

**Is there a role for traditional medicine in basic health services in Africa?
A plea for a community perspective.**

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Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective

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Summary

Traditional medicine in Africa is contrasted with biomedicine. Most traditional medical theories have a social and religious character and emphasize prevention and holistic features. Traditional medical practices are usually characterized by the healer's personal involvement, by secrecy and a reward system. Biomedical theory and practice show an almost opposite picture: asocial, irreligious, curative and organ-directed; professional detachment, public knowledge and – until recently – 'free of charge'. It is suggested that local communities do not expect that basic health care will improve when traditional healers become integrated into the service. They ask instead for improvement of basic health care itself: more services with better access, more dedication and respect from doctors and nurses, more medicines and personnel. Fieldwork needs to be done at the community level to arrive at a better understanding and assessment of the community's opinion concerning a possible role of traditional medicine in basic health care.

keywords traditional medicine, basic health care, primary health care, cooperation, quality of care, community perspective, Africa

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Introduction

The quality of modern health care services in Africa is increasingly being criticized in recent literature (Hours 1985; Van der Geest *et al.* 1990; Gilson 1992; Gilson *et al.* 1994; Booth *et al.* 1995). The consequences of structural adjustment are strongly felt in the diminishing budgets for health care. At the microlevel, the attitude and behaviour of health personnel towards patients have been singled out as problematic. Compared to local traditional healers, health workers in the basic health services are often found to show little concern and respect for patients. The question could be raised whether integration of traditional healers in basic health care would help to improve its quality.

Since 1978 the WHO has been calling for more cooperation, even integration, of traditional medicine and biomedicine. The role of traditional medicine was viewed as an integral part of primary health care with its

basic philosophy of self-reliance. Obviously, traditional healers and traditional self-care were considered a form of self-reliance.

The idea was inspiring and breathed the spirit of optimism of those days. However, national governments and their ministries of health, controlled by biomedical practitioners, were less enthusiastic. They did pay lip service to the WHO suggestion, created token departments of traditional medicine, but did not give the idea much chance to materialize. Green (1996) provides a useful overview of government policies, ranging from banning traditional medicine to programs for integrating it into the regular national health service, but most policies existed merely on paper to please international donors. I shall return to this intentional misunderstanding later on when discussing the multilevel perspective. In the meantime the WHO itself has – almost silently – changed its position and placed traditional medicine in the Division of Drug

Management and Policies where it is dying a slow death (Ventevogel 1996).

By now we have a library of publications advocating or rejecting the idea of integrating traditional and biomedical services. Most authors who have contributed to that discussion base their argument on their own assessment of the complementarity or incompatibility of the two – or more – medical traditions (for overviews see Bichmann 1995; Green 1996; Ventevogel 1996). Some have interviewed local healers and/or biomedical practitioners about their views on a possible cooperation. Overall, however, their conclusions reflect their own logic. Amazingly, the question whether *local communities* favour an integration of traditional and modern medicine has hardly been raised, let alone investigated by medical anthropologists. This article is a plea for such research and at the same time carries the cautious suggestion that local communities may be less enthusiastic about the idea of integration than some of its advocates assume.

African medical traditions

It has become a tradition in Africa to refer to medical practitioners outside the realm of biomedicine as 'traditional healers'. In the same vein, their practice and knowledge is called *traditional* medicine. The term is misleading, embarrassing and naive. It is misleading because it suggests that there is a more or less homogeneous body of medical thought and practice which can be put together under one name. Such a body does not exist, however. If one examines the type of medical practitioners who are designated *traditional*, one will find an extreme diversity both in theories and practices. The only thing these practitioners have in common – like *alternative* practitioners in Europe and North America – is that they are non-biomedical. That is why the term is embarrassing. Lumping together everything which is not 'ours' and treating it as if it were one type is a school example of ethnocentric ignorance. Finally, the term is naive because it suggests that 'our' medical system is not traditional, meaning *handed over*, from generation to generation. Clearly, biomedicine *is* being handed over all the time, in medical schools, in hospitals, in books and articles, through conferences and the media. Biomedicine therefore is as traditional as any other medical tradition.

Another misunderstanding is brought about by the term 'medical system', which suggests a coherent whole of beliefs and practices. Anthropologists, however, have shown that medical ideas and practices do not always harmoniously fit together. There is often confusion, ignorance and contradiction in what people think and do around health and illness. To a Western-trained scientist the statements and activities of traditional healers and their clients may seem outright illogical and unsystematic.

Having said this, I will nevertheless – with some embarrassment – try to make a few general observations about African traditional medicine. African medicine consists primarily of self-help. For various reasons, self-care and self-medication are far more widely practised in African families than, for example, in my own society, the Netherlands. Self-care is not only something of people's own choice, it often is bare necessity due to poverty or lack of good medical facilities (Van der Geest & Hardon 1990). Home remedies and popular knowledge of herbs and other therapeutic substances take up the greater – and perhaps the better – part of African medicine. Its efficacy is publicly discussed and, for that reason, open to critique and adjustment. Popular knowledge therefore is a most valuable part of the medical tradition. It needs to be safeguarded and strengthened if we want to enhance people's ability to cope with health problems and to improve the quality of health care.

It is more difficult to speak in such general terms about the specialists in African medicine, the traditional healers. To risk overlooking their cultural diversity and to simplify the complexity of their medical practice, I shall discuss four more or less characteristic features of their medical theories and three features of their style of practice.

Most African medical theories have a *social* character. The description and explanation of illness is often phrased in terms of social interaction, in particular between members of one kinship group. The origin of illness, its treatment and prevention is linked to the quality of human relationships. Jealousy, hatred and moral wrong-doing are associated with physical and mental dysphoria. Ancestors and witches are believed to play a crucial role in bringing about illness and other misfortune. Disorder in the community leads to disorder in the health condition of its members. An illness of one family member therefore is seen as an illness of the

entire family. Finding a solution to the problem is the responsibility of the group to which the sick person belongs.

The second feature is the *religious* dimension of medical reasoning. Religion permeates every aspect of human existence, including health and disease. Medical problems are often interpreted in religious terms and, conversely, religious rituals are nearly always linked to the maintenance or restoration of well-being in the community. Many medical practitioners are also religious specialists. Healing the body while neglecting the deeper religious grounds of the problem is senseless.

African medicine's third characteristic will be a surprise to most readers: its orientation to *prevention*. There is a popular western prejudice that Africans do not worry about the future and are little interested in preventive medicine. It is one of the most stubborn misconceptions about Africa circulating in the rest of the world. Prevention, however, is central in people's everyday life and follows logically from their preoccupation with religious and social values. As we have seen, traditional healers concentrate on the deeper origins of illness and insist that something should be done about them to avoid a repetition of the misfortune. They provide their patients with moral and social guidelines to prevent them from catching the same illness again. The preventive character of traditional medicine is, however, hardly recognized by outsiders who do not believe in the social and religious roots of illness and consider the healers' suggestions irrelevant to health and illness.

The fourth characteristic of medical theories in the African tradition is that health and illness are *more comprehensive* concepts than in the Western tradition. As a matter of fact, 'health' cannot be adequately translated in many African languages. Indigenous terms closest to it comprise a much wider semantic field. They refer to the general quality of life including the conditions of animals and plants, the entire physical and social environment. 'Well-being' or even 'happiness' seem better English terms to capture the meaning of traditional African medical concepts. As a consequence, the English term 'medicine' is also a misnomer, but interestingly the term has been indigenised in many African languages and now entails much more than restoring bodily health. Medicine is any substance that can bring about a change, anywhere, anyhow. Medicines heal a sickness, catch a thief, help someone to

pass an exam, make a business prosper, kill an enemy and win someone's love (Keller 1978; Whyte 1988). In the explanatory model of many African healers there is no neatly demarcated field of physical health. Their medical perspective is holistic in the most holistic sense of the word. Interestingly, their vision is not so different from the idealistic and much criticized WHO definition of health: a state of physical, mental and social well-being.

Three prominent, more or less general features of the practice of traditional medicine in Africa are the healers' emotional commitment in the therapeutic process, the secrecy surrounding their practice and the healers' reward.

Several students of traditional medicine have described the deep *personal involvement* of African healers in the treatment of patients. Therapeutic sessions lasting more than an hour, and continuing over a period of several months are common. The style of treatment also indicates the healer's concern. Patients are frequently touched and their social and mental problems extensively discussed, often in the presence of their relatives.

Many traditional healers consider their medical knowledge as personal property which they protect by keeping it *secret*. Only a few select people are allowed to know their secret, for example an apprentice who has paid for his training or a relative who is destined to succeed the healer in the future. The secrecy may be medically legitimized: if the secrecy around a treatment is broken, the treatment loses its efficacy (Cohen 1969; Buckley 1985; Pearce 1986, 1989; Van Sargent 1986, Wall 1988). The secrecy also has consequences for the healer-patient relationship. The patient knows nothing and must totally surrender to the healer (Buckley 1985; Wall 1988).

A final characteristic, contrary to some popular beliefs, is that traditional healers are *rewarded* for their service. Their personal involvement does not imply that their work remains unrewarded. The social context of the therapeutic act requires reciprocity. In most cases the positive outcome of a treatment needs a response from the patient or his relatives. Paying for received treatment is a sign of respect and appreciation. No payment implies no obligation, no appreciation, no relationship (Van der Geest 1992). If no reward is given, the patient runs the risk of falling sick again. Like the concept of secrecy, the reward too has been built into

medical theory. The payment contributes to the efficacy of the treatment.

The imported tradition

The imported biomedical system is in many respects the opposite of the above described indigenous tradition. The religious dimension is totally absent and the social dimension only plays a marginal role. In European history, biomedicine made its great advances after it had isolated the human body from its wider context and was able to concentrate on technical failures of the body-machine. Its great achievements were in the field of curative medicine while prevention received far less attention. Biomedicine has an uneasy relationship with all medical traditions which hold a more holistic view of human health and disease; the African traditions being a case in point.

It is no wonder that also in its practice biomedicine strongly contrasts with the African way. In the first place, biomedical doctors or nurses usually do not want to get personally involved in the problems of their patients but prefer to keep some distance. Anthropologists who compared biomedical with other practitioners observed that the latter devoted much more time to their patients than the former and that they were closer to their patients in their choice of words and in their behaviour.

Knowledge in biomedical science and practice is, almost by definition, public. Doctors openly discuss their practice with colleagues and advice is frequently exchanged among them. Progress in biomedical science is made possible through conferences and publications in which scientists make their discoveries known to the world.

The contrast in the reward system is perhaps less prominent, but until recently, biomedicine in government institutions was – at least nominally – free of charge in a large number of African countries. The absence of any form of remuneration usually confirmed the absence of a personal relationship between doctors (and nurses) and their patients.

This brief contrasting picture is, however, incomplete and over-schematic. It describes the imported system *in abstracto*. In the actual situation of African communities, biomedical knowledge and practice are often indigenised and adjusted to local needs and expectations. Self-help, for example, continues to be

practised in hospitals and clinics. Relatives bring herbs, pharmaceuticals and other popular remedies to patients in hospitals who use them alongside the professional treatment they receive.

Visiting biomedical institutions one may discover that the religious factor has entered biomedicine. Hospitals have become favourite places for religious activities. The experience of pain and suffering invites metaphysical questions among patients and their relatives. During my own admission to a Ghanaian government hospital, some years ago, I encountered more preachers than doctors and nurses.

A similar observation can be made with regard to the social factor. Relatives of patients are conspicuously present in hospitals and health centres. They occupy themselves with numerous chores such as feeding and bathing patients and going out to buy medicines for them. It would be difficult for hospitals and health centres to function without the assistance of those relatives. It is true that the social factor has not entered the doctor's aetiology and diagnosis, as is the case in the traditional setting, but social relationships do play a crucial role in the therapeutic activities in biomedical institutions. As far as the other two characteristics are concerned, the emphasis on curative and organ-orientated medicine, the indigenization and transformation of biomedicine is less prominent.

The impersonal and unconcerned attitude of biomedical doctors and nurses to their patients may apply to the majority of cases, but there are significant exceptions. When there is a family or other relationship between health worker and patient, one may witness a totally different therapeutic encounter. The health worker will show concern and affection and spend a lot of time with the patient (Gilson *et al.* 1994).

The openness of the doctor to colleagues and patients may be far less than one would expect from a biomedically trained person. Especially to patients, doctors (and nurses) are taciturn and secretive. Nothing is explained to them. The image of the all-knowing but secretive traditional healer is transposed to the biomedical physician. The patient just trusts him because he is the doctor.

Finally, the claim that government medical services are (were) free of charge is in many cases a myth. They were only free in theory, in the official political rhetoric. In actual practice, patients had to pay a sum of money to establish a relationship with the doctor or the nurse

to oblige him/her in order to get the treatment and medicines they desired (Van der Geest 1982). The traditional concept of reciprocity was informally – and illegally – reintroduced into biomedical settings. Payment was not necessary if the doctor/nurse and patient were in some way related. In those cases, payment was superfluous, since another form of reciprocity already existed. In most countries therefore the cost recovery introduced by the Bamako Initiative is a confirmation of an existing practice rather than an innovation.

Arguments for cooperation between traditional medicine and biomedicine

The problems and frustrations encountered in the modern health care system seem to call for a rapprochement between biomedicine and traditional medicine. Health planners and social scientists have provided several reasons why cooperation between the two traditions should be considered an option to alleviate the present problems in health care.

The first reason is the shortage of personnel in the biomedical sector. Training traditional healers as community health workers would be a quick and inexpensive way to fill some of the gaps in biomedical services. The second argument refers to the mainly rural character of the logistical problems in government health care. Doctors and nurses are reluctant to settle in rural areas and even community health workers disappear after some time to try their luck in an urban environment (Van der Geest *et al.* 1990). Traditional healers are far less inclined to leave their rural community. They usually are farmers, tied to the land. Moreover they depend on the local flora and/or on local deities for their medical practice. For most of them a life in the city, where they will lose the prestige they enjoy in the home community, is not attractive. To train and install them as community health workers therefore seems a wise policy decision to improve the accessibility of basic health care in rural places.

A plea for cooperation with traditional healers is also in accordance with the Primary Health Care (PHC) philosophy of self-reliance. Where possible, dependence on external services should be replaced by reliance on local resources. Traditional healers are part of the available local resources and suit the PHC concept.

The cultural affinity between traditional healers and their patients is a fourth reason to support greater involvement of healers in the health care system. The fact that healers and patients share ideas about the origin, meaning and preferable treatment of illness enhances the efficacy of treatment. The lack of such a cultural affinity between biomedical practitioners and their patients is often blamed for the limited compliance by patients and the frustrations of doctors and nurses.

The last reason for biomedicine to make overtures towards traditional medicine lies in the assumed unique value of the latter. The belief that African traditions contain valuable insights and therapeutic techniques which are unknown in the biomedical tradition is considered by many a sufficient grounds for closer cooperation which hopefully leads to mutual enrichment.

These five arguments in favour of cooperation between the two traditions mainly reflect the outsider's perspective. They may make sense from the points of view of policy makers, idealists and social scientists, but what do people in rural communities think about this option? Would it be attractive to them if traditional healers were included in the basic health services? Would a dose of traditional medicine enhance the quality of health care to them? These questions are not easily answered because little is known about community perspectives on traditional medicine.

A multilevel perspective

Health policy is usually conceived and pushed by discussions on the level of national ministries and supra-national organizations, where the interests and ideas of the local population hardly get through. Moreover, health planners are often not prepared to listen to community demands. They are convinced that people in the villages do not know what is good for them or come with impossible requests. Nevertheless, suggestions for the improvement of health care which have been produced by high-level policy makers are often presented as plans reflecting the interests of the people directly affected by them.

What is needed is a research strategy for the study and comparison of health care ideas at different levels of social organization. The multilevel perspective provides such a tool to gain an understanding of the contrasting and conflicting views between people at different social

levels. It brings into focus possible conflicting interests at different levels. Opposite interests give shape to conflicting ideas about health care and health care policy. The same words may be used but with very different meanings. Language thus becomes a camouflage of conflicting ideas and interests. The appreciation of traditional medicine is a good example. Different opinions are probably hiding behind general statements pledging support for the inclusion of traditional medicine in the regular health care system. In the Alma-Ata document collaboration with traditional medical practitioners was recommended in the following terms:

Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly (WHO/UNICEF 1978).

In addition, the WHO (1978) devoted a report to the integration of Western and traditional medicine. Optimism about possible cooperation between representatives of different medical cultures also predominated in a collection of articles Bannerman *et al.* (1983) published under the auspices of the WHO.

Although some scepticism about traditional medicine still exists, the idea seems to prevail at the international level that additional training and involvement of traditional practitioners can partly fill the shortage of personnel in PHC or at least ease it and that such practitioners will make valuable community health workers. Their close relationship with fellow-villagers is seen as a guarantee of good communication.

At the national level lip service is often paid to the above-cited passage in the WHO document. Promotion of traditional medicine frequently serves the purpose of national and cultural self-awareness. In practice, however, there is hardly any example of real collaboration and exchange between modern and

traditional medicine in the framework of PHC. Health workers within the biomedical system are generally opposed to the idea of collaboration, whereas traditional practitioners are often more responsive. The latter expect an increase in prestige and income through their association with the official health care system (Green 1988; World Bank 1994; Venter 1996).

As yet, little is known about the reaction of local population groups to the incorporation of traditional medicine into PHC. While they have long been accustomed to Western and traditional medicine being used side-by-side, they are likely to see themselves fobbed off with second rate provisions when traditional practitioners are mobilized as community health workers (Green 1988).

Community perspective

How do ordinary people perceive traditional medicine and would they favour some kind of integration of traditional medicine into basic health services? I have already pointed out that hardly any research has been done on this question. The only example of such research which comes to mind is a twin project in Ghana and Thailand (Le Grand & Wondergem 1990). Most researchers deal with the opinions of policy makers, medical doctors and traditional healers.

The first and most appropriate answer to the above question is of course that we need proper field research at the community level. Bearing in mind the caveats expressed at the beginning of this essay, we should reckon with considerable differences in community perspectives in different African societies. African medical traditions vary enormously and so will people's appreciation of them.

I can only speculate about community perspectives, based on rather subjective impressions and experiences in various African countries (particularly Ghana, Cameroon, Mali and Zambia) and on reading – mostly between the lines – a large number of publications and unpublished reports.

The first impression is that on the whole people do not favour a mix of biomedical and traditional services. It has been frequently observed that people have divided their health problems between biomedical and traditional practitioners. In their view, some complaints can only be treated in the hospital or health centre and other ones only by the local healers. Integrating the two

traditions would not help them. As a matter of fact they have already made some kind of integration in their heads. They know where to go for what kind of health problem. The medical situation in Africa is indeed essentially pluralistic. Moreover, and quite rightly, they would suspect that they are being cheated with cheaper and – as they call it – ‘second rate’ health care if traditional practitioners would become their basic health workers. In the present situation, they have access to traditional medicine whenever they want it and they probably prefer to keep it that way.

People do want better quality of care from biomedical doctors and nurses: more concern and respect. Anthropological research in biomedical institutions in Africa is practically nonexistent. Anthropologists, usually of western origin, were after the exotic (diviners, witchdoctors, herbalists and traditional midwives) and neglected what was familiar to them (hospitals, clinics, doctors and nurses). Overviews of the functioning of hospitals and health centres in Africa, including the recent *Better health in Africa* by the World Bank (1994) only discuss problems of cost-effectiveness and limited accessibility. What is widely known, though hardly mentioned in written sources, is that the quality of care in Africa leaves much to be desired. Doctors and nurses are frequently accused of not respecting patients and lacking concern. Paradoxically, that negative judgement does not prevent people from frequenting biomedical institutions. They are well aware of their technical efficacy. Patients who make use of basic health services want their own ideas and home remedies to be taken seriously. They ask for good medicines in sufficient supply. They want the services to be more accessible to them. One could perhaps say that they ask for some of the qualities of traditional healers in their biomedical practitioners, but that does not mean that they want traditional healers to replace them. The biomedical tradition has become an integral part of local community life and people do not want to lose it. They rather ask for more of it: more and better medicines, more health workers, more facilities.

It is significant that people in Ghana and Thailand were not very enthusiastic about the idea of introducing traditional herbs into modern health facilities. To them, herbs were out of place in the setting of a health centre (Le Grand & Wondergem 1990). The authors, however, recommend the promotion of herbal medicine by

biomedical workers. They argue that integrating herbs into basic health care would be far preferable to the integration of traditional healers. As we have seen before, herbs which are commonly and widely used have to some extent proved their efficacy. It is uncertain, however, that the practices of secretive healers are equally effective.

Some healers claim that the therapeutic efficacy of a plant does not lie in the plant itself, but that they give the plant its medicinal power through a ritual act such as a prayer or a blessing. Yoruba healers in Nigeria, for instance, awake the power of a plant by incantations. The incantation is not directed to the patient (who cannot understand it) but to the medicine (Buckley 1985). Without the magical formula the medicine would not work. Similarly, in Burundi, for 80% of herbs used by specialist healers, the efficacy is added to the herb by the healer. The healers emphasize that it does not matter which herb they use; the only thing which counts is that they make it into a medicine (Baerts & Lehmann 1993). How they do this is a well-kept secret. Mallart Guimera (1977), who did research in South Cameroon, discovered a disquieting lack of consensus among healers as to which herb was effective against which medical problem. Their completely different perspectives on efficacy would make their cooperation with biomedical practitioners extremely problematic.

Moreover, the motives of healers who do join the public health care system are sometimes opposed to those of health planners. Green (1988) reports that a survey among healers in Swaziland showed that:

... if they were to choose which aspects of Western medicine they could learn about, they would choose X-ray technology, blood transfusions and injections of antibiotics.

Healers hope to raise their social prestige and increase their income by learning the ‘mysteries of modern medical science’ and sharing the prestige and income of biomedical practitioners. It is no wonder that many of their biomedical colleagues have their reservations:

A plan to develop healers as promoters and distributors of packaged oral rehydration salts was defeated by physicians and health officials who felt traditional healers could not be trusted with modern medicine. (Green 1988)

Conclusion

My – admittedly hypothetical – impression is that most communities do not expect improvements in basic health care when traditional healers become integrated into the service. They ask instead for improvement of basic health care itself: more, and more accessible services, more dedication and respect from doctors and nurses, more medicines and personnel. Medicines used in traditional *self-care* also deserve more attention from policy makers.

Most importantly, fieldwork needs to research at the community level to arrive at a better understanding and assessment of the community's opinion concerning a possible role of traditional medicine in basic health care. Suggestions to integrate traditional medicine into basic health care are insufficiently founded on the views and preferences of those who would be most directly involved in such a policy. Pleas for the integration of traditional and modern medicine seem to be mostly inspired by romantic – and simplistic – ideas concerning traditional medicine or by economy motives. Medical anthropologists should assess the rationality and feasibility of such recommendations by studying the views of people in the community.

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