THE ROLE OF TRADITIONAL THERAPY IN THE TREATMENT OF INFERTILITY

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This article examines the utilisation of certain indigenous techniques and materials in the management of infertility in married women in some communities in Kenya. The ability to beget children is the true mark of womanhood in African societies. Because of this, a childless woman will try anything which promises to enable her to conceive.

Recent studies have shown the seriousness with which infertility is viewed among Kenyan women. For example, Kimani (1981) in a study of the patterns of utilisation of church health services, has shown that the majority of the patients who used the health services studied were children and women, the latter mainly aged between 15 and 50 years. About sixty per cent of the complaints presented by the women were related to obstetrical and gynaecological problems.

In another study conducted at Kenyatta National Hospital gynaecology clinic, it was established that infertility is a common complaint in Kenya despite the rapid rate of population growth. Infertility is the presenting complaint of almost two thirds of the patients at the clinic (Walton and Mati 1976). While this might not appear to be an important health hazard, it is a serious and devastating problem to women in many of our African cultures where children continue to be regarded as an assurance of personal immortality and old age insurance.

Though western health services abound in Nairobi, a large number of women in the city still use indigenous forms of therapy when faced with infertility. In the following, some examples are given of how this happens. The examples are meant to illustrate the close interrelationship between western and traditional therapies.

This article is based on data gathered at the clinics of traditional healers in Nairobi's Eastern division and Mathare Valley. A random sample of 25 women who visited the clinics of waganga* complaining of "barrenness" or

*Waganga pl. for mganga the Swahili term for "healer", in this context used to refer to indigenous healers.

"being unable to conceive" is considered. The data was obtained during a study that attempted to establish the existence and use of traditional forms of health care in the city of Nairobi. Our visits to these clinics were unscheduled and patient follow up incomplete, since the study was designed with other objectives in mind. The example of a rural community, the Samburu, is also referred to.

Our findings show that both the healers themselves and all patients felt that barrenness is a condition for which traditional therapy is appropriate. In an open-ended question, each of the healers was asked to list the condition he/she felt most competent to treat. Out of 48 healers in the Eastern division of Nairobi 22 (46%) mentioned barrenness. Out of 65 healers in Mathare Valley, 37 (over 50%) also mentioned barrenness.

Barrenness continues to carry a strong social stigma and the unfortunate couple is subjected to a lot of social pressure from close kin and friends. It is no wonder, therefore, that the majority of the patients who go to seek professional help for this particular condition are usually accompanied by other female friends and kin. Some of the patients interviewed stated that these women accompanied them so they could assist in remembering details about the therapeutic measures which are recommended by the healer. Although the process of treatment usually required the male's participation and co-operation, the mganga did not specifically require the male partner to come to the clinic. He usually gave the instruction to the female partner to pass on to her male partner. A few healers did mention that males could also be infertile although very few of the men could admit it. Men in most African societies blame the woman if a couple are childless, even when it may be the man who is to blame.

While many of the urban healers demonstrated a good knowledge of the menstrual cycle and fertile period in a woman, the story is different in many rural communities. As an example, although the Samburu of Northern Kenya calculate fertile and "safe" periods by relating a woman's menstrual cycle to the phases of the moon, many women reported that the most fertile period was from the fourth to the tenth day after menstruation started, while from the tenth day onwards the safe period set in and continued until after the next menstruation. The so-called "safe" period thus appears to coincide with the time when ovulation is most likely to take place! The Samburu women, however, insisted that this method had never failed as far as they were concerned. One

of the possible reasons for the reported success of this method could be due to the fact that the male partners practice the withdrawal method of birth control as well.

The Samburu are aware of several things which may effect fertility. For instance, miscarriages are believed to be caused by illness, severe beating, or sudden fall of the pregnant woman. Too much hard work is also not recommended. A pregnant woman should therefore take precautions to avoid all these dangers.

When a woman seeks treatment for infertility, the results of such treatment become obvious before very long. She either becomes pregnant or she does not. Among the traditional healers studied, a majority of whom do not keep any records of their patients, there is a systematic method of paying in cases of infertility. In almost all the cases observed, the patient paid one half of the fees at the onset of treatment. The rest of the fee was then paid in instalments through the gestation period and delivery and even up to three months post partum. This means that according to the traditional health care system, the healer will only receive his total fees after proof of his success. Default rate is low since the patients dread the wrath of supernatural sanctions.

Before a healer takes up a case of "barrenness," he takes a detailed history of the patient. There was little agreement as to what constituted infertility in a woman among the traditional healers interviewed, and varying time intervals since marriage or since the last pregnancy were given as definitions. These ranged from nine months to ten childless years since marriage. A mean time interval of 2-5 years was considered enough proof that a woman was infertile. Many healers recognized that there were a number of causes which might be implicated, as well as the fact that it is physically impossible for some women to conceive. The major causes listed were supernatural influence, absence of menstruation altogether, witchcraft, promiscuity, prior abortions and sexually transmitted diseases.

Infertility from the first two causes was reported to be incurable. The others are thought treatable through a long procedure of herbal administration, ritual and ceremony in order to "cleanse" the patient. Some Kamba healers use a live white chicken (for purity) which is beaten to death against the patient's body and then discarded by the patient without looking at it. The chicken is

supposed to get rid of witchcraft but it is always followed by herbal remedies. Emetics are administered orally in order to cause diarrhoea which "washes the dirt in the stomach"; some red herbal mixtures are also given to "strengthen blood". Sometimes amulets containing leaves of plants are worn around the waist to ward off evil forces.

It was emphasised by some of the healers that it would be useless to attempt to treat a woman who has never menstruated or one who is over thirty years of age since such an attempt would only give her false hopes.

Many of the patients who consulted the traditional healers reported that they had already been treated for their complaints by modern doctors. In Nairobi this was particularly true and many, if not all, of the women in our study had been previously seen at the Kenyatta National Hospital gynaecology clinic, or at the city council health centres.

According to publications by Mati et al (1973) and Walton and Mati (1976), a high proportion of cases of infertility seen at the gynaecology clinic were due to organic causes. Partial or complete tubal occlusion caused by pelvic inflammatory diseases, was the commonest problem. Of the others, a few cases were demonstrated to be due to factors such as disorders of menstruation (including anovulation) and uterine abnormalities (such as fibroids).

According to patient histories, it appears that there is a high degree of promiscuity and venereal disease among the patients seen by the city waganga. Such problems potentially lead to salpingitis and secondary infertility. In spite of this, many healers reported a high success rate (evidenced by the number of babies shown to us) and they have earned themselves enough reputation to keep patients coming.

It is not easy to arrive at any conclusions as to how the indigenous healer attains success. What we saw is usually the end product, the baby. In some cases we met the patient during her first visit to the mganga. Sometimes we witnessed one or two treatment episodes then a year later we saw a happy mother with her baby on a visit to the doctor to pay the final instalment of his fees. In the patient's words "I have come to say thank you....."

The treatments of waganga are both herbal and ritual. It could be true that some of their success may be purely biochemical and pharmacological in nature. Not all the waganga were willing to disclose in detail the herbs they used.

However, the empathetic care, including ritual which makes emotional sense to the individual, may result in complete relaxation of the patient and hence conception.

In conclusion, one could say that infertility, particularly since it is often due either totally or in part to organic causes which are hard to correct, is a difficult problem to treat and results in the best of medical institutions are often unsatisfactory. Despite this, traditional healers continue to treat "barren" patients and continue to have sufficient numbers of successful outcomes to ensure a continuous flow of patients. The mechanisms by which treatment results are obtained need further examination. The explanatory models used by the waganga in our study showed the effect of exposure to modern medicine as well as accurate empirical observation. Their recommendations to their patients, particularly those advising intercourse during the fertile period, contain much common sense. Their herbal medicines may ultimately be shown to contain active substances. However, even those which prove chemically inert, when combined with rituals performed by empathetic individuals, may act to relieve stress.

Since barrenness is a common complaint in Kenya, since traditional methods of treatment appear to be successful in a significant number of cases and since success is easily documented without complicated scientific instrumentation, it should offer an excellent model for evaluating the success of traditional therapy in general. Stress has been implicated as a significant factor in the etiology of infertility. Since stress also underlies many diseases such as peptic ulcers and diseases of the cardiovascular system, and may contribute to others in ways not yet completely understood, traditional medical therapy may ultimately be shown to be as helpful in their treatment as in the treatment of barrenness. Contemporary medicine is moving beyond the classic biomedical model to an appreciation that the integrity of the body is dependent upon a complicated interplay of neuro-physiological and psychosocial forces.

Thus a treatment regimen which combines elements of cosmopolitan medicine and traditional belief systems may in some cases be more efficacious than one modality alone. While the explanatory models of traditional medicine may not always be scientifically accurate, they show a potential for change which, if sympathetically nurtured and met by equal open-mindedness on the part of the scientific community, might augur well for future collaboration in this and other areas.

ACKNOWLEDGEMENTS

This paper is based on a field project on traditional medicine in Kenya conducted between 1977 and 1979 in Nairobi and in 1982 in Samburu district. I wish to express my deep gratitude to Drs. Sydney and Selig Katz. Portions of the material included in this paper are adapted from another paper we are jointly preparing for another journal.

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