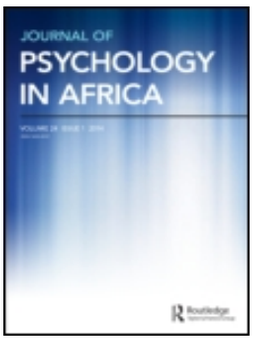

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Cultural Embeddedness of Health, Illness and Healing: Prospects for Integrating Indigenous and Western Healing Practices

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Culture influences conceptualizations about illness, health and healthcare. In this article we argue that Western-oriented health care models have limited success when applied to health conditions of people of non-Western cultures and contend that culture is an important factor in health, illness and healing. We present two cultural modes of illness and healing to illustrate that many health conditions are meaningful and can be effectively managed with consideration of the cultural contexts of the communities concerned. We illustrate, by case examples, how these cultural conceptualisations influence the treatment of illness in three different cultural settings. In addition, we identify some of the key challenges to integrating traditional healing into counselling and psychotherapy. Integration of different cultural healthcare models is a best practice in comprehensive context sensitive delivery of healthcare.

Keywords: Culture and healthcare, illness, traditional healer, traditional healing, Western-oriented healthcare systems, integrating healthcare systems

Culture is an important factor in healthcare (Jackson, 1987). According to MGOMA (2003), the most significant instrument in healing or healthcare delivery is the client's culture. Vontress (2005) also asserts that, in therapy, the most effective therapeutic agents are those who embody the culture of their clients. Maraich (2003) observes that every human society has its own cultural system(s) for responding to diseases and restoring health to individuals who are ill. The various cultural realities people have constructed, whether these be in terms of beliefs, values, languages, institutions, customs, labels and laws, all have significant influence in human functioning, and, therefore, in how health, is defined. Good and Good (1982) note that the meaning of illness (or health) for an individual is grounded in the network of meanings of an illness (or health) of that individual's culture. Included in this network of cultural meanings of an illness are the metaphors associated with the illness, the care patterns that shape the experience of the illness and the social reactions by the sufferer. Since illness or disease (physical, social and mental including pains, distress, loss, sorrow and bereavement) is a condition that is experienced by all humans, irrespective of culture, So (2005) contends that each culture has its own conceptual or explanatory model for illness and health. Since all cultures have their own unique explanatory models of illness (or health), the non-Western cultural models of healthcare are simply of different conceptual frameworks of illness and or psychological discomfort when compared with Western models (Buhrmann, 1986; Moodley, 2000). There is no single universal worldview regarding causation of illness or appropriateness of treatment (Moodley & Sutherland, 2010). The different cultural conceptualizations of realities pertaining to illness and health simply mean that there can be no universal applicability of one cultural healthcare system. Therefore, in terms of therapeutic approaches to healthcare, such simplistic notions as considering one approach universally primary or superior are no longer tolerable (Moodley & Sutherland, 2010; Tseng & McDermott, 1975).

In this article, we argue that culture is an important factor in healthcare and that each culture has its own unique conceptualization(s) about illness, health and healthcare. To support this position we, in this section, first discuss the widespread practices and or uses of indigenous traditional healthcare especially in non-Western societies of the world. We then discuss further how cultural beliefs influence perceived causes of illness and the theory or theories of cure. We do this by tracing the history of Western medicine to indicate that Western-oriented healthcare is a derivative of Western cultural values and beliefs. We also present two non-Western cultural conceptualizations of illness (Indian and African) to further our argument that there can be no one single cultural healthcare model that has universal applicability

Influences of Cultural Beliefs on Perceived Causes of Illnesses

Cultural or indigenous knowledge systems regarding healthcare, or traditional healthcare approaches and methods, have been in existence since time immemorial. They have been playing significant roles in improving human conditions, or elevating the quality of life, promoting health, curing diseases, preventing illness, facilitating personal empowerment and social transformation (Vontress, 2000). Traditional healthcare is generally commonly used in most parts of Africa, Asia and Latin America and for millions of people living in the rural areas of these parts of the world traditional herbal medicine, traditional treatments and traditional practitioners are the main, if not the only sources of healthcare (Chan, 2008). The Pro-Culture

Health Organization (2005) asserts that only 10 to 30% of worldwide healthcare is delivered by conventional biomedically-oriented practitioners and that in poor, rural and marginalized populations the number of traditional practitioners, making use of their cultural or indigenous knowledge to deliver healthcare, often exceeds Western-trained healthcare providers. This means that traditional or indigenous healthcare systems are very significant to the overall healthcare of the peoples of the world. By traditional approach to healthcare it is meant the sum total of all the indigenous knowledge and traditional cultural practices (whether explicable or not) used in the diagnosis, prevention and elimination of physical, mental and social imbalance which rely exclusively on practical experiences and observations handed down from generation to generation, mostly verbally, but also, to some limited extent, in writing (Conserveafrica, 2006). The systems of healthcare are described as traditional because they are deeply rooted in the socio-cultural contexts and values of the communities. Traditional healthcare, therefore, represents structured systems of ordering, classifying and explaining illness as well as for delivery of healthcare services (Ataudo, 1985).

The history of Western medicine is traced back to the writings of Hippocrates (c.460 – c.360 B.C.), a Greek physician, who argued that all forms of illness (including mental illness) result from some malfunction within the body (Holmes, 1994). Hippocrates' attribution of various illness types to natural causes was a significant departure from the supernatural views of illness that were popular during his time. According to Holmes (1994), it is the work of Hippocrates that influenced Kraepelin in the late nineteen century to develop the first truly comprehensive classification of mental disorders which subsequently paved the way for the World Health Organisation's International Classification of Diseases (now in its tenth version) and the American Psychiatric Association's (1994) Diagnostic and Statistical Manual which is now in its fifth version. What is very important to note here is that the ascendancy of the medical approach as pioneered by Hippocrates resulted in a situation where biology became the bedrock of all forms of illness (Kleinman, 1995). In other words, all forms of illness were perceived as a result of an individual's inner processes whilst all social and cultural layers of reality were only held as epi-phenomenal. Historically, Western psychological practice relies heavily on natural science whilst ignoring the role that social conditions, power relations and societal institutional arrangements play in shaping peoples' conceptualization of illness, health, healthcare and associated help-seeking behaviours (Angelique & Kyle, 2002; Vijver, & Leung, 2000). A good example here is that of depression which would be regarded as a consequence of some malfunction within an individual's bodily or psychical structures, when considered from Western perspectives. On the other hand, the conceptualization of depression (including the associated help-seeking behaviours) in many sub-Saharan Africa communities take into account the spiritual, social and cultural factors (Sodi, 2009; Swartz, 1997). According to Mdleleni (1990), Mzimkulu (2000) and Ngubane (1980), *"amafufunyana"* which is described as an extreme form of depression with psychotic features (including hysteria and suicidal tendencies) is explained in terms of spirit possession. Mabetoa (1992), while also alluding to the etiology of psychoses as spirit possession states further that spirits are not simply relics of past but archetypes of the collective unconscious of individuals.

A number of studies have pointed out that medicine and mental health disciplines such as psychiatry and psychology (whose subject matters include nosological categories like depression, paranoia and anorexia) are knowledge systems that are premised on conceptual frameworks that are deeply embedded in a European socio-cultural matrix (Gergen, 1992; Landrine, 1995; Nobles, 1976; Wu, 1982). While it is often taken for granted that counselling and psychotherapy are aspects of Western culture, assisting people to function effectively in their communities is not unique to Western cultures. All cultures of the world have different unique ways of explaining illness and of bringing health to the people. Thus and according to Shweder and Bourne (1982), the Western-oriented conceptual framework reflects only a minority view among the cultures of the world. This point is eloquently expressed by White and Marsella (1982) who wrote that:

> *"[Even] … the very notion of 'mental illness' as a domain of behavioural and medical experience is a product of specific cultural and historical traditions which regard certain forms of behavioural dysfunction as essentially psychological and medical in nature . . . . (p. 5)*

To further illustrate the socio-cultural embeddedness of the notions of illness and healing and to expose the danger of reliance on single cultural models of healthcare we present two cultural models of illness and healing which are meaningful if understood from within the cultural context of the communities concerned.

Indian Cultural Model of Mental Illness

The first cultural model of (mental) illness and healing that we present is the theory of psychological medicine in the ancient Indian medical tradition of Ayurveda. According to Obeyesekere (1982), there are three fundamental assumptions that could be regarded as the foundation of Ayurvedic medicine. First, the universe is believed to be comprised of five *"bhutas"* or basic elements (atoms), which are ether *("akasa")*, wind *("vayu"*), water *("ap"*), earth (*prthvi"*), and fire *("agni"* or *tejas"*). These five universal elements are also believed to be present in all life, including the food that we eat. "As these five elements contained in the food are 'cooked' by the fires of the body, they are converted into a fine portion *('ahara-prasada'*) and refuse *('kitta'* or *'mala'*)" (Obeyesekere, 1982, p. 237). Second, the body is comprised of the fine portion of food which has been transformed and refined and has seven components *('dhatus'*), namely: food juice *('rasa'*), blood *('rakta'*), flesh *('mamsa'*), fat *('medas'*), bone (*asthi'*), marrow (*majja'*) and semen *('sukra'*). The latter component which is believed to be the most highly refined element in the body, serves to tone down the whole organism. Third, there are three humours (i.e., the universal element of wind, fire appearing as bile, and water appearing as phlegm) that are supposed to be held in a harmonic balance.

According to Ayurvedic medical theory, the harmonic balance of the above three humours is essential for the maintenance of physical and mental health. Once this homeostatic condition is upset, these humours become '*dosas*' or 'troubles' that will lead to an illness of the organism. The '*dosa*' may also damage one or more of the seven components of the body. According to Caraka (cited in Obeyesekere, 1982, p. 239), the causes of humoral upset are numerous and may include the following: faintheartedness, mental shock, consumption of improper foods, wrongful bodily activity, other diseases, or those whose " … *minds have been impaired by the attacks of lust, anger, greed, excitement, fear, infatuation, fatigue, grief, and also those that are injured by trauma"* (p. 239)

African Cultural Model of Mental Illness

The second cultural model of illness and healing that we present looks at how some African communities conceptualise and deal with some physical, mental and social dysfunctions. According to Swartz (1997), the indigenous African communities in South Africa perceive harmony between the individual and the ancestors as critical in maintaining good mental health (see also Edwards, this Issue). This harmonious situation is considered to exist if the individual and his/her family have met their socio-spiritual obligations to the ancestors. Some mental illness conditions are believed to occur when this harmonious relationship between the ancestors and the living is disturbed. In such illnesses that are a result of disharmony, treatment by a traditional healer is aimed at restoring the balance between one's family and the ancestors.

The idea of harmony in health and illness is also important in other indigenous communities in other parts of Africa. For example, among the Bambara of Mali, the fundamental concepts regarding health and illness are based on the idea of balances and imbalances between the components of the organism, and between those components and the elements of nature such as earth, water, fire, metal and heavenly bodies such as the sun, moon and stars (Koumare, 1983). Each element is seen as capable of exerting a specific influence on certain organs. Thus from birth, the newborn infant is subject to the control of elements of nature, and survival depends on the capacity to establish equilibrium in an environment containing both favourable and unfavourable elements. Within the context of the Bambara community, an illness is bound to result in cases where there is an imbalance either in the components of the organism or in situations where these components of the organism are in disharmony with the elements of nature.

Cultural Approaches to the Treatment of Illness

Looking at the above notions of health and illness, it is evident that efforts aimed at restoring health to individuals who are ill are shaped by the cultural and social realities of a particular society or culture. Consequently, a psychiatrist in Western medicine, the Indian shaman or the African traditional healer have two critical functions to perform when they encounter someone who presents with a problem. First, they must attempt to identify and diagnose the particular phenomenon experienced by the patient. Second, they must link the patient's idiosyncratic experience with a culturally meaningful theory, which will enable them to integrate the patient back into the cultural mainstream (Awanbor, 1982; Kleinman, 1995). In other words, the healer (whether Western or traditional) must redefine the vague complaints presented by the patient in terms of some causal agent like anger of the ancestors, or the violation of a taboo. By narrowing down the cluster of symptoms and complaints and giving a focus on something (a diagnosis), the healer is in a position to define the problem and to provide a culturally meaningful remedial action. The following cases are illustrative:

Case 1: George (England) - George is a 32 year old single male carpenter who has been staying alone in a flat in downtown London for the last 8 years. In the last six months or so, he started showing a number of symptoms which among others included the following: feelings of emptiness, diminished interest in most activities that he used to enjoy, difficulties falling asleep, inappropriate guilt, difficulties in concentrating and recurrent thoughts of death. He was advised by a neighbour to consult a psychiatrist. The psychiatrist who saw him did a full clinical assessment which involved a clinical interview, a medical examination, psychological testing and some laboratory tests. The results of the clinical assessment suggested that George is suffering from a major depressive episode. This was attributed to a number of psychosocial stressors that included a recent breakup with a girlfriend. The psychiatrist suggested a number of interventions which included admission to a hospital, medication, psychotherapy and a sick leave that would take him away from his place of employment for two months.

As illustrated in the above case, the patient consults a psychiatrist alone after he was advised by a neighbour to do so. Upon arrival, the psychiatrist uses some clinical procedures including a medical examination and laboratory tests. The remedial action that is suggested is informed by the diagnostic picture that emerges during George's consultation with the psychiatrist. In this case, the psychiatrist uses culturally meaningful diagnostic and intervention theories to redefine the symptoms and to provide some form of relief to the patient.

Case 2: Mohammed (India) - Mohammed is a 32 year old single male factory worker in Calcutta. He stays with his elderly parents, two brothers (both married with children), two sisters and several nephews and nieces. In the last six months or so, he started showing a number of symptoms which among others included the following: feelings of emptiness, diminished interest in most activities that he used to enjoy, difficulties falling asleep, inappropriate guilt, difficulties in concentrating and recurrent thoughts of death. His elderly parents and one of his brothers brought him to a shaman. Through his dealings with the spiritual world, the shaman determined the cause of the patient's problems and suggested that Mohammed has been called to enter the shamanic profession. The remedial course of action prescribed included the following: a). Mohammed was required to go through a process of apprenticeship under the tutelage of a master shaman; b). During this period, he was expected to perform regular rituals of the family deities; c). He had to regularly undergo periods of fasting; and, d). He was instructed to live according to the prescribed conduct and rules that govern shamanic training.

The case above illustrates the spiritual, social and cultural context of illness. Mohammed's illness mobilised the family to consult shaman, who is believed to be in touch with the spiritual forces that govern the universe. The explanation given for his illness, including the treatment thereof is meaningful in the context of this patient's culture.

Case 3: Sello (South Africa) - Sello is a 32 year old single male machine operator who stays with his parents, three brothers and three sisters in Soweto township in Johannesburg. In the last six months or so, he started showing a number of symptoms which among others included the following: feelings of emptiness, diminished interest in most activities that he used to enjoy, difficulties falling asleep, inappropriate guilt, difficulties in concentrating and recurrent thoughts of death. His parents took him to a traditional healer in the deep rural area of Limpopo Province which is about four hundred kilometres north of Johannesburg. The traditional healer that was visited threw the divination bones on a mat and suggested that Sello suffers from a condition called 'senyama" (loosely translated to mean "bad luck"). The traditional healer suggested that the "senyama" was visited on Sello by angry family ancestors who feel that his parents have "turned their backs on them". As a remedial action, Sello's family was advised to organise a black goat that was to be slaughtered and sacrificed to the ancestors.

Through the use of divination bones, the traditional healer in the above case is able to interpret the patient's symptoms as an indication of ancestral displeasure. Based on this interpretation, some specific interventions (i.e rituals) that are culturally meaningful are suggested by the traditional healer. .

The Challenges

Within each culture of practice, some health care practices appear to have evidence of efficacy. For instance, African indigenous health approaches have evidence of more relative success in treating mental health conditions than physical conditions (Mpofu, Peltzer, & Bojuwoye, 2011). In fact, there are many positive attributes of African and other non-Western traditional healthcare methods and these are responsible for the high confidence in their practices and practitioners by people in developing countries. Among these attributes are its strong historical and cultural roots which make its practice context sensitive (Chan, 2008). Its accessibility and affordability are also important attributes as well as its philosophy of seeing the person holistically rather than through a Cartesian divide (Chan, 2008; Moodley & Sutherland, 2010). However, despite these attributes the suggestion that different cultural healthcare models be integrated for comprehensive healthcare coverage is likely to be met with many challenges. Among the challenges we discussed in this paper are epistemological challenges, challenges related to attitudes, abuses, treatment methods and other practice issues as well as research challenges.

Epistemological questions. Philosophies underpinning the healing approaches of Western medical and non-Western health practices are considerably different. These healing traditions appear to be shaped, among others, by conceptualisations of the self in different cultures (Geils, 2011; Shweder & Bourne, 1982). For example, in American and European societies there is a greater tendency to use individuated psychological types of explanatory constructs in describing social behaviour. As in the case of George in the above case study, the psychiatrist defines the problem in terms of George as a bounded and complete universe that is unable to cope with a number of psychological stressors. As Myers (1988) has pointed out, the tendency in Western epistemology is to break the world or human experience into different parts that are to be understood 'objectively' by means of the five senses. On the other hand, most non-Western societies tend to conceptualise reality holistically and dynamically in terms of its material and spiritual dimensions (Myers, 1988). For example, a traditional healer may interact with the ancestors by means of dreams to help him/her to understand a patient. As Grills (2002) has pointed out, such sources of knowledge relating to health and illness are not considered legitimate in popular Western knowledge systems (Grills, 2002). Therefore, any effort aimed at integrating traditional healthcare or psychotherapeutic practices with Western-oriented models is likely to be confronted with some difficulties given the divergent epistemological origins of Western and indigenous traditional models.

Challenges related to practice issues. Some criticisms about traditional healthcare practices are that they are harmful, unhygienic and unscientific. For example, in his submission to the Gauteng legislature (South Africa) during public hearings on traditional medicines, the late Dr Nthato Motlana (one of the most successful medical practitioners and influential black businessmen in South Africa) expressed his strong views against traditional healers:

> *"There are many people who would want us to continue to believe in mumbo jumbo while the West moves into CAT scans and advanced sonars for diagnosis. They want us to believe that the dried-up bones of a monkey's ankle can provide us with a diagnosis (The Sunday Times, 08/06/1997).*

Similar sentiments and concerns have also been expressed by many critics of traditional healthcare practices or indigenous psychotherapies describing them as exotic, primitive, demonic, sorcery, magic and witchcraft (Chevez, 2005; Marshall, 2005; Moodley, 2007; Praglin, 2005). Atherton (2007) also claims that African traditional healthcare has been described as being characterized by low hygiene standard, incorrect diagnosis, imprecise dosage and wild claims. African traditional healers have also been criticized for their inability to keep patient history and records of assessment (Conserveafrica, 2006). Such challenges described as being characteristic of traditional healing are also not uncommon with Western-oriented healthcare systems. For instance, at any time, over 1.4 million people worldwide suffer from infectious complications acquired in hospital (Tikhomirov, 1987). Wenzel, Thompson, Landry, Russell, Miller, de Leon, and Miller, Jr., (1983) also state that nosocomial, hospital-acquired infections, occur in 5% to 10% of patients admitted to hospitals in the United States of America. According to WHO (2002), nosocomial infections are promoted by many factors including invasive procedures, crowded hospital populations and poor infection control practices. However, we are not justifying these malpractices and this explains the reason for our next discussion to further expatiate on malpractices in traditional healthcare system.

Peltzer (1987) described some assessment procedures used by traditional healers which are potentially dangerous to patients. One example is village cleansing by identification of witchcraft among a whole community in an African country. In the process, all village inhabitants are summoned and asked to surrender their witchcraft instruments on the understanding that if they didn't, they and their families could be visited with great misfortunes. In a typical cleansing process villagers would be made to pass by the healer and those who lose consciousness and collapse while on the queue or as they pass the healer are presumed to be witches weighed by their evil medicines. In some instances, some villagers may lose consciousness from exhaustion, anxiety or actual conviction of guilt due to some wrongs done or something which has been done, even if in unrelated situation. What also makes this process dangerous is that sometimes the witch hunting ceremony may be an attempt to identify someone with whom the traditional healer (or an influential member of the community on whose behalf the traditional healer is acting) has had previous disagreement or someone who they want to get rid of from the village for some personal reasons (such as competition for some resources). While this is a fair criticism there is also evidence of malpractices in Western-oriented healthcare practices as is evident in the following extract from e! Science News, 2011:

> *Poorly co-ordinated care increased the likelihood of medication and medical errors by 110% to 200% across the countries, with the highest levels in the Netherlands, followed by Germany and the UK. Cost-related barriers increased the likelihood of medication and medical errors by 50% to 160%, with the highest levels in the UK, followed by New Zealand and Australia.*

In another study by investigators from the Indiana University School of Medicine it has been revealed that most contributors to medication errors and adverse drug events in busy primary care practice offices are communication problems and lack of

knowledge in the safe and effective use of drugs (e! Science News, 2010).

Very common criticisms associated with traditional healthcare practices are those around excesses and abuses of patients' human rights by practitioners. For instance, the use of ropes to tie the legs together and thereby physically restrain aggressive mental patients, the forcing of medications on patients and the forced sexual intercourse (or rape) as treatment procedures are some of the abuses levelled against African traditional healthcare practitioners (Peltzer, 1987). Some Chinese traditional healing sessions have also been described as characterized by abuse as they are conducted in "cramped facilities" (So, 2005). Other criticism of traditional healthcare is that its practitioners are poorly educated (Atherton, 2007).

While these criticisms may be justified, it must also be stated that these also represent Western critics' attempts at concentrating attention only on isolated cases of malpractices of traditional medicine. On the contrary, the Western critics' practice is to de-amphasize many good practices of non-Western traditional medicine, for example, the standard practice by African traditional healers in the use of community and participatory approaches to the treatment of psychiatric patients. However, there are current efforts at training traditional healthcare workers in many African countries in order to reduce, if not eradicate completely these few cases of malpractice in traditional medicine. For instance, the World Health Organization, WHO, has sponsored seminars and workshops to train traditional birth attendance and midwives in many African countries (Conserveafrica, 2006). There is also a report of efforts by University of Kwazulu Natal Medical School, in South Africa, of providing series of training workshops for traditional healers in an effort to improve their role in healthcare delivery (Packree, 2007).

Attitudinal Challenges. Related to the challenges of excesses and abuses associated with practice of traditional healthcare is the negative attitude which it has engendered among Western –oriented practitioners. This negative attitude particularly manifests with regard to difficulty with getting Western-trained or oriented practitioners and traditional healthcare practitioners to work together. This challenge seems to be well illustrated in a report by Peltzer and Mngqundaniso (2008) on the South African experience which revealed that the effort to integrate traditional and Western healthcare systems appeared to be met with suspicion and lack of communication among the two different types of healthcare practitioners (with differences in trainings and or orientations). The report indicated it is as if there were two parallel healthcare systems being operated, making difficult cooperation and/or prevention of unnecessary competition, conflicts and misinformation among the two groups of professionals. Moreover, getting western-oriented practitioners to work in rural communities of Africa presents its own challenges, not the least, that of poor or non-existing infrastructural facilities (Atherton, 2007).

Research challenges. Challenges associated with research into traditional or indigenous healthcare practices are often more emphasized than most other challenges. Non-Western traditional healthcare, unlike Western healthcare, has little scientific or empirical evidence on safety. Chan (2008) also asserts that non-Western traditional healthcare practices have no research data, no powerful methodologies for proving efficacy, ensuring quality, standardizing good manufacturing practices, testing for safety and conducting post-marketing surveillance for adverse effects. Identifying appropriate research strategies for the provision of scientific evidence or data through test results have also been considered as challenges to traditional or indigenous healthcare (Mpofu et al, 2011; World Health Organization, WHO, 2002, 2008).

Absence of infrastructural facilities, particularly literature or documented information has been described as a major factor contributing to difficulties in researching traditional healthcare. These difficulties are probably due to traditional practices that rely mostly on oral history and folklore, known only to initiate traditional healers, and taught to others by healers themselves or spiritual agents. Chamberlain (2003) used the term "performed knowledge" to describe healing power or indigenous ways of healing also referred to as "living texts" in orality. The belief is that these could lose power or become ineffective, if recorded (Solomon & Wane, 2005). Researching and documenting traditional healing practices (including songs, dances, ceremonies, sacred medicines and traditional language serving as vehicles and tools of traditional healers), would, therefore, meet with opposition from practitioners who might be reluctant to cooperate to disclose and share information relevant to their highly protected healing power if it would be reduced to writing and kept in recorded forms.

Challenges Related to Patenting and Uses of Traditional Herbal Medicines

Traditional herbal treatments comprising herbs, herbal materials, herbal preparations or finished herbal products are becoming popular forms of traditional medicines often referred to as alternative or complimentary medicines (ACM) which have become lucrative on the international market (Bojuwoye & Sodi, 2010). The World Health Organization (WHO, 2008) notes that a number of challenges with ACM revolve around patients' safety and effectiveness. Also noted are the challenges of differing definitions and categorizations of traditional therapies because it has been discovered that a single product can be defined as either food, a dietary supplement or herbal medicine depending on the country. Moreover, the growing market and great commercial benefits of alternative or complimentary medicines, all these have the potential of leading to over-harvesting of many indigenous plants which in turn pose very serious risk to biodiversity. The World Health Organization (2008) also notes the challenge of intellectual property right and the depriving of indigenous people of the benefits accruing from sales of their indigenous plants as many of these plants end up being patented by Western pharmaceutical laboratories without references to where these herbal treatments have been obtained.

Summary and Conclusion

In this article we argued that illness, health and healthcare are culturally embedded. We stated that each culture of the world has its own unique ways of explaining illness and of bringing health to the people and that, all healthcare systems or models are cultural products . The Western-oriented healthcare system, in its own right, complete with its systems of beliefs, values and faith as well as methods and forms of knowledge, is a cultural system just like any non-Western traditional healthcare system, except that the two healthcare systems have different conceptual frameworks of health, illness or psychological discomfort. We pointed out the danger of relying on single cultural healthcare model as no single healthcare system has universal applicability. Since all cultural healthcare systems have beneficial contributions to make to the overall healthcare system of

the world, we supported the calls by other healthcare researchers and practitioners that different cultural healthcare systems be integrated for effective context sensitive practices. We highlighted challenges to such integration of different cultural healthcare systems especially those challenges emanating from the criticisms of traditional healthcare systems by Western critics.

We pointed out that the usual tendency of critics of traditional healthcare is to focus on risk and pass judgement based on worst case scenarios and or outcomes while playing down the efficacy of traditional medicine and the expertise of traditional healthcare practitioners. Our view is that excesses, abuses and malpractices are not peculiar to non-Western traditional healthcare practices as these are also happening in Western-oriented practices. However, researchers have revealed that non-Western traditional health practitioners are as effective in bringing health to the people as are Western-oriented healthcare practitioners (Epp, 1998). For example, according to Conserveafrica (2006), African traditional healers are found to be experienced and skilled in biomedical components of their professions, including an array of biomedical methods and cultural practices ranging from fasting and dieting to herbal therapies, and from bathing and massage to surgical procedures. Edwards (2004) also contends that non-Western traditional healthcare providers are skilled and experienced in psychotherapeutic practices using procedures, methods and materials surprisingly resembling contemporary psychotherapies including establishing trusting relationships with patients, diagnosis of problems, uses of imagery, dream interpretation, self-regulation and group support. It is on account of the efficacy of traditional healthcare and its significance in bringing health to the majority of people of the world that the World Health Organization recommended integration of traditional healthcare with Western oriented mainstream systems as the surest means to achieve total healthcare coverage (Conserveafrica, 2006). Our contention is that it is in an integrated system that most of the challenges attributable to traditional healthcare can be addressed.

Our argument is that to overcome the constraints related to integration, education, training and research is necessary. Education and training for traditional healthcare providers are important for their acquisition of knowledge, attitudes, values and skills relevant to effective healthcare and particularly to the development of appropriate attitudes and values for breaking old habits and creating new characters in order to reduce patients' abuses and excesses often associated with their practices (Bojuwoye & Sodi, 2010). We further argued that the main goal of education and training for traditional healthcare practitioners should be for capacity building in view of their expanded roles in health promotion and illness prevention and to enhance their leadership roles and legitimate voices as trusted health authorities of their people (Bojuwoye & Sodi, 2010). In terms of education for Western-oriented practitioners, this would be for acquisition of appropriate knowledge and better understanding of traditional healthcare to enable them to change attitudes of disrespect and suspicion to attitudes of appreciation and respect for the skills of traditional healthcare providers. This way, Western-oriented practitioners are more unlikely to see traditional healthcare providers as competitors, but more likely to trust and collaborate in sharing information for effective healthcare delivery. Western-oriented practitioners stand to benefit from training to understand and utilize appropriate indigenous knowledge systems including cultural practices and materials or tools for effective context sensitive practices.

An integrated healthcare system will depend greatly on research to create new knowledge, understanding and better interpretations of cultural practices and tools that are relevant to health promotion and illness prevention. Both traditional healthcare and Western-oriented practitioners need training in finding modern truths in ancient wisdom, reassessment, re-interpretation, and reconstruction of concepts, principles and processes, the giving of new meanings to cultural practices and providing alternative forms of knowledge, approaches and way(s) of explaining.

In terms of re-interpretation and reconstruction of concepts, principles and processes, an important issue for research into traditional healthcare is the use of foreign languages which completely distorted certain traditional cultural practices. There are no adequate English language equivalence for certain traditional concepts and principles. For instance, the traditional theories of ill-health as being external and largely attributable to angry ancestral spirits or their human agents would need to be re-interpreted to reflect the fact that these so-called "angry ancestral spirits and or human agents" could be nothing more than the contextual socio-economic and other environmental conditions which put people in competition with one another and are responsible for putting people at risk of ill-health. The notion of ancestral spirits would have to be reinterpreted since in actual fact these are largely legacies and or strong traditional values left behind by legendary ancestors and not real spirits in the ordinary interpretation. These legacies have implications for lifestyle choices which are health promoting as living descendants consider inculcating the exemplary behaviours and values of their ancestors and as some of these behaviours serve as models and or motives for decisions and or choices making. The ritual ceremonies should no more be seen as ancestral or devil worship but simply as procedures used for modifying human behaviours, procedures employed to mediate harsh environmental conditions, or as procedures for facilitating and encouraging people to rethink human relationships from rather being competitive to being collaborative and as sources of support and avenues for learning new human relationships and coping skills. There is no doubt that the success of integration will depend largely on collaborative research works between western-oriented and traditional healers. The latter would also need education in helping them to view their practices in completely new ways and training to cooperate with western-oriented practitioners.

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