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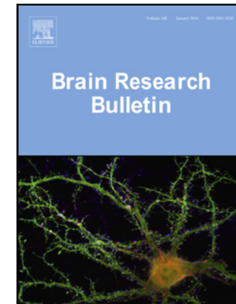

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Authors: Abbo C., Odokonyero R., Emilio Ovuga

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A Narrative Analysis of the Link between Modern Medicine and Traditional Medicine in Africa: A Case of Mental Health in Uganda.

AbboC[1], Odokonyero R[1], Emilio Ovuga[2].

[1]Makerere University, College of Health Sciences, Kampala, Uganda; [2]St Raphael's Counseling Centre, P.O. Box 1867, Kampala, Uganda.

Corresponding Author: Abbo Catherine, MBChB,MMED (Psych), MPhil, PhD, Senior Lecturer. Makerere University College of health Sciences, School of Medicine, Department of Psychiatry. P.O.BOX 7072, Kampala. Telephone: +256700700470 Email: cathya180@gmail.com

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Highlights

- **Mental disorders arise from the brain that is culturally and socially constructed**
- **Sociocultural issues cannot be divorced from mental disorders and their management**
- **In Africa, use of both traditional healing and modern medicine systems is prevalent**
- **The two systems depart in several areas but their links are unrecognized**
- **This calls for acknowledging departure points and ways of enhancing the links**

Abstract

Background: Traditional Medicine Practices (TMP) which are premised on indigenous knowledge and experiences within a local context of the culture and environment, are common place in low income countries. In Africa and in Uganda specifically, nearly 80% of the Ugandan population relies on TMP for the care of their mental health but they also use Modern Medicine. There are areas of departure between Traditional and Modern Medical practices in Africa that have been cited. What has attracted less research attention, are the areas of convergence.

Objective: This paper aims to critically examine the link between Modern Medicine and Traditional Healing Practices in Africa, citing Uganda as case example.

Method: A Narrative literature review with critical element assessment was undertaken to identify documented points of departure, areas of common practice, and ways in which the two models can co-exist and work together through a carefully thought out integration.

Results: Points of departure between Modern Medicine and Traditional Medicine Practices are philosophical underpinnings of both practices, training of practitioners, and methods and ethics of work. Common areas of practice include human rights perspective, descriptions of mental illnesses, clinical diagnostic practice, particularly severer forms, intellectual property

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rights, and cross prescriptions. Exhibiting cultural humility on the side of the modern medicine practitioners is one of the ways to work together with TMPs.

Conclusion: Points of departure are more documented and explicit and overshadow areas of common practice while the links between the two are mainly implicit but sadly unrecognized. Mental disorders are disorders of the brain and in neuroscience; the brain is culturally and socially constructed. Sociocultural issues therefore cannot be divorced from disorders of the brain and their management. For better patient outcome and patient-centered approach of care, it is necessary to acknowledge and enhance the links in teaching, clinical and policy level and carry out research on how the links could be improved.

Key words:

Traditional Healing, Traditional Medicine, Modern Medicine, Mental Health, Uganda, Traditional Healing Practices, Modern Medicine Practices.

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Background:

Traditional Medicine Practices (TMP) are common place in Africa, Asia and Latin America(Quick, Zhang et al. 2002) and they precede Modern Medicine. Traditional Medicine Practice is premised on indigenous knowledge and experiences within a local context of the culture and environment (Tabuti, Dhillion et al. 2003).The line between 'traditional' and 'modern' is sometimes blurred as a result of globalization. "Traditional" medicine has been modernized in important ways, reflecting historical and cultural transformations as well as ongoing innovations by practitioners. National associations' efforts at standardizations of traditional practitioners in Uganda are some examples of the modernization of the traditional medicine in this case. On the other hand, the so called 'Modern Medicine' seems to have a streak of "traditions" in themselves. Some scholars argue that Biomedicine is not particularly 'modern' any more than 'traditional' healing may be "traditional". These discursive positions are commonly used in many African settings, not just in relation to medicine. Indeed it has been widely illustrated that what is termed 'traditional' may be much more heterogeneous and dynamic than this term implies. Both biomedicine and traditional medicine have evolved over time and actively incorporate novel elements(Luedke and West 2006).Some of the well-documented examples of innovation in traditional healing and incorporation of novel elements include examples from Ghana (Agyei-Baffour, Kudolo et al. 2017). The use of the term 'traditional' remains rooted and significant because it is thought that it has particular value and is often used strategically to position the healer's authority as drawing on long-standing practices

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aligned with particular values. Biomedicine also has a distinct culture and ritual for example, the use of white coats with a stethoscope around the necks, and individualized treatments. Just like traditional practitioners, biomedical practitioners commonly position themselves as 'modern' to distance themselves from other forms of healing and align themselves with progress and development.

In order to simplify the terrain and for the purposes of this paper, the authors chose to base their discussion on the dichotomy of 'traditional' versus 'Modern' Medicine.

It is sometimes a challenge to draw a line between the different practitioners of traditional medicine as they often combine the various methods. However, they identify themselves as herbalists, bonesetters, psychic healers, traditional birth attendants, faith healers, diviners and spiritualists who use indigenous knowledge for developing their materials and procedures. Using complex combinations of activities (that include careful history taking and attending listening), knowledge, beliefs and culture, the traditional medicine practitioner elicits a diagnosis and plans the desired management and prevention strategies to restore physical, psychological and social well-being(Quick, Zhang et al. 2002). Traditional medicine practitioners use a variety of techniques when dealing with mental illnesses and physical disorders including; herbs (phytotherapy), psychotherapy, psychodrama, symbolisms, rituals, spirituality and prayer(Abbo 2003). What helps the traditional medicine practitioner is the fact that he/she usually lives in the same community where he/she practices, speaks the same language, and has extensive knowledge of the strengths, weaknesses and resources available to the community, which the modern medicine practitioner often lacks.

The early European incursions began in the 1400s with slave trade which was well disguised as opening up of Africa to trade but merely served the purpose of exploitation; then came the

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colonization of Africa in the 1800s and 1900s; and finally, came the civilization of Africa through religious evangelism. Modern Medicine thus found its way to Africa to serve the above three interests. It is therefore plausible that the early European doctors came to Africa to: treat European explorers, Colonial administrators and Missionaries; to fight in wars of colonization and religion; and to use medicine to spread the word of God. To further entrench Modern Medicine in Africa, teacher training colleges, nurse training schools and theological schools were begun at the time(Musisi and Musisi 2007).

Meyer Birgit (1998) attributes the origin of the terms “Traditional” to this period(Meyer 1998). Through her works in Ghana, Birgit further posits that the use of the term “tradition” was derived from the early Protestant missionaries who intended to draw a parallel between what they brought and what they found among the indigenous people. Traditional therefore was used to refer to things of the past that ideally should have best been left there. The current challenges faced by Modern medicine today were equally faced by the early missionaries and which is that; converts would not fully comply with the protestant modern ideal to break with the existing practices such as worship of ancestors and familial gods, and reliance on native medicines. Birgit argues that the temporalizing rhetoric that was created that represented tradition as a thing of the past was needless especially considering that it concerned a life form which co-occurred with the so called modern life(Meyer 1998).So, Modern Medicine and Traditional Medicine today, find themselves at similar crossroads. Borrowing a caution from Birgit may be wise, that should Modern Medicine not view life as a continuation of longstanding traditions, then modern subjects will erroneously focus on “an elusive present that has to be renewed constantly by breaking it away from the past.”. What is clear then, is that the antipathy between Modern Medicine Practices and Traditional Medicine Practices began a long time ago when

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epistemological categories that draw rifts began such "us versus them", God versus Devil" and "Modern versus Traditional".

Modern Medicine, historically, emphasized cure of infections and neglected other areas of Medicine such as Mental Health and Public Health. For instance the first mental asylum, a prison in nature, was established in Hoima in Western Uganda, not a real treatment center, but as a seclusion institution to keep the dirty and disheveled Africans with psychotic illness out of circulation, during the colonial era in Uganda (1894 – 1962)(Mahone 2006, Mahone 2006).Moreover, there was biased reporting of African diseases with attributes to bad air being popular at the time. Modern Medicine regarded Traditional Medicine as being satanic in keeping with religious teaching of the times (F̀reeman and Motsei 1992). They arrived at this conclusion through casual observations and no early studies were undertaken at the time. Consequently, African Traditional Medicine was ridiculed and banned altogether. So, from an early stage, it seemed that there would be no common ground for the two types of medicine. African cultural explanatory model of diseases and illnesses took a backstage and were discussed in hush tones thereafter. Similarly, Traditional Medicine practices also went underground and flourished silently amidst ridicule and shame for those who engaged in them (Musisi and Musisi 2007).

Historically, there has been some attempts made at combining psychiatry with traditional and faith healing dating back to the beginning of African Psychiatry. For example, the works of Lambo in West Africa in the 1960s(Lambo 1966, Lambo 1969)and those of Edgerton in East Africa in the 1970s(Edgerton 1971, Edgerton 1980), report this phenomenon. However, no real wide spread and tangible collaboration has materialized since then. World Health Organization at the Alma Ata declaration of 'Health for All by the year 2000' in 1978 stated that unless traditional healers were included, Health for All by the year 2000 would not be

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achieved(Organization 1978). It is clear that this was not achieved. Moreover, in some parts of the Sub Saharan Africa, worse health situations have been reported(World Health Organization 2003, TO 2003). Would it have been different if Traditional Medicine Practitioners had been included? The working together of Modern Medicine Practitioners and Traditional Medicine Practitioners remains a challenge in Sub Saharan Africa, todate.

The earlier mentioned schism between Traditional Medicine and Modern Medicine has persisted through the decades and centuries. Despite recent sluggish interest by modern medicine to reach out to Traditional Medicine, its efforts are still regarded with suspicion among practitioners of Traditional Medicine. In the end, it seems, it is the patients that lose the mostespecially, since their choices of health care seem to oscillate between the two systems(Asare and Danquah 2017)

Few studies have focused on the interface between traditional medicine practice and mental health in Uganda, moreover, even these available studies dwelt upon a narrow description of mental health disorders either by looking at discrete disorders such as depression and anxiety(Ngoma, Prince et al. 2003, Patel, Saraceno et al. 2006) or by looking at a small cluster of disorders using the term psychosis(Okello, Abbo et al. 2006, Abbo, Ekblad et al. 2008, Abbo, Okello et al. 2008) (8,9,10) or neuropsychiatric disorders such as epilepsy and culture(Allotey and Reidpath 2007). These studies however left out a broad range of disorders that affect the central nervous system altogether that result in emotional, cognitive and behavioral outcomes.

Mental disorders are found throughout the world (WHO:MhGAP, 2008). Unfortunately, as a result of cultural differences and misconception, mental disorders were often overlooked, ignored, or misdiagnosed, especially, in sub Saharan Africa, particularly during the colonial era. However, current evidence indicates that the burden of Mental illnesses is both significant and significantly underreported and it is on the rise as a result of increased education and awareness,

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social and political strife with attendant armed conflict, and increasing economic pressures in various African countries. World Health Organization had projected that by 2020, depression would be number one cause of morbidity but this has come much earlier by 2017(.http://www.cbc.ca/news/health/lancet-canada-1.4548587)

In Sub Saharan Africa, the mental health situation can be described as triple jeopardy, namely: a High burden of mental illnesses, inadequate formal resources coupled with underutilized informal resources and a big treatment gap. For many countries, this means relying on the underutilized and unrecognized informal resources like traditional healers for health care. These providers are more accessible than Mental Health specialists who are few in numbers, and they frequently provide continuity of care and social support for patients (Okello, Abbo et al. 2006, Abbo, Ekblad et al. 2008).

A systematic review of traditional and religious healers in the pathway to care for people with mental disorders in Africa by Burns and Tomita reported that about half of the people seeking formal health care for mental disorders in Africa, opted for traditional and religious healers as their first care provider(Burns and Tomita 2015). This was corroborated by a recent study by Asare and Danquah in Ghana(Asare and Danquah 2017) Whereas on the one hand, seeking health care from the Traditional healers first has been associated with delays in seeking formal health care and therefore unfavorable clinical outcomes(Kohn, Saxena et al. 2004)., the popular choice of Traditional healers over Modern medicine has often been justified by the fact that they better explain etiology of unexplainable medical phenomena and thereby gives hope to the seekers of these services(Asare and Danquah 2017)

Another recent systematic review of the effectiveness of traditional healers in treating mental disorders by van der Watt and others in 2018, established that some evidence exists for

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psychosocial interventions by traditional healers for mild to moderate anxiety and depression but not for severer forms of mental illnesses(van der Watt, van de Water et al. 2018)). This review however, included qualitative and subjective improvement that is usually reported by clients of traditional healers even in the presence a worsening clinical situation(Kleinman 1980).

Despite the widespread use of traditional healers in sub-Saharan Africa in identifying and managing mental disorders, there is no standard of care and there is little evidence from which to assess its effectiveness (Harlacher, Okot et al. 2006). As a result, there is an ongoing debate as to whether traditional healers should be recognized as part of the healthcare delivery system, and, if so, how they could be more formally integrated into the healthcare delivery system. This argument is complicated by the fact that the introduction of modern medicine is closely linked to religion that considers traditional practices as evil. A consideration that is confirmed by media reports of malpractices of some traditional practitioners like ritual killing (ttps://www.newvision.co.ug/new_vision/news/1247477/police-arrest-healers).

Nonetheless, the traditional medicine practitioners cannot be disregarded in the management of mental disorders when a significant number of people use them.

The onus is therefore upon all those whose interest is the health of the patient, to be able to identify the areas of common practice even before the discussion on standardization and regulation of Traditional Mental Health care is embarked on. The United Nation in Uganda recommends that the government and International actors need to acquire a greater understanding of cultures, societies and in particular, traditional healing practices, if they are to successfully develop a reliable environment for Traditional Medicine and Modern Medicine to work together to ensure quality-assured treatments and appropriate referrals between the two systems (United Nations, Uganda (2011)).

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Given the above background, it appears that to discuss the divergence of Traditional Medicine from Modern Medicine is a much easier task than to discuss their convergence.

A previous review by Gureje et al reported mainly divergences of the two systems regarding nature and causes of mental disorders (Gureje, Nortje et al. 2015), while in the neighboring Kenya, Ndetei et al. attempted to draw the complementarity of traditional and faith based healing to western medicine(Ndetei, Khasakhala et al. 2008).This Kenyan study called for research that draws a linkage between Traditional and Faith healing practices and Modern medicine practices, the focus of our paper.

Through a narrative literature review with a critical element, this paper, will address both and further discuss ways in which the two can work together.

This discussion will be anchored on the experiences in Uganda, a Sub Saharan country, located in East Africa. Uganda is a multicultural society with 43 living languages diverse religious and regional groupings which may reflect different spiritual and cultural traditions and approaches.

Points of Departure between Modern Medicine and Traditional Medicine Practices

Degegment pour engagement (disengage to engage), a French saying is applicable to Modern Medicine Practices (MMP) and Traditional Medicine Practices (TMP). It is often necessary to elucidate specific differences before suggesting the terms of any relationship. In carefully delineating the respective worlds of Modern Medicine and Traditional Medicine Practices, we hope to expose the morphology of differences and certain absolute distinctions must be acknowledged upfront at operational level. The previous section on historical background sets the stage for this evaluation. Traditional Medicine Practices are concerned with supernatural, traditional causation and treatment of ailments while Modern Medicine is concerned with

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biological aspects. However, at the neuroscience level, the brain is culturally and socially constructed (Ames and Fiske 2010). This implies that modern medicine practitioners cannot divorce cultural and social issues from disorders and illnesses of the brain and their management.

Explanatory models:

Efforts to employ bio-psycho-socio-cultural model has eluded Modern Medicine in the clinical arena since its inception in 1977(Engel 1977). Often the sociocultural aspect disappears along the way and the two continue to remain distinct: The universalistic approach, a notion that mental illnesses are universal but only presentations may vary because of cultural influences (WHO, 1946; WHO 1995) that formed the basis of the extensive programmes of epidemiological research carried out by the World Health Organization in the 1950s and 1960s would mean that MMPs and TMPs see the same illnesses but only differently (WHO, 1995). However, given the distinctions, in important aspects, they may actually be seeing different things. In phenomenological terms, they are interested in different meanings and the way in which these meanings are constituted by specific activities of the mind (Boehnlein 2008).

The mind in turn is shaped by different social and cultural experiences and activities, which is why traditional approaches can be a resource.

Skills and Practices:

Another point of departure is how MMP and TMPs acquire the skills to practice. Both MMP and THP providers go through training in order to practice. However, the criteria for enrollment into training and duration differ. To become a modern medicine practitioner in Sub Saharan African medical training institutions, one must have a minimum academic requirement in science subjects; the training duration varies from 6 to 8 years in different universities including

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internship of 1 to 2 years (Mullan, Frehywot et al. 2011). On the other hand, to become a traditional healer, direct previous contact with a practicing healer either as their former patient or as a family member is necessary(Ovuga, Boardman et al. 1999). Others get divine revelation or a calling from the spirits (Kale 1995) and yet others get into the practice for the purposes of making money. Apprenticeship with an experienced healer for a number of years has also been reported (Abbo 2003).There are attempts at professionalizing healing practices and integrating TMPs in the health care system e.g. in Ghana there are university courses in traditional medicine and registered TMPs are practicing in some hospitals. In 2016, a South African higher education and training Minister announced plans to have BSc course in witchcraft included in the University curriculum across the country (http://livemonitor.co.za/south-african-universities-to-offer-bsc-witchcraft/). Although the title 'witchcraft' is restrictive and connotes communication with the spirit world with the traditional healer serving as a medium, and may not depict the proposed curriculum content or reflect appropriately what the TMPs do, this is a step towards traditionalizing modern university training.

Diagnosis:

Last but not least, there are significant points of departure in diagnosis and management methods: Although the general approach to a patient of history taking, examination and treatment are followed by both MMPs and THPs, what actually takes place and the 'how' differs. During history taking, the TMP listens with spiritual and socio-cultural ears while MMP with a mostly biological one unless the MMP has been exposed to social and anthropological sciences. The TMPs picks up spiritual, cultural and psychosocial, and rarely biological issues while the MMPs pick up biological and to varying degrees psychosocial issues and almost never spiritual issues. Some healers (diviners), in a possession state communicate with ancestors for revelation of

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spiritual and psychosocial issues(Ovuga, Boardman et al. 1999). Cowrie shells, bones, precious stones and other regalia have been reported to be used as diagnostic tools as well. Prescription of treatment depends on the diagnosis and for TMPs, these include rituals, psychodrama, use of herbs and behavioral change (Ovuga, Boardman et al. 1999, Abbo 2003). For MMP, it is mainly medication with minimal psychosocial interventions

Ethical standards and issues:

Debates on whether or not to subject similar ethical standards to the practice of THPs rages on (Tangwa 2007, Van Bogaert 2007, Munyaradzi 2011). Whereas MMPs are guided by documented internationally recognized ethical standards in their practice, the TMPs are not directly governed by these. In fact, some of the interventions by TMPs are reported to be harmful to the mentally ill patients and they have been reported to lack both business and medical ethics (Munyaradzi 2011). In the most recent publication by Ofori-Atta, a randomized controlled trial of psychiatric care and faith healing in a prayer camp(Ofori-Atta, Attafuah et al. 2018), the authors came under ethical scrutiny on various fronts of ethical principle(Hughes 2018, Patel and Bhui 2018). This is an example of how working together can bring about discussions on some of the reasons that keep the two systems apart, but for the purposes of protecting traditional and modern medicine practitioners and their consumers.

Although MMP may be governed by formal ethical codes, there may be some moral codes governing the practices of TMPs which may be congruent with these. A further understanding of what these ethical codes may be calls for further investigations which is beyond the scope of this paper. Culture is not statistic, changes do occur and since TMP's work is embedded in culture, TMP's ethical practices will change as MMP work together with them to cause a positive change. Change takes time, it took many years for MMP to evolve from the prehistoric times (

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3000BC) when conceptualization of medicine was based on spirits and gods; to the times of Greek Empire(1500-300BC) when medicine was based on religion, the Temples of Asclepius to anecdotal collections of symptoms and treatments of diseases by Hippocrates around 400BC and finally the beginning of scientific medicine in 1500s(Hajar 2015). In the meantime, to minimize harm to patients and unethical practices like involuntary restraint, the involvement of wider communities, traditional and religious authorities may be of value in ensuring the ethical practice of TMPs.

Another issue which can be considered under ethical standards is Intellectual property rights.

Intellectual property relates to who owns traditional knowledge on various herbal preparations that appear to be useful in the cure of symptoms, both mental and somatic. TMPs are reluctant to collaborate with MMPs in herbal research for fear of losing their indigenous knowledge and herbal plants, and therefore the finances that would accrue from the use of the knowledge and herbs concerned. Traditional medicine practices are a source of income, and a form of profession for TMPs. However it is prudent that TMPs are made aware of their obligations to the safety of their communities and individual clients. Though TMPs are always quick to respond to public outcries and complaints about harm to general members of the communities as a result of kidnappings and murder in the form of ritual sacrifices, this fact needs to be put to them through concerted education. General members of the community also need to be engaged in dialogue to highlight the harm associated with their often secretive use of TMPS, some of whom are believed to practice human sacrifice. Waves of human sacrifice that happen in Uganda have been blamed on some TMPs. However, TMPs through their associations have dissociated themselves from human sacrifice saying their culture does not allow them to sacrifice human beings(Bukuluki and Mpyangu 2014).

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Genuine dialogue is needed between MMPs and TMPs in the areas of intellectual property and ethical practices so that those with indigenous knowledge do not see themselves losing out to the modern medicine practitioners while ensuring that truly ethical use of herbal products are used in the best interests of service users. Commercial aspects relate to who gains and who loses out when MMPs and TMPs collaborate. Recognition of TMPs and their participation in health care means that MMPs will formally share the financial benefits in health care.

Areas of Common Practice between Traditional Medicine and Modern Medicine.

To describe this section, we start with clinical examples that is a true depiction of two typical clinical situations in two mental health facilities in Africa.

Case 1:

"After doing rounds of shopping and exhausting financial resources in various private hospitals in the city, the parents of a 9 year old girl brought her to a general hospital. The girl presented with high grade fever and disturbance in behavior. Because of the family's strong belief in witchcraft, they sneaked the girl away from hospital in the night to a traditional healer for intervention. The MM practitioners then called up the parents to explain about the fever and the dangers of not having it investigated and treated properly. The father of the girl, a lawyer by profession disagreed with the mother and brought the girl back to hospital. The mother, a teacher by profession, refused to come to take care of the girl in hospital as she was convinced their child would not be helped in hospital. MM practitioners declined to readmit the girl, saying the parents lost their opportunity as the ward was always overflowing with patients. Her bed had already been taken by another patient. The father then decided to take his daughter to a nearby private clinic where she would be taken to the healer at night and broughtg back in the

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morning". In this way, the girl was able to get her fever investigated and managed but also, the parents and the healers' needs were met.

Case 2:

A three-years-old male child was brought to a psychiatric institution after he spent three months in a traditional healer's shrine, and a few more weeks with a second traditional healer without relief. The child's hands were crepe-bandaged to prevent further self-injury. He had fresh and healed scratch injuries on both sides of his head. He continued to mercilessly and continually hit himself on both sides of the head despite the fact that he was obviously exhausted from his self-injurious behavior. The reason the child was brought to the mental hospital was his failure to recover in the hands of two experienced traditional healers. Investigations for organic brain disease or epilepsy yielded negative results. Careful history taking with keen observation by nurses under the supervision of the psychiatrist (third author)revealed history of child neglect and severe battering by the mother following the birth of a sibling, as he exhibited intense feelings of sibling rivalry. The child recovered after two months of behavior modification therapy for emotional and obsessive-compulsive disorder.

Case 3:

A consultation was received by the first author regarding a mother of four school going children and a wife to a businessman who decided to go do business in South Sudan when they gained

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independence. Before he left, he decided to take all his children to boarding school to lessen work for his wife. He did not communicate when he would be back and he hardly telephoned his wife back home. Three months later, his wife gets possessed by ancestral spirits from her family lineage. Through her the spirits demanded traditional marriage, a church wedding and some rituals to be carried out in the following month in the presence of the husband of their daughter. The first author was consulted by a family member who happened to be a Medical Doctor. She had been physically evaluated and was found to be fine. Further inquiry revealed that in between the attacks, she goes about her duties normally. There was no history suggestive of psychiatric illness except that one relative heard her complain that she had been left for rats that make noise for her at night, possibly indicating that she could be having poor sleep.

Family members were divided whether to consult a traditional healer or not. Meanwhile, the advice from the first author included the following:

1) *The husband to get in touch with the wife via phone and find out how she is, tell her how he is etc.*
2) *Family members to consider positively what the spirits are saying and immediately begin to prepare for the ritual and ask the husband to be around for the ritual.*
3) *While he is around, draw a plan for traditional marriage and church wedding*
4) *He needs to plan regular calls with the wife, perhaps after every 2 days and plan dates to return home at least every 6 weeks and when he fails to make it , he communicates*
5) *Encourage wife to join women groups in the community, go to church and participate in community functions.*

Two years later, there are no more spirit attacks reported but because of war in South Sudan, the husband now does business within Uganda.

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Herein lies the rationale for engagement with TMP. The two realms provides parallel vectors in insight and understanding that while not intersecting at that level are mutually connected through the patient and their relatives.

In Uganda, the problem of imported drug shortages are common place and therefore, a majority of the people both in rural and urban settings depend largely on herbal medicines for treating various ailments including mental illnesses(Hamill, Apio et al. 2003, Galabuzi, Agea et al. 2010) hence not only increasing the demand for traditional medicine practitioners for medicinal plants but also push patients away from MMP, thus weakening efforts at collaborations with TMPs who always have something tangible to offer their clients. Regarding modern medicine, it is a well-known fact that some drugs prescribed by MM practitioners are processed herbal medicines. For centuries, Africans used the leaves of *quinacinhona* to treat Malaria and other ailments. Later, quinine was extracted and processed from the same plant (Rates 2001). In the second half of the 20th Century, chemists discovered that in addition to getting dyes from coal tar there was potential for getting medicines including antipsychotic chlorpromazine that is still widely use in Africa(López-Muñoz, Alamo et al. 2005). Reserpine, the first modern drug to treat hypertension in the 1950s, an alkaloid derivative is extracted from the root of *RauwolfiaVomitoria* plants that is widely found in Africa. In traditional medicine, it is brewed as tea and it was used to treat mental illness, hypertension, snakebite and cholera(Goodwin and Bunney 1971, Curzon 1990). Erogmine, an anti-migraine, is a derivative of ergot alkaloids produced by fungus genus *clariceps* found in cereal kernels and grass seeds(Silberstein and McCrory 2003, Tfelt-Hansen and Koehler 2008).In terms of collaboration, this gives a strong basis for the two systems to strengthen this bond that was created by the virtual of the fact that some modern medicines are based on photochemical that have been used by TMPs for centuries(Gilani 2017).

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Intentions of both MM and TMPs are to restore physical and mental health and provide care to those in need.

An area to begin the discussions is to take the human rights approach. International Covenant on economics, social and cultural rights of December 1966, Part one of article 1 and part III article 15 states that *"All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development".*

The States Parties to the present Covenant recognize the right of everyone:

(a) To take part in cultural life;

(b) To enjoy the benefits of scientific progress and its applications;

(c) To benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Culture is a way of upbringing, ways of understanding mental illness and therefore ways of coping and help seeking behaviors. Jenkins and Bernet in 2004 defined culture as "Shared symbols and meanings that people create in the process of social interaction," which orient "people in their ways of feeling, thinking, and being in the world."(Jenkins, Jenkins et al. 2004).By patients' use of both systems concurrently, the providers violate their rights by not recognizing the links. To Quote Nelson Mandela: "To deny people their human rights to culture and beliefs is to challenge their very humanity".

Another area for discussion is to examine the language used in describing various mental health conditions. Traditionally, most communities in Uganda have various terms that usually describe

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severe forms of mental illness. In most communities in Uganda, the terms used translate as "madness". In Northern Uganda, the term is "*Apoya*" while in Central Uganda, it is "*Edalu*". These terms encompass different disorders in Modern Psychiatry such as schizophrenia, Mania, Bipolar disorder, and psychosis. The communities in Uganda will explain the causes of this madness to include; their hereditary nature, or as an end point to such conditions as spirit possession, HIV/AIDS, head injury, "overthinking", "over-drinking" or due to bad memories. It is believed that with the exception of the hereditary type of madness, the others due to specific causes can be treated, though not always successfully (United Nations in Uganda, 2011).

Another area of common understanding arises from the African concept of "spirit possession". Whereas, there are many slight variations in cultures in Africa and in Uganda in particular, "spirits" are common to their worldview. A large number of Ugandans professing to Christianity and Islam, not withstanding, most people continue to hold a dual cosmology (Harlacher, Okot et al. 2006, Hopwood, Lanyero et al. 2008). The spirits commonly referred to as "*Joggi*" in the Luo dialect; "*Empewo*" in the Kiganda dialect; or *ori* in Madi dialect, essentially refer to spirits of the ancestors and others associated with rivers and mountains and the clans where they are located. There are also the "free spirits" which are generally known to be responsible for mental illnesses and other forms of misfortune (Harlacher, Okot et al. 2006). The vengeful spirits or ghosts of someone who died in a bad way are common and increase in conflict affected areas such as Northern Uganda, and can often afflict the killer or the person responsible, a person who witnessed the killing or someone who touches the remains of the dead person(Harlacher, Okot et al. 2006, Van Duijl, Nijenhuis et al. 2010). This form of vengeful spirit can be passed through the generations and can sometimes spread to the whole clan. The symptoms of vengeful spirits are similar to those seen in Post-traumatic Stress Disorder (PTSD): dissociative states,

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nightmares, flashbacks and psychosis(Van Duijl, Nijenhuis et al. 2010). Despite the overlap in symptoms of spirit possession and PTSD, and the general understanding that vengeful spirits fit in the psychiatric understanding of traumatic stress, the cultural understanding is not usually linked to traumatic psychological impacts of the experiences because the concept of vengeful spirits also culturally have further symptoms such as bad luck and misfortune, including sickness or death of oneself or one's children. The earlier mentioned overlap in symptoms provides a unique opportunity for further studies and exploration, as it might offer clues for potential complementarities between traditional and Modern medicine.

Yet another area for linkage between the Traditional healing practices and modern medicine, is the fact that, in the course of offering their treatments, traditional healers often involve members of the family into a patient's care. This social capital mobilization has been fairly challenging to mobilize in the practice of modern psychiatry in Africa.

Some researchers have made observations that traditional healing practitioners already have access to modern medicine like benzodiazepines and some antipsychotics. This is sometimes mixed in their herbs and given to patients who may later present with extra pyramidal sides effects to mental hospitals(Abbo 2003). Some MMPs also prescribe herbal medicines in form of supplements.

By explaining areas of common practice and points of departure and thus clearing any potential for confusion, it is now possible to discuss how MMPs can make appropriate contact with THPs and vice versa. Psychiatry and Mental Health is a product of cultural world which leads to critical appreciation of the implicit assumptions and historical grounding of theory and practice. This awareness of these assumptions opens the doors to real dialogue with traditional healing practitioners and patients (Kirmayer and Minas 2000).

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Table 1: Actions needed for the two systems to work together at Policy, Practice, Community and Family levels

Levels	Actions
Policy	➢ Integrating training of both TMP and MMP at all levels of learning i.e primary, secondary and tertiary ➢ Establishing a contact desk for TMP at all health care levels ➢ Establishing monitoring and evaluation team at all health care levels ➢ Inclusion of TMPs in budgetary component ➢ Formulation of a communities strategy between the two systems
Practice	➢ Certification and subscription to the integration in order to practice ➢ Workout Cross referrals and agree on which patients to refer to which system ➢ Regular meetings of TMPs and MMPs to be set up this may help in improving interpersonal relations ➢ Clear referral processes and formalized pathways ➢ Create environment for positive and rewarding experiences for both systems by acknowledging what each party brings to the table ➢ Build insight and enhance or create desire where non exists to work together ➢ Either system to be willing to mentor and educate the other party.
Community	➢ To work in a more equal partnership with Modern Medical Practitioners and Traditional healing practitioners ➢ To be receptive to non community members, particularly MMPs who may be from another culture ➢ TMPs in the community to allow TMP in their operational areas to observe how they work
Family	➢ To share cultural knowledge and acquire mental health literacy ➢ To be open and comfortable to discuss use of both systems

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How the two systems could work together:

Options of the two systems to working together have been described in literature(Ȑreeman and Motsei 1992, Shields, Chauhan et al. 2016). Some models have been tried out, for example in Ghana and South Africa, especially with HIV/AIDS patients, and they include; Opposition,Incorporation and Intergration,Cooperation and Collaboration, and finally, Total Integration.

In the current global world, there is no place for Opposition although one study in South Africa reported that MMP were more inclined to opposition(Campbell-Hall, Petersen et al. 2010).Incorporation or integration means TMP are incorporated in the modern practice to carry out services researched and designed within the modern health care system including curative, preventive and promotive. World Health Organization used this model in the 1970s for control of Tuberculosis and in 2000s, some African countries used it for Control of HIV/AIDS and other STDs(Ȑreeman and Motsei 1992, Mokgobi 2013)

In Uganda, this would be equivalent to the work of Village Health Teams (VHTs) who are volunteers within the community; they identify and refer community members who may be in need of health service. Working with this model would mean that there is a possibility of keeping watch on operations of TMP as they would be supervised by Ministry of Health just like VHTs are. Uganda is in some kind of pseudo integration where TMP are expected to refer patients to health centers although this is not a policy.

The other model described is Cooperation or Collaboration, which means both systems remain autonomous, each retaining their methods and ways of operation and explanations they give to

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their patients regarding etiology, diagnosis and treatment of ailments. The strength of the cooperation lies in the recognition of the importance and value each other brings to the table. In such arrangements, referral, is mutual. This model also gives the patient freedom to openly choose which system to consult, either one or both for the same illness. The adoption of this model makes it possible for both systems to work in the formal sector. China and North Korea are the two countries that have adopted this model. The challenge however arises in which conditions should be referred to whom? Research is needed to delineate those conditions that can be referred to TMP and to MMP.

Last but not least, Total Integration, which involves the evolution of a new healing system through blending the two systems right from training of the practitioners. This means the practitioner should be competent in both systems and treatment may mean applying either one or both methods depending on the diagnosis and the needs of the patient. This model appears to be the most challenging to adopt because of the different philosophical underpinnings of the two systems.

There is need to have a policy and regulatory framework in place for a smooth collaboration between the two systems. Any collaboration within the current health policy framework in place is deemed illegal. In Uganda, a practicing Modern Medicine practitioner risks losing their license. The referral system

in Uganda works in such a way that referral is done from lower levels of health system with limited resources and lowly qualified health workers to higher levels supposedly with adequate resources including highly qualified experts within the formal sector. Traditional health practitioners are considered to be informal, outside the health care system therefore MMP referring to them patients maybe considered incompetent and unethical.

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In 2005, WHO report on national policy on TM/CAM and regulation of herbal medicines stated that only 32%of African countries reported having a policy in TM/CAM(Organization 2005). A number of countries including Uganda reported that the policy was being developed. For Uganda, the policy has never been passed into law.

It would therefore seem appropriate for the MMP to conduct research on collaboration with TMP and use the results to get involved in advocating for policy that usefully and meaningfully includes THPs and ways of working together.

The two systems have to understand each other and investment must be made on both sides, however, the MMP who study bioethics and go through formal training are obliged to ask the question: “Are we doing justice to our patients if we are not collaborating with TMPs?”Discussions as to whether TMPs should be subjected to modern medicine methods have been ongoing (Incayawar, Wintrob et al. 2009). One reason for these discussions is that the researches done on TMPs are by Modern Medicine practitioners who see things differently as their views are outside the cultural views that underlie TMPs (Incayawar, Wintrob et al. 2009).

MMP therefore need to understand the THPs’ roles, what they do, what they value, their attitudes, behaviors, what excites them, what turns them off, and their likes and dislikes etc. MMP need to begin to see what TMP see, only then shall MMP claim to practice patient-centeredcare, which is considered 'respectful of’ and ‘responsive to’ individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions and supports self-management (Epstein, Fiscella et al. 2010).

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Another way for MMP and THP to work together is for each to put aside their own points of view as this prevents them from seeing each other's view point. Moreover they each believe their practices are the best for the conditions they treat.

MMPs need to practice the concept of cultural humility conceptualized as "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]"(Tervalon and Murray-Garcia 1998).

Tervalon& Murray-Garcia ,elucidated three guiding principles in cultural humility.

Lifelong commitment to self-evaluation and self-critique is the first one and underlying this principle is that there is no end to learning(Tervalon and Murray-Garcia 1998). There is no such as a thing as 'I have arrived' when it comes to acquiring knowledge and learning. Therefore, MMPs must be humble and flexible, and courageous enough to look at themselves critically and desire to learn more of the other's world view. In addition to the desire to learn more, they need to acknowledge and be willing to act to fill the knowledge gap. Understanding is only as powerful as the action that follows. Secondly, cultural humility has aspects of fixing power imbalances particularly where none shouldn't be (Tervalon and Murray-Garcia 1998) . Acknowledging the different viewpoints and therefore MMP and TMP bring something different to 'the table' helps both to see the value and appreciate the importance of each other. TMPs are the experts in cultural issues, the MMPs holds a body of knowledge that the TMPs don't have, but the TMPs has an understanding of cultural issues, supernatural issues that affects life outside the scope of MMPs. Both parties must collaborate and learn from each other for the best outcomes for the patient. One holds the power in scientific issues and the other in cosmology.

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Lastly, cultural humility involves aspiring to develop partnerships with people and groups who advocate for others (Tervalon and Murray-Garcia 1998).Creating positive change through communities and groups results in greater impact than when individuals do it alone. TMPs are respected community members and opinion leaders. MMPs must advocate partnerships with TMPs for purposes of prevention and promotion of mental health in the communities. It is through these partnerships that awareness and education regarding TMPs' obligations to the safety of their communities and individual clients can be raised.

Potential Challenges in the two systems working together

In the two systems working together, many potential challenges have been cited in literature (ref), including but not limited to: giving prestige to TMPs and unfair competition with MMPs, legitimizing inappropriate and harmful TMPs practices; Ministry of Health Budget implications, failure of registration of all TMPs and poor trust and secrecy of TMPs. In Uganda, what might be seen as the greatest deeper challenge is that Ugandans possess two faces of religion which is intimately associated with the coming of modern medicine and their African tradition and values. Nearly all health facilities in Uganda, Government owned and Private not for profit are affiliated to religious denominations. Even in rural areas, it is not uncommon to find a hospital build on church land. Yet Ugandans remain true to their African values and beliefs.

Conclusion:

Research into the links between Modern Medicine and traditional healing practices is a neglected and under researched area of public health concern particularly in Sub -Saharan Africa. In order to forge a relationship between MMPs and TMPs, there is need to recognize the differences that exist, identify and capitalize on what is common between the two

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systems. Most African countries have no policy or regulatory framework for traditional healing practices, or they are forever in the process of developing them. An important starting point therefore is advocacy for the framework to be put in place. Whatever else that follows in enhancing the relationship is likely to succeed if the principles of cultural humility is employed.

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