Paraji and Bidan in Rancaekek : integrated medicine for advanced partnerships among traditional birth attendants and community midwives in the Sunda region of West Java, Indonesia

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Chapter II THEORETICAL ORIENTATION

Chapter II reviews the theoretical orientation of medical social sciences towards medical pluralism in Maternal and Child Health (MCH) as mentioned in the Chapter I. Important studies on health-care utilisation behaviour, carried out worldwide, are discussed below in order to show how this topic has attracted so many scholars in the recent past. Although pregnancy is not formally recognised as an illness, the dependency experienced by pregnant women during childbirth somewhat resembles that of patients undergoing health treatment for their symptoms.[1] Therefore, the discussion will seek to contribute to existing knowledge, on one hand, while expanding our understanding about the relationship between pregnancy and parturition and MCH utilisation behaviour in a rural community, on the other hand. The model for medical pluralism which includes traditional, transitional and modern medical systems is used to describe Maternal and Child Health in Rancaekek. Traditional and modern MCH systems are represented by *paraji* (TBA) and *bidan* (CMW), respectively, while the transitional medical system remains under-represented in Maternal and Child Health. Currently, the Indonesian Ministry of Health is promoting integration between different MCH systems in order to develop better community health services across the country. For example, in 2002, the Indonesian Government drafted Amendment UUD 1945, Paragraph 33, and Articles 1–3, which entrusts the implementation of social insurance for everyone while Paragraph 34, Article 2, guarantees that: "*The country develops social assurance for all citizens and empowers poor communities appropriate to human dignity*".

The utilisation of MCH services by pregnant women and their families is known to be influenced by various factors: *e.g.* socio-demographic, psycho-social, perceived pregnancy, and enabling. Moreover, Maternal and Child Health as an organisation also affects how medical systems are perceived by the clients seeking health care.

2.1 Concept of Medical Pluralism

Medical systems develop from practices and traditions to which peoples from various socio-cultural backgrounds (Leslie 1978) attach importance. For example, such medical systems include healing methodologies employed by ordinary folk or indigenous healers. Foster and Andersen (1978: 39) state that: "*The major institutions of every culture are related to each other and fulfill specific functions in relation to each other. Each institution is essential to the normal functioning of the culture in which it is found and each, in turn, draws on the others for its own continued existence. Medical institutions are no exception. … In short, medical systems cannot be understood solely in terms of themselves; only when they are seen as parts of total cultural patterns can they fully appreciated. [...] medical systems are integral parts of cultures is to view them at a basic, but fairly obvious level. But medical systems are parts of cultures at a more abstract level, in that content and form they reflect patterns and values that are less obvious*".

Medical systems can be conveniently classified by referring to their geographical and cultural settings (Dunn 1976: 135): "*Thus there are local medical systems, a category which can accommodate most systems of 'primitive' or 'folk' medicine; regional medical*

systems, such as Ayurvedic, Unani, and Chinese medicine; and the cosmopolitan medical system (often referred to as 'modern', 'scientific', or 'Western' medicine).[2] Furthermore, Dunn (1976) continues that local and regional systems are almost invariably indigenous, traditional, and normally intracultural; the traditionalism of the local system tends to be popular and non-scholarly. The modern (cosmopolitan) medical system is a transplant in most parts of the world, in the sense that it arose in the 'West' and retains 'traditional' elements which betray its regional origins. Dunn (1976: 136) also points out for the 'modern' or 'scientific' medical system which: "*... if we accept a broad definition of science it can be readily demonstrated that scientific elements are present in local and regional medical systems*".

Leslie (1980: 191) observes that: "*All medical systems can then be conceived of as pluralistic structures in which cosmopolitan medicine is one component in competitive and complementary relationship to numerous 'alternative' therapies*". This reference can be interpreted for multiple medical systems in a community, each with its own concepts of disease and illness among patients and their families, multiple categories of healers and health workers, and multiple choices for therapy. The interest of medical anthropology is in the socio-cultural context of 'alternative' medicine practiced within a community. The definition of ethnomedical systems is rather different from that for biomedical systems; Hughes (1968: 88) states that: "*... those beliefs and practices relating to disease which are the products of indigenous cultural development and not explicitly derived from the conceptual framework of modern medicine*".

Healing methodologies differ between specific medical systems, *e.g.* ethnobotanical knowledge systems (EKS) for traditional remedies and modern biomedical techniques. Many medicinal plants used in traditional medical systems are now recognized as having specific and beneficial pharmacological effects. During the 20th century, the scope of pharmacological research has been extended into the area of traditional herbal remedies and their properties. Doctors, anthropologists and medical anthropologists use the concept 'popular' or 'folk' medicine to describe the origins of traditional medical systems as well as to describe the health practices of ethnic peoples around the world, placing particular emphasis on their ethnobotanical knowledge systems (EKS). Furthermore, studying the rituals surrounding therapies has helped demarcate the cultural limits of biomedicine (Comelles 1996). The concept 'folk medicine' has been adopted by medical anthropologists to help differentiate 'magical' practices. Using such concepts, medical systems could be shown to be a specific product of each ethnic group's cultural heritage. Moreover, in this way, scientific biomedicine could also be seen as a medical system and therefore be studied as a product of culture. Meanwhile, medical anthropologists are gaining a much more sophisticated awareness of the problems posed by cultural representations and social practices related to health, disease and medical care which are now understood as being universal but with very diverse local forms articulated in transactional processes.

2.1.1 Medical Pluralism and Health-Care Utilisation

Medical systems are basically complex because indigenous knowledge and practices were already existent long before the introduction of modern medicine into socio-cultural life in developing countries. Historically, developing countries have experienced an ongoing

process of acculturation, where people have encountered differing types of medical systems due to the earlier migration of peoples through regions such as India, Arabia and China[3]. Later, in the 1800s, a more cosmopolitan Western medical system was introduced into Indonesia as part of Dutch Colonial Rule established by the end of the 19th century. Currently, medical systems in developing countries show characteristics found in different traditional, transitional, and modern medical systems which have developed from within the country and overlap both in theory and practice. As Slikkerveer (1990: 58) notes: "*Medical traditions have tended to develop along the same lines as the historical processes of acculturation and transculturation between the various major cultures in the Third World*".[4] Similarly, the classical study of comparative cultural systems by Redfield (1956) shows that such a complex medical system may be: "*... comprised of little and great traditions which have interacted in the past and which are still interacting today*". Landy (1977: 512) notes that: "*These concepts divide phenomena in different ways but they all predicate the pluralistic character of these medical systems*". In addition, Landy describes that: "*The medical systems of all complex societies are socially and culturally pluralistic, but the professionalisation of cosmopolitan medicine, which has progressed rapidly in this century, is an effort to reduce the degree and to govern the nature of medical pluralism*".

Some of the related methodological complications basically refer to the difficulty that certain Western scientists experience in understanding local knowledge systems, in particular the value of belief systems as part of the indigenous 'knowledge–practice–belief' complex, regarding the own systems of indigenous peoples (Wells 1995). The prolonged ignorance, indifference and incapability of Western scientists to come to grips with the largely invisible socio-cultural phenomena which eventually prove most relevant to the complex process of health and healing find their roots in the initially negative attitudes predominant during the colonial period towards indigenous peoples and their systems of medical knowledge, perceptions and practices which over generations have managed to cope with a variety of diseases in a particular culture area (Slikkerveer 2003). Afterwards in their pioneering study in East Africa, Buschkens & Slikkerveer (1980: 10–11) demonstrate that the population's accessibility to health services has specific gaps or various kinds of 'distances', such as geographical, economic, social and cultural.

- 'Geographical distance' refers to the largely unwarranted physical distance which must be covered to reach a particular health service, based on what members of the public consider the norm. King (1966: 2–7) defines: "*The average number of outpatient attendances per person per year fall precipitously the greater the distance that separates the patient's home from the modern health institution*".

- 'Economic distance' is a function of people's inability to pay direct fees for health services or their considering such fees too costly; the concept also refers to the inability of many people, who believe themselves ill, to bear the loss of income if they need be away from work (*e.g.* as farm labourer) for extended periods of time.

- 'Socio-cultural distance' refers *e.g.* to people's negative recollections of past experiences at a health institution and their generally failure to grasp the complicated administrative procedures or treatment processes to which they were subjected.

Fink (1969) states that: "*The under-utilisation of health facilities was initially measured more especially through analyses of the data contained in the available patient records, or the so called 'patient studies'* ". Such studies enable investigators to ascertain whether a given medical service is performing below or above capacity in terms of staff : patient ratio, as well as to establish the principal characteristics of the target group. Furthermore, Bushkens & Slikkerveer (1980) show that this approach provides insufficient insight into the pattern of health-care utilisation in the population towards which the health service is aimed as a whole. To gain better insight into the process of health-care utilisation, it is necessary to conduct research among the population itself by means of household surveys; for instance, in a so-called community-based study, survey questionnaires about illness behaviour are put to the relevant population. This research strategy enables the identification of weak spots in health care and helps explain why a certain proportion of the population fails to make use of services offered or turns to alternative medical systems in case of illness.

In this study, the concepts 'traditional' as well as 'indigenous' and 'modern' are used to describe the differences between two Maternal and Child Health (MCH) systems within the community. Indigenous communities, *i.e.* peoples and nations, are social units which share an historical continuity with pre-invasion and pre-colonial societies within their contiguous surroundings and consider themselves distinct from other social groups now prevailing there. At present, indigenous communities form non-dominant sectors of society which are determined to preserve, develop and transmit to future generations their ancestral land and ethnic identity, all of which anchors their continued existence as peoples, in accordance with their particular cultural patterns, social institutions and legal systems (*cf.* UN–ECOSOC 1980). 'Traditional' refers to the way in which knowledge is acquired and put to use, not to information which has become out of date or obsolete. In other words, the social process of learning and sharing knowledge, which is unique to each indigenous culture, lies at the very heart of its 'traditionality'. Much 'traditional' knowledge is actually quiet new, but it has a social connotation and legal character entirely unlike any other form of knowledge. Posey and Dutfield (1997) state that traditional livelihood systems are constantly adapting to changing social, economic and environmental conditions. These are dynamic and – no matter the change – embrace principles of sustainability. In referring to pluralistic medical configurations, Slikkerveer (2001) defines these systems as follows:

(a) 'Traditional' system is one governed by local perceptions, practices and beliefs which have evolved over a long time span in a particular culture or region;
(b) 'Transitional' system is a system where drug vendors are the final link in the sales chain, acting almost as sales representatives for the pharmaceutical industry which is finding lucrative markets in developing countries;
(c) 'Modern' medical system is one governed by biomedical opposed to ethnomedical paradigms.

The three medical systems described above exist independently, virtually side by side. Although transitional health care is officially linked to the modern medical system, and obtains most of its drugs from the modern pharmaceutical industry, there is no evidence

that they are adequately integrated. As far as the ethnomedical system is concerned, the Indonesian Ministry of Health's Regulation No. 1076/Menkes/SK/VII/2003 (Depkes 2003: 28) employs the following classification: (1) skilled indigenous healers: *pijat urut* (massage*), patah tulang* (broken bones), *sunat* (circumcision), *dukun bayi* (Traditional Birth Attendant), *pijat refleksi* (reflection massage*), akupresuris* (acupressurist), *akupunturis* (acupuncturist), *kiropraksi* (chiropractor), and others; (2) indigenous healers using herbal concoctions: *jamu* (person who gives health care by preparing ingredients from plants, animals, minerals, and others), *gurah* (person who provides health care by preparing solutions from the bark of the *sengguguh* tree to cure breathing problems), *shinshe* (Chinese healers), *tabib* (Indian healers), homeopathy, aromatherapies using essential oils extracted from plants, and others; (3) indigenous healers with a religious approach; and (4) indigenous healers with a supernatural tint: *tenaga dalam or prana* (bio-energy or inner power), paranormal using the sixth sense in curing, *reiky master* (Japanese bio-energy), *Qigong (*Chinese bio-energy), *kebatinan* (related to spiritualism), etc.

With regard to Maternal and Child Health (MCH), the ethnomedical system is represented by *paraji (*TBA) while the modern biomedical system is represented *bidan* (CMW). Burke (1993) points to the antithetical types of 'traditional' and 'modern' societies: hierarchy in a traditional society is based on ascription and low social mobility in contrast to hierarchy in a modern society which is based on achievement and high social mobility. The mode of antithesis is characterised by attitudes, for instance differences in attitudes towards change. In a traditional society, where change is slow, people are often unaware that adjustment has occurred. In contrast, in a modern society, change is rapid and continuous. Traditional society is naturally religious, superstitious, and more overtly irrational, in comparison to modern society which is considerably secular, rational and scientific. In reality, Slikkerveer (2003) states that: "… *a valuable aspect of traditional knowledge should be understood, respected and synthesized with global knowledge in a balanced, humane way*". Moreover, Adimihardja (2007) mentions that, in fact like modern societies, traditional cultures contain innovative and creative elements, which illustrates that they too are dynamic. However, a traditional culture is not 'isolated' or 'immune' to contact with other cultures and can develop through cultural exchange in this global world. Traditional cultures should be interpreted as ongoing phenomena with a diversity of ideas, innovations and organisations. Moreover, Yanagi (2007) uses the analogy of the 'human organ' which must be alive in order to grow and develop into a physical body. Finally, Slikkerveer (2007) refers to the synergy between all interactive components of human society and plural medical systems.

2.1.2 Traditional Medical System

The WHO has recognized Traditional Medicine since 1978 as a means to achieve basic health for the world's total population. In this same year, an International Conference held in Alma Ata endorsed the Declaration on Primary Health Care (PHC) which introduces the concept of a primary or basic health care which is applicable in a variety of health systems, including Traditional Medicine used by more than 85% of the world's population. In 1978 WHO's motto 'Health for All by the Year 2000' launched a set of strategies aimed at providing basic health care worldwide during the following decades.

Kyomya (1994: 87) says that: "*historically, traditional medical systems and the use of traditional plant materials may be deemed to have started soon after the appearance of mankind*". Then down through the ages and in all indigenous societies, the use of local natural resources and indigenous beliefs coalesced to create what is now well known as traditional medical systems. Such systems are rooted in cultural experience and religious beliefs, such as animism, spiritualism, shamanism, and divination. Strategies used in traditional medical systems include the application of herbal medicines and manual therapies, such as massage, acupuncture, and acupressure, and mind therapy such as meditation. The value of plant resources for healing is based on unique systems of belief which address the concepts health, disease, diagnosis, and treatment. Traditional knowledge of medicines and practices, dating back many centuries, represents a rich cultural heritage common to many societies which modern Ministries of Health sometimes ignore or fail to recognize.

In 1976, WHO defined Traditional Medicine as: "*a total of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium which rely exclusively on past experience and observation handed down from generation to generation*". Later WHO (2000a) states that Traditional Medicine, which is based on suppositions, beliefs and experiences indigenous to different cultures, is being adopted by other populations (outside indigenous cultures) and often labelled Complementary and Alternative Medicine (CAM). Traditional Medicine (TM) includes herbal preparations and products which contain parts of medicinal plants with active ingredients.

The field of medical anthropology studies the interaction between various medical systems and society. Bodeker (1994: 98) argues that: "*the term 'traditional medicine' or 'traditional system of health care' refers to the long-standing indigenous systems of health care found in developing countries and among indigenous populations. The paradigms of these traditional medical systems view humanity as being intimately linked with the wider dimensions of nature*". In addition, Bodeker (1994: 98) refers to the WHO conceptualisation of Traditional Medicine as: "*one of the surest means to achieve total health care coverage of the world population, using acceptable, safe, and economically feasible methods*". According to Good & Kimani (1980: 303), Traditional Medicine is also recognized as: '*ethnomedicine*', '*folk-medicine*' or '*native medicine*'.

Generally the indigenous healer holds a respectable position in the community because of his/her expertise in applying Traditional Medicine. In many communities, indigenous healers are specialized in the use of various techniques, such as bone fixing, assisting childbirth, circumcision, calling upon supernatural powers, etc. Because their wisdom and knowledge about healing represents a rich cultural heritage, the role of indigenous healer leaves a lasting imprint on their place in a community. Initially the indigenous healer was envisioned as a mediator between the human and spirit worlds because of their ability to cure sick members in the community. Many people still believe that a indigenous healer in trance is possessed by a spirit. However, most indigenous healers acquired their abilities through personal experience and/or from wisdom knowledge passed down from generation to generation by family members or senior healers.

In most developing countries, where 80% of the population is dependent on Traditional Medicine for their basic health needs, the use of traditional medical systems continues, or is

even increasing. In recent years, the West has renewed its interest in exploring traditional and herbal remedies to treat, in particular, chronic diseases such as diabetes, mental disorders and HIV/AIDS. Traditional Medicine differs from cosmopolitan or modern Western medicine in terms of its underlying cultural and historical contexts. In 1977 WHO declared that: "*all medicine is modern in so far as it is satisfactorily directed towards the common goal of providing health care, despite the setting in time, place and culture*". This dichotomy between 'traditional' and 'modern' is also a cultural construct related to a country's socio-political dynamics. Traditional Medicine, in this case, is clearly intertwined with a community's system of beliefs.

In summary, the character, practices and products of Traditional Medicine vary between societies, depending on their social and cultural heritage, religiosity and political identity. Traditional Medicines are found in all societies throughout history and before modern science was introduced into local societies during Western colonial rule at the beginning of the 19th century. Traditional Medicines embrace cultural perceptions of health and definitions of illness, beliefs or causes, and appropriate preventive and curative practices. Indigenous practitioners not only treat illness but also advise individuals about good health in order to safeguard the well-being of the entire community. Traditional beliefs and practices develop not in isolation but as part of integrated social institutions within cultural systems. Consequently, they are multi-functional and often resist change, even when the cultural tradition itself is no longer practiced.

2.1.3 Transitional Medical System

Today medical systems throughout the world are pluralistic. Indigenous therapeutic traditions and imported cosmopolitan Western medical practices are intertwined and co-exist at every level of society (Janzen 1978). Moreover Janzen (1978: 37–38) says that: "*The therapy managers in individual cases move back and forth between specialists and activities of both systems. Yet, the beliefs and practices constituting these systems rest upon different premises. For most people translation from one to the other is difficult, and individuals usually manipulate them separately rather than synthesize them*".

'Transitional' is a concept which refers to an intermediate medical model, the origin of which is rooted in commercial pharmaceutical which exists alongside traditional and modern medical systems.[5] In his article entitled "Rural Health Development in Ethiopia, Problems of Utilization of Traditional Healers", Slikkerveer (1990) presents a model for the plural medical system (see Figure 2.2) which can be applied in almost every developing or developed country around the world. More frequently the plural medical model is part and parcel of a changing society.

Figure 2.1. Some samples of transitional medicines for backache and rheumatism found in the market and sold by drug vendors
Source: Household Survey (2005)

The transitional medical system, with its roots in commercial pharmaceutical drugs, is a phenomenon similarly found in Asia, Western Europe and the United States (Slikkerveer 1982; Buschkens and Slikkerveer 1982). Ayalew (1979) points out that the transitional medical system provides health care which includes elements from both modern and traditional systems while being virtually beyond the control of either. Before Ayalew, Taylor (1977: 288) describes a corresponding type of system in Punjab as: "… *an underground system of health care that provides the bulk of medical treatment for the people in India*". In addition, Taylor (1977: 288) reminds us that: "*The greatest hazard is the tendency of such pseudo-indigenous practitioners to use the most powerful drugs possible in order to achieve quick results*". Furthermore, Buschkens and Slikkerveer (1982: 53) stress that those types of systems for health care can be observed in most developing countries. "*The pillars of these systems are persons who make a living by supplying modern and often also traditional medicines to the population on a commercial basis. They practice almost exclusively curative medicine. They generally have minimal modern medical training, so that their diagnoses can be qualified as extremely dubious by the standards of modern medicine [...] these persons generally live among the people as drug-sellers or travel from village to village with their wares. There is little social distance between them and the people. Thus they are usually fairly well acquainted with the people's medical practices, so that they are able to prescribe traditional remedies as well*" (Buschkens and Slikkerveer 1982: 53).

Practitioners of transitional medicine belong to neither the traditional nor modern system. Slikkerveer (1990: 211) explains that: "*They are often laymen with scant knowledge either of traditional or cosmopolitan medicine who sells pills, capsules, medicinal drinks and injections in shops or as they travel to markets throughout the country. Their practices are often illegal and contravene regulations concerning making up*

and dispensing prescriptions, but in many developing countries where facilities are scarce, it is virtually impossible to prohibit these being sold".

Plural Medical System	Traditional Medical System	Local medical (sub)system of Cushitic medicine Regional medical (sub)system of Arabic medicine Regional medical (sub)system of Amharic medicine
	Transitional Medical System	Medical system of commercial pharmaceutical medicine
	Modern Medical System	Medical system of cosmopolitan medicine

Figure 2.2 Model of a plural medical system in Eastern Ethiopia (Slikkerveer 1990)

Transitional practitioners are not easily identified by researchers but more commonly reveal themselves through what they relate during interviews about transitional medicine. One social group which frequently turns to transitional therapies comprises low-income labour workers who know from experience that such strength-enhancing products are cheap and effective for the rapid healing of their muscles. In recent years, many types of drugs and cosmetics smuggled into Indonesia from China are being sold by small vendors in the marketplace. Thanks to today's technology, such vendors can advertise their wares not only in print but also on the Internet. Such 'medicines' are usually food supplements and sex-enhancing remedies; the cosmetics are lipsticks, facial foundations and powders, and bleaches for lightening the skin.

2.1.4 Modern Medical System

Leslie (1976) explains that modern medical systems include those elements of scientific biomedicine which originated in Europe at the end of the Middle Ages and eventually developed into today's cosmopolitan system of medicine. Citizendium Medical Encyclopedia illustrates that: "… *medicine is practiced within the medical system, which is a legal, credentialing and financing framework, established by a particular culture or government. The characteristics of a health care system have significant effect on the way medical care is delivered*". Most countries provide health care through implementation of a compulsory system, with either social or government health insurance for the poor (ASKESKIN: *Asuransi Kesehatan*). Health-care services may be provided by state-owned hospitals or private medical practices and clinics.

Medical health care is classified as primary, secondary and tertiary. 'Primary' Health Care (PHC) is provided by physicians or other health professionals with whom patients first make contact when seeking medical treatment, *i.e.* in a physician's private clinic, health centre, or other nearby locality. Primary Health Care involves prevention and treatment of acute and chronic illnesses as well as health education for both men and women of all ages. 'Secondary' health care is provided by specialised doctors in private practices, hospitals, or health centres after a patient has been diagnosed and/or treated then referred by a PHC provider. Referrals are generally patients who must undergo specialised

procedures (*e.g.* surgery, physical therapy, high-risk childbirth, laboratory and diagnostic tests such as endoscopy) which can only be carried out in a hospital, out-patient clinic, emergency room, intensive-care unit, etc. 'Tertiary' health care is provided at specialised hospitals or regional centres equipped with diagnostic and treatment facilities (*e.g.* trauma units, advanced neonatology services, etc.) which are generally unavailable at local hospitals. Utilisation of modern medical systems is dependent on what the public has learned through various sources such as leaflets, newspapers and magazines as well as nowadays also through radio, television and the Internet.

The doctor–patient relationship, which forms the basis upon which modern medical systems rely, can be understood from various perspectives, such as anatomy, physiology, pathology, and psychology. Ideally, a physician should view the patient holistically, although such an approach is not inherent to modern medical systems. After familiarising himself with the patient's history and conducting an examination, the physician will make a diagnosis based on the patient's symptoms and propose a treatment for the suspected disorder. In this respect, the physician resembles a human biologist who interprets the human condition in terms of 'normality'. During diagnosis, the physician should evaluate the patient not as an 'ambulatory medical problem' but rather in terms of potential 'good health' before determining to what degree s/he deviates from 'normality'. Using such an approach, it is of vital importance that the physician takes into account the patient's social and cultural background (*e.g.* family, work, stress, beliefs).

Creating a high-quality doctor–patient relationship, based on mutual respect and trust, is invaluable for all parties concerned. In this way, the patient will feel more confident to pinpoint clearly and concisely which conditions adversely affect his health and well-being. In turn, the physician will be better able, in the time allotted, to make an accurate diagnose and clearly inform the patient about the possible choices for treating the problem. During the last 30 years, patients in the West were increasingly afforded more autonomy in decision making, in terms of social empowerment to take economic measures. As physicians gradually gained more respect, they were increasingly entrusted with prescribing drugs as public health measure. Such a concentration of power has both advantages and drawbacks for certain types of patient. During the last 25 years, as the cost of medical care has soared, government health insurance (ASKESKIN) must today cover health-care costs for members of disadvantaged communities.

Although Andersen and Newman's model includes patient-related factors, Slikkerveer's (1990) model proves to be more suitable for community-based research on the utilisation of traditional and modern Maternal and Child Health in a plural medical system. Slikkerveer's model has the capacity to help determine dependent factors – in this case MCH utilisation – employing correlations between such independent factors as background characteristics of respondents. His model also allows incorporation of two independent factors: 'institutional' (*e.g.* local government and NGO) and 'intervening' (all MCH programmes in the research area shown to be instrumental).

2.2 Research on Maternal and Child Health Utilisation

Maternal and Child Health (MCH) systems are an important part of Primary Health Care (PHC) endorsed during the Alma-Ata Conference in 1978. The proposed PHC model illustrates the need for a comprehensive health strategy which not only provides health services but also addresses underlying social, economic and political causes of poor health. The global strategy aimed at 'Health for All' represents the formalised beginning of a social model for health, with Primary Health Care as its basis. The Declaration of Alma Ata (1978) defines Primary Health Care as: "… *essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's medical system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national medical system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process*".

In 1998, WHO adopted 'Health for All in the 21st Century' and, several years later, promised to prolong its main strategy 'Health for All' to ensure the continuing development of necessary policies beyond the year 2000. Primary Health Care has been reformed in order to accomplishment the following four goals (WHO 2008: xvi):

(1) Universal coverage reforms – to ensure that medical systems contribute to health equity, social justice and abolish exclusion, primarily by moving towards universal access and social health protection;
(2) Service delivery reforms – to re-organize health services such as Primary Health Care around people's needs and expectations, in order to empower them socially and make them more responsive to their changing world while obtaining better outcomes;
(3) Public policy reforms – to secure healthier communities by integrating public actions with Primary Health Care (PHC) and by pursuing healthier public policies across sectors;
(4) Leadership reforms – to replace disproportionate reliance on command and control, on one hand, and laissez-faire state disengagement, on the other hand, by inclusive, participatory, negotiation-based leadership necessary for coping with the complexity of contemporary medical systems.

Although the role of Traditional Medicine has been accepted in Primary Health Care, synergy remains imperfect in the day-to-day reality of the plural medical system. As indicated, Primary Health Care is in need of reform in order to reach the aspired level of community health for all. Families can be empowered to make choices relevant to their particular health issues. For example, joint discussions between an expectant mother and the staff at a health facility might cause her make plans should an eventual emergency arise during childbirth. Other relevant topics might include where to give birth and how to

provide for other children and run the household during childbirth. Discussion might turn to topics such as how to cover medical expenses, how to arrange for transport to a health facility, and where to obtain medical supplies, as well as how to identify a compatible blood donor in case of haemorrhage. Community MCH programmes are being implemented in countries as far afield as Egypt, Guatemala, Indonesia, The Netherlands and the United Republic of Tanzania (WHO 2008) to empower people to start taking part in decision-making processes related to health issues such as pregnancy. To achieve a successful outcome, empowerment strategies which rely strongly on direct relationships between the public and community health workers must be embedded in the community's social infrastructure.

When a woman initially experiences symptoms such as nausea, vomiting, and headache, she might suspect that she is pregnant. How she experiences and interprets such symptoms will influence her choice of MCH services in the community. A woman experiencing pregnancy for the first time might worry more about her condition than someone who has been pregnant before. A newly pregnant woman may seek information from more experienced friends or family members. Slikkerveer (1990: 63) states that: "… *the utilisation of health care has a number of special features which include the plural character of the services, the phenomenon of multiple utilisations ('healer shopping') and the extent of self-care*". Kaplan *et al.* (1993: 72) remind us that: "… *symptoms are subjective interpretations of experiences and may not be directly observed. Sign described characteristics of illness that can be observed by others. When people become ill they interpret their symptoms in an attempt to do something about them. Often people go to a search process in which to attempt to determine whether or not their symptoms are a matter of concern. Although the illness itself may be affected by biological conditions, pregnancy behaviour can be affected by variety of social circumstances*". Whether to use a particular medical system is a decision-making process which involves weighing a number of complex choices. For example, because social and financial conditions vary among households, one must carefully calculate the cost-effectiveness for different health-care services on offer. If a pregnant woman or her family has insurance, she can afford health care provided by a modern MCH facility. However, if she comes from a lower socio-economic background, her only alternative might be to choose a traditional medical system, in spite of having social security.

2.2.1 Utilisation of the Traditional Maternal and Child Health System

Although pregnancy is not considered an illness, how a woman experiences pregnancy will, to a large extent, depend on her biological and psychological make-up. While some women suffer no side effects, other pregnant women will continue feeling poorly during the first stage of pregnancy and most likely consult friends and family to learn how to alleviate the situation. Although an expectant mother usually knows where to seek health care, her decision will ultimately depend on the household's socio-economic status (SES) as well as on the family's particular beliefs and customs. Her choice of Maternal and Child Health (MCH) system will mirror not only her own preference but also that of her husband and senior female family members. A pregnant woman and members of her family will be all too aware that choosing a *bidan* (CMW) might drain the household budget whereas a *paraji*

(TBA) will charge no fee for her services. Another determinant is the influence of senior women (*e.g*. mother, mother-in-law) in the household who once put themselves in the trustworthy care of a *paraji*.

Alisjahbana (1993) draws attention to the fact that, in contrast to India, training *paraji* in the use of modern technology has not impacted the perinatal mortality rate in Indonesia. Births assisted by *paraji* have increased from 3–4 to 12 each month. Alisjahbana's research on traditional knowledge, attitudes and practices shows that most *paraji* are women aged 31–75 years who are usually married or widowed; ca. 50% of the indigenous healers have never received formal schooling. *paraji* (TBA) are frequently consulted for matters concerning illness (93%), death (83%), and fortune telling (10%). They also prepare *jamu* (herbal concoctions), especially for treating post-partum women. Wolffers (1990) states that: "*Traditional medical practitioners and birth attendants are found in most countries. They are often members of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal medical system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community*".

Traditional Medicine is considered less expensive, more readily available and culturally acceptable compared to modern pharmaceuticals. Interestingly, although the WHO has set up a special department for Traditional Medicine, the organisation has never made its position clear. When discussing medical pluralism, use of terms such as 'traditional' *vs.* 'modern' or 'indigenous' *vs.* 'Western' is unavoidable, and every medical system has its own adherents and users. The use of indigenous medicine in a pluralistic society refers to herbals, home remedies, or industrially produced and packaged *jamu* concoctions, as in Indonesia. In 1983, WHO decided to promote the use of Traditional Medicine, taking into account local practices and various types of indigenous healers and birth attendants, to create a healthy and economically productive society for all peoples.

Slikkerveer (2003) reminds us that: "*Medicinal plant and herbs have always played a major role in the development of medicine and public health in both Western and non-Western countries, as reflected in the historical process of culture contacts which goes back to the pre-Renaissance times of the great European explorations of the non-Western world. [...] After initial fascination for traditional medicinal plants as potential resources for the Western* materia medica*, the interest declined after the accumulating 'scientific' discoveries of germ theory, antibiotics and advanced medical technologies which were made since the late 19th century*". Later some people became disenchanted with biomedicine and its prospects for the future, not only because of certain side effects. Because natural resources threatened to become scarce in developing countries, prices were forced up to exorbitant levels. At the same time, debates flared up regarding the possible integration of traditional and modern medical systems because alternative therapies appeared less costly. Slikkerveer (2003) explains how herbal medicine differs from modern pharmaceuticals. Herbal medicines are usually made from whole plants or parts thereof including bark, seeds, leaves, fruits, roots or stems. They are processed and administered as pills or capsules, teas or tinctures. This recent reorientation confirms the general view that, compared to modern pharmaceuticals and cosmetics, herbal concoctions have the advantage of being less expensive, derived from locally available plant resources, and less complicated to produce and distribute. Moreover, such natural mixtures are relatively safe

in terms of having fewer side effects, compared to remedies produced from a single isolated substance.

2.2.2 Utilisation of the Transitional Maternal and Child Health System

In a transitional medical system, 'specialists' and their practices belong to neither a traditional nor cosmopolitan system. Slikkerveer (1990: 211) states that: "… *the practitioners of transitional medical system are often laymen with scant knowledge either of traditional or cosmopolitan medicine who sells pills, capsules, medicinal drinks and injections in shops or as they travel to markets throughout the country*". Transitional medical systems are sporadic and unstructured. Important points which must be considered here refer to one of the driving forces behind transitional medicine: *e.g.* intermediaries who seek commercial profit, who are fascinated by the pharmaceutical industry and its financial markets, and who prefer to move outside the limits of government control. The public must therefore weigh up the benefits of high-priced drugs and health services against word-of-mouth endorsement of transitional medicine. The social group which most frequently chooses transitional products is composed of manual labour workers (*e.g.* tricycles drivers (*tukang becak*), street sweepers, construction workers) and market merchants who suffer from common ailments like stiff muscles, back pain, rheumatism, headache, diarrhoea, etc.

In recent years, individual vendors have been spotted in Indonesia's larger cities selling remedies for sexual enhancement and complaints, especially for men. Such products, usually made in China, are advertised in newspapers and magazines, including information about whom to contact for 'direct delivery to your door'. Transitional medicine can be bought in the marketplace and small shops in the form of pills, capsules and *jamu* mixed with powerful drugs which impart a feeling of well-being. In particular, *jamu gendong* vendors sell both industrial *jamu* in sachets as well as bottled homemade concoctions. All respondents surveyed replied that such remedies might prove harmful for the user.

Regardless of their often blatant disregard for the principles and practices upheld by traditional and modern medical systems, data show that transitional practitioners are seen to be under-represented in Maternal and Child Health. A major concern is that, ignorant to the inherent dangers of some transitional remedies, an uneducated woman might unknowingly swallow pills for backache which could cut short her pregnancy or harm the developing foetus.

2.2.3 Utilisation of the Modern Maternal and Child Health System

In 2005, the 'Safe Motherhood Initiative' (SMI) defined reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and its functions. Reproductive health therefore implies that people can have a satisfying and safe sex life and that they have the freedom to decide if, when and how often to have a child. Implicit here is that both men and women should have the right to make informed choices; to have access to safe, effective, affordable and acceptable methods for reproductive health and family planning; to choose how to regulate fertility legally; and to obtain adequate health care to prevent maternal and child morbidity and mortality.

In 1998 WHO compiled a comprehensive range of basic reproductive health-care services: *i.e*. for family planning (contraceptives, etc.); for abortion and treatment of post-abortion complications; for voluntary sterilization; for basic infertility problems; for management of sexually transmitted diseases (including HIV and specific cancers in the reproductive system; and for ante- and perinatal care and childbirth. In recent decades, some countries have made great progress in the area of maternal and reproductive health using selected programmes, while in other countries the availability of comprehensive and high-quality reproductive health services has yet to be realized. Family planning is the key to many success stories.

Indonesia has supported several efforts, such as the 'Safe Motherhood' programmes in 1988, to reduce the Maternal Mortality Rate (MMR). Many local communities, government agencies, and Non-Governmental Organisations (NGO) are now active participants with the backing of international organisations. Indonesia has successfully reduced its MMR from 450 deaths per 100.000 in 1985 to 334 deaths per 100.000 in 1997. Although the rate has significantly decreased, the national target of no more than 125 deaths per 100.000 by 2010 is still out of reach. This target is based on Indonesia's global commitment to the Millennium Development Goals (MDG) which aim to reduce the number of maternal deaths to one-third of the present number by 2015. The National Department of Health has established a long-term strategy to reduce Indonesia's MMR. In contrast, Koblinsky and Randolph (2003) show that the MMRs remain high in many countries and vary widely between regions. For example, for all of Africa, the total MMR is 1.000 deaths per 100.000, while MMRs measured in different sub-regions range from 1.300 deaths per 100.000 in Eastern Africa to 360 deaths per 100.000 in Southern Africa. Even in Europe, sub-regional differences are found: while for Eastern Europe the MMR is 50 deaths per 100.000, for other European sub-regions the average MMR is 13 deaths per 100.000. In recent years, there has been relatively little improvement in the reduction of maternal deaths worldwide, notwithstanding successes booked in a few countries such as Sri Lanka, Malaysia, China, Egypt, Honduras, and Tunisia. Moreover, Koblinsky and Randolph (2003) provide direct and indirect determinants for maternal mortality and presents what is known about the underlying determinants of maternal health. It is well established that five major complications are the chief determinants for more than 70% of maternal deaths: haemorrhage (25%), infection (15%), complications arising from unsafe abortion (13%), hypertension or pre-clampsia (12%), and obstructed labour (8%) – as well as other indirect (20%) and direct (8%) causes.

The above-mentioned complications can occur any time during pregnancy and childbirth, often without forewarning, and usually require immediate treatment at an emergency obstetric facility (*Safe Motherhood Technical Consultation Report* 1997). Indirect determinants are defined as pre-existing diseases or diseases which develop during pregnancy (not directly related to obstetric determinants) which are aggravated by the physiological effects of pregnancy. Principal indirect determinants in many settings include anaemia, malaria, hepatitis and diabetes. In addition to direct and indirect determinants, a range of underlying social, cultural, medical, and economic factors can have a profound effect on maternal health and, ultimately, on maternal mortality. Indirect and underlying determinants are best studied from a supply-and-demand perspective, organized into

pathways at different levels: at the individual–household–community level, at the medical system-related sector level, and at the government policy–action level.

Choosing which health-care service to use depends on a variety of different factors. Conceptual frameworks for understanding such choices have been presented clearly by several scholars. The conceptual framework provided by Anderson & Newman (1973) names three components ('predisposing', 'enabling' and 'level of illness' factors) which influence individual determinants for health-care utilisation. The first component, 'predisposing factors', is sub-divided into three categories of variables: demographic, social and belief. Demographic variables include age, sex, marital status, and past illnesses. Social variables include education, race and other personal characteristics. Belief variables include values, attitudes and knowledge. The second component, 'enabling factors', is sub-divided into two categories: personal resources, such as income, health insurance and access to medical care, and community resources. For example, some areas have large numbers of health providers relative to the size of the population while, in rural areas, there are too few doctors to treat the ill. The third component, 'level of illness factors', is often referred to as 'medical care need', which represents the degree of disability, symptoms experienced, and general state of health as perceived by the patient. It also includes a component for the evaluation of illness by a health-care provider.

Slikkerveer (1990) states that utilisation of medical services relates to a number of special features such as their plural character, the phenomenon of 'healer shopping' and the extent of self-care. He refers to the literature review by Van Etten (1976) who divides anthropological studies on illness behaviour and utilisation into several categories. The first category, covering research among peasant communities, focuses on the exclusive utilisation of local medicine by the rural population. The second category mainly concerns research on the dual use of traditional and modern medical systems. This category pertains to the research setting in Rancaekek where dual Maternal and Child Health (MCH) systems are provided in the community in tune with the social and economic needs of the users. Slikkerveer (1990) adds that several studies on the behaviouristic model of utilisation include an entire range of indicators, ending with the 'WHO model' used by Kohn & White (1976) which includes four blocks of factors: 'predisposing', 'enabling', 'perceived morbidity', and 'health-service system'.

As part of the latter study, comparative research has focused on the utilisation of modern medical systems in twelve areas in seven countries. Predisposing factors include certain social demographic variables (*e.g.* age, gender, marital status, level of education, etc.) while enabling factors include the cost of medical treatment, level of income, etc. Perceived morbidity is the most important determinant for utilisation behaviour in this model, while factors regarding how medical systems functions relate in particular to how the services are organised (Slikkerveer 1990). These types of research have important implications when formulating policies to improve health care in the regions studied.

2.3 Towards Integration of Traditional and Modern Maternal and Child Health Systems

Indonesia is one of the developing countries which still provide dual Maternal and Child Health (MCH) systems. This is also true for other developing countries where the majority of the population continues to use local herbal remedies for their basic health care. People are often reluctant to visit a health centre or consult a medical doctor because they are poor and cannot afford such services or because they are ashamed to speak with or be examined by a health provider. If possible, they try to avoid modern medical doctors and health services such as *Puskesmas* or hospitals and generally take drugs bought from a *warung* (small retailer) or *jamu* recommended by the local population. In this way the awareness is growing of how important Traditional Medicine remains in Indonesia. The WHO estimates that about 80% of the world's population uses some form of herbal remedy (Slikkerveer 2006).

Quah & Slikkerveer (2003) note that: "*Today, a large segment of the rural population in the tropics still remains deprived of adequate health care, which is often only partly based on the incorporation of traditional healing and midwifery. Mainly as a result of the continuing, artificial separation – and sometimes opposition – between biomedicine and ethnomedicine, the envisaged integration as the ultimate result of traditional medical systems negotiating successfully the challenges posed by science and technology is still facing several theoretical and methodological complications which need further study and analysis*". An alternative form of health care, integration of both modern and traditional medical systems in the community provides the advantage of being less costly and more available locally.

In response to the WHO Report in 2008, emphasis is shifting from concern for specific Maternal and Child Health to concern for the health of each member of the community, as the realisation increases that the health of future generations must be safeguarded through adequate health policies. Integration of Maternal and Child Health (MCH) systems is essential to improve health conditions throughout the country. While Traditional Birth Attendants (*paraji/dukun bayi*) still play a major role, today it is the formally educated *bidan* (CMW), assigned by the National Ministry of Health, who provide modern MCH services. Kroeger (1983) points out that: "*there exists a wider range of health services, both in quality and quantity, as well as in socio-economic conditions, such as family size, income, social networks*". Slikkerveer (1990) reiterates that an extremely important aspect when dispensing health care in developing countries is: "*the presence of several co-existing medical systems. The complex situation in a large number of Third World countries inhabited by regional or local population groups with separate medical traditions requires a specific research methodology in order to analyze concepts of illness and health within the appropriate socio-cultural context. Medical traditions have tended to develop along the same lines as the historical processes of acculturation and transculturation between the various major cultures in the Third World*".

Historically speaking, Indonesia with its thousands of islands has been inhabited by a diversity of ethnic peoples, each with their own social and cultural ways of living and particular indigenous medical systems, also for treating women and children in particular.

Throughout history, adventurous peoples (South Asian, Chinese, Portuguese, British, etc.) have been migrating, taking with them their own social and cultural customs and local knowledge and wisdom. Colonised for 350 years by the Dutch, Indonesia has since formally adopted modern European systems for health care, although Traditional Medicine is still practiced today.

Foster & Anderson (1978: 7) state that: "*Health workers in cross-cultural settings came to see far sooner that those working within their own cultures, and particularly those involved in clinical medicine, that health and disease are as much social and cultural phenomena as they are biological. They quickly realized that the health needs of developing countries could not be met simply by transplanting the health services of industrialized countries*". This statement cautions that local medical traditions cannot be surgically extracted from the community in which they have evolved and come to reflect the socio-cultural background of its people. Each component of a medical system has its own specific function within the community as well as its own devotees. Moreover, Foster & Anderson (1978: 37) state that: "*A health care system is a social institution that involves the interaction of a number of people, minimally the patient and the practitioner. The manifest function of health care system is to mobilize the resources of the patient, his family and his society to bring them to bear on his problem*".

In her research Alisjahbana (1993) describes three types of delay in dispensing skilled MCH services: *i.e.* delay at home (indecision about whether to seek help); delay in transporting a parturient woman to an adequate health facility; delay at the health facility in providing adequate care. Such delays, especially when faced with high-risk complications, tend to be blamed on the family's ignorance, financial straits or preference for a *paraji* (TBA) during childbirth.

Another important contribution to understanding illness behaviour is expressed by Suchman's model (1978: 81–84) which enumerates various stages of illness perception: "*When individuals perceive themselves as becoming sick they can pass through as many as five different response stages, depending upon their interpretation of their particular illness experience. These stages are (1) the symptom experience, (2) the assumption of the sick role, (3) medical care contact, (4) the dependent-patient role, and (5) recovery and rehabilitation".* Suchman (1978) elaborates further on the decision-making process and MCH utilisation behaviour which resembles the 'delay at home' described by Alisjahbana (1993). However, while Suchman (1978) excludes other members of the household, Alisjahbana (1993) notes their significance, including members of the extended family, in the decision-making process for utilisation of Maternal and Child Health. Which type of MCH system is selected will depend on knowledge, perception, demographics, economic factors, and availability of health services as well as on the husband's advice and persuasions of other senior family members (*e.g.* mother and mother-in-law). Stages in Suchman's (1978) model correlates with the stages of pregnancy. In Stage 1, the woman suspects that she is probably pregnant due to familiar signs such as delayed menstruation, expanding abdomen and morning sickness. In Stage 2, believing that she is pregnant, the woman begins to resemble someone suffering from an illness. In Stage 3, the woman makes preliminary contact with a medical system, while visiting a MCH facility for an examination. In Stage 4, after learning that she is indeed pregnant, the woman becomes dependent like a patient; now she must forego any heavy physical labour and ask for other

people's help until after giving birth. In Stage 5, immediately after parturition, the vulnerable mother and her newborn will begin a process of recovery during which time she will regain her strength and return to her normal activities.

The decision made by the National Ministry of Health to opt for the biomedical model in its health policies and programmes has resulted in a disregard for indigenous knowledge and practices. Collaboration between *paraji* (TBA) and *bidan* (CMW) requires that the *paraji* be educated and trained according to biomedical norms of hygiene and health. The threat remains that such efforts will be wasted should *paraji* return to their own traditional practices and knowledge systems. Furthermore, integrating *paraji* into a modern MCH system will not necessarily make them more appreciated. Sciortino (1995: 240–241) says that: "*physicians reject any cooperation with traditional healers, since they feel that these healers cannot be put on the same level with modern specialists. As physicians, they regard themselves higher in status than their traditional colleagues for two reasons. First, as public employees and representatives of the official medical system, they deserve more prestige. They are on the winning side, constantly receiving legitimacy from the national policy; second, they are arguing that dukun cannot compete with them as far as education is concerned*".

Moreover, in his study on whether government policies are capable of regulating traditional medical practices, Leslie (1980: 314–315) says that: "*the state policies concerning traditional medicine are largely negotiated and supervised by people trained in modern scientific medicine. The irrational element*[6] *in this situation derives from the fact that for more than a century the movement to professionalized modern scientific medicine has used the state to eliminate or drastically to curtail and subordinate other forms of practice. This movement has shaped the education of health professionals to an occupational perspective which distorts their comprehension of other systems*". Voorhoeve (1998: 47) elaborates upon how to eradicate traditional beliefs which are dangerous: "*To reduce the use of dangerous traditional practices several solutions are possible. A national programme of public health education may produce some results, but often, the belief in native medicine is very strong. Cooperation between traditional and Western medicine is the general policy of the World Health Organization, especially in Maternal and Child Health. However, this cooperation does not always reduce or correct traditional treatment. Sometimes cooperation with modern medicine may stimulate dangerous native treatments*".

In Rancaekek, Focus-Group Discussions (a qualitative technique) illustrate that *bidan* (CMW) consider people who seek the help of a *paraji* (TBA) to be 'primitive'. To eradicate stereotypical perceptions on both sides, mutual understanding should be encouraged through the sharing of interpersonal and intercultural experiences. While local knowledge about reproductive health and its practices have gained legitimacy over time through social and cultural acceptance in the community, the authenticity of modern Maternal and Child Health must in turn be acknowledged by the community in which it functions. However, in reality, balance is difficult to maintain. For example, during a difficult delivery when a pregnant woman desperately requires treatment at a modern obstetric facility, a *paraji* might perhaps continue to stroke her client's hand, telling her to be 'patient' and *pasrah* (accept her condition).

Physicians complain bitterly that pregnant women in need of biomedical treatment rely too long on indigenous healers before seeking further help at a *Puskesmas* (Community Health

Centre) or private biomedical practice. This situation places the guilt of delayed treatment directly upon the shoulders of *paraji*.

2.3.1 Three Delays when Seeking Care for Childbirth

Behaviour is best understood in terms of how an individual perceives his/her social environment (MacKian 2003: 7). Help- or health-seeking behaviour is one aspect of a medical system. Taking a decision with regard to one's health will first require weighing the potential risks or benefits of a particular choice, which will depend on one's actual environment, socio-cultural background and general view of life. Having a proper understanding of illness facilitates one's health-seeking behaviour and can reduce delay to diagnosis, improve treatment compliance and support health-promotion strategies in a variety of contexts.

This study demonstrates that, with regard to Maternal and Child Health, utilisation behaviour – or how one engages with a particular medical system – is affected by a variety of socio-economic variables such as gender, age, (women's) social status, access to MCH facilities and perceived quality of medical services. When attempting to explain patterns of behaviour and the factors involved, one should consider which obstacles pregnant and parturient women must overcome to contact MCH facilities in the community. A conceptual model should help clarify correlations between different factors and the behavioural process at the household level from the time a woman learns she is pregnant until after she has given birth (Slikkerveer 1990). With this approach, many variations in terminology tend to be categorised as perceptions, beliefs, or psycho-social, geographical, socio-economic, or institutional factors. While this is neither immediately apparent nor necessarily relevant to health-seeking behaviour during and after pregnancy, it is inherent to that process and must therefore be acknowledged.

"*Maternal health and health seeking behaviour of mothers have a huge impact not only on the lives of women, but also on the lives of their children*" (MacKian 2003: 12). Lash (2000) suggests that, in order to understand the complexities of how people make particular decisions or take actions, how and why they weigh options as they do, the attention should focus on "*reflexive communities*". This concept refers to the ways in which individuals behave, think and make decisions which, in turn, reflect their social position in a wider society at a particular time. Reflexive communities do not act solely on knowledge and processed information but rather reflect in a far more complex way in emotional, social and pragmatic behaviour. In order to understand how people make decisions and act upon them, with regard to health issues, it should be determined how they find and interpret their sources of information. Equally important is how they act upon underlying, unspoken, subconscious thoughts and feelings which fuel the cognitive process and its outcome.

Since the focus of this dissertation is on pregnant and perinatal women, some relevant factors concerning livelihood will affect a woman's capacity to seek health care: *e.g.* actual financial income, social status, life style, social networks, autonomy and liability. Such factors illustrate the complexity of decision-making processes which women face on a daily basis. WHO–SEARO (2000) states that each minute of every day one woman dies as a result of complications during pregnancy or childbirth, and eight newborns die because of

poorly managed pregnancies and deliveries. As stated above, women die from haemorrhage, infections, high blood pressure, oedema, obstructed labour, unsafe abortion and a range of diseases which are aggravated by pregnancy – such as malaria, hepatitis, rheumatic heart disease and diabetes. In addition, WHO–SEARO (2000) provides details underlying the medical causes of maternal mortality and disability, especially important when a pregnancy is complicated, which express a range of social, cultural, economic, and geographical factors which contribute to women's overall health and nutritional state before, during, and after pregnancy.

Therefore, to assure safer deliveries, a concerted effort must be made at the community level. Recall that, as mentioned in Section 2.3, WHO's three types of delays more or less parallel those reported in Alisjahbana's (1993) research: *i.e.* delay in deciding to seek help at the household level; delay in transporting a parturient woman to a nearby health facility; delay at the health facility in taking rapid and necessary treatment measures. Aside from placing blame on the family's poor education, meagre finances or preference for a traditional *paraji* to assist childbirth, Prayudha (2003) takes an inquisitive approach and asks the pivotal question: Why do people not visit *Puskesmas* (Community Health Centres)? Three reasons were put forward: (1) geographical distance – cost of transportation exceeds that for health services; (2) social distance – gap in knowledge and poor communication between health providers and clients; (3) unsatisfactory perception about health-centre providers – reflected in long delays, inadequate care, and so forth (*cf.* Section 1.2). Moreover, as already discussed above, some underlying reasons for the three types of delay open several avenues for enquiry. Belated identification of danger signs during pregnancy can point to the woman's lack of empowerment, to her inability to make her own decisions, to family members' ignorance of the risks pregnancy can bring or to their insufficient attention to the trials of labour. Moreover, although her family might recognize her precarious situation and wish to contact an appropriate obstetric facility, a shortage of money for transportation or the geographical distance might present a major obstacle – if roads and public transportation are even available. However, in hilly and mountainous areas where there are no roads, transporting a pregnant woman in labour means having to carry her by foot for hours to reach any health facility. There is thus a greater need for more community and financial support than for available transportation. Once a pregnant woman reaches a health facility, she might discover that its health care is mediocre. She might not receive appropriate treatment rapidly or the facility might be inadequately equipped with the necessary staff, equipment, medication, blood for transfusion, and so forth.

The criticisms voiced do not suggest that health providers are responsible for solving all of the community's health problems or that every health programme should consistently be implemented from one integrated point of delivery. Nevertheless, a Primary Health Care (PHC) team should be able to respond to the bulk of health issues in the community. When problems extend beyond their reach, other resources should be mobilised by referral. Moreover, the range of community self-help medical services on offer usually includes *paraji* (TBA) and modern certified *bidan* (CMW) as well as community-supported organisations such as volunteer health cadres, *Puskesmas* (Community Health Centre), *Polindes* (Village Maternity Home) and *Pustu* (Satellite Community Health Centre). One

need not relinquish one's own responsibility just because a PHC team is available to help navigate this complex environment.

The WHO Report (2008) points out that establishing a comprehensive integrated medical system in the community which can address the bulk of assorted health issues is more efficient than setting up separate services for select problems. One reason is partly because comprehensive health care leads to better understanding among the population and builds greater trust through mutual reinforcement. Medical systems which offer a comprehensive range of services increase uptake and coverage, *e.g.* preventive programmes, and help improve health outcomes. A comprehensive integrated system helps facilitate early detection of disease and prevent illness. Even in the absence of explicit demand, community health services should take the initiative, focusing on detection of disease and treatment modalities, preventive care to reduce the incidence of poor health, promotion of healthy behaviour, and on factors which affect public health. Moreover, pro-active volunteer teams or health cadres are an invaluable part of a medical system. As familiar faces in the community, they can lend support at public health facilities and, for many problems, are the only people in a position to address certain health problems effectively: *e.g.* pregnancy and early child development.

2.3.2 Use of Traditional Medicine in Maternal and Child Health Services

Implementation of modern Maternal and Child Health (MCH) is actually a natural step in the process of social and cultural change, as society moves away from local traditional systems. From the perspective of a modern MCH system, supported by the National Ministry of Health, modern methodologies have been permeating traditional medical systems and initiating changes in social and cultural lifestyles in correlation with medical systems in the community. Cultural contact with predominately cosmopolitan medical systems affects local traditions. In the case of traditional Maternal and Child Health, the role of *paraji* (TBA) as only care provider during and after pregnancy has been transformed into that of a mediator between traditional and modern MCH systems in the community. *paraji* are now expected to adopt a number of modern MCH methodologies such as hygiene.

Interestingly, some modern health-care providers continue to believe in the efficacy of *jamu*, *i.e.* traditional remedies the definition of which includes the sum total of knowledge, skills and practices based on theories, beliefs and experiences from the local community. *Jamu* is rooted in indigenous cross-cultural traditions formed as ethnic peoples migrated from place to place over centuries. Regardless of its efficacy, *jamu* (Traditional Medicine) is, in fact, used in Indonesia not only to maintain health but also to prevent, diagnose, improve or treat physical and mental illness. Its preventive function is the reason why communities still turn to Traditional Medicine. Sargent & Johnson (1996: 154) state that: "*By its very nature, ethnopharmacology uses some of the methods of bioscience, but neither its methodology nor its theoretical underpinnings form the basis of anthropological studies in the area. Anthropologists are not concerned with plant chemistry to judge whether some indigenous peoples 'got it right' (use pharmacologically active plants in a way that is consistent with the principles of biomedicine), but instead to ply the techniques of bioscience as one aspect of broad-based inquiry into plant use. [...] criteria that are*

applied in the selection of plants are complex include physical characteristics such as texture, taste, color, and smell; age and maturity; growing location; and physiologic action. All of these are qualities that affect or are affected by the chemical composition of plants. For many medical cultures, plant selection overlaps cognitive principles based in binary oppositions such as sweet–sour, hot–cold, or yin–yang. These reside in explanatory models that emphasize balance and proportion – more typically in the symbolic realm than the physical."

Much research on traditional medical systems puts forward the questions: how does a community classify illness, how do patients and healers experience and interpret illness, how do ethnomedical knowledge systems influence health-seeking behaviour, and how can we come to understand the efficacy of traditional healing methods. Furthermore, there are records on the nomenclature of indigenous plants – including their morphology, efficacy, and distinctive features – an on their use which reflect how people experience and interpret life in their environment.

Paraji (TBA) make use of traditional remedies when assisting pregnant and parturient women. Niehof (1992: 235) explains that: "*in Madura herbal cures are important to folk medicine. There are four domains where the use of herbal medicine is prominent: (a) for minor ailments; (b) for febrile skin diseases; (c) in the field of sex and eroticism; (d) during pregnancy and postpartum period*". Both Sunda and Madura illustrate several similarities in the use of herbal cures, especially for ante- and perinatal care.

2.3.3 Health Communication and Partnerships

In Indonesia, three health sectors are interconnected: *i.e*. Maternal and Child Health (MCH) services, the National Ministry of Health, and all the health policies implemented by Provincial Health Offices. Structurally, policies will be further implemented in sub-districts (*kecamatan*) and villages (*desa*) where community beliefs, values, knowledge, attitudes and practices are reflected in MCH systems. Communication, which means the transmission or exchange of information, is the key to understanding change: with regard to health issues, learning more about the reproductive process, changing attitudes about women's health during and after pregnancy, establishing norms for making pregnancy safer, and broadening the minds of local inhabitants to trust new ideas and aspirations for improved health behaviour. By spreading information to educate the public, communication can shake the foundations of existing values and social norms. According to *Healthy People 2010*, the Office of Disease Prevention and Health Promotion's definition (2008: 1) is: "… *health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health and is increasingly recognized as a necessary element of efforts to improve personal and public health*".

Maternal and Child Health (MCH) systems include concepts such as safe pregnancy and childbirth as well as specific methodologies. However, in general, communication is invaluable not only to provide information helpful to pregnant women who must decide which MCH system to choose. On another level, communication helps increase awareness about how relatives and neighbours view the reproductive process and how their behaviours influence the decision-making process during pregnancy and childbirth. Rogers

(1973) says that originally communication was conceptualized as a simple one-way transmission of messages from a source to a receiver in order to bring about an intended effect, usually limited to expressing some point of view which in this case would be safe pregnancy and childbirth. In contrast, modern integrated information systems, in which the exchange of information is multi-directional, produce a consolidated record. Necessary information is accessible to authorized recipients in 'real time', *i.e.* at the point where service is provided. The functionality of multi-directional communication affects every aspect of Maternal and Child Health such as the community itself, traditional and modern practitioners, volunteer health-care cadres, as well as doctors and staff at *Posyandu* (Integrated Services Post) and *Puskesmas* (Community Health Centre).

Health literacy

The National Network of Libraries of Medicine (2008) defines health literacy in *Healthy People 2010* as: "*The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions*". Health literacy, which is differs according to context and setting, and is not necessarily related to years of education or general reading ability. Health is a concept not easily understood. Although an individual is well educated and trained to provide health care, s/he might prove to be marginally or inadequately literate in a health-care situation. Many health-care providers and policymakers remain largely unaware of the extent of this elusive problem. Health literacy relates to how clients grasp information and whether they take active steps to overcome health problems. Therefore it is essential that health providers develop strong communication skills.

The inability to read, understand and effectively follow basic medical instructions is one of the least recognized but most widespread health-care challenges to improve health outcomes and lower health-care costs. Health literacy also involves the ability to listen, speak and conceptualize knowledge. Buono (2008) states that low health literacy can affect any segment of a population, regardless of age, ethnicity, educational level and income, and cannot be detected by physical symptoms or examinations. Because health illiteracy is a hidden threat to health care, arising from various educational, social and cultural factors, it is important that diverse disciplines work together to eradicate this obstacle.

In Indonesia, the level of health literacy is reflected in the use of modern *vs.* traditional MCH systems. Generally, traditional Maternal and Child Health and the *paraji* attract less educated villagers who are illiterate to the ways of processing health-care information. National health-care policies and programmes should focus on ways to improve communication and increase health literacy about Maternal and Child Health in the community. Patients' verbal skills are equally important in a multi-directional communication system in which they must learn to articulate their concerns and describe their symptoms accurately. To do so, patients must learn to ask pertinent questions and understand oral advice about conditions and treatments. In an age of shared physician–patient responsibility in health care, patients must develop and actively make use of newly gained communicative skills.

Partnership[6]

Starting in 2003, the Partnership for Clear Health Communication (PCHC) Programme launched its first solution-based initiative, designed as an effective tool to improve health communication between patients and health-care providers. Discussions between patients and providers helped leading health-literacy experts to develop educational material. Three simple but essential questions were formulated which patients should repeatedly ask their health-care providers during every interaction and that health provider, in turn, should never fail to answer clearly and in depth. Monteiro (1998) views the concept 'partnership' in international health care as a nice word. When someone defines a mutual relationship as: '*we are partners'*, then, someone must question: '*but I am more partner than he (or she)'*.

Partnership can sound condescending when it is not based on equality. Lap (1998: 291) explains that: "*First of all, partnership means there is some sort of relationship in the case of development cooperation. Relationship is supposed to be more than just the transfer of financial and technical means or knowledge. It implies the sharing of common aims (and in a broader sense, the sharing of a vision) between donor and receiver, between North and South. It also implies common commitment or engagement to solve problems. In other words, partnership is not just the mere existence of a relationship surrounded by good intentions, but it says something about the quality of this relationship. These are a sense of mutual trust, equality and reciprocity*". Lap (1998) concludes that while partnership cannot be enforced (which would prove counterproductive), failing to strive towards partnership would mean surrendering oneself to the arrogance of power.

Table 2.1 Three Basic Models for the Physician–Patient Relationship

	Model	Role		Clinical Application	Model Prototype
		Physician	Patient		
1	Active-Passive	Treats patient	Recipient (unable) to respond	Anaesthesia, acute, trauma or coma, delirium, etc.	Parent-infant, Parent-child (adolescent)
2	Guidance-Cooperation	Instructs patient	Co-operator (obeys)	Acute infectious processes, etc	Adult-adult
3	Mutual Participation	Helps patient to help him/herself	Participant in 'partnership'	Most chronic illnesses	Psycho-analysis etc.

Source: Szasz & Hollander (1978)

Table 2.1 provides three models for the doctor–patient relationship. In the first model (Active–Passive), the doctor–patient relationship resembles that of a helpless infant and its parent. In the second model (Guidance–Cooperation), the patient demonstrates his/her willingness to 'cooperate' with the physician. In the third model (Mutual Cooperation), both the doctor and patient stand on level footing: "*Philosophically, this model is predicated on the postulate that equality among human beings is desirable. It is fundamental to the social structure of democracy and has played a crucial role in occidental civilization for more than two hundred years. Psychologically, mutually rests on complex processes of identification – which facilitate conceiving of others in terms of oneself – together with maintaining and tolerating the discrete individuality of the observer and the observed. It is crucial to this type of interaction that the participants (1) have*

approximately equal power, (2) be mutually interdependent (i.e. need each other), and (3) engage in activity that will be in some ways satisfying to both".

In their article "The Basic Models of the Doctor–Patient Relationship", Szasz & Hollander (1978: 102) provide three basic models for the physician–patient relationship as shown in Table 2.1. Although these three models are designed to examine a bilateral doctor–patient relationship, they can also be applied in Rancaekek to the more complex trilateral *bidan–paraji*–client relationship. Moreover, a simple model for the *paraji–bidan* relationship in Rancaekek shows that both traditional and modern MCH systems share the same objective – to make pregnancy safer for the benefit of both mother and her offspring. To make motherhood safer, one might actually need to look carefully at more diverse points of view among a variety of disciplines; however, the chief partnership is basically that between traditional and modern MCH systems. Jha & Hanson (2002) note, that in recent years, 'Close-to-Client' health care has been identified as the principal vehicle for addressing a number of determinants, such as maternal, foetal and neonatal mortality, which account for the higher mortality rates in developing countries[7].

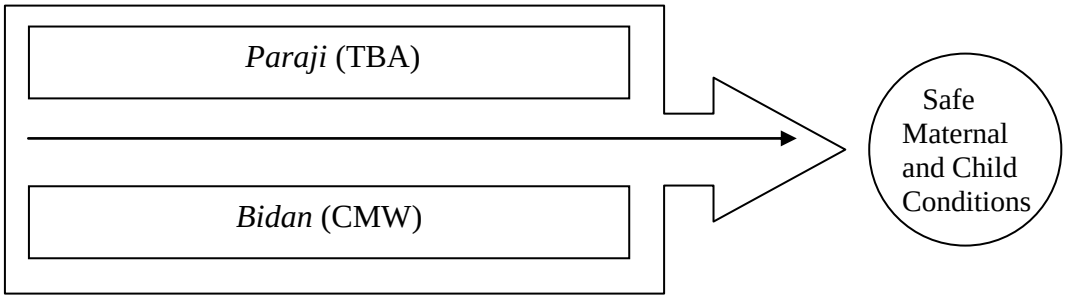

Figure 2.3 'Making Pregnancy Safer' approach (WHOCC–PMC–UNPAD) for safe reproduction through partnership
(Source: MPS 2001)

Figure 2.3 illustrates the real state of affairs in Rancaekek where both traditional and modern MCH systems share similar objectives but travel down different roads to achieve safe pregnancy and childbirth: *i.e*. the *bidan* by providing professional formalized care in health centres or private practice and the *paraji* by providing expert ethnomedical knowledge and practices in a family setting. Furthermore Jha (2002: 8) adds that: "*Since the risks for adverse birth outcomes are so high at the time of labour and delivery and in the immediate postpartum period, the quality of care at that time becomes the major focus. Reducing the significant burden of maternal, foetal, and neonatal mortality will require good-quality maternal and neonatal services along with effective referral systems*".

Sofoluwe (1985) state that: "… *the interest of redefinition of community health where in addition to physical, mental and social health, also include moral and spiritual health which recently take into account for all human being, the understanding of indigenous and traditional peoples' knowledge systems as to protect and maintain their natural and cultural heritage".* In her survey on traditional midwifery in Indonesia, Niehof (1992) finds that mediation has clearly failed in cases where the mother or child dies. *paraji* (TBA) have the responsible task of assisting during labour and delivery to bring a healthy newborn

into this world. In addition, Niehof (1992) adds: "*If she fails in this, the supernatural powers are regarded as having gotten the upper hand. It is important to note that in general in such cases the Traditional Birth Attendant (TBA) is not personally blamed. Failure is attributed not so much to any particular physical act or omission, as to an apparent incompatibility between the Traditional Birth Attendant, the supernatural powers and the client – in those particular circumstances and at that particular moment*".

Paraji (TBA) have extensive experience with and knowledge about indigenous processes: *i.e.* knowledge about the stages of pregnancy, about good foetal position, about women's physical and psychological perceptions during pregnancy. Therefore, a *paraji* will know: when to apply massage, what herbal medicines to prepare, which foodstuffs should be consumed or avoided, how to fend against evil forces since pregnancy weakens a woman's resistance. In countries with high Maternal (MMR) and Infant (IMR) Mortality Rates, it is usually an indigenous healer along with the pregnant woman's relatives who provide care for the post-natal woman and her baby, especially in rural areas. For example, from the 1960s to 1980s, China successfully reduced its MMRs and IMRs by employing 'barefoot doctors' who were well-trained indigenous healers.

Whether provided by traditional, modern or integrated medical systems, each individual in a community has the right to basic, accessible, acceptable and affordable health care. Primary Health Care (PHC) as focal point and pathway to higher levels of health care must ensure that local medical systems in the community meet the needs of its individuals. Two important components of Primary Health Care – community participation and health education – are essential if community health programmes are to be sustainable and affordable. Moreover, the public must become health literate and able to define its own specific needs. Only in this way can they become empowered as 'owners' of community projects and work towards sustainability.

Table 2.2 Models of Health Care during Labour and Delivery

Model	Birth Attendant	Delivery Location	Referral Capacity	MMR/Country (per 100.000)
1	Non-professional: often a community member with little or no medical training	Home	Referral and transportation needed for complicated cases	115 Rural China (1994) 120 Fortaleza, Brazil (1984)
2	Professional: often a physician, alternations and provide basic essential care	Home	Many barriers and may involve long distances	50 Malaysia (1970–1980) 7 The Netherlands (1983–1992)
3	Professional: often a physician, alternatively, a midwife	Health clinic or hospital with basic essential obstetric care	Referral and transportation needed for complicated cases	43 Malaysia (1980–1990) 30 Sri Lanka (1996)
4	Professional: most often a physician	Hospital with comprehensive essential obstetric care	Some barriers may involve long distances	9 United Kingdom 12 United States 114 Mexico City (1988)

Source: Adapted from Koblinsky, Campbel & Heichelheim (1999)

Koblinsky *et al*. (1999: 399–406) state that: "… *the essence of Primary Health Care and referral for labour and delivery is the presence of a skilled attendant backed up by good quality, readily accessible emergency care. The wide range in services and settings in countries for labour and delivery can be described in terms of four models of care, based on the type of caregiver and the setting in which delivery takes place*" (Table 2.2). Three of these four models are discussed along with the country's programme.

Model 1: *Labour and delivery at home with a non-professional attendant and referral for complicated cases*: Note that, in Table 2.2, no model for home delivery uses a non-professional attendant without referral for complicated cases.

Model 2: Labour and delivery at home with a professional attendant and referral for complicated cases: Deliveries at home and care of the newborn, usually by a midwife, is available in some developing countries, generally in rural areas. In countries where skilled birth attendants or midwives manage at least one-half of the deliveries, such as in Sri Lanka and South Africa, MMRs and IMRs are among the lowest in the developing world. Marthur, Damodar, Sharma & Jain (1979: 21) state that: "… *providing quality model 2 care involves the training component of birth attendants and provision of equipment. It also involves transportation and communication capacity for referrals. Provider and community attitudes that can be major barriers to the use of skilled birth attendants and other health care services need to be overcome*".

Model 3: Labour and delivery in hospital/clinic including basic essential care: Deliveries attended by skilled experienced birth attendants can gain further support when they take place in hospitals or clinics which provide basic essential obstetric and neonatal care. WHO (1996) states that: "*Model 3 services for the mother should include at least paren-teral medications (antibiotics, oxytocic drugs, and anticonvulsants) and manual removal of the placenta and other retained products in basic essential obstetric care services. However, in comprehensive essential obstetric care services, provision for surgical proce-dures, anesthesia, and blood transfusion in addition to the above should be included*".

Model 4: Labour and delivery in hospital/clinic with comprehensive essential care: Model 4 incorporates all of the services provided in Model 3, as well as anaesthesia, surgery (particularly Caesarean section and surgical repair such as vesico-vaginal tears), blood transfusion, and the ability to care for distressed or at-risk neonates. This most sophisticated model of care is available in some urban areas in developing countries, where MMRs and IMRs are low. In Rancaekek, *paraji* are considered 'helpers' who can apply their ethnomedical skills (midwifery) to help pregnant and perinatal women, *e.g*. perhaps for relaxation, and are always willing to accommodate the woman's family and children as well. According to Niehof (1992), the ability of *paraji* to communicate with the supernatural or spiritual world is part and parcel of indigenous midwifery. Niehof (1992: 12) goes on to say: "*It is hard to get a more specific definition of the supernatural powers involved. Traditional healers tend to keep silent on this subject, and the Traditional Birth Attendant is no exception. Traditional Birth Attendants in Islamic areas will only say that they request to God*".

Any attempt to achieve 'Safe Motherhood' should not overlook the importance of creating strong partnerships between a pregnant woman, members of her family, and community health practitioner as well as addressing essential issues such as community funding, health research and decision-making behaviour. Partnership implies the equal sharing of knowledge, resources and commitments in order to reach a common goal. In the case of Maternal and Child Health, mutual respect and transparency are essential. In Rancaekek where most *paraji* are trained in the use of modern MCH methodologies, the Regional Health Office evaluation has shown that the type of training is not conform traditional midwives' levels of education. Volunteer health-care cadres, appointed to mediate between MCH providers within the community, are accustomed to motivate pregnant women to seek help at *Puskesmas*. Because health cadres come from the same community and live alongside indigenous healers and their clients, they can successfully function as mediator between different medical systems and the public.

Following the Alma-Ata Declaration in 1978, which advocates using indigenous healers and practitioners in Primary Health Care, numerous studies were published and discussions held among experts in the field about how to integrate ethno- and biomedical systems. Young (1994: 62–66) delineates five types of relationships as follows:

(1) *Intolerant Orthodoxy [...] biomedicine has monopoly on health care and uses its power base to prevent alternative healing traditions from obtaining legal status. In societies in which biomedicine has this kind of power, it is referred to as orthodox system and all other systems are considered unorthodox. This type of intolerance usually did not eliminate indigenous healing traditions but simply forced them underground. [...] many indigenous healing traditions lost their positions of their 'structural superiority', but they did not necessarily loss their 'functional strength'. Although type 1 societies may be characterized by unofficial medical pluralism, relations between biomedicine and indigenous healing traditions are characterized by structural inequality and intolerance on the part of biomedical practitioners*."

(2) *"Tolerant Orthodoxy, in type 2, as in type 1, there is a single orthodox healing tradition, but many of its practitioners are tolerant of alternative traditions. In an attempt to provide culturally-appropriate health care, tolerant orthodox practitioners make an effort to understand the beliefs and behaviours of minority patients. It is important to note, however, that in societies characterized by tolerant orthodoxy, alternative healing traditions are not accorded legal status. Unofficial health care pluralism exists in practice, and may even be encouraged, but a single training and licensing of legally-recognized practitioners. In other words, despite its tolerance, biomedicine retains its position of structural superiority.*"

(3) "*Parallel Independent Traditions, rather than a single orthodox system, there are two or more traditions that legally recognized. Although patients have freedom of choice, there is little active collaboration among practitioners of the different traditions. Relations among practitioners of biomedicine and traditional medicine are generally characterized by indifference, and the choice of what kind of healer to utilize for a particular condition is*

left to the patient. In brief, type3 societies have official health care pluralism, but at least in term of interaction among health care practitioners, it is of passive type."

(4) "*Collaboration and Combination, in type 4, the practitioners of two or more legally recognized healing traditions engaged in active collaboration resulting in a combination of therapeutic techniques, or else the beliefs, practices and medicines of two or more traditions are combined by a single individual. A more active kind of collaboration is practiced in China where 'interdisciplinary' teams can consists of biomedical personnel, traditional Chinese medicine practitioners, and even personnel trained in one of the minority traditions such as Mongolian or Tibetan medicine. Type 4 includes a range of options which provide for active collaboration among practitioners of different healing traditions and/or combination of different therapeutic techniques and medicines within the same practice.*"

(5) "*Integration, in type 5, the goal is to synthesize the theory and practice of different healing traditions into a more comprehensive system. This goes beyond collaboration among practitioners from different traditions, or combining different techniques in a single practice.*"

To conclude the theoretical discussion, ethnomedical systems found in almost every society and culture will reflect how local people perceive health, how they define disease and illness, which beliefs underlie their patterns of behaviour and which preventive and curatives practices are appropriate and applicable to the situation. The indigenous healer's task is not only to provide traditional health care but also to function as mediator in the community.

Notes

1. A person who is ill occupies an admittedly exceptional position in society. To be ill means to suffer – in a twofold sense. To suffer means to be passive. The sick individual is cut off from active life to the extent that s/he is even unable to procure necessary food. The individual is literally helpless and dependent on the care of other individuals (Sigerist 1977: 389).
2. A dictionary definition of 'cosmopolitan' is "belonging to all or many parts of the world", rather than being limited or provincial in scope or bearing; involving peoples in all or many parts of the world (Dunn 1976: 135).
3. Alternative healing traditions can be aboriginal or ethnic in origin, such as Native healing, traditional Chinese medicine or Ayurvedic medicine in Canada. These are healing traditions which were once dominant in their original cultures but which are now considered unorthodox in other countries. Alternative healing can be base upon specific diagnostic or treatment procedures, some of which have always been considered unorthodox. Examples are homeopathy, iridology, therapeutic touch, and reflexology (Young, 1994: 68).
4. 'Transculturation' is used as a synonym for acculturation to refer to the process of cultural change resulting from contact between cultures. 'Acculturation' is the process by which culture is transmitted through ongoing first-hand contact between groups with different cultures, one often having a more highly developed civilization.

5. A review of socio-historical factors which influence medical systems highlights important processes such as cultural re-interpretation and indigenization which characterize what could be more appropriately described as ‘transitional’ medical systems. Changes in cultural forms, such as the acceptance of Western pharmaceuticals, may still rely on traditional cognitive frames of reference, suggesting eclecticism amid conservatism. Issues of theoretical and practical concern are outlined at the end of the article (Tan 1989).
6. Partnership with women involves mothers to recognize and realize the priority of maternal health problems and together with local health authorities create plans to minimize this problem.
7. In the ‘Close-to-Client’ model of Primary Health Care, relatively simple hospitals and health centres provide effective interventions against major causes of death and disability in poor populations. Health care in such settings, which can often be provided by non-physicians (nurses, midwives, community or village workers, and other paramedical staff) is complemented by a referral system which offers access when needed to higher level care (WHO 1994).