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## CHAPTER V   HEALTH CARE IN TANZANIA

5.1 General Characteristics

As with many countries which were former colonies at one time, located in this tropical zone, most of the early institutionalised medical facilities were based on the various missions, from as early as 1880. Tanzania has its share of mission hospitals and clinics, which were later complemented or sometimes substituted by government institutions. Prior to that, traditional medicine (TM) [20, 21] existed all around since almost every ethnic group has its own references to specific plants and therapies which have migrated along with its people. At the same time there was no original recording of most sources or methods, apart from the oral transmission among healers and their off spring, as the non-sharing of knowledge was still much in fashion (WIPO 2015), in contradiction to today's practices of commercialising, advertising, and even inviting authorities to scientifically determine active components (WHO Nr. 134, 2008). Simultaneously there was a mutual lack of understanding or even distrust, up to the level were the traditional system was being stigmatised by modern practitioners (*cf.* Chirangi 2013), mostly instigated by the representatives of the religion with which the mission facilities were affiliated. The modern system subsequently became officially recognised as the mainstream endorsed health service, although, according to the history narrated by most respondents, everyone used TM at least at one time during his life.

   After independence health care was initially government funded and the service was considered free of charge. The consolidation of these services however demanded intervention after the recessions of the 70's and 80's, and around 1990 a first formal health policy was developed, while user fees were introduced (1993). After 1999 the introduction of health insurance schemes took off, initially directed at formally employed workers *e.g.* the National Health Insurance Fund purposely dedicated to civil servants, later extended with a Community Health Fund (CHF) in 2001, which is a voluntary scheme, and similar local initiatives on village level. There is a separate ministry of health on Zanzibar which co-operates parallel with the WHO Tanzania country office.

   The infrastructural set up is analogous to many other -rural- areas as there is a complementary system of government and mission owned facilities which alternately function as steps in a referral system, depending on their distribution within a given area. There are basically five levels starting from village health posts, dispensaries, health centres, to district hospitals and regional hospitals. The prime distinction is the level of professional training of the personnel with which they are staffed. The Village Health Posts are staffed with a Community Health Worker, or 'Village' in VHW, who is trained in applying first aid, and is capable of recognising potential health hazards, but is primarily functional in early warning and detection and is supposed to refer to the first line dispensaries whenever possible. He is consulted often, though his status is not always appreciated by the average village inhabitant. The system makes a higher claim on his social communications abilities then the pure medical ones. From a dispensary and up a Clinical Officer and a Nurse will be the required minimum expertise, with an optional Midwife. From health centre and above, more elaborate reproductive services, laboratory analysis and auxiliary technical staff such as pharmacists come into view. The Clinical Officers can at Health Centre level be complemented by Assistant Medical Officers. At district level major surgery can take place although in some instances there will be yet another referral level in place for cases to specialised surgeons at regional level. A limited number of these regional hospitals are zonal consultancy centres as the highest level of

referral. The catchment area of a dispensary can cover as much as 10,000 inhabitants at times, as an indication of the demands on the system. The scale of the number of facilities put in a national comparison shows that out of the total of 7,335 facilities listed with the MOH & SW, 6,500 (88%) are dispensaries at elementary level. The co-operation between government and private institutions is illustrated by the division between them, which is now 65% vs 35% over all facility types, with the 'mission' Designated Council Hospitals (38) representing 40% of the total at district level. The supervision of all primary health care and rural emergency operations resides with local government public health departments integrated at council level (*cf.* Boex *et al.* 2015).

Figure 2. Tanzanian Health and Social Welfare System
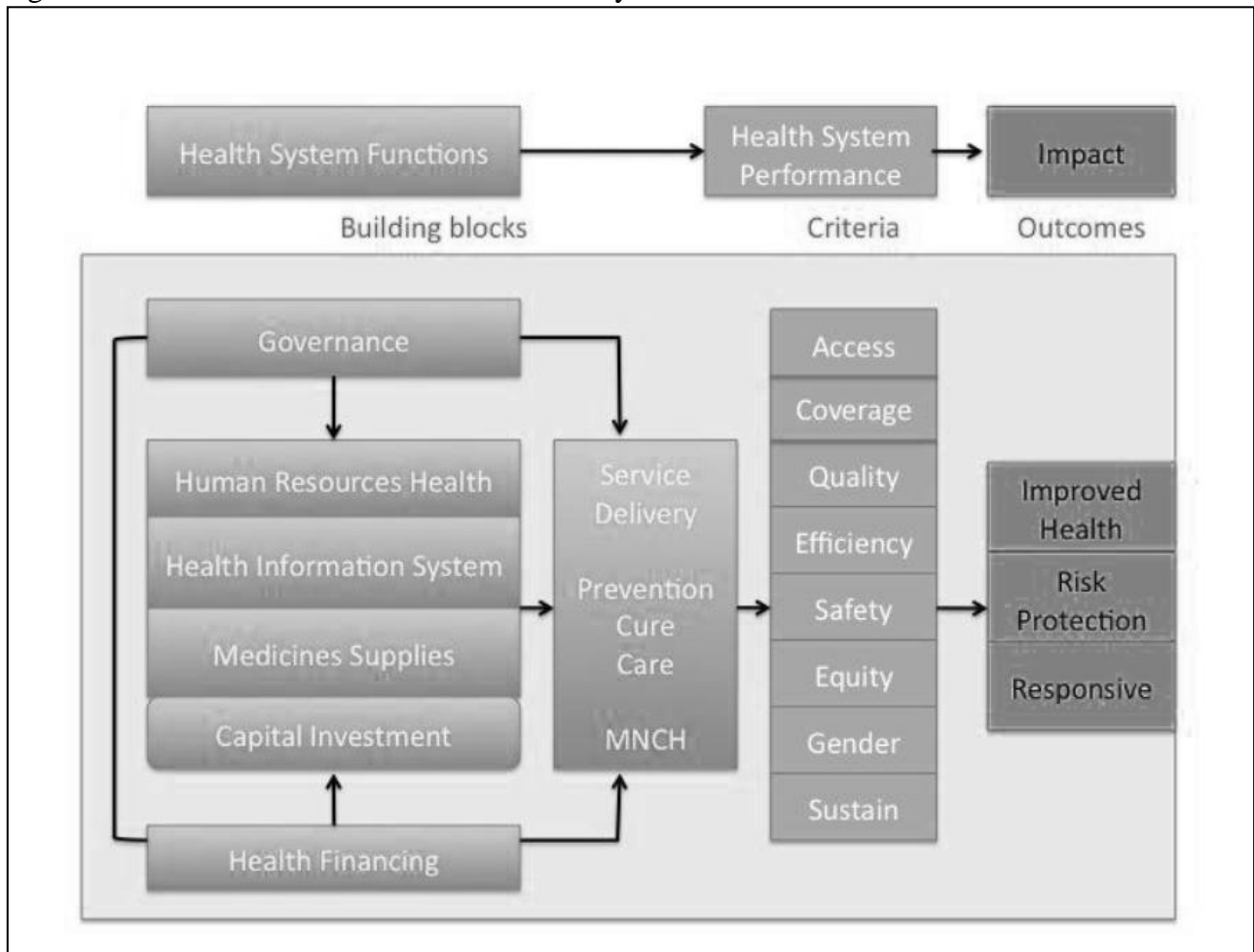
Source: Health Sector Strategic Plan IV, Min. of Health & Soc. Welfare 2015-2020

In Mugumu the public health department's office is located on the district designated hospital compound, an indication of how interrelated they are. As an illustration of the specific type of operations within the system, reference is made to the Serengeti District elaborate profile in chapter IV, 4.1. National programmes run parallel to the institutionalised facilities, encompass Maternal & Child Health (MCH), Communicable Disease Control (CDC), Non-Communicable Disease Control (NCDC) - including Mental Health -, and Community Health Promotion & Disease Prevention

which includes environmental health and management information systems, and Health Professional Training within the formal higher education system. As far as the cost component of health care is concerned, the beforementioned Community Health Fund (CHF) established in 2001, coverage is below the desired impact with quoted margins of around 12 to 15%. Most of the patients are still confronted with transaction costs, even for those services which are advertised today as being free, as Maternal and Child Health (MCH) or care for the elderly. Most people indicate that even though there are no official bills, the staff will still demand an 'administrative fee'. Consequently, there was also a health service card system developed named TIKA (acronymed from *'Tiba kwa Kadi'*) which is aimed at the urban population but has not yet increased coverage extensively. The recent development is that these insurance schemes are regrouped under an umbrella organisation in the form of a National Health Insurance Fund (NHIF) [25] to extend their impact through central governance (*cf.* Mills *et al.*, 2012). The relevance of this enrolment is that apart from increasing the coverage and the quality of care, it was also intended as an incentive for the community members to become more involved in health-related challenges (*cf.* Boex *et al.* 2015)

An example of such a mechanism is provided by a liaison between a local agricultural growers' association, a private produce company and a CHF whereby the members as well as the company agree to pay contributions to the fund as a mutual benefit, to consolidate the scheme (*cf.* Stoermer *et al.* (2012). In this particular case it was preceded by sensitisation campaigns among informal groups sponsored by an outside NGO. In order to increase the attractiveness of such a fund, the classic balance between user fees and the type of service covered becomes pivotal. The coverage of hospital cost for example is not implicit everywhere, and will impose the biggest claim on the resources, yet it is a prime expectation for inexperienced new members. Just as with TIKA the extension to other non-governmental services is expected but not always feasible without intervention by the local authorities. In general, Stoermer *et al.* indicate that a successful CHF depends on a combination of factors, such as; a) the functioning of the District Health Management Team (DHMT), in its members' intrinsic motivation, b) appointing a dedicated person to co-ordinate communications between funds, facilities and authorities, c) ensuring the supply and availability of medicines, d) and the maintenance of quality of services. The suggestion is that promotion encouraged from within the system is not sufficient to increase membership; it will have to be achieved through 'social marketing', sensitisation campaigns, and control of membership premiums and benefits through good registration. Another improvement option is the facilitation of the spreading of payments of membership or user fees, which may produce similar results.

5.2. Current Public Health Challenges in Tanzania

According to Country Co-operation Strategy (WHO 2016) it is envisaged that because of the current economic progress, Tanzania will become less dependent on foreign assistance with regard to health care, and the government is aligned to increase its contributions to national health care over the next decade. As far as the Sustainable Development Goals (SDG's) are concerned, the agenda is determined by developing an emergency early warning and response system (*i.c.* EWAR), the general reduction and management of national health risks (*cf.* International Health Regulation standards 2005), emphasis on containment and decrease of non-communicable diseases (NCDC), and improve the co-ordination of the approach of the 'social determinants of health' with reference to community level reactions during the recent Cholera outbreak experiences. At the same time

some achievements were also recorded which deal with the reduction of the prevalence of malaria and HIV, a decrease in infant mortality, as well as higher coverage rate for immunisations. Remaining challenges are left with maternal morbidity, insufficient medicinal drug supply, and a shortage of budget allocations to health care tasks (<10%) referring to the Abuja target of 15%. One of the key areas identified in this policy document is the distribution of human resources for health to as many as eleven regions (*cf.* Health Sector Strategic Plan IV, 2015–2020). The CCS III agenda as it was formulated shows the operational details connected to the summary above;

a) Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental topics;
b) Reducing the burden of NCDs through health promotion and reduction, prevention, treatment and monitoring of their risk factors;
c) Contributing to reproductive, maternal, neo-natal, child and adolescent health (RMNCAH) and well-being and promotion of health through addressing the social determinants of health;
d) Strengthening health systems to improve the quality, equity in access and utilisation of health services;
e) Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management.

Without wanting to recapitulate specific objectives from earlier plans, which ran from 2005 up to 2015, there is a coherence with other national five-year development programmes which focus on more infrastructural improvements, social services, as well as a focus on the quality of life and human well-being. In terms of targets which can be expressed in numbers, safe water sources are destined to reach 85% in rural areas and 90% in urban areas, a life expectancy of 66 years, striving for infant mortality to be reduced to 45/1,000 live births, with maternal mortality coming down to 250/100,000 live births. On an operational level, the HSSP IV mentions the mobilisation of Community Health Workers (CHW) to engage more intensively in front line of MCH services, complemented by e-Health applications, such as a dedicated CHW application, possibly through the assistance of PPP's, and the expansion of Emergency Obstetric & Neo-natal Care.

5.3. Health Manpower Shortage

One of the most important aspects recognised by the Ministry (MoHSW) is the Human Resources for Health shortage, estimated at 56% in 2014, based on population size and demand from the number of facilities in operation (*cf.* McFarlane & Kayaa 2012; Sirili 2014). Although health staff encompasses quite a number of professional levels, ranging from nurses, pharmacists, technicians, management and support staff, the physicians are in focus for this section. Apart from MD's (medical doctors / officers) at hospitals, there are assistant medical officers (AMO's) at Health Centres with three years extra clinical experience and two years of rotation, more than clinical officers (CO) with a minimum of three years of training stationed at Dispensary level. The AMO's can also perform surgery and midwifery with limited supervision. Many AMO's have had prior experience as detailed CO's so they grew accustomed to their working conditions. In the geographical distribution over the country there is a bias towards urban areas in numbers (including

private services), while minimum staffing requirements for rural facilities are not always met. Part of the problem is that a substantial number of candidates who graduate from professional training, disappear before entering an obligatory internship. Various reasons are listed as; low quality working environment, poor accommodation, low allowance, delayed salaries, and bureaucratic procedures, among others. It implies that completing a final internship is somehow postponed, or circumvented, but the consequence of not becoming a certified physician seemingly does not prevent a large number of the graduated pool to disappear (*cf.* Sirili et al 2014);

'Health professionals are being educated but not absorbed into the public health system. 'Many are not employed due to governmental financial hardship. There has been too little attention for human resources for health by big donors and the government. 'The most critical factor driving health system performance, the health worker, has been neglected and overlooked for too long'. There is more money for medicines, but human resources for health remain underfunded. Godfrey Philimon stresses the need for advocacy for more financial support from donors to enable countries to mobilize the human resources they need. (de Jong & Nedermeijer 2017: p.1).

The analysis provided seems to indicate that the system is not actually capable of absorbing all potential candidates regardless of the shortage. In any case graduates either leave the country to take up a position elsewhere, are employed at private facilities, while the remainder may be employed outside the health sector. Other graduates may be unavailable because of further studies for upgrading, or because of employment with health-related NGO's. The main reasons for the exodus of physicians from regular services, especially in a rural context are listed as a lack of employer benefits (retention scheme), low financial reward (remuneration), inadequate equipment or medical supplies, poor accommodation, an incidentally, physical remoteness. The Ministry reported that ca. 60% of the doctors finally showed up at their assigned stations, while 13% leave their station after a year because of dissatisfaction with their living conditions. The number of positions approved by the government, the number which are entering education and the number which are eventually installed, show large discrepancies.

On the other side of the process the improvement of the volume of training facilities is now in focus, with 116 training institutions striving to maximise their influx. The limitations are identified as insufficient non-teaching infrastructure, lack of qualified students, lack of financial resources for teaching staff, exiting senior staff, no subsidies for on campus student housing, and no flexible curricula to shorten the academic training periods. Reducing the number of years of tutoring to expedite output, may have an impact on quality, as was applied for nurses training earlier. For the training institutions to attain increases in academic output, the type of measures in view are extending the training capacity with new technology (e-Learning, MOOCS, SPOCS, Augmented Reality, sharing on line academic repositories, etc.) increase training fees, or to integrate various professional training schemes within one institution [22]. E-Learning would also be suitable for continued medical education for the layers of CO's and AMO's, as a way of maintaining quality.

Another is to look for partnerships with alternative institutions (NGO's), either domestic or foreign, to invest in education as a collaborative effort, as in Public-Private Partnerships (PPP). With reference to the analysis of the Tanzanian Training Centre for International Health (TTCIH) [23] it explains the proportions in a 2014 estimate at 90,000 manpower deficit. With the recruitment of 500 health staff trainees annually, among whom at least 50 assistant medical officers, the situation is actual and urgent (*cf.* Sue *et al.* 2016). The government regards this as one of the main obstacles to reaching intended Sustainable Development Goals (SDG's) especially in the domain of Maternal

and Child Health (MCH). One of the ways for TTCIH to tackle this problem was considering these PPP's, as the intention was to have the said institute turn into an independent entity, already generating 80% of its own budget; '*An arrangement between the public and private sector entities whereby the private entity renovates, constructs, operates, maintains, and/or manages a facility in whole or in part, in accordance with specified output specifications. The private entity assumes the associated risks for a significant period of time and in return, receives benefits and financial remuneration according to agreed terms'* (PM Pinda quoted in Sue *et al.* 2016).

This approach will probably attract more potential if it can be demonstrated that external funding or subsidising these new private or NGO based institutions can assure a larger output of well qualified staff, because of their access to other interested philanthropic or relevant knowledge sources. Multi- or bilateral agreements can also enhance these capabilities as long as they are identified within larger regional co-operation funding schemes. The future demand in staff however may concentrate on the implications of the 'social determinants of health' (WHO 2018), which means that in the public health objectives the so called 'de-medicalisation of health care*'* is crucial for reaching SDG's. It will put the emphasis in staff training on coping with lifestyle and behavioural aspects, social communications, culture and traditions, especially for medical staff working in the first line of duty, as well on community level as in urban settings.

Figure 3. Health Care Pyramid & Referral Levels, Public & Private.
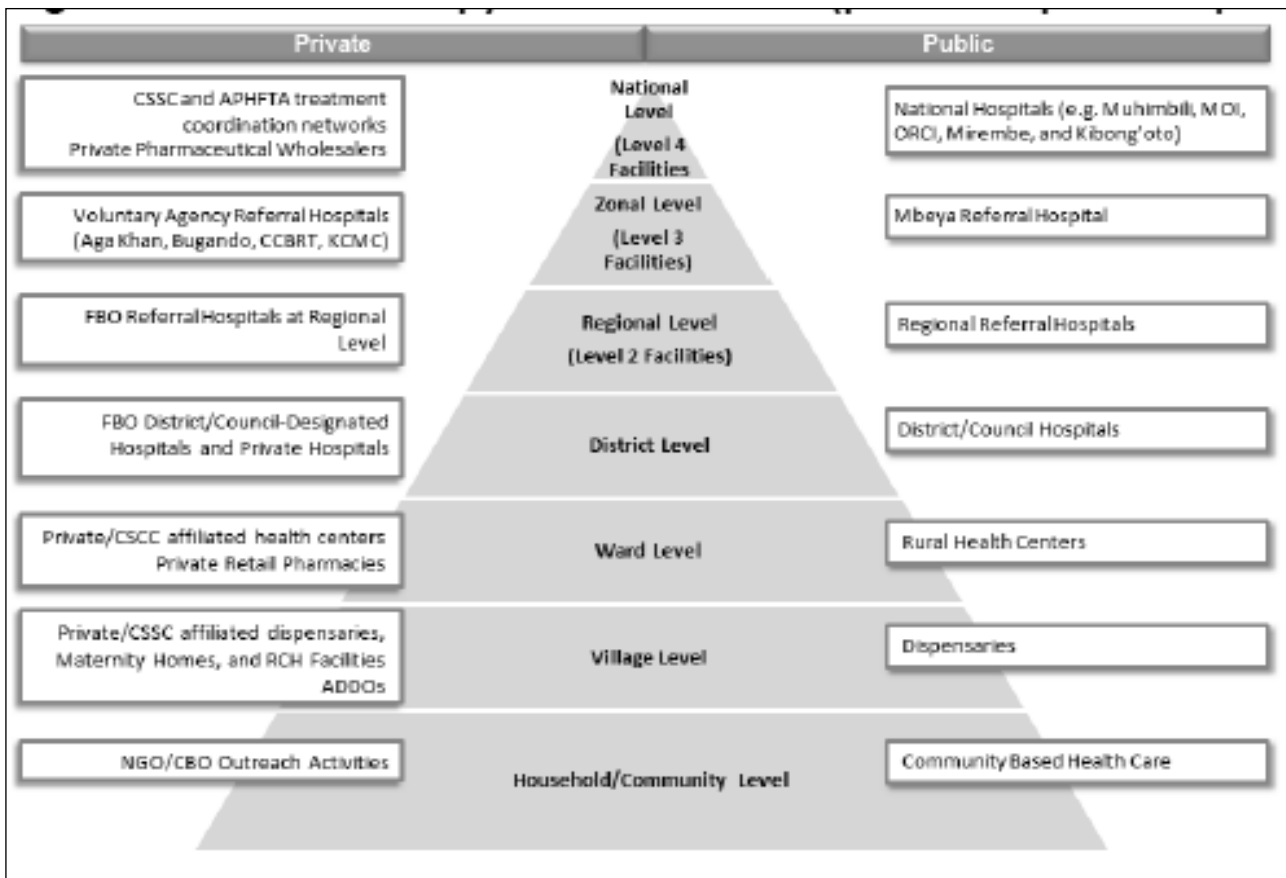
Source: Health Sector Strategic Plan IV 2015-2020 Min. of Health & Soc. Welfare

5.4. Options towards Integrating Traditional Medicine

As early as 1978, the WHO in Technical Report Series 622, already recognised and promoted the role of traditional medicine (TM) in the wider aim of universal health care development. From that moment on, the number of initiatives to examine possible integration with formally institutionalised forms of modern health care (MM) have been ample. The fields of interest which were identified by the WHO at that time were quite elaborate with regard to their applicability. The rallying of support for the promotion of traditional medicine was first addressed to get it on the agenda of national health policies. The steps to accompany this acceptance included the gathering of information on the available knowledge, means and therapies, as well as categorising the type of healers involved. It called for an inventory of the types of diseases which were successfully treated by traditional healers, as well as investigating the environmental factors the healers relied upon. The main policy goal, which was aimed at however, was in "the application of traditional medicine to primary health care" (Recommendation Nr. 7.5). The added value of this integration was to receive tangible proportions. For the following recommendations dealt with manpower development, *i.e.* the recognition of these categories of traditional healers as an HRM potential. They were regarded as professionals within an existing system, supported through multidisciplinary research programmes which not only covered efficacy, called '*validation*', but also 'studies in psychosocial and cultural aspect, and behavioural patterns' (Recommendation Nr. 7.7). Adapted by some scientist in period, the implications of that potential were put into a framework which was designated Indigenous Knowledge Systems & Rural Development; '..*Since it had become apparent…that the integration of traditional and transitional healers would constitute a cautious piecemeal procedure over a long period of time, it was considered essential to initiate this process by training new types of health workers for the practise of an integrated form of traditional, transitional and modern medicine, where new health cadres could function well within the expanding PHC services of the central government.'* (Slikkerveer 1982: p. 12)

   The degree to which individual countries in Sub Saharan Africa (SSA) have been adaptive of such a policy is highly varied. It may be useful to make a distinction in the sense of purpose behind any type of integration when regarding traditional medicine against the background of an already institutionalised health care system. Firstly, there can be the approach of an all-encompassing integration, taking into account all aspects, meaning the original practice and its features as it exists, together with its holistic cultural context, without any restraint. Then there is an approach whereby there would be conditions, *i.c.* a relationship with specific morbidities, an established record regarding the efficacy of the medicine, non-medical aspects of the eligible therapy, or the degree of professionalism demonstrated by the practitioner. Another scenario may have the practitioner co-opted to help promote a mainstream health education aspect, as was demonstrated with the ORS training in Ghana (*cf.* Warren 1988; Ventevogel 1996). It was repeated at later stage with regard to HIV/AIDS counselling by traditional healers because of their special position in the community (*cf.* Homsy *et al.* 2004; Kaboru *et al.* 2006; Kayombo *et al.* 2007). There should be room for reciprocal actions, as is incidentally demonstrated where hospital doctors refer patients to well-known bonesetters because the quality of their work is unanimously recognised (*cf.* Oppong 1989). In the reasoning of Homsy *et al.* (2004), the human resources management (HRM) aspect returns. They indicate that traditional healers remain the first line of contact in more than two thirds of all cases, outnumbering biomedical physicians by far. It would make them more suitable to realise any change

in behaviour. Nuances between these types of collaboration are immediately recognised, in particular with respect to the transfer of knowledge. There might be an exchange of ideas on a voluntary basis, but also health education training standards and treatment protocol parameters which are stringent, and they have to be met on both sides in order to make it all functional. These aspects may not bridge the difference in attitude towards therapy, in other words, where TM applies holism and rituals, MM refers to 'scientific results' and protocol, but it should not take away the readiness to co-operate: *…key elements are; building mutual respect between biomedical and traditional health practitioners through dialogue on matters of interest, signing a memorandum of understanding; stressing complementarities of both systems by referral from one health system to another…showing humility and respect during workshop regardless of level of education; cultivating transparency through dialogue and negotiation, eagerness to learn from one another.'* (Kayombo *et al.* 2007: p.3/9).

Similar to the core competences of TM as they have been acknowledged by MM, such as bone setting, psychiatry, psychotherapy and obstetrics, there can be a core competence of community-based health communication in acquiring these professionals to play a role in preventive health education (*cf.* Elujoba 2005; Stanifer *et al.* 2015). As Marsland (2007) noted in her work on '*Hybrid Traditional Healers*' in Tanzania, there is an eagerness on the side of the traditional healers to incorporate many aspects from modern medicine which would contribute to making their work be received as professional, such as hygienic preparation, testing, conservation of products, consistent multiplication of therapies, quality control, and so forth. It may come down to willingness on behalf of the modern system primarily to find common ground and renew the initiative, preferably within a thematic framework *e.g.* HIV/AIDS, and a practically feasible co-operation. As Chirangi (2013) has explained the necessary policy context in Tanzania was established earlier; '*In 2002, Parliament passed the Traditional and Alternative Medicine Act, which became operational in 2005; the Act recognises the role of traditional medicine in the national healthcare system and supports co-operation between physicians and traditional healers.'* (Chirangi 2013: p.135)

Although at least since 2005, TM has seen a revival in terms of receiving attention, not only from the health care sector, but also from the Tanzanian government with purposely aimed new legislation (Stangeland *et al.* 2010). It has not resulted in a consolidated position within the wider official health establishment, although the spread of commercialised TM activities, increasing its visibility, is without contention. The main motive behind the legislation was apparently directed towards securing biodiversity and maintaining the heritage of traditional knowledge (*cf.* Msuya *et al.* 2009). Expectations may have been high that the collaboration would lead to a formal relationship within a referral system, but there are no signs of that as yet. Still, as Langwick (2010) clearly shows, the anchoring was already done by the Office of Traditional Medicine annex the Ministry of Health and Social Welfare. Langwick explains that under the set up all alternative practices were clustered under one umbrella, such as homeopathy, acupuncture, chiropraxy, among others, with a side note on the exclusion of the occult versions of *dawa za kienyeji*. Langwick's starting point is relevant here as she maintains that the role of traditional (herbal) medicine viewed as an economic driver for the nation. Especially early post-independence politicians played a large part in the current establishment of TM products as commodities for market use in Tanzania and abroad. In that sense TM could be viewed as institutionalised.

The benefit for public health in turning TM professionals into a human resource for health development in Tanzania, as the policy had first intended, does now not yet materialise. In

Langwick's analysis the tone is determined by the expectation of discovering hidden treasures which may yield large profits in the pharmaceutical field, instead of solving a human resources problem or insufficient drug supply in health care. Although that may have changed with the Act in 2002, up until today there has unfortunately not been a tangible contribution to curing AIDS, malaria or Ebola from indigenous herbal medicine bases through officially co-ordinated efforts.

The capturing of TM potential on account of economic motives is not controversial per se, but it is not the role envisaged by the WHO in its original form. What might evolve, as is noticed by more authors on the same topic (*cf.* Marsland 2007; Kamat 2010; Jangu 2012; Denisenko 2013), is that the commercialisation of large-scale manufactured products with a distinct indigenous herbal signature can emancipate the role of TM, away from biomedical stigma or scientific scepticism. As Langwick sheds light on the role of trading with China as a background to this commercialisation, it is not a result of emancipation from the roots, as in recognised common interest identified by consensus among organised exponents of TM in Tanzania. It does result however in an export of a database of indigenous knowledge to an invisible overseas partner. The ingredients are sent to China, produced there in numbers and sent back packaged and labelled. On another plane, the local research into plant medicine has produced insights which are complementary to the commercial movement, but of a different order (*cf.* Tilburt & Kaptchuk 2008). The problems encountered by traditional healers are mainly preoccupied with quality management. It refers to finding the right species, repeat the preparation of medicinal plants within a certain timeframe, and without deterioration to their efficacy; 'they have to be fresh and made on the spot to be useful' (see Chapter VI). It does however not imply that there are no herbal treatments which can be conserved. As is shown by Chirangi (2013) many of these products are now sold on the streets by commercialised traditional healers, also in urban areas such as Musoma and Mwanza.

Returning to a broader meaning of 'human resources for health', in the Tanzanian context there are various types of TM practitioners just as elsewhere on the continent which are categorised in professional groups. They range from herbalists, spiritual healers (diviners - *wafumu)*, practitioners who practice a combination of skills, circumcisers, soothsayers, bone setters, midwives, and crossovers, as many of the TBA's also have knowledge of herbs. Then a distinction can also be made as to their convictions, as in pagan, Christian or Islamic in as far as it has an impact on their practices (*cf.* Jangu 2012).

In identifying the most suitable partners for collaboration in a formal setting the TBA's were the first to be actively recruited, already in the early 1990's. The main reason initially was because of the emphasis on Maternal and Child Health (MCH) as a priority within the Primary Health Care concept. The number of TBA contacts which were then reported on district statistical level already showed that they represented the first line in obstetrics on community level. In the setup of the training the ultimate goal was to establish an early warning system in referral so that serious pregnancy related complications (PRC) would be handled in time at a properly equipped facility. In practice there are many variations which range from recognising symptoms and timely referral, to learning to deal with complexities themselves. There were many forms of trying to extend the system (*cf.* Byrne & Morgan 2011, Ambaretnani 2012).

Apart from training the TBA's they could also be connected to a specialised health worker on district level, who becomes a regular liaison and secures updates in knowledge and practice, preferably on the level of a senior Public Health Nurse Midwife. TBA's could as well be equipped with special delivery kits and visual quick reference aids with mobile back up.

Another method to involve the TBA is by having her attending the eventual delivery in a hospital, as an indirect way of familiarising with different techniques. The length and intensity of the training and supervision is definitely a criterion in the quality assessment. Over time the experiences have been mixed but the potential is still recognised (*cf.* Pfeiffer & Mwaipopo 2013). Because of the numbers involved it is a resource which is yet to be fully exploited. In Tanzania the TBA's which were approached, have mostly been trained and registered by the district public health department, and in practice, some actually accompany their patients to the hospital when they foresee complications. Some are functioning within the IMCI framework as community-based counsellors, but they are limited. The point made from the analysis by Pfeiffer *et al.* is that early experiences learned that the TBA extension could not become a substitute for the lack of MCH facilities within safe accessibility margins (WHO 2004).

Having established that the TBA's role is not necessarily in attending delivery, constituting the primary line of contact by advising pregnant women to seek professional assistance timely, their role is as ever essential. Because of their familiarity with the community inhabitants, analogous to the practitioners mentioned earlier, they are capable of influencing behaviour sustainably. The scenario to see them actively involved in preventive health education is currently contended by health workers who had ambivalent experiences during the training exercises.

In the case of Serengeti, the programme [24] to train TBA's as an extension of the first line in the Maternal and Child Health (MCH) referral system, was approached with scepticism, apparently because of a lack of "suitable" candidates. In this case it was explained by the Principal Nursing Officer that the midwives were not sufficiently receptive of medical biological knowledge transfer, to become safely operational, as noted at the MCU station in Mugumu. The district maternal services staff labelled them 'still a risk' notwithstanding the initial enthusiasm on both sides. It was not meant as a disqualification of the commitment or experience of these traditional midwives, it was presented as the assessment of the MoH trainers, that the candidates were not capable of fully acquiring the implications of certain pregnancy related complications or hygiene protocol, to satisfy the requirements of the standard of the training. Although other studies in Tanzania have reported dissatisfaction with TBA involvement (Mbaruku *et al.* 2009), it leaves unchallenged that their position in the community can be seen as comparable with a Community Health Worker, as capable of bridging the gap with a formal facility-based health care. The notion of a knowledge gap should not be generalised too soon. The midwife trainer from Kisare College noticed during the interviews with TBA's that their knowledge built from practical experience was beyond her expectations. Additionally, it was noticed that the awareness of complications is high, and the readiness to refer someone to the hospital is already demonstrated. Despite those instances where knowledge may be crucial, as in recognising symptoms of pre-eclampsia for example, the social communications and trust with inhabitants is as yet unrivalled and must be utilised. It must be possible to identify a set of tasks which a TBA can perform without risk and with sustained quality, preferably in coherence with Community Health Workers, instead of circumventing them on the basis of not meeting bio-medical knowledge standards, no matter how scientifically solid they may be. As suggested by Byrne & Morgan (2011) from their analysis, there was an overall correlation of TBA involvement with increased skilled birth attendance. The current Health Sector Strategic Plan IV does not make any mention of collaboration, or incorporation any specific type of TM professionals or facilities, in any case not regarding prevention, promotion, referral, or Human Resources for Health challenges, or in connection to the '*social determinants of health*' (WHO 2018).

5.4.1 Towards a Transitional Role of Traditional Medicine

Jangu (2012), based on his work in Mwanza in connection to HIV, remarks there is a new role of traditional medicine (TM) in an increasingly commercialising health care market, which is changing the stage. In the broader sense, the migration of professional healers (to urban areas), and the adaptation of some TM treatments into serial production modes, may remove the connection between healing and the spiritual or cultural dimensions in which it was formerly embedded. There is a risk of this separation becoming enhanced as well through the loss of biodiversity, and the lack of appropriate conservation techniques. But foremost it removes the ritual and its social function from the healing process. At the same time, Jangu maintains, the role of traditional healers is still essential as they are the gauge for changes in society, which makes them better capable of putting these changes in a proper context for developing health care in the frontline. Jangu's estimation of the share of the population consulting TM professionals at any one time is 80% which is coherent with other local utilisation studies (*cf.* Hausmann-Muela *et al.* 2000; Langwick 2011; Denisenko 2013; Stanifer *et al.* 2015).

   To further support his notion, Marsland (2007) already described a tendency of TM professionals of wanting to adapt certain 'modern' features into their practice because of a number of reasons. Apart from losing their stigma of being 'backward' in the eyes of modern medicine, they want to demonstrate their eagerness to innovate, and learn new methods to prepare and conserve their natural resources-based medicine. The same was noticed during fieldwork, as mentioned in the qualitative analysis, many traditional healers were insisting on investigating the active components of their products in a scientific way to regain their rightful position in providing a well-received and established therapy. It would not only increase the efficacy of their labour-intensive production process, but as well increase the scale and flexibility in application, and eventual turnover. It would also enable them to compete with regular over the counter drugs and create an image of being progressive, without losing their knowledge input, or the connotations of the drugs in question. Marsland (2007) as well puts this into a wider historical perspective of the underlying struggle for recognition between 'traditional' and 'modern' medicine, resulting in an undesired dichotomy which is maintained by health institutions as well as local authorities over time.

Chapter V Notes:

20. Traditional Medicine is defined by the World Health Organisation (WHO, 1978a) as 'the sum total of knowledge or practices whether explicable or inexplicable, used in diagnosing, preventing or eliminating a physical, mental or social disease which may rely exclusively on past experience or observations handed down from generation to generation, verbally or in writing. It also comprises therapeutic practices which have been in existence for hundreds of years before the development of modern scientific medicine and are still in use today without any documented evidence of adverse effects'.

21. In 2013 it was defined as: It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (WHO 2013).

22. *'Academic institutions can work with health systems to provide health professionals with adequate pre-service and continuing education to prevent and reduce the disease burden of populations; and that collaboration between academic institutions can provide opportunities to develop and share best practices, for example, in curriculum development, teaching and assessment methods, and faculty development'* (MacFarlane & Kayaa 2012: p.S3)

23. The Tanzanian Training Centre for International Health (TTCIH), a public-private partnership between the Tanzanian Ministry of Health and Social Welfare (MoHSW), the Novartis Foundation, and the Swiss Tropical and Public Health Institute in Ifakara, a small town in rural Tanzania.

24. From 2008–2014, Johns Hopkins University led three USAID-funded programmes for Maternal and Child Health, HIV-counselling and testing, and the scale-up of Voluntary Medical Male Circumcision (VMMC): 1) the Mothers and Infants, Safe, Healthy and Alive Program; 2) the Universal HIV/AIDS Counselling and Testing Program; and 3) the Maternal and Child Health Integrated Programme (MCHIP).

25. In Tanzania the National Health Insurance Fund (NHIF) covers civil servants, who consist of 6% of the population, at a rate of 6% of their income. Such a change would be a drastic leap from the current single digit per capita health spending by the majority of the Sub-Saharan African countries. The informal sector may purchase insurance from the CHF, which is a voluntary insurance scheme which also insures those classified as "indigents" and others unable to afford one, as well as people which are "less likely to get treatment due to user fees" (*cf.* Wong 2013).