

Master Thesis Submitted in Partial Fulfillment for the Award of
Master of Science Degree in Public Health Sciences



Modernity in Traditional Medicine

Women's Experiences and Perceptions in the Kumba Health District, SW Region Cameroon

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2011

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Qualitative Research Methodology II

DEDICATION

“I am not bound to win, but I am bound to be true. I am not bound to succeed, but I am bound to live by the light I have. I must stand with anybody that stands right, and stand with him while he is right and part with him when he goes wrong”

Abraham Lincoln (US President 1861-65)

This Piece of work is dedicated to

My Dad

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Abstract

Background: Traditional medicine plays a vital role in the delivery of primary health care in most developing countries including those in Africa. The WHO has long recognized this and called on governments of the WHO member states to foster collaboration between traditional doctors and modern biomedical doctors so as to achieve the goals of the primary health care initiative. This is geared towards integration of traditional health system into the National Health Service system which in most cases is dominated by the modern biomedical system. However, opinion of users of traditional medicine cannot be undermined in the process leading to integration of traditional medicine into the National Health Service. In this thesis work I set out to explore and assess prevailing ideas about modernity in traditional medicine in Cameroon and to explore the perceptions and experiences of women in Kumba Health District regarding Modernity in Traditional Medicine.

Method: The study was a qualitative study that analyzed interviews, notes from informal conversations and observations, assess and explore women`s perceptions and experiences in the Kumba Health District regarding traditional medicine.

Main Findings: The main findings were categorized into; *i) conceptualization of modernity in traditional medicine* which describes the meanings attributed to modernity in traditional medicine in Cameroon, *ii) Experiences associated with the initiation of traditional medicine use* which gives an overview of the factors that cause women to start making use of this health care option, *iii) Experiences related to prolong use of traditional medicine* which is a sample of the outcome and patients perception of traditional medicine as a health care resource.

Conclusion: The concept; modernity in traditional medicine is controversial amongst female users of traditional medicine. Traditional medicine in Cameroon is a mixed blessing.

Keywords: modernity, traditional medicine, experience and perception, Kumba health district, south west region, Cameroon.

Preface

My interest in Traditional Medicine is not newly founded. While working in one of the health facilities in the Kumba health district, I noticed that many patients who attended out-patient department have tried treating themselves at home. A great proportion of them used traditional medicine. The case of a month old baby who was rushed to the hospital from a neighboring village particularly caught my attention. The doctors had gone out on out-station visit to the neighboring health center when a teenage mum (sixteen years of age) and the grandmother aged fifty five came to consult on behalf of the baby. The doctors suspected meningitis and immediately referred the baby to the hospital. At the hospital the baby was diagnosed for meningitis and treated. However, treatment had commenced late because the child had been treated with traditional medicines at home when he showed with the first signs and symptoms. Of course treatment was successful but the child had long term complications which would have been averted if treatment was sought straight away. Since then I have pondered on how traditional medicine users such as the women mentioned above will tell their stories and that was my main motivation for carrying this study. I personally used traditional medicines during my childhood and the early part of my teenage years and I still acknowledge its benefits. However I strongly believe that there is still gap for improvement.

Historically traditional health products were obtained from traditional health shrines usually located in the rural areas. Later on traditional doctors migrated from the rural areas where they used to have their shrines to the urban centers and cities where they have opened Clinics and traditional health centers. This has also seen an increase in fake traditional health products in the urban markets and a multiplicity of individuals without the requisite skills who parade the street with the sole aim of duping and extorting money from their victims. With this you may be tempted to question the quality and efficacy of traditional medicine in Cameroon. This thesis provides an opportunity to examine this looking at users' perceptions, opinions and experiences with a primary focus on women.

Introduction

The sick, just like the poor, will always be present in the world. In sub-Saharan Africa where you may find some of the world's poorest populations, there exist also a high burden of disease with huge rate of morbidity and mortality. The combined life expectancy for male and female is estimated at 48.6. HIV/AIDS, malaria and other communicable diseases are responsible for the high morbidity and mortality, (Kasilo O, Soumbe-alley E, Warmbebe C & Chatora R, 2005). The Joint United Nations Programme on HIV/AIDS, 2002, reported that up to 28.1 million adults are infected with HIV and there were 3.4 million new infections and 3.4 million deaths in 2001 alone. Malaria accounts for more than a million deaths each year, of which over 80% occur in tropical Africa, where malaria is the leading cause of mortality in children under five years of age, (WHO 2004). In fact, although Africa has 11% of the world's population and 24% of the global burden of disease, it has only 3% of the world's health workers commanding less than 1% of world health expenditure, (WHO 2006a p.1). As a result of rapidly increasing globalization and an increase in the global burden of non-communicable diseases, Africa is also undergoing significant epidemiological or health transition with a considerable prevalence of non-communicable disease and mortality associated with it. Health transition represents an enormous challenge to health, (Maher and Sekajugo, 2011). Sub-Saharan Africa particularly faces significant problems in responding to health transition, that is, a double burden of communicable and non-communicable diseases. In a situation such as is depicted above all sources of healthcare needs to be used to their fullest potentials.

In resource poor settings traditional medicine (TM) has proved to be a useful resource which could be exploited to tackle some of the health problems in the community. This is particularly important in Africa especially at a time when Africa faces serious problems in the health systems including skilled worker migration and brain drain (Parker 2009). The movement of physicians from developing African nations to Canada is exacerbating the regional shortage of health care workers and further constraining access to health services (Marchal et al 2003). Traditional medicine has been used by Africans for the prevention, diagnosis and treatment of social, mental and physical ailments of different origins before and even after the advent of conventional medicine (WHO, 2004). Research has shown that Traditional medicine is effective in the treatment of malaria, sickle cell disease and diabetes mellitus (WHO, 2009) Currently more than 80 per cent of the populations in Africa rely on traditional medicine for their primary healthcare needs. It is not surprising that traditional

medicine is the only source of healthcare available or accessible to some people living in this part of the world, (WHO 2005, Romero-Daza 2002). Traditional medicine is not only used in Africa where there are limited resources for healthcare, it is also used in other developing countries in Asia as well as the developed countries of Europe and the Americas. For instance, 70% of the population in Canada and 80% in Germany have used, in their lifetime, traditional medicine under the title complementary and alternative medicine, (WHO, 2010). In total around 3.9 billion people are making use of traditional medicine globally reports the World Health Organization (WHO).

In 1978, WHO during the International Conference for Primary Healthcare also known as the Alma Ata Declaration in which the ambitious “Health for All” by 2000 was launched, acknowledged the importance of traditional medicine in providing primary healthcare and encouraged WHO member states to develop official policies concerning traditional medicine, (Saleh 1993: 21–22 as quoted by Hillenbrand, 2006).

In 2000, the UN in a bid to reaffirm commitment in the Alma-Ata declaration of 1978 started promoting a set of health related and development goals known as the Millennium Development Goals (MDGs) to be achieved by 2015. However Africa still faces lots of problems, ranging from poverty to high level of disease burden. Maternal, infant and child mortality remain very high, HIV/AIDS is still a major health problem in many lands and a collapsing health system which is unable to reverse the situation. As a result these challenges facing health systems in Africa, the popularity of traditional medicine has skyrocketed. In addition to the above mentioned problems traditional medicine has gained credibility among populations in African because it is culturally developed and forms part of a wider belief system. Traditional medicine assumes a holistic approach in the treatment of the sick unifying the patient’s physical, psychosocial aspects of health needs and is readily available where and whenever needed signifying its importance in the indigenous African community. The relative ratios of traditional practitioners and biomedical doctors in relation to the whole population in African countries showcase this importance. For example, in Ghana, in Kwahu district, for every traditional medical practitioner there are 224 people, against one biomedical doctor for nearly 21,000. In Swaziland, the same situation applies where for every healer there are 110 people whereas for every biomedical doctor there are 10,000 people. In Cameroon for every biomedical doctor there are 5270 patients while for every traditional medical practitioner there are 200 patients, (WHO,2006, World Health Statistics;2006).

What is traditional medicine?

Traditional Medicine encompasses diverse practices usually with conflicting characteristics. It is used to describe a variety of health practices which are indigenous to the people who use it and which form a part of a wider belief system prevalent in that community and which is historically developed. Thus the diversities in traditional medicine can be understood partly from a historical point of view as well as from various beliefs of health and illness. Various systems of traditional medicine exist in different parts of the world. In the Americas and Western Europe, it is referred to as complementary and alternative medicine (CAM) and therapies (Bodeker, G. 2005) or non-conventional medicine.

As a result of the diverse nature of traditional medicine several definitions have been proposed. For example, the South African Traditional Health Practitioners Act defines Traditional Health Practice as “the performance of a function, activity, process, or service based on a traditional philosophy that uses indigenous African techniques and principles that include traditional medicines or practices, including the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth (sexual and reproductive health), and death” (Act 22, p. 5). This definition is rather too narrow to include all the different aspects that involve traditional medicine because it focuses only on African traditional medicine. The WHO has however observed the difficulty in assigning a single correct definition that describes the diverse range of elements that characterize traditional medicine, and has suggested a working definition which could be applied wherever necessary. The WHO definition for traditional medicine therefore states that:

“Traditional Medicine is the sum total of the knowledge, skills, 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 illnesses.”

Based on the WHO definition, traditional medicine involves a variety of products as well as practices which may involve herbal treatments, animal products such as snake fats or oils, skeletons, beliefs and meditations and even those which cannot be explained such as the practice of spiritual healing. Traditional medicine can be divided into two groups; medication therapy and non-medication therapy.

Medication Therapy

Medical therapies are therapies involving the use of medications e.g. herbal medication. They include traditional African medicine, traditional Chinese medicine, homeopathy and Unani medicine and other traditional medicine popularly used world-wide.

Non-Medication Therapy

These therapies are also referred to as traditional procedure-based therapy. These therapies do not use medication internally. They include acupuncture, chiropractic, osteopathy and meditation therapies.

Modernity in traditional medicine

The concept of modernity in traditional medicine has been used for decades by local traditional medicine practitioners as a strategy for commercializing traditional medical services and traditional medical products. Some in the allopathic medical system are skeptical about such branding of traditional medicine. Modernity in traditional medicine is therefore controversial as many have different views and opinions about modernization. Modernity in traditional medicine could be thought about as a “marriage” between modern medicine and traditional medicine. It could be viewed as a transition from the primitive method of traditional medicine in which witchcraft is used to diagnose and treat patients to a more scientific-based approach in diagnosis and treatment of ailments. In this section I have chosen to discuss modernity or modernization of traditional medicine in the light of Mutabazi, 2008. He discusses modernity in traditional medicine taking into account four important points which he describes as the tenets of modernization of traditional medicine namely;

Autonomy

He acknowledges that granting autonomy to traditional medicine practitioners would increase their self-awareness, highlight their central role in society, and enable them to exercise their rights as traditional practitioners and citizens. To him modernity in traditional medicine entails self policing, self-management and self-governance. He criticizes that form of partnership between traditional doctors and biomedical doctors that subject traditional medicine practice to the lens and scrutiny of the biomedical health systems.

Training

Undertaking training of traditional health practitioners will improve traditional knowledge systems, practices, capacities and capabilities. This will consequently improve the quality and efficacy of traditional medicine. Training of traditional medicine practitioners could involve identifying diseases that can be effectively cured by traditional medicine, so as to avoid making traditional medicine appear to be a panacea for all illnesses. Training will also help to preserve indigenous knowledge.

Documentation

Documentation is essential if traditional medicine is to gain status in the National Health Service. Documentation has the advantages of recording the treatment successes as well as failures of traditional health remedies. Making traditional knowledge available for future generations and dispelling the false and imperialistic notions that traditional medicine is not scientific, showing evidence of the efficacy of traditional medicines and systematizing the discourse (Mutabazi 2008). It is worth noting that most traditional practices in developing countries are not documented thus making it impossible for traditional medicine to be evaluated. Training and documentation can be enhanced by education of traditional health practitioners in the basic writing and numerical skills which is largely lacking amongst traditional doctors as most may be illiterate.

Peer Education, Monitoring and Regulation

Autonomy, Training and documentation pave a way for the evaluation of traditional medicine. Evaluation may be done by independent evaluation bodies or peers. The aim of evaluation is to verify whether traditional doctors are doing what they are supposed to be doing or how well they do the things they ought to do. However evaluation may also be difficult owing to the diverse nature of traditional medicine practice and the fact that most health services in developing countries are skewed towards the biomedical health systems.

Systems of traditional medicine

Various systems of traditional medicine exist in different parts of the world. In the developed countries this form of medicine is referred to as complementary and alternative medicine (CAM) or non-conventional medicine to differentiate it from the conventional biomedicine or the so-called western medicine. For the purpose of this thesis' work the following systems of traditional medicine has been identified.

Ayurveda

Ayurveda is an ancient Hindu act of medicine. The word Ayurveda literally means “the science of life”. This form of traditional medicine dates back to the 10th century BC. It is the type of traditional medicine practice in South Asia especially in Bangladesh, India, Nepal, Pakistan, and Sri Lanka. It is a holistic health system, which fosters the natural harmony between body, mind and soul. Ayurveda considers the human being as an inseparable unity of body, mind and soul. Instead of dealing only with the health or disease of separate organs, the well-being of the whole person is emphasized, (www.vedic-academy.com). Ayurveda philosophy is attached to sacred texts called the Vedas, and is based on the theory of Panchmahabhutas which states that all objects and living bodies are composed of the five basic elements; earth, water, fire, air and the sky. It assumes that there is a fundamental harmony between the environments and the individuals. This relationship is perceived as the Macrocosm and the Microcosm relationship. Therefore acting on one, results in an influence on the other. Ayurveda is not only a system of medicine but also a way of living used both to prevent and to cure diseases. Ayurveda medicine makes use of herbal medicine and medicinal bath.

Chiropractic

Chiropractic is a system of medicine similar to osteopathy. It was founded in the end of the 19th century by a magnetic therapist practicing in Iowa; USA called Daniel David Palmer and involves spinal manipulation and spinal adjustments. This is based on the association between the spine and the nervous system and the self healing properties of the human body. Research into the effectiveness of spinal manipulation has resulted in some acknowledgement of its use by independent agencies in Canada, the United States, the United Kingdom and Denmark, which has led to increased integration of chiropractors into mainstream health care delivery systems, (Haldeman, S et al, 2001). Chiropractic has been proven to be more effective in the treatment of low back pain than conventional medical therapy. It is practiced in every

region of the world. Chiropractic training programme is recognized by the world federation of chiropractic if they adopt an international standard of education and require a minimum of four years of fulltime university level education.

Homeopathy

There are several claims that Hippocrates (462-377BC), the father of medicine is the first person who used homeopathy. Homeopathy comes from two Greek words; “*homeo*” which means similar and “*pathos*” which means suffering (or disease by extension). It is generally accepted that the German Physician Samuel Hahnemann (1755-1843) established the basic principles of homeopathy; the law of similar, the theory of the minimum diluted dose and the therapy of chronic diseases. The law of similar states that a substance which can cause symptoms (when too much is taken) can also cures those symptoms when given in a very small dose. In homeopathy, a disease is treated with remedies that will in a healthy person produce a symptom similar to those of the disease. For example a case of insomnia is treated by giving a minute dose of a substance such as coffee which in large doses can cause sleeplessness in a healthy person. Surprisingly it is believed that this can enable the person to sleep naturally, (Dunn, 2008). Rather than fighting the disease directly as in biomedicine, the treatment is intended to stimulate the body to fight the disease. By the latter half of the 19th century homeopathy was practised throughout Europe as well as Asia and North America, (Bodeker et al, 2005, WHO, 2005). Homeopathy has been integrated into the main healthcare system in some countries even though it still faces stiff criticisms.

Unani Medicine

Unani Medicine is based on ancient Greek theory postulated by Hippocrates (462-377 BC) Hippocrates was a Greek physician who freed medicine from the realm of superstition and magic and gave it a scientific status. Unani medicine is based on the four bodily humours; blood, phlegm, black bile and yellow bile. The idea is that disease is caused by an imbalance in the four bodily humours. Its foundation was greatly enriched by the contributions of other scholars such as Galen (131-210 AD), Rhazes (850-925AD), and Avicenna (980-1037AD). Unani medicine is also known as Arabic medicine and it draws from other systems of traditional medicine practised in China, India, Egypt, Iraq, Iran etc. (www.lifemojo.com)

Traditional Chinese Medicine

Traditional Chinese medicine (TCM) has been in use in China for over two thousand years. It has its own unique theories for treating disease and to enhance health, (WHO, 2010). With such a long history, TCM has formed a unique system used for health promotion as well as to diagnose, treat and cure diseases. Diagnosis and treatment is based on a holistic view of the patient and patient symptoms expressed in terms of the balance in yin and yang. Yin represents the earth, cold and femininity while yang represents the sky, heat and masculinity. The action between yin and yang influences the interaction of five elements that make up the universe; metal, wood, water, fire, and earth. Practitioners of TCM seek to control the level of yin and yang through 12 meridians that bring energy to the body. TCM involves a range of practices including acupuncture, herbal medicine, manual therapies, exercises and breathing techniques as well as moxibustion; a therapeutic technique that involves the burning of mugwort herb to facilitate healing, (WHO, 2010). TCM is practised in almost every part of the world. The most common technique used in TCM is acupuncture. The drug Artemisinin that is used to treat malaria is extracted from the plant *Artemisia annua*; a plant that has been used in TCM for centuries, (Biesen, 2010).

Traditional African Medicine

Based on the definition in the South African traditional medicine act which defines TM in the light of the African context Traditional African Medicine, TAM is the system of traditional medicine which has its origin and root embedded in the culture and beliefs of the African continent. Reports from the WHO state that less than 50 per cent of the populations in Africa especially sub-Saharan Africa have regular access to pharmaceuticals. Ninety percent of TAM is based on herbal therapy. Herbal therapy or medicine include herbs, herbal materials, herbal preparations and finished herbal products, which contain as active ingredients parts of plants, or other plant materials, or combinations thereof. Africa is blessed with a rich biodiversity estimated to over forty thousand plant species about 6,377 plant species are used in tropical Africa, four thousand of which have medicinal value. This rich biodiversity in tropical Africa serves as a ready source of medicinal plant products. A famous traditional medicine practitioner called Dr. Fru coined the term Candalogy to describe TAM. He defines Candalogy as the scientific study of bark of trees which is one of the sources of Traditional health products.

Prevalence of use of traditional medicine

With the growing popularity of traditional medicine globally (WHO, 2002) many people now depends on traditional healthcare either for primary, secondary or complementary healthcare. The WHO has consistently estimated that up to 80% of the populations of African rely on traditional medicine for their basic health care needs, either on its own or in conjunction with modern biomedical care. Traditional medicine appears to be the only source of healthcare in such communities in Africa (Romero-Daza, 2002). However the percentage of people using traditional medicine varies from country to country. Reports from WHO show traditional medicine use in Uganda and Tanzania at 60 per cent, in Benin and Rwanda at 70 per cent, and in Ethiopia at 90 per cent (Figure 1). Also within the African continent the proportion of individual using the five most popularly used systems of traditional medicine varies as follows; 80 per cent of the population use herbal therapies, 13 per cent make use of spiritual therapies, 5 per cent use manual therapy and less than 1 per cent use both homeopathy and chiropractic. Studies show that demand for traditional medicine is increasing in many other countries (*Bannerman, 1993*). In recent years there has been a surge in the number of people using traditional medicine as an alternative or a complement to biomedicine in the western world. Research carried out in the United States reported that Americans made 425 million visits to complementary and alternative health care providers in 1990, a figure that exceeds the number of visits made to modern healthcare physicians in that same year, (Neldner, 2000). Also in a 1994 survey of physicians in a wide array of medical specialties in the US and Israel reveal that 60 per cent recommended complementary and alternative therapy to their patients at least once in the preceding year. Forty seven percent of these physicians also use alternative healthcare themselves and twenty three incorporated them into their practices, (Astin, 1998). In industrialized countries, almost half the population now regularly use some form of Traditional or complementary and alternative medicines, TCAM (United States, 42%; Australia, 48%; France, 49%; Canada, 70%), and considerable use exists in many other developing countries (China, 40%; India, 70%; Chile, 71%; Colombia, 40%, (Unnikrishnan; 2009, WHO; 2002) These figures are not surprising as traditional medicine continues to gain popularity both in the developing and developed countries. The WHO reported that Traditional medicine (TM) and complementary and alternative medicine (CAM) are attracting more and more attention within the context of health care provision and health sector reform

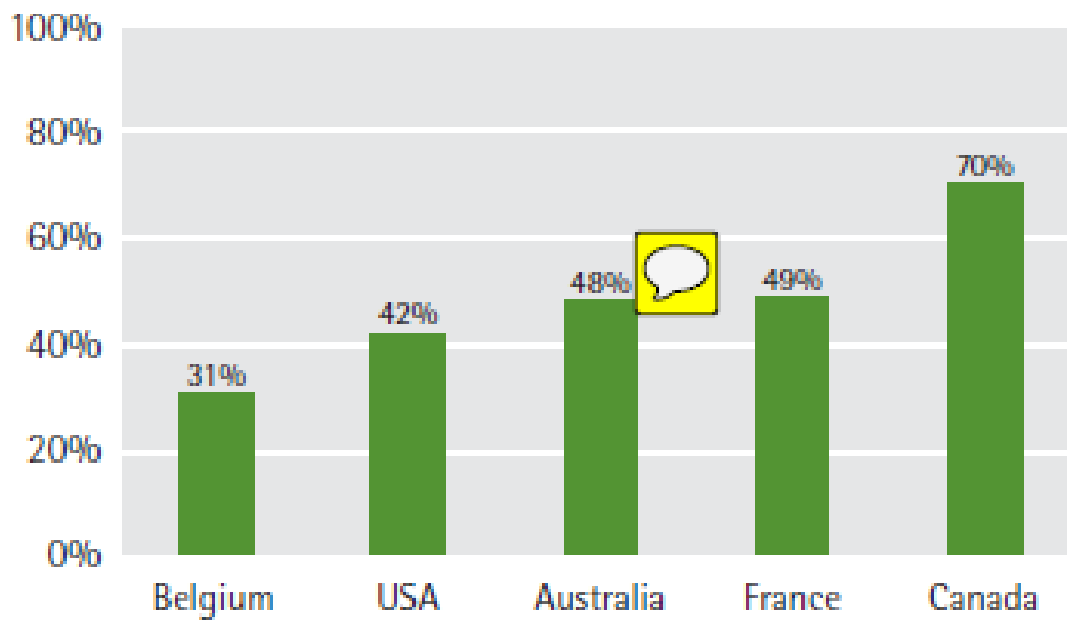


Figure 1: Percentage of population that have used CAM at least once

Source: World Health Organization 2002

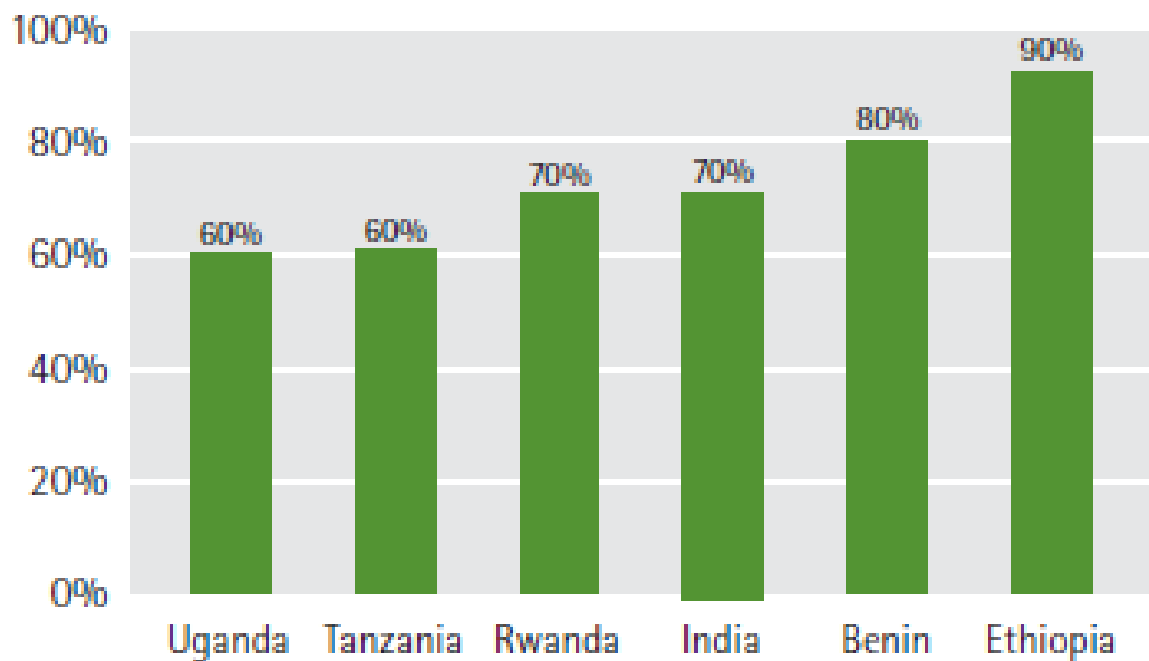


Figure 2: Proportion of population that use TM in selected African countries

Source: World Health Organization 2002, Chatora, 2003

Models of healthcare systems

Throughout history and across different continents in the world peoples act and react differently and consequently adopt various approaches as regards traditional medicine. Attitudes towards traditional health procedures range from uncritical criticism to uninformed skepticism states the world health organization, (WHO TM Strategy, 2002-2005). Policy formulators are concern about questions concerning safety, efficacy and quality of traditional medicine. Some biomedical doctors have express strong reservation and often frank disbelief about the purported benefits of traditional medicine. At the same time traditional health practitioners and some consumers will resist any health policy that will limit access to traditional healthcare. Based on this diversity in views several models of health system have developed historically. The WHO has suggested the following healthcare models to depict the level of integration of traditional medicine in different health systems;

The Monopolistic Health Care Model

This health care model allows only modern biomedical (allopathic) doctors and health practitioners to practice health care. In this type of health care model, traditional medicine and complementary and alternative medicine are not legal practices. This form of health care system may encourage the illegal practice of traditional medicine. In such cases traditional healthcare users may have no protection. This model was predominant in most African countries during the colonial era. The monopolistic healthcare model is almost rare to find the world over with the increased popularity gained by traditional medical practice.

The Tolerant (Co-existence) Health Care Model

In the tolerant health care model, the traditional health practitioners are allowed to practice but are not officially recognized. The practice is usually done under an unofficial capacity. The main national health care delivery system is based entirely on allopathic medicine or biomedicine. This is found in many countries with no regulatory or legal mechanism for the practice of traditional medicine.

Parallel (Inclusive) or Dual Health Care Model

The inclusive health care model comprises of two health care systems each operating independently but acknowledging and respecting the contributions of each system. The traditional and modern allopathic are separate components of the national health care system. In some cases, the national authorities are developing the appropriate frameworks for traditional medicine related policy, regulation, practice, health insurance coverage, research and education. Examples of countries practicing the inclusive system of integrating traditional medicine into their national health care systems are Benin, Burkina Faso, Cameroon, Equatorial Guinea, Guinea, and Cote d'Ivoire, the Democratic Republic of Congo, Equatorial Guinea, Niger, Nigeria, Madagascar, Mali, Mozambique, Swaziland, Tanzania and Zimbabwe.

Integrative Health Care Model

In this situation, traditional medicine is fully recognized and incorporated into all areas of health care delivery including national medicines policy, registration of traditional medicine products, regulation of traditional medicine practice, establishment of traditional medicine hospitals, inclusion of traditional medicine in national insurance schemes as reimbursable items, establishment of relevant research institutions on traditional medicine, and training of traditional medicine practitioners at all levels of education, including universities. Integration also subsumes visibility of traditional medicine international health programmes, and its reflection in national planning and budgeting schemes. Globally only four countries – the People's Republic of China, the Democratic Republic of Korea, the Republic of Korea and Vietnam - have integrated traditional medicine into their national health care systems. No country in the WHO African Region has yet established this integrative system regarding the incorporation of traditional medicine into national health care systems.

Traditional medicine practitioners need support, education and cooperation. Olson & Nkiwane (2006) observed that traditional health systems are often misunderstood, sometimes to the extent of causing fear and advised that this system of healthcare should be examined with an open mind, further developed and finally integrated with the national healthcare system for it to provide the best healthcare benefits possible.

The traditional model of health

Health is a complex term and different people have different ways to interpret it. Laverack (2007) observed that health is subjective and its interpretation is based largely on personal experience and influenced by the culture and environment in which people live and function. Individuals may define their health based on ability to carry out certain roles and responsibilities for self or community rather than the absence of disease or illness. Nelms and Gorski (2006) stated that the African woman's conceptualization of good health is characterized by a disease-free state and the ability to work and perform tasks, take care of the children, and keep the house and clothes clean and attribute poor health to the influence of supernatural forces. The WHO definition of health states that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 2006). Laverack (2007) pointed out that physical wellbeing deals with a healthy functioning of the body, biological normality, physical fitness and capacity to perform tasks. Social wellbeing on the other hand includes interpersonal relationships as well as wider social issues such as marital satisfaction, the ability to engage in paid work and community involvement. Mental well-being involves self-efficacy, subjective well-being and social inclusion and the ability to adapt to the environment and society in which an individual lives and functions. However, critics hold that the WHO definition of health lacks the emotional and spiritual aspect of health (Ewles & Simnett, 2003). In the traditional model of health, the emotional and spiritual aspect of health is greatly emphasized. Snow (1983) in a study carried out among poor African-Americans, reported that lower class African-Americans classified illness into two groups; Natural and Unnatural illnesses based on their perceptions of the causes of the illness. This influences their interpretation of health. Causality beliefs can well be used to differentiate the different medical systems, i.e. traditional medical systems from the biomedical system or conventional medical systems. Foster (1976) reported two basic principles of Causality that characterize the traditional (non-western) medical system; the Personalistic and the Naturalistic Etiologies of illness. This is because in the traditional model of health, the perception of health is inextricably bound up with religion, morality and the supernatural, so that natural versus unnatural are closely allied with good versus evil or godly versus ungodly. Naturalistic Causality explains illness in terms of the natural forces or conditions such as cold, heat, dampness etc. Natural events take place in the world as God made it and as He intended it to be. Natural illness could come about as a failure to take care of self (body) or by sinful behavior (failure to take care of soul) in which case illness is seen as divine punishment. Personalistic Causality allows little room for chance. It accounts for the

etiology of the so-called unnatural illness which cannot be explained using the ordinary laws of nature. It explains the cause of a disease to be due to an active and purposive intervention of an agent who may be a human (a witch or wizard); a non-human (ancestral spirit) or a supernatural being such as a deity; (Foster 1976). This is usually termed the work of the devil. This is based on the belief that a being with extraordinary power can influence the natural course of events and cause illness in people. Even emotional disturbance such as fear, envy and shame or grief are attributed to evil spiritual forces. The sick person is usually seen as a victim. Such illnesses are believed that they cannot be cured by orthodox biomedicine but traditional medicine or through divine intervention. Such belief is common in society where life is seen as a challenge and the world as hostile, where God or an ancestral spirit may strike you down for sinning or an envious neighbor may bewitch you through dark magic, (Snow, 1983). Such health beliefs leave all members in the community suspicious of each other, friendship is fragile and relationships are brittle and even family members are not to be trusted. The traditional model of health is largely based on the personalistic etiology of disease or illness.

Rationale for the study

In as much as it is generally accepted that traditional medicine and traditional health products have many benefits in primary healthcare, its popularity in Cameroon has not been without some factors that are not directly related to health. A walk through the streets or a trip by bus will confirm this. Some of these factors are economic factors; with the introduction of user fees in Cameroon some people of low economic standing will opt for a health care which they judge to be cheaper even if they are not so sure of a positive outcome. The economic crisis in the eighties have also made many jobless people who may have little or no skill in the use of traditional medicine to start parading the street as traditional doctors; a phenomenon which is referred to as Charlatanism (which is synonymous to quackery in modern biomedical healthcare system) has inflated the purported benefits of traditional medicine in the country. As a result users of traditional medicine face serious risk associated with delay in seeking appropriate health care. It is essential for policy makers in the country to consider quality of care in traditional health practice so as to protect its users. Questions regarding the efficacy, safety and quality of traditional medicine and traditional health products are important issues that are gaining attention in research. There have been few (if any) studies assessing users' perception of quality in traditional health care in Cameroon. For policies regarding traditional medicine

ultimately geared towards integration of traditional medicine into the National Health Service to be formed and implemented, users opinions and perceptions need to be sampled so that policies taken will be able to protect the interest of those making use of this health care option. It is based on this that I intend to find out and report users' perceptions and experiences regarding traditional medicine and traditional health product with a particular focus on women users.

The aims and study context

Study Aims

The aim of this study is to explore and assess prevailing ideas about modernity in traditional medicine in Cameroon and to explore the perceptions and experiences of women in Kumba Health District regarding Modernity in Traditional Medicine

Research Questions

For the purpose of this thesis the following research questions were formulated in order to guide the study to meet its aims and objectives.

- How do women in the KHD conceptualize Modernity in Traditional Medicine?
- What are the perceptions of Traditional health care among women in the KHD?
- How do women in the KHD experience Traditional health care?

Research Context

This research took place in Cameroon; a country located in the heart of Africa, where traditional medicine forms a major part of the health system although not integrated into the National Health Service System. Traditional medicine plays a major role in the lives of the majority of Cameroonians because it is cheap, and easily accessible in both the urban and rural community

Geography

Cameroon is known to those familiar with the tourism industry as Africa in miniature. This is because Cameroon`s diversity of climate, culture and geography which is a blend of what is in almost all of Africa. The climate range from the beaches and rainforests to deserts and mountains. Cameroon's wildlife draws both safari goers and big game hunter as Cameroon is home to many of Africa´s iconic animals: cheetahs, chimpanzees, elephants, giraffes, gorillas, hippopotami, and rhinoceroses. The country Cameroon is located in Central Africa within the gulf of Guinea extending from the Atlantic Ocean to Lake Chad in the North. It is bordered by Nigeria to the West, Chad to the Northeast, Central African Republic to the East and Gabon, Congo and Equatorial Guinea to the South. It has a land surface area of 475,440 Km² and a population 18,175,000 (WHO, 2008)

Demography

According to the WHO the Cameroon population is estimated at 18,175,000. More recent estimates states that the population of Cameroon is 19,294,149 (CIA World Fact book, 2010). Fifty eight per cent of the total population is urban. English and French are the officially languages. Besides these official languages, there are more than 200 linguistics groups each speaking a peculiar dialect. The people are spread among five ethnic groups namely; *a*) Western Highlanders that make 31 per cent of the total population and is composed of the Bamileke, Bamoum, Ngemba, *b*) Northwestern Bantu that make up 8 per cent of total population consist of the Bassa, Duala, Sawa, *c*) the Equatorial Bantu 19 per cent, Fulani and *d*) Eastern Nigritic 17 per cent and *e*) the Kirdi which make 11 per cent of the total population. The remaining 14 per cent is formed by other Africans and non Africans that form part of the Cameroonian community



Figure 3: The political map of Cameroon

History

Cameroon was annexed by Germany in 1884. In 1919 when Germany was defeated in the 1st World War, it was divided by the League of Nations between France and Britain to be administered as trustee states, hence the genesis of bilingualism in the country. France ruled over 80 per cent of the territory while Britain had 20 percent. After independence in 1960 and 1961 respectively, French and British Cameroon decided through a referendum to unite and form the Federal Republic of Cameroon. In 1972, the population voted to adopt a new constitution which led to the formation of a Unitary State called the Republic of Cameroon to replace the former Federal Republic of Cameroon.

Politics

The Republic of Cameroon is made up of ten administrative regions namely Far North, North, Adamawa, Central, Littoral, East, South, Northwest, West and Southwest Regions. Each Region is headed by a governor appointed by the head of state. Amongst all the ten administrative regions only the North West and South West Regions have a predominantly English speaking population. Yaoundé is the political capital and the second most populous city in Cameroon and Douala which is the economic capital is the largest and most populous city in the country.

The Economy

Cameroon is endowed with a vast array of natural resources and conditions that favor agriculture. In addition, the country enjoys a rear form of political stability undisturbed by serious civil conflicts and enjoys an advantageous geographic position between Nigeria and several central African countries that provide growing markets. Cameroon also provides a transportation system that links other African countries to the rest of the World.

For quarter century after independence, Cameroon was one of the most prosperous countries in Africa. Beginning in the early 1980s, petroleum became Cameroon's largest single export commodity, accounting for nearly half of export earnings. Although agriculture continues to occupy most of the country's workforce, petroleum contributes the largest share of its export earnings. Falling prices and decreasing production levels reduced oil revenues to 30 percent of export earnings in the 1990s, but a surge in oil prices doubled Cameroon's oil revenues in 1999-2000. Timber is

Cameroon's second largest export, providing an additional 20 percent of export revenues. Agricultural commodities, especially coffee, cocoa, bananas, and cotton, account for most of the remaining export earnings. Cameroon also produces a number of food crops and light industrial goods that are sold in domestic and regional markets. However the Cameroon economy is plagued by a challenging business environment that is characterized by economic mismanagement and pervasive corruption. In the mid eighties the country suffered severe economic recession. The government with the help of the International Monetary Fund (IMF) and the World Bank embarked on a series of structural adjustment and reform programmes which aims at reducing public expenditure and encourage foreign investments.

The Health System

The health system model operating in Cameroon is the dual health system with a predominant allopathic health facility and an overwhelming presence of traditional medicine (both indigenous African and Chinese traditional medicine). The National health system comprises both the private and public sector with the public sector as the principal provider of health services. The private sector is made up of faith-based, private for-profit health facilities and NGOs including private clinics, pharmacies drug retailer and traditional doctors' clinics. The system is financed by multiple financing sources with the main financing sources being the government, public enterprises, foreign aid donors, private enterprises, households, religious missions and NGOs (Ntangsi J, 1998)

The public sector comprises a university teaching hospital, three central hospital, ten provincial hospital, 178 health district, 162 district hospitals and about 2043 medical centers. A number of state owned enterprises also operate health facilities for the staffs. Such facilities may also be opened to the public. The private sector is dominated by the Catholic and Protestants Missions; the Catholic Mission Cameroon owns and runs 179 facilities (including 8 hospitals) with a staff of 1,315 and the Protestants operates 122 health facilities (including 24 hospitals) with a staff of 2,633 (World Bank, 1996). There are roughly 200 for-profit health facility and a few thousand traditional healers (Lantum, 1996). The ministry of Public Health is responsible for the development, implementation and evaluation of health policies in the country. It is responsible for preventive medicine and organizes, manages and develops public hospital facilities and also inspects private medical facilities and traditional health clinics in the country.

Traditional medicine use in Cameroon

Traditional medicine was the only system of health care available for centuries in the history of Cameroon. It was used for the prevention, diagnosis and treatment of social, mental and physical illnesses. Traditional medicine has played a crucial role in combating multiple and complex health problems in Cameroon (Lantum & Monono, 2003).

Since colonial times, Western medicine was the only formally accepted medicine in Cameroon; all traditional medicine practices were categorically condemned as witchcraft or sorcery and banned (WHO, 1990). Despite massive stigmatization during the colonial era traditional medicine continued to thrive.. The practice of traditional medicine then was mainly underground. Recently the dual integrative health system model is emerging in the Cameroon society in which traditional medicine and western medicine exist side by side. Results from a 2002 report of the Ministry of Health confirmed that that this was mainly because traditional medicine is a product of the socioeconomic environment as well as the cultural traditions that has evolved over centuries to enhance health. Decreasing national income, decrease in international development aids (IDA) as well as the recent economic crisis that resulted in low salaries and devaluation of local currencies and the institution of user fees in public health facilities caused many Cameroonian to resort to the use of traditional medicine for their health care needs. The economic crisis and the failure of the social security system have created an intensive return to traditional health services. It is estimated that 7 per cent of the average household health budget goes to traditional medicines. Nearly twice as many people from poor households rely on traditional medicine as do people from rich households (*Strategie Sectorielle de Santé*, 2002: 32–49).

One other reason that has led to the increased popularity in traditional medicine in Cameroon is the decrease in the quality of health services provided in the biomedical health sector (Kofi-Tsekpo, 2004). Kofi-Tsekpo, 2004 emphasized that the increasing cost of allopathic healthcare and modern pharmaceuticals as well as their unavailability to many people are major contributors to the popularity of traditional medicine. Also, because of the historical development of traditional medicine, the custom and heritage of the Cameroonian people has played a crucial role in the popularity gained by traditional medicine practitioners in the country. Healers understand the social problems and cultural experience of their communities: “They use this knowledge in their diagnosis to better treat the invalids, to whom they are

very close. If a sick person tells [the healer] that he was beaten all night in his bed, the indigenous healer will understand him and help him chase away the spirits.” (Lantum, 1978). The highest prevalence of use of traditional medicine is mainly amongst the poor and the disadvantaged usually located in rural areas who cannot afford modern pharmaceuticals or access modern biomedical care even though it is shown that ‘‘Cameroonians of all works of life and background make use of this system of health care often simultaneously with conventional or allopathic medicine’’ (Hillenbrand, 2006).

The HIV/AIDS pandemic has also forced public health officials throughout the country especially those of the Ministry of Public Health to reconsider its attitude towards traditional medicine. It is recognized that traditional healers may be instrumental in preventing the spread of the virus as well as caring for the sick, particularly in rural areas with few conventional medical facilities or practitioners (Hillenbrand, 2006). In vitro studies of an indigenous plant species from Cameroon; *Ancistrocladus korupensis* which has proved to be effective against two strains of the HIV virus but it is still too toxic for use in patients. (Cragg and Boyd 1996: 128–132). This is evident that medicinal plants actually hold the key to combating the HIV/ pandemic hence the need for collaboration between traditional health practitioners and conventional doctors.

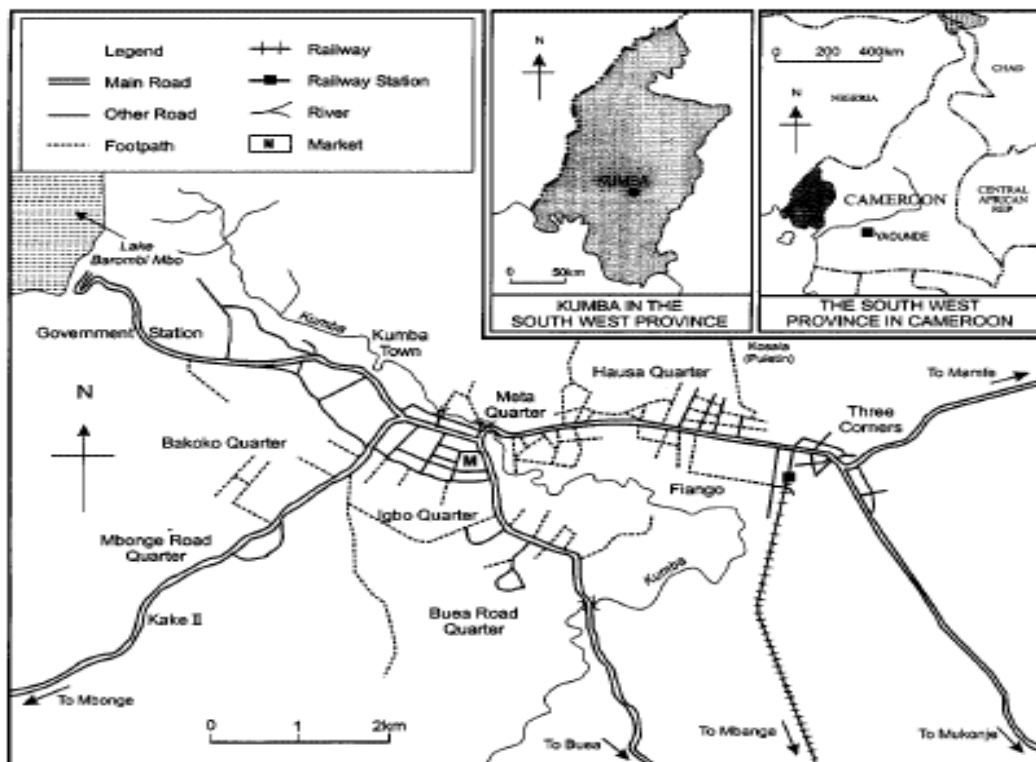
Based on the Alma-Ata Declaration of 1978 and the WHO advocacy for traditional medicine in the provision of primary health care and owing to its increase popularity, acceptability and accessibility (WHO; 2002), the government of Cameroon has renewed its commitment in the recognition and subsequent integration of traditional medicine in the National health system. However integration is still farfetched due to lack of adequate studies that can provide evidence for policy design, formulation and implementation regarding traditional medicine.

Methodology

Study Setting

This study was conducted in the Kumba Health District, one of the fourteen health districts that make up the South West Region. It is located some 35 kilometers from the South West regional capital; Buea. This area has a marked dry season extending from November to mid-March and a rainy season during the remaining months of the

year. Rainfall averages 233cm per year while average daily temperatures range from 22-26°C (Ndamukong et al, 2002). The town has a district hospital which serves a population of 311688 inhabitants and also as a reference health facility to the health centers in all the neighboring villages. Among the few public health facilities in the Kumba Health District, there are four faith-based health facilities and over fifteen private for-profit health organizations offering services such as diagnosis, primary health care and/or specialist medical care. There are also several traditional healers` clinics. The study area is shown in figure 4 below.



Source: Acho-Chi, 2002

Figure 4: Map of the Kumba Health District showing the study site

Study Design

This study is a qualitative study in which six in-depth interviews were performed with women from the Kumba health district to ascertain beliefs and perceptions regarding traditional medicine and also to capture and understand the women's experiences with traditional health care. Other data collection methods used includes observations and informal conversations.

Sampling of Informants

In order to capture the unique slice of experience, the informants who participated in this study were purposively sampled based on their encounter with traditional health care or traditional health product and their willingness to participate in the study. I identified potential participants in informal conversations to find out those who had knowledge of, and had experienced traditional health care and were willing to share their experiences. This was also a useful data collection tool in the field as many people could “open up” more during casual conversations than in formal interview settings (Dahlgren et al, 2007). However, the ethical aspect of this method is questionable since informants do not know that they are being researched. All informants who accepted to take part in the study were invited for an interview at a time a place that best suit them. Five of the interviews took place in the informants’ premises. Only one interview was carried out in the interviewer’s home. This location was mutually agreed upon by both interviewer and the informants because it was more convenient there than in the informants premises.

Data Collection

Data collection was through observations, conversations and interviews. I observed how traditional health product was distributed and marketed in the urban settings, and I also engaged in informal conversations with potential informants. Then those who were willing to participate in the study were invited for interview. Five of the interviews took place in the respondent’s premises and one in my home during the months of December 2010 and January 2011. I developed the interview guide to guide semi-structured interviews. Three of the interviews were tape recorded, three participants declined tape recording. In such cases notes were taken by the researcher. During the interview the informants were asked to share their feelings and experiences regarding traditional medicine. They were also encouraged to describe their contacts with traditional medical practitioners. Interviews were either conducted in the English language or Pidgin. Recorded interviews were transcript verbatim and translated into the English Language when there was the need. Field notes from informal interviews or conversations and observations were very important sources of data used in my thesis.

Data Analysis

The data analysis was based on qualitative content analysis as described by Graneheim & Lundman, (2003). Content analysis deals with ‘the objective, systematic and quantitative description of the manifest content of communication’ (Berelson, 1952.) This definition is supported by Kvale & Brinkman (2009) However, Graneheim & Lundman, 2003 expanded this definition to involve not only the quantitative description of the manifest content in communication but also the qualitative interpretation of the latent content of texts. The quantitative approach of content analysis was predominant in the 1950s when content analysis was mainly used in media research. In this study we used the qualitative approach branded qualitative content analysis to interpret texts based on interviews, observations and conversations. The interview texts, observation notes and conversations constituted the units of analysis for the study. The study participants were six women between 18-53 years who have experienced traditional medicine at least once in their life. The interviews were transcribed verbatim and then read several times to check for correctness and to capture the overall picture in the texts.

Examination of the texts revealed the following content areas; Conceptualization of modernity in traditional medicine, experience associated with initiation of traditional medicine use, experience related to traditional medicine i.e. the experiences related to a positive or negative consequence of traditional medicine. The analysis process proceeded with the identification of meaning units. Each meaning unit was condensed and then labeled with a code. Labeling the condensed meaning unit allows the text to be abstracted and thought of in a completely new way. The research context was very vital in the identification and labeling of the meaning units with the various codes. The codes were then grouped and compared to show connections based on their similarities and differences with each other. The codes were then sorted into categories which constitutes the manifest meanings or contents of the texts.

Although the analysis process is presented here in a linear step-by-step procedure, the actual data analysis was an iterative and reflexive one.

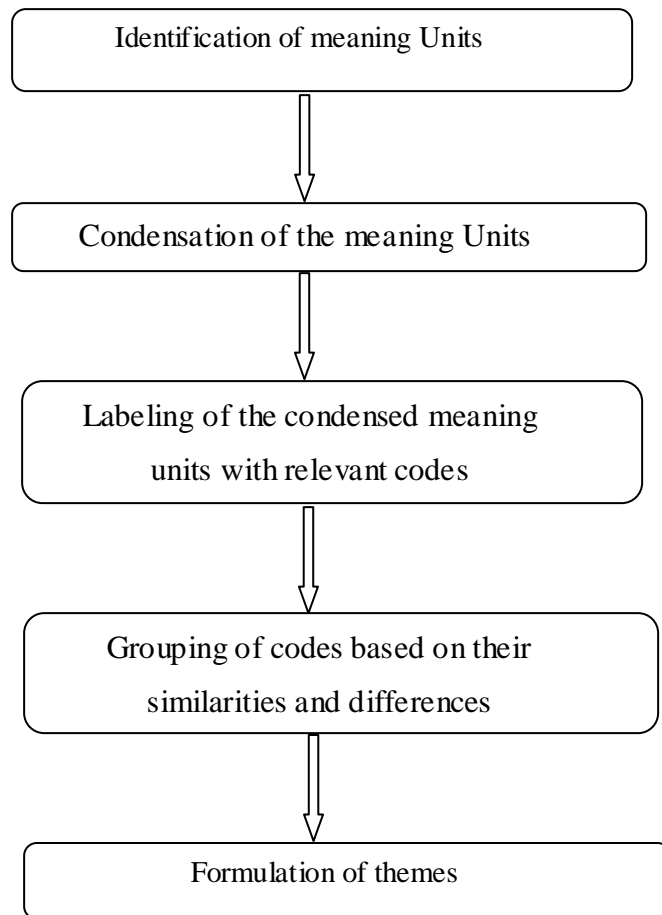


Figure 5: Step-by-step representation of the analysis process

Below is an illustration of the analysis of a meaning unit, going through meaning condensation, coding and meaning interpretation.

Original text \longrightarrow Condensed meaning unit \longrightarrow Code

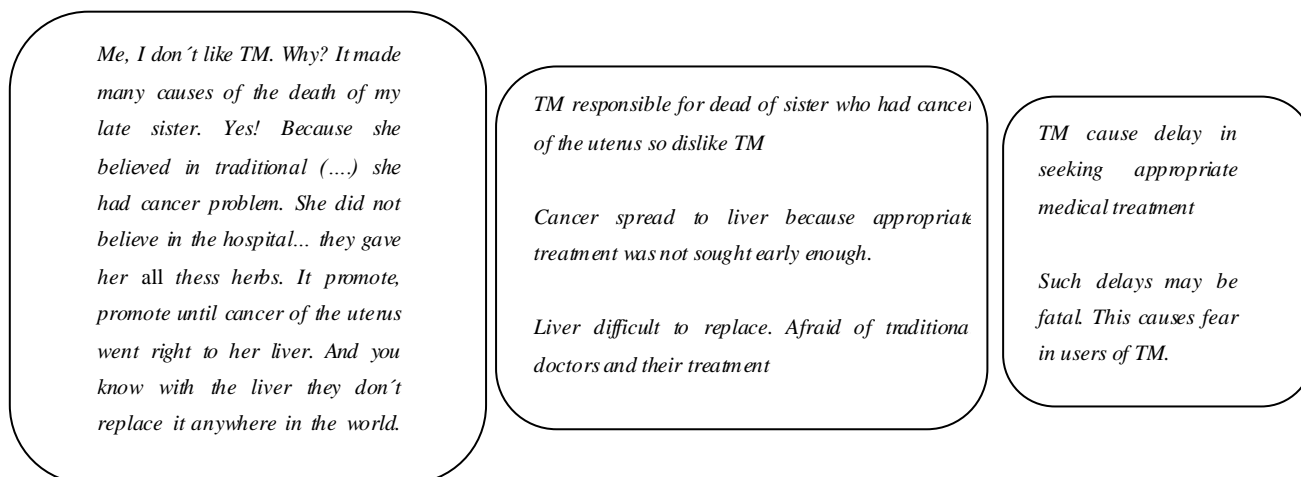


Figure 6: An Illustration of Data analysis

Meaning Condensation is a technique that renders the meanings as expressed by the interviewee into shorter formulations. Long statements are compressed into briefer statements in which the main sense of what is said is rephrased in a few words. Meaning Coding is the process of attaching one or more keywords to a text segment in order to permit later identification of the statement, whereas categorization entails a more systematic conceptualization of a statement. (Kvale S & Brinkman S, 2009). The categories generated allow for a more concise abstraction of the underlying meaning in the interview texts.

Trustworthiness

Trustworthiness in qualitative research is used in the evaluation of a study based on different criteria depending on specific aspects of the research (Strauss and Corbin 1998). Dahlgren et al 2007 suggested that judgment should be made regarding the credibility, transferability, dependability and conformability criteria. The credibility of this study may have been affected owing to the short period of engagement between the researcher and the informants as well as the low number of informants interviewed. However, this is compensated for by triangulation that was used in data

collection. Also I as a researcher conducting research happened to be familiar to some informants. This makes it difficult for me to feign Naïveté. In addition, the fact that I am a male interviewing woman has some implications for the trustworthiness. The findings in this study can well be transferred to other settings in Cameroon as well as in Africa since the results were grounded in the data collected.

Ethical Considerations

Permission to carry out the study was obtained from the Divisional officer for Kumba I Sub-Division. The research proposal was presented to the District medical officer for the Kumba Health District who approved the study and issued a Clearance and a recommendation to the Divisional Officer to grant the permission for the study to be carried out. Oral informed consent was obtained from all participants and their right to withdraw from the study at any time in the study was emphasized. Interviews were tape recorded except in cases where participants declined. In cases where interviews were not tape recorded notes were taken. All notes, recordings and transcript were kept confidential.

Results

In this section the main findings in the study are presented taking into consideration the objectives and aims of the study. After the analysis of the texts, three main categories were identified; Meanings ascribed to modernity in traditional medicine, Experiences associated with the initiation of traditional medicine use, Experiences related to long term use of traditional medicine.

Meanings of Modernity in Traditional Medicine

Modernity in traditional medicine as perceived by the informants is the used of scientific methods in the diagnosis of disease before the administration of proper traditional medical products or procedures. They summarized modernity in traditional medicine as ``traditional medical practice which makes use of modern medical techniques'' in the diagnosis of diseases and monitoring of treatment outcome in patients.

``Well, some of them do have (modern laboratories)... but they are not quite advance like in the modern health system so I recommend the modern health system.`` (Informant 3, Aged 37 years)

However all participants hold that knowledge and techniques of modern medicine used in traditional medicine is still of low quality and sometimes even lacking, in which case the concept; modern traditional medicine is simply a means to attract more patients and clients. They also believe that traditional doctors can acquire modern skills and knowledge of biomedicine through education which will then qualify them to become modern traditional doctors.

``Well, for me I think that they should help them, that is, they should educate them so that, let them really know ... because some of them they don't really know what they are doing. First of all they should understand the importance of human beings, one, how to deal with the people, two they should know that they should run some test before treating.`` (Informant 2, Aged 35 years)

Experiences associated with the initiation of Traditional Medicine Use.

Participants started using traditional medicine either as a child during which parents let them into the use of traditional medicine. They said that their parents thought it was more economical to use traditional medicine.

When we were youngwe always use traditional herb... because we (our parents) did not have enough money to go to the hospital. (Informant 3, Aged 37)

Parents' beliefs and the role traditional medicine played in their social lives and culture may have influence this choice which they passed on to their children.

Some started using traditional medicine later in life when they or a close relative were facing serious health problems usually a chronic one that did not subside with the help of the available modern health facility.

The women supported the fact that poor quality of modern medical services and failure of the modern health system to meet the expectations of their clients and patients cause some women to start making use of traditional medicine.

`` We first of all went to the hospital with her, we went there she was treated so after ... she started again so they told us that we should carry her first to the traditional healer.`` (informant 2, Aged 35)

The women believed that some traditional healers have exaggerated their potentials, some claim to do more than they are able to do all to the detriment of their patients. The women approached traditional healers hoping to obtain magical solutions to their health problems, many of which have left disappointed. They reported that traditional healers never refused that they were unable to treat any sickness. They always accepted even when they knew they could not cure a disease.

Poverty coupled with the profit making focus of most modern medical doctors has been a factor that influence peoples debut with traditional medicine

`` Poverty too contributes to... because if you don't have money, how can you go to the hospital. You cannot go because if you go to the hospital without money nobody will even look at you. You see! ... Even if you are dying it does not concern them but they say that it is general hospital.`` (Informant 2 Aged 35)

The women regretted that even public hospitals are no longer for poor people. They mentioned that the relationship between modern health personnel and their patients had deteriorated causing many to turn to traditional medicine for their healthcare needs which they considered more patient centered than the modern medical healthcare systems.

The women conceptualization of health had a strong influence on their preferred healthcare option. Those who thought health was "like taking care of self" preferred the modern medical system. They emphasize the importance of hygiene, sanitation and nutrition in staying healthy. Those with the traditional model of health will advocate for traditional healthcare believing not only in the healing potentials of traditional health product but also the supernatural power solicited by the traditional "doctor".

Experiences related to prolonged use of Traditional Medicine

Analysis of the texts revealed that after prolonged use of traditional medicine the women found out that traditional medicine have both their advantages and disadvantages. Their attitude towards traditional medicine range from fear of adverse reaction of the traditional health product to Traditional medicine fanaticism. Those that

have experience some negative outcome with traditional medicine were more critical of traditional medical treatment. However some were still loyal to traditional medicine even after a negative experience. They reported that traditional doctors when they specialize on specific ailments can make huge contributions to the improvement of health of the community. They recommended traditional medicine in psychiatric care and some tropical diseases such as malaria, typhoid etc. One woman said she uses traditional medicine when she is not sick so she can stay healthy but when she falls sick she must go the hospital for proper medication. This illustrates that traditional medicine is being use in preventive healthcare. Some women prefer traditional medicine for primary healthcare while other takes it as a last resort saying that when the hospital fails to give a proper diagnosis of an illness, they turn to traditional medicine assuming it to be a spiritual problem and hoping to get spiritual remedies from the traditional healer.

Charlatanism which is synonymous to quackery in the modern health system was identified as the main cause of negative effects associated with traditional medicine. Also the risks associated with the untested medicine product and unregulated practices in traditional medicine. The women thought that traditional medical practitioners never limit the lists of services they offer. They claim to cure everything. Such traditional medicine practice is flawed with mediocrity. This has consequences on the patient as a treatable medical condition can deteriorate to a point where the situation cannot be reversed. Some of these women have suffered serious losses because of delay in seeking health care.

``Hmmmm! Yes, I do with one of my sister who is of late, so we went there and they told us that that one is like that is like that and so on. The man told us that he will be able to treat her but at the end we discover that he could not do it but before we could carry her to the hospital it was late and she gave up.``

The lady quoted above explains her predicaments with lots of regrets and wish they were a little wiser enough to discern that the traditional doctor was not able to help them. She narrated that she was pretty sure that if they had gone directly to the hospital her sister would not have died. This is an agonizing experience she is forced to live with for the rest of her life. She spoke with deep feelings of disgust for traditional doctors especially those who have branded themselves modern traditional doctors as she puts it in her own words,

‘‘There is nothing like a modern traditional doctor because even with the modern ones they don’t even conduct any tests.’’

Some of the women were of the opinion that over reliance on traditional health remedies can cause major delays in seeking appropriate healthcare.

It should be noted that women who were more conscious about their health and wellbeing and who were also more financially viable would opt for western medical treatment.

All women although they acknowledge the useful potentials of traditional medicine, thought that traditional medicine constitute a potential danger to health because the drugs used were untested and largely unregulated. Traditional medicine prescriptions are seldom written; usually they are given orally so much so that any negative effect could blame on the patients. It is interesting to note that most of the women still hold that traditional medicine constitute a useful resource which if developed through research and cooperation will provide a lot of health benefits to the population. They called on the government to help educate traditional doctors in order to enhance their performance.

Discussion

This study is one of the few studies so far that examines women’s perceptions of traditional healthcare in Cameroon and have tried to develop a concept of modernity in Traditional medicine in Cameroon based on female user’s perspective. All other studies have focused on traditional healers and allopathic doctors looking at ways of fostering collaboration between the two systems of healthcare namely; the traditional health systems and the modern medical system in order to integrate both systems (Hardy A, 2008).

Other authors have discussed about modernizing traditional medicine (Mutabazi, 2008). For the sake of this thesis I will see modernization as a process that leads to an end which could be seen as the state of modernity in traditional medicine. Mutabazi, 2008 suggested some of the tenets of modernization. From his paper we could conclude that the modernization of traditional medicine in Africa has commenced and is on-going in many nations. However its end- Modernity in traditional medicine - is still long ahead and the road is bumpy. Much concern is placed on the problems that

arise when modernity is characterized and defined by political and scientific development, industrial production and urbanization, (Lynn, 2011)

This research has pointed important aspects regarding traditional medicine. It highlights some factors that promote traditional medicine use in Cameroon such as poverty, women conceptualization of health and disease, as well as their perceptions of modernity in traditional medicine. This agrees with a study carried out by Nelms and Gorski (2006) which stated that the African woman's conceptualization of good health is characterized by a disease-free state and the ability to work and perform tasks, take care of the children, and keep the house and clothes clean and that poor health is the work of a supernatural force. The causes of illness and disease were viewed as punishment from God or a curse from a witch, evil spirit, or evil eye. This emphasizes the functional and the spiritual aspect of good health. Those who had this model of health that places emphasis on supernatural causes and spiritual influences that affect their daily lives were more comfortable with traditional healthcare. However those who defined health as ``taking care of self'' were more critical of the traditional health system but favored a situation where traditional medicine can be developed to meet the expectations of its potential users. From this is could be concluded that women's attitude towards traditional medicine is influenced by their perception of health. Several authors have advocated traditional medicine in for mental health including K. Sorsdahl, D.J. Stein, A. Grimsrud, S. Seedat, A. Flisher, D. Williams et al. (2010) who concluded from a national survey carried out in South Africa that traditional medicine plays an important role in mental health care. The women shared the same opinion but thought that traditional medicine is more effective in mental healthcare than modern medicine. This stance is probably influenced by the fact that mental health in Cameroon has been neglected and only traditional healers venture in the rehabilitation of the mentally ill patients. This could also be because of the belief that mental illness has a supernatural origin and can be treated only through supernatural means.

Limitations of the study

This study was limited by the few number of women interviewed. However, this was compensated by the information obtained from informal interviews and observations. It cannot be claimed that saturation was reached but the information obtained is substantial to represent the views of a good proportion of the population in the Kumba health district.

Another limitation was the fact that I was familiar to many of the interviewees even in cases where I did not know them; this made them to assume that I have knowledge of the phenomenon discussed so they could have unconsciously withheld valuable information which would have been useful for the purpose of this thesis.

Time used for data collection was a great limitation reason why only six interviews were analyzed alongside data from informal interviews and observations. The question of how women in Cameroon perceive modernity in traditional medicine could be answered more specifically if more interviews are conducted in both the rural and the urban centers. Other areas to be researched include how women in Cameroon use traditional medicine for self medication and the types of traditional health products available for such treatment.

Conclusion

This thesis presents opinions and perceptions of women in the Kumba Health District regarding modernity in traditional medicine and their attitude towards traditional medicine in general. The women interviewed believed that traditional medicine has both strengths and weaknesses. Findings from conversations showed that women try to balance their health care needs based on these strengths and weaknesses. They count on their judgment or that of close relative and friends to decide which health care is most appropriate at every given occasion.

The women`s perceptions of traditional medicine as well as their experiences indicate that the concept; modernity in traditional medicine as used by some local traditional medicine practitioners is controversial amongst female traditional medicine users.

Based on the strength and weaknesses, traditional medicine in Cameroon can be described as a mixed blessing; when practice correctly, traditional medicine helps to protect and improve the health of the population. However, the practice in Cameroon is flawed with uncertainties in outcome which may constitute a danger to population health. It is therefore important for the government of Cameroon to hasten the process of modernization of traditional medicine as it moves towards the World Health Organization`s definition of an integrative health system of Traditional and western medicines.

Recommendation

In order to aid the process of modernization of traditional medicine I recommend that the government of Cameroon should put in place educational, professional and legal frameworks to govern the practice of traditional medicine in Cameroon.

Traditional medicine in Cameroon should adopt modern scientific approaches in their practices. This entails that they use traditional medicine products and therapeutic techniques which are effective and safe and that are applicable for specific indications. Research in traditional medicine using biomedical techniques should be fostered so that practice of traditional medicine will be backed by evidence from research.

Practitioner of traditional medicine, policy makers and policy planners within and outside the ministry of public health should take steps to ensure quality and safety of traditional medicine in Cameroon in order to protect both the practitioners and users of traditional medicine. This could be achieved by setting the appropriate frameworks for registering and regulating traditional medicine in the country as well as making sure that traditional medicine practice meets minimum levels of adequate knowledge, skills and awareness of indications and contraindications.

Acknowledgement

I thank the Almighty God for seeing me through my studies in Umeå University.

I am immensely grateful to the members of Umeå International School of Public Health Sciences especially to my supervisor Kjerstin Dahlblom for her encouragement and guidance during the developing of this piece of work.

I also want to thank the following whose contributions are immeasurable the course administrator for the Masters in Public Health Programme; Sabina Bergsten and all the teachers in the MPH programme who contributed to my success in Umeå University.

To my friends I am grateful for the time we share in encouraging and inspiring one another and keeping one another company even in the darkness of the winter. Such moments are rare to find. I wish you all the best as you continue to pursue your career.

To my family back home I will like to thank you all for your patience and support that was very instrumental in my success.

May the good God replenish you all!

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Appendix

Interview Guide

The interviews were design to cover topics like:

health - choices of healthcare - sources of healthcare financing - knowledge about traditional medicine - experiences involving traditional medicine - perception of traditional healthcare - attitudes towards traditional medicine - feelings regarding modernization of traditional medicine - knowledge about the concept “modernity in traditional medicine”.

This is a summary of the questions asked during the interview, amidst probes to clarify the topics.

In your own words can you tell me what health is to you?

When you fall sick, where do you mostly go for treatment?

How do you often pay for your treatment? Do the sources of financing affect your choice of healthcare provider?

Have you ever used traditional medicine before?

What is traditional medicine to you?

When did you start using traditional medicine?

How do you perceive the care given by traditional doctors?

It is common that people talk about modern traditional clinics here. What does that mean to you?

How do you think traditional medicine can be improved to serve the needs of the population to a better degree?