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"You must only drink one cup": Revisiting the tension between *"Kikombe cha Babu"* and biomedicine in Tanzania

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Abstract

In 2011 tens of thousands of people from all over East Africa flocked to Loliondo in Tanzania seeking a cure for several diseases, including diabetes, tuberculosis and HIV. Ambilikile Mwasapile, a former Lutheran pastor, administered a miracle dose popularly known as "kikombe" charging about $0.33 for his concoction per patient. The Ministry of Health while concluded that the dose in Babu's "cup" was safe, it did not endorse such drink as a "cure." In this paper, I revisit the Traditional and Alternative Medicine Act of 2002 in order to understand the tension that exists between traditional health practice and biomedicine in providing health services in Tanzania. Using modernisation theory, I argue that although the 2003 National Health Policy declares that traditional medicine and biomedicine are complementary to each other, the law seeks to modernise traditional medicine. Consequently, traditional medicine has always been treated as lacking scientific validation, efficacy, safety and quality. This in turn has posed serious health risks to users of traditional medicine.

Keywords: Tanzania, Modernisation, Ambilikile Mwasapile, Biomedicine, Traditional Medicine

Introduction

The use of traditional medicine (TM) was recognized in Tanzania through the National Health Policy of 1996 and the Traditional and Alternative Medicines Act, No. 23 of 2002. It is estimated that between 60 and 80 percent of the population especially in rural areas depend on TM for primary health care.[1] Yet, there are over 80,000 traditional healers with healers to population ratio of 1:400 compared to 1:30,000 medical doctors to population ratio.[2] A recent study of HIV prevention and treatment indicates that most Tanzanians believe in traditional medicine:-

> …a high awareness of alternative treatments available in Tanzania, with 95.3% of 2,313 adults having heard of these treatments. Of

> those, 6.0% had actually sought the treatment, and 46.8% had an acquaintance to seek it. However, 81.0% indicated these treatments were not easily accessible. There is a high level of belief in the ability of these alternative treatments to cure HIV, with 44.0% of people who had heard of these treatments indicating they believe such treatments can cure HIV. Additionally, many people indicated having these alternative treatments available would result in decreased condom use (15.6%), no need to use condoms (94.9%), and no need to take antiretroviral therapy (81.7%). However, 57.4% indicated they would be more likely to get tested for HIV if alternative treatments were available. Belief in the ability of alternative treatments to cure HIV in Tanzania is high and should be further explored due to its implications for potentially sidelining HIV prevention and treatment initiatives (Kaufman et. al., 2014).

The above data indicates that the role of traditional medicine to Tanzanian people is significant. At policy level, it implies that traditional medicine should be improved and recognised to offer a complementary role to biomedicine cure. Notwithstanding, the legal framework is designed in such a way that it constrains the development of traditional medicine. Yet, Tanzania has a very long history of traditional medicine. Like many other developing countries in Africa and elsewhere, during the pre-colonial period, the governments of the tribal chiefs recognised the role of traditional medical practitioners, although there were no written policies. They were highly respected and often acted as famous advisors to the tribal chiefs on issues related to illnesses, environments, socialisation and behaviours. They were allowed to practice their knowledge and skills freely (Chirangi, 2013).

However, during colonial times both the German and the British colonialists made efforts to suppress the work and role of the traditional healers, while their foreign religious teachings were also against the practice of traditional medicine associating them with witchcraft (Stangeland, et al. 2008). This may have been done intentionally to suppress and discredit indigenous people from participating in the health sector or was just a misconception of Africa's indigenous cultures (Ross, 2008; Stangeland, et al. 2008). After independence in 1961, the government still did not grant official recognition to traditional medicine. This is notwithstanding the fact that in 1991 the government established the Institute of Traditional Medicine

(ITM) at Muhimbili University of Health and Allied Sciences (MUHAS) with the broad objectives of seeking materials of plant and animal origin that might be of medicinal value, and to establish a record of cultural significance (Stangeland, et al. 2008). In 1996, the United Republic of Tanzania (URT) through its National Health Policy for the first time recognised traditional and alternative medicine. The introduction of the policy was subsequently followed by the Traditional and Alternative Medicines Act, No. 23 of 2002.

There are several accounts as to why the majority people use traditional medicine as their primary health care in Tanzania. First and foremost is the fact that biomedicine is not adequate. Most of such services are limited in urban centres. This is attributed to underfunding the health sector. For example, Tanzania budgeted 8.9% of its total budget in 2011/12 financial year below the required 15% agreed during the 2001 Abuja Declaration. Surprisingly, in 2016/17 budget, the government allocated 3.4% of its total budget to the health sector. By any standards, underfunding the health sector affects provision of both the adequacy and quality of services. Related to this, another explanation is that prior to 1980s, Tanzania used to practice state-led economy under *Ujamaa*, a form of socialism. Under this system, all social services were provided freely of charge. In that case, one could access available health services without paying any money. However, in late 1980s Tanzania like many other African countries adopted the World Bank and IMF Structural Adjustment Policies which required among other things – cost sharing in order to obtain social services. Hence accessing biomedicine started to be something expensive taking into account that the majority people are poor and cannot afford medication. The third explanation is based on social cultural values. As hinted earlier, before the colonial regime came to Africa, African societies had their own cultural life and traditions which also informed traditional medicine. A traditional healer simply used certain plants and in some cases certain belief systems to cure diseases. This value is still entrenched in most communities. Taking into account that Tanzania has more than 120 tribes and most of the population (about 70%) live in the rural areas, it goes without saying that they will depend much on traditional medicine as their primary health care. The fourth explanation is that traditional medicine is natural and without any side effects. This has made it possible for some people even in urban areas to prefer traditional medicine to biomedicine. Lastly, with increasing spread of chronic diseases such as HIV-AIDs, diabetes and cancer which are not cured by biomedicine, traditional medicine which claims to cure such diseases is regarded as a referral.

Despite its popularity, the most critical issue with regards to traditional medicine is on its credibility. The literature raises issues of efficacy, safety and quality of the traditional medicine (Mbwambo et al, 2007; Adamu 2013; WHO 2013). The issue of credibility concerns lack of scientific validity, lack of appropriate dosing, lack of education, and lack of effective regulations to control traditional medicine (Stanifer 2015). It is on that basis, for example, the WHO has developed the 2014-2023 Strategy to assist in developing the traditional medicine sector. WHO further provides risks which may associate with the use of traditional medicines such as use of poor quality, adulterated or counterfeit products; unqualified practitioners, misdiagnosis, delayed diagnosis, or failure to use effective conventional treatments; exposure to misleading or unreliable information; direct adverse events, side effects or unwanted treatment interactions (WHO 2013).

Unlike the traditional medicine, biomedicine is considered scientific, universal and Western (Clyde, 1962). It was introduced into Tanganyika (formerly German East Africa) by the Germans in 1890. The purpose of biomedicine was essentially to serve the colonial masters present in the colony (Rodney 1972). It was due to this fact that though the colonial government did suppress traditional medicine, it was not possible as it was mainly used by the indigenous African people as their primary health care. It seems therefore that the tension between traditional medicine and biomedicine at that particular time was not only based on scientific validity but also socio-cultural values entrenched in African societies as well as availability of biomedicine for Africans. This tendency of looking at biomedicine as more superior to traditional medicine continued even after independence. The post-independent government continued to marginalise traditional medicine even though the majority people used such medicine as their primary health care. In 1996 the National Health Policy recognised traditional medicine and stated that traditional medicine and biomedicine are complementary to each other. Nonetheless, it is not clear from this policy which complements the other and to what extent (Kabyemela 2017). In this paper, I revisit one historical phenomenon of traditional medicine popularly known as *"Kikombe cha Babu"* in order to understand the law and practice in regulating traditional medicine. I argue that although there is a tendency by the government to regulate and set standards for traditional health remedies and practices, that trend is a contradiction since it compels traditional health practice to work like biomedicine. This implies that the government does not support for the co-existence between traditional medicine and biomedicine but rather seeks to modernise traditional medicine thereby abandoning traditionalism. Yet, despite the existence of the law, several traditional health practitioners are not registered thereby posing a serious challenge for the government to exert effective control over them.

"Kikombe" Phenomenon: A Miracle?

In 2011 tens of thousands of people from all over East Africa flocked to Loliondo in Tanzania seeking a cure for several diseases, including diabetes, tuberculosis and HIV. Ambilikile Mwasapile, a former Lutheran pastor, administered a miracle dose popularly known as "kikombe" charging about $0.33 for his concoction per patient. It is said that "Babu" used to collect up to around $ 7,500 per day. The dose was administered by "Babu" himself and no delegation to his assistants was allowed. He used to have a prayer and this was followed by the distribution and drinking of the medicine and collection of a small fee (Vähäkangas, 2016). "Babu" claims to have received dreams from God for a long period of time to prepare a divinely revealed medicine that can heal a person of practically any disease including AIDS, cancer, diabetes and malaria. The pick of his healing was between February and June 2011.

Photo: Rev. Ambilikile Mwasapile

Source: https://www.bbc.com/world-africa-12878811 (accessed 15.12.2018)

During the time of this miracle, several people came from Tanzania and other neighbouring countries. Since in Loliondo village there were no any developed infrastructure systems like roads, telephones, internet, it was extremely difficult to reach Babu. Indeed, it took several days in a traffic jam before one could manage to reach Babu. During this time most cars normally used for tourism had to carry people to Loliondo.

It is interesting to note that the political class comprising of senior politicians – especially ministers and senior government officials also went to drink the medicine. The Minister responsible for infrastructure pledged to construct roads to Babu's home. Moreover, the Ministry of Health decided to test the medicine in order to validate it scientifically through its organs the Tanzania Food and Drugs Authority (TFDA), the Institute of Traditional Medicine, the National Institute for Medical Research (NIMR) and the Chief Government Chemist. It was concluded that "Kikombe" was safe. However, the government stated that further research is needed to understand whether "Kikombe" is an effective medicine to cure HIV, diabetes, cancer, and malaria.[3] Today it is almost the eighth year since the "Kikombe" phenomenon without any outcome.

A survey conducted by Synovate between 2 and 19 May 2011 indicated that 78% of respondents 1,994 opined that the dose was effective to cure their diseases while 7% held that "kikombe" did not cure them.[4] This survey again seems to have endorsed Babu's medicine. Nonetheless, it was the Medical Association of Tanzania (MAT) which issued a bold statement against "Kikombe". The Association protested the Ministry to tell people the truth that Babu's medicine could not in any way cure diseases like HIV and cancer.[5] In short, the Association was concerned about peoples' health especially when they decided to abandon taking biomedicine in favour of "Kikombe". Indeed, it is said that the majority people died. It was not until June 2011, especially after the realization by most people that "Kikombe" could not cure their patients that its popularity suddenly waned. That was the end of this phenomenon. Recently, Babu has come out and advertised another miraculous cure but no one has paid attention. Babu has become very unpopular.

Tradition and Modernity: Revisiting Modernisation Theory

Modernization is a theory of change mainly from a traditional to a modern stage of development. Under this theory, societies are classified as either traditional or modern, partly on the basis of their structural characteristics (Hayes-Bautista & Minkler 1979). Traditional societies are thus described as agrarian, rural, non-scientific, with low level technology, and as having diffuseness of function, while, in contrast, modern societies are characterized as being industrial, urban, scientific, having a high level of technology, and by possessing high differentiation of function (Parsons, 1951). According to modernization theory, traditional structures and values need either to be changed to or replaced by modern ones in order that modernization might take place. The modernization process thus is held to be necessary, universal, and unavoidable (Lerner 1958; Rostow 1959; Eisenstadt 1964; Huntington 1971; Inglehart and Baker 2000). In his model of stages of development Rostow forcefully holds that underdevelopment is an original state concomitant with backwardness or traditionalism. In order to attain modernity, there is only one way of replacing traditionalism by imitating the economic development of the West. This can be achieved by exposing backwardness of the underdeveloped societies to the West through trade and investment flows. Huntington (1999) notes that as non-Western societies begin to modernize, they also often attempt to adopt many elements of Western Culture. In contrast, modernity stage is marked by mature and stable economy. Besides, a society ceases to accept the extension of modern technology as a primary, if not over-riding objective and instead it concentrates to offer, by public measures, increased security, welfare, and, perhaps, leisure to the working force; to provide enlarged private consumption including single family homes and durable consumer goods and services on a mass basis; and to seek enlarged power for the mature nation on the world scene (Rostow, 1959:11).

Based on the above, medical modernization can be conceptualised as that process by which a society changes its mode of achieving a healthy population from use of traditional non-scientific ways to modern, rational and scientific ones (Hayes-Bautista and Minkler, 1979). As Parsons (1951) has correctly pointed out, medical care is a product of modern society. This is so because the state of any health care system is deeply rooted in a society and reflects that society's perceptions and definitions of the world in general. In this case, a traditional society will exhibit traditional system of health care while a modern society will have a modern and scientific health care system.

In developing countries four institutional characteristics with regards to medical modernisation can be identified (Hayes-Bautista and Minkler, 1979). Firstly, modernisation signifies active, often formalized opposition to indigenous health care systems. Usually, homeopathic and other forms of "traditional medicine" are not accorded legitimacy by Western trained health officials and ruling elites, who see these competing systems as thorns in the side of "real" (Western/scientific) medical care. Second is concerned with the quest for quality. Planners in many developing countries compare the quality of their systems to those of the developed countries, and always strive to attain those standards by ensuring the highest levels of training for the urbanized health care professionals. Third is that modernization process in developing country entails the rise in spending for facilities and care. This means that the budget allocated for health care should be substantial. However, in developing countries the budget is small to sustain modernisation.

According to modernisation theory, biomedicine is considered a modern health care system. It applies scientific methods of treatment. Moreover it is universal in nature since it provides universal explanations of causes and treatment of diseases. It operates strictly under certain policies and legal frameworks. Biomedicine therefore entails proper training of professionals to run the sector as well as adequate investment in medical infrastructures. In contrast, traditional medicine is viewed as backward and based on non-scientific validity. It is sometimes embedded with socio-cultural values of beliefs to the extent that it is extremely difficult to tell how diagnosis and cure take place. Traditional medicine is therefore localised and limited to a certain community. This kind of medicine lacks scientific validity; its quality is highly questionable and its efficacy is unknown. It should be emphasised however that many societies in developed nations as well as in the developing world practice both traditional medicine and biomedicine. It should be emphasised that in developing world the traditional medicine system is more dominant.

Notwithstanding, traditional medicine is not static. It is increasingly becoming more popular and changing. The general tendency is for both the international actors and national actors to push for traditional medicine to modernise. The WHO Traditional Medicine Strategy 2014-2023 is designed in such a way that while it promotes the use of traditional medicine it at the same time modernises traditional medicine mainly through the use of policy, laws, and science.

Examining the Policy and Law

As was noted earlier, traditional medicine was not officially recognised in Tanzania until 1996 when it was incorporated in the National Health Policy. This policy was reviewed in 2003. The main objectives of the policy include among other things to promote traditional medicine and alternative healing system and regulate the practice. The policy acknowledges that the role of traditional and alternative health care to Tanzanian people is significant. The policy states clearly that traditional and alternative healing services and conventional health services are complementary to each other. I have to state right away that the complementary role to each other is doubtful. As was stated earlier, the government has historically been suspicious about traditional medicine. In the current National Heath Policy (Draft Six October 2017) reforms, the attitude of the government towards traditional medicine is clearly stated. Despite the wide use of TAM, genuine concern from the public and scientists/biomedical health practitioners (BHP) on efficacy, safety and quality of TAM has been raised. Such problems threaten the health of many who are the users of such services.[6] The policy states further that the government will ensure quality and safety of traditional and alternative medicines in use; strengthen basic and scientific research on traditional medicine practice, traditional medicines and medicinal plants for improvement of traditional health services and lastly the government will promote industrial manufacturing of traditional medicine.

It is clear that the government perceives traditional medicine as a threat to users since its scientific validity and safety are questionable. Hence, at the policy level the government seeks to control this sector while at the same time modernising it through scientific research and industrial manufacturing. In order to implement the policy effectively, the government enacted the Traditional and Alternative Medicines Act, No. 23 of 2002.

The Traditional and Alternative Medicines Act of 2002 provides several conditions for one to practice as a traditional healer. The first and foremost condition is to be registered. Section 14 (1) of the Act provides that any person who apply to be registered as a traditional health practitioner shall be required to present to the Registrar any relevant documents and a written statement from the local government authority within which he is practising. Section 35 (1) provides for the duty of traditional or alternative health practitioner including to attend and treat their patients with clear knowledge, skills and right attitude. Subsection (2) further provides that the traditional or health practitioner shall ensure that:-

(a) that he is compatible with the traditional and alternative health profession;
(b) his conduct does not amount to professional misconduct;
(c) his conduct is commensurate to traditional and alternative health ethics and professional etiquettes;
(d) He adheres to the secrecy and confidentiality aspects of his patients;
(e) He transfers difficult cases to hospitals or other practitioners;
(f) He has a good system of keeping records to all cases attended by him;
(g) He observes cleanness of himself, appliances used and premises under which the service is rendered.

Section 29 of the Act provides for non-adherence to professional ethics and etiquettes. It states that any person registered or enrolled under this Act shall be in breach of professional conduct and personal behaviour if:-

(a) he neglects or disregards professional responsibilities to patients in respect of their care and treatment;
(b) he abuses professional privileges and skills; ethics and etiquettes;
(c) his personal behaviours and conducts are derogatory to the reputation of the traditional and alternative health medicine;
(d) he disparages his professional colleagues;
(e) he associates in his work with unqualified persons; and
(f) his conduct would amount to an offence against the law relating to the control of dangerous drugs.

Section 55 (2) of the Act empowers the Minister to regulate traditional and alternative health sector. The Minister may regulate sale and storage of traditional medicine and alternative medicine remedies; regulate manufacturing, importation, exportation, distribution and labelling of traditional medicine remedy; provide regulations of registration of traditional and alternative remedies, methods and equipments; provide titles, descriptions, abbreviations and dosage.

Discussion

The policy and law suggest that traditional medicine occupies an inferior status and potentially threatening the health of users. In this case it has to be regulated probably by subjecting it to scientific validation and the law. There is no classification of health facilities so as to facilitate referrals in case one practitioner fails to cure certain diseases. Worse still, these practitioners do not know each other. This makes it difficult to apply referral system which is common to biomedicine. As a result, most of these referral cases are taken to hospitals. The controversial case is that which is related to “Kikombe cha Babu”. In this material case, patients who were suffering from cases such as diabetes, tuberculosis and HIV attempted to get cured by the “miracle” administered through “Kikombe cha Babu”. It is important to note that “Kikombe” was embedded with some elements of faith to the extent that it was not possible to question the efficacy of the cure. As a result, most patients abandoned the biomedicine dose in favour of “Kikombe”. It should however be noted that in some cases patients start with traditional medicine before they seek for biomedicine cure. But this again depends on the availability and quality of biomedicine at a particular space and time. The situation is more critical in rural areas where the majority people are not exposed to modernisation as well as quality and adequate medical facilities.

Related to the above point, the law has not been effectively implemented. This is because there is poor coordination between the national government and the village government where traditional medicine is supposed to be located. The study by Kabyemela (2017) found that majority of traditional medicine practitioners practice using illegal facilities or premises. Most of the practitioners use their homes to provide such services contrary to the law. The government has not been strict to this practice mainly due to the fact that biomedicine is not provided adequately. Moreover, some diseases are known to have no cure in hospitals and when these are taken to traditional healers it implies that the patients are simply getting some kind of psychological therapy. Yet, in other circumstances policy makers and law enforcement officers attend such traditional facilities thereby endorsing the cure. In the case of “Kikombe”, some senior officers from the government sought for cure. It is perhaps due to this fact that there was no any formal agency of the government which came out clearly to endorse the cure though it was stated that “Kikombe” was safe. Until to date, there are no any formal results which have been put in public about the efficacy of "Kikombe" as a cure of diseases. Be as it may, the mere attendance by senior government officers to drink "Kikombe" was sufficient enough to tell the public that it was a cure.

The experience of "Kikombe" indicates clearly that the medicine was not tested before but thousands of people had already used this medicine. More so, Babu was not a registered traditional medicine healer but no action was taken against him. It is difficult to tell if he really upheld the professional standards of traditional medicine. It is true that most medicine by traditional healers is not tested implying that there is high risks on the part of users. Moreover, the majority of them have not yet been registered. It is also a fact that the majority traditional medicine practitioners are uneducated. This makes it difficult for them to provide credible services including but not limited to unregistered equipments and untested medicines.

The law recognizes TMA as a profession. This is a clear strategy by the government to compel for transformation and modernization of tradition medicine. As a standard to any profession, it implies that traditional healers are required to undergo formal training to acquire requisite qualifications before they get registered. Strangeland et al. (2008:290) maintain that "in Tanzania TM is experiencing a renaissance in being formally recognized, integrated into mainstream health care, formal establishment of practitioners, and gaining the interests of different sectors." Notwithstanding, there is no formal training that is provided across traditional healers. It seems that the government is not interested in strengthening traditional medicine. This is despite the fact that the 2003 National Health Policy declares undertaking of research to improve the quality of traditional medicine.

Yet, the National Health Policy of 2003 stipulates that TM and biomedicine are complementary. This means that there is reciprocity between the two systems. However, the reality of the matter is different and there are no any mechanisms in place to facilitate this symbiotic relationship. The Traditional and Alternative Medicine Act of 2002 seems to establish the boundary between TMA and biomedicine in the same way as traditionalism and modernity. As usual, biomedicine which symbolizes modernization occupies a superior status. Based on modernisation perspective, 'traditionalism' is not a permanent situation hence TMA is changing. It is against that background that scholars like (Marsland, 2007) would argue in favour of "modernisation traditional medicine" and therefore "hybridity". This means that there is no such a thing like "tradition" since this is simply a transitory situation.

Conclusion

Traditional medicine still occupies an inferior status in Tanzania despite the fact that it is recognised by the law and that majority Tanzanians access it as their primary health care. This is so due to the fact that traditional medicine sector suffers from credibility crisis – lack of scientific validation, efficacy, safety and quality. The policy and law have been designed in such a way that they do not facilitate for the co-existence of traditional medicine and biomedicine but rather they seem to compel traditional medicine to undergo modernisation. Yet, the policy and law in Tanzania have not been effective to regulate traditional medicine. As a result of this, several traditional health practitioners are not registered and therefore administer untested medicine and possess unregistered equipments and premises. This in turn has posed serious health risks to users of traditional medicine.

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Notes

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