Abstract-The focus of this paper was on the practice of Traditional Bone setting among the Igala people of Kogi State, Nigeria. It was aimed at documenting the practice among the ethnic group. To do this, Survey Research design was employed using interview as instrument for data collection. The data was analysed using percentages. The findings revealed that the majority of the Bone Setters (62.5%) had no formal education. The practice cut across the three religions of the people; 62.5% was Muslim, 25% was Christian while 12.5% was of the African Traditional Religion (ATR). None of the practitioners had any medical training. Referral practice was also found to be poor as only 37.5% did refer serious case to the orthodox medical centres. Bone setting or reduction of fracture was done raw without the use of any anesthetics. All the practitioners employed both local and modern materials in the management of fractures. Herbs commonly used were; Inyakpechi, Ode, Ache, Atamanyiwo; Ebe, Ilie (Carpet grass), Ohiegbo or Ugbolo-Ejo, Oko-Omekpa and Akpoti-Abala. Common to them all was the use of the herb, Ebe. Challenges commonly faced by all the practitioners were lack of accommodation for the In-patients and scarcity of the herbs during the dry season. It was recommended that Government, Non-Governmental Organisations (NGOs) and public spirited individuals should aid in providing accommodation at the centres. Integration of the practice into the Orthodox Medical Practice and collaboration between the Orthodox Orthopaedists and Traditional Bone Setters were also recommended.

Keywords: Traditional; ethnic; culture

1 Introduction

The art of traditional medicine in Africa predates the introduction of orthodox medicine in the developing world. It will not be an over statement to say it is as old as the appearance of man on earth. Adesina (2013) describes this form of medicine as a cultural gem in various communities around the world. He notes that it includes all kinds of folk medicine, unconventional medicine and any kind of therapeutic practices that had been handed down by the tradition of a community or ethnic group. He classifies this practice into Herbal Medicine, Traditional Birth Attendance, Traditional Surgery, Traditional Medicinal Ingredient Marketing, Traditional Psychiatrics and Traditional Therapeutic occultism. He considers traditional bone setting under traditional surgery as the practitioners have to contend with wounds requiring surgery. The focus of this present study is on Traditional Bone Setting. The practice, traditional medicine enjoys high patronage by the people. As reported by the World Health Organization, WHO (2002), it accounts for up to 80% of health care in Africa.
Part of traditional health practice as earlier noted is traditional bone setting. This is the equivalent of the modern orthopedic medicine. The report that up to 80% patronage of traditional medicine by WHO (2002) might still be conservative or low for the patronage of Traditional Bone Setting for several reasons. For instance, high cost, delay, fear of amputation and the application of plasters of Paris in orthodox orthopedic centers may constitute other reasons for the high patronage. Worst still, is as reported by Omololu, Ogunlade and Gopaldasani (2008), that in Nigeria, at the time of their report there were only three major tertiary orthopedic hospitals and less than 200 orthopedic surgeons, indicating high doctor-patient ratio. They noted that Traditional Bone Setting has been in Nigeria for centuries and that up to 85% of patients with fractures present first to the traditional bone setters before coming to the orthopedic hospital. Similarly, Dada, Yinusa and Giwa (2011) reported that the practice of Traditional Bone Setting is extensive in Nigeria and it enjoys enormous patronage by the populace but that the outcome is usually poor. It should however be noted that poor outcome of a practice does not justify discarding the practice, it only calls for studies on how to improve on the practice as it is most often done in modern medicine. Given this high patronage by the people and the scarcity or lack of documentation of the practice, the need for studies of the practice with a view of coming up with ways of improving it cannot be over looked. This should however be preceded by documenting what is on ground. This is exactly what this study is poised to do.

A review of the available literature of bone setting practices in Nigeria shows that much needs to be done especially when the wide practice and patronage is borne in mind. Most of the literatures found in reports are on the practice in China and India with few in Nigeria and little or nothing among the Igala people, occupying the eastern flank of Kogi State in North Central, Nigeria.

It is common knowledge that Traditional Bone Setting is a common practice found in almost every community in the area. To document the practice among the Igala people is therefore needful so as to preserve and seek for ways of improving on it. Consequent upon this need, this study was designed to find out the attributes of Traditional Bone Setting among the Igala people, the mode of treatment, herbs commonly used, the challenges and the coping strategies and to document same for the purpose of reference and further research in the area.

2 Methods

The study design was survey. Personal visits were made to nine Traditional Bone Setting Centers. The instrument for data collection was an interview schedule in which some items require restricted responses, while in some others, the respondents were allowed to freely talk or relay their experiences from which the researcher makes notes. The respondents were the Heads of the respective nine Traditional Bone Setting Centers that were sampled for the study. These centers were:
1. Ukele Traditional Bone Setting Centre, Emewe-Ochadamu in Ofu LGA;
2. Ofante-Emojo Traditional Bone setting Centre, Ofante-Emojo in Ofu LGA;
3. Eneche Traditional Bone Setting Centre, Ochi-Adegbe in Ofu LGA;
4. Omatiga Traditional Bone Setting Centre, Ologba in Dekina LGA;
5. Drisu Traditional Egah Bone Setting Centre, Ologba-Ojiwo in Dekina LGA;
6. P&P Traditional Orthopaedic Home, Ajagwumu in Dekina LGA;
7. Haruna Traditional Bone Setting Centre, Ejegbo, in Ankpa LGA;
8. Agwumagwu Traditional Bone Setting Centre in Ankpa LGA;
9. IchabaAkorTradomedical Centre, Ejegbo in Ankpa LGA.
The selection of these centers was based on their popularity and effectiveness within the area of study. Random and informal interaction with people from the area on the availability or location of Traditional Bone Setting Centers revealed that they were the most popular within the area.

3 Findings

Of the nine Traditional Bone Setting Practitioners, one declined comment and so the analysis was based on responses from eight practitioners. All the practitioners and their support staff were male, five were Muslims (62.5%), Christian were two (25%) while one (12.5%) was of the African Traditional Religion (ATR). Except for one (12.5%) of the Head Practitioners who was eighty years of age, all the other seven (87.5%) had their age ranging between 30-55 years. Similarly one (12.5%) had up to diploma level of education, two (25%) with School Certificate while five (62.5%) had no formal education. None was aware of any professional body for the practice of Traditional Bone Setting in Nigeria but were all registered with the Traditional Medicine Practitioners Association of Nigeria.

Except one (12.5%) Head Practitioner who acquired the skill through apprenticeship which took him two years and at present has up to 15 years practicing experience, seven (87.5%) others acquired the skill via family inheritance and had practicing experience ranging from 15-25 years. In addition to the Head of the centres there were 2-4 persons, mostly family members assisting in the practice in each of the centres. The assistants were qualified professionals but since the practice was a family business, they all worked under the family head.

Of the 82 In-patient found at the centres, two of the centres had 2-5 in-patients while six others had 15-25. Of this numbers 34 (41.5%) were females while the males were 48 (58.5%). Accommodations for the In-patients were centrally arranged by the Heads of the centres in personal houses of members of the community which the practitioners said were willingly given and not paid for. There were also no registration charges at the centre but patient pay some token to enable the practitioners fetch the herbs. Two of the centres (25%) charged between 15-60 thousand naira on discharge of a patient depending on the number, nature and complication of the fractured parts. Six practitioners (75%) claimed the patients pay what they feel they can afford. Payment could be in cash or kind in the six centres. On the issues of public access to the patients, the eight Head practitioners agree that there were no restrictions.

Mode of treatment in all the centres was direct contact with the injured part of the body. Diagnosis in all the centres was by observation, running the fingers through the body surface and applying pressure on the injured part. The fractured bone is set raw without the use of any pain relieve or anesthetics. When the bone is set the traditional medicine (herbal cream) is robbed over the area. Splint is applied and bandage is used to hold it in place. This is done in six of the centres. In two centres, (25%) baton for ceiling were cut into sizes and placed round the injured part. Bandage is used to hold the pieces of baton in place. In two (25%) of the centres the splint or pieces of baton are removed everyday to check for faults in the setting of the bone. If the setting was found to be in place, hot water will be applied to the injured part, the herbal cream is then applied and the splint or baton is again retied to the injured part. This is done on daily basis until the fracture is healed. In six (75%) other centres, the checking and pressing with hot water is done every other day while the use of herbal cream and tying back is the same. In one centre (12.5%) however, the hot water used must be the extract or filtrates of the herbal preparations.

In all the centres, the injured parts are placed by fire or life charcoals to keep the area warm. Similarly, in all centres visited, patients were allowed to use modern medicine in addition to the herbal
preparations especially pain relievers and antibiotic in situations where there were wounds. On whether or not they refer cases to other Traditional Bone Setting Centres, all the eight practitioners claim they do not but that other centres refer cases to them. On referral to orthodox practitioners, three (37.5%) of them agreed that they do refer especially when there were serious wounds requiring suturing. The other five (62.5%) agreed that they do not refer to orthodox practitioners and should there be a case requiring dressing of wound, they do it themselves and in serious cases, they invite health personnel nearest to them to assist and the patient concerned pays for such services.

In terms of assistance from government, Non-governmental organizations or individuals all the practitioners indicated that they never got any. All the eight practitioners except one (12.5%) do not keep the records of their patients. The one that used to keep records had to stop as he felt there was no need. Two of the practitioners (25%) agreed they run around to free their patients from the attack of the devil at the cost of the patient concerned and in some instances, they request the patient’s relatives to do something about it. Refusal to do so could lead to forceful discharge of the patient.

The major challenges faced by all the Traditional Bone Setting centres covered by the study were, inadequate accommodation for In-patient and scarcity of herbs especially during the dry season. To cope with these challenges, the Bone Setters resort to begging members of the community to assist in accommodating some patients. The challenge of scarcity of herbs during the dry season was addressed by harvesting them in good quantity during rainy seasons for storage against dry season period.

Herbs commonly used include:
1. Inyakpechi Ode;
2. Ache;
3. Atamanyiwo;
4. Ebe;
5. Ilie (Carpet grass);
6. Ohiegbo or Ugbolo-Ejo;
7. Oko-Emekpa;
8. Akpoti-Obala.

Of these herbs, only Ebe was commonly used by all the practitioners. Three practitioners (37%) combine as many as four herbs while five others (62.5) use one or two herbs.

4 Discussion

The age of seven practitioners (87.5%) ranged between 30-35 years, an indication that there is hope for the continuity of the practice as young men are still involved in the practice. Even the practitioner who was over 80 years had his grown up children as Assistants.

Religion was also not a barrier to the practice of bone setting as the practitioners cut across the three main religions, Islam, Christianity, and Africa Traditional Religion (ATR) being practiced by the people covered in the study. That only one (12.5%) out of eight practitioners practices African Traditional Religion (ATR) is a pointer to the fact that the practice of traditional bone setting is not synonymous with Africa Traditional Religion as claimed by the report of Udosen, Otei and Onuba (2006) that poor union of fractured bones is usually attributed to charms and witchcraft though the position of two (25%) of the practitioners that they may have to run around to ward-off evil spirit tends to support them. Disputing this view Oresanya (2008) posited that worshipping of native deities
is not a part of bone setting. Any practitioner who includes divination and sacrifices in the practice does that purely at his own discretion.

The finding also shows that there is generally low level of education among the practitioner, five (62.5%) out of eight had no formal education and only one (12.5%) was educated to diploma level. None of them also had any form of medical training. All these allude to the fact that their dressing of wounds and prescription of drugs amount to quackery which contradicts proper health care practices. This finding agrees with that of Udosen, Otei and Onuba (2006) that all the Traditional Bone Setters had little or no formal education.

Only one (12.5%) of the eight practitioners acquired the skill of bone setting by apprenticeship while the other seven (87.5%) was by family inheritance. This agrees with the report by Omololu, Ogunlade and Gopaldasani (2008) who noted that Traditional Bone Setting is a tradition that is usually passed on from father to son but that outsider can acquire the skill by apprenticeship. The use of Splints and other local materials as found in the study agrees with a report by Adesina (2013) on the use of local materials in the practice of bone setting. The finding of his study however differs a little by the use of modern materials like bandage, plaster, and orthodox drugs in addition the local materials.

The poor referral services of the Traditional Bone Setters contradict good practice in health care practice as no individual can be a master of all knowledge and practice. They also do not consult one another as commonly practiced among the orthodox medical practitioners.

5 Limitations of the Study

The usual draw backs associated with the use of interview for data collection were very much evident. In addition, outright refusal of some respondents to comment on certain issues and none availability of English names of some herbs were limitations of this study.

6 Conclusion

This study has established the availability of Traditional Bone Setting Centres in the area of study. It was also established that the practice enjoys high patronage and that the practitioners use both local and modern materials in the practice.

In the words of Agarwal and Agarwal (2010), Traditional Bone Setting has its strengths and weaknesses. With the current socio-economic conditions and the types of health needs prevailing in Nigeria, it would be difficult to abolish Traditional Bone Setting. The practice has wide-spread community acceptance and support. Complications can be minimized and practice potentially improved with training and education and with Government and Non-Governmental Agents and public spirited individual’s supports.

7 Recommendations

Despite several draw-backs and castigations by orthodox orthopedists, several literatures attest to the fact that Traditional Bone Setting enjoys high patronage. And considering the situation in Nigeria where most people especially those living in rural communities which is estimated to be about 75% of Nigeria population, has no access to orthodox medicine and the rising cost of health care in orthodox
medical centres vis-à-vis Nigerian’s low per capita income, the need to strive at improving Traditional Medicine generally and Traditional Bone Setting in particular becomes indispensable.

To do this, the following recommendations are made:

1. Government should strive at bringing about co-existence between the Traditional Bone Setters and the Orthodox Orthopedists to enable them to learn from each other’s practices and to bring about mutual trust and avoid the present castigations of each other. This can be achieved either by way of integration or collaboration since both have a common goal of restoring health. To integrate is to make the two parties part and parcel of each other while to collaborate is to work hand in hand rendering services to each other, supporting each other in areas of weakness. To do this effectively, Nwachukwu, Okwesili, Harris and Katz (2011) suggested that the first step is for the government of the federation to appoint unbiased third party organisation charged by the Nigeria health-care system to bring the two groups of practitioners together.

2. With integration successfully completed or achieved, there should be training programmes geared not at eliminating the traditional practice but to improve on them. Agarwal and Agarwal (2010) agreed with this position when they reported that bone setting has its strengths and weaknesses but complications can be minimised and practice potentially improved with training and education. Omololu, Ogunlade and Gopaldasani (2008) recommended that the training of the Traditional Bone Setters should include the need to introduce radiographs especially to those living in urban areas, identification of open and closed or displaced fractures, approximate duration of fracture healing, recognition of complications in the course of treatment and when to refer cases for orthodox health care centres. Training in record keeping is also important in any health care practices. Omololu, Ogunlade and Gopaldasani (2008) emphasised that the training should be in the local language as many of the Traditional Bone Setters are not literate. They further recommended that the training curriculum should include basic hygiene, simple sterilization techniques and education on management of both open and closed fracture. They emphasised that such education and training should be provided by Orthodox Orthopedic Surgeons with a view to minimise mismanagement.

3. Considering the high patronage of the Traditional Bone Setting Centres and the fact that Orthodox Orthopedic services are not accessible to the majority of Nigerian due to low per capita income and lack of infrastructures, it is suggested that government should provide assistance in these centres. Principal among these should be provision of accommodation for the In-patient and provision of facilities that could aid rehabilitation such Clutches and Wheel chairs. It is further suggested that this should be done by direct labour with government agents playing supervisory role. This method of assistance for sure, will reduce cost and guarantee delivery of the facilities to the target centres.

4. Official directive by appropriate authority to the community health officers to render official medical services to the centres will also be a good step in the right direction. This will minimise quackery in the management of some medical cases associated with fracture.

References


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