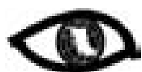
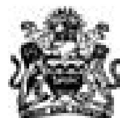




Collaboration with African Traditional Healers for the Prevention of Blindness

Paul Courtright
British Columbia Centre for Epidemiologic & International Opthalmology, Canada

Moses Chirambo
Lilongwe Central Hospital
WHO Collaborating Centre for the Prevention of Blindness, Malawi

Susan Lewallen
British Columbia Centre for Epidemiologic & International Opthalmology, Canada

Harjinder Chana
Norwegian Association for the Blind, Zimbabwe

Steve Kanjaloti
Chikwawa District Hospital, Malawi

World Scientific
Singapore • New Jersey • London • Hong Kong

Collaboration with African Traditional Healers for the Prevention of Blindness

Published by

World Scientific Publishing Co. Pte. Ltd.
P O Box 128, Farrer Road, Singapore 912805
USA office: Suite 1B, 1060 Main Street, River Edge, NJ 07661
UK office: 57 Shelton Street, Covent Garden, London WC2H 9HE

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library.

COLLABORATION WITH AFRICAN TRADITIONAL HEALERS FOR THE PREVENTION OF BLINDNESS

Copyright © 2000 by World Scientific Publishing Co. Pte. Ltd., P. Courtright, M. Chirambo, S. Lewallen, H. Chana and S. Kanjaloti

All rights reserved. This book, or parts thereof, may not be reproduced in any form or by any means, electronic or mechanical, including photocopying, recording or any information storage and retrieval system now known or to be invented, without written permission from the Publisher.

For photocopying of material in this volume, please pay a copying fee through the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, USA. In this case permission to photocopy is not required from the publisher.

ISBN 981-02-4377-4 (pbk)

Printed in Singapore.

This publication was made possible by support from The Task Force for the Prevention of Blindness, for which we are grateful. The authors also thank the participants at the Blantyre meeting (listed in Appendix B). The Blantyre meeting was also sponsored by the World Health Organization and logistic assistance during the meeting was provided by the International Eye Foundation. We are grateful for all of their assistance.

PREFACE

Traditional healers are plentiful and culturally accepted health care providers throughout Africa and much of the developing world. Until recently, few traditional healers have been involved in primary eye care activities. Findings from existing collaborative programmes suggest that healers can be a positive force for community-based prevention of blindness.

The intent of this publication is twofold. Section 1 gives brief background information on traditional healers and explains why they should be involved in prevention of blindness activities. Section 2 gives specific recommendations for working with healers and may serve as a training manual.

This publication is a result of review of existing programme activities in Malawi, Zimbabwe and Nepal, and the September 10–12, 1997 International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness (Blantyre, Malawi), organized by the British Columbia Centre for Epidemiologic and International Ophthalmology and the Lilongwe Central Hospital WHO Collaborating Centre for the Prevention of Blindness. The statement of consensus and recommendations arising from this symposium are given in Appendix A and a list of the participants is provided in Appendix B. The symposium was supported by the NGO Task Force for the Prevention of Blindness and co-sponsored by the World Health Organization. The editors would like to thank the NGO Task Force and WHO as well as the International Eye Foundation for their support of the symposium.

CONTENTS

SECTION 1 **1**

Rationale: Why work with traditional healers? 3
Background information on traditional healers in Africa 4
Traditional eye practices 6
Collaborating with traditional healers 7

SECTION 2 **9**

Teaching traditional healers 11
  Curriculum structure 13
Teaching units 14
  1. Orientation 14
  2. Cataract 15
  3. Trichiasis 18
  4. Assessing vision 21
  5. Red eye 23
  6. Neonatal conjunctivitis and other childhood eye diseases 26
  7. General health, hygiene and nutrition 28
  8. Referral and continuing education 30

APPENDICES 33

A	Summary and recommendations from the International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness	35
B	Participants at the International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness in Africa	38
C	Bibliography	40
D	Should traditional healers use Western eye medicines?	43
E	Methods to determine prevailing traditional eye practices by healers	44
F	Evaluation of training programmes	46
G	Research priorities	48
H	Illustrations on trachoma and cataract	49

SECTION 1

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.

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

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.

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.

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.

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.

SECTION 2

TEACHING TRADITIONAL HEALERS

The following issues need to be addressed:

- Who should be the trainer?
- Which healers should be trained?
- How do you work effectively with healers?
- What should the curriculum include?

Teaching traditional healers will need to be approached differently from teaching health assistants or village health workers. The intent is not to turn traditional healers into health assistants or village health workers.

It is best to conduct orientations and trainings in the local setting. The ophthalmic assistant is usually the most appropriate person to run the trainings as it is he or she who has the best chance of establishing an on-going relationship with the healers. Presumably, it is also the ophthalmic assistant who will be receiving any referrals made by the healers. It is important that other biomedical personnel at health centers or district hospitals are aware of the collaborative work the ophthalmic assistants are doing. It will probably be necessary to conduct an orientation with district hospital and health center staff to inform them of activities so that patients who present after seeking care from healers are not criticized for doing so.

It will be impossible to train all healers; priorities for selection of healers for training will need to be set locally and may be based on such considerations as level of activity and interest of individual healers, and proximity to training sites. Keep in mind, though, that healers who live great distances from the hospital are often those who provide more eye care services.

In working with healers, general considerations are as follows:

- Teaching should be recognized as a two-way street; the instructor is also the student. It is important for the instructor to admit that biomedicine also cannot cure all eye diseases.
- Respect must be shown. Many healers believe that they are more knowledgeable about the subject than the instructor.
- Be very careful about offering criticism, especially during orientation or early programme activities. Seek areas on which you can agree with healers and try to reinforce "good" practices (e.g. counselling patients, face-washes) by showing your agreement and offering praise.
- Do not expect to find "success" quickly; developing a programme will take time and results cannot be expected immediately. It is difficult to change long-held beliefs.

Use the following specific teaching recommendations as a checklist as you are developing and implementing a training programme with healers:

- Sessions need to be short and only address a few points at a time.
- Groups being trained should be of reasonable size to ensure that interaction is feasible.
- Involve both male and female healers; they have different clienteles.
- Teaching materials should be pictorial rather than written. Drawings, showing the whole face, should be used rather than photographs.
- Training should involve participation, not just lectures. Healers will become bored if you lecture to them. Keep the lessons lively; encourage healers to participate in the lesson by asking them what they do at home or in their clinics. Some healers will dominate the interaction. It is important to draw out other healers and give them a chance to present their views. By treating all healers equally, the more timid ones will be encouraged to participate.
- Explanations are best made through appropriate analogies within the culture; it is not advisable to try to provide a biomedical explanation to everything. Find out what beliefs are associated with the disease you are talking about. If the beliefs (witchcraft or sorcery in many cases) are not

harmful, do not discourage them. Keep your messages related to discouragement of specific practices as brief as possible. When it is necessary to discourage a practice, always let them discuss the practice — its perceived benefits and dangers. Lead the discussion so that they reach the consensus that the practice should be stopped. When discouraging a practice, be sure that the healers can suggest other possible approaches to treatment of the same condition.

- Plan for considerable repetition of topics through a variety of methods. Many healers are elderly and will have difficulty following the instruction.
- Find a healer who could benefit from cataract or trichiasis surgery and encourage him or her to accept surgery.

Curriculum Structure

The curriculum has been divided into eight units (orientation and seven specific units), each addressing a different aspect of primary eye care. The first part of each unit is devoted to background information and rationale for the learning objectives. Then, one or more learning objectives is stated. For each objective, a number of specific teaching methods are discussed.

The curriculum is designed to be used over a number of days, not within a single day. It is suggested that the curriculum be divided into three to five separate sessions, each to be held 3–4 months apart. Although repetition is not found in the text, it will be essential to reinforce messages over and over again.

TEACHING UNITS

Unit 1: Orientation

Do not rush into conducting training sessions before adequate planning and investigation have been done; these will, in the long run, provide a valuable base for collaboration.

It is helpful to conduct an orientation with healers prior to the start of a training programme. Orientation is used to build respect and trust between biomedical personnel and the healers and it helps set the tone of the relationships and the pace of interaction. It is a time to display good will and get to know some healers on a personal basis and to discuss the objectives of the programme. Two to three hours is often sufficient for health staff and healers to talk about some of the following issues:

- Why the district hospital wants to collaborate with healers.
- Services provided by the district hospital.
- Why it is not possible for the district hospital to provide eye care for everyone.
- Some of the concerns of the healers.
- How training activities will be organized.
- Expectations of both the healers and the biomedical personnel.

Unit 2: Cataract

Background

It is common for healers to report that they would like to learn more about cataract. Cataract is the leading cause of blindness in the world, accounting for approximately 40% of all blindness. In many developing countries the cataract blind do not avail themselves of the services available. Some of the barriers that prevent people from accepting cataract surgery include:

- distance to the hospital
- fear of surgery or lack of faith in the outcome of surgery
- lack of social support to seek services
- cost
- belief that cataract is a part of the aging process and cannot be corrected.

Women, in particular, have poor access to surgery. Healers can significantly influence some of these barriers. In particular, they can allay some of the fear, increase the social support, and confirm the potential good outcome of surgery. Healers live side by side with the cataract blind in the community, often unaware that a cure is possible.

Healers can recognize cataract if you show illustrations and have patients for examination. It is very important to know what cataract is called in their own language since it differs from place to place even in the same district. Although it can be difficult, it is worth trying to teach healers the difference between a cataract and a corneal scar, both of which cause a “white spot.”

Objectives

Healers will be able to:

1. describe the symptoms of cataract and describe which patients are most likely to have this problem.
2. describe the treatment for cataract and when patients should be referred for this.

3. refer patients for cataract surgery when the patients can no longer see well enough for daily work or activities.

Teaching Methods

- Use pictures (line drawings) to help the healers understand that it is only the black part of the eye that has become white, not the whole eye. Healers should be encouraged to examine the eye and see that the white part is round in cataract but usually not round in corneal scar. Ask healers to describe what the patients complain of and what age they generally are. Describe other features of the eye (white, not painful). It is important to agree upon one name to be used to describe cataract.
- Find out if any healer has a cataract. If so, strongly encourage the healer to have surgery. Provide transport and any other necessary support. Treat the healer as a colleague during surgery. This individual will then be a good advocate for the value of surgery among other healers.
- Ask healers if they know any people in their village with cataract. Have one or more of them bring these patients to the next training session for all healers to see. As a group convince the patient to have surgery and following surgery, discuss how it has changed the patient's life. Make sure the referring healer is part of the process. (Referral systems are discussed in Unit 7.)
- Invite a few healers to join cataract surgery day in the district. Bring the healers into the operating room and show them how surgery is carried out.
- Many misperceptions about surgery exist. Explain that cataract surgery is a small, relatively painless operation which takes only a few minutes and the patient is not put to sleep. Even old people will benefit from a cataract operation because they can become more independent.
- Helping patients to reach a decision about when to have surgery is an important role of healers. It is helpful for male and female healers to discuss what elderly people do. For example, female healers will probably report that elderly women still fetch water, look after children, and other important tasks. It is for the individual with cataract to decide (with the

assistance of the healer) when they can no longer see well enough for their daily work or activities.

- Healers should not be discouraged from trying their own cures for cataract before referral if these cures are not damaging to the eye.
- If aphakic glasses are used after cataract surgery the healers should be aware that glasses need care and must be kept clean and stored safely at night. They should be worn all the time and need to be replaced, if broken.

It may be necessary to improve the quality of cataract surgery in your District to ensure good outcome.

Couching

As described earlier, couching is practiced in West Africa and some areas in Asia. The following recommendations may assist those working in areas where couching is practiced:

- Focus educational messages on the traditional healers rather than on the couchers. Couchers are itinerant and thus collaboration would be difficult. It is difficult to stop couchers as they make their living from couching.
- Encourage traditional healers to refer patients with mature cataracts to the eye care services.
- In cases where a patient insists on seeing a coucher, let the traditional healer instruct the patient to have only one eye done and inform the patient that couching is a procedure that carries considerable risk.
- Include messages about the risks of couching in routine health education messages; make sure that these messages do not criticize community healers not involved in couching.

Unit 3: Trichiasis

Background

Trichiasis, like cataract, is also a disease of the elderly and involves a surgical intervention; many of the same educational approaches are involved. Trachomatous trichiasis is the second or third leading cause of blindness. Similar to cataract, in many developing countries patients with trichiasis do not avail themselves of the services available. Some of the barriers that prevent people from accepting trichiasis surgery include:

- distance to the hospital
- a fear of surgery or lack of faith in the outcome of surgery
- lack of social support to seek services
- cost
- the belief that trichiasis is bothersome but not blinding.

Women, in particular, have poor access to surgery. Healers can significantly influence some of these barriers. In particular, they can allay some of the fear, increase the social support, and confirm the potential good outcome of surgery.

Healers can recognize trichiasis if you show illustrations and have patients for examination. It is very important to know what trichiasis is called in their own language since it differs from place to place even in the same district.

Objectives

Healers will be able to:

1. describe the symptoms of trichiasis and describe which patients are most likely to have this problem.
2. describe the treatment for trichiasis and when patients should be referred for this.
3. refer for trichiasis surgery when the lashes are abrading the eye ball.

Teaching Methods

- Help the healers understand that lashes that abrade the eyeball can eventually damage it. Using a long hair from the tail of some animal, demonstrate what happens when lashes are cut; help the healers recognize that the cut end is blunter, stiffer, and more damaging to the eye.
- Find out if any healer has trichiasis. If so, strongly encourage the healer to have surgery. Provide transport and any other necessary support. Treat the healer as a colleague during surgery. This individual will then be a good advocate for the value of surgery among other healers.
- Ask healers if they know any people in their village with trichiasis. Have one or more of them bring these patients to the next training session for all healers to see. As a group convince the patient to have surgery and following surgery, discuss how it has changed the patient's life. Make sure the referring healer is part of the process. (Referral systems are discussed in Unit 7.)
- Trichiasis surgery may also be appropriate for demonstration, although it is more bloody than cataract surgery and the immediate postoperative cosmetic view is not particularly appealing.
- Many misperceptions about surgery exist. Explain that trichiasis surgery is a relatively painless, small operation, takes only a few minutes, and the patient is not put to sleep.
- Convincing patients with trichiasis to have surgery is often more difficult than convincing patients with cataract to have surgery; while cataract surgery is sight-restoring, trichiasis surgery is not. This needs to be made clear to healers.
- Reaching a decision about when to have surgery is an important role of healers. It is helpful for male and female healers to discuss what elderly people do. For trichiasis, surgery should be discussed when trichiasis is recognized with the aim of preventing corneal damage through early surgery.
- As many women with trichiasis will not self-present, even to a healer, it is recommended that, in areas where trachoma is highly endemic, healers should look for trichiasis when interacting with women.

The quality of trichiasis surgery in the district may need to be improved to ensure good outcome.

Unit 4: Assessing Vision

Background

Decreased visual acuity is one of the most important signs characterizing most serious eye diseases. Measurement of visual acuity is helpful for following the progress of disease and determining its severity. Creation of visual criteria for referral will depend on the ophthalmologic capacity of the area as well as the visual needs of the population. In some areas, < 6/60 will be used while in other areas, < 3/60 will be used. From the perspective of the traditional healer and his relationship with the patient, it might be helpful to use visual function as a criteria for referral.

Teaching visual acuity testing is important, partly because healers wish to gain this skill and partly because this skill helps them recognize that there may be visual problems that the patient did not admit to at first.

Objectives

Healers will be able to:

(i) measure vision in all their patients with a history of blurred distance vision.
(ii) learn to use visual acuity to follow patients.

Teaching Methods

- Discuss the concept of visual function. Ask healers what sort of activities their clients do which require good vision (e.g. sorting beans, avoiding potholes, recognizing faces). Discuss the need to refer patients who can't see well enough to perform daily tasks.
- Ask them if they have ways to measure how bad someone's vision is. Demonstrate that they may be able to count fingers at 1 meter, 3 meters or 10 meters but not at 20 meters. Point out that sometimes one eye can see well but the other eye cannot. Be sure the healers understand that there is a difference between a blind eye and a blind patient.

- Have the healers practice measuring visual acuity on each other. Expect to have to repeat many times the necessity to check one eye at a time. When practicing on each other, start with those that appear to understand the technique. Be sure that everyone in the class participates.
- On follow-up days, ask healers to bring their patients who have poor vision. The OMA can measure vision and discuss visual function along with the healer.
- It is not recommended to teach healers eye anatomy except the minimum amount needed to discuss a specific condition.
- It is not recommended that visual acuity charts be distributed, unless this can be sustained by the national programme. Finger counting should be used.

Unit 5: Red Eye

Background

The red eye is the commonest eye condition which healers treat and it is one of the diseases the healers have the most potential for helping or harming. Harm can occur in two ways:

- Some healers instill harmful substances into red eyes in an attempt to cure the condition. This can lead to destruction of the cornea.
- Some healers attempt their own treatments (benign or otherwise) for a long time and thus delay the patient from getting to other medical facilities until it is too late.

Discussion of the red eye and its management can potentially be the most controversial and should be approached only after a degree of trust and rapport has developed between the instructor and the healers. In most situations, healers do not distinguish between different eye diseases that result in a "red eye".

Objectives

Healers will be able to:

1. recognize a normal (white) conjunctiva.
2. start to understand the dangers of instilling substances directly into the eye.
3. recognize the importance of referring patients with red eyes that are not improving after three days.

Teaching Methods

Different methods for teaching about the "red eye" include the following:

- Start with a discussion of what a normal eye looks like. Examine each other's eyes and point out normal features. The simple concept that the

clear part should be clear and the white part should be white may be appropriate depending on how astute the healers are at examination. After they have looked at each other, they should also discuss and describe any abnormalities of the cornea they have seen.

- Discuss the symptoms a patient complains of when he/she has a red eye (pain, irritation, watery discharge, purulent discharge, photophobia, low vision). Which of these would they view as alarming? Healers should be encouraged to practice their vision taking skills in patients with red eye. Try to lead the healers towards a consensus that decreased vision and severe pain in patients with "red eye" should lead to immediate referral.
- Have healers discuss methods (not necessarily the actual traditional eye medicine used) which they use to treat red eyes. You may ask healers if they have seen such practices result in complications and encourage discussion of this. Encourage discussion of other "treatments" (e.g. face washes and "fume baths") for the red eye. These benign (and potentially helpful) practices should be encouraged as a substitute for instilled medicines. Show respect for methods which do not include direct application.
- Healers may be hesitant to discuss the specific plants they use in front of other healers (the competition); avoid pressuring healers to reveal more than they are comfortable revealing.
- The timing of referral for "red eye" will depend on the local circumstances. It is important for them to discuss and agree on a practical cut-off they can follow. Healers who live far distant from the hospital will probably report that it is difficult to convince people to travel a long distance. Consideration should be given to creating outreach activities in the health centres in out-lying areas and setting up schedules that the healers are informed about.
- Remember that many healers do not use examination as a principal method of diagnosis, relying more on history. It is important to discuss these histories as they help clarify how the "red eye" is viewed within the culture. If these etiologies lend themselves to a discussion of preventive measures (e.g. for inflammatory trachoma or seasonal conjunctivitis), it may be possible to reach a consensus regarding prevention.

- The use of charms, talismans, or spiritual healing should not be discouraged as long as the patient is getting better and not displaying the "alarming" symptoms discussed above.

Unit 6: Neonatal Conjunctivitis and Other Childhood Eye Diseases

Background

Conjunctivitis of the newborn children is discussed separately from red eye since it is seen in a different population (children) and healers often recognize and treat this type of conjunctivitis as a separate disease. In the healer's mind, it may be associated with disease in the mother or with something the mother ate during pregnancy. In many cases, infants with neonatal conjunctivitis will be taken to a healer first. Female healers are most likely to be consulted. In some areas, female healers also serve as traditional birth attendants; some have received training by the Ministry of Health or NGOs.

Objectives

1. The healers must recognize the great urgency in treating neonatal conjunctivitis and their important role in convincing the mother to accept treatment.
2. The healers should recognize that this is a sexually transmitted disease
3. The healers should recognize the importance of referring children with protruding eyes (orbital lesions) or leukocoria urgently.

Teaching Methods

- Before starting a session on neonatal conjunctivitis and other childhood eye diseases, find out if some TBAs in the district have been trained by the Ministry of Health or NGOs. If so, determine what was discussed regarding eye disease and get the names of TBAs considered to be the most influential and educated.
- Start by discussing how often the healers see this condition and how they think it is caused. It is not important to correct mistaken beliefs as long as they are harmless. It is worthwhile encouraging healers to believe that the mother also has a disease and will require treatment, but the real urgency is for the baby. Since healers may lump all conjunctivitis in

young babies into one category, it is worth emphasizing that the conjunctivitis which occurs within a few days of birth is the most dangerous, although all cases should be referred urgently.

- Healers who are TBAs often recognize the link between disease in the mother and newborn conjunctivitis. They should take a leading role in these discussions. All healers are familiar with sexually transmitted diseases and if there is no current understanding of the relationship between neonatal conjunctivitis and STDs, this should be discussed.
- Traditional birth attendants should be encouraged to discuss what they do soon after birth of every child. This should include immediate cleaning of the eyes of the newborn baby with a clean swab/cloth to reduce the risk of infection.
- Discussion should cover the differences between an infant's eye and an adult's eye (the infant eye being very tender) and the additional hazard of applying "eye drops" to a child's eye. They should wash the eye very often and the children should be referred to the hospital with both parents for treatment. It is necessary to treat both parents.
- Poor vision and blindness in young children (e.g. from congenital cataract or retinoblastoma) are often viewed as bewitching of the family for some transgression; help the healers reach a consensus regarding referral of these children.
- Measles is readily recognized by most healers as is the conjunctivitis associated with it. It should be included in a discussion of the "red eye".
- Have healers discuss the children they have seen with protruding eyes or leukocoria and the ultimate outcomes of these children. Try to lead them to understand that early referral can save some of these children.

Unit 7: General Health, Hygiene and Nutrition

Background

Even though healers are not educated in the germ theory of disease, they may have an idea that dirty habits are connected with disease. Many employ practices such as baths, face washing or cleaning as part of their daily or healing rituals. The idea is to build on the pre-existing connections between hygiene and disease. While nutritional factors, per se, are not generally viewed as a cause of eye disease, the consumption of certain foods (particularly during pregnancy) may be believed to cause some eye conditions.

We have found that the healers who are willing to undertake community-based educational activities are generally healers with large practices. Healers with large practices are generally well-accepted by their communities; this respect should be used to bring primary eye care messages into the daily lives of the community. Although female healers generally have smaller practices than male healers, they should be encouraged to undertake educational activities.

Objective

To help healers make or affirm the connection between hygiene, nutrition and health.

Teaching Methods

- Pictures (line drawings) of unhygienic and hygienic households (contrasting the presence of a clean latrine versus no latrine, clean faces versus dirty faces, etc.) should be shown for healers to discuss differences in the scenes.
- Ask them which practices might improve hygiene. Face washing in particular should be discussed, noting the need to keep eyes closed. Steam baths can also be included.

- Help healers understand that clean water alone can do a lot to prevent many eye diseases.
- Encourage the healers to discuss the role of flies in the transmission of disease. In particular, female healers should be asked what they have recognized in children with flies clustering on their faces.
- Since healers are often members of village health committees they should be a good example to the community. The surrounding of their houses should be clean. They should be encouraged to have a latrine.
- Discuss community activities which healers might use to teach about hygiene.
- Discuss the valuable properties and "healing qualities" of locally available healthful foods such as those rich in vitamin A or protein. The healers are in an important position to influence dietary behaviors.

Unit 8: Referral and Continuing Education

Background

Throughout the sessions, we have suggested that certain patients be referred by the healers to health assistants or OMAs. A system will have to be established so that this can be done. In order to do this, the trainer needs to understand the local situation.

Healers and trainers need a clear understanding of how referral will work. This is important as healers should not perceive that they are “turning over” patients (their financial livelihood) to biomedicine.

Creating a long-term collaborative relationship between biomedical personnel and healers may not be possible. On the other hand, creating an atmosphere of trust and mutual respect is possible. It will be necessary to ensure that local biomedical health staff always participate in training programmes to ensure that an appropriate relationship is established.

Objectives

Healers and trainers will:

1. establish a mutually satisfactory system for referral of patients from the healer to the ophthalmic assistant (or other appropriate biomedical health care provider).
2. establish goals for continuing education and collaboration.

Points to consider in creating a referral system:

- Training is only one component of a programme; follow-up is essential.
- Training needs to be periodic to help sustain the interaction.
- Most healers will prefer to refer the patient to their trainer. The healers will probably find it easier to talk to their trainer about their patients than another eye care provider.
- OMAs who make visits to local health centres should be sure that the area healers are aware of the scheduled visits. To avoid large distances that patients must travel to reach the district hospital, referral of first

choice should be to local health centers during OMA visits. Naturally, failure to keep these visits will undermine the trust and relationship being established between the trainer and healer.

- Healers can bring patients themselves to a health center; this has advantages in the fact that the healer can learn more about the patient's condition and the link between the patient and the healer is maintained.
- One of the more effective referral systems involves the preparation and distribution of short "referral letters" which healers can send along with a patient if they cannot accompany a patient. Healers who are not literate should be shown how to use a "referral letter".
- There should be a follow-up for the healers who refer patients. The OMAs should make sure to tell (or write) the healers regarding the diagnosis of their patients and what they have done. Returning referral letters will encourage the healer to maintain relations with biomedical personnel and continue to refer patients.
- Healers should be encouraged to see patients whom they have referred to note improvement or need for ongoing care.
- A representative from the local health center (from the area the training is being conducted) should be available to answer some questions which the healers may have concerning non-ophthalmologic issues. This will also help address questions that are raised when the OMA is not present.
- As it is impossible to reach all healers with training activities, the healers should be encouraged to meet other healers and discuss the recommendations. This will also encourage leadership and responsibility.
- Referral of patients (particularly cataract and trichiasis) to the hospital should be presented as a collaborative activity with the healer as a vital link in the process whereby sight is restored.
- When possible, visit healers at their homes; it will improve their reputation in the village and make them more keen to collaborate. It is a way of demonstrating that their collaboration is valued.

APPENDICES

Appendix A

Statement of Consensus and Recommendations on the Need for Collaboration Between African Traditional Healers and Biomedical Eye Care Workers in Eye Care.

Prepared by participants at the *International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness in Africa*, Blantyre, Malawi, September 10–12, 1997.

Traditional healers are an integral and important part of most cultures and will remain so. They are respected members of their communities and live and work in the most rural areas. They are the most commonly consulted and most accessible primary health care providers in all African communities.

Eye care programmes have been effective at the district hospital level in many countries. There has, however, been limited success in expanding activities beyond this level and in overcoming many of the barriers precluding cataract surgery uptake by rural communities.

Collaboration with traditional healers in Zimbabwe and Malawi has been successful with an increase in the cataract surgery uptake and a decrease in the incidence of blinding corneal ulcers due to harmful traditional eye medicines.

Eye care programmes could increase accessibility of services to rural communities by including them, following appropriate reorientation, in the network of primary eye care providers in the locality. Traditional healers are interested in collaborating with eye care workers. There is now a clear imperative for collaboration. This should be based on mutual trust and respect with the two disciplines as both should complement each other to the benefit of the patient.

Recommendations

1. Collaboration should focus on improving the capacity of traditional healers to assist their patients, on referral, on counseling patients and their families, and on decreasing harmful traditional practices.
2. There is tremendous variation in traditional healer practice; approaches to collaborative blindness prevention programmes, therefore, must reflect local conditions.
3. A clear understanding of traditional eye care practices is necessary prior to the development of collaborative activities and training.
4. Such collaborative activities should be consistent with Ministry of Health policy and guidelines.
5. Ministries of Health are encouraged to set policy and guidelines, and establish and regulate traditional healer associations. To protect the public, regulations concerning advertisements and service outcome should apply to all health providers be they traditional healers, couchers or biomedical personnel.
6. If Ministry of Health allows the use of pharmaceuticals by traditional healers, consideration should be given to sustainability and possible adverse effects of combining pharmaceuticals and traditional eye medicines.
7. Collaborative activities should be patient focused, community based, culturally appropriate, and sustainable.
8. Training programmes for healers should be participatory in nature, reflecting the unique role healers have in their communities; the proposed manual should be adapted as necessary.
9. Collaborative eye care programmes should only be established where there are adequate training, support, referral, and feedback capacities.
10. Couching remains a significant cause of visual loss and blindness; the provision of affordable, accessible high quality modern cataract surgery with good visual outcome would reduce this practice.
11. Operational research is needed to clarify the best approaches to collaborative interventions.

Organizing Institutions

BC Centre for Epidemiologic & International Ophthalmology
University of British Columbia, Vancouver, CANADA
&
Lilongwe Central Hospital WHO Collaborating Centre for the Prevention of Blindness
Lilongwe Central Hospital, Lilongwe, Malawi

The International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness, held in Blantyre, Malawi, from September 10–12, 1997 was supported by the Task Force of the Partnership Committee of Non-Governmental Organizations Collaborating with the WHO Programme for the Prevention of Blindness. Symposium participants included eye care professionals from Africa, North America, Europe, and Asia as well as traditional healers from Zimbabwe and Malawi. The organizers and participants would like to thank the NGO Task Force and WHO as well as the International Eye Foundation /Malawi for their support of the symposium.

APPENDIX B

International Symposium on Collaboration with Traditional Healers for the Prevention of Blindness in Africa, Blantyre, Malawi, September 10–12, 1997.

Participants

Dr. Nico Dekkers
Oisterwijksedreek 10A
5076 NA Haaren
NETHERLANDS

Ms. Edna Berhane
ORBIS International
1900-330 W. 42nd St.
New York, NY, 10036, USA

Dr. Moses Chirambo
Sight Savers
P.O. Box 30858
Lilongwe 3, MALAWI

Dr. Steve Kanjaloti
Ophth. Medical Assistant
Chikwawa District Hosp.
Chikwawa, MALAWI

Dr. J. Eloff
Nkhoma Hospital
P.O. Box 48
Nkhoma, MALAWI

Dr. Regina Gobel
St. Benedict's Hospital
P.O. Box 1003
Ndanda via Mtawara
TANZANIA

Mr. Don O'Dwyer
Operation Eyesight Universal
P.O. Box 123, St. M
Calgary, AB
CANADA, T2P 2H6

Dr. Francis Mulwanyi
Lions Aid
Norway, UGANDA

Dr. Jerome Msonthi
Zomba, MALAWI
Minister of Health
Lilongwe, MALAWI

Dr. Colin Cook
Christoffel Blindenmission
Edendale Hosp, Private Bag
X509, Plessislaer 3216
SOUTH AFRICA

Mr. John Barrows
Int. Eye Foundation
7801 Norfolk Ave.
Bethesda, MD
20814 USA

Mr. Thomas Bisika
Ctr. For Social Research
Univ. of Malawi
P.O. Box 258
Zomba, MALAWI

Mr. Aggrey Ndyara
Ruharo Eye Centre
P.O. Box 14
Mbarara, UGANDA

Dr. Cora G.W. Dekkers-Hulshoff Pol
Oisterwijksedreek 10A
5076 NA Haaren
NETHERLANDS

Dr. Hannah Faal
Sight Savers
Eye Unit
Royal Victoria Hospital
Banjul, GAMBIA

Ms. Dawna Crawford
Operation Eyesight Universal
P.O. Box 123, Station M
Calgary, AB CANADA
T2P 2H6

Mr. G. Kankwamba
Nkhoma Hospital
P.O. Box 48
Nkhoma, MALAWI

Mr. Bendict F.M. Mawingo
Mission Hospital
P.O. Box 19
Peramiho, TANZANIA

Dr. Roe Gronnevet
Lions Aid
Norway, UGANDA

Dr. C.P. Ozemela
The National Eye Centre
PMB 2267
Kaduna, NIGER

Dr. Harjinder Chana
Norwegian Assoc. for the Blind
P.O. Box 1250
Mutare, ZIMBABWE

Dr. Paul Courtright
BC-EIO, UBC, St. Paul's Hospital
1081 Burrard Street
Vancouver, B.C. V6Z 1Y6
CANADA

Mr. Dighton Divala
Kasungu District Hospital
P.O. Box 19
Kasungu, MALAWI

Miss Grace Funsani
International Eye Foundation
P.O. Box 142
Nchalo, MALAWI

Dr. Jean Francois Schemann
I.O.T.A.
BP 248
Bamako, MALI

Dr. Volker Klauss
MathildenStrasse 8
Munich, 80336
GERMANY

Mr. George Mekisini
International Eye Foundation
P.O. Box 142
Nchalo, MALAWI

Dr. Wahida H. Shangali
P.O. Box 8690
Tatcot, Moshi, TANZANIA

Dr. Susan Lewallen
BC-EIO, UBC, St. Paul's Hospital
1081 Burrard Street
Vancouver, B.C. V6Z 1Y6
CANADA

Mr. Peter McGeachie
Sight Savers International
P.O. Box 34690
Nairobi, KENYA

Dr. Amos Twinamasiko
Mbarara University of Science & Technology
P.O. Box 1410
Mbarara, UGANDA

Ms. Karin van Dijk
Christoffel Blindenmission
Education for the Blind
Montfort College
P.O. Box 5192
Limbe, MALAWI

Dr. Christine Witte
International Eye Foundation
P.O. Box 2273
Blantyre, MALAWI

Mrs. Fanny Nsona
(traditional healer)
Ngabu, MALAWI

Dr. Geoffrey Wabulembo
Lions Aid
Norway, UGANDA

Mr. Yohane (traditional healer)
Chikwawa, MALAWI

Mr. Bimal Poudyal
SEVA, P.O. Box 780
Katmandu, NEPAL

Dr. Boateng Wiafe
Mwami Adventist Hospital
P.O. Box 5
Chipata, ZAMBIA

Dr. Nkume Batumba
Operation Eyesight Universal,
Eye Ward, Queen Elizabeth Central Hosp.
P.O. Box 95
Blantyre, MALAWI

Appendix C

Bibliography

Adefule-Ositelu AO. Ocular drug abuse in Lagos, Nigeria. *Acta Ophthalmologica*, **67**:396–400 (1989).

Barbe RF: Traditional Native Medicines and Optic Neuritis. *Ophthalmology World News*, Sept. (1995).

Brandt F, Hennig A, Prasad LN, Rai NC, Upadhyay MP. Ergebnisse der operativen Reklination der Linse (Eine Studie aus Nepal). *Klin Mbl Augenheilk,* **185**:543–546 (1984).

Carmichael TR, Wolpert M, Koornhof HJ. Corneal ulceration at an urban African hospital. *British Journal of Ophthalmology*, **69**:920–926 (1985).

Chana HS. Integration of modern and traditional ophthalmic practices (unpublished).

Chana HS, Schwab L, Foster A. With an eye to good practice: traditional healers in rural communities. *World Health Foundation*, **15**:114–116 (1994).

Courtright P. Eye care knowledge and practices among Malawian Traditional Healers and the development of collaborative blindness prevention programmes. *Soc. Sci Med*, **41**(11):1569–1575 (1995).

Courtright P, Lewallen S, Kanjaloti S. Traditional healers in primary eye care. *British Journal of Ophthalmology*, **79**:506 (1995).

Courtright P, Lewallen S, Kanjaloti S. Changing patterns of corneal disease and associated vision loss at a rural African hospital following a training programme for traditional healers. *British Journal of Ophthalmology*, **80**:694–697 (1996).

Courtright P, Lewallen S, Kanjaloti S, Divala DJ. Traditional eye medicine use among patients with corneal disease in rural Malawi. *British Journal of Ophthalmology*, **78**:810–812 (1994).

Du Plessis PA. Some traditional Tonga eye remedies. *Medical Journal of Zambia*, **12**(4):94 (1978).

Foster A, Sommer A. Corneal ulceration, measles, and childhood blindness in Tanzania. *British Journal of Ophthalmology*, **71**(5):331–343 (1987).

Harries AD, Cullinan T. Herbis et orbis: The dangers of traditional eye medicines. *The Lancet*, **344**:1588 (1994).

Klauss V. Traditional eye medicine. In *Epidemiology of Eye Disease.* (1998) pp. 38–44.

Klauss V. Traditional eye medicine practice. In *Programmes in Prevention of Blindness*, Chana HS (ed.) pp. 148–155.

Klauss V, Adala HS. Traditional herbal eye medicine in Kenya. *World Health Forum*, **15**:138–142 (1994).

Lewallen S, Courtright P. Peripheral corneal ulcers associated with use of African traditional eye medicines. *British Journal of Ophthalmology,* **79**:343–346 (1995).

Lewallen S, Courtright P: Role for traditional healers in eye care. *The Lancet*, **345**:456 (1995).

Loewenthal R, Pe'er J. Traditional methods used in the treatment of ophthalmic diseases amoung the Turkana tribe in north west Kenya. *Journal of Ethnopharmacology*, **33**:227–229 (1991).

McMoll TE, Bordoh AN, Manube GMR, Bell EJ. Epidemic acute haemorrhagic conjunctivitis in Lagos, Nigeria. *British Journal of Ophthalmology*, **68**:401–404 (1984).

Mariotti JM, Amza A. Traitement traditionnel de la cataracte du Niger. A propos de 22 cas. *J. Fr. Ophtalmol*, **16**(3):170–177 (1993).

Newlin S: Traditional healers join new ways with old. *Ophthalmology World News,* 1996.

Ntim-Amponsah CT: Traditional methods of treatment of cataract seen at Korle-Bu Teaching Hospital. *West African Journal of Medicine*, **14**(2):82–87 (1995).

Phillips CM: Blindness in Africans in Northern Rhodesia. *The Central African Journal of Medicine*, **7**(5):153–158 (1961).

Rambo VC: Couching Operation in Tibet. *AMA Archives of Ophthalmology Correspondence,* pp. 471–473.

Taylor HR, Cadet J-C, Sommer A. Folk medicines and acute hemorrhagic conjunctivitis. *American Journal of Ophthalmology*, **4**:559–560 (1994).

Yorston D, Foster A. Traditional eye medicines and corneal ulceration in Tanzania. *Journal of Tropical Medicine and Hygiene*, **97**:211–214 (1994).

Appendix D

Should Traditional Healers Be Encouraged To Use Western Eye Medicines?

Encouraging traditional healers to use Western eye medicines could be problematic and consideration of the following is required. Consider the following before making a decision.

- If distribution is encouraged, can the programme sustain long-term distribution of Western eye medicines? Is cost recovery a realistic option and does cost recovery fit within the practice of traditional medicine?

- Does the national drug policy allow for or restrict distribution of medicines to traditional healers? Are there any legal issues involved?

- What mechanisms can be put in place to ensure the proper use of Western medicines by traditional healers? Combination of traditional and Western eye medication must be avoided. Will storage facilities be adequate and what methods can be put in place to avoid the use of outdated drugs?

- What training and supervision is necessary to ensure that Western eye medicines are used appropriately; can supervision be maintained?

- Are there ethical considerations that must be considered?

- In some places traditional healers are already using Western medicines. This practice is likely to continue, and will even expand.

Appendix E

Methods for Determining Prevailing Traditional Eye Practices by Healers

There are some simple, yet important, steps to undertake in order to determine the prevailing traditional eye medicine practices by healers.

- Contact the National Prevention of Blindness Committee to determine if studies have been undertaken in your country or a surrounding country.
- If there is no locally appropriate information that can assist you, pepare a list of issues and questions such as those included below. Use these questions to help create a "picture" of traditional eye practices in your area.
  - Be sure to sensitize the healers regarding the reasons for your questions
  - Be sure to define your area of study (make it reasonable)
  - The person who carries out the questionnaire needs to be accepted and respected by healers and eye care personnel
  - Put the answers in a form that can be easily summarized
- Suggested recording form for assessing traditional eye practices of healers

DATE: .... VILLAGE: ....

DISTRICT: ....

NAME of HEALER: ....

TREATS EYE DISEASES: YES / NO

TREATS EYE DISEASE IN:
- CHILDREN
- ADULTS

TREATMENT METHODS (EYE DISEASES):

Yes	No	
[ ]	[ ]	DRINKING OF MIXTURES
[ ]	[ ]	FACE WASHING
[ ]	[ ]	WEARING OF AMULETS
[ ]	[ ]	SMOKE/POWDER BLOWING
[ ]	[ ]	DIET/FASTING
[ ]	[ ]	LICKING
[ ]	[ ]	INCANTATIONS
[ ]	[ ]	SCARIFICATION
[ ]	[ ]	POULTICING/CUPPING
[ ]	[ ]	TOPICAL INSTILLATIONS
[ ]	[ ]	FUME BATHS

SURGERY (FOR EYE DISEASES)

Yes	No	
[ ]	[ ]	EPILATION
[ ]	[ ]	EYELID SURGERY
[ ]	[ ]	COUCHING
[ ]	[ ]	OTHERS ______________________

Yes	No	
[ ]	[ ]	AWARENESS OF EYE CARE FACILITIES
[ ]	[ ]	DO YOU REFER TO EYE CARE FACILITIES?
[ ]	[ ]	DO YOU WANT COLLABORATION WITH EYE CARE SERVICES/HOSPITAL?

Appendix F

Evaluation Methods

Some simple and inexpensive methods for evaluating programme activities are listed below. If not currently undertaken, the creation of a routine register will also benefit.

Hospital- or Clinic-Based

- Routine information collection on corneal cases associated with traditional eye medicines. Compare pre- and post-intervention findings.
- Routine information collection on cataract patients presenting for surgery. Ask all patients if they were referred by a healer and compare pre- and post-intervention findings:
    1) blindness
    2) bilaterality
    3) TEM used
    4) time since symptom started
    5) traditional healer visited
- If neonatal conjunctivitis is common, record routine information on all children presenting with neonatal conjunctivitis. Compare pre- and post-intervention findings.

Traditional Healer Practices

- At periodic times, ask healers questions regarding their practices (questions given in the previous appendix will serve as a guide) and compare their findings.
- Ask healers how they have changed their practices since the initiation of the programme.

- Ask healers what they found the most helpful.
- Ask healers what additional information they would like to learn, and why.

Patients

If blindness surveys or rapid assessments are planned, include a couple of questions on eye care use patterns.

Appendix G

Research Priorities

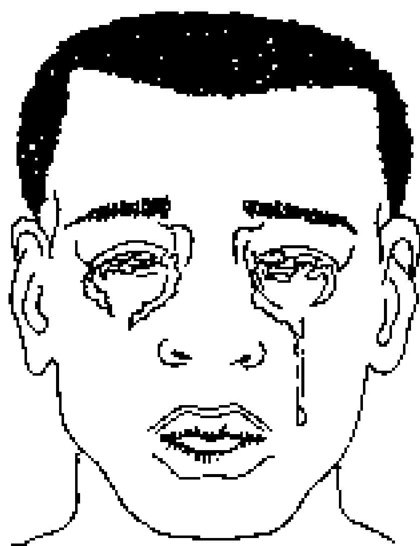
There is still considerable research that needs to be undertaken to aid our understanding of TEM use and how best we can collaborate with healers to reduce blindness. Some issues that should be addressed include:

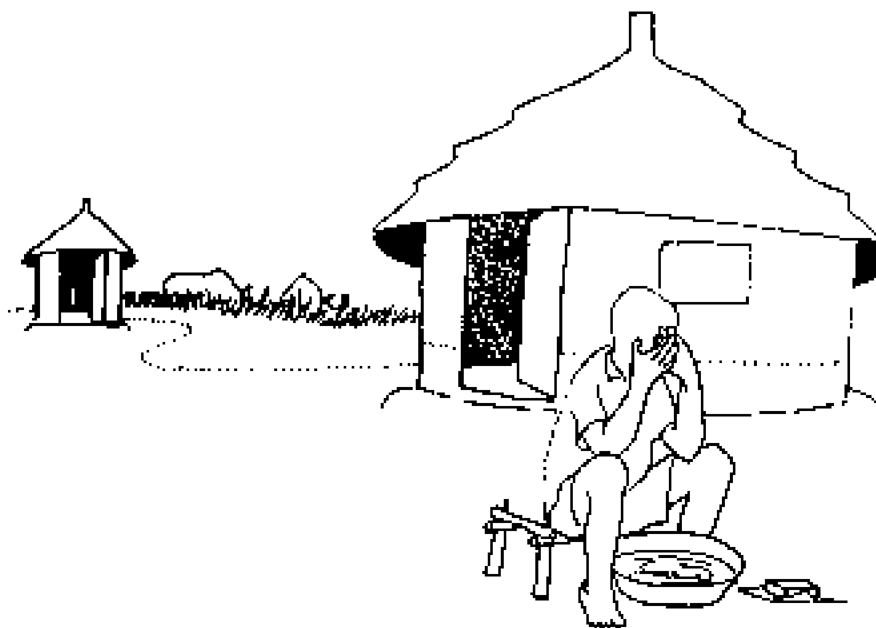
- What is the relative contribution of popular (general population) and folk (traditional healer) traditional eye practices to eye care practices and corneal disease?
- How does gender affect the use of traditional eye medicines and eye care practices?
- Are there plant products used for traditional eye medicines that have particularly helpful biochemical properties?
- Are there endangered plant species used as traditional eye medicines?
- What is the community perception of couching versus modern cataract surgery?

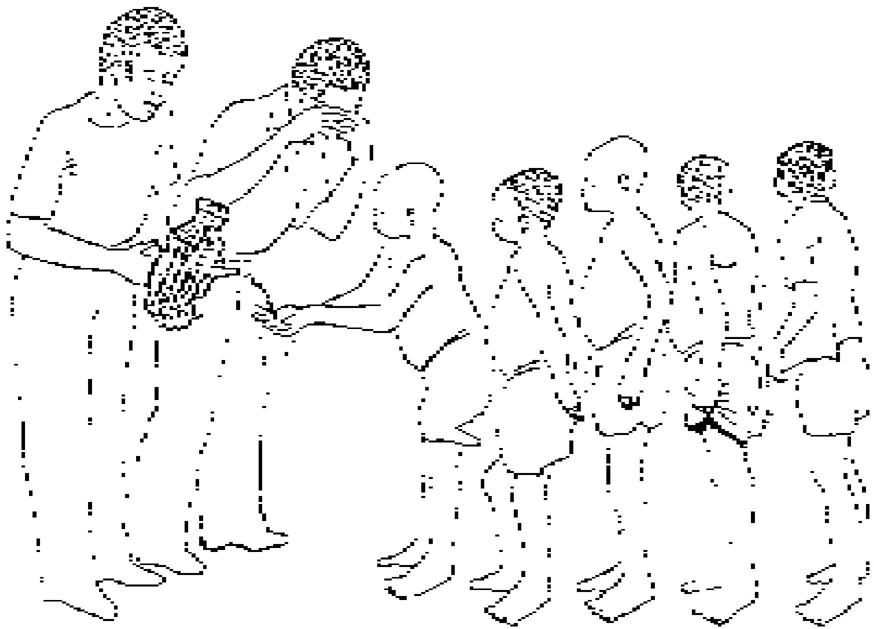
Appendix H

Illustrations on Trachoma and Cataract

Trachoma







This picture shows demonstration in a school of face washing in the prevention of trachoma.

Do you see that in one eye the center is black, as it should be, while in the other eye, the center is white? This means the patient has a cataract in the eye with the white center and cannot see through that eye.

If a patient cannot see with either eye and has a cataract in one or both eyes he/she should go to the district hospital and see Mr. Kanjaloti. A simple surgery can be done that will restore sight in that eye.