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Afya Jumuishi : towards Interprofessional collaboration between traditional and modern medical practitioners in the Mara Region of Tanzania

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Citation

Chirangi, M. M. (2013, April 17). *Afya Jumuishi : towards Interprofessional collaboration between traditional and modern medical practitioners in the Mara Region of Tanzania*. Leiden *Ethnosystems and Development Programme Studies*. Retrieved from <https://hdl.handle.net/1887/20753>

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Title: Afya Jumuishi : towards interprofessional collaboration between traditional and modern medical practitioners in the Mara Region of Tanzania

Issue Date: 2013-04-17

CHAPTER II THEORETICAL ORIENTATION

The goal of this chapter is to indicate and discuss specific concepts, definitions and related theories used as a point of embarkation of this study of interprofessional collaboration among different practitioners in both traditional and modern medical systems of Tanzania.

The chapter begins by exploring the components of culture and their linkages to human health (Herman 2001; White 2002; Taylor 2003), the determinants affecting people's choice in health services utilisation (Slikkerveer 1990), the *mandala* of health, showing the way culture relates to people's health and medical systems (Hancock & Perkins 1985), the concepts of indigenous *aetiology* (Helman 1994), and the indigenous knowledge and practice of Medicinal, Aromatic and Cosmetic (MAC) plants from the largest source of raw materials and products of indigenous medicaments (*cf.* Slikkerveer 2006).

Thereafter, the chapter draws attention to the concept of health sector reforms. The Paragraph focuses on the need for a paradigm shift as propagated by World Health Organisation (WHO 1978) to de-medicalize, culturally redefine and integrate health care. The pertinent ideological and operational issues to be addressed in the Tanzanian health sector reforms are highlighted. The first refers to the study of interaction between local and global knowledge systems concerning MAC plants, also known as the *Ethnobotanical Knowledge System* (EKS) (*cf.* Slikkerveer 2006). The second refers to the *community-based approach* as opposed to the *clinic-oriented approach* for the promotion and development of traditional medical practitioners, products and services.

Then, the chapter draws attention to the concept of health sector reforms. The Paragraph focuses on the need for a paradigm shift as propagated by the World Health Organization (WHO 1978) in the way the medical system has to be de-medicalized and culturally redefined and integrated. The pertinent ideological and operational issues are to be addressed in the Tanzanian health sector reforms are highlighted. A study of interaction between local and global knowledge systems of plants well known as Ethnobotanical Knowledge System (EKS) and *community based approach* as opposed to *clinical oriented approach* for promotion and development of traditional medical practitioners, products and services are presented.

Acknowledging that collaboration is a step towards integration, the chapter also discusses the difference between Traditional and Modern Medicine, the concept of integrating modern and traditional medical systems, the existing problems and required institutional support for Traditional Medicine (TM) in Tanzania.

The last Paragraph of the chapter traces the introduction of the term *collaboration* as well as its definitions in various disciplines. Different theories of collaboration are observed, and notable gaps in recent research are mentioned. Following the Theory of Reasoned Action (TRA) developed by Ajzen & Fishbein (1980; 2010), collaboration is described as a step on a continuum of strategies towards integration (Dotterich 2006) and eventually as a behavioural act under the *knowledge-belief-practices* paradigm (Slikkerveer 1990), which accentuates the utilisation behaviour model widely supported by researchers in different disciplines such as Kohn & White (1976), Cox & Claus (1984), Slikkerveer (1990 1995), Agung (2005), Ibui (2007), Leurs (2010), Djen Amar (2010), Ambaretnani (2012). The different stages and management of collaborative behaviours in organisations are further explored.

Finally, the concept of interprofessional collaboration is operationalised as a pattern of behaviour of practitioners under study, exchanging resources and working jointly towards their clients, and where a working definition operationalises the adaptation of the selected conceptual model with various categories or blocks of variable, further described in Chapter III.

2.1 Culture and Health

2.1.1 Components of Culture and their Linkage to Human Health

Anthropologists perceive, that: “*culture is for a human being what water is for a fish*” (Haddon *et al.* 2001). Although the word originates from the Latin word ‘cultura’, meaning ‘to cultivate’, there exist a historical number of definitions for the term ‘culture’ going back to Kroeber & Kluckhohn (1952).

With different definitions, researchers and academics in general reflect on different theoretical orientations or criteria to refer to the universal human capacity to interpret, classify, codify and communicate life experience in different circles. Allen (1992) outlines seven different uses of culture as *generic* (learned behaviour); *expressive* (artistic expression); *hierarchical* (show of superiority in social structures); *superorganic* (interpretation of everyday behaviours); *holistic* (connection of different parameters of life such as; gender, politics, religion, technology, etc.); *pluralistic* (existence of different forms in one setting) and *hegemonic* (relationship between social groups and power distribution).

The United Nations Educational, Scientific and Cultural Organization (UNESCO 2000) has labelled ‘culture’ as the set of distinctive spiritual, material, intellectual, and emotional features of a society or a social group, and it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs. It is imperative to note that any society may have numerous heterogeneous cultures and cultures are not static. From the Twentieth Century, anthropologists and sociologists generally use the term ‘culture’ to refer to the set of shared and learned attitudes, values, beliefs, principles, goals, knowledge, practices (behaviours), symbolisms and artefacts identifying an institution or a social group as well as the human capacity to classify and interpret experiences.

In the same way, the Center for Advanced Research on Language Acquisition (CARLA- US has characterised culture as the shared patterns of behaviours and interactions, cognitive constructs, and affective understanding which are learned through a process of socialization. Members of a certain society are either identified or distinguished from others, based on those shared patterns. Culture serves as a road map for both perceiving and interacting with the world. Culture influences or determines the way a person thinks, believes, behaves, eats, sleeps, puts on clothes, relates to others and to the environment, works, perceives, consults in case of pain, and interprets diseases and ill health in general. Thus, there is a close link between culture and health or illness: cultures shape people’s health as much as their genes do.

Gathering from various definitions such as in Medical Anthropology (Herman 2001), Medical Sociology (White 2002), Health Psychology (Taylor 2003) as well as from the UNESCO (2000) and all other related research institutes and centres, five major common themes concerning components of culture can be deduced, either as they shape people’s health or as they affect interprofessional collaboration between traditional and modern medical practitioners, underscoring the *raison d’être* of this study:

Communication Components: consisting of languages, symbols etc.

Both in the traditional and modern medical system, there exist diverse communication patterns and symbolisms, which attributes to different meanings in services. The different naming (classification) of diseases and ill health by use of different languages can be one of the major hindrances towards behavioural patterns of mutual collaboration between two groups with the same customer.

Cognitive Components: consisting of ideas, assumptions, knowledge, technology, accounts etc. When the type and levels of education are much different between the two groups of modern and traditional medical practitioners, their interventional approach is varied. For example, just the different level of knowledge of human anatomy and physiology has been used by some modern medical practitioners to despise the indigenous knowledge acquired by traditional medical practitioners. “*How do you work together with someone to treat a patient with Asthma when he or she doesn’t know the ABCs of the human respiratory system?*” interrogates Doctor A, during an interview.

Behavioural Components: consisting of mores, norms, values, laws, rituals, beliefs, folkways, religion, intimacy and economics. People’s religious belief, values, norms etc. have affected the way they behave. Organisational culture and ‘groupthink’ factors either motivate or demotivate the process of resource exchange and joint working between the two systems.

Material Components (Material Culture): Consisting of created objects, artwork, fashions, designs, clothes, housing, means of transport, infrastructures, foodstuffs, tools etc. When the trend has been to focus on acquiring sophisticated advanced technological medical equipment and big structures of modern health facilities, traditional healers and traditional midwives feel isolated from the national health care system.

Organisational Components: Consisting of social structures, political organs, family and organisational ties and relations, membership identity, gender, politics, institutional support etc. The traditional medical system has a different organisational setting with a simple organogram, has fewer hierarchical levels and a kind of cobweb communication network. In contrast, the tall structured network of the Modern Medicine system has several hierarchical levels. In order to integrate them, one needs to take into consideration their present situation, other related institutional support and policy framework.

All five components of culture have a twofold direct or indirect link to this study. Firstly, when culture is seen as the base which prompts re-evaluation of the importance of Traditional Medicine (TM) and its practitioners in the overall contribution of people’s health levels and secondly, when practitioners’ collaborative research topic is understood to be a behavioural act of either exchange of resources and or working together within their cultural context.

The classical definition of the World Health Organization (WHO 1945) of the concept of health as “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*” clearly shows that health has a social component. From a wider socio-cultural context, ill health can be perceived of as a process, which brings a person into a *sick role*, and evaluates his or her ability or failure to meet the obligation of the society (Mechanic 1995). However, the *sick role* model has been criticized as fitting more in short-term than long-term illnesses and some sick people may not necessarily give up their social roles, and may resist dependency and avoid to be known publicly, especially when the disease is stigmatized in the society. Furthermore, the *sick role* can be blamed as well in cases such as alcoholism (Chalfont & Kurtz 1971). In summary, several studies have shown that ill conditions are not only dependent on biological or cognitive factors, but also on ecological, social and cultural determinants (Koos 1954; Marmot 2005; WHO 2010). In addition, as has been shown by Slikkerveer (1990), these determinants affect people’s choice in their patterns of health care utilisation.

Figure 2.1 shows the *Mandala of Health*, which provides a holistic guide towards the understanding of health and the way culture and environment are shaping peoples' health. It shows that the culture of a community's affects family livelihood, spiritual life, psychological experiences, work patterns, the political and legal framework, social organisation and medical systems, and as is the case in biological factors, it affects individual health.

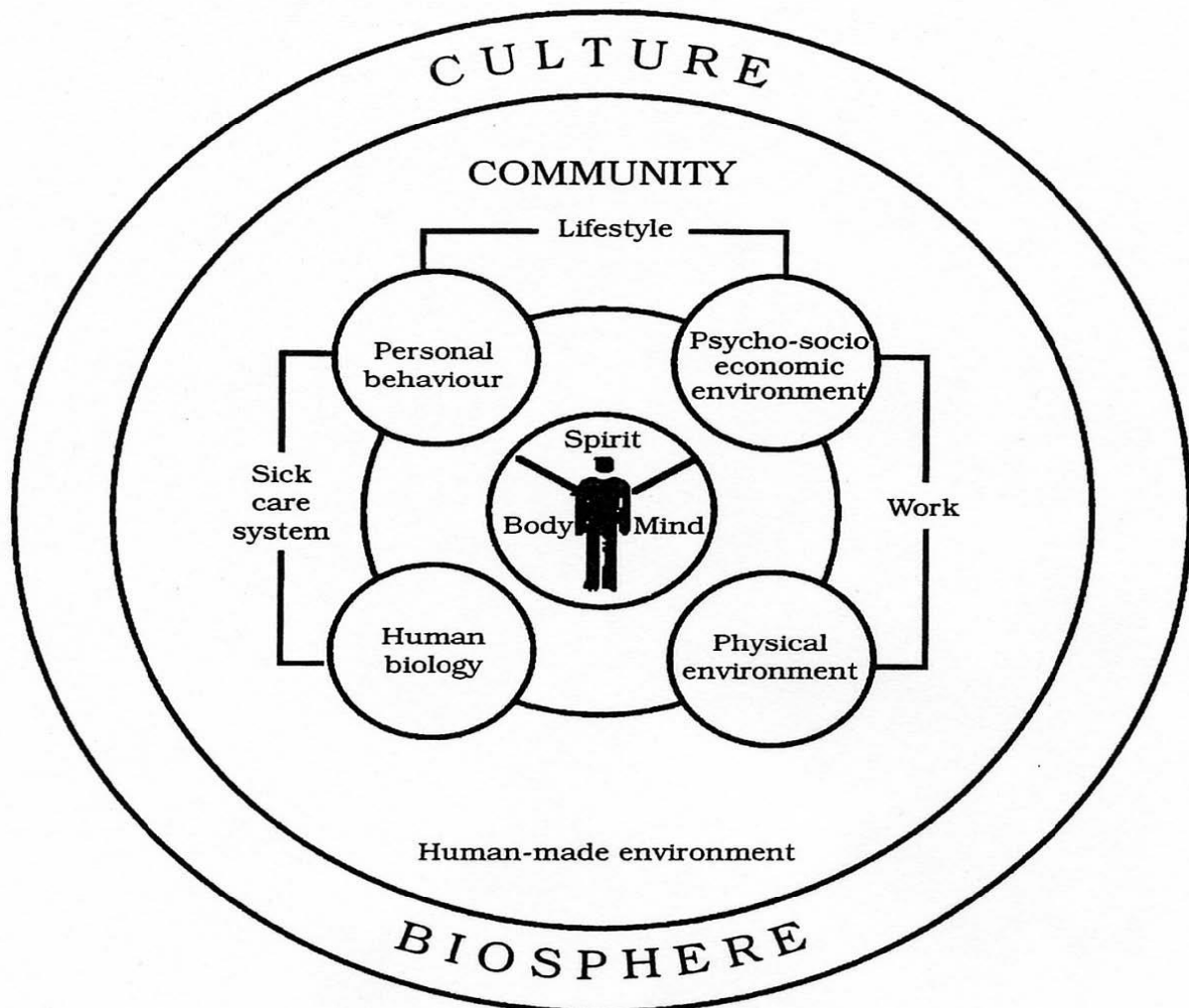


Figure 2.1 The *Mandala of Health*: How culture relates to people's health

Source: Hancock & Perkins (1985)

Consequently, all these factors are interdependent, generating the cause-and-effect impact to the overall levels of health. The following study begins by accepting that the ultimate aim of any health policy and strategy is to improve and maintain the health of the population at a high level. From a behavioural science point of view, as argued by Monroe (1977), this concept provides the analytical framework of non-mutually exclusive factors other than the (formal) medical system which determines the health levels of the population. These factors include both *endogenous* and *exogenous* factors, which can be elaborated more in detail as follows:

Endogenous Factors include genetic, biological, temperament and personality, cognitive and behavioural factors. Certainly, the way people are raised and socialized in a multi-ethnic and religious pluralistic country with 120 tribal groups like Tanzania contributes or moulds their personality and understanding of 'health' and health care systems. This includes the ability to withstand, react and adjust to morbidity, the propensity to take risks and other ill-health related factors. Though individuals have some degree of autonomy in their behaviour, to a large extent, the choice one makes reflects the norms and mores of the larger society or a subgroup culture exposed to him or her. In short, behavioural factors encompass a major social role, both familial and occupational; preferences and level of food consumption; and housing and personal hygiene.

Exogenous Factors explain the way social groups and relationships (formal and informal) affect one's health status. These include the degree of strain and conflicts, provision of security and other forms of subsistence against internal or external threat, maintenance of moral values and public health activities for example disposal of wastes and sanitation, pollution control, immunization and isolation measures. Both the physical and ecological environments play a substantial part in people's health. Not just the catastrophic disasters, topography and the distance from a health facility matter, but also the microbial, parasitic and their respective vector lives in a particular environment. This being the case, it is paramount that health planners and policy makers recognize the relative impact of each factor and, even more challenging, get the optimal distribution of scarce resources amidst demands from these factors.

2.1.2. Indigenous Aetiology and Health Care Utilisation

In his work '*Culture, Health and Illness*,' Helman (1994) presents traditional 'lay' theories of illness causation (*aetiology*) in different sites of the individual, the natural world, the social world and the supernatural world; factors which are usually linked together. Any medical system is a result of the socio-cultural context. In the contemporary, complex Tanzanian society, one can identify four mainly overlapping and interconnected medical systems as follows.

Firstly, the Western, *modern medical system* which comprises the legally sanctioned professions encompassing therapies, which are based on principles of conventional allopathic and biomedicine. Practitioners are physicians of different specialities and *para*-medical professions.

Secondly, the indigenous or *traditional medical system* which includes heterogeneous groups of folk health service providers such as herbalists, spiritual healers, soothsayers, fortune tellers, bonesetters, traditional midwives, astrologists, acupuncturists, witch doctors, traditional circumcisers, teeth mutilators, and traditional cosmeticians.

Thirdly, the *transitional medicine system* which includes commercial pharmaceuticals, forming a syncretism between traditional and modern medicine, mostly practiced by traditional healers who prescribe both herbs and modern medicines such as analgesics, admit people in modern wards and use thermometers and blood pressure instruments. Finally yet importantly, there is the *popular medical system* where self-medication and health maintenance, advice from non-professional friends or relatives, and spiritual healing is being used. Here the main actors are mothers, evangelists from Christian charismatic movements, Muslim Sheikhs and people with personal experience with specific illnesses and disorders.

In Medical Anthropology where ‘disease’ is defined as the objective morbid condition of the human body, ‘illness’ refers to the subjective psycho-social experience of a perceived unhealthy condition (Kleinman 1980; Twaddle 1981). Bank *et al.* (1973: 24) further elaborate that illness is not simply an individual condition but a social process whereby after observing symptoms of illness, the individual accepts the *sick role* due to limitations of his or her social role, before accepting the dependent ‘patient role’. The progress from *sick role* to ‘patient role’ has already been described by Suchman (1965) in his classic study on *Stages of Illness and Medical Care*.

Therefore, illness in Tanzania, as in other countries, can be regarded as both a personal and a social concept, embedded within the lives of individuals and communities, and interpreted and responded to in the context of medical pluralism with all the related complexities of different theories, practices, medicaments, institutions and functionaries.

Apparently, although there is so much emphasis and practical support for the modern formal medical system even in the current *Health Sector Reform Action Plan* discussed later in this chapter, there are reasons why the traditional medical system should be incorporated and integrated. Some of the pertinent issues, which can no longer be denied, include the following considerations:

- Western medicine sometimes fails to deliver. Untreatable diseases and illness remain; therefore, biomedicine is not sufficient in providing a universal account of the human body, illness and health.
- Due to the increased production costs of modern medicines, the previous effects of the International Monetary Fund (IMF) structural adjustment programmes and the world economic recession, many Tanzanians are unable to buy drugs according to doctors’ prescriptions, and instead buy according to their purchasing powers. However, the side effects of under-dosing are apparent (Chirangi 2000) (1).

Referring to the available Tanzania country health indicators (later shown in Paragraph 2.2.1 and 6.1), the modern health services are neither satisfactory nor accessible for all people. Indigenous medicinal plants usually provide relatively low-cost remedies, especially in the rural areas. This phenomenon became the theme of the National Summit of the *Herb Research Foundation on U.S.-African Relationships*, held on February 16-20, 2000 in Washington. The Summit has been attended by 11 Heads of African Nations, U.S. Administration and Cabinet Officials, Congressional Representatives and Mayors, and has been reported by *Agribusiness in Sustainable Natural African Plant Product* (ASNAPP 2000). Furthermore, a study conducted by the *Wildlife Trade Monitoring Network* (TRAFFIC) working with the *World Wildlife Fund* (WWF) and the *International Union for the Conservation of Nature* (IUCN) also confirmed that the use of Traditional Medicine (TM) in East and Southern Africa is widespread, and that it is not only affordable but also accessible and culturally acceptable (*cf.* Marshall 1998).

The concept of health care utilisation is more complex than just a focus on *illness* as a determinant of the search for treatment and the use of services. Slikkerveer (1990) embarks on the above mentioned study of Suchman (1965) concerning the stages of illness and medical care, and explains how Bank (1973: 24) deduces the processes through which a person goes before seeking help from a medical practitioner. In this process, an individual experiences symptoms of illness and then accepts the *sick role*, and as the social roles become limited, the dependent *patient role* is assumed, followed either, by treatment and recovery, or death.

The shift from *sick role* to *patient role* for individuals who experience such disorders is also relevant for the situation in Tanzania, whereby there is a difference between ‘having an illness’ or being categorized as a ‘patient’. Such differentiation is found among the members of the Jita ethno-cultural group in the Mara Region, referred to as *Omwasisibwa* no *omurwaye* respectively.

2.1.3 Indigenous Knowledge and Practice of MAC Plants

Medicinal, Aromatic and Cosmetic (MAC) plants form the largest source of raw materials and products of the *material medica* of Traditional Medicine (TM). In the traditional African societies, the way in which medicinal plants have been utilised, illustrates the ‘holistic’ approach of placing humankind between the visible and invisible surrounding environments. Such cosmovision shows how humans relate to the social world, the natural world and the supra-natural world, found in many countries around the globe. Indeed, throughout the greater parts of the developing societies, people perceive the universe as made up by the three worlds: the spiritual world, the human world and the natural world (*cf.* Millar 1999; Agung 2005).

Traditional African communities are characterised by certain customary values, which serve as guidelines for the proper utilisation of MAC plants. These values are still playing a role today in community life, and as such continue to influence the patterns of utilisation of these plants, which, in turn, are the major components of Traditional Medicine (TM). The specific customary values which determine proper utilisation of MAC plants can be considered as the socio-cultural obligations of the communities, and include the following notions: trust, being human-centred, encouraging community development, being environmentally friendly, and finally, having a special ‘calling’ (Hedberg 1982; Cunningham 1993; Gessler 1995; Mhame 2005), as indicated below:

Trust

It is perceived that in every activity in health, there must be total trust and good will between the healer and the individual(s) in need. Traditionally, this has been underscored by upholding close and more friendly communication to clients. Today, the situation has changed because of the widening in social distance in communication between the medical practitioners and patients, while less time is spent in the interaction process.

Human-centred

The way to restore the human harmony and quality of life is embedded in the individual’s relational life to the world in its totality. The shift towards this understanding of disease and the dependence of the status of the organs has been the beginning of the acceptance that euthanasia in case of an incurable disease is or when the organs are less normal functioning, such as in the case of old age.

Community development

The ultimate aim to prescribe or use medicine has been focused on the welfare and development of the community. During the fieldwork (2010), however, it has also been noticed that today a number of individuals tend to visit traditional healers for merely personal reasons without considering the welfare of others.

Environmentally friendly and contextual

Harvesting of medicinal plants has been done with a view to ensure sustainable use and conservation. Therefore, the local communities took special care with harvesting. Healers

would only collect those plants, which were needed for a particular patient. The current situation of a growing number of plants under threat of extinction leaves the question; what the effect will be of continuing commercial collection of MAC plants for sale in the market? It is not uncommon to meet an herbs vendor who ignores the conservational and socio-values of the people in the areas.

Special 'calling'

Only those who were 'called' among community members became traditional medical practitioners in specialities, which have been handed down to them by their mentors or parents. In the contemporary time, there are also traditional healers who claim that they are specialists in the treatment of all illnesses. During the fieldwork in Musoma and Bunda, some of these 'self-sworn' practitioners were observed with long lists of diseases, which they claimed that they could treat them. Such unfounded claim fosters the public criticism of these healers' capabilities. The traditional use and management of MAC plants in Tanzania, as in many other African countries, is based on the dedication of the members of local communities, who feel responsible for the sustainable utilisation and management of their resources (*cf.* Cooper 1985; Davis 1986; Good 1987; Kingdom 1990; Cunningham 1993). Such attitudes include planning, organising, staffing, leading, controlling and evaluating, as explained below.

Planning

Angina (1987), Gordon (1988) and other medical anthropologists contrast different aspects of modern medicine with traditional African medicine. For one, modern medicine focuses on the individual patient or even an individual organ, while the traditional orientation is committed to the whole person and one's physical, social and spiritual environment. Therefore, the major vision and community assignment in any planning activity has been to regard humans living in harmony with their fellows, the physical environment and the spiritual beings through ancestral linkages. This cosmological orientation links up with the above mentioned cosmovision;

Organising

It has been the society, which determines and recognises the roles of the traditional healers in the patterns of social stratification. The practices of traditional healers have mainly been performed at one specific place or residence, with the exception of a few services, which need to be executed in certain locations aside the environment. For example at sanctuaries, or during initiation ceremonies or attending births, and, of course, when the patient could not move from his or her site. At present, however, an increasing number of signposts have been erected, inscribed with texts such as "*Mganga Bingwa wa Tiba Asilia yuko hapa*" (A Specialist Traditional Healer is available). These signposts appear at guesthouses, market places, streets, open areas, kiosks, and residential places, particularly in urban areas. The healers are mobile and tend to keep on shifting and doing a lot of self-advertisement. This phenomenon can easily give the impression of unreliability, professional arrogance or even incompetence.

Staffing

The traditional medical practitioners are driven by a 'calling' and not by material gain. The community, however, provides them with security and a sense of belonging and support. In most ethno-cultural groups, this 'calling' has been among the sacred activities, typically passed on only through traditional ceremonial rites. Such 'calling' assures the preservation and continuity of the indigenous medical knowledge within the community. The misappropriation of the common intellectual rights in the communities has not been possible.



Figure 2.2 Service notice of a traditional healer for clients in Musoma.
Source: Fieldwork (2009)

Leading

While in the past, only traditional healers, traditional birth attendants and midwives, and circumcisers could make use of traditional medicines, nowadays, ordinary people have access to both traditional and modern medicine. Junior health personnel can now give instructions, even if they lack experience and understanding of the surrounding community life concerning the use of the medicines.

Controlling

Every society has honoured the enforcement of the communal ethical standards and justice. For example, the control of the utilisation of medicinal plants has been subject to a number of norms, such as strict observance of the harvesting times and the season, never uprooting the Medicinal, Aromatic and Cosmetic (MAC) plants, and adherence to the age restrictions of people who are participate in such indigenous activities. In addition, local taboos and beliefs – often grounded in rational considerations - have substantially contributed to preservation of several rare species of plants and animals often under threat of extinction. At the same time, the relatively low level of technology has so far limited the mass exploitation of these important local resources. The sustainable use of resources further developed, following the way in which people assumed their responsibilities. To the present day, the Traditional Birth Attendants (TBAs) in the Mara Region of Tanzania are presented with a small token after they provide their service. In the region, the knowledge of Traditional Medicine (TM) has largely been passed on through the oral tradition and the transfer and exchange of experience, further enlightened by artifactual representations in drawings and carvings.

Evaluation

The evaluation of the usefulness and efficacy of Traditional Medicine (TM) has been a major component of community life, executed by the whole society, not just by health personnel. The evaluation is sanctioned by an often informal reward system. Corrective measures are often promptly taken, while quality control is mandatory and observed at every stage. The responsibility of the local community continues to ensure that all its members can obtain acceptable health care. In essence, this principle also forms the base behind the philosophy of 'access to basic health care for all' of the Primary Health Care (PHC) strategy (WHO 1978).

2.2 Health Sector Reform

2.2.1 The Paradigm Shift in Health Care

With the introduction of the concept of Primary Health Care (PHC) by the World Health Organization (1978), the beginning of a clear paradigm shift emerged in the thinking about the way in which "*Health for All*" could best be achieved worldwide. For a long time, health care had been controlled and dealt with in a *triad*, known as the 3-Ds: *Doctors, Drugs and Dispensaries*. The triad represents the dominant focus on modern health, medicines, health facilities and medical personnel. In practice, such focus is manifest in the allocation of resources, especially regarding the procurement of drugs and vaccines, professional control, molecular biological research and technical innovation.

Gradually, there emerged a general feeling in the late 1970s, that health care had to be de-medicalized, culturally redefined and integrated. In the following *Declaration of Alma Mata* (1978) Primary Health Care (PHC) has been defined 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 the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*".

While the previously mentioned triad of the 3-Ds, are important, the following considerations are similarly essential:

- To consider people as participants and not just as beneficiaries of health planning, implementation and evaluation;
- To study the traditional medical system, as well as the socio-cultural determinants of health and health care utilisation;
- To empower local communities and traditional medical practitioners to complement and co-operate with modern medical practitioners of the formal medical system;
- To carry out research, guided by a participatory methodology with the indigenous people in different health-related fields, such as medical anthropology, medical ethnobotany and ethnomedicine.

According to the early work of Claridge (1970), in addition to the pharmacological properties of medicines – for the larger part derived from the knowledge and practice of traditional healers over many ages since the Sixteenth Century - the preferences and effects of any medication made available to an individual also depends on other factors, such as:

- The recipient's characteristics, *e.g.* socio-cultural background, education, experience, personality, age, etc.;
- The prescriber's or dispenser's characteristics, *e.g.* sense of authority, trustworthiness, attitude, professional status, age, etc.;
- The setting, *e.g.* the environment and context in which the medicine is administered;
- The characteristics of the medicines, *e.g.* taste, shape, colour, name, etc.

As regards the study of use of medicines, advanced research on health care utilisation has recently focused on the differentiation between traditional and modern medicines, and operationalised analytical models of interactions among and between various predisposing, enabling and dependent factors in order to identify significant relationships as a basis for future health care policy planning and implementation (Slikkerveer 1990; 2011). Similarly, an international study on the provision and consumption behaviour of clients and patients with regard to non-prescribed and prescribed medicines in a number in several South-European countries has in this complementary qualitative and quantitative way documented various determinants of the use of both types of medicines on the basis of such advanced multivariate analytical model (*cf.* Slikkerveer, La Grange & Lionis 2012). As is further described in Chapter III, this interesting analytical model is also used and adapted for the present study in the Mara Region of Tanzania.



Figure 2.3: A Modern pharmaceutical shop in Musoma
Source: Fieldwork (2009)

Public/private partnership and equity of access to quality primary health services are key policy themes under sector reforms in decentralized management, as is people's participation in financing and governance of health services. An essential health intervention package provides the main frame for prioritization, with such diseases as HIV/AIDS, Tuberculosis, Malaria and MCH at the apex.

National resources such as human, financial and material including essential medical equipment and medicines are still insufficient to ensure the availability of and access to essential health services of adequate quality. While health resources management and retention in work are at the centre of current debate, the search for sustainable financing to be able to pay workers decently and making payment exemption mechanisms to work to the benefit of the poor is now a priority in the health care delivery system. Also, the ability to produce and use health information as a means to strengthen the skills for evidence-based health planning and management is another priority.

In addition, unequal access to social services, largely the result of unequal income distribution and high levels of income is non-functional for the social protection of the poor. The low income of the majority of the population at the community level hinders their accessibility to health services and medicines. At the national level, low financial capacity limits adequate resource allocations in the medical system, leading to inadequate provision of health care services.



Figure 2.4: The Theoretical Pyramid of the General Needs of People.

Source: Adapted from Greenhalgh (2007).

Contemporary medical practitioners both of the traditional and modern medical systems suffer from a growing moral degradation of the profession. Borgtein & Mulongo (2011) question if entrepreneurship in health care is a truly moral issue. Increased costs of health care services and less emphasis on the preventive care of patients than on treatment indicate that there is a

growing need for medical practitioners to change their attitude from a business-s to a service-orientation in health care, as well as from curative to preventive care.

Health indicators recently presented in the *Tanzanian Annual Health Statistical Abstract* (2008), and in the *General Tanzanian Nation Economic Review* (2000) indicate several challenges, such as the increase in the national average number of individuals per nurse of 5,000, and the increase in the national average number of individuals per doctor of 138,000. The number further increases for specialist doctors such as oral and dental practitioners, while the records of the Ministry of Health and Social Welfare (MoHSW) show an average of 356,000 individuals per dental assistant.

These numbers imply a huge workload for modern health personnel, resulting in less time spent per patient and even some patients left unattended. In short, the profile of human resources and the distribution in the health sector shows a deficit of about 65% of the required health professionals in all health facilities of Tanzania (*cf.* Ministry of Health and Social Welfare, 2008).

Recently, morbidity patterns have changed from acute to chronic diseases. There is a great need to change the focus from the few patients who need specialized, hospital-based services to a larger number of patients who need basic health services, preventive care, and health promotion. The pyramid below represented in Figure 2.4 shows the general needs of health care by the population (Greenhalgh 2007).

2.2.2 Pertinent Issues in the Tanzanian Health Sector Reforms

The present Tanzanian Health Sector Reform (HSR) started with a strategy note (Ministry of Health (1993) which emanated from the country's need to re-examine the present health services delivery system. After conducting a number of meetings and workshops for appraisals, analyses and plans for actions by multisectoral health stakeholders, the *Tanzanian Ministry of Health HSR Programme of Work (July 1999 – June 2002)* has been finally formulated.

Currently, the Health Sector Reform (1993) is implemented through the comprehensive *Health Sector Strategic Plan (HSSP) II* of 2007 is in line with the *Local Government Reform and Decentralization by Devolution* of 1994; the *National Strategy for Growth and Reduction of Poverty (MKUKUTA)* of 2005, *The Millennium Development Goals (MDGs)* up to 2015 and the *Primary Health Care Services Development Programme, (PHCSDP)* of 2007–2017 well known as *Mpango wa Maendeleo wa Afya ya Msingi (MMAM)*.

The main issues outlined in Table 2.1, call for a paradigm shift in the Tanzanian health perspective as a prerequisite to understanding and addressing the *problem statement* pertaining to integrated health development in Tanzania as presented in Paragraph 2.2.3 The nation has to learn from the experience of the Indian forum of around 20 networks, associations, federation and movements of the civic societies of 7 April 2000 in Hyderabad to bring about positive changes in the medical system.

2.2.3 Ethnobotanical Knowledge Systems and Health Promotion

It becomes almost impossible to discuss health sector reform strategies in a traditional medical system without considering the *Ethnobotanical Knowledge System (EKS)* of the specific population. While Ethnobotany refers to the study of the relationship between local people and their indigenous MAC plants in terms of their knowledge, practice and behaviour, the concept of *Ethnobotanical Knowledge System (EKS)* focuses on the interaction between local and global knowledge systems of these MAC plants (*cf.* Slikkerveer 2000).

Table: 2.1 Issues Addressed in the Recent Tanzanian Health Sector Reforms

Issues	Explanations
Ideological	Community participation in health planning, financing and management. Community taking an active role in disease prevention and health promotion. Government adopting a policy of being complementary rather than confrontational with the private health system.
Organisational	Government becoming more of a facilitator, monitor and regulator than the sole health provider. Decentralisation and devolution of the authority to District level. Refinement of the referral medical system.
Managerial	Effective supervision, quality assurance and co-ordination of health services within the Primary Health Care, Management Committees and Programmes. Capacity building and motivation of human resources.
Financial	Diversification and adoption of more sustainable sources of health financing. Efficient budget allocation to services with greater impact on the health status of the community.
Public/Private Mix	Amendment of legislation and development of institutions promote active private system participation in health service delivery including that of traditional medical practitioners.
Population and Nutritional	Regulating population growth through intersectoral family planning strategies and improvement of the health and welfare (especially) of the mothers and children. Reduction of malnutrition and elimination of micronutrient deficiencies.
Research	To strengthen the national research institutes/centres and encourage appropriate research both operational and bio-medical related to the needs of the medical system.

Source: Tanzania Health Proposal for Health Reforms 1994, and Health Sector Strategic Plan III, July 2009-June 2015, MoHSW.

The concept is operational in various dimensions, including the utilitarian aspects of local plant use, the cognitive aspects of perception and belief about these plants, the ecological aspects of the conservation of plants, and the scientific validation aspects of MAC plants used in Traditional Medicine (TM).

The role of plants in different cultures carries a substantial weight of human welfare and life. As an interdisciplinary field, Ethnobotany brings together contributions from a variety of disciplines such as botany, ecology, anthropology, ethno-pharmacology, history, linguistics and economics. In general, Ethnobotanists study indigenous knowledge and practice of MAC plants for medicine, food, decoration, shelter, clothing, fuel and religious ceremonies.

Humankind has used plants for medicine since the prehistoric times, and the role of today's herbalists in Tanzania is deeply rooted in the early human history in this significant part of the world, known as the '*Cradle of Humankind*'.

Although the modern synthesized medicines have had much attention in developed countries, particularly since the 1990s, the field of pharmacognosy as the study of bio-chemical components of MAC plants has further increased for the development of new medicines.

The knowledge of the use of MAC plants has created a new booming business for the informal sector through the provision of self-employment for medicinal plant collectors and street vendors, especially in urban areas.

From a historical perspective, Warren (1989) and Slikkerveer (1996) note that traditional knowledge in the former colonies was ridiculed, ignored and marginalized, while modern systems of knowledge and technology developed in the Western world, often using indigenous knowledge and practice as a fruitful resource without any compensation for the local people.

By the middle of the Nineteenth Century, European missionaries established churches in many regions of Africa and started to propagate Christianity offering new belief systems and practices, distinct from the traditional religions. The communication of the faith and doctrines of Christian churches introduced the cultural aspects of the mother church, often declaring most of the indigenous knowledge and belief 'ungodly'. Not all such actions, however, can be backed by biblical absolutes. The challenge therefore in today's dynamic Tanzanian society, is to contextualize African Christianity and all other religions, but without losing virtues, because faith and religious orders are still part and parcel of the total life of many Africans. Additionally, religious bodies have also shown to be powerful agents for social change in many societies.

A good example of this initiative is provided by the preliminary explorations of the gospel and the culture by the *Research Institute on Christianity in South Africa* (RICA), sponsored by the *World Council of Churches* (WCC) (4). Chavunduka (1999) in his article '*Christianity, African Religion and African Medicine*' concludes: "*The way forward for the Christian Church is to examine carefully African religion and medicine and other cultural aspects, with a view to identifying clearly those practices are not against Christian faith and morals and incorporate them into modern medicine and Christian worship; if possible, they should also try to find a way out of what are considered non-Christian rites and other cultural practices. A few Christian churches are already doing this*". A failure to address this challenge of communicating religion in the people's culture is to lay unnecessary yolk to believers and perpetuate hypocrisy with a dualistic identity of being an African (in hidden forms) and a Christian (openly) instead of being with one identity, an African Christian or Christian African.

Evidence of a re-orientation can be observed in the *Declaration on Primary Health Care* (WHO 1978), in which not only the role of traditional healers and village health workers, but also the potential of traditional medical systems is appreciated and recognised. A growing awareness and a 're-invention of the wheel' of indigenous knowledge have also continued in the agricultural and environmental sectors in developing countries during the 1980s (*cf.* Chambers 1987, Warren, Slikkerveer & Brokensha 1995). The key concept in the study of *Ethnobotanical Knowledge Systems* (EKS) is *sustainable development*: a process which is environmentally friendly, humane, in line with social justice, economically viable, and adaptive. In the context of this study in Tanzania, the major challenging question therefore is: "*What is the appropriate approach to the promotion and implementation of indigenous medical knowledge and practice for the integration of traditional and modern medical systems?*"

In a comparative study of Ghana and Thailand, Le Grand & Peter (1990) narrate two major approaches to promotion activities. Firstly, the *Clinic-Oriented Approach* (COA) which focuses on laboratory research on MAC plants and their industrial production. As Tenambergen (1988) notes, this approach aims at the introduction of all scientifically validated Traditional Medicine (TM) property into modern health care.

Secondly, the *Community-Based Approach* (CBA), which involves research directed at the identification of commonly used traditional remedies and their use in relation to local perceptions of health and healing. It aims at enhancing and promoting positive traditional practices within the context of the community. While the earlier approach centres mainly around laboratories, research centres and pharmaceutical companies from different disciplines such as toxicology, pharmacology, phytochemistry, the latter deals with the study of traditional

medical practitioners, self-care and community health organisations. The *Community-Based Approach* (CBA) allows for more flexibility, bringing motivation to the traditional medical practitioners.

Table 2.2: Community Based Approach (CBA) versus Clinical Oriented Approach (COA) in Promotion of Traditional Medicines

CBA (Advantages)	COA (Disadvantages)
Has fewer ethical problems, as the local medicine being investigated has already been used by people	Tedious difficulties in laboratory coordination and poor Information dissemination on specific approved medicinal plants
Influences attitudes and behaviours of the community, therefore aiding the understanding of practices and organisation of indigenous health service provision	Interest in more scientific publication than relevance to health provision
More beneficial to the local population's health stakeholders than pharmaceutical industries	Scientific validation contributes very little to acceptance of Traditional Medicine (TM) and practices as a whole

Source: Le Grand & Peter (1990)

The present study in the Mara Region further operationalises the *Community-Based Approach* (CBA), well established for the 'bottom-up' perspective of health care development (*cf.* Pousset 1989; Farnsworth *et al.* 1985; Tan 1981; Labadie 1985; Slikkerveer 2000). Table 2.2 shows the major advantages of *Community-Based Approach* (CBA).

Health Education (HE), a social concept of health promotion, is a process through which people become aware of their health situation and work towards improved health status. The common objective of HE as developed by the World Health Organization (WHO 1953) is still valid: "*To help individuals to become competent in and to carry on those activities they must undertake for themselves as individuals or in small groups in order to realize fully the state of health*". However, in a socio-anthropological perspective, the approach takes a notable shift from conventional elements to integrated health promotion (Green & Richard 1993).

In fact the issue of concern today is not just a quantitative argument of adding 'years to life', but more to add 'life to years,' meaning to improve the quality of life (*cf.* Van der Velden 1995). Nevertheless, the life of the people is very much shaped by their culture. Therefore the strategy will not only focus on patient and pathology, but to all factors which determine health behaviours and status, including individual and community livelihood, social structures, economic status, contribution of health planners and health service delivery, both traditional and modern. The dichotomy of the health promotion approaches is presented in Table 2.3, in which the new approach to health education is being recommended.

Table 2.3 Health Education Approaches

Conventional, 'old' HE approach	'New' HE approach
Most teachers were medical and Para-medical personnel	Acceptance of other professionals in social sciences, indigenous knowledge, etc.
Mainly targeted the sick and relatives of sick people at hospitals and villagers on a specific health campaign duration	Looks at a wider target (including traditional healers and health policy makers) with varying demography, in different contexts as an on-going lifelong health promotion commitment

Top down approach from Government ministries (health and education)	Involving communities in their own health diagnosis planning and execution of agreed strategies
It has been 'victim blaming' to individual behaviours like smoking, drinking, prostitution, health service malpractices etc.	Tries to look at all possible causes in the society as a whole, with awareness of and sensitivity to reasons behind certain behaviours.
Focused mainly on population and epidemiological medical research	Includes baseline study of prevailing beliefs and socio-cultural practices related to people's health and any other crucial issues such as gender equality and poverty alleviation
Teachers were considered 'all knowing' with subject- object relationship with the community	Facilitators are ready and willing to learn from the community's indigenous knowledge and practices

Source: Van der Velden (1995)

The JUA Project, established by the researcher and further explained in Paragraph 3.2.3, has laid the foundation for this study, where traditional medical practitioners participate in human resource capacity-building workshops with a *participatory learning methodology*, an approach aligned with the new health education approach, as represented in Figure 2.3.



Figure 2.5 Traditional medical practitioners in *JUA* Capacity-Building Workshop
Source: Fieldwork (2005)

2.3 Integration of Medical Systems

2.3.1 Differences between Traditional and Modern Medicine

Meticulous differentiation in terms of the taxonomy and nomenclature has been used in naming and/or identifying these two medical systems. These include *Allopathic Medicine* versus *Biomedicine* (Hahnemann 1810); *Professional* versus *Folk* (Kleinman 1978) and *Professional*

versus *Lay* (Herman 2001). Other current terms are *Western* versus *non-Western*; *Conventional* versus *Unconventional*, *Orthodox* versus *Unorthodox* and *Mainstream Medicine* versus *Complementary and Alternative Medicine* (CAM) and *Modern Medicine* (MM) versus *Traditional Medicine* (TM). This last term is preferred, as it highlights transformations with time, whereas some other names tend toward derogatory, despairing, abstraction, amusing and misleading, and/or Eurocentric euphemism.

Modern and traditional medical systems can be differentiated through various aspects, such as the *worldview* the care is based on (Leininger 1978, Barner & Wrubel 1989, Holland 1999, Helman 2001), the *focus of care* (Brink 1999, Kennedy 1999), *care orientations* (Illich 1976, Serkkola 1994, Miller 2000) and the *components of care* (Bevan 1998, Greenhalgh *et al.* 1998). Whilst modern therapies put emphasis on an individual sick person, traditional therapies instead encompass a broader spectrum, where an individual is only part of the entire cosmological wholeness and ancestral influence plays as integral part (Buhrman 1984: 94).

2.3.2 The Concept of Integrating Modern and Traditional Medicine

According to Lionis *et al.* (2009), the basic understanding of integration can be deduced as the focus on different systems rather than just one. This means all systems involved are recognised and valued, and all involved health providers must have trust among themselves. For example, in Greece and other countries, particularly the developing countries, there is severe scarcity of human resources in health care. In Tanzania, once TM practitioners are appropriately integrated in the medical system, timely provisions of needed health services can be ensured. All these can be achieved in the presence of an enabling environment. Akerele (1987) echoes this thought, saying, “*Traditional Medical Practitioners are important and influential members of the communities who should be associated with any move to develop health services*”.

The Concise Oxford School Dictionary (1997) defines the term *incorporate* as, “include as part” and *integrate* as “join together harmoniously to make parts into a whole”. The title of this work suggests collaboration is a process towards integration. These are two relevant, connected steps. Firstly, including Traditional Medicine (TM) as part of the national medical system (*incorporate*) and secondly, letting all medical systems collaborate harmoniously (*integrate*) to make parts into a whole.

Furthermore, Frank (1973) notes that Modern Medicine (MM) has continued its emphasis on ‘what’ is wrong, therefore attempting to treat the symptoms, while downplaying the ‘why’ being in an ill situation a problem is also important to be addressed. The enabling environment for incorporating and integrating TM practitioners therefore can be elaborated well by looking at the institutional support to the systems as explained in Subparagraph 2.3.4

Integration in health care is inevitable due to increased differentiation and specialization in various existing systems and professions. Organizational theory shows that integrating different activities in different organisations is more difficult than integrating different departments within the same organisation (Weick 1979). Integration is even more challenging for different activities within different organisations in the different systems of traditional and modern health. For integration to happen, the coordination of the existing traditional hierarchy must be substituted by voluntary collaboration between organisations in the different systems. Although regarded as reality, as in all other organisations, different health facilities are abstract phenomena which can be regarded as cultural artefacts created by human interactions, institutionalised while their roles and authorities are legitimized in society (Poll 1991; Scott 1992).

In order to achieve a common goal of health improvement of humanity, it is important to accept the many differentiations in roles and tasks ranging from prevention, curative care, health promotion, education, rehabilitation, and so on in different health organisations. Therefore, there is a need to integrate their functions, structures and organisational cultures with their respective practitioners' attitude to attain unity of direction (Bate 2000).

Institutional economic theory, explains that inter organizational integration can be achieved through, management hierarchy (top – down), market competition (contractual relations) or networks of voluntary cooperation (Williamson 1975, Child and Faulkner 1998). Integration patterns of organisations can be categorized into two main dimensions; vertical and horizontal (Hvinden 1994, Axelsson 2002). While the vertical takes place within the organisations' departments or units at different levels of the hierarchy, the horizontal, integration takes place between organisations' departments or units on the same level of the hierarchy. There are differences in emphasis on the different forms of integration as shown in the Axelsson & Axelsson (2006) scheme Figure 2.6.

		Horizontal Integration	
		-ve	+ve
Vertical Integration	+ve	<i>Coordination</i>	<i>Cooperation</i>
	-ve	<i>Contacting</i>	<i>Collaboration</i>

Figure 2.6: Scheme of different forms of integration

Source: Axelsson & Axelsson (2006)

The Axelsson scheme of integration shows that for *contacting*, there is low level of both horizontal and vertical integration. It is a superficial form of integration where the organisations involved, with their different organisational structures, enter a contact of relational agreement (Saltman 1994). *Coordination* has a high degree of vertical integration but low degree of horizontal integration. This is the kind of integration where there is typically a common management hierarchy where decisions are made at the top for the lower levels to implement (Meyer 1985). *Cooperation* requires a high degree of both vertical and horizontal integration. Although decisions can be made at higher levels of the organisational structure, lower levels have the discretion to make adjustments, and there is viable communication among organisations involved (Mintzberg 1993). For *collaboration*, there is a high degree of horizontal integration, and low degree of vertical integration. Here most of the undertakings are carried out through voluntary agreement and mutual understanding among the organisations involved. This is the perfect scenario of intersectoral integration between modern and traditional medical systems, where there must be willingness for practitioners of the two systems to work together (Alter & Hage 1993).

2.3.3 Problem Statement on Tanzanian Traditional Medicine (TM)

Practical gaps of the Tanzanian health sector reform

Much has been researched, discussed and written in Tanzania and globally as a sign of commitment to sustained, purposeful change to improve efficiency, equity and effectiveness

through the Health Sector Reform (HSR 1993) with a special emphasis on increasing participation of the private system. This can be witnessed in a number of sources, including: World Bank (1993), Berman & Bossert (2000), Frenk (1994), Chabot *et al.* (1995), Gilshon *et al.* (1994), Gene (1987), McPake (1994), Kagodya & Mchomvu (1996), and WHO (1998). In Tanzania the same pledge is echoed in the *Tanzania Development Vision 2025* (United Republic of Tanzania 1998: 10-11), as well as in the *Health Sector Strategic Plan (July 2009 - June 2015)*. However, despite all the strategies and objectives of health sector reform formulated in all policy levels as narrated by Berman (Ed.) (1995), be it *systemic* for equity; *programmatic* for allocative efficiency; *organisational* for technical efficiency or *instrumental* for institutional intelligence and performance enhancement, the implicit focus in the writings, discussions and activities have mainly been on the modern medical system (public and private).

To sum up, there is a discrepancy between the ideals enshrined in the Health Sector Reform (1993) proclamation and the realities for the promotion of active participation of and collaboration with traditional medical practitioners in the Tanzanian medical system, despite the existence of the Tanzanian Act no. 23 of 2002 which governs traditional and alternative medicine practices (United Republic of Tanzania 2011). The programmes, institutions, actors and policies of Health Sector Reform (1993) have neglected to enforce of this law, and collaboration within the medical system includes the visible but dissented indigenous or traditional medical system. This system encompasses those medicines, therapies and other health services which are not based on the same principles as conventional (allopathic) modern medicine, but have significant effects (both positive and negative) to people's health as they are utilised openly or secretly by people of all demographic profiles, and beliefs both in the rural and urban settings.

Traditional Medical system Identification and Common Characteristics

Although neither terminology nor concept has ever stood without criticism, in this study, the names, *traditional medicine practitioners* and *traditional medical practitioners* have been used frequently. However, some writers contend that the term *traditional medicine* may be misleading as it polarizes the system into a narrow corner of pharmacology, leaving health workers such as spiritualists and fortune-tellers, who hardly employ medicine but have substantial impact on the well-being of their clients spiritually, psychologically and even physically physically (*cf.* Van der Velden *et al.* 1995: 360).. Furthermore, there is not such a simple homogenous body of medical theory and practice, which can be put together under such name, second, it is naive to suggest 'Western medicine' is not traditional for now biomedicine cannot be considered outside the realm of the traditional culture in time.

Although Complementary and Alternative Medicine (CAM) is sometimes confused and used to denote Traditional Medicine (TM), the two are quite different. CAM defines other medicaments and health services and procedures originated outside a certain culture. *Alternative* is a prejudiced term, alluding to the role of a spare. The name *complementary medicine* harmonizes the two systems of medicine, but does not distinguish the one from the other. On the other hand, the term *informal medical system*, as accepted by the International Labour Organisation, (ILO) has also been used to denote unregistered people working as sanitary workers, funeral undertakers, herbalists, birth attendants, midwives, fortune tellers, drug vendors, circumcisers, 'spiritualist' healers, transcendental meditators, acupuncturists, homoeopathists, phytotherapists, iridologists and so on.

The following paraphrased ILO (2000), definition of informal sector, offers insight into to various elements and common characteristics of the informal medical system: "*They are small*

scale units and individuals producing and or distributing therapies and health related services which consist largely of independent, self-employment or community volunteering. In most cases the art of practicing is considered to be ascribed by God or family given and not achieved. Some of its practitioners employ family labour and rarely hired worker operating with little capital or none at all. They utilize low level of modern technology and skills; therefore operating at low levels of productivity. For those who consider it as the sole means of employment for income, they generally provide low and irregular income. They are generally, less supported by government but recognised and held high in their community and so much attached to the culture and lifestyle of the people in their vicinity. They are unregistered or unrecorded in official statistics; they tend to have no access to organised markets, to credit institutions, to formal education and training institutions and less regulated by the government". Following this definition, the term *informal medical system* is provocative and leads policy makers to think strategically and plan for appropriate actions to strengthen, change or get away with any practice which impedes traditional medicine in the overall health sector reform process towards a functioning efficient medical system.

Present status of traditional medicine (TM)

The major problem facing traditional medicine in Tanzania is its low status and assumed poor performance, in particular among government circles, characterized with less support and an enabling environment, as transpires through the following:

- There is weak institutional support to formulate and institute a stable mechanism which promotes integration and synergic collaboration between traditional and modern medical practitioners. For example, signposts at hospital entrances with inscriptions, such as: *"No traditional medicines are allowed inside the wards"* are rather blind strategies to curb supposed health malpractices;
- Although mentioned clearly in the *Public/Private Mix Strategy* of the Health Sector Reform (1993): *"There is a need to put a system will facilitate the promotion of traditional medicine at district, region and central level"* there are no specific activities and tangible indicators laid down for a comprehensive sectoral institutional support, nor capacity development for the providers of Traditional Medicine (TM);
- Furthermore, the Tanzanian Act No. 23 (2002) governing traditional, alternative medicines and practices have not been enforced accordingly. For example, until today, no functional councils are in place at the regional and district levels;
- Whilst it is spoken of as a crucial system, the present resource allocation for medical system, only takes care of the formal system, namely for modern drugs, rehabilitation of health facilities, Primary Health Care (PHC), modern medical research, administration and Health Information Systems (*cf. The Tanzanian Funds Requirements and Proposed Allocation for Health Sector of the Rolling Plan and Forward Budget for the years 1999/2000 – 2001/2002*, pp. 22);
- Despite of their unique potential for both the public and private formal systems, such as being independent, being without much problems of inability to recover costs, commitment to the whole individual (physiologically, pharmacologically, psychologically, pathologically socially, and spiritually), spending more time with a patient, providing more sense of touch

and socialisation, some traditional medical practices continue to be faced with various challenges of quality and rationality.



Figure 2.7 A traditional medicine vendor displaying her products in Shirati, Mara.
Source: Fieldwork (2009)

- Some of those evident practices are Female Genital Mutilation (FGM), children teeth mutilation, uvulectomy and other ill practices by opportunistic ‘non ethical’ practitioners found also in the formal health sector. There is still substantial documentation about Female Genital Mutilation (FGM) practices as part of the general most common reproductive health problem in the world today, excluding not Tanzania. Retzlaff (1999) explains that Female Genital Mutilation (FGM) in different forms is practiced today in at least 28 countries in Central and North Africa. Some communities in the Arab Peninsula, Malaysia and Indonesia also practice Female Genital Mutilation (FGM). Lefeber & Voorhoeve (1998) also show that Female Genital Mutilation (FGM) as part of the initiation rite is practiced in a great area of East Africa and West Africa (Kenya, Somalia, Sudan, Togo, Ivory Coast, Mali, Central African Republic). The practice is observed among Muslims, Christians and believers of African traditional religions alike and is common to both uneducated and educated groups with differing socio-cultural significances.

As most Female Genital Mutilation (FGM) has been left to be considered in the realms of criminology: *‘bring the perpetrators to justice’*. While this kind of intervention cannot be overruled, the continuation of female circumcision today signifies failure of a blunt

prohibition of the practice through political propaganda and judicial threats. It is still imperative to consider Female Genital Mutilation (FGM) as a gender and socio-cultural issue. As Hardon (1998) notes, the implementation of reproductive health care today requires a revolution by health planners and providers to adapt integrated services shaped to specific needs of diverse clients in different settings. In the contemporary society, in addition to the physical and mental suffering of women undergoing this traumatic traditional operation, there is the psychological and spiritual burden of some 'uninitiated' women living in fear and the social exclusion of not to belong to the communities. It is also sensible to consider other positive aspects of the overall initiation ceremony, such as sexual and parenthood health education and the socio-recognition of the rites of passage. In order to understand the notion of reproductive health and the reasons for Female Genital Mutilation (FGM) in people's view is essential for any appropriate form of health education and planned intervention. For this reason, this study envisages to identify acceptable alternative 'initiations' and long-lasting solutions on sexual and reproductive rights of women, rather than just condemning the practice and search for female genital mutilators.

Unfortunately, still some of them have continued the practice in secrecy in cooperation with parents and in an even more risky manner, as in the following painful reported case in one of the Tanzanian local newspaper as reported by Susuma from Dodoma in a local Newspaper *Komesha*, on Saturday, 04 July, 2001. It was reported that, an innocent student girl of standard six Tatu Chibago (14), bled to death on June 22, 2001 in Uhelela village of Dodoma rural, when the operation has been forcefully and crudely conducted around midnight. The reporter explicitly explains the alluded circumciser in a person of Jemina Hoya Komite (imported) from Singida region, had to be paid extra money (about € 1.36 on top of the operation fee of about € 2.4) as a compensation penalty for not finishing with the normal initiation ceremony. All this has been done this way for fear of punishment under the rule of law. Thanks to the neighbours who reported their suspicion to the village authorities as the body was been about to be buried secretly in a tomb dug in the night by the bereaved unit family, uncommon practice in most of the communities in Tanzania.

- Notwithstanding, quackery found in both medical systems (modern and traditional), it is notable mentioning, any system in place ought to be effective in identifying and dealing with quacks without delay. Presently, there is inadequacy of standard references to the definitions of quackery is wrongly focusing only on pretence leaving the promotion for profit all those medical schemes and related services known to be false.
- There is no strong unified national or regional Indigenous Information System for both medicinal plants and disease classification and Ethnobotanical Knowledge System networking. The present Tanzanian Health Management Information System (MTUHA) does not include data about traditional healers and their contribution to health care. As a result, lack of supporting data from this system has undermined efforts to show the public and interested partners its real role in health and health related issues.
- There is lack of proper representation, participation and appreciation of indigenous health providers in planning, decision - making and overall managing health services especially from the District to the National level. This is with exception of trained traditional birth attendants and village health workers in the Primary Health Care (PHC) strategy who too despite of their essential contribution, most communities are not able/ willing to pay them

as it has been noted in as a weakness of PHC in the Tanzanian 1994 for Health Sector Reform proposal.

- For many years traditional medicaments could be obtained relatively easily from specific spices of medicinal plants and animal products within the vicinity. A constant extraction (without preservation measures) of these resources has now categorized most of them as 'endangered rare species. These 'nature on the run' are also results of environmental and habitat degradation and increasing use of natural land for agricultural and other human uses. According to Wildlife trade monitoring programme (TRAFFIC) of World Wide Fund (WWF) for nature conservation union-Eastern/Southern Africa news over 100 key species of plants and 29 species of animals have become scarce. An example of the most threatened type of vegetation in Tanzania is the coastal forests of Zanzibar Inhambane regional Mozaic. Some medicinal plants in East Africa are also reported under TRAFFIC network to be scarce due to excessive exploitation. Such traditional medicines include: *Ehretia amoena* root and leaf (treating viral infections, sores and intestinal parasites); *Acalypha fruticosa* root, stem and bark (treating sores, rashes toothache); *Acacia mellifera* barks (treating stomach ache, malaria, syphilis); *Cadaba farinose* roots (treating bilharzia) (Kahatano, 1997, Mbuya *et al.*, 1994, Ross, 1979). In spite of all, the point of departure for this study and necessary actions to improve the status and services offered by traditional medical practitioners cannot be overemphasized because there is substantial weight of good and efficacious services beyond the mere assumptions of popular opinions and arrogance of orthodox medicine (Fugersons 1995). Their services continue to be offered to complement the inadequacy of both public and private modern medical system. This inadequacy could be in terms of resources or even failure of the orthodox medicine to deliver the goods. The Tanzanian Health Reform Proposal of 1994 has documented that about 40% of total deliveries in the country were attended by traditional birth attendants. This shows that out of the three systems it must be ranked either the 2nd or the 1st if Private and Public modern systems serve 30% each. Further, as documented by Mhame (2000), The National average ratio of traditional medical practitioners to population is 1: 400 while of medical doctors to population is 1: 23,454.

The opposite, however is also true, there are a number of people being maltreated, affected or whose deaths are total or partial the result of malpractices of some members of traditional medical system. For example the Adult Morbidity and Mortality Project of the Ministry of Health and Social Welfare (MoHSW) in three districts manifests health services used in the period of July 1997 – June 1998 leading to death, as represented in Table 2.4.

Table 2.4 Adult Morbidity and Mortality in Three Cities

Service/Place	Dar es salaam	Morogoro	Hai	Total	Average Total
Government	65	53	48	166	55.3
Private/ Voluntary	30	10	42	82	27.3
Traditional	10	42	2	54	18
Self	5	10	35	50	16.7

Key. The values are % of deaths of those who used the service in question.

Source: Tanzania, *Health Statistics Abstract 2000. Vol. I*, Ministry of Health and Social Welfare (MoHSW).

Although no simple deductions on quality of service can be made from the above data, this however provides a clue of significant weight on traditional health service utilisation by the population. It is not a surprise to learn such services do also contribute to people's lives and deaths though no record is often provided in the Health Management Information System (HMIS), abbreviated in Swahili as *MTUHA*. At the *Nyerere Designated District Hospital*, where the researcher has worked, it is not uncommon to admit children who are severely anaemic and in coma, after a long health care by traditional healers. The parents will then be trying to consult the modern medical system, as the last resort. In this case the government and private hospitals death rates (highest rates seen in paediatric wards) are connected to the quality of services offered earlier by fellow indigenous healers found in The modern medical practitioners usually lack important information of earlier traditional medication history of their patients. Often, the parents will not reveal the type nor the details of preceded health care services obtained from the healers. Dubbing those parents as liars for concealing information is unjust for usually it is due to the fear of foreseeable experience of intimidation, mockery and sometimes denouncing remarks as a response from the health workers.

Notwithstanding, it should be marked rationalization of inappropriateness does not guarantee quality services for while on one end others will romanticize traditional health, the opposite camp takes a blanket opposition on anything is not biomedical. Incorporating traditional health services in the national health policy, plans and activities becomes a firm step to get away with extreme helpless attitudes.

2.3.4 Institutional Support for Traditional Medicine

Institutional support for Traditional Medicine (TM) refers to an organised system for support and assistance through a wide range of organisations, associations and agencies, as well as education institutions, the development of an indigenous database, and biodiversity networking. An overarching goal of institutional support is to improve the *status* of the marginalised Traditional Medicine (TM) system and ensure its active *participation* in health care. The two concepts are further elaborated below.

Status

Denoting development of an enhancing legal framework, registration and increased public recognition. Apparently, it does include a need for religious bodies (especially the Christian church as an agent of positive changes in the area) to seriously embark on contextualization of African Christianity or what Stott (1999) calls the '*naturalisation of the gospel*' and thence advocating '*cultural transposition*' to respect traditional medical practitioners and their positive contribution to health improvement to our nation.

Participation

Referring to Stiefel & Wolfe (1994) definition, participation is: '*the organisation of efforts to increase control over resources and the regulative institutions in a given social institutions, or the part of groups and movements of those hitherto excluded from such control*'. Participation therefore may entail encounters between the traditional medical system and those elements in the society, which maintain or reinforce exclusion. Levels of participation to be considered range from a sheer provision of information and viewpoints to health planers to fully involvement in planning, implementation, control and evaluation of health care policies, strategies and resources (finances, human, physical and information) for the community. It

should be noted that there are some (constructed) barriers hinders integration especially between biomedical health personnel and traditional healers.

Courtright *et al.* (2000) affirm that existing collaborative programmes in Malawi, Zimbabwe and Nepal suggest healers can be a positive force for community-based health. The writers point out a number of the barriers, including some with which this study concurs. One such barrier is biomedical personnel apprehension in working with traditional health practitioners, fearing this will legitimise improper health practices. The opposite is also true, and traditional health practitioners may fear that their knowledge will be discarded by Modern Medicine (MM) practitioners. Government and non-government officials usually have little or no knowledge of the actual practices (and impact) of traditional healers. However, the notion that a natural competition for patients can be sighted as a barrier towards collaboration is contentious. This may be more of a perception than a reality, however, as there is more competition among biomedical and even among the so-called para-medical practitioners themselves, which is not considered a problem. However, the notion that a natural competition for patients can be sighted as a barrier towards collaboration is contentious. This may be more of a perception than a reality, as there is more competition among biomedical and even among the so-called para-medical practitioners themselves and yet never considered as barriers.

In short, when two or more systems of health care provision are integrated, it does not necessary mean that all of them has got to operate in the same way and in the same venue, say parading all herbalists in a hospital and force them to be dispensing their herbs instantly from a medical store.

The World Health Organization (WHO 1978) call for cooperation between the two systems has been accepted by some policy makers and medical practitioners. However, Warren *et al.* (1982); Pritech (1991) and Van der Geest (1995) have expressed some general dissatisfaction with the way in which the traditional healers have been treated, as follows:

- there has been uneven co-operation (indigenous medical practitioners are considered inferior);
- projects were geared towards retraining traditional healers so they could find employment in biomedical services;
- those healers were only appreciated because they were respected in the communities and not because of any valuable contribution to people's health.

Therefore, effective integration requires some common shared grounds, such as mutual cooperation, trust, respect, recognition and active participation of traditional health service providers after they have been incorporated pragmatically in the existing reforms.

2.4 Collaboration of Medical Practitioners

2.4.1 Collaboration Defined

Historically, early collaborative network were seen on long distant barter trade business dealing between one Kingdom and the other. Later, the term *collaboration* has also been used in a pejorative sense to denote an act of being a 'traitor' since World War II. Collaboration has been known to be behaviour of some individuals and or groups who crossed the line to help a foreign occupier such as of those of the Nazi Germany against their European countries. In this view, a

new differentiated nomenclature of *collaborationism* as defined in the fourth edition of the American Heritage Dictionary of the English Language has been introduced later to differentiate it from the art of more or less equal partners working together towards a shared goal.

The Business Dictionary (WebFinance-Inc. 2010) defines collaboration as: *'a cooperative arrangement in two or more parties (may or may not have any previous relationship) work jointly towards a common goal'* (13). Collaboration is a key tenet of knowledge management. As organizational and management specialists, Prahalad & Ramaswamy (2001) elaborate, opposing collaboration nowadays is against quality or maybe even profitability. Managers accept they need to collaborate with partners, suppliers, clients, competitors etc. Graham & Barters (1999) in their review of multidisciplinary literature in management and administration, sociology, social work, education, and psychology define collaboration in four dynamic relational properties: it is a relationship of two or more stakeholders, a relationship to link stakeholders, it forms synergies, and finally, the relationship exists in a bounded structure within the system.

Gray (1989) defines collaboration as: *'the process through parties who see different aspects of a problem can explore constructively their differences and search for solutions go beyond their own limited vision of what is possible'*. Referring to the area of negotiations, collaboration is a conflict resolution strategy uses both assertiveness and cooperation to seek solutions advantageous to all parties. It succeeds usually where the participants' goals are compatible.

Other authors, such as Kanter (1994); Rickkets (1995); Lasker *et al.* (1997) and Mayo (1997) describe collaboration as a process which enables different individuals and organisations to combine their human and material resources so that they can accomplish objectives which they are unable to do alone.

Within the subject of organizational and community change, Bruner (1991) defines collaboration as a process to reach goals which cannot be achieved by one single agent, and which includes the following components:

- jointly developing and agreeing on a set of common goals and directions;
- sharing responsibility for obtaining those goals; and
- working together to achieve goals by use of expertise and resources of each collaborator.

In order to attain the objectives of offering quality and accessible health services, collaboration between the tradition and modern medical systems is inevitable. In health care services, both functional and structural differentiation are outcomes of the environmental complexities which include among others, the needs of the patients, professional ethics, regulatory framework, type of health problem and so on. In general, these concepts link up with the contingency theory which seeks to provide principles of management within a specific situation (*cf.* Lawrence & Lorsch 1967).

As a result, as Ovretveit (1993) notes, that fragmentation of responsibility emerges to respond to the different structures and functions. A need for integration and involvement of different systems becomes evident to address problems of fragmentation, which include inconsistencies, duplication of work, undone work and work interruptions (*cf.* Glendinning 2003).

The willingness to integrate eventually gives rise to the extent of collaboration among the systems involved as shown in Figure 2.8 representing the causal relationships leading to the intersectoral collaboration diagram.

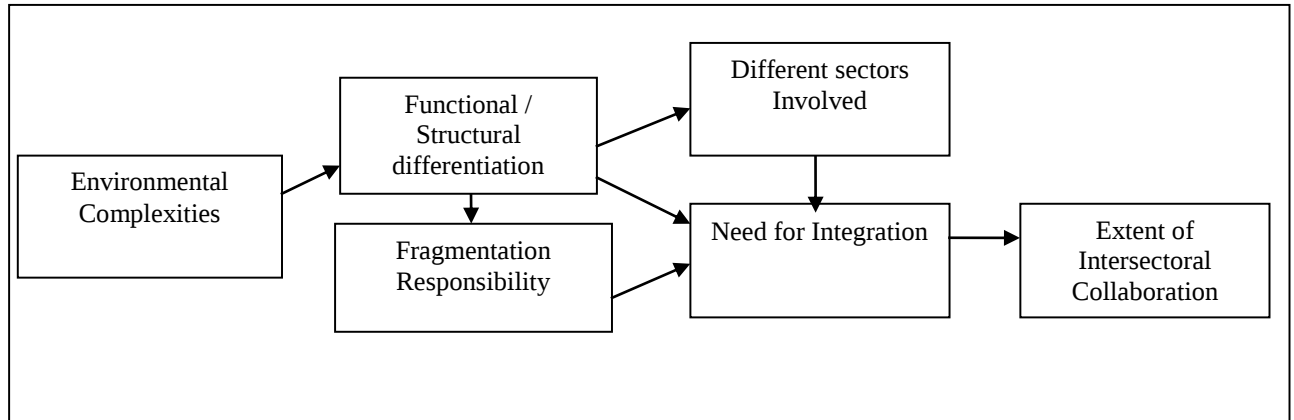


Figure 2.8 Causal Relationships Leading to Intersectoral Collaboration
Source: Theoretical Framework Adopted From Axelsson & Exelsson (2006).

2.4.2 Collaboration as a Behavioural Influenced Action

Among the social psychological theories of voluntary behaviours is the Theory of Reasoned Action (TRA) developed by Ajzen & Fishbein (1980; 2010). The basic assumption in this theory is that most behaviours of social relevance are done on wilful control of the individual and the person has to have a positive attitude towards the behaviour to be undertaken. It explicates one's intention to certain behaviour due to one's attitude towards the behaviour and the general subjective norms of the society motivated by one's *significant others*. Placing it into perspective, this theory can be used to explain a health care practitioner would want to collaborate with another practitioner of the other system if he or she believes (has got attitude) interprofessional collaborative behaviour leads into positive or beneficial results (behavioural belief) and most of his/her reference group accepts or favours such kind of collaborative behaviour (normative belief).

In a different approach in a more detailed manner, Fogg (2003), in his Behaviour Model narrates for a target *Behaviour (B)* to take place, the person must have sufficient *Motivation (M)*, sufficient *Ability/Simplicity (A)* and effective *Triggers (T)*, expressed as: $B = MAT$. Following Fogg (2003), one can determine whether a modern medical practitioner will have more possibilities of collaborating or not collaborating with a traditional medical practitioner and vice versa if he/she is sufficiently *motivated*, perceives to have the ability to do so while there are effective *triggers* which reminds him/her to collaborate.

On *Motivation (M)*, the practitioner should evaluate the pleasure and/or pains to be experienced upon collaboration or non collaboration, and assess hope and/or fear as the result of collaboration. Lastly but more important, the practitioner asks him/herself whether by collaboration with practitioners of the other system, he/she is more or less accepted or socially rejected in the society or in accordance with their organisational culture. On the *Ability (A)*, the practitioner's scarce resources such as financial, material, time, workspace, skills etc. will be weighed in relation to the decision to collaborate. On *Triggers (T)*, more possibilities to

collaborate by the practitioner, should be seen when there exists more available reminders and calls for actions towards collaboration, be it through the government notices, campaigns, policies and promotions by the ministry or through the society at large.

In a wider theoretical framework, collaboration refers to a behavioural act which can be investigated by measurement of the influence of people's knowledge, beliefs and practices of a particular type of collaborative behaviour. The *knowledge-belief-practice complex* has been used extensively as a framework for the interaction behaviour model by various researchers in different evidence-based scientific inquiries with the transcultural setting of developing countries, such as by Slikkerveer (1990; 1995), Agung (2005), Ibui (2007), Leurs (2010), Djen Amar (2010), and Ambaretnani (2012).

Since the consideration of the *knowledge-belief-practice complex* refers to all-inclusive factors in human behaviour, the analysis of this study is also based on this framework in order to adapt the analytical model by the authors mentioned above, and construct the research questionnaire for the collection of data of this study by investigating both the traditional and modern medical practitioners' knowledge, beliefs and their practices underlying their level of collaborative patterns of behaviours.

2.4.3 Studies of Interprofessional Collaboration and Notable Gaps

Gray & Wood (1991) present an insightful work entitled: '*Collaborative Alliances: Moving from Practice to Theory*', and to date there is no single theoretical perspective which provides for an adequate foundation for the general theory of collaboration. Leading researchers have written on theories of collaboration and related concepts such as *network*, *coordination*, *cooperation* and *integration*, mostly in the following areas:

Technology e.g. in IT social networking;

Project Management e.g. in Military mission where different commands combined efforts for a common course;

Academia e.g. when interdisciplinary Colleges, Staff and Students with different expertise or area of specializations work together;

Art Work e.g. when a Musical Album has been produced by different Artists jointly;

Business Venture e.g. when a spare part manufacturing company is cooperating with a car assembly plant;

Health Service Delivery e.g. when two or more modern health cadres (*e.g.* Nurses) decide to work together with the others, *e.g.* surgeons.

There are some documented studies and results on the topic of interprofessional collaboration in health care, including Scanzoni (1979); Coluccio & Maguire. (1983); Baggs (1994); Bogden *et al.* (1997; 1998); Leape *et al.* (1999); McDonough & Doucette. (2001); Boudreau *et al.* (2002); Borenstein *et al.* (2003); Hammond *et al.* (2003); McDonough *et al.* (2004); Zillich *et al.* (2004); and Doucette *et al.* (2005).

However, such studies are still few and not spread over all health-related disciplines, and even more so is the literature on interprofessional collaboration between practitioners of traditional and modern medical systems rather limited. By use of the MESH Medline (PubMed) systematic search, 261 general hits have been found, out of which only 9 are specifically dealing with interprofessional collaboration between traditional and modern medical practitioners, and mainly regarding the care of HIV/AIDS. The majority falls into the area of education, training and research, followed by the incorporation of spiritual services in health facilities. Most studies on interprofessional collaboration, however, involve collaboration between physicians and nurses, and pharmacists and complementary and alternative medical practitioners.

A study with a *Hermeneutic Phenomenology* analysis, such as conducted by Grace & Higgs (2010) in Integrative Medicine Clinics in Austria is one of the very few examples of a study of interprofessional collaboration in a medical pluralistic configuration. However, while it provides insight into different styles of practice in terms of power sharing and roles between general practitioners and practitioners of Complementary and Alternative Medicine (CAM), the study does not show factors which contribute or interact in collaboration or non-collaboration among different practitioners. Therefore, with the existing research results and literature on interprofessional collaboration in health, mainly within the modern medical system, it is evident that there are certain gaps, such as the lack of unified conceptual frameworks and theories as well as the narrow inclusiveness of few professionals, mainly nurses, physicians, pharmacists and chaplains. The researcher observes that in some cases the operationalisation of factors of collaboration is weak. The observation is made in the work of Doucette *et al.* (2005), in which, *professional interaction (context characteristics)* and *relationship initiation (exchange characteristics)* are all taken as independent variables, while they are actually part of the dependent variable (*collaborative behaviour*) as they are output responses of questions which show how practitioners in two cadres - pharmacists and physicians - had worked together in a process of providing services to patients.

2.4.4 Interprofessional Collaboration Stages and Management

As differentiation is inevitable in organisations, the achievement of suitable optimal integration is necessary. Lawrence and Lorsch (1967) affirm that the most important assignment of any management is to achieve differentiation and integration to match all available external and internal environments surrounding the organisation in an open system. Collaboration as a process does not happen naturally all at once, but is rather purposefully achieved through four stages (Daft, 1999). The first stage is *forming* where practitioners ready to work together and exchange resources (collaborate) are identified and allowed to be in contact. Secondly, *storming* appears where conflicts arise due to differences in values and organisational structures among the practitioners. *Norming* is the third stage, in which the different groups build trust, settle disagreements and formulate common corporate goals and a team culture, and embed values and standards. In the last stage of *performing*, the groups start working jointly and exchange resources to achieve common goals.

When two or more professionals try to collaborate there seem to be some barriers which derail the process. These barriers can be due to differences in administration styles, structures and boundaries, differences in regulatory and procedural frameworks, and/or differences in cultural values and interests (*cf.* Van Raak *et al.* 1999; Glendinning 2003; Vangen & Huxham 2003). Different skills and actions are necessary for nurturing or managing interprofessional collaboration in relation to the four mentioned stages, as follows.

In the *forming* stage, great effort goes into facilitating contact through increased communication links, while in *storming* stage, multidisciplinary conflict management and resolution is needed. There must be high sensitivity of the different values, the building of social capital and carrying necessary negotiations across the isles to pass through the *storming* stage. In the *norming* stage, leaders must emphasise team work, while maintaining mutual trust among the practitioners of the different systems. A Memorandum of Understanding or regulations and joint plans may be drawn at this stage. It is evident that mutual trust is one of the most important factors in any type of collaboration (Ring 1997; Child & Faulkner 1998, Exelsson & Exelsson (2006).

Leaders have to ensure an equal distribution of power, a just reward system and open, effective communication among the actors. In the *performing* stage, the leaders continue to motivate practitioners to continue respecting and trusting each other while exploring their fullest potential to increase productivity and quality health service delivery. A working mechanism of feedback and continuous quality controlling is necessary to keep effective collaboration for achievement of goals.

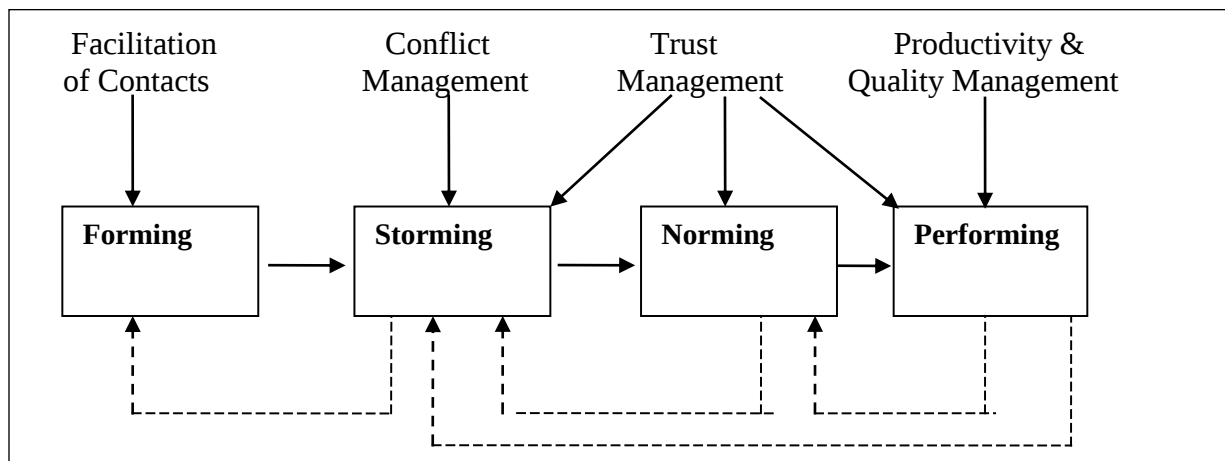


Figure 2.9 Stages and management focus on interprofessional collaboration

Source: Adapted from Axelsson & Axelsson (2006).

At times things do not go as planned, therefore a backward step may be necessary as shown with the dotted lines in Figure 2.9, depicting stages and management's focus in the process of interprofessional collaboration.

2.4.5 Conceptualisation of the Theoretical Model

Creating a good environment for successful collaboration has never been easy, as there are challenges associated with any collaborative strategies. Despite the best intentions, attempts to collaborate often fail or are blocked due to different barriers such as *time*, *trust* and *turf*, as further expounded by Dotterich (2006).

From a wider view, Dotterich (2006) regards collaboration as a step along a continuum of strategies towards integration with different components and situations. Collaborative efforts take *time* to develop, and *turf* issues surface when an imbalance of benefits occurs, perceived or real, for example, when partners do not see each other as equal in terms of decision making, when observing benefits of collaboration, when there is lack of *trust*.

Trust can be influenced by prior or current troubled working relationships, by lack of understanding on how agencies or disciplines operate, or by personal factors, such as personality or the temperament of an agency representative.

The explanation of strategies is represented in Figure 2.10, showing the collaboration continuum which highlights the following:

- **Networking:** Exchanging information for mutual benefit. This is easy to do; it requires low initial level of trust, limited time availability and no sharing of turf;
- **Coordinating:** Exchanging information and altering program activities for mutual benefit and to achieve a common purpose. It requires more organizational involvement than networking, a higher level of trust and some access to another's turf;
- **Cooperating:** Exchanging information, altering activities and sharing resources for mutual benefits and to achieve a common purpose. Increased organisational commitment, may involve written agreements, shared resources can involve human, financial and technical contributions. It needs a substantial amount of time, a high level of trust and significant sharing of turf.
- **Collaborating:** Exchanging information, altering activities, sharing resources and enhancing each other's capacity for mutual benefit and to achieve a common goal. The qualitative difference to cooperating is that organisations and individuals are willing to learn from each other to become better at what they do. Collaborating means organisations share risks, responsibilities and rewards. It requires a substantial time commitment, very high level of trust, and sharing turf;
- **Integrating:** Completely merging two organisations in regards to client operations as well as administrative structure.

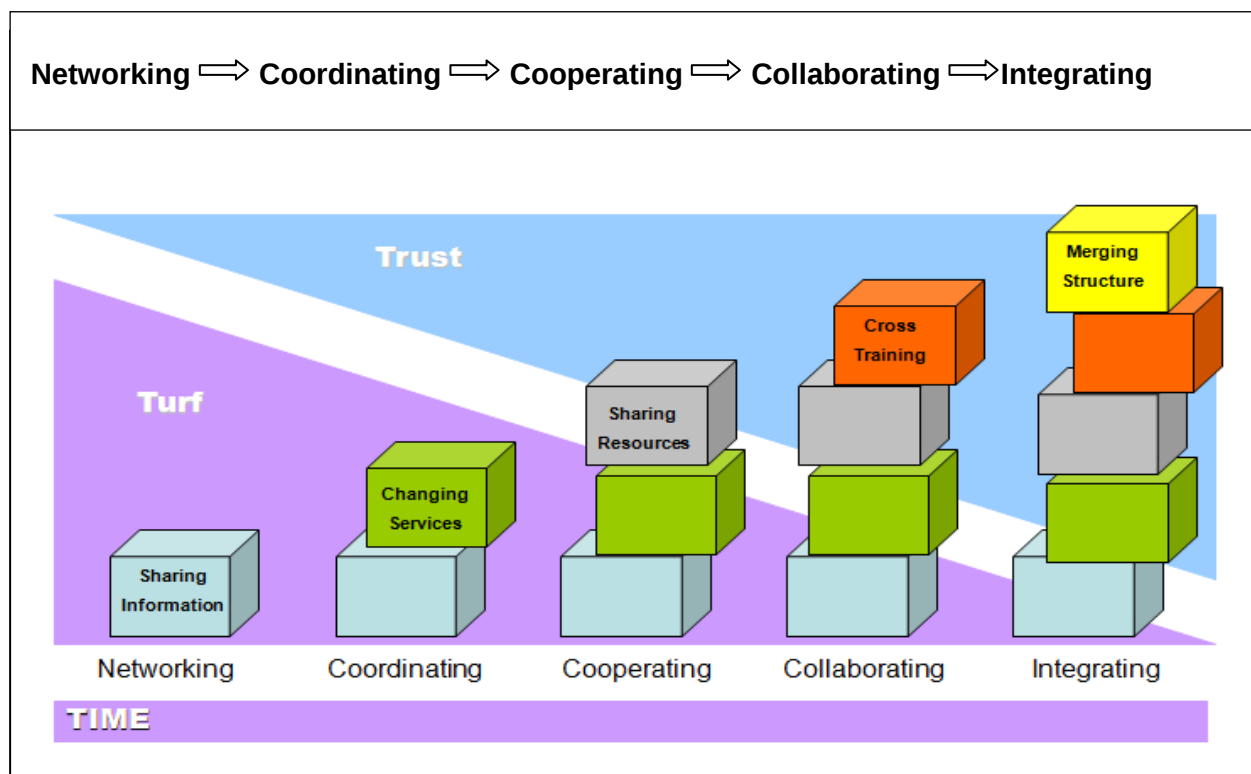


Figure 2.10 Illustration showing the stages of integration, their components and situation.
Source: Dotterich (2006).

It is important to understand that each of these strategies can be appropriate for particular circumstances. Support from all levels of an organisation and in all kinds of communication from the bottom up and vice versa must be available for collaborative efforts to be successful in facilitating change.

Similarly, according to the Centre for Advancement of Collaborative Strategies in Health (2003), interprofessional collaborations as part of synergy formation has two components as independent factors: a) the sharing of resources and b) working together under some sort of common management for a customer.

The theoretical point of embarkation for this research is that interprofessional collaboration is an interactive behavioural action of human beings influenced both at the individual and institutional level. The subsequent review of the theory of reasoned behaviour (Ajzen & Fishbein 1980); the conceptual scheme on stages of integration (Dotterich 2006); the causal relationship leading into interprofessional collaboration (Axelsson & Exelsson 2006); the Behavioural Model of Fog (2003) leads to the operationalisation of the interactive behavioural model based on the *knowledge-beliefs-practices* complex, as developed by Kohn & White (1976), Cox & Claus (1984), and further elaborated for the transcultural perspective in plural medical configurations by Slikkerveer (1990; 1996), later adapted by Agung (2005), Ibui (2007), Leurs (2010), Djen Amar (2010), and Ambaretnani (2012). By adding the concept of *trustworthiness* as a separate variable (Doucette *et al.* 2005), the selected conceptual framework of interprofessional collaboration between traditional and modern medical practitioners for this study is based on the relationship and interaction among various categories or blocks of factors. These factors include the independent factors such as the socio-demographic and psycho-social factors, enabling factors, factors of trustworthiness and organisational factors, the intervening factors and dependent factors of interprofessional collaboration between the traditional and modern medical practitioners in the Mara Region. The related analytical model and its components are further elaborated in Chapter III.

Notes

1. From a Master's course term paper presented at the Institute of Social Studies, entitled *The Social Effect of Structural Adjustment Programme: Gender Dimensions*. The Hague, January 2000.
2. The earliest records are found in Babylon circa 1770 BC in Hammurabi and in Egypt circa 1550 BC as stated by Connie Veilleux and Steven R. King in '*An introduction to Ethnobotany*' (1996) <http://www.accessexcellence.org/RC/Ethnobotany/page2.php> surfed on March 31st, 2013
3. As reported by Stephen Martin facilitator and editor at: <http://web.uct.ac.za/depts/ricsa/commiss/gosculc/gosplcul.htm> surfed on February 2nd, 2013.

