

# **Constructing Collaborative Processes between Traditional, Religious, and Biomedical Health Practitioners in Cameroon**

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## **ABSTRACT**

Collaboration between biomedical doctors, healers, exorcists, priests and prophets has emerged in most African countries as an inevitable of health care. Cameroon remains one of the African countries where no formal collaboration exists. Conducted in Yaoundé (Cameroon), this study aims to examine potential strategies of collaboration and exchange. Individual and group qualitative interviews were conducted. Results indicated that biomedical practitioners and priests expressed reluctance in building reciprocal relationships with traditional healers and prophets. Such reluctance derives from the social, ideological and political order Africans have inherited from colonialism. We suggest appropriate strategies that can be used to overcome resistance and negotiate conflict.

*Keywords:* traditional, religious, biomedical, collaborative processes, Cameroon.

## **1. INTRODUCTION**

Cameroon is a country with 22 million inhabitants. With no system of universal health coverage, more than half of the population survives with less than two dollars a day (EDSC-III, 2004). The economic crisis of 1980 forced the state to downsize the number of official health practitioners. There is now 1 doctor per 14,730 inhabitants; a ratio lower than the standard of 2,3 doctors per 1000 inhabitants recommended by World Health Organization (Tsala Tsala 2004: 140). Healthcare in Cameroon is delivered by three sectors: 1) public medical care; 2) private medical care (privately owned clinics and hospitals where clinicians are either medically trained missionaries or lay doctors and nurses) and; 3) care provided by traditional practitioners and religious healers. Traditional practitioners can use a combination of witchcraft, spirits, magic, ritual therapeutics, herb and divination to heal (Ministère de la Santé Publique, 2002). While religious healers, such as exorcists and prophets, use only religious practices to treat illnesses (De Rosny 1981: 313; Pordié 2008; Tonda & Gruénais 2000; Tonda 2001). Exorcists base their practices on Christianity,

while prophets, combine both ancestral African religions and Christianity, to guide their therapeutic rituals (De Rosny 1992: 139). Despite the collaboration of medicines initiated by the WHO, Cameroon remains one of the African countries where no formal collaboration exists. A few years ago, studies carried out by Lantum have focused on informal relationships between health practitioners in Cameroon (Lantum & Monomo 2005; Lantum 1978, 2002). In her research on the collaboration of the medicines in the same country, Hillenbrand said: «*In many [African] countries, policy maker are reluctant to accept traditional medicine, and there is critical lack of collaboration between conventional and traditional medicine practitioners. [...] There is still resistance to officially accepting traditional medicine*». In addition, our recent studies conducted in paediatric healthcare context confirmed the absence of formal collaboration between traditional and conventional health practitioners (Wamba et al., submitted).

## 2. BACKGROUND

After the World Health Organization [WHO] conference held in Almaty (OMS 1978), all African countries officially recognized traditional medicine as a partner of biomedical medicine. Following this, the fight against HIV/AIDS increasingly compelled biomedical practitioners and traditional practitioners and healers to work together (Bodekera, Kronenberg, & Burforf 2007; Liverpool et al. 2004). However, we do not know how this collaboration is, or could be, applied in Cameroon, where the status of traditional practitioners and healers remains ambiguous. Nowadays Although they can practice with a wide margin of freedom, an official recognition of their profession still face some challenges at three levels: at a socio-political level, they have restricted access to public space, limited freedom of speech, and therefore, are disabled to participate in any political decisions regarding legislature projects governing and protecting their professions and services (Djemo 2009: 189). Juridically, there is an absence of recognition based on the law, namely the existence of explicit legislation governing their profession. At the economic level, there is no law regulating remuneration of health services rendered by healers. In other words the legal status granted to traditional healthcare practitioners in 2007 is in no way different from the status they occupied after the Almaty conference of 1978: «*[...] although they explicitly recognize the legitimacy of traditional medicine, they do not regulate or sanction it. Many people will probably be surprised to learn that traditional medicine was never outlawed by legal codes, either during colonial times or since the independence of African countries*» (Bibeau, 1982: 1844). Furthermore, the recognition process, led by the biomedical health professionals, was conditional to the proof of the pharmacological properties of the medicinal plants they used (Pordié 2005: 231–232). By relying on the latter criterion only, practices such as divination and

rituals, considered by many to be effective, become unrecognizable and de facto, disqualifying for religious healers and most traditional practitioners that rely on these magical or ritual procedures coined this recognition strategy as a disqualifying acknowledgement (Rosny 2006; Roy 2008: 203), or negative acknowledgement (Renault 2004: 185). Unfortunately, Western-oriented codes of law, such as they generally exist in African States until now, are limited in their capability to integrate these dimensions.

### 3. UTILIZATION OF THE THREE MEDICAL HEALTH CARE SECTORS

“In Cameroon today, patients seek healthcare services from the three aforementioned sectors (Mounyol à Mboussi 2006: 253). The public and private medical care being concentrated in urban areas (i.e. Douala, Yaoundé), it is used only by 25% of the population. Traditional healers are widespread both in rural and urban area, and their services are relatively accessible and affordable while providing health care to 75% of the population. In Cameroon, traditional healers and biomedical doctors work independently from each other. While biomedical clinicians have known reluctance to collaborate with traditional healers, a few biomedical clinicians nevertheless engage in some sort of informal interactions with the latter (Wamba 2005).

### 4. RECOGNITION AS A STAKE OF FIGHT AND CONTROL IN HEALTH FIELD

Experiences of collaboration in Mali revealed that biomedical practitioners were interested in traditional healers mainly because of the possibility to discover pharmaceutical values of the medicinal plants (Tinta 1993). Consequently, some traditional healers have become reluctant to release information to biomedical practitioners because “they [healers] protect themselves against exploitation by Western researchers and pharmaceutical companies. They also do not wish to be seen as weak junior professionals of low status” (Meissner 2008: 901). Studies have revealed that the WHO has used collaboration as a pretext for maintaining control over traditional medicine perceived as a counterbalance to conventional medicine (Gruénais & Mayala 1988; Hours 1992). From this point of view, the problem at stake is competition and fight over the control of fields of health practices between traditional healers and scholarly educated medical doctors. Moreover, differentiation among knowledge objectivation modes appears to be the basis for relations of sociopolitical domination, according to (Bourdieu, 1987). Building on Bourdieu’s concept of field (Bourdieu 1976: 92), one can say that biomedical and traditional medicines are two fields fighting to control

health practices. At stake in this fight is the control of power; a power consisting primarily of imposing the biomedical's definition of health in conformity with its political, economic, social and scientific interests.

Thus, apart from collaboration experiences in some regions of Ghana (Tabi, Powell, & Hodnicki 2006), and Tanzania (Stangeland, Dhillion, & Reksten 2008), very few have been successful (Green 1988). One of the factors responsible for this is the failure to truly integrate the work of traditional medicine with biomedicine, as opposed to placing traditional medicine as a simple annexation of biomedicine, with the corresponding power imbalance it betokens (Dozon & Sindzingre 1986). In the hope to change this, some African researchers have placed their hopes in the WHO's model that advocates for the various health sectors to induce profound modifications that would lead to innovation in care (Bibeau 1979, 1984; Nguete, Bibeau & Corin 1979; OMS 1976). Though interesting, this method did not yield its desired results for two reasons: first because the initial idea was the brainchild of biomedical practitioners and, second, because traditional healers, who were the major stakeholders, were not consulted from the onset (Bastien 1987). WHO's model appeared ill adapted to a key principle of social innovation, namely the participation of all stakeholders (Kloos 2005).

In her study on collaboration in Cameroon, Hillenbrand (2006: 1–2) showed high degrees of interaction, strong stated desire for collaboration, and several fairly organized attempts at improved collaboration. Her study also highlighted the actual mistrust between the three medical sectors, for some of the reasons named above: that biomedical practitioners were after medicinal plants, for example. Apart from this study, in the case of Cameroon in particular, the few researches that have explored the reciprocal relationship between indigenous medicine and biomedicine have not been able to show the ways in which practitioners participate in the construction of collaborative mechanisms to settle their differences (McMillen 2004). Indeed, in many African countries collaboration between healers and biomedical clinicians have focused either on describing the actual lack of cooperation between the two (Kayombo et al. 2007), or on the identification of the obstacles to collaboration limited to the policy level (Kaboru et al. 2006: 1). These investigations were limited to the report of an imbalance in knowledge and power between health workers of different health sectors. In light of the health care situation of Cameroon, likewise many other African countries, there is a need to produce knowledge on the construction of collaborative methods and a process that highlights the ways, disagreements and conflict are negotiated between traditional healers and biomedical clinicians involved in a collaboration process of care. In our study, our focus is on exploring the process by which agents from different formal and informal health sectors can actually construct collaborative processes in a way that supports reciprocity between traditional healers, prophets, priests, and biomedical practitioners. Before doing so, we give a brief background on the place where the study has been conducted.

## 5. METHODOLOGY

The data presented in this article were collected during fieldwork carried out in Yaoundé, Cameroon from March to May 2006, in preparation of the PhD thesis of the first author. In Yaoundé, traditional medicine, biomedicine, and religious healing practices cohabit. Participants in the study were chosen through purposive sampling. This technique increased the chances of selecting therapists whose knowledge permitted them to address the research objectives. Participants were also selected based on the criteria of perseverance: in the sense that the study lasted approximately three months, and only individuals committed to stay till the end were chosen so that result should accurately reflect initially collected data. Seven of the thirteen therapists we had contacted were selected. They included two traditional healers, two biomedical practitioners, two exorcist priests, and one prophet. They represented, respectively, traditional medicine, biomedicine or conventional medicine, the Christian religion, and independent churches of the prophetic movement. The sample size was limited to seven since, beyond this number, it becomes difficult to verify the effective participation of all members and to observe group dynamics (Anzieu 1990). We used four different methods of qualitative data gathering: individual interviews, group interviews (focus group), self-confrontation, and confrontation (Clot, Faïta, Fernandez & Scheller 2001). The two last methods were based on the audiovisual material of the focus groups in which two or three sequences were selected for each participant. They were used mainly to appreciate the impact of the focus groups on the participants that participated in the focus groups (Kitzinger, Markovà & Kalampalikis 2004), and to introduce the participant's point of view in the analysis of data. The combination of these methods contributes to enhance the credibility or internal validity of the data, a known strength of qualitative research (Groleau & Cabral 2009; Groleau, Young & Kirmayer 2006). All participants were informed from the start that data to be collected were to remain confidential and that participants' identities would be kept secret.

### 5.1 INDIVIDUAL INTERVIEWS

Individual interviews allowed us to select two clinical topics to serve as a springboard for discussion: malaria and sickle cell anemia. The latter is a hereditary disease that provokes stoppage of blood flow in the capillaries. It is marked by the presence of an abnormal S hemoglobin (sickle hemoglobin) in red blood cells (Lainé 2004). Though these topics have a biomedical resonance, we chose them because all the research participants knew them.

## 5.2 FOCUS GROUPS

Focus groups bring together participants with or without similar experiences to discuss a specific topic of interest of the researcher. They are based on the interactions between participants and are used as an instrument for collecting data (Krueger & Kasey 2000). The groups in this study discussed various clinical topics. Discussion sessions were led by a moderator (the first author), who introduced the clinical topic and encouraged participants to delve further. Participants and the moderator sat at the same table. An observer was seated in the background and noted the major themes covered. The latter also had the logistical role of video recording the sessions. Four sessions were held, separated by approximately one week. The discussions were conducted in French with each session lasting an average of two hours with four breaks.

## 5.3 SELF-CONFRONTATION INDIVIDUAL INTERVIEWS

The self-confrontation interview (Clot et al. 2001) consisted of viewing the video recorded sequences with each participant. Through questions prepared in advance, dialogue is generated with individual participants, who explain their position and the difficulties they encountered in their particular practice. Self-confrontation is an instrument of self-examination that places participants in a position of self-analysis vis-à-vis their own practice, thus enabling them to step away or depart from their usual analytical framework and to re-examine, with hindsight, their perceptual categories. Confronted in this way with their own practice, participants relive what they said or did in a new context and recall what they omitted or ought to have said or done. Self-confrontation indirectly measures the participant's adoption of a new stance towards themselves and their practice.

## 5.4 CONFRONTATION GROUP INTERVIEWS

In confrontation interviews, participants are confronted with each other's activities in pairs. The dialogue is maintained between the two participants. The researcher's role is limited to keeping the analytical framework in focus and revisiting each participant's point of view so that it may be analyzed by the other (Kostulski & Clot 2007). The objective is to encourage professional debate on each other's approaches and to go beyond "well-known territory" to discover new possibilities. In our study, traditional healers, biomedical practitioners, priests, and prophets, in turn, were confronted with each other's video recorded sequences. Such confrontation allows participants to formulate assumptions about each other's positions. It involves an indirect assessment of the changes in a participant's position vis-à-vis other participants and their practices. Through

confrontation, one understands how differences in practices are perceived, and transcended; and sees where and how practitioners meet and diverge.

## 6. CONCEPTUAL APPROACH GUIDING THE ANALYSIS

Our first step was to confront participants in order to determine factors giving rise to conflict or consensus in order to pinpoint those fostering collaboration. This dual approach calls for a triple analytical framework emphasizing collaborative actions. The first, namely strategic analysis (Crozier & Friedberg 1992), focuses on the interactions that favor some therapists over others, and how one wins acceptance of their mode of practice by remaining different from others. The second, namely symbolic interactionism (Blumer 1937; Le Breton 2004), is a methodology for analyzing interactions that allows an understanding of the conflicts between various agents. The third framework, the theory of translation allows a problematic statement to be translated into a problematic statement of another language or form of knowledge (Callon 1975).

## 7. RESULTS

Two categories of collaborative processes emerged between traditional healers, prophets, priests, and biomedical practitioners that participated in this study. The first category, that we named, therapeutic referrals, involves the exchange of patients between therapists. The second category of collaborative processes, that we named cooperative discourse, involves discursive and cognitive practices. In the following section, we will define and provide examples for these two collaborative processes.

### 7.1 FIRST COLLABORATIVE PROCESS: ‘THERAPEUTIC REFERRALS’

Therapeutic referrals involve the referral of a patient by a therapist to another, as illustrated in excerpt #1:

*Priest #1:* «When I am not capable of treating some disease, I refer the patient to another more experienced exorcist like Rev. Father H. When it is a disease that can be treated with modern medicine, honestly, one should go to the hospital. However, I have not had occasion to send a patient to a traditional healer.»

*Healer #2:* «When it is difficult, I look where the ancestors guide me. If they ask me to direct the patient to the hospital, I ask them to go straight to the hospital. If it is to some other healer, I give the name to the patient. If the case requires exorcism, I direct the patient to a priest.»

*Prophet*: «I send patients to traditional healers or to the hospital. I also send them to the priest I talked about before.»

*Biomed #2*: «I admit that I have never referred a patient to a healer. When I cannot treat a disease, I try to think of a more experienced MD who is better placed to handle the case.»

In excerpt #1, relations between therapists are established through patients who are shuttled from one medical practice to another. Such relations are structured by two mechanisms: internal therapeutic referral and external therapeutic referral. Internal referral involves the exchange of patients between agents of the same health system, such as a traditional healer referring a patient to another traditional healer. Discussions revealed that all participants engage in that practice.

External referral involves the exchange of patients between agents of different health systems, such as a traditional healer directing a patient to a biomedical practitioner. The analysis of this form of exchange reveals three kinds of patient exchange: 1) reciprocal exchange (traditional healers refer patients to prophet and vice versa) was rarely practiced by participants, except in the isolated case of exchanges between traditional healers and Prophet; 2) discriminatory exchange (priests refer patients solely to biomedical practitioners and not to prophets or traditional healers); 3) unilateral exchange (traditional healers, priests, and Prophet refer patients to the biomedical practitioner but do not receive patients directed to them by the latter). Regarding collaboration, the results suggest that there is an imbalance in the exchange relations between health practitioners.

The referral relationship between the group of traditional healers and prophets, and the group of priests and biomedical practitioners, is unidirectional. Indeed traditional healers and prophets refer some of their patients to priests and biomedical practitioners, while the latter group of practitioners does not refer patients to the former. We therefore coined the first group as “universal donors” and the second as “universal receivers”. The “universal receiver” position of the biomedical practitioners can be explained by the biomedical deontology that forbids biomedical clinicians to refer patients to non-biomedical practitioners. But, this position does not prevent patients to establish links between biomedical and alternative or spiritual practices. In the context of the fight against HIV/AIDS for example, the experience of collaboration also showed in many African Sub-Saharan countries that HIV patients went always from traditional healers to biomedical practitioners (King 2005). The unidirectional patients’ referral is the consequence of the lack of a strong recognition based both on the law and on the economy. Although the ban on traditional medicine practice has been lifted since 2007, these two recognitions are not yet effective, thus contributing to the roots of conflicts between official and non-official practitioners. On recognition based on the law, one of the healers note:

“The Government recognized us, healers. But this is insufficient, because there is no law that protects us in our profession. So we need a law that



allows patients to see us as they also seek doctors. if I can confess something: do you know that very often we prescribe traditional medicines here based on the results of laboratory tests that a doctor prescribes to the patient? We do this regularly in the case of diseases like Chlamedia, malaria, diarrhoea” (Healer #1). On recognition based on the economic, another healer says: “In focus groups, the doctors said that we have no right to take money from the patients, because for them, we are illiterate. But today, many healers have gone to school. There are even some who have Bachelor's degree in Biology. I went to school. I can read and write. One cannot any more mislead me. So things have changed. It's not like in the days of our ancestors, where they gave free medicine to patients. Some medicinal barks become very expensive. They cost money to buy them. But at the hospital, everything is paid for by patients: the ticket of cession, the book consultation, drugs. We will fight as long as possible in this medicine, because health has become a field of trade” (Healer #2).

Even though biomedical practitioners are considered universal receivers, our study showed that when patients transit from one practitioner to another, they contribute to create a discursive space between traditional medicine, biomedicine, animistic and formal therapeutic religions. In Africa, some reciprocal collaboration experiences have been seen in Ghana (Tabi et al., 2006); in Tanzania with Tanga AIDS Working Group (Stangeland et al. 2008); and in Uganda with Traditional and Modern Health Practitioners Together against AIDS (THETA 1999). As Pordié (2008) indicated in the case of India, these experiences were focused on the practical applications, which take into consideration only the pharmacological aspects of the medicinal plants. However, these aspects alone are insufficient to provide better care in a society where severe poverty characterizes most people's daily life, and where people cling to religion hoping for a miracle. Because, the ritual need does not dissociate in traditional societies from the quest of health. Some national Health care systems try to combine pharmacopeia and ritual need. In Brazil, the Barreto's therapy community team owes its success to the respect of equality between biomedical doctors, healers and priests with regards to knowledge and power in the healthcare field. In this team reciprocal exchange between biomedical and alternative or spiritual practices has been seen, because all health practitioners were part of medical apparatus. In some situations, the skill and talent of a medium or prophet were associated with certain clinical situations when it comes to evil spirit (Boyer & Barreto 1996: 153, 155). In addition, medical student were accompanied by traditional healers during their internship in social medicine, while future priests were also in the favelas [poor quarters], where lived medium and prophet, for training in psychology and sociology of traditional religion.

## 7.2 SECOND COLLABORATIVE PROCESS: COOPERATIVE DISCOURSE

Cooperative discourse is a discursive exchange that generates reciprocal influence among participants. It emerges within the context of discussion groups, and evolves in the presence of several practitioners. Cooperative discourse is marked by direct interactions and exchange of information and points of view among practitioners. Two exchange mechanisms were identified: convergent and divergent discourse.

## 8. CONVERGENT DISCOURSE

Convergent discourse, emerges when participants agree by adjusting their positions to each other after one presented an idea. In the case of one of the clinical topics, sickle-cell anaemia, participants' points of view were mutually oriented towards achieving consensus, as illustrated below (Excerpt #2):

*Healer #1*: «When a child is suffering from asthma, backache, tradition recommends that we search the child's blood to determine whether they have good blood in relation to the parents»

*Biomed #1*: «You are talking about searching the blood. How is that done in concrete terms?»

*Healer #1*: «Searching the blood is the expression that our parents used in the past.»

*Biomed #1*: «But how is blood searched?»

*Healer #1*: «In hospital.»

*Biomed #1*: «Ok. The child goes for blood tests because there is the Emmel test to diagnose...»

*Healer #1*: «Yes.»

*Biomed #2*: «Is that what searching the blood means? Indeed, to my mind, I thought that it meant carrying out some practices to help you determine the child's problems.»

*Healer #2*: «But that dimension is not to be discarded. In traditional medicine, there is what we call [ngambi]: clairvoyance. Through the ancestors, [ngambi] reveals to the healer that the child has bad blood, but does not give details. So, the child is sent to the hospital for the doctor to determine whether their blood is normal.»

*Prophet*: «For that particular disease, we first turn to traditional practice and only go to the hospital later.»

*Biomed #2*: «So, it is both? But the diagnosis is confirmed in the hospital.»

*Priest #1*: «Exactly! The people always consult an “nganga” (diviner) first before going to the hospital.»

The illustrative sequence above confronts divination with the Emmel test, two methods for diagnosing sickle-cell anaemia used respectively by traditional medicine and conventional medicine. The first is a procedure for generating truth through prediction in order to identify an illness's etiological factors and possible treatment. The second is a test for identifying sickle-cell patients by isolating a drop of their blood and placing it between two slides. If, in the absence of oxygen, the red blood cells take on a crescent shape, then sickle-cell disease is diagnosed.

According to Healer #1, who initiated the idea generating the controversy, when traditional medicine suspects sickle-cell anaemia, it recommends that "we should go and search the blood," as shown in the following excerpt:

*Healer #1:* « [...], quand l'enfant arrive et qu'il a différents symptômes, parfois des crises d'asthme, la bronchite accompagnée de ce ballonnement (du ventre) et les douleurs osseuses et le fait que l'enfant ne grandit pas. Ca nous amène à nous poser des questions, et après avoir posé le diagnostic, manqué des réponses à plusieurs niveaux, on demande à voir traditionnellement ; on disait que on aille fouiller le sang de l'enfant pour voir si l'enfant a le bon sang par rapport à ses parents. Donc traditionnellement, c'est un peu ça qui se faisait.»

*Biomed #1:* «Est-ce que je peux lui poser une question?»

*Chercheur:* «Oui, vous pouvez. Allez-y.»

*Biomed #1:* «Vous parlez de "on envoie fouiller le sang". En l'absence de l'électrophorèse, ça se traduit par quoi?»

*Healer #1:* «Quand je dis fouiller le sang, je dis un peu le langage que nos parents utilisaient auparavant.»

*Biomed #1:* « Oui. Mais il pose cette question, et il dit : il faut aller fouiller [...] ; il demande d'aller fouiller le sang. On va fouiller le sang, c'est en l'absence [...] ?»

*Healer #1\_FG1:* «Non, c'est à l'hôpital. On va fouiller à l'hôpital.»

*Biomed #1:* « D'accord. Donc on est toujours dans le même [...]. Donc on quand même dans l'optique de la présence de l'hôpital. Ok. Donc, il va faire les tests à l'hôpital ?»

*Healer #1:* «Oui.»

*Biomed #1:* «C'est ça qu'on appelle fouiller le sang. Parce que dans ma compréhension, c'était ceci : on va fouiller le sang, cela voudrait dire que on irait quelque part, on exercerait quelque chose de certaines pratiques et rites traditionnels à partir desquelles on comprendrait que l'enfant a des problèmes, je veux qu'il est drépanocytaire.»

*Healer #1:* «Mais ce côté n'est même pas aussi à ignorer, parce que dans la tradipratique, il y a ce qu'on appelle le "Ngambie": la voyance. Tout à l'heure on a parlé d'un voyant hein, qui est très prêt à détecter que ça doit être ça [la drépanocytose]. Mais à nos jours pour la confirmation, on envoie toujours faire ça à l'hôpital. Parce que généralement, quand les papas lançaient leur Ngambie ou bien leur cauris de voyance, on les fait savoir que l'enfant-ci a un mauvais sang. Mais les cauris ne vous disent

pas, ne vous donnent pas le groupe sanguin, ne dit pas ceci ou cela. Puisqu'on sait déjà que cet enfant a un mauvais sang, bon va donc à l'hôpital pour que le docteur essaie de fouiller pour voir si ton sang est normal.»

The biomedical practitioners took an interest in divination and wanted to know the tools used by traditional healers for diagnosing the disease. Biomed #1 asked the following question: “how is that done in concrete terms?” As revealed by our participant, the question was not intended to destabilize the traditional healer’s position but to have him explain his procedure further. The latter responded “in the hospital,” which was contrary to what the biomedical practitioner expected. Though the traditional healer's response was perceived as biomedically correct, there was a degree of ambiguity in his exact position. The biomedical practitioner was relatively satisfied, for he assumed that “in traditional medicine there must be practices” for diagnosing sickle-cell anaemia. The biomedical practitioner's preoccupation corresponded to a dual concern: on the one hand, knowing that there is a diagnostic method specific to traditional medicine; on the other hand, knowing how such a method is validated. Healer #2 benefited from the biomedical practitioner’s stance by adjusting his position to the latter’s: “...there is clairvoyance” (one of the divinatory methods).

According to the prophet, divinatory diagnosis does not rule out biomedical testing. This idea is developed further by the biomed #2 and the priest #1. As such, these participants expressed their agreement by adjusting their positions to one another. Their statements contribute, through adjustment of varying points of view, to the mutual acceptance of the first speaker’s position (healer #1). Accordingly, there was a convergent formulation of the idea that divination and the Emmel test could be considered complementary diagnostic techniques. Adjustment thus appears as a general regulation mechanism co-constructed by participants.

## 9. DIVERGENT DISCOURSE

We also identified divergent discourse, which engenders socio-cognitive conflicts that emerges when there is confrontation of different interpretations (of the disease). The following excerpt #3 is an example:

*Prophet:* «If a child convulses because of the bird disease (malaria), I carry them and put their head in a latrine hole. We burn the bird pepper. If the child sneezes, then the convulsion is over.»

*Biomed #1:* «I have not studied traditional healing, and it is difficult for me to recommend it to somebody.»

*Healer #1:* «That reaction is surprising. I think a medical officer should give a family the latitude to save their patient with the traditional method

they can afford. You (medical officers) do not want to take the risk of advising a patient to go to a traditional healer.»

*Priest #2:* «My grandmother used to stop convulsions using that method. But I am against it.»

*Biomed #2:* «Latrines are not clean.»

*Biomed #1:* «Personally, I tell myself that when we turn the child upside down, blood flow caused by gravity improves in the brain. As a result, oxygenation and irrigation of the brain increase. This is physiological. That is my explanation of the phenomenon. I think the outcome is normal.»

*Healer #2:* «Yes! Exactly, when the child sneezes, he or she is taken to the hospital.»

*Biomed #2:* «It is the result that is normal, but the medical technique is not convincing.»

*Biomed #1:* «Those who do not consider the technique normal are those who are evaluating it. I am not interested in evaluating the act, but in its result.»

The socio-cognitive conflicts here were sparked by the debate around the traditional technique for stopping convulsions, a serious complication of malaria in children. According to Prophet, “when the child convulses, we traditionally turn them upside down in a latrine hole to stop the convulsion.” Such is the method used in rural areas where people do not have easy access to biomedical health facilities.

Though known to participants, the traditional healer’s method sparked strong debate. Priest #2 and Biomed #2 were against the method because it is not hygienic. Biomed #1 said that he was not for or against it because he has not studied it. His response was perceived by Healer #1 as evasive. It could also be explained by the fact that Biomed #1 did not want to publicly take a stance about local techniques for arresting convulsions. Two opposing arguments developed on this subject. The first, defended by the traditional healers and Prophet, favoured the use of the traditional method for arresting convulsions. The second, defended by Biomed #2 and Priest #2, was against it. The second argument questions the traditional method by raising the issue, on the one hand, of the validity of such techniques, and on the other hand, of the status of local knowledge with respect to conventional medicine. This argument is grounded in common ideology regarding the power granted to biomedical practitioners by academic institutions. Mid-way between these two arguments, Biomed #1 tries to understand the approach of traditional healers without legitimizing it. By turning the child’s head upside down, he argues, “blood flow caused by gravity improves,” thus helping oxygenation of the brain.

According to Biomed #1, although the approach of traditional healers can pose a problem of hygiene, it produces a perceptible physiological health result. Biomed #1 was thus able to find a compromise between the participants by explaining the empirical technique of the traditional healers in biomedical terms.

Compromise thus appears as a general conflict regulation mechanism that helps to transcend professional debate. Compromise is the negotiated result of new points of convergence between several systems initially opposed to one another. The position of Biomed #1 could easily contribute to building bridges between the various health sectors.

## 10. CONTRIBUTION OF SELF-CONFRONTATION AND CONFRONTATION TO DATA ANALYSIS

In the next section, we will highlight how the self-confrontation and confrontation interviews help to understand why biomedical practitioners and priests expressed reluctance in building reciprocal relationships. During the self-confrontation interviews, biomedical practitioners justified their reluctance based on the fact that they could not ascertain the academic training of traditional healers and prophet as illustrated by the following excerpt (Excerpt #4):

*Biomed #2:* «I think it is an ethical problem in biomedical training. Professional ethics does not authorize experiments on human beings. When one does not have proof that a therapist's cure is based on proven academic experiments and references, we do not get involved.»

In the case of priests, the absence of reciprocal collaboration seems to be due to a fear of excommunication for maintaining relations with traditional healers (Excerpt #5):

*Priest #1:* «I hope my bishop is not there because otherwise, things would be rough for me for having accepted to participate in this kind of meeting in which we are discussing health issues with traditional healers.»

In both cases, the absence of reciprocal relations seems to be linked to compliance to ethical and institutional rules aimed at protecting conventional medicine and Christian religion from competition with traditional medicine and ancestral religion respectively.

## 11. DISCUSSION

The processes of therapeutic referral and cooperative discourse allow health agents to carry out various forms of collaboration. However, some of the mechanisms used by health agents are not relevant to structuring reciprocal and lasting collaborative relations. In the next section, we will discuss, in light of our results, mechanisms that are both relevant and non-relevant to collaboration.

## 11.1 INTERPRETATION OF THE LOCAL MODEL OF THERAPEUTIC REFERRAL

The process of therapeutic referral uses two collaborative mechanisms: internal and external therapeutic referral. These two mechanisms underpin the actions of health agents who refer patients in relation to a network actor logic (Crozier & Friedberg 1992), in which the network is made up of agents who may or may not belong to the same health system. Internal and external referral mechanisms reveal two networks: homogenous and mixed. Homogenous networks are made up of members of the same health system; mixed networks are made up of members of different health systems. According to the sociology of organizations, the relevance of collaborative mechanism is measured by its capacity to establish reciprocal exchanges between members of alternative health systems (Amblard, Bernoux, Herreros & Lidivian 2005). In this case, the internal referral mechanism is not relevant and is, in fact, a barrier to successful collaboration. It does not meet the expectations of patients and is less suited to therapeutic resource innovation.

Our study shows that biomedical practitioners favour a homogenous network, which limits patients' access to other health systems and tends to restrict the diversity of health care models. It could also have a negative impact on the promotion of public health, especially in Cameroon, where biomedical practitioners are known sometimes to threaten to suspend treatment of patients who consult traditional healers. Christie (1991: 549) notes that in Norway, still, "some patients are afraid to tell their doctor that they visit alternative practitioners. They feel that this dishonesty spoils the trust between doctor and patient."

On the other hand, the external referral mechanism is relevant to effective collaboration. In organizations, external collaboration is considered to be the most productive source of knowledge innovation (Crozier & Friedberg 1995). Apart from the reciprocal exchanges between traditional healers and prophets, our results revealed an absence of effective collaboration on that level: priests and biomedical practitioners refusing to refer patient to traditional healers and prophets. This refusal bespeaks to power relations inherent to these professions. First, biomedical ethical rules prohibit medical doctor to collaborate with non-biomedical practitioners or practices. Second, catholic ethics, also prohibits relations between the clergy and local animistic competing religion. Catholic religion and biomedical practice are linked ,in that they have positioned themselves in colonial action as fields of power (Hardiman 2006: 14; Fandio & Madini 2007: 132). The unidirectionality of referrals as a phenomenon, thus replicates the politico-historical relations between professional traditions of the colonizing nation and local traditions of the colonized nation. From this standpoint, we argue that unidirectional patterns of referrals reflect political, historical and institutionalized power relations. We would like to stress here that the reference to colonialism is explained by the fact that African doctors are

regarded as successors of white doctors. They have replaced the white colonizer and have become in their turn the black colonizers. And according to Singer (1977: 68), the ruling white colonialists in recently independent countries of Africa have been supplanted by a newly emerged African urban managerial class. In his words, this newly class is «part of a continuing socio-economic exploitation. The author suggests that traditional healing is encouraged as part of a new colonialism». But what is more interesting here is that «universal donors» and «universal receivers» are both here complicit in the maintaining of asymmetry power.

## 11.2 RELEVANCY OF COOPERATIVE DISCOURSE

Cooperative discourse has a relative advantage over therapeutic referrals. The latter is considered a general mechanism that occurs during collective activities in which participants learn to cooperate and negotiate their differences in the context of confrontation group interviews. In this regard, we can argue that the inability to develop effective collaboration between health agents of different health system could be attributed to the absence of collective learning experiences. In our study, such learning took place in group interviews that are similar to concrete action systems (Amblard et al. 2005; Crozier & Friedberg 1992). Through cooperative discourse, focus groups create an environment of dynamic exchange, enabling health agents, on the one hand, to learn from each other, and on the other hand, to understand and recognize the limits of their own practice and that of others. Such recognition can help break down resistance and create the opening to other therapists (Koenig 2006). In our study, adjustment and compromise strategies enabled practitioners to share some point of views and to establish various levels of dialogue between the different health sectors. In the case of the diagnosis of sickle-cell anaemia, adjustment allowed participants to reconcile the various diagnostic techniques available, i.e. the Emmel test was considered complementary to the divinatory diagnosis of traditional medicine (Excerpt #2). Thus, through complementary interplay, practitioners were able to achieve a meta-diagnosis that enabled them to go beyond the appearance of irreconcilable ontology and epistemology of biomedical and traditional medicine. In the debate over the treatment of malaria (Excerpt #3), Biomed #1 was the compromise broker, because his contribution helped to find biomedical correspondences and interpretations of an empirical procedure used by traditional healers to stop convulsion. Practitioners meet at the level of the results of this procedure. In fact, these meetings were so fruitful that they led the participants to create a collaborative health association they called «Progrès, Santé par Espèces Naturelles» (PROSENAT), through which they continued meeting and carried out exchanges with regard to knowledge sharing and exchange of patients.



This outcome differs from that of other studies on collaboration in two ways. The first reason relates to methodology. Focus groups played the triple role of data collection, cooperative mechanism, and cognitive tool (Kitzinger et al. 2004). As a cognitive tool, it enabled participants to identify barriers to collaboration and to use this knowledge to bring about change. Focus groups has also facilitated the creation of PROSENAT that can then compared to the community group therapy described by Barreto, a psychiatrist in Fortaleza, Brazil (Boyer & Barreto 1996), that was successful because both healers and priests were part of the same community therapy with biomedical practitioners and psychiatrists. It can also be compared to the Tanzania Working Group on AIDS, an interdisciplinary group, which includes biomedical physicians, service providers, traditional healers, social scientist and botanists (Stangeland et al. 2008). We acknowledge the fact that the study is based on a small purposive sample. And one could reproach us the attempt to generalizing the findings from a small sample to the entire sectors: traditional, religious and biomedical health practitioners. But we would like to mention that the objective of the methodological approach we choose is obviously not the representativeness, even though the lack of representativeness constitutes a methodological bias. But this bias has been overcome by varying, on the one hand, the scales of observation: four research methods have been combined: individual interviews, focus group interviews and post focus groups interviews [self-confrontation and confrontation]; and on the other hand, by diversifying the sample: all people who work as health practitioners has been included in the sample, namely healers, prophets, exorcists priests and physicians. The variation of observations scales and the diversification of the sample constitute the guarantee of the validity of the results and that of research methodology.

### 11.3 WHERE DIVERGENCE ARISES

Practitioners diverge at two major points, namely, ethics relating to the medical profession (i.e. Excerpt #4 and #5) and therapeutic approaches of malaria (i.e. Excerpt #3). However, these points alone are not sufficient in explaining the resistance biomedical and priest practitioners have against traditional healers and prophets. In the sense the main point regarding this resistance is a matter of fight and competition to control political, economic and social power in health field. Historical analysis suggest that such resistance is a perpetuation of the social order imposed by and inherited from colonialism expressed in a two-fold negation (Fassin 2000: 81): 1) the denial by African countries and WHO of a professional status for traditional healers within medical faculties; 2) the denial by churches of the existence of an African religion. This two-fold negation is also known to prevent traditional healers and diviners or prophets from performing the political and health roles embodied by traditional medicine. Furthermore, the dismissive attitude of biomedical practitioners is another way

to show to healers that they are the official health authority, who possess the legitimate social and authorized competence in the field of health. Therefore, they express their dominant position through refusal to refer patient to healers, as the data from interview show: *“In all countries here in Africa, medical doctors are not used to send their patient to the healers, because that would reverse the order of things”*. (Biomed #2). Although it appears that biomedical hegemony is not yet challenged today, the results of our study suggest that this hegemony is now broken through: *“According to my experience» said one interviewee, I feel that, as paradoxically as it may appear, patients go more and more to the healers [...] healers have made names, they are consulted. One does not support any more these people who play with the health of the patients, whereas they do not have any education”* (Biomed #1).

In fact, the number of people consulting traditional healers is beyond expectation both in urban and rural areas. Due to the resilience of traditional healers to give up their practices some biomedical practitioners are now ready to accept traditional healers as their partner: *“ [...] After focus groups, I discover another face of the healers. I cannot totally reject any more en bloc what they say, since some have proven their effectiveness. Maybe now, I could tolerate, because before it was not easy to accept. They are a possible therapeutic pathways”* (Biomed #1). Therefore, *“I will respect and accept the patient’s choice now, because it is a sacred law in therapy. If he chooses the bark of the healer, I do not oppose it, although, paradoxically, I could not refer him to the healer”* (Biomed #2). This acceptance implies at the same time that biomedical practitioners are now open to the diversity of treatment options and therapeutic pluralism: *“Here! I take for example a patient who consults here in Cameroon, in Yaoundé where we are. He may, depending on his etiological model of representations of illness, go to Jamot hospital, a renowned psychiatric hospital in Yaoundé; he may choose a priest exorcist, if he is a Christian, etc. There is the Catholic mental health center Benoit Menni at Mvolyé [Yaoundé] that receives and cares Catholic patients. Here! There are healers here in Yaoundé who receive also patients who are quite simply convinced that their disease is of mystical origin. We must now admit that.”* (Biomed #1)

On the one side, reciprocal affinity has been found in this study between traditional healers and prophets, and it seems to be the consequence of the resistance biomedical and priests practitioners have against them. Although they belong to Christian churches, prophets evolved from diviners (Barret, 1968; De Rosny 1981, 1992, 2004); they represent the mystical resistance to colonialism and the churches (Boahen 1989: 447; Rétif 1959). Moreover, the prophetic movement started in Africa, as said Bureau in Ivory Coast context (1976: 47), where the implantation of the Christian church was very ancient. In the case of Cameroon for example, first missionaries arrived in Douala around 1943 (Bureau 2002). The prophetic movement supported the political party of Houphouët-Boigny in Côte d’Ivoire during that country’s struggle for independence. Thus, the affinities between traditional healers and prophets may

be interpreted as a strategic relationship for re-establishing the socio-political power destabilized by colonialism.

On another side, absence of reciprocal collaboration has been also found between prophets and priests, and it thus seems to be the result of a conflict of charismatic legitimacy. The non-reciprocal collaboration between traditional healers and biomedical practitioners would be the result of a conflict of social legitimacy (Le Breton 1990). However, between biomedical practitioners and priests the problem cannot be explained by a conflict between charismatic and official legitimacies. As described by Hardiman (Hardiman 2006: 14), “from the 1870s onwards the demand for medical missionaries became more vociferous. Increasingly, medicine was viewed as powerful aid to conversion. It was argued that in the heathen mind, religion and healing went hand-in-hand.” Both the Church and conventional medicine are considered state institutions with professional legally recognized status. The openness of priests to biomedical practitioners would seem to be because the latter’s “involvement in patient welfare was limited to their biomedical expertise [...] and because the actions of the Church were situated in the context of colonialism, in which the desire to civilize meant as much healing bodies as saving souls” (Dozon & Sindzingre 1986: 50; Dozon 1987). In the majority of colonized countries, religion and medical practice were viewed as intertwined, as illustrated by Lowe (1887): “In India, China, Africa, Madagascar and in almost every heathen land, crude systems of medicine are intimately associated with the religions of the people, and the treatment of disease, such as it is, is monopolized by the priests, or by others under their control.” In contrary, experiences of health seeking shows that patients created a space of therapeutic sociability where animistic, traditional healers, exorcists and formal biomedical practitioners are linked, through the mediation of patients who went from one health sector to another. When patients are sick, they seek a practitioner who will restore their health, and not the practitioner who benefits from official or formal legitimacy.

As stated by Weber, traditional, charismatic, and official legitimacies are used to describe the place of individuals and the hierarchy of practices within society (Weber 1959). Each type of legitimacy possesses a cultural wealth whose social prestige is measured by the “objectivation mode” of its knowledge. The objectivation mode of traditional healers knowledge is oral, while that of biomedical practitioners is written. Because the latter affords social legitimacy to medical practice (Le Breton 1990: 10), academic biomedical knowledge enjoys greater social prestige and legitimation than that of traditional healers, which is considered more difficult to formalize. Thus, social prestige and legitimation appears to be the basis for sociopolitical and economical fights. In *Social Space and Symbolic Power*, Bourdieu revealed that the issue of these fights depends on the social and cultural capitals of each field (Bourdieu 1987). Catholic church and biomedical practices enjoyed greater social capital than animistic religions and traditional medicines; hence, they constitute two models of domination. Through this two-fold domination, biomedical practitioners and priests replicate and perpetuate the domination of the colonizer over the

colonized. They became as (Young 1994: 23) says: “successors to the colonial regime, inheriting its structures, its quotidian routines and practices, and its more normative theories of governance.” The collaborative processes observed in our study remain part of an incomplete mediation, for they represent the action of only one group, and therefore merit further research and substantiation. It was not easy to access genuine traditional healers, for example those whose knowledge come from ancestors. Even though they participated in focus groups discussions, it took us one week to convince them. We have won their trust through a healer whom we knew during a previous research.

However, we would like to highlight the fact that the leap from Africa/world stage (WHO) to the specific case in Yaoundé [Cameroon] is mainly for the purpose of a broader contextualization of the collaboration issue. Such a contextualization allows distinguishing formal encounters from the informal encounters [built at the periphery], which can only be observed from therapeutic referral practices and interviews with practitioners of biomedicine, traditional medicines and therapeutic religions. We show, from observations of therapeutic referral practices between official and non-official health practitioners, that the collaboration of medicines initiated in Africa by the World Health Organization is ineffective for covering all forms of encounters [informal and formal encounters] between healers, physicians, priests and prophets. The results show that the formal and informal encounters are not necessarily opposed, to the extent that the biomedical and non-biomedical professionals are involved in their construction, despite the conflicts that characterize them. In addition, informal encounters are the result of compromise between the biomedical and non-biomedical systems of justification.

## 12. CONCLUSION

Our study has revealed the existence of a true collaborative between traditional healers, prophets, and priests. As for biomedical practitioners, they are willing to engage in reciprocal exchange of health care services, but their willingness is limited by the corporatist standards of biomedicine and the conflict posed by its epistemology. There is a need for biomedicine to alleviate its corporatist rules, especially in a continent like Africa where health knowledge is ancestral and needs definitely important. The use of focus groups however proved to have a positive influence on biomedical practitioners while constituting an excellent tool for mediating conflict between systems of meaning, and practices. Adjustment and compromise strategies enabled practitioners to overcome their differences and develop behaviors that promote open dialogue and true collaboration. The creation of PROSENAT also represents a real contribution to the promotion of public health, mainly for the collaboration efforts it offers to patients but also because it proves that formal collaboration is possible beyond the historical limits posed by colonialism.

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