



Research article

Integration of medicinal plants into the traditional system of medicine for the treatment of cancer in Sokoto State, Nigeria



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ABSTRACT

This study was designed to explore and record various medicinal plants integrated into the traditional system of medicine for the treatment of cancer. The traditional system of medicine is a routine practiced among the indigenous ethnic groups of Sokoto state. A semi-structured questionnaire was designed and used for data collection around the selected Local Government Areas. A substantial number of plant species were identified, recorded, and collected for preservation. Data collected for each specie was analysed to assess its frequent use among the medicinal plants. A total of 67 species belonging to 31 families have been identified and recorded. Out of the 473 frequency of citation (FC), *Acacia nilotica* was the most frequently cited specie (32 FC, 64% FC, 0.6 RFC), followed by *Guiera senegalensis* (27 FC, 54% FC, 0.5 RFC), *Erythrina sigmoidea* (17 FC, 34% FC, 0.3 RFC), and subsequently *Combretum camporum* (15 FC, 30% FC, 0.3 RFC). The most common parts of the plants used include the barks (55.2%), the roots (53.2%), and the leaves (41.8%). Additionally, decoction (74.6%), powdered form (49.3%), and maceration (46.3%) are the most frequently used mode of preparation. The historical knowledge of a traditional system of medicine practiced by the native traditional healers of Sokoto for the treatment of cancer has been documented. The present study further provides a baseline for future pharmacological investigations into the beneficial effects of such medicinal plants for the treatment of cancer.

1. Introduction

Cancer is a major global disease burden with heavy morbidity and mortality affecting people around the world. Africa accounts for 7.3% of the cancer deaths and 5.8% of the total cancer incidence worldwide (Bray et al., 2018). While cancer incidence among males has varied 6-fold from 79 per 100,000 (Ferlay et al., 2015) to 95.6 per 100,000 (Bray et al., 2018) in the West African region, it was recoded in Nigeria (2012–2013) at 94.2 per 100,000 and 160.2 per 100,000 among males and females, respectively (Morounke et al., 2017).

Medicinal plants have played an important role in the life of people across the globe. To date, traditional medicine practitioners (TMP) are primarily considered as the first-line healthcare providers in a rural

community. The frequent use of traditional herbal medicine is often ascribed to the failure of orthodox treatment. Africa is one of the continent richly endowed with medicinal plants (Mgbeahuruiketa et al., 2019) and Nigeria is among the African region that regularly used complementary and alternative medicine (CAM) concurrently with traditional belief for the treatment of various forms of diseases (Shinkafi et al., 2015).

Nigeria is indigenously rich in plant biodiversity commonly used as medicine for the management and treatment of different form ailments. The use of CAM by the locals across the region has been known for generations and preserved through the transmission of knowledge towards the younger generation. Furthermore, the frequent dependency on the use of herbal remedies has been attributed to the inability of patients

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access convention therapy, thereby relying on TMP for their health care needs (Ekanem and Udoh, 2009). In Sokoto state, the traditional system of medicine has long been practiced among the indigenous ethnic groups before the advent of Usman bin Fodiyo. Historically, the state is known for traditional medicine practice and herbal trade, which attracts many people across the West African region (Shinkafi et al., 2015).

The use of herbal medicines in Sokoto state has been documented for the management of diabetes (Shinkafi et al., 2015) while for the treatment of malaria, peptic ulcer, and other ailments have been reported elsewhere (Adebisi and Alebiosu, 2014; Oluranti et al., 2012a, 2012b). On the other hand, the use of medicinal plants for the treatment of cancer has received less attention and priority over the years due to the apparent focus on tropical and communicable diseases such as malaria, diabetes, polio meningitis, HIV/AIDS, etc. At the time of writing this report, there has not been any documented information on the use of folk medicine in relation to cancer treatment. This study was designed to explore and record various medicinal plants used as folk medicines for the treatment of cancer among the indigenous ethnic groups of Sokoto state.

2. Materials and methods

2.1. Study area and survey design

The present study was conducted in Sokoto state located in the North-West of Nigeria (Figure 1). Approximately, the region is located on the

coordinates: 11°33'04"N latitude and 5°14'E longitude with a total coverage area of 25,973 km² at the extreme end of the Northern region neighbouring the Saharan Countries (Adegboyega et al., 2016). The state has over 3.6 million populations (NPC, 2013) comprising different ethnic groups including Hausa, Fulani, Zabarmawa, and Tuareg. Hausa is considered as the largest ethnic group dominated in the region. Agriculture is predominantly the most common practice among the population living in the region. On the other side of the region, Sokoto borders with Zamfara to the south and Kebbi State to the West. Among the twenty-three (23) Local Government Areas (LGAs) contained, Sokoto-North, Sokoto-South, Wamakko, Dange-Shuni, and Bodinga LGAs were selected for the study. The LGAs were selected due to the closeness to the central region where herbal trade and traditional medical practice is most prominent.

A modified semi-structured questionnaire was adopted (Shinkafi et al., 2015) to quantitatively and qualitatively acquire different forms of information relevant to the study (Lee et al., 2018). The questionnaire used comprises personal information such as the name, age, sex, religious views, contact number, local tribe, and nationality. Additional information such as informant's area of specialty, duration of practice, means of diagnosis, mode of preparations, route of administration, admissions, and referrals were also included. The target participants for this study were primarily the traditional healer (e.g., TMP), those with knowledge of medicinal plants (e.g., herb sellers or older inhabitant), and herbalist. A total number of fifty (50) participants residing in the selected LGAs were randomly visited for the interview.

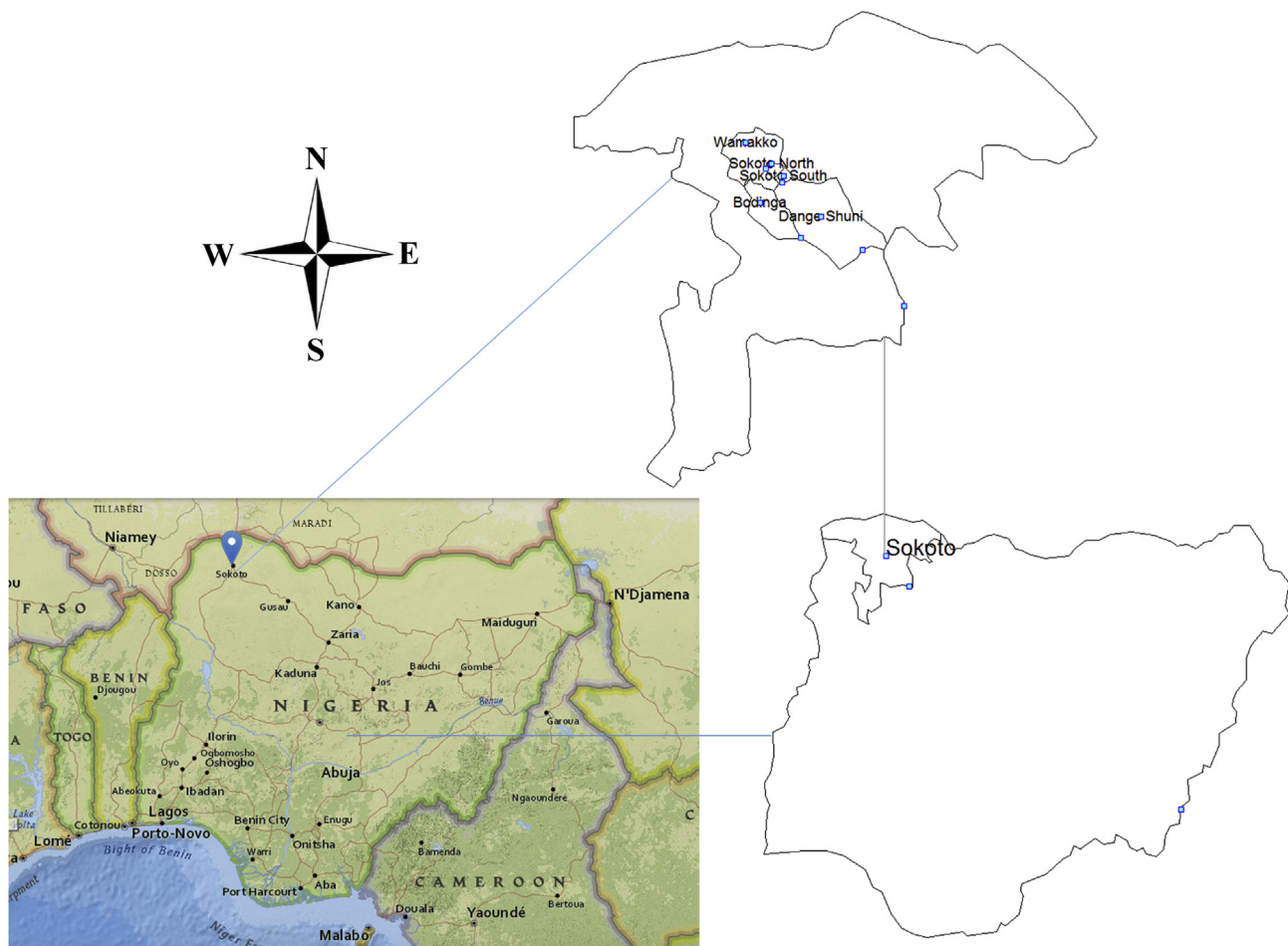


Figure 1. A map of Nigeria (bottom left corner) located along the Gulf of Guinea retrieved from MapMaker Interactive (<https://mapmaker.nationalgeographic.org/>); map of Nigeria (bottom right corner) showing Sokoto province where the study was performed; only the study areas involved are presented in the map. The maps are designed using academic version of Map Maker 4 software obtainable from www.mapmaker.com.

2.2. Data collection

An ethnobotanical survey was conducted from June to October 2018. Prior to the survey, consent of the interview was requested and granted by the Sokoto branch of the National Association of Nigerian Traditional Medicine Practitioners (NANTMP) and the procedures approved by the University Ethical Committee (PTAC/MP/AL/SQ/02–20). Informants involved during the interview include TMP, herbalist, and herb sellers. Informed consent was obtained from each of the informants prior to the administration of the questionnaire. An oral interview was granted to the informants that are unable to read or write, and the questionnaire was completed on their behalf. Each medicinal plant revealed by the respondent is recorded in the local names commonly recognised in the region. During specimen collection, informants were contacted for specimen collection and processed for identification. Subsequently, local names of medicinal plants were used to identify and collect specimens for proper identification. Each specimen was identified and assigned voucher number at the Herbarium of the Department of Pharmacognosy and Ethnopharmacy, Faculty of Pharmaceutical sciences, Usmanu Danfodiyo University, Sokoto. Furthermore, each plant species was validated via the Plant List database (<http://www.theplantlist.org>), Global Plants database (<https://plants.jstor.org>), and West African Plants database (<http://www.westafricanplants.senckenberg.de>).

2.3. Data analysis

Data generated from the ethnobotanical study were examined in a Microsoft Office application 2013 (Excel). To assess the local importance of each of the species identified, percentage Frequency of Citation (FC) (Shinkafi et al., 2015), Relative Frequency of Citation (RFC) (Ahmad et al., 2014), and Informant Agreement Ration (IAR) (Heinrich et al., 1998) were used to analyse and compare the use of a single specie among the medicinal plants.

$$FC (\%) = NC/TI \times 100$$

where, NC = total number of citations, TI = total number of informants

$$RFC = FC/N$$

where, FC = frequency of citations, N = total number of informants

$$IAR = (Nur - Nt)/(Nur - 1)$$

Where, Nur = number of used reports recorded as being used for a particular cancer type, Nt = number of plant species recorded for that type.

3. Results and discussion

3.1. Target participant for ethnobotanical studies

A total of 50 informants with knowledge of traditional medicine in the region were approached and interviewed for this study. For the period of the survey, the vast majority of the TMPs encountered were males (96%), whilst females constitute only 2% of the overall data. Culture, religious beliefs, and practices are the socio-cultural factors attributed to gender differences among the practitioners in Nigeria (Abara, 2012), which are predominantly found in most of the Northern parts of the country. A greater percentage (56%) of the respondents with substantial years of experience in practice are found ranging from 51 – 65 years of age while the least of the respondents found at the age of between 18 – 35 and 66–70 account for 4% and 6%, respectively. Furthermore, the Hausa ethnic group largely account for the highest percentage (66%) of the respondents in the survey followed by the Fulani ethnic group (32%) and both ethnic group specialised mainly in TMP and herbalism (Table 1).

On the other hand, 96% of the data obtained from the informants have revealed to physically assess patients while the remaining informants (4%) do not specify. From the data obtained, none of the informants directs patients for conventional diagnosis. A significant number of traditional healers in the region are uneducated, and therefore, diagnose patients at their discretion. In a similar report, Shinkafi and co-workers have shown that traditional healers from the same region do not apply the services of conventional methods to diagnose patients (Shinkafi et al., 2015) hence the present report is consistent in respect to the author's observation. The most notable physical examination performed on the patients includes skin examination of the affected area, breast examination for the presence of swellings in the affected area, examining the presence of lumps in an inflamed area of the neck or armpits, and belly examination of an inflamed area for any sign of an internal tumour. They argued that the technique used in the evaluation is effective in identifying and treating tumour disease. Other physical observations encountered during diagnosis include foul breath, excessive coughing, bitterness in the mouth, numbness in the sole of the feet, hotness in the palm of the hands, among others. These observations serve as indicators for the presence of internal tumours (e.g., lung).

In relation to this, the traditional healers in the region classified tumours into two different classes according to their origin. The internal tumours are those found inside the body of a patient such as a lung, liver, colon, and gynaecological tumours. The outside tumours on the other hand, are those visibly found outside the body of a patient such as a breast and skin. A significant number of the informants argued that

Table 1. Demographic characterises of the informants.

Parameters	Specifications	% NI
Age	18–35	4
	36–50	34
	51–65	56
	66–80	6
Gender	Male	96
	Female	2
	Unspecified	2
Tribe	Hausa	66
	Fulani	32
	Others	2
Speciality	TMPs	58
	Herbalist	32
	Herb sellers	6
	TMPs/Herb sellers	2
	Unspecified	2
Year of practice	1–10 years	0
	11–20 years	34
	21–30 years	44
	31 and above	10
	Unspecified	12
Method of diagnosis	Physical	96
	Psychological	0
	Biological	0
	Others	0
	Unspecified	4
Admission of patients	Yes	4
	No	92
	Unspecified	4
Referral	Senior colleague	48
	Hospital	38
	Senior Colleague/Hospital	12
	Unspecified	2

NI: Number of informant.

internal tumours often developed from the outside tumours, e.g., the tumour from the breast can be transferred to the lung. Others believe that communicable diseases such as malaria and typhoid can lead to cancer development when they become intense. The implication of their techniques is that patients with different conditions are susceptible to misdiagnosis. For instance, we noted that almost all TMP mistakenly refers to inflammatory disorder for cancer. Generally, they defined cancer (commonly known as “iska” in Hausa) as any inflammatory disorder developed outside or inside the body. In some instances, some of the informants identified swelling and stiffness of the skin or inflammatory bowel disorders (e.g., irritable bowel syndrome) as a tumour. However, only a few of the respondents that have gone through years of experience argued to differentiate between the two inflamed characters. From our observation, these TMP diagnosed patients based on physical symptoms to commonly known disorders.

Furthermore, we noticed that 92% of the informants chose to offer outpatient care, and 4% advised their patients to reside for the duration of treatment. We asked them in what ways they handle patients beyond their capability, and we realised that 45% refer their patients to senior colleagues that have gone through years of experience. However, a significant percentage of the respondents (38%) willingly sent patients to a hospital, and the remaining respondents (12%) seek for either senior colleagues or professional assistance.

3.2. Data collection and analysis

Data obtained from the overall survey have identified a total of 67 species belonging to 32 families claimed to have been used for cancer treatment in different communities of Sokoto-South and North, Dange-Shuni, Bodinga, and Wamakko LGA. Sokoto-South LGA presented the highest percentage (25%) of the plant species identified, whereas about 47% of the species were equally distributed among Sokoto-North and Dange-Shuni LGA (Figure 2A). Further to this, Bodinga and Wamakko LGA provided 22.4 and 17.9% of the plant species, respectively. The overall plant species documented in the present study are provided alphabetically in the order of a genus (Table 2). Out of the total species identified, Leguminosae is recorded as the most commonly used family representing 19 plant species, while Malvaceae, Combretaceae, and Anacardiaceae provided 6, 5, and 4 species, respectively. Others provided to 3 or less of the remaining plant species.

For the period of data collection, we noticed that more than one local name described a single species, e.g., ‘Kayar kusa’ or ‘bera’ ascribed to *Asparagus Africanus* Lam., ‘Runhuu’ or ‘Runfuu’ ascribed to *Cassia singuana* Delile., ‘Dany’a or ‘Nunu’ ascribed to *Sclerocarya birrea* (A.Rich.) Hochst, among others. The differences are attributed to different ethnic groups in the region as well as the traditional uses of the species for a different purpose. In some cases, both language and traditional use in the region mix up at least two if not more than two species having the same local name. For instance, “Girgizi” ascribing to *Cyperus difformis* L. can also be described as *Borassus aethiopum*, *Cyperus digitatus*, and *Hyphaene thebaica*. There are other relevant instances, but we ensured the right plant is properly collected and identified in an appropriate manner.

In this study, we have recorded a total number of 473 FC by the informants. *Acacia nilotica* (L.) Delile (32 FC) was the most frequently cited, followed by *Guiera senegalensis* J.F.Gmel. (27 FC), *Erythrina sigmoidea* Hua. (17 FC), *Combretum camporum* Engl. (15 FC), *Lannea acida* A. Rich. (14 FC), *Ziziphus mucronata* Willd. (14 FC), *Cassia sieberiana* DC. (13 FC), *Dichrostachys cinerea* (L.) Wight & Arn (13 FC), and *Ficus polita* Vahl. (12 FC). Others include *Leptadenia hastata* Vatke., *Nauclea diderrichii* (De wild.) Merr., and *S. birrea*, each having 11 FC. Furthermore, leguminosae (28.4%) has recorded the highest number of species in the families, followed by malvaceae and combretaceae, which accounted for 9% and 7.5%, respectively (Figure 2B).

On the other hand, *A. nilotica* (64%) has recorded the highest percentage FC with an RFC of 0.6, followed by *G. senegalensis* (54% FC, 0.5 RFC), *E. sigmoidea* (34% FC, 0.3 RFC), *C. camporum* (30% FC, 0.3 RFC),

L. acida (28% FC, 0.3 RFC), *Z. mucronata* (28% FC, 0.3 RFC), *C. sieberiana* (26% FC, 0.3 RFC), *D. cinerea* (26% FC, 0.3 RFC), and *F. polita* (24% FC, 0.3 RFC). The most frequently cited species in this study are shown in Figure 2C and their RFC values, which appeared in Table 2.

Furthermore, skin cancer was recorded to have the highest IAR value of 0.82, followed by breast (0.75), head and neck (0.74), colon (0.71), lung (0.71), cervical (0.67), and scrotum (0.50). The IAR values ranging from 0 to 1 indicate the number of times any plant species use by many informants for a specific disease type (Heinrich et al., 1998). The high ranking of IAR values might be attributed to the most notable tumours

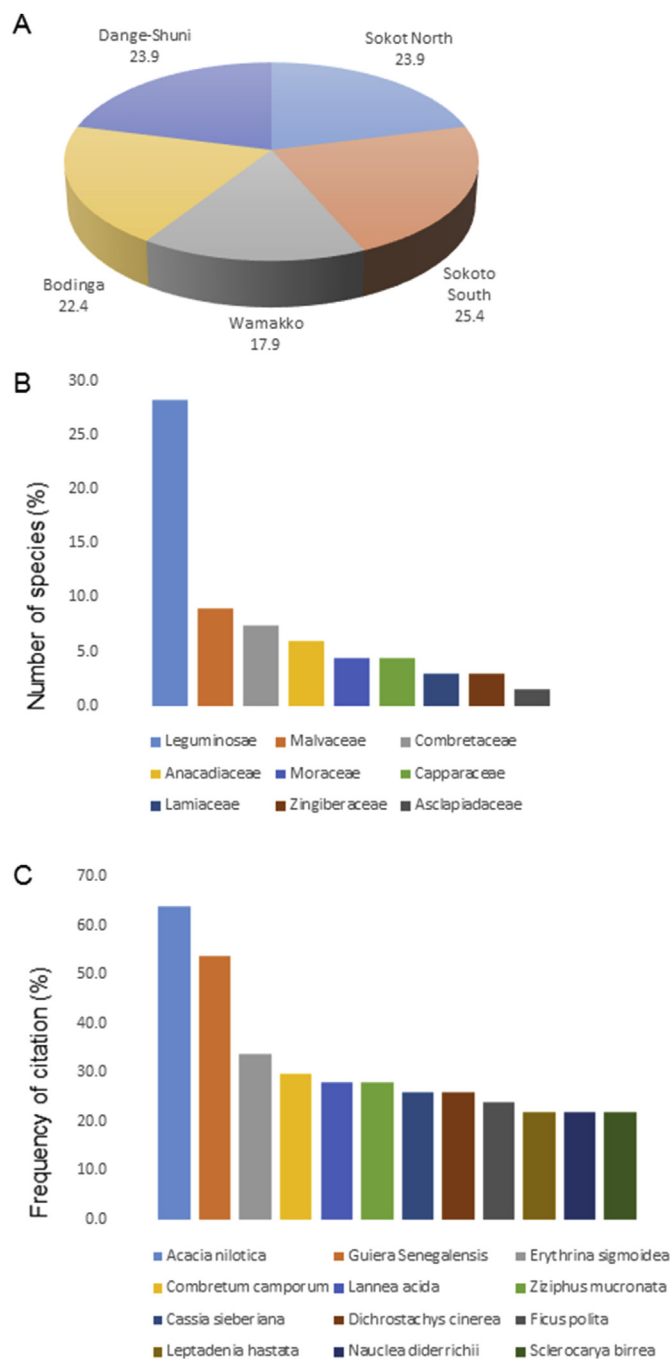


Figure 2. Percentage number of: A. plant species identified in each of the LGAs used in different communities; B. plant species recorded as being used for cancer treatment in a particular family; C. times any plant was cited as having used for cancer treatment.

Table 2. List of medicinal plants identified to be used for cancer treatment by the native traditional healers of Sokoto province.

Scientific name	Family	Common name	Local name	VN	LGA	PPU	MP	RT	RFc
<i>Acacia nilotica</i> (L.) Delile	Leguminosae	Egyptian mimosa	Bagaruwa	PCG/UDUS/Legu/0008	SS	L/B*/R/S	P/M/D*	O/T	0.6
<i>Acacia sieberiana</i> DC.	Leguminosae	Paperbark thorn	Farar kaya	PCG/UDUS/Legu/0001	SS	L/B*	P/M/D*	O/T	0.1
<i>Albizia chevalieri</i> Harms	Leguminosae	Silk plant	Katsari	PCG/UDUS/Legu/0002	SS/SN	B*/R	M/D*	O	0.2
<i>Allium cepa</i> L.	Amaryllidaceae	Onion	Albasa	CG/UDUS/Amar/0001	SS	L/B*	D*	O	0.1
<i>Anacardium occidentale</i> L.	Anacardiaceae	Cashew	Yazawa	PCG/UDUS/Anac/0002	SN/D	B*/R	M/D*	O	0.1
<i>Anogeissus leiocarpus</i> (DC.) Guill. & Perr.	Combretaceae	African birch	Marke	PCG/UDUS/Comb/0001	D	L/B*/R	P/M	O/T	0.2
<i>Aristolochia albidia</i> Duch.	Aristolochiaceae	Duchiman pipe	Duman Dutse	PCG/UDUS/Aris/0001	SN	S	D*	O	0.2
<i>Asparagus Africanus</i> Lam.	Asparagaceae	Asparagus	Kayar kusa/bera	PCG/UDUS/Aspa/0001	SN	L	D*	O	0.0
<i>Balanite aegyptiaca</i> Del.	Zygophyllaceae	Desert date	Aduwa	PCG/UDUS/Zygo/0002	W/SN	B*/L	D*	O	0.2
<i>Bauhinia rufescens</i> Lam.	Leguminosae	Silver butterfly	Jirga	PCG/UDUS/Faba/0019	B	L/B*/R	P/D*	O/T	0.1
<i>Boscia senegalensis</i> (Pers.) Lam.	Capparaceae	Basari	Anza	PCG/UDUS/Capp/0001	W	L/R	M/D*	O	0.2
<i>Cadaba farinosa</i> Forssk.	Capparaceae	herds boy fruits	Bagayi	PCG/UDUS/Capp/0002	D	L/B*/R	M/D*	O	0.1
<i>Cassia sieberiana</i> DC.	Leguminosae	African laburnum	Malga	PCG/UDUS/Legu/0004	SS	B*/R/S	P/D*	O/T	0.3
<i>Cassia singuana</i> Delile.	Leguminosae	Sticky pod	Runhuu/Runfuu	PCG/UDUS/Faba/0003	B	L/B*/R	P/M	O/T	0.1
<i>Citrullus lanatus</i> (Thunb.) Matsum. & Nakai.	Curcubitaceae	Water melon	Kankana	PCG/UDUS/Curc/0001	SN	S	P	T	0.0
<i>Combretum micranthum</i> G. Don	Combretaceae	Bush tea	Geza	PCG/UDUS/Comb/0003	B	L/B*/R	P/M	O/T	0.0
<i>Combretum camporum</i> Engl.	Combretaceae	-	Taramniya	PCG/UDUS/Comb/0004	SS	B*/R	M/D*	O	0.3
<i>Combretum molle</i> R.Br. ex G.Don	Combretaceae	-	Wuyan damo	PCG/UDUS/Comb/0005	B	B*	P/M/D*	O/T	0.1
<i>Curcuma longa</i> L.	Zingiberaceae	Turmeric	Gangamau	PCG/UDUS/Zing/0001	SS	P*	P/D	O/T	0.1
<i>Cyperus difformis</i> L.	Cyperaceae	Rice sedge	Gizgiri	PCG/UDUS/Cype/0001	B/SN	S	M	O	0.2
<i>Detarium senegalense</i> J.F.Gmel.	Leguminosae	Tallow tree	Taura	PCG/UDUS/Legu/0014	W	L/B*/R	P/D*	O/T	0.2
<i>Dichrostachys cinerea</i> (L.) Wight & Arn	Leguminosae	Sickle bush	Dundu	PCG/UDUS/Legu/0005	D	B*/R	P/D*	O/T	0.3
<i>Diospyros mespiliformis</i> Hochst. ex A.DC.	Ebenaceae	Jackal berry	Kanya/Kaiwa	PCG/UDUS/Eben/0001	D	B*/R	M/D*	O	0.0
<i>Entada Africana</i> Guill. & Perr.	Leguminosae	Entada	Tawatsa	PCG/UDUS/Legu/0006	SN	B*/R	M/D*	O	0.0
<i>Erythrina signioidea</i> Hua.	Leguminosae	Frankincense tree	Hano	PCG/UDUS/Legu/0017	SS	R	P/D*	O/T	0.3
<i>Faidherbia albidia</i> (Delile) A.Chev.	Leguminosae	Winter thorn	Gawo	PCG/UDUS/Legu/0007	B	B*	P/M	O/T	0.1
<i>Ficus gnaphalocarpa</i> (Miq.) Steud ex Miq.	Moraceae	Ficus tree	Baure	PCG/UDUS/Mora/0002	B	B*/R	P/D*	O/T	0.1
<i>Ficus platyphylla</i> Delile.	Moraceae	Red rubber tree	Gamji	PCG/UDUS/Mora/0003	W	B*/R	P/D*	O/T	0.2
<i>Ficus polita</i> Vahl.	Moraceae	Herat leaved fig	Durumi	PCG/UDUS/Mora/0001	B/D	B*/R	M/D*	O	0.2
<i>Grewia mollis</i> Juss.	Malvaceae	The air potato	Kamumuwa	PCG/UDUS/Malv/0002	B	R	D*	O	0.0
<i>Grewia villosa</i> Willd.	Malvaceae	Gray way	Dargaza	PCG/UDUS/Malv/0004	B	B*/R	M/D*	O	0.2
<i>Guiera senegalensis</i> J.F.Gmel.	Combretaceae	Moshi medicine	Sabara	PCG/UDUS/Comb/0002	SS	S*/R	P/D*	O/T	0.5
<i>Gynandropsis gynandra</i> (L.) Briq.	Capparaceae	African cabbage	Yar anguwa	PCG/UDUS/Capp/0003	D	L	D*	O	0.0
<i>Hibiscus cannabinus</i> L.	Malvaceae	Jute	Rama	PCG/UDUS/Malv/0003	SN/SS	S	S*	O	0.1
<i>Hibiscus sabdariffa</i> L.	Malvaceae	Roselle	Zobo	PCG/UDUS/Malv/0001	SN	S	S*	O	0.1
<i>Indigofera tinctoria</i> L.	Leguminosae	True indigo	Baaba	PCG/UDUS/Legu/0009	SN	R	M/D*	O	0.1
<i>Ipomoea asarifolia</i> (Desr.) Roem. & Schult	Convolvulaceae	Morning glory	Duman kada	PCG/UDUS/Conv/0001	D	L	D*	T	0.1
<i>Khaya senegalensis</i> (Desr.) A.Juss.	Miliaceae	African mahogany	Madaci	PCG/UDUS/Mili/0001	D	B*	P/D*	O/T	0.1
<i>Leptadenia hastata</i> Vatke.	Ascladiaceae	Butterfly weed	Yadiya	PCG/UDUS/Ascl/0001	W/D	L/R	P/D*	O/T	0.2
<i>Lansea acida</i> A.Rich.	Anacardiaceae	Donbeya	Faru	PCG/UDUS/Anac/0004	W	B*/R/S	M/D*	O	0.3
<i>Lophira lanceolata</i> Tiegh. ex Keay	Ochnaceae	Red iron wood	Namijin Kade	PCG/UDUS/Ocho/0001	SS	L	P/D*	O/T	0.1
<i>Mangifera indica</i> L.	Anacardiaceae	Mango	Mangwaro	PCG/UDUS/Anac/0001	W/SN	L/B*	M/D*	O	0.1
<i>Mimosa pigra</i> L.	Leguminosae	Mimosa	Gumbi	PCG/UDUS/Legu/0013	B/SS	L/B*	P/D*	O/T	0.1
<i>Moringa oleifera</i> Lam.	Moringaceae	Drum stick tree	Zogale	PCG/UDUS/Mori/0001	SS	L	D*	O/I	0.1
<i>Nauclea diderrichii</i> (De wild.) Merr.	Rubiaceae	African peach	Tafashiya	PCG/UDUS/Rubi/0001	SN	B*	M	O	0.2
<i>Ocimum basilicum</i> L.	Lamiaceae	Basil	Sarakkuwar Sauro	PCG/UDUS/Lami/0002	SS	L/R	S**	O/DA	0.1
<i>Ocimum gratissimum</i> L.	Lamiaceae	Clove Basil	Doddowa	PCG/UDUS/Lami/0002	B	W*	D*	O	0.1
<i>Parkia biglobosa</i> (Jacq.) G.Don	Leguminosae bean tree	African locust	Doruwa	PCG/UDUS/Legu/0010	SS	B*/R	D*	O	0.1
<i>Pennisetum pedicellatum</i> Trin.	Poaceae	Nigeria Grass	Kyasuwa	PCG/UDUS/Poac/0001	D	L	D*	O	0.1
<i>Piliostigma thonningii</i> (Schum.) Milne-Redh.	Leguminosae	Camels foot	Kalgo	PCG/UDUS/Legu/0011	W	B*/R	D*	O	0.1
<i>Pericopsis laxiflora</i> (Baker) Meeuwen	Leguminosae	English satin wood	Makarho	PCG/UDUS/Legu/0012	D	B/R	P/M/D*	O	0.1
<i>Psidium guajava</i> L.	Myrtaceae	Guava	Gwaiba	PCG/UDUS/Myrt/0001	B	L/R	M/D*	O	0.1
<i>Schwenkia Americana</i> L.	Solanaceae	Slender herb	Dandana	PCG/UDUS/Sola/0001	SN	W*	M	O	0.1
<i>Sclerocarya birrea</i> (A.Rich.) Hochst.	Anacardiaceae	Marula	Danya/Nunu	PCG/UDUS/Anac/0003	SN	L/B*	P/M/D*	O	0.1
<i>Senegalia polyacantha</i> (Wild.) Seigler & Ebinger	Leguminosae	White thorn	Karoo	PCG/UDUS/Faba/0018	B	B*/R	P/M	O	0.1
<i>Senna occidentalis</i> (L.)	Leguminosae	Coffee senna	Sanga-sanga	PCG/UDUS/Legu/0016	W	L	D*	O	0.1

(continued on next page)

Table 2 (continued)

Scientific name	Family	Common name	Local name	VN	LGA	PPU	MP	RT	RFC
<i>Sesamum radiatum</i> Schumach. & Thonn	Pedaliaceae	Benni seed	Yodo	PCG/UDUS/Pedi/0001	D	L	S*	O	0.1
<i>Stachytarpheta jamaicensis</i> (L.) Vahl	Verbenaceae	Blue potter weed	Tsira-hoko	PCG/UDUS/Verb/0001	B	R	P/D*	O	0.1
<i>Sterculia setigera</i> Delile	Malvaceae	Karayagum tree	Kukuki	PCG/UDUS/Malv/0006	SS	B*/R	P/M/D*	O	0.1
<i>Stereospermum kunthianum</i> Cham.	Bigoniaceae	Pink jacaranda	Sansami	PCG/UDUS/Bigi/0001	SN	R	P/D*	O	0.1
<i>Strychnos spinosa</i> Lam.	Loganiaceae	Monkey ball	Kokiya	PCG/UDUS/Loga/0001	B/D	B*/R/S	P/D*	O	0.1
<i>Tamarindus Indica</i> L.	Leguminosae	Tamarind	Tsamiya	PCG/UDUS/Legu/0015	W	L/B*/R/S	P/M/D*	O	0.1
<i>Vitellaria paradoxa</i> C.F.Gaertn	Sapotaceae	Shear tree	Kadanya/Kade	PCG/UDUS/Sapo/0001	W	L	P	O	0.1
<i>Waltheria indica</i> L.	Starculiaceae	Sleepig morning	Yankufa	PCG/UDUS/Star/0001	SS	R	P/M	O	0.1
<i>Ximenia Americana</i> L.	Malvaceae	Wild olive	Tsada	PCG/UDUS/Malv/0005	D	L/B*	P/M	O	0.2
<i>Zingiber officinale</i> Roscoe	Zingiberaceae	Ginger	Citta	PCG/UDUS/Zing/0002	D	P*	D*	O	0.0
<i>Ziziphus mucronata</i> Willd.	Rhamnaceae	Buffalo thorn	Magaryar kura	PCG.UDUS/Rham/0001	W	L/B*	P/M	O	0.3

Local name: Name of plant known by the local people; VN: Voucher number; LGA: Local Government Area (SS – Sokoto South, SN – Sokoto North, B – Bodinga, D – Dange-Shuni, W – Wamakko); PPU: Plant parts used (L – Leaf, R – Root, B* – Bark, S – Seed, P* – Pod, W* – Whole plant); MP: Mode of Preparation (M – Maceration, D* – Decoction, P – Powder, S* – Soup, S** – Smoke); RT: Route of Administration (O – Oral, T – Topical, I – Inhalation, DA – Dermal absorption); RFC: Relative Frequency of Citation.

found outside the body of patients, e.g., skin cancer. The IAR values recorded ranging from 0.50 to 0.82 is tabulated in Table 3.

Collectively, the most frequently used plant species cited by the informants are *A. nilotica* and *G. senegalensis*. *A. nilotica* is a thorny tree native to the African region and grows wild in Nigeria particularly, in the Northern region (Alli et al., 2016). In Sokoto state, the tree is found virtually in every community around the area. The plant parts are used traditionally for different treatment of disease to include cancer. It was observed that seeds obtained from the plant are used to treat patients with breast, colon and head and neck tumours. The seeds are crushed into a fine powder, mixed with a small portion of water, and applied around the breast. In some cases, seeds are mixed with other herbal materials to improve effectiveness. Furthermore, the whole herbal materials can be used for treatment, but seeds are most often used by the TMP. Pharmacologically, there have been several reports validating the anticancer properties of the *A. nilotica*. Its potentials have been demonstrated *in vitro* against colorectal (Hakim et al., 2018), breast (Barapatre et al., 2016; Sundarraj et al., 2012), lung (Sundarraj et al., 2012), cervical (Kalaivani et al., 2011), glioblastoma, and ovarian cancer (Salem et al., 2011). Similarly, *in vivo* pharmacological properties have been further validated against oral (Mohan et al., 2017), lymphoma (Sakthive et al., 2012), hepatocellular carcinoma (Singh et al., 2009), skin (Meena et al., 2006), and breast cancer (Kaur et al., 2002). Thus, the reported studies have backed up the traditional use of *A. nilotica* in the region.

G. senegalensis and *E. sigmoidea* is commonly found widely distributed in the Northern region of Nigeria. Both the Hausa and Fulani ethnic groups in the region used powdered preparation of the plant materials to treat patients, whereas in some cases, a decocted crude drug is also used for patients with suspected internal tumours. Pharmacologically, the traditional use of *G. senegalensis* and *E. sigmoidea* for cancer treatment has also been demonstrated *in vitro* against prostate, breast, and liver (Bello et al., 2017; Kuete et al., 2016, 2014), leukaemia (Kuete et al., 2016, 2014, 2012), cervical, colon (Fiot et al., 2006; Kuete et al., 2016, 2014), and glioblastoma (Kuete et al., 2016, 2014). A quite number of plant species that have been pharmacologically validated with anticancer properties are listed in Table 4. On the contrary, over 60% of the species identified in this study have not been verified, pharmacologically. Despite the fact that some of the genus such as *Combretum* spp, *Cyperus* spp, *Erythrina* spp., *Ficus* spp. *Mimosa* spp., among others, are widely known for their anticancer properties, yet none among the species identified in this study have been validated for similar properties.

In a similar study, the traditional use of medicinal plants for cancer treatment around Borno state in the far Eastern region of Nigeria has been reported elsewhere (Ngulde et al., 2014). In the present study, a vast number of species identified in Sokoto are consistent with that of the species documented in the region of Borno state. For instance, *A. nilotica*,

C. sieberiana, *D. cinerea*, among others, have also been cited by the native people of Askira/Uba LGA of the Borno state. Culturally, hausa and fulani ethnic groups formed the minority in the region when compared to Sokoto state. The study reported by Ngulde and co-workers was insufficiently documented, even though both regions lie in the Sudan savanna. In the study, respondents are reported to collect herbs during the day any time between sunrise through sunset of the plant. In the present study, informants argued that leaves are actively collected from the beginning of the flowering to premature fruiting. Barks, on the other hand, are best collected during the dry season before the beginning of the rainy season. This approach, they argued, is effective in collecting medicinally active principles of the plants.

3.3. Parts of plant used, method of herbal preparation and route of administration

The most frequently used plant parts are barks, roots, and leaves, which account for 55.2, 53.2, and 41.8%, respectively. Furthermore, seeds have accounted for 16.4% of the plant parts used, while the whole plant (3%) and pods (3%) are equally the least used by the TMP (Figure 3A). For the period of documentation, we noticed that the TMP injudiciously collects medicinal herbs by uprooting or cutting down the whole plant in the forest. This method of collection is operational in most parts of the region, and it is based on the belief that the plant species are accessible at all times. Some respondents are aware of the importance of medicinal plant conservation that may protect plant biodiversity, while some pretend ignorant for economic gains. In the present study, the higher percentage accounted for the bark and root parts can be attributed to unregulated access to the forest and disregarding the safety of plant biodiversity. The frequent use of plant bark and root by the TMP has been described unsustainably for traditional medicine development (Heinrich and Jäger, 2015). On the contrary, certain TMP argued that the collection

Table 3. IAR by cancer type.

Type of cancer	Nur	Nt	IAR value
Skin	29	155	0.82
Breast	32	127	0.75
Head and neck	21	77	0.74
Colon	17	56	0.71
Lung	13	42	0.71
Cervical	3	7	0.67
Scrotum	5	9	0.50

Nur: number of use reports; Nt: number of species.

Table 4. List of plants that were pharmacologically validated for their anticancer properties and their traditional use in the region of Sokoto state.

Medicinal plant	Reference	Traditional use for type of cancer
<i>A. nilotica</i>	Hakkim et al. (2018); Mohan et al. (2017); Revathi et al. (2017); Barapatre et al. (2016); Sakthive et al. (2012); Sundarraj et al. (2012); Kalaivani et al. (2011); Kalaivani et al. (2011)	breast, skin, head and neck, scrotum
<i>A. cepa</i>	Pan et al. (2018); Nile et al. (2018); Fredotovi et al. (2017); Abdelrahman et al. (2017); Lee et al. (2014); Wang et al. (2012); Shrivastava and Ganesh (2010)	skin, and colon
<i>A. occidentale</i>	Santos et al. (2018); Taiwo et al. (2017); Ashraf and Rathinasamy (2017); Shilpa et al. (2015)	head and neck
<i>A. leiocarpus</i>	Hassana et al. (2018); Olugbami et al. (2017b); Salau et al. (2013)	breast, head and neck, skin
<i>B. aegyptiaca</i>	Yassin et al. (2017); Hassan et al. (2016); Saleh and Emara (2016); Issa et al. (2015)	breast, lung, skin
<i>B. rufescens</i>	Garbi et al. (2015)	skin
<i>B. senegalensis</i>	Elkhateeb et al. (2019)	breast, colon
<i>C. longa</i>	Li et al. (2018); Coker-Gurkan et al. (2018); Li et al. (2018); Zhao et al. (2018); Frassová and Rudá -Kučerová, 2018; Arumai Selvan et al. (2018); Perna et al. (2018); Naqvi et al. (2017); Mou et al. (2017); Wang et al. (2017); Zang et al. (2017); Zhou et al. (2017); de Campos et al. (2017); Rivera et al. (2017); Wang et al. (2017); Zhou et al., 2016; Santos et al. (2016); Liu et al. (2016); Mishra et al. (2016); Abdel-Lateef et al. (2016)	breast, lung, head and neck, skin, cervical, scrotum, colon
<i>D. cinerea</i>	Long et al. (2009)	skin
<i>E. Africana</i>	Cioffi et al. (2006)	skin, breast
<i>E. sigmoidea</i>	Kuete et al. (2016); Kuete et al. (2014)	breast, colon, skin
<i>G. senegalensis</i>	Bello et al. (2017); Abubakr et al. (2013); Kuete et al. (2012); Fiot et al. (2006)	breast, lung, skin, colon
<i>G. gynandra</i>	Pettit et al. (2005)	skin
<i>H. cannabinus</i>	Wong et al. (2014)	breast
<i>H. sabdariffa</i>	Hassan et al. (2016); Tsai et al. (2014); Lin et al. (2011), 2007; Hou et al. (2005); Lin et al. (2005); Lin et al. (2002); Tseng et al. (2000)	lung, colon
<i>I. tinctoria</i>	Renukadevi and Suhani Sultana (2011); Kameswaran and Ramanibai (2008)	breast, head and neck
<i>K. senegalensis</i>	Olugbami et al. (2017a); Rabadeaux et al. (2017); Androulakis et al. (2006); Zhang et al. (2007)	breast, head and neck, skin
<i>M. indica</i>	Bai et al. (2018); Tan et al. (2018); Deng et al. (2018); Fernández-Ponce et al. (2017); Ganogpichayagrai et al. (2017); Ediriweera et al. (2017); Nemecc et al. (2017); Nemecc et al. (2016); Nguyen et al. (2016); Abdullah et al. (2014); Ramos et al. (2014); Kim et al. (2012); García-Rivera et al. (2011); Wilkinson et al. (2011); Noratto et al. (2010)	breast, skin, lung, colon
<i>M. olifera</i>	Antonini et al. (2018); Tiloke et al. (2018); Cuellar-Núñez et al. (2018); Jaafaru et al. (2018); Abd-Rabou et al. (2017); de Andrade Luz et al. (2017); Giacoppo et al. (2017); Adebayo et al. (2017); Abd-Rabou et al. (2016); Charlette et al. (2016); Michl et al. (2016); Jung et al. (2015); Al-Asmari et al. (2015); Elsayed et al. (2015); Krishnamurthy et al. (2014);	lung, breast
<i>O. basilicum</i>	Minari et al. (2018); Torres et al. (2018); Bayala et al. (2014); Behbahani (2014); Shirazi et al. (2014); Al-Ali et al. (2013); Kathirvel and Ravi (2012)	skin, head and neck
<i>O. gratissimum</i>	Lin et al. (2014); Ekunwe et al. (2014); Nangia-Makker et al. (2013); Chen et al. (2011); Ekunwe et al. (2010); Ye et al. (2010); Nangia-Makker et al. (2007)	skin
<i>P. biglobosa</i>	Fadeyi et al. (2013); Adetutu et al. (2012)	breast, skin
<i>P. guajava</i>	dos Santos et al. (2018); Qin et al. (2017); Ashraf et al. (2016); Rizzo et al. (2014); Levy and Carley (2012); Bontempo et al. (2012); Lee and Park (2010)	colon, head and neck, skin, breast, scrotum
<i>S. birrea</i>	Armentano et al. (2015); Tanih and Ndip (2013)	head and neck
<i>S. occidentalis</i>	Qin et al. (2016); Yang et al. (2016); Bhagat and Saxena (2010)	breast, head and neck
<i>S. spinosa</i>	Isa et al. (2014)	skin
<i>T. indica</i>	Lim and Song (2013); Aravind et al. (2012); Shivshankar and Shyamala Devi (2004)	lung, colon
<i>V. paradoxa</i>	Zhang et al. (2015), 2014; Tagne et al. (2014); Mbaveng et al. (2011)	skin, head and neck
<i>W. indica</i>	Monteillier et al. (2017);	breast, skin
<i>X. Americana</i>	Murtaja et al. (2018); Pervaiz et al. (2016); Pervaiz et al. (2015); Bayer et al. (2012)	breast, skin
<i>Z. officinale</i>	Al-Otaibi et al. (2018); Fuzer et al. (2018); Morimoto et al. (2018); Oh et al. (2018); Mansingh et al. (2018); Luo et al. (2018); Li et al. (2018); Wang et al. (2018); Muhammad et al. (2018); El-Ashmawy et al. (2018); Li and Chiang (2017); Liu et al. (2017); Jaksevicius et al. (2017); Pashaei-Asl et al. (2017); Elkady et al. (2017); Al-Tamimi et al. (2016); Ansari et al. (2016); Lee (2016); Rubila et al. (2016); Cojocarú et al. (2015); Das et al. (2015); Wee et al. (2015); Marrelli et al. (2015); Akimoto et al. (2015); Tahir et al. (2015); Elkady et al. (2014a); Elkady et al. (2014b); Park et al. (2014)	lung, breast, colon, cervical
<i>Z. mucronata</i>	Beg et al. (2016); Sigidi et al. (2016); Bhatia et al. (2011)	skin, head and neck

of leaves from the plant is justified and, this will limit the exploitation, thereby preserving the extinction of the plant species from the area.

Furthermore, there are different methods of herbal preparation observed by the informants. In this study, decoction (74.6%) is the most frequently used mode of preparation by the informants followed by powder (49.3%) and subsequently maceration (46.3%). The least among the methods include soup (4.5%) and smoking (3%) mode of herbal preparation (Figure 3B). To obtain an herbal extract, it was observed that the TMP constantly boils water containing herbal material for at least two hours. Alternatively, the herbal material is allowed to macerate in water for a period of time, typically two to three days. Either way, the resultant herbal preparation is administered to patients at the dose recommended by the informant. In contrast, an herbal powdered drug is prepared from the dried herbs and pulverised into a fine powder. The powdered drug is then mixed with either water, milk, or any locally made drink (e.g., 'fura' or 'kunu') at the dose recommended by the informants. Interestingly, it was further observed that a few of the TMP used the method of smoking to treat patients. In this method, herbal material is placed on the burning charcoal and allowed smoke from the burning herbs to spread directly on the patient. Their argument was that by allowing smoke to spread through the patient's skin is quite effective in treating outside tumours.

The most common routes of administration cited by the informants are the oral route (82.1%) and topical application (32.8%) (Figure 3C). Sometimes, oral route and topical applications are concurrently applied to treat patients. Additionally, 1.5% of the informants treat patients either by smoke inhalation or dermal absorption (a process where smoke is absorbed through the patient's skin). During our discussion, it is interesting to document that patients are given an herbal drug such as *O. oleifera* to sniffs through the nostril in case of suspected lung cancer. In a similar treatment, smoke burnt from the aerial parts of the herbal material is inhaled by the patient through the nasal cavity to treat lung cancer.

3.4. Toxicological risk associated with the use of herbal medicines in the province

The ethical implications for the use of herbal medicines in the region have also been considered in the present study. The frequent use of herbal medicines has been implicated in cases of acute renal failure in other regions of the country (Akpan and Ekrikpo, 2015; Bamgboye et al., 1993; Kadiri et al., 1999; S. Kadiri et al., 1991). For the period of discussions, informants were asked the implications of prescribed herbal medicines, as a result, it is alarming to know that none among the informants could account for any side effects from the patients. They argued that herbal medicines are natural and therefore, considered safe for use ascribing to the long history of use. However, few of the experienced TMP are aware of the implications and, thus, recommends a minimal dose, e.g., a cup of decocted herbal material daily. In severe cases, patients were prescribed to a higher dose disregarding the toxicological implications for their therapeutic use.

For instance, *Aristolochia albidia* Duch (0.2 RFC) has been prescribed for cancer treatment. While a species of *Aristolochia* have been documented in a similar study (Ngulde et al., 2014), its toxic side effects have yet to be established. Generally, *Aristolochia* and one of its chief components aristolochic acid have been known for its carcinogenic, and nephrotoxic effects for a very long time (Michael et al., 2009). Recently, several toxicological risks associated with a history of using herbal medicines containing aristolochic acid amongst cancer patients have been reported (Aydin et al., 2017; Ban et al., 2018; Chen et al., 2018; Hoang et al., 2016; Hung et al., 2016; Kanaan et al., 2016; Popovska-Jankovic et al., 2016; Xiong et al., 2018; Zhong et al., 2017). Despite the reported cases on the use of herbs containing aristolochic acid around the world, a similar effect associated with the use of *Aristolochia* spp has yet to be reported in Nigeria.

Herb-drug interaction is another major risk factor implicated in a widespread form of adverse effects (Amadi and Orisakwe, 2018). In the

present study, we noted that patients with cancer cases recourse to traditional healers at the same time receiving orthodox treatment. These patients are desperate for treatment, which subject them to various forms of adverse drug reactions. For instance, we noticed a case of a patient undergoing chemotherapy for colorectal cancer at the same time the patient is receiving treatment from a traditional healer. The patient is administered a very high dose of decocted herbal medicine disregarding the effects of herb-drug interaction. There are several unknown similar cases of this type found most often in the region, an approach that requires government urgent attention.

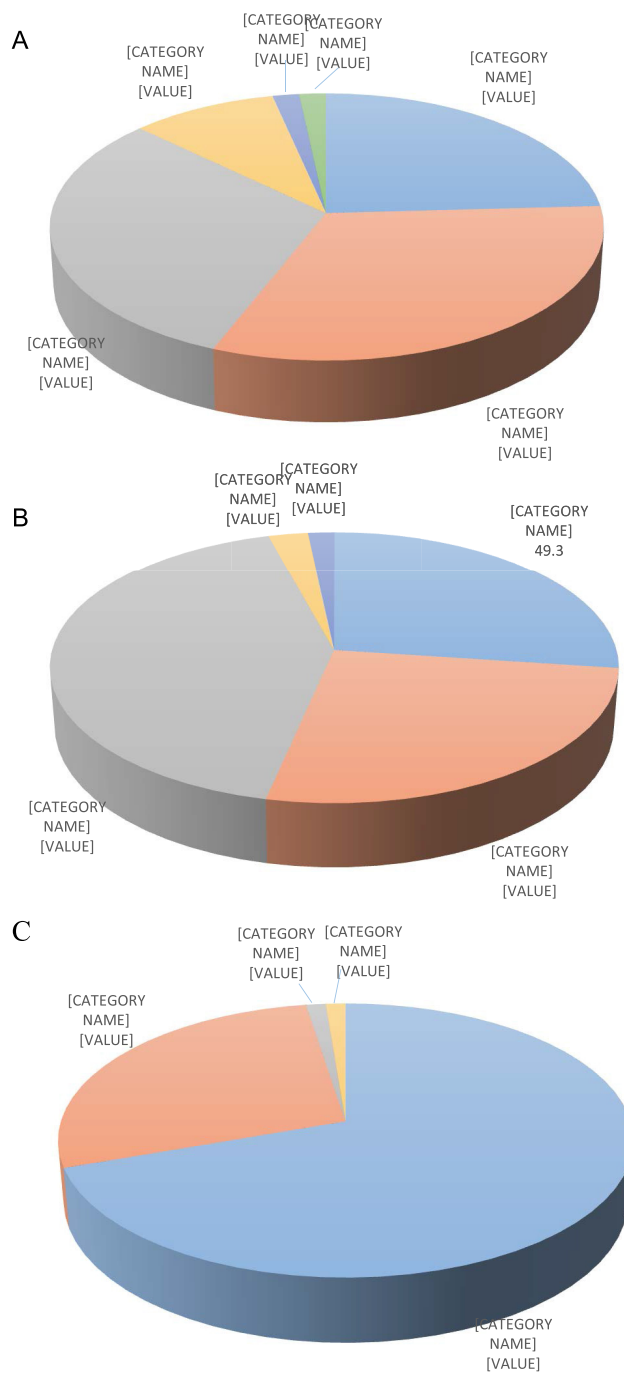


Figure 3. Percentage number of: A. parts of plant used; B. methods of herbal preparation used; and C. routes of administration used.

4. Conclusions

Concisely, we have documented for the first time traditional knowledge of medicinal plants integrated into the traditional system of medicine for the treatment of cancer in Sokoto state. In the present study, a total of 67 species of medicinal plants belonging to 31 families have been documented. Out of which, *A. nilotica* recorded the highest use-reports, followed by *G. senegalensis*, and subsequently *E. sigmoidea*. Additionally, various forms of diagnosis, the plant parts used, their modes of preparation, and different routes of administration have also been documented. The present study provides a baseline for future pharmacological investigations into the beneficial effects of local medicinal plants for the treatment of cancer.

Declarations

Author contribution statement

I. Malami: Conceived and designed the experiments; Analyzed and interpreted the data; Wrote the paper.

N. Jagaba: Conceived and designed the experiments; Performed the experiments; Analyzed and interpreted the data.

A. Muhammad and A. Alhassan: Conceived and designed the experiments; Wrote the paper.

I. Abubakar: Analyzed and interpreted the data.

P. Waziri, H. Mshelia, I. Yahaya and S. Mathias: Contributed reagents, materials, analysis tools or data.

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Competing interest statement

The authors declare no conflict of interest.

Additional information

No additional information is available for this paper.

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