Continuity and Change in the Practice of Traditional Medicine in Modern Nigeria

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DOI:10.36108/NJSA/8102/61(0260)

Abstract
Traditional Medicine (TM) is the indigenous system by which different societies provide health care for her members. It developed based on the cultural conception of health and illness, and therapeutic materials that abound in the physical environment of a people. TM involves preventive, diagnostic and curative approaches that do not necessarily align with the methods of modern science. With a pre-historic origin, TM has culminated in its present form through various evolutionary processes including innovation and invention. The system has continued to thrive in modern-day Nigeria, in spite of modernization and advances in western medical science and technology. This is not without modification and adjustments in the bid to adapt to the challenges of modern times. This paper presents theoretical views on observable changes and continuity in the practice of traditional medicine in Nigeria. Guided by the general systems theory (GST), this paper implicates TM’s inherent capacity to adapt to the challenges of each epoch of human development, while aligning with societal constructions about health, illness and healing. Recommendations emanating from the paper will advance strategies for leveraging on the current state of affairs of TM, towards improved access to healthcare for the benefit of the generality of Nigerians.

Keywords: Traditional, medicine, change, continuity, Nigeria

Introduction
The World Health Organization (2000) described traditional medicine (TM) as the sum total of knowledge, skills and practices that are based on the theories, beliefs and experiences, indigenous to different cultures and used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses. Traditional Medicine is the indigenous and culturally developed response to the health problems that threaten man’s existence. Like its western alternative, traditional medicine has different categories of practitioners, including traditional bonesetting, diviners, medical ingredient sellers, traditional surgeons, traditional psychiatrists, traditional birth attendants, faith healers and the general practitioners (Abdullahi, 2011). Inspite of modernization in African societies, Amzat and Razum (2018) noted that about 80% of people in Africa rely on TM for their primary health needs. All these practitioners do not have uniform approaches to healing. To start with, they
expertise vary across the different health problems that threaten man’s existence. They also vary across the various cultures and peoples of Nigeria, within which contexts, the practice evolves. Thus, there are as many traditional medicines as there are cultures in modern Nigeria (Ojua and Ishor, 2013). The users of traditional medicine cut across demographic and socio-economic divide. This is due to the prevalent belief about disease etiology which, in addition to recognizing biological/physical causation, also emphasizes on the spiritual component of and consequently, spiritual solutions to health problems. Today, the use of TM is visibly prominent in the prevention of health problems as well as management of chronic health conditions (Adefolaju, 2010; Owumi, Taiwo and Kolo, 2016).

As noted by Auguste Comte, social static (stability or continuity) and social dynamic (social change) are two issues that affect social phenomena, and sociological analyses should focus on them (Abraham and Morgan, 2004). In this context, the concepts respectively refer to the persistence or retention of certain elements in traditional medical practice over time; and the transformations, shifts or alterations that have taken place in the practice of TM, including innovation and invention. It is in the contexts of this framework (continuity and change – two major concepts that constitute the bedrock of sociological enterprise and scholarship) that this paper situates TM.

The concepts of change and continuity, as will be demonstrated, are relevant to understanding the evolution of TM vis-à-vis its persistence and adaptability and resilience to the ‘threats’ of modernity in Nigeria. The General systems theory by Ludwig Von Butterlanfy is engaged as a theoretical lens for analysis. The paper begins with an explanation of the concepts of ‘change’ and ‘continuity’ of TM, followed by a discussion on healthcare system and its role in modern Nigeria, as well as observable change and continuity in TM practice. It further advanced arguments for the re-positioning of TM for greater access to healthcare in Nigeria. We conclude that TM is not as static, conservative or redundant as it is believed in many quarters. There is sufficient evidence that TM has demonstrated tremendous prospects for innovation and development. We therefore recommend that stakeholders should harness the potentials that abound in TM as a sustainable source of healthcare, particularly in a resource-constrained developing country like Nigeria.

**Continuity, Change, Traditional Medicine and the Modern Nigeria: A Conceptualization**

The concepts of ‘change’, ‘continuity’, ‘traditional medicine’ and the ‘modern Nigeria’ are central to the subject of this paper. There is therefore the need to understand them as it applies to the work. Each of them is conceptualized as presented below:

**Continuity:** this refers to the persistent existence or operation of a phenomenon or process over time. It espouses the maintenance of a given
pattern or status quo in relation to a particular aspect or component of human society. Continuity implies the practice of TM in spite of modernity and advances in biomedical science and technology (Adefolaju, 2010).

**Change (Social change):** Change refers to qualitative or quantitative alterations in social phenomena or processes. It also implies fluctuations or metamorphosis in society from one state to another. Auguste Comte described social change as the reorganization of society in terms of time and place, using its law of the three stages of human progress: theological or fictitious stage; the metaphysical or abstract stage and the scientific or positive stage (Abraham and Morgan, 2004).

Sociologically speaking, change occurs at macro, meso and micro levels. This resonates with change at societal, organizational or individual levels, respectively. It can be induced through legislative or executive actions of government or her agencies, by citizens organizing social movement, by diffusion from one culture to another or by intended or unintended consequences of technology, disaster, growth, education, or through the natural course of events (Scott and Marshall, 2009).

**Traditional Medicine (TM):** This basically entails indigenous systems through which different societies provide health care for her members. World Health Organization (2008) defines traditional medicine as the sum total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing. The art was developed based on the cultural conception of health and illness, and therapeutic materials that abound in the physical environment of a people. The system has continued to thrive in modern-day Nigeria, inspite of modernization and advances in modern medical science and technology. This is not without modification and adjustments in the bid to adapt to the challenges of modern times. Overtime, the efficacy of traditional medicine in management of human health has been established. World Health Organization (2011) observed that, over three-quarters of the world population rely on plants and their extracts for healthcare needs.

Ozyazicioglu & Oncel (2011) asserted that reasons for the utilization of TM lies in the belief and acceptance, quick and easy accessibility, negative experiences with modern health care institutions and the healthcare professionals. Other reasons specified include the inability to get results with modern medical practices, dissatisfaction with health care workers, insufficient medical staff-patient relations due to high demand, insufficient time being allocated to patients, lack of trust in organization, high cost of medication, side effects and sometimes the lack of therapeutic effects, the spiritual dimension, rejection of modern technology and medical treatment, as well as the thought that the cure and remedy to everything is in nature (Kaplan, 2010).
The Modern Nigeria

Modernity can be seen as a new way of life, new modes of transportation, new technologies, new sources of power and energy, and advancement in the healthcare system. It is a departure from traditionalism towards higher levels of ‘sophistication’ in human existence and social organization. In the case of Nigeria and most countries in Africa, the appearance of the Europeans brought about significant change in the history of this age-long tradition. To a large extent, colonialism, western religion, western education, globalisation and mass media have affected the perception about TM in Africa. In spite of more than several decades of existence of modern medicine in Nigeria, the evolution of TM in the management of human health still remains a viable option in the health care system. Thus, the quest for and use of TM have continued to grow not only in Africa but indeed the entire world. Mass media have contributed a lot in the modern day health care. Information about incidence of a particular disease can be electronically transmitted to large, perhaps millions or billions of people spread across the world within a short time. However, Change in the approach of traditional medicine has enhanced the use of the natural products in the management of multi-various ailments.

General Systems Theory (GST) by Ludwig Von Bertalanffy

The General Systems Theory (GST) was developed by the German thinker Ludwig VonBertalanffy. The theory views the world and the tangible, intangible as well as socio-cultural phenomena as composed of systems, made up of component parts, with clearly defined boundaries, interacting with each other in a coherent manner. A system can be defined as a collection of independent and interrelated elements or components organized in a meaningful way to achieve an overall goal, by converting or processing materials, energy, and/or information into a product or outcome for use either within the system or in the immediate environment or both (Hayajneh, 2007). GST presents phenomena in terms of an input, through-put and output framework within the environment. The theory emphasizes on the adaptive capacity that systems possess in relation to changes in environment. Like other systems, TM receives input (such as medicinal plants or ill-health conditions) from the environment, processes it using its throughput component (e.g. practitioners of TM and other mechanisms that process therapeutic resources from the environment) which produces output in the form of therapeutic services for population health. The theory acknowledges, however, that the environment or society is not static or dynamic but is due to alterations which brings to bare changes in component institutions, structures and processes.

Using the concept of adaptation, GST provides important insights into the persistence of TM vis-à-vis transformations it has undergone in the bid to ‘adapt’ to the challenges of modernization within the context of the Nigerian
environment. Having evolved from culture, TM continues to be relevant through its capacity to adapt to challenges posed in the environment. Alluding to this are the emergence of new chronic non-communicable diseases, advances in modern biomedical science, social change due to modernization and capitalism, developments of Asian TM and so forth. The theory views TM, not as a ‘closed in’ end in itself, but an ‘opened up’ intermediate structure in constant interaction with and the environment which serves as the operational context, from where inputs are received for processing, towards the production of therapeutic service. Similar to the position of Abdullahi (2011), as change occurs in the environment (taste, market, science and technology, healthcare system and disease emergence), it impacts on TM itself. GST presents TM as a system comprising of human and non-human agents which receives input from the environment, ‘processes’ it using the throughput mechanism, for the production of desired outcomes (healing of BJM conditions) for members of the community. For example, patients, practitioners and other agents in the TBS system (modern primary healthcare, therapeutic materials and other traditional medical practitioners) all emerge from the environment as part of input for TM. These input are subsequently processed by the TBS system which serves as throughput, while the ultimate output is the production of therapeutic for the patients/community.

From the foregoing, GST implicates culture and adaptation in explaining continuity and change in the light of this paper. Being an aspect of the indigenous cultures of the Nigerian peoples, TM will ordinarily resist change or demonstrate resilience in the face of modernization of which dynamics are usually averse to indigenous ways. TM thus tends to persist or ‘continue’ in the systems milieu. However, the practice does not totally resist influences of the modern Nigeria in their entirety. It acknowledges the validity of certain accepts of modernity and adopts them in the bid to adapt to societal change – the modern Nigeria. This way, TM itself changes in resonance to market/taste, standards, law, emerging health problems as well as its stance on biomedical science and technology (Abdullahi, 2011; Amzat and Razum, 2018). In spite of this, TM still retains fundamental aspects of its practice, including conceptions about disease aetiology, the role of supernatural factors and therapeutic materials.

Health Care Systems and Role of Traditional Medicine in Modern Nigeria

There has been a conspicuous concern for health care and the cure of the diseases throughout the human history. This development thereby facilitates the use of traditional medicine. TM could be said to possess two special characteristics that distinguish them from chemical drugs; use of crude herbs and prolonged usage (Anushri, Yashoda & Puranik, 2015). The traditional therapeutic system of care is a significant component of health care delivery in Nigeria because it enjoys considerable support in the populace. The agitation for the recognitions of traditional healers and for the acceptance of traditional therapeutics in Nigeria dated back to 1922 when a guild of healers wrote a
petition against the authorities, requesting the recognition of their services in several quarters (Erinosho and Ayorinde, 1988).

Since this period, the role of TM in health care delivery including their efficacy remains contentious. There are two schools of thought on the role of TM in Nigeria. On the one hand are those who view TM as doing more harm than good, and on the other hand, those that view endless benefits in the use of TM. The following are some of the issues raised by the proponents of TM.

1. **Accessibility:** The promoters of traditional medicine are of the views that traditional healers and therapeutics contribute to health care through their accessibility to the populace than the western health care providers.

2. **Management of Chronic Diseases:** TM has demonstrated remarkable efficacy in the management of chronic non-communicable diseases such as diabetes, hypertension and mental illness, which often defy western solution and are usually costly to treat. In line with this, Adefolaju (2010) noted that populations in developing countries generally adopt TM as the preferred source of care. This has contributed to the increase in the number of ‘institutionalized’ TM practitioners.

3. **Rural healthcare delivery:** Aside the inequality in the location and distribution of health facilities (Jegede, 2002), rural areas which constitute more than 70% of Nigeria, are generally disadvantaged in terms of availability of modern healthcare services (Scott-Emuakpo, 2010). For these people, TM is the readily available as well as accessible source of healthcare.

4. **Pharmacological active:** Another reason given in support of the traditional medicine include the fact that some of their medicines are pharmacological active and beneficial to patients, for instance the use of *rauwolfia* and many other herbs which Yoruba healers use in the treatment of those who are physically or severely mentally-ill (Kafaru, 1994).

5. **Communication:** Practitioners of TM demonstrate intimate rapport in relating with their patients, as most of their diseases are interpreted from cultural.

6. **Dexterity in psychotherapeutic techniques:** This explains the fact that traditional healers are of grater skills in the management of mild, moderate and severe neurotic disorder.

The main arguments of critics of the traditional medicine are that the indigenous healers lack the expertise and skills needed to proffer correct diagnosis on very serious disorder. They are also of the views that some of the traditional products suffer from standard dosage and are not being subjected to scientific verifications and proof.

The role of traditional medicine in healthcare delivery in Nigeria cannot be ignored, most especially in the context of a recessed economy in which a substantial proportion of Nigerians cannot afford care in the western health
institutions. As a result of this, the traditional medicine commands support owing to the aforementioned parameters and through its utilization by both the educated and non-educated citizens. Adefolaju (2014) noted that the traditional healthcare system has continued to thrive not only in the rural areas where over 70 per cent of the population live but also in the urban centres which have greater access to orthodox medical facilities.

However, traditional medicine’s relevance to man’s quest for the prevention and treatment of diseases is confirmed by the fact that many drugs known to orthodox medicine derive from herbs. International Development Research Centre (IDRC) (2001) notes that 25 per cent of medications produced and marketed in the world are from herbs. Aspirin was cited as a derivative of a plant called Meadonas sweet, Artemisinin from Artemisia Annual and Quinine from Papover Somniferun. It is worthy of note to state that traditional medical practitioners in Nigeria have ‘modernised’ their methods and practices. This is more apparent in the areas of recruitment, education and training (for instance, many qualified pharmacists are now involved in the practice), specialisation, use of modern equipment for diagnosis, packaging and marketing. This is in addition to routine evaluation and monitoring by the regulatory agency, the National Agency for Food and Drug Administration and Control (NAFDAC) as well as Consumer Protection Council and other regulatory agencies. Also many of them now own medicinal/botanical gardens where herbs are grown and thereafter collected for use, thereby reducing the threat to the forests through over-harvesting of medicinal plants and thus contributing towards the conservation of natural resources.

Continuity and Social Change in Traditional Medical Practice: The Case of Nigeria

Auguste Comte, the founding father of sociology has for long recognized social static and social dynamics as the central themes in the discipline of sociology (Abraham and Morgan, 2004). These concepts refer to the phenomenon of social change and continuity, which as implied by Comte’s writings apply to every aspect of or element in human society. From its inception, traditional medical practice has undergone certain transformations due to the impact of large social change processes, such as industrialization, urbanization, globalization as well as developments in western biomedical medicine. In spite of this, traditional medicine has continued to thrive, retaining certain of its principles, methods and materials in the provision of healthcare services (Adefolaju, 2010). This is evident in the conceptions about aetiology (causes) of disease, prevention, diagnostic approaches as well as curative methods.

Mishra, Kusuma & Babu (2013) assessed continuity and change in the purview of health and illness among migrant tribal community (slums of Bhubaneswar) in an Eastern Indian city. It was revealed that the present migrant tribal community has been changing at a certain pace in line with their concepts of health and illness; and that cultural values showed a profound
impact on perception of illness among the community. The authors concluded that healthcare needs of such migrant communities is necessary in order to make the available public health interventions and medical care available, accessible and acceptable to these vulnerable communities.

Ventevogel, Niyonkuru, Ndayisaba, Reis & de Jong (2018) discussed change and continuity in Burundian divinatory healing. Their report was based on the data collected through the use of interviews and observations with seven Burundian abapfumu (diviner-healers), and 14 focus group discussions with community members. The results of the study indicated that the position of traditional healers towards tradition was becoming ambivalent, with increasingly lesser emphasis on the role of ancestor spirits in causing and healing misfortunes. They also noted that the rise of exorcist healing in Burundi might have been a reaction to the breakdown of community structures resulting from the collective violence and mass displacements that had occurred over the past decades as in vogue elsewhere in Africa. They concluded that Burundian healers have considerable flexibility in adapting to new circumstances.

The persistence of TM in Nigeria is manifest in the utilization of many aspects of its practice, which accounts for continuity in the context of this paper. This can be viewed from three major dimensions: belief about aetiology, diagnosis and therapeutic issues. In terms of aetiology, the culture of the people continues to play important roles in their conception and perception about the causes of disease and the influencing factors, as well as corresponding actions in terms of health seeking or illness behaviour (Amzat and Razum, 2014). It is a common belief across Africa that illness arises from natural, supernatural and preternatural causes, which may not be amenable to scientific explanations (Erinosho, 1998; Jegede, 2002). Belief about aetiology is an important factor determining illness behaviour as well as pathway to the utilization of care. TM is usually the first point of call by patients, after which patients sometimes proceed voluntarily to the modern hospital and then, back to TM if there is perceived need (Owumi, 1994; Amzat, 2014). The centrality of TM to healthcare utilization in modern Nigeria is largely attributable to perception and belief about disease aetiology and course which resonates more to TM than biomedicine. The widespread utilization of traditional medicine across demographic and socio-economic divide attests to the role of aetiological conceptions that lie purely outside the purview of western biomedicine (Adefolaju, 2010; Owumi, Kolo and Taiwo, 2016).

In terms of diagnosis, the Diviner who specializes in employing supernatural methods in identifying the causal underpinning of any given case is accorded a special place of importance, due to the role they play in clarifying aetiological issues and giving directions about therapeutic milieu (Owumi, 1989; Amzat and Razum, 2014). Although the advent of modern medicine led to an expansion in the conceptual scope about disease aetiology among
Nigerian peoples and cultures, the traditional belief about aetiology seems to have come to stay as proven by its influence on healthcare utilization and associated issues. In terms of diagnosis, traditional medical practice relies mainly on indigenous methods physical observation using insights based on the sense organs (eye, ear, skin, nose, tongue), as well as employing spiritual methods such as prayer, sorcery and divination (Erinosho, 1998). These and other surrounding issues of TM practice contribute to the advancement of indigenous knowledge which, according to Tharakan (2015), can be harnessed into rich resource for general technological development in Nigeria.

However, TM has also witnessed transformations in important dimensions, which constitute change in its practice in Nigeria. These transformations within the context of the modern Nigeria are discussed below:

1. **Commercialization and profiteering:** TM is believed to be a free gift of nature for the sole purpose of bringing succor to man. Surrounding mythologies prohibit the commercialization of the practice with a view to making profits, and the contravention of this attracts ‘sanctions’ which include perceived loss of therapeutic efficacy (Ekong, 2006). This is underpinned by the philosophy of altruism and benevolence of TM which cuts across different cultures. However, such philosophy has undergone enormous change in recent times. Traditional medical practice has been largely commercialized with outlets being run like other business outfits, aimed at making profits. Aside the institutionalized/large-scale practitioners (such as Yem-Kem International, Pax Herbal centre, Iris trado-medical centre, Oko Oloyun Worldwide etc) who have invested huge resources in traditional medical practice, there are also small scale vendors who engage in itinerant sale of their products along major streets in cities and rural areas. This shift towards profiteering was not characteristic of TM in times past.

2. **Modern innovations and competitive packaging:** The practice of TM in Nigeria today has transcended the conservative or culture bound character that used to obtain. Practitioners now adopt modern techniques in a bid to keep abreast of the times. They now employ modern science and technology in the formulation of herbs which they also present to the National Agency for Food and Drugs Administration and Control (NAFDAC) for safety and therapeutic validation. Traditional medical practitioners further adopt modern techniques and innovations to promote their operation with a view to outwitting competitors in the trade. Like traditional birth attendants in rural Cameroun (Mbiydenyuy, 2012), a study by Owumi, Kolo and Taiwo (2016) has identified traditional bonesetters as one of the TM practitioners in Nigeria that engage auxiliary nurses and patent medicine sellers in certain modern procedures such as administration of anesthesia, surgical suturing and blood transfusion to complement their own limitations in the therapeutic process. In Nigeria today, herbs and other products of TM practitioners are now being packaged in forms that comply with ‘taste and fashion’ of modern times,
after the manner of western bio-medical products. Well packaged Capsules, Tablets, ointment and Syrups are common products of traditional medical practice. As part of the competition, practitioners engage different fora and platforms for the advertisement of their products and services. These include newspapers, magazines, radio, television and the internet. Traditional medical practice is fast assuming the status of a lucrative enterprise in Nigeria.

3. **Increased formalization of TM practice:** TM has witnessed tremendous transformations towards formalization. This may be attributed to practitioners’ perceived need to conform with the global developmental trends which emphasize ‘formality’ as a major criterion for relevance (Nwokocha, 2012). Like many countries within Africa and beyond, boards have been established by governments at various levels for the regulation and promotion of traditional medical practice. In addition to these, other formal structures also exist with various nomenclatures to advance the cause of traditional medicine: Nigerian council of physicians of natural medicine, the research institute of traditional and alternative medicine and the Nigerian natural medicine development agency. Private individuals or groups have also established laboratories and training institutions towards the standardization of the practice (Owumi, 2012). According to Amzat and Razum (2018) African countries are increasing demonstrating willingness in the incorporation of TM into their healthcare systems.

4. **Emerging academic engagement of TM:** Historically, practitioners of TM were known to shroud their practice and therapeutic procedures in mystery and away from the ‘public’ sphere, partly in the bid to wield monopoly or outwit competitors (Subedi, 1992). Today, the practice is gradually giving way to intellectual scrutiny in what may be described as the ‘academicization of TM’. This may be attributed to the incursion of educated persons into the practice, who beyond unionizing, deem it fit to generate as well as disseminate knowledge about TM with a view to training colleagues while advancing their collective cause (Langwick, 2015). To this end, conferences, seminars, workshops and symposia are being organized to this end, which is a landmark development. Universities and relevant government agencies are beginning to collaborate with TM practitioners, while research institutes are being established for the purpose of developing traditional medicine. On 24th August, 2017, the University of Lagos in Nigeria organized a symposium in commemoration of the African traditional medicine day. The research institute of traditional and alternative medicine (RITAM) in collaboration with NAFDAC has also concluded on plans to commence training for herbal practitioners for ultimate aim of incorporating them into federal PHC facilities across the country (http://www.ritam-nigeria.org/index.php/membership-training), while Pax herbal also collaborated with the federal institute for industrial
research and development institute in organizing a conference, also towards repositioning TM through intensified research in indigenous knowledge (https://www.pasafricana.org/event/conference-indigenous-traditional-knowledge/). Although the academicization of TM is happening at a rather slow, gradually unfolding pace, the fact is that there is development which points to progress in the practice of TM.

**Healthcare Access: An Agenda for the Repositioning of Traditional Medicine in the Modern Nigeria**

Given the important role that TM plays in the functionality of individuals and populations, the centrality of health to human and national life cannot be overemphasized. This accounts for the high priority accorded health, and the undaunted role of national governments as well as the international community towards developing formidable systems for the delivery of care to the people. Scholars, development partners and other stakeholders have advanced strategies towards the improved access to health by Nigerians. Genuine as these strategies may be, they do not adequately posit TM vis-à-vis its potential capacity to improve access to care. As an aspect of culture, TM naturally corresponds to the belief system and behavioural milieu of the African peoples (Owumi, 1989; Amzat and Razum, 2014). This particularly confers on it the advantage of acceptance among people which has implications both for utilization and sustainability (Abodunrin, Bamidele, Olugbenga-Bello and Parakoyi, 2010). If properly posited, traditional medicine can therefore play unquantifiable roles in improving access to care in Nigeria.

According to Penchansky and William (1981), the specific dimensions of ‘access to healthcare’ are: availability, proximity, accommodation, affordability and acceptability. Experience in Nigeria has shown that traditional medicine possesses attributes of these various dimensions of access to healthcare (Erinosho, 1998; Jegede, 2002; Amzat and Razum, 2014). In terms **availability**, TM abounds in different forms among the various peoples and cultures of Nigeria (Ekong, 2006). By implication, practitioners and therapeutic resources of TM exist in the immediate environment. This also addresses the problem of **proximity**, whereas the modern healthcare system is usually located some distance away from the domestic sphere of the people, thereby adding to treatment costs incurred by the people (Jegede, 2002). In TM, patients may not necessarily go to the practitioner, especially when the individual involved is bed-ridden; practitioners often visit patients to attend to their needs in their home (Adefolaju, 2010).

Whereas a recurrent decimal in public hospitals is the lack of bed-space for teeming patients, TM is community-based, such that patients do not have the problem of **accommodation** which is readily available within their immediate community. Thus, they do not get alienated from their people and culture as would have been the case if they had sought healthcare in a formal hospital. Consequently, TM is also affordable to the people, since regimen is usually sought from the physical environment, and treatment does not require modern
hi-tech equipment or facilities. Practitioners of TM generally believe that their ability to heal is a gift and a calling to bring succor to mankind, and not for merchandise or profiteering (Ekong, 2006; Adefolaju, 2010; Owumi et al., 2016). This confers the advantage of affordability on traditional medical practice. Unlike ‘alien’ western medicine, TM is integral to the respective cultures into which Nigerians are socialized. This further engenders general acceptability towards TM as a healthcare system. It also points to TM’s inherent potential for sustainability.

Given Nigeria’s healthcare delivery structure, the positioning of TM will be strategically best suited for primary healthcare as well as the management of chronic non-communicable diseases which constitutes enormous population health burden in the country. These two areas (primary healthcare and non-communicable chronic diseases) are important components of healthcare delivery requiring serious attention in Nigeria (Scott-Emuakpo, 2010). This is attested to, by massive importation of complementary and alternative medicine (CAM) from other countries mostly on the Asian continent (Adefolaju, 2010). Thus, improved healthcare access in Nigeria will confer various other potentially huge benefits if investment of resources and traditional medicine can be accorded proper priority in Nigeria. An advocacy of this nature is even more appropriate at a time when the national healthcare system is fragile and ridden with myriads of problems hindering effective access to healthcare services by the Nigerian peoples. If realized, the positioning of TM will also have serious implications for strengthening the health sector as a means to various other ends of socio-economic character.

**Conclusion and Recommendations**

The foregoing demonstrates that TM practice in Nigeria is not as static, conservative, closed-in or stagnant as it would have been thought to be in many quarters. The framework of ‘continuity and change’ is a veritable tool in assessing the state of TM in Nigeria vis-à-vis the impact of general social progress. Whereas TM has been conservative in certain regards, particularly in terms of ideology and beliefs about the practice, the considerable shift in the direction of progress indicates great prospects in TM as a source of healthcare. Whereas this opportunity is already being utilized in countries such as China and India, only a few African countries have yet to key into it. Leveraging on the potential for innovations and practitioners’ willingness to improve in their practice, there is the need to direct resources to uncover the range of possibilities towards positing TM as a viable therapeutic as well as socio-economic sector of in a resource-constrained country like Nigeria. The framework of ‘continuity and change’ is a veritable tool in assessing the state of TM in Nigeria vis-à-vis the impact of general social progress. It is based on these that the paper makes the following recommendations:
1. Research should be intensified in the various areas of TM, with a view to assessing the level of resources that are available and generating relevant information on the actual state of affairs. This will inform strategy and formulation of evidence-based policies. Research in this sense should be multi-disciplinary, involving social scientists, pharmaceutical experts, pharmacognosists, ethno-botanists, and so forth.

2. Regulatory bodies such as traditional medicine board already existing in some states, should be duplicated in all thirty-six states, while other relevant organizations like national agency for food and drugs administration and control (NAFDAC) should also be involved in the drive to reposition TM.

3. Local government Authorities which are closer to the grass-root people in Nigeria and more abreast with TM practice in their domain should be incorporated into the movement to reposition TM. There should be synergy between the regulatory agencies, local authorities and the central coordination mechanism which should be domiciled in the federal ministry of health for unit administration.

4. Basic education/training, incentives and adequate recognition should be accorded practitioners of TM and their practice, with a view to formally incorporating them into the national healthcare system.

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