

THE UNIVERSITY OF HULL

**The Opportunities and Challenges for Cooperation between
Contemporary and Traditional Health Practices Under the
National Health System in Tanzania**

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By

Richard S. Gellejah (MPH) Boston University

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Dedication

I dedicate this work to my grandfather Mr. Samson Lohumbula Nkulila for imparting to me the passion to seek wisdom and learning. I also dedicate this work to my parents the late Mr Jacob Shigikile Gellejah and Mrs Agnes Gellejah who did not live long enough to witness the fruit of their dedication.

Abstract

In response to the increased popularity and use of Traditional/Complementary Alternative Medicine, not only in less-developed countries where it is a first line of contact for the majority of people but also in developed countries, initiation of Integrative Medicine Clinics has been triggered particularly in Western countries. In addition, there are increased opportunities of research and associated criticism on the subject. Whereas such investigations have provided some interesting understandings on how the integrative clinics are managed, surprisingly, many of the investigations have been carried out in developed countries where biomedicine is affordable and accessible for the majority of people. There is a dearth of information about the opportunities and challenges for contemporary and traditional health practices to work together in less-developed countries where accessibility and affordability of modern medicine is a huge challenge. The objective of this thesis then was to offer some exploratory perceptions into how key stakeholders of health in Tanzania recognize the opportunities and challenges that are there for the two health practices to integrate under the National Health System.

An ethnographic stance was utilised to explore the views of 35 participants from four regions in Tanzania, among whom were biomedical and traditional practitioners, policy-makers, and religious leaders; researchers of traditional medicine from two national research institutes, participants with multiple roles and clients of the two practices. In-depth, semi-structured interview was the main method of data generation. Data was analysed thematically, from which the study revealed that despite the potential opportunities for the two practices to work together, integration of the two practices cannot take place due to emergence of two schools of thought of traditionalism and modernity that were irreconcilable. Instead cooperation is possible under the framework of Negotiated Order Theory that feeds three processes of Integration and Differentiation, Hybridization of Traditional Medicine and Negotiating Modernity.

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CHAPTER ONE: INTRODUCTION TO THE THESIS

1.1 Background to the Study

Traditional, Complementary and Alternative Medicine (T/CAM) are the centuries-old types of medicine that can be found in almost every culture all over the world. Their growth, popularity and demand have equally increased and in recent times they have attracted attention and interest at all levels globally (Kaboru et al., 2006; Broom et al., 2007; Tovey, 1997). In the larger picture, T/CAM have been defined in connection with modern medicine, which in this thesis the term is used interchangeably with biomedicine and contemporary medicine. In other words, the relationship between modern medicine and other practices dictates how the other practices should be defined (Eran Ben-Arye et al., 2008). Taking traditional medicine as a case in point, the World Health Organization (2012) defines this centuries-old type of therapy as “traditional, conservative, knowledge and practices applied in identifying disease and treating them to bring about total health and creating societal balances. It relies on practical knowledge and experience passed down by word of mouth or in written form from one generation to another” (WHO, 2012:2). The key words in this definition that differentiate traditional medicine from modern medicine are “total health”: whereas traditional therapy brings about total health or holistic health, modern medicine is disease-orientated, treating parts of the body.

CAM therapies, on the other hand are also defined depending on how closely they are accepted by biomedicine. For example, ‘alternative therapies’ is a term applied for CAM that are used as a substitute for modern medicine, meaning that the two practices are incompatible. CAM used along with modern therapy are regarded as ‘complementary medicines’, in this case the CAM are complementing modern medicine and not otherwise; while integrative medicine is defined as inclusion of ideas, cultural values and practices from the three aspects, namely alternative, complementary and modern therapies (Rakel, 2003). Indeed, the naming of CAM denotes the level of acceptance by and reconciliation with the dominant biomedical practice (Gale, 2014). For example, local indigenous CAM that are completely non-reconcilable with modern medical practice are referred to as alternative medicine; traditional medicine in Africa being one example (Tsey, 1997). CAM that have received less resistance and isolation

are named complementary medicine: examples of such CAM are aromatherapy, Chinese acupuncture and hypnotherapy (Weil, 2001). Other forms of CAM have received recognition, acceptance and have been reconciled with modern practice to the degree that they have been integrated in the system; these are referred to as integrative medicine (Leckridge, 2004). Examples of such CAM include reflexology, therapeutic massage and acupuncture, which have gained acceptance into biomedical practice. In the UK, these practices are used in some British NHS hospitals and hospices (Broom et al., 2007). If one has to put various non-biomedical therapies on the scale as to which one is mostly and closely reconciled to biomedical practice, the scale would read in a descending order to reconciliation as: integrative medicine, complementary medicine, alternative medicine practised in the Western countries; and the last would be traditional medicine in Africa, South Asia, South America and other non-western countries (Kaboru et al., 2006). The logic of this order is that traditional medicine, for example in Africa is rarely mentioned and has been a marginalized area compared to other practices (Hollenberg et al., 2009).

The term 'traditional medicine' is used by the WHO and other health policy making organs worldwide to denote all practices that are not modern medical practice. In other words, the term includes Traditional, Complementary and Alternative Medicines. However, the use of the term 'traditional medicine', borrowing words from Geest (1997), is 'embarrassing and naïve'; it is embarrassing because there is no such thing as 'traditional medicine'. What is termed 'traditional medicine' is composed of types of therapies with extreme diversity in approach, theories and practice. What labels them as traditional medicine is the fact that all have one thing in common: they are non-biomedical. However, stocking together all forms of therapies that are non-biomedical and treating them as if they are one type shows a great deal of negative bias and presumed superiority of the critics as well as lack of information about traditional medicine in its theoretical and practical aspects. It is naïve because as Geest puts it nicely, the term traditional medicine lacks good judgment. It is assumed that biomedicine has never passed over from one generation to another as was the case with traditional medicine. The fact is that biomedicine was and is still being handed over in many forms through medical training in colleges, hospitals, seminars, conferences and media (Geest, 1997).

The term tradition is both controversial and complex to describe (Scheid, 2006). To redefine the notion of tradition, Scheid (2006), uses Chinese Medicine as a case in

point to describe how the West perceive it as Traditional Chinese Medicine, whereas the Chinese themselves simply refer to it as Chinese Medicine. The notion that any medicine that is not modern is traditional in this context can be traced back to the late nineteenth century when Chinese intellectuals were forced by the Western military colonial powers to denounce their own 'intellectual and scientific traditions' (Scheid 2006:60). Since then Chinese scientists have made a deliberate move to name their medicines as 'traditional' when exporting them to the western world, while at the same time, they were busy improving the image of their medicines to resemble more meticulously the scientific modernity of western medicine. Derived from the term *tradere* in Latin, which means 'to hand over' tradition was originally attached to the passing of knowledge or doctrine. However, later, other things were included that could be passed on over time, things such as respect, authority and duty. Thus, there was a shift of meaning from an emphasis on process to items that are static in nature. Following this logic, tradition is perceived in a positive way as the continuity of culture, but in a negative connotation as something that prevents development, increases inertia and degenerates into traditionalism. According to Hobsbawm et.al., (1983), 'genuine traditions are neither revived nor invented' (1983:8). Applying the same metaphor to Chinese medicine, if Chinese medicine has reinvented itself from one era to another as claimed by historians, then it was never a genuine tradition. On the other hand, if it is a genuine tradition as claimed by Chinese practitioners, then what would explain its innovative and revived development that has been witnessed in the past century? This argument suggests that the western notion that indigenous medicines are traditional because they are static does not hold truth as traditional medicines are capable of developing, innovating and re-inventing in the same way as modern medicine (Weber 1947).

The confusion that surrounds the term traditional medicine is also inherent in describing modern medicine. The universally known expression medical pluralism, is where different forms of health practices commonly referred to as 'others' compete for legitimacy with modern medicine as the dominant health practice (Janzen 1978). However, the study by MacFarlane et al., (2010) has led to the view that modern medicine is equally surrounded by complexity and controversy. What is termed modern medicine is not a homogeneous entity; rather within modern health practice there is heterogeneity. The authors take refugees from Eastern Europe who settled in the Republic of Ireland as their case in point; although these refugees visited the Irish

modern health practitioners to seek treatment, they questioned the legitimacy of the Irish general practice. Hence, they preferred to seek various treatment options, including consulting general practitioners from their home countries. The researchers concluded that modern medicine is 'a diverse and plural set of culturally mediated practices and sets of discourses' (MacFarlane et al., 2010:182).

The controversies and complexities surrounding both traditional and modern health practices suggest that the naming of medicines or practices that are not modern as traditional is inaccurate as the so called traditional medicines or practices can be revived, reinvented and innovated as was the case of Chinese medicine. Following this argument, there are views that suggest that modern medicine and modern health practice should not legitimately bear the expression of modernity as it has borrowed or appropriated or subjugated several culturally mediated practices and sets of discourses from various traditional health practices (Adams et al., 2009). The ideal approach for the World Health Organization and other policy making organs according to Scheid (2006) was to name the medicine according to its origin; thus, medicines from China would be Chinese medicine, those from Africa - African medicine and western medicine for those from the West. However, for the sake of clarity in this thesis, I will settle for the terms traditional/CAM medicine and modern medicine as used by the World Health Organization.

It is here reaffirmed that T/CAM have extreme diversity in approach, theories and practice and that they cannot be stocked together. Even where the practices have commonality in treating certain conditions still they differ in theory and applications. Worldwide T/CAM are categorized in five major types. These include, complete medical systems, for example - Ayurvedic, and Traditional Chinese Medicines (Coulter, 2005). The second type of T/CAM is mind-body therapy, for example meditation, prayer and relaxation, music and dance (Faas, 2001). The third type of T/CAM is the biologically based, for example dietary supplements and herbal medicines (Barnes 1998a). The fourth type is body-based and manipulative, for example osteopathic and chiropractic manipulation, and massage (Kaptchuk and Eisenberg, 1998). The fifth and last type is energy medicine for example *prana and Qi* (Baer, 1992).

As for Africa, most of the literature categorizes traditional healers in Africa into four main categories (Bamidele, 2009; Madiba, 2010). The first type is diviners or

spiritualists, those who use divination or spiritual methods to diagnose illness. They are mainly women: before becoming diviners, most had previously fallen seriously sick. Some become diviners after getting a dream from their ancestors telling them to be healers. The second type of healer is the herbalists, who are predominantly men: they use herbal-based cures. These are the largest in number of all traditional healers and their form of knowledge is nearest to that of modern medicine in that they use herbs to cure the causes of disease and this is closest to the idea of cause and effect, an idea accepted in biomedicine (Peltzer et al., 2002). The Traditional Birth Attendant (TBA) is a third type of traditional healers who are normally women in their middle age with long successful experience in pregnancy and delivery of babies. Pregnant women, in sub-Saharan Africa are attended by TBAs to the tune of 65 to 80 per cent of cases (Vyagusa et al., 2013). The fourth and final type of traditional healer is the bone-setter, whose skills resemble much of orthopaedic practice, the difference being that the bonesetter expedites bone union and healing by the use of traditional medicine (Asante et al., 2012).

Other scholars such as Tsey, (1997) prefer the categorization of traditional healers into spiritually based and non-spiritually based healers. The two practices differ in the belief systems although both of them use animal products and herbs for cure. Traditional healer who are spiritually-based advocate that spirits of ancestors and gods are responsible for human misfortunes and illnesses; subsequently, the treatment of such conditions, require dealing with the cause of the illness, the spirits ancestors (Ngokwey, 1994; Geest, 1991; Bierlich, 1995). Non-spiritual practitioners believe in the efficacy of their healing plants. In Tanzania four forms of traditional practices are recognized by the law through Act number 23 of 2002. The practices are herbalist, bone-setting, mental health practice and traditional birth attendants (Kayombo et al., 2007).

Unlike CAM from the rest of the world which has enjoyed less resistance and isolation from biomedical practice, traditional medicine and traditional healers in Africa have never enjoyed that privilege. The practice has been almost permanently isolated and relegated to the backyard where it has never been promoted (Bamidele, 2009). The tug of war between the two practices is historical and goes back to colonial times. Taking Tanzania as a case in point, traditional healing practice dates to before the arrival of the western nations who colonized Tanzania (MOH, 2000). The practice was dominant until the arrival of the Germans in the 18th century. Germany and later Britain

introduced modern medicine with the close assistance of missionaries from the same nations (MOH, 1992).

Apparently, the colonists and the missionaries had one agenda: to support and promote their culture and civilization and to degrade the indigenous ones. Four critical channels were used to indoctrinate the indigenous people (Mahunnah et al. 2012). The first channel was through the education system, which introduced the belief that an educated person is not expected to visit a traditional healer because the practice is not scientific: his place for seeking medical attention is in the Western-oriented hospital. The second channel was through the Christian religion, which expounded that traditional healers and their medicines were closely linked to African religions, which were perceived as satanic and evil, and that people needed 'salvation'. The third channel was through the medical system, which propagated that traditional medicine was not tested and was therefore unsafe for human consumption. The final channel was through the legal framework, which enacted a law to abolish witchcraft and suppress traditional healers' practice. In the eyes of the colonial rulers, traditional medicine and witchcraft were one and the same thing (Marsland, 2006). By the use of these influential frameworks, the colonizers were able to transform the mind-set and attitude of many Africans (Richter, 2003): and on the basis of the same influences, biomedicine was introduced, nurtured and allowed to grow (Addis et al., 2002).

In the larger picture, the biomedical system was regarded as the best alternative, and thus it slowly but steadily side-lined if not submerged the traditional healing practices, since the elite group, religious leaders and policy-makers had negative attitudes towards traditional practice. They publicly praised biomedical practice and looked down upon the traditional practice. That was the beginning of marginalizing traditional practice. This historical background explains why in Tanzania, over a century now, biomedical professionals, some policy-makers, elite group and religious leaders have not been able to reconcile traditional practice with modern medicine.

Despite the relegation and marginalization of traditional medicine in Africa including Tanzania, traditional medicine remains the most depended upon medicine in the continent and its popularity and use have recently been reported to be on the increase (Asante et al., 2013). The emergence of chronic non-communicable conditions in Africa and especially the epidemic of HIV/AIDS has increased its use partly because

modern medicine has no cure for the disease. Traditional healers have increasingly become the recipients of terminally ill people due to untreatable chronic conditions such as cancer, advanced diabetes, and kidney and heart failures (WHO, 2013). The majority of rural and hard-to-reach communities in Africa depend on traditional medicine and its practitioners for their day-to-day health needs, the urban communities have joined hands with rural communities in using traditional medicine because of these new emerging conditions, whose prevalence is predominantly high in the well-to-do class of people who are mainly living in urban setting (Faas, 2001).

Based on new developments, the popularity and increased use of T/CAM that are reported worldwide, I decided to research on the opportunities, challenges and barriers for the contemporary and traditional health practices to work together under the National Health System for three reasons. First, it is indisputable that traditional medicine is the most used therapy in developing countries including Tanzania: it is therefore imperative that the opportunities that are there for collaborating with biomedical practice, and the challenges and barriers for its acceptance by biomedical practice, which include the negative attitude, beliefs and practice, be addressed by providing well-thought concrete evidence. Secondly, while the countries that colonized Africa including Tanzania are now working hard to encourage integration of CAM and biomedical practice as a response to the pressure and demand from users, in Africa, leaders have maintained the same colonial mentality of despising and marginalizing traditional medicine. It is high time research on traditional medicine should focus on providing the missing link between the distorted view that elite people hold of traditional medicine and the reality about the practice. Third, there are promising findings that have shown that traditional medicine is effective in managing certain chronic conditions. Research such as this may change the mentality of key influential people about traditional medicine so that more people will have faith in traditional medicine. My motivation to undertake this study was given impetus by the statement given by the WHO Director General. At the International Conference on Traditional Medicine for South-East Asian Countries in 2013, Dr Margaret Chan stated –

“Traditional medicines, of proven quality, safety, and efficacy contribute to the goal of ensuring that all people have access to care. For many millions of people, herbal medicines, traditional treatments, and traditional practitioners are the main sources of health care, and sometimes the only source of care. This is care that is close to homes, accessible and affordable. It is also culturally acceptable and trusted by large numbers of people. The affordability of most of traditional medicines makes them all

the more attractive at a time of soaring health-care cost and nearly universal austerity. Traditional medicine also stands out as a way of coping with relentless rise of chronic non-communicable diseases” (WHO, 2013:2).

Generally, I believe this study will assist my audience in gaining understanding of the opportunities and challenges that are there for cooperation between biomedical and traditional health practices. Specifically, it will show factors that demarcate the two practices as well as the friction between them. It will also help the practitioners of the two practices to think critically whether the historical reasons for not collaborating between them are still valid. The facts and findings of this study may help both modern and traditional practitioners to view each other as companions rather than competitors, which may be a positive step towards improved cooperation between them. This study may potentially encourage the honest and genuine practitioners from either practice to come forward and work together with their counterparts.

1.2 Organization of the Thesis

The thesis is organized into seven chapters, including this introduction. Chapter two reviews the literature on the opportunities and challenges for contemporary and traditional health practices to work together under the National Health System in Tanzania, and states the information gap, the central research question and the general objective of the study. Chapter three discusses the approach used to investigate the possibilities and the difficulties in two health practices to work together under the National Health System. Chapter four presents the findings and discusses the inclusion and separation of Traditional Healers from Traditional Medicine. Chapter five explores the potential cooperation between Contemporary and Traditional Health Practices, while chapter six discusses the deterrents to cooperation between the two practices. Chapter seven is the concluding chapter and discusses the merits of using the ethnographic stance, policy implications, recommendations and proposed area for further research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Literature Search Technique

Literature review was a process that took most of my first year of study. Initially the search of literature was general and wide as to find out what information there is about the area of interest in my research, in this case T/CAM narrowing down to Traditional Healthcare Practice (THCP) in Africa and later in Tanzania. The search helped me to gain understanding of a gap in the information regarding traditional medicine and its practitioners, as a result I was able to review and sharpen my research question (see below) to reflect the real situation in Africa and particularly in Tanzania. After obtaining a central researchable question, my search of literature changed from being general to a more focused, comprehensive, rigorous and systematic one, making sure no information was left unsought regarding the opportunities and challenges for the contemporary and traditional health practices to cooperate together under the National Health System.

It was this comprehensive systematic approach which helped me to obtain information with regards to T/CAM and medical pluralism globally. Literature search was an on-going process throughout the study using different electronic databases but also searching from unpublished materials (grey materials). Guided by the central research question, I was able to demarcate the type of literature I needed to address it. To realize that, I developed search terms that were closely related to the topic/research question. To make sure that I searched all information regarding the study, I developed inclusion and exclusion criteria to enable me to search all the articles/materials I needed. Inclusive criteria among other things included all articles on the research subject written in English. Articles written in language other than English were excluded as obtaining a translator was not feasible physically and financially. Empirical studies and hence evidence was mainly from developed countries where integrative medicine is practised. The evidence was important as it ensures a high quality of argument about the study and thereby ensures the robustness and validity of overall study findings.

Using the databases subscribed to by the University of Hull, a literature search was based on subject guide. I identified five subjects: Health and Social Work, Sociology, Nursing and Midwifery & Applied Health, Medicine and Psychology. From the five subject guides, I was able to access the following databases - Cumulative Index to

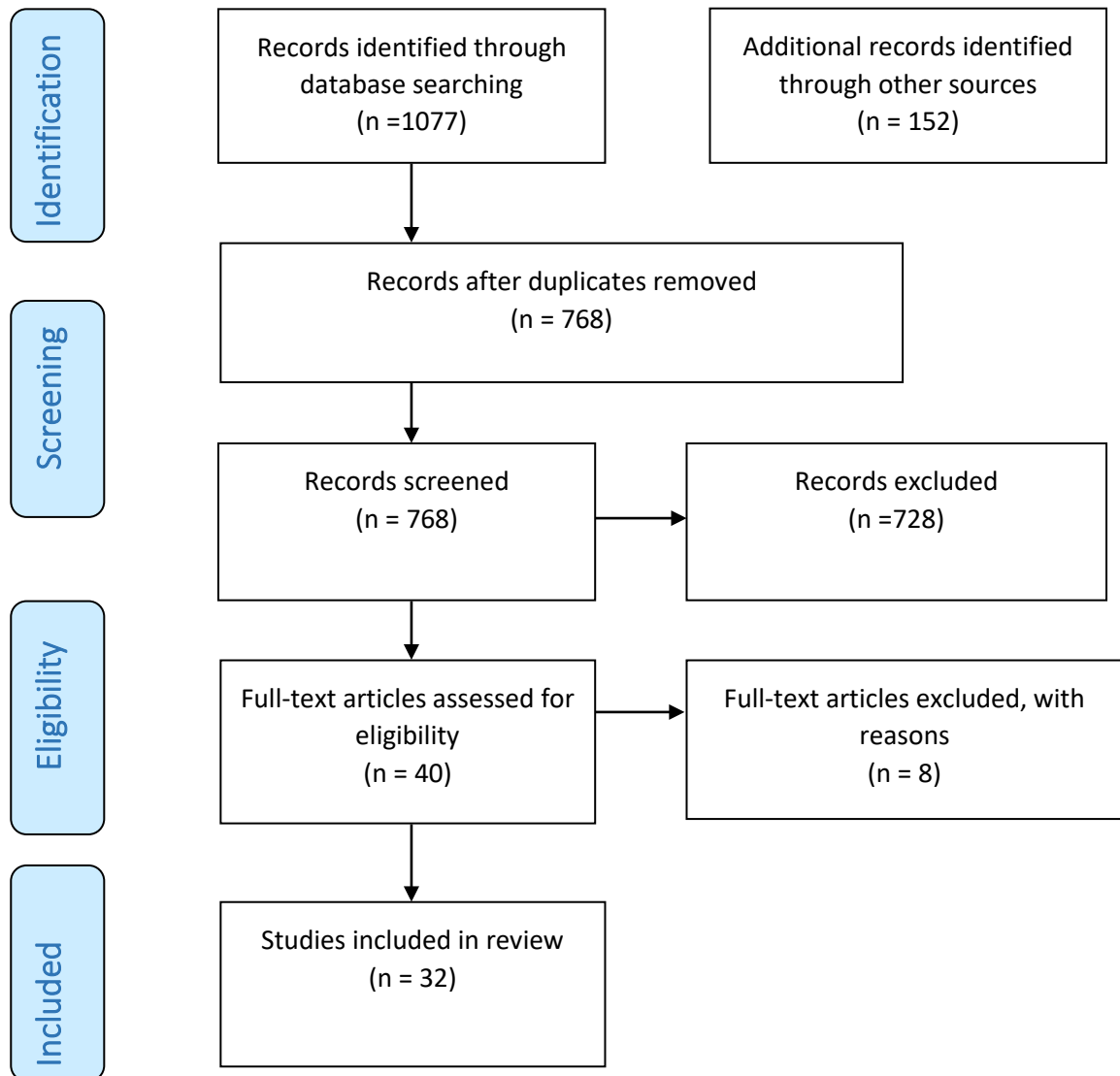
Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Scopus, Pub Med and PsycINFO. These databases were selected because they were related to traditional/complementary and alternative, biomedicine and integrative medicine.

The key words and Boolean logic applied to gather the literature include biomedicine OR contemporary medicine AND traditional medicine OR complementary medicine OR alternative medicine. Other key words include integration AND biomedicine AND traditional medicine; also, integrative medicine, traditional healers, sociology AND medicine, sociology AND complementary medicine. There was a limit of search in terms of years as the initial reading showed that integrative medicine was a new concept and development, and was unheard of before 1980. Consequently, to obtain the history of integrative medicine I only researched literature dated from the 1980s onwards.

2.1.1 The Process of Screening Records

By using the above five subject databases and other sources such as references from searched articles, I was able to retrieve 1077 articles. The number of articles retrieved from each source are Medline (55); PsycINFO (229); CINAHL (268); Scopus (252); and Pub Med (273). Apart from searching internet subject databases I also visited internet search engines, particularly Google Scholar. In addition, I also searched through other sources such as reference lists and grey literature, which included past PhD theses, reports and newspapers, and other media, which amounted to 152 records, making a gross total of 1229 articles. Articles to the tune of 461 were excluded as duplicates. The remaining articles (768) were screened by revisiting the titles and abstracts. 728 records were excluded as they were irrelevant to the area of study. Consequently, I read through the full text of 40 articles identified, out of which 32 articles qualified for a review. All the 40 included records/articles were published in peer reviewed journals. The majority of the articles, over 65 per cent, were on integrative medicine in developed countries, implying that they reported on collaboration of CAM and biomedical health practice, while 35 per cent of the articles were from the least developed countries, which reported mainly on collaboration between contemporary and traditional health practitioners. Figure one below summarizes the screening process.

Figure 1: Results of the Screening Process of the Systematic Literature Search



Source: Adopted from PRISMA 2009 flow diagram of the literature reviewing results

2.1.2 The Assessment of Study Quality

I applied a ten question Critical Appraisal Skills Programme (CASP), checklist to assess the quality of evidence for the qualitative studies (Balsheem et al., 2010); a twelve question Critical Appraisal Tool for Quantitative Studies developed by Oxford Centre for Evidence Based Management; and Evaluation Tool for Mixed Methods

Study Designs developed by School of Healthcare, University of Leeds. The checklists grade the quality of methodology as high, moderate and low quality, where 'high quality study' indicates that the study had few limitations due to the fact that all questions were answered 'yes' according to a relevant checklist; studies that scored 'moderate quality' had some limitations because some of the questions were answered 'no' or 'can't tell'; and studies that were categorized as 'low quality' had serious limitations as almost all questions were answered 'no' or 'can't tell'.

2.1.3 Depiction of the Included Studies

The review confirmed that all the 32 included studies had been published in peer reviewed journals. Close to half of them were qualitative studies (15). The remaining studies were quantitative (13) and mixed studies (4). As the field of integrative medicine is still growing, all the studies were published in the span of 25 years, between 1992 and 2013. Slightly over 50 per cent of the included studies (18) were conducted in the Western countries, Canada, USA, Australia, UK, Germany and Sweden. Fourteen (14) studies were conducted in Africa. Figure 2: Shows the summary of included articles and how they were evaluated.

Table 1: Included studies on Integration of Biomedicine and CAM/Traditional Medicine

| Date | Reference | Country | Design | Sample | Setting | Focus of the study | Findings | Limitation of study | Outcome |
|------|--|--------------|--------------|--|---|--|---|--|--|
| 1992 | Upvall MJ. | Swaziland | Qualitative | 65 nurses | Clinic setting | To examine how nurses from various health care settings perceive collaboration between indigenous and cosmopolitan health care systems | Religious affiliation and clinical setting may affect perceptions of collaboration. Nurses in mission and private rural practice perceive collaboration positively. Government nurses in rural settings indicate a need for national health policy to structure collaboration efforts, while government nurses in urban settings were ambivalent or expressed negative perceptions. | Doctors and traditional healers who are key in bringing about integration were not included in the study | Utilizing rural health motivators as culture brokers was suggested to enhance collaboration between indigenous and cosmopolitan health care systems. |
| 1999 | Burnett A, Baggaley R, Ndovi-Macmillan M, Sulwe J, Hang'Omba B, Bennett J. | Zambia | Mixed study | 38 traditional healers and 27 formal health workers. | Community and Hospital | To determined knowledge of traditional healers and formal health workers and practices in the field of HIV/AIDS and examine training needs and in preparation for planning joint training workshops. | Both traditional healers and formal health workers have significant and complementary roles in the field of HIV/AIDS in Zambia, but there is much debate concerning the relationship between them. | The findings did not represent the entire formal and traditional health sectors, due to small sample size and non-random sampling methods, | Willingness of traditional healers and formal health workers to collaborate in training and patient care in the field of HIV/AIDS. |
| 2001 | Peu D, Troskie R, Hattingh, P. | South Africa | Mixed study | 100 community health nurses | Clinic setting | To explore, identify and describe the attitude of community health nurses towards the integration of traditional healers into primary health care. | Respondents demonstrate positive attitudes towards working with traditional healers, especially in the provision of primary health care. | Traditional healers were excluded, hence, the opinions of important partners in the collaboration were missing. | Respect, recognition and sensitivity of traditional healers were emphasized |
| 2002 | Peltzer K, Khoza L. | South Africa | Quantitative | 84 registered professional nurses | Registered professional nurses at health centres and clinics. | To investigate the attitudes and knowledge of nurses towards traditional healing, faith healing and complementary therapies | Nurse's perceptions were positive toward ethnomedical therapy (traditional healing, faith healing and complementary medicine); this also included their integration into the primary health care. | Population was from only two regions; Lowveld and Northern regions. As populations differ from one region to another, the results were not representative. | Faith healing was more preferred than CAM Implications are relevant for policy. |

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|------|--|----------|--|--|--|---|--|--|---|
| 2002 | Addis G, Abebe D, Genebo T, Urga K. | Ethiopia | Quantitative | 14 modern practitioners and 80 traditional Healers | Shirka District of Arsi Zone, Ethiopia. | Evaluate perceptions and practices of modern and traditional health practitioners about traditional medicine in Shirka District of Arsi Zone, Ethiopia. | To substantially reduce the drawbacks and promote its positive elements, both of practitioners expressed willingness to collaborate among each other and asked for government support. | The study was specific to one district, which makes it impossible to generalize the findings to other locations outside of Shirka district. | Government commitment and coordination of various institutions was key for development of TM. |
| 2003 | Barret B, Marchand L, Jo Scheder, Bert Plane M, Maberry R, Appelbaum D, Rakel D, Rabago D. | USA | Qualitative exploratory & descriptive, | Random selection of 20 CAM practitioners and 17 users of both CAM and contemporary medicine. | University of Wisconsin Madison | Investigate the knowledge, attitudes, and practices of clients and providers of CAM therapies. | CAM is more holistic and empowering; psychologically reflects commonly held values, less financially, intuitive and institutionally accessible for those with health insurance and limited income, yet less legitimate. Biomedicine is more deductive. | The views of biomedical practitioners who are key in integration were not included in the study | Economic organizational and scientific differences and lack of understanding impedes integration. |
| 2004 | Barrett B, Lucille M, Scheder J, Appelbaum D, Plane B, Blustein J, Maberry R, Capperino C. | USA | Quantitative: cross-sectional reproductive health survey. | 32 CAM practitioners | Madison Wisconsin | To explore the beliefs and practices of complementary and alternative medicine (CAM) practitioners. | The CAM practitioners stressed the holistic, empowering, and person-centred nature of CAM. They described themselves as employing attentiveness, touch, and love to increase self-awareness and strengthen the healing process, usually in chronic illness, often with pain. | The study excluded biomedical practitioners | CAM practitioners want to work with modern practitioners in seeking patient centred, integrated health care system. |
| 2004 | Van Haselen R, Reiber U, Nickel I, Jakob A, Fisher P. | UK | Quantitative Survey | 149 GPs, 24 practice nurses, 32 other primary care team members. | Parkside Health catchment area Northwest London | To assess primary care health professionals' perceptions of need and ways to integrate CAM in primary care. | 83% of study sample had previously influenced referral for CAM treatments. Few were against any integration of CAM in mainstream primary care. 66% felt that CAM therapies should be provided by doctors or other health professionals trained in CAM | Results are based on 'urban' GP population. The attitudes of GPs in other areas may be different. | Interest in CAM among health professionals, and suggested referral. |
| 2005 | Moritz, S Kelly, M Vintila, R Quan, H Verhoef, M Rickhi, B | Canada | A cross-sectional Survey of a random sample of CAM practitioners | 457 CAM practitioners 85 GPs | Mailed a questionnaire at three time points in 2003. | To explore the issue of CAM integration from the provider viewpoint | The collaborative model was rated as the most acceptable by all CAM practitioners and GPs, across all therapies. | Poor response rate, especially that of the GPs. The study sampled only practitioners in Western Canada; the findings may not be generalizable. | Integrative healthcare system would facilitate such working relations. |

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|------|---|------------|--|---|-----------------------|---|--|---|---|
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| 2005 | Coulter I, Singh B, Riley D, Der Martirosi C. | New Mexico | Mixed method | 33 licensed providers: medical doctor, doctor of osteopathy, physician assistant, doctor of chiropractic, and doctor of oriental medicine). | Hospital setting | Determine the inter-referral patterns among physicians and CAM providers in an independent practice association integrated medical system. | Primary care physicians (PCPs) preferred limited number of referrals to CAM providers. Although chiropractic practitioners got more referrals, they were also more concentrated among selected providers than the oriental practitioners | The results are not representative of the entire formal and traditional health sectors. Clients' view was missing | Inter-referral patterns among the PCP and CAM providers was not balanced. |
| 2005 | Hollenberg D. | Canada | Qualitative: | 21 Participants 13 Biomedical practitioners 8 CAM practitioners | 2 Integrative clinics | Patterns of professional interaction among CAM and biomedical practitioners' in integrative health care settings | Dominant biomedical patterns of professional interaction continue to exist in the integration of biomedicine and CAM | The study recruited only two settings which may not be representative of all settings | Dominance of biomedical practice |
| 2006 | Kaboru B, Falkenberg T, Ndulo J, Muchimba M, Solo K, Faxelid E. | Zambia | Qualitative | Focus group with 21 community leaders and community members. | Community setting | To explore community perspectives on preconditions for useful collaboration between traditional and modern health workers in the management of STIs and HIV/AIDS. | Coordination at health system level, among providers and in the community is key to set up fruitful collaboration between modern and tradition health practitioners to strengthen available resources | Biomedical practitioners and traditional practitioner who are crucial in integration were not included in the study | Need for collaboration between modern and tradition health practitioners |
| 2006 | Kaboru B, Falkenberg T, Ndubani P, Höjer B, Vongo R, Brugha R, Faxelid E. | Zambia | Quantitative | 152 biomedical health practitioners (BHPs) and 144 traditional health practitioners (THPs) | Community setting | Explore biomedical and traditional practitioners' experiences of and attitudes towards collaboration and to identify obstacles and opportunities for them to collaborate regarding care for sexually transmitted infections and HIV/AIDS patients | Very low level of experience of collaboration, predominated by BHPs training THPs (mostly traditional birth attendants) on issues of safe delivery. Inter-sectoral contacts addressing STIs and HIV/AIDS care issues were less common | Biases for using THPs or BHPs as research assistants to interview their colleagues, where respondents did not want to be seen as deviant and tried to conform to commonly accepted views in their profession. | Missed opportunities though practitioners from both sectors seem willing to strengthen collaboration with each other. |
| 2007 | Hollenberg D. | Canada | Qualitative: Ethnographic observation and document | 38 in-depth interviews 15 biomedical, 8 CAM practitioners. 13 patients and 2 health | 3 Integrative clinics | How have private CAM therapies affected IHC settings combining CAM and biomedicine in a | Although CAM has therapeutic value, the unfunded nature of CAM therapies in public health systems, does not contribute to an equitable partnership | Private and Public health care insurance corporations were not included into the study | Future analyses of IHC need to take into account the complexities of health system context that |

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|------|--|----------|--|---|--|---|---|--|--|
| | | | analysis | care managers. | | publicly funded health care system? | when attempting to integrate biomedicine and CAM. | | continues to shape IHC. |
| 2007 | Broom A, Tovey P | UK | Qualitative: | Medical specialists 12 Specialist nurses - 6 CAM - 6 Radiologists 2 Pharmacists 4 Occupational therapist | Hospice and Hospital. | How integration is managed in each organisation, examining professional boundary disputes and inter-professional dynamics. | Significant differentiation in how differently positioned cancer clinicians view and utilise the biomedical hierarchy of evidence. | Patients who are the primary beneficiaries were not included | Biomedical practitioners were strategically controlled patients flow |
| 2007 | Sundberg T, Halpin J, Warenmark A, Falkenberg T. | Sweden | Quantitative: Cross-sectional study (Cohort) | 14 participants - 1 Senior researcher 1 Doctor student 1 Specialist general 8 Senior CT providers 2 Research assistant 1 CT assistant | Clinical setting of a primary care unit in Skarpnäck | Towards a model for integrative medicine in Swedish primary care | IM model that aimed for a patient-centred, interdisciplinary, non-hierarchical mix of conventional and complementary medical solutions to individual case management of patients with pain in the lower back and/or neck. | The CAM practitioners were not included into the study | The principles behind CAM may open up opportunities for integrative medicine. Biomedical practitioners should take a public health stance in their work, |
| 2007 | Maha N, Shaw A. | UK | Qualitative | Nine doctors; Eight were general practitioners (GPs) and one was a homeopathic doctor. | Bristol Area | To explore academic doctors' views of CAM and the rationales they provided for their views. | The doctors expressed a spectrum of views on CAM, falling into three broad groups: the 'enthusiasts', the 'sceptics' and the 'undecided'. | The findings of this study may over-emphasise the importance of scientific evidence to doctors. However, sample size was small; | Perceptions of the evidence base may remain a significant barrier to greater integration of CAM within the NHS. |
| 2007 | Kayombo E, Uiso F, Mbwambo Z, Mahunnah R, Moshi M, Mgonda Y. | Tanzania | Mixed | 192 traditional healers. | Community setting | To initiate sustainable collaboration with traditional healers in managing HIV/AIDS. | Influential people and leaders of traditional healers' association were willing to encourage other traditional healers to collaborate with the ITM in managing HIV/AIDS patients | Biomedical practitioners who are key in the integration initiative were not included in the study | Initiating collaboration is not as easy as it appears to be from the literature |
| 2008 | Frenkel M, Arye E, Carlson C, Sierpina V. | USA | Quantitative | 502 patients | Academic family medicine clinic | Explore perspectives on integrating CAM into the conventional primary care setting among patients treated at a large academic family medicine clinic in | 66% indicated use of CAM during the past year, 77% would be interested in using CAM during the next year, and 55.4% would like CAM therapies to be provided in their primary care clinic. | The study was specific to one primary care location, which is unlikely to generalize the findings to other locations outside southern Texas. | The use of CAM in primary care settings in southern Texas is widespread |

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|------|--|--------------|--------------|--|--|--|--|---|--|
| | | | | | | Texas. | | | |
| 2008 | Ben-Arye B, Frenkel M, Klein A, Scharf M. | Israel | Quantitative | 1150 patients, 333 Primary Care Physicians, (PCPs) and 241 CAM practitioners | Health Maintenance Organization | To explore the attitudes of patients toward complementary and alternative medicine (CAM) use, their family physicians' role regarding CAM, and models for CAM referral and treatment | Patients supported more CAM practitioners than PCPs; wished physician could refer them to CAM, have updated knowledge about CAM, and offer CAM treatment in the clinic. They preferred to receive CAM in a primary care setting rather than PCPs' prescribing CAM. | Patient participants were recruited from a single primary care clinic in Israel, making the findings difficult to generalize across other patients and locations; Low response rate of PCP. | Participants suggested physicians to refer patients to CAM rather than they provide CAM treatment. |
| 2008 | Pinkoane M, Greeff M, Koen M. | South Africa | Qualitative | 9 Policy makers | Gauteng, North West and Free State provinces | Explore perceptions and attitudes of policy-makers regarding incorporation process of TMP and modern health practices, and how to achieved it. | Results reflect that policy makers are in favour of incorporation process of the two health practices. | Biomedical practitioners and traditional healers who are instrumental to successful integration were excluded in the study | Incorporation needs to be undertaken by both CAM and biomedical practitioners |
| 2009 | Ben-Arye E, Karkabi K, Karkabi S, Keshet Y, Haddad M, Frenkel M. | Israel | Quantitative | 3840 patients attending seven primary care clinics. | Primary care clinics | To evaluate patient perspectives on CAM integration within primary care clinics. | Respondents in the two groups reported comparable overall CAM use during the previous year, but the Arab respondents reported more use of herbs and traditional medicine. Both respondents expected a physician to refer them to a CAM practitioner. | Sample selection bias as all the participants came from one HMO. Results may not represent the total population but rather the population of patients who actually came to the clinics. | Respondents in both groups supported a theoretical scenario of CAM integration into primary medical care |
| 2009 | Vaka S, Stewart M, Foliaki S, Tu'itahi M. | New Zealand | Qualitative | 8 Tongan Traditional Healers 8 clinical staff from the psychiatric unity. | Hospital and community | To explore the mental health-related beliefs and practices of Tongan Traditional Healers and Tongan workers in the Western-style mental health services in Tonga. | The Traditional Healers had negative view of the Western-style system, viewing it as inadequate to address mental health. Western trained staff accepted traditional healing, and incorporated Tongan culture into their practice, but not CAM healing practices. | Exclusion of psychiatric patients' views was a huge limitation of the study | There was distrust and animosity between the traditional and western approaches. |
| 2010 | Madiba S. | Botswana | Quantitative | 60 biomedicine health practitioners. | Hospitals and clinics | The aim of this study was to determine Biomedical Health Practitioners' views on | Majority of BHPs were in favour of collaboration with THP despite the low levels of awareness of the policy on | The findings were not representative as the sample was drawn from two primary hospitals and | BHPs insisted that collaboration with THPs in HIV/AIDS care should be on their terms. |

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|------|--|-----------|---------------------|---|--------------------------------|--|--|--|--|
| | | | | | | collaboration with THPs in Tutume sub district | collaboration and unwillingness to refer patients to THPs. | clinics in Tutume Sub-District | |
| 2010 | Wiese M, Oster C. | Australia | Qualitative | 19 participants' non-mainstream practitioners from five traditional systems of medicine. | Community setting | To understand how CAM practitioners are responding to the adoption of their traditional therapies by the mainstream health care system, and how modern practitioners perceive these therapies. | The fear of losing control over their occupational domain – CAM practice was identified as their main concern. | The study relied on non-mainstream practitioner. The findings cannot be generalized to the broader population. | 'Becoming accepted' as a legitimate health care provider in the mainstream health system. |
| 2010 | Ragunathan M, Tadesse W, Tujuba R. | Ethiopia | Quantitative | A total of 23 modern health professionals (MHPs) and 19 traditional health practitioners (THPs) | Traditional Medicine in Dembia | To perceive their attitude toward the integration and co-recognition of both systems of medicine. | Almost all the practitioners in both systems expressed their willingness to collaborate among each other to promote the positive elements of TM. | The results are not representative of the entire bio-medical and traditional practitioners' population due to the small sample size. | Improved relevant education is required for both sides. |
| 2011 | Abbott R, Hui K, Hays R, Mandel J, Goldstein M, Winegarden B, Glaser D, Brunton L. | USA | Quantitative Survey | 68,000 US medical Students | US medical schools | This study was conducted to develop and evaluate an instrument and assess medical students' attitudes toward CAM and integrative medicine (CAIM). | Students responded more positively to the principles of CAIM than to CAIM treatment. | The key stakeholders, modern and CAM practitioners were excluded | A CAIM-medical education and research would facilitate integration of CAIM into medical curricula. |
| 2011 | Awodele O, Agbaje E, Ogunkeye F, Kolapo A, Awodele D. | Nigeria | Quantitative Survey | 170 Traditional Medicine Practitioners (TMPs). | Awolowo market, Odi-Olowo | To determine the knowledge of TMPs about their practices, and their disposition towards ensuring safety measures in their practices towards subsequent integration into NHCS. | A few (18%) believed herbal preparations have adverse effects. The majority (54%) wanted to collaborate with orthodox medical practitioners. 76% believed the levels of education may have roles to play in their practices; 59% intended to improve their educational status. | The sample was from a single source | Traditional and Western medicines are valid options, yet each has its limitations and neither has all the treatment answers. |
| 2012 | Keshet Y, Ben-Arye B, Schiff E. | Israel | Qualitative | 3 Medical directors, 3 surgeons, 5 senior nurses, 4 CAM | General surgery department | To investigate what integration and 'holism' mean to the diverse professional groups and | Most of nurses, surgeons and directors and some patients believed that CAM treatments were of value in addressing the | This study discusses only one facet of integrative medicine. | Patient care tends to become more comprehensive when |

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|------|------------------------------|-----------|------------------------------------|---|---|--|---|---|--|
| | | | | practitioners and 15 hospitalized patients. | | whether treatment becomes more holistic when CAM is integrated. | psychological needs of patients within this predominantly somatic-oriented department. | | CAM is integrated. |
| 2013 | Asante E, Avornyo R. | Ghana | Quantitative | 33 Scientific Medical Practitioners practising in the Central Region of Ghana | Central Region Hospital | The attitudes and perceptions of SMPs towards TM in Ghana and proposed measures for full integration of TM into Ghana's healthcare system. | SMPs wanted full integration of TM, however they were reluctant to accept them as equal partners since they perceived the practice as inferior to their own. | The findings of this study may over-emphasise the importance of scientific evidence to medical practitioners. | Regular dialogue among practitioners of the two systems |
| 2013 | Shuval Judith Mizrahi Nissim | Israel | Qualitative | 4 Ambulatory clinics 14 practitioners; 9 physicians, 5 CAM; 4 hospitals 15 practitioners 5 CAM 3 Biomedical 7 CAM trained in Medicine | 4 Ambulatory clinics 4 Hospitals | Changing Boundaries: Modes of Coexistence of Alternative and Biomedicine | The boundaries of the epistemological core of biomedicine are not necessarily congruent with the organizational lines of demarcation | Patients who are the primary beneficiaries were not included | CAM practitioners were not happy with the cooperation |
| 2013 | Willis K, Rayner J. | Australia | Qualitative, interpretive approach | 23 Medically registered doctors | Two states of Australia (Victoria and Tasmania) | Explored how they drew on CAM philosophical approaches to health and healing and how such approaches shaped their approach to practice | Integrative medical practitioners draw on CAM to understand causes of health problems, approaches to healing, and the role of the individual in healing. The key tenets of the philosophical approach identified by doctors were holism, vitalism, and empowerment. | The study relied on doctors only. The findings cannot be generalized to the broader population. | Doctors see their practice as distinctly different from CAM, view biomedicine as too limited to in its approach. |

N.B: The information in this table were recorded as direct quotations from the abstracts of the reviewed articles

2.1.4 The Strengths and Weaknesses of the Included Articles/ Studies

As reported in the previous section, there are 32 articles/studies on integrative medicine, most of which were carried out in developed countries. Hence, they reported on collaboration between the practitioners of biomedical practice and CAM, a term preferred to describe health practices in the West that are not biomedically orientated. Few studies have been carried out in least developed countries targeting the cooperation between traditional healers and biomedical health practitioners.

The strength of the included studies especially from western countries is that they have highlighted the accounts of both traditional/CAM and biomedical practitioners regarding the current integrative initiatives. What became clear from all these studies is that practitioners from both traditional/CAM and biomedical practices seem to accept the collaboration between them and integrative initiatives already in place. However, deeper analysis of these studies has revealed that each party has joined the ‘integrative camp’ with different motives. Practitioners in each practice are working hard to achieve certain objectives which are not quite obvious to the other party. In other words, each party is taking advantage of the other party to advance its agenda. For example, traditional/CAM practitioners perceived that working with modern practitioners or in modern facilities increased their acceptability (Hsu, 2006). A large part of this chapter will discuss these overt, sometimes covert, strategies used by each party to gain acceptance, legitimacy, popularity and power over another party.

The limitations of the reviewed studies were that most of them examined the attitudes and perceptions of either traditional CAM practitioners or modern practitioners, and how each of them were faring and coping in the integrative setup. For example, Wiese et al., (2010) examined the views of alternative practitioners regarding the integrative setup in Australia. Adams (2003) included in his study General Practitioners in Edinburgh and Glasgow and studied their views on integration. Asante et al., 2013 reported on the biomedical practitioners’ accounts on integration in Ghana. Few studies examined the perceptions of both CAM and biomedical practitioners on integrative medicine (Baer et al. 2008 and Coulter 2004). In addition, very few studies looked beyond CAM and biomedical practitioners; for example, Hollenberg et al., (2010) included in their study CAM, biomedical practitioners and patients. In view of the designs inherent from evaluating the perceptions, attitudes and practice of only one or two forms of health practice, the studies have not taken into considerations the accounts

of other critical stakeholders who could contribute to addressing the missing link between an ideal and a flawed collaborative practice.

The huge difference between the studies carried in Africa and those carried in western countries is that the studies in western countries examined the integrative clinics that were already in place. Thus, the actual and practical opportunities and challenges encountered in a day-to-day life of an integrative clinic were presented; whereas in Africa the studies were assessing the attitude, perceptions and views about the possibilities of initiating collaboration between traditional and biomedical practice: therefore, the studies were more theoretical. The findings reflected the views inherent in both practices. Traditional healers' opinions were a reflection of their perceived dormant practice and how they are perceived by both contemporary practitioners and local society. Biomedical practitioners on the other hand had views that showed their supremacy over traditional practice. Hence such studies are not likely to change the views of either side. What is missing in these studies is the contribution of other key stakeholders besides the traditional and modern practitioners, who could inform them the challenges that prevent them from collaborating, and point out the opportunities which could enhance their chances of working together.

Given the weakness inherent in these studies, the current study incorporated in its sample not only traditional (10) and biomedical (12) practitioners, but also health policy-makers (2) who are responsible for filtering the policy agendas from health stakeholders, formulating, implementing and reviewing health policies. The study also included religious leaders (3), as they are key health stakeholders in formulating health policy but more importantly they are a stumbling block for the acceptance of traditional health practice particularly in Africa, citing it as Satanic and a work of darkness.

The sample for this study also included researchers (3) from two institutions that have been mandated to research traditional medicine in Tanzania. These are The Institute of Traditional Medicine (ITM) under the Muhimbili University of Health and Allied Sciences, which has been researching traditional medicine in Tanzania for the last 40 years; and the National Institute of Medical Research, which apart from researching on medical conditions, is charged with responsibility to research traditional medicine. Included in the study also were participants with multiple roles (5); among them was a medical doctor, traditional healer and policy-maker; a medical doctor and traditional healer; a medical doctor and policy-maker; a researcher and policy-maker; and a traditional healer and University professor. Finally, at one time or another in their

lifetimes all participants were presumed to be patients or clients attending to either practice. Hence, in this study, apart from representing their respective groups they doubled as clients of both practices. The relevance of including these seven categories of key participants is to obtain a wide range of views beyond the scope of the included studies by digging deeper to identify opportunities and challenges for the contemporary and traditional health practices to collaborate under the National Health System. This is the contribution of this study to the body of knowledge.

2.2 The Organization of this Chapter

Within this chapter, I have reviewed the literature on the opportunities and challenges for the traditional and contemporary health practices to cooperate under the National Health System, taking Tanzania as a case in point. The review is systematically organized into three major domains of knowledge.

The first domain is related to the sociology of T/CAM). The domain covers the definition of traditional/CAM medicine, its use, efficacy, safety and quality. It also covers the health-seeking behaviour of both urban and rural populations globally. Other issues included in the domain are control, regulation and ethical considerations with regard to the use of traditional/CAM medicine, intellectual property of the same and the policy implications of traditional medicine. Throughout this thesis the term ‘traditional health practice’ will be synonymous with ‘traditional medicine’ including ‘traditional practitioners’ or ‘traditional healers’. The term ‘traditional medicine’ will be used as a short form of traditional, complementary and alternative Medicine.

The second domain describes the sociological perspectives on modern medicine, also known as ‘contemporary medicine’. Throughout the thesis the term biomedical health practice will be equated to National Health Systems (WHO, 2012), as the mainstream of health systems worldwide mainly consists of biomedical health practice. The domain describes the dominance and controlling power of modern medicine and its practitioners over other health practices, particularly over T/CAM. The domain describes the perspectives of functionalism, political economy and social constructionism theories and how they are related to the doctor-patient relationship.

Integrative medicine is a third domain that examines the perspectives of anti-colonial and post-colonial views (Hollenberg, 2010) as well as a Critical Social Science

Approach to integrative medicine (Adams et al., 2009). Finally, the challenges inherent in integrative medical settings worldwide from included studies will be highlighted.

2.3 Definitions and Naming of Health Practice

As described in the background chapter, the World Health Organization (WHO) define traditional medicine as “Including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and /mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness” (WHO, 2005:2): whereas CAM is defined as “A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (Shuval et al., 2004:676). Other terms that describe T/CAM are natural, holistic and unconventional (Bombardieri et al., 2000).

Many scholars are not in favour of categorizing medicine into modern or traditional medicine because it is assumed that medicine, be it modern or otherwise, is expected to go through a series of phases of being traditional before being modern (Kaboru et al., 2006, Kayombo et al., 2007, Green, 2006, Geest, 1997). In reality, what makes a difference between them is that one type of medicine, in this case biomedicine, has passed the test of time set by reductionist-scientific thinking, and has been acknowledged globally as the standard medicine while other types of medicines are still struggling to gain acceptability within their geographical and cultural localities. The naming of other modes of treatment was a function of the hegemonic influence of biomedicine and Eurocentric thinking that promoted biomedicine (Harding, 1996). The global acceptance of biomedicine was the beginning of its hegemonic characteristics, which control and dictate the naming and status of other therapies. For example, the name ‘traditional medicine’ refers to indigenous health systems such as Indian Ayurveda, traditional Chinese medicine, Arabic Unani medicine and African traditional medicine (Hollenberg, 2005).

The hegemonic nature and self-claimed superiority of biomedical practice categorizes practices which were not modern as ‘others’ (Zhang, 2000). With time and depending on the level of acceptance by contemporary health practice, different therapies were named differently. For example, in countries where modern medicine was the dominant health care system and the national health system has not incorporated traditional medicine, it was named as complementary, alternative or non-conventional medicine

(Shuval et al., 2004). However, within the ‘others’ there is still a sense of segregation and the hegemonic power of modern medicine over them. To illustrate this, the term ‘traditional medicine’ is used to denote traditional therapies in South America, Africa, Asia and Western Pacific. In contrast, the term CAM is used when referring to indigenous therapies in Australia, New Zealand, Europe and North America. The former continents comprise developing countries whereas the latter contain developed countries.

Naming and categorizing all ‘other’ therapies as traditional medicine, and claiming a single definition that encompasses all traditional therapies globally is not realistic (Abdulahi, 2011). Influenced by history, philosophy and personal attitude, people in Africa, the Middle East (Arabia), Asia, Central and South America and Oceania have different cultures and have developed a variety of indigenous traditional health systems throughout their existence. As such the practices may differ tremendously from one location to another and from one continent to another. In addition, their philosophy and application also vary enormously when compared to contemporary medical practice (Patwardhan, 2005). While some forms of traditional medicine may be put under regulation, taught overtly, practised widely and in a systematic way, and enjoying the experience of many years (Ayuveda and chiropractic are good examples), other forms are highly secretive, localized and supernatural, with their knowledge and practice being passed orally from one generation to another, African traditional medicine is an example of the latter (Tsey, 1997).

In addition to naming ‘other’ practices, the WHO (2008) has classified four approaches or health systems by which the relationship between the traditional health practice and the national health system can be described (WHO, 2008). First, is a tolerant health system where the biomedical system is the only recognized medical system, but the law tolerates traditional/complementary medicine and it is informally allowed to practise. Second, is a parallel system where the mainstream health system recognizes both modern and traditional medicines, which work as distinct elements of the mainstream health system. India is a good example of a parallel health care system. The third approach is an inclusive system, which recognizes traditional medicine/complementary medicine, but regulation of T/CAM, delivery of health services and training are not part of the inclusion. Developing countries that operate an inclusive system include Equatorial Guinea, Nigeria and Mali. In developed countries, Canada and the United Kingdom have not incorporated T/CAM training, but issues of quality and safety of

traditional/CAM are guaranteed. The last approach is an integrative system, where T/CAM is part and parcel of the mainstream health system and is given full official recognition: for example, the national drug policy acknowledges traditional medicine and T/CAM medicines are registered and regulated; health insurance covers traditional treatments; research in traditional medicine is undertaken; and education in traditional medicine is available. There are only four countries worldwide that operate an integrative health system; these are the Republic of Korea, China, Viet Nam and the Democratic People's Republic of Korea (WHO, 2008). This WHO classification of approaches of health systems is another manifestation of biomedical hegemony.

The next section discusses the Sociology of Traditional Complementary and Alternative Medicine.

2.4 The Sociology of Traditional, Complementary and Alternative Health Practice

Traditional medicine was the dominant health practice in Africa before the arrival of colonizers who introduced biomedicine (Asante et al., 2013); and it is still in use by the majority of people in the continent and throughout the world as it was the major first point of contact for health care service provision before biomedicine was introduced (WHO, 2012). Historically traditional medicine enjoyed supremacy until biomedicine was introduced into Africa by the Western countries in the 18th century. Since then traditional medicine has been an area of dispute and controversy in the modern scientific world (Wiese et al., 2010). The biomedical health practice which is a product of modern science is alleged to be superior and hegemonic while traditional medicine is inferior, subordinate and backward (Kaboru et al., 2006). Consequently, the practice of 'other' forms of medicine, including African traditional health practice, became a downgraded domain of health practices. Since the colonization of Africa, its traditional health practice has not been given serious consideration, even in Africa (Asante et al., 2013).

2.4.1 Traditional Health Practice: Regaining its Popularity and Legitimacy *a) A Global View*

T/CAM therapies have gained popularity in the last three decades, and so their use has increased (Burnett et al., 2006, Tovey, 2007). The major factor for increased use, popularity and legitimacy of T/CAM stems from a change of health-seeking behaviour

among the populations in developed countries of North America, Europe and Australia (Coulter, 2004). There has been a shift of mentality and change of health-seeking behaviour among users of biomedicine in developed countries from embracing biomedicine to preferring traditional and complementary medicine for various reasons. First, people are dissatisfied and disappointed with the outcome of modern therapies (Shuval et al., 2004). For example, clients are reluctant to take large numbers of modern drugs, which they perceive to bear unwanted side effects. Secondly, some clients were displeased with the hegemonic influence of modern practitioners over their clients pointing out that there have been unequal power relations between modern health practitioners and their clients. Instead, people are in favour of a holistic approach where they are felt to be part of the treatment process (Baer et al., 2008). The increased effects of globalization saw proliferation in the use of T/CAM in developed countries, which has had a ripple effect on developing countries where people who had been brain-washed by the colonial mentality of despising T/CAM are now turning to traditional medicine. Meanwhile the same medicine continues to be the dominant approach to seeking health for the majority of the population (Green, 2006).

There are different driving forces for people seeking help from a traditional healer or using traditional medicine. The availability and accessibility of T/CAM are some of the factors for the use of traditional medicines. Some use traditional medicine because of its affordability, efficacy, safety or quality, while some use traditional medicine because of a combination of these factors (Hollenberg et al., 2010). However, there are those in developing countries who seek traditional medicine because it is the only accessible, available and affordable treatment. They use the remedies not necessarily because they perceive them to be effective but because they live in rural and hard-to-reach areas, and do not have any alternative (Gellejah et al., 2010). However, there are those who seek dual treatment and move from modern to traditional medicine and vice versa: their motives are different from those of the former group. They may decide to abandon one form of therapy after being dissatisfied with one practice in favour of another therapy. Some use the second practice to confirm or reaffirm the diagnosis made by the first practice or simply to affirm that all options have been sought, particularly when trying to find a cause or treatment of a serious disease, or when dealing with a life-threatening condition (Kayombo et al., 2006).

On the other hand, people especially in poor countries make use of traditional medicine because they cannot afford modern medicine and the inaccessibility of modern health

facilities: sometimes the facilities are not available at all especially in rural areas (Mahunnah et al., 2012). As for the quality of modern medicine, there has been evidence of increased resistance to antibiotics and anti-malarial treatments in some bacteria species and malaria parasites respectively (Patwardhan, 2005). In addition, there are claims over unwanted effects of modern drugs and there is a general belief that traditional medicines are safe (Saad et al., 2006). Also, the public has shown a tendency to prefer the more humanistic approach to managing diseases which is practised more by traditional/CAM practitioners than modern practitioners: this preference has led the majority of people in both less and most developed countries to favour traditional medicine/CAM (Broom and Tovey, 2007). Traditional health care on the other hand, is readily available and affordable locally, hence playing a vital role in national health systems worldwide. While modern medicine demonstrates evidence-based practice, the clients' preferences are pointing in an opposite direction where scientific knowledge is not a critical factor for decision-making (Patwardhan, 2005).

As a consequence of the increased use of traditional/CAM worldwide, there are three major developments. First, there is an economic gain for those practising traditional/CAM (Baer et al., 2008). For example, Australians and Americans pay from their pockets for complementary and alternative health services. While Australians spend more money on complementary/alternative medicine than they spend on all prescription drugs, Americans spend more money from their own pockets on buying CAM than they spend on all hospitalizations (Tindle et al., 2005). At the same time complementary therapies are now covered by major American health insurers: and a similar trend is observed in Britain (Bodeker, 2002). To demonstrate the increased use of TM/CAM in developed countries, Eisenberg et al. (1998) researched in the US to determine the patterns, cost and prevalence of CAM use such as chiropractic and acupuncture. The study reported about 34 per cent of the US population had used at least one such therapy in the span of one year and about 30 per cent of these had visited a traditional practitioner on average 19 times in the previous 12 months, paying \$27.60 per visit on average.

In addition, the study showed that the use of traditional treatments differed according to socio-demographic categories, for example non- black people with higher income and more education aged 25 to 49 were reported to have the highest use of traditional therapies. Those who sought traditional therapies had chronic conditions as opposed to acute illnesses. The study also showed that 83 per cent of those who sought traditional

medicine for acute illness also attended a modern clinic. However, about 72 per-cent did not disclose to the biomedical doctor that they were using other therapies. Estimation of visits to traditional care use in the US population suggests that in 1990 American people visited traditional practitioners 425 million times in contrast to 388 million visits made to US primary care providers. In the same year expenditure on traditional therapy in the US was estimated to the tune of \$13.8 billion out of which \$10.4 billion (three quarters) came from patients' own pockets while out-of-pocket money spent annually for all hospitalization stood at \$12.8 billion (Eisenberg et al 1998). Several other researchers (Broom et al., 2007, Hollenberg, 2006, and Adams et al., 2009) have shown that close to 50 per cent of the people in developed countries now use traditional/complementary medicine.

Secondly, traditional medicine is now becoming a good source of foreign funds for the originating countries: exporting medicine supports their economies. For example, China annually earns over \$600 million from the export of traditional medicine. Thirdly, following the high preference for traditional CAM therapies and the enormous amount of money they generate, biomedical practice is being forced to integrate some CAM practices or train some of the modern practitioners on some form of CAM therapies in order that the physicians can offer specialized CAM services. This move is a strategy for biomedical practice to maintain its dominance over CAM practices but more important for competing on economic and financial gains (Shuval et al., 2008).

Ab) A Regional View (Africa)

One of the reasons for extensive use of traditional medicine in Africa apart from affordability, preference and accessibility, is the availability of numerous medicinal plants and traditional healers. For the majority of people in Africa, traditional healers are the source of information, they offer counselling, and therapy to the sick and their families in intimate manner based on their understanding of the local environment of their clients (Gurib-Fakim, 2006; Gurib-Fakim et. al., 2013). As Africa lies within the tropics and subtropical region, it has a climate which favours vast biodiversity and consequently has enormous resources. Africa leads the world for its number of plant species with potential for development. It is estimated that Africa has 216 million hectares of forest in which there are between 40,000 and 45,000 species of plant, out of which 5,000 species have already been identified as medically useful and are being used as medicines (Mahomoodally, 2013).

But notwithstanding the availability of medicinal plants, the pressing challenge is the increased anthropogenic activity, which puts danger to the existence of these plants and also the loss of traditional knowledge that goes untapped from knowledgeable traditional healers. Africa has the highest rates of deforestation in the world, with the rate of 1 per cent of deforestation per year (Gurib-Fakim et al., 2013). Intriguingly, Africa is known to have the highest rate of endemism, with Madagascar having an outstanding endemism by 82 per cent. As for biodiversity, Africa contributes in the region of 25 per cent of the world trade. Nevertheless, the inconsistency is that despite the diversity and huge potential, the continent has only few medicines that are commercialized worldwide (Mahomoodally, 2013).

Since ancient times, traditional medicine has been and still is the dominant health practice in Africa (Abdullahi, 2011). For example, in Ethiopia, about 90 per cent of people visit a traditional healer as their first point of contact for seeking primary health care as is the case for 80 per cent of people in Tanzania, 70 per cent in Rwanda, Benin and India (WHO, 2012). The density/ratio of physician (contemporary medicine) per 100,000 individuals in 2004 in different countries was: Uganda 4:70, Ethiopia 2:85, China 64:24 and India 51:25, with a huge difference for the US, which stands at 548:91 (WHO, 2005). Against this background, it is observed that the ratio of traditional healers in Tanzania, Uganda and Zambia is the region of 400 to 500 per 100,000 individuals which is less than but close to the ratio of biomedical doctors available to the US population. At the same time figures show that the proportion of traditional healers in sub-Saharan Africa is 100 times that of contemporary medical doctors (WHO, 2005).

2.4.2 Safety and Efficacy of Traditional Medicine vs Evidence-Based Medicine

In line with the increased use of herbal remedies as described above, there are concerns regarding the efficacy, safety and quality of traditional medicine. Central to the debate about the quality and safety of traditional healthcare are issues of the cultural, technical, and philosophical aspects of traditional medicine (Waldram, 2000). Little is known about medicinal plants and their potential to cause unwanted side effects and toxicity because herbal medicines are not subjected to rigorous testing as is the case with biomedicine (Barrett, 2003). In addition, it is assumed that traditional medicines are safe because they are natural and have not been processed. Consequently, most

traditional medicines lack government regulatory control because the medicinal plants are harvested by individual healers and are dispensed without prior certification or regulation of their harvesting, purity and concentration. As is documented (Waldram et al., 2000), the active ingredients of a traditional medicine depend on a number of things, such as the timing of harvest, the maturity of the plant concerned, the amount of moisture and soil acidity. Other factors include the location where the plant is being harvested (whether it is mountainous or in a valley), the soil chemistry (whether it is volcanic, or has been altered by adulterants and contaminants). Saad et al., (2006) revealed that traditional medicines in Arabic countries were found to be contaminated by microorganisms that may cause illness. In addition, lead poisoning in children was a common occurrence due to heavy contamination of Ayurvedic preparations with heavy metals such as mercury and arsenic (Anderson, 1992).

Thus, adulteration, interaction of drugs and lack of knowledge of the plant concerned could lead to unwanted effects which can sometimes be fatal (Carson et al., 1995). It is therefore recommended that the quality assurance of traditional medicine must be assured throughout sourcing, harvesting, processing, storage and transporting (Fugh, 2000). All these factors have an impact on the active ingredients of the medicinal plants, as medicines harvested within the same area may have different concentrations of active ingredients and therefore the curative rate could be volatile, unstable and often unknown (Nyika, 2006). Given the possibility of toxic contaminants pregnant women and children may be more vulnerable to the effects of toxicity than adults. The contamination of traditional medicine may be associated with effects in liver, kidney skin, cardiovascular system, and they may also be carcinogenic (Waldram, 2000).

As regards the efficacy of traditional medicine, the terms ‘curing’ and ‘healing’ which denote the notion of efficacy of remedies is a debatable and controversial area (Saad et al., 2008), some argue that the demarcation between the two terms is blurred. However, there is a general consensus that curing is related to a biological process that aims at repairing a malfunctioning organ, while healing is related to the ‘wider psychosocial process of repairing the social, spiritual and affective dimension of illness’ (Waldram, 2000:604). Curing and healing describe a process of recovery from sickness. The concepts of illness and disease are also criticized as they are inherent in biomedical practice, in that symptoms are related to illness and signs are linked to disease. While the distinctions between illness and disease, and healing and curing remain controversy, debatable, and confusing there is a general feeling that modern medicine is more

associated with curing parts of the body (organs), and healing is a function of traditional medicine (approaching a patient holistically as a whole person). However, it is not a hard and fast rule that only traditional medicine heals, and biomedicine cures a disease; both can cure and heal a condition.

As regards evidence of efficacy, the clinical efficacy of traditional medicine has been documented, for example the active role of acupuncture in taking care of nausea and pain is acknowledged globally (Kim, 2006). *Artemisia annua* is an herbal remedy known for treating malaria (Hsu, 2008). *St John's wort* is an herb used for relieving depression (Waldram, 2000). Many medicinal plants have been identified as retaining anti-inflammatory, anti-cancer, antipyretic and vasodilatory properties (Saad et al., 2006). However, only a few of them have really undergone thorough randomized-controlled studies to investigate their pharmacological effects. There are mixed responses on a few traditional medicines that have undergone thorough randomized controlled studies. The WHO (2005) stresses that traditional medicine needs different methods of testing its efficacy and that randomized clinical trials have a minimal role to play.

Research based on evidence has become “a new paradigm” in clinical medicine through which all drugs need to be tested to determine their efficacy (Broom et al., 2000). Such high standards subject traditional medicine to a similar high degree of rigour to that required of modern medicine. As pointed out earlier the cultural, philosophical and practical aspects of traditional therapy render research based on evidence less important in evaluating traditional medicine. For example, Traditional Chinese Medicine (TCM) and herbal medicine are the most frequently used of all CAM therapies, with TCM being used by 60 to 90 per cent of clients with arthritis (Elvin, 2001). However, TCM has its own philosophy: it is necessary to understand its theoretical system before one can test it (Hsu, 2009). Central to TCM philosophy are the solid organs that function as the store of ‘qi’ (energy) and the patent or hollow organs are the reservoirs that help to control the circulation of ‘qi’ and blood which act as dynamic substances of life. The balance of all these structures ensures good health, while the blockage of the flow of vital substances from any of the organs signifies a health problem.

Based on this philosophy TCM does not treat a disease; rather it treats a person by ensuring that all the structures are in harmony with each other and are all functioning well (Hsu, 2009). In this respect measuring the changes in ‘qi’ – a crucial subject in traditional Chinese medicine – or to determine an individual’s constitution using the

concept of *Prakriti* in the Ayurvedic system, the role of science is invalid. Consequently, the conservative standards of evidence used in modern medicine cannot be relevant in their totality to traditional health systems. Coupled with this fact, the historical marginalization of traditional medicine has led to the limited allocation of research funding for evaluating traditional medicine. Thus, limited randomized control trials on traditional medicine have led to assertions that the evidence in support of its efficacy is feeble. But, as Patwardhan (2005) noted, ‘absence of evidence is not evidence of absence (2005:54)’. The opponents of traditional medicine have used quality control failure as a weapon to limit the use of traditional medicine. While effective quality control is certainly needed for traditional medicine, quality control failure should not in any way constitute a bias against traditional medicine by obscuring public access to traditional medicinal preparations.

In a similar vein the opponents of traditional medicine have questioned the quality of traditional medicine by directing the blame to traditional healers for using untested medicines, instead of accusing policy-makers and other government organs which are responsible for regulating medicines and ensuring the quality of traditional medicine. The answers to questions such as ‘who is responsible for quality control of T/CAM?’ ‘Who is answerable for the safety of indigenous medicine and its consumers?’ and ‘Who is accountable for laying down regulatory mechanisms for T/CAM?’ should be offered by the state governments and stakeholders of the national health policy. While most of the population makes use of traditional medicine, the practice has been marginalized to such an extent that, of the national health budget in African countries, it receives less than 1% (WHO, 2005). The largest portion has been directed towards researching biomedicine, neglecting traditional medicine. More effort and focus are needed in research for traditional medicine to ensure the availability of information on its quality, efficacy and safety. Unless the efficacy of traditional medicine has been disproved one cannot refute the importance of herbal medicinal preparations. The issue of safety should be two-way: raising the evaluation standards for traditional medicine but also realizing that applying the ordinary standards on biomedicine is not being fair to the former. The safety and side effects of all medicines regardless of the type of practice should be emphasized across all practices. For example, in the USA a study has revealed that 51% of FDA-approved drugs have serious adverse effects that had not been identified before their approval. The study estimated that 1.5 million clients were so seriously affected annually by drugs prescribed by doctors that they required

hospital admission. The problem was identified once the client was hospitalized. Severe and lethal drug side effects in the US hospitals is the fourth to sixth leading cause of death in the US (Tindle et al., 2005).

It has been suggested that in areas where randomized clinical trials are of less value in evaluating traditional medicine, epidemiological observational studies should be employed for many reasons. First, observational epidemiological studies are related to both quantitative epidemiological methods and quantitative sociological methods whereby data is assembled through observing the participants. Secondly, the assumption is that natural scientific testing in traditional medicine is already underway as providers are prescribing and clients are using the medicines, thus allowing the collection of the first line of findings without the requirement of obtaining ethical clearance (WHO, 2005). Thirdly as suggested by WHO (2000), the validity of randomized clinical trials in traditional medicine would be questioned if they were done without initial foundational studies such as observational epidemiological studies.

2.4.3 Regulation of Traditional Health Practice, Supporting Indigenous Knowledge and Ethical Considerations

There have been calls to regulate the quality standards and safety of traditional medicine all over the world (WHO, 2012). Recently, various national agencies and authorities across the world have given fresh impetus to prompting, regulating and standardizing the quality control of herbal medicine. Their mandates include registering, regulating and controlling traditional practitioners. The policy, legal and regulatory mechanisms regarding traditional medicine differ from one country to another. While in some countries herbal medicines are well established, in others, where efficacy claims are not allowed they are regarded as supplements (Waldram, 2000). Some countries make a distinction between formally approved medicines and authoritatively recognized medicine; the former require technical assessment of the quality, efficacy and safety before they are allowed into the market, while the latter products can be marketed without technical assessment by the authority (Zhang, 2000). Intriguingly, the sellers and the buyers of herbal medicine have a unique behaviour towards regulation. The label may not indicate efficacy of the medicine, but sellers use word of mouth to market and promote the efficacy of a particular drug. As for buyers, with or without a label that claims the efficacy of a medicine, they will buy the product once they are satisfied with, and trust the source of that medicine.

In traditional medicine drug discovery follows a reverse pharmacological framework (Mizrachi et al., 2005). Whereas in contemporary medicine research, clinical experiences, observation and available data are the last things to be done, in traditional medicine they are the starting point because traditional medicine has been used for many years, hence its clinical evidence comes as a given assumption. Nevertheless, systematic trials are necessary to prove the traditional healers' claims and to create more objectivity (Adams et al., 2009). It is important to make sure that traditional medical manufacture/preparations are in line with global standards and with current good manufacturing criteria for herbal products. The need for new regulations for traditional medicine has been emphasized: the decision taken by WHO to set guidelines to test traditional medicine differently from the ones for biomedicine have shed some light to positive steps towards development of traditional medicine (WHO, 2006).

As regards supporting indigenous knowledge, recently there have been increased partnership and support for the preserving and exchange of Indigenous Traditional Knowledge within countries, between countries and between Africa and South Asia (Bordeker, 2001). The World Bank has been supporting several community-to-community learning exchanges in different projects. Among the projects the bank has supported are national workshops to develop policies and strategies for utilizing Indigenous knowledge. In Tanzania for example, the support led to a partnership of NGOs, government institutions and academia that support traditional healers and recognize their knowledge as an important area for research (Kayombo et al., 2007). In Uganda, the support has led to a national strategy that makes use of indigenous knowledge in the country's Poverty Eradication Action Programme. In Ethiopia and Ghana, a similar process has led to the development of medicinal plants for the domestic market. In Eritrea, the Bank is supporting the agenda on early childhood development through indigenous practices. In Burkina Faso indigenous practices are disseminated, through the Bank's support, to increase agriculture production yields in areas that experience drought (WHO, 2005).

In the same spirit the World Bank has funded partnerships geared towards researching traditional herbal medicine and therapeutic practices. The partnerships were between development partners, research organizations, local regulatory institutions and non-governmental organizations. For example, in Tanzania the World Bank linked the Tanga AIDS Working Group with scientists at the National Institute of Health and The George Washington University in the United States. The National Institute of Health,

the Ministry of Health and the traditional healers in Kenya are exploring the use of herbs in managing HIV/AIDS opportunistic infection. Regarding the validation of traditional medicine, the World Bank is supporting the scientific centres of excellence in Africa and Asia on the role of South to South transmission of knowledge and how partnerships can improve it (WHO, 2005).

2.4.4 Two decades of Traditional Medicine in Africa 2001 -2010 and 2011 to 2020, Policy and Commitment towards Integration

In its effort to support the WHO, governing bodies and member states that have adopted different resolutions as an ongoing support of the 1978 Alma-Ata Declaration which recognized local healers as a crucial part of Primary Health Care in responding to health needs of communities, the WHO Regional Committee for Africa approved a strategy for promoting traditional medicine in health systems all over Africa. The strategy was named the First Decade of Traditional Medicine in Africa, which ran from 2001 to 2011 (WHO, 2013).

The strategy encouraged the governments of member states to recognize traditional medicine and institutionalize it. Other values and philosophies that guided the strategy include advocacy and partnership, while its priority areas are: policy formulation, development of locally made traditional medicine, promotion of research, conservation and cultivation of herbal plants, capacity building, preserving intellectual property rights and indigenous knowledge (WHO, 2002). The regional strategy was given impetus by The African Heads of State Summit in 2001 which declared a workable action plan for its execution, and specified that traditional medicine research was a priority area.

Another development was realized in 2008 when emphasis was given to researching traditional medicine and supporting health systems by the Algiers Declaration, taking into consideration the sociocultural context of the local people (WHO, 2012). The same year the Alma-Ata Declaration was restated, persuading countries to initiate workable strategies for supporting the availability, accessibility and affordability of both traditional medicines and essential drugs and the use of community-based approaches. Further development was marked in the year 2010 when Africa celebrated a Decade since the adoption of Regional Strategy. Following the completion of the First Decade of Traditional Medicine in Africa, its review was carried out and the deliberation of a way forward was adopted by The African Union Ministers of Health in 2011.

Notable progress has taken place in Africa regarding the development, support and promotion of traditional medicine in terms of advocacy, research and integrating it within national health systems (Abdullahi, 2011). For example, in 2001 a Regional Expert Committee on traditional medicine was established by WHO to help the member states to execute the Regional Strategy efficiently and put in place a strategy for monitoring and evaluating the development made in traditional medicine. Assisted by the financial support offered by the Canadian International Development Agency, the member states were able to implement the WHO Regional Strategy on Health Systems and promoting Traditional Medicine. Emphasis was given to traditional medicines that can help to manage priority diseases (WHO, 2013). Other notable progress includes strengthening of institutional capacity, whereby there was an increase in the number of countries that have developed national policies from 8 countries at baseline to 12 in 2002, 22 countries in 2005, up to 39 countries at the end of the first decade of traditional medicine in Africa in 2010. In addition, there was an increase in the number of countries that have put in place regulatory mechanisms for traditional medicine.

Alongside capacity-building, there was encouraging progress in the establishment of expert committees and national programs for the development of traditional medicine in Ministries of Health. 31 August each year is set for celebrating the African Traditional Medicine Day: during the celebrations, traditional healers, scientists, and other stakeholders join together to hold panel discussions and debates, and carry out exhibitions and cultural shows, which have an impact in raising the awareness and popularity of traditional medicine. Given the progress made in the First Decade of Traditional Medicine in Africa, it was proposed and agreed by the member states that the decade of African Traditional Medicine should be renewed, hence the Decade of African Traditional Medicine 2011-2020. During the Decade, apart from strengthening the previous strategies, two more areas will be given weight. These are: researching traditional medicine so as to generate evidence of quality and safety of traditional medicines by increasing financial resources; and supporting the regulation of traditional medicine and its practitioners. The Decade of traditional medicine in Africa has to a great extent helped to instil a change of mind-set among African leaders who were initially shy to acknowledge traditional medicine publicly (WHO,2000). The table below shows the summary of the progress made based on evaluation surveys made in 2002, 2005, and 2010.

Table 2: Progress Made in the Official Recognition of Traditional Medicine in Africa

| Indicators | Number of Countries | | | |
|---|----------------------------|-----------|-----------|-----------|
| | Baseline Survey 1999/2000 | 2002 N=35 | 2005 N=37 | 2010 N=39 |
| National policies on Traditional Medicine | 8 | 12 | 22 | 39 |
| Legal framework for practice of Traditional Medicine | 1 | 5 | 16 | 28 |
| National Strategic Plans/National Health Strategic Plans that include traditional medicine | 0 | 2 | 10 | 18 |
| Code of ethics for traditional practitioners | 0 | 0 | 1 | 18 |
| National Office of Traditional Medicine in Ministry of Health | 22 | 25 | 31 | 39 |
| National Expert Committee for traditional medicine | 10 | 16 | 18 | 25 |
| National traditional medicine programme in Ministry of Health | 10 | 12 | 15 | 24 |
| Law or regulation on Traditional Medicine practice | 8 | 10 | 15 | 21 |
| Registration system for traditional medicines | 4 | 8 | 10 | 15 |
| Issuance of marketing authorizations for traditional medicines | 1 | 1 | 4 | 12 |
| National research institute on Traditional Medicine | 18 | 21 | 28 | 28 |
| Law or regulations on herbal medicines | 10 | 12 | 16 | 20 |
| Inclusion of traditional medicines in national lists of essential medicines | 1 | 1 | 2 | 5 |
| New research institutes | 0 | 2 | 3 | 4 |
| Local production of traditional medicines | 15 | 17 | 15 | 17 |

Source: AFR/RC61/PR/2 2011:5. Adopted from WHO Regional Office for Africa, Review of the End of the Decade of African Traditional Medicine 2001-2010

The table above shows that during the Decade of Traditional Medicine in Africa there has been encouraging development in the official recognition of traditional medicine in the continent - greater than in the combined post-independence years of the continent. For example, in the span of these ten years, the number of countries that have a National Policy on traditional medicine in place rose from 8 countries, at the baseline in 1999, to 39 countries in 2010.

2.5 The Sociological Perspectives on Modern Medicine

As discussed in the Background section of this study the sociology of biomedicine, its influence and its superiority over traditional/CAM practices in Africa and other parts of the non-Western world was cemented and supported by three establishments, namely the Christian religion, the Western educational system and the Western legal framework, all of which were introduced by the countries of Western Europe which ruled Africa and other parts of the world (Mahunnah et al., 2012). This section will examine the influence of biomedicine on an individual person hereinafter referred to as the ‘patient’, its power on society and its power and influence on other non- biomedical practices.

2.5.1 Brief History of Biomedicine and Source of Its Legitimacy

The history of the hegemonic power of biomedicine can be traced back to 1858 when Britain passed the Medical Act, which formalized what appeared to be unregulated and unrelated groups of conventional healthcare providers. The act recognized biomedicine as the supreme health system in western countries (Wiese et al., 2006; Turner, 2005). The colonization of Africa brought with it biomedical health practice, which was declared not only the dominant health system but became the national health system of all colonized countries (Gale, 2014). Most often in Africa when one is referring to the national health system or health sector, one is referring to biomedical practice that is divided between public and private health sectors (WHO, 2008). The source of the legitimacy of biomedical practice over other non- biomedical practices can be described in five areas. First, during the colonial era, the colonialists were promoting and popularizing biomedicine in their colonies (Tsey, 1997). Thus, the native health practice that had been perceived as the dominant treatment became a complementary therapy to biomedicine, so biomedicine that had been thought to be an alternative therapy to the native one took top position. Secondly, because of colonization, currently state governments worldwide are all supporting biomedical practice as the only established, legitimate and genuine health system (Hollenberg, 2006). Thirdly, it is perceived as a scientific approach that is supported in its hierarchy of evidence by applying systematic randomized clinical trials (Broom et al., 2007). Fourthly, the decision of biomedical practice to use the evidence-based medicine protocol and procedures, and the use of advanced technological equipment have been the

springboard of its supremacy over other practices (Adams et al. 2009). Finally, the power of the multinational pharmaceutical companies that produce drugs for biomedical use has made biomedicine powerful even where those drugs simply treat the symptoms rather than curing the root cause of illness (Hahn, 1995).

In analysing the supremacy of biomedical practice, this section will discuss the theoretical perspectives that describe the attitudes of biomedical practitioners towards other practices. Biomedicine, viewed from the perspective of sociology, is powerful not only over traditional/CAM, but also over societies, and even individual clients (Theberge, 2008, Soklaridis et al., 2009). This does not mean that biomedical practice occupies the dominant seat unchallenged. Foucault, the French philosopher and historian who identified himself as poststructuralist, and feminist scholars of gender began to challenge the so-called 'effectiveness and benevolence' of medicine (Lupton, 1994). Most critics of the biomedical profession are grouped in five predominant theoretical perspectives in the history of medical sociology. These theories are Functionalism (Parsons, 1987), the Political Economy Theory (Marx, 1848), the Social Constructionism Theory (Lupton, 1994), the Post-Colonial or Anti-Colonial Perspective (ACP) (Hollenberg, 2010) and the Critical Social Sciences Perspectives (CSSP) (Adams et al. 2009). The first three theories are discussed below and can be grouped in the current section on the sociology of modern medicine; and the remaining two are discussed under the domain of the sociology of integrated medicine.

2.5.2 The Functionalist Theory

The functionalist theory has been fading since the 1970s, yet it is worth referring to it since it touches on the power struggle between doctor and patient (Lupton, 1994). The functionalist model explains the unequal power relations between biomedical practitioner and an individual patient. Failure to adjust to society's expectations and norms in behaviour including social deviance is how classic functionalists view illness. Illness is regarded as an abnormal body condition causing social and physical deviance from what is considered normal. The role of the biomedical personnel is to control the social institution and use its influence to decide between normality and deviance (Lupton, 1994).

Talcott Parsons (1987), a believer in the functionalist theory of medicine, gives the explanation of demand and function of the patient and the outcome of the doctor-patient relationship. According to Parsons (1987) and his followers, a patient with a serious disease has three characteristics. First, they are exempt from performing social obligations, secondly, they are not blamed for their illnesses or conditions; and thirdly they are not expected to feel guilty if they are unable to perform their duties or obligations. However, the theory argues that a patient is expected to get well within a reasonable period: if not, the patient is accused of pretending to be ill. To be sick according to the theory is to admit and seek the help of biomedicine to return to normal health. The patient is therefore socially vulnerable to the power of the doctor who is expected to draw a line between malingering and normality. The doctor is regarded as socially beneficent. The relationship of doctor and patient, though it seems to be built on terms of agreement, is characterized by an unequal power relationship (Parsons, 1987). It is this unequal power relation that has propelled many people in developed countries to seek an alternative holistic approach (Shuval, 2008; Tovey et al., 2007)

The functionalist perspective presents a picture of patients as people who are easily guided, docile and thankful: and doctors are presented as beneficent, able and selfless (Turner, 1995). However, there is a conflict of interests: critics of this theory do argue that there is a power struggle and a tug-of-war between the doctor and the patient (Gerson, 1976). The conflict is represented by different and conflicting interests: while doctors are interested in earning a living and gaining prosperity from their careers, patients are interested in getting cured. Another perspective that suggests the influence of biomedicine but points to a different direction is political economy, as described in the next section.

2.5.3 The Political Economy Theory of Biomedicine

The Political Economy theory of biomedicine was the most widely held over four decades ago; it is still persuasive in medical sociology (Lupton, 1994). The theory defines good health in political terms; it takes into consideration not only the aspect of a universal definition of health – a state of spiritual, social and physical wellbeing – but also aspects of access and power over the basic services and material resources, that are there to promote and sustain health (Baer et al., 1986). The theory proposes that people who are ill, aged or physically incapacitated are marginalized by society because they

do not play a part in the production and consumption of services and commodities (Freidson, 1970). Considering that these groups are unable to access health care services, they suffer poorer health; they become sick and no one cares in some cases. The biomedical institution is viewed in this perspective as attempting to assist people to remain healthy and contribute to economic growth as both producers and consumers. However, the perspective is challenged for its failure to see how health care and resources can be provided to those in need and those who are unable to re-join the labour market. From this standpoint biomedicine is accused of continuing to create social inequalities and divisions between the privileged and under-privileged for no sound reason (Manderson, 1998).

Political Economy proponents of biomedicine argue that modern medicine has created a social disequilibrium where capitalistic health care is incompetent, unaffordable, and poorly regulated. The vast power of the biomedical sector is imposed on society and has led to other social problems being inappropriately redefined as illness, thus increasing the power and influence of the medical profession without questioning the right and balanced use of resources (Illich, 1976). The political economy critics of biomedicine suggest that contemporary medicine is an enormous institution of social power which is above religion and law (Zola, 1981). Freidson's (1970) view is that modern medicine is socially and physically bad and harmful because its professional control over other therapies has caused people to regard biomedicine as a magic bullet. This power struggle removes the power of personal decision-making from the individual in matters of personal health.

Functionalist and political economy theories share the common view that medicine is used to define normality, punish those who are sick and keep the general order of society to maintain social order. However, the two do vary in that political economists perceive the dominance of biomedical practice as detrimental and misused by the medical profession. The political economy critics of biomedicine question the legitimacy of biomedicine that dictates health-seeking behaviour (Strong, 1979). Scholars argue that health care as a commodity is being promoted for profit by the capitalist economic system. Thus, the relationship between a doctor and a patient is shaped by conflict and incompatible priorities and interests. Biomedicine has oriented itself from the wider causes of ill health to a single physical factor (disease orientation) upon which treatment is focused. Due to this approach, medical care is orientated

towards treating symptoms using drugs that are produced by the multimillion-dollar pharmaceutical companies using expensive medical technology rather than concentrating on the prevention of disease or maintaining good health through holistic orientation (McKee, 1988).

The proponents of the political economy theory of biomedicine argue that there is a symbiotic relationship between health care and capitalistic production. They argue that ill health, in some cases, is caused by socio-economic factors, for example consumption of over-processed foods from capitalist factories, toxins and pollution (McKee, 1988). In addition, they point out the state's failures to appreciate the place of environmental toxins emitted by factories in causing illness; and to standardize the production and marketing and to discourage the advertising of harmful products such as tobacco and alcohol as they endanger health (Russell and Schofield, 1986). The symbiotic relationship here creates a compatible system where the capitalist industry creates health needs which will eventually necessitate the securing of a healing process through medical treatment (Navarro, 1976). The political economy theory of biomedicine on the other hand has been criticized for failing to recognize advances in health status and an increase of life expectancy associated with improvements in sanitation, supply of clean water, a rise in the standard of housing and advances in medical treatment which are linked to the capitalist economic system (Hart, 1982). The next section discusses the social constructionism theory, a theory that shares some concerns of political economy but concentrates more on knowledge of medical pluralism.

2.5.4 Social Constructionism

The perspective of social constructionism has received increased attention in medical sociology. The increased expression of social constructionism is in line with the increasing influence of Foucauldian scholarship, Post-Structuralism, and the feminist movement (Epstein, 1978). Post-structuralism questions the claim to the existence of essential truth. The proponents of this theory argue that if truth is, as claimed by this theory, a product of a power struggle, it is not neutral, and it changes with time: it acts in the interests of someone. Human subjects are made up through social practice and discourses. The central interest is the examination of how common knowledge that constitutes a society, or a culture is generated and reproduced (Lupton, 1994). The application of social constructionism to the area of medical sociology considers issues

of power relations at the micro level, thus taking into consideration some concerns of the point of view of the political economy theory of biomedicine (Lupton, 1994).

The focus of social constructionists is to question the social scenario of biomedicine, the progress of medico-scientific and non-professional medical knowledge and practices. The approach emphasizes that illness and the history of a patient are connected, and should be seen via the patient's social life and considered through social and cultural analysis (Lupton, 1994). Consequently, medical knowledge is viewed as a continuation of improvements that are predicated upon the past setting of society in which they occur and are steadily being adjusted to meet the needs of the society. The approach, therefore, allows flexibility in thought about the truth as claimed by medicine, indicating them to be as much cultural products as non-expert knowledge of medicine (Berger and Luckmann, 1967). Proponents of the belief that biomedicine is a product of much lay knowledge are many, including Foucault (1979), Wright and Teacher, (1982) and Brandt (1991). The feminist movement led the way by criticizing scientific and medical knowledge, which is applied to put at liberty the class of influential groups over the others. For example, the criticism is directed towards biomedicine for using Biology as a dogma adopted in the medical context to deny women full involvement in the societal sphere (Armstrong, 2002).

As the discussion of the second domain of medical sociology comes to an end where three critiques of biomedicine have been laid out, at this juncture it is worth introducing the third domain, the sociology of integrative medicine. The third domain introduces the Post- or Anti-Colonial Perspective (Hollenberg, 2010) and a Critical Social Science Perspective (Adams et al., 2009). As an extension to the social constructionism discussion, the post-colonial perspective discusses in detail the hegemonic influence of biomedicine over other practices, which sees biomedicine locating itself as a continuation of European Science, a set of values with a history and culture of possessiveness (appropriation) and adoption (assimilation) of native peoples' knowledge for selfish use (Hollenberg, 2006).

2.6 The Sociology of Integrative Medicine

This section will cover among other things, the history of integrative medicine. The Post or Anti-Colonial Perspectives and a Critical Social Science Perspective will be

introduced, and provides discussion on how both perspectives challenge the models of integrative medicine.

2.6.1 The Historical Perspective of Integrative Medicine

The popularity and professionalization of nineteenth century therapies such as the hygiene movement that were once perceived as disorganized, form a strong basis of what is now known as integrative medicine (Hollenberg, 2009). In the early 1970s, the holistic movement became famous in the West Coast of the USA (Baer, 2001). The movement spread quickly to the whole of the USA and other English-speaking countries such as the UK, New Zealand, Canada and Australia. Later, the movement spread to Western European countries. These holistic movements which were by no means similar evolved in different locations and countries depending on the local culture and the prevailing health practice. As a result, they were accepted by local people. Although the holistic movement had different orientations they had one common goal – to challenge the dominance of biomedicine (Baer et al., 2008). That saw the emergence of practices such as chiropractic, naturopathy, osteopathy and herbalism, which drew expressions from Western societies as well as from Eastern health practices such as Indian Ayurvedic and Chinese Traditional Medicine (Adams et al., 2009).

History reveals that by the late 1970s the biomedical associations in the US were aware that they were losing a large number of patients who were in favour of alternative medicines. In addition, they acknowledged the limitations of biomedicine in treating some conditions. Consequently, in 1978 a group of doctors set up The American Holistic Medical Association. Similarly, the American Holistic Nurses Association was established, which awarded certificates to nurses in various alternative practices. More biomedical and nursing schools incorporated training programmes on alternative medicines. By the year 2002, out of 125 biomedical colleges in the US 85, were offering courses in alternative medicine, in contrast to the UK and Australia which were slow in offering courses in the same. The term integrative medicine was invented by a Harvard-trained doctor, Andrew Weil, who is a prominent holistic health authority. He is remembered for creating an integrative medical setting in 1994 at Arizona University. Weil is also credited for establishing the *Journal of Integrative Medicine* in 1998 (Baer et al., 2008).

Since then integrative medicine has been growing and different models of integrative medical settings have been introduced. Several health care researchers and theorists have come up with models to isolate critical values that may facilitate the smooth running of integrative care (Sundberg et al., 2007; Mykleburst et al., 2008; Boon et al., 2004; Tataryn et al., 2001). They suggest that using such theoretical models may facilitate the categorization of possible patterns of collaboration of modern and TMCAM practices in different health care contexts. For example, Boon et al., (2004) developed a conceptual framework based on a comprehensive review of integrative health care literature and an international workshop. Their framework comprises seven different integrative health care models, namely parallel, “consultative, collaborative, incorporation, coordinated, multidisciplinary, and integrative” 2004:12; indicating different ways in which modern medicine and CAM integration can be achieved. These models are developed around four key themes or components: philosophy, structure, process and outcomes. This implies that any move from one component to another would involve diversity of health care philosophies, complexity of organizational infrastructure, communication and degree of well-being upon which practitioners focus (Boon et al., 2004).

Theorists Mann et al., (2004) introduced 7 integrative health care models, to signify different degrees of conventional health care and CAM integration: They noted the following models.

- 1) “The informed clinician who communicates his or her knowledge about CAM to patients;
- 2) the informed, networking clinician who adds ‘referral networks with CAM practitioners’ to his or her knowledge of CAM therapies;
- 3) the informed, CAM-trained clinician who incorporates specific CAM therapies into his or her practice;
- 4) the multidisciplinary integrative group practice where ‘practitioners provide both conventional and complementary therapies in a partnership’;
- 5) the interdisciplinary integrative group practice ‘in which care providers in multiple disciplines see patients together as a team’;
- 6) hospital-based integration; and
- 7) integrative medicine in an academic medical centre” (Mann et al. 2004:157-164)

Other theorists who have developed models of integration include Coulter (2003) who outlines four items of an integrative model, and Sierpina (2001) who demarcates eight aspects of an integrative model. All theorists seem to have one thing in common: they appear to suggest that the initial structure and subsequent development of integrative health care practice in a health setting are dependent upon the motivation, interest, and skills as well as experience of practitioners. Apart from constructing conceptual models, other researchers have identified factors or elements indicating acceptance and a decision to establish the perfect integrative health care clinic. These factors include appropriate staff, solid referrals, adequate marketing, good record-keeping, two-way communication, and exchange of professional information, provision of compensation as well as informative organograms (Barrett, 2003; Vohra et al., 2005; Mulkins et al., 2005; Boon et al., 2008).

Other health care researchers have used a different approach of demarcating integrative health care. The model is named “the complicated health systems approach which denotes considering the occurrence of health or illness as a developing property of a multifaceted and dynamic system” (Adams et al., 2009:13:). This approach, which depends entirely on biological and ecological science, emphasizes that a better integrative health care model should take into consideration a special service arrangement, which allows modern and traditional practitioners to work in harmony and mutually support each other for the betterment of the patient’s health. This model of integrative medicine tries to go beyond focusing on health integration at the individual practitioner or practice level to the synergetic exchange of information by involving several various health practitioners, professions and practices (Bell et al., 2002).

There is an accumulation of studies on anthropological and sociological aspects of both biomedical and CAM practices as separate entities (Gale, 2014, Asante et al., 2013, and Adams et al., 2009). While the sociological analysis of integrative medicine is still new, it offers an area of research in integrative medical sociology. Results from such sociological study on co-operation between the two different systems are expected to reveal both opportunities and challenges of combining health practices that are inherent in different epistemologies and philosophies (Hollenberg et al., 2010). It asks questions such as how may biomedical and CAM therapies be combined? What types of therapies are in the inventory should be selected for integration? Do the two practices interact at any one point? Against what type of background is integrative medicine to be

preferred? How would the practitioners coming from two different training regimes, experiences and backgrounds interact? Would the organizational setting and consideration of allocation of responsibility and the dictates of economics be favourable to such integration? Such questions must be answered amidst studies examining the opportunities/challenges for integrating the two practices.

It is true that different forms of integrative medicine are going on all over the world although several questions in this connection have not been answered (WHO, 2002; Faass, 2001; Hollenberg et al., 2009). Despite the lack of answers to the questions posed, university medical centres and hospitals are facilities where illnesses such as orthopaedic conditions and back pain are being treated successfully through integrative medicine (Faass, 2001). Although not widely published, success stories in some studies have shown the significant clinical advantages in integrated medicine (Edelman, 2006). However, an integrative medicine that combines two health practices that have different backgrounds, cultures, philosophies and ideologies cannot assume that cooperation between the two is without challenges or problems. Social scientists need to question the motives and the drive behind moving biomedicine to collaborate with other practices that are perceived to be inferior to it. There are questions such as ‘What does holistic practice essentially mean when practised in integrative medicine?’ and ‘Does integrative medicine really occur when biomedicine and CAM work together or it is simply appropriation or coadaptation of CAM therapies?’ If any of these terms is applied, at what level of cooperation do the appropriation and coadaptation occur? Is it at the philosophical or the therapeutic level? These and other questions are being addressed by anti- or post-colonial scholars as well as those from the Critical Social Science Perspective (Hollenberg et al., 2010, Adams et al., 2009).

2.6.2 Post- or Anti-Colonial Perspective in Integrative Medicine

Authoritative scholars of the Anti-Colonial perspective, such as Dei et al., (2000), Shiva (1997), and Battiste (2005) claim that the influence of CAM/traditional medicine in integrative medicine represents a subjugated knowledge. The post-colonial perspective is challenging the dominant views by supporting the marginalized people or knowledge with a goal of providing alternative perspectives (Adams et al., 2009). Consequently, anti-colonial perspectives identify with the paradigms and epistemologies of China, Africa, and South America and other traditions that are not part of Western historical traditions. There is evidence to show that there was an

exchange of sciences between Africa, India and Asia for millennia before Columbus' voyages in 1492 (Asante et al., 2013). Consequently, the claim of existing modern medical knowledge is corroborating evidence of the assimilation of knowledge from 'other' practices (Boom, 2006).

Harding defines science as any systemic effort whose outcome is a production of knowledge regarding the natural universe. There is no single dimensional science: instead several sciences occur (Harding, 1998). Multiple sciences are compared to the thinking spaces that have been made available by different social and discourse relations. Within the spaces, new inquiry may be put forward and new feasible prospects can be distinguished and discussed (Harding, 1998). Consequently, modern health practices that are appropriating traditional/CAM practices drawn from an anti-colonial perspective are in line with the historical notion of misappropriation. For example, the colonial regime took samples of remedies from Tanzanian traditional healers, which it referred to as downgraded medicines. Having proved the medicines were effective, they appropriated the knowledge, but its source was not credited (Mahunnah et al., 2012). The European misappropriation of native knowledge was the reason for the suppression of traditional medicine. The European attitude of pretending that they did not value native knowledge while they actually appropriated and assimilated it is an invasion upon traditional health practice. Historically non-European knowledge has been demoted in the quest of one 'factual' interpretation of nature. As a result, this has contributed to what Harding (1998: 168-169) refers as the 'systemic ignorance' of contemporary health practitioners. Given that Europe does not harbour unique knowledge but is combination of knowledge obtained from other paradigm sources, it does not make sense to argue that only European civilization produced an unanimously binding knowledge, while others did not (Baer and Coulter, 2008).

Proponents of the anti-colonial perspective urge that the concept of paradigm appropriation can be linked to European colonial enlargement. It goes hand in hand with the down-grading of knowledge and philosophies of the dominance of European scientific epistemology over non-European epistemologies, where other paradigms were only accepted when used by and absorbed by European science (Harding, 1999). Followers of the anti-colonial perspective continue to argue that local epistemologies from all parts of the world were assimilated to fulfil the colonial objective of enlargement; at the same time the same knowledge was distorted and demolished after

appropriation. In Africa, for example, remedies were replaced by imported modern medicines. In other areas, traditional medicine was declared illegal and was not allowed to operate (Banerji, 1981).

The current European misappropriation of T/CAM by biomedicine, according to Hollenberg and his colleagues, is evident when biomedicine adopted some of the modalities of CAM at the same time as rejecting the philosophical framework and the origin of the techniques (Hollenberg, 2006). At this juncture, it is important to separate theoretical appropriation from assimilation. Paradigm appropriation is said to be when one health practice adopts certain elements of therapeutic traditions from another health practice without acknowledging the origin of that therapeutic elements. While paradigm assimilation refers to an incident in which one practice not only takes over another complete healing system, but ends up changing and re-interpreting it (Gale, 2014). The philosophical features and qualities of the appropriated practice are then redefined, renamed or eliminated, being given new meanings by the assimilating practice just like the tendency of European immigrants to give towns new names in colonized territories (Harding, 1998).

Paradigm assimilation is common in integrative settings in different studies (Broom and Tovey, 2007; Hollenberg et al., 2010; Mizrachi and Shuval, 2005). For instance, the understanding among modern medical doctors about the efficacy of acupuncture is that it treats defective connective tissues, such as muscle pain. The perceived view, which is globally accepted among biomedical practitioners, is a result of testing acupuncture using biomedical interpretations, instead of studying the Chinese medical philosophy, which is readily available. In this case therefore, the practice assimilation occurs when acupuncture is incorporated into biomedical practice and is re-interpreted into biomedical philosophy. The attempt of biomedical practice to establish integrative settings was made to create room to absorb integrative graduates who were trained by medical schools as integrative physicians who assimilate T/CAM modalities with the ultimate goal of marginalizing T/CAM practitioners (Benjamin et al., 2007).

To summarize the subject of appropriation and assimilation, biomedical practice is accused of two major faults. The first is that it pretends that it has a knowledge that is unique, when it has a long history of appropriating knowledge and technologies from other origins without acknowledging them: hence, it tries to underestimate the successes and accomplishments of other scientific and technological civilizations

(Harding, 1998). The second accusation is more serious than the first: that biomedical practice not only appropriates and assimilates other knowledge without acknowledging it, but it distorts T/CAM practices for its own benefit.

The following perspective - a Critical Social Science Perspective (CSSP) - aims at correcting the shortfalls in integrative medicine by allowing a voice to the marginalized groups in the multifaceted power relations with the supreme groups in contexts of potential integration.

2.6.3 Integrative Healthcare from a Critical Social Science Approach

Integrative medicine is a term that describes the partnership or integration of biomedicine and T/CAM (Faass, 2001; Micozzi, 2006). The developing fast growth of integrative medicine has invited re-examination of the terminologies surrounding health practices (modern medicine as opposed to traditional) and the birth of new names to describe a balanced form of health care practice (Horriga, 2003; Stumpf, 2008; Barrett, 2005). A few different models have been developed on the subject of integrative health which have involved debates on what integrative medicine is and what its nature is (Baer, 2005).

This section introduces an extension of the debate around integrative care by proponents of the “Critical Social Scientific Perspective” (Adams et al., 2009; Held et al., 1995) who argue that the attempts to create integrative health care have lacked a Critical Social Science Perspective (CSSP). A CSSP requires that the process and establishment of health systems is determined by a social structural process which is characterized by disparities of power struggle, marginalization, and superiority of one dominant health system, practice or knowledge over another. Indeed, the claim by a CSSP bears similarities with the claims of social constructionism and political economy discussed above which incorporates a belief that things can be reworked and challenge the status quo and proposes re-organization of health provision.

The proponents of CSSP begin by critiquing the popular models of integrative health care. They argue that integrative care as defined and devised in conceptual models is impractical as the models have paid no attention to the cultural and structural contexts governing integrative health care in practice. As a result, they have introduced a CSSP framework that might be applicable to investigate integrative health setting. The central point in this perspective is to allow a voice to disregarded groups in the multifaceted

power relations with superior group in contexts of potential or already attempted integration. They argue that without extensive consideration of professional dynamics such as dominance, marginalization, and negotiation, the nature of integrative health care cannot be properly understood (Mizrachi et al., 2005)

2.6.4 Drawback of the Current Integrative Models

Although the proponents of a CSSP approach agree that these conventional approaches to studying integrative health care offer a valuable set of theoretical tools for clinicians to define integrative practices, they point out limitations in explaining the effect of integrative health care practice in health care settings. Specifically, two major setbacks are pointed out. First, the discussion of integrative health care tends to ignore the contradictions and pressures essential in various health care practices. The proponents of CSSP argue that conceptualizing integrative care as a matter of degree is determined exclusively by the interests of the providers of health care or health facilities. The mainstream discussions downplay the topic of incompatibility between the epistemological positions (Hollis, 1982) and is led by the assumption that the integration of biomedicine and TM/CAM modalities is without challenges. In reality this is not true, as different health practices hold different stances regarding the mechanism of illness causation and treatment (Nedrow et al., 2007).

It is a common finding that the prescription of one medical paradigm is irreconcilable with that of the other, and it can be hard to get the practitioners of the two paradigms to come to agreement. Coulter and Willis, (2007) give the example of homeopathy to illustrate the difficulties involved in integrating different therapeutic paradigms. The potency of a therapeutic substance, according to contemporary medicine, is weakened when the substance is diluted. However, in homeopathy, the more one dilutes a substance the higher the potency will be. The debate on the role of the placebo is an area that indicates the friction in combining different therapeutic paradigms (Adams et al., 2009). While contemporary health practice stresses evidence by controlling biases and confounding factors like the personality of the therapist, subjectivity and treatment settings from the causes and experiences of illness, many CAM practitioners consider these a critical part of the healing process (Yamey, 2000) which cannot be subjected to randomized controlled trials.

The second setback of the conventional approach is that the integrative health care models are perceived as necessarily impassive constructs and may not be compatible

with what is taking place in the actual implementation of integrative medicine in day-to-day health care settings (Boon et al., 2009). While it is accepted that the mandate of an ideal model of integrative care is to highlight elements of a social order that may be potentially appreciated, there are thoughtful barriers to associating and assimilating such models to the actual practical integration as acknowledged by research. As a truism, evidenced studies reveal that practices of integrative health care are complex and hardly come close to the well-painted pattern described by the theoretical models. For example, the patterns of services are dictated by power relations and which professional group controls the available resources, and also dominate the philosophy of health policy (Mizrachi and Shuval, 2005).

In many cases, the ideal of comprehensive access to promotive health, preventive health and community-based CAM and contemporary health care services has been found to be missing from practice realities. Instead, biomedical options in integrative health care have been shown to take priority over CAM options, mainly because they are covered by national health care insurance plans and viewed as superior to CAM. As a result, patients must prematurely terminate the CAM part of their treatment plan because they cannot afford private CAM treatments. This leads CAM practitioners to experience low patient flow, low salary, and ultimately marginalization in integrative health care settings (Barrett, 2003).

Proponents of a CSSP conclude by urging that the paradigm models that fall short of considering the social and historical specifics of health practice have restrictive scope in explaining the underlying forces of integrative health care. They believe a CSSP will provide good consideration of the development and future of integrative health care.

2.6.5 The Applicability of A Critical Social Science Perspective

Critical theory (Adams et al., 2009) recognizes that existing social arrangements may not dissipate all possibilities, and it advocates the need for crucial engagement with contemporary social structure and power relations. By systemically probing the political, social and historical environments upon which human behaviours depend, the critical theory approach is ideologically positioned towards encouraging a critique of power, promoting individual emancipation and social justice. In a different but related context, recent sociological studies of science and professions examine scientific (and medical scientific) inquiry as social activity. By locating scientific practice within wider social and structural contexts, these studies systematically examine the

intersection, segmentation and rivalries within the scientific community as well as the processes of professionalization and legitimation (Kligler et al., 2004).

A critical social scientific perspective (CSSP) on health movements and practices has three main characteristics. First of all, this perspective emphasizes the importance of contextualizing health care activities and trends within macro structural and historical specificities. The attempt to link the transformation of scientific practices to wider social and political parameters, offers a better and deeper understanding of the phenomenon under study. The second characteristic of the CSSP is based on examining health care activities and professions in context. The CSSP calls for special attention to the complexities and underlying forces of power and strategy in instituting knowledge, authority and/or resources. The third characteristic is located by analysing the historical construction of specific practices as well as the conditions under which professional demarcation is established: a critical perspective helps create “windows on possible worlds” (Giddens, 1989:289) for different actors.

To sum up, a CSSP studies a situational analysis of criticism, knowledge and power. In sociology, power is perceived as a multifaceted concept (Joerges, 2003). Power is perceived to be the capacity of a person or a group to decide in an uncompromised context. However, that is one form of demonstrating power. In principle, power can also be perceived when an individual or a group can influence a policy agenda so that a difficult situation is repressed or blocked: what Adams et al., (2009: 794) referred to as “an ability of non-decision making”. A third aspect of power is philosophical in nature as Lukes (2005) argued, and it is the ability to manipulate the thoughts, wishes and values of people with the ultimate goal of making them question their own values and causing them to behave negatively towards their own will or interest. It is probably the worst type of power struggle for an individual, society or organization to experience, as it influences people’s wishes against their own interests. This entails that the mind-set of marginalized people should be in a framework that does not value their own traditions, culture and norms as a society. Instead they must embrace another form of values, culture and traditions that is decided by the people with power. It strips off the identity of a society, for a society without values or culture is a non-existent society.

The situation is more complicated when knowledge is central to the discussion. Foucault’s (1977) studies have outlined the situations in which knowledge is central in the control of domination.

2.6.6 Challenges of Integrative Medicine from both the Anti-Colonial and CSS Perspectives

As pointed out earlier, little is known about the challenges of integrative medicine as this field is still in its infancy (Baer et al., 2008). A few studies that have been done by proponents of both Anti-colonial and critical social science perspective on integrative medicine suggest that integrative medicine is not without challenges and shortcomings (Baer and Coulter, 2008; Tovey and Adams, 2002). Consideration of these shortcomings is critical if integrative medicine is to be successful, not only for the practitioners of the two practices that come together but more important for the patients who are the primary beneficiaries of integrative medicine (Broom, 2006). This section will discuss the challenges of integrative medicine from the thirty-two studies identified and reviewed during this study's systematic search.

Although there have been calls advocating integrative health care worldwide, it remains critical to reflect on the inter-professional association between conventional and alternative medicine, particularly at the grassroots, and its wider socio-historical contexts. While the integrative models suggest that the collaboration of health practices is smooth and linear, the defenders of CSSP propound that the development of integrative medicine and the association between contemporary and traditional medicine is uneven because the process of collaboration is governed by a struggle for acceptance, professional and quality legitimization (Adams et al., 2009).

There is evidence to show that the growth and popularity of traditional/CAM have been constructed and decided by ethnic, gender and class relations in the wider society (Baer, 2005; Baer, 2001) and by resources decided by supportive association leaders (Kelner, 2006). Consistently, and within the same vein, it has been claimed that the popularity of TM/CAM is taken as evidence of biomedicine being weak professionally, leading to reduced monopoly of the medical paradigm, its autonomy and its power over clients (Hollenberg, 2009; Lewis, 2003). The notion of the reduced influence of biomedical practice has been challenged by some studies and has been regarded as incorrect and over-simplified. Mizrachi et al., (2005), Shuval et al., (2004) and Shuval et al., (2002) give examples of clinical settings in Israel where both acknowledgement and marginalization of TM/CAM practitioners in integrative health care settings were simultaneously evident. Even though only a small portion of alternative practitioners were part of the health care team and their practices were absorbed by biomedical

practitioners, they were not taken in as regular members of staff, and their disregarded position was labelled by applying geographical, organizational and symbolic signals in the clinical settings that assisted in putting a demarcation line between the modern medicine and alternative medicine.

A study by Barret et al., (2003) among 20 CAM practitioners and 17 clients in the US showed that the fundamental barriers to integration between CAM and contemporary practitioners occurred in terms of organizational structure that would suit the two practices, difference in scientific orientations and philosophy between the two sets of practitioners, and the issue of equal economic distribution. The chief barrier was poor mutual understanding and acknowledgement: even though there was integration, neither of the parties understood the other. As for the study by Wiese et al., (2010) in Australia, CAM practitioners' main concern was fear of losing control of professional ground, especially loss of integrity. Participants feared losing market control and autonomy because of biomedicine taking over control. In addition, CAM practitioners used negotiation strategies to obtain space within the integrative setting. As they were the only ones negotiating for acceptability, they in a way used one-way referrals as a symbolic gesture that they respected and acknowledged the supremacy of biomedical practice. The participants complained that they did not receive reciprocation from biomedical practitioners.

Likewise, Theberge's (2008) study on the inclusion of chiropractors among integrative medical care workers in sport medicine was based on their readiness for their practice to be marginalized. The study by Asante et al., (2013) in Ghana on possible integration of traditional practice in the mainstream health system showed that although biomedical practitioners had no objection to incorporating traditional medicine into the mainstream system, when asked to suggest how they would work with traditional practitioners, they were unwilling to regard them as equal partners. In a similar vein, Hollenberg's (2006; 2007) studies on integrative health care settings in Canada cast doubt upon the notions prescribed by the models and theory of integration, as he found the common concepts used in integrative health care settings such as 'synergism', 'respect', 'trust', 'interdisciplinary practice' and 'widespread collaboration' were not as effective as would be expected. The biomedical practitioners were overtly marginalizing the practice of alternative practitioners by using the strategies of exclusion and restricting the duties and activities of T/CAM practitioners through controlling client registration, referrals and diagnostic tests.

In evaluations of collaborative initiatives in Mali, Senegal, Uganda and South Africa carried out by the WHO regional office (2010), the findings showed that what appeared as integration of traditional and biomedical practices was actually biomedical practitioners working together with traditional practitioners to study and test traditional medicines that have proved to be effective in treating chronic conditions such as opportunistic infection of HIV/AIDS. According to Busia et al., (2010), who provided a special issue to mark the decade of African Traditional Medicine (2001-2010), the collaboration was configured by unequal power relations, lack of transparency and mistrust between parties. Biomedical practitioners were dictating the terms and dominating the process of collaboration. In Asia, traditional practice experienced the same effects of relegation by the dominant modern practice. In Korea for example, during the Japanese colonial era Korean traditional medicine was regarded as ancient and unscientific (Kim, 2006). Consequently, Korean medical colleges were closed, and Korean traditional professional bodies were not allowed to practise. In Japan, a similar story is reported, towards the end of the 19th century western medicine was perceived as better equipped to deal with infectious diseases and surgical conditions, hence Japan adopted the German system of medical education (Watanabe et al., 2011). Following that decision, the practice of Japanese traditional medicine commonly known as ‘Kampo’ was suppressed and eventually it deteriorated.

Adams et al., (2009) advocate that, when using a CSSP, there should be a chain of amendments to verify the existing social setting rather than view it as a failure in professional control. Broom and Tovey (2007) suggest in their study on integrative health care in the United Kingdom that effort should not be directed towards viewing “waxing or waning of the biomedical profession: rather integration should represent complex process whereby multiple actors, health care settings, and institutions are reacting in implementing the concepts differently” (2007:36). Consequently, co-operation may be viewed as adoption and appropriation of some CAM skills, knowledge and procedures than about partnership between TM/CAM and modern medicine (Broom and Tovey, 2008). What is becoming clear in the argument put forward by the proponents of a CSSP is that any effort towards integration does not demolish the power of modern practitioners: instead they are strategically positioning to face the challenges of integration by changing their status as medically privileged

practitioners within the multitude of health practitioners available. They argue that through a CSSP, practices of marginalization and adoption can be recognized, exposed for investigation and possibly addressed in future models of integrative health care settings.

The value of a critical social science point of view lies in refining understanding on transformations and progress in health care practice with its concern to investigate power and knowledge. The perspective highlights the tension and intricacies that are the preconditions for partnership of various paradigms of health care practice. Integrative health care involves combining different paradigms based on knowledges that are essentially incompatible. Viewed from a CSSP, specific forms of integrative health care are social and historical constructs and an account of possible patterns of integration between modern medicine and alternative medicine that does not pay attention to social, historical, and institutional specifics is potentially misleading.

In conclusion, the proponents of the perspective argue that integrative health care would benefit if researchers were to examine a number of specific areas related to integrative medicine such as the interface, power relations, and dynamics between key integrative medicine providers in a range of different settings. Having discussed the analysis of theoretical context of integrative medicine, the next section introduces the study area.

2.7 The Country Profile and the History of Traditional Medicine in Tanzania

The history of Tanganyika now Tanzania as a country and that of traditional medicine in Tanzania is as old as mankind. In 1959, the solidified remains of *Zinjanthropus*, estimated to be 1.75 million years old, were discovered by Dr Louis Leakey in the Olduvai Gorge in northern Tanzania (Potts et al., 1981). About 30 kilometres from Olduvai Gorge at Laoteli a track of hominid footprints calculated to be 3.6 million years ago were discovered (Leakey 1971). Tanzania is a United Republic of two independent countries, namely Tanganyika and Zanzibar, which were united in 1964. The history of the Tanzanian people is marked with numerous experiences of external influence, such as the Phoenicians, and the Persian/Arab merchants who traded by barter in the 7th to 8th centuries. These were followed by the Portuguese explorers who settled briefly along the Eastern coast in the 16th century (Potts et al., 1981). Later, people experienced a slave trade with traders coming from different areas of the world.

Finally, were the colonizers from Germany and Britain in the late 18th century, a time when the Germans ruled the Tanzanian mainland and named it “Deutsch-Ostafrika”. Following the Agreement with the Sultan of Oman, Zanzibar became a British protectorate. After the First World War, when the British defeated Germany the Tanzanian mainland was ruled by the British crown and Deutsche Ostafrika was renamed Tanganyika. Tanganyika continued to be under British administration as a UN Trusteeship Territory, until in 1961 the country attained its Independence (Lakes et al., 1979). In January 1964, the Sultanate of Oman’s government in Zanzibar was overthrown; three months later the two countries merged to form The United Republic of Tanzania. Tanzania is situated in East Africa. Its neighbours to the North are Kenya and Uganda, while to the West there are Rwanda, the Democratic Republic of the Congo, and Burundi. To the south, Tanzania borders Mozambique, Malawi and Zambia. The Indian Ocean makes the eastern border. Tanzania has a total area of 945,087 square km: its total area is the same as the total area of Kenya, Uganda, Burundi and Rwanda combined. There are 30 administrative regions in Tanzania, 25 regions in Tanganyika and 5 in Zanzibar.

The 2012 National Population Census projected the Tanzanian population to be 49,625,354. The country has more than 120 diverse ethnic groups, each with its unique local language. Kiswahili is the national language that is commonly spoken. English is a medium of communication in education and administration. About 99 per cent of the local people are native African and the remaining one per cent consists of Arabs, Asians and Europeans. The majority of people belong to the Christian and Muslim religions. As indicated above, the collective culture of Tanzania has a mixture of African, Arabic, European and Indian culture, while the values of the majority of population are consciously accustoming to modern life. Agriculture is the backbone of its economy, accounting for more than 45 per cent of GDP. It contributes 80 per cent of total exports and employs 85 per cent of the total workforce (Tanzania Bureau of Standards, 2013). Tourism and mining contribute greatly to the national economic growth.

2.7.1 Traditional Medicine in Tanzania

The history of traditional medicine in Tanzania goes back to the era before the arrival of Arab/Persian merchants and European explorers. During that period, traditional

medicine was the only dominant health system, where through trial and error humanity had discovered the means of relieving pain, suffering and illness (Kayombo et al., 2007). Slowly there was an accumulation of effective medicines that were earmarked for treating certain conditions. That way a compilation of knowledge of remedies that were known to treat different illnesses was made available. The members of the community who were searching for knowledge of remedies for fixing ill conditions were named ‘*waganga*’ (healers) (Mahunnah et al., 2012). Different *waganga* specialized in treating different conditions. Some became bone-setters, herbalists, spiritualists (Ritualists or diviners), while some who were called Traditional Birth Attendants (TBAs), dealt with women’s issues.

The philosophy of African traditional medicine assumes that the existence of disease and illness is at three levels. People may acquire illness because of natural means, supernatural reasons such as spirits and gods, and for violating the ethnic social code of ethics or cultural norms. Consequently, treatment follows the nature of the condition depending on the perceived cause (Abdullahi, 2011). The treatment takes into consideration the social, physical, mental and spiritual aspects of a patient and the environment in which a patient resides. Depending on the severity of the condition, the patient may be treated at home using lay knowledge of remedies that are commonly known by all people. In a difficult situation, a traditional healer is consulted, and in a severe situation a healer may refer the case to another healer. The medicines include medicinal plants, animal products and minerals. The remedies may or may not be accompanied with rituals when the condition is assumed to be natural. However, rituals are compulsory when the condition is supernatural. For the supernatural and where the cultural norms are violated a special dance with drum music is executed as part of spiritual healing. The means of identifying the illness is through oral history-taking, divination and consulting demons or spirits for conditions of supernatural origin or causes.

2.7.2 Traditional Healing During the Colonial Era in then Tanganyika

Traditional healers in Tanganyika (now Tanzania) enjoyed a wide array of control over health issues before the inception of the colonial regime. German and British colonial rulers were not in favour of traditional practice: as a result, healers were prosecuted, killed and their collective control over health affairs was eliminated (Mahunnah et al., 2012). Christian missionaries who accompanied the colonial regime perceived the

healers as antagonistic to Christianity due to their involvement in witchcraft, magic and worshipping spirits and gods. Nonetheless, some of the missionaries took some of the remedies and tried them in their clinics. After receiving reports from the missionaries that some of the medicines were effective, in 1885 it was ordered that the military medical doctors should take samples of medicines to Germany for research. A report from a high-ranking official in the Germany Protective Force, Dr Weck, revealed that the remedies were indeed effective. Consequently, in 1907 selected traditional healers were allowed to practice and certificates were awarded which specified the illnesses the healers could effectively treat and the geographical area in which they could practise (Mahunnah et al., 2012).

In 1920, during British rule, there were complaints of witchcraft and this led to the enacting of the Witchcraft Ordinance in 1929, which strongly made it an offence to bring accusations of witchcraft. However, traditional healers were allowed to practice benevolent witchcraft such as for the restoration of the affection of a separated wife (Becky, 1979). If the community and the local authorities were happy with what appeared benevolent witchcraft, the government did not interfere. The distinction between malevolent and benevolent witchcraft was legally ambiguous, to the extent that the Witchcraft Ordinance required the governor's consent before execution of the penalty (Becky, 1979).

2.7.3 Traditional Medicine Post-Independence Era

The attitude and mentality of Tanzanian post-independence government officials were not different from those of the colonial regime. The government treated traditional healers with suspicion and mistrust. Consequently, traditional healers could not differentiate between the colonial and the post-independence government. For example, immediately after independence traditional medicine was placed under the Ministry of National Culture instead of the Ministry of Health (Kayombo et al., 2006). This is evidence that the attitude of the government officials was that traditional medicine had something to do with societal traditions, culture and norms. However, recently there have been dramatic changes in the direction of the government regarding traditional health practice. In 1989, a major change happened when the department of traditional medicine was transferred to the Ministry of Health after having been under the Ministry of National Culture for 28 years.

In 1974, The Traditional Medicine Research Unit was established under the Faculty of Medicine at the University of Dar es Salaam, which was elevated to the Institute of Traditional Medicine in 1991. In 1990, traditional medicine was officially recognized by the health policy of Tanzania. This was followed by legislation adopted by the parliament to enact the Traditional and Alternative Medicine Act no. 2002 (Mahunnah et al., 2012). Tanzania has subscribed to the Lusaka and Algiers declarations of the African Union Heads of State to endorse the periods of 2001-2010, and 2011 - 2020 as decades of traditional medicine in Africa (MoH, 2010). It has been estimated that 80 per cent of the population in Tanzania use traditional medicine. The ratio of traditional healer to patient is 1:400 compared to that of biomedical doctor to patient of 1:25,000 to 30,000. The distribution of modern health in Tanzania inherited the colonial plan of having one hospital for each district/region.

While the colonial plan worked at that time, by the time Tanzania got its independence in 1961 the population of Tanzania was 9 million: currently the facilities are overwhelmed by the number of patients as the population has grown close to six times that of 1961. Consequently, the access to modern health facilities is not equitable in rural areas where the majority depend on traditional medicine.

After having discussed the domains that underpin this study and the situation of traditional medicine in Tanzania, the next section presents the statement of the problem of this study.

2.8 Statement of the Problem

As explained in the Background Section, traditional medicine was universally applied in Tanzania and the rest of Africa before the coming of Western colonizers. The colonizers established their rule of law. They also created educational, medical and legal establishments (MOH, 1992). Assisted by the Christian missionaries who accompanied them or came immediately behind them, they were able to establish schools, hospitals and to build churches for African Christian church members in the colonized countries. As anticipated, in any situation where there is a struggle for power, the colonizers faced a few challenges in putting these establishments in place because on their arrival they found that the indigenous people had their own ancestral religions, traditional healers were responsible for the health care system, and cultural values, beliefs and customs were already observed in the societies. In short, Africans had their own cultural systems which were totally incompatible with those of the colonizers. For

example, the colonialists could not differentiate between spiritual-based healing and indigenous religion as both involved some sort of cultural ritual. The colonizers could not differentiate between malevolent and benevolent rituals: as such the total life style of Africans was seen in the eyes of the colonizers as satanic and primitive (Tsey, 1997). The colonizers saw the need for the Africans to adopt new Western values based on Western culture.

Using the influential channels of religious doctrine, the educational system and the legal framework, the colonizers were able to transform the mind-set and attitude of many Africans (Richter, 2003). Christianity expounded that African religions were satanic and evil, and that people needed 'salvation'. The educational system introduced the belief that an educated person is not expected to visit a traditional healer: his place for seeking medical attention is in the Western-oriented hospital. The legal framework enacted a law to abolish witchcraft and suppress traditional healers' practice. On the basis of the influence from these three channels, biomedicine was introduced, nurtured and allowed to grow.

Biomedical and traditional practices are not reconcilable with each other for several reasons (Addis et al., 2002; Geest, 1997). First, biomedical practice deals with, and is directed towards the corporal senses of vision, taste, touch, sound and smell. Its interventions, therefore, are geared towards openly experienced areas of human cultures, activities, behaviours and practice. Traditional medicine on the other hand has to do with an individual as associated with the mind, body, emotions, relationships and spirit. It considers forces that cannot be seen with the eye, and these include how the patient regards situations, beliefs, attitudes, values, aspirations and ambitions, perceptions and interpretations. A better term to encompass all these is holism. Traditional medicine is holistic in nature and approach.

Secondly, building on the first point, historically, biomedicine as opposed to traditional medicine is believed to operate based on evidence. Evidence-based medicine which was introduced in the 1970s, gathered momentum in the 1990s; from that time, it has been the base whereby biomedicine has been able to maintain its supremacy over traditional medicine. Its supremacy is supported by the biomedical hierarchy of evidence. According to Broom et al., (2007), the hierarchy of evidence consists of systematic reviews with meta-analysis, experimental studies, as well as observational studies. Apart from a few herbal medicines that have undergone testing, most of

traditional medicines have never been studied. Thirdly, probably the most striking factor for non-reconciliation between the two practices is the theory behind the spiritually oriented healers who will not make a diagnosis nor treat the patient until divination rituals have been performed (Addis et al., 2002). Spiritual healing is a theory that is difficult to share or teach others as the technique is based mainly on the relationship between the healer and supernatural powers. The healer is literally told what to do during the ritual process; the supernatural powers direct the healer what to say do and advise the client. In the absence of divine rituals, the healer cannot perform his/her duties and therefore cannot share his/her knowledge (Kayombo, 2006).

Regardless of the factors for non-reconciliation between the two practices, it is a truism to say that the challenges and frustrations the modern health care system faces have changed the relationship between contemporary medicine and other therapies, and particularly between modern medicine and African traditional medicine, in the eyes of local and international health stakeholders (Geest, 1997). As a result, there are more calls for possible co-operation between the two practices (Broom et al., 2007; Tovey, 1997; Madiba, 2010). Factors put forward for co-operation include, shortage of trained health personnel, or, to be precise, a crisis of human resources for health in the biomedical sector. Sub-Saharan Africa has a large majority of traditional healers that are concentrated in the rural areas, which as mentioned before has high ratio as contrasted to the ratio of physician to patient (Bannerman, 1993). Geest (1997) urges that a better and less costly way to fill the gap in the need for health workers would be to train traditional healers for the post of community health staff wherever they are accepted.

The second argument for this recommendation is that conventionally trained doctors and nurses from Medical Schools and Nurse Training Schools do not like to work in rural areas where as many as 80% of the people live (Bamidele, 2009). Many of these trained staff disappear from rural areas after obtaining vacancies in urban areas. Traditional healers are likely to be at home because apart from being tied to the land as farmers, their medicines are obtained from a rural setting and they are more marketable there than in urban areas. In urban areas, there are more alternative means of treatment. In addition, the traditional healers are respected in their local surrounding communities and command immeasurable respect from the community. Their advice and counselling are taken seriously by the people who go to them for help. Also, the cost of their

services is considerably lower than other systems of treatment; while their interpersonal touch is hard to find in other modes of therapies (WHO, 1978a).

Thirdly, the budget set aside for the health sector in most African countries is so meagre that it can cater for only 30% of the total population (Kaboru et al., 2006). Most of the funds are allocated towards managing referral, regional and district hospitals, which are situated in urban areas leaving the rural people with no option but to turn to traditional healers for help. Fourthly, and this is probably the most striking frustration of the biomedical and health sector, is the emergence of chronic conditions in Africa, diseases such as HIV/AIDS, cancer and diabetes (Madiba, 2010). The allocation of public funding and placement of human resources in Africa has been skewed towards these conditions while other priority health needs have received scanty funding. Biomedicine has no cure for these diseases at an advanced stage: what is given is palliative treatment. Profoundly, traditional medicine/CAM have proved to be helpful in lessening the pain and suffering brought about by these diseases, not only because of the efficacy of their medications but more importantly because of their holistic approach. The last argument in favour of involving traditional healers in the National Health System is the cultural link observed between traditional practitioners and their clients (Geest, 2010). They have a lot to share about the cause of diseases and the societal implications of disease and treatment. This helps in enhancing compliance and the efficacy of treatment.

Despite the challenges that biomedical practice is facing now not, only in Tanzania but also in the rest of Africa, which could call for cooperation with traditional health practice; and in spite of the increased popularity and use of traditional medicine in Tanzania and Africa in general, which could also facilitate the need for collaboration with modern health practice, the current situation does not show any promising sign of cooperation between the two practices in Africa and particularly not in Tanzania. In addition, the empirical evidence from the western countries where integrative medicine has been established, has shown that the collaboration is loaded with mistrust and hegemony of biomedical practice over the traditional practice. Furthermore, there are elements of subjugation of traditional knowledge by contemporary health practice. In Africa including Tanzania the existing cooperation between modern and traditional medicine is in the form of seminars and workshops to sensitise traditional healers to follow the guidelines and directives from biomedical practice. There remains no study

that has sought to gain understanding why these two practices do not collaborate by involving not only biomedical practitioners or traditional healers, as some of the studies have done in the past; but involving other key stakeholders.

This study, therefore, intended to obtain the views of key stakeholders of health on the opportunities that are there for enabling traditional health practice to work together with modern health practice; at the same time, to identify the challenges and barriers for integrating the two practices within the context of the national health system in Tanzania. The outcome of this study may help to bridge the knowledge gap regarding what has kept the two practices apart and how the two practices could maximise the potential of opportunities that are there for them to work together. This then, is the essence of this study.

2.8.1 Central Research Question and General Objective

This study will be guided by one overarching research question and one general objective.

2.8.1.a Central Research Question

What are the opportunities and challenges for the traditional and contemporary health practices to work together under the National Health System in Tanzania?

2.8.1.b General Objective

To identify the opportunities and challenges for the traditional and contemporary health practices to work together under the National Health System within the context of the local Tanzanian environment.

2.8.2 Significance of the study

The study will build upon the body of knowledge regarding integration of traditional and contemporary health practices. The study will also highlight the mechanism through which traditional practitioners can work together with those of biomedical practice even in the least promising environment. Specifically, the study will do the following: -

- It will explore in depth the opportunities and challenges for traditional and biomedical practices to work together.
- It will suggest a workable generic adaptable model of collaboration between the traditional and biomedical practices.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

Within this chapter, I describe how I collected data and verified my findings to answer the central research question: “What are the opportunities and challenges for the traditional and contemporary health practices to collaborate under the National Health System in Tanzania” as clarified in chapter two. In order to address the question, I have introduced the study design or strategy that shows a way of thinking and studying social phenomena. I have described the methods that I have employed to collect data and evidence for the study. Finally, I have outlined and discussed the sampling techniques, ethical considerations, data analysis and strategies for validating findings. In each of these sections I have shown the rationale for my decision to arrive at the use, application or choice of one approach over the other.

3.2 A General Framework for this Study

Crotty (1998) suggested four questions to consider when designing a study proposal. The first question has to do with the theory of knowledge - what epistemology is attached to the theoretical perspective of the study? The second questions the philosophical position of the study – what theoretical perspective supports the methodology of the study, positivism or interpretivism? Third, what strategy or methodology provides a bridge between the techniques and the study outcomes – the methodology that will eventually guide which methods will be employed? The last question is about the methods – what techniques have been used and what is the rationale for the choice? These four questions were my guide in every critical decision that I made at every stage of writing this chapter.

3.3 Epistemology Claim and Ontological Position

Lincoln & Guba, (2000) define the term epistemology as knowledge assimilated and constructed in a defined context. As a concept of knowledge, epistemology reflects on two scenarios, “whether knowledge is attainable, or is personally experienced” (Burrell & Morgan, 1992: 3). This is a theoretical approach that defines “how knowledge is constructed in terms of how we know, what we know” (Crotty, 1998:16). In a larger picture the central research question guided the literature search that I undertook, which in turn established the epistemological stance of the study. I decided to adopt interpretivism which is frequently combined with social constructivism. As the term

claims, it is constructed and interpreted within a society, hence the terms social constructivism and interpretivism respectively (Bryman, 2008]). From a philosophical perspective I adopted a constructivist-interpretivist approach to suit my aspiration of understanding the experiences of the study participants. The knowledge claim helped me to obtain in-depth appreciation of the social order of the working lives of participants, and how they interact and negotiate with one another, including their perceptions, acceptability and rejection of each other.

Undeniably, it is claimed that an interpretive approach to study collaboration between traditional and modern health practices allows us to develop rich understandings of the commonalities and differences of the two practices but also the struggle and power relations between them (Fetterman, 2010). Such awareness is important in helping to reflect beyond essentially insensitive representations of practice. According to Denzin (1992), the constructivism-interpretivism perspective relates to symbolic interactionism, and it examines how people react towards things and other people. It also offers insights about social interactions and meaning constructed in relation to these things and people. As cited in Denzin (2001), Herbert Blumer (1969) noted “finally how these meanings are handled in, and modified through, an interpretive process used by person in dealing with the things he/she encounters” (2001:2). Expressed in a different way, it emphasises how people interpret the social order that they engage with.

The father of this idea was Mannheim (1960). Other contributors such as Berger and Luckmann drew attention to it: in their *The Social Construction of Reality* (1966) they noted that “experience of social reality is multi-layered and constructed through processes of social interaction” (Avis, 2005:10). Others include Lincoln and Guba (2000) who argue that social reality is constructed rather than found. In their writings, Neuman (2000), Schwandt (2000) and Crotty (1998) propound that individuals seek meaning and understanding of the world around them based on their historical and cultural norms and social perspectives. As people face challenging situations in their life, they face the circumstances by actively involving individuals in the construction of social reality through the creation of meaning and knowledge about a social phenomenon. The ultimate goal of this research therefore, depended solely on the participants’ points of view on opportunities and challenges for collaboration between

modern and traditional health practices in Tanzania. The participants constructed the meaning of a phenomenon based on discussion and interaction with other people (Atkinson, 2015). The prominence is on using a small sample to attain in-depth, rich accounts, and employing 'thick interpretation' of the study framework so as to gain deeper understanding of the participants' lived experiences (Markula & Silk, 2011; Howell, 2013; Denzin, 1989).

3.4 Qualitative: An Approach for the Study

Based on the knowledge claim of the study - interpretivism and constructivism - and the central research question, I opted for a qualitative approach. Bryman (2008) argues that qualitative study is suited where little is known about the phenomenon. The nature of the research question indicates that the concept or phenomenon under the study is poorly understood because there is dearth of information on the opportunities and challenges of integrating traditional health practice into the National Health Systems not only in Tanzania but also in Africa and generally all over the world. The desire of this study, therefore, is to gain understanding of the views of participants, which makes the choice of this approach driven by both practical and theoretical considerations.

Most researchers have concentrated on the safety and efficacy of traditional medicine as a barrier to cooperation between traditional healers and biomedical practitioners (Nyika, 2006; Bogaert, 2007; Waldram, 2000); the role of traditional medicine in the developing world (Patwardhan 2005); or in integrative medicine (Mizrachi et al. 2005, Shuval et al., 2004, Hollenberg, 2006). Others have investigated the attitude of biomedical practitioners regarding the possibility of integrating traditional practice into the national mainstream (Asante et al. 2013, Adams et al., 2009), while others have sought the response of traditional healers to the acceptance of traditional practices by the National Health System (Wiese et al., 2010). There is no study in Tanzania that has looked on the challenges and opportunities for the traditional and modern health practices to work together under the National Health System. Indeed, there is no a study either in Africa or in the world that has sought the opinions of seven different key participants on the opportunities and challenges of integrating traditional healers in the National Health System. The lack of information in this area, and the fact that this study was set to obtain the opinions, views, suggestions, feelings and experiences of seven different key stakeholders of both traditional and biomedical practices on the subject, cemented the need to use a qualitative approach.

Through qualitative approach I gathered information from dominant, well established and scientifically oriented biomedical practitioners (Adams and Tovey, 2005); at the same time, I obtained the accounts and feelings of the traditional healers who are perceived by the former as primitive, underdeveloped and marginalized (Shuval, 2005), who spoke their minds about working together. Furthermore, I obtained the views of key stakeholders in setting and implementing health policy about the possibility of cooperation between modern and traditional practitioners. These stakeholders include policy-makers, religious leaders and researchers; others were participants with multiple roles and users of both practices.

Qualitative research has its roots in inductive, interpretative and naturalistic orientations that focus on a complicated process whereby a researcher generates meaning from the facts collected from the field. Human beings construct meanings as they engage with the world around them, and this study was carried out in a natural setting where the participants live (Fetterman, 2010). Therefore, the attempt to explore the meaning and interpretation of challenges and opportunities and barriers of integrating traditional and contemporary health practices under the national health system was at the heart of this study.

3.5 Judging the Study

A few decades ago, when conducting qualitative research, one had to offer much discussion to convince the audience of the legitimacy of picking the approach. Of late there has been a consensus on what qualitative research is all about (Creswell, 2003). However, critics of qualitative research, particularly quantitative researchers, are still pointing the finger over the weakness of the approach. The major criticism levelled against the qualitative approach is its lack of scientific rigour, and consequently that the findings are too subjective. More often the approach draws a conclusion based on a few cases studied (Hammersley, Martyn and Atkinson, 1995). There is no consensus as to which method is suitable for evaluating qualitative studies (Flick, 2006). Corbin (2008) asks how we arrive at assessing quality: are we referring to validity or rigour, trustfulness or goodness or are we immersed in integrity. In reaction to this criticism, ethnographers developed the concept of naturalism, a substitute view to the nature of social science. Naturalism suggests that the social order should be studied in its natural state and left unaltered by the researcher. The ultimate goal should be to describe the social settings in dimensions identified by Spradley (1980). These include,

Space – location of the research; *Actors* – the people who take part in the setting; *Activity* – the actions of people; *Objects* – things located in setting; *Act* – a single act of participants; *Events* – what is happening in the setting; *Time* – sequencing of activities and time frame; *Goals* – what people aim to do; and *Feelings* – emotions that participants have (1980:78).

While I understood that not all information can be contained by this framework, my role was to remain open minded to any other alternative views (Hammersley and Atkinson, 1995). Building on Hammersley et al., (1995) on the issue of demonstrating a commitment to rigour, Bryman (2008) quoting Lincoln and Guba (1985) proposed terms for assessing the quality of qualitative approaches that are different from those used in quantitative approach. Central to the criteria on which to judge qualitative research is the term trustworthiness. The collateral variables include credibility, transferability, dependability and confirmability. Despite the fact that Lincoln and Guba's (1985) trustworthiness criterion is still regarded as the prime quality of deciding the worth of qualitative research in health systems integration, this standpoint has been questioned by Sparkes and Smith (2009) and Sparkes (1998, 2002). Their argument is that the criteria parallel to those used by quantitative research to achieve credibility are not suitable for its application to qualitative study. They criticized Lincoln and Guba's (1985) stance of prolonged engagement as an approach to achieve credibility in qualitative study, arguing that lengthy duration of engagement is not by itself a good measure of quality.

In addition, they argued that Lincoln and Guba (1985) acknowledged the limitations and problems inherited by their proposed criteria. They identified a conceptual contradiction in the formers' study, suggesting that while "they support ontological relativism on the one hand they advocated epistemological foundationalism in the framework that decides between the trustworthy and untrustworthy interpretations of social order on the other hand" (Sparkes and Smith (2013:493). Certainly, it was established that these two paradigm stances are irreconcilable. Instead, Sparkes and Smith (2013) advocate that the criteria should be used with caution, taking into consideration the research question. In other words, the criteria should not be regarded as ready-made tools to ascertain the quality of any qualitative study regardless of the features of quality study mentioned above. They propose that in judging the quality of qualitative studies researchers and readers should use, apart from Lincoln and Guba's (1985) criteria, other measures of judging quality. Given the criticisms, Sparkes and Smith (2013) advocated employing a different stance proposing that researchers should

do away with old-fashioned views regarding trustworthiness, and propose “relativist criteria to judge the suitability of a qualitative study” (2013:52). The benchmark suggested by Smith et al., (2014) should take into consideration ‘the type of study being judged, its tenacity, and the achievement made in the research field’ (Allanson, 2015:81).

This study, therefore, can be judged against the criteria propounded by Smith et al., (2014) by addressing a set of questions. First, was the current study a *worthy topic*, timely appropriate, substantial and thought-provoking in the domain of health systems integration? Secondly, has this study develop a *width* that is; is there enough evidence to support the analysis and interpretation made? Likewise, the study can be judged on how *believable* the results are, given that the findings presented are a function of my own interpretation of the participants’ accounts. As Morse and Field (1996), suggested there is no single accurate interpretation. Finally, does the current study create an *impact* upon another researcher or a reader, to create new avenues for further research and motivate new thinking to improve practices? While I believe, this study has sufficiently addressed all the questions, readers are also invited to judge it being guided by the same set of questions.

In conclusion, Seale (1999:7) writes “quality is elusive, hard to specify, but we often feel we know it when we see it. In this respect research is like an art rather than science”. I concur with Corbin et al. (2008) who summarize that ‘in spite of all the confusion and the debate around quality of qualitative research, we are still convinced qualitative research is a creative as well as scientific and artistic encounter, and that quality of qualitative findings will reflect all these aspects’ (2008:298). What is important in ensuring the quality of qualitative research is to attempt to have a combination of aspects of critical applications of research techniques, presentation of clear unambiguous evidence and reasonable claims coupled with balanced innovative and elegant thinking (Whittemore et al., 2001).

3.6 An Ethnographically Informed Qualitative Study: A Study Design

Based on the nature of the central research question, which is both exploratory and descriptive, and the epistemological claim of the study, which aims to construct the meaning and knowledge of key informants, I employed an ethnographically informed qualitative study also known as the Principles of Ethnography (Draper, 2000) or

“Ethnographic Stance”, a term preferred by Hockey (2002), as a strategy to explore the opportunities, challenges and barriers for the traditional and contemporary health practices to collaborate under the National Health System in Tanzania. Although I recognise this thesis does not offer an ethnographic study, it borrows from the approach and is imbued with ethnographic elements. At this point it is important to highlight the role of ethnographic sensibility as driving the methods. I approached the participants with an ethnographic sensibility that I cultivated before and during interviewing participants, which helped me to approach each group of participants with an open mind seeking to study the worldview of each towards traditional health practice and how the attitude of each group influenced the stance concerning traditional health practice of other groups. Ortner (2006:42) defines ethnographic sensibility as “Not only an embodied one, it is as much an intellectual (and moral) positionality – a constructive and interpretative mode - as it is a bodily process in space and time”. Ortner, a believer in Geertz’s “thickness” of study, describes an “ethnographically informed qualitative study as one that produces understanding through richness, texture, and detail, rather than through parsimony, refinement, and elegance” (2006:43).

Ethnography has three main characteristics: immersion in fieldwork to study the culture of a setting; key informants’ emic dimension; and thick rich description (Atkinson, 2015). Geertz refers to a culture as the total way of life of people, while he defines emic as ‘seeing things from the actor’s point of view’ (Geertz, 1993:14). He also refers to emic as a *verstehen* approach, which means “interpretive understanding of social action in order to arrive at a causal explanation of its course and effects” (Weber, 1947:88). On the same page, Geertz defines thick description as information about an action or event that is produced, perceived and interpreted by people. To be able to take up the three dimensions of ethnography a researcher needs to “use both the ethnographic eye (observe) and ethnographic ear (listen to informants)” (Martin, 1990:16). As my study employed ethnographically informed qualitative approach, I used mostly the ethnographic ear by employing semi-structured interviews to tape opinions of key informants about the opportunities, challenges and barriers for the traditional and contemporary health practices to collaborate under the National Health System.

I will provide explanation why the stance was adopted in this study. Traditional ethnographers who follow in the footsteps of Malinowski (1922) and Boas (1928) would likely criticise the design, arguing that ethnography that does not involve prolonged participant observation is weak and poor. Although classical ethnography is

well established to study culture in depth (Rapport, 2000), in this study I did not opt for it for several reasons. First, as will be described in section 3.7 about the study area, Tanzania is a large country with diverse ethnic groups, and more than 120 different tribes. As such, research sites and prospective participants in my study were heterogeneous and scattered (Hockey, 2000), and therefore the culture of the key participants was not expected to be homogeneous. Rather their social locations and backgrounds dictated their value systems (Fetterman, 2010). Although both biomedical and traditional healers have overarching cultures that distinguish them from each other, within them there are group values, cultures and behaviours of each sub-group specialization. Holloway (2010) refers to this organization as “socialisation”. For instance, it is well known that the biomedical profession is made up of several professions with each one having a unique culture. Although nurses and doctors in a surgical department might share common values and perceptions (especially about their patients) the cultures which have been built through their education and training may be in conflict with each other. Likewise, for doctors, although they are all regarded as physicians, their cultures differ depending on their specialities, thus surgeons and paediatricians have different beliefs and values (Holloway, 2010).

The same can be said of traditional healers, traditional birth attendants, herbalists and spiritualists: although they are grouped together as traditional healers, they don't share the same inner culture. Thus, engaging classical ethnography would have entailed prolonged, immersed study of the culture of each speciality in both biomedical and traditional practitioners, which might have not been feasible. This is not to say that I did not study their culture at all. I studied the general culture that identifies them as practitioners of their practices using in-depth interviews, as Agar echoing (1996:157) ‘Aren't people behaving when they talk, and don't they talk when they behave?’ When Hockey (2000) was interviewing widows, widowers and divorcees, the encounter evoked memories and strong emotional reactions for the interviewees. The mere fact that Hockey was conducting an interview occupying a seat that had been used by the late/former spouse was enough to bring back memories of their loved ones. They could recall the incidents and light moments they had shared together with their spouses. Hockey had this to say: “interviews allow past and future to be assessed via the present and create space for what has been left unsaid and what remains invisible”. She adds, “In the moment of the one to one interview, not only the past but also the dead are present” (Hockey, 2000:214).

Secondly, I favoured the use of an ethnographically informed qualitative study rather than classical ethnography because of the nature of the central question. Classical ethnography would have been the best design had integration of the two practices already been underway. The aim of the study would then have been to explore the culture of the newly formed group: what were the experiences of working together under the umbrella of integrative medicine? In this context, the purpose would have been to explore the position of both partners in the integrative setup: how the powerful, influential and dominant partner, that is the biomedical practitioners (Adams and Tovey, 2005), behave in the partnership; and what are the experiences of the less influential, marginalized and subordinated partner, the traditional healers (Shuval, 2005) as part of an integrative medical framework? As it was not the purpose of this thesis to study in detail the culture of each block of practitioners separately, classical ethnography was not the option preferred.

Thirdly, though renowned ethnographers such as Hockey (2000) and Agar (1996) agree and recognize the role of traditional ethnography, they strongly support the use of ethnographically informed qualitative interviews as a stand-alone study design. Hockey says, ‘Arguments to say that skilled interviewing can yield material of a quality which almost matches the products of participant-observation are persuasive’ (Hockey, 2000:210). Though Hockey was advocating the use of an ethnographically informed qualitative stance for studying British ethnography, the same can apply for Tanzania. With regard to interviewing as a core methodology Agar (1996:157) comments:

‘I also know that if you watch people doing things, you learn something you can’t get by just talking with them, although you can’t learn much unless you do talk with them before, during, and after the event. I think it might be more profitable, in the underdeveloped state of ethnographic methodology, to take the transcribed informal interviews as the methodological core, and then ask how other kinds of things ethnographers do relate to it’ (1996:157).

The bottom line was that the ethnographically informed qualitative stance, and hence the employment of ethnographic interviewing, was able to produce in-depth, rich and thick description on its own right, a stand that is supported by Draper (2000), Hockey (2000) and Geertz (1973).

3.7 Study Areas in Tanzania

The study was carried out in four different regions namely Dar es Salaam, Dodoma, Shinyanga and Tanga. The justification for picking those regions was that Tanzania is a large country of 364,900 square miles or 945,200 square kilometres; its size is about 3 times that of Italy, or the areas of Kenya, Uganda, Burundi and Rwanda combined together. Although Tanzania has 30 regions with more than 120 tribes, there is similarity of culture among the tribes of a certain geographical area. Hence, 30 regions in Tanzania can be divided into seven zones, with regions that constitute a zone bearing a similar culture. Although the aim of picking four regions was not to draw a representative sample, the four regions closely represent four different zones and four different cultures out of seven zones. The zones represented were Eastern zone (Dar es Salaam), Central zone (Dodoma), Northern Zone (Tanga) and Lake Zone (Shinyanga). Zones that were not represented were South, West, and Southern West (Southern Highlanders).

The regions represented important social aspects or contexts which had an impact on the study. For example, Dar es Salaam is the most important city for policy-making in Tanzania; it represents the power of the state through the Ministry of Health and Social Welfare. This is where health policy is formulated, and policy-makers make major decisions about the health of Tanzanians. In addition, Dar es Salaam harbours the Muhimbili University of Applied Health Sciences which houses The Institute of Traditional Medicine (ITM). The National Institute of Medical Research (NIMR) is also in Dar es Salaam. Both ITM and NIMR are mandated to research and advise on the use of traditional medicine in the country. All national religious leaders are in Dar es Salaam. What they say is taken seriously by their religious followers, country-wide. Dar es Salaam is represented by a sample of 11 participants, 2 policy-makers, 3 religious leaders and 3 researchers from ITM and NIMR and 3 participants with multiple roles. Tanga, Shinyanga and Dodoma regions had a total of 24 participants; each region had a sample of 8 participants, who were practitioners of one of the two practices (biomedical and traditional). The three regions represented different contexts of traditional healers in Tanzania.

Tanga region represents the culture of the traditional healers of the Coast belt and partly the Northern part of Tanzania. In addition, Tanga is the home of a collaboration model in Tanzania, the Tanga AIDS Working Group (TAWG), in which biomedical

and traditional health practitioners, local scientists and scientists from the National Institute of Health and the George Washington University in the United States work together towards developing traditional medicines that have proved effective in treating HIV/AIDS opportunistic infections. The group is sponsored by the World Bank. There are also a number of other initiatives to bring both traditional healers and biomedical practitioners to work together in two districts in Tanga region sponsored by TAWG. Tanga region, therefore, was the best place to study a model of collaboration between the two health practices.

The remaining two regions represented two diverse situations. Shinyanga region represents a culture that is immersed in superstitious, supernatural powers and witchcraft. Some traditional healers are involved in both malevolent and benevolent activities. Traditional healers in Shinyanga and Lake Zone in general are implicated in the killings of albinos and red-eyed elderly females for superstitious reasons. Dodoma region represents a culture of communities that embrace traditions and the cultural practice of female genital mutilation (FGM) that is perceived to have negative health outcomes. Female traditional healers are responsible for carrying out the procedure although the practice is illegal in Tanzania. What is interesting about the Shinyanga and Dodoma regions is that the same people who would like to see the killings of their loved ones and the practice of female circumcision come to an end, are the ones who go to traditional healers willingly for consultation when there are unexpected deaths of loved ones or when they need surgery. The map of the United Republic of Tanzania showing the study area is attached as appendix 9; also, Tables 3.1 and 3.2 below depict the situation of regions.

3.8 Sample and Sampling Techniques

Following the weakness inherent in the studies reviewed in Chapter Two where one or two group of participants were recruited for the study, this study has a wide representation involving seven different groups of participants whose relevance to the study is given in section 3.8.1. The participants' groups, sex and their number are shown in table 3.1 and 3.2 below. In the same vein the participants came from four regions, each region representing a zone. Hence, four out of seven zones were included in the study. The study was expected to draw a total of 40 participants into the study. Thirty-five (35) participants agreed and participated in the study which brings the

response rate to 87.5 per cent. The breakdown by category and sex is shown in table 3.1 below.

Table 3.1 Sample Size by Category, Response Rate and Sex

| Category | Proposed Sample | Actual Sample | Percentage | Sex | | Characteristics |
|----------------------------------|-----------------|---------------|------------|-----|----|---|
| | | | | F | M | |
| Biomedical Practitioners | 14 | 12 | 85 | 5 | 7 | BMP government employed |
| Traditional Healers | 15 | 10 | 67 | 5 | 5 | TH- Herbalists, TBAs, BS, MHP, Spiritualists |
| Religious Leaders | 4 | 3 | 75 | 1 | 2 | Christians (Protestants & Pentecostal, |
| Policy Makers | 3 | 2 | 67 | 1 | 1 | From the Ministry of Health |
| Researchers | 4 | 3 | 75 | 1 | 2 | NIMR & ITM |
| Participants with Multiple Roles | 0 | 5 | 500 | 2 | 3 | BMP, PM & TH; BMP & TH; BMP & PM; RES & PM; TH & UP |
| Total | 40 | 35 | | 15 | 20 | |

N.B: 1) All participants also played a role as clients for either biomedicine or traditional medicine. 2). See Section 3.14 for explanation of omitted representative of Islam religion.

Key for table 3.1 & 3.3: BMP - Biomedical Practitioners; TH - Traditional Healers; TBAs - Traditional Birth Attendants; BS – Bone Setters; MHP – Mental Health Practitioners; PM – Policy-makers; RES - Researchers; MR – Multiple Roles; UP – University Professor; RL –Religious Leaders.

Source: Compiled by the Current Researcher

Table 3.2: Sample by Region, Category and Sex

| Region | BMP | SEX | | TH | SEX | | RES | RL | PM | MR | TOTAL |
|-------------------|-----------|----------|----------|-----------|----------|----------|----------|----------|----------|----------|-----------|
| | | M | F | | M | F | | | | | |
| Shinyanga | 4 | 3 | 1 | 4 | 2 | 2 | - | - | - | - | 8 |
| Dodoma | 4 | 2 | 2 | 3 | 1 | 2 | - | - | - | 1 | 8 |
| Tanga | 4 | 2 | 2 | 3 | 2 | 1 | - | - | - | 1 | 8 |
| Dar es Sal | - | | | - | | | 3 | 3 | 2 | 3 | 11 |
| Total | 12 | 7 | 5 | 10 | 5 | 5 | 3 | 3 | 2 | 5 | 35 |

Note: Sex identification for Researchers, Religious leaders, Policymakers and participants with Multiple Roles is as shown in Table 3.1

Source: Compiled by the current researcher

Table 3.3 Health Practitioners by Practice and Speciality

| Type of Healing Practice | Herbalists | Bone-Setters | Mental Health | Traditional Birth Attendants | Spiritual Healer | Total |
|--------------------------------------|------------|--------------|---------------|-------------------------------|---------------------|-----------|
| Traditional Health Practice: N:10 | 3 | 2 | 1 | 2 | 2 | 10 |
| Modern Health Practice N:12 | Doctors | Nurses | Pharmacist | Medical Laboratory Technician | Public Health Nurse | |
| | 4 | 3 | 1 | 1 | 3 | 12 |
| Grand Total | 7 | 5 | 2 | 3 | 5 | 22 |

Source: Compiled by the Current Researcher

3.8.1 Sampling Technique

As pointed out earlier I obtained detailed accounts or perspectives from the key participants who were my active collaborators as they informed me about issues in their worldviews. In selecting them I used a non-probability purposive sampling technique, also known as criterion-based sampling (Gerrish, 2010). Non-probability sampling

technique differs from probability sampling in that the latter draws a sample that is representative of the whole population, with all members of that population having equal chances to be selected, while the former draws a sample based on who is most likely to answer the research question (Marshall, 1996). Criterion-based sampling is governed by the central research question to ensure that those selected will be able to answer the question. In this scenario traditional healers, biomedical practitioners, policy makers, religious leaders, and researchers were chosen on the basis that they had experience and knowledge related to the phenomenon under study.

Traditional and biomedical practitioners were selected because they represented their health practices, researchers were recruited because they are engaged in researching the efficacy of traditional medicine, while policy-makers were included because they are responsible for setting the health policy agenda, which is formulating and implementing health policy. Religious leaders on the other hand were included because they are one of the principal stakeholders in setting a policy agenda but also because historically religion, especially Christianity, was used by colonialists to push down traditional medicine, from which it has never been promoted. As such, Christian religious leaders are historically not reconciled to traditional healers in Africa (Geertz, 1997).

Recruitment was based on inclusion and exclusion criteria. For biomedical practitioners the inclusion criteria were middle and lower medical practitioners in public health facilities. The rationale for selecting these was the fact that they deal with most of cases and they are available at all levels from dispensaries and health centres to tertiary hospitals. Dispensaries and health centres are the initial level of the biomedical health system where cooperation between the two practices is more likely to be feasible. The exclusion criteria excluded specialist doctors in public referral hospitals, biomedical practitioners working in private facilities and those employed by the faith-based facilities, the rationale being that on one hand the integration of the two practices is likely to be between the traditional healers and biomedical practitioners working in government-owned facilities, and cooperation between the two practices is likely to involve the lower cohort of biomedical practitioners who are posted in rural areas.

For traditional healers, the inclusion criteria were traditional healers who were registered with their local association. All traditional healers in Tanzania are required by law to be registered and work under the umbrella of their local associations. It is these associations which offer recommendations to the government as to whether a

traditional healer should be licensed to practice. The exclusion criteria were traditional healers who were not registered with a local register. As for religious leaders, I selected one religious leader each from Christian denominations: Roman Catholic, Protestants, Pentecostal churches, and Islam, as these are the major religions known in Tanzania. Recruitment was through the facility gatekeepers; biomedical practitioners were obtained through their respective Regional/District Medical Officers; as for the traditional healers the gate keepers were the Regional Traditional Healers' Coordinators; the directors of NIMRI and ITM were the gatekeepers for obtaining the researchers in those two institutions. The Ministry of Health was the gatekeeper for recruiting policy-makers, and religious leaders were recruited through the Secretary General of the respective religion. In all categories gender balance was ensured so that where possible recruitment was 50 per cent male informants and 50 per cent female informants.

After obtaining permission from the district/regional authority I personally approached the practitioners and asked them to be in my study. I left a letter with those who agreed that explained the purpose and procedure of the study for them to read, internalize and decide whether they wanted to participate; after three days, I went back to them to get a reply. The same procedure was employed with religious leaders, policy-makers and researchers. The response was amazing as almost all potential participants agreed to participate in the study. A copy of information for participants is shown as annex 10

3.9 Methods of Data Collection

Data collection methods or research methods are tools that collect information from the participants to address the research questions. In this study, I used both source and data triangulation to collect data from multiple sources attesting to the same phenomenon. Multiple sources of data allow the researcher to address a broader range of attitudinal, historical and behavioural issues (Flick, 2006; Bryman, 2008; Denzin, 2009). Source triangulation made use of traditional healers, biomedical practitioners, religious leaders, policy-makers, researchers and participants with multiple roles. Method triangulation was initially planned to involve semi-structured interviews, focus group discussion, and documentary review. However, since data collection was done in the month of Ramadan and most traditional healers were Moslems who were fasting, focus group discussion could not be held. Even after the fasting month of Ramadan it was not possible to call for focus group discussion because the healers had resumed their clinics

and there was a huge backlog of patients waiting for their services. Thus, method triangulation involved semi-structured interviews and documentary review. Bryman (2008), Silverman (1993) and Gubrium and Holstein (1997) concurred that the semi-structured interview is the most commonly used method in a qualitative approach

3.9.1 The Semi-Structured Interviews

The semi-structured interview was the major method of collecting views, opinions, suggestions, feelings, facts, reservations and comments from key informants about the collaboration between traditional and modern health practice under the National Health System. Proponents of the interview method (Pettermann 2010, Atkinson 2015) claim that interviewing is one of the powerful means to gather the views of individuals and groups whose knowledge has been assimilated, appropriated and marginalized, such as the knowledge of traditional medicine (Shuval, 2005, Hollenberg, 2010). Interviews provide a framework to obtain in-depth, thick and rich description from participants about the phenomenon under study (Miller and Glasser, 1997). Semi-structured interview was the preferred method in qualitative research since as Burgess (1984) suggested, the technique creates space for respondents to express themselves freely. This view is supported greatly by Harding (2013), who describes it as an enabler for participants to take full advantage of their position and reduce the power relation between researcher and participants. The method allowed unlimited room of expression to both the researcher and the participants. While the researcher was flexible in phrasing questions, the participants were free in answering the questions (Bryman, 2008).

Interviews were conducted with all key participants as mentioned in the previous section; and the rationale for their choice was given above in the sampling section (3.8.1). However, it suffices at this point to say that their selection was based on specific criteria to ensure that they answered the central research question. In making sure that I was able to obtain rich views from the key informants, I borrowed the list of ten criteria of a successful interviewer propounded by Kvale (1996), as reported by Bryman (2008).

In conducting the interviews, I used open-ended questions guided by what Bryman (2008) calls an interview guide. An interview guide, unlike the aide-memoire used in unstructured interviews, enabled me to cover specific topics related to integration of the

health system. Although an unstructured interview was capable of obtaining the same outcome, the issue of cooperation with modern medical practitioners or integration into the national health system was unlikely to be a priority given the fact that traditional healers in Tanzania are struggling for their legitimacy, what is important for them is to be accepted and allowed by the government and the public at large to perform their work freely. Consequently, it was very unlikely the participants would bring up or mention the subject if they were left to tell their story guided only by an unstructured interview.

I used the interview guide flexibly depending on the situation and circumstances. In other words, I did not strictly adhere to the interview guide in order to avoid questions having to be answered in order, as in the survey method. My approach to the interviewing was to let participants talk freely and uninterruptedly, applying minimal directive strategy (Morse and Field, 1996). I created an atmosphere where participants led the interview and my role was to seek clarification where need arose, borrowing the strategies of reflecting, clarifying, summarizing and focusing (Connor et al., 1984). For example, a focusing question would be, 'Tell me about the relationship between religious leaders with traditional healers?' A clarifying question sounded like 'Would you say biomedical practitioners refer their clients to traditional healers?' An example of a reflecting question is 'If you [biomedical practitioner] had a client who would not benefit from biomedical therapy and you are aware of a traditional healer who is known to alleviate such condition would you recommend a referral?' An example of a summarizing question is 'Having discussed the pros and cons of integrating traditional healers into the national health system do you see the possibility of the two practices working together?' Details of these questions and prompts are in appendix 3 to 8.

The interviews were tape-recorded so that during data analysis I was able to listen again and again before transcribing them verbatim. An interview took between approximately 60 and 90 minutes. The exact time was decided after pre-testing the study. Experience from many researchers (Corbin and Strauss, 2008; Croswell, 2003), including myself is that informants tend to begin a very constructive discussion soon after the tape recorder is switched off. This happened frequently. Depending on the sensitivity of the information provided, common sense helped me to decide whether to make notes immediately after the interview in my car. If the topic was not sensitive but important I asked the participants' permission to jot down a few lines regarding their contributions. An example of sensitive information given to me includes how the

government mistreated all traditional healers in a geographical area where an albino had been killed for superstitious reasons, regardless of who had been involved.

Participants decided where and when they wanted to be interviewed as I tried as much as I could not to interfere with their work schedules and to ensure they were comfortable with the environment. Sharkey and Larsen (1998) discuss that the researcher-participant relationship and the issue of power relationship between them will influence the outcome of data especially if the researcher is, or is perceived to be, a practitioner. To tackle the issue of power relationship, I established a good working relationship with a participant in the first minutes of the interview by building trust and rapport before the interview proper was done. Issues related to anonymity, confidentiality and liberty to drop out of the study were assured and stressed. I took precautions to reduce the power relations between myself as the interviewer and the interviewee by avoiding as much as possible questions that started with 'why'. 'Why' questions, according to Becker (1998), create defensiveness on the part of the participant. Instead he suggests the use of 'how' questions. A question such as; 'why do biomedical practitioners not collaborate with traditional healers', puts participants on the defensive to defend why they do what they do. A better question, instead, would be 'how could biomedical practitioners collaborate with traditional healers?'

My personal experience in the field was that it was not always the case that a researcher was more powerful than the participants; in some instances, participants tried to be more powerful than me by dominating the interview and the direction of inquiry. My winning technique was always to be flexible and exert a certain degree of control over the dominant participants without hurting their feelings. For example, I would ask them politely to elaborate on a certain point in order to put to an end a lengthy discussion – 'Thank you for a detailed explanation concerning your relationship with researchers: would you please say more about your relationship with religious leaders especially those of Christian denominations?'

In closing the discussion of interviews, I find it important to share my experience concerning interviewing female participants. The academic literature has documented the worries of researchers particularly among feminist researchers, that gender can influence the course of research especially when men interview women (Lather, 1988; Seibold, 1994; Harding, 1987). In my study, I interviewed female participants. Some were powerful such as policy-makers and biomedical practitioners. My first reaction was to acknowledge that power relations were unavoidable when men interview

women and vice versa, especially in the Tanzanian context, although it does not always work in a predictable way. Sharkey and Larsen (1998) argued that acknowledging that there will inevitably be a certain kind of power control from a researcher whether male or female, is part and parcel of the reflexivity of research.

As my approach to both male and female participants was similar, my role was to minimize any power relation between the participants and me as a researcher, regardless of the gender and the position of the interviewee. First, I explained the purpose of my study in very clear terms so that every participant saw the importance of the study. Secondly, I placed myself as far as possible as a receiver of information rather than an all knowledgeable practitioner by showing my eagerness to learn from them, and by allowing every participant to be at the centre of the study so that each one of them felt a sense of ownership of it, and that without them the study would not be successful. Thirdly I instilled in all participants a sense of pride that they represented many people in the country in contributing to a study that carries with it great importance to the country and beyond. The greatest achievement was for me to be very transparent and honest with them. Using these empathetic but honest techniques I was offered great support from both female and male participants; while in some areas it was women who were more engaging and informative than men.

My experience of working with female participants in this study speaks against the works of Lather (1988), Seibold (1994), and Harding (1987) who argue that gender can influence the course of research especially when men interview women. On the contrary, my experience was supported by McKee and O'Brien (1983) who suggested that gender influences what will be disclosed and what will be withheld in an interview. In my case women participants shared more critical information with me than male participants. Draper (2000) also nullified the notion of a gender barrier when she was interviewing men (expecting fathers): she found them neither monopolizing the discussion nor hiding information during the interviews. On the contrary, men were very understanding, helpful, and supportive to her project. Draper (2000:95) summed up boldly 'It is perhaps style and technique, rather than gender that is significant'. I agree with Draper; it is a matter of approach.

3. 10 My own Reflexivity and Role as the Researcher

My epistemological stance in this study is that key informants (traditional healers, biomedical practitioners, religious leaders, policy makers, researchers and, in addition

to my study participants, the lay community) have answers as to what are the challenges, opportunities and barriers for the traditional and modern health practices to collaborate under the National Health System. My academic and professional background placed me well to engage with these groups (Creswell, 1994). I am trained as both a medical doctor and a public health specialist, having majored in International Health. Professionally I am a University trainer, consultant and a researcher which partly explains the genesis of choosing this research topic (Finlay, 2003, Denzin et al., 2003). My background gives me an added advantage in successfully carrying out this study because during interviews I identified myself to traditional healers as a public health specialist, while with biomedical practitioners I identified myself as their colleague; this helped to build rapport and trust. Participants respond well or poorly based on the race, gender, age and class of the researcher (Miller et al., 1997). Mismatch between the researcher and participants may cause participants to doubt the credibility of the researcher. My historical background also drew me closely to this study and research participants.

I was born towards the end of the British colonial era, a few years before Tanzania acquired its independence. My grandparents as well as my parents were staunchly devoted Christians. Thus, no wonder I was born and raised as Christian, a strong churchgoer and a believer in the existence of God in three Spirits, the father, the Son - Jesus Christ who is Lord and Saviour- and the Holy Spirit. This stance was completely contrary to the values and belief system of my tribe. I originate from Shinyanga, a region known to be immersed in superstitious beliefs, where performing rituals is the order of the day for most people. Rituals were and are still performed over a new-born child to ensure its survival. In my childhood days, rituals replaced immunization: every child in the village had a charm or magic spell entangled in a black cloth worn round the neck or around the arm to protect him or her from evil spirits. Normally there was a special incantation, or a ritual performed when the charm is put on a child to protect him or her from the evil eye. In our village, children from our family and a few others from the 'born again' Christian families were the only ones who never went through those rituals. As children, we used to argue; they told us we would be harmed by evil spirits because we were not protected, and we boldly replied that we were protected by the blood of Jesus. I had never stepped inside a traditional healer's door in my life until four years ago when I was involved in a study to explore the health-seeking behaviour of Tanzanians. The mere fact that I was sitting in a traditional healer's house was

enough to give me goose bumps as I could sense the incompatibility of my faith with the environment where I was. I was forced to make frequent silent short prayers between the interviews as I sensed there was a tug-of-war in a spiritual realm.

At the age of seven I went to school. The environment at school was similar to the one at home: we were taught principles of good health, personal hygiene and encouraged to go to biomedical health facilities when we become sick. Traditional healers were regarded as enemies of development. Thus, the educational system and the Christian faith had something in common, degrading indigenous medicine and praising biomedicine. Later, I joined a medical school where the education and training I obtained nurtured and cultured me to see traditional healers as a stumbling block to total liberation for Tanzanians in the field of health. As a practitioner, I was annoyed when a patient confessed that he or she had been receiving treatment from a traditional healer.

It was not until I went for my Public Health masters' degree that I started opening my eyes to see the other side of the world. The training helped me to be less critical and judgmental about traditional medicine and its practitioners. I started questioning the legitimacy of biomedicine as the sole care provider in the health sector. I searched in the Bible to find a verse that was contrary to traditional medicine, but I could not find one. Probably the Bible was in favour of biomedicine I thought, but the Bible was silent on the subject; after all biomedicine came after the Bible was written. I could feel anger and frustration inside me, but this time my anger and frustration were not directed towards traditional healers. My disturbed mind was directed to the government, first to the colonial government and later to the Tanzanian government. Before and after independence both the colonial government and post-independence governments concentrated their efforts on establishing good health facilities in urban areas, leaving the rural areas, where 80 per cent of people live to depend on substandard health facilities, if not traditional healers. The most disturbing question was if the government was knowingly confessing, with or without proof, that traditional medicines were useless and unsafe, why and how would it leave the majority of its people to depend on something that is known to be unsafe? These disturbing questions prompted me in 2010 to research the factors behind the health-seeking behaviour of Tanzanians. The findings of that research were the genesis of this current study.

My background not only influenced the choice of my study, but it also explains that I am approaching the study from both insider and outsider perspectives. As an insider

(emic perspective) I share the knowledge, experience and frustrations of biomedical practitioners, I know their stance and the reasons for that stance. In the same vein, I share the segregated and marginalized life, struggles and experiences of traditional healers. But more importantly my heart goes to many of my relatives and Tanzanians at large who live in rural areas, and who depend on traditional medicine, a medicine that religious leaders, policy makers and the government officials do not trust and about which they have done nothing. I identify myself with Christian religious leaders based on my faith. I understand and share their minds which are disturbed by the heavy workloads for deliverance of people who are oppressed by demonic power. Based on the way I was brought up spiritually, I am not only a leader in my church but also have close friendship with many religious leaders inside and outside Tanzania. My triple relationship with these three groups placed me in an advantageous position to carry out the study. Lewis (2003) supports my stance: he asserts that when researcher and participants share a common cultural background it enriches the investigator's knowledge of the participants' perspectives and the language they use. At times a researcher stops for a moment, steps back and mirrors his or her experience as those of participants. This is creative interviewing that invites thick description because the researcher has created a climate for mutual revelation (Douglas, 1985).

Although I regard myself as an insider, an emic perspective can be unfriendly to the study as investigators can rely on assumptions and lose awareness of their position and function. In my case I was carried away with empathy for the rural people who depended on traditional medicine. In addition, I approached the study with a biased mind against the government because of its position on traditional medicine. To offset or counterweigh the effects of emic perspectives I also took the stance of an outsider (etic perspective). To that end, I tried to be as neutral as I could, and allow the themes that were derived from the interviews to dictate the framework of the phenomena that emerged. In addition, I employed Weber's *verstehen* logic, which not only seek to explain, but also to understand human action and social behaviour (Weber, 1947). Following this, although I did not share beliefs with some traditional healers, I understood and accepted their desire and behaviour that was intentional to be part of the National Health System: thus, I was able to accommodate them as well as their behaviour. The interpretation of the findings was through the eyes and minds of the participants, as this empowered the participants and created space for their voices to be heard rather than my desires as a researcher (Denzin et al., 2003; Finlay, 2003);

Holloway et al., 2002). This is what *verstehen* analytic understanding is all about. The next section discusses the pilot study.

3.11 Pilot Study

The pre-testing of the current study was conducted at Mzumbe University Hospital, where I interviewed biomedical practitioners, a university chaplain, and traditional healers from the villages close to Mzumbe University before embarking on the full-scale study. The major purpose of conducting a pre-test study was to identify potential problems in the study. Specifically, I tested the reactions of participants to the research procedures, for example the availability of the study population and how the study interfered with work schedules, acceptability of questions, and willingness of the participants to answer the questions. Secondly, I tested the data collection tools to determine whether the tools allowed me to collect the data needed, whether there was a need to revise the sequence of questions, review the wording of the questions and whether the translations were accurate. The pre-testing indicated some problems of sequencing of questions and the wording of some questions was revised. Apart from those challenges there was no other problem.

3.12 Data Analysis

3.12.1 Introduction

In this study, data were analysed using a thematic approach guided by the framework developed by Harding (2013) which follows four steps. Before discussing the steps that I followed in the process of analysing data, it is important to define a few terms as employed in this model. Categories in this thesis ‘refer to broad subjects under which the data were grouped’ (Harding, 2013: 83), initial categories were identified as I read and re-read the full transcripts. Codes, normally are annotated in the margin of an interview transcript and can be in a form of a phrase, full word or an abbreviation. “A code draws attention to a commonality within a data set” (Gibson and Brown, 2009:130). Furthermore, when one code relates to case A but not to B, this can evoke a difference between cases. Moreover, detecting patterns as to where codes appear and where they do not appear can help in discovering relationships. Thus, codes are regarded as a vital tool for conducting thematic analysis of a phenomenon, and coding assists in realizing the triple aims of thematic analysis, that is exploring commonality,

exploring differences and exploring relationships. The codes used in this thesis are in the form of full words of which the primary role is 'selecting, separating and sorting data' (Charmaz, 2006:45). Thus, categories serve the function of separating and sorting data.

Let me declare from the outset that I analysed the data in this study manually for the following reasons. First, analysis in simple terms is about moving from data to concepts, and within concepts, moving from lower concepts to higher concepts while maintaining intimacy with the data. To be able to do that, I was immersed in the data by spending more time with it so as to gain insight and sensitivity, two important variables that enabled me as a 'researcher to group events under more conceptual label[s]' (Corbin and Strauss, 2008:52). Corbin goes on to say, 'being open to all possible meaning in data as well as potential relationships between concepts, is very important in early analysis' (2008: 52-53). The ultimate advantage of this immersion was to create as many codes as possible so that all important information is captured and to prevent early closure or rush to a conclusion by having a small number of codes.

Secondly, basically analysis is interpretation of other people's accounts (Blumer, 1969). Interpretation almost always distorts the original meaning (Denzin, 1998), so much so that it is only through deep immersion in data that one can translate or interpret experiences, actions, and issues expressed by the participants. Analysing data manually, I believe, keeps the intimacy between the data and the researcher. In this study, the process of analysis involved detailed description of the views, opinions and suggestions of key participants: traditional healers, biomedical practitioners, policy-makers, researchers and religious leaders followed by analysis of the data for themes (Stake, 1995). Handling of my data manually was advantageous, for even with electronic aids, the interpretation of data remains the role of a researcher. The overall objective of the study was a guiding principle as to which data should be sorted in the category, while the challenge was to write a code that summarised data in way that it does not lose its original meaning.

3.12.2 Why Thematic Analysis

At the outset of this section I have attempted to make it clear the data were analysed thematically. As indicated earlier, the study design employed was the principles of ethnography, and a semi-structured interviewing was the main method of data collection. However, the data were not analysed using traditional ethnographic methods

for a number of reasons. First, conventional ethnography makes use of prolonged observation of participants, series of interviews and field notes. As such the ethnographic analysis text books have steps that take into consideration the three data collection methods. Since my study did not employ traditional ethnography, the ethnographic analysis was neither compatible with nor relevant to my data.

Given that this study employed the constructivism-interpretivism perspective, I decided to use thematic analysis approach due to its flexibility to be engaged across a number of epistemological and theoretical approaches (Braun et al., 2006). Hence, it is well-matched with both essentialist and constructionist frameworks, in which it seeks not only to discuss the participants' views regarding the opportunities, challenges and barriers of cooperation between traditional and biomedical health practices, but also to scan the degree to which those views, beliefs and experiences are interwoven with the thinking as well as making sense of wider socio-cultural ways of collaboration between modern and traditional health practices. Thematic analysis approach suited the data, topic and context of the study because it was able to report the way in which actions, social order, values and experiences are the consequences of a variety of discourses working within society.

The central objective of the ethnographic stance as a framework is to describe the lives and world perspectives of other people and their culture. That is where thematic analysis and ethnographic stance converge. My role, therefore, was to make use of participants' experiences and insights by integrating different views and data sources in a complete investigation (Sharkey and Larsen, 2010). The generation of data in a progressive way shaped the process of analysis: "It was about asking questions of the data and benchmarking how the answers were interpreted to make sense" (Sharkey and Larsen, 2010:56). Ryan and Russell (2003) offer the best description of a link between thematic analysis and ethnographic stance: they comment, as ethnographic data are recorded in the form of text, the process of analysis begins with free-flowing text by coding, identifying themes and concepts and building conceptual models.

3.12.3 Inductive Thematic Analysis and Latent Themes

There are two frameworks in which themes or patterns can be recognized from data in thematic analysis. First, in a bottom-up or an inductive method (Braun et al., 2006); secondly in a top-down or deductive or theoretical framework (Hayes, 1997). The current study employed the former approach in which the identified patterns were

closely associated to the data themselves (Patton, 1990). Thus, the themes neither had a link to the list of questions that were asked during the interviewing nor my theoretical interest in the topic as a researcher. In other words, there was no preconception or pre-set coding framework through which an inductive analysis tried to fit the data into it. The analysis was therefore data driven.

At which level were the themes to be identified, was another decision that I had to make as a researcher. Boyatzis (1998) propounds that themes can be identified at an explicit or semantic level on the one hand, or at an interpretative or latent level on the other. In the former approach the themes are identified within surface meanings of the data. The analytic process moves in a sequential order of, first, the description of data, where the data are arranged to show patterns in semantic content. In the next step, the data are summarized without losing track of the initial meaning obtained from the participants. Finally, the data are interpreted, whereby efforts are directed towards theorizing the importance of the patterns and their wider meanings and associations (Patton, 1990). On the contrary, a thematic analysis working at the latter level is more involving than the semantic content of the data. The process begins by reflecting on the primary philosophies and assumptions that are conceived of as informing the semantic content of the data. Consequently, as themes are developed, the process involves interpretation, and the product of analytic process goes beyond description. Indeed, it is already theorized. Guided by a constructionist framework (Burr, 1995) in the current study the researcher identified themes at a latent level.

3.12.4 Steps Used in Analysis

The four steps of analysis in the Harding (2013) model that I used were as follows:

Step 1: “Identifying initial categories based on reading and re-reading the transcripts.

Step 2: Writing codes alongside the transcripts

Step 3: Reviewing the list of codes, revising the list of categories and deciding which codes should appear in which category

Step 4: Looking for themes and findings in each category” (Harding, 2013:83)

The strategy for coding employed in this study was empirical codes (Brown and Gibson, 2009) that are derived while reading through the data, as issues of significance and commonality were identified. As my research was inductive in nature, empirical codes were relevant because the data was examined and analysed before considering the existing theory and literature.

3.12.5 STEP 1: Identifying Initial Categories

I read thoroughly all 35 transcripts line by line and compared them with the tapes for accuracy, as the data were transcribed by another person. As I read through the data, a process that Sharkey and Larsen (2010) referred to as asking of data, I identified broad subjects of interest that helped me to gain understanding of a general holistic picture of the data being generated. By trying to dig beneath the data to discover the tone, the general impression and ideas participants were expressing, I was translating the key participants' words and actions for the audience that I desired to reach. At that point, I underlined the key phrases and wrote a data memo of all issues of interest that I came across. Each participant narrative was stored in a separate file constituting a dossier of the participant's account.

As I read the transcripts, I identified initial categories, which were like general subject areas in which I placed the codes. As I read one transcript after the other, line by line, I sorted and arranged facts into various categories as I picked out key phrases and noted things of interest. Thorough reading of the transcripts gave me five initial categories as follows:

1. Practicalities of Traditional Health Practice (THP)
2. The perceived detrimental practice of THP
3. Favourable circumstances for cooperation between THP and Biomedical Practitioners (BMP)
4. Social, political and economic challenges of cooperation between THP and BMP
5. Feasible support, development, promotion and regulation of THP

Essentially the categories were made up by selecting and sorting data that addressed the central research question. Thus, categories were mainly made by data that either explored opportunities for the traditional health practice to cooperate with biomedical practitioners or data that sought to show the challenges for the two health practices to work together. For

example, category number one above was a broad subject that included data that explored the opportunities for cooperation by listing the practical advantages of traditional medicine and its practitioners. Data that showed the elements of availability, accessibility, affordability, acceptability, effectiveness and safety of traditional medicine were the contents of the first category. Indeed, by reading and re-reading the transcripts and identifying the initial categories the coding process had already started, as categories cannot be formed in the absence of data, and assigning data to a category is essentially coding.

3.12.6 STEP 2: Writing Codes Along with the Transcript

The second step involves in-depth analysis with a process of coding. Sharkey and Larsen (2010) referred to this process as microanalysis of data. Thus, I began to write codes alongside the transcripts. This exercise served three elements, summarizing, selecting and interpreting data. As I summarized the data I reduced it; reduction of data helped to facilitate analysis as I was able to see beyond the coverage of the individual participant (Richards, 2009). By selecting data, I decided to write down or label things that appeared to be important. I coded as many codes as I could so that I would not leave behind an important part of the transcript that would turn out to be a crucial theme. I applied what Harding (2013) suggested: “it is better to err on the side of caution and to limit the amount of selection, introducing codes that may be discarded later, rather than risk failing to code an idea that could become an important feature of the analysis” (2013:84).

The decision on what should be coded and what left out was determined by the general research objective. However, my mind was open to going beyond the research objective as participants may awaken an important theme that may be identified from the data, but was not predicted. Apart from being guided by the central objective, searching for commonality was another guiding principle for deciding what to code. As I was coding I also assigned the code to a respective category among the initial five categories that were identified when I did a critical reading (see the first step above). To simplify the process of assigning codes to respective categories I allocated a colour to each of those five initial categories. Thus, as I wrote a summary at the margin of a transcript, that note was highlighted with a particular colour to indicate that the code belongs to a particular category. For example, a category named – ‘The perceived detrimental practice of THP’ was allocated red. Hence, all data related the killings of innocent people due to witchcraft were summarised as witchcraft and were highlighted with red.

The third element of coding was interpreting the data; some data (codes) required interpretation based on the context in which the participant gave his or her detailed account. Some of the codes whose meaning seemed unclear needed interpretation as some of the participants used a metaphor or gave a story to explain a difficult situation. For example, when a participant described the habit of some senior government officials to depend on traditional healers to acquire and keep their position, s/he used a metaphor “Big shots spend some time in *Mlingoti* to acquire and maintain their position”. ‘Big shots’ was a term used to mean top government officials and *Mlingoti* is a famous place along the Tanzanian coast belt where one can find the strongest witches in the country. However, s/he never meant that all government officials go to *Mlingoti*: the name *Mlingoti* was used to mean some government officials all over the country have built a habit of visiting traditional healers in their respective areas. Appendix 1 is attached to show how I wrote the codes and assigned them to a category.

3.12.7 STEP 3: Reviewing the codes, Revising the Categories and Deciding Codes in each Category

In the second step of analysis I spent time writing codes in the margin and assigning them to respective preliminary categories. The process showed that there were a good number of codes that did not fit in any of the initial categories. In addition, some of the categories were over-loaded with data (codes) to an extent a review was necessary. The third step of analysis was geared towards addressing the challenges inherent from step two. This step involved searching for commonality among the codes and grouping together those that address similar subjects. This was not achieved in the first attempt but as analysis progressed I engaged myself in searching for new connection between codes (Hesse-Biber et al., 2006 and Flick, 2009).

The third step of analysis addressed the following concerns. First, it was clear that all the codes could not be accommodated in the preliminary categories. As I examined critically all the codes, I was able to look for connections between codes that were not obvious in the first instance. Consequently, I identified codes that were misplaced or completely left out and determined a proper place for them. As such, I decided to allocate the codes that were left out and re-allocate misplaced codes to more appropriate categories. My engagement in searching for commonality and connections between codes helped me to identify codes that should have been accommodated in the initial categories but were missed in the earlier exercise. Secondly, as I critically read and re-read the list of codes and examined the initial

categories I saw a number of common factors in the codes that warranted a need to create new categories to accommodate a huge number of codes that could not fit in any of the preliminary categories. This undertaking required me reshuffle some codes and place them to appropriate new or existing categories. The four new categories were: -

1. Commonalities between BMP and THP;
2. Hindrance to cooperation between THs and BMP;
3. Multifaceted power relations; and
4. Methods of adapting to challenges, barriers and power relations

Third, there was a need to create sub-categories that could take up relevant codes within main categories. Further scrutiny of connection revealed that it was cumbersome to place all codes in one category. Hence, there was a need for creation of sub-categories. For example, a category of 'The perceived detrimental practice of THP' was over-loaded with codes on the killings of albinos, killings of red-eyed elderly women, witchcraft, demonic power and multiple identities of traditional healers. A decision was reached to create a sub-category of supernatural power which took care of witchcraft and demonic power, leaving behind the killing of innocent people and multiple identities of traditional healers in the main category.

Finally, a decision was required on the codes that would not fit in any of the preliminary and newly formed categories, as even after considering the precise categories for as many codes as possible, there were still some codes that could not fit in any of the categories but applied to a reasonable number of participants. In qualitative research the quality of data is more important than the prevalence of participants to whom the data (code) applies. However, Miles and Hubert (1994) argue that thematic analysis is about identifying patterns and consistency of data in a specific arrangement. In other words, counting of participants to whom data applies is inevitable. Regarding codes that could not fit in any categories, I employed the wisdom of Harding (2013) that a code outside the categories would qualify for a study finding if it applies to one-quarter of the participants. The codes in which this applies are, 'the difference in approach between traditional healers and biomedical practitioners', 'the subjugation of traditional knowledge by biomedical practice', and 'the double standards (hypocrisy) of key stakeholders of health policy regarding traditional medicine'. Table 5 below summaries the categories and the source of codes.

3.12.8 STEP 4: Identifying Themes and Findings

The coding process assisted me in searching for commonality within the codes. The grouping together of data that address similar subjects was the cornerstone for identifying the themes for the study. As I was reviewing the codes and revising the categories, I was able to identify key messages from the codes and categories. After examining critically, the data within categories, I identified eight themes, under which there were some subthemes. Table 5 below shows how the nine categories produced eight major themes. The codes and the sources of codes that gave rise to the subthemes and eventually the major themes are also shown.

Table 5: The Categories, the Source of Codes, Subthemes, Themes and the Underlying Concepts

| No | Categories | Participants in whom the codes were identified | Sub-themes | Major Theme | Underlying concepts |
|----|--|--|---|--|---|
| 1 | The practicality of Traditional Health Practice (THP) | THs 1, 2, 7, 10, 9 PM 1,2 RL 1,2,3 RES1,2,3 BMP 12, 10, 11, 9 MR 2, 3 | Availability, Accessibility, Affordability, Efficacy and Safety of THP | Inclusion of TM and THs <i>'We Value Both Traditional Medicine and the Healers'</i> | Acceptability an all-inclusive concept. Popularity and Legitimacy of THP. Holistic approach and Empowerment of clients by THs |
| 2 | Perceived Detrimental Activities of THs | BMP 2, 4, 6, 7 RL 1, 2, 3 RES 2,1, 4, 3 THs 6,8,9, 4, 7 PM 2 MR 1,3,4 | THs are agents of demonic satanic and works of Darkness Multiple Identities of THs Involvement of THs in witchcraft | Separation of TM and THs <i>We Value TM but despise THs</i> | Uncertainty, Suspicion and Distrust of THs Traditionalism and Modernity |
| 3 | Favourable circumstances for Cooperation between TH and BM | PM1, 2 RL 1, 2, 3 BM 6,5,4; RES 2 TH 1, 2, 3, 4, 5, 6, 9, 8 RES 1, 2, 3, MR 2, 3, 5 | Emergence of Chronic Conditions Informal referrals between TH and BM Dual use of BM and TM | Environments conducive to cooperation between BMP and THP in Tanzania: <i>Complementarity of health practices</i> | Efficacy of TM and Chronic Conditions The process of Negotiating Modernity The process of Integration and Differentiation |

| | | | | | |
|---|--|---|---|--|---|
| 4 | Commonalities between BMP and THs | TH2 BM1,4,6 MR 4, 5 | Same medicines different forms Same approach to patients Patient is a common factor | <i>What brings us together</i> | Negotiated Order Theory Colonial Legacy and the concepts of Traditionalism and Modernity |
| 5 | Feasible support of THP Development, Promotion & Regulation of THP | RES1, 2, 3 PM 1, 2, 3 BM 3, 4, 5, 9 MR 1, 2, 3, 4, 5 | Legal and structural support for TM. Training and curriculum development for TM) Research on TM by NIMR, TFDA, & ITM | Support, development promotion and regulation by TM stakeholders: <i>Institutional Support for THP</i> | |
| 6 | Hindrances to cooperation between THs and BMP | RL1, 2, 3 BM1, 2, 3 BM11, 12, 3 TH4, 5, 8, 9 PM1, 2, 3 MR 1, 3 | Killings of people with albinism Killings of red-eyed elderly women Witchcraft and sorcery | Barriers to cooperation between BHP and THP: <i>Detrimental activities of THs</i> | |
| 7 | Social, political and economic challenges of cooperation between THP and BMP | PM 1, 2, 3, BMP 7, 6, 9, 12, 3, THs5, 9, 3, 11, 10 RL 1, 2, 3 RES 4, 3, 2, 1 MR.3, 5 | Multiple Identity of TH Educational level of THs Competition for fame Intellectual Property of TM Secrecy of THs | Social, Political and Economic Challenges for collaborative initiatives: <i>Friction between THs and BMP</i> | Western Epistemological Export vs African Agency |
| 8 | Multifaceted power relations | BMP 4, 5, 9 THs 7, 5, 3, RES 2,3, 4 RL1, 2, 3 PM 2, 3 MR 2, 5 | The colonial legacy Christianity as power relation Wavering support of government towards THP Government double standards Biomedical dominance over THP | Power relations and how they impact on THs/TM: <i>Bias towards THP</i> | Multifaceted powers over THP The process of Hybridity of Traditional Medicine The process of Integration and Differentiation. |

| | | | | | |
|---|--|---|---|--|--|
| 9 | Methods of adapting to challenges, barriers, and power relations | BMP 2, 3, 6 THs 5, 7, 10, RES 2,3, RL1, 2, 3 PM 1, 2 MR 2, 5 | Education/awareness Research, Training TM and BM forums | Way forward Key findings and concepts | Negotiated Order Theory as Higher concept |
|---|--|---|---|--|--|

Key to abbreviations used in the table

BMPs – Biomedical Practitioners

TM – Traditional Medicine

BM - Biomedicine

RL – Religious Leaders

PM – Policy Makers

RES – Researchers

MR –Multiple Roles

NIMR –National Institute of Medical Research

ITM – Institute of Traditional Medicine

TFDA – Tanzania Food and Drug Authority

3.12.9 Reflection of the Analysis Process

Categories, concepts or themes are the product of the coding process or microanalysis of data which generates description from key participants. Concepts are named using codes identified through the process of coding. Coding took care of emerging and potentially changing categories, as such data were allocated to more than one category, which changed as the process of analysis continued. The challenge I faced, which apparently, many qualitative researchers face, was whether I should create a long list of narrow categories so that I would stay attached to the data (the bit-by-bit approach) or establish broad categories (holistic approach) which facilitate manageable discussion of data but at the expense of losing valuable data (Dey, 1993).

To avoid losing data I kept a logbook of emerging categories that gave the description and purpose of each category. When categories were merged, or separated I made a note in the logbook to track the development of my coding system and transparency of the same. Initially I tried, a holistic approach, starting with a few categories (four), only to realize that much data (codes) was left unaccounted for. I changed to the bit-by-bit approach. After going through a few transcripts, I was overwhelmed with the number of categories (20 in number) I was able to produce. To tackle the problem, I opted for the middle order approach (Dey, 1993), which helped me to yield nine categories (Morse and Field, 1996). These categories and later themes that developed from them became major findings and constituted major conceptual ideas in my study's findings.

3.13 Ethical Considerations

Ethical issues surfaced across the entire research journey – from identification of the research problem to the presentation and dissemination of the findings. As such almost every chapter of this thesis has raised an ethical issue. Because of its importance an entire section is devoted for it. The aim is to ensure that the research sites and participants were not harmed by the study.

Without delay I will discuss a very important cultural issue with regards to the Faculty of Health and Social Care's requirement for ethical consideration as stipulated in the research ethics committee proposal forms. Although the forms were rigorous, they involved issues which were not applicable in an African, and particularly in a Tanzanian context. Tanzanians, particularly those from rural areas are sceptical about talking to a stranger. They cannot distinguish between an honest researcher and a

secretive investigator whose interest is to obtain information to be used against them. The only way one can gain true views from them was to reassure them of anonymity. Reassurance of anonymity should be in both words and deeds. The best anonymity was not to ask their names. One cannot reassure them that their views would be confidential when at the same time one is recording their true names, recording their voices, and asking them to sign a consent form. For them signing a consent form, coupled with recording their voices, was clear evidence and a rubber stamp that a researcher could use their information to her or his own advantage against them, and their will. What was likely to follow was that a researcher would be given inaccurate information from the beginning to end of the interview. For the sake of the committee I adhered to what was required of me in the forms, but I established a sense of balance when I was in the field. This stance is supported by Johnson and Long (2010) when they commented – “it should be noted that excess of concern in gaining consent and maintaining research ethics could make respondents feel that research is more harmful than it really is” (2010:30).

Before commencing data collection, I obtained permission to proceed from the Faculty of Health and Social Care, the University of Hull (see appendix 1). In Tanzania, such a project would require permission from the National Medical Research Institute of Tanzania (NMRI). However, NMRI has delegated its power to the universities’ ethics committees. Taking advantage of my being a member of academic staff, a consultant and a researcher at Mzumbe University, I requested the Director of Postgraduate Studies to write a letter on behalf of NMRI to introduce me to the gatekeepers at ministerial, regional and district levels (see appendix 2). However, within regions I obtained a letter of permission to access public health facilities and visit traditional healers, and researchers. Within the facilities, I used the heads of institutions (gatekeepers) to reach the participants. Potential participants were informed by the gatekeepers that the purpose of the study was to fulfil my PhD requirement and that the information was to be used for publication in journals and conferences. The nature of the study and its impact on participants was explained in simple clear terms. I used my own initiative to establish rapport and seek cooperation from administrative leadership at every level rather than depending too much on the letter of introduction from higher authority, as top-down introductions might not be honoured by the recipients.

With regard to informed consent, I provided informants with an information sheet about the study (see appendix 10). I left a copy for those who knew how to read and

write to read and internalize before they decided whether or not they wanted to join the study. I read it to those who were illiterate and asked if they would like to join the study. After three days, I went back to them to check their decision. The majority of them replied through phone messages that they were willing. A good number of them assented on the spot. Those who were willing to join the study were at liberty to sign a consent form if they wish. The consent form indicated their willingness to join the research and also to be tape-recorded (see appendix 11). Also, it gave participants the right to drop out of the study whenever they wished. They were assured that their privacy would not be invaded, and that any kind of deception would be avoided (Bryman, 2008).

I was relieved as all my participants agreed to participate in the study within two days, with the majority readily agreeing to participate as I handled them information sheets. Sometimes allowing a long time before the actual interview may be hazardous to the study as rumours may go around to distort the purpose of study. A few years ago, my colleagues and I (research team) were misunderstood as officials from the Treasury Office checking on people who have not paid their taxes. In another area, our research team was misinterpreted as officials from the blood bank who came to take blood coercively. To avoid such problems, I always walked around with a permission letter and used village government officials as my hosts to allay any misconceptions about my visit.

3.14 Limitations and Potential Problems with Regards to Ethical Consideration

As I was collecting data during the month of Ramadan I anticipated a problem of maintaining appointments with key informants. Some of the participants especially the traditional healers were Moslems who were in the month of fasting. Biomedical practitioners, researchers, policy-makers and religious leaders were busy people with heavy schedules: getting them to adhere to appointments was a challenge. The strategy to deal with this challenge was to arrange at least two appointments, in case the first one did not work, then the second appointment should be there. After obtaining my permission letter to proceed with research, I reported to the Ministry of Health to obtain a letter to introduce me to the regional and district medical officers. The same letter was to introduce me to the regional and district traditional medicine coordinators. Due to the importance and urgency of data from this study, the Ministry of Health wrote and

directed all coordinators in the study area to ensure that I was given maximum support during my data collection phase. The coordinators in all the regions and districts took that letter seriously as a directive. As such they escorted me to the respective regional/district chairperson of the traditional healers' association who kept a register of all healers in his/her jurisdiction.

As if that were not enough the coordinators took me to the healers that I had recruited and sat beside me to listen to the interviews. Even where I asked them politely to give me space so that I could interview traditional healers privately, they insisted that they wanted to make sure everything went well as they claimed that they were required to report back to the Ministry. Their presence affected freedom of speech for the healers. I could sense that their responses were not genuine, but intended to please the government official. At times, they sounded polite and apologetic to the government because of the mistrust between them and the government. Due to the presence of a government official most of their answers were short, either yes, no, or I don't know, as if they were answering closed-ended questions.

To curb that flaw, I decided to interview five additional healers without being accompanied by a government official. One of them was a traditional healer who was also a medical doctor and policy-maker in the Ministry of Health, the second was a traditional healer and professor in botany in an Agricultural University; and the third one was a traditional healer but also a medical doctor, and one of the officials at Tanga AIDS Working Group. These extra healers provided me with rich and wide understanding which I would not have obtained had I stuck to the healers I interviewed in the presence of government officials. Another limitation of this study was the exclusion of Islamic religious leaders. The exclusion was not intentional, the one who was earmarked could not be recruited because he was fasting. However, his absence did not affect the study as some Moslem traditional healers were also Sheikhs (informal local Moslem leaders) in their areas.

3.15 Exit strategy

As the intention of any researcher is to leave the site undisturbed, I made sure that I maintained good relationships with all research stakeholders so that no participant was left disturbed. In addition, the participants were assured of accessibility to the outcome of the study as they form an important part of it.

3.16 Conclusion

In this chapter I have described how the methodological decisions taken over the course of the study linked the background and literature review, which identified the information gap on one hand, and the finding chapters, which will fill that gap on the other. In particular, I have presented how an ethnographic stance as an approach and a thematic analysis made it possible to present the interpretations of data. The next three chapters will present the study findings, which address the central research objective.

CHAPTER 4: INCLUSION AND SEPARATION OF TRADITIONAL HEALERS FROM TRADITIONAL MEDICINE

4.1 Introduction

This chapter is the first of three chapters on the study findings and is geared towards addressing the general objective of the study - what are the opportunities and challenges for cooperation between the contemporary and traditional health practices under the National Health System in Tanzania. This study recruited 35 participants from four regions in Tanzania: Dar es Salaam, Tanga, Dodoma and Shinyanga. The 35 participants are from seven different groups. The groups, with the number of participants in brackets: biomedical practitioners (12), traditional healers (10), Christian religious leaders (3), policy-makers (2), researchers of traditional medicine (3), participants with dual or multiple roles (5) and all participants as users of the two health practices (35). Those with multiple roles include, medical doctor, traditional healer and policy-maker; another one had the roles of a medical doctor and traditional healer; another participant was a medical doctor and policy-maker; while the fourth one was a researcher and policy-maker; and the final one assumed the roles of a traditional healer and university professor.

To ensure confidentiality and anonymity of participants, they are referred to as BM for biomedical practitioners, TH for traditional healers, RL for religious leaders, PM for policy-makers, RES for researchers, and MR for multiple roles. They are given numbers to differentiate one participant from another. In this thesis, the term ‘traditional health practice’ is used interchangeably to mean traditional healers and traditional medicine, including the traditional healthcare system; whereas the term contemporary practice is used interchangeably to mean biomedical practitioners, biomedicine, modern medicine and modern healthcare. In fact, the difference between contemporary health practice and National Health System is insignificant, they mean one and the same thing. The term integration, in this thesis, is also used synonymously with the words cooperation, collaboration or working together.

There are two major themes in this chapter, which addresses the overall objective of this study. First, the inclusion of traditional medicine and its practitioners gives rise to the first thought – ‘We value both traditional medicine and the healers’. This school of

thought reflects the perception of participants who support both traditional medicine and traditional healers. The second theme is about the separation of traditional medicine from traditional healers in Tanzania, from which arises the second school of thought – ‘We accept and value traditional medicine, but we do not trust the healers’- This school wants to see the separation of traditional medicine from traditional healers. These two subthemes explain two dichotomous schools of thoughts of participants on traditional medicine and its practitioners. This chapter sets the scene for discussing subsequent findings in the succeeding chapters by providing the framework for later discussion of opportunities and challenges for traditional and modern health practice to work together.

4.2 Inclusion of Traditional Medicine and its Practitioners: ‘We Value Both Traditional Medicine and the Healers’

In the first school of thought, ‘we value both traditional medicine and the healers’, participants perceived traditional medicine and traditional healers to be vital and to constitute a dependable health system for the majority of Tanzanians. They maintained that traditional medicine and its practitioners are part and parcel of the cultural fabric of Tanzanian societies, implying that traditional medical practice and the societal culture are bonded together, and inseparable. In expressing their views, the participants backed their opinions with the elements of availability, accessibility, affordability, efficacy and safety. The totality of these elements denotes the acceptability of traditional health practice.

4.2.1 Availability of Traditional Medicine and its Practitioners

Drawing upon participants’ views on the importance of traditional medicine and its practitioners, participants raised three important aspects related to the availability of traditional medical practice. First, the term ‘availability’ was used in relation to the abundance of traditional healers in the country. Second, participants explained the vast availability of medicinal plants in Tanzania, which is the source of traditional medicine. Third, participants mentioned and differentiated the availability of three hierarchical sources of knowledge about traditional medicines in Tanzania.

a) Availability of Abundant Traditional Healers in Tanzania

Participants commented that there was a high concentration of healers in Tanzania to ensure the smooth running of the local system. The abundant availability of traditional healers was at three levels. First, there are plentiful healers regardless of their specialization.

Eeh! they are there in great numbers. It is estimated that there are 80,000 traditional healers. This is a number that all workers in modern health sector cannot rival – take all workers from doctors, nurses, paramedics, drivers, and sweepers **(MR2)**.

Just think of it, in some areas, there are as many as 20 traditional healers in each village on the average. I visited, at one time, an area known as Yogwe, where there are as many as 200 healers in one Ward **(PM1)**.

Second, the country has numerous types of healers who have specialized in different conditions. There are four classifications of healers who are legally allowed to practise and recognized in law by the Tanzanian government through Act no 23 of 2002. The director in the Ministry of Health attested as follows.

For that in the law in question, we decided to recognize officially the traditional medicine general practitioner, traditional medicine bone-setters, traditional medicine mental health, and traditional medicine birth attendants **(PM2)**.

Thirdly, there are healers who are not recognized by the law, but are tolerated by the government and are informally allowed to practise. These include the spiritualist healers of different backgrounds.

The law does not approve spiritualist healers..., we have them, they operate and majority of them are registered under one of the recognized practice, as herbalists, or healers of mental conditions or as birth attendants. But as spiritualist we do not recognize them **(PM1)**.

b) Availability of Medicinal Plants as a Source of Traditional Medicine

Participants submitted that the medicinal plants that are the raw materials for traditional medicine are available all over the country. Hence, the availability of herbal/medicinal plants was a high motivation for their use. When discussing medicinal plants as the primary source of traditional medicine, participants claimed that even modern

medicines are derived from traditional medicine in the form of medicinal plants. Thus, they propounded that herbs are not only the primary source for traditional and modern medicines, but they are the heart of treatment in all practices worldwide. Participants gave similar estimations (70 to 80%) of the proportion of biomedicines that have their source in medicinal plants.

Even the medicine we get from hospitals are derived from plants though I did not study to be a doctor, this much I know, that 80% of the hospital medicines are obtained from plants (**RL2**).

Yeah!! Personally, I regard traditional medicine as very useful, and I can tell you 80% of all drugs on shelves are from plants and micro-organisms. And this has been the case since ancient times (**RES2**).

History proves that modern medicine is basically similar and the same in nature as traditional medicine, they (modern medicine) have been processed before being prescribed as cures. About 71% of drugs in use in hospitals are made from natural products, and a greater part is from traditional medicine (**RES1**).

According to participants, the availability of native medicine is assured in almost all zones of the country because Tanzania has long ranges of forest that are the source of traditional medicine. A traditional healer who doubled as a medical doctor and owns a medicinal plant garden attested to this fact.

..., another opportunity is the abundant availability of medicinal trees in Tanzania. I have a botanical garden outside my house; it carries a great variety of medicinal plants. Another encouraging thing is that our land is very fertile and medicinal plants can grow and retain the medicinal properties (**MR3**).

This statement given by **MR3** was supported by **RES3** a researcher at NIMR

We in the tropics have a fabulous wealth of untouched flora plants with potentials of discovering a great deal of stuff. Of prime importance are medicinal plants for the treatment of non-communicable disease like cardiac muscular illnesses, high blood pressure, kidney disease, diabetes, cancer, etc. (**RES3**).

A policy-maker, medical doctor and traditional healer gave his admiration of the availability of traditional medicine in the quote below.

Third, their remedies are always available, nothing is said to be out of stock. A traditional healer may give you medicine of which he is not sure whether it will help you, but he will be doing so not because the right medicine is out of stock (**MR2**).

The excerpts above are a clear indication that the availability of traditional medicine is not debatable. Stakeholders in the health sector may debate on the efficacy and safety of traditional medicine but not its availability. The availability of traditional medicine has promoted its use, and has legitimized it.

c) Availability of Knowledge about Traditional Medicine

Participants propounded that there were three sources of knowledge about traditional medicine in Tanzania. Moreover, these sources of knowledge make a form of a hierarchy of discourse of traditional medicine knowledge that is available in the country.

i) Lay Knowledge about Traditional Medicine

Participants suggested that the lay knowledge of native medicine is the basic knowledge about traditional medicine and it is common knowledge to every member of the society. For example, they said that almost every family in Tanzania knows at least three types of remedies that are known to take care of common conditions. Individuals, friends, families and ethnic groups share and exchange different knowledge and experience about traditional medicine. Almost every participant attested to having lay knowledge of at least three traditional medicines. The following quotations are examples of that knowledge.

One traditional cure for typhoid fever, it is claimed, is fresh honey mixed with one and a half organically grown eggs, mixed and taken by the patient (**RL1**)

Honey and goat soup boiled together with a particular branch of a medicinal plant is recommended food for lactating mothers. The mother lactates plentifully, and the baby has much milk to suck as natural baby food (**RL2**).

Way back in my home place we had a plant, its use is now banned and illegal ... bhang seeds ... the cannabis seeds are roasted and pounded and then blended with vegetables. When the mother took this kind of dish, she would lactate profusely, plentifully, to produce plenty of milk for the infant baby to feed on **(RES2)**

Lay knowledge ranged from lactation enhancement, malaria treatment to stamina boosting.

Many tribes use cinchona to treat malaria. If you were to take cinchona alkaloids to a clinical trial, you would find it defends itself...it boasts as being able to cure malaria (laughing).....**(RES1)**

People think this concoction (pointing to herb) is processed in laboratories, it is not; it is '*mbigiri*'. '*Mbigiri*' boosts stamina, it increases mental energy and alertness, it is of help to those having to do hard work. **(RES3) [*Mbigiri* is a thorn seeded creeping grass that is found all over Tanzania].**

Some knowledge about traditional medicine was limited to one ethnic group; some information was known across the nation. A policy-maker and medical doctor gave the following example.

There are herbs that are used to stimulate labour in an expecting mother during labour, and these herbs are known to many tribes. So, you find there is a sort of similarity in traditional health delivering systems. You may find that some tribes, perhaps a half of all tribes in Tanzania do use similar or the same medicine plants to cure the same or related diseases **(MR4)**.

Lay knowledge about some traditional medicine spreads beyond the Tanzanian borders. A researcher gave a following example.

The Arabian market is most especially interested in essential oil from a plant called '*nyonyo*'. This oil is used as a contraceptive in birth control practice. Some of the buyers are local people who flock to the market to collect medicines they need **(RES1)**.

[ii\) Knowledge of Traditional Medicine that Belongs to Traditional Shop Attendants](#)

Participants mentioned the second knowledge of traditional medicine as that belonging to the attendants of traditional medicine drug-stores. According to the participants the

attendants are not necessarily healers but have been briefed about a list of medicines in the store, and the conditions the medicines can cure or heal. Based on the problem, the attendants decide which medicines are appropriate for the client. At times, the client may be knowledgeable about a medicine for his/her problem but needs a second opinion from the drugstore attendant.

I have oriented my attendant to all the medicines you see in our shop. The patient discusses with my attendant her/his problem and she suggest a medicine, if the client is happy he pays for it. Some patients already know their problem and the medicine but want assurance from my attendant about their choice (TH3)

Buying traditional medicine from a drug store that stocks traditional medicine without consulting a healer is closely related to the over-the-counter system of biomedical pharmacies where the user obtains the medicine without prescription. A traditional healer who owns a drug store described how the shop operates.

We have opened a traditional medicines shop goes by the name 'BORESHA' which means 'IMPROVE'. The medicine is well packed, well labeled and well displayed on attractive shelves. In the beginning, everyone who visited the shop thought it was a pharmacy stocking modern (imported) medicines (TH6).

Richard: what are the clients' comments on your 'Improved shop'?

The visitors would be surprised to find out later that the store stocked traditional medicines. "How would a store stocking traditional medicine look as smart as this?" Why don't we see gourds or calabashes? This store has been a showcase of creativity in the city (TH6).

Most of these drugstores stock local herbs dispensed in a powder form, as well as traditional medicines from China, Arabia, and India that have been produced in the form of capsules, tablets, creams, oils and liquids. According to participants the drug store is suitable and friendly to people of different classes from different backgrounds. For example, Christians, biomedical, and Western-oriented people are likely to find a drugstore a friendly environment for them because it is clean, drugs are well packed, and stocked in nicely displayed glass cabinets. The medicines from outside the continent have characteristics, quality and form that mimic biomedicine; as a result, the shops attract more clients than traditional healers' clinics. Thus, drugstores have removed the barriers of traditional medicine use, especially for the people who would hesitate to visit a traditional healer because of their faith or because they do not like the raw form of the medicine or they do not trust the integrity of a healer.

These days, traditional medicines are being promoted nearly all over the place, in markets, drugstores and streets. The medicines are in tablets or capsules; the dosage is clearly shown on a leaflet. We buy them, the sellers give straightforward instructions; there are no rituals required to be observed, as these are merely gimmicks of no value and foolish tricks **(RL2)**.

From participants' views, there is evidence to show that the use of traditional medicine has now taken a new form where people do not necessarily have to consult a traditional healer to obtain it. Traditional medicine is now sold in the markets and drug stores, and some is exported outside the borders of Tanzania.

iii) Knowledge of Traditional Medicine that is preserved by Traditional Healers Only

Finally, the respondents mentioned the knowledge of traditional medicine that is known by healers only. There are medicines and procedures whose knowledge is known and preserved by nobody other than the inventors, the healers. According to participants, the healers may have accumulated experience as a result of their apprenticeship with renowned healers, or they might have gathered information from their peer healers, or their knowledge could be a function of trial and error especially combining a number of medicines to make a stronger one.

For nine years I was under the mentorship of different renowned healers. Some taught me for free, but many of them charged me a fee for teaching and showing me the medicinal plants. During the apprenticeship, I read many books to complement the knowledge that I got from my mentors. But also, I learnt that the traditional medicine is attached to the culture and traditions of our tribes, the two go together **(TH8)**.

When the knowledge or information about a certain medicine is owned and preserved by the healer, the only way one can access that medicine or that procedure is by visiting the healer. Clients will visit the healer depending on the type of the knowledge that the healer has.

My dad taught me this profession. However, I did not think much about this profession. Nevertheless, as people were used to getting help from our place and as my father was dead it became, now it became..., 'so and so can also treat as his father', news began to spread. 'Do you see?

People began to visit me. People began to flock in. Slowly but surely, slowly but surely, a time came when I began to be known to more members of the community (TH10).

These three sources of knowledge of traditional medicine form a hierarchy of knowledge about traditional medicine in the country. In hierarchical order, knowledge preserved by a healer is perceived to be very effective, special and rare, followed by knowledge obtained from the store and finally lay knowledge.

The next section discusses the second element – the accessibility of traditional medicine.

4.2.2 Accessibility of Traditional Medicine/Healers

In the last section, participants discussed the abundant availability of the traditional healers and the existence of the long ranges of forests that are the source of traditional medicine. The availability of traditional healers and medicine is closely related to accessibility; one cannot access a service that is not available. According to participants, accessibility of traditional healers and local medicine is at three levels. First because of the high number of healers particularly in rural areas, the accessibility of traditional practitioners is guaranteed. A policy-maker in the Ministry of Health, traditional healer and a modern doctor describes accessibility with figures.

The availability of 80,000 traditional healers in Tanzania, majority of them living in the rural areas, ensures easy accessibility to their services...., Also, the current ratio of one traditional healer per 400 patients (1:400) guaranteed accessibility; compared to the ratio of one physician: 30,000 patients (MR2).

In the absence of a regulatory mechanism, this figure can be subjected to debate as this number may also include quacks and dishonest healers. However, as it stands now the accessibility of traditional healers in Tanzania is not questionable according to many participants. At the second level the accessibility of traditional medicine is related to the availability of ranges of forest that harbour medicinal plants. Accessibility is ensured because individuals can harvest the medicinal plants that are perceived to be effective. There are medications that are known to the community to be effective in managing endemic diseases/conditions like malaria, snake and insect bites, diarrhoeal diseases, and other common conditions, as well as remedies for taking care of common domestic accidents like burns, strains, cut wounds and poisoning. The nature of these

conditions requires emergency management, hence families keep these medicines in stock at home in case of any eventuality.

We have no hospitals here...that bush is our hospital..., you must be prepared as you may be bitten by a snake anytime..., a couple of days ago my neighbour was bitten by a poisonous snake..., a black cobra. He had his medicine ready which I dispensed to him some time ago, took some by mouth and applied some on the wound. I went to see him recently; he is completely healed (TH8).

The quotation given above does not only appear to indicate easy accessibility of traditional medicine but also suggests its perceived efficacy in treating snake bite. Although there was no clear evidence to prove that the person was actively bitten by the mentioned snake; as there is a possibility of a poisonous snake bite without injecting its venom.

4.2.3 Affordability of Traditional Medicine

Regarding affordability, the participants propounded that traditional medicine is affordable for many people because it is readily available in its raw form and also because of the increased presence of traditional healers, especially in rural settings. In addition, traditional medicine is affordable because of the flexibility in paying the treatment fee. It is a common occurrence for people in the rural area to obtain services from a healer without paying money on the spot. Many come to pay later after being cured of their condition. Moreover, in most cases the cost of treatment is negotiable particularly in rural areas where people tend to know each other. Traditional healers shared their experience.

Our fees are negotiable. We may treat you even if you do not have money for the medical fee, you will pay later, whereas in the case of modern doctor, you pay his fee first then treatment follows (TH3)

Richard: How much do you charge to treat one patient?

There are times when a patient has nothing to pay, he has spent millions of shillings for his treatment in hospitals without success, yet he visits here, having been told by a person “go to such and such a place”, and here he comes penniless, so I do give free service. I do not charge a fixed rate of a fee (TH5).

Richard: So, you charge depending on how a person is able to pay, is it so?

Yes. There are some patients whose relatives have failed to pay any fee, and they have refused to collect them. They have stayed here for as long as three to six months, and they are healed. A person fails to collect his patient for failure to pay a fee for successful treatment (TH5).

Another traditional healer explained how he charges his clients

Our costs, the fees we charge are negotiable.... The prices are low and negotiable and in most cases, they are low compared to modern medicine. Of course, there are a few who are business oriented, and these do charge higher fees especially those who sell their drugs in cities..., (laugh) (TH2).

According to many participants, affordability is at two levels, first people can meet the cost of the traditional medicine dispensed by the traditional healer; second, affordability also is at the level where a patient walks to her/his garden or to a nearby bush to cut a branch of tree or dig a root of a certain herb that is known to treat a particular condition. It is like a patient obtaining services over the counter for pain killers. The difference is that in obtaining medicine over the counter one must pay, whereas an herbal medicine requires one to access a nearby bush.

4.2.4 Efficacy of Traditional Health Practice

In the views of participants, the efficacy and safety of traditional medicine were probably the most critical reasons for the high use and acceptability of traditional medicine in Tanzania. The safety of traditional medicine will feature in the next section. The efficacy of a medicine is defined as "the perceived capacity of a given practice to affect sickness in some desirable way" (Young, 1983:1208). Young (1979) emphasises that efficacy should be examined at three levels; first, there should be empirical proofs that are attached to the material world and established by explicable events. Secondly, there should be scientific evidence observed using scientific methods; and third, there should be symbolic suggestions related to the organization of actions and objects that give meaning to, and allow the people to manage, the occurrences of illness. Considering efficacy at these levels inform us that efficacy can be observed from numerous different perspectives. Notwithstanding these levels of

evidence, the determinants and definitions of efficacy shift within a specific illness and more so within different health practices. For example, participants in this study testified to the efficacy of traditional medicine after using it; while the traditional healers reported conditions from which they have recorded successful results and obtained positive feedback from their clients. Taking into consideration the controversies inherent in the definition of efficacy, this thesis is not about judging or establishing the efficacy of traditional medicine, but rather, about how participants report on, talk about or perceive the efficacy of the medicines they use in their day to day lives.

a) Efficacy as Reported by Herbalists

A traditional healer who doubles as a university professor of botany gave a lovely rounded description of his knowledge and the experience of treating his clients.

Seedlings, even if it is only one type of seedling, there are in it a number of healing compounds so much so that if you give a patient a certain herbal medicine to treat say ulcers, when he is cured of ulcers, he may come to you and say, for instance; “I had trouble with asthma, it is now gone” (MR1).

Richard: are you suggesting that one seedling has multiple healing properties?

.... That is right, another patient that you had given him an herbal cure for high blood pressure will say, for instance, “I had trouble with back pains, it is gone”. That is why, on the front door of my clinic there is a long list of conditions that I manage to treat successfully with herbal medicine (MR1).

The information provided by a healer who is also a professor of botany explains why healers may have a handful of medicines displayed on their counter but the list of conditions they claim to treat is long. This differs by a large margin with biomedicine where each drug is specified for treating a particular condition. As a result, traditional healers, according to the participant, do not specialize in one type of disease, but they are general practitioners in herbal medicine. When he was asked, what clients’ report of his treatment, the healer and medical doctor argued that his clients are happy with the results. He mentioned several conditions he can successfully treat, including long-standing chronic conditions.

My experience with my clients ... Aaa!! Thank you, Jesus, is great; it is very friendly ... because we thank God that there is a great success, so much so that we are amazed a great deal when we score exceptionally exciting success that we did not expect at all. I can heal ulcers, asthma, epilepsy, kidney disease, leukemia, and cancer, and many other conditions (MR2).

As regards the efficacy of their drugs in treating chronic diseases, an herbalist who is also a professor had this to say.

We have succeeded to eliminate the HIV virus from the blood stream. We have examples supported by laboratory tests results. After using our herbal medicine, our patients went for a viral count check-up. The viral count went down, and it kept going down, through a time came when the final result read 'Target not detected' (MR1).

The healer showed the current researcher a report of his client whose blood was free from HIV virus after using his medicines. To safeguard the client's privacy, his/her name was not disclosed but I was able to read the findings. A similar success story was echoed by one of the directors in the Ministry of Health, about a traditional healer from Shinyanga region, who was reported to treat sickle-cell disease successfully. A healer from Dodoma claimed to treat a congenital heart condition and was proud to refer me to his patients who were completely cured.

I can treat many diseases, from short illness like stomach diseases, amoeba, and worms; to long-standing diseases such as epilepsy, mental cases, and stroke. I also treat successfully heart diseases including congenital heart condition, heart enlargement, and gynaecological diseases. You are welcome to visit my clients who were completely healed (TH6).

As regarding efficacy of traditional medicine, most traditional healers reported favourable results of their medicines. However, caution is needed regarding these claims as there were no patients to ascertain them; also, there was no proof that patients who were reported to have received healing had actually suffered from those conditions.

b) Efficacy as Reported by Bone-Setters

The experience of a bonesetter was not different from the herbalist (TH6) above; he also registered success stories of treating patients with fractured bones, some of whom had not benefited from modern treatment. Unlike the herbalist who merely reported the

type of conditions he was able to treat, the bonesetter introduced me to several patients who had recovered from complicated fractures. Among them was a young man (Joseph) who explained to me his ordeal after falling from a tree and sustaining an injury to his backbone. As a result, he developed paraplegia, and incontinence both faecal and urinary. He was admitted to a zonal consultant referral hospital for five months, but the condition got worse to the extent that his leg developed early gangrene. That was the time his relatives decided to snatch him out of the hospital and send him to the bonesetter I was interviewing, who managed to treat the infection and early gangrene, restored the dislocated vertebrae and the patient was able to walk and regained his continence. Joseph, now an apprentice to a bone setter explained:

I am so thankful to my uncle for his timely arrangement of absconding me from the hospital. I was due for an operation to amputate my leg because of gangrene. But when they brought me here, within two weeks, I was completely healed. This healer is a hero to me **(Joseph is now apprenticed to a bone-setter (TH 2))**

TH2 (Joseph's trainer) gave his experiences of dealing with patients with fractures:

There are many of them here. Those who fell from storied buildings, motor vehicle accident victims ... many of them, you can't believe it, and they are all healed. And if I feel that this is a case I would not be able to manage successfully, I tell the patient in advance. It may be the bone is rotten, and I do not have tools to enable me to perform surgery to remove a dead part of body **(TH2)**

Unlike, the herbalist who simply mentioned the conditions he is able to cure, the bone-setter introduced me to his clients who were at different stages, some had just started treatment, some had come to pay after being healed of their conditions.

c) Efficacy as Reported by Healers of Mental Health Condition

According to participants, mental conditions like other chronic illnesses such as heart disease, diabetes, and cancer cannot be treated successfully in the hospital. However, some healers claimed great success in managing these conditions.

I also cure mental conditions ..., and epilepsy **(TH1)**

I treat epilepsy and mental diseases successfully. The doctors in hospitals have medicines to alleviate for a short time, whereas when I treat these diseases healing is complete and lasting **(TH7)**

These quotations were supported by a medical doctor who admitted that traditional medicine is efficacious in treating conditions of mental ill health.

There are also mental conditions that we fail to cure, and some traditional healers do succeed to cure. So, there are conditions or illnesses that we moderns cannot cure (**BM1**).

Both traditional and modern practitioners seem to agree mental health conditions are better treated by traditional healers than biomedicine

d) Efficacy of Traditional Medicine as Experienced by Participants

The following quotations are from participants who spoke as users of traditional medicine. It was interesting to note that all participants including biomedical practitioners and religious leaders spoke of their experience of using traditional medicine and the positive outcome. A researcher gave the experience of his own child who benefited from traditional medicine.

Traditional medicine is necessary because there are some diseases for which there are no modern medicines for them so far. My personal experience is a good example. My child used to fall sick frequently. I took him to a healer; she gave us some medicine along with instructions on how to administer it. He got healed completely (**RES2**).

A biomedical doctor gave his testimonial of how he encountered a difficult situation and had to ask the help of a nearby healer who came to his rescue.

I can give an example based on my own experience, I was faced with a case of strangulated hernia that I could not manage, and there was no transport to take the patient to a hospital; so, I asked a traditional healer to come and help. When he appeared, the patient was treated, and he recovered in 5 minutes, stood up and walked away, completely healed (**BM2**).

Richard: as a medical doctor, what message do you want to put across?

Aah! These modern medicines..., (clearing his throat) .., are not able to cure completely some of the diseases, and there is evidence backing my statement. Some cases we do fail to manage successfully. However, when patients visit traditional healers, the results are good, healing is reported (**BM2**).

However, a few participants held different views regarding the efficacy of the traditional medicine. First, they claimed that the success stories given by traditional healers are self-proclaimed; there is no scientific evidence to back up what they claim. Secondly, claims of successful treatment of certain conditions were experienced in a few isolated cases, which could be due to other confounding factors rather than the treatment itself.

Sometimes it is difficult to draw a line of efficacy of traditional medicine because patients tend to exercise dual use of treatments. They start with traditional medicine and end up with biomedicine and vice versa, sometimes they use both treatments simultaneously. It is hard to state which treatment was efficacious (**BM1**).

There are patients who start by visiting a traditional healer in an emergency. When they get a bit better, they decide to go for modern laboratory tests and further treatment from a modern hospital (**PM1**).

Efficacy of traditional medicine depends on the causative agents. Where the cause of illness is perceived to be in line with ethnic philosophical understanding, such as supernatural cause or violation of ethnic norms and traditions, the treatment of traditional medicine seems to be efficacious as recovery is expected when the demands of the gods and spirits that have been violated are sufficiently met. As for the natural conditions, which are treatable by herbs, efficacy of the remedy depends on the nature of the active ingredients that are in the medicine, and how they act on the causative agent. For example, participants gave a few experiences where traditional medicine was the only therapy that helped them. Some of the participants in the current study were happy with the efficacy of traditional medicine; others were of the view that efficacy must be scientifically proven. Consequently, the efficacy of traditional medicine is evaluated and perceived differently by different people. Efficacy is a primary reason for the increased use of traditional medicine in Tanzania. A further discussion of the efficacy of traditional medicine in managing both natural and supernatural conditions is given in the next chapter.

4.2.5 Perception of Traditional Medicine: Its Safety

Several participants expressed the view that traditional medicines are safer than biomedicine. Participants preferred traditional medicine to modern medicine and

showed their disapproval of biomedicines, citing them as toxic and ones that are likely to cause harm to the body.

I think the human body is designed to agree with something natural as having its source in plants or something of that sort. You will find that side-effects that appear as a result of using modern medicine are very severe, as compared to side-effects from using traditional medicine. **(PM1).**

Factory mass production is easy, but the final product is not as good as the natural product. So, it is possible that the synthetically prepared product is much different from the natural product, and the former may be a bit harmful in terms of side-effects. **(PM2)**

Even religious leaders who were not comfortable to use medicines dispensed by traditional healers, as will be discussed later, were willing to point a finger to the toxicity of biomedicine and hailed traditional medicine as safe.

Hospital drugs also are not safe..., they contain chemicals. That is why a patient is told to eat much food and to drink much water when taking these hospital drugs, it is better to use medicinal plants because they are more natural, and nothing is added to it **(RL2).**

The present trend worldwide is that many patients do use herbal drugs. They say they are tired with chemical drugs; they complain that these synthetic drugs are hurting them from severe side effects **(RES2).**

Participants debated on the safety of traditional medicine as well as its efficacy. Some argued that safety is assumed and rarely questioned as natural medicines are seldom tested to determine the level of safety or toxicity. Other participants maintained that the native medicines are safe. As a researcher from the Institute of Traditional Medicine noted 'it is a wearer who knows where the shoe pinches most', If patients take traditional medicine and experience fewer side effects compared to the use of biomedicine, then they have reasons to believe the medicine was safe. Although the absence of immediate side effects does not mean that the drug is safe.

4.2.6 Acceptability of Traditional Health Practice: An All-Inclusive Concept

As mentioned earlier acceptability of traditional medicine is an encompassing concept for its practicality and legitimacy. According to participants, the acceptability of traditional health practice was probably the strongest motivation for Tanzanians to use

traditional medicine. The acceptability of traditional medicine is an inclusive concept that encompasses all the elements of availability, accessibility, affordability, efficacy and safety of traditional medicine discussed earlier. As one cannot accept something that is not available, the availability of traditional medicine and healers is a precursor to its easy accessibility. When the accessible medicine is affordable, it increases the level of its use and hence its acceptability. However, the strongest factors for the acceptance of traditional medicine according to participants were its efficacy and safety.

Acceptability of traditional practice, according to participants was at two levels: first, acceptability of the practice because of encompassing the aspects of availability, accessibility, affordability, efficacy and safety of traditional health practice as discussed above; and second, the level of acceptability of traditional practice as related to the culture, when the practice is offered according to the culture of a local society, its acceptability is unquestioned.

4.2.7 Traditional Medicine: Offered According to Societal Culture

In a different but related context, participants believed the acceptability of traditional health care is enhanced when the treatment is offered according to the culture of the society in which the care is offered. Participants' views were that when traditional medicine is offered or practised in the accordance with the customs, and traditions of a particular society, and especially when it is related to the local theoretical knowledge of disease causality, the medicine is likely to be highly valued and accepted.

First, they provide services according to the customs, culture and traditions of the communities of Tanzanians. For that reason, they enjoy a high degree of acceptance among the people (**PM1**).

In the perspective of participants, acceptability of traditional medicine and its practitioners encompass a worldview of Tanzanian societies about their health, and health-seeking behaviour. It incorporates the social, cultural, and political environment of societies and how these phenomena affect and influence their health, and health-seeking behaviour of the community. One example is how the local societies perceive disease causation. The existence of disease and its treatment in people is in line with the knowledge and belief systems of the societies.

My practice as a spiritualist healer assumes that the existence of diseases in our community is at three levels; people may acquire disease because

of natural causes or due to supernatural powers, the gods, and spirits. There are times people suffer because they have breached the society's customs. (TH1)

Richard: How do you approach each of these situations?

For the natural one, I will use herbs or animal products. For the conditions caused by the supernatural powers, remedies are given along with the performance of rituals. For those who have violated the cultural norms, special dance '*ngoma*' is performed, the animal is offered as a sacrifice and part of a healing process (TH1).

Moreover, traditional health practice is accepted because of the approach the healers apply in creating rapport and in showing empathy with their clients. Participants commended traditional healers for being attentive and good listeners to their clients; they take time to listen to their clients to understand what troubles them. They are quick to establish rapport, and their inter-personal skills have attracted the admiration of the clients. Consequently, clients feel obliged to open and share their private information with them.

In the manner of approaching patients, traditional healers do employ a more rounded, friendly approach to patients as they can make the patient feel welcome and at home. The patient becomes so relaxed and confident that he is able to disclose more information than he would if he were being attended to by a modern doctor (MR4).

As you know illnesses can manifest in different forms depending on the cause, healers are knowledgeable in tackling every angle of your life to determine precisely the nature of the problem. Literally every aspect of physical, mental, spiritual and social health is sought out (MR5)

The above quotations suggest a concept of holistic approach (Barret et al. 2003), which will be discussed in detail later. The traditional healers' approach to serving clients is holistic, and is offered in a friendly way, which is in line with the belief system and expectations of many societies in Tanzania. When treatment is provided according to the customs and norms of an ethnic group, not only does it deal with illness according to the nature of disease as prescribed by the belief system of that particular group, but also the approach suggests that no area of the human as a person will be left unattended.

Traditional healers have a significant role to play, especially in rural areas because of the proximity of traditional practitioners to members of the communities they serve, especially how their profession is related to morals, customs and traditions of a society as well as physical, social, spiritual and mental aspects **(PM1)**.

Furthermore, participants showed their admiration for the process the healers use to reach a diagnosis. In establishing a rapport, the healer encourages the client to open up and allows them to be central in identifying their problem. As the clients are crucial in providing information on which the healer can base a diagnosis, they form a firm basis for decisions that will eventually affect them. PM2 narrates his experience in an encounter with a healer.

As a client I feel I am put on the pilot's seat, I see myself part of the process of managing my health, contrary to when I visit a contemporary medical practitioner, where I frequently feel left out **(PM2)**.

The participants compared the approach taken by traditional healers and that offered by biomedical practitioners. **TH4** challenged the biomedical approach.

The modern doctor is proud of his knowledge; the patient is put in the receiving end; the doctor has all the power and the final decision. As the relationship is weak, the patient gets into a state of anxiety, uneasiness and fear that the doctor may do him harm. This affects how much a client is likely to speak freely. Healers do quite the opposite **(TH4)**

The excerpts given above introduce a concept of 'Client Empowerment' (Meeker 2000; Barrett et al. 2003), which will be discussed later in this chapter. The clients are empowered to decide/suggest the management of their illness. In addition, participants commended the single-handed approach the healers use, citing that the healer works as a welcome desk officer, a physician who takes a history of a client, a laboratory investigator and dispenser of the medicines. Participants described a healer as a complete health facility or institution. They propounded that the healer's approach is important in creating trust between the client and the healer. Clients are likely to share deep-seated and private information as they know the information will be shared only between the two, unlike in biomedical practice where the information of a client is written down and can be accessed by all staff concerned. Participants hailed healers for operating as comprehensive medical institutions in the quotation below.

I have special praise for a traditional healer because s/he combines all the skills required to attend patients; s/he is a doctor, laboratory technician, and dispenser; in other words, he is a complete hospital, he needs no external help, what he offers is perfect and confidential **(MR3)**.

The previous sections offered detailed of the views of participants from the first school of thought, ‘we value and trust traditional medicine and its practitioners’. The next section outlines the second school of thought where participants want separation of traditional medicine from the healers for various reasons.

4.3 Separation of Traditional Medicine from Traditional Healers

The previous section discussed the first school of thought namely, ‘we value both traditional medicine and its practitioners’. Proponents of that school believed traditional medicine and its practitioners were fundamental, linked and inseparable. In this section, the discussion is on the second school of thought, where the participants want to separate traditional medicine from traditional healers. Their views were ‘we value traditional medicine, but we distrust traditional healers’. The following subsections discuss the reasons for their stance.

4.3.1 Traditional healers’ practice is demonic, Satanic and a Work of Darkness

Participants advocated the separation of traditional medicine and traditional healers because they perceived that the practice of the latter was related to Satanism and the works of darkness. Different participants aired their views.

Generally speaking, we do not trust traditional healers. First it was handed down to us that traditional healers are morally evil people. Their practice is satanic and devilish. We see traditional healers as people who mix lies with the truth **(RL1)**.

Present Government leaders including doctors were trained by the Western trainers, and it is these very same trainers that brainwashed the people to agree with them that native treatment was foolish, satanic and nonsensical **(PM2)**.

When the current researcher probed deeper, asking why the religious leaders, especially of the Christian religion, regard healers as satanic agents and what was the source of their stance, they responded as follows.

As religious leaders, we are taught in a college that modern medicine is better than traditional medicine because traditional medicine has to do with demons and Satan. This is what was handed down to us....**(RL2)**.

The religious stance is seen as promoting biomedicine and at the same time degrading traditional medicine. In the attempt to get to the crux of the matter, why they value traditional medicine but disregard the healers, one religious leader spoke as follows.

We have no problem with the medicinal plants or plants concerned. In Genesis and Revelation, the Bible states, God gave us medicinal plants that are effective in treating illness. Satan created nothing, never even medicinal plants. Our problem is with traditional healers as they are the agents of Satan **(RL1)**.

For the religious leaders to accept traditional medicine but discredit the healers who are the custodians of the medicine, raises pertinent questions - who is qualified to handle God's creation without contaminating it? What should be done so that God's creation is not contaminated? Intriguingly, religious leaders believe medicinal plants are God's creation, and the Bible confirms this. However, once this medicine is processed by a local healer, it is perceived as satanic. When the same medicine is handled by a Western factory, it becomes God-given medicine as **RL2** attests below.

Use of traditional medicine is something innocent so long as it is not confused or mixed with traditional (demonic) rituals. We prefer biomedicine because it is not involved with satanic things **(RL3)**

As religious leaders we do not subscribe to the medicines prepared by the traditional healers. They are pretenders, quacks and works of darkness especially healers who consult demons [*wapiga ramli*]. We are against their practice straight away, because they mix up things including performing satanic rituals **(RL2)**.

The religious leaders' stance regarding traditional healers is based on a doctrine that was passed on by the first Western missionaries who evangelized Christianity in Africa. However, religious leaders are part of the society; they are aware of the challenges the community is facing, for example the dynamics of chronic diseases and the emerging diseases that have found no cure in modern medicine. They are also aware of the success stories of some traditional medicine in combating some of these challenges.

Responding to the possibility of traditional healers managing conditions that have no cure in modern medicine, a senior Christian leader noted:

If the medicinal plant used by spiritualists were to be tested by experts, it would probably be found to be a real cure for a certain disease. So, religious leaders would not oppose something that is scientifically proven to be a good medicine (**RL1**).

The excerpt given by **RL1** above implies that traditional medicine dispensed by a local healer will continue to be local, ‘traditional’, demonic and a work of darkness until such a time as science will intervene and transform it through ‘modernity’ by proving its efficacy and safety. What makes a traditional medicine “holy” and acceptable in the eyes of a religious leader is when science proves the efficacy and safety of that medicine. In other words, ‘modernity’ in the name of science is an agent for the sanctification of a traditional medicine invented by a traditional healer. This suggests that their stance is not grounded in the interpretation of the Bible but was imposed by the Western social process.

Although the Bible does not specifically point out that traditional healers are evil, some of their actions are viewed as satanic according to the Pentecostal bishop, who stated that ‘you will know them by their deeds and outcome’. He cited the involvement of traditional healers in the killings of albinos and red-eyed old women in Tanzania, and the demonic instructions they give to their clients. According to the Bishop, the few examples he outlined do not describe the whole picture of evil actions performed by traditional healers behind the scene. He gives an example of such evil deeds.

You are instructed to kill your own daughter or lay on 5 different graves in a single night so that you may become prosperous, or a thief is assured he will never be seen, if he sleeps with an infant, he will be invisible, and then he is caught (**RL3**)

This section has highlighted the stance of some participants, mostly Christian religious leaders and have put forwards reasons why they perceive traditional healers are agents of Satan. Their interpretations of some instructions given by the healers are completely satanic and the work of darkness.

4.3.2 Multiple Identities of Traditional Healers

In chapter six a detailed historical narrative is given by participants how traditional healers in Tanzania attained multiple identities. In this sub-section, the multiple

identities of traditional healers is discussed as one of the reasons why participants want to separate traditional medicine from the healers. In the previous sub-section it was shown that traditional healers and their practice were perceived as satanic by some participants. This perception was given a push by the existence of spiritualist healers who are believed to work closely with demons to manage supernatural conditions; at the same time they use herbal medicine to treat natural conditions. Although they are not recognized by the Tanzanian government, spiritualist healers are the most powerful and influential healers.

Moreover, they are the most consulted and most respected practitioners. Several of the spiritualist healers in the current study admitted that in the course of performing their duties, they perform rituals and offer sacrifices which are demanded by the demons, ancestors or spirits. However, they also use herbs to treat their clients. Thus, they double as supernatural healers at the same time as herbalists. One healer may be knowledgeable in bone-setting while at the same time he is a spiritualist. Another may double as a birth attendant and a spiritualist.

Mmh I can present to you in numerous forms..., depending on your need. If you visit as a patient, I am an herbalist. If you visit as a seeker of prosperity, fame and power I will be a spiritualist..., I will give you instructions. If you need to know whether you have natural or supernatural illness, I am a super-naturalist **(TH 9)**.

Intriguingly, it was a common practice for spiritualist healers to identify themselves as belonging to one of the four types of healers that are recognized by the law. Thus, they claimed to be either herbalist, bone-setters, mental health specialists or traditional birth attendants. A policy maker who is also a traditional healer but trained as a medical doctor articulated the reasons for spiritualist healers to identify with one of the specialties that are recognized by the law.

They hide under the state recognized identity as a cover, so as to lawfully legitimate their spiritualist practice. They are registered as herbalist, bone-setter, mental specialist or traditional birth attendant, but the main role is spiritualism. They also want to command recognition and respect that they are multidisciplinary **(MR2)**.

Articulating their experience of attending a spiritualist's clinic, some participants suggested that depending on the need of the client and the circumstances, a spiritualist may first present as spiritualist then identify him/herself as belonging to one of the

legally recognized types of healing practice. Alternatively, they may introduce themselves as belonging to one of the legally recognized practices, and then mention spiritualism as an added expertise. This finding suggested that healers have more than one identity; they demonstrate multiple identities. Depending on the problem of the client, healers can present and identify themselves differently under different circumstances.

Aaah!! I am like a Minister without special portfolio because to a greater percentage the healing is administered by demons; they do the treating of diseases for me. I depend upon them to direct me what to do..... Mmh I treat conditions involving unclean spirits, demons, etc. I also cleanse peoples' stars and other diseases caused by demons. Also, I treat normal natural diseases **(TH9)**

The multiple identities of traditional healers, especially their association with the supernatural use of demons in treating human beings, works not only against the scientific approach which is evidence-based, but also does not agree with the Christian perspective which maintains that demons cannot be good to humanity, as demons are perceived as satanic agents according to a Christian religious leader.

4.3.3 Involvement of Traditional Healers in Witchcraft

Participants in the study perceived the involvement of traditional healers in witchcraft as an additional significant factor in asking for a separation between traditional medicine and traditional healers. Witchcraft was the area most debated by the participants. Those who trust traditional medicine and its practitioners wanted to demarcate the practice of healing from that of witches, saying the two are not synonymous and do not work together. In contrast, those who distrust traditional healers submitted that traditional healers and witches are one and the same people doing similar evil deeds. A senior official in the National Council of Traditional Medicine commented on traditional healers who double as witches.

Mmh..., there are people who were seen as performing two different things at one and same time, combining medicine with witchcraft practice. Those were known as practitioners of traditional medicine but were also witchcraft practitioners **(PM1)**

The policymaker admitted that there are healers who double as witches. The policymaker's submission was in line with the religious leaders who insisted that there are

healers who are purely herbalists while some combine herbs and witchcraft, but to differentiate those pure herbalists from witches is extremely difficult. A bishop articulated a story he was told by his fellow preacher who happened to have been a healer before his conversion to Christianity. The former healer confided to the bishop that healers and witches are the same people.

There are those who consult the spirits and demons [*Wapiga Ramli*] to torment people, to cause misfortune. The second type is those that cause healing to a person having been attacked and oppressed by demons. I asked him what the relationship between them was. He said the two types were related. Their work has one basis; they are both servants of the same master. I asked who that master is, he said “It is Satan.” (RL1)

Participants maintained that it is hard to draw a line between pure traditional healing practice and witchcraft, as the two practices are carried out by the same healer. Hence, a healer can easily cross the line from benevolence to malevolence and vice versa depending on the need of the client. Following that logic, the multiple identities of traditional healers is at three levels: first, a healer may combine a legally recognized practice such as herbalism, bone-setting, mental health or birth attendant with witchcraft or sorcery which is under the label spiritualism, a branch of traditional practice that is not recognised by the government. Secondly, multiple identities may be evident when a legally acknowledged healer uses medicinal plants (herbs) when treating natural illness, and at the same time seeks the help of demons to treat a supernatural condition. Thirdly, when a healer has competences in witchcraft, and at the same time has the knowledge to decontaminate it. According to the participants, depending on the circumstances when a perceived benevolent identity is publicly and purposely made dominant over the other, but behind the scenes a detrimental identity is active, it invites suspicion and mistrust.

4.4 Discussion

This chapter has presented dichotomous worldviews of participants that form two schools of thought. The first school want the inclusion of traditional medicine and its practitioners, and perceive the healers as the backbone of traditional health system in Tanzania. The second school of thought consists of participants who want a separation of traditional medicine from the traditional healers. A number of underlying concepts were drawn on relating to these two schools of thoughts which will form the basis of discussion in this section.

4.4.1 Acceptability, Popularity and Legitimacy of Traditional Healthcare System

The acceptability of the traditional healthcare system to participants in this study represents two assumptions. First, the acceptability of the traditional healthcare system is an over-arching concept that denotes a number of elements tied together. These include the availability, accessibility, affordability, efficacy and safety of traditional medicine. In a second assumption, the traditional health care system is viewed as acceptable when the traditional therapy is offered according to the local culture. These two assumptions regarding the acceptability of traditional practice constitute the worldview of participants who support the first school of thought, valuing both traditional medicine and its practitioners; and perceive the healers and traditional medicine as inseparable entities

In the first assumption, the findings are in line with studies done by Barret et al., (2003); and Waldram et al., (2000) who found that traditional medicine was accepted by users because it was easily accessible and also available. The studies by Tsey (1997) as well as Kaborou (2006) mentioned availability, accessibility and affordability of traditional medicine and that its practitioners were central for the acceptability of traditional health care in Nigeria and Zambia respectively, while Broom et al., (2007) and Hollenberg (2009) submitted that efficacy and safety of complementary medicine were reasons for its acceptability in the UK and Canada respectively.

As for the efficacy and safety of traditional medicine, this current study submits that societies put them top of the list of elements that make traditional medicine acceptable. Participants in the current study were of the opinion that efficacy and safety of traditional medicine were measured at two levels. First, they were measured through the positive experience of clients using a particular native medicine that had healed certain conditions without unwanted side effects (Waldram, 2000). Consequently, the clients have gained experience, knowledge and satisfaction about the remedy. Secondly, the efficacy and safety are measured when traditional medicine is tested scientifically to identify the active ingredients that can treat a particular condition. Of the two measurements, the former is more applicable to traditional medicine than the later (Patwardhan, 2005). Most of the traditional medicines have not been tested

scientifically but have been in use for many years and the users are happy with the results (Waldram, 2000).

In the second but related assumption, traditional health practice was perceived to be acceptable when the practice was carried out in accordance with the local culture. The current study submits that Tanzanian societies assume the existence of disease could be natural, or caused by supernatural powers, the gods, and spirits, or when a member of the community breaches society's customs and traditions. Following this logic, it can be argued that the local beliefs on disease causation must link with the mode of diagnosing, treating and healing the conditions that occur as a result of that causative agent. Consequently, a traditional healer is assumed to be immersed in the cultural values and knowledge of a particular ethnic group so as to understand its philosophy of disease causation, and the approach to managing disease is endorsed by the cultural norms of that particular ethnic group. It also follows that the skills and expertise of a healer reflect the society's norms (Tsey, 1997). If a healer is an expert in witchcraft decontamination, it is because the surrounding society believes in and practises witchcraft. Likewise, if a healer performs rituals to appease gods and spirits, it is because the society believes in the presence of such spirits. It can be argued, therefore, that the culture of a society and the practice of traditional healers are bound together to an extent that one cannot operate in the absence of the other (Kayombo et al., 2007).

The acceptability of traditional healthcare practice is indeed the foundation from which the concepts of the popularity and legitimacy of traditional medicine are built (Waldram et al., 2000; Barret et al., 2005; Frass et al., 2012; Cant and Sharma, 1999; Meeker, 2000; Partwardhan, 2005; Tovey and Adams, 2007). The acceptability of traditional health practice is mirrored in its increased use (Mahunnah et al., 2012), while increased use of traditional practice among the societies denotes its popularity (Gale, 2014). The greater the popularity of traditional medicine as a result of its increased use among the community, the higher its legitimacy (Asante et al., 2013).

4.4.2 Holistic Approach and Empowerment of Clients by Traditional Healers

The findings of the current study suggest that traditional healers use a holistic approach to manage their clients. One example is where a healer takes time to take a client's history probing all aspects of life in the attempt to locate the cause of illness. The participants felt that every aspect of life was searched for. These findings echo those of

Zhang (2000) whose study found that the traditional healers' approach sought all aspects of health from physical, social, and mental to spiritual, covering all human areas. As the practice was offered according to the local culture, the holistic approach took into consideration the social, political and economic aspects of the local society, hence, consolidating the notion that traditional health practice is accepted because it is associated with local culture, and that the healers and the local culture are inseparable.

Holistic as a concept and also as an approach (Barret et al., 2003; Kayombo et al., 2007; Green, 2006) is tied to the local assumptions about disease causation within a society as physical, social, mental and spiritual aspects of health are sorted out. The participants in this study showed consistently 'belief-centred, value-laden and social-cultural' reasons for trusting the healers as their approach tallied with their way of life, values and their expectations (Barret et al., 2003:942). In a similar context, traditional healers were perceived by the participants to be good at creating rapport and showing empathy to clients, and at being attentive listeners to their clients. Consequently, they were quick to establish rapport, and clients felt obliged to open up and share their intimate information with the healer. A holistic approach coupled with observing cultural norms has both psychological and social advantages. Psychologically, the client leaves the clinic knowing that his/her problems have been thoroughly considered from all aspects of health. It mimics the modern clinic where the client is investigated thoroughly by the use of modern technological equipment. Socially, there is satisfaction that all aspects of the human being have been investigated. Thus, if there was any social responsibility that needed to be fulfilled as part of the healing process, such as offering sacrifice, that option is sought at the meeting with the healer, and the client is happy to fulfil that obligation. Rutherford (1999), working on witchcraft in Zimbabwe, found out that villagers were willing to contribute towards the cost of a sacrificial animal that was to be offered as a ritual to cleanse the village from bad omen.

The findings in this current study show that the holistic approach is closely related to the empowerment of the clients by the traditional healer, highlighting the concept of empowerment (Meeker, 2000; Barrett et al., 2003). The process of reaching a definite diagnosis was not the function of a healer only; the healer needed the cooperation of the client. In the process of establishing rapport, the healer encourages the client to open up. As the client is central to the discussion of her/his problem, s/he takes a critical part in the process of reaching a diagnosis and forms a firm basis for decisions that affect her/him. Thus, the client is empowered to decide, suggest and manage her/his illness.

These findings are consistent with those of Kelner and Wellman (1997) whose participants felt they were involved in making critical decisions about their health. When comparing the approach of traditional healers to that used by the modern practitioners, the participants of this current study felt that the modern doctors were proud of their knowledge, which kept the patient at the receiving end. The doctors had all the power and made any final decisions.

As the relationship was weak, the patients were in a state of anxiety, uneasiness and fear that the doctor might do them harm. These findings correlate with the studies of Kayombo (2006) and Barret et al., (2003) who submitted that “conventional medicine is said to harbour a great deal of prejudice” (2003:13), in sense that a medical doctor having identified the diagnosis, may decide the mode of treatment with minimal participation of the client concerned. In addition, participants argued that a healer operates as the sole practitioner in the process, he is at a welcome desk, he takes a history, decides on a medicine and dispenses it, as result clients are likely to share deep-seated and private information as they know the information will be shared only between them two. This is unlike in biomedical practice where the information of the client is written down and can be accessed by all staff concerned.

4.4.3 Maintaining ‘Traditionalism’

The concepts of the acceptability and popularity of traditional healthcare (Adams et al., 2009; Ernst, 2001); a holistic approach (Barret et al., 2003; Fadlon, 2005), and the empowerment of clients (Tovey et al., 2007; Kayombo et al., 2006)) have one goal in common: they raise the value and popularity of both traditional medicine and its practitioners, while at the same time they demonstrate the importance of the inclusion of traditional medicine and traditional healers. In other words, they strive to maintain the legitimacy of traditionalism (Green, 2006; Kaborou, 2006), which acknowledges that traditional healers are the custodians of societal values, traditions and culture. The concepts denote that traditional medicine and traditional healers cannot be separated because they are accepted by the societies, which increases their accessibility and use, which in turn increases their popularity. The holism and empowerment concepts consolidate the acceptability of the practice, which promotes and legitimates the healthcare. This is in line with the first school of thought that values both traditional medicine and its practitioners. Indeed, this school represents the traditionalism of

healthcare because the practice of traditional healers is linked to indigenous medicine, local culture and traditions.

4.4.4 Uncertainty, Suspicion and Distrust of Traditional Healers

The second school of thought denotes the stance of participants who value traditional medicine but distrust traditional healers. In other words they want to see traditional medicine, which in their eyes is innocent, separated from traditional healers who are perceived as ‘unholy’ and agents of Satan. Participants articulated their views along the lines of three notions; that the practice of traditional healers was perceived as demonic, satanic, and the works of darkness; they accused the healers of having multiple identities; and their involvement in witchcraft. Following their logic, the discussion can be positioned along the concepts of uncertainty, suspicion and distrust of traditional healers as propounded by Asante et al., (2013), Abdullahi (2011), and Gale (2014) whose works suggest that traditional healers were viewed with uncertainty, suspicion and mistrust mixed with derision not only by biomedical practitioners but also by the state government.

Traditional healers are not trustworthy because they mix truth and falsity. The comments from religious leaders cite some healers that work closely with demons, creating a sense of suspicion about their motives, as demons, according to the findings are known to be agents of Satan. Harries (2010) argues that the devil is perceived to be the prime enemy of humanity; hence, Satan is not expected to take part in treating sick people. Traditional healers were accused of having multiple identities, which they use to enhance certain aspects of their identity in order to achieve a specific goal, be it benevolent or malevolent. At the same time they tend to suppress a certain identity in order to hide their true ambitions which may be perceived to be evil (Harries 2010). This invites doubt, uncertainty and mistrust of the outcome of their interventions. Finally, native healers were accused of practising witchcraft, which consolidates the sense of mistrust and doubt about the intentions of traditional healers. These findings are consistent with the work of Rijk van Dijk (2001) and also see Federici (2010), who noted that the Pentecostal church in Malawi and Kenya was in the forefront of carrying out deliverance missions to people who were oppressed by demonic power and witchcraft carried out by healers. In the views of this church, traditional healers were responsible for causing disharmony in societies by practising witchcraft. The proponents of the second school of thought advocated the separation of traditional

medicine from traditional healers, which is in line with the promotion of the modernity philosophy of the use of scientifically tested traditional medicines at the expense of traditionalism.

4.4.5 Traditionalism vs Modernity

The two schools of thought discussed above represent the philosophies of traditionalism and modernity (Marsland, 2007). ‘Traditionalism’ emerges from African agency, while ‘Modernity’ is a western epistemological export (Nyamnjoh, 2001). The two philosophies cannot be reconciled with each other. The African discourse perceives traditionalism, in the name of traditions and cultural norms, as the guiding principle for the day-to-day life of African societies. Thus local beliefs recognize the indigenous knowledge of the existence of disease and how to manage it. It accepts that a traditional healer is a legitimate practitioner to handle all health-related issues in accordance with the culture. In the same vein the same beliefs acknowledge the presence of spirits, gods and ancestors and the practice of both benevolent and malevolent witchcraft (Geschiere, 2003). Traditional healers are expected to know how to practice benevolent witchcraft such as concoctions for a barren woman to counteract occult causes of infertility, or to bring home a husband who has neglected a family due to a concoction prepared by a concubine (Becky, 1979). At the same time traditional healers are practising malevolent witchcraft that is capable of causing harm to evil people as a defensive mechanism (Sanders, 2001).

The western epistemological export on the other hand is identified through the aspects of modernity, development and progress, which carry with them hegemonic power that dominates not only social science studies about Africa, but also distorts the perceptions by Africans themselves (Mudimbe, 1988). Under the supremacy of western epistemological import, most accounts of African culture bear its terminologies but paint a completely different picture and produce different connotations when applied in Africa (Nyamnjoh, 2001). For example, a western epistemological export on development, modernity and democracy tends to recognize individuals and country as real, but either chooses to disregard the reality of intermediate communities, or treats these as regressive in the movement towards modernity (Geschiere, 2003). It is inclined to diminish the supremacy and position of society, social arrangements, community and cultural uniqueness and harmonies by “trumpeting instead the uncompromising

autonomy of individual, rights-bearing, physically discrete, monied, market-driven, materially inviolate human subjects” (Comaroff and Comaroff 1999a:3).

Indeed, when we examine the logic of the western mind, we see that the western epistemological export perceives African culture, indigenous knowledge, traditional medicine, its practitioners and their belief system as primitive and underdeveloped and in need of civilization (Green, 2006). Consequently, witchcraft is perceived as nothing but a harmful and satanic practice, ignoring the fact that the majority of people consult traditional healers for “benevolent witchcraft”. The African agency, through traditionalism, views the multiple identities of traditional healers as an added advantage since the client can obtain multiple services at one sitting, and recognises that multiple identities are an important aspect for practising holistic treatment. Meanwhile, the western epistemological export through modernity sees the multiple identities of traditional healers as an attempt to deceive people, especially when one identity is intentionally made dormant to hide the ‘evil’ side of the expertise. An extension of this discussion will follow in chapter six.

4.5 Conclusion

This chapter has presented two dichotomies of thought about traditional medicine and its practitioners. The first school of thought stands for the inclusion of both traditional medicine and its practitioners, as they form a complete healthcare system. The second school of thought supports the separation of traditional healers from traditional medicine as they accuse the native healers of contaminating the ‘holy’ medicinal plants. The discussion has moved from examining the two schools of thought to exploring the philosophies behind these two schools of thought – these are the concepts of ‘traditionalism’ and ‘modernity’ (Marsland, 2007). These philosophies have their different origins: traditionalism has its origin from African discourses, while modernity finds its origin from the western epistemological export (Nyamnjoh, 2001).

What comes from this discussion is that the African and western epistemologies cannot be reconciled with each other. Indeed, there is a power relation between the two epistemologies which is translated by the antagonistic relationship between traditionalism and modernity (Abdullahi, 2011). The effects of rivalry between traditionalism and modernity leads to a weak cooperation between traditional and modern health practitioners, which will be a central discussion in chapter six.

Traditionalism and modernity represent two unequal bipolar power relations, with the former being subordinate over the latter. The strong wall between the two makes it harder for the two philosophies to work together as they have different value systems and they see things through different lenses. The western epistemological import from which biomedicine is conceived, is directed towards the physical senses of vision, taste, touch, hearing, and smell. Its interventions, therefore, are geared towards openly seen areas of human cultures, activities, behaviours and practice (Zhang, 2000). On the other hand, the African epistemological thinking from which the traditional medicine and healers operate, is associated with the mind, body emotions, communal relationship and spirit. It considers forces that cannot be seen with the eye, and these include how people regard situations, beliefs, attitudes, values, aspirations, ambitions, perceptions and interpretations (Zhang, 2000).

The conflict between traditionalism and modernity has created barriers, and the only way the practitioners of traditional and biomedical practices can work together is for one epistemology to adapt to the culture of the other epistemology. Due to its prejudice and hegemonic control over other practices, the possibility of the modern practice adapting to the culture of traditional practice is rare. Although slowly, the modern health system is responding to demands and social pressure from the public; as a result it is opening doors for traditional/CAM practitioners to work together. The outcome has never been encouraging as will be discussed in chapter six. One way to ensure collaboration between traditional and modern practitioners is to encourage traditional healers to negotiate modernity (Marsland, 2007), to acquire aspects of modernity. Alternatively, traditional healers and biomedical scientists should form a joint venture where traditional healers would voluntarily offer their medicines for the scientists to test and develop them. Through these partnership they will create a hybrid medicine through the hybridization of traditional medicine (Watanabe et al., 2006). Negotiating modernity and the hybridity of traditional medicine will feature extensively in chapters five and six respectively.

CHAPTER 5: POTENTIAL COOPERATION BETWEEN CONTEMPORARY AND TRADITIONAL HEALTH PRACTICES

5.1 Introduction

The discussion in the preceding chapter examined the worldviews of participants about traditional health practices in Tanzania. Two dichotomous schools of thought were presented, ‘we want the inclusion of both traditional medicine and its practitioners’, a school of thought that will be discussed further in this chapter; versus the school of thought that wanted the separation of traditional medicine and traditional healers whose further discussion will feature in the next chapter. The discussion in the previous chapter about the first school of thought presented an overview of the remedies available, how effective they are and the health-seeking behaviour of people of Tanzania. Based on their views, the participants saw the need for biomedical and traditional practitioners to work together.

This chapter will discuss in detail the views of the participants about the possibilities of cooperation between traditional and contemporary health practices. Potential cooperation between the two practices is the major theme under which there are two subthemes. The first subtheme covers the practical circumstances for cooperation between biomedical and traditional practitioners. The second subtheme examines the social, economic and financial support for the promotion and development of traditional health practice from different stakeholders, which directly or indirectly would help to bring about cooperation between biomedical and traditional health systems.

5.2 Conducive Environments for Cooperation between Contemporary and Traditional Health Practices in Tanzania

This subtheme outlines the favourable circumstances for cooperation between traditional and biomedical practices. A favourable environment for cooperation includes the emergence of chronic conditions, informal cooperation between biomedical and traditional practitioners, the dual use of biomedicine and traditional medicine and commonalities between traditional and biomedical practices as described by the participants.

5.2.1 Emergence of Chronic Conditions in Tanzania

Baxter et al., (2013) define “chronic disease as illness that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely” (2013:9). Participants were of the opinion that chronic conditions, which were previously predominant in the Western countries, are now emerging in Africa. These include conditions such as heart disease, cancer, diabetes, sickle cell disease and now HIV/AIDS. These conditions are not sufficiently managed in modern medical facilities, while there are success stories from the traditional health practice of healing and managing some of these conditions. According to a participant, (a researcher at ITM), the healers know natural medicines for some of those conditions. Hence, the knowledge, skills and expertise of healers to cure chronic diseases is an opportunity for cooperation between modern and traditional medicine.

Mmh patients are there, and new diseases are emerging, surfacing and there is no way these diseases could be tackled without retreat and resort to natural medicine, the plants. However, the question is who have the knowledge of these plants? It is the traditional healers. That is one great opportunity for cooperation between modern and traditional practices **(RES2)**

The above quotation implies that the new and emerging diseases can be managed adequately by native medicine rather than contemporary medicine. A biomedical doctor acknowledged that biomedicine has never been successful in treating chronic illnesses.

We cannot treat all diseases successfully, for instance, there are some types of cancer against which we have not found a cure. Aaah!! Some of the diseases like diabetes, hypertension, and HIV/AIDS are managed on the basis of symptoms, a patient has to go on with medication throughout her/his life by lowering the levels of the symptoms **(BM1)**.

While the biomedical practitioner admitted failure to manage chronic diseases successfully, a policy-maker who is a western trained doctor but also a traditional practitioner testified to the efficacy of traditional medicine.

Biomedicine does not cure non-communicable diseases...there is no single biomedical medicine that can cure a non-communicable condition. But traditional medicines can treat effectively some of the non-communicable diseases. Let me take one example, all over the world there is no cure for the sickle-cell disease, but the Sukuma tribe in Tanzania have a cure for this illness **(MR2)**.

Traditional medicine is perceived by participants as being able to treat some of the chronic diseases successfully. Hence, they suggest that cooperation between the two practices would help to share the knowledge and expertise of managing chronic ailments that would otherwise be declared incurable. Also, traditional medicine is considered to have attained a global reputation, popularity and acknowledgment to an extent that its legitimacy warrants recognition. A researcher attests to this fact.

The opportunity there is in traditional medicine is that it is fast gaining global acceptance and popularity as it has proved to be superior in treating some diseases that have found no cure in modern medicine (RES3).

These quotations from different participants introduce two concepts; the ‘efficacy’ and ‘effectiveness’ of traditional medicine in managing chronic illness (Broom et al., 2007; Smallwood et al., 2005; Baxter, 2013), which will be expanded on later.

5.2.2 Informal Cooperation between Biomedical Practitioners and Traditional Healers

Participants stated that although there has been no policy allowing formal cooperation between biomedical and traditional practices, practitioners from the two practices had developed informal cooperation between them. Although this was on a small scale, in the eyes of the participants, it was a good sign towards establishing official collaboration between the two modes of treatment. The description below is the experience of the Tanga AIDS Working Group (TAWG), which is an internationally acknowledged model of cooperation between biomedical and traditional health practice in Tanzania.

a) The TAWG: A Tanzanian Model

The Tanga AIDS Working Group (TAWG) is a non-governmental organization committed to promoting traditional medicine in Tanzania. I did not take TAWG as a case study, but members of its staff were part of the sample of the current study. As they were responding to my questions they drew on the experiences of their organization in relation to possible collaboration between modern and traditional health practices. As TAWG is made up of traditional and biomedical practitioners, and one

mandate of TAWG is to promote cooperation between the two sets of practitioners, a discussion of their experience in Tanga region (one of the regions this study sampled) is worthy reporting. TAWG is regarded by the global health community as a Tanzanian model of cooperation between the two sets of modern and traditional health care (Kayombo et al., 2007; WHO, 2014).

According to the TAWG manager, the TAWG was formed as result of an initiative by a medical doctor in the Pangani district in Tanga region who invited traditional healers to a forum to discuss issues of mutual interest. The major agenda was to convince the healers to hasten referral of patients to the hospitals as it was observed that patients came to hospital almost too late for modern medical intervention to be of any help. During the seminar, it was apparently felt that the discussion was pointing only in one direction, asking healers to refer patients to the hospital and not the other way around. Healers demanded to be heard: they claimed to have medicines that could treat and cure AIDS. Initially every medical doctor in the seminar room laughed as they believed nothing good could come from the healers. However, the healers insisted and persisted to be heard.

The healers were adamant, demanding to be heard otherwise they would stop attending the proceeding seminars. The Pangani hospital management accepted their proposal to have their medicine tried to a dying HIV/AIDS patient after consenting **(BM9)**

For the first time in Tanzanian medical history, a traditional medicine was administered in a hospital ward to a dying AIDS patient. To the amazement of everybody the patient improved steadily. A patient who was bedridden and unable to eat due to oral thrush was able to eat after few days of the medicine use. Within two weeks the patient was able to sit up and eventually was able to walk. The patient was discharged after six weeks having gained weight, and being cured of all opportunistic infections. The drug was administered to two more patients and they both responded well.

We were overwhelmed by the results, we had to report the findings to the regional authority, they demanded the sample of medicine to be sent to them, patients at the regional hospital also responded well. The regional authority reported the news to the Ministry of Health, which sent researchers from NIMR, and they were also surprised by the efficacy of the medicine **(BM9)**

Richard: What happened thereafter?

The findings were reported to the World Health Organization, who sent their officials to verify the findings. NIMR is now in phase two studying the medicine so that mass production can be made. This is how TAWG came into existence **(BM9)**

What appeared like an ordinary meeting intending to sensitize healers so that they would refer patients early to the hospital, turned out to be a model of collaboration between the two health systems; and since then, thousands of patients have benefited from that medicine.

a) TAWG Initiative to foster Cooperation between Biomedical and Traditional Health Practices in Mkinga District-Tanga

The cooperation between traditional and biomedical practitioners which led to the formation of TAWG, was a driving force for it to sensitize other districts within Tanga region to enhance the cooperation between the two practices. To start with they arranged a seminar of traditional healers and biomedical practitioners in Mkinga District. Initially, two separate seminars were organized, one for traditional healers and the other for doctors; later, the two groups were brought together. According to the seminar participants who were also participants in this study, the experience in the first two days was tense, with each camp blaming the other camp for mishandling the health systems in the country. There was insulting, disrespectful and demeaning name-calling on both sides.

At the beginning of a seminar the atmosphere became so heated that we were about to fight..., in my opinion the organizers were wasting our precious time as we did not expect anything good could come from the seminar and especially from the healers. **(BM8)**

However, from the third day to the sixth and final day, the atmosphere gradually changed. There was genuine appreciation of each side by the opposite profession. They realized that the traditional and modern healthcare practices are two different but complementary systems that are dissimilar but do co-operate in disease treatment and prevention and to harmonize the body's working mechanism. Taking a focus on new insights, participants shared understanding of distinctions between them particularly in philosophical causes of illness and disease. At the same time, they appreciated the similarities and dissimilarities in patient's approach and the potential complementarity that may be brought by one practice to another. For example, both practitioners of the two practices use history taking as a principle mode of establishing a diagnosis; the

distinction being that traditional healers' approach to patients is from holistic point of view, while that of biomedical practitioners is organ orientated. The TAWG manager described how in the last day of the seminar the members of the two groups were hugging each other as friends, eager to work together. A participant (a medical doctor) commented on the outcome of the seminar:

Let me say that before the seminar, I had a negative view in relation to healers, believing that they were mere quacks. Yet a point was reached that we all acknowledged our mistaken view of one side against the other side, and we agreed to co-operate together in harmony **(BM9)**

Another participant (a doctor at the Mkinga Heath Centre) commented about the seminar this way:

Before the seminar, I hated the healers. Given my Christian faith I counted them as devils. Some of the children that were brought here wearing charm armlets..., I used to keep a pair of scissors to cut those charm armlets ... (laughing) **(BM 11)**

Richard: why did you cut those charm armlet, did they interfered with your work?

I was ill informed about the true nature of the traditional healers' practice. Also given my faith as a Christian, that was an occasion to discourage them to attend healers' clinic, but after the seminar, I found out that we were essentially in the same practice with differing approaches. Now, we are co-operating well. They refer to us. We are now friends, seeing things eye to eye **(BM11)**.

Richard: In your opinion was the seminar successful?

Oh yes it was successful, we now get [from traditional healers] the kind of patients that we never used to receive. This has also created an opportunity for us to advise them on a number of cases they bring up to our attention **(BM8)**

As for the traditional healers who attended the seminar, they had this to say about the outcome of the seminar:

My clients are amazing with changes that have taken place at my clinic since I attended the seminar; I now keep a register of patients I attend to. My working place is neat and clean as you can see. I make sure I put on clean uniform see this white coat I am putting on **(TH9)**.

Another traditional healer had this comment:

More important now than ever before I tell my clients what I am good at and if it is outside my mandate I refer them to another healer or make a note to the hospital where they are received quickly without the hassle of queuing (TH7).

A traditional healer TH10 explained how her status in the village has improved because of the seminar:

I am getting more clients now than in the past. There is a word going on in the village that my practice is recognised by the government because they saw a team of medical professionals from the district hospital visiting me. When I refer my patients to the hospital they get first class attention and the doctors give my clients a letter to bring back to me acknowledge attending them. This has raised my reputation in the neighbourhood (TH10).

Deeper analysis of these quotations indicates that the collaboration initiated at the seminar in Tanga realised two different objectives, each benefitting one side of the practice. While the seminar assisted the modern practitioners to convince the healers to refer patients early to them and improved the wellbeing of the clients, the doctors were not reciprocating by referring patients to the healers. However, healers were happy to attain a low profile because at the end the cooperation has raised their reputation and raised their popularity and legitimacy. Their referrals were taken seriously as the doctors gave priority to the cases referred to them by the healers. In addition, doctors were required to write back to the healers to acknowledge receipt of patients. This type of relationship was a huge motivation and consolation to the healers as they felt that at long last they were respected and recognized by the modern practitioners.

a) Traditional Healers Referring Patients to Biomedical Practitioners

Apart from the cooperation that was initiated by TAWG in Tanga region, traditional healers in other regions within the study area also used to refer patients to the hospital when they felt the case was beyond their ability to manage. The referrals made by healers were informal as the government does not have in place a regulation to ask the healers to refer patients to the hospitals.

In our case, we willingly and freely refer our patients to the modern hospital when we feel we have tried our best and failed. I admit before my patient and say, “I am not authorized to conduct laboratory tests, so go to the hospital for laboratory tests then bring the results to me” (MR1).

And when tests are taken, I ask the laboratory technician or a radiographer to jot down his observations and comments. If it is an x-

ray examination that is required, we know hospitals have x-ray experts to interpret it (**TH6**).

Richard: How many patients so far have you referred to the hospital?

I fail to make a quick count because when a patient visits with a disease that I cannot manage, I phone the hospital. I have referred many patients to the hospital. I have agreed to work together with the hospital so that I may have many patient visits (**TH10**).

In depth analysis of the three quotations above raises several issues. First, by referring patients to the hospital, the traditional healers admit and acknowledge their professional limitations. This kind of approach puts them in a unique category of healers, as the majority of healers according to participants tend to claim endless ability to cure illnesses. Secondly, consciously or subconsciously healers are aware of their practice being regarded as inferior to biomedical practice as stated earlier by participants. The only way for them to gain popularity is through working closely with modern practice. Traditional healers **MR1** and **TH6** above used to send their clients for medical laboratory and X-ray investigations in a hospital, and once the results were available, they were shown to the healers so that they might decide on a proper treatment.

The healers were taking advantage of the availability of modern technology to identify the patient's problem accurately, which in a way, eased their diagnostic work. In the event a healer is assisted to establish a proper diagnosis by the help of modern technology and, given that s/he has efficacious medicine to treat a particular condition, the cure rate is likely to be high. 'Trial and errors' diagnoses are minimized because of scientific and advanced technology. Thus, the higher the precision of diagnoses, the higher the curative rate and the greater the popularity and legitimacy of the medicine and its practitioners. Traditional healer **TH10** summarized the scenario nicely, 'I have agreed to work together with the hospitals so that I may have many patient visits'. Some patients decided to visit traditional healers not necessarily to get treatment but to obtain a referral to the hospital as they were aware patients referred by traditional healers were given priority and were not required to queue in line waiting to see a doctor.

The trend of traditional healers in the study area to embrace modern technology links with two concepts introduced in the previous chapter. First, the concept of negotiating modernity (Marsland, 2007). In their study Marsland found out that healers were eager to identify themselves with modern technology, as a way to increase the legitimacy of their practices. Secondly, the concept of hybridity of traditional medicine (Kim, 2006; Watanabe et al., 2011). These studies reported the desire of traditional healers to cooperate with scientists of Korea and Japan respectively to research traditional medicine to form medicines that were neither traditional nor biomedicine – hybrid medicines. These concepts will be discussed in detail in this chapter and in the next one.

b) Biomedical Practitioners Referring Patients to Traditional Healers

Despite the widespread belief among the participants that biomedical doctors are both incompatible with and irreconcilable with traditional healers, some medical doctors confirmed that they sought help from traditional healers to treat cases that have no cure in modern medicine. A policy-maker articulated how a medical doctor in Mwanza, Tanzania was cooperating with a traditional healer:

I witnessed in Mwanza, medical doctors do believe traditional medicine cures some diseases that are not cured in hospitals. One of the doctors said he has started using herbal medicine by co-operating with a traditional healer, and he says he is amazed to find that there are real cures in traditional medicine and not in modern medicine (**PM3**)

Another medical doctor testified how a traditional healer came to rescue a situation where he could neither establish what was wrong with the patient nor think of a treatment.

I can give an example based on my personal experience whereby I was faced with a case I could not diagnose nor treat; so, I referred the case to a traditional healer. The healer had to be called. When he appeared, the patient was treated, and he recovered within a short time, stood up and walked away, completely healed (**BM2**).

Another doctor admitted and acknowledged that when they fail to treat patients they do refer them to traditional healers, and the outcome has been encouraging.

There are some cases that we moderns do fail to manage successfully. However, when we tell our patients to visit traditional healers, they do so, and the results are good, healing is reported **(BM7)**.

When the native healers were asked whether they receive patients that were referred to them by the modern doctors, some agreed that they do. A bonesetter from Tanga region narrated how the doctors at the Tanga Regional Hospital (Bombo) contravened the procedure of referring complicated cases to Muhimbili Hospital, a Zonal Referral Hospital, which is also a National Hospital. Instead patients were referred to him.

The service I render to the community is of great value. So, it is proper and fitting that the Government should be aware of this so that it recognizes it. It happens many times that doctors at Bombo Hospital do refer patients to me instead of referring them to Muhimbili National Hospital **(TH5)**

It was not easy to check the claims made by the healer as no patients were available with whom to confirm his claims that patients were referred to him from a medical practitioner. However, according to his account, his expertise in treating cases of fracture has attracted the admiration of hospital doctors at the regional hospital to the extent that some of the doctors visited him. He was also invited to visit the Kilimanjaro Christian Medical Centre (KCMC), another consultant - teaching referral hospital, where he worked for a while. There were times when patients were sent to and fro so that the patient received services from the hospital and at the same time from a bonesetter.

There are occasions when we had patients here whose injuries were such that some body tissues had got into the broken bone of say a leg or an arm; so I referred them to the Hospital so that the body tissues could be removed, and then they took them back to me **(TH5)**.

I asked him whether his expertise was appreciated and recognized by all doctors in the KCMC orthopaedic department. He replied:

There was one European doctor called Paul. Paul was very helpful to me concerning patients whose legs were fitted with nails (metal plates) those must be removed to enable me to conduct the procedure for joining the broken leg. But the rest of the doctors never bothered about me **(TH5)**.

Referrals were not limited to bonesetters only as spiritualists also received patients from modern doctors.

They phoned me when they had a patient they cannot help, or they bring the patient to me. It was a verbal referral; they did not give patients a note to bring it to me (TH4).

Richard: You are a spiritualist healer, a speciality that is not recognized by the law; how come contemporary practitioners from a government institution referred patients to you?

(Laugh)...., the secret is I manage well some conditions that are impossible to find a cure in hospitals, condition like epilepsy and mental diseases. They have medicine to alleviate for a short time whereas when I treat these diseases, healing is complete and lasting (TH4).

When I asked the healer whether the doctors sent their patients with a referral note, she replied as follows.

The government-set regulations do not allow them to write a letter (TH4).

When another spiritualist healer from Shinyanga region was asked to describe his relationship with biomedical doctors, he responded this way:

Relations are good in the sense that hospital doctors refer some patients to our clinic, and we refer some of our patients to hospital doctors (TH1).

Richard: Do the doctors send the clients with a referral letter?

There was a time when they were sending them bearing a note, however when our licences were suspended by the government; they stopped sending patients bearing a note. This went on to the present day when licences have been put back in place (TH1).

Lack of written referrals from biomedical to traditional healers and vice versa makes it hard to estimate the magnitude of cooperation between the two practices. As the policy does not allow such referrals, it makes hard to know the level of acceptance of traditional medicine among the modern practitioners. Sometimes referrals may not be

specifically mentioned but implied. For example, when doctors have identified an advanced stage cancer, and the hospital cannot be of any help, the relatives are informed about the condition of the patient and are advised to seek 'other options'. When a consultant hospital gives such a statement it is obvious for the relatives that the statement implies that they should consult a traditional healer.

As discussed earlier, the majority of biomedical doctors are not reconciled with traditional healers; however, there were a few who had discovered that traditional medicine was effective, and in some conditions, it was even more effective than biomedicine. These are the ones who were ready to violate the regulations and procedures laid down by the government to help patients. Intriguingly, the government officials had slightly different views from those of the practitioners of both biomedical and traditional medicine regarding patients' referral between the two practices. While they saw the need and importance of referrals, they advocated a one-way referral over a two-way referral. A one-way referral is when traditional healers refer patients to hospital, an option that is preferred by the government. A two-way referral is when practitioners of either side refer a patient to the opposite practice. The government has yet to allow this practice because, among other reasons, it does not have a list of certified traditional healers with whom the biomedical practitioners can exchange referrals. The senior official of the National Council of Traditional Medicine was optimistic that one day there will be an official referral from traditional healers to hospitals.

We are looking further into the possibility of introducing one day, a referral system at District level **(PM2)**.

One of the directors of the Ministry of Health and Social Welfare had this opinion.

As far as Tanzania is concerned ... Eee!! Yes, there is a possibility; in the area of setting up a referral system. Through this system, a patient can be referred from traditional healers to the modern hospital and vice versa. This set up can be made to fit all healers and modern hospitals all over the country. This would be the well-working integration of its kind **(MR2)**.

Richard: Are you suggesting a one-way referral from traditional healers to the hospital or a two-way referral system?

For a start, it is better to begin with a one-way type, traditional healers to biomedical but the best is the two-way type **(MR2)**.

Another senior official at the National Council of Traditional Medicine had this to say.

As a Council for Traditional Medicine, in the near future we want to educate traditional healers to be able to recognize what diseases they can or cannot treat well, so that they refer to modern hospitals those patients whose diseases they are not able to handle. We have instituted a procedure whereby a referral form will be filled out by the traditional healers attending to a patient being referred to a modern hospital (**PM1**).

The views and accounts of the government officials emphasise the need of traditional healers to refer a patient to a doctor and not otherwise. The quotation from **PM1** above is assuming that healers are not capable of knowing the conditions they are able or unable to treat successfully. In other words, the council will have a list of conditions that the council thinks the healers are not competent to treat and, therefore, such cases should be referred to the hospital in time. While it is true that there are conditions that the healers cannot handle because they involve special skills that the healers do not possess, like blood transfusions or rehydrating a patient through intravenous infusion, the quotation represents an assumption that traditional healers are ignorant, and that they need orientation regarding treating certain cases. Participants on the other hand blamed biomedical practice for keeping patients with chronic conditions for a long duration, just to discharge them at a time when they would never benefit from the traditional medicine. Thus, they suggested, education needs to be offered to the practitioners of both sides so that early referral can benefit the patient.

Moreover, the spread of new types of diseases that are difficult to diagnose and to cure have created a situation where patients are advised to go back to their homes for lack of proper treatment. That is when the traditional healer has yet another role to play to fill the gap. Some traditional healers have succeeded, and others have failed to be of practical help because of the delay (**RES2**).

The discussion on the informal cooperation between traditional and biomedical practices signifies that a small percentage of biomedical practitioners make use of traditional medicine and traditional healers' services. The majority of biomedical practitioners do not trust traditional healers. Consequently, they are hesitant to refer patients to them. This finding introduces the concept of mistrust and suspicion between

the two practices (Tsey, 1997; Kim, 2006; Marsland, 2008; Asante et al., 2013), which will be discussed in detail below.

5.2.3 Commonalities between Traditional and Contemporary Practices and Dual Use of both Biomedicine and Traditional Medicine

Participants were of the opinion that there were some commonalities in the way biomedical and traditional practitioners engage with their patients. The significant common ground that brought the two sides together was the patient. They emphasized that cooperation between biomedical and traditional practices could be made possible because both regimens have a mandate to serve the patient.

Our common aim is to treat the patient. So, our shared customer is a patient, and that is the point of meeting or convergence. When a patient visits us, it is because he wants treatment. When he visits a traditional healer, it is still for the same reason, that he wants treatment **(BM4)**.

Another similarity that can bring the two practices together is the approach they use to discern the patient's problem. Both depend on history-taking to discover the clues that help to establish a diagnosis.

The way we and they receive the patient is similar; we ask the patient what she is complaining about, what troubles her. They impose some restrictions on some patients about the use of some foods, for instance in the case of diabetics, just as we do. Here again is a similarity between them and us **(BM1)**.

A third aspect of commonality between traditional and biomedicine practitioners is the desired outcome of their practice, which is to see a patient regain her/his health. Also, the source of the medications they use is similar, that is medicinal plants.

Our mutual aim is to treat patients, and that is what we both share, we want the patient to get healed and resume normal healthy life. He uses his medicines, and I use modern medicine. But you find that even modern medicines are derived from tree barks, roots and leaves **(BM2)**.

As for dual use of both traditional and modern medicine, participants reiterated repeatedly that they saw a similarity between traditional medicine and biomedicine since the majority of the medicines in the two health care systems originate from plants.

Hence, they found it convenient to use both medicines, as stated by both a medical doctor and a policy- maker respectively in the quotations below.

You know 80 per cent of biomedicines are from medicinal plants. These were tested scientifically and were recommended for public consumption **(BM3)**

It is estimated that 60 to 80% of Tanzanians depend on the services of traditional healers for health care. Some start with a modern treatment and end up with traditional treatment, and some do combine the two together at one and the same time **(PM1)**

As discussed in the previous chapter, some patients commenced with a spiritualist healer to establish whether they are suffering from natural or supernatural disease. Once ‘a diagnosis’, or the nature of the disease, is determined, then the patient decides whether to use traditional medicine or opt for biomedicine. Dual use is frequently employed in natural disease, whereby the deciding factor is the patient’s progress. In the event that the patient does not experience remission of symptoms, s/he is likely to switch to another treatment regimen.

So, what normally happens is that most patients do visit traditional healers first and having failed to get healed, they visit a hospital, at times both treatments are taken simultaneously **(MR4)**.

There are patients who begin by visiting a traditional healer in an emergency. When they get a bit better, they decide to go for modern laboratory tests and further treatment from a modern hospital. One commences with traditional healer then he/she goes to a modern doctor for further treatment **(PM1)**.

The majority of participants attested that clients are happy to use both traditional and modern medicine simultaneously or consecutively.

5.3 Support, Promotion and Development of Traditional Health Practice in Tanzania

In the previous sections, the participants told of potential circumstances that, if used correctly, could bring about cooperation between biomedical and traditional medical practices. In this section, participants revealed that traditional medicine and its practitioners are receiving support and promotion from both local and international organizations. In their opinion, that support is another significant area that can enhance cooperation between the two health practices.

5.3.1 Support of Traditional Medical Practice from Individuals

As reported in previous chapter, with exception of some participants who were reluctant to trust traditional healers, all participants valued and supported traditional medicines; indicating that it has a crucial role to play in the health sector. Religious leaders were the first to commend traditional medicine.

For one reason, I believe that some of the trees that God created are medicinal, and the Bible confirms this. “Then the angel showed me the river of the water of life, on each side of the river bearing twelve crops of fruit And the leaves of the tree are for the healing of the nations”
(RL1)

Perhaps I should use more clear language. I believe medicinal plants do cure, it is the medicine that God created. Yes, anybody that uses the right medicinal plant may be healed. It is a cure that we were given by God
(RL2)

The two excerpts from the religious leaders indicate that they support traditional medicine though they may be referring to a different medicine from the one dispensed by a healer. Other participants who supported traditional medicine include the researchers:

Yeah!! Personally, I regard traditional medicine as very useful. Just think of medicinal plants for the treatment of non-communicable disease, like a muscular disease of a heart, high blood pressure, kidney disease, diabetes, cancer, etc. One plant was sampled from Tanzania that proved to be a strong anti-cancer treatment **(RES3)**.

A researcher and policy-maker noted the following:

There are medicinal plants for the cure of mental illness and viral infections. Our ancestors used these medicines to treat viral diseases, but they did not know how severe and fatal the diseases were. There are also plants that cure two or six different diseases just like modern medicine **(MR2)**.

On the individual level, traditional medicine is accepted as a legitimate medicine that can manage a variety of conditions as proved by the evidence from various participants.

5.3.2 Legal and Structural Support for Traditional Health Practice: Local and Global Initiatives

All participants were aware that traditional health practice in Tanzania is legally recognized through Act of Parliament No. 23 of 2002 (Mahunnah et al., 2012). Therefore, healers are operating lawfully. Also, there is a policy in place, in favour of traditional health practice. Consequently, based on the formulation of the policy, several other initiatives have been taken on board. For example, according to a senior official in the National Council of Traditional Medicine, Tanzania is an active participant regarding the WHO recommendations concerning the promotion and improvement of traditional medicine. Also the African Union (AU) of which Tanzania is a member state, pursues a policy of encouraging African member states to implement decisions of the WHO in connection with traditional medicine. For instance, at the start of the millennium it had the AU programme named “the first Decade of Traditional Medicine year 2000 to 2010”, and now the second programme “2011 to 2020” is under implementation.

There is now the second decade of traditional medicine, the year 2011 to the year 2020 in which some programmes will be implemented concerning traditional medicine. I think there is a plan of action spelling out what each of the African countries is supposed to focus on during this decade (**PM2**).

Apart from legal support, participants were of the opinion that the Tanzanian government has put in place structural support for traditional health practice. To that end the government has established six institutions, which by virtue of their establishment and structure, have a mandate to develop, support or promote traditional medicine in the country. The first institution is the Institute of Traditional Medicine (ITM), which is housed in the Muhimbili National Hospital and is part of the Muhimbili University of Medical Health and Allied Sciences. ITM was established by Act of Parliament No. 9 of 1991 after upgrading the then Traditional Medicine Research Unit, which came into existence in 1974 (Kayombo, 2006). The Institute of Traditional Medicine is responsible for researching traditional medicine.

Besides that, at the Muhimbili University of Health and Allied Sciences, there is an Institution of Traditional Medicine that carries out research on

traditional medicine that is taken there to be researched at the request of any traditional healer **(BM1)**.

The second institution is the National Institute for Medical Research (NIMR). NIMR was created by Act of Parliament No. 23 of 1979, and is mandated, among other things, to research the potency and safety of traditional treatment with a view to recognise that treatment is safe and able to cure a number of human diseases (Mahunnah et al., 2012). Consequently, an inventory of potent medicines must be compiled and be made available to the Ministry of Health and Social Welfare so that they are introduced into the formal health sector.

That is where there is an engagement between the Institute [NIMR] and traditional healers. This should enable us to register those practitioners that have good medicines; it would further enable us to enter into agreements with them, having researched the medicines they use **(RES1)**.

The third institution is the National Council of Traditional Medicine. In accordance with the accounts given by the senior official in the Council, it was established for the objectives mainly of guidance and the promotion of traditional and complementary treatment in the country by representation of the Government. Therefore, this is a legally recognized organization that was established, according to Act of Parliament No. 23 of 2002 Cap 244 (MoH, 2005).

The objectives of establishing the National Council of Traditional Medicine were to regulate and provide guideline for practitioners of traditional treatment and complementary medicine in the country **(PM1)**

The fourth institution is the Government Chemist established under the Ministry of Health during the German colonial era in 1895, as a centre for researching tropical diseases. Currently its mandate includes quality analysis of drugs in accordance with National and International Standards. The fifth institution is the Directorate of Traditional Medicine at the Ministry of Health and Social Welfare established in 1996. This is a policy-formulating body and the overseer of the traditional health system in the country.

In my directorate, apart from supporting traditional medicine we are educating traditional healers by using TV and radio, to understand the importance of registering their practice with the Tanzania Council for

Traditional and Alternative Medicine, we encourage them to come forward and register without suspicion nor fear **(PM1)**.

The sixth and last institution is the Tanzania Food and Drug Authority (TFDA, 1978). It is stipulated in the Act governing its operations and in the mandate concerning its responsibilities that TFDA shall register traditional medicines and shall enable such medicines to be on the market through pharmacies and to let them be used in hospitals (Mahunnah et al., 2012). These six organizations depend on each other to discharge their duties, roles and responsibilities efficiently. For example, ITM and NIMR need to feed TFDA with facts about their findings about the safety and efficacy of the traditional medicines before TFDA can register those medicines for use. But, on the other hand, TFDA is also required to register a medicine before NIMR can compile a list of traditional medicine to be included in the national pharmacopoeia. It is only after NIMR has compiled a list of traditional medicines that the Ministry of Health can recommend such traditional medicines for use by public health facilities.

We cannot work in isolation of each other, we depend on each other; however, when one organization does not approve the work of another organization there is nothing that can be achieved. For example if TFDA does not register the medicine, the medicine will not be used by the public even if NIMR has tested it **(RES2)**

To emphasize the importance of coordination among the institutions in order to advance traditional medicine one interviewee, a researcher, described ITM and NIMR as cases in point. The two institutions have been conducting investigations on traditional medicine in Tanzania for the past 40 years. However, in the span of 40 years, no single medicine has been registered by TFDA for use by the health sector. In other words the efforts of 40 years have not yielded the intended results nor have the objectives of establishing these institutions been realised. Researchers at NIMR did not hide their frustrations at the reluctance of TFDA to register traditional medicine in the country. A researcher and a senior official at NIMR had this to say:

The Government has the policy to promote traditional medicine, has all the regulatory machinery and quality assurance system in place; why hasn't TFDA registered even a single type of traditional medicine so far? TFDA is the significant and decisive partner in permitting new medicine to be registered and allow it into the market. What are the missing factors that are a drawback against these medicines, and what steps have they (TFDA) taken to educate or inform traditional healers? **(RES3)**.

According to the quotation above, TFDA is seen as a stumbling block for the development and promotion of traditional medicine in the country. The quotation shows how the situation is viewed as vexing and annoying. It is a sign of poor coordination and communication within the government institutions as was revealed by a deeper probing.

Richard: If you (NIMR) have researched one particular medicine and you are happy the medicine is safe and efficacious, why would TFDA hesitate to register it?

It is a difficult question. However, what I know is that it is only medicines that have been condensed or reduced in bulk into tablets, injections, capsules or liquid form that are registered by TFDA. Our traditional healers have no capability to own machines to process and condense medicines into conventional, modern form of tablets, etc.
(RES3).

The vexation expressed by a researcher is suggestive that the government has a double standard. On one hand, the government is committed to supporting traditional medicine by establishing institutions to develop traditional medicine. On the other hand it is not prepared to take hard decisions to enforce the institutions to develop traditional medicine. The government is accused of double standards, a tendency that has led some of the participants to think that the country is wasting resources by having institutions that do not yield the intended outputs. They accuse the government of carrying out legislation on paper but failing to implement it. They argue that the government has established a legal and institutional framework to satisfy the global community but it doesnot have the commitment to develop traditional medicine. Consequently, participants argued that these institutions are perceived as suppressors rather than supporters of traditional health practice in the country.

Notwithstanding the weak coordination among the government intitutions, participants were of the opinion that as a result of the formulation of a policy, coupled with the establishment of an institutional framework, traditional medicine is now regulated down to a district level; a new cadre having been created to be coordinators for traditional healers at district and regional level.

We have institutional framework..., we have a political framework, and we have a directorate of traditional medicine. Traditional medicine is now regulated at District level. In every Regional and District Office, from

2011, there is an official who is responsible for regulating affairs of traditional healers. When the Government launched this setup, it also put in place a monitoring and auditing mechanism, and that was a big commitment **(PM2)**.

According to some participants, Tanzania has probably the best structure for advancing traditional medicine given the institutional frameworks that are in place, had the commitment to develop the medicine been there. In addition they submitted that if the institutional framework were to be effectively employed, coupled with the availability of both medicinal plants and knowledgeable healers, Tanzania could be one of the countries in the world with the potential for possessing an effective traditional pharmacopoeia.

Therefore, there is a great opportunity for success, and there are large stocks of herbs that can be harvested, can be processed for use and local sale and finally exported to other countries. This potential development would enhance the local and national economies in the country starting from individual level to corporate level **(PM1)**

The above discussion implies that Tanzania has all the necessary frameworks to develop, support and promote traditional medicine. What is required is a firm political commitment that would help to develop traditional medicine, which in turn, would propel the integration of traditional healthcare system into the National Health System.

5.3.3 Training and Curriculum Development for Traditional Medicine

As for the training and curriculum for traditional medicine, the National Council of Traditional Medicine in Tanzania in alliance with ITM has initiated training whereby health care providers at different levels will be trained in traditional medicine. At the same time, healers will be oriented in modern medicine.

Traditional healers will be trained to gain knowledge of modern medicine to a certain degree. There is also, on the other hand, a plan to train modern doctors to have knowledge of traditional medicine. We as the council will set up centres for the training of modern doctors in traditional medicine. This kind of training is being carried out in Ghana and Nigeria (West Africa) where they have training colleges that teach traditional medicine **(PM2)**.

According to the accounts given by both a policymaker and a researcher, African countries have prepared a training programme for modern doctors to teach them about

traditional medicine. Those just starting medical school, as students, will learn traditional medicine in classrooms. This is possible seeing that teaching books have been prepared already for all African countries through 'The Centre for Traditional and Alternative Medicine' in Congo Brazzaville.

When we start to popularize traditional medicine through teaching about it in school classes, people will begin to accept it and to feel its presence. That will be easy to integrate traditional medicine with modern medicine because, besides the use of school classes, modern doctors will be trained in traditional medicine (MR2).

Richard: what do you anticipate will be the reaction of biomedical doctors receiving such training?

Doctors will see that traditional and modern medicines are two different but complementary systems that are dissimilar but can co-operate in disease treatment and prevention and to harmonize the body's working mechanism. You will find that this is going to be a long journey, and it is better we start it now and make progress, and, one day, we shall arrive where others have arrived so far (MR2).

Echoing the views of the policy-maker, a researcher at ITM submitted that the picture is now dramatically different in that traditional medicine studies have been incorporated into the medical school curriculum. Doctors are now being trained in traditional medicine as a response to the law (Act No. 23 of 2002) that promotes traditional medicine. The whole range of hospital staff, from doctors to nurses, and pharmacists are being trained in traditional medicine.

We now have students pursuing Masters and PhD in traditional medicine. The present trend now is that doctors that were trained in traditional medicine will be prescribing traditional medicine, and they are agreed that it is good (RES2).

In the mind of one researcher interviewed, in order to institutionalize this initiative, there are two sides to be considered. These are first the academic side of the effort; and the second has to do with social responsibility. As far as the ITM is concerned, they are through with academic considerations as they have introduced the traditional medicine into the curriculum, and traditional medicine is taught to medical students at the Muhimbili Medical School. In addition, a certificate program in traditional medicine for the practising doctor is already under way to train all doctors countrywide.

It has been approved by the Muhimbili University of Health and Allied Sciences, and it will be applicable from September 2015. We are developing this curriculum to a certificate level, aiming to upgrade it to diploma level in the near future **(RES3)**.

As for the social responsibility, the WHO has issued some guidelines concerning this initiative that is known as ‘training of traditional practitioners’ (WHO, 2008). It will enable them to have a grasp of modern medicine. Furthermore, there is another tool geared to train traditional healers to raise their knowledge about modern medicine (WHO, 2012).

5.3.4 Research on Traditional Medicine

As outlined above the ITM and NIMR are two government institutions entrusted with researching traditional medicine in Tanzania. It is not known why the government decided to establish two institutions with such similar assignments. NIMR came into existence in order to produce scientific evidence essential for the improvement of better methods and techniques of improving the control, prevention and management of diseases in Tanzania. However, the second function of NIMR is the same as the objective of the ITM, that is to research into traditional medicine. When asked the difference between the activities of NIMR and those of ITM, a researcher from NIMR replied:

We are actually doing one and the same thing **(RES2)**.

Richard: So, should we call it a duplication?

For me Aaah those at ITM have components having to do with trading. This unit [NIMR] has the duty to regulate traditional medicine research as it is a pioneer of medical research **(RES2)**.

The two organizations are under two different ministries, ITM is under the Ministry of Education while NIMR is under the Ministry of Health and Social Welfare. The director in the Ministry of Health and Social Welfare emphasised the difficulty of coordinating resources in two establishments that are doing similar activities but managed under different ministries.

We have informed ITM that we shall raise funds towards their research work, so they can update their laboratory to attain best manufacturing practice compliantly. The challenge they are facing is a shortage of some equipment and manpower. Unfortunately, we operate under different

Ministries and therefore communication is not that fast because of bureaucracy (**MR1**).

Regardless of the structural challenges, the two organizations have registered some success in conducting research in traditional medicine. According to a researcher at NIMR, the primary task of NIMR is to translate that which the traditional healers know into modern (modern in the user-friendly sense) products through the long process of research.

We need to engage ourselves with herbalists, those who are the reservoirs of indigenous knowledge. The primary source of the medicine is derived from plants. So, the knowledge of which plants are medicinal is stored by traditional healers (**RES3**)

The researcher explained the process through which they test the efficacy of medicinal plants. There are several tasks to be carried out in the course of testing the effectiveness of medicinal plants that have been identified by traditional healers. For example, to know whether plant A or B is useful for a certain disease, the researchers have to work as a team. First, they need to liaise with a traditional healer, and seek the cooperation of a health botanist and ordinary people in rural villages. Ordinary people in rural villages have a part to play because they too have some knowledge of medicinal plants. As the majority of them were brought up with a village background, as children they got, informally, knowledge of endemic medicinal plants in the bushes or forests surrounding their villages.

Our major duty is to map the chemistry and pharmacological properties of medicinal plants that are brought here by traditional healers. We have to identify the molecules in a particular medicinal plant and test those molecules against a specific disease or pathogens (**RES3**).

Secondly, according to this researcher, they isolate the active principles from plants. Active principles, however, are less active, so they use the extract; from the extract they discern its formula, as do traditional healers, the difference being that NIMR knows the chemistry of a particular plant. This knowledge enables NIMR to develop a profile, which they standardize to allow them to know the kind of vital chemicals that are needed in the product.

The second task we carry out is to develop quality control protocols. That is how we regulate traditional medicine. We may visit a market and take a sample of medicine from a healer. We study the chemistry of that medicine

and then prepare quality control protocols. Personnel from the Tanzania Food and Drug Authority may borrow the protocol if they so wish, for the purpose of regulating other medicines **(RES3)**

When I probed further into which approach they employed to research traditional medicine, the researchers from both ITM and NIMR acknowledged that they use the WHO guidelines for researching traditional medicine - an approach that is different from the one they use for biomedicine. Researching traditional medicine is different from biomedicine testing in the sense that testing traditional medicine in human beings is the first stage as the medicine has already been in use for quite some time. The aim, therefore, is to identify the active ingredient and test it against the microorganism the medicine claims to treat. Hence the stage at which the test is carried out is an advanced one as the medicine is already tested in everyday use. This is contrary to biomedicine testing where the medicine is tested in stages and the human testing is done as the last stage of verification.

Earlier in this chapter it was reported that there are a number of government institutions that are responsible for the advancement of traditional medicine. The availability of these institutions has created a demand from the public to have traditional medicine tested for efficacy and safety. The demand to see that traditional medicine is safe and potent has been shifted from the government to individual healers. Almost all participants wished and demanded that all traditional healers would take advantage of the availability of these regulatory and quality assurance systems to test their medicines. Intriguingly, even the officials in the government institutions who are quite aware of the challenges the government is facing in developing and promoting traditional medicine were pushing healers to have their medicines tested. The following are excerpts from various participants who wished healers would do something about their medicines.

What I advocate is that traditional healers should go and register or patent their medicines for research process so that those that are potent may be incorporated for use by prescribing by modern doctors..., when it is put ready for such use, a doctor who sees it listed in the national pharmacopoeia will recognize it and will prescribe to his patient **(PM1)**.

It is interesting to note that since the establishments of ITM, NIMR and TFDA about 40 years ago, no single traditional medicine has been registered for use by the

mainstream health system. Yet the officials were pushing traditional healers to venture into a project that the government has failed to achieve for the last 40 years.

So, we encourage traditional healers to have their medicines prepared in modern form, say that of tablets, etc. after quality certification by the Government Chemist or the Tanzania Food and Drug Authority. In this way, prescribers will have confidence in such traditional medicine (**RES1**)

To emphasise the importance of researching traditional medicine, even Christian religious leaders who are known to be great adversaries of traditional healers were ready to accept medicine from their rivals, the spiritual healers, as long as the medicine was scientifically proven:

Religious leaders would support traditional medicine used by spiritualist healers if it were scientifically tested to be potent (**RL2**)

Research on traditional medicine, training and curriculum development for traditional medicine and legal and structural support for traditional medicine are evidence that traditional health practice occupies an important position in medical pluralism. The next section provides the discussion of the findings of this chapter.

5.4 Discussion

This chapter partly addresses the over-arching research question: what are the opportunities and challenges for the contemporary health practice to cooperate with traditional health practice under the National Health System in Tanzania? The chapter has examined the participants' views on the possibilities of cooperation between biomedical and traditional health practitioners. The findings showed that there are two major potential areas for cooperation between biomedical and traditional medical practitioners: first, a conducive environment for cooperation between the two healthcare practices, and secondly, a meaningful support and promotion of traditional health practice from various stakeholders. The discussion of the findings in this chapter has been guided by a broader theoretical framework that includes two underlying processes through which the participants described the possible collaboration between the two health practices.

5.4.1 'Negotiated Order Theory', 'The Process of Integration and Differentiation'; and 'The process of Negotiating Modernity'

Negotiated Order Theory propounded by Strauss et al. (1963) is a broad framework that has guided the discussion of the findings not only in this chapter but in the entire thesis. Within this chapter, it furnishes two processes through which participants described and suggested a possible cooperation between traditional and contemporary health practices. Negotiated Order Theory is an important tool in this study due to its origin in 'symbolic interactionism', in which negotiation is the prime means to reach consensus among diverse parties that want to work together to achieve a common goal. Negotiated Order Theory as a guiding philosophy facilitates the first process of Integration and Differentiation developed by Hoenders et al., (2012). Hoenders et al. propound that integration and differentiation are two polarised phenomena that represent two dichotomous movements with the same strength that work as a response to each other. The potentials for cooperation between the contemporary and traditional health practices, which are central in the discussion of this chapter, and the challenges for cooperation between the two practices that will be discussed in detailed in Chapter Six, represent the processes of integration and differentiation respectively.

As the process of integration and differentiation is a subset of the broader theoretical framework of Negotiated Order Theory, so is the second process of 'Negotiating Modernity' by traditional healers propounded by Marsland (2007). The initiative of traditional healers to dissociate from traditionalism and embrace modernity as a strategy to be accepted and win legitimacy is not only in line with the process of negotiating modernity but also an evidence to support Hoenders et al.'s (2012) philosophical thinking: that "when there is too much differentiation, the parties lose sight of each other and create a need for more integration" (2012:441).

As will be revealed later, actors in the two processes need to regulate their roles in the process of integration and differentiation through negotiation and interactions. This move will create a middle ground that will enable integration of traditional and modern health practices to take place smoothly, at the same time allowing differentiation by maintaining the identities and autonomies of both practices.

5.4.2 Negotiated Order Theory: A Broader Framework

In Chapter Four, two schools of thought were examined in relation of the perception of participants regarding traditional health practice. The two schools of thought gave rise to the concepts of traditionalism and modernity. A demarcating line between the two concepts was characterized by conflict and non-reconciliation between them, which had created barriers against the practitioners of traditional and modern health practices working together. However, the findings in this chapter have indicated that there is a growing desire of the two to work together. This new development is partly because there are limitations inherent from each practice to address the needs and demands of clients. There is no single practice that has all the answers to the challenges humankind is facing. Consequently, in the search for solutions, the practitioners of traditional practice are adapting the knowledge of biomedical practice and vice versa. Indeed, the findings in this chapter are pointing to potential cooperation between the two practices, and the initiatives for cooperation are originating from both sides, traditionalism and modernity.

The collaboration between the traditional and modern health practitioners can be analysed within the broader framework of Negotiated Order Theory propounded by Strauss et al. (1963). As described before, the relevance of Negotiated Order Theory to this study is based on ‘symbolic interactionism’, in which negotiation between the parties concerned is central in reaching consensus on the type of integration. The genesis of this theory takes us back to 1963 when Strauss and his team carried out research in two psychiatric hospitals and concluded that the hospital as an organization was a negotiated order, rather than viewing order in a hospital as a pre-existing feature. Their argument was that it is through negotiation of the key stakeholders in the hospital that the facility was able to run smoothly. It is not the hospital that imposes constraints on the actors; rather rules, guidelines and regulations are constructed by the actors (stakeholders) to make the hospital run smoothly. With time the rules and regulations may be “established, renewed, reviewed, revoked, revised or changed” (Strauss et al., 1973:316-317) depending on the demands and needs at a given time. The fundamental foundation of Negotiated Order Theory is that stability and social order in any entity is created through social interaction. The theory propounds that “healthcare practice or organisations arise as individual health practitioners, departments, and stakeholders negotiate the terms of interactions with each other” (Asante et al., 2013:257).

In the views of Strauss and his team, a health system such as integrative medicine is a product of “negotiation, succession of conflicts, accommodation, and assimilation” among practitioners (Asante et al., 2013:257). The theory propounds that any change or disturbance to the context triggers a new series of negotiations to fix the emerging challenge. For example, the current study has reported a TAWG model, a collaboration between traditional healers and biomedical practitioners which was established out of the needs and demands (finding an effective medicine to manage HIV opportunistic infections). The model was a result of interactions and negotiations between traditional healers and medical doctors, which led to testing some remedies offered by traditional healers for treating opportunistic infections of HIV/AIDS. The outcome was amazing as the medicine was found to be effective. This is an example of the Negotiated Order that emerged when practitioners from diverse practices (members of TAWG) teamed with researchers from NIMR, and other international stakeholders, in deciding their common objective and agree on the approach they would realise that objective (Crozier and Friedberg, 1980). The promotion of common purpose is the ultimate goal of a negotiated order that is achieved through the convergence of interests and the actions of individuals. Subsequently, they construct shared understanding, meanings and perceptions of actions and responsibility and develop recognition of the contributions of each member (Boje, 1982).

In a different but related context, Negotiated Order Theory in this study was applicable when the government and other stakeholders were persuading traditional healers to offer the medicine they know to be effective to scientists for testing against certain conditions. Persuading traditional healers is a complex process, encompassing government regulatory institutions, research firms, biomedical and traditional practitioners, and industrial technological experts. Negotiated Order Theory is central in describing the role of different sets of actors in realizing that goal. Setting a team of collaborators to persuade traditional healers to work towards modernity would involve considering things like intellectual property, sizeable financial rewards to the healers, mass production of the medicine, marketability; and technological aspects. While this is a challenge to scholars, government institutions and practitioners of the two practices to identify and agree on a context for social interactions, their outcomes and how they could develop traditional medicine, the process is an example of the use of Negotiated Order Theory.

The adoption of Negotiated Order Theory in this study not only describes the process of interaction and negotiation among the practitioners of the two practices, but also supports the processes of Integration and Differentiation (Hoenders et al., 2012), and Negotiating Modernity (Marsland, 2007), since both require a high degree of interaction, negotiation and agreement as discussed below.

5.4.3 The Process of Integration and Differentiation: Merging Traditionalism and Modernity

Integration means creating a larger entity by bringing different parts together. The contrasting term for integration is differentiation, which involves recognising diverse parts that make a homogeneous entity (Hoenders et al., 2012). The philosophy of integration and differentiation is in fact observed in the day-to-day life of people. Couples get married and divorce, cells merge and divide; and companies unite and split. Integration and differentiation are not necessarily in mutual partnership; rather they are processes where each phenomenon react to one another. Hoenders et al. (2012) describe the relationship between integration and differentiation in the quotation below:

“When there is too much integration, the different parts lose their identity or experience a lack of autonomy. This provokes differentiation, leading them to profile themselves independently from each other. When there is too much differentiation, they lose sight of each other and each other’s interests, which increases the risk of polarisation and conflict. This will invariably lead to a need for more integration” (2012:441).

The nineteenth century was marked as a period of ‘differentiation’ of health practices following the naming of practices as modern or traditional. During that period laws were enacted in different countries to formalise what formerly seemed to be unregulated and unrelated cluster of conventional health practitioners. For example, in 1858 the act endorsed biomedicine as the supreme medical system in England; in the Netherlands, such a law was passed in 1865; and that in the USA in 1910 (Wiese et al., 2006; Turner, 2005). In Africa, the colonisation of the continent within the same period came with the establishment of biomedicine. Consequently, contemporary health care was established and identified as a scientific paradigm, while at the same time it distinguished itself and separated from ‘other practices’. Other practices that were perceived to be different from modern practice were named traditional, complementary or alternative (Hoenders et al., 2012).

After a century of differentiation that has seen the dominance of modern health practice over others, there is a growing impulse for integration from the users of both practices worldwide (WHO, 2014). The need and demand for integration is from within as well as outside the practices. For example, this study and evidence from other sources (WHO, 2012; Gale, 2014; Asante et al., 2013; Abdullahi, 2011) show that the international and regional organisations as well as the state governments all-over the world have goals in their plans to encourage integration of traditional and modern health practices under the mainstreams of the National Health Systems. This move is contrary to the process of differentiation where the practitioners seek to uphold their identity and autonomy. Notwithstanding the resistance to integration from some of the practitioners of the two practices in the study area, the next few paragraphs highlight the potential areas for integration between traditional and modern practices as described by the majority of participants.

Most participants mentioned the emergence of chronic conditions that were rare but are now becoming endemic in Sub-Saharan Africa as one of the conducive environments for cooperation between biomedical and traditional practitioners (WHO, 2012). Emergence of chronic conditions that are better managed by traditional medicine than with modern medicine is a potential area for initiating and enhancing cooperation between the two practices. The current findings show that conditions such as heart diseases, cancer and mental illnesses and opportunistic infections of HIV/AIDS are more efficiently and effectively managed by traditional medicine than in contemporary medicine. There is much overlapping between the findings of this study and those of Bernstein et al., (2001), Smallwood et al., (2005), Broom et al., (2007), Armstrong et al., (2011), D'Onise et al., (2013), and Baxter et al., (2013). For example, Smallwood et al., (2005) in their investigation found out that there was sufficient evidence to suggest that some CAM therapies were more efficient than orthodox treatments in managing certain chronic and psychosocial conditions. Bernstein et al., (2001) and Broom et al., (2007:1) found cancer patients were 'prolific users' of CAM in the UK.

The trend of disease patterns and the epidemiology of chronic conditions have increased the popularity and demand of traditional medicine/CAM worldwide (Wiese et al., 2010; Abdullahi, 2011; Asante et al., 2013). Reasons for the increased use of traditional /CAM differs from developed countries to developing countries like Tanzania. In developed countries, the health care system is mainly market-driven which

has created a high demand for CAM by customers. Hence, public demand has increased the use of CAM. As a result, biomedical practice is now progressively integrating CAM into medical training and practice (Coulter, 2005). On the contrary, in Africa, traditional medicine has always remained the mainstream healthcare system for most people (WHO, 2005). In addition, in recent years, more people in developing countries have turned to traditional healers and traditional medicine because of the emergence of chronic non-communicable conditions and HIV/AIDS disease (Gyasi et al., 2013). The wind of change towards embracing traditional medicine is not accidental: it is partly due to the inability of the medical profession to cure those conditions (Mahunnah et al., 2012). Healers, on the other hand, are reported to have successfully managed some of the chronic conditions (Hollenberg, 2006). As for HIV/AIDS, although there is no complete cure for AIDS reported so far, traditional healers in Tanzania and some other parts of Africa have been successful in treating and curing opportunistic infections (Kayombo et al., 2007; Mahunnah et al., 2012).

The findings of this study show that healers were able to manage AIDS symptoms successfully to an extent that patients whose HIV status was positive were declared by laboratory investigation negative after a series of treatments. This finding is consistent with the findings of the study done by Kayombo et al., (2007). The authors found that AIDS patients receiving traditional medicine improved tremendously to such an extent that traditional healers misinterpreted negative HIV results of a patient whose previous status had been positive as a sign of curing AIDS. In their study in Zambia, Kaborou et al., (2006) claimed that traditional healers were perceived a suitable underutilised resource to enhance prevention of HIV/AIDS and provide reasonable care, and that “an effective response to the HIV/AIDS crisis requires consideration of the collaboration between traditional and biomedical health providers” (UNAIDS, 2011:11). At its meeting in Kampala, Uganda in 2000, the UNAIDS stressed that traditional medicine was central in carrying the burden of HIV/AIDS in Africa, a fact that has been widely ignored by the state governments and international organisations (UNAIDS, 2000).

The commonality of accounts across different studies Kayombo et al., 2007; Kabouru et al., 2006; Viall, 2005) points to the existing evidence of traditional medicine curing HIV opportunistic infections. They also stressed the need for cooperation between orthodox and traditional practitioners in the fight against HIV/AIDS. Success stories of traditional medicine in managing chronic conditions have, among other reasons, led to

the establishment of both formal and informal cooperation between biomedical and traditional practitioners in Sub-Saharan Africa (WHO, 2014). This study reported an established model of cooperation between traditional and biomedical health practitioners in Tanzania, that of the Tanga AIDS Working Group (TAWG). Such models have been established elsewhere in Africa, for example, Traditional Healers and Modern Practitioners Together Against AIDS (THETA) in Uganda, and the Zimbabwe National Traditional Healers Association (ZINATHA) in Zimbabwe (WHO, 2005). Also, similar collaborations in the management of HIV/AIDS are reported in Mozambique, South Africa and Cameroon (UNAIDS 2000).

In Tanzania, there is no policy that allows collaboration between modern and traditional practitioners. However, due to the efficacy of traditional medicine in managing some chronic conditions, there has been some sort of informal cooperation between modern doctors and traditional healers at an individual level. Although this form of collaboration is happening at on a small scale, the findings indicated that biomedical practitioners were informally referring patients to traditional healers, at the same time as traditional healers were also referring patients to modern doctors. These findings are in line with Smallwood's study (2005) where biomedical practitioners in the UK were referring patients to CAM practitioners for conditions that were poorly managed by biomedical practice.

In another development the current findings suggest that the Tanzanian government is persuading traditional healers to embrace modernity as a way to improve their practice and delivery of their services. A number of initiatives have been put in place towards realising that goal. First, the government of Tanzania has established the Traditional and Alternative Medicines Act, 2002 (Act No. 23 Cap 244), which suggest the commitment of government to support traditional medicine. The legislation, along with the Standard of Practice and Code of Ethics composes the lawful context for the traditional health practice in Tanzania. The legislation invests power to the National Council of Traditional Medicine (NCTM) to register all traditional healers and sets regulatory standards for their practice, with an aim of modernizing the practice.

Secondly, apart from NCTM, the government has established five other institutions that are mandated to develop, support, promote and modernize traditional medicine through research, regulation and policy implementation. These are ITM, NIMR, TFDA, the

government chemist, and the Directorate of Traditional Medicine in the Ministry of Health. In the same line, the ITM and NCTM have initiated courses for traditional healers in elementary human anatomy and physiology and other issues related to health so as to raise the level of understanding of traditional healers and expose them to aspects of modernity. Moreover, at the district and regional level, traditional health practice is being coordinated by a modern medical official whose role is to promote modernity to traditional healers. And finally, traditional healers are encouraged by research firms to offer their medicines for research to determine their safety and efficacy with the aim of modernizing them.

All these initiatives by the Tanzanian government and other stakeholders point to the process of ‘integration and differentiation’ (Hoenders et al., 2012). It is evidence that the country is in transition from the process of ‘differentiation’ where traditionalism and its attributes were devalued, to a process of integration where the unique contribution of traditional health practice is valued. The transition from differentiation to integration is not without resistance and criticism; however, integration can only succeed in the presence of differentiation. For it is in understanding the difference between traditional and modern health practices that makes the necessity of creating integration. In the absence of differences between the two practices there is no push nor demand for integration. Hence the higher the need for integration the bigger the difference between the practices. In other words, integration should maximise the contributions of each practice at the same time it should accommodate and maintain what makes the two practices different so as to uphold their identities.

Cooperation as a result of the process of ‘integration and differentiation’ (Hoenders et al., 2012) is different from cooperation as a consequences of negotiating modernity (Marsland, 2007) by traditional healers. In the former, the cooperation between the two practices is a function of the natural reaction of integration to differentiation. It is about each practice appreciating the role and contribution of a counterpart, at the same time allowing the space and identity of each process. The triggers of that process originate externally, mostly from a request, negotiation or demand from stakeholders of health and wellbeing who would like to receive holistic treatment under the integrative medicine. While in the Marsland process, the urge to embrace modernity comes from within the healers. The next section discusses the process of Negotiating Modernity by

traditional healers as subset of both Negotiated Order Theory and the process of Integration and differentiation.

5.4.4 Negotiating Modernity by Traditional Healers

As mentioned earlier ‘Negotiating Modernity’ (Marsland, 2007) is a subset of the broader ‘Negotiated Order Theory’. Adapting modernity requires traditional healers to interact and negotiate with modern practitioners. In the same vein, it is a sub-set of the ‘Process of Integration and Differentiation’ because the desire of traditional healers to embrace modernity springs from their appreciation that modern practice is different and offers things that their practice does not possess. Several authors (Marsland, 2007; Watanabe et al., 2011; Hsu, 2009) have written on the subject of negotiating modernity, as a coping strategy for traditional health practice to attain legitimacy after being marginalized by the dominant modern health practice. Marsland (2007) defines “modernity as opposite to traditionalism, and from here a series of familiar dichotomies, urban-rural, male-female, knowledge-belief, developed-undeveloped emerge” (2007:572). While modernity is associated with Western culture and its attributes, traditionalism is related to ancestor spirits or ethnic identity; it is about local traditions, values and culture (Niehaus, 2001). When the two are put together, modernity takes a superior position over the traditional.

Worldwide CAM/traditional health practices were and still are disregarded (Hollenberg, 2006). This study shows how traditional health practice in Tanzania was despised and marginalized by the colonial regime and later by the Tanzanian post-independence government. It was regarded as primitive, satanic and related to the work of darkness to such an extent that the practice was placed under the Ministry of National Culture immediately after independence, implying that traditional medicine was a traditional-cultural thing. Traditional medicine in Tanzania and Africa is regarded as backward and satanic not because the practitioners are satanic people but because of the interpretation brought to bear by the western mind-set. In the same spirit, biomedicine is regarded by Christians in Africa as a ‘Genuine Godly Given Medicine’ not because people who work in the factories that dispense the medicine are ‘Godly People’, but it is the same western mind-set that interprets the goodness of modern medicine (Harries, 2010). Abdullahi (2011) reports how indigenous knowledge and native medicine in Africa were stigmatized, demoted and denied the opportunity to develop. In almost all countries South of Saharan Africa, laws were enacted against

witchcraft. 'The Witchcraft Suppression Act' in most of the Sub-Saharan African countries declared traditional medicine was unsafe and was equated to witchcraft, thereby prohibiting traditional healers from practicing (Erinosho, 2006). In South Africa, for example, traditional practice was outlawed and banned during the apartheid era (Hassim et al., 2011).

In Asia, traditional practice experienced the same effects of relegation by the dominant modern practice. In Korea for example, during the Japanese colonial era, Korean traditional medicine was regarded as ancient and unscientific (Kim, 2006). Consequently, Korean medical colleges were closed, and Korean traditional professional bodies were no longer allowed to practise. In Japan, a similar story is reported. Towards the end of the 19th century western medicine was perceived as better equipped to deal with infectious diseases and surgical conditions, hence Japan adopted the German system of medical education (Watanabe et al., 2011). Following that decision, the initial practice of Japanese traditional medicine commonly known as 'Kampo' was suppressed and eventually deteriorated.

To break off from the realm of stigmatization, marginalization and seclusion, traditional healers in the study area have engaged in negotiating modernity as means to cross the boundary that demarcates them as traditional and shift them into modernity where they expect to be accepted and acknowledged. In their desire to negotiate modernity, the traditional healers emulated elements of modern medicine. For example, some traditional healers, especially those who are educated, were referring their patients to modern facilities for modern investigations such as X-ray, medical laboratory, and ultra-sound. Based on the results of the biomedical findings, the healers were able to establish proper diagnoses, which made it easier for them to decide suitable therapies. Consequently, the trials and errors in reaching a diagnosis and managing patients were minimized. As their medicines were perceived to be effective, the cure rate was expected to be high. Some traditional healers had in their clinics an ultra-sound machine and a medical laboratory where blood, stool and urine samples were investigated by trained medical laboratory technicians and the results were interpreted by the same and sent to the healer for him/her to prescribe traditional medicine.

One clinic belonging to a traditional healer in the study area had acquired a 'Quantum Magnetic Resonance Analyzer' (QMRA) a non-invasive computerized diagnostic

device that helps the healer to do several investigations within a few minutes and arrive at an accurate diagnosis. The device can give a range of readings showing different organs' levels of function, vitamins and electrolytes levels, blood composition and body fluids. The history-taking of a patient coupled with the laboratory investigations and QMRA readings helps a healer to narrow down differential diagnoses. Further evidence of moving from traditionalism to modernity was reported in Chapter Four, where some traditional medicine shops in urban Tanzania were housed in good looking buildings, medicines were dispensed in clean, well-maintained, labelled plastic and paper sachets, and drug containers were shelved in glass cupboards. The label showed the dosage and dosing of a medicine, while traditional shop attendants were dressed in clean white coats. Apart from dispensing traditional medicines that were neatly packed they also stocked biomedicine, Chinese traditional medicine, and Arabic medicines that were reduced in tablets, capsules and creams.

These clinics were attractive: they drew large crowds of people, more than those medicinal shops that sold traditional medicine alone or biomedicine alone. In other words, these clinics broke the barriers that prevented people from using traditional medicine by embracing elements of modernity. These changes can be compared with traditional practice where healers are known to dispense medicine in a filthy environment, sometimes in the middle of a bush, wearing distressed and tattered dress, a ragged hat and no shoes. In this situation, the healers' medicines are stored in a calabash, and to show s/he is not an ordinary person, the healer puts on a mask and displays the bones and skins of dangerous animals (Kaboru, 2006). The change from wearing tattered clothes to clean white coat symbolises embracing modernity but more importantly the healers are identifying with modern practice, which may imply that they are dissociating with detrimental traditional practice and other malevolent activities that are performed by a 'traditional' healer.

In another development, a few healers in the study area were prepared to give their medicine to the scientists for them to study and test for efficacy and safety. This development was quite unusual as many traditional healers were reluctant to share the knowledge of their medicines, which they regard as top secret. When asked to comment on why they would offer their medicine without a prior assurance of a reasonable reward from the scientific institutions, their answer was, a scientific certification of the safety and efficacy of their medicines was far more profitable to their practice than the

patent of the medicine. Once their medicines were declared safe and efficacious by the scientific institutions, the business turnover would be considerable (Reddy, 2002). This development where traditional healers refer patients to modern facilities for investigations or acquiring in their work places, modern laboratory equipment and technology to assist with diagnosis and treatment; coupled with their willingness to offer their medicines for scientific testing, is in line with the concept of 'Negotiating Modernity' (Marsland, 2007).

As a reaction to marginalization Watanabe et al., (2011) described how the Japanese practitioners negotiated their way out from the influence of ancient Chinese traditional medicine into Kampo, a legitimate independent Japanese traditional medicine. One of the unique techniques that was invented by Kampo practitioners was palpation of the human body as a method of identifying physical conditions. The method was later appropriated by the biomedical practice and is currently in use worldwide. Notwithstanding the success of Kampo, it fell short of being accepted within and without Japan. To increase its acceptability, practitioners of Kampo had to undergo a second round of negotiation; this time they negotiated their way into modernity by offering Kampo to the scientists who evaluated its efficacy and safety. Today Kampo has 148 preparations that are reimbursable by the National Health Insurance, and which are registered by the Japanese National Health System. Approximately 70% of the physicians in Japan prescribe Kampo, which is accepted inside and outside Japan.

Negotiating Modernity is a new strategy applied by traditional healers of adopting techniques, skills and technology from modern practice so that traditional medicine can establish its legitimacy (Hollenberg, 2006). Negotiating modernity is a form of appropriation where traditional healers, appropriate elements of biomedical practice in order to modernize their practice, while maintaining the uniqueness of their traditional medicine (Hsu, 2008).

5.5 Conclusion

This chapter has presented findings on potential cooperation between traditional and modern health practices. The findings have pointed out areas that are likely to bring the two practices together: first, the emergence of chronic conditions that have found no cure in modern medicine but are well managed by traditional medicine; and secondly, informal cooperation between the two practices and anecdotes about bilateral referral of

patients from and to either side. The commonalities of the two practices and dual use of both therapies were among the reasons for encouraging cooperation and even integration of the two practices. Other areas that provide a conducive environment for cooperation between the two practices include individual support, and the legal and structural support of the government agencies that are mandated to develop traditional medicine. In addition, training and curriculum development, research and development for traditional medicine are additional areas for enhancing cooperation between the two practices.

The contribution of this chapter is that the scenario regarding the cooperation of the contemporary and traditional practices has shifted from viewing them as two distinctive health practices as discussed in Chapter Four, to viewing them as two forms of healthcare practices that have the potential to work together. However, the potential cooperation between traditional and modern healthcare systems is not without challenges and resistance as will be discussed in chapter six. The current chapter suggests that cooperation between the two practices is possible under the auspices of the broader framework of Negotiated Order Theory (Strauss et al., 1963), where negotiation and interaction of key stakeholders is emphasised to realize a shared goal. Secondly, it is possible through the process of integration and differentiation (Hoenders et al., 2012), where the differences between the two practices is central in motivating integration. Finally, cooperation is possible through the process of negotiating modernity (Marsland, 2007) where traditional healers have the desire to incorporate aspects of modernity, which will shift them from traditionalism to modernity. While the question of power relations during the process of integration between the dominant and a subordinate practice cannot be sidestepped, as will be discussed in the next chapter, a successful integration of two practices is only possible where there are obvious dissimilarities of skills, knowledge or approach between them. Integration that respects such dissimilarities will help to gain recognition of the contributions of each party, which is an important step towards a much stronger integration (Boje, 1982).

CHAPTER 6: DETERRENTS TO COOPERATION BETWEEN MODERN AND TRADITIONAL HEALTH PRACTICES

6.1 Introduction

In the previous chapter, the discussion centred on the potential areas identified by participants for possible cooperation between biomedical and traditional health practices. The discussion described the opportunities of cooperation between the two healthcare systems. This chapter will discuss the challenges and barriers which may prevent the two systems from cooperating in Tanzanian context.

This chapter will be guided by one major theme: ‘The Deterrents to Cooperation between Traditional and Biomedical Health Practices’. There are three subthemes, first, ‘Detrimental Activities of Traditional Healers’ as some of the activities of traditional healers are perceived as barriers to the cooperation between the two practices. The second subtheme - ‘Frictions Between Biomedical and Traditional Health Practices, examines the social, political and economic factors that create friction between the two practices and stand as stumbling blocks for cooperation. The third one, ‘Bias towards Traditional Health Practice’ discusses the power relations and their impact on traditional health practice.

6.2 Detrimental Activities of Traditional Healers: Barrier to Cooperation with Biomedical Practice

Participants pointed out the involvement of traditional healers in the killings of innocent people, citing the killings of people with albinism and red-eyed elderly women for superstitious reasons, and witchcraft, as barriers against the traditional and contemporary health practices working together.

6.2.1 The Killings of People with Albinism for Superstitious Reasons

Participants accused traditional healers of being behind the secret killings of innocent people such as albino people in some regions of Tanzania for what are alleged to be superstitious beliefs. It is believed that spiritualist healers use parts of the albino body as necessary ingredients for preparing a concoction that can make the rich richer and the mighty mightier. It is alleged that miners, fishermen, politicians and business

people pay large sums of money to obtain such a concoction. A biomedical doctor explains the motive of these killings.

Concerning the killing of albinos, there is false belief that in order for your business to prosper, be it gold mining, transportation or for any project such as to win a political election, a piece of body of an albino must be available as an ingredient in the concoction that will bring fortune **(BM7)**.

A religious leader expressed his regret and disappointment over the murders of innocent people.

We simply are opposed to spiritualists' practice, as it is satanic. Albinos are killed as a result of spiritualists' practice. Aaah!! Many albinos have been killed, including red-eyed older women and all sorts of killings have been going on in our nation. It is our duty as religious leader to stand up and offer prayers and petitions to God **(RL1)**.

Several participants argued that the killings of albinos have stained the image of traditional healers in the country, and many maintained that these events pose a significant barrier to cooperation between traditional healers and biomedical practitioners. A biomedical practitioner asked, how would a medical doctor cooperate with a murderer?

Aaah!! It is true the killings of albinos and red-eyed elderly women have tarnished the public image of traditional healers. This is a result of false belief based on some practice of traditional healers, that if you were to use a remedy mixed with part of an albino, you would become rich. Or that old woman has bewitched my children. How do you expect us to cooperate with killers? **(BM2)**.

The participants mentioned specifically that spiritualist healers that consult spirits and demons are responsible for the disharmony in societies. A religious leader drew an association between the practice of spiritualist healers and works of darkness.

Satanic dreaming is bad, a fortune teller may dream that an albino's hair or part of the body is a required ingredient in the preparation of a fortune attracting concoction; we know straight that is inspired by the powers of darkness **(RL2)**.

Another religious leader pointed a finger to the demon-directed healers as the most notorious healers for they are also involved in witchcraft and tormenting people.

There are those “*wapiga ramli*” [diviners], who consult the gods and demons and those who use ‘*tunguli*’ [witchcraft mirrors] to torment people, to make them fall sick and so on (**RL3**)

Richard: Is there concrete proof that spiritualist healers are involved in the killings of albinos?

There is no proof because this is a closed secret, it is a tightly closed secret, between the practitioner and the client. It is also a closed secret between the practitioner and the parent. The albino child's parent is paid a great sum of money to create artificial circumstances to show that the child went missing. So, you find three people do form a collusion to carry out a shared secret mission (**BMP6**).

Participants, mainly religious leaders and biomedical practitioners were of the opinion that traditional healers were involved in the killing of albinos

6.2.2 Killings of Red-Eyed Elderly Women

Participants accused traditional healers of being behind the killings of red-eyed old women ranging from age 60 to 80 in some parts of Tanzania. It is alleged that when there is a sudden death in the family or a calamity in the clan, the family members may decide to seek an explanation from a spiritualist healer. In the course of performing rituals, an old red-eyed woman in the village may be singled out by the healer as responsible for the death of their loved one. In revenge for the loss, the old lady becomes a target for secret killing.

The root cause of the murders of older women is to be found in spiritualism-based treatment. In this type of treatment, they practise by reading the divining board [*kupiga ramli*] whereby they identify the guilty party which normally becomes a red-eyed older lady and she is singled out for killing in closed secret (**BM5**).

It is not known why spiritualist healers pick on red-eyed elderly women as witches, because in rural areas, according to participants, it is very rare to find an old lady with bright eyes. Most of the ladies have red coloured eyes (corneas) due to the use of wood fires for cooking throughout their entire lives. However according to some participants, there is a common myth among societies in Tanzania that witches must have red eyes. Following belief of this myth, it raises the question, why are only elderly females picked as witches when there also men with red eyes. This notion introduces the

concept of patriarchal dominance over women (Kohnert 1996), which will feature in the discussion section.

6.2.3 Witchcraft and Sorcery

In Chapter Four, the participants advocated the separation of traditional healers and native medicine due to their involvement in witchcraft. According to participants, witchcraft and sorcery are terms that have different connotations in English but in Tanzania the two terms means the same thing. The Swahili term “*Uchawi*” is used to mean both witchcraft and sorcery; evil deeds where the motive is to harm another person because of envy, jealousy or detestation. However, participants were of the opinion that “*Uchawi*” has a third connotation, a ‘perceived good witchcraft’ where for example, one seeks help from a healer to change the attitude of a husband who has abandoned his family or ask for a concoction to catch a thief who is planning to steal or a concoction to enable a football team to win a match miraculously. Consequently, the term “*Uchawi*” is used to mean both good and evil acts of witchcraft. While another term “*Agua*” is a term used for a concoction or a ritual applied to counteract evil witchcraft. In most cases the healer who specializes in ‘*uchawi*’, is also a specialist in “*agua*”.

“*Uchawi*” can be sweet or bitter. ..., they have medicine to cause harm. They also have one for protecting from your enemies. The same healer has “*Agua*” a medicine that neutralizes witchcraft. I believe if you know how to neutralize witchcraft then you must know how to bewitch someone
(RES3)

Advertisement of good witchcraft is everywhere in radio, television, newspapers and even in signboards in town, such as ‘medicine to make women fall in love with you’, or remedies that brings lucky in business or ‘protect your property’ (PM2)

Witchcraft in Africa is a controversial topic, when described in European nomenclature. As the quotations above show, witchcraft in Africa particularly the benevolent one is something that is openly talked about it and traditional healers publicly speak and advertise about it. Witchcraft was even more controversial and confusing during the colonial era, which forced the colonial regime to pass the Witchcraft Legislation Act number 29 of 1929 (Becky 1979). The Act is still in use today. The controversial aspect of the Act is that it suppresses witchcraft by

discouraging the bewitched from complaining, even to name a witch. In other words, the law protects the witch because the court of law could not handle witchcraft cases, as to prove someone has been bewitched would involve another healer to provide that evidence. Thus, the law prohibits witchcraft accusations even pointing a finger to a suspect. Detailed discussion on witchcraft is given in the discussion section of this chapter.

Apart from witchcraft, participants mentioned other incidents performed by traditional healers that were related to superstitions, which were perceived as detrimental to the cooperation between the two health systems. They cited a witch ‘technology’ of flying during the night on a tray made up of the woven bulk of a tree or on the hyena’s back.

Europeans to beat us a great deal, they build motor vehicles, aircraft, and now we have these mobile phones. But we Africans, a man can change himself into a cat by associating himself with witches, use witchcraft know-how to fly through the air at night using trays [*ungo*], or riding on the back of hyenas at night etc. **(RL3)**.

Other detrimental practices of spiritualist healers include instructions to clients given as rituals. According to participants, some clients were required to sleep on a grave, kill the close member of the family or have a sexual affair with an infant as a condition for the concoction to work properly. Such instructions were given as part of “*uchawi*” or “*Agua*”.

There is an example I would not like to use; a person visits a traditional healer seeking HIV treatment. He is given some medicine with accompanying instructions that, having taken the medicine, he must have sexual intercourse with a six-month baby. He will do as instructed, he will be caught and taken to court. Now he is not able to defend himself, but the pre-condition was given to him by his healer, **(BM3)**

Many have been involved in devilish, foolish and embarrassing traps and snares. You are told to kill your son or lay on a grave the whole night so that you may become prosperous, or a thief is assured he will never be seen, he will be invisible, and then he is caught **(RL2)**

Participants also mention how someone may be a target for secret killings without her/his knowledge because a healer has pointed a finger at her/him as responsible for the misfortune that has occurred in a particular family.

The trouble begins when a traditional healer consult demons, and is directed that a certain person, without naming him but describing him by appearance and skin complexion, 'saying the one is a witch, bewitching your son'. If you have similar qualities as the one described by the demon, then your days are numbered **(BM4)**.

As reported in chapter four, the majority of religious leaders and biomedical practitioners who were in favour of separating the traditional healers and the medicine, perceived the healers as witches and sorceresses. On the other hand, almost all policymakers, researchers, and traditional healers who valued both traditional medicines and its practitioners were of the opinion that there are pure traditional healers who are not involved in witchcraft, although, they also admitted there are healers who are involved in both treatment and witchcraft, and they conceded that to differentiate the two was very difficult. A senior official in the National Council of Traditional Medicine elucidated the difficulty of differentiating witches and healers.

You cannot feel the cutting point of the Witchcraft Act and the Traditional Healers Act. There are those who are good, these are bona-fide traditional healers. There are those that are bad, these are using witchcraft in their practices; these should be handled by the authority of the Witchcraft Act. However, where is the cutting point between the two categories of practices? There is none. It is not there. So, it is a challenge. We cannot wipe it out automatically so quickly because these bad things operate through culture and no culture in the world has been destroyed **(PM1)**.

Richard: are you suggesting that in every culture there is witchcraft practice?

Oh yes! Go to the United Kingdom, the most powerful country historically, you will find witches and witchcraft because they are in the social culture and that cannot be changed. At the beginning of the year 2013, I happened to be listening to a radio programme when witchcraft killings in Shinyanga (Tanzania) were the topic. It was said that in a period of 5 years about one thousand people had been killed through witchcraft practice. It was then said that some parts of Europe and Germany were leading with 75,000 witchcraft killings reported. However, a time will come when these cultures will evolve in conformity with modern education and technology. Let me say there are challenges to be faced **(PM1)**

Another policymaker had comments that resembled her colleague's:

It is not easy so far to distinguish between a traditional healer, pure and simple, and one who combines both traditional medicine and witchcraft practice. However, I think given time, as we continue to educate ourselves, there will appear traditional healers on the scene who totally use researched medicinal herbs and no false faith nor witchcraft practice. These will gain personality and many people will flock to their clinics for treatment **(PM2)**.

There seemed to be a contradiction in the statements given by two policymakers. First, they seem to claim that witchcraft is part and parcel of the culture and therefore it is difficult to eradicate it, giving an example of developed countries. Secondly, and this is where there is a contradiction, both policymakers were optimistic witchcraft will wither as education and technology advances. It is a contradiction because European countries including Germany have developed and, yet they are still practising witchcraft according to their views, although the participant did not specify when killings of suspected cases of witchcraft took place in European countries. The opinions of participants have raised a concept of development, modernity and progress versus witchcraft in Africa (Nyamnjoh, 2001; Geschiere, 1997; Comaroff, 1999) which will be discussed in detail in the discussion section of this chapter.

As for the healers, they were not defensive in their accounts. They disclosed and echoed the views of researchers and policymakers that among them there are pure and genuine healers, and there are healers who also engage in witchcraft. However, some healers made a sharp distinction between healing and witchcraft saying the two are not compatible though they may be performed by the same person. Moreover, they regretted and were annoyed when all healers were labelled as witches.

Some people believe that traditional medicine is associated with false faith, false belief, witchcraft and sometimes satanic rituals. Unfortunately, it is true that some of us, the healers, have their practice based on witchcraft. These have smeared the otherwise good name of the traditional healers in our society, especially among the educated, and the religious circle (TH6).

Participants in the study were of the opinion that witchcraft was another significant barrier to integrating traditional practice with the contemporary health system. They argued that it will be hard for biomedical practice to work together with witches.

6.3 Friction between Traditional and Biomedical Practices: Social and Economic Challenges for Cooperation

Participants gave their accounts regarding the social and economic challenges that they saw could be stumbling blocks for the modern and traditional healthcare systems to work together. They cited the multiple identities of traditional healers, their low educational levels and healers' fear of loss of their reputation; the unreliable and

unpredictable rewards of intellectual property in traditional medicine, and secrecy around traditional healing practice as aspects that are likely to discourage collaboration between the contemporary and traditional healthcare systems.

6.3.1 Multiple Identities of Traditional healers

The multiple identities of traditional healers as a concept was first mentioned by participants who advocated the separation of traditional medicine and traditional healers in Chapter Four. The reason for advocating such a separation was their belief that a healer who has multiple identities harbours both benevolent and malevolent activities. In this section, the historical origin of multiple identities of traditional healers is provided by participants. According to a policymaker who is also a western-trained doctor and traditional healer, multiple identity has its origin from colonial history. In the 19th century Tanzania had a powerful indigenous health system that was organized into small chiefdoms throughout the country. The local health system was made of four types of traditional healers. The first group consisted of traditional healers who were purely concerned with treating sick people. The second group of healers consisted of those who advised the chief in all matters concerning the administration of his chiefdom. The third category assisted the chief in the defense of the chiefdom against foreign invasion and how to fight the enemy. The duty of the fourth type of healers was to advise the chief what should be done in order that the chiefdom might prosper, for instance, what was the right time to start cultivating, when harvest time should start.

..., of these four categories, one category, that of curative healers was eliminated.... The Germans killed the therapeutic healers..., (MR1)

Richard: So, what happened to the sick people after the curative healers were eliminated?

There is no community anywhere in the world that exists without the services of traditional healers to treat the sick community members. A decision was made to train one healer in each category of healing system to become a multi-skilled healer. So, one person became knowledgeable in the duties of all four categories of healing practices (MR1).

In the views of participants, what appeared as a coping strategy for the traditional healthcare system to survive against external invasion, became the beginning of multi-purpose healers; healers with multiple identities and healers who practised across the

border of their original expertise. From the excerpt given above it is clear that the colonial power was the agent responsible for creating the multiple identities of traditional healers in Tanzania by eliminating a category that was specialized for treating people.

Participants especially policy-makers and researchers claimed that if the German rulers had not killed the curative healers, Tanzania would have continued with the four distinctive types of healers and probably multiple identity would have not taken place. As chiefdoms were abolished after Tanzania became independent in 1961, the skills of healers who supported the chief, with exception of curative skills, would become extinct and die naturally. Even if they were to survive they would probably be weak given that their expertise would not be needed in the current times. A policymaker in the Ministry of Health and Social Welfare noted:

I think the elimination of chiefdoms when we became independent country could sign a natural death warrant to the services of some healers that were purely earmarked for the chiefs. And if they were to persist they would not have been strong **(PM1)**.

Policy-makers were of the opinion that the post-independence government officials were no longer advised by traditional healers. Consequently, the only cadre of healers that would survive would be the curative healers who knew nothing else but treating sick people. However, since one healer was trained in four different skills the healers continued offering all four services at an individual level depending on individual needs.

Following the abolition of chiefdom after independence, healers were no longer needed by the government, but they turned out to be advisers to individuals including some government officials though privately and secretly **(TH10)**.

The participants presented the idea that a healer with multiple identities is likely to offer both curative and malevolent services, which can be dangerous to the wellbeing of patients. Participants argued that as biomedical practitioners are trained to help and cure patients, not to harm them, they cannot work with healers who also offer malevolent services.

6.3.2 The Level of Literacy of Traditional Healers

All participants excluding traditional healers were of the opinion that the low level of education of traditional healers is a stumbling block for cooperation between the modern and traditional practitioners. They posed a question, how would an educated western trained doctor work together with an illiterate, someone who has never been to school? Two religious leaders noted.

There are several challenges, including differing attainment of educational levels, as some traditional healers did not go to school, whereas modern doctors are educated. How would you get these two to work together..., It is really a challenge ..., there is a challenge (**RL2**).

To get these two to sit down and cooperate ..., it is a challenge. I think a time will come when some of these traditional healers will be in the category of the educated. So, it is going to be easy to get these two work together. However it will take a long time (**RL1**).

The perception one gets from the quotation given by religious leaders indicate that differences of educational level are a huge barrier for the collaboration of biomedical practitioners and traditional practitioners. The religious leader continued that working together between the two practitioners will only be feasible when traditional healers would acquire knowledge and education to the same level as western trained practitioners. To emphasize his point, he gave an example:

I can see there is an obstacle. You cannot take a professor and get him seated here, and take a person who did not go to school, completely illiterate and get him to be seated next to the professor, I think, doctor, this is a great obstacle ..., (laughing). Now you take a dreamer and a professor and get them to sit at one table ..., (laughing). I think doctor that is something impossible (**RL1**).

Another religious leader provided similar comments. However, he went deeper to explain a chain of characteristics of traditional healers which he saw as barriers or obstacles to the healers collaborating with biomedical practitioners:

The modern is educated..., the other is illiterate. They are brought together. For them to speak the same language (professionally) and to get to understand each other can be very difficult. The traditional is alleged to be a witch, the modern is labelled to be a mere scientist; when you bring them together that can be a challenge. This one is recognized and is acceptable by

and to the Government. The other is not yet fully acceptable by and to the Government. That too is a challenge. Looking from an angle of religion, the modern is acceptable to religion even if his faith is remote ... (laughing) ... but the other, the traditional, even if he is a Christian, is not acceptable **(RL3)**.

Biomedical practitioners allege that it is hard to learn from traditional healers because they are illiterate, their approach is not scientific, and their knowledge is not written down.

Traditional healers are trained informally and whatever they learn and practise is not written down, so it becomes difficult to learn from them. They have a traditional approach; we have a scientific approach, and that is where and how we differ **(BM11)**

Another biomedical practitioner commented:

..., another challenge is that their knowledge is passed from one person to another informally. There are no training institutions as organs of spreading knowledge **(BM12)**

The two biomedical practitioners are showing their inability to learn from traditional healers because the latter's approach is not scientific. In the excerpt below another biomedical practitioner is doubting the ability of traditional healers to understand contemporary practitioners:

The challenge is to be found in the ability of the traditional to understand the modern. He (the traditional) may fail to understand the modern **(BM3)**.

The majority of traditional healers had different opinions from those of religious leaders and biomedical practitioners regarding their level of education.

If he wants to co-operate, I am not worried, I will teach him what I know. If I was able to understand traditional medicine, why should I find it difficult to understand biomedicine? The mistake they [biomedical practitioners] have in their mind is that we are not trainable, that it is not true **(TH9)**.

A bone setter made the following comment:

Eeh! That camp, the camp opposite ours is made up of the educated. We missed education, but the Government, sees this, it knows this; that we are capable of understanding our clients' problems and treat them successfully.

This is the Government's responsibility, because "These are my people, and these too, although they are not educated, are my people still and the patients they treat are my people". The Government should have reasoned this. Therefore, it should have brought us together (TH7).

The excerpts from traditional healers show that, even though they admit that they are not as educated as biomedical practitioners, they are knowledgeable with skills and knowledge that are unique and that biomedical practitioners do not have. A traditional healer who is also a university professor provided a more rounded answer to this debate:

The differing of educational level is indeed a stumbling block and a big one too. However, let us make this clear, to every practice, there is the art-side and the science-side. There are some fields of study that have the characteristics of both art and science. What is art on this context? A person knows that this does that, this treats that disease though he does not know the how and why of it, but it is true it does what is claimed it does, because he has been told and he has seen it with his own eyes. This is the art-side of knowledge (MR2).

Richard: Are you implying that traditional healers have the art side of knowledge and they lack the scientific part of it?

Oh yes; however, it is better to know exactly why such, and such herbs do cure for example cancer; that is the science-side of knowledge. Aaah!! So, it is true that tomatoes are a cure because it contains anti-oxidants (you must become a scientist now to know that). So, anti-oxidants do work in treating cancer because they fight free radicals, whereas free radicals do work to aggravate disease. Now, when you know this, you will go on to realize that there are other 'anti-oxidants' such as vitamin C; Aaah!! So, you will find that other plants like Aloe-Vera also contain vitamin C, therefore other bio-products having vitamin C must cure cancer, so you will have a wider option/usage; broaden your field of choice. However, an uneducated person must stick to one thing (say herbs) that he knows that it cures. And this is a challenge to a great number of traditional healers. Ignorance is a handicap to them (MR2).

The above quotation is addressing the opinions and worries that religious leaders and biomedical practitioners have with regards to the level of education of traditional healers. Although some traditional healers are illiterate, they are not completely ignorant as traditional healers are knowledgeable of medicinal plants that have the ability to treat: that is art-side of knowledge which is equally important. What most traditional healers lack is the scientific side of the knowledge, for example, why there is variation of efficacy between a medicinal plant harvested from high hills as opposed to those harvested in valleys and how does the medicinal plant cure a disease.

Commenting on the level of education of traditional healers, a policy-maker in the Ministry of Health and Social Welfare expounded as follows:

It is true we have succeeded to institutionalize traditional medicine, by lending official recognition and approval, but the pace towards integration is very slow. Reason for the snail's pace are there, but the chief reason is lack of formal knowledge, formal education on the part of traditional healer. Some are illiterate, they do not know numeracy, writing and reading even in Swahili, the local language. So, the problem of ignorance is a snag **(PM2)**.

However, the policy maker in the National Council of Traditional Medicine dismissed the difference of level of education between traditional healers and biomedical as a barrier for the two practitioners to cooperate together:

Obstacles ... let us visualize as walls preventing this from recognizing that, that is just not there. There are those of a superficial nature, and these based in faith and otherwise confidence – that “this is not educated as I am. I am educated, how can my practice be integrated with his, he has not studied human anatomy ...” This is the reason why we want to promote traditional healers’ knowledge, so they get to know the human body, and how it works ... how it...eeh!! so that when the two sit down to discuss something, there should be mutual respect **(PM1)**.

The policy-maker seems to downplay and underestimate the challenge of the low level of education of native healers by protesting that the issue is magnified and exaggerated by people who are against traditional medicine. Intriguingly, at the end of her statement she suggested plans to promote traditional healers’ knowledge of human anatomy so that they are on equal terms with biomedical practitioners. Indirectly she is acknowledging the need to advance the knowledge of traditional healers so that the two can work together smoothly.

Some researchers also agreed with other participants that the differing level of education between the two practitioners was a challenge, but they also mentioned that biomedical prejudice is a major stumbling block for the two to work together. A researcher at ITM commented:

The first barrier is education and training. Experts in modern medicine are educated and are professionals. Experts in traditional medicines have scarce and poor education. Second, experts in modern medicine on the basis of the training they had, have failed, through prejudice perhaps, to sit down together with experts in traditional medicine and discuss about

even elementary problems of primary importance about treatment of patients. So, that barrier has created a situation whereby each of these two groups keeps away from the other (**RES1**).

The level of education too is a problem. Education levels are different, and there is no question about this. ‘This went to school, that did not’ that too poses a problem. The moderns are ideally supposed to educate the traditional. Few are willing to do that. As an institution, we have started a course whereby some traditional healers are taught basic anatomy of the human body, to enable them to know something about muscles and so on including hygiene. Should we work hard, I think we shall be improving traditional healers’ practice (**RES2**).

These excerpts from researchers tally with the comments made previously by the policymakers about the courses ITM is preparing for the healers on elementary human anatomy. However the views of the researchers in this study are that the differing level of education cannot be a barrier for the two practitioners to collaborate. The discussion on the differing of education levels between modern and traditional practitioners introduces a concept of ‘dominance and hegemonic influence of biomedicine’, which has also been highlighted by Gale (2014).

6.3.3 Competition for Reputation between Traditional and Modern Health Practices

Participants mentioned competition for reputation between traditional healers and biomedical practitioners as a barrier for collaboration between them. For example they cited the struggle by traditional healers to advertise their practice by degrading biomedicine as ineffective therapy, and one that has bad side effects. A biomedical doctor directed his anger to the government for letting traditional healers do as they like.

However, some traditionals have a negative attitude towards the moderns, as witnessed by their advertisements in the media that modern medicines do carry poison with them, and so they create an atmosphere of unfair competition. However, we do not hit back, and it appears the Government is letting them freely publicize hostility against moderns. It would be fair if this hostility comes to an end (**BM6**).

Another biomedical doctor questioned the silence of the government for allowing traditional healers to publicize their practice, arguing if it is unethical for a modern doctor to advertise his profession, then it should be the same for a traditional healer.

In the area of policy making, the Government, however leaves much to be desired. For instance, I, as a doctor cannot stand up in front of people and mention diseases I treat as it is ethically prohibited but traditional healers have been advertising and publicizing their practice a number of times **(BM8)**.

From the quotation above it is evident that the traditional healers are taking advantage of their knowledge of the side effects of biomedicine and the complaints from patients about the poisons biomedicine carry with them to discredit biomedicine. In the world of competition, the traditional healers have won credit for understanding the weakness of the competitor and taking advantage of it to promote their medicines. The struggle for fame is not one sided: biomedical practitioners have also criticized traditional practice as unscientific based on guess-work, as the quotation below shows:

The greatest barrier is that we moderns on the one hand and traditional, on the other, do not understand each other; we do not see things eye to eye. We have a scientific approach. They have a different approach. We think their practice is based on guess work, trial-and-error; because they are not able to diagnose what exactly is the trouble with a patient. You may find, for instance, one traditional treating diabetes, but he does not know what causes diabetes. Another challenge has to do with earnings as income; they see that to refer patients to us would diminish their sources of earnings as income **(BM10)**.

Apart from competing for fame participants described the fear of traditional healers that they will receive unequal rewards if they decide to work together with modern practitioners. A bonesetter expressed his worries that traditional healers may not get an equal share.

You know; it is fear, worry, hesitation. Fear of being short changed when it comes to sharing medical fees. He (traditional healer) will be doing the donkey work but he will be under-paid. He overlooks the advantage of publicizing his practice whereby he would draw more patients to patronize his practice. **(TH7)**.

Fear of receiving uneven rewards was compounded by uneven recognition by the government. Traditional healers feel that the government regards Western-trained practitioners with esteem and provides attractive incentives for them while traditional healers receive nothing. A researcher who has worked closely with traditional healers attests as follows:

What is of uttermost importance is social recognition, that the modern is employed by the Government, good and attractive housing is provided for him, he is paid handsome salary, he eats good food, he is better endowed with several favours, but the other practitioner (the traditional healer) has to earn a living by the sweat of his brow. So, I see this as another great challenge **(RES1)**.

On the other hand, traditional healers are not keen to work closely with biomedical practitioners as they suspect their counterparts may appropriate and subjugate their knowledge of herbs for their own benefits. At the same time, biomedical practitioners are concerned that cooperation between native healers and biomedical practitioners will improve the services of traditional healers including that of the traditional birth attendants who are already preferred by the majority of pregnant women in Tanzania over modern natal services.

A barrier on the side of traditional healers is the feeling, the suspicion that the moderns would steal their knowledge of herbal medicine, and patients will flock to their hospitals. At the same time the biomedical practitioners are worried if there is improvement in the work of traditional birth attendants then most of the expecting mothers would be attended to by traditional midwives **(PM2)**.

In other words, both sides, the moderns and the traditionals, have become conservative by deliberate choice fueled by fear, consciously or unconsciously, of losing fame, legitimacy and popularity; and also, losing part of their prospective patients

6.3.4 Secrecy and Intellectual Property of Traditional Medicine

Participants articulated their opinion about the secrecy of traditional practice. Most of the participants were of the opinion that the knowledge of traditional medicine, especially medicinal plants, is top secret for a healer. It is knowledge that a healer shares with very few people, and in most cases, it is a son or daughter who is likely to carry on the practice after the healer's demise. The attitude of concealing the knowledge of medicinal plants is seen as a barrier to traditional and modern practitioners working together. This, coupled with secrecy, is the informal means of passing knowledge of traditional medicine from one generation to another. In most cases the passage of knowledge is oral, hence the knowledge cannot be accessed beyond the healers' immediate apprentices. A biomedical doctor told how they would find it hard to work together with someone who is hiding vital information:

The first challenge is about secrecy. Traditionals do not like to make their knowledge known to others, fearing probably that their fame will fade away if many people were to gain the knowledge they have, and also there would be competition (BM9).

Another medical doctor had the similar opinion that traditional practice knowledge is not preserved electronically, which it makes it difficult to learn from the healers:

Traditional healers do inherit their skills from ancestors and grandparents or are trained by some other person. Traditional healers are trained locally and whatever they learn and practice is not written down, so it becomes difficult to learn from them. They have a traditional approach; we have a scientific approach, and that is where and how we differ (BM4).

However, the traditional healers were of the opinion that a concealed knowledge of their medicinal plants is something special and it is that knowledge that differentiates them from non-healers. They argue that every healer has knowledge of medicines that s/he prefers to keep as a tight secret. Some healers reasoned that once knowledge of particular medicinal plants becomes public, they remove that plant/knowledge from their secret list.

As a healer, I possess information about medicines that is only known to me as an inventor..., I also own knowledge of some medicines that is possessed by few healers that we share among ourselves. Our knowledge is a top secret (TH8).

When traditional healers were asked whether they would cooperate with scientists to show them the medicinal plants they know for them to test, this is how they responded:

Eeh ! I will be willing to look for the medicine, prepare it and to let them (scientists) study it (TH1).

Richard: Would you offer the dispensed medicine or plants?

I will offer medicine first (laughing)(TH1)

Richard: Why not offer the plant itself?

As for the plant, I would tell them later (laughing) There are conditions to be fulfilled first before offering the name and part of the plants (TH1).

Several traditional healers were ready to offer their medicines to a scientific research team for testing on condition that they would submit the medicine in a raw form without the need to mention its source. In the event, that medicine proved to be effective, the patent of the medicine would still be in the custody of the traditional healer as the scientists would never identify the medicinal plant, unless it is disclosed by the healer. Thus, from participants' point of view traditional healers are very good at protecting their intellectual property. However, a few traditional healers were less protective, as they were ready to show the species of the plants to the researcher.

Richard: Suppose experts in scientific research of traditional medicine were to visit here today would you be willing to show your herbs?

I will agree, because my main concern is to promote the public interest. The community is faced..., is having to struggle with so many diseases that are difficult to manage. That is why I serve, I attend to patients that have no money to pay, as fee for service rendered. The problem with traditional healers is self-centredness. They think that should they show the medicinal plants they know to strangers; they would be the losers ultimately (TH10).

His eagerness to offer the secret of his knowledge triggered more interest to find out why he would offer his knowledge without the assurance of equitable reward. His comments were:

Do not overlook the advantage of advertising my practice. What would happen if my medicine would be found by scientists to be effective? The scientists would be my publicity agents for the medicine. I will be confident about my medicines whereby I would draw more patients to patronize my practice (TH10).

The excerpt above suggest that some traditional healers were ready to offer their medicines to the scientists as a strategy to seek authentication of their medicines. A scientific proof of the medicine would help to advertise it and penetrate the market. A medicine that is found to be scientifically sound would increase its legitimacy and draw more clients to use it. This strategy where traditional healers are voluntarily prepared to offer their medicine to be tested introduces the concept of 'negotiating modernity' (Marsland, 2007). That concept was first introduced in chapter four and was discussed in chapter five. Generally speaking, the majority of traditional healers, especially the good ones from the rural areas, prefer to safeguard their knowledge from external

invasion according to the researchers from ITM and NIMR, the two institutions that work closely with traditional healers in researching traditional medicine in Tanzania. A researcher from NIMR articulated the following:

The real experienced and best healers are in the rural areas. They have enormous knowledge of the medicinal plants. They are the hardest to reveal their knowledge. If you persist and insist to ask them they will end up telling you that they mix more than 50 trees to get the medicine just to discourage you from further asking questions (**RES1**)

When asked why the healers would hesitate to disclose their knowledge, a researcher explained as follows:

Part of the problem is trust between us researchers and traditional healers, the healer wants to be assured well in advance about how he will benefit from disclosing his knowledge. In most cases they want advance payment by simply mentioning the plant even before the test is done. They are worried once we find the medicine is efficacious they may not be rewarded sufficiently. But we cannot pay them in the absence of evidence (**RES3**).

Richard: What do you do to convince them to cooperate?

We, on our part, have an agreement form that may be signed by parties to enable us work in co-operation with traditional healers in the knowledge that their intellectual property rights will be acknowledged and rewarded if research findings are good and favourable (**RES1**.)

In the views of some participants, the challenge is that the healer is not part of the scientific team that is working on his/her medicine. Thus, trust is essential as scientists may conduct a study just to inform the healer the medicine was not effective when actually the medicine was potent. According to researchers they have to convince the healers in advance that research takes a long time and investments in it are high. The traditional healers are made to understand that considerable benefits that will accrue to them, having considered the total costs of investment as input.

So, the traditional healer may receive a dividend of say 10 or 20 per cent after deduction of capital costs as a contribution. In the normal process of production, things like bottles, labels, medicine, capsules, formulae, salaries and wages for workers must be considered. This means that if profit stands at say 1 million Tanzanian Shillings, we must pay him 100 thousand or 200 thousand Tanzanian Shillings depending on whether the agreement stipulates 10 or 20 per cent respectively as his dividend (**RES1**).

According to researchers' experience of dealing with traditional healers, it is difficult to convince the healers to accept anything below 50 per cent of the dividend. As far as they are concerned they feel their contribution is central, as without their knowledge no research can be conducted, and therefore they deserve a sizable share.

Many traditional healers find it difficult to understand and accept, they wish it would suit them fine if the profit were divided on a 50 - 50 basis, between them and ourselves. However, research investment is normally very high. Take the example of research we are conducting now on medicinal herbs brought to us by Tanga AIDS Working Group; we are now in the second year of research and we have spent around TZS 260 million [£ 87,000]. We are paying the traditional healer, as a co-investigator (**RES3**).

All researchers in the study area admitted that when they engage with traditional healers to study their medicines they are guided by the WHO guidelines in researching traditional medicine. Researchers explained how one would face two crucial questions when presenting a paper on research findings about a traditional medicine in an International Conference on Traditional Medicine. The first question would be 'how did you get to know the plant in question was a cure for a particular disease or a number of diseases?' The next question would be 'how would your guides benefit from sales of the medicine?'. The second question implies that, the researcher was guided by other people, s/he did not guide her/himself. These are the basic questions that are asked time and time again at such conferences. A senior scientist at NIMR explained how his institution engages with traditional healers.

When we set out to find medicinal plants with a view to registering intellectual property rights, we start by signing a Memorandum of Understanding (MoU). This is a kind of contract between ourselves, and the other party to the agreement would be the traditional healers and others that are willing to share information about the traditional medicine they would be using in the treatment of a disease our research is intended to focus on (**RES2**)

The aim of the agreement would be to ensure that both parties to the agreement are going to benefit from the research if the final findings are successful. According to researchers, the guides are not supposed to disclose vital information to them. So, the researchers remain ignorant of what the healer/guide knows. Equally, the healer remains ignorant of the knowledge of a researcher in the process of testing the medicine. The traditional healer keeps vital information to himself, the name of the

plant and where it is found. This information is his forte and is secret. However, the healer tells the researcher what the medicine cures, so that the researcher can conduct research into the efficacy of the medicine against the disease.

So, they have their part that they keep as a closed secret. I have mine, in the form of research know-how. It is my closed secret (**RES2**).

When asked, what would happen if the research was successful, who would file the patent of the medicine, a researcher explained.

Yeah!! A better arrangement would be for an institution to state specifically that having found that his medicine is potent and a traditional healer is willing to team up with us in a partnership; we will share responsibility as well as the proceeds of the business performance between the two parties. The healer would be responsible for identifying the medicinal plants to the scientists and probably to collect sample. The intellectual property right would be held in by the partnership (**RES2**)

In the opinion of all researchers who were interviewed, there are rules of confirming and validating the efficacy of the medicine. When it comes to filing the patent, the person who files the patent becomes the owner of the patent depending on how 'ownership' is defined. Trust is the best policy: a researcher should be honest. S/he is required to incorporate all those who have played a part in successfully developing the medicine as there must be some people behind the success who, although they did not have knowledge of a scientific nature, yet had the Indigenous Knowledge. Consequently, when a researcher enters into an agreement with traditional healers and other people, it is fair and good to tell them openly that if research findings are successful, the researcher and the healers will share the outcome as agreed in the MoU.

According to researchers at ITM who participated in the study, an alternative to this arrangement would be that in the case that the traditional healer wants the intellectual property right to be his and his only, the scientists would still conduct research on condition that if results are good, the healer would have to disclose the name of the plant concerned, and its uses so that researchers have a basis from which they may start.

These facts would be a closed secret between the healer and the institution; we would be bound not to disclose the name of the plant and its uses as a cure. For instance, if it is a guava tree, we would be free to say, "The guava tree is treatment for disease X" However we would not

be supposed to disclose what it cures, and what part of the guava tree is a cure. The mode of preparation would be the institution's closed secret **(RES2)**.

Most researchers and all policy-makers were of the opinion that where traditional healers are ready to cooperate with scientific institutions to research their medicine, their contribution is equally significant as that of scientific institutions. The ultimate by-product of this cooperation is a hybrid medicine that has both traditional and scientific inferences; and whose ownership is equally shared by both parties. These revelations introduce the concept of 'Hybridization of Traditional Medicine' (Watanabe et al., 2006; Kim, 2006; Hsu, 2009), which will be discussed in detail in the discussion section of this chapter. In the next section, a third subtheme - Power relations and how they impact the traditional healthcare system will be discussed.

6.4 Bias towards Traditional Practice: Power Relations and their Impact on the Practice

Participants submitted that there are power relations within Tanzania that are working against the interests of the traditional healthcare system. These sources of power are the colonial legacy, the wavering government support, the dominance of the biomedical healthcare system, and Christian ideology.

6.4.1 The Colonial Legacy

Several participants asserted that before the advent of Western regimes that brought with them Western culture and biomedicine, traditional medicine was the dominant healthcare system in Africa. Participants were of the opinion that the western regime perceived the local culture and traditional medicine as primitive, backward and uncivilised and that the western culture was irreconcilable with the local culture.

The colonial powers that ruled us, the Germans, and later the British, and on the religious front, the Christian missionaries were all opposed to traditional healers' practice, and that included our post-independence leaders. Even after independence, their opinion was that traditional healers' practice was nothing but quackery **(PM2)**.

Using different strategies, the western regimes were successful in dividing the population between those who embraced the Western culture versus those who remained local. According to participants, "*Waliostaarabika*", literally meaning 'the

civilised' or "*Walioendelea*", 'those who have developed', were terms that described those who went to school to attend formal education, individuals who were converted to Christianity and people who received treatment from the Western health facilities. Individuals who were not exposed to Western culture were known as "*Washamba*" meaning 'the local' or 'primitive people'. The western culture was superior to the local one, and anyone who embraced the Western culture had indeed embraced civilization, development and modernity.

Let me tell you doctor, the colonial regime divided us so that it can rule us easily. We fought each other, and we started calling our fellow countrymen names, *wasioelemika* [primitive], *washamba* [underdeveloped] and *wapagani* [people without religion]. '*Walioendelea*' were those who followed the western culture and were perceived as civilized and modern (**PM1**).

It was from these divisions of perceptions that internal forces against traditional medicine and its healers received great impetus. Participants were of the view that the prevailing clefs between biomedical and traditional practitioners; Christians and non-Christians; literate and illiterate people; and formal education and indigenous knowledge are the consequences of the clash between Western and local culture. Indeed, it is a colonial legacy that is at work that continues to segregate people according to their social strata. Participants pointed out three areas where the colonial regime and its legacy were responsible for degrading the traditional healthcare system in Tanzania. First, they killed traditional healers:

It must be remembered that during the era of exploration and colonization of Africa, the rulers, the colonial powers were studying our weaknesses and strengths. When they found out that the health system of Africans was 'soft-tone' they saw they could eliminate traditional healers; many healers were killed (**MR4**).

Another policy maker gave a similar comment:

Their [traditional healers] contribution was there before the advent of foreign [colonial] rule, and these foreigners tried to muzzle it by murdering the local practitioners, but it survived all the same (**PM2**).

Secondly, they influenced the mind-set of influential people including the legal framework to work against the traditional healthcare system.

That colonial mind-set contributed to a great extent to a negative attitude in the minds of government officials, biomedical practitioners, and religious leaders towards traditional medicine. They discouraged our medicines and introduced theirs. So, Europeans were of no help, they played a negative role whereby we lost our indigenous knowledge **(TH3)**.

Third, they strove to devitalize the strength and vigour of the local culture including traditional medicine by replacing it with western culture and biomedicine respectively.

Aah their aim was to kill our culture and our native medicine using all sorts of power they had especially by showing weak points of our health practice but also, they showed their ignorance of our culture **(RES1)**.

When the researcher was asked why would the colonial rulers engage in changing peoples' attitude towards their health system? He replied:

They realized that if they were to let the people retain the whole gamut, the entire range of their traditional medicine and healers, they would fail to rule this country. Without destroying what they called satanic culture, they would not control the people and country as it was so powerful. Take an example of the Hehe tribe under the Chief Mkwawa who fought the Germans led by the '*Maji Maji*' ideology. The Hehe culture was strong, so strong that it was not easy to bring it to its knees, and so they had to dismantle it **(RES1)**.

Majority of participants viewed the colonial rulers not only as responsible for establishing the western culture that was incompatible with the local culture, but also used the culture as a weapon to divide the local people along the lines of civilized people as opposed to uncivilised. In the process of social division local religion and health practice among other aspects were degraded in the country. The role of the colonial regime and its legacy in Tanzania will continue to be the focus of the next three sections where the Christian ideology that is against traditional healers, uncommitted government support for the traditional healthcare system, and biomedical dominance over traditional practice, all of which have traces of the colonial legacy, will be discussed in detail. While this statement may seem generalizing, the objective of colonial regime, Christianity during the colonial times and the education system could not be differentiated as they were all managed by the same people who colonized Africa.

6.4.2 The Power Relations of Christianity

In chapter four, participants who advocated the separation of traditional healers and traditional medicine argued that traditional healers' practices were perceived as related to Satanism and works of darkness. In this section, participants claimed that Christianity is a power relation that works against the traditional healthcare system.

I mean Christian religious leaders, have no faith in traditional healers. This is a result of the kind of education we got years back... **(RL1.)**

Another religious leader echoed his fellow religious leader:

Doctor, we religious leaders do regard traditional healers as pretenders, quacks, those that use powers of darkness and who perform satanic rituals **(RL2).**

A third religious leader echoed the arguments given before:

Well, in actual fact, religious leaders, I mean Christian religious leaders, have no faith in traditional healers... instead we believe that modern medicine is better, it is actually far better than traditional medicine **(RL3).**

Probing more deeply as to why Christian religious leaders do not trust traditional healers, a religious leader contributed the following:

Instead of dispensing their medicine as something pure and simple, they add lies, false beliefs to be observed by the patient and unnecessary instructions and claims, such as demand to perform satanic rituals. Religions leaders see traditional healers as people who mix lies with the truth **(RL3).**

As claimed before by participants, the western regime used all means in its disposal to increase the influence of western culture and degrade the local culture. Thus, the Christian ideology of viewing traditional healers as satanic and primitive was carefully injected into the educational system, biomedical profession and legal framework. All these avenues were strategically crafted to send a similar message 'Embrace western culture; disregard your local culture' according to a researcher. Consequently, the Christian stance regarding traditional health practice had strong influence over the government, the biomedical sector, the legal framework, and the formal educational system although each sector had its own reasons to disregard traditional health practice.

So, there is that negative attitude towards traditional healers fueled by school education, Christianity, legislation and modern medical practice. These combined together to throttle our culture because when you throttle and kill a culture; that is the end of the story **(MR3)**.

To consolidate the notion that the campaign against traditional health practice was comprehensive, a policy maker attested how the government officials and biomedical practitioners were also targetted.

Government officials and modern doctors were trained by Western trainers and they were brain-washed to settle with them that the local medicine was primitive and satanic and of no use. They did that in order that they destroy the indigenous knowledge **(PM1)**.

When participants were asked whether or not there has been any change of mentality after more than five Decades of independence, they replied:

A change of mentality and perspective has not been witnessed yet among those who were so brainwashed as to come to reject traditional medicine, to regard it as Satanic **(PM2)**.

A researcher also gave a similar comment:

This prejudice is still there both on the religious and on the modern doctors' front. You know, the trouble with modern doctors is the oath they take which makes them stubborn, rigid and prejudiced to the point of despising traditional healers' practice. **(RES2)**.

Another researcher from NIMR gave an account how researchers at NIMR, a government institution, distance themselves from spiritualist healers as if NIMR was a department in one of the Christian denominations.

Aaah! The category we do not deal with is that of spiritualists; because their treatment is based on ritual ceremony. It is a treatment based on faith, whereby you cannot evaluate a patient both before the rituals start and at the end of the rituals, and it is the kind of treatment you cannot evaluate, and you cannot reproduce it. We deal with the herbalist. The herbalist is as good as a physician. He knows some medicinal plants and their relevance to treatment **(RES1)**.

The researchers at NIMR are guided by the belief that spiritualists are not their favourite counterparts; instead they prefer working with herbalists for the explanation that their herbs are similar to biomedicine. This point of view is shared by the Christian leaders who reiterated that they trust biomedicine and they distrust traditional healers

especially the spiritualists. When he was probed more deeply about what happens if the spiritualist is also knowledgeable of medicinal plants that need to be researched, his reply was:

Yes, yes and we deal with such a practitioner, taking into account only the medicine he can bring to us. We ignore the spiritualism part of the medicine, as even the Act, the law of the land, does not allow this. We take superficial note of the report that spiritualism was involved in identifying the medicine in question, but we do not go further than that. We are focused in herbalism all the time **(RES1)**.

Another researcher at NIMR confirmed the account given by the previous researcher that they deal with traditional medicine that has been brought to their attention by the traditional healers; they are not bothered with the philosophy behind the medicine.

Yes, we deal with traditional healers; that is main to us. Our interest is in endemic medicinal plants; they know the plants. Their knowledge is of great value to them and ourselves as workers at NIMR. We are interested in herbs, pure and simple, and nothing else. These herbal medicines may be in combinations of a number of different herbs, it is all the same to us, so long as they are herbs and nothing else **(RES3)**.

Richard: Are you not interested in the philosophy and theory behind the medicine?

The most important thing to us as science-based researchers are the medicinal plant species, and nothing else. So, we deal with both including the spiritualists so long as they show us the plant species, and nothing else. We are not interested in demons, and we do not intend to listen to them even for an iota of a second **(RES3)**.

Richard: Suppose that knowledge of traditional medicine originates from demons.

How do we know, what do we know about demons? That is not our business. We don't care about demons. Because at the end of the day we must admit that this plant standing here is an innocent plant. We dig it, we collect the roots and that is all **(RES3)**.

The quotations discussed above seem to suggest that the foundational attitudes laid down by the western regime that traditional healers are satanic seems to have penetrated every level of society and has negatively influenced the Tanzanian societies regarding traditional health practice.

6.4.3 The Wavering Support of the Government towards Traditional Healthcare Practice in Tanzania

Several participants viewed the government as a powerful agent against the traditional healthcare system. The way the current Tanzanian government reacts towards traditional healthcare practice reflects the colonial regime that was against the local health system. They see the post-independence government following the footsteps of the colonial government. A researcher who is also a policymaker attests to this fact.

The present Government leaders including doctors were trained by Western trainers and it is these very same trainers that brain-washed the people to agree with them that native treatment was foolish, satanic and nonsensical. And they did that for a purpose, they knew what they were doing and aiming at **(RES1)**.

A senior official in the National Council of Traditional Medicine provided evidence of how the post-independence government was influenced by the colonial legacy. Soon after gaining independence, the Tanzanian government placed the Department of Traditional Medicine in the Ministry of National Culture instead of placing it in the Ministry of Health.

As we know, alternative medicine practice was regulated by the Ministry of National Culture soon after independence. When we speak of traditional and complementary medicine and treatment, we know this has to do with giving service to treatment to human beings. So, to place this service in the sector of culture was a misplacement, a gross oversight **(PM1)**.

According to participants the decision to place traditional medicine under the Ministry of National Culture was a reflection of the colonial regime that saw traditional medicine as a cultural, traditional and ritualistic practice. As evidence suggesting that the government was following in the footsteps of the colonial mentality, it placed the traditional medicine in the ministry that deals with the national culture, traditional music, dance, and exhibitions of traditional garments. It took almost three decades for the government to move traditional health practice into the Ministry of Health. Even after transferring the department to the Ministry of Health, the department was perceived as an outcast, not worthy to be in the Ministry of Health. It was excluded socially, politically and financially according to a policy-maker.

So even after transferring the department to the Ministry of Health the government failed to realize the role of traditional medicine, the department was marginalized and despised, it received the least budget and other resources **(PM2)**.

A director in the Ministry of Health gave us an enlightening account of his experience as an official who was assigned to promote traditional medicine in the country having been appointed to head a Department of Traditional Medicine in the Ministry of Health and Social Welfare before it was promoted to be a directorate:

If the minister is not interested in traditional medicine, it is going to affect the morale of executives who would like to promote traditional medicine. When I moved into the Ministry, to establish a Department of Traditional Medicine; the minister was against traditional medicine. Thus, I had opposition. All in all, the greatest drawback is an atmosphere of phobia that there is in the Western world against traditional medicine, as the Western world actually rules Africa. They do not want to see traditional medicine succeed **(MR1)**.

Richard: are you suggesting that a minister can go against the government decision to develop and support traditional health practice in his own ministry?

Eee! The leaders in authority each have his/her own point of view concerning the role of traditional practice in health sector. If you were to ask some individual officials, he would reply, he realizes the important role of traditional practice but as a collective government it does not support the practice **(MR1)**.

The excerpt above suggests that government support is visible on paper, but remains merely lip service; its commitment to support traditional health practice is lacking. Lack of government commitment is also reported by a researcher at NIMR who aired his frustration with the government for not taking seriously the findings of their studies on traditional medicine:

In traditional medicine there are known cures for non-communicable diseases. Yet when we report results of our research work to the Government we are handicapped because it appears there is an atmosphere of suspicion and fear that draws the Government back from sharing this information with the development partners who would probably be of help. So, we as immediate stakeholders are demoralized for lack of government support **(RES3)**.

The above quotation seems to show that the government is not only against traditional medicine but also frustrates the efforts of its officials who are employed by the government to advance traditional medicine in the country. The Minister for Health has a mandate to develop traditional medicine, according to the instrument s/he is given when s/he enters the office. However, participants were confused and frustrated at the inconsistency that a minister was free to disregard some of her/his own functions. As reported by a senior policymaker:

Of course, that is a challenge. It all depends on the way a particular minister in office views traditional medicine. One of the elements the Minister of Health is supposed to promote is traditional medicine development, this is according to the instrument there is in the office. So it all depends on the minister in office, not any of the executives (**PM2**).

The experience of the director in the Ministry of Health was echoed by researchers at ITM who explained their experience of researching six traditional remedies offered to them by traditional healers, which had the potential to treat HIV/AIDS opportunistic infections. The initial findings were very impressive that encouraged the team to solicit funds. Subsequently, the team had presented their concept paper to the Tanzania Commission for AIDS (TACAIDS) for financial support. The chair of the commission was impressed, supportive and encouraged the group to write a full proposal and submit it for funding. When the researchers went back to submit the document, they found a new chairperson appointed who was totally against traditional medicine.

We were carrying out a research project on HIV/AIDS we came to identify “six killers” which could have made a huge difference. We signed a MoU with the TACAIDS. The Commission’s Chair told us “Go on with your research, develop those ‘giant killers’ which have shown good results, prepare them and make trials on patients”. The next step was to ask the traditional healers to show us the medicinal plants from which they had got the medicines. However, a new Chairperson interjected: “How did you raise the funds towards research, in the first place? I do not recognize your effort and work” (**MR5**).

These two experiences reported by two government officials who were eager to develop and promote traditional medicine but were discouraged by the Minister and the Chairperson respectively, suggest the government’s negative perception of traditional health practice. The behaviour of the officials who were against traditional medicine speaks loudly of the undeclared but indisputable government stance of ignoring traditional medicine.

When traditional healers were asked to comment on their relationship with the government, they submitted that they do not trust the government and that there was a strong sense of mistrust between them. They argued that the genesis of that mistrust can be traced back to the colonial era when the colonial government persecuted and killed native healers. Thus, there still lingers on a hang-over of suspicion of the older traditional healers, and the mistrust they had in regard to the colonial regime. Following that logic, the participants argued that the government is now struggling to encourage traditional healers to come forward and register, but the best traditional healers are not responding.

We think the suspicious lot think that registration will prove to be a snare whereby it would be easier for the Government to trace them, grab them and kill them. So we are having an uphill task to convince them that our intention is good and it is designed to work to promote their interest and practice (MR4).

The traditional healers are overwhelmed by a burden of suspicion, and probably of fear or total confusion, wondering whether the Government's intention really is friendly, benevolent and potentially fruitful. The healers have maintained their fear and unfriendly atmosphere towards the government because according to their views they see little difference between the colonial government and the post-independence government. Participants represented the view that although the government has institutionalized traditional medicine and has established various frameworks in favour of traditional medicine, its efforts are overwhelmed by the mistrust between the government and the native healers.

6.4.4 Double Standards of Some Government Officials

Earlier it was submitted that the government does not seem to support the traditional health practice, as the practice is not given the due significance it deserves. However, participants were of the opinion that individually the government officials' position regarding traditional health practice is completely different from the government's stance. Some government officials depend on traditional healers, particularly spiritualists, for obtaining and maintaining their position in the government.

At individual level ... (laughing) some government officials have harmonious relations with spiritualist healers ... they consult together. You cannot believe it... many big shots in the Government do visit

spiritualist healers in a particular part of the Coastal Belt near Dar es Salaam **(RES2)**.

A traditional healer commented...

There is a show of derision from the Government to us, whereas a very reasonable number of Government officials depend on us. When they seek high positions in the office or when they want to clean their stars, restore status or win election; they do not visit hospitals for help, they come to us for help **(TH3)**.

These assertions from a researcher and a traditional healer were echoed by a Pentecostal Bishop who challenged government leaders for displaying double standards.

...When there is a problem in a community people blame the spiritualist, and the government agrees with the community. But the traditional healers shake off the responsibility, they feel they are being picked scapegoats for no reason. They say “as we practise, it is these very same government leaders that visit us; we are the very ones who enable them to get the high positions they occupy in office”, this kind of challenge..., (laughing) ..., **(RL1)**.

The same people who say traditional healers are of no use are the same people who visit them [traditional healers] secretly. It is a traditional healer who instruct say a government minister: “Take this medicine, do not turn back, (as you leave) just walk backwards (laughing) And when using this medicine, you must face South or North ... (laughing) Or you must cover yourself with a black calico cloth” **(RL3)**.

The above excerpts suggest that some government officials have double standards and double cultural attachments. In public, they demonstrate the government culture of despising traditional practice. In private, they show their true colours by embracing their local culture.

6.4.5 Biomedical Dominance over Traditional Medicine

According to participants, biomedical practitioners seem to have a Western mind-set that despises traditional health practice. The attitude of modern health practitioners that seems to discredit the traditional healthcare system is potentially perceived as a huge stumbling block towards cooperation between contemporary medical practice and traditional healers.

Biomedical practice inherited the Western mind-set about traditional medicine, to an extent that after independence native modern doctors who graduated from medical school were trained to dishonour traditional practice and were prohibited from cooperating with traditional healers (**PM2**).

Those on the modern medicine front have been brain-washed by the colonial legacy, and they regard traditional medicine as something based on customs, culture and traditions; and that is related to witchcraft (**PM1**).

The two quotations above suggest that biomedical practitioners are the product of Western culture and their behaviour has been influenced by the same culture. Consequently, they view the traditional healthcare system as nonsensical. Participants questioned the negative attitude of biomedical practitioners and wondered if they had not been attended to by traditional healers when they were young.

Take the great number of 75,000 traditional healer that are all over the country; are we to be told and believe that none of our modern doctors were attended to when young and sick by one of the 75,000 native healers? Well knowing that some doctors grew in remote villages where there are no modern facilities to the present moment, and where traditional healers were the first and last resort..., are there none of them who were brought up in families of traditional treatment? (**MR3**).

A similar comment was made by a researcher at NIMR who questioned whether biomedical practitioners had never been treated by traditional medicine in their life:

The main obstacle to this recommendation is that the majority of modern doctors have a low opinion of traditional medicine, not remembering that some of them were treated, as babies, as toddlers as young people in their 'teens and twenties by traditional healers in villages where they grew before growing the grey hair they have now (**RES3**).

Another policymaker asserted that biomedical practitioners who were brought up from remote areas do harbour a double standard. At work, they follow western-oriented culture but behind the scenes they cling to their local customs, traditions and culture:

They are under the influence of the West because they must obey leadership, but behind them are to be found their grandmothers engaged in the old practice. Leaders do stand on platforms to castigate

spiritualism but behind this, they consult soothsayers whereby albinos become prey to go missing in times of political party elections **(PM1)**.

As a result of the colonial legacy that seems to despise traditional practice, biomedical practitioners are perceived to assume supremacy over traditional practice. Biomedical superiority is felt in their account when they were commenting on the possibility of cooperation between them and native healers. The hegemonic power of biomedicine was also demonstrated by various participants who were pessimistic about cooperation between contemporary medical care and traditional practice.

The quotations below appear to illustrate the hegemonic attitude of biomedical practitioners over traditional healers. The statements assume that traditional healers have no intuition nor knowledge that guides them in understanding the problem of a patient, and that their decision is always a mix of guess-work and trial and error. Although it is undisputable that biomedical practitioners were trained in a formal medical school, however, it is not true that all traditional healers inherited their skills: most of them, according to participants, were trained by renowned healers. In their effort to show their dominance and superiority, biomedical doctors articulated how they see themselves as highly intellectual and more knowledgeable than traditional healers:

Aaah! I think the difference is the way I gained my expertise and the way the traditional healer gains his expertise. We as modern doctors, have to attend medical school, we are taught about cause of disease, how it can be spread, and how it is treated and how medicine works and how some medicines can produce how and what harmful side-effects. Traditional healers do inherit their skills from ancestors and grandparents or are trained by some other person **(BM2)**.

The different is that I went to school, I was trained in a medical school and was instructed in health care skills to benefit the patient according to results of laboratory tests. This is dramatically different from the practice of traditional healers, who would, for instance decide to incise patient's skin without exact knowledge of what he is treating **(BM4)**.

We have formal training, they have none. We are exposed to a number of things, and we know more than they do. They know the medicine, but they do not know how it works, what are its possible harmful effects; their knowledge is inherited, they know this cures that disease **(BM5)**

Considering the quotations given above, there seems to be a common pattern in the statements made by medical doctors. They all pointed out that they know more than traditional healers, they have been to schools, they are scientific and so on. While it is a fact that they are more trained than the native healers, what is missing in their statements is the acknowledgement that traditional healers have something to contribute in the health sector and in their cooperation. For example, according to participants, the majority of people in Tanzania depend on the traditional healthcare system but the biomedical doctors have decided to downplay this significance. In addition, the participants were of the opinion that the practitioners of modern medicine do not want to admit that in some areas traditional healers have recorded greater success than biomedical practice.

As far as traditional healers are concerned, their views collectively suggest that they are aware that biomedical practice is dominant, but they reminded us that, before biomedicine was introduced in the country, people depended on traditional medicine. There were many people whose lives were saved by the use of traditional medicine. A bone setter articulated how traditional medicine was the only treatment for fractures before biomedicine came into existence:

But some doctors appear to be argumentative, not believing that even in centuries past, people broke their legs and the bones had to be joined by using medicinal plants (TH6).

Yeah!! It is outright derision. If it were not for derision they would remember even in times of old, people were breaking their legs, where did they get treated, if not by traditional healers? (Laughing) (TH9).

These illustrative excerpts from different participants seem to suggest the dominance of biomedical practice over traditional practice. However, participants were of the opinion that regardless of the flaws of traditional medicine, it was the only dependable medicine for sick people in the past and it is still an asset in the current days.

6.5 Discussion

The findings reported in Chapter Four, seemed to present two non-reconcilable contentions or arguments. The first advocated the inclusion of both the traditional medicine and its practitioners, and appeared to epitomize and maintain forms of the local traditionalism. The analysis of findings that link the first argument suggests that despite the two dichotomous contexts of traditionalism and modernity that were identified in the study, there are potential areas for cooperation between the traditional

and modern health practices, implying that modernity and traditionalism can potentially work together.

The second contention supports the separation of native medicine from traditional healers because they perceived the healers to be the agents of demonic power, have multiple identities that facilitate both good and evil acts, and to be involved in witchcraft; this context seemingly representing western modernity. The discussion of the findings in this chapter is the extension of the discussion about the second school of thought where the participants advocated modernity by demanding the separation of traditional healers and traditional medicine. In the same vein, this school of thought fits well with the process of integration and differentiation (Hoenders et al., 2012) as will be discussed later.

The next few sections of the discussion will highlight the challenges, barriers and power relations that can prevent traditional and contemporary health practices from working together. The underlying concepts of traditionalism and modernity, among others, were developed in the course of presenting the findings and these will form a basis of this discussion.

6.5.1 The Colonial Legacy and the Concepts of Traditionalism and Modernity

The concepts of traditionalism and modernity (Marsland, 2007) were first introduced in Chapter Four where they were used to demarcate traditional and modern health practices. According to the findings of this study, the dichotomous and polarized stance regarding traditional medicine and its practitioners has its roots in the colonial legacy, a legacy that was against the traditional healthcare system. The concept of colonial legacy (Abdullahi 2011) in this study denotes the western culture that used different strategies to influence the western mind-set into the mind of local people. According to the findings, the strategies used by the colonial administration included the colonial education system, the biomedical profession, the legal system and Christianity, although they had different implications but aimed overall to promote western values and degrade African standards (Kaboru, 2006). Thus, the use of term ‘colonial legacy’ or ‘western mind-set’ is the total sum of the combined efforts of the strategies mentioned earlier.

The agents of the colonial legacy that represent western culture that currently spearhead the western mind-set in Tanzania include the post-independence government and its officials, Christians and Christianity, formal education system and its graduates, and the biomedical health system and its practitioners. These agents, according to the findings, have embraced the western culture to the extent that consciously or unconsciously they have continued to plant the seeds of mistrusting traditional medicine and its practitioners that were originally sown during the colonial era by the west. The current findings suggest that the colonial regimes, post-independence governments, the biomedical profession and Christianity were external power relations that were against traditional health practice. These powers represent a series of dichotomous power struggles, the then colonial regime and now the post-independence government working against the local village ritualistic society. Traditional health practice is struggling for legitimacy against the dominant biomedical practice, Christianity is wrestling against the perceived local satanic religion. Similarly, formal education is tussling against indigenous knowledge, and the western culture is in a 'battle' with local culture. Although, these power relations are diverse and each power is engaging to achieve its goal, they have one characteristic in common: they have either western values or local ideals, which are at loggerheads (Harries, 2010). Consequently, these values that are attached to western culture will affect traditional health practice negatively in one way or another.

These 'battle fields' between western aspects of civilization and the local elements of African civilization can be represented by the 'wrestling' between forms of knowledge as discussed by Brigitte Jordan (1997). Jordan propounded that for any field of knowledge, several different knowledges exist. She submitted that some systems of knowledge, coercively or by compromise, are more dominant than others because they have been supported and promoted by science or patriarchy, or sponsored and protected by mainstream governments. In the same vein, Jordan submits that people may move between parallel epistemologies that have equal legitimate influences. She presents the term 'authoritative knowledge' to label the product of a process that may occur when one form of knowledge gains dominance over the other. The effect of the legitimization of one knowledge as authoritative is the degradation and even elimination of other knowledges. In the case of this study biomedical practice remains authoritative knowledge and traditional medicine is a subordinate one.

To advance further the discussion about colonial legacy, Eurocentric thinking influenced elite people in the developing world including Africa to believe that biomedicine was the only best, trusted, effective, scientific and safe medical therapy (Harding, 1998). Consistently and within the same framework, they also instilled the notion that traditional medicine was nothing but primitive, unsafe, satanic medicine and the works of darkness (Asante et al., 2013). This mind-set is alive and well and according to Adams et al., (2009) is the major cause for preventing collaboration between modern and CAM practices. Taken at face value, the current findings point to the colonial legacy as responsible for degrading traditional medicine in Tanzania and Africa through the means and strategies discussed earlier.

It is unquestionable that the concepts of ‘traditionalism’ and ‘modernity’ made more sense and were clearly evident when modernity was introduced in Tanzania by the west through formal education, biomedicine and Christianity. Participants articulated the view that during the colonial era and immediately after independence, people who gained formal education, converted to Christianity, sought treatment from a biomedically oriented health system and embraced a Western lifestyle were in the category of the civilized social world. In the words of participants, they were perceived as “*Wastaarabu*” meaning civilized people, and “*Wenye maendeleo*” - developed people - or “*walioelimika*” people who are exposed to Enlightenment. Civilization and development were linked to each other. Thus, it can be argued from these findings, that the negative mind-set of the agents of the colonial legacy towards traditional medicine is the major barrier for integrating traditional healthcare system into the National Healthcare System in Tanzania. Coincidentally, the same agents of the colonial legacy are the major stakeholders setting and influencing health policy agenda in the country (Mahunnah et al., 2012).

However, while it is true the western countries that colonized Africa introduced and promoted modern medicine at the expense of traditional medicine (Asante et al., 2013) this fact is only one side of the story. Deeper reflection on the findings suggests another side of the story which was superficially given due attention by participants but remained an important finding of this study. The current notion of ‘traditionalism’ and ‘modernity’ is not only considered a function of colonial legacy, but is also a ‘way of life’ of Tanzanians and Africans in general (Nyamnjoh, 2001). Currently, in Tanzania the terms ‘*maendeleo*’, ‘*mambo ya kisasa*’ ‘*mafanikio*’ and ‘*uzungu*’ are used

interchangeably to mean ‘development’, ‘progress’, ‘prosperity’ and ‘modernity’ respectively. In the current thinking development, progress and modernity are terms attached to material gain, literacy, and the ability to acquire or purchase (Nyamnjoh, 2001). Thus, people who have attained formal education, gained wealth, are able to build a modern house, and have strong purchasing power are classified as modern or developed people; the term modernity is also extended to cover people who live in urban areas as opposed to people living in rural areas, who are below the poverty line, illiterate, have low social status and survive by the use of traditional medicine. These are in the category of ‘*hawajaendelea*’ meaning ‘underdeveloped’, or ‘*washamba*’ that is ‘primitive and deficient’. They are also designated as substandard, poor and backward people (Marsland, 2007). Consequently, the goodness and richness of social, cultural, political and economic life is attached to modernity.

As a result, ‘traditionalism’ and ‘modernity’ are seen both through the lens of the colonial legacy, as well as the way of life of Tanzanians. Following this logic, the term ‘modernity’ may also be associated with science, technology, urbanization and globalization (Kim, 2006), while, poverty, illiteracy, indigenous knowledge, local customs and traditions are associated with ‘traditionalism’. Between ‘traditionalism’ and ‘modernity’ not only there is a demarcating wall that divide these two concepts, but also a struggle for power between the two (Gale 2014). Thus, in the logic of participants the question of collaboration between traditional and modern health practices was like bringing ‘traditionalism’ and ‘modernity’ together. When one weighs this possibility in the light of ‘traditionalism’ and ‘modernity’ as a ‘way of life’, common sense declares it an impossibility as historically the two have never been together (Hsu, 2008).

6.5.2 Western Epistemological Export versus African Agency and their Impact on the Traditional Healthcare System in Tanzania

Following the link of traditionalism to local traditions, which seem to attain a lower status in society, the findings in this study suggest that traditional health practice is seen in the eyes of western mind-set as primitive, backward and non-modern because, in part traditional healers were perceived to have multiple identities which potentially may facilitate their involvement in the killings of innocent people and in witchcraft. In other words, traditionalism seems to relate to evil outcomes; while modernity is seen as synonymous with civilisation. The concepts of traditionalism and modernity which are

the pillars of this study may be well understood by examining the western epistemological export and African agency (Nyamnjoh, 2001). The western epistemological export that combines suitably with science and ideology seems to ignore African agency, which is the capacity of Africans to act independently and make their own choices (Mudimbe, 1988). Instead, the hegemonic export seems to control the social science of and about the continent of Africa and distorted perceptions of Africa even by Africans themselves (Nyamnjoh, 2001). Under the authoritative western epistemology and the influence of colonialism, several discourses and interpretations of African cultures and experiences seems to be labelled and described through the understanding of the Western point of view (Chinweizu, 1987). As a result of dichotomous perceptions and standards regarding the western and African epistemologies, the views of participants of this study on the cooperation between traditional practice and contemporary health system were influenced by the two shadows of polarised epistemologies. Those influenced by the imported western knowledge questioned the validity and legitimacy of traditional medicine, disqualified the expertise of traditional healers, and despised the indigenous knowledge of local people including that of the spiritualist healers. On the other hand, the African agency represented the perception and appreciation of the indigenous African worldviews, the local healing system, the native culture, and local belief and the way they see things in their day- to- day life, which is reasonably different from the western way of seeing things.

To illustrate the two dichotomous epistemologies, this study has reported that witchcraft and sorcery were mentioned as barriers to cooperation between traditional and modern health practices. Several scholars have written on the subject of witchcraft and sorcery in Africa (Moore, 2001; Greenwood, 2000; Morris, 2000; Melley, 2000; Comaroff and Comaroff, 1999). What is clear in their argument is that to import Western epistemological thinking about witchcraft and sorcery, and apply the same to an African setting is to adapt a world-view perceived in the image of the west without considering the contextual difference the African epistemological order offers (Chinweizu, 1987). Rasmussen (1998) warns that pursuing occult practices and contemporary witchcraft under the lens of European understanding runs the risk of a serious misconception. For example, witchcraft is defined and perceived differently by different people (Nyamnjoh, 2001). In Western circles witchcraft in Africa is synonymous with magic, sorcery and enchantments which are associated with harmful activities, such as zombies, ritual murder, commodification and manipulation of human

body parts, general occult powers and magic (Moore et al., 2001). These examples of witchcraft incidents bear a resemblance with the definition of witchcraft in Africa as given by European authors.

In African settings witchcraft, power and magic are not necessarily associated with harmful activities. For example, societies in Northwest, Cameroon employ three distinct terms for describing witchcraft. These are local knowledge, power, and interpretation of misfortune. ‘And there are both positive and negative uses of such power and knowledge’ (Bongmba, 1998:168). The same is for the Nyakyusa tribe in Southern Tanzania, they have a term ‘*Ubulosi*’ meaning aggressive witchcraft that is perceived as bad; and *amanga* meaning defensive witchcraft, which is ‘good witchcraft’; and *imbepo sya bandu* ‘the breath of men’ meaning the power of witchcraft used in accordance with public opinion (Wilson, 1936:85). Thus, witchcraft in Africa may be malevolent or benevolent (Moore, 2001; Geschiere, 1997). Consequently, European authors addressed only one side of witchcraft in Africa – the malevolent – and left the other side, of benevolent witchcraft, unattended.

Inspired by the western epistemological export, the findings of the current study suggest that participants viewed witchcraft as a sign of underdevelopment, illiteracy, backwardness, primitiveness and being traditional (Moore, 2001). Induced by Western Enlightenment thinking, the notions of development, progress and modernity were linked to societies whose social life was influenced by education, science and material gain (Green, 2006). Hence, acquiring formal education, the application of science, and material gain were symbols of advancement and modernity. Social evolutionary theory propounds that a society advances along a linear road map from ‘primitive’ to ‘modern’ (Geschiere, 2006). The views of participants in this study were in line with this theory that, with increased levels of literacy, development, and science and technology, witchcraft will wither and die naturally (Frazer, 1959). Their views bear similarity with western epistemology drawing from the European’ experience of the withering of witchcraft following western enlightenment. The current findings are consistent with Nyamnjoh’s work (2001) which criticised westerners for believing that “Once decontaminated, disinfected, exorcized or enlightened by science through education and urbanization, rural Africans would abandon their desire for witchcraft beliefs, accusations and counter-accusations just as Europeans have succeeded” (Nyamnjoh, 2001:32).

However, the findings of this study and that of Nyamnjoh (2001) are challenged by Ashforth (1996), Bastian (2001) and Dijk (2001), who disagreed with the western assertion that people who practice witchcraft are uneducated, underdeveloped and primitive. Instead, their works suggest that witchcraft in Africa is practiced by all categories of people. The educated, renowned religious people and urban dwellers are practicing witchcraft in one way or another. Contrary to western perceptions, education, progress and modernity are not antidotes to witchcraft: instead, the same elements that propelled Europe to weakening the practice of witchcraft are the catalyst for witchcraft in Africa (Moore et al., 2001; Shaw, 2001; Bastian, 2001).

Education, development and modernity are elements that have created classes within the societies in Africa, 'the haves' and 'the have nots' (Geschiere and Nyamnjoh, 2000), which are the source of witchcraft in Africa. Witchcraft in Africa is, therefore, a result of keeping a distance from the community by acquiring a high class of life. "Witchcraft is both a source and resource of personal and collective power against various forms of inequality, individualism, exploitation, and marginalization. It is a function of disequilibrium between those who have accumulated material gains and those who have not" (Comaroff, 2006:23). The key antidote to witchcraft in Africa therefore, is sharing the opportunities and prospects of one's prosperity with one's immediate family and the community directly or indirectly.

In concluding this section, the perception and accounts of participants in this study as verified by the findings seem to reflect a heavy legacy of Western epistemological export. For example, western epistemological export appears to interpret the local culture, local religion, the traditional healing system and the indigenous knowledge of Africans with undesirable prejudice (Abdel-Malek, 1967). To emphasise how the increased variation between the haves and have nots may lead to increase acts of witchcraft, the next section will discuss the change of political ideology of Tanzania and how it seems to have increased the gap between the have and the have nots; and its relevance to increased detrimental activities in the country.

6.5.3 Economic Hardships and Proliferation of Detrimental Activities

Although not practiced by all, the individualistic way of life seems to be a western style of life, which differs extensively from the communal life of many developing countries. After Independence, Tanzania, under the first President Mwalimu Julius Nyerere, pursued self-reliance and socialism as a state ideology (Green, 1977). Under socialism, communal villages were established where people lived together, had communal fields to cultivate food and cash crops for the community. The objective was to have a community that shared whatever little was realized: equality was the slogan, which was geared towards narrowing the gap between the haves and the have nots. During the Mwalimu Nyerere era (1961-1985) incidents of killings of innocent people were rarely reported. The second phase of independent rule in Tanzania 1985 – 1995, the third phase of administration 1995 - 2005 and fourth presidency 2005 - 2015 saw major ideological changes. Following global recession, the World Bank and International Monetary Fund (IMF) put more pressure on developing countries to accept public sector reforms through the Structural Adjustment Programmes (SAP) and adopt western policies (Hahnel, 1999). As a result of these changes Tanzania dropped socialism and embraced capitalist politics. Since then, the difference between the haves and the have nots has continued to grow. Consequently, those who were rich became richer and the poor became even poorer (Mahunnah et al., 2012). During this period witchcraft and detrimental incidence of killings of innocent people proliferated in the country (Quarmyne, 2011), for example, the killings of albinos, and red-eyed elderly women for superstitious reasons.

The killing of albinos in Tanzania is a recent phenomenon, as reported in the findings, there is a widely circulating myth that part of albino body is an important ingredient for preparing a good-lucky-working concoction. According to the Director of the Non-government Organization, Under the Same Sun, over 75 albinos were killed in Tanzania between 2006 and 2014 (more may have occurred between October 2014 and September 2016). About 58 albinos survived attempted killings while 11 were left with permanent disabilities (see appendix 12). There were 150 incidents of attempted killings of albinos out of which 15 are in the law court. So far 10 cases have been decided, as of October 2014; (Under the Same Sun, 2014; IPP Media, 2014). All culprits were sentenced to death. There have been eighteen (18) attempts to exhume albinos' dead bodies from their graves, of which 16 bodies were taken away, and 2 attempts failed according to the Under the Same Sun report. The latest report shows that 4 albino people were ambushed in Tanzania during the two months of campaign

for the general election in October 2015 (Under the Same Sun November 2015), with the most recent incident in December 2015 where a 70-year old lady had her thumb mutilated by a gang of five people.

As for the killings of red-eyed elderly women, the current findings indicated that older women ranging from 60 to 80 years old were killed predominantly because they were accused of witchcraft in some regions in Tanzania. This sometimes follows a sudden death in the family; as the family members seek explanation from a spiritualist healer, an old red-eyed woman in the village may be picked on by the healer as responsible for the death of their loved one. In revenge for the loss, the old lady becomes a target for a secret killing. As reported in the findings, it is rare to find an old lady in the rural areas who have clear bright eyes: the majority of them have red eyes because of the use of wood fires throughout their lives. Accusing women with red eyes as witches when in the societies there are also old men with red eyes, raised the concept of patriarchal dominance over women (Barstow, 1988; Brain, 1982; Federici, 2010; Kluvitse, 2012). Barstow (1988) found that, although in the early 19th century men in Europe were accused of witchcraft and were prosecuted for the same, only a small number were involved; the trend showed that women were primarily targeted. His findings showed that 80 percent of those who were accused of witchcraft, and 85 percent of those who were killed because of witchcraft were female. Reasons put forward for accusing women for practising witchcraft were predominantly sexual, medical, religious and economic. According to Barstow (1988), women in Europe were powerful; in order to bring them under the dominance of men a long list of accusations were levelled against them. Women were blamed for making men impotent, preventing conception and also causing abortion and stillbirth. Other accusations were related to sexuality, 'women were accused of seducing men, having sexual relationships with devils and giving birth to demons' (Barstow, 2005:8)

Recently, throughout Africa, India and Nepal women and children have been singled out as witches and subjected to horrifying torture and abuse (Federici, 2010). Such incidents were reported in Ghana, the Central African Republic, South Africa, Nigeria, Angola, Kenya, the Democratic Republic of Congo, and Tanzania (Kluvitse, 2012). The experience in these countries is that although men and women are likely to be suspected of witchcraft, the enormous majority were women, particularly the ageing. According to Federici (2010), in patriarchal societies barren, or unmarried women and

widows are the most liable to be picked out as witches for they have not achieved the anticipated gender standards. Moreover, unmarried women and widows frequently lack social protection systems and they lack a powerful person to protect and support them.

In the same vein, there appears to be a high association between the inability of women to cater for the financial needs of the family and witchcraft accusation (Green, 2006). A woman who lacks the security, support and protection of a man, be it a son, husband, father, or a brother, is enormously liable to be accused of witchcraft according to a survey conducted by ActionAid in one of the witchcraft camps in Ghana. Ghana has a number of witchcraft camps where women and children accused of witchcraft live after being expelled from their communities (Kluvitse, 2012). The survey showed that over 70 per cent of women in the camps were accused and exiled as witches following the demise of their husbands. These findings in Africa are evidence that men accuse women of witchcraft as a means of dominating them, which demonstrates and signifies the concept of 'patriarchal dominance over women' (Quarmyne, 2011).

The killings of albinos and red- eyed women are not isolated incidents in Tanzania: there have been other related incidents where innocent people have been killed due to superstitious belief instigated by the healers. Two decades ago, the killings of men with baldness (alopecia) in the Kigoma region in the western part of Tanzania was rampant (Mwananchi, 2013). The severed head was used by traditional healers to prepare a concoction for bumper fishing in Lake Tanganyika. As the murder of men with baldness subsided, another wave of killing of young people took place in Mbeya region (Southern West of the country) about 15 years ago where boys were skinned, and their sexual organs were chopped off. It was believed that the human skin and sexual organs were in high demand by spiritual healers who use them as crucial ingredients in preparing potent concoctions for prosperity. Human skin was sold within the country as well as in the neighbouring countries of Malawi, Zambia and Democratic Republic of Congo. In 1999 only, and over the span of six months, a total of six youths was found killed and skinned in Mbeya (Sanders, 2001). Those who were apprehended and sentenced in a court of law proved the healers were behind the killings.

The perceived detrimental acts of the killing of innocent people and witchcraft suggest the role of multiple identities of traditional healers who are thought to be responsible for treating people at the same time are involved in evil acts. However, the significance

of this study has shed new understanding about these evils acts, the fact that the services offered by traditional healers are requested by some clients who are the members of society, the detrimental practice of the healers reflects the society itself.

6.5.4 The Dominance of Modern Health Practice over Traditional Health Practice

The current findings suggest that the legitimacy of biomedicine in Tanzania, and Africa in general, is built on three strongholds. First, the support it receives from strong allies such as the state governments and global organizations such as the WHO, IMF and World Bank (Abdullahi, 2011); secondly, the evidence base it receives from medical research institutions and clinical trials (Broom and Tovey, 2007). Third, biomedicine receives support from the factory and industry sector that produces high technological medical equipment for diagnostic and therapeutic purposes, and the multinational pharmaceutical companies (Asante et al., 2013). These three strongholds are the source of legitimacy for biomedicine, and have led biomedical practitioners to exercise an arrogant sense of superiority over traditional healthcare system (Kaborou, 2006). Unfortunately, on the other hand, the same strongholds that legitimize modern medicine, work against traditional medicine (Gale, 2014). Consequently, any attempt to integrate traditional health practice into the national healthcare system cannot ignore these three major stumbling blocks.

The current findings show that modern health practice was and is still dominant and hegemonic over other practices. The hegemonic influence of modern practitioners was evident in this study when they declared that they would find it hard to cooperate with traditional healers because the healers were illiterate, their diagnosis was based on trial and error, and their practice was not scientific. In addition they argued that traditional healers were involved in malevolent activities, healers were not ready to share their knowledge and finally, they had multiple identities which makes it difficult to know who they are at any given point in time. As a demonstration of the dominance of biomedical practitioners over traditional healers, the current findings reported the forums that brought together modern practitioners and traditional healers. The agenda in those forums was to create awareness among the traditional healers of the signs and symptoms of fatal conditions that needed immediate biomedical intervention. Thus, the objective of the forums was to ask traditional healers to refer those cases without delay. Conversely, modern practitioners did not show any urge to learn from the native

healers, believing that they had nothing to learn from them.

These findings tally with the study done by Asante et al. (2013). They noted that when biomedical practitioners in Ghana were asked to comment on the potential opportunities of collaborating with traditional healers they were unwilling to receive them as equal associates because they alleged their profession was substandard to theirs. In their works on several integrated health settings in Israel, Mizrachi et al. (2005) showed the presence of a double standards where CAM providers were concurrent recognized and downgraded in clinical sites. While a few alternative practitioners were permitted to practice, and their procedures were adopted by modern doctors, they were marginalized as ordinary staff members. It was evident that their despised status was unmistakably clear as the boundary between CAM and contemporary medicine was drawn.

Equally, Theberge's study (2008) of the incorporation of chiropractors into health groups in sport medicine with multiple specialities showed that it was conditional on their assenting to a marginalized space of practice. In his study on integrated healthcare settings in Canada, Hollenberg (2006) revealed that modern practitioners applied "strategies of exclusionary and demarcationary closure" (2006:53) that constrained the freedom of alternative practitioners to fully discharge their duties effectively. Similarly, Broom and Tovey (2007) studied the current efforts to integrate CAM with contemporary medicine in the United Kingdom. They submitted that such determinations should not be perceived as either the "waxing or waning of the biomedical profession" (2007:555); rather, integration involves a multifaceted process whereby several actors, and institutions are responding to and executing the concepts of integration differently. Subsequently, integration may be more about appropriating, assimilating and subjugating some traditional health technologies and procedures to modern practice than the cooperation between the two practices.

In order that a workable collaboration can be established, there is need for the two partners to demand equal mutual respect. There should not be a dominant health system and a subordinate one. Each and every practice should appreciate the contribution of the other, and each should accept that the two health systems have different paradigms and philosophies, and these differences should be respected. This section suggest that modern health practice is strategically positioned to be dominant over traditional practice, regardless of the level of cooperation between them.

6.5.5 Multifaceted Powers over Traditional Health Practice

The dominance of modern practice illustrated above suggests that the relationship between modern and traditional practitioners is based on unequal power relations. Many commentators have indicated that power is a multifaceted concept (Lukes, 2005; Joerges 2003; Hollenberg, 2010). Power is frequently recognized as the capacity of a person or a group to monopolize the process of decision making without compromise, as was the case in this study when the biomedical practitioners instructed traditional practitioners to refer ‘at risk cases’ to them. However, that is only one way of manifesting power. In principle, power can also be perceived when an individual or a group has the ability to influence a policy agenda so that a difficult situation is repressed or blocked, what Adams et al., (2009: 794) referred to as “an ability of non-decision making”. The findings of this study showed that research institutions in Tanzania were established more than forty years ago and were given a mandate to study medicinal plants and come up with recommendations to develop medicines for public use. However, until the end of the data collection period for this study (August 2013), no single medicine had been registered by the Tanzania Food Drug Authority for wider public use, despite the fact that research institutions had a number of medicinal plants that had been tested for quality and efficacy and found to be safe for human consumption. This is an example of a non-decision-making kind of power relation that simply prevents an organization taking crucial decisions for no apparent reasons.

In other words, the reluctance of TFDA, which is a government institution entrusted with the mandate to register traditional medicine for public use, is frustrating the efforts of other government institutions such as the Institute of Traditional Medicine (ITM) and the National Institute for Medical Research (NIMR) that have also researched traditional medicines. It is interesting to note that TFDA and NIMR are institutions under the same Ministry of Health and ITM is housed in the national teaching hospital compound, yet they seem to lack good coordination. Similar experience has been reported by other traditional medicine research institutions in Africa. For example, Asante et al. (2011) reported related challenges facing the Centre for Scientific Research into Plant Medicine (CSRPM) in Ghana. CSRPM was established the same year as ITM in Tanzania, 1974, with a mandate to study the safety and efficacy of traditional medicines and recommend them for public use. Its programs are supervised

by a research committee whose members originate from the Ministry of Health, Research Institutions and the University. Surprisingly, the Ghanaian Ministry of Health, which is a member of the research committee, has not approved the use of over 40 traditional medicines that had been researched by the Centre and certified by the Ghana Food and Drug Board. This is an illustration of non-decision-making power relations.

The experience of these two research institutions is an expression of a third aspect of power relation, which is philosophical in nature (Lukes, 2005). Lukes, argued, that it is the ability to manipulate the thoughts, wishes and values of people with the ultimate goal of making them question their own values and causing them to work contrary to their own will or interest. The decisions of the two governments not to approve over 40 herbal medicines processed by CSRP in Ghana and those processed by ITM in Tanzania seem to suggest that the two governments do not trust their own scientists. This third aspect of power relation, I suggest, is probably the worst type of power struggle for an individual, society or organization to experience, as it influences people's wishes against their own interests. In reference to the experience of Ghanaian and Tanzanian' scientists, this power relation frustrates their creativity and initiatives to develop traditional medicine, demoralise their zeal to advance their profession and demolish their confidence as true scientists (Melley, 2000).

The discussion in this chapter has revealed that the colonial legacy that has impacted the mind-set of key stakeholders of health to act negatively towards traditional health practice, the dominance of modern medicine over traditional practice and the multifaceted power relations that are all against traditional health practice suggest that integration of contemporary and traditional health practices is not possible under the current Tanzanian context. As an alternative to integration, the study is recommending hybridization of traditional medicine (Kim, 2006).

6.5.6 The Hybridization of Traditional Medicine

The current findings reported that some traditional healers were prepared to offer their medicines to the ITM and NIMRI for them to test for safety and efficacy. In the same spirit the research institutes articulated how they engaged with traditional healers who were willing to offer their medicines for research. Their engagement with the healers follows the guidelines approved by the WHO, which stipulate recognition, compensation and reward of the healers when the outcome of the research is favourable

(WHO, 2012). This form of cooperation, where traditional healers cooperate with scientific institutions to offer their medicines for research, signifies that both the healers and scientific institutions have significant contributions to offer. The ultimate by-product of this cooperation is a hybrid medicine that has both traditional and scientific features. These revelations introduce the concept of 'Hybridity of Traditional Medicine' (Watanabe et al., 2006, Kim, 2006; Hsu, 2009), which is a subset of 'Negotiated Order Theory' (Strauss et al., 1963) introduced in Chapter Five.

Kim (2006), defines "'Hybridity' as combining or mixing among various cultural resources and entities: a process of cultural extension for which agents actively construct a new culture without recourse to a single point of origin" (2006:70). Hybridization denotes a detachment from a source of a single culture and embraces abundance and the varieties of elements of cultures in a given setup (Hsu, 2009). Hybridity does not embrace all aspects of the merging cultures, but alternatively, chooses some elements that suit the entity in question. Hybridity is not 'tamed' within cultural boundaries but transcends the dichotomous demarcations of 'traditionalism' and 'modernity', South and North, local and global, and science and indigenous knowledge. Hybridity in this study denotes the combination of traditional medicine with elements of science, language and technology in which the effort of both parties is acknowledged. The outcome is the birth of an entity that bears the aspects of traditionalism and modernity. It calls for traditional healers to surrender the medicines they trust and know to be efficacious in treating certain diseases, voluntarily to the scientists and scientific institutions to isolate the active ingredients that can be tested against disease/pathology. Once the findings of the tests are validated then technology in the form of industry should come in to mass-produce drugs for public use. That way traditional medicine and its practitioners will gain recognition, reputation and legitimacy, as they are contributors to the invention of that specific hybrid medicine.

As indicated earlier, the concept of hybridity surpasses the boundary of traditionalism and modernity. The idea of 'Hybridity of Traditional Medicine' may provide a better substitute for possible integration between traditional and modern practices. Hybridization of traditional medicine is about each practice contributing towards the birth of hybrid medicine, whereas integrative medicine is about one practice inviting another practice into its space. Integration is marshalled by the hegemonic power of biomedicine and one that has been proved to face many challenges (Asante et al., 2013; Kim, 2006; Hsu, 2008, Hollenberg, 2006). Integration of traditional healthcare system

into the National Health System is proving a failure, as evidenced by many studies carried in different parts of the world (Hollenberg, 2009; Adams et al., 2009; Broom and Tovey, 2007; Wiese et al., 2010; Baer et al., 2008). In their studies, they observed that integration invited a bipolar struggle of power between dominant and subordinate health systems where the practitioners of the marginalized health practice was complaining of being left out of vital decisions. CAM practitioners were not allowed to practise according to their philosophical beliefs and instead were forced to interpret their practice using biomedical language.

Hybridity of traditional medicine seems to be the best option because hybridity requires each party to contribute towards the outcome. Thus, there is a sense of belonging for each partner, which surpasses the ‘wrestling’ of power between two systems of health, when one practice is invited into an integrative setup. Instead of struggling for the legitimacy of their individual practice, the effort will be directed towards promoting their ‘new product’. For example, take a newly developed medicine for HIV/AIDS opportunistic infections that was offered to scientists in Tanzania by a traditional healer. After confirming its efficacy, there are plans to do mass production for public use. Had the healer had been invited into an integrated hospital setup to dispense his medicine, he would have been challenged by medical doctors. However, through hybridization of the same drug, the medicine is currently being promoted by medical doctors.

Hybridity of traditional medicine has a number of advantages. First, when issues of patent and intellectual property are made transparent, considered equitably, and the healers are substantially rewarded, good traditional healers are more likely to agree to cooperate and show their medicines for testing. Second, the government will have, in its stock, a list of effective traditional medicines (hybrid) that can be added to the national pharmacopoeia for use in the health sector. Third, an established National Traditional Medicine Pharmacopoeia could be a catalyst for the government to integrate knowledge of traditional medicine into the university medical curriculum. Fourth, traditional medicine will truly be complementary to biomedicine, but in the same vein biomedicine will also be complementary to traditional medicine. Fifth, the wall that divides traditionalism and modernity will be demolished, which will increase the users of pure traditional medicine as well as hybrid medicine, and enhance the status of traditional medicine and its practitioners in the country. And lastly, the demolition of the wall that demarcates traditional and modern practice will lead to

genuine, mutually respected cooperation between the two practices.

Hybridization of traditional medicine requires a high commitment from the government leadership. Countries that have been successful in supporting and promoting their native medicine through hybridization of traditional medicine include China, South Korea, Japan and Vietnam (WHO, 2005). Their success did not come easily. In China for example, the then Chinese leader Mao Zedong initiated a major communist revolutionary vision in 1955 that saw China reforming its health sector by challenging the pomposity of western health policies (Watanabe et al., 2011). South Korea under the Presidency of Kim Young-Sam in 1995 initiated a top-down globalized vision for Korea (Kim, 2006). Led by a Presidential Globalization Promotion Committee, a solid foundation for the vision was laid down. The government commitment was translated into deeds by providing massive funds for research into Korean traditional medicine. The government commitment and the support in terms of funds was paid back as Korean medicine and knowledge gained a reputation, recognition and acknowledgement within and beyond the Korean borders (Kim, 2006). This is a lesson for Tanzania that a change of mind set for the leaders is very critical in order to transcend the three forms of power relations discussed in the previous section. A good country leadership whose mind-set values the natural inheritance of the nation can change the culture of its people to think and behave differently towards their national inheritance.

Undeniably, the issues of power relations cannot be sidestepped when a perceived weaker partner 'borrows' skills, expertise and language from a perceived stronger partner. However, in hybridization of traditional medicine the notion of power is not simply between traditional and biomedical practices; rather it involves numerous other power structures and relationships (Frank and Stolberg, 2004a), such as scientists, industry and regulatory bodies. Subsequently, the involvement of various power structures will be in a form of negotiation, bargaining and agreement rather than competing for supremacy as would be the case when the two practices integrate. This is where the Negotiated Order Theory (Straus et al., 1963) whose central stance is in interaction, negotiation and agreement becomes a broader framework through which Hybridity of traditional medicine can succeed. Hybridity of traditional medicine involves give and take which stands a greater chance of success than when two power relations are fighting for dominance. Kim (2006) gave the experience of the process to hybridize Korean traditional medicine, where traditional medicine, science and industry

came together to produce Korean Hybrid Medicine. Kim noted in the quotation below that there was a 'give and take' in realizing hybridization of Korean medicine (KM):

Though the networking among KM, science, and industry creates new research and business realms, it is not a straightforward process. A close look at KM's experimentation and commercialization reveals complex negotiations and struggles among multiple agents and systems. In the course of KM's scientization, KM theories and methodologies disappear, replaced by scientific explanations and methodologies (Kim, 2006:79).

Although hybridity of traditional medicine has its flaws, in the Tanzanian context, it remains a potential option for gathering the knowledge from the best healers. Otherwise, Tanzania will continue to lose the best indigenous knowledge, which will be lost when the knowledgeable healers reach the end of their lives, thus, robbing generations to come of their national inheritance. It is high time the knowledge of good healers is recorded for the use of many Tanzanian generations to come and beyond the borders. The governments and people of Africa cannot afford to see this wealth of knowledge lost without any effort to preserve it. Hybridization of traditional medicine is a strategy that if used may change the mind-set and attitudes of those who see traditional medicine as primitive, backward and satanic medicine. The next section discusses the process of integration and differentiation (Hoenders et al., 2012) as a higher concept that encompass all the concepts that described the study findings in this chapter.

6.5.7 The Process of Integration and Differentiation: An All-Encompassing Concept for the Research Findings

The process of integration and differentiation (Hoenders et al., 2012) was introduced in Chapter Five, which described the context in which contemporary and traditional health practices can work together. The process suggest that integration and differentiation are two bipolar concepts that contrasts with time but work as a reaction to each other. Integration cannot succeed without differentiation. A workable cooperation between two health practices depends on the balance between the influences of integration and differentiation by encouraging the practitioners of the two practices to integrate but at the same time allowing them to maintain their differences in terms of their identities and autonomies. In the previous chapter the discussion was in favour of the first part of the process – 'the integration' as the findings were pointing towards the potential opportunities of cooperation between traditional and modern health practices. In this

chapter, the concentration has been on the second part of the process, ‘the differentiation’, as it is about the challenges for cooperation between the two practices.

The concept of ‘differentiation’ is central not only in discussing the current findings, but also encompassing the concepts that describe the challenges of cooperation between the two practices. The colonial legacy that brought about the concepts of traditionalism and modernity in Africa; the ‘wrestling’ between the Western epistemological export and the African agency and their impact on traditional health practice; the perceived detrimental activities of traditional healers; and the multifaceted powers over traditional health practice are examples of differentiation process that pull the two practices apart. Discussing challenges and barriers to cooperation between the two practices is acknowledging the aspects that differentiate the two practices and also the qualities that maintain the identity of each practice.

Hoenders and colleagues (2012) discussed the dissimilarity between integration and differentiation and emphasised that the more the differentiation the higher the need for integration. For it is in the sharp differentiation where the uniqueness and values of each practice are observed which encourage imitation or appropriation of such values. Likewise, when there is increased integration the associates tend to lose their identities and legitimacy, which triggers differentiation and a desire for autonomy. The shift from integration to differentiation or vice versa is often met with criticism and resistance. For example, in the current study the criticisms and resistance against integration were directed towards traditional healers as they were perceived to be less educated, and their practice was not scientific, but based on trial and error. To make integration work it is important to settle somewhere in the middle where appropriate efforts are directed towards keeping integrated associates adequately differentiated, at the same time allowing each associate to maintain their identity.

As described earlier, the nineteenth century saw the period of differentiation where biomedical practice was established and differentiated itself as the dominant health system, and while ‘other’ health practices were made inferior. However, differentiation should not be understood as antagonistic to integration; rather they are two social orders that take turns. Too much differentiation invites polarization and conflict between parties. These could be in the form of skills, efficacy, effectiveness or legitimacy (Asante et al., 2013). These differences invariably invite integration by increasing the keenness of parties to learn, imitate or appropriate knowledge from the opposite party. The attempts of practitioners of both practices to work together in this

study as well as other initiatives of integrative medicine reported worldwide are examples to show that when differentiation is at peak, there is passion for integration. Hybridity of traditional medicine discussed earlier is a demonstration of collaboration between modern scientists and traditional healers, a process born out of a longstanding differentiation.

6.6 Conclusion

This chapter has offered a discussion of the deterrents to cooperation between contemporary and traditional health practices in Tanzania. The challenges for cooperation between the two practices ranged from the perceived detrimental acts of traditional healers and social and economic factors, and how they have an impact on traditional practice to power relations that are within the traditional practice and those external to the practice. The discussion attempts to move away from simply mentioning the challenges and barriers for the cooperation between the two practices to describing an alternative ‘process of integration and differentiation’. The process suggests that integration can only take place when there is clear differentiation between the two practices. In other words, the aspects that make the two practices different and unique, are the triggers for integration. While differences between the two practices that are extreme, such as the killing of innocent people and witchcraft, may discourage the two practices from working together, differences that are tolerable and acceptable such as the efficacy and effectiveness of medicines and improved skills to manage certain conditions could be the catalysts of cooperation between the two practices.

As a point of entry towards cooperation between the two practices that have unequal influence, the concept of hybridization of traditional medicine may provide a better substitute for integration between traditional and modern practices where scientists and traditional healers work together to form a hybrid medicine. Hybridity of traditional medicine surpasses the dichotomous cultural boundaries of traditionalism and modernity as each practice will be required to contribute towards the realization of a hybrid medicine. Hybridity of traditional medicine is a potential answer to the failing integrative medicine which is about one practice inviting another practice into its space. The next chapter discusses the contribution and limitation of this study, and proposed areas for further studies.

CHAPTER 7: CONCLUDING CHAPTER

7.1 Introduction

The concluding chapter highlights the merits of using an ethnographic stance as an approach. It also lays out the key findings of the thesis and their contribution to the body of knowledge. In addition, it offers discussion of policy implications of this study and proposes areas for further research, building on the lessons learnt from this study and its limitations.

The findings have answered the central research question, which is about the opportunities and challenges for the contemporary and traditional health practices to cooperate under the National Health System in Tanzania. The findings have indicated that given the current situation integration of the two health practices in Tanzania is not feasible. However, cooperation is possible within the broader framework of Negotiated Order Theory, which serves the processes of Integration and Differentiation, Hybridization of Traditional Medicine and Negotiating Modernity.

7.2 Merits of Using an Ethnographically Informed Qualitative Stance

In the attempt to address the overall research question – what are the opportunities and challenges for traditional and contemporary health practices to cooperate under the National Health System in Tanzania - this study engaged an ethnographically informed qualitative stance (Draper, 2000; Hockey, 2002) as an approach to generating contextual data. While it was possible to draw on a range of study designs to obtain data from various participants, the ethnographic stance adopted had its merits in the sense that it helped to describe the lives and worldview perspectives of participants, their values and culture (Atkinson, 2015; Fetterman, 2010). Although I did not carry out field work with prolonged participant observation to explore the culture of the participants in detail, due to resource considerations, the ethnographic stance however helped me to:

- Approach each group of the participants with an open mind.
- Explore the worldview of each group of participants towards traditional health practice.
- Consider how the attitude of each group might influence the other groups' stance concerning traditional health practice.
- Gain rich conversational data that included peoples' descriptions of everyday contexts

as well as policy context and indications of historical developments.

- Explore both emic and etic perspectives of reality – the situations and behaviours of the participants.
- Gain understanding of the overview culture of both practices.

While conventional ethnography that involves prolonged participant observation could generate richer data than depend on semi-structured interviews as the sole method of data collection, such an approach would demand adequate resources as the study participants and research sites were heterogeneous and scattered. In addition, there was socialisation of study participants as there were cultures and sub-cultures within and without the groups of participants. Hence, undertaking traditional ethnography would need to study intercultural and intracultural aspects of the participants which would be hard in the given context. Ethnographic informed qualitative study using semi-structured interviews helped me to examine the attitude of each group towards traditional health practice and how they relate to each other. By prioritising interviews, I was able to talk with people from diverse pool of geographical regions and to seek out representatives from a range of roles and perspectives.

The use of interview helped me to gain understanding of the overviews cultures of participants. As Agar (1996) argued, ‘Aren’t people behaving when they talk, and don’t they talk when they behave?’ (1996:157). When I was interviewing different participants, the encounter evoked memories and strong emotional reactions for the interviewees. The mere fact that I asked them about their experience in witchcraft and detrimental activities of traditional healers, was enough to bring back memories of their loved ones who had been affected by traditional healers’ actions. Hockey summarises well: “interviews allow past and future to be assessed via the present and create space for what has been left unsaid and what remains invisible”. She adds, “In the moment of the one to one interview, not only the past but also the dead are present” (Hockey, 2000:214).

The descriptions that constitute the findings came from 35 participants from Dar es Salaam, Tanga, Dodoma and Shinyanga regions in Tanzania. The participants (with their sample size) were: biomedical practitioners (12), traditional healers (10), Christian religious leaders (3), and policy-makers (2). Others were researchers of traditional medicine (3) and participants who had dual or multiple roles (5). Among those with

multiple roles were a policy-maker, medical doctor and traditional healer; a policy maker and researcher; a policy-maker and medical doctor; a modern doctor and traditional healer; and finally, a traditional healer and university professor. In addition, all participants assumed the role of 'a client' as they have been patients or clients of either of the two practices. The advantage of conducting interviews with seven different groups of participants whose background and working cultures were different, was that it provided me with rich insights into their political, social, cultural and human aspects within their respective groups, and the impact that each group's rich qualities had on traditional health practice. Through their accounts, I could hear what they said they were doing collectively as groups but also was able to gain perspectives individually; gain indications of their belief systems, their values and how these aspects might affect traditional practice positively or negatively.

An ethnographic stance helped me to approach the study in both emic (that is 'seeing things from the actor's point of view') (Geertz, 1993:14) and etic perspectives (being an outsider), depending on the type of a participant I was interviewing. For example, when I interviewed the biomedical practitioners and Christian religious leaders I engaged with them as an insider, as their colleague because of my background in medicine and also, I am a Christian who is aware of the conflict between biomedical practitioners/Christians and traditional healers. When I was interviewing other groups, such as traditional healers, policy-makers, and researchers, I had to engage with them from an etic perspective. Being an outsider, the key feature was the idea that I was ignorant of their culture and practices, and I was prepared to learn from them. My genuine eagerness to learn empowered my participants to decide and shape the direction and content of the interview. In so doing the participants helped me understand their worldview which connected us as people to the extent that at times the interviews elicited strong emotions such as shedding tears when some participants gave accounts of the killings of their loved ones due to witchcraft. I could see anger and frustrations as religious leaders described how people are made to obey foolish instructions from traditional healers such as sleeping on graves or having sex with a six-year old girl.

Furthermore, the decision to use source triangulation (Taylor, 2005; Sharkey et al., 2005) where participants from seven different groups were recruited for study has assisted in bringing further depth and understanding of the phenomenon under the study. Seeing through the lenses of the participants from seven groups paved the way

for a critical analysis that led to some understandings and the unique ways that people thought about the issues. All this brought the ethnographic perspective into a real-life context and meaningful descriptions could be gathered. For example, it was interesting and even surprising to learn that all participants accepted and valued traditional medicine, but a few of them were reluctant to work with traditional healers. This raised the question of which traditional medicine they were referring to when they chose not to trust the inventors of that medicine.

As I reflect back, I see the merits of using the ethnographic stance as a design in this study in a number of ways. First, the use of source triangulation helped me as a researcher to study each group of participants in a distinctive way. It was interesting to note how the same question was interpreted and answered differently by different groups. For example, all religious leaders accused all traditional healers of being agents of Satan, while most of the policy-makers were of the opinion that there were trustworthy healers and malevolent ones. The majority of researchers, in their views perceived traditional healers as having multiple identities, while some of the biomedical practitioners saw the healers as quacks. Secondly, the findings highlighted the relationship between the groups and how the values and culture of one group affected the values and culture of the other group. For example, traditional healers took advantage of knowledge of the side effects of modern medicine to discourage people from using it. Biomedical practitioners informed the users of traditional medicine that the medicines had not been tested and could be dangerous to them.

At times two groups held similar views against the other three groups. For instance, religious leaders and biomedical practitioners questioned the efficacy of traditional medicine to manage chronic conditions but researchers, policy-makers and traditional healers mentioned herbal medicines that could treat chronic conditions: the healers even went further to invite me to talk to clients who had been healed as a result of their interventions. There were times when all groups seemed to have a common standpoint: for example, all participants expressed the importance of medicinal plants as the source of both traditional and modern medicines. In some areas, some groups confirmed points raised by other groups; for example, traditional healers claimed to have some poor relationships with both the government and biomedical practitioners, a claim that was supported by other groups. But there were also contradictions. For example, policy-makers, biomedical practitioners and religious leaders accused the healers of causing disharmony in societies. However, most of the traditional healers rebutted the claim,

citing in their astonishment that some of their clients were religious and government leaders who visit them in the night times. The most balanced group in this research in terms of their accounts was the participants with multiple roles. For example, all five participants with multiple roles shifted their position depending on the nature of the question but remained supportive of traditional practice. As they were knowledgeable of the state of affairs regarding traditional medicine in the country as policy-maker, at the same time their involvement in other areas such as researchers, traditional healers and modern doctors, made their inputs not only valuable, but well thought-out.

Another merit and advantage of using an ethnographic stance was that this study was able to challenge the assumptions taken for granted (Geertz, 1973) For example, during the course of data generation traditional healers were singled out as responsible for causing disharmony in Tanzanian local communities, but at the same time participants commended the healers for practising according to the culture of the local ethnic group. Consequently, it was taken for granted that traditional healers were responsible for the evil actions in society. However, the findings showed that actually, local people were the ones who demanded such services from the healer. The 'evil deeds' performed by the traditional healers as claimed by participants, were a reflection of local society itself.

Although the sample was not representative, the participants' accounts represent the wide social-cultural aspects of the Tanzanian communities. It can, therefore be concluded that an ethnographic stance provided some insights into accounts of the multidimensional group behaviours of Christian religious leaders, biomedical practitioners, traditional healers, government leaders, policy-makers and researchers of traditional medicine who are apparently the major stakeholders in setting the health policy agenda that could affect the traditional health practice positively or negatively. It also revealed the interrelationships, among complex dimensions of groups' interactions and provided context for their behaviours. An ethnographic stance revealed qualities of group experience in a way that other research methods could not provide to a similar level.

In addition, the decision to include four regions in the study area (Dar es Salaam, Tanga, Dodoma, and Shinyanga) provided in-depth understanding and widened the scope of inquiry. The four regions are geographically different, and the ethnic groups are diverse and therefore have dissimilar cultures. This provided a rich description of the uniqueness of each ethnic group, and at the same time the commonality between

and among diverse ethnic groups as discussed in chapter three - methodology. The use of multiple sources of data generation and multiple sites was the unique contribution of this study as other studies that sought to study the opportunities and barriers of integrative medicine interviewed biomedical practitioners only (Wiese, 2010), traditional healers only (Kaborou, 2006), or traditional/CAM and biomedical practitioners only (Hollenberg, 2006). This study is unique in the sense that it involved not only traditional and biomedical practitioners, but also religious leaders who remain crucial stakeholders in formulating a health policy agenda, policy-makers who are critical in filtering, approving and implementing health agenda, and the researchers who have immense information on the development of traditional medicine in Tanzania since independence, and have official close relationships with traditional healers. More important the study recruited five participants who had multiple roles, being involved as either policy-maker, researcher of traditional medicine, traditional healer, biomedical practitioner or university professor in botany. Consequently, the findings of this study, have illuminated aspects of multifaceted power relations that are for and against cooperation between traditional and biomedical practices.

7.3 Reflection on the Central Research Question: The Insightfulness and Significance of the Key Findings

The central objective of this study was to explore the opportunities and challenges of cooperation between contemporary and traditional health practices under the mainstream health system in Tanzania. The theoretical framework employed in this study has its roots in a constructionist/interpretivist approach, in which the study seeks not only to discuss the participants' views regarding the opportunities, challenges and barriers of cooperation between traditional and biomedical health practices, but also to reflect upon the degree to which those views, beliefs and experiences are interwoven with wider socio-cultural ways of thinking about, and making sense of, collaboration between modern and traditional health practices. I perceive this as a reciprocated process, whereby participants' views on both health practices are informed by broader socio-cultural values, but on the other hand, such views feed back into, and help make up, that socio-cultural context. "Constructivism as an ontological stance that, asserts that social phenomena and their meanings are continually being accomplished by social actors" (Bryman, 2008:19). As individuals seek meaning and understanding of the world around them based on their historical, cultural norms and social perspective; such

logic is in agreement with an ethnographic stance, which is about studying the culture of communities and society.

The discussion in this concluding chapter highlights the key concepts of the findings that address the central research question, and how these key concepts build up to higher concepts or processes as well as to the conclusion of this study. The discussion is guided by broader framework of ‘Negotiated Order Theory’ (Strauss et al., 1963) through which the higher concepts or processes of ‘Integration and Differentiation’ (Hoenders et al., 2012); ‘Negotiating Modernity’ (Marsland, 2007); and ‘Hybridization of Traditional Medicine’ (Kim, 2006) form a basis of discussing the key findings.

7.3.1 Negotiated Order Theory and Processes of Integration and Differentiation, Negotiating Modernity and Hybridization of Traditional Medicine: As Higher Concepts

As the central research question seeks to explore the opportunities and challenges for contemporary and traditional health practices to work together, ‘Negotiated Order Theory’ propounded by Strauss et al., (1963) is a broader framework that has guided the discussion of the findings in this thesis. Negotiated Order Theory is an important tool in this study due to its origin in ‘symbolic interactionism’, in which negotiation is the prime means to reach consensus among diverse parties that want to work together to achieve a common goal. It furnishes three higher concepts or processes through which participants give their accounts on the possible cooperation as well challenges for the cooperation between traditional and contemporary health practices. ‘Negotiated Order Theory’ as a broader framework is umbilically linked to the processes of ‘Integration and Differentiation’ (Hoenders et al., 2012); ‘Negotiating Modernity’ (Marsland, 2007); and ‘Hybridization of Traditional Medicine’ (Kim, 2006) through its philosophical base of interaction, negotiation and agreement. As the success of any of the processes mentioned above would need the practitioners of both practices to interact, negotiate and agree on fundamental aspects that bring them together.

The process of ‘Integration and Differentiation’ developed by Hoenders et al., (2012) propounded that integration and differentiation are two polarised concepts that represent two dichotomous movements with the same strength that work as a response to each other. It follows that too much integration of traditional and modern health

practices would lead to loss of identity and autonomy of both practices. This could provoke differentiation, compelling the practitioners of both practices to redefine their profile freely from each other. In the same vein, too much differentiation of the two practices, defines the line of demarcation between them, which invites polarity and struggle for legitimacy; creating a need for more cooperation between them.

As indicated earlier, the nineteenth century was marked by the establishment of modern health practice, which legitimised itself as a scientific practice, and ‘other’ practices as belonging to undefined space. Hence, it was a period of ‘differentiation’ of health practices, which was marked by naming health practices as modern or traditional, and the founding of traditionalism and modernity concepts. According to the findings, traditionalism and modernity denoted two dichotomous entities. Traditionalism was linked to the local culture, indigenous knowledge, local religion and traditional medicine; whereas modernity was attached to western ways of thinking, western culture, formal education, Christianity and biomedicine. In a different context, traditionalism and modernity denoted the way of life. Modernity was associated with urbanization, wealth, development and improved economic power. In an alternative explanation, traditionalism was related to rural life, poverty, ignorance and underdevelopment. Thus, once labelled as traditional, whether from being linked to local culture or because of being economically disadvantaged the chances of combining with modernity by any sense was slim if not impossible. Influenced by the notions of traditionalism and modernity, the participants in the current study talked more of ‘differentiation’ of the traditional and modern health practices than ‘integration’ of the two practices.

After a century of differentiation that saw the dominance of modern health practice over other practices, there is a growing impulse for integration between traditional and modern health practices worldwide (WHO, 2014). The desire for integration is partly because the two practices over a century have been growing, developing and increasing their users, popularity and legitimacy. This move has created a distinctive difference between the two practices. It is from these variations that a need and demand for integration is created from within as well as outside the practices. Following the logic of integration and differentiation process, too much differentiation invites some sort of integration, for it is in the process of differentiation of health practices that the distinctive knowledge and values of each practice are vividly understood, which may invite replication, appropriation or even subjugation of the values of practice of one by

another. The current findings saw the need of cooperation between traditional and modern practices because, among other reasons, traditional medicines were found to be more effective in managing chronic conditions than modern medicines. On the other hand, traditional healers made use of modern technology to establish accurate diagnosis before dispensing their medicine, hence minimizing trial and error in reaching a diagnosis. In a different context, too much differentiation of health practices has led to increased supply of diverse health options, from which users could choose. The preference for holistic health care and integrative medical setups in western countries are examples of such demands by users, although modern practitioners were not in favour of such cooperation. Consequently, a successful integration of traditional and modern health practices cannot work in the absence of differentiation, which calls for a middle ground in which each practice in the integrative setup is allowed to maintain its identity and autonomy.

Hoenders et al. (2012) argue that differentiation and integration are not antagonistic to each other rather they are a response to one another. The movement from differentiation to integration and the other way around, is met with opposition and criticism. The current findings showed how a variation in the level of education between traditional and modern health practitioners, involvement of traditional healers in detrimental activities including witchcraft, and their involvement in spiritualism on one hand; and the dominance of modern practice on the other hand were perceived as evidence of resistance for the two practices working together. The mode of cooperation between traditional and modern practices in the current findings and the experience of other initiatives of cooperation especially in the western countries fall short of qualifying to be integrative medicine because the integration is not built on the middle ground. The cooperation is skewed towards differentiation. The parties are more concerned with maintaining their identities, autonomy and legitimacy, than seeking cooperation. They are keener on finding weaknesses and limitations in their counterparts than identifying aspects of common interest for the two practices. They have concentrated on competition and insulting each other rather than acknowledging the strength of their rivals. Unless there is a balance between integration and differentiation, no mutual cooperation can take place between traditional and modern practices not only in Tanzania but all over the world. The biggest challenge for creating balance between integration and differentiation with regards to cooperation of the two practices in Tanzania is more to do with western legacy that has brain-washed the

minds of some government officials, modern health practitioners and scientists to believe that there is only one true medicine – biomedicine.

As the process of integration and differentiation is a subset of the broader theoretical framework of Negotiated Order Theory, so is the second process of ‘Negotiating Modernity’ by traditional healers propounded by Marsland (2007). Negotiating modernity is viewed as a coping strategy for the traditional practitioners to increase their popularity and legitimacy. The initiatives of traditional healers to dissociate with traditionalism and embrace modernity as a strategy to be accepted and win legitimacy, is not only in line with the process of negotiating modernity but also evidence to support Hoenders et al’s (2012) philosophical thinking: that ‘when there is too much differentiation, the parties lose sight of each other and create a need for more integration (2012:441)’. Finally, the process of ‘Hybridization of Traditional Medicine’ (Kim, 2006) is also a subset of Negotiated Order Theory in the sense that, to produce a hybrid medicine there must be interaction, negotiation and agreement among the stakeholders. Hybridity of traditional medicine requires traditional healers, modern practitioners and scientists to work together to produce a medicine that is a product of contribution of traditional healers by offering their medicine, modern technology and knowledge of the scientists.

7.3.2 Negotiated Order Theory and the Processes of Negotiating Modernity and Hybridization of Traditional Medicine: As Alternative Accounts of Integration

In answering the central research question, the initial findings indicated early signs of the difficulty for biomedical and traditional health practices to work together. The two health practices were represented by two schools of thought. In the first school of thought the participants valued both the traditional medicine and its practitioners and perceived the two as inseparable. This school of thought represented the concept of traditionalism (Marsland, 2007) that is identified with traditional medicine and its practitioners, local culture and traditions, society norms and indigenous knowledge. In an alternative to the first school of thought, the second school of thought demanded a separation of traditional medicine and the practitioners because they perceived traditional medicine as something innocent, which, if researched, might be useful to humanity. However, they perceived the healers as primitive, pretenders and involved in

witchcraft and devilish activities. Participants who were in favour of a separation of traditional medicine and its practitioners were identified with the concept of modernity, having aspects of a western mindset, from which western-orientated entities such as biomedicine, formal education, Christianity, science, modern technology, urbanization and globalization were developed (Kim, 2006). Not only traditionalism and modernity were irreconcilable with each other but also the health practices that originate from these two concepts, the traditional and contemporary health practices, were incompatible.

The division of participants into modernity and traditionalism was not only an early sign of challenges, barriers and difficulty for the two health practices to work together, but it also raised a number of other concepts which set the scene for discussing further findings. For example, the concept of 'Traditionalism' gave rise to concepts of the acceptability, popularity and legitimacy of traditional medicine. The rise of these three concepts was a result of the perception of participants that traditional medicine and its practitioners are readily available, accessible, affordable, safe and effective. These concepts formed a basis for discussing a major theme of potential cooperation between modern and traditional practices in Chapter Five. The concept of 'Modernity', on the other hand, gave rise to concepts of 'Uncertainty, suspicion and distrust of traditional healers' (Abdullahi, 2011). These concepts laid a foundation for discussing the deterrents, challenges and barriers for the cooperation between modern and traditional health practices in Chapter Six.

While the initial findings reiterated the participants' views that kept apart the concepts of traditionalism and modernity as entities that are not likely to work together given their historical background, at a later stage of analysis the findings propounded the view that there were some potential areas for cooperation between modern and traditional health practices. However, the potential areas for cooperation were perceived to be weak and insignificant as there was no scientific evidence to support the idea that traditional medicines were able to cure what they claimed to do. Where collaboration between modern and traditional healers was reported as a potential area for cooperation, such collaboration was informal, local and involved only a few practitioners, so much so that the cooperation neither had ripple effects nor was replicated for a wider application. Consciously or subconsciously, traditional healers were aware that their practice was substandard, and was perceived by biomedical

practitioners as unscientific and primitive. Hence, the chances were slim for them to be accepted by the dominant modern practice. Consequently, as a coping strategy, traditional healers engaged themselves in the process of negotiating modernity where the healers were embracing and imitating modern practice by dispensing herbs in some clean plastic sachets, which were clearly labelled, showing the dosages divided into two or three times a day. In addition, healers improved their working premises by making sure the 'clinic' was clean and they put on white coats when serving clients. These were among the initiatives taken as means to increase their acceptance by the community.

The school of thought that advocated the separation of traditional medicine and its practitioners was made explicit when participants gave their opinions on the challenges of cooperation between traditional and modern health practices. The majority of participants compellingly propounded that the cooperation between traditional and contemporary health practices under the National Health System which is dominated by the hegemonic modern health practice was impossible due to a number of reasons. First, the two practices are philosophically incompatible, which make it impossible for them to work together. Secondly, there are social, political and economic factors that make it hard for the two practices to work together. Thirdly, the historical background of the two practices and the requirements needed by the practices to work efficiently are quite different; modern medicine requires specialized training, whereas to be a healer does not require such a rigorous process.

However, in a different but related context, the modern health practitioners and scientists in the current study, having realized that they could not work under the 'same roof' with traditional healers, have been convincing traditional healers through a process of hybridization of traditional medicine (Kim, 2006) to offer their medicines to be tested by the scientists. This move was a response following information that some traditional medicines have been reported to be effective in managing some conditions. The strategy seemed to work well to the practitioners of both practices. For the healers who were ready to be part of the process, working with modern practitioners and scientists to produce a hybrid medicine was a strategic decision to legitimize their practice. For the scientists and biomedical practitioners, the opportunity was a strategy for them to get their hands on a potentially effective medicine.

In Chapter Five the usefulness of Negotiated Order Theory (Strauss et al., 1963) in this study was given. In line with its roots in interactionism, the principal stance of negotiated order theory is that an organization or a health practice is formed or developed through social interactions and negotiations. Social structures such as a biomedical health system or a traditional practice develop through interactions and negotiation among stakeholders who have common goals and share a social context. Based on social interaction and negotiation that form the heart of a social order, Negotiated Order Theory distances itself from theories that postulate the stability and inaction of social systems (Dokko et al., 2012). In other words, the theory rejects the view that a phenomenon such as traditional health practice is a pre-existing characteristic. Instead, it is argued that the social order is a social construct. In line with this logic the processes of negotiating modernity, in which traditional healers acquire and adopt modern procedure of treatment, and of hybridization of traditional medicine where traditional and modern health practices work together to form a hybrid medicine can be used to examine cooperation between scientists, modern practitioners and traditional healers within the framework of Negotiated Order Theory developed by Strauss.

The theory is a useful tool for considering the processes of interaction and negotiation that take place when traditional healers negotiate modernity or engage in the hybridization of traditional medicine. Slight changes to the context such as the need to ascertain the efficacy of traditional medicine, the increased acceptability of traditional health practice, the emergence of chronic diseases that have found no cure in modern medicine, the outbreak of communicable diseases, the acute shortage of healthcare providers or the inaccessibility of modern practice could activate renegotiation, and reevaluation that can lead to a new social order of cooperation. Indeed, even the pressure and demand from users about the toxicity of modern medicines, and the need to have traditional medicines tested for their efficacy are strong catalysts for interaction and negotiation between the two practices. The negotiated order arises when health stakeholders or health systems in partnership set up their mutual goal and decide how they would realise that goal (Crozier and Friedberg, 1980). Models of cooperation between traditional healers and biomedical practitioners in combating HIV/AIDS in Tanzania (TAWG), Uganda (THETA) Zimbabwe (ZINATHA) are examples of such initiatives.

A central idea in examining the process of negotiating modernity and hybridization of traditional medicine is to acknowledge that traditional medicine, like modern medicine, is growing: its acceptability, popularity and legitimacy have increased, so has the number of its users (Wiese, 2011; Adams et al., 2009). This idea overturns the ontological postulation that traditional medicine as a social order is fundamentally stable, primitive and underdeveloped (Asante et al., 2013). As an alternative, traditional medicine, its practitioners and their stability are social achievements that need explanation (Strauss, 1978; Maines, 1982). The calls for integration, cooperation or collaboration between traditional and modern practices, and even the desire of traditional healers to negotiate modernity, are triggered by the fact that traditional medicine is not characterised by inertia: rather, it is growing, it is popular, and it is a legitimate therapy that has found a significant place in medical pluralism. Unfortunately, the school of thought, which demands the separation of traditional medicine and its practitioners (refer to Chapter Four), seems to be guided by theoretical perspectives that see traditional medicine as stable and inert, that is not growing nor developing (Dokko et al., 2012). Consequently, where there were calls for integrating traditional practice into the national health system (Hollenberg, 2007; Adams et al., 2009) the tendency has been to relegate and marginalize traditional practice as if it has nothing significant to offer. Such calls were characterized by the dominance of biomedical practitioners over traditional healers through giving instructions to healers as to what needs to be done so that biomedicine can work smoothly and serve patients effectively. The current study has given examples of integrative setups that did not work because modern practitioners showed a great deal of prejudice against and dominance over traditional/CAM practitioners (Hollenberg, 2006, 2007, 2009; Wiese, 2010; Adams et al., 2009).

Negotiated Order Theory and its attributes of Integration and Differentiation, Negotiating Modernity and Hybridization of Traditional Medicine seem to be a potential alternative to the failure of integration of modern and traditional practices because integration involves two practices with unequal influence, power and skills. The power relation between them is about one practice wanting to be superior to the other one. Given that one practice is representing traditionalism, which is perceived to be weak, and the other is representing modernity, which is dominant, the outcome of such cooperation has never been a healthy one according to several other studies (Abdullahi, 2011; Wiese et al., 2010; Hollenberg, 2009). Negotiated Order Theory on

the other hand, insists on the need to interact, which means there must be a situation that will cause the two to interact. For example, the models of cooperation between modern and traditional practitioners in Africa reported earlier were triggered by the devastating uncontrollable outbreak of HIV/AIDS. At times a situation for interaction may originate from the demand of the users who are not satisfied with either practice, for example, the inability of modern medicine to manage chronic conditions or the demands to improve the traditional medicine into a reducible form.

Secondly there must be a kind of negotiations between parties. Negotiations can only take place where one party perceives the other party they are negotiating with has something to offer. Subsequently, when the two decide to cooperate, the decision does not spring out of a desire to compete for power; rather, circumstances dictate the terms. For example, a shortage of health staff, poor distribution of health facilities, availability in large number of traditional healers in rural areas, and the success stories of treating chronic conditions by the same are factors that may trigger interactions and negotiation for cooperation in order to find a long-lasting solution. When traditional healers are engaging with scientists and biomedical practitioners in researching a traditional medicine that has been offered by a traditional healer, (hybridization of traditional medicine) the level of interaction is different from where traditional practice is invited to practise in an integrative setup. In the former, each and every party has something to bring to the table of negotiation, without the contribution of a traditional healer the hybridization of the medicine will not be successful, likewise without the role of scientist there would be no hybrid medicine. In the latter case (that of being invited to practise in an integrative setup), the presence of traditional healers in the integrative setting may be used by modern practice to demonstrate its dominance rather than improve the wellbeing of clients. In a worst-case scenario, the cooperation might invite appropriation, assimilation and subjugation of traditional medicine by the modern practice (Hollenberg, 2009).

As outlined in the findings, when traditional healers are engaged in both negotiating modernity and hybridization of traditional medicine the issue of power cannot be sidestepped. The dominant modern practice would still want to dominate the project in terms of language, medical terminology and technology, and even a struggle over which philosophy should prevail (Kim, 2006). However, where the concept of hybridization of traditional medicine is involved, the power relation is not bipolar

involving two practices: rather it is multifaceted and distributed among several actors, and no single actor has all the power. The central premise for Negotiated Order Theory is interactions, negotiation, a “succession of conflicts, accommodation, and assimilation” (Asante et al., 2013:257). It follows that in a negotiated order, parties or stakeholders who want to work together merge their ambitions and actions to support a mutual goal. In the process, they share a common purpose and cultivate a mutual recognition, understandings and respect of the contributions each party brings on table (Boje, 1982).

Based on the findings of this study, is my conclusion that the integration of traditional and contemporary health practices within the national health system under the current situation is practically impossible in Tanzania. This submission may also apply to other Sub-Saharan African countries, given that the historical, political, social and economic context of these countries are similar. The two health systems should be allowed to operate in parallel with each other in a context where a national health system has both modern and traditional health practices as separate components. As forms of cooperation get better and are improved through informal and formal settings like negotiating modernity and hybridization of traditional medicine, the country can then move from a parallel system to an inclusive system as an intermediate stage towards an integrative system (WHO, 2012). Addressing these processes means that the government and other health care stakeholders have to recognise they need to work within the framework as outlined within Negotiated Order Theory. Describing it in the philosophical thinking of Hoenders and his colleagues, Tanzania is currently skewed more towards differentiation than integration, where key stakeholders of health are immersed in discussing the challenges rather than identifying the opportunities for cooperation between the two practices. Until the time when there will be a balance between integration and differentiation, where the effort is directed towards keeping traditional and modern health practices as integrated parts adequately differentiated, at the same time allowing them to maintain their autonomy and identity, there will be no integration of traditional and modern health practices in Tanzania.

7.3.3 Negotiated Order Theory and Malevolent Practice

While I strongly submit that negotiating modernity by traditional healers and hybridization of traditional medicine under the framework of Negotiated Order Theory

are alternative strategies to integration of traditional health practice into the National Health System, because of its ability to interact with and negotiate a social order, the success of these two processes would help to absorb the knowledge currently owned by traditional healers into the hands of the state through the national pharmacopoeia. Indeed, the transfer of knowledge of traditional medicine from the healers to the state would take away the benevolent part of the traditional healers. However, the malevolent part of them would remain. It is this part that is responsible for the killing of innocent people, witchcraft and causing disharmony in local communities (refer to the killings of albinos, elderly people and people with alopecia and skinning of young people in Chapter Six).

Using the same theory (Negotiated Order), collaborative groups initiated in Africa between modern practitioners and traditional healers such as TAWG in Tanzania and THETA in Uganda could increase their partnership by including the religious leaders of all denominations to help tackle the killing of innocent people. These forums will help to bring together traditional healers and Christian religious leaders who under normal circumstances would not meet. This could be a prime opportunity for the Christian leaders to interact and hold dialogues with traditional healers. Such forums could help, for example, to find out how the healers are involved in the healing process and what are their views regarding their practice. The current findings could be taken as the basis for encouraging such interaction and negotiation among religious leaders and traditional healers, as some of the spiritualist healers in the study area were not happy to carry on healing activities (alleged malevolent activities), but had been forced to practise because they had been chosen by ancestors, gods or spirits.

A few spiritualists informed me how they wished they had not been picked to be healers and swore that they would do everything to prevent their children from succeeding to their practices. Some of the spiritualist healers were looking for means to opt out but they have been oppressed by the demonic power, and they are not aware of a way to escape. The influence and inclusion of the religious leaders in the forum, particularly the Christians would assist those healers who wish to refrain from practising spiritualism. Religious leaders should not wait for the government or law enforcement to act. The government has its part to play, but there is a limit to what the government can do as there is no army, law, or policy that has the power to change an evil heart. There is no government that can transform an evil or sinful heart; while

people who were convicted of killing albinos have been sentenced to death, yet the killings continue.

It is spiritual transformation that can take away the malevolent part of the traditional healers. The disclosure that some spiritualists healers are looking for an exit from their practice is an invitation for religious leaders to intervene by assisting those traditional healers who are ready to stop spiritual healing engage in an alternative practice. Indeed, religious leaders have a role to play in intervening and preventing the killings of innocent people like albinos, red-eyed women and those who are traumatized by witchcraft. Integration of religious leaders in such collaborative initiatives such as TAWG will challenge the religious leaders to come out of their comfort zones, interact and negotiate with healers aimed at transforming their lives, rather than wait to pray for the victims who have been tortured by malevolent practitioners. The concept of negotiated order can be the guiding principle for godly people to stop the killing of innocent people.

7.4 Policy Implications of the Study: The Place of Traditional Medicine

It is a truism that traditional healers and their medicines have a potential key role to play in the health sector in developing countries (WHO, 2010). Despite being perceived as a substandard therapy whose quality, efficacy and safety is questionable, traditional medicine remains a dependable health-seeking option for rural and hard-to-reach communities in developing countries (WHO, 2008). Moreover, traditional medicine has the advantage that it is inexpensive and easily available, so that a majority of individuals in developing countries are capable of paying for it out of their own pockets (Kaboru, 2006). Traditional medicine has been used for centuries by communities and has been found to be effective through their experience. As a result, some countries, such as China and India among others, have given governmental support in terms of research, training and developing traditional medicine (WHO, 2012). China has more than 165 Chinese traditional medicine hospitals, each specializing in a particular condition such as heart and vascular diseases, cancers and liver diseases (Hepeng, 2004).

Some countries in Africa are considering the integration of traditional medicine into their national health care strategies (Kimani, 2004). In addition, traditional medicine is now becoming a good source of foreign funds by exporting medicines, hence

supporting their economies. For example, China earns over \$1 billion from the export of traditional medicine annually (Patwardhan, 2005). This study found that the sales of traditional medicine from only the Dar es Salaam market to the neighbouring countries ranged from \$365 thousand to \$ 2.2 million annually.

Based on the above explanation and the current findings, this study is recommending that, as a matter of policy, governments in developing countries, including Tanzania, should invest in developing and promoting traditional medicine through supporting the hybridization of traditional medicine and encouraging traditional healers to engage in negotiating modernity. One way to achieve this goal is for the government, through the use of Negotiated Order Theory, to commit enough funds to research traditional therapy for common conditions as well for chronic ones. By doing so, the governments will not only be addressing the issue of inequality of health care delivery between rural and urban populations but more importantly, they will be weakening, if not demolishing, the wall that demarcates traditional and modern health practice. Furthermore, as traditional medicine will be in government's custody, the notion that traditional medicine is satanic and a work of darkness which is held by the Christian faith will fade away. Indeed, by investing in the regulation of traditional medicine, it will ensure that the medicine is safe for human consumption so that more people who currently hesitate to use traditional medicine will turn to it. It is not enough to discourage people from using traditional medicine and urge people to use biomedicine when modern medicine is not available in rural areas, inaccessible and unaffordable (Kayombo, 2007).

In addition, the involvement of government and research firms in supporting the hybridization of traditional medicine and encouraging healers to negotiate modernity will move the knowledge of traditional medicine from the hands of traditional healers into the national pharmacopoeia. Hence, the healers will be stripped of their hidden knowledge and it will be turned into a national heritage, so that death will not take away the resources and skills that are buried along with the best healers. In the same vein, the availability of essential list of traditional pharmacopoeias would facilitate the development of the curriculum for traditional medicine in medical universities. When these two initiatives are developed, and put in place then truly the integration of traditional medicine into the national health system can take place.

As an important step towards the integration of traditional medicine into the national health system in future, the government could allow and encourage traditional healers

to make use of modern medical laboratories, X-rays, ultra sound and other investigations; and those who can put in place those facilities and hire certified technicians to run them could be encouraged to do so. This will help healers to reduce trial and error in making diagnosis. Given that they claim to have effective medicines, when they are assisted by modern technology and experts to make accurate diagnoses then the curative rate is likely to be high. Some well-regulated clinics with clear guidelines and supervision will prevent healers misusing this privilege. At the moment, traditional healers who are registered to dispense traditional medicine are not allowed by the law in Tanzania to mix their practice with modern medicine, although there are a few who do mix the two practices. Should the state government and global institutions support and promote traditional medicine, not only will that tackle the issue of inequality between rural and urban, but also that of disparity between developing and developed countries. Disparity in health care delivery in developing countries especially in relation to availability, accessibility and affordability is an issue of great concern for the global community (Hills, 2006).

7.4.1 Global Disease Burden and the Role of Traditional Medicine

There are three key characteristics that distinguish developing countries from the developed countries: unequal population growth, unequally low prevalence of diseases, especially communicable ones, and unaffordable costs of medical care for the majority of people (WHO 2006). Based on these characteristics it is critical and urgent to address the inequalities of health care delivery in low income countries.

The world population is estimated at 7.3 billion. Of these, over 80% live in the developing countries (US. Bureau of Census, 2011). Over one billion people on planet earth survive on less than a dollar a day: 2.5 billion individuals live without proper sanitation, Globally, the diseases of poverty, which consist of maternal and perinatal conditions, diseases related to poor nutrition and communicable diseases contribute to over 50 per cent of the burden of disease in developing countries: this figure is estimated to be ten times higher than the burden in developed countries (WHO, 2006). Policy-makers, scholars and leaders all over the world should look for solutions to complex problems facing the developing countries. There is no single miraculous solution to these problems. It is under such conditions that it makes sense to explore traditional medicine as one among several possible solutions for providing affordable healthcare to large inaccessible or underserved populations in less developed countries.

While it is undisputed that modern medicine might be the best solution for humankind, its limited availability, accessibility and, more important, limited affordability leave traditional medicine as the best substitute in the developing world.

In addition, about 15.3 million individuals are infected with HIV in Indonesia, China, Vietnam, India and Latin America, while sub-Saharan Africa leads the world in having over 25 million people living with the infection (UNAIDS, 2004). This is in comparison with 1.6 million individuals who are infected with HIV in the industrialized nations combined. The incidence of acute malaria is estimated at 300 million cases annually worldwide, causing over one million deaths. It is estimated that 90% of mortality cases occur in Africa, affecting mostly young children, whereas malaria is virtually non-existent in developed countries (Roll Back Malaria, 2004). Over 1.5 billion people lack safe drinking water, and due to these deficiencies about 3 million individuals, especially children and women, die yearly from diarrhoeal diseases (Patwardhan, 2005). Such huge numbers of deaths could be avoided by the use of easily accessible traditional medicine or elementary training of traditional healers who would curb sanitation and water-related diseases with simple messages of health promotion and disease prevention. Traditional medicine and traditional healers could provide a fast-cheap alternative therapy for large uncovered populations in less developed countries.

To change focus, the density/ratio of medical doctor per 100,000 individuals as of 2004 in different countries was: Rwanda 2:00, Ethiopia 2:90, Uganda 4:75, Benin 5:80, India 51:30 and China 164:24, which are very different from that in the USA (548:91) and Australia (249:13) (WHO, 2005). Against this background, it is observed that the ratio of traditional healers in Tanzania, Uganda and Zambia is in the region of 400 to 500 per 100,000 individuals which is less than but close to the ratio of medical doctors available to the US population. At the same time figures show that the number of traditional healers in sub-Saharan Africa is 100 times that of contemporary medical doctors (WHO, 2005). A better and less costly way to fill the gap in the need for health workers would be to train traditional healers for the post of community health staff especially in rural areas wherever they are socially accepted (Geest, 1997). As a matter of policy, this study submits that sustainable efforts should be directed towards making use of traditional healers in preventive and promotive health strategies. Such a move would reduce dramatically the global burden of diseases, especially in less developed countries including Tanzania.

The opponents of traditional medicine have used quality control failure as a weapon to limit the use of traditional medicine. As it is the role of government to ensure the essential modern medicines used in the country are safe, it remains its obligation to lay down regulatory mechanisms for traditional medicine and ensure its safety and that of consumers. While the majority of the population make use of traditional medicine, the traditional system has been marginalized to the extent that it receives less than 1% of the national health budget (Barret et al., 2003). The large part of financial resources has been directed towards researching and supporting biomedical interventions, neglecting traditional medicine. This study suggests that more effort and focus is needed in researching traditional medicine to ensure the availability of information on its quality, efficacy, safety and toxicity. It is not fair to deny the importance of herbal medicinal preparations when their efficacy has not been proved or disproved. While certainly effective quality control is needed in place for traditional medicine, quality control failure should not in any way constitute a bias against traditional medicine by obscuring public access to traditional medicinal preparations. Since the development of contemporary medicine has gone far ahead of traditional medicine it is now high time for public policy-makers to give traditional medicine the impetus it deserves to develop. Support is needed in research to ensure traditional medicine is safe for consumption. Traditional medicine could be used to complement modern medicine, but also as a stand-alone effective intervention in its own right, as is the case in China, Korea and Vietnam.

7.5 Recommendation of this Study

As indicated earlier, the collaboration between traditional and contemporary health practices under the National Health System (modern medicine) is not likely to take place soon given the current challenges and barriers. However, since Tanzania has institutions that have been mandated to develop traditional medicine, and the vision of the Tanzanian government is to see the integration of the two health practices in future, this study offers the following recommendations. First, there is a need for government officials to change their mentality towards traditional health practice. The negative attitude of government officials towards traditional practice is not creating a conducive environment for cooperation between the two practices. Secondly, the government should set a timeframe to realize cooperation between traditional and modern health practices under the National Health System, and should have indicators to monitor the

progress. Thirdly, consistent with the second recommendation, the government should set aside funds to research traditional medicine and reward healers who will be willing to cooperate with scientists to develop hybrid medicine. Fourth, traditional healers who are currently negotiating modernity should be encouraged. At the moment, the regulatory bodies discourage traditional healers from mixing traditional and modern approaches. Fifth, as said earlier, religious leaders should interact with and talk to traditional healers and help out those who would like to opt out of malevolent activities. Finally, there should be frequent forums between traditional healers and biomedical practitioners, religious leaders and government officials. Such forums will help create a sense of understanding and consolidate the trust among members of each group.

7.6 Limitations of this study and areas proposed for further research

Although this study had its strengths, especially the use of the ethnographic stance, source triangulation and the use of multiple sites to generate data, it also had its shortcomings. The limitation of this study was the way the traditional healers were recruited into the study, which affected their freedom of expression. After obtaining permission to proceed with research from the Mzumbe University on behalf of NIMR, I reported to the Ministry of Health to obtain a letter to introduce me to the regional and district medical officers. The same letter was to introduce me to the regional and district traditional medicine coordinators. Due to the importance and urgency of data from this study, the Ministry of Health wrote and directed all coordinators in the study area to ensure that I would be given maximum support during my data collection phase. The coordinators in all the regions and districts took that letter seriously as a directive. As such they escorted me to the respective regional/district chairperson of the traditional healers' association. The chairperson had a register of all healers in his/her jurisdiction.

As if that were not enough the coordinators took me to the healers that I recruited and sat beside me to listen to the interviews. Even where I asked them politely to give me space so that I could interview traditional healers privately, they insisted that they wanted to make sure everything went well, as they claimed they were required to report back to the ministry. Their presence affected freedom of speech for the healers, as their responses may have been constrained, not genuine, and geared towards pleasing government officials. At times, they sounded polite and apologetic to the government for the mistrust between them and the government. Due to the presence of a

government official most of their answers were short, yes, no or I don't know, as if they were answering closed-ended questions. To curb that flaw, I decided to interview an additional four healers when I was not accompanied by a government official. These four healers provided me with rich and wide understanding which I would not have obtained had I stayed with original healers I interviewed in the presence of government officials. Another limitation of this study was the exclusion of Islamic religious leaders. The exclusion was not intentional; the one earmarked could not be recruited because data collection was carried out during the month of Ramadhan. However, the views of Islamic religious leaders were taken on board as some of the traditional healers were Moslems and a few were identified as Sheikhs in their areas.

I believe the findings, and the contribution of this study to the body of knowledge, have provided a fruitful avenue for further research on the cooperation between the traditional and modern health practices. I think it was critical and essential to use an ethnographic stance to obtain the sense of the worldview of participants regarding the meaning and understanding of the cooperation between the traditional and modern health practices. While I believe the approach, I used was convincing in developing an empirical and theoretical understanding of the relationship between the traditional healers and biomedical practitioners on one hand and traditional healers and other interested parties on the other, I believe that the findings of this study can shed light for other researchers who would like to undertake further research in two areas. The first is research on the views of traditional healers on negotiating modernity: what are their aspirations and expectations of cooperation with modern practitioners under the umbrella of negotiating modernity? The second is to examine the perceptions of traditional healers and modern practitioners on possible cooperation based on the concept of hybridization of traditional medicine. What conditions and environment are conducive for effective hybridization of traditional medicine? In this respect, further study focusing on creating an enabling environment for good traditional healers to give the medicines in which they trust voluntarily to the scientific researchers to ascertain and isolate the active ingredients will be welcomed.

There should also be consideration given to issues of intellectual property and equity rewards. Through employing an ethnographic stance, future inquiry could focus on what would help to obtain the trust of the traditional healers to agree to participate in hybridization of traditional medicine. Indeed, a carefully designed ethnographic study could be employed to develop more contextually sensitive and dynamic accounts of

traditional and biomedical practitioners and scientists in research institutions towards the realization of hybridization of traditional medicine. Furthermore, future research is required to examine the viewpoints of appropriate stakeholders at different hierarchical levels, for example, the Ministry of Health, the National Council of Traditional Medicine, the NIMR and the ITM.

Furthermore, regarding the theoretical perspectives underpinning this study, forthcoming research could use both Critical Social Science Perspectives (CSSP) and Anti-Colonial perspectives (ACP) to examine the relationship and environment in which biomedical, scientists and traditional healers could work together to ascertain the safety of traditional medicine. Here the work of CSSP and ACP theorists (e.g. Adams et al., 2009; Hollenberg, 2006, 2007, 2009; Dei et al., 2000; Neuman, 2000; Harding, 1996;) could be employed to further advance our theoretical understanding of the complex, multifaceted power relations in negotiating modernity or the hybridization of traditional medicine. In realizing that goal, we can gain more understanding of the struggle the traditional healers are facing to negotiate modernity and the hybridization of traditional medicine. In addition, we will examine to what extent these experiences are acknowledged and appreciated by other stakeholders as embodied ones.

While scholars in the domain of CAM/traditional medicine have progressively considered the role of CAM/traditional medicine in treating chronic conditions and therefore the need for cooperation between the two practices (e.g. Broom and Tovey, 2007; Wiese et al., 2010; Baxter et al., 2013; Smallwood et al., 2005), little comparable attention has been given to the study of negotiating modernity by traditional healers. Undeniably, while there have been increases in the wider knowledge of traditional medicine, which have contributed to a better understanding of the philosophy of integrative medicine in western countries (Adams et al., 2007; Broom et al., 2007), there is a dearth of such information in Africa. This is rather astounding as, in line with the importance of studying the integration of CAM and modern medicine in Western/developed countries where modern medicine is accessible to and affordable by the majority of people, greater emphasis and research effort might have been expected to focus on Africa where the majority of people depend on traditional medicine. Indeed, it could be argued that people from developing countries and particularly those in rural areas have the right to demand and ask the state government to invest in researching traditional medicine so that people are provided with efficacious and safe medicine. This can be carried out by utilizing a Negotiated Order Theory framework.

References

1. Abbott R, Hui K, Hays R, Mandel J, Goldstein M, Winegarden B, Glaser D, Brunton L. (2011) Medical Student Attitudes toward Complementary, Alternative and Integrative Medicine. Hindawi Publishing Corporation Evidence-Based Complementary and Alternative Medicine, Article ID 985243, 14 pages doi:10.1093/ecam/nep195.
2. Abdel- Malek, A. (1967) Sociologie du développement national : Problèmes de Conceptualisation, *Révée de L’Institut de Sociologie* 2:249-264.
3. Abdullahi AA. (2011) Trends and challenges of traditional medicine in Africa. *African Journal of Traditional, Complementary and Alternative Medicine*, 8(Suppl.): 115–123, accessed 3 September 2013).
4. Adams, J. (2003) ‘Demarcating the medical/nonmedical border: Occupational boundary-work within GPs accounts of their integrative medicine’ in Tovey, P.; Easthope, G. and Adams, J. (eds) *The Mainstreaming of Complementary and Alternative Medicine* Routledge: London, pp. 140-155.
5. Adams, J.; Hollenberg, D.; Lui, C.; and Broom, A. (2009) ‘Contextualizing integration: A critical social science approach to integrative health care’ *Journal of Manipulative and Physiological Therapeutics* 32(9): 792-798.
6. Agar M.H (1996) *The Professional Stranger: An Informal Introduction to Ethnography* 2nd Revised ed. Edition, Academic Press.
7. Allanson, A. (2014) *Understanding Coach Educators’ Experiences of Everyday Practice*. Unpublished Dissertation, School of Life Sciences, Hull University, UK

8. Anderson, R. (1999). A case study in integrative medicine: Alternative theories and the language of biomedicine. *The Journal of Alternative and Complementary Medicine*, 5(2), 165–173.
9. Armstrong D (2002) Theoretical tensions in biopsychosocial medicine. In: Marks D, Murray M, Evans B and Willig C (eds) *The Health Psychology Reader*. London: SAGE, pp. 66–76.
10. Asante E, Avornyo R (2013) Enhancing Healthcare System in Ghana through Integration of Traditional Medicine *Journal of Sociological Research* ISSN 1948-5468 Vol. 4, No.2
11. Ashforth A, (1996) 'Of secrecy and the commonplace: witchcraft and power in Soweto', *Social Research* 63, 4: 1183-1234.
12. Ashforth A, (2001) Witchcraft, development and paranoia in Cameroon: Interactions between popular, academic and discourse: In: Moore H L, Sander T. eds, *Magical Interpretations and Material realities: Modernity, Witchcraft, and the Occult in Post-Colonial Africa*. New York: Routledge, pp.
13. Atkinson, P. (2015) *For Ethnography*. London. Sage.
14. Awodele O, Agbaje E, Ogunkeye F, Kolapo A, Awodele D. (2011) Towards integrating traditional medicine (TM) into National Health Care Scheme (NHCS): Assessment of TM practitioners' disposition in Lagos, Nigeria. *Journal of Herbal Medicine*; 1: 3-4: 90-94.
15. Baer HA. (1992) The potential rejuvenation of American naturopathy as a consequence of the holistic health movement. *Med Anthropol*; 13:369–383.
16. Baer, H, and Coulter, I. (2008) *Towards an integrative medicine: Merging alternative therapies with biomedicine* AltaMira Press: walnut Creek, CA

17. Baer, H.A (2004) Towards an integrative medicine: Merging alternative therapies with biomedicine Altamira Press: Walnut Creek, CA
18. Baer, H.A., Singer, M. and Johnsen, J.H (1986) Towards a critical medical anthropology. *Social Science and Medicine*, 23 (2), 95-8
19. Baer, HA. (2005) Towards an integrative medicine: merging alternative therapies with biomedicine. Lanham: AltaMira Press;
20. Balshem H, Helfand M, Schunemann H, Oxman AA, Kunz R, Brozek J, et al. (2011) GRADE guidelines 3: Rating the quality of the evidence - introduction. *Journal of Clinical Epidemiology* 64(401):406.
21. Bamidele, J. O. Adebimpe, W. O. and Oladele, E. A. (2009). 'Knowledge, Attitude and Use of Alternative Medical Therapy amongst Urban Residents of Osun State, Southwestern Nigeria'. *African Journal of Traditional and Complementary/ Alternative Medicine*, 6 (3): 281 – 288.
22. Banerji, D. (1981) 'The place of Indigenous and western systems of medicine in health services of India' *Social Science and Medicine* 15A: 109-114
23. Bannerman R H et al. (eds) (1993) Traditional medicine and health coverage. WHO. Geneva
24. Barnes J. (1998a) Homeopathy. *Pharmaceut J*; 260:492–497.
25. Barrett B. (2003) Alternative, complementary, and conventional medicine: is integration upon us? *J Altern Complement Med*; 9:417-27.
26. Barrett B, Lucille M, Scheder J, Appelbaum D, Plane B, Blustein J, Maberry R, Capperino C. (2004) What Complementary and Alternative Medicine

Practitioners Say About Health and Health Care. *Ann Fam Med*; 2:253-259.
DOI: 10.1370/afm.81.

27. Barstow A. (1988) On Studying Witchcraft as Women's History: A Historiography of the European Witch Persecutions. *Journal of Feminist Studies in Religion*. 4; 2: 7-19.
28. Bastian M L. Witchcraft and Sceptism by Proxy: (2001) Pentecostalism and laughter in Urban Malawi in Moore H L, Sander T. eds, *Magical Interpretations and Material Realities: Modernity, Witchcraft, and the Occult in Post-Colonial Africa*. New York: Routledge.
29. Battiste, M (2005) 'Post-colonial remedies for serving Indigenous knowledge and heritage' in Tripp, P. and Muzzin, L. (eds) *Teaching as activism: Equity meets environmentalism* McGill-Queen's University Press: Montreal, Quebec; Ithaca, NY.
30. Baxter J O., Brown L. (2013) Complementary medicine use in chronic disease: What is the evidence? *Crisis Research Roundup* Issue 26. ISSN 1839-6348
31. Beck A. (1979) The Traditional Healer in Tanzania. *A Journal of Opinion*. 9; 3:2-5.
32. Becker, H. (1998) *Tricks of the Trade: How to Think about Your Research While You're Doing It*. Chicago: The University of Chicago Press.
33. Bell, I.R.; Caspi, O.; Schwartz, G.E.R.; Grant, K.L.; Gaudet, T. W.; Rychener, D.; Maizes, V., Weil, A. (2002) 'Integrative medicine and systemic outcomes research' *Archives of Internal medicine* 162:133-140.

34. Ben-Arye E, Karkabi K, Karkabi S, Keshet Y, Haddad M, Frenkel M. (2009) Attitudes toward integration of complementary and alternative medicine in primary care: Perspectives of patients, physicians and complementary practitioners. *Patient Education and Counseling*, 70: 395–402.

35. Ben-Arye E, Karkabi K., Karkabi S., Keshet Y., Haddad M., Frenkel M. (2009) Attitudes of Arab and Jewish patients toward integration of complementary medicine in primary care clinics in Israel: A cross-cultural study. *Social Science & Medicine* 68; 177–182.

36. Benjamin, P.J.; Phillips, R.; Warren, D.; Salveson, C.; Hammerschlag, R.; Snider, P.; Hass, M.; and ACCAHC/OCCIM Task Force (2007) 'Response to a proposal an integrative medicine curriculum' *The Journal of Alternative and Complementary Medicine* 13(9):1021-1033.

37. Berger, P.L. and Luckmann, T (1967) *The Social Construction of Reality*. London: Allen Lane

38. Bernstein, B. and Grasso, T. (2001) Prevalence of complementary and alternative medicine use in cancer patients, *Oncology*, 15, 10, 1272–83.

39. Bhargava, V, Gong-Soog H and Catherine M. (2012). 'Use of Practitioner-based and Self-care Complementary and Alternative Medicine in the United States: A Demand for Health Perspective.' *Family and Consumer Sciences: Research Journal* 41(1): 18–35.

40. Bierlich B. (1995) Notions and Treatment of Guinea Worm in Northern Ghana. *Social Science and Medicine* 41, 501-509.

41. Blumer, H. (1969) *Symbolic Interactionism: Perspective and Method*. Englewood Cliffs: Prentice-Hall.

42. Bodeker G, Kabatesi D, King R, Homsy J. (2000) Regional task force on traditional medicine and AIDS. *The Lancet*, 355:1284.
43. Bogaert V. K (2000) Ethical considerations in African traditional medicine: a response to Nyika. *Developing World Bioethics*. 7: 1 pp 35–40.
44. Boje, D., Whetten, D. (1981). Effects of organizational strategies and contextual constraints on centrality and attributions of influence in inter-organizational networks. *Administrative Science Quarterly*, 26, 378-395.
45. Bombardieri D, Easthope G (2000) Convergence between Orthodox and Alternative Medicine: A Theoretical Elaboration and Empirical Test. *health: 4(4): 479–494.*
46. Bongmba E. K (1998) Toward a hermeneutic of Wimbum Tfu, *African Studies Review* 41, 3: 165-191.
47. Boon H, Verhoef M, O'Hara D, Findlay B: (2004) From parallel practice to integrative health care: a conceptual framework. *BMC Health Serv Res*, 4:15.
48. Boon HS, Kachan N: 2008 Integrative medicine: a tale of two clinics. *BMC Complement Altern Med*, 8:32.
49. Boyatzis RE (1998) *Transforming Qualitative Information*. Sage: Cleveland
50. Brain, J. L., (1982), "Witchcraft and development," *African Affairs* Elias, Norbert, *iiber den Prozea der Zivilisation* - (London), Vol. 81 pp. 371-384.
51. Brandt, A.M. (1991) Emerging themes in the history of medicine. *Milbank Memorial Quarterly*, 69 (2). 199-214 Brandt, A.M. 01991] Emerging themes in the history of medicine. *Milbank Memorial Quarterly*, 69 (2). 199-21

52. Braun, V. and Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101. ISSN 1478-0887
53. Broom, G. M., Casey, S., & Ritchey, J. (2000). Concept and theory of organization-public relationships. In J. A. Ledingham & S. D. Bruning (Eds.), *Public relations as relationship management: A relational approach to the study and practice of public relations* (pp. 3-22). Mahwah, NJ: Lawrence Erlbaum.
54. Broom A. (2006) Reflections on the centrality of power in medical sociology: an empirical test and theoretical elaboration. *Health Soc Rev*; 15:496-505.
55. Broom A; Tovey P. (2007). Therapeutic pluralism? Evidence, power and legitimacy in UK cancer services: *Sociology of Health & Illness* 29(4)
56. Broom, A and Philip T. (2008). 'Exploring the Temporal Dimension in Cancer Patients' Experiences of Non-Biomedical Therapeutics.' *Qualitative Health Research* 18(12): 1650–61.
57. Broom, A. (2009). 'Intuition, Subjectivity, and Le Bricoleur: Cancer Patients' Accounts of Negotiating Therapeutic Options.' *Qualitative Health Research* 19: 1050–9. *care. Explore (NY)*.;4:42-47.
58. Bryman, A. (2008), *Social Research Methods*, Oxford University Press.
59. Burrell, G., & Morgan, G. (1992). *Sociological Paradigms and Organisational Analysis*. Aldershot: Ashgate.
60. Burgess, R.G. (1984). *In the Field: An Introduction to Field Research*. London: Unwin Hyman.

61. Burman, E. and Parker I. (1993) *Discourse Analytic Research: repertoires and readings of texts in action*, London: Routledge.
62. Burnett A, Baggaley R, Ndovi-Macmillan, Sulwe J, Hang'Omba B, Bennett J. (1999) Caring for people with HIV in Zambia: are traditional healers and formal health workers willing to work together? *AIDS Care*; 11:481-491.
63. Burr, V. (1995) *An Introduction to Social Constructionism*. Routledge, London & New York.
64. Busia K., Kasilo O. (2010) Collaboration between Tradition Health Practitioners and Conventional Health Practitioners: Some Countries Experiences. Special Issue 1 4 • Decade of African Traditional Medicine, 2001-2010.
65. Cant, S.; and Sharma, U. (1999) *A new medical pluralism? Alternative medicine, doctors, patients and the state* UCL Press: London
66. Carson CF, Riley TV. (1995) Toxicity of the essential oil of *Melaleuca alternifolia* or tea tree oil. *J Toxicol Clin Toxicol*; 33:193–4.
67. Chacko, E. (2003). 'Culture and Therapy: Complementary Strategies for the Treatment of Type-2 Diabetes in an Urban Setting in Kerala, India.' *Social Science & Medicine* 56(5): 1087–98.
68. Charmaz K (2006) *Constructing Grounded Theory: A practical guide through qualitative analysis*. Sage Publications
69. Chinweizu, I (1987) *Decolonising the African Mind*. Sundoor Publication
70. Comaroff, J.L. Comaroff, J (2006). 'Law and disorder in the post colony: an introduction,' in J. Comaroff and J.L. Comaroff (eds), *Law and Disorder in the Post*

- colony. Chicago: Chicago University Press.
71. Comaroff, Jean & Comaroff, John (1999a). "Occult economies and the violence of abstraction: Notes from the South African post colony." *American Ethnologist* 26 (2): 279-303.
 72. Connor, M. Dexter, G. Walsh, M. (1984) *Listening and Responding* York. The College of Ripon and York St John.
 73. Connor, L. H. (2004). 'Relief, Risk and Renewal: Mixed Therapy Regimens in an Australian Suburb.' *Social Science & Medicine* 59(8): 1695–705.
 74. Corbin, J. and Strauss, A. (2008), *Basics of Qualitative Research* 3e London, Sage.
 75. Coulter, I. (2003) 'Integration and paradigm clash: The practical difficulties of integrative medicine' in Tovey, P.; Easthope, G. and Adams, J. (eds) *The Mainstreaming of Complementary and Alternative Medicine* Routledge: London, pp. 103-120.
 76. Coulter I. (2004) *Integration and paradigm clash: the practical difficulties of integrative medicine*. In: Tovey P, Easthope G, Adams J, editors. *The mainstreaming of complementary and alternative medicine: studies in social context*. London: Routledge; p. 103-22.
 77. Coulter I, Willis EM, (2004). The rise and rise of complementary and alternative medicine: a sociological perspective. *Med J Aust*, 180:587-589.
 78. Coulter I (2005) *Integration and Paradigm Clash*. In: Tovey P, Easthope G, and Adams J (eds) *Mainstreaming of Complementary and Alternative Medicine*. London: Routledge, 103–122.

79. Coulter I, Willis E, (2007); Explaining the growth of complementary and alternative medicine. *Health Soc Rev*; 16: 214-25.
80. Cresswell, J.W. (1994), *Research Design*. London: Sage Publications.
81. Creswell J (2003) *Research Designs Qualitative and Quantitative Approaches*. Sage Publications.
82. Crotty M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage Publications.
83. Crozier M, Friedberg E (1980) *Actors and Systems: The Politics of Collective Action*. Chicago: The University of Chicago Press.
84. Dacher ES. (1995) A systems theory approach to an expanded medical model: a challenge for biomedicine. *J Altern Complement Med*; 1:187-96.
85. Dei, G.J.S.; Hall, B.; and Rosenberg, D. (2000) *Indigenous knowledges in global context: Multiple readings of the world*, University of Toronto Press, ON, pp.3-17
86. Denzin K. N (1992) *Symbolic Interactionism and Cultural Studies: The Politics of Interpretation*. Cambridge, UK: Basil Blackwell
87. Denzin K. N (2001) *Interpretative Interactionism* (2nd Ed) London, Sage
88. Denzin, N.K., & Lincoln, Y.S. (2005). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The sage handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage
89. De'Onis, M., Dewey, K., Borghi, E., Onyango, A., Blössner, M., Daelmans, B., Piwoz, E., Branca, F. (2013) The World Health Organization's global target for reducing childhood stunting by 2025: rationale and proposed actions. *Maternal and Child Nutrition*. 9 (Suppl. 2), pp. 6–26

90. Dey I. (1993). *Qualitative Data Analysis: A User-Friendly Guide for Social Scientists*. Routledge. London and New York.
91. Dokko G, Nigam A, Rosenkopf L. (2012) Keeping Steady as She Goes: A Negotiated Order Perspective on Technological Evolution DOI: 10.1177/0170840612443624 33: 681
92. Douglas, J. D. (1985), *Creative Interviewing*. Beverly Hills, California, Sage Publications.
93. Draper J (2000) *Fathers in the Making: Men, Bodies and Babies*. Unpublished Dissertation, School of Social Sciences, Hull University, UK
94. Edelman D, Oddone EZ, Liebowitz RS, Yancy WS, Olsen MK, Jeffreys AS, Moon SD, Harris AC, Smith LL, Quillian-Wolever RE, Gaudet TW. (2006) A Multidimensional Integrative Medicine Intervention to Improve Cardiovascular Risk. *Journal of General Internal Medicine*; 21: 728-734.
95. Eisenberg DM, Davis RB, Ettner SL, Appel S, Wilkey S, Van Rompay M, Kessler RC. (1998) Trends in alternative medicine use in the United States, 1990–1997. *JAMA*; 280:1569–1575.
96. Elvin-Lewis M. (2001) Should we be concerned about herbal remedies? *J Ethnopharmacol*; 75:141–64.
97. *Emerging Confluences*, in Denzin N. K and Lincoln Y. S (eds.) (2000), *Handbook of Qualitative Research*, 2nd Edition, pp. 163-188 Thousand Oaks: Sage Publications.
98. Enosi S (2010) *History of Education*. African Virtual University
99. Epstein S.S (1978) *The politics of Cancer*. San Francisco: Sierra Club Books.

100. Eran Ben-Arye, Schiff E, Steiner M, and Silbermann M (2010) Wheatgrass in Afifi's Garden: Sprouting Integrative Oncology Collaborations in the Middle East. *Journal of Clinical Oncology* 10.1200/JCO.33.4532
101. Erinosh, O. A. (2006). *Health Sociology for Universities, Colleges and Health Related Institutions*. Ibadan: Abuja: Bulwark Consult. Reprint.
102. Ernst E, Eisenberg DM, Pittler MH, Stevinson C, White A. (2001) *The Desktop Guide to Complementary and Alternative Medicine: An Evidence-Based Approach*. Edinburgh: Mosby.
103. Faas, N. (2001) *Integrating Complementary Medicine into Health Systems* Gaithersburg: Aspen Publisher.
104. Fadlon, J. (2004b). 'Unrest in Utopia: Israeli Patients' Dissatisfaction with Non-Conventional Medicine.' *Social Science & Medicine* 58(12): 2421–9.
105. Fadlon, J. (2005) *Negotiating the Holistic Turn: The Domestication of Alternative Medicine* State University of New York: Albany NY.
106. Federici S (2010) Women, Witch-Hunting and Enclosures in Africa Today. *Sozial.Geschichte Online* 3 (2010), S. 10–27
107. Fetterman, D. (2010) *Ethnography; Step-by-step*. Applied Social Research Methods Series, volume 17. London. Sage.
108. Finlay, L. (2003), *Through the Looking Glass: Inter-subjectivity and Hermeneutic Reflection* in L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 105-119), Oxford, England: Blackwell.
109. Flick, U. (2006), *An introduction to qualitative research*, 2nd ed, London: SAGE

110. Foucault M. (1973) *The Birth of the Clinic: an archaeology of medical perception*. London: Routledge.
111. Foucault, M. (1979) *The History of Sexuality, Volume 1: An Introduction*. London: Penguin.
112. Frank, R.; and Stollberg, G. (2004) 'Medical acupuncture in Germany: Patterns of consumerism among physicians and patients' *Sociology of Health and Illness* 26(3):351-372.
113. Frass M et al. (2012) Use and Acceptance of Complementary and Alternative Medicine Among the General Population and Medical Personnel: A Systematic Review. *The Ochsner Journal*, 12(1): 45-56.
114. Frazer J. (1959) *The Golden Bough*, Garden City: Anchor Books.
115. Freidson E. (1970) *Professional Dominance: The Social Structure of Medical Care*. New York: Atherton Press.
116. Frenkel M, Arye E, Carlson C, Sierpina V. (2008) Integrating Complementary and Alternative Medicine into conventional Primary care: The Patient Perspective. *Explore*; 4:178-186. © Elsevier Inc.
117. Fugh-Berman A. (2000) Herb-Drug Interactions. *The Lancet* 355 (9198): 134-8.
118. Gale N (2014). *The Sociology of Traditional, Complementary and Alternative Medicine* *Sociology Compass* 8(6): 805–822.
119. Geest S (1997) Is there a role of traditional medicine in basic health service in Africa? A plea for a community perspective. *Tropical Medicine & International Health* vol 2 No 9 pp 903-911

120. Geertz, C. (1993) Religion as a cultural system. In: The interpretation of cultures: selected essays, Geertz, Clifford ed, pp.87-125. Fontana Press.
121. Gellejah R S, Mbano S J (2010) Health Care Usage Under Liberalized Markets. Mzumbe University Press
122. Gerson, E.M (1976) The social character of illness: deviance or politics? Social Science and medicine, 10.219-24
123. Gerrish K, Lacey A (2010) The Research Process in Nursing, (5th ed) Wiley-Blackwell.
124. Geschiere P (2003) Witchcraft as the dark Side of Kinship, Etnofoor XV (1): 43-61.
125. Gibson W, Brown A (2009) Working with Qualitative Data. Sage Publication.
126. Giddens A. (1989) A reply to my critics. In: Held D, Thompson JB, editors. Social theory and modern societies: Anthony Giddens and his critics. Cambridge: Cambridge University Press, 249-301.
127. Glaser BG (1994) More Grounded Theory Methodology: A Reader. Mill Valley, CA: Sociology Press.
128. Gray, R, E., Fitch, M., Greenberg, M., Voros, P., Douglas, M.S., Labrecque, M. and Chart, P. (1997). Physician perspective on unconventional cancer therapies. Journal of Palliative Care 13(2), 14-21
129. Gray N. A (2000) The legal history of witchcraft in colonial Ghana: Akyem Abuakwa, 1913-1943, PhD dissertation submitted to Columbia University.

130. Green, Gill, et al. (2006). “‘We Are Not Completely Westernised’: Dual Medical Systems and Pathways to Health Care Among Chinese Migrant Women in England.’ *Social Science & Medicine* 62(6): 1498–509.
131. Green, M (1997). ‘Witchcraft suppression practices and movements: public politics and the logic of purification’, *Comparative Studies in Society and History*, 39, 319-345.
132. Greenwood, S. (2000) *Magic, Witchcraft and the Otherworld: An Anthropology*, Oxford: Berg.
133. Gubrium, J. F., Holstein, J. A. (1997) *The New Language of Qualitative Method*. New York: Oxford University Press.
134. Gurib-Fakim A (2006). Medicinal plants: traditions of yesterday and drugs of tomorrow. *Mol Aspects Med* 27: 1 - 93.
135. Gurib-Fakim A. and M.F. Mahomoodally. 2013. African Flora as Potential Sources of Medicinal Plants – Towards the Chemotherapy of Major Parasitic and Other Infectious Diseases- A Review. *Jordan J of Biological Sciences*. 6(2); 77-84.
136. Gyasi R, Tagoe-Darko E, Mensah C. (2013) Use of Traditional Medicine by HIV/AIDS Patients in Kumasi Metropolis, Ghana: A Cross-sectional Survey. *American International Journal of Contemporary Research*. 3: 4.
137. Hahn, R. (1995) ‘Biomedicine as a cultural system’, in Hahn RA (ed) *Sickness and healing: An anthropological perspective* Yale University Press: New Haven, CT; London, pp.132-172.
138. Hahnel, R. (1999), *Panic Rules: everything you need to know about the global economy* Cambridge: South End Press.

139. Hammersley, M.; and Atkinson, P. (1995) *Ethnography* (2nd ed) Routledge: London.
140. Harding, S. (1987) Is there a feminist method? In Harding, S. (ed) *Feminism and Methodology Social Science Issues* Milton Keynes Open University Press
141. Harding, S.G. (1998) *Is Science multicultural? Post-colonialism, Feminisms and Epistemologies* Science: Bloomington & Indianapolis: Indiana University Press
142. Harding J. (2013) *Qualitative Data Analysis from start to finish*. London. Sage.
143. Harries J. (2010) *Witchcraft, Culture, and Theology in African Development* African Nebula, Issue 2
144. Hart, N. (1982) Is capitalism bad for your health? *British Journal of Sociology*, 33 (3), 435-43
145. Haug MR. (1998) A re-examination of the hypothesis of physician de-professionalization. *Milbank Q*; 66:48-56.
146. Hayes N. (1997) *Doing Qualitative Research in Psychology*. Psychology Press
147. Henderson A. M. and Parsons, T. London: Oxford University Press
148. Held, D., McGrew, A., Goldblatt, D., Perraton, J. (1999). *Contents and Introduction in Global Transformations: Politics, Economics and Culture*. Stanford University Press, 1-31.
149. Hepeng J. (2005) *Chinese Medicine set for Protection*. Science and Development Network. March 2015 [<http://www.scidev.net/en/news/chinese-medicine-set-for-rotection.html>]

150. Hesse-Biber S., Leavy P. (2006) *The Practice of Qualitative Research*. London: Sage.
151. Hoenders H., Appelo M., De Jong J. (2012) Integrative Medicine: A Bridge between Biomedicine and Alternative Medicine Fitting the Spirit of the Age. *Sociology Mind*. 2; 4: 441-446.
152. Hollenberg D. (2007) How do private cam therapies affect integrative health care settings in a publicly funded health care system? *Complement Integr Med*; 4:1-16.
153. Hollenberg, D. (2006). 'Uncharted Ground: Patterns of Professional Interaction Among Complementary/Alternative and Biomedical Practitioners in Integrative Health Care Settings.' *Social Science & Medicine* 62(3): 731–44.
154. Hollenberg, D. (2010) Epistemological challenges to integrative medicine: An anti – Colonial perspective on the combination of complementary/alternative medicine with biomedicine. *Health Sociology Review*. 19(1): 34-56
155. Holliday, K. V. (2008). "“Folk” or “Traditional” Versus “Complementary” and “Alternative” Medicine: Constructing Latino/a Health and Illness Through Biomedical Labeling.' *Latino Studies* 6(4): 398–417.
156. Hollis M, Lukes S, (1982) editors. *Rationality and relativism*. Oxford: Blackwell.
157. Holloway, I. and Wheeler, S. (2002), *Qualitative Research in Nursing*, 2nd Edition, Oxford: Blackwell.
158. Holloway I, Todres L (2010) *Ethnography*, In Gerrish K and Lacey A ed; *The Research Process in Nursing* 6th edition. Wiley- Blackwell, pp 165-176.

159. Horriga BJ. (2003) *Voices of integrative medicine: conversations and encounters*. St. Louis: Churchill Livingstone.
160. Howell, K. (2013). *An introduction to the philosophy of methodology*. Los Angeles, CA: Sage.
161. Hsu E. (2002) "The medicine from China has rapid effects": Chinese Medicine Patients in Tanzania", *Anthropology & Medicine*, 9(3): 291-313.
162. Hsu E. (2006) Reflections on the 'Discovery' of the Antimalarial Qinghao. In J. K. Aronson, ed. *Clinical Pharmacology: Past, Present and Future*. *British Journal of Clinical Pharmacology* 61(6):666–679.
163. Hsu, E. (2009) Wonders of the Exotic: Chinese Formula Medicines on the East African Coast. In K. Larsen, ed. *Knowledge, Renewal and Religion: Repositioning and Changing Ideological and Material Circumstances among the Swahili on the East African Coast*. Uppsala: Nordic Africa Institute, Pp. 280–299.
164. Illich I. (1976) *Medical Nemesis: The Expropriation of Health*. New York: Pantheon Books.
165. Joerges B, Nowotny H, (2003). *Social studies of science and technology: looking back, ahead*. London: Springer.
166. Jordan, B. (1997) *Authoritative Knowledge and Its Construction in Davis-Floyd, R. E. Sargent, C. F. (eds) Childbirth and Authoritative Knowledge Cross Cultural Perspectives* Berkeley University of California Press 55-79.

167. Kaboru B, Falkenberg T, Ndubani P, Höjer B, Vongo R, Brugha R, Faxelid E. (2006a) Can biomedical and traditional health care providers work together? Zambian practitioner experience and attitudes towards collaboration in relation to STI and HIV/AIDS Care: a cross sectional study *Human Resources for Health* 4:16.
168. Kaboru B B, Falkenberg T, Ndulo J, Muchimba M, Solo K, Faxelid E. (2006b). Communities' views on prerequisites for collaboration between modern and traditional health sectors in relation to STI/HIV/AIDS care in Zambia. *Health Policy*. Oct;78(2-3):330-9.
169. Kaptchuk TJ, Eisenberg DM. (1998) Chiropractic: origins, controversies, and contributions. *Arch Intern Med*; 158:2215–2224.
170. Kayombo E J, Uiso F C, Mbwanbo Z H, Mahunnah R L, Moshi M J & Mgonda Y H. (2007) Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania: *Journal of Ethnobiology and Ethnomedicine*, 3(6).
171. Kelner M, Wellman B. (1997) Health care and consumer choice: medical and alternative therapies. *Soc Sci Med*; 45:203-12.
172. Kelner M, Wellman B, Welsh S, Boon H. (2006) How far can complementary and alternative medicine go? The case of chiropractic and homeopathy. *Soc Sci Med*;63: 2617-27.
173. Keshet Y, Ben-Ayre E, Schiff E. (2012) Can holism be practiced in a biomedical setting? a qualitative study of the integration of complementary medicine to a surgical department. *Health*, 16:585–601.

174. Kim, J (2006). "Beyond Paradigm: Making Transcultural Connections in a Scientific Translation of Acupuncture." *Social Science & Medicine* 62, 12: 2960-72
175. Kligler, B.; Maises, V, Schachter, S.; Park, C. M.; Gaudet T.; Benn, R.; Lee, R; and Remen, R.N. (2004) 'Core competencies in integrative medicine for medical school curricular: A proposal' *Academic Medicine* 79(6):521-531
176. Kvale, S. (1996), *Interviews: an introduction to qualitative research interviewing*, London: Sage.
177. Lather, P. (1988) "Feminist Perspectives on Empowering Research Methodologies," *Women's Studies International Forum*, 11(6), 569-581. Reprinted in *Debates and Issues in Feminist Research and Pedagogy*, edited by Janet Holland and Maud Blair (Clevedon England: Multilingual Matters Ltd., 1995, 292-307).
178. Lazarou J, Pomeranz BH, Corey PN. Incidence of adverse drug reactions in hospitalized patients: a meta-analysis of prospective studies. *JAMA*. 279:1200-1205.
179. Leakey, M. D. (1971) *Olduvai Gorge* Vol. 3 London and New York. Cambridge University Press.
180. Leckridge B. (2004) The future of Complementary and Alternative medicine. 10(2):413-16.
181. Leslie, C. (1980). Medical pluralism in world perspective. *Social Science and Medicine*, 14B, 191-195
182. Lewis J, Marjoribanks T, Pirotta M. (2003) Changing professions: general practitioners' perceptions of autonomy at the front line. *J Sociol*. 39:44-61.

183. Lewis, J. (2003), Design Issues in Ritchie, J., and Lewis, J (eds), *Qualitative Research Practice: a guide for social science students and researchers*. Pp. 47-76, London: Sage Publications.
184. Likupe, G. (2011) *Motivation, Migration and Experiences of Black African Nurses in the United Kingdom*. Unpublished Dissertation, Faculty of Health and Social Care, Hull University, UK
185. Lincoln, YS. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.
186. Lincoln, Y. S., and Guba, E., G. (2000), *Paradigmatic Controversies, Contradictions and*
187. Little M, et al. (2007). 'Pragmatic pluralism: Mutual tolerance of contested understandings between orthodox and alternative practitioners in autologous stem cell transplantation.' *Social Science & Medicine* 64(7): 1512–23.
188. Lukes S. (2005) *Power: a radical view*. 2nd ed. London: Palgrave Macmillan.
189. Lupton D. (1994) *Medicine as Culture: Illness, Disease and the Body in Western Societies*, London: SAGE Publications.
190. Madiba S. (2010) Are biomedicine health practitioners ready to collaborate with traditional health practitioners in HIV and AIDS care in Tutume sub district of Botswana. *Afr. J. Trad. CAM* 7 (3): 219 – 224.
191. Madriz, E. (2000). Focus groups in feminist research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 835-850). Thousand Oaks, CA: Sage.
192. Maha N, Shaw A. (2007) "Academic doctors' views of complementary and alternative medicine (CAM) and its role within the NHS: an exploratory qualitative study," *BMC Complementary and Alternative Medicine*, 7;17.

193. Mahunnah LA, Uiso FC, Kayombo EJ, (2012) Documentary of Traditional Medicine in Tanzania: Dar es Salaam University Press.
194. Maines, D. R. (1982). In search of mesostructure: Studies in the negotiated order. *Urban Life*, 11, 267–279.
195. Malinowski B. (1992) *Magic, Science and Religion and Other Essays*. Waveland Pr. Inc.
196. Manderson, L. (1998) Applying medical anthropology in the control of infectious disease. *Medical Anthropology and infectious disease control*; 3(12): 1020-7.
197. Mann D, Gaylord S, Norton S. (2004) Moving toward integrative care: rationales, models, and steps for conventional-care providers. *Complement Health Pract Rev*. 9:155-72.
198. Mannheim, K. (1960). *Ideology of Utopia*, London: Routledge (First Published 1936).
199. Markula, P., Silk, M. (2011) *Qualitative Research for Physical Culture*. Palgrave- Macmillan UK.
200. Marshall, M. N. (1996), Sampling for Qualitative Research. *Family Practice* Vol.13 (6), 522- 525.
201. Marsland R (2006). Community Participation the Tanzanian Way: Conceptual Contiguity or Power Struggle? *Oxford Development Studies* 34: 1, 65-79.

202. Marsland R (2007). The Modern Traditional Healer: Locating 'Hybridity' in Modern Traditional Medicine, Southern Tanzania: *Journal of Southern African Studies*. 33(4):751-765.
203. Martin, E. (1990) *Science and Women's Bodies: Forms of Anthropological Knowledge* in Jacobus, M. (ed) *Body Politics: Women, Literature and the Discourse of Science* New York Routledge Chapman Hall.
204. Mckee, J (1988) Holistic health and critics of western medicine. *Social science and Medicine*, 26 (8), 775-84
205. McKee, L. & O'Brien, M. (1983) Interviewing men: taking gender seriously, in: E. Gamarnikov, D. Morgan, J. Purvis & D Taylorson (Eds) *The Public and the Private*, pp. 147–161 (London: Heinemann)
206. Meeker WC. (2000) Public demand and the integration of complementary and alternative medicine in the US health care system. *J Manip Physiol Ther*; 23:123–126.
207. Melley, T. (2000) *Empire of Conspiracy: The Culture of Paranoia in Postwar America*, Ithaca: Cornell University Press.
208. Micozzi MS, (2006) editor. *Fundamentals of complementary and integrative medicine*. 3rd ed. St. Louis: Saunders Elsevier.
209. Miles M., Huberman A. (1994) *Qualitative Data Analysis*, 2nd Edn. London: Sage
210. Miller, J., Glassner, B. (1997). The inside and the outside: finding realities in interviews. In Silverman, D. (ed): *Qualitative Research: Theory, method and practice*. 98-11. Sage Publication.

211. Mizrachi N, Shuval JT: (2005), Between Formal and Enacted Policy: Changing the Contours of Boundaries. *Soc Sci Med* 60(7):1649-1660.
212. Mahomoodally F. (2013) Traditional Medicines in Africa: An Appraisal of Ten Potent African Medicinal Plants. *Evidence-Based Complementary and Alternative Medicine*, Article ID 617459, 14 pg.
213. Moore H L, Sander T. (2001) *Magical Interpretations and Material realities: Modernity, Witchcraft, and the Occult in Post-Colonial Africa: An Introduction*. New York: Routledge.
214. Morris, R.C (2000) *In the place of origin: Modernity and its Mediums in Northern Thailand*, Durham: Duke University Press.
215. Morse JM, Field PA (1996) *Nursing Research: The application of qualitative approaches*. Chapman and Hall, London
216. Mudimbe, V. Y. (1988) *The Invention of Africa: Gnosis, Philosophy, and the Order of Knowledge*, London: James Currey.
217. Mulkins AL, Eng. J, Verhoef MJ. (2005) Working towards a model of integrative health care: critical elements for an effective team. *Complement Ther Med*; 13:115-22.
218. Myklebust M, Pradhan EK, Gorenflo D. (2008) An integrative medicine patient care model and evaluation of its outcomes: the University of Michigan experience. *J Altern Complement Med*; 14:821-6.
219. Navarro, V. (1976) *Medicine under Capitalism*. New York: Prodist.
220. Nedrow, A. R, Heltkemper, M.; Frenkel, M.; Mann, D.; Wayne, P.; and Hughes, E. (2007) 'Collaborations between allopathic and complementary

medicine health professionals: Four initiatives' *Academic medicine* 82(10): 962-966

221. Neuman, W. L. (2000). *Social research methods: Qualitative and quantitative approaches* (4th ed.). Boston: Allyn and Bacon.
222. Ngokwey N. (1994) The President's Illnesses: Culture, Politics and Fetishism in Benin. *Culture, Medicine and Psychiatry* 18, 61-84.
223. Niehaus, I.A., (2001). *Witchcraft, power and politics. Exploring the occult in the South African Lowveld*. London: Pluto Press.
224. Nyamnjoh, F. B (2001) Delusions of development and the enrichment of witchcraft discourse in Cameroon; In Moore H L, Sander T (ed), *Magical Interpretations and Material realities: Modernity, Witchcraft, and the Occult in Post-Colonial Africa: An Introduction*. New York: Routledge, Pp: 28-49.
225. Nyika, A. (2006). Ethical and regulatory issues surrounding African traditional medicine in the context of HIV/AIDS. *Developing World Bioethics*, 7 (1), 25-34.
226. Parsons, T. (1987) *Illness and the role of physicians; a sociological perspective*, In J.D Stoeckle (ed.), *Encounters between Patients and Doctors: An anthropology*. Cambridge, Massachusetts: MIT Press, pp.147-56
227. Patton, M. Q. (1990), *Qualitative Research and methods*, (2nd Edition), Newbury Park: Sage Publications.
228. Patwardhan B. (2005) *Traditional medicine: modern approach for affordable global health*. Geneva, CIPIH study paper, (<http://www.who.int/intellectualproperty/studies/B.Patwardhan2.pdf>,
229. Peltzer K. and Khoza, L.B. (2002). Attitudes and knowledge of nurse practitioners toward traditional healing, faith healing and complementary

- medicine in the Northern Province of South Africa. *Curationis: The South African Journal of Nursing*, 25(1): 31-41.
230. Peu, MD., Troskie R., & Hatting SP. (2001) Attitude of community health nurses towards integration of traditional healers in Primary Health Care in North West Province. *Curations*. 25 (1) 49-55.
231. Pinkoane M., Greeff D., Koen D. (2008) Policy makers' perceptions and attitudes regarding incorporation of traditional healers into the national health care delivery system. *Curationis*. Dec;31(4):4-12.
232. Potts, R., Shipman, P. (1981) Cut marks made by stone tools on bones from Olduvai Gorge, Tanzania. *Nature* 291, 577 – 580.
233. Quarmyne M. (2011) Witchcraft: A Human Rights Conflict Between Customary/Traditional Laws and the Legal Protection of Women in Contemporary Sub-Saharan Africa. *William & Mary Journal of Women and the Law*. 17; 2.
234. Ragunathan M, Tadesse W, Tujuba R. (2010) A cross-sectional study on the perceptions and practices of modern and traditional health practitioners about traditional medicine in Dembia district, north western Ethiopia. *Pharmacogn Mag*: 6(21): 19-25.
235. Rakel D. (2008) The salutogenic-oriented session: creating space and time for healing in primary.
236. Rapport, N. (2000) 'Best of British': The New Anthropology of Britain *Anthropology Today* 16 (2) 20-22.
237. Rasmuseen, S. (1998) Ritual power and social tensions as moral discourse among the Taureg, *American Anthropologist* 100, 2: 458-468.

238. Reddy, S. (2002). 'Asian Medicine in America: The Ayurvedic Case.' *The Annals of the American Academy of Political and Social Science* 583(1): 97–121.
239. Richards L. (2009) *Handling Qualitative Data*, 2nd edn. London: Sage.
240. Ritchie J, Lewis J. (2003) *Qualitative Research Practice: A guide for social science students and researchers* London: Sage.
241. Roulston, K. (2001) Data Analysis and Theorizing as Ideology. *Qualitative Research*, 1(3), 279-302.
242. Russel, C., Schofield, T. (1986) *where It Hurts: An Introduction to Sociology for Health Worker*. Sydney: Allen and Unwin
243. Rutherford, B. (1999). 'To find an African witch: anthropology, modernity and witch-finding in North-west Zimbabwe', *Critique of Anthropology*, 19, 89-109. Teleology
244. Ryan, G., Russell, B. (2003) Techniques to identify themes. *Field Methods*, 15, 85-109.
245. Saad B, Azaizeh H, Abu-Hijleh G, Said O. (2006) Safety of Traditional Arab Herbal Medicine. *CAM* 2006;3 (4)433–439 doi:10.1093/ecam/nel058
246. Saldaña, J. (2009). *The coding manual for qualitative researchers*. London: Sage.
247. Sanders, T. (2001) *Save Our Skins: Adjustment, Morality and the Occult in Tanzania*. In Henrietta L. Moore and Todd Sanders, eds. *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*. London: Routledge, Pp. 160– 184.

248. Schwandt, T. A. (2003). Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In Denzin, N. and Lincoln, Y (Eds.), *The Landscape of Qualitative Research: Theories and issues*. (pp. 292-331). Thousand Oaks, CA: Sage.
249. Seale, C. (1999). *The quality of qualitative research*, London: Sage.
250. Seibold, C. Richards, L. Simon, D. (1994) Feminist method and qualitative research about midlife. *Journal of Advanced Nursing* 19 394-402.
251. Sharkey, S., Larsen, J. (2005) *Ethnographic exploration: Participation and Meaning in everyday Life*. In Immy Holloway eds. *Qualitative Research in Health Care*. London. Open University Press.
252. Shaw R. (2001) *Cannibal transformations: colonialism and commodification in the Sierra Leone hinterland*. In Henrietta L. Moore and Todd Sanders, eds. *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*. London: Routledge, Pp. 50-70.
253. Shiva, V. (1997) *Biopiracy: The plunder of nature and knowledge* South End Press: Boston, MA
254. Shuval JT, Mizrachi N: (2004), *Changing Boundaries: Modes of Co-existence of Alternative and Bio-Medicine*. *Qual Health Res* 14(5):675-690.
255. Shuval, J.T.; Mizrachi, N. and Smetannikov, E. (2002) 'Entering the well-guarded fortress: Alternative practitioners in hospital settings' *Social Science and Medicine* 55:1745-1755
256. Sierpina, V.S. (2001) *Integrative Health Care: Complementary and Alternative Therapies for the Whole Person* Davis: Philadelphia PA.

257. Silverman, D. (1993). *Interpreting qualitative data*. London: Sage Publication.
258. Smallwood, C. (2005) *The Role of Complementary and Alternative Medicine in the NHS: An Investigation into Potential Contribution of Mainstream Complementary Therapies to Healthcare in the UK*. NHS Report.
259. Smith, J.A. and Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.) *Qualitative Psychology: A practical guide to research methods*. London: Sage.
260. Smith, B., Papathomas, A., Martin-Ginis, K.A., & Latimer-Cheung, A.E. (2013). Understanding physical activity in spinal cord injury rehabilitation: Translating and communicating research through stories. *Disability & Rehabilitation*.
261. Soklaridis, S.; Kelner, M.; Love, R.; and Cassidy, J.D. (2009) 'The organizational support necessary for integrative health care (IHC): A Clinic for artists in a hospital setting' *Journal of Complementary and Integrative medicine* 6(1): Article. informahealthcare.com/doi/abs/10.3109/13561820902886287
262. Sparkes A (1998) Validity in qualitative inquiry and problems of criteria. Implications for sport psychology. *The Sport Psychologist*, 12, 363-386.
263. Sparkes A.C (2002) Autoethnography: Self-indulgence or something more? In A.P Bochner & C. Ellis (Eds). *Ethnographically speaking: Auto-Ethnography* (pp.209-232) Oxford: Altamira Press
264. Sparkes A.C & Smith B (2009) Judging the quality inquiry. *Criterionology and relativism in action. Psychology of sport & exercise*, 10, 491-497.
265. Sparkes A.C & Smith B (2013) *Qualitative research in sport, exercise & health science: From Process to Product*. London: Routledge

266. Spradley, J.P., (1980) Participant Observation. New York: Holt. Rinehart and Winston.
267. Stake, R. E. (1995). The art of case study research. Thousand Oaks, CA: SAGE Publications.
268. Strauss A., Schatzman L., Ehrich D., Bucher R., Sabshin M. (1973) 'The hospital and its negotiated order' in G. Salaman and K. Thomson (eds), People and Organizations. London: Longman.
269. Strauss, A., Schatzman, L., Bucher, R., Ehrich, D., Sabshin, M. (1963). The hospital and its negotiated order. In E. Friedson (Ed.), The hospital and modern society. New York: Free Press.
270. Strauss, A. (1978). Negotiations: Varieties, contexts, processes and social order. San Francisco: Jossey-Bass.
271. Strauss, A. and Corbin, J., (1998). Basics of qualitative research: techniques and procedures for developing grounded theory. 2nd ed. California: Sage Publication
272. Strong, P. (1979) Sociological imperialism and profession of medicine: a critical examination of the thesis of medical imperialism, social science and medicine, 13A, 199-215.
273. Stumpf SH, Shapiro SJ, Hardy ML. (2008) Divining integrative medicine. Evid Based Complement Alternat Med; 5:409-13.
274. Sundberg T, Halpin J, Warenmark A, Falkenberg T. (2007) Towards a model for integrative medicine in Swedish primary care. BMC Health Serv Res; 7:1-9.
275. Tambiah S, (1968). 'The Magical Power of Words', Man N.S., 3(2):175-208.

276. Tataryn DJ, Verhoef MJ. (2001) Combining conventional, complementary, and alternative health care: a vision of integration. In: Tataryn DJ, Verhoef MJ, ed. Advisory Group on Complementary and Alternative Health Care. Perspectives on complementary and alternative health care: a collection of papers prepared for Health Canada. Ottawa: Health Canada. Publications; VII.87-VII.109
277. Taylor, K. (2005) *Medicine of Revolution: Chinese Medicine in Early Communist China*. London: Routledge.
278. Theberge, N. (2008) 'The integration of chiropractors into healthcare teams: A case study from sport medicine'. *Sociology of Health and Illness* 30(1): 19-34.
279. Tindle, H., Davis, R., Philips, R., Eisenberg, D. (2005) Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Altern Ther Health Med*. 11(1):42-9.
280. Tovey P (1997) Autonomy and Practice: The Case of Complementary Practitioners in the UK. *International Journal for Quality in Health Care* 9(1): 55-59.
281. Tovey, Philip and Alex Broom. (2008). 'The Problematic Nature of Conflating Use and Advocacy in CAM Integration: Complexity and Differentiation in UK Cancer Patients' Views.' *Health Sociology Review* 17(4): 384-95.
282. Tsey K (1997) Traditional medicine in contemporary Ghana: a public policy analysis *Soc. Sci. Med.* Vol. 45, No. 7, pp. 1065-107.
283. Turner BS (2005) Foreword: The End of Scientific Medicine? In: Tovey P, Easthope G, and Adams J (eds) *Mainstreaming of Complementary and Alternative Medicine*. London: Routledge, xiii-xx.

284. UNAIDS: (2000) Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: a literature review. In UNAIDS Best Practice Collection Geneva, Joint United Nations Programme on AIDS.
285. Upvall MJ. (1992). Nursing perceptions with indigenous healers in Swaziland. *International Journal of Nursing Studies*. Feb;29 (1):27-36.
286. Vaka S, Stewart M, Foliaki S, Tu'itahi M. (2009) Walking Apart but Towards the Same Goal? The View and Practices of Tongan Traditional Healers and Western-Trained Tongan Mental Health Staff. *Pacific Health Dialog*. 15;1.
287. Van Dijk R. (2001) Witchcraft and scepticism by proxy: Pentecostalism and laughter in urban Malawi: In Henrietta L. Moore and Todd Sanders, eds. *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*. London: Routledge, Pp. 97– 117.
288. Van Haselen R., Reiber U., Nickel I., Jakob B., Fisher P. (2004) Providing Complementary and Alternative Medicine in primary care: the primary care workers' perspective. *Complementary Therapies in Medicine* (2004) 12, 6—16.
289. Viall J. (2005) Traditional healers join fight against Aids Independent. Online, 2013 [<http://www.iol.co.za>].
290. Vohra S, Feldman K, Johnston B, Waters K, Boon H. (2005) Integrating complementary and alternative medicine into academic medical centres: experience and perception of nine leading centres in North America. *BMC Health Serv Res*; 5:1-7.
291. Vyagusa DB, Mubyazi GM, Masatu M (2013). Involving traditional birth attendants in emergency obstetric care in Tanzania: Policy implications of a study of their knowledge and practices in Kigoma Rural District. *International Journal for Equity in Health*, 12(1): 83

292. Waldram J. (2000) The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues: *Medical Anthropology Quarterly* 14(4):603-62
293. Walugembe F (2009) Health care in Sub- Saharan Africa: Traditional Healers in Modern Sub-Saharan Africa health Care System; Lambert Academic Publishing AG & Co. KG Koln
294. Watanabe K, Matsuura K, Gao P, Hottenbacher L, Tokunaga H, Nishimura K, Imazu Y, Reissenweber H, Witt C (2011) Traditional Japanese Kampo Medicine: Clinical Research between Modernity and Traditional Medicine—The State of Research and Methodological Suggestions for the Future. Evidence-Based Complementary and Alternative Medicine Article ID 513842, 19 pages doi:10.1093/ecam/neq067
295. Weber, M. (1947), *The Theory of Social and Economic Organisation*, translated by A. M. Henderson, Talcott Parsons Review by: S. E. Thorne *The Yale Law Journal* Vol. 57, No. 4 (Feb., 1948), pp. 676-678.
296. Weil A. (2001) Integrated medicine. Imbues orthodox medicine with the values of complementary medicine. *Br Med J*; 322:119–20.
297. Whittemore, R., Chase, S., Mandle, CL. (2001) Validity in Qualitative Research. *Qualitative Health Research* 11 (4): 522-37.
298. Wiese M, Oster (2010) 'Becoming accepted': The complementary and alternative medicine practitioners' response to the uptake and practice of traditional medicine therapies by the mainstream health sector: *Health* 14:415
299. Wiese, M, Candice O and Jan P. (2010). 'Understanding the Emerging Relationship between Complementary Medicine and Mainstream Health Care: A Review of the Literature.' *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 14(3): 326–42.

300. Willis K, Rayner J. (2013). Integrative medical doctors—Public health practitioner or lifestyle coach? *European Journal of Integrative Medicine*; 5; 1: 8-14.
301. Wilson, G. (1936) An African morality, *Africa* ix, 1: 75-99.
302. WHO/UNICEF (1978). Primary health care: report of the International Conference on primary health care. Alma Ata, USSR.
303. World Health Organization. (2000). General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine.
304. World Health Organization. (2002) Traditional medicine strategy 2002–2005 Geneva, Document.
305. World Health Organization (2006): Draft outline: World health report 2006 [http://www.who.int/hrh/whr06_consultation/en/index.html].
306. World Health Organization. (2008) Traditional medicine declaration Geneva, Document. Available at: http://www.who.int/medicines/areas/traditional/TRM_Beijing_Declaration_EN.Pdf [Date of access: 14 February 2014].
307. World Health Organization. (2012) Development of traditional medicine in the South-East Asia Region (communication with WHO). New Delhi, WHO South-East Asia Regional Office (SEARO), progress report.
308. World Health Organization (2013) WHO Traditional Medicine Strategy 2014-2023.
309. Wright, P. and Teacher, A. (1982) Introduction: In P. Wright and teacher (eds), *The Problem of Medical Knowledge: Examining the Social construction of Medicine*. Edinburgh: Edinburgh University Press, pp.1-22

310. Yamey G. Can complementary medicine be evidence based? *West J Med* 2000; 173:4-5.
311. Zhang X. (2000) Integration of traditional and complementary medicine into national health care systems. *J Manip Physiol Ther*; 23:139–140.
312. Zola, I.K (1981) Medicine as an institution of social control. In P. Conrad and R. Kern (eds), *The sociology of Health and Illness: Critical Perspectives*. New York: St Martin's Press, pp. 511-27.

Appendices

Appendix 1

Letter of approval



Dr. Richard Gellejah
Faculty of Health and Social Care
University of Hull
HU6 7RX

FACULTY OF HEALTH AND SOCIAL CARE

T: 01482 464530

E: j.kelly @hull.ac.uk

Our REF 102

06 June 2013

Dear Richard

Strengthening the National Health System: Opportunities and Challenges for the Integration of Contemporary and Traditional Health Practices Under the National Health System in Tanzania

Thank you for submitting the above proposal to the Faculty of Health and Social Care Ethics Committee, which was considered on 28 May 2013.

You have sufficiently addressed the issues raised by the Committee, therefore I am in a position to grant Chair's approval for your study as per the Terms of Reference of the Committee.

Yours sincerely

Dr. Janet Kelly
Chair, Research Ethics Committee
cc. supervisors/ file

Appendix 2

Letter of introduction from Mzumbe University



MZUMBE UNIVERSITY OFFICE OF THE VICE CHANCELLOR

Tel: +255 (0) 23 2604380/1/3/4
Fax: +255 (0) 23 2604382
Cell: +255 (0) 754 694029
E-mail: drps@mzumbe.ac.tz
Website: www.mzumbe.ac.tz

P.O.BOX 63,
MZUMBE
MOROGORO, TANZANIA

Ref. No. MU/ DPGS/ PGS/ PhD/ 39/ 204

25th June 2013

The Permanent Secretary
Ministry of Health and Social Welfare
Dar es Salaam

RE: INTRODUCTION OF Dr, RICHARD S GELLEJAH

The bearer of this letter is a member of academic staff of Mzumbe University pursuing PhD Studies at the University of Hull, in the United Kingdom. As part of requirements for completion of his studies, he is collecting data on **“STRENGTHENING NATIONAL HEALTH SYSTEM: OPPORTUNITIES AND CHALLENGES OF INTEGRATING CONTEMPORARY AND TRADITIONAL HEALTH PRACTICES UNDER THE NATIONAL HEALTH SYSTEM IN TANZANIA”** in selected regions. The exercise is expected to take place between June to October 2013.

This letter serves to achieve three purposes. Firstly, to verify that he is granted permission to undertake the mentioned research; secondly, to introduce him to you and thirdly, to request you to facilitate any form of assistance he might need. We can assure you that this activity is entirely for academic purposes.

We trust that you will accord our staff with necessary assistance.

Sincerely yours

Signed

Dr. Fred Alfred
For Vice Chancellor

Appendix 3

Interview Guide for traditional healers

- 1) Had you expected to be a traditional healer?
- 2) Tell me how did you become a traditional healer and which area of specialization are you engaged in?
- 3) How would you describe your experience of working with clients
- 4) How would you describe your relationship with the following groups
 - Government
 - Biomedical practitioners
 - Religious leaders of major religions in the country

A follow up question- do you see them (each of them) as enabler and supportive partner or as a stumbling block in your carrier?

- 5) Do you personally, or traditional healers in general, collaborate with biomedical practitioners? Follow up questions - If yes how? - If no why?
- 6) In your opinion
 - What are the opportunities for cooperation between traditional healers and biomedical practitioners?
 - What are the challenges for cooperation between traditional healers and biomedical practitioners?
 - What are the barriers for cooperation between traditional healers and biomedical practitioners?
- 7) What could be done to improve the relationship between traditional healers and the following: - government, religious leaders and biomedical practitioners?

N.B: All participants were asked question 6 &7.

Appendix 4

Interview Guide for Biomedical Practitioners

- 1) Had you expected to be a biomedical practitioner?
- 2) What makes you as a biomedical personnel different from a traditional healers
- 3) Are there common features that you share with traditional healers?
- 4) Do you see biomedicine being in a position to treat all conditions and improve health of people?
- 5) Apart from biomedicine what other therapy that you trust?

Appendix 5

Interview Guide for Religious Leaders

- 1) How can you describe relationship between you as a religious leader and traditional healers
- 2) What can be done to improve the relationship between your religious leaders and traditional healers?

- 3) How do you see the role of traditional healers in improving the health of Tanzanians?
- 4) Do you see the possibility of biomedical practitioners working together with traditional healers?

Appendix 6

Interview Guide for Researchers NIMR and ITM

- 1) How would you describe traditional medicine?
- 2) Tell me about your involvement with traditional medicine?
- 3) Tell me about your relationship with traditional healers (which category do you collaborate with)
Prompts- about efficacy, safety, use, acceptability and intellectual property
- 4) How would you describe the relationship between traditional and biomedical practitioners
 - Government officials

Appendix 7

Interview guide for policy makers

- 1) What is the role of traditional healers in health sector
- 2) What is the position of government with regards to traditional healers and medicine?
- 3) Tell me about the relationship between traditional healers and government?
- 4) Do you see the likelihood of traditional healers to be integrated into the National Health System?

Appendix 8

Interview guide for Clients

- 1) What is your experience with the use of traditional medicine/biomedicine
Prompts in terms of safety, efficacy, affordability and accessibility?
- 2) What is your opinion with regard to traditional healers
- 3) What is your opinion on traditional healers working together with biomedical practitioners

Appendix 9:

Tanzania Map



Appendix 10:

Information for Participants

Title of the project: Opportunities and Challenges for Integrating Traditional Healers into the National Health System in Tanzania

You are invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and be free to discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not to take part. Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to explore the opportunities and challenges for integrating traditional healers into the national health system in Tanzania

Why I have been chosen?

You have been chosen to take part because you are a traditional healer, a biomedical practitioner, a policy maker, a religious leader, a client or user of traditional/biomedical medicine [member of the community], a researcher and you fall in the group that I wish to include

Do I have to take part?

There is no obligation to participate. It is up to you to decide whether or not to take part. If you wish to take part you will be given this sheet information to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

You will be interviewed by[a researcher]. to give your views as.....For this I will ask for your permission to audiotape the interview, which will last for no more than 60 minutes

What do I have to do?

You do not have to do anything; the interview will be done at your convenient time and place

What is being discussed?

You will be invited to give your opinion, views and suggestion on the topic of the study. The conversation will be recorded on a tape recorder for analysis but it will not be made available to anybody except[a researcher] and his supervisors and the person who will transcribe the tapes. The tapes will be destroyed as soon as transcription is done. You will be given the opportunity to see and approve the transcribed interview if you wish.

What are possible disadvantages and risk of taking part in the study?

As the objective of the study is geared towards obtaining the views, opinions and suggestions from key informants like you, I do not foresee any risk or disadvantage of taking part in the study. However, should any risk or disadvantage arise the researcher is strategically prepared to minimize the effects of that risk. In addition, should you feel that you are at risk for taking part in this study, you should feel free to withdraw from the study any time you wish. If you decide to continue with the study all information you are going to provide including any inconveniences, you may have felt will be strictly treated with high confidentiality. This study is part fulfilment of my PhD study and is not meant for any investigative purposes.

What are the possible benefits of taking part?

The possible benefit is that the study will identify the opportunities and challenges for integrating traditional healers into the national health system; the findings may pave way to a sound policy on medical pluralism in Tanzania.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. Any information about you will have a pseudonymised name so that you will not be recognized.

What will happen to the results of the study?

The results will be used as part the fulfilment of my PhD study and conference presentations. The government may also use them to review its policy on traditional healers in the country. It will also be used for publication so a wider audience will be informed.

Who is organizing the research?

The research is being organized by the University of Hull and the host in Tanzania is Mzumbe University

Who has reviewed the study?

The Local Research Ethics Committee and the Research and Development Department of the University of Hull have reviewed and approved the study. The study has also been approved by the National Medical Research Institute

Contact for further information

Richard S Gellejah.....[a researcher].

Mzumbe University

P.O Box 2 Mzumbe

Tel +255748 605759

You will be given a copy of this information sheet and your signed consent form to keep

N.B: This information sheet is adopted from Likupe (2011).

Appendix 11

Consent Form

Title of the project: Opportunities and Challenges for Integrating Traditional Healers into the National Health System in Tanzania

Name of Researcher:

I confirm that I have read and understood the information sheet dated 1st January 2013 for the above named study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason and without my legal rights being affected.

I agree to take part in the above study

| | | |
|---------------------|-------|-----------|
| ----- | ----- | ----- |
| Name of Participant | Date | Signature |

| | | |
|-------------------------------|-------|-----------|
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |

| | | |
|------------|-------|-----------|
| _____ | _____ | _____ |
| Researcher | Date | Signature |

N.B: This consent form is adopted from Likupe (2011).

Appendix 12

Tanzania albino murders: 'More than 200 witchdoctors' arrested



An albino lady who survived an attack after her two arms were chopped off by a gang of people testifying before the crowd. **Source: TBC 2015**

- 12 March 2015
- From the section [Africa](#)

Share

Image copyright Getty Images Image caption Albinism affects around one in every 1,400 Tanzanians, far higher than average

More than 200 witchdoctors and traditional healers have been arrested in Tanzania in a crackdown on the murder of albino people.

The killings have been driven by the belief - advanced by some witchdoctors - that the body parts have properties that confer wealth and good luck.

President Jakaya Kikwete has described the murder of albino people as an "evil" that has shamed Tanzania.

Nearly 80 albino Tanzanians have been killed since 2000, the UN says.

The latest victims include a one-year-old albino boy, killed in north-western Tanzania a few weeks ago.

The government banned witchdoctors in January as part of its efforts to prevent further attacks and kidnappings targeting people with albinism.

Lizard skin and warthog teeth

Last week, 32 witchdoctors were detained.

According to the [Red Cross](#), witchdoctors are prepared to pay \$75,000 (£50,000) for a complete set of albino body parts.

Tanzanian police arrested 225 unlicensed traditional healers and soothsayers across the country, the AFP news agency reports.

"Some of those arrested were found in possession of items like lizard skin, warthog teeth, ostrich eggs, monkey tails, bird claws, mule tails and lion skin," police spokesperson Advera Bulimba told the agency.

Albinism is particularly prevalent in Tanzania with one in 1,400 affected, according to a 2006 BMC Public Health report. This compares with one in 20,000 in Western countries.