Research Report

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GL CLINIC

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Coordinating Research Cluster: Gender, Culture and Identity (IADS)

THE PLACE OF TRADITIONAL MEDICINE IN THE FIGHT AGAINST MALARIA

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Background

Malaria remains one of the most devastating infectious diseases, even after so many decades. According to the World Health Organization, there were an estimated 282 million malaria cases and 610,000 deaths globally in 2024 across 80 countries (WHO, 2025a). Africa carries a disproportionately high share of this burden, with 95% of cases and 95% of deaths worldwide, affecting approximately 75% of children under five (WHO, 2025a).

Despite this reality, there has been significant improvement. Since the year 2000, an estimated 2.3 billion malaria cases and 14 million deaths have been averted worldwide, and 47 countries and one territory are now officially certified as malaria-free by WHO (WHO, 2025b). Nevertheless, serious threats continue to undermine this remarkable progress. Artemisinin partial resistance, which is affecting modern malaria treatment, has been confirmed in Eritrea, Rwanda, Uganda, and Tanzania, and is suspected in Ethiopia, Sudan, Namibia, and Zambia (WHO, 2025c). World Malaria Day provides an important platform to reflect on progress, raise awareness, and strengthen commitment toward malaria elimination. The year's theme, *"Driven to End Malaria: Now We Can. Now We Must"*, reflects the need for urgency of ending malaria.

In light of this, a critical, often underexplored area in global malaria control is the role of traditional medicine. According to the WHO (2022), more than 80% of people in Africa continue to rely on traditional medicine as a primary source of healthcare, including the treatment of malaria in many malaria-endemic countries, like Nigeria. Traditional healers and herbal remedies are widely used in low and middle-income countries, shaping treatment practices and outcomes (Suswardany et al., 2015). Herbal medicine serves as the first line of treatment for individuals presenting with high fever resulting from malaria (Abdullahi et al., 2011). For instance, the GL Clinic, a research hub of the Institute of African and Diaspora Studies (IADS) at the University of Lagos, reported significant malaria treatment in 2024 (Akin-Otiko, 2024). This highlights the importance of integrating safe, evidence-based traditional medicine into formal healthcare systems. Therefore, this one-day seminar seeks to explore the intersection of modern medical approaches and traditional medicine in malaria prevention and treatment.

Statement of the Problem

Malaria continues to be a major public health problem, especially in countries like Nigeria, yet the place of traditional medicine in the fight against malaria is not well documented. Although malaria specialists hold the position that Africans do not have remedies for destroying Plasmodium (malaria-causing parasites), herbal practitioners and users of indigenous remedies argue from their lived experience that indigenous remedies prevent and treat malaria symptoms. In an attempt to fill this gap, the Institute of African and Diaspora Studies (IADS), University of Lagos, organized a one-day seminar to showcase indigenous methods that Africans, and in particular Nigerians, have used to prevent and manage malaria and its symptoms. This aligns with global efforts to end malaria and its effects, as outlined in the World Health Organization's programme for the 2026 World Malaria Day.

Aim & Objectives

This seminar explored the role of traditional medicine in malaria prevention and treatment, which is closest and most readily available to the people. The objectives are:

1. To identify culturally appropriate strategies, including remedies used in selected four geographical zones of Nigeria.
2. To educate the populace on what is available, affordable, and effective in the indigenous knowledge system of Africans, particularly Nigeria.
3. To encourage collaboration between Western-trained healthcare professionals and traditional medicine practitioners in order to generate data for research.

Methodology

The team sourced preventive and treatment regimens from selected parts of Nigeria, representing four geographical zones. The collected regimens were analysed to show similarities and the trajectories of herbs used across the selected regions. The regions were selected because they are endemic to malaria parasites. The situation of malaria prevention programmes in Nigeria was discussed in a panel session that was made up of Professor Wellington Oyibo, Professor of Medical Parasitology, College of Medicine, University of Lagos, who spoke about malaria research in Nigeria; Mr. Hakeem Bello, Registrar Lagos State Traditional Medicine Board, who spoke about the government's effort and programme to prevent and manage malaria in Lagos State, using indigenous methods; and Mrs Taiwo Subair Egberongbe, a licensed traditional practitioner in Lagos State, who spoke about types of *Ibà* (fever) and how malaria is prevented and managed with herbs. Thereafter, there was a session to showcase the malaria treatment regimen used in Western Nigeria. This was prepared as *àgbo ibà* (malaria decoction). The purpose was to create awareness and give people the opportunity to taste, although this is clearly not treating malaria as the Yorùbá say, '*gbà mu 'ò tán ibà*... (take and taste does not treat fever..).

Observatory Results
Malaria Treatments and Trajectory Across Selected Endemic Regions in Nigeria

Malaria Treatments East (E)	Malaria Treatments North (N)	Malaria Treatments South (S)	Malaria Treatments West (W)	Similarities
i) Guava leaves (Ugwoba; leaves) iii) Lemongrass (Achara ehi; leaves) iv) Lime juice (Oroma nkirisi; fruit) v) Male pawpaw leaves (Okwuru ezi; leaves) vi) Mango leaves	i) Barbados nut (Cindazugu; bark) ii) broadleaf fig tree (Gamji; bark) iii) Garlic (Tafarnuwa; bulb) iv) Ginger (Chitta; root) v) African Rosewood (Madobiya; bark) vi) Red potash	i) Bitter leaves (Sio; leaves) ii) Cashew leaves and bark (Kaju Pere, Kaju Timbi; leaves and bark) iii) Lemongrass (Akposo; leaves) iv) Mango (Mango Pere, Mango Timbi; leaves and bark)	i) Stool wood (Ahun; leaves & bark) ii) Boundary Tree (Akoko; leaves) iii) African Yellow Wood (bark; Awopa) iv) African Peach (Egbesi; bark) v) Lemon grass (Ewe Tii, leaves)	i) Lemongrass (Common in E, S, W) ii) Mango leaves (Common in E S, W) iii Lime (Common in E &S) iv Henna (Common in S & W)

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vii) Siam weed (Azikiwe; leaves) viii) Stone breaker (Chanka; leaves) ix) Virescens palm fruit (Osukwo; fruit) x) Uziza (West African black pepper; seed)	(Jar Kanwa) vii) *Leptadenia hastata* (Yadiya; Hagalhadjar; bark)	x) Neem (Dogoyaro; leaves) xi) Pawpaw (leaves; Papa Akara) xii) African Yellow Wood (Awopa; bark) xiii) Henna (Leno; leaves) ix) Lime (fruit and leaves; Oto, Oto Pere) x) Pineapple peel (fruit; Anana Furo)	vi) Henna (Láàlì; leaves) vii) Mango bark (Mangoro; bark) viii) brimstone tree (Oruwọ; bark)	x African Yellow Wood (Common in S & W)

(The table does not comprehensively represent all that is used in the selected regions, it however provides the basic regimen for the treatment of malaria found in the selected regions).

Discussion

i) The findings of this study reveal that malaria is not responded to in a monolithic way across Nigeria. Each region has developed its own treatment tradition, shaped by its environment, its culture, and what is available locally.

ii) A profound observation is how the North has a treatment regimen that is different from the other geographical areas. While the East, South, and West share a number of remedies such as lemongrass, mango leaves, henna, and African Yellow Wood, the North draws on an almost entirely separate set of plants and substances. For instance, Barbados nut, Gamji, African Rosewood, red potash, and *Leptadenia hastata* do not feature in the other zones. This divergence is not difficult to explain. Northern Nigeria has a dry, semi-arid climate, which produces a different landscape and communities have simply worked with what that landscape provides. The environment, in other words, shapes the medicine.

iii) This leads to the study's central argument: if the East, South, West, and North are each responding to malaria differently, then the idea of one universal treatment for malaria deserves to be questioned. The data suggest that malaria treatment has never truly been uniform. It has always been adapted to place, to culture, and to circumstance. Recognising this is precisely where the role of traditional medicine becomes significant, which is what this study set out to examine.

iv) Communities across Nigeria have been using treatment regimens unique to their environment without waiting for external validation. They have been treating malaria for generations, using what their environments offer and what their knowledge systems have refined over time. However, the fact that lemongrass, mango and lime appear across the East, South and West raises a fascinating question: *have these remedies travelled across regions because of their potency or did different communities simply arrive at the same answers independently?*

v) Furthermore, the findings provide a hypothesis around the issue of anti-microbial resistance. Usually when treatment fails in a particular area, resistance is often the first explanation offered. But the results here suggest a hypothesis, ***'that the treatment may simply not be suited to that environment or population'.*** What works in one region may not work in another and that may have less to do with the parasite and more to do with the mismatch between a standardised intervention and a highly localised disease experience.

vi) The continued and widespread use of these indigenous treatments is itself evidence that these regimens have stood the test of time, having been passed down from one generation to another. This means that a single therapeutic (Western) approach cannot adequately serve communities whose disease environments, cultural contexts and available resources differ so significantly. Research in indigenous remedies deserve more funding to document, provide genuine scientific explanation in view of integration into broader healthcare conversations.

Recommendation

1. Malaria treatment policies should reflect indigenous regional realities. A single universal standard is not sufficient.
2. Indigenous remedies across the four zones should be formally recorded, scientifically studied, and integrated into mainstream healthcare.
3. Traditional healers and Western trained healthcare professionals should collaborate to produce better data and more culturally appropriate treatment outcomes.
4. Regional research into active ingredients should be prioritised. This could help explain why certain remedies are effective in some areas and why some malaria medications fail in others.

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