used to make a lot of money without the communities where it came from sharing in the benefits accruing from the sales. The country lacks proper policies that guide the traditional healers despite the fact that they are highly consulted by people and this could jeopardise the lives of those who seek help from them. There is therefore need for the government to engage the traditional healers more so that better practices are observed to ensure that the patients benefit. Objectives: The broad objective was to determine whether traditional healers treat mental disorders and whether they are aware of intellectual property rights. Method: This study was carried out in the urban informal settlements of Kibera, Kangemi and Kawangware. Snowballing mode of sampling was used. An in-depth interview was done with each traditional healer. An in-depth interview with each patient of the traditional healer was also done together with the MINIPLUS to counter check the diagnoses arrived at by the traditional healers. Data was collected using the self-developed questions for social demographic and in-depth interviews, and the MINIPLUS for adults. Data was treated using descriptive statistics and some of it was analysed qualitatively. Results: Results showed that traditional healers are consulted for mental illnesses and use various methods for treating these illnesses. However, they have no or little knowledge on intellectual property and benefit sharing.

1. Introduction

1.1 Background of the Health Sector of Kenya

Immediately after independence, the young Government, in the Sessional Paper No. 1, 1965, declared war against three enemies: poverty, illiteracy and diseases. For the Health Sector, the Government's policy objective was to have affordable, effective and accessible health services that promote well-being, and improve and sustain the health status of all Kenyans. The Health Sector expanded over the years with several providers offering a wide range of services. With the expansion, the sector realized a decline in crude death rate from 20 per 1000 person in 1963 to 13 in 1987, and 12 in 1991. Life expectancy increased from 40 to 58 years in 1960 and 1994; infant mortality declined from 126 per 1000 in 1962 to 60 per 1000 in 1994, and the immunization coverage rose to 70% in 1994 from less than 40% at independence in 1963.

The introduction of the Structural Adjustment Programmes by the World Bank in Kenya (1980s) brought cost sharing in Kenya's social sector to relieve the Government of the financial burden of providing public services. In the Health Sector, cost sharing was introduced in December 1989, and this meant that the beneficiaries of public health services, who previously received almost free medical care, would henceforth contribute substantially to the financing of health care delivery. Declining financial resources adversely affected the quality of services received from the public health facilities. This was because inadequate financial resources translated to inadequate supplies of drugs and medicine, reduced personnel training, low remuneration for health personnel, and non-expansion of health facilities. It is behind this scenario that there arose the establishment of many private clinics, some of which had no licenses, selling of expired drugs and even fake drugs (sometimes reported over the media). Traditional medicine also continued to thrive. It is estimated that about 70% of Kenyans visit traditional healers.

Status of Traditional Medicine in Kenya
Traditional medicine in all its form was the only mode of treatment in Kenya for the various communities before the white man came to Kenya. It was practiced in various forms; for example, use of herbs, animal parts, divination and others. However, with the coming of the Christian missionaries and the colonial settlers' modern medicine was introduced. With the establishment of Mission hospitals and clinics, there followed deliberate discrediting and fight against the use of traditional medicine in schools and churches. They were considered to be primitive and so declared illegal by the colonial authorities. After independence, the Kenyan medical practitioners who took over from Europeans continued to shun traditional medicine practitioners despite their contribution to meeting the basic health needs of the population, especially the rural people. However, recent progress in the fields of environmental sciences, immunology, medical botany and pharmacognosy have led researchers to appreciate in a new way, the precise descriptive capacity and rationality of various traditional taxonomies as well as the effectiveness of the treatments employed.

In the 1979-1983 Development Plan 8, the Kenya Government officially acknowledged the major role of traditional medicine in primary health care, and thus called for research to "evaluate the role and functions and to determine the extent of the usefulness of traditional medicine. In 1985, the Department of culture recognized traditional medicine as a part of

Kenya's rich cultural heritage and began to identify genuine practitioners with the aim of distinguishing positive aspects of traditional medicine and discarding the negative ones for development.

1.2 Problem Statement

With the majority of the population in informal settlement living on less than a dollar a day, the residents might not give health issues and especially mental illness - which does not hurt - a priority when allocating their income. Kenya has a shortage of psychiatrists, the ratio being approximately 1:500000 with many of them operating privately in the Central Business Districts, with none in the informal settlements and their charges are out of reach for the people in the informal settlements. There is ample scientific evidence from Kenya and elsewhere that traditional healers are easily accessible, affordable and accepted by the communities and highly consulted including for mental illnesses.

2. Objectives

The main objective of this study is to find out if traditional healers in the informal settlements in Nairobi are consulted for treatment of mental illnesses and if the TH is aware that the knowledge that they have on traditional medicine if properly protected and shared can lead to benefits not only to them but their communities.

Specific objectives

1. To find out if traditional medicine is practiced in urban cosmopolitan informal settlements of Kibera, Kangemi and Kawangware in modern Kenya
2. To document the various types of mental illness seen and treated by the traditional healers.
3. To determine the validity of the mental disorder diagnoses made by the traditional healers
4. To document the treatment modalities for mental illness offered by the traditional healers
5. To document the knowledge, attitudes and practice in regard to access, benefit sharing and intellectual property by the traditional healers in Kenya

3. Literature Review

Human communities have always generated, refined and passed on knowledge from generation to generation. Such traditional knowledge is often an important part of their cultural identities. Often, indigenous traditional knowledge systems contain a rich understanding of plant, crop and tree species, medicines, animal breeds, and local ecological and biological resources. They may also include useful technologies and an adaptation to local environments Traditional knowledge is dynamic. Sophisticated and adaptive, it evolves and responds to changes in the physical and social environment.

Unlike the western custom of disseminating knowledge through publications, traditional knowledge systems are transmitted through specific cultural mechanisms such as songs, proverbs, stories, folklore, community laws, common or collective property and inventions, practices and rituals and also often through designated community knowledge holders, such as elders. The knowledge is considered collective to the community, not private to one individual or small group.

The importance of traditional medicine as a source of primary health care was first officially recognized by the World Health Organization (WHO) in the Primary Health Care Declaration of Alma Ata (1978) and has been globally addressed since 1976 by the Traditional Medicine Programme of the WHO. According to WHO, 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. 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 context.

In many countries, traditional medicines provide the only affordable treatment available to poor people. In developing countries, up to 80% of the population depend on traditional medicines to help meet their healthcare needs. 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. This was recognized in Kenya by Dr Otsyula, who reported in 1973 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.

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.

Traditional healers are the first professionals contacted for mental illness in many parts of Africa. 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. 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 emergency.

3.1 Traditional Medicine Therapies

The traditional medicine therapies include the use of the following:
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 1925 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', which is psychosis, regardless of the cause or type.

Psychotherapy: The practice of psychotherapy and behavioural therapy is 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) 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 Ndetei.

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

3.2 Intellectual Property Rights and Access to Benefits Sharing

Whereas most inventions are protected by way of patents or plant breeders' rights, TK does not fit neatly into any scheme of intellectual property rights protections. At the same time, to obtain patents under the existing framework, awareness among indigenous community is needed and services of qualified professionals are required which is not readily available locally on most of the occasions. The hurdle is not only in obtaining a patent, but also in maintaining them and managing the rights profitably. To manage the rights profitably, the community would need to have a market surveillance mechanism to monitor infringements and take appropriate legal actions where necessary. This would mean incurring costs that may be beyond the reach of many traditional healers or their communities. However, the TK belongs to the community and does not have joint inventors. Other people can extract the components from the herbs and then get patency as an inventor; hence the traditional knowledge is lost.

The global realization on the need to protect the diminishing resources led the international community to negotiate the Convention on Biological Diversity (CBD). In addressing this concern, the CBD asserted the sovereign rights of the states over the genetics resources

within their jurisdiction and to facilitate access through mutually agreed fair and equitable terms. The Convention on Biological Biodiversity (CBD) also explicitly recognizes the rights of indigenous and local people in traditional knowledge and innovations. Article 8(j) of the CBD, is the most authoritative provision dealing with traditional knowledge. It provides that each Contracting Party shall, as far as possible and as appropriate, "subject to its national legislation; respect, preserve, and maintain knowledge, innovations and practices of indigenous and local communities embodying traditional lifestyles relevant to the conservation and sustainable use of biological diversity and promote their wider application with the approval and involvement of the holders of such knowledge, innovations and practices and encourage the equitable sharing of the benefits arising from the utilization of such knowledge, innovations and practices. The problem is that traditional knowledge is rarely recognized as a matter for intellectual property rights.

At the regional level, members of the African Regional Intellectual Property Organization (ARIPO), at a diplomatic conference held at Swakopmud (Namibia) on 9th August 2010, adopted the Swakopmud Protocol on the Protection of Traditional Knowledge and expressions of Folklore. The purpose of the protocol as stated in Section 1.1 of the protocol is:

- to protect traditional knowledge holders against any infringement of their rights as recognized by this protocol; and
- to protect the expressions of folklore against misappropriation, misuse and unlawful exploitation beyond their traditional context.

The development of the Swakopmud Protocol has been hailed as positive and much welcomed by the countries in the region. Kenya, being a member state of ARIPO needs to take steps to domesticate the protocol for the benefit of the local communities. This will provide an environment that enables the traditional healers to develop their traditional medicine without fear. By taking steps to domesticate the protocol, the government will be assuring the traditional healers of the protection of knowledge and innovations.

3.3 Policies in Place Relating to Traditional Medicine

Several attempts have been made towards development of policies and regulatory framework for traditional medicine. However, despite the enthusiasm prevailing in initial stages of dialogue, most of the initiatives seem to hit a debacle or derail as soon as they take off. The national development plan of 1979-1983 made an attempt to bring traditional medicine in the agenda of national planning. This attempt led to the introduction of the administrative regulation of traditional medicine practitioners. The development plans that followed sought to recognize traditional medicine. The National development plan of 1989 to 1993 made a commitment to the promotion of the welfare of the traditional medicine practitioners. The Health Policy Framework through the National Drugs Policy sought to encourage traditional medicines.

The current draft of the National Policy on Traditional Medicine and Medicinal Plants has addressed areas of safety and efficacy. The other three areas of attention are: conservation, production and domestication and finally commercialization. Under commercialization, one of the goals is to enhance protection of property rights and ensure equity in distribution of benefits. The policy did not address the issue of how the traditional healers can collaborate with the western trained doctors in the provision of mental health.

4. Methodology

4.1 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. These are also areas where Africa Mental Health Foundation already has study projects.

Kibera is situated in Nairobi's South Western Peri-urban zone, approximately seven kilometres from the Nairobi City Centre. Kibera as a whole is an informal settlement comprising of ten villages with a population of about 260000 people. Most of them work in the industrial area of the city as casual labourers. Most of the houses are made of mud and roofed with either corrugated iron sheets or covered with polythene papers.

Kangemi is a cosmopolitan area found in the Western part of Nairobi. 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 6 main 'villages'. 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 organisations, community-based organisations and faith-based organisations.

Kawangware is a mixture of formal and informal settlements. It is in Dagoretti Constituency. The slum has a population of over 100000 people. 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. It comprises of various villages.

4.2 Study Population

The study population comprised of the traditional healers and their patients drawn from the three informal settlements.

a) 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.
3. Patients who were 18 years and above

a) Sample size determination

The number of patients treated by the traditional healers was determined using the Fisher et al 33 sample size calculation. $n = \frac{Z^2 p^2 q}{d^2}$;

Where; Z is confidence interval; p is the proportion of the population with the mental illness; q is 1-p and d is the significance level set at 0.05

$(1.96)^2 * 0.13 * (1-0.13)$

0.052 = 173.793 (174) adult patients in each study site

The patients were distributed among the traditional healers practicing in the study sites giving: 42*2=84 hence 174/84=2 patients per traditional healer.

4.3 Sampling Method

Using the help of the 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 are currently 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 us ask them to give us 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.

4.4 Recruitment and Consenting Procedures

With the help of community health workers, after getting all the necessary clearances,
We were able to identify the THs. 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 withdraw the consent any time in the course of the study. Those who signed the consent forms were recruited. A Focus group discussion was held with them in each of their sites. The THs then availed to us their patients who were recruited and consented.

4.5 Data Collection Instruments

1. All the instruments used were translated into Kiswahili.
2. Social demographic for both traditional healers and the patient - described above
3. In depth interviews for both traditional healers and the patients - described above
4. MINI PLUS for the patients. The MINI-International Neuropsychiatric Interview (MINI (-Plus) is a structured diagnostic interview, which was developed by Sheen DV 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.
5. Focus Group Discussion guides

5. Results

5.1 Quantitative Data

A total of 59 traditional healers were enrolled in the study and they were distributed as follows: Kangemi n=16 (27%), Kawangware n=21 (36%) and Kibera n=22 (37%). Table 1 summarizes the social-demographic characteristics of the traditional healers.

Table 1: The social demographic characteristics of the traditional healers

Gender n=59	**N.I**	**Male**	**Female**				
	1 (1.69)	33 (55.93%)	25 (42.37%)				
Level of education n=59	**N.I**	**No schooling**	**Primary school**	**Secondary school**	**college**		
	3 (5.08%)	7 (11.86%)	33 (55.93%)	15 (25.42%)	1 (1.69%)		
Years of practice n=59	N.I	< 10	10-19	20-29	30-40		
	1 (1.69%)	13 (22.03%)	23 (38.98%)	13 (22.03%)	9 (15.25%)		
Age n=59	**N.I**	**18-20 Years**	**21-30 Years**	**31-40 Years**	**41-50 Years**	**51-60 Years**	**61-70 Years**
	4 (6.77%)	1 (1.69%)	3 (5.08%)	10 (16.94%)	27 (45.76%)	7 (11.86%)	7 (11.86%)

N.I = Not indicated

From table 1 above, there were more male than female traditional healers. The majority of the healers (83%) were over 40 years of age and 62% had practiced for more than 10 years. A total of 305 patients of the traditional healers accepted to participate in the study. Table 2 summarizes the characteristics these patients. The overwhelming majority of the patients were females, compared to the traditional healers where the majority were males. 54% of the patients were currently married. The patients tended to be better educated than their traditional healers. Most patients were not in gainful employment.

Table 2: The social demographic characteristic of the patients of the traditional healers

Gender = n 305	**Male**	**Female**				
	50 (16.45 %)	255 (83.6 %)				
Level of education n=305	**No schooling**	**Primary school**	**Secondary school**	**College/ university**		
	12 (3.9%)	159 (52.1 %)	112 (36.7%)	22 (7.2%)		
Marital status N=305	**Single**	**Married**	**Divorced/ Separated**	**Deceased/ Widow**	**Not Indicated**	
	111 (36.39 %)	157 (51.47 %)	29 (9.50%)	5 (1.63%)	3 (0.98%)	
Age n=305	18-20 Years	21-30 Years	31-40 Years	41-50 Years	51-60 Years	61+ Years
	8(2.6%)	104 (34.1 %)	97 (31.8%)	67 (22.0%)	19 (6.2%)	10 (3.3%)

5.2 Findings by Study Objectives

5.2.1 Objective 1: To find out if traditional medicine is practiced in urban cosmopolitan informal settlements of Kibera, Kangemi and Kawangware in modern Kenya

305 patients of the traditional healers were recruited. This was a sign that the traditional healers still practice in the communities in Kenya. They had given various diagnoses to their patients as summarized in table 3 below. This indicates that most of the traditional healers are visited for treatment of physical illnesses.

Table 3: What did the traditional healer say you (the patient) were suffering from?

Type of illness	frequencies	%
Physical illness	236	77.37
Mental illness	27	8.85
Epilepsy	5	1.63
Spirit/Demonic possession	2	0.65
Witchcraft	13	4.26
Physical and Mental illness	3	0.98
Physical illness and Epilepsy	3	0.98
Somatization	5	1.63
Not told	11	3.60

Total	**305**	**100**

A total of 13 (4.26%) 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.

5.2.2 Objective 2: To document the various types of mental illness seen and treated by the traditional healers

Of a total of 305 patients seen by the traditional healers, only 30 patients were diagnosed with mental disorders as shown in table 4 below. Only 14 patients were given specific mental disorders. Nine (9) patients though told they had a mental disorder were not given a specific mental disorder, while 7 were told that they were thinking too much.

Table 4: The type of mental diagnoses the traditional healer gave the patient

Types of mental illness seen by the TH	Frequencies	%
Madness/psychosis	9	30
Depression	5	16.66
Thinking too much	7	23.33
General mental illness	9	30
Total	**30**	**100**

5.2.3 Objective 3: 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. Table 5 shows the types and prevalence of the different types of DSM IV disorders that were identified in the patients. However, note that DSM IV does not pick epilepsy as epilepsy is a neurological disorder.

Table 5: Types of mental illness by the MINI PLUS

Types of mental illness by the MINI PLUS	Frequencies	%
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
Total	**322**	**105.7**

There were more DSM-IV diagnoses than actual number of patients, implying high co-morbidity of mental disorders. This is the reason why there are 322 cases of mental disorders according to MINI PLUS compared to 305 patients

5.2.4 Objective 4: To document the treatment modalities for mental illness offered by the traditional healers

The THs use different methods for treating mental illnesses depending on the severity of the disease and the cause but they include: (i) Counselling - being the most popular method of treatment; (ii) Use of different types of herbs which can be taken orally, others for washing while others are inhaled (as shown in pictures 1and 2); (iii) Combining herbal treatment with counselling; (iv) Consulting the spirit world including the ancestors who then give instructions on how the patient should be treated; (v) moving to the patients home to help him/her remove certain items which the TH claims have been used to bewitch the patient.

Figure 1: Samples of raw herbs used for treatment

Figure 2: Sample of processed herbs used for treatment

5.2.5 Objective 5: To document the knowledge, attitudes and practice in regard to intellectual property by the traditional healers in Kenya

All the THs had little, if any, knowledge on intellectual property. However, during the capacity building on this particular area it became clear that they are wary of researchers who want to find out about their methods of treatment. This is because they reported that those who have 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) get rich from the TH's sweat. They did not want to take any of their information to any government body. They said that others will 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.

5.3 Other Important Findings of the Study Drawn From the In-depth Interviews of both the Traditional Healers and the Patients

5.3.1 Main reasons why people seek help from the traditional healers

All the patients were asked why they sought help from the traditional healers and yet there were government health centres near them. The responses were as follows; They: (i) do not get well despite visiting the hospital (30.6%); (ii) are advised by friends to seek help from the traditional healers (14.1%); (iii) health workers in the hospitals did not provide adequate treatment (13.77%); (iv) hospitals being expensive (8.52%); (v) 3.27% of the patients felt that they could only be treated by the traditional healers.

5.3.2 Satisfaction with traditional healers' services

Only 15 (4.9%) patients said that they were not satisfied with the traditional healers' services. The rest (95.08) said that they were satisfied with the services of the traditional healers.

5.3.3 Combining traditional healing and modern medicine

Less than 20 (6.55%) patients combine traditional medicine with modern medicine. Some of the patients who combine claim that they only take pain killers when they have sudden headaches, while others said that they go to hospital for investigations then tell the traditional healer who then treats them while one or two said that they will go to the hospitals when they have money. The rest of the patients (93.44%) will stick to one mode of treatment only.

5.3.4 Moving from one TH to another

The patients stick to one traditional healer. Those who consult another traditional healer claim that they do so when they are not getting well or they have moved upcountry and get sick and so they consult the nearest traditional healer.

5.3.5 How patients pay the TH

The payment to the traditional healer is both in cash and kind. Some combine 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.

5.3.6 Comparing the affordability of the TH to the health facilities

Asked whether the traditional healers were more affordable compared to the hospitals many patients responded yes, but depends 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.

5.3.7 Accessibility of the TH

On the question of accessibility of the traditional healers, every patient said that they are easily accessible with some making home visits. When they travel to look for their herbs, they can take a while.

5.3.8 Training of the traditional healers

49 (83%) of the 59 traditional healers said that they had been trained. Seven (7) of those not trained said that they inherited their treating methods from their grandparents or parents,1 said that the healing came to him naturally, while 2 said that they observed as other traditional healers treated and in the process learnt.

5.3.9 How traditional healers make a diagnosis

Asked on how they get to know that the patient has a mental illness, various responses were given which included: (i) Examining the patient; (ii) Observing his/her behaviour and mode of talking; (iii) Getting the history of the patient; (iv) Some traditional healers use the mirror to arrive at a diagnosis (spiritual 'imaging'); (v) Others pray to get revelations from spirits (divination); (vi) Some beat a drum to get revelation (kupiga ramri)

5.3.10 Whether the TH refer 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 the hospitals for more tests. They also said that they always encouraged the AIDS patients on ARV to continue with their medications. A few claimed that they can cure HIV/AIDS. They also said that though they refer their patients to the hospitals, the doctors do not reciprocate. They felt that the doctors do not recognise them.

Discussion

The traditional healers were able to recognize certain mental disorders –p value 0.010 with psychosis being the most easily recognised. These findings were similar to those in Uganda 16. It is possible that the patients given the diagnosis of "thinking too much" or "stressed" by the traditional healers could have been suffering from depression. From the focus group discussion, the traditional healers mentioned patients who think too much. However, few had the concept of depression. These findings are similar to those found by Sorsdahl et al 2010 14. At the same time, in our African context, there was no name for depression. The only obvious mental illness was "madness" which could be easily detected from the behaviour of the patient.

Of the patients diagnosed by the TH as having depression and madness/psychosis the MINI PLUS correctly identified them as having those. 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 results of the MINI PLUS, it is clear that many patients' with mental disorders were missed/ misdiagnosed by the TH.

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.

The traditional healers' services were not necessarily less expensive than health facilities. However, the fact that one could pay in instalments and in kind made the people visit them (flexibility in mode of payment). However, of more significance is 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. No traditional healer sent the patient away due to lack of money. THs also operate a waiver system strictly on the ability to pay. If the TH sends a patient away on the basis of genuine inability to pay, the TH will be punished by their spiritual mentors.

The findings that many patients had visited the health centres before visiting the traditional healers were also similar to findings in Uganda. 16 Many traditional healers have inherited the skill from their parents or grandparents and this is a common phenomenon as is reported by Nwoko. 35 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.

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.

6. Conclusions and Recommendations

6.1 Conclusions from the study

1. Traditional healers are consulted by members of the community for various illnesses including mental illnesses and therefore cannot be ignored. Instead, they should be engaged constructively to promote better understanding of mental illnesses, their diagnosis and the possible referrals, while at the same time, discouraging harmful practices.
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 offer counselling as a mode of treatment. The counselling makes the patients go back to them as they feel that there is somebody willing to talk to them. This method is not offered in the public health centres due to the huge work load on the health workers and hence lack of time.
4. 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, for example KEMRI in Kenya is important. However, this must be accompanied by fool proof assurance that their intellectual knowledge will be safeguarded.
5. The traditional healers get their medication from plants in our forests and even neighbouring countries hence the need for environmental conservation.
6. THs are not aversive to cooperation with health facilities and therefore are willing and do, in fact refer patients, creating a channel of increased referrals; they could be empowered through constructive and positive engagement with them and supportive supervision through continuous education on the various psychiatric disorders and their manifestations.
7. The traditional healers did not want to share their information with government agencies, regarding protection of their work which was quite evident. They said that they used their own methods of protection, which involved passing their knowledge to selected members of their family in form of a child or grandchild. However, this method has the risk of the traditional healers dying with their knowledge if it has not been passed on or maybe the selected person has no interest due to the influence of education. The other risk is that knowledge needs to be shared so that the community can benefit. The secrecy held by the Traditional healers' makes them vulnerable to exploitation as there is no way that they will come out and defend any knowledge leaked out to outsiders. They need to be educated on intellectual property and how their shared knowledge can be of benefit to them. All this was lacking in the field.
8. The traditional healers are not aware of the draft National Policy on Traditional Medicine. Many are not registered for fear that it is expensive or they will be arrested or their knowledge taken away. Since the traditional healers are dealing with human life, there is need for them to be recognized appropriately by the government and be put in the relevant Ministry.

6.2 Policy Recommendations

The following policy recommendations were made and presented:

1. Though the government is aware that the traditional healers exist there is need for them to be recognised formally and their large clientele. This recognition will help to stream line the operations of the traditional healers and hence protect the clients.
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 to 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.
5. The government to make it easy for the traditional healers to register and practice.
6. There is need for the traditional healers to be engaged in constructive dialogue by bodies that can fight for the interest of the traditional healers. These include but not limited to; Kenya Medical Research Foundation, the various Universities, KIPI. Through this kind of dialogue, the traditional healers would be educated on the need to have their herbs tested, the need to have their work protected using the legal means and even the process that are involved if collaborative research has to take place and the legal processes that are required. Through this, the traditional healers are not exploited and neither is their knowledge used without their consent.
7. There is need for environmental conservation. This is because African medicinal plant resources may be doomed to extinction by overexploitation resulting from excessive commercialization (unsustainable use of medicinal plants), habitat destruction and other natural and man-made destructive influences unless energetic conservation measures are taken to ensure their continued availability. This can be done through the establishment of medicinal plant gardens and farms. The acquisition of large scales of land required for cultivation can be a serious obstacle.
8. The government should adapt the conventions that have been passed in the region and customize them so that the THs' knowledge can be protected and guidelines are taught to them on when and how to share the information that they have with the outside world. This will eliminate the secrecy that surrounds traditional healing and which is at risk of disappearing with the death of the TH and the shunning of traditional medicine by the younger generation as they go to schools. The instruments of protecting traditional knowledge and hence medicine so that there can be benefit sharing and protection of the knowledge must be developed and made simple for the TH to follow. Finally, the THs need to be given information on the importance of sharing the information that they have with the right people and bodies in order to avoid bio piracy and also get benefits if their methods of treating are unique.

6.3 Problems Experienced

1. It took time to get ethical clearance (it was given in May 2010), delaying the start and subsequent activities.
2. Interviewing the patients at the clinics of the THs was problematic due to lack of space. Appointments with the patients had to be made to see them in their homes. The THs had few patients with mental illnesses according to them. This made us enrol patients with physical illnesses but they turned up to have mental illnesses.
3. Getting the patient to complete the whole questionnaire was time consuming. However this limitation was minimized by giving short breaks to the patients in between.
4. Not all ethnic groups had TH practices in the respective sites. We had to work with those we could get.
5. Though we trained the THs (capacity building and sustainability) on simple ways of identifying mental disorders and IP, there is need to carry out another study to find out the effectiveness of the training provided.

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