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Recognition and development of traditional medicine in Tanzania

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Abstract

The aim of this paper is to trace developments in Traditional Medicine (TM) and legislation concerning conservation and use of biodiversity in Africa, with Tanzania as a case study. Based on field trips, interviews with different actors, site visits, and literature we explored the history, current status, re-establishment, and development of TM. A summary of laws and regulations concerning forests, access and benefit sharing is presented. During the last decade the Government of Tanzania put forth legislation to address national health needs, traditional knowledge, and the resource base for TM (e.g., practitioners, biodiversity). Our findings indicate that TM is the most common form of health care, and that the HIV pandemic has highlighted the need to work across health sectors. New legislation has facilitated this need. 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. More studies on bioactivity, safety, domestication, and sustainability of use of medicinal plants are needed. Development of TM can also, other than making a significant contribution to health care and livelihoods, provide income possibilities. It is however yet to be seen if the recent regulations can be made fully operational and implemented.

Keywords: Bioprospecting; Biodiversity conservation; Community-based management of natural resources; Ethnobotany; Indigenous knowledge; Traditional medicine

1. Introduction

Traditional medicine (TM) is the diagnosis and treatment of psychological and medical illnesses based on local knowledge and socio-cultural and religious beliefs, developed over time by local people within their belief systems and specific environmental (particular biodiversity) conditions of a particular area (Grenier, 1998; Diallo and Paulsen, 2000; Tabuti et al., 2003). It is a well-established system of medicine, parallel to the western or orthodox medicinal system, still in active use by rural communities in developing countries (Iwu and Laird, 1998; Tabuti et al., 2003). Due to the lack of proper conventional health care systems, TM is often the first choice for providing primary health care. In Tanzania (Fig. 1), the accessibility to conventional medical doctors is very low (1:33,000) compared to that of traditional medicine practitioners (TMPs) (1:350–450) (Marshall, 1998; IRIN, 2006).

In Africa, during occupied periods colonial powers connected TMPs to the use of supernatural forces or witchcraft, and TM was subject to discredit and legal bans. When colonization ended, independence made some nations more tolerant towards TM, regaining African identity and developing national and cultural values. Two nations fully incorporating TM in their health care systems are Ghana and Mali (Diallo and Paulsen, 2000; Romero-Daza, 2002). Other nations like the Ivory Coast, Comoros, Seychelles and Cape Verde are less favourable towards TM:

Abbreviations: ABS, access and benefit sharing; CBD, Convention of Biological Diversity; CITES, Convention on International Trade on Endangered Species; CRFs, catchment reserve forests; DMT, Département de la Médicine Traditionelle; GDP, gross domestic product; GURT, Government of the United Republic of Tanzania; ITM, Institute of Traditional Medicine; MAPs, medicinal and aromatic plants; MNRT, Ministry of Natural Resources and Tourism; MPs, medicinal plants; NFP, National Forest Programme; NGOs, non-government organizations; PAs, protected areas; PIC, prior informed consent; TAWG, Tanga AIDS Working Group; TM, traditional medicine; TMPs, traditional medicine practioners; TPI, Tanzanian Pharmaceutical Industries; WHO, World Health Organization.

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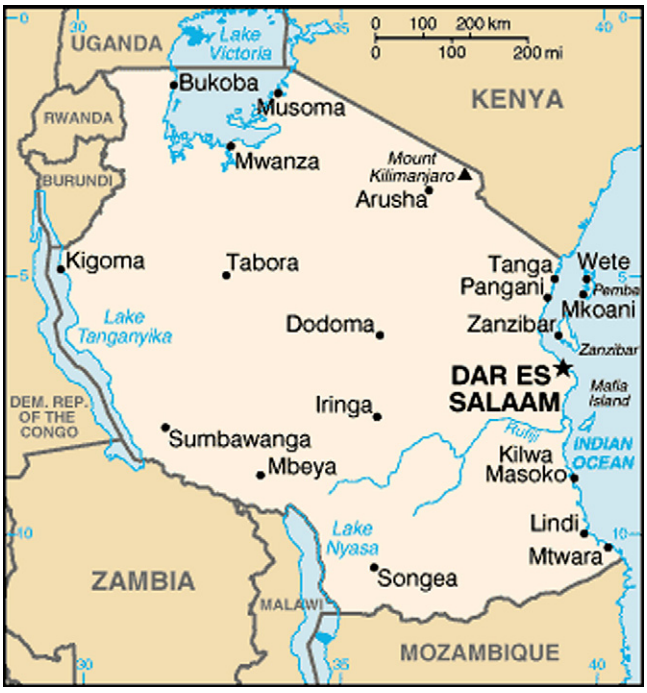

Fig. 1. Map of Tanzania. (See ref. University of Texas and Libraries, 2007).

TMPs are not involved in the official health system and no regulations exist for their registration or licensing. Other countries, like Angola and the Central African Republic, have established systems for registration of TMPs but do not officially recognize their practices.

Most of the 45,000 TMPs in Ghana are recognized and licensed in various associations under the umbrella of the Ghana Federation of Traditional Medicine Practitioners' Association. The Traditional Medicine Unit was established as part of the Ministry of Health in 1991, working directly with TMPs (Romero-Daza, 2002). In Mali the Phytotherapy Institute was established in 1968 as the first research establishment for the study of medicinal plants (Diallo and Paulsen, 2000). After several changes, the establishment is now called the Department of Traditional Medicine (Département de la Médecine Traditionelle, DMT). DMT became a collaborating centre of the World Health Organization (WHO) for research in TM in the early 1990s. One of the primary objectives of DMT is to establish a mechanism to assure that TM becomes complementary to conventional medicine. In South Africa the governmental health service only provides western medicine (Light et al., 2005), but TM is still used by the majority of people, especially in rural areas. The new government and National Research Foundation, however, are now promoting more research on natural resources, and have allocated more funding to studies in Indigenous Knowledge Systems. This promotion had precipitated in significant increase in research, e.g., in the last 10 years the number of publications from South Africa in the Journal of Ethnopharmacology increased from about 20 to 55% of all African publications.

Internationally, TM has received much attention the last decades. In 1977 the World Health Assembly urged member states to utilize their traditional systems of medicine (resolution WHA30.49). In 1978 the International Conference on Primary Health Care, held in Alma-Ata, recommended that governments give high priority to the utilization of TMPs and Traditional Birth Attendants, and incorporate proven traditional remedies into national drug policies and regulations (Akerele, 1987) (Table 1). During the nineties several conferences and meetings on the topic were held in Tanzania and other African countries, starting with the International Conference of Experts from Developing Countries on Traditional Medicinal Plants, Arusha, February 1991. In a Meeting of the Inter-African Experts Committee on African Traditional Medicine and Medicinal Plants in the Organization of African Unity (OAU) the Decade of African Medicine was proclaimed from 2001 to 2010 (Mahunnah, 2002), and the African Traditional Medicine Day was set to be on the 1st of September. Tanzania celebrated the day for the first time in 2003. The urgency of recognizing TM has been further heightened by the HIV/AIDS pandemic (Romero-Daza, 2002) as many HIV positive individuals use herbal remedies to boost the immune system and to fight opportunistic diseases (Scheinman, 1998; IRIN, 2006).

Recent studies indicate the importance of TM among rural people in Africa today (Jäger and van Staden, 2000; Light et al., 2005) and that legislation concerning conservation/use of biodiversity and TM are increasingly adopted (Diallo and Paulsen, 2000; Romero-Daza, 2002). Tanzania we believe is one of the countries that has been championing TM and its practice, and in fact may be an example of good practice. We use it as a case study tracing developments in recognition, facilitation, and re-establishment of TM from current and historical perspectives. In light of the Convention on Biodiversity (CBD) and appreciating the close link between wild plant species and traditional medicine, the current status of biodiversity, conservation/forest legislation, and access and benefit sharing (ABS) to biodiversity in Tanzania is described briefly, followed by a comprehensive overview of the current status of traditional medicine in Tanzania. The case sheds light on salient processes and links that have been core to the 're-'establishment of TM in Tanzania.

1.1. Methods

Informal and semi-structured interviews and group meetings with NGOs, traditional healers, medicinal plants collectors and researchers were conducted along with an in-depth literature survey. Field information was gathered during three visits to Tanzania in February 2002, October 2003 and August 2004. All information has been kept updated until the submission of this paper through communication with local informants. A chronology of related events in relation to TM and biodiversity was constructed and is provided in Table 1.

2. History, biodiversity, legislation and trade

The Republic of Tanganyika was formed in 1962, with Julius Nyerere as president (Table 1). Tanganyika and Zanzibar merged in 1964 to form Tanzania. Nyerere's political programme was socialistic, founded on African collectivistic traditions and village community. Up to the mid-1970s, the economy of Tan-