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Hemorrhoidal Disease: Knowledge, Attitudes and Practices Traditional Healers in Brazzaville

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1. Abstract

1.1. Objective: evaluate the knowledge, attitudes and practices of traditional health practitioners in Brazzaville on hemorrhoidal disease.

1.2. Population and Method: This was a descriptive and cross-sectional study from April 1 to October 30, 2020 in the 9 districts of Brazzaville. It concerned all adult traditional practitioners, resident in the capital for at least 6 months and consenting to the study. The variables studied were related to the epidemiological aspects of the study population but also to the knowledge of the diagnostic and preventive aspects of the hemorrhoidal disease. The attitudes and practices of traditional practitioners regarding this disease were also applied. These parameters were judged based on pre-established criteria. The data collected were entered and processed with Excel R (Core Team) version 3.6.3 software.

1.3. Results: a total of 60 traditional practitioners were included in the study, including 51 men and 9 women, a sex ratio of 5.6. The mean age was 32.8 ± 9.2 years. The transmission subsidiary was the main source of information in 50% of cases. The majority of participants, 71.7%, had a secondary education level. The knowledge of traditional healers, relating to the origin of the hemorrhoidal disease, the risk factors of appearance, the signs, the complications and the therapeutic means was weak in 92% of the cases (55/60). The attitudes and practices of traditional practitioners were considered inappropriate because they were based solely on the data from the interview. Referral to a doctor in the event of treatment failure was low (6.7%).

2. Introduction

Hemorrhoidal disease (HD) is the leading cause of proctology consultation. Its frequency is difficult to assess precisely but ranges from 4 to 70% according to various studies [1-6]. In Congo, it was estimated at 32% by Deby Gassaye et al in 2009 [7]. The most common factors favoring HD are transit disorders such as drifting and constipation [8]. Its symptoms are numerous but not specific and should only be treated as such if they are clearly related to the disease [9]. An interesting pathology, HD is a shameful and taboo condition in the African environment. In this context, recourse to traditional pharmacopoeia constitutes a preferred alternative. According to estimates from the World Health Organization, 80% of the population in developing countries consider traditional care as the main source of health care provision [10]. However, these practices are often done blindly without examining the patient and without taking into account the real stage of the disease. In order to contribute to improving the care of people suffering from HD, we carried out this study which aimed to evaluate the knowledge, attitudes and practices of traditional practitioners on HD.

3. Population and Method

It was a descriptive and transversal study carried out in Brazzaville for 7 months, precisely in the traditional care centers of each of the

nine districts of the city. The study population consisted of tradipractians aged at least 18 years old, practicing in Brazzaville for at least 6 months. Non -consenting persons to participate in the study and those not recognized by the National Union of Tradipractians have not been included. We have proceeded by a consecutive sampling of tradipracticians meeting the inclusion criteria. Age, sex, level of study of tradipractians were the epidemiological variables studied. The clinical survey consisted in determining the level of knowledge of tradipracticians on different aspects of the MH (origin, risk factors, manifestations, complications, prevention) but also to assess their attitudes and practices in the management of this disease.

The level of knowledge of tradipractians was tried good when the percentage of fair responses was greater than or equal to 60%, average when it was between 30 and 59%, low when it was less than 30%. Regarding the attitudes and practices of tradipractician They were deemed adapted when the percentage of correct response was greater than or equal to 50%, unsuitable when the percentage of correct response was less than 50%. For each question asked a tradipratician, a bad answer made a good answer canceled.

4. Results

4.1. Socio -Demographic Aspects of Tradipracticians

The collection of data made it possible to include 60 tradipracticians in the study including 51 men and 9 women, a sex-ratio of 5.6. The extreme ages were 18 and 68 years old, the average of 32.8 ± 9.2 years. The majority of participants were an age less than 45, representing 75% of the study population.

All tradipractians had been educated and the majority had a secondary level of study or 71.7% (n = 43). Nine tradipracticians (15%) had not exceeded the primary level.

4.2. Evaluation of the Level of Knowledge on the Clinical Aspects of the MH

In half of the cases (50%), the source of information was parents. In 23.4% of cases (n = 14), information came from a colleague. Some tradipractians spoke of divine revelation (13.3%) and others were self -taught (13.3%).

Food was cited as the origin of the most frequent hemorrhoidal disease (67%). In 18 % of cases (n = 11) it was an infectious pathology, a disease linked to a bad spell in 8 % (n = 5) of cases or a hereditary pathology in 2 % of case (n = 1). Only 5% (n = 3) of the study population had reported a just answer, namely a vascular and mechanical origin. As a result, the level of knowledge was deemed low in 98% of cases and average in 2% of cases.

Regarding the risk factors of MH, alcohol was the most cited by Tradipracticians in 31.7% of cases followed by spicy meals. The level of knowledge was deemed low in 98% of cases and average in 2% of cases. (Figure 1) illustrates the distribution of tradipraticians according to the knowledge of the risk factors for the occurrence of the MH.

Anal bleeding was the most cited sign by tradipracticians in 48.3% of cases. The other most cited signs were constipation (48.7%) and abdominal buzzing (43.3%). The level of knowledge was deemed low in 93% of cases (n = 56), average in 5% of cases (n = 3) and good in 2% of cases. (Table 1) presents the distribution of tradipraticians according to the knowledge of the signs of the MH. Tradipractians considered sexual weakness as the most common complication in 45.1%, followed by infertility in 23.3% and anal prolapse in 8.3% of cases. The other complications mentioned were infection and anal cancer in 10% of cases. Knowledge had been deemed weak in 100% of cases. Knowledge of the differential diagnosis of the MH was deemed weak in the entire study population. Indeed, anal ulcers due to a bad fate in 16.3% of cases had been reported. Concerning the preventive measures of the MH, the regularization of the intestinal transit was the most reported measure in 71.7% of cases, followed by the eviction of alcohol (38.3%), of the fight against sedentary lifestyle (10%) and the eviction of any sexual intercourse (8.3%). The level of knowledge was deemed average in almost half of the cases or 42%.

All the subjects included in the study claimed to have knowledge of hemorrhoidal disease. However, the overall level of knowledge was low in 92% of cases. (Table 2) shows the global level of knowledge of tradipracticians on hemorrhoidal disease

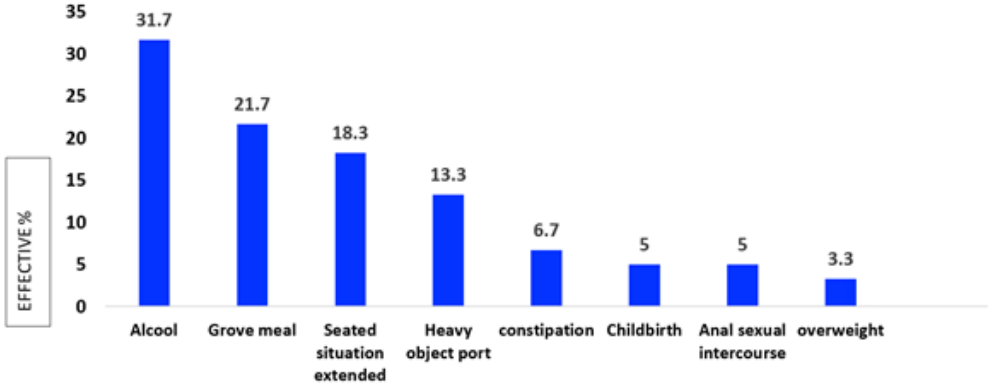

Figure 1: Distribution of tradipractians according to the knowledge of risk factors

Table 1: Distribution of tradipraticians according to the knowledge of the signs of the MH

Variable	Answers	N = 60	
		n	%
Do you know the signs of hemorrhoidal disease?	Yes	59	98.3
	No	1	1.7
What are the signs of the hemorrhoidal disease you know?	Bleeding	29	48.3
	Anal pain	8	13.3
	Thrombosis	3	5
	Pruritus	11	18.3
	Oozing	2	3.3
	Buzzing	26	43.3
	Constipation	29	48.3
	Abdominal pain	14	23.3
	Sexual weakness	19	31.7
	Low back pain	22	36.7
	Hemorrhoidal prolapse	6	10

Table 2: Global level of knowledge of tradipractician on hemorrhoidal disease

Variable	Answers	N=60	
		n	%
Do you know the hemorrhoidal disease?	Yes	60	100
	No	-	-
Global level of knowledge	Weak	55	92
	Average	5	8
	Good	-	-

4.3. Assessments of Attitudes and Practices on HD

The diagnosis of HD by traditional practitioners was made solely from anamnestic data in 78.3% of cases. However, nearly a quarter of the study population (21.7%) carried out a physical examination, but anoscopy, which is the key examination for the diagnosis of HD, was not mentioned by any traditional healer. As a result, the assessment of the diagnostic approach of traditional practitioners was judged to be unsuitable in 93.3% of cases. All traditional practitioners considered the treatment of HD based solely on functional signs. Concerning the type of treatment, they used traditional pharmacopoeia in 85% (n=51) of cases. Medications are frequently administered in the form of herbal teas (93.3%) or powder. The most common routes of administration are oral (96.7%) and/or intra-rectal (61.7%). The use of conventional medical treatment such as analgesics and NSAIDs was observed in only 15% of cases. (Table 2) shows the different forms of traditional treatment used by traditional healers. Regarding the action to be taken in the event of treatment failure, the choice to refer the patient to a conventional medical consultation represented only 6.7%. More than half of the traditional healers (53.3%) repeated the treatment after failure; 26.7% referred the patient to a colleague and 13.3% claimed not to experience any treatment failure.

5. Discussion

The male predominance of the study population is found in several works published in Africa. Indeed, similar studies carried out in Mali and Niger reported a male predominance in 86.7%; 76.8% and 85.7% of cases respectively [11, 12, 13]. These results demonstrate the first place for men in the exercise of certain professions in our societies, with women generally being absorbed by household tasks. The youth of the study population is similar to that observed in the survey by Kamboule et al in Burkina Faso which found 77.9% of traditional practitioners aged at least 30 years, i.e., an average age of 40.4 years [14]. Indeed, it is in this segment of the population that we find people fully exercising a profession. On the other hand, Mamadou et al in Niger as well as Maiza et al found an average age higher than ours, around 50 years. Their justification is that the activity of traditional healer is reserved for people of "mature age" [12, 15].

Concerning the level of education, this result proves the acceptance of Western education in our country although contrary to the socio-cultural and religious concepts of Africans as is the case of the studies carried out in Mali where non-schooling had represented 30.4%; 66.7% and 57.1% of traditional practitioners [11, 14, 13]. The results concerning the sources of information from our traditional practitioners on knowledge of HD show the importance of filial transmission in African customs. This involves transmission in the form of initiation by a close relative, either by a direct ascendant or a grandparent or even by a colleague. Our results are similar to those of Kamboule et al who found 71% of traditional practitioners trained by parents and 26% by another traditional practitioner [14].

Mamadou et al as well as Apema et al also reported predominant filial transmission in their study [12, 16].

In the present study, traditional practitioners did not have a good understanding of the pathogenesis of HD. However, the origin of HD is vascular and mechanical. Indeed, this pathological state results from the progressive dilation of the hemorrhoidal venous plexuses naturally present from birth and the rupture of the support elements. It is not a food or infectious pathology, hereditary formations or linked to bad luck (witchcraft, bewitchment) as reported by some participants. Also, there is no influence of race, ethnicity or religion [8].

According to literature data, the role of alcohol and spices, which are the risk factors most cited by the study population, has not been proven with certainty [8]. Our results are similar to those of Kamboule et al who reported food in 77.9% followed by alcohol in 8.8% of cases [14]. Diarra reported diet in 66.7% of cases [13]. On the other hand, prolonged sitting and carrying heavy objects cause abdominal hyper pressure with the consequence of arterial hypervascularization and an alteration of the supporting tissues, thus explaining the signs of the disease. The same goes for childbirth and excess weight, which are rarely cited by our traditional practitioners, but especially constipation which is one of the main risk factors. Depending on its internal or external location, HD is expressed by different signs. The bleeding which was reported by almost half of the respondents can be explained by the fact that this is the most common mode of expression of HD. On the other hand, the low level of knowledge observed could be justified on the one hand, by the fact that the majority of traditional practitioners confuse the symptoms with risk factors for HD, such is the case of constipation which is normally a risk factor. but which was cited as a sign in almost half of the cases; on the other hand, by the existence of signs not documented in the literature such as abdominal buzzing, low back pain and sexual weakness. Our results agree with those of Kamboule et al as well as Diarra who also found confusion between signs and risk factors for HD

among traditional practitioners in Mali [14, 13]. The same finding of association with HD and sexual disorder was observed by Kambou et al in Burkina Faso in 11% of cases with a significant difference [17]. A study carried out in Taiwan in 2012 found a statistically significant link between HD and erectile dysfunction, especially in men aged at least 40 years old. This phenomenon could be explained by the discomfort caused by the irradiation of the inflammatory process affecting the blood vessels in the region located between the bursae and the anus [18]. However, this hypothesis has no scientific basis. Complications that have been the subject of scientific proof are anemia in the event of bleeding persistent bleeding, infection and post-operative stenosis. The low level of knowledge of our participants regarding the differential diagnosis of HD could have a link with their main source of information (family initiation) which could explain their erroneous knowledge on the subject. Indeed, depending on the main signs of this condition, namely, rectal bleeding, pain and hemorrhoidal prolapse, it is legal to look for anal cancer, anal fissure, rectal prolapse, large hypertrophic papilla. Although the assessment of knowledge concerning preventive measures for HD was considered quite good in almost half of the cases, the fact remains that the knowledge of traditional practitioners is inspired by beliefs or unfounded popular concepts. on scientific evidence.

According to our traditional practitioners, the majority of proctological signs are linked to hemorrhoidal disease, which explains why, in the majority of cases, the diagnosis is only based on the data collected during the interview. The other reason is linked to African customs which advocate respect for the private parts of all individuals, except in cases of absolute necessity. Anoscopy, which is the key examination for the diagnosis of HD, has not been cited by any traditional practitioner. However, the physical examination, particularly proctological, is, after the questioning, the essential stage of diagnosis. It must be complete, meticulous and must be done successively, respecting different times.

Concerning the use of traditional pharmacopoeia, this observation was also made by Kamboule et al [14]. Another study done in Iran by Sahar Dehdari et al showed the importance of plants in the treatment of HD [19]. Indeed, as its name suggests, this ancestral practice must be based solely on the use of natural products. Thus, all parts of plants, with some differences, are used in the composition of various remedies with multiple therapeutic properties (analgesics, anti-inflammatory, antibiotics). As for the most cited routes of administration, our results agree with those of Nzuki et al in the DRC as well as Kimpouni et al in the Republic of Congo who found the oral route in 71% and 63% of cases respectively [20, 21]. Nadembéga et al found the oral route in 62.7%, the cutaneous route in 44.4% and the rectal route in 11% of cases [22]. However, these traditional remedies, manufactured by traditional practitioners themselves and derived from several plants, although natural, are prepared in a context of imprecision concerning dosages, dosages and side effects, even if certain traditional health practitioners claim to exploit and know the active ingredients as well as the therapeutic properties of plant metabolites. A small proportion of our traditional practitioners associate the use of conventional medical treatment with traditional pharmacopoeia, especially in cases of proctalgia. This could be explained by the youth of the study population in search of new experiences.

The filial transmission of knowledge and the conviction of know-how explain why the majority of traditional practitioners do not refer patients to doctors in the event of treatment failure, which also justifies the low level of overall knowledge of this population of study. In the present study, modern medical knowledge was used to appreciate traditional medicine. These two disciplines, although having opposing approaches, can be complementary. Traditional health practitioners can rely on data from modern medicine, considered safe and reliable, to provide care to seekers. This requires a good interface between the two areas of care practice.

6. Conclusion

Our study showed a low level of knowledge of traditional health practitioners about hemorrhoidal disease. The treatment of patients with hemorrhoidal disease by traditional practitioners is different from modern medicine and is unsuitable. These results require better training of the latter.

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