

Fall 2006

The Missing Piece: Understanding Nairobi's Traditional Medical Practitioners

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The Missing Piece:

Understanding Nairobi's Traditional Medical Practitioners

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Kenya: Development, Health, and Society
Fall 2006
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ACKNOWLEDGEMENTS

This study could not have been completed without the support and enthusiasm of many people and organizations. The author would like to express his gratitude,

To Swarthmore College and the School of International Training, for presenting him the opportunity to visit Kenya for four months and complete this investigation.

To Odoch Pido and Jamal Omar, for their help in acclimating to Kenyan society and providing endless moments of light-heartedness that made the journey unforgettable.

To Donna Pido, for her constant honesty, vision, and pragmatism—without which this study would not have taken off the ground.

To the various traditional medical practitioners, biomedical physicians, patients, and residents of Nairobi who were enthusiastic about sharing their thoughts and lives.

To the Kenyan Ministry of Health and Ministry of Culture, who opened their doors to this investigation and helped provide the initial logistical support.

To Aga Khan University Hospital, for its eagerness to shed light on this issue in an effort to promote discussion of improvements in health care.

And, to my fellow colleagues in the Kenya: Development, Health, and Society program, without whose constant humor, support, and advice this project would not have been completed.

“For all the revolutionary and dramatic improvements in human health in the 21st century, life in Africa begins with and is sustained by the support of traditional medicine.”

–Ibrahim Samba, former WHO regional director

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ABSTRACT

Currently, there is a problem of access to biomedical health services to large portions of Nairobi's population. Traditional herbal medicine has long been practiced in Kenya, and though studies have shown that traditional medicine has been effective against certain acute and chronic illnesses, it has been marginalized in the health service sector. By integrating traditional medicine into mainstream healthcare, a larger proportion of the Kenyan population will be able achieve access to adequate health services. However, there has not been enough discussion about traditional medicine from a holistic point of view. Without adequate discussion, traditional medicine will remain in the shadows, thereby eliminating a possible method of improving the lives of Kenyans. This study aims to initiate that discussion by presenting traditional medicine through the lenses of traditional practitioners, biomedical physicians, hospital administrators, patients, health insurance companies, government officials, and Nairobi residents. The results of this study indicate that though traditional medicine and conventional biomedicine have different characteristics, these differences are complementary rather than competitive. There are many advantages to integration, including better health care delivery, entry into a lucrative global market for traditional medicine, and improved knowledge about medicine through collaboration with biomedicine. Current policy efforts to recognize, regulate, and integrate traditional medicine have been hurt by internal opposition, bureaucratic inefficiency, and external economic pressures. Though progress has been made, better communication and more candid discussion is necessary to truly maximize the potential of traditional medicine.

INTRODUCTION

Catherine, a 32-year old mother of three, was sitting on a bench outside Nairobi's Kenyatta National Hospital. Her husband was very sick, but she could not remember exactly what was wrong this time. The doctors that briefed her spoke very quickly, and she could not understand exactly what they were saying.¹ However, she did know that her husband had been sick for a long time; he had been diagnosed with diabetes the previous year, and recently had suffered a heart condition only a few months earlier. Throughout that time, he had still managed to make it to work as a lecturer, priding himself on not missing work because of his medical issues. However, now he was sick again—and this time, he was too sick to go to work. Actually, having to take time off from his job finally convinced him to get examined again by a doctor.

Money was the immediate concern. Even though her husband had a good job, and they by no means could be considered as “part of the poorer people in Nairobi,”² the costs were adding up. They had to ask their friends and family for financial help—yet another attack on her husband's pride. Yet even with the aid, they were still running low on money. Now, Catherine felt, “as if [she] were stuck,” because “there were no other treatment options and his health was more important than anything else.”³ When asked about the option of seeing a traditional medical practitioner as an alternative to the relatively high costs and poorer services she complained of from conventional medicine, she laughed. Though she believed in the efficacy of herbal medicine, it was “foolish thinking” to even consider going to a herbalist. After all, how would she know which one to go to, especially when “there are so many quacks in the city who were just after her money?”⁴

This short encounter with Catherine epitomized a large contemporary problem within Nairobi's urban health service sector. Biomedical services have largely become out of reach of a very large proportion of Nairobi's population, most often because of financial barriers. Traditional medicine, once considered a legitimate and trusted form of health care for the majority of Kenya's population, now is entrenched in bureaucratic problems; without societal

¹ “Catherine,” interview with the author, 17 November 2006

² Ibid.

³ Ibid.

⁴ Ibid.

and official government recognition and regulation, the integrity of the field is suffering.⁵ Traditional medicine in general refers to a variety of specialties, including herbalism, spiritualism, and massage therapy, among others. Due to time and resource restrictions, this study will only investigate the role of what are commonly referred to as herbalists, practitioners who mainly use plants and occasionally animal-derived products to treat acute and chronic illnesses.⁶ Thus, the use of term “traditional medical practitioner”, or TMP, in this study will refer specifically to herbalists, and will not concern traditional practitioners who work with conditions having spiritual etiologies or treatments.

In a broad sense, this study aims to investigate the current health care picture in Nairobi—what are the options for Nairobi’s residents when it comes to health care, and what role traditional medicine plays within this context. The central argument of this study is that TMPs can potentially act as a vital health care provider in Nairobi’s health services sector, and thus there is a need to understand and demystify traditional medicine. Specifically, this investigation will examine the role of traditional medical practitioners in Nairobi, including the characteristics of their profession and the efforts that have been taken to integrate them into mainstream health care. However, before further discussing the findings of this study, it is critical to first review the historical context of health care services in Kenya in order to establish an appropriate contextual framework.

The Biomedical Colonial Policy

Though there have not been many studies on the specifics of colonial medical care before 1920, the literature does make it fairly clear that the medical services were lacking. During this time, the focus of medical treatment was largely on the colonial government employees and European settlers.⁷ This focus was primarily shaped by the goal of ensuring the continued running of the colonial economy. As a result, diseases, such as the plague, that threatened the ability of workers to enter the urban labor force received much attention, despite the fact that the plague did not play a significant role in morbidity at the time.⁸ Conversely, diseases that largely afflicted a major proportion of rural Kenyans (i.e., malaria, yaws, and intestinal parasites) did not receive as much attention. The colonial government assumed that because those types of

⁵ Dr. Mahinda, interview with the author, 15 November 2006

⁶ Some herbalists in this investigation also practice massage therapy, though this was not a condition of the study.

⁷ Dawson, 418

⁸ Ibid.

conditions could not quickly spread among the labor force, there were enough reserves of African workers such that if a few became sick, they could be easily replaced⁹.

This attitude towards medical services soon changed in 1920. On the one hand, there was increasing pressure in British Parliament to improve the health services made available to Africans in light of the large numbers of Africans who lost their lives fighting for the British in World War I.¹⁰ On the other hand, officials within the colony itself felt the need to improve medical care for different reasons. First, the prevailing line of thought was that because the natives were paternalistically seen as agents of disease transmission, keeping the natives healthier would better protect the European settlers from becoming sick. Additionally, ensuring better health of the African population would not only allow the colonial government to be seen in a more favorable light in the world's eyes, but it would also keep the labor force stocked with healthy workers.¹¹

As a result, there was soon thereafter a movement to improve the colonial system of primary health care in the Kenyan colony. Chaiken (1998) defines primary health care as advocating “a series of specific practices aimed at disease prevention and management, predicated on a philosophy of egalitarian access to health care”.¹² The goal to increase the role of community responsibility in preventing disease was met with problems of poverty, gender and class inequality, and mediocre infrastructure.¹³ In addition, studies indicate that the colonial government's services were largely hierarchal, coercive, and paternalistic.¹⁴ However, despite these problems, the government's sound strategy and strong will to prevent illness allowed for the implementation of programs that were quite effective.¹⁵

The aim of the British colonial government to work towards preventive, rather than curative, care seems to stem from various causes. One, physicians working for the colonial government outright acknowledged that curative treatments would be limited in their ability to improve community well-being.¹⁶ This makes sense in light of the limited availability of resources such as antibiotics and anti-malarial medicines, especially in the time before World

⁹ Ibid.

¹⁰ Dawson, 419

¹¹ Dawson, 418

¹² Chaiken, 1701

¹³ Ibid.

¹⁴ Good, 35

¹⁵ Chaiken, 1702

¹⁶ Chaiken, 1703

War II. The reasoning followed that many of the conditions afflicting the Africans were due in part to environmental issues, and thus it was more effective to fix the problems at their root. Another cause might stem from colonial paternalism. Some have argued that while there may have been government officials with sincere intentions of improving the health of the Africans, many felt the need to do so because they considered the Africans backward and needing social uplifting.¹⁷

Regardless of the justification for improving primary health care, the methods of doing so are widely agreed upon. It is worth mentioning four specific successes of the colonial government in this respect. Taken in the aggregate, these four initiatives vastly improved the health of the population, and were a major part of the population surge that clearly has had affects on modern-day health care access. In addition, if implemented properly, these four initiatives remain as potential ways of further improving the health of Kenyans today.

First, the colonial government was able to decentralize health care services rather effectively. Before the implementation of Local Native Councils (LNC) in 1924, the central and local governments were responsible for the health care needs of the African population. After the LNCs were put into place, however, much of the responsibility fell upon the Africans themselves. The LNCs, composed of elected members of each community, were liable for levying taxes on the local indigenous population, and mandating and funding services that were not adequately provided by the central government.¹⁸ This decentralization was effective for multiple reasons: first, it was seen by the colonial government as a way of teaching democratic principles to the Africans. Second, the LNCs allowed for a forum by which locals could express their feelings and opinions of the way the community was being run. Third, it reduced the risk of Africans simply sitting back and allowing the colonial government to run their affairs—it forced the locals to be more active and involved in their community.¹⁹ This seemed to be a win-win situation; not only did the LNCs work well with the colonial government, but they were also successful in improving the health of their constituents. They regularly mandated health care services and included large provisions for resources to be allocated towards maternal and child

¹⁷ Good, 35

¹⁸ Ibid.

¹⁹ Chaiken, 1704

welfare clinics.²⁰ In addition, they were able to locally raise money such that medical services offered at dispensaries and other health centers could be made free to the Africans.²¹

Another success of the colonial administration was the implementation of medical safaris that visited local communities. Medical personnel going on these safaris were responsible for performing diagnostic and curative services, teaching public health, and conducting immunization campaigns.²² Some studies have indicated that the safaris were not effective because medical officials did not conduct them often enough, and performed cursory functions when they did go.²³ However, this view seems to be unfair, especially in light of the fact that the safaris continued through the Depression, during which supplies were hard to obtain, and the traveling costs to these small communities was substantial. This dedication was noted in the 1932 Kenya Colony and Protectorate Medical Department Annual Report:

“It is to the lasting credit of the staff of medical officers and sanitary inspectors that in the period of depression when the financial provision for traveling became entirely inadequate to meet the needs of the districts, and incomes as well as allowances had been reduced, no officers reduced the amount of their traveling opportunity, but all without exception continued to the utmost extent that they could afford to carry on their work at their own expense.”²⁴

Finally, the government was also successful in its immunization campaigns and attempts to improve sanitation. Vaccines were produced in Nairobi and transported across the country as needed. These campaigns were initially met by resistance. Parents were fearful of this novel treatment, sometimes hiding their children and thus preventing inoculations.²⁵ Also, there were logistical problems with staffing and keeping vaccines cold during transport. As a result, campaigns were started only in response to reports of disease outbreaks.²⁶ Eventually, the government tried to move towards having more regular, systematic immunization campaigns. In a span of two decades during the 1930s and 1950s, major advances were made in the control of smallpox and polio.²⁷

²⁰ Ibid.

²¹ Ibid.

²² Chaiken, 1708

²³ Good, 36

²⁴ KCP, 1932, p.7—originally quoted in Chaiken, 1709

²⁵ Chaiken, 1711

²⁶ Ibid.

²⁷ Ibid. Mombasa was completely vaccinated against smallpox in 1930—over 70,000 people received the vaccine within one night (KCP, 1930, p. 20—originally quoted in Chaiken, 1711). In 1949, a smallpox outbreak in Nyanza province resulted in the immunization of 45,000 people in Kisumu, 426,445 in central Nyanza, and 633,460 in

Many colonial officials also saw the general hygiene and sanitation of the local Africans as needing improvement. However, efforts to control sanitation were also met with initial resistance. This was an area of the colonial health policy that was one of the more aggressively pursued, often manifesting in the forms of mandatory brush clearing, destruction of flea-infested homes, and harsh penalties for violations of cleanliness standards that were set by health officials.²⁸ Inspectors would examine latrines, shops, marketplaces, water sources, and homes for cleanliness. In addition, there were extensive efforts to control vermin and insects. While the intention behind these actions seems relatively sound, the actual efficacy of practice is debatable. The government's aversion to rats resulted in large rat-killing campaigns; records indicate that over the span of one particular year, as many as 2 million rats had been killed.²⁹ As Chaiken asserts, it "appears that two outcomes were considered evidence of the effectiveness of vermin control staff, either the absence of any cases of bubonic plague, or an increase in the number of rats killed over previous months."³⁰ For the most part, these rules and inspections were opposed by locals—yet despite this opposition, the colonial government felt that they were important enough to keep pursuing strongly. Though not completely solving many of the health problems of the time, sanitation yielded very important insights into the prevalence and trends of malaria, a condition that plagues Kenya even today.

Simply ending a historical analysis at this point would not explain why there is still a vicious cycle of poverty and poor access to health care in Kenya today. Specifically, the nature of this relationship is that poorer people cannot afford health care. As a result, they fall sick and cannot work, which leads to their original poverty. The roots of this cycle come from the fact that despite the successes in bettering the health of the population, the colonial government was exploitative. Africans were taken advantage of, and their treatment was in large part predicated on the economic benefit to the colonial administration. Some Kenyan developmental analysts suggest that the foundations of the cycle might be found in disadvantageous colonial labor policies, which had major public health impacts that are still lasting. Using a labor policy based on "humane pressures" such as taxation, persuasion, and eventually coercion, the colonial

southern Nyanza. Between 1940-45, over 1.4 million people were immunized against smallpox. In addition, in the 1950s, over 210,000 people were immunized against polio in response to reports of infection in areas outside of Nairobi. (Chaiken, 1711)

²⁸ Chaiken, 1712.

²⁹ Ibid.

³⁰ Ibid.

government was able to recruit able-bodied men to move from their villages and on to the European plantations. Once at the plantations, the laborers were faced with demanding contractual obligations enforced by harsh criminal penalties. Sometimes, wages were deliberately kept below the tax rates; if the laborers did not earn enough to pay their taxes, they would have little choice but to continue working.³¹

One relevant repercussion is that because the men were sent to the plantations to work, the women were left behind in the villages and forced to take on additional responsibilities. All of a sudden, instead of just being the primary caretakers of the home, they were also charged with farming, plowing, and harvesting. This resulted in the women becoming overworked, allowing for periodic food shortages that eventually helped lead to malnutrition. Additionally, the labor policies called for 75% of the wages of the plantation laborers to be sent back to the colonial government in the form of taxes.³² Therefore, compounding the problems of a stifled economy and malnutrition was the fact that the workers were left with insignificant financial remuneration for their efforts;³³ money that could have gone to maintaining the health of their families was now in the government's pockets, and thus the cycle began.

It is important to review the colonial policy on biomedical care because it is apparent that many of the conditions that Africans suffered from in those times are the same problems of today. Malaria, respiratory infections, intestinal worms, and mal/under nutrition have lasted throughout the colonial period, and are still alive. The fact that forms of those colonial primary health care initiatives are still being utilized, with relatively large proportions of the population still being afflicted by these conditions, should be an alert that the current system needs to be revised.

Traditional Medicine Colonial Policy

Traditional medicine was always a part of the culture in Africa, even before the British arrived.³⁴ The colonial government recognized this, and there were not any systematic efforts to prohibit the practice of traditional medicine. In fact, the government preferred to leave them alone as long as they did not disturb the peace.³⁵ However, there was some resistance on the part

³¹ Dr. Mahmoud Jama, lecture, School of International Training, 4 October 2006

³² Ibid.

³³ Ibid.

³⁴ Good, 37

³⁵ Good, 37

of the missionaries. While there was no explicit opposition to the practice of using herbs and natural remedies to cure others of sickness, the missionaries often called for the “cessation of traditionally sacred observations and consultations with diviners and other religiously-medical specialists.”³⁶

It is appropriate now to describe what seems to be one of the root causes of the misconceptions facing TMPs today. During colonial times, traditional witches in Kenya were often seen as either men or women “in whose psyche the normal human failings of greed, jealousy, anger, and meanness were magnified to pathological proportions, a state which enabled them to kill without scruple.”³⁷ Clearly, one needs to be committing malicious acts against others in order to fit that description. However, despite that definition, herbal doctors have also sometimes been associated with witchcraft. Some modern day TMPs feel that because their predecessors were able to heal the sick—often to the bewilderment of the other locals—they were branded as having supernatural powers, like witches.³⁸

Thus, because of this association, herbal doctors were also caught up in the enactment of the Witchcraft Ordinance of 1925³⁹; because no new legislation has passed that directly addresses traditional medicine, most TMPs feel that they are still governed by that ordinance. Studies indicate that the Witchcraft Ordinance was originally put in place as a way for the colonial government to balance indigenous cultural infractions with their own laws that did not have provisions for such crimes.⁴⁰ Africans had their own justice system for those accused of being witches, and the accused most often did not receive fair treatment. The killing of witches was accepted within some communities, and this presented a problem for colonial law enforcers. In order to gain credibility with the Africans, the colonial government had to have some legislation against witches, while at the same time remaining true to punishing those who killed others. Thus, one can also make the argument that the ordinance was passed as a way for the

³⁶ Ibid.

³⁷ Waller, 12

³⁸ Dr. Mahinda, personal interview with the author, 20 November 2006

³⁹ Roberts, 488. Specifically, section 2 calls for “imprisonment up to 5 years on a person who holds himself out as a witch-doctor able to cause fear, annoyance, or injury to another in mind, person, or property, or who pretends to exercise any kind of supernatural power, witchcraft, sorcery, or enchantment calculated to cause such fear, annoyance or injury”. Section 3 calls for, “imprisonment up to 10 years for persons professing knowledge of witchcraft or charms, who advises how to bewitch or injure persons, animals, or other property, or supplies articles purporting to be means of witchcraft”. Under Section 4, “a person is liable to 10 years imprisonment who, with intent to injure, uses knowledge of witchcraft in a way calculated to cause fear, annoyance, or injury to a person or property”

⁴⁰ Waller, 2

government to maintain power—the concept of witches and witchcraft was a threat to the control that the government had over the people. By punishing witches, the government was better able to maintain their control.

As a piece of legislation, however, the act failed from the very beginning. Many locals felt that the government was not catching witches well enough, and so they took matters into their own hands.⁴¹ Also, even when alleged witches were put on trial, many of the cases were dismissed because of insufficient evidence or technicalities. This presented another problem. While having a trial in the first place would appear to endorse the local beliefs, losing trials caused the government to lose credibility as well. Alleged witches would boast about how they were immune to the justice system, thus further creating discontent within the local communities.⁴² As a result, the law “could neither establish its authority over witches nor demonstrate its own protective powers.”⁴³

Another major problem with the act, one that undoubtedly led in some part to the stigma against TMPs today, was its lack of definition. There were not clear definitions of what was considered evil magic (black magic, with intent to injure) versus beneficial magic (white magic, with intent to aid). Consequently, even those who worked to help others could be associated with witchcraft. Originally written as a way “to reform and civilize local practice,” the act had socially manifested itself into an, “uncivil instrument of blind deterrence, punishing all traffickers in magic, the witchdoctor and the witch together, with alien impartiality, driving them underground and doing nothing to address the legitimate fears of Africans.”⁴⁴

As time progressed, these small-scale associations of herbal doctors with witchcraft expanded on a larger scale, eventually turning into full-scale stereotypes—via speeches from the pulpit, people in hospitals or dispensaries, administrators, and teachers in school, African medicine was seen as composed of native superstition, black magic, and witchcraft.⁴⁵ As a result, there was strong social stigma against using traditional medicine to treat illnesses. Many colonized Africans felt pressured to choose; on one hand, they wanted to seem more modern, yet on the other, they wanted to stay within the confines of their own heritage. This resulted in a

⁴¹ Waller, 4

⁴² Waller, 5

⁴³ Ibid.

⁴⁴ Waller, 9

⁴⁵ Good, page 38

“strong ambivalence”⁴⁶ towards traditional medicine and TMPs in general, an ambivalence that largely permeates through the health sector even today.

Statement of the Problem

Juxtaposing the two histories described above, it becomes evident where the problems lie within the present health sector in Kenya. Biomedical services are out of reach for the majority of the Nairobi population. While poverty may be one reason for inadequate access, another may be the high cost of resources needed to operate biomedical facilities, which are passed on to the patient.

Many people who have used Nairobi’s biomedical services in the past claim that biomedical treatment is “too expensive,”⁴⁷ and often medical care in general “becomes secondary to putting food on the table.”⁴⁸ One taxi driver claimed he was not sick, despite the author’s observation that he had a very deep cough, one that could have led to serious infection if left untreated. Upon suggesting that he seek medical advice, he claimed that “[he] was not sick—people cannot afford to be sick in Kenya,”⁴⁹ a sentiment shared by many other Nairobi residents. This was the case with Catherine, the woman introduced at the beginning of this paper. Her husband only felt like he needed to get examined by a physician after his conditioned had worsened such that he could no longer go to work. The problem with this attitude, as illustrated by a Nairobi physician, is that most patients who enter medical treatment facilities after having been sick for a while are too sick to be treated effectively.⁵⁰

Currently, there are several biomedical facilities that are available for the residents of Nairobi to utilize if they should need treatment. At the primary level, small dispensaries and clinics are all over the city and often one of the first stops for treatment.⁵¹ Kenyatta National Hospital is the nation’s largest government subsidized health facility, and is located at the heart of Nairobi. In addition, there are smaller government and missionary hospitals scattered across the city, as well as larger private hospitals, such as Nairobi and Aga Khan Hospitals.⁵² Both

⁴⁶ Ibid.

⁴⁷ “Marsha,” interview with the author, 17 November 2006

⁴⁸ Ibid.

⁴⁹ “Charles,” interview with the author 17 October 2006

⁵⁰ Biomedical physician, interview with the author, 18 November 2006

⁵¹ Dr. Mahinda, interview with the author, 20 November 2006

⁵² Dr. S Ochola, interview with the author, 29 November 2006

these private hospitals charge tens of thousands of shillings just to spend a night, sums that are far out of the range of the working and lower class of Nairobi's population.⁵³

While the private hospitals cater more towards the elite population of the city, Kenyatta National Hospital serves all sectors of Nairobi's residents. While part of the cost of services at Kenyatta Hospital is shared by the government, they are still too expensive for many people. One man who had recently received treatment at Kenyatta Hospital shared his experience:

"It was not so good. I went there because I had no other choice. The service was poor, it was not clean, the supplies were not there, there were so many people. I felt sicker in there."⁵⁴

The medical director of Aga Khan University Hospital in Parklands echoed the need to improve health access in Nairobi. Admitting that "we can do better,"⁵⁵ he went on to describe that the cost of health services was the biggest problem facing health care in Nairobi today. Even when the costs are manageable, the facilities are not good enough. If the facilities are in order, then there is a lack of supplies or adequate personnel. In other words, the system has many flaws, and there needs to be discussion of alternative ways to reform the system such that a larger proportion of Nairobi's population can have adequate access to health care services.

Health insurance is also a problem in the contemporary health sector. Most cannot afford health insurance, and those who can pay hefty premiums every year. AAR, the largest private health insurance company in East Africa, has about 50,000 individual accounts and 800 corporate accounts in Nairobi.⁵⁶ The high costs of insurance prevent these numbers from being higher. The minimal coverage plan that AAR offers still requires a Kshs. 682 premium every month, a fee that one government employee described as "more than I can afford to pay—especially when I don't get sick every month!"⁵⁷ While there have been recent initiatives by organizations such as the National Health Insurance Fund to eliminate the costs to its members of certain medical procedures at major hospitals for a minimal monthly premium (as low as Kshs. 160 a month), programs such as these have yet to be widely implemented.⁵⁸

⁵³ "Schedule of Fees and Deposits," The Nairobi Hospital, 23 November 2006.

⁵⁴ "Martin," interview with the author, 22 November 2006

⁵⁵ Dr. John Maganga Tole, interview with the author, 30 November 2006

⁵⁶ Ms. Carol Wangunyu, AAR marketing executive, interview with the author, 16 November 2006

⁵⁷ "Mary," interview with the author, 16 November 2006

⁵⁸ Nzioka, Patrick. "Now 5 Million to Get Free Care in Hospital." The Nation 10 Oct. 2006.

With all these problems of access in the biomedical sector, there needs to be another option. TMPs can be that alternative. Herbal medicine has been accepted as effective in treating a wide variety of conditions, both acute and chronic.⁵⁹ However, the problem with traditional medicine is that it is not currently regulated by the government. Currently, TMPs need only to register with the Ministry of Culture in order to be recognized. However, there is still no legislation regulating traditional medicine—as a result, among other problems, there are a large number of unqualified people (“quacks”) pretending to be TMPs practicing in the city, a lack of educational standards, no umbrella self-governing organization.. This lack of policy also results in a lack of faith among a large proportion of the Nairobi population; many find it hard to consider traditional medicine a safe and viable alternative to conventional biomedical care.

⁵⁹ Mwea, Maina. "Herbal Medicine: Witchcraft or Modern Healthcare?" The Herbalist Sept. 2006: 3-4.

SETTING AND METHODOLOGY

This study was done in Nairobi, Kenya. A cosmopolitan city of approximately three million residents, Nairobi was an ideal place to complete this particular study about urban traditional medical practitioners. It was important to restrict this study specifically towards *urban* TMPs, in contrast to rural TMPs, for many reasons. Primarily, studying the urban situation offered the possibility of yielding better insight into the differences between conventional biomedicine and traditional medicine. Also, because of the abundance and close proximity of both biomedical and traditional medical health facilities, there was a better opportunity to see why patients would prefer to choose one health system over another. In contrast, many rural milieus do not have readily accessible biomedical facilities, and thus the option of choosing conventional hospitals or clinics for treatment is reduced.

Nairobi was specifically chosen as the urban setting of choice for this study because it is the site of the largest biomedical hospital in East Africa, many smaller hospitals and clinics, several traditional medical practitioners, the offices where legislation concerning traditional medicine are drafted and debated, the headquarters of many health service companies, and also government buildings such as the Ministry of Health. Thus, Nairobi was the place where this topic could be studied through the greatest number of angles.

The bulk of the information for this study was obtained via formal and informal interviews. Specifically, formal interviews are defined as those which were made by appointment and followed structured interview questions. Formal interviews were completed with seven Nairobi traditional medical practitioners, one Ministry of Health representative, one marketing executive for AAR Health Insurance, the Provincial Medical Officer of Nairobi, and the Medical Director of Aga Khan University Hospital. Informal interviews were less structured and often lasted for a much shorter time period, yet still provided significant information. Interviews of this nature were conducted with several biomedical physicians working in major Nairobi hospitals, patients of both biomedicine and traditional medicine, and other residents of Nairobi. Information was also gathered from observation at hospital and traditional medical offices.

Those individuals who agreed to be quoted in formal interviews are listed under Works Consulted, and appear on the record within this report. Out of concern for patient confidentiality and by request of specific interviewees, informal interviewees were not named within this paper

and do not appear in the Works Consulted list. In addition, formal interviewees who wished to have certain remarks remain anonymous have been so cited. In addition, the author has tried his best to express the views of individuals as originally conveyed; any misinterpretation is purely accidental. Finally, views in this paper that are not of the author are to be associated with particular individuals to whom they are cited, and not to any larger organization or agency to which they may be affiliated.

DISCUSSION

CHARACTERISTICS OF TRADITIONAL MEDICINE

Anthropological in nature, it is beneficial to begin this discussion by examining various anthropological definitions to which the term “traditional” refers. In his dissertation, *Africa and the Economy of Tradition*, Dutfield noted that it is not easy to develop distinct definitions of “tradition” and “traditional”. However, he did state that in the present context, these terms often carry a negative connotation, often suggesting “extreme conservatism which clings on to the outdated, the obsolete, the antithetical to material improvement, and sometimes event the inhumane.”⁶⁰ However, it is critical to note that tradition in itself also has many positive aspects. It acts as a way of bringing people together, serving as the “social glue”⁶¹ that fortifies relationships and identity. Also, the idea that tradition only encompasses the outdated also seems misleading. True tradition should not be a measure of old and new, but rather as the medium by which information is transmitted.⁶² Stepping back, this makes sense when we consider that tradition is unique in its ability to survive for long periods of time. Only by adapting to modern influences can this long-term survival exist. Barsh describes this well when he writes,

“What is ‘traditional’ about traditional knowledge is not its antiquity, but the way it is acquired and used. In other words, the social process of learning and sharing knowledge, which is unique to each indigenous culture, lies at the very heart of it “traditionality.” Much of this knowledge is actually quite new, but it has a social meaning, and legal character, entirely unlike the knowledge indigenous peoples acquired from settlers and industrialized societies.”⁶³

Good has a different definition of traditional medicine, or “folk medicine,” as he describes it. According to his study, traditional medicine is based upon paradigms that are different from the dominating medical system of a society.⁶⁴ This definition would imply that conventional biomedicine can also be considered traditional medicine in certain geographical areas if it is the weaker of two or more concurrent medical systems.

The definition that seems to be more commonly accepted, especially among Nairobi’s TMPs, is that of the World Health Organization. In a policy fact sheet distributed in 2003, the WHO writes that traditional medicine refers to

⁶⁰ Dutfield, 5

⁶¹ Ibid.

⁶² Ibid.

⁶³ Barsh, 73—originally quoted in Dutfield, 5

⁶⁴ Good, 22

“health practices, approaches, knowledge and beliefs incorporating plant, animal, and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses or maintain well-being.”⁶⁵

In fact, several of the TMPs interviewed in this study agree that traditional medicine, as they practice it, should be defined using the WHO definition.

When asked about the characteristic differences between conventional biomedicine and traditional medicine, some TMPs pointed to better health results than conventional biomedicine. Most adamantly claimed that traditional medicine was superior to biomedicine because traditional medicine had many fewer side effects.⁶⁶ Some TMPs went as far as to claim that traditional medicine has “no side effects at all, only side benefits.”⁶⁷ Other TMPs claimed that the main difference between traditional medicine and biomedicine was that traditional medicine was inherently more curative because it fixes the root causes of the illness, rather than only the symptoms. One TMP illustrated this assertion using diabetes as an example.⁶⁸ He explained that in conventional biomedicine, the main form of treatment is to provide the patient with insulin and monitor sugar levels. However, when he treats his diabetic patients, he administers certain herbs that revitalize the pancreas.⁶⁹ Doing so treats the actual cause of the disease, which he claims is more effective than treating the signs of the condition. In fact, he has claimed to eliminate diabetes from patients within a two-month treatment period, a timeline that conventional biomedicine cannot match.⁷⁰

Other TMPs claim that the main difference from biomedicine is in the approach to treatment. They examine the overall condition of the individual patient, instead of focusing on a particular ailment that the patient is suffering from. Patients who are currently undergoing treatment using traditional medicine corroborate this statement. Diane, a 41 year old woman, is using traditional medicine to treat her chronic hypertension. She claims,

“[My traditional doctor] treats me differently. We usually spend as much as two hours talking about my problem. And not just about my [blood] pressure; we spend a lot of

⁶⁵ Traditional Medicine Fact Sheet, WHO, 1-- However, as stated earlier, for reasons of limited time and resources, this study will restrict itself to those TMPs that use plant, animal, and mineral based medicines, as well as manual techniques and exercise.

⁶⁶ Dr. Billy Njuguna, interview with the author, 14 November 2006

⁶⁷ Dr. Reuben Mbugua, interview with the author, 14 November 2006

⁶⁸ Dr. George Karago, interview with the author, 15 November 2006

⁶⁹ Ibid.

⁷⁰ Ibid.

time talking about my life, why I have high pressure, and how I can change my life to fix it.”⁷¹

Another characteristic of traditional medicine cited by TMPs is the cause of efficacy. Some TMPs claim that the gift of curing is “inherent,”⁷² and that not all people can become true TMPs. They feel that they can cure patients of their ailments because of special abilities *they* possess. Other TMPs suggest that while their treatments are scientifically sound, treatment efficacy depends on the patient’s faith in the process.⁷³ If the patient feels that the medicine will work, than it will; otherwise, the patient will remain sick. Finally, there is a third class of TMPs who claim that their treatment is so grounded in pure science, that it doesn’t matter if the patient has any faith at all. The treatment has to work “because the body as a chemical factory will react only in a certain way.”⁷⁴ Those who belong in this third group also do not necessarily believe that the knowledge needed to administer this treatment is inherent. They feel that the healing ability comes via the same mechanisms as medical education in biomedicine—years of training and hard work.

When posed with the same question, medical doctors had different views. Most focused on the idea that traditional medicine could not be considered true medicine because many of its treatments have not been independently tested using clinical trials. They felt that without verifying efficacy using established standards, classifying the treatment as *medicine* is inappropriate.⁷⁵ Other medical doctors added that true medicine was taught in the classroom, and thus felt that because traditional medicine was largely a product of “cultural inheritance of knowledge,”⁷⁶ it was not legitimate. It is important to note that none of the biomedical physicians interviewed placed traditional medicine on the same level as biomedicine. While some of them acknowledged that treatment using traditional knowledge may work for certain conditions, they still placed biomedicine on a higher pedestal.

Traditional medicine has been criticized by many in the biomedical community on two main grounds. The first issue is of dosage. One biomedical physician summarized the views of many others interviewed, when he claimed that dosage is a problem because there is a lack of

⁷¹ “Simon,” traditional medicine patient, interview with the author, 20 November 2006

⁷² Dr. George Karago, interview with the author, 15 November, 2006

⁷³ Dr. Reuben Mbugua, interview with the author, 14 November 2006

⁷⁴ Dr. Billy Njuguna, interview with the author, 14 November 2006

⁷⁵ Biomedical physician, interview with the author, 18 November 2006

⁷⁶ Biomedical physician, interview with the author, 30 November 2006

standards. Different traditional doctors “know different things,”⁷⁷ and there is no sharing of knowledge. Because of that, there are also “no accepted dosage requirements among [the TMP] community...How is that medicine?”⁷⁸

In response to this criticism, several TMPs simply dismiss the problem. One TMP suggested that dosage is not really a problem within the traditional medicine field; instead, it is simply something that biomedical physicians harp on to cast doubt upon TMPs and their abilities.⁷⁹ Other TMPs agreed with this view, and many went on to state that the numerous success stories are proof that “this problem is really a non-problem.”⁸⁰ If patients are being treated effectively, then they claim it should not matter if dosage is set by each individual practitioner instead of through broad standards.

The other main criticism against traditional medicine is research. Members of the biomedical community feel that because traditional medicine is not thoroughly tested using the same rigor and standards that are part of biomedical research, administration of traditional medicine is neither safe nor responsible. However, TMPs feel that while research into their treatments may enhance their practice, lack of research is not debilitating. One TMP went so far as to say that research is what “restricts biomedicine.”⁸¹ Because conventional biomedicines cannot be administered without undergoing a certain testing process, he felt that patients end up losing in the long run. The lack of research and testing requirements allows for “more creativity”⁸² within the field, and thus “patients can benefit by receiving effective treatment as soon as [TMPs] know it works.”⁸³

ROLE OF TMPs IN SOCIETY

Terminology

The first thing that most TMPs wanted to discuss when asked about their role in society was terminology. All of the TMPs in this study agreed that the term “witchdoctor”, or anything related to witchcraft, was destructive to their profession. In addition, many did not like to be called “traditional medical practitioner” because they felt that the term was too broad; it

⁷⁷ Biomedical physician, interview with the author, 18 November 2006

⁷⁸ Ibid.

⁷⁹ TMP, interview with the author, 16 November 2006

⁸⁰ TMP, interview with the author, 15 November 2006

⁸¹ TMP, interview with the author, 16 November 2006

⁸² Ibid.

⁸³ Ibid.

encompassed many other fields, such as spiritual healing, that they do not practice. About half of the TMPs interviewed considered themselves “herbalists” while the other half felt more comfortable calling themselves “doctor”. However, the idea of using the term “doctor” to refer to TMPs has been controversial. Recently in Uganda, there was a proposal to prohibit TMPs from using “doctor” as a title.⁸⁴ Though not independently verified by the author, many TMPs said that the “doctor issue” was also a controversy in Kenya. Many TMPs felt that this problem has been explicitly created by the biomedical community. According to one TMP, biomedical doctors “feel that their ego has been usurped...[biomedical doctors] have a problem with themselves, not with us.”⁸⁵ Another TMP had a more angry response, claiming that biomedical doctors,

“...are mesmerized by the faith and trust from their patients and the society at large and therefore are tempted to play God. This naturally gives them an unreasonable sense of pride and arrogance, making them hostile to anybody, any science, or any practice that would challenge their elevated position.”⁸⁶

It seemed apparent that for many urban TMPs, the title of doctor implied a certain societal recognition of their healing abilities. In a related study done in the 1980s by Charles Good, he found that one of the main aspirations of the urban TMP was the need for recognition and prestige.⁸⁷ He went on to find that many TMPs migrated from rural environments into the cities precisely because of the greater economic benefit; this financial remuneration, however, could only come if society considered them as legitimate.⁸⁸ This desire of recognition is a pattern that seems to continue even today.

The TMPs in this study all felt that the term “doctor” should be applicable to their field as well since they too successfully treat patients. Some TMPs have decided to find a happy medium, calling themselves “herbal doctors”, usually abbreviated as “HDr.” Despite the apparent conflict, however, nearly all the TMPs interviewed claim that it is what their patients think that matter the most. For those practitioners, their reputation is less dependent on titles, and more on the respect shown to them by those they treat. One TMP claimed that his patients,

⁸⁴ Etyang, Jude. "Doctors Embrace Traditional Healers." New Vision 10 Apr. 2006.

⁸⁵ Dr. J. K. Wanjeru, interview with the author, 16 November 2006

⁸⁶ Mwea, Maina. "Herbal Medicine: Witchcraft or Modern Healthcare?" The Herbalist Sept. 2006: 3-4.

⁸⁷ Good, 211

⁸⁸ Ibid.

many of whom are high-level university professors, all call him “doctor.”⁸⁹ However, in the long run, he noted that as long as his patients feel healthier, they can call him whatever they want.

Patients

The contemporary urban traditional medical practitioner feels that he/she has many roles within society. While some confine themselves to simply “making herbal medicine available to everyone”⁹⁰ or “alleviating suffering,”⁹¹ others feel that their roles expand to that of a teacher. One TMP felt that “every patient is a student,”⁹² and that it was her responsibility to teach them how to not only cure their immediate illness, but also how to live healthier lives in the future. Other TMPs felt that the burden of health care for the majority of the Kenyan population was on their shoulders. Dr. J. K. Wanjeru, a Nairobi TMP who also practices in Karatina, explained that TMPs collectively treat over 80% of the Kenyan population; therefore, he felt his field has a major role in determining the health of the nation.

The TMPs in this study collectively have treated a wide variety of patients. Some practitioners have catered more towards the elite population of Nairobi’s residents, while others have treated a wider segment of the population. Many of them have treated poorer patients as well, many of whom cannot afford to pay for the medical services even if they are considerably less expensive than services at biomedical facilities. However, all of the TMPs interviewed stated that they would never turn a patient away because he/she did not have enough money. One TMP captured the sentiment of many of his colleagues by saying he was “a God-fearing man...we all have ethical obligations to humanity, especially those like us, who can heal the sick.”⁹³

Demographically, it seemed that most of the patients that sought the services of TMPs were adult women. None of the practitioners interviewed claimed to have treated children often; usually they found that children’s bodies do not biologically react well to their medicines. One practitioner explained the overall high prevalence of women visiting his practice as a cultural

⁸⁹ Dr. George Karago, interview with the author, 15 November 2006

⁹⁰ Dr. Reuben Mbugua, interview with the author, 14 November 2006

⁹¹ Dr. George Karago, interview with the author, 15 November 2006

⁹² Dr. Alike Mahinda, interview with the author, 20 November 2006

⁹³ Dr. Reuben Mbugua, interview with the author, 14 November 2006

phenomenon. He felt that in Kenyan society, women were “pioneers,”⁹⁴ and were the more visible presence (in contrast to men) in other places such as churches and hospitals. This trend could not be independently tested, but it may be a point of future study. From the author’s experience and observation, however, there seems to be some credence to this assertion. Most of the observed patients waiting for traditional medical care were women, and the majority of patients seen at Kenyatta National Hospital were also women. This gender discrepancy may also be a random coincidence due to the times of investigation, yet the imbalance is worthy of note.

All of the practitioners in this study also claimed that the vast majority of their patients had sought their services after unsuccessfully trying biomedical treatment options first. This pattern of seeking hospital or clinic treatment as a first resort is interesting to explore. It seems that many patients feel more comfortable utilizing biomedical services because they trust them more. When asking a patient who was seeking services at Kenyatta National Hospital why she chose to go there instead of seeking traditional medicine, she said that she “didn’t believe” in the efficacy of traditional medicine, and that going to a hospital first was what “[she] was taught and expected to do.”⁹⁵ Other personal interactions with Nairobi residents yielded similar sentiments—traditional medicine was not viewed as a legitimate medical option. People saw biomedicine as far and away the better (and often, only) course of treatment.

This line of thinking may be a result of several different factors. Many TMPs have felt that it was an aftereffect of colonial policies; traditional medicine was inaccurately branded as witchcraft early in Kenya’s history, and that view has permeated into today’s society. They also have felt that there is a strong social stigma against using traditional medicine. One TMP who has served a large elite population said that most of her wealthy patients “stay quiet about it”⁹⁶ because people would look down upon them if they were exposed. Another TMP claimed that potential patients are scared away by the thought of public criticism if the treatment were to be unsuccessful. He felt that people are afraid others would accuse them of not being responsible by going to see a TMP, even though “people die at hospitals under biomedical care all the time.”⁹⁷ However, it also seems that this attitude towards health care is a product of living in an urban, highly-Westernized, environment. While it may be true that traditional medical practices

⁹⁴ Dr. George Karago, interview with the author, 15 November 2006

⁹⁵ “Susan,” interview with the author, 17 November 2006

⁹⁶ TMP, interview with the author, 20 November 2006

⁹⁷ Dr. George Karago, interview with the author, 15 November 2006

may be rooted in culture, much of the traditional culture seems to have been lost as a result of the influences of city life (including ethnic mixing, Western commercialization, and media influences). Biomedicine is more visible in society, and it therefore makes sense that it would be the first line of treatment for Nairobi's residents.

In his book, *African Indigenous Medicine: an Anthropological Perspective for Policy Makers and Primary Health Care Managers*, Nyamwaya claims that there are four patterns by which patients interact with both conventional biomedicine and traditional medicine.⁹⁸ The first pattern is called *sequential zig-zag*, in which patients switch back and forth between biomedicine and traditional medicine, depending on the course of the illness. For example, if a patient tries biomedical treatment for a chronic condition and it does not get better, he/she may then try traditional medicine as an alternative. Conversely, a *supplementary* relationship exists in cases where only one of the two forms of medicine can be used to treat or prevent an illness. Though outside the context of this study, this may occur if a patient feels he/she is suffering from a spiritually-induced illness, in which case biomedicine would not offer a viable solution. A *competitive* scenario occurs when both biomedicine and traditional medicine can be used to treat a condition, yet the patient chooses one over another. For example, if a patient has an acute illness, he/she may choose one medical treatment option instead of the other based on previous experiences with a similar illness, cultural and social constraints, economic position, or interpretation given to a particular episode of illness. Finally, a *complementary* relationship exists when patients consider both forms of treatment to be necessary for healing; for example, certain illnesses are known to have both a biological and spiritual etiology, and thus both medical treatment systems are necessary for complete healing. TMPs in this study felt that their patients fell into the *sequential zigzag* category, in which they have tried biomedicine, it has not worked, and thus they have turned to traditional medicine.

Often, traditional practitioners notice that once patients come to them, they don't go back to biomedicine. The preference to stay with traditional medicine may come because of the approach to treatment. One TMP said that his patients liked his way of healing because he is "friendly, they know the treatment works, there is little confinement, it is painless, and there is more personal interaction with the patient."⁹⁹ Patients of traditional medicine echo that feeling;

⁹⁸ Nyamwaya, 29

⁹⁹ Dr. George Karago, interview with the author, 15 November 2006

one patient currently undergoing herbal treatment for an intestinal condition said that he came to traditional medicine because he “was paying too much for biomedical services without any real benefit.”¹⁰⁰ Additionally, some patients claim that they use traditional medicine because they are afraid of the effects of “ingesting chemicals”¹⁰¹ that they believe are in conventional medicine. One TMP explained this fear by saying that people in general “prefer being closer to the Earth,”¹⁰² and thus she attempts to keep her treatment, which includes massage therapy and reflexology, as natural as possible. Her theory is “if it can’t go in your mouth,”¹⁰³ she will not use it for treatment.

In his 1980s study, Good found that most of the TMPs in his investigation were not eager to treat patients who presented with acute conditions that could theoretically be handled more effectively in a biomedical facility.¹⁰⁴ Good went on to explain that TMPs prefer to refer these cases to the biomedical sector because it minimizes the chance of unsuccessful treatments, and therefore legal repercussions.¹⁰⁵ This was not consistent with the findings of this present study. TMPs interviewed by the author claim to treat a wide variety of conditions, both acute and chronic (see Appendix II for a list of ailments treated by one particular TMP). The most commonly treated conditions include diabetes, arthritis, and gynecological conditions. Most patients who come to TMPs after trying biomedicine first present with chronic conditions that could not be treated effectively by doctors in hospitals. The TMPs in this investigation also reported high prevalence of patients with HIV/AIDS, hypertension, and respiratory ailments.

TMPs also reported varying levels of expectations on the part of their patients, with reference to treatment success. Some TMPs claimed that their patients expect to be healed every time they come, partly a result of reputation, but also because of prior experiences with the treatment. Many patients also expect quick results, some “expecting visible results within one week.”¹⁰⁶ These high expectations sometimes present a problem for TMPs, especially because they admit that their medications, while effective, are generally slow-acting and require discipline. One TMP shared that payment is sometimes also a source of frustration. He claimed that many of his patients expected to be treated at a very cheap price, and that many times he

¹⁰⁰ “David,” traditional medicine patient, interview with this author, 20 November 2006

¹⁰¹ Ibid.

¹⁰² Dr. Alik Mahinda, interview with the author, 15 November 2006

¹⁰³ Ibid.

¹⁰⁴ Good, 240

¹⁰⁵ Ibid.

¹⁰⁶ Dr. Alik Mahinda, interview with the author, 15 November 2006

barely gets enough money to break even. However, this was an isolated concern; no other TMPs listed this as a problem. When actual patients were asked the same question, they seemed to recognize that treatment with traditional medicine was a long-term process, but they still expected to be cured. Michael, a patient with diabetes, claimed:

“I know it will work, I have complete faith in [my doctor’s] treatment. It may take some time, but it will work better than hospital treatment. I’m willing to wait for results because I know they will last. I might get sick again if I visit a hospital doctor.”¹⁰⁷

Misconceptions and Other Challenges to the TMP Practice

Despite the fact that many patients end up staying with traditional medicine after using it, there is still “bitterness” among TMPs that there are many misconceptions about their practices. Many TMPs in this study blamed the misconceptions on an unflattering colonial legacy. Specifically, they fault Christian missions for the damaging stereotypes. Because of the association with witchcraft, consulting TMPs was seen as a sin in the eyes of the missionaries, and thus people in society kept a distance from their services. In the same vein, there is also the perception that TMPs are uneducated because some do not consider TMPs as practicing “real” medicine. As one TMP described, people view those in his field as “simple village people”¹⁰⁸ because they associate herbalism with spiritualism. However, he felt that this association is particularly hurtful because as a medically-trained physician, he believes in the science of his craft. In his words, “herbalism is different from spiritualism—herbalism can be scientifically tested.”¹⁰⁹ Other traditional practitioners blamed the government for the current public perception towards TMPs. Because traditional medicine is currently under the jurisdiction of the Ministry of Culture instead of the Ministry of Health, they feel that society sees them as a “cultural option” instead of a “medical option” and that society will only start taking them seriously once they come under the control of the Ministry of Health.

The concerns of the TMPs appear to be corroborated by some residents of Nairobi that participated in this study. In general, when asked about thoughts on traditional medicine, many people chuckled and claimed that traditional healing is “from the past”¹¹⁰ and “not even a consideration”¹¹¹ when deciding who to consult about medical problems. When asked why they

¹⁰⁷ “Michael,” traditional medicine patient, interview with the author, 20 November 2006

¹⁰⁸ Dr. Billy Njuguna, interview with the author, 14 November 2006

¹⁰⁹ Ibid.

¹¹⁰ “Josh,” Nairobi resident, interview with the author, 21 November 2006

¹¹¹ Ibid.

feel traditional medicine is not an option, the subconscious connection of herbal medicine and spiritualism becomes apparent. One man stated rather bluntly that when he is sick, he “needs to see a real doctor, not some person who gives me plants and tries to get the spirits out of me.”¹¹² The majority of people, however, accept that traditional herbal healing works. Many recall how their grandmothers effectively used herbs to treat them as children. But now that they have moved into the city, they feel that quacks “are everywhere” and “there isn’t anybody [they] can really trust”¹¹³ when it comes to traditional medicine. Thus, it seems that the misconceptions of witchcraft are less of a concern than the lack of quality control measures among those studied in Nairobi.

The misconceptions can be alleviated, according to TMPs, by standardizing and increasing the exposure of their field. Common suggestions from traditional practitioners to legitimize the field in the eyes of the public include increasing documentation, incorporating high-class clinics, and constructing labs and pharmacies dedicated solely to traditional medicine. Also, some TMPs suggested spreading education about the benefits and workings of traditional medicine, not only in medical schools, but also to the general public.

National Development and Traditional Medicine

In a recent article in Ghana’s *Concord Times*, there was a claim made that its elites, presumably referring to its political leaders, have adopted Western ideals of development for the country.¹¹⁴ As part of this vision, they have tried to marginalize cultural relics, such as traditional medicine, in favor of Westernized counterparts (such as conventional biomedicine). There has been much public outcry in Ghana against this mode of thinking; many feel that if development of the country is to occur, it must come from within Ghana itself rather than from abroad. Ghanaian analysts have claimed that their government is having trouble incorporating traditional medicine into the national system because,

“Ghanaian elites still think Ghanaian values, which [have] sustained Ghanaians and their ancestors since time immemorial, is inferior because their education system, which was imposed on them, tells them it is so.”¹¹⁵

¹¹² “Geoffrey,” Nairobi resident, interview with the author, 21 November 2006

¹¹³ “Elyse,” Nairobi resident, interview with the author, 21 November 2006

¹¹⁴ “Ghana: the Elites and Traditional Medicine.” *Concord Times* 8 May 2006.

¹¹⁵ Ibid.

Many Nairobi TMPs feared that this marginalization of traditional practices, including their herbal medicine, is also happening “to a lesser degree” in Kenya. However, they agreed with the author of the Ghanaian article that they are a critical part of development. While all the TMPs in this study felt that their work was an essential part of development, some TMPs felt this way because of simple reasoning: as one practitioner described, part of the role of development in his mind was to alleviate suffering. If conventional biomedicine “could not provide all the health care answers”¹¹⁶ for the population, but traditional medicine could help in that respect, then “why not include traditional medicine in the development vision”¹¹⁷ for the nation? This practitioner went on to explain that his abilities to heal could help more people become healthy and work, and that “is where development begins”¹¹⁸. Every person has the potential to contribute to the economic and social development of the country, so it “does not make sense to let people stay sick.”¹¹⁹

Other practitioners reacted in a more resentful manner to this issue. They claim that “some African elites are more European than Europeans themselves,”¹²⁰ and blame Western-packaged development for the struggles that Kenya is currently facing. According to them, biomedicine came with Westernization in an effort to “keep [Africans] down.”¹²¹ The West did not want Africans to come up with their own treatment options, and so they imposed their own varieties of medical care on the people they colonized.¹²² One TMP, who has a particular interest in all-natural lifestyles, blamed the poor health of Kenya’s population on development efforts. Specifically, she cited the use of cleansers, sterilization, food coloring, microwaves, and aluminum pots and pans as reasons that people get sick more often. In her words, “development, exactly that word, is what is killing us.”¹²³ While the validity of her claims is questionable without relevant scientific studies, the idea that she tried to convey was clear: If Kenya wants to truly progress as a nation, she needs to develop her own development paradigms, ones that include tried and tested traditional practices that have been sustaining the indigenous populations for generations.

¹¹⁶ Dr. George Karago, interview with the author, 15 November 2006

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ TMP, interview with the author, 22 November 2006

¹²¹ TMP, interview with the author, 20 November 2006

¹²² Ibid.

¹²³ TMP, interview with the author, 15 November 2006

REGULATION OF TRADITIONAL MEDICINE AND INTEGRATION EFFORTS INTO MAINSTREAM HEALTH CARE

Need for Policy and Relevant Issues

The World Health Organization, in 2002, declared that national policies regulating traditional medicine was necessary in those countries where the population relies greatly on traditional medicine for their health care.¹²⁴ This is the case in Kenya, where WHO estimates that nearly 80% of the population has used traditional medicine at least once in their lifetimes.¹²⁵ Effective government policy is needed on issues including safety and quality, licensing of providers, and standards for training. Incorporating such measures would allow for the promotion of better practice, more equitable access, and safer treatments. Recent successful efforts to create national policy concerning traditional medicine in other African nations include those done in Nigeria,¹²⁶ Mali,¹²⁷ and Uganda.¹²⁸

This need for government regulation and recognition was also shared by nearly all the TMPs in this study. Many felt that the government was ignorant about the potential benefits of traditional medicine on several aspects of Kenyan development, and as a result the country as a whole was being hurt. They cited the positive impacts that policy would have on farmers, who could grow and harvest herbs that could be used in traditional medicines. They further pointed to the potential benefit to the industrial sector of the economy, where factories that package and export traditional medicine could help Kenya tap into the booming market for herbal medicines (as was done recently in Ghana).¹²⁹ Many practitioners refer to China's successes in this regard, and hope to one day replicate their achievements. However, the most important impacts of regulation would be felt by practitioners and patients, who could feel better assured that their treatments were both secure and effective.

At the same time, there are a relative minority of practitioners who felt regulation would hurt their practice. While they acknowledged that they would be afforded more benefits and

¹²⁴ Traditional Medicine-Growing Needs and Potential. World Health Organization. Geneva: World Health Organization, 2002.

¹²⁵ Traditional Medicine Fact Sheet. World Health Organization. 2003. 22 Nov. 2006

¹²⁶ "FG Endorses Bill to Regulate Traditional Medicine Practice." Vanguard 17 Aug. 2006

¹²⁷ "Mali Adopts National Traditional Medicine Policy." PANA 13 Oct. 2005

¹²⁸ "National Policy on Traditional and Complementary Medicine in Pipeline." New Vision 26 Apr. 2006

¹²⁹ Hatsu, Irene E. "Traditional Medicine Practitioners to Go Into Hi-Tech Manufacturing." Public Agenda 3 Nov. 2006.

security from official policy, they feared the restrictions that would be placed upon them by the government. One TMP claimed that his creativity would be stifled, and that the government would cripple his practice by forcing him to only use certain treatments that had been officially tested, even though he knew other treatments which have not been independently are just as effective. He felt that while a lack of policy would allow more quacks to infiltrate the system, he was confident enough in his reputation among patients in his healing abilities that his practice would not suffer if new policy were not put into place. Still there is a third group that hopes to have regulative policy, yet cautions against close-mindedness once it is enacted. As one TMP warned, they need to remember the foundations of their craft, yet not become restricted by the rules of the policy.

Education and Registration

There are a number of specific issues for TMPs and government and health officials in this study that have been seen as essential to include in any policy framework. The first is the need for education and registration standards. Currently, TMPs need to register with the government through the Ministry of Culture. According to recent studies, criteria for registration consist of forms to be filled out and submitted to the Ministry of Culture, presentation of five herbal remedies to KEMRI,¹³⁰ and approval from local authorities. Nearly all those who are involved in this policy-making process, and participated in this investigation, agreed that this registration process is not sufficient to ensure that only appropriately trained herbalists are allowed to practice. Thus, many feel that there is a need to have a central governing board, composed of TMPs themselves, who can determine the fitness of a person to practice traditional medicine (governing boards are another important issue that will be discussed later in this paper).

Part of the debate surrounding appropriate registration procedures centers around what type of educational standards, if any, need to be implemented. Through an overview of the backgrounds of each of the TMPs in this study, it is readily apparent that their educational backgrounds are vastly different. A few have known they wanted to practice traditional medicine, and thus took appropriate courses in small schools or through research institutions such as KEFRI. Some have biomedical backgrounds, having studied either in medical school in Kenya or in science-related graduate schools abroad. One TMP was a biomedical physician

¹³⁰ Dutified, 7 – these samples are tested for safety and the results are sent to the practitioner along with possible uses.

practicing Family Medicine, while another TMP was at one point the pharmacist-in-chief of Kenyatta National Hospital before turning his attention to solely herbal medicine. Others began careers in botany and plant pathology and eventually became trained in herbal medicine. There are also those who began their careers in totally different fields but eventually decided on practicing herbal medicine. For example, one practitioner in this study started her career running hotels and designing, yet through experiences in Greece, the US, and India, trained herself in traditional medicine and now has become very highly-respected in the city, having treated high level government officials and university professors.

A cursory examination of these selected few examples shows that different TMPs have different knowledge bases, and thus there is debate about how much one needs to know about traditional medicine in order to be considered an official practitioner. There are currently no standardized tests or licensing procedures based on examinations. In part, some TMPs feel that this lack of educational standards is inherent in cultural practices. One practitioner who has worked closely with the government in formulating policy says the imposition of educational standards is not fair for the many TMPs who practice in small rural communities. Several of the rural TMPs have not had formal schooling, and thus, it is “not fair to ask them to take a paper and pencil test so they can continue a practice they have been doing for years.”¹³¹ One TMP added that traditional medicine “ceased to be traditional”¹³² if formal education was to be forced upon it, and felt that the idea of educational standards was another sign of the Western idea of development. In his opinion, if a TMP “has a book education, fine; if not, let him be.”¹³³ Solutions to this problem by other TMPs include interviews with certification candidates which are conducted by fellow practitioners to ensure a certain attainment of predetermined educational standards, also set by fellow practitioners.

Nevertheless, there is widespread agreement that there are too many quacks currently in the system, and imposing educational standards of some sort is necessary in order to preserve the integrity of the field and ensure government recognition. Thus, there have been efforts to develop institutions that specifically train students in herbal medicine. In Zimbabwe, for example, it was considered a major milestone for the progress and recognition of traditional practitioners in that country when a new school specifically designed for herbal medicine was

¹³¹ Dr. J. K. Wanjeru, interview with the author, 16 November 2006

¹³² Dr. George Karago, interview with the author, 15 November 2006

¹³³ Ibid.

constructed in May 2006.¹³⁴ In Kenya, there are similar options. Kenyatta University has a program designed for traditional medicine, as does the Abhalight College of Natural Medicine, both based in Nairobi. Started in 2000 as an informal classroom for students from the Korogocho slums and Nairobi, Abhalight College now offers diploma and certificate diploma level courses in Homeopathy, Herbology, and Reflexology.¹³⁵ Eligibility for the institution includes fluency in English, C-level grades of KCSE or O-level courses (or alternatively at least one year of work experience in naturopathy or other health-related fields), a love of serving humanity, and a passing score on an entry exam or interview.

The director of the Herbology course is also a practicing TMP in Nairobi and Karatina, and teaches a 2-year course in herbal medicine. The class meets for 6 hours per week, and includes units in History & Development, Identification of Medicinal Plants, Growing Medicinal Plants, Production, Conservation of Medicinal Plants, Diseases, Diagnostic Methods, Current Status for the Profession, and Entrepreneurship & Marketing¹³⁶ (see Appendix III for complete syllabus). Though the author was not able to observe a class because of the time this study took place, an examination of course materials showed an extensive array of textbooks and reference materials serving as the main teaching resources.

Intellectual Property Rights (IPR)

There has been increasing awareness of the necessity for protection of intellectual property, in terms of the uses of traditional herbal medicine. Many traditional medicines are used as inputs in biomedical research; African communities have produced medicinal drugs that have been used in the discovery, development, and preservation of a plethora of medicinal plants and therapeutic herbal concoctions.¹³⁷ However, despite the large international market for herbal medicines, the profit that resulted from use of this indigenous knowledge has not reached the African communities themselves; instead, they have landed in the pockets of large international pharmaceutical companies. Since the early 1980s there has been a concern that African traditional herbalists were being exploited by large health corporations. This concern manifested as early as 1979, when the Organization of African Unity promoted the secrecy of herbal

¹³⁴ "Launch of Traditional School a Milestone." The Herald 8 May 2006.

¹³⁵ Herbal Medicine Syllabus. Nairobi: Abhalight College of Natural Medicine, 2006

¹³⁶ *Ibid.*

¹³⁷ Dutfield, 7

medicine research so that developed countries could not steal the information and sell the resulting products back to developing countries at marked-up prices.

TMPs in Nairobi echoed the concern over securing indigenous knowledge. Among the traditional practitioners that participated in this study, there was unanimous agreement that some sort of IPR protection needed to be included in any national policy regulating traditional medicine. Some felt that because developed countries do not want Africans to develop things on their own, the West was subjugating African traditional medical practices by not enacting harsher IPR laws and fighting international patents coming from Africa. One TMP shared a story of his colleague who had invented an herbal cocktail to treat HIV patients and subsequently had the ingredients to the basis of his mixture taken by a major US pharmaceutical company and marketed as a biomedical drug. Some TMPs feel so strongly about exploitation that they are willing to “be completely secretive and die with their knowledge”¹³⁸ instead of having it stolen.

The literature makes it clear that there is great commercial value in ethnobotanical knowledge. Recent studies show that up to 74% of plant-derived human drugs are eventually used for the same purpose as the native population originally discovered them.¹³⁹ Some estimate that as many as 7,000 medical compounds in Western medicine are derivatives of plants.¹⁴⁰ Schuler found that the “value of developing-country germplasm to the pharmaceutical industry”¹⁴¹ was \$32 billion in the early 1990s. During that same time, the estimated market value of plant-based medicines sold in OECD countries was \$61 billion.¹⁴² Not surprisingly, little to none of those profits ever reached the communities from which the information was taken.

Currently, there are many problems facing Kenyan TMPs against exploitation. First, the holders of traditional medicine do not see the profits made from their knowledge. The United Nations estimates that developing countries lose at least \$5 billion annually in unpaid royalties to multinational corporations that appropriate traditional knowledge.¹⁴³ Second, the holders of indigenous knowledge cannot apply for their own patents when others already own them. Third, contesting patents is very expensive, far out of the reach of Nairobi’s TMPs. It is also hard for

¹³⁸ TMP, interview with the author, 15 November 2006

¹³⁹ Schuler, 160

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

¹⁴² Dutfield, 9

¹⁴³ Visser, 213

many of Kenya's TMPs to apply for patents when the processing of the herbs usually involves simple grinding; this process is not novel enough to warrant a patent. Finally, when contesting patents, some legal systems require written evidence that the object being patented is not original. This is a problem for some traditional medicines, especially when the use and dosage has been passed on orally from previous generations.

One solution to the IPR problem includes harmonizing and making IPR protection laws equitable in both developed and developing countries.¹⁴⁴ This is a problem for countries like Kenya, simply because the cost to implement laws up to par with developed countries is extremely expensive. Another proposed solution is to place ethnobotanical knowledge in the public domain. That way, by keeping careful records, there is documentation of when certain drugs or techniques have been discovered. Some feel that the only currently viable option for Kenya's TMPs is Utility Model Protection.¹⁴⁵ The grant of Utility Model (UM) is not subject to novelty and inventive step requirements. It is valid in Kenya for only 10 years and is not renewable. Through collaboration with research institutions, many Kenyan lawyers feel that TMPs have the best chance of using UM to protect themselves.

Hospital Integration

Among the TMPs in this study, the vast majority look to China as a model of success in its ability to integrate biomedical and traditional medicine in the hospital environment. In some hospitals in China, patients who walk in for treatment are offered the choice of whether they would prefer to be treated using traditional herbal medicine or conventional biomedicine.¹⁴⁶ The TMPs interviewed in this investigation hope to see that occur in Nairobi's hospitals as well. Some practitioners see integration with biomedicine as the one of the first steps towards societal recognition and development of the industry. Some TMPs are not so eager to become integrated into clinics and hospitals. One TMP explained by claiming that if traditional medicine were to work side-by-side with biomedicine, the Ministry of Health would be forced to restrict traditional medicine such that only practices that were extensively researched and tested would be allowed to be carried out in the hospitals.¹⁴⁷ Once again, the creativity in the field would be lost, and

¹⁴⁴ Schuler, 177

¹⁴⁵ Mwasi, Mwasengu. "Intellectual Property Protection: the Dilemma." *The Herbalist* Sept. 2006: 7

¹⁴⁶ Dr. Elizabeth Ogaja, 28 November 2006

¹⁴⁷ TMP, interview with the author, 16 November 2006

many treatments would not be permitted until they were tested, a result that would “clearly be to the detriment of the patients”¹⁴⁸ who are awaiting care.

Some TMPs feel that the answer is not necessarily to integrate into hospitals, but to create their own hospitals that are staffed only by traditional practitioners. Officials from the Ministry of Health also recognize that this is a desire of some TMPs, since it would afford them the societal recognition that they desire so much.¹⁴⁹ There have been examples of clinics that are run entirely by traditional practitioners. In Kenya, the Makini Clinic is an example of such an institution. Though the author was unable to investigate the clinic in-depth, it was apparent that the clinic was run by traditional herbal doctors and serves as a professional, fully-staffed and functional health care facility.

Both the Ministry of Health and private hospitals in Nairobi feel that there must be more work done before integration can take place on the hospital level. Dr. Elizabeth Ogaja, the Ministry of Health representative in charge of helping develop policy on traditional medicine felt that there first needed to be extensive research into the medicines that herbal doctors are prescribing; clinical trials to investigate the efficacy of medication is an example of such a step. Also, in order to ensure safety of patients, she felt that there needed to be effective licensing procedures before traditional doctors could practice in hospitals. Even if all of these things occurred, however, Dr. Ogaja still doubts that traditional medicine and conventional biomedicine could ever realistically work side-by-side in treating patients. While the idea of giving patients a choice on form of treatment remains a distinct possibility, she does not foresee both types of physicians working around the same operating table.

The Medical Director of Aga Khan University Hospital also feels that there are several challenges that need to be addressed before the integration process can take place. While acknowledging that traditional medicine must be useful to a segment of the population since it has survived for so long, he doubts that integration is currently an appropriate option. Describing biomedicine and traditional medicine as two useful “institutional pillars,”¹⁵⁰ he claims that before integrating, each individual pillar should first be strengthened. Society needs to better explore and understand the nature of traditional medicine, appropriating adequate

¹⁴⁸ Ibid.

¹⁴⁹ Dr. Elizabeth Ogaja, 28 November 2006

¹⁵⁰ Dr. John Maganga Tole, interview with the author, 30 November 2006

support in the forms of research, documentation, sharing of knowledge, and analysis. After this has taken place, then integration should take place if it is appropriate.

Environmental Concerns and Health Insurance

Two other major concerns that TMPs hoped new policy would address are environmental conservation and the inclusion of traditional medicine under health insurance coverage. Conservation of the environment is critical to the sustainability of the traditional medicine profession. Currently, TMPs complain that they are finding it more difficult to obtain the necessary herbs and plants they need in order to make medicines. Several practitioners in this study have their own shambas (farms), where they grow the herbs they use on a regular basis. Other TMPs in Nairobi who do not have plots of land in the rural areas rely on third-party stores to provide the necessary materials. One such company is Health U, a chain of stores that sells many things related to nutrition and wellness, including among other things, organic foods, vitamins, massage items, and herbs. The TMPs interviewed hope that there are enough clauses for environmental protection in any new policy that Parliament passes. Enactment of such clauses would also directly affect farmers who own and run these kinds of farms in the rural areas. Though time and resource limitations prevented the study on the impact of traditional medicine regulation on farmers, this may be a fruitful topic of future study.

Another concern is that health insurance companies in Kenya currently do not include the services of TMPs under their coverage packages. TMPs in this study have indicated that this becomes a source of conflict for their patients—they believe many more patients would come to seek their services if insurance companies would share the majority of the cost. This sentiment was shared by Nairobi residents who currently have health insurance coverage. In East Africa, the largest health insurance provider is AAR. One of their members, a 55-year old female with four children, shared some of her concerns about the current coverage she is receiving. She admitted that she was forced to see the doctors provided by AAR, and “though they did a good job,”¹⁵¹ she wishes that she could see a doctor of her choice. If given the choice to see a traditional practitioner, she claims she would because she has “heard that they work better”¹⁵² than biomedicine. One marketing executive at AAR’s main office in Nairobi acknowledged the appeal of traditional medicine to many of her clients. However, she noted that AAR’s main

¹⁵¹ AAR Client, interview with the author, 21 November 2006

¹⁵² Ibid.

priority is ensuring the health of its members, and thus, she felt confident that once effective policy is passed by Parliament that enacts educational and professional standards on traditional medicine, that her company would begin to also cover visits to traditional healers.

Construction of an Umbrella TMP Organization

Another concern, and probably the most important, is the construction of an umbrella organization of TMPs that is self-regulating. In terms of responsibility, traditional practitioners would want the board to be responsible for creating their own educational standards, lobbying for government resources, creating their own code of ethics, and disciplining those who diverted from the accepted rules. Currently, there are several independent organizations composed of TMPs from different backgrounds. This study will examine the two major groups involved, National Association of Traditional Healers and Practitioners (NATHEPA) and Nairobi Herbalists Association (NHA). As will be explored later in this discussion, these two groups have been fighting each other for power; this has caused an internal resistance to policy-making and regulation.

However, traditional practitioners still feel that this is one of the most important parts of any potential government policy. Many hoped that the organization will be composed of traditional practitioners and other medical specialists, but not biomedical physicians. They feel that the inclusion of biomedical physicians would complicate matters because “they speak a different language and don’t understand what traditional medicine is about.”¹⁵³ There are also claims that biomedical physicians, if allowed on such a board, would promote the causes of pharmaceutical companies—a result that all TMPs in this study agree would be to the detriment of their profession. As one Nairobi TMP said, “biomedical doctors are on the leash of pharmaceutical companies, of course they would be against us.”¹⁵⁴

Resistance to Policy Implementation

There are two commonly cited sources by TMPs of resistance to policy implementation and possible integration into the mainstream health sector. The first source of resistance is external, and comes from the pharmaceutical companies. Nearly all the TMPs interviewed as part of this study claimed that large Western pharmaceutical companies were trying to suppress

¹⁵³ TMP, interview with the author, 19 November 2006

¹⁵⁴ TMP, interview with the author, 19 November 2006

their field, purely for economic reasons. They feel that these drug companies are aware that there is much potential in the herbal medicines that are prescribed by TMPs, and do not want their patients to have another legitimate option for treatment. According to some traditional practitioners, pharmaceutical companies would “steal their knowledge in an instant”¹⁵⁵ and use it to create mass-market drugs that could be sold at a high premium. As one practitioner frankly noted, “nobody likes competition.”¹⁵⁶ It would be interesting to investigate the feelings of pharmaceutical companies on traditional medicine; this would be a fine topic for future study. Results of such a study would have a large impact on the global market for herbal medicine, and is of direct consequence to both drug companies and TMPs in developing countries.

Infighting amongst TMPs themselves is an internal source of resistance, and is much more of a tangible threat. As mentioned previously, there are two major groups of TMPs, NATHEPA and NHA. Both have been involved in a power struggle with one another, and this has delayed the progress of policy implementation. Currently, the Ministry of Culture is working directly with NATHEPA in formulating policy. A high-ranking official in NATHEPA explained that previously, there was a very inefficient group of TMPs that was dissolved by the Ministry of Culture in lieu of NATHEPA.¹⁵⁷ The leaders of NATHEPA were democratically elected, and are now the official umbrella organization of Kenya’s traditional practitioners. With over 20,000 members, NATHEPA is hoping to now travel to the grassroots level to meet with rural and small-town TMPs in order to share objectives and progress. Members of NATHEPA feel that NHA is a side group of this larger organization.

Members of NHA, however, do not agree with that assessment. One high-ranking member of NHA claimed that NATHEPA is not a legitimate or “respectable”¹⁵⁸ organization because its members were not elected by TMPs; instead, he feels that they were hand-picked by the government. He explained that much of NHA is composed of TMPs who have “significant scientific backgrounds and professional outlooks.”¹⁵⁹ Because of their knowledge, he feels that the government has chosen people who will not think for themselves, but instead carry out the wishes of the government, as leaders of NATHEPA. Other members of NHA share this feeling,

¹⁵⁵ TMP, interview with the author, 20 November 2006

¹⁵⁶ TMP, interview with the author, 17 November 2006

¹⁵⁷ NATHEPA member, interview with the author, 16 November 2006

¹⁵⁸ NHA member, interview with the author, 22 November 2006

¹⁵⁹ Ibid.

and add that the government once used to consult them about policy matters, but have now marginalized the NHA members once they “stopped agreeing with [them].”¹⁶⁰

This infighting has not escaped the notice of the Ministry of Health. As described by Dr. Ogaja, this internal conflict has been the biggest difficulty for the Ministry in its efforts to establish policy. She acknowledged that currently NATHEPA and the Ministry of Culture have a working relationship, but she would not comment on the legitimacy of either group. Instead, she hoped mainly that the various groups would reconcile their differences and work together. In her words, “this is not a war, we all want the same thing.” She made a comparison to biomedicine, where there are many smaller organizations separated by specialty (i.e., cardiology, neurology, etc.), but all the organizations fall under the umbrella Kenya Medical Association. She noted that it was the Ministry of Culture’s responsibility to ensure unity, but urged the leaders of the organizations to come to an agreement and associate together such that policy making can be mutually beneficial to all TMPs.

Previous and Current Policy Efforts

There have been previous efforts to construct policy to regulate traditional medicine. In 2002, an inter-ministrial group drafted the Traditional Health Practitioners Bill. One TMP who was involved in this drafting policy scoffed at that attempt by the government. With clauses that “tried to kill”¹⁶¹ the profession via unrealistic standards and restrictions enforced by harsh monetary and penal penalties, he noted that the bill was rejected by TMPs across the board. Later in 2004, The Constitution of Kenya Review Commission included the regulation of traditional medicine in The Draft Constitution of Kenya 2004, a document that was never passed. However, TMPs involved in this process acknowledge that had the constitution draft been passed, traditional practitioners would have received more power. Examination of the proposed constitution reveals several clauses in Chapter 5 (Culture) that address such matters as research into traditional medicine, intellectual property rights, farming and environmental conservation, and international collaboration.¹⁶²

Although very recently rejected by TMPs, during the course of this investigation another inter-ministrial committee drafted a new proposed policy, The National Policy on Traditional

¹⁶⁰ NHA member, 14 November 2006

¹⁶¹ TMP familiar with draft, interview with author, 16 November 2006

¹⁶² Kenya. The Constitution of Kenya Review Commission. The Draft Constitution of Kenya 2004. Nairobi, 2004

Medicine and Medicinal Plants. According to representatives from the Ministry of Health, this inter-ministerial committee was headed by the Ministry of Planning because they saw traditional medicine as a multi-faceted issue, not just a medical one. Thus, representatives from many other departments of the government were included in the drafting, including the Attorney General's Office, Ministry of Agriculture, Ministry of Trade and Industry, pharmacy boards, museums, commercialization/marketing boards, and various parastatals. Each department was given different responsibilities depending on their specialty.

After reading the proposed policy, the author asked various TMPs their thoughts and comments. It quickly became apparent that not many of them had even known the policy draft existed, let alone have a comment on its contents. This came out as one of the primary problems noticed about the process; it seemed that TMPs were neither appropriately briefed nor consulted on policy that would ultimately govern how they worked. Many TMPs complained that they were never included in the decision making process, and that "technocrats and civil servants think they can make policy for things they do not understand."¹⁶³ Some added that if those who write the policy on traditional medicine "do not believe in it, they would have no reason to fight for it."¹⁶⁴ Many TMPs see the Ministry of Health as involved in the process only for the economic benefit and "prestige"¹⁶⁵ of interacting with organizations such as the World Bank and United Nations; they are very skeptical of the Ministry's actual motives.

However, one TMP who was familiar with the panel that drafted the policy offered many critiques of the draft after having consulted with other high-ranking members of NATHEPA. One of the major criticisms was that the policy catered towards the elite population of TMPs, instead of including benefits for the illiterate or uneducated TMPs living in rural or small town environments. This feeling arose because there were many clauses which required certain educational standards that would be hard to achieve for TMPs who have not had formal education. Another criticism was that under the "Objectives" section of the proposal, TMPs were only included in one out of the six total objectives. This was a cause of concern because TMPs felt that they should be included in every facet of their regulation. This exclusion on relevant matters also was apparent to the author through the administrative model (see Appendix IV). By leaving TMPs out of decision making processes, it effectively stripped them of power

¹⁶³ TMP, interview with the author, 21 November 2006

¹⁶⁴ TMP, interview with the author, 15 November 2006

¹⁶⁵ TMP, interview with the author, 16 November 2006

over matters that directly concerned them. In the words of one TMP, under the provisions of this new policy, they “would be stepped on”¹⁶⁶ by people under the “administration of those who do not contribute to the development of the profession.”¹⁶⁷ Another shortcoming was that the policy only addressed herbalists, even though the term *traditional medicine* encompasses a wide variety of specialties, as discussed earlier. Finally, there was also the concern that there were too many ministries involved in this process, and that ultimately this would lead to power struggles of which TMPs would definitely lose.

The Ministry of Health offered some responses to a few of the criticisms levied by the traditional practitioners. For example, one MOH representative acknowledged that the policy only addressed herbalists, but she explains that this was a conscious decision on the part of the Director of Medical Services, who felt that the ministry could not do everything at once. Because herbalism is “tangible,”¹⁶⁸ there are easier possibilities for quality control, and thus is a useful field with which to begin. There needs to be more research into other fields before regulation of those specialties can take place. In response to the claim that too many ministries are involved, she noted that this may be a potential problem; however, she was confident that if each department kept within the confines of their mandates, they could work cooperatively rather than competitively. She had noticed some conflict between the Ministry of Culture and the Ministry of Health; according to her knowledge, many TMPs had used the Ministry of Culture to come to the forefront, but now wanted to be under the jurisdiction of the Ministry of Health because they felt their field was inherently a medical issue, not a cultural one. In her opinion, these criticisms would be worked out once the policy was debated, and she hoped a final draft could be passed within six months.

Successful Examples of Collaboration

Despite the current struggles to draft and enact policy, traditional practitioners, government officials, and other health workers agree that collaboration between conventional biomedicine and traditional medicine is necessary. There have been many examples abroad, and a few in Kenya itself, in which successful collaboration has already taken place. For example, some NGOs have been created specifically to promote this collaboration. One such organization

¹⁶⁶ TMP familiar with policy efforts, interview with the author, 16 November 2006

¹⁶⁷ Ibid.

¹⁶⁸ Dr. Elizabeth Ogaja, interview with the author, 28 November 2006

is the Association for the Promotion of Traditional Medicine (PROMETRA), an international NGO that believes the collaboration between both fields is the “only solution in resolving health-related problems that assail the African people.”¹⁶⁹

Within Kenya, one outstanding example of the benefits of collaboration is Women Fighting AIDS in Kenya (WOFAK). Based in Nairobi, WOFAK was originally started in 1993 as a support group for HIV infected women who faced “discrimination, stigmatization, and rejection”¹⁷⁰ because of their disease. However, membership has since grown to over 450 members, all of whom share and support each other as HIV infected women. There are 20 permanent staff members and five volunteers, including counselors, educators, home-based caretakers, and since 1999, traditional healers. Inspired by the First International Meeting on Traditional Medicine and AIDS in Senegal, as well as with funding from the Ford Foundation, WOFAK embarked on a mission to incorporate traditional healers into the care of their members while also promoting traditional medicine as a profession. One way this is accomplished is by having two treatment rooms at the WOFAK center side-by-side; one room is staffed by conventional biomedical doctors, the other by traditional herbal healers. WOFAK encourages cross-referral between both types of treatment, such that its members can benefit from both types of medicine. In addition, WOFAK works closely with KEFRI to identify traditional medicines that work for illnesses the members have while still keeping herbal medications that are deemed effective a secret, so that traditional practitioners feel comfortable that their medicines will not be stolen for commercial use abroad. In addition, patients benefit from cost-sharing and income-generating measures such that members can receive treatment for little to no charge.

WOFAK has been very successful in its efforts to gain the trust of TMPs while still encouraging the involvement of biomedical physicians. TMPs tend to trust WOFAK when they learn that it is not an organization of researchers, and that the main goal of WOFAK was to treat people infected with HIV/AIDS, not to steal their samples. In addition, WOFAK serves as a way for TMPs to generate income, thus contributing to the development of the field. This organization is a model for what benefits can be achieved through collaboration between both fields. There is a large emphasis on sharing of ideas, and the biomedical physicians feel

¹⁶⁹ Gbodossou, 1

¹⁷⁰ King, 10

comfortable knowing that the ideas suggested by traditional practitioners have been independently verified by trusted research bodies.

Growth of the Field

There is a general optimism among TMPs in this study that traditional medicine, as a field, is growing and moving in the right direction. In terms of patients, several practitioners feel that the trust in traditional medicine is increasing among the population. They attribute this mainly to the success stories they have achieved—they feel that more and more people hear about the successes of traditional medicine, and therefore are more inclined to consider it a legitimate form of therapy. One TMP is convinced that traditional medicine is inherently more desirable than biomedical care, and thus “everyone will eventually turn to traditional medicine.”¹⁷¹ There is also a belief that students who are contemplating a career in medicine or health services will look more closely at traditional medicine as an alternative to conventional medical school.

¹⁷¹ Dr. Alik Mahinda, interview with the author, 15 November 2006

CONCLUSIONS

Traditional medicine is a critical part of the health service sector that needs to be discussed and taken out of the shadows. Clearly, there is a problem of access to conventional biomedical services for a large proportion of the Nairobi population. Health services are too expensive for many, and health insurance is not a realistic possibility for those who do not obtain coverage from their employer. Traditional medicine offers an alternative treatment possibility, one that has been shown to work on many conditions to the same degree, or even better, than conventional biomedicine. It makes sense that this field needs to be explored and researched so that society can take advantage of its benefits. Unfortunately, there has been a very lasting colonial legacy that has stigmatized and marginalized traditional medicine from sharing the health sector spotlight.

Potentially, traditional medicine could aid in the process of bettering medical care for a large proportion of Nairobi's residents. Traditional medicine also has a huge economic impact. Entering the global market of traditional herbal medicine could significantly boost Kenya's economy, and thus there are large incentives for this issue to work out well. The first step in this process is to initiate discussion, bringing together and sharing viewpoints of various parties who have a vested interest in the field, including TMPs, hospital administrators, agricultural officials, and economic analysts. By getting different views on the table, there can be effective discussion. It is the author's hope that this study has contributed to that effort.

Though it is hard to comment on policy efforts without a more in-depth study, the author does believe it is a positive sign that the government has drafted a policy to regulate the practice of traditional herbal medicine. While the concerns and reservations of the TMPs are duly noted and significant, there should be healthy debate in which efficient compromises can be reached. However, if TMPs want their field to progress, they must find a way to depoliticize their field. They need to form one organization that is inclusive and working for the mutual benefit of all of Kenya's TMPs. In addition, there must be more communication not only between the government and the TMPs, but also between the TMPs themselves. Without these keys, implementation of policy in the near future may prove difficult.

RECOMMENDATIONS

Because of limited time and resources, this holistic study on the role of urban traditional medical practitioners was necessarily superficial. However, there are many related areas of study that would add to the results of this investigation. First, it would be important to conduct an analysis of the effects of integration of traditional medicine into mainstream health care on the agricultural sector of the country. If integration took place, the efficient farming of herbs and conservation of the environment would be critical for the survival of the field. Additionally, it would be interesting to investigate the role that pharmaceutical companies play in the integration of traditional medicine into national health care. There is an obvious economic interest on the part of the pharmaceutical companies, and this would be a useful area of study. In addition, this study should be expanded to include other types of TMPs, including those that work with conditions that have spiritual etiologies or treatments. Finally, there is also ample opportunity to study the social implications of traditional medicine. This study touched on that area slightly when discussing why women were more visible in seeking health services. However, studying these patterns in depth would yield valuable insight into what the consumer of health services is searching for.

APPENDICES

- I. Prepared Interview Framework for TMPs
- II. Conditions Treated, Nairobi TMP
- III. Abhalight College of Natural Medicine: Herbal Medicine Syllabus 2006
- IV. Proposed Institutional Framework: The National Policy on Traditional Medicine and Medicinal Plants

Appendix I: Prepared Interview Framework for TMPs

PART ONE: INTRODUCTION

- (1) My information
 - a. Swarthmore, SIT, ISP
- (2) What my project is about
 - a. Role of TMPs in an Urban Kenyan Setting
 - i. Policy
 - ii. Patients
 - iii. Profession
 - b. Explain confidentiality, can pull out whenever
 - c. Results of study are available upon request
- (3) Get Basic Sociological Data
 - a. Gender
 - b. Age
 - c. Education Levels
 - d. Religion
 - e. Occupation
 - f. Residence
 - g. Socio-economic level
 - h. Marital Status
 - i. Nationality/Tribe

PART TWO: TRADITIONAL MEDICINE IN GENERAL

- (1) Terminology—what do you like to be called?
- (2) Characteristics of profession—what makes them different from biomedicine?
 - a. Differences in urban/rural
 - b. Smaller doctor/patient ratios, thoughts
 - c. Their patients
 - i. Who are they? (Professions, ages, socio-econ levels)
 - ii. What conditions do they have?
 - iii. Why do they come to you? What is appeal of TM?
 - iv. What are their expectations?
- (3) Preventative versus curative imbalance?
 - a. Treatment of HIV/AIDS versus prevention
- (4) Appeal to new doctors
- (5) Where do you want profession to be? Like China (given choice in hospital, marketed as separate, exports)?
- (6) Relationship to Biomedicine
 - a. TM as alternative or complement?
 - b. Is there mistrust between clinical/traditional medicine?
 - c. Should TMPs be allowed to use modern medicine and vice versa?

PART THREE: ROLE OF TMPs IN SOCIETY

- (1) What is your role in society?
- (2) Public perceptions, misconceptions, association with witchdoctors
 - a. Effect of colonialism?
- (3) Using modern medical titles—proposal to prohibit in Uganda?
- (4) Historical/cultural significance—as it relates to legislation
- (5) Role of elites in society (Ghana)—development, how important is it to maintain traditional knowledge?
- (6) Role of advertising?

PART FOUR: POLICY

- (1) Importance of policy in general
 - a. Advantages of regulation
 - b. Relevance to development?
 - c. Who is developing policy? Right people?
 - d. Nigeria, Mali, Uganda have policies in place, thoughts? Can Kenya learn from them?
- (2) Policy Specifics
 - a. Need for council/board that is self-regulated and run
 - b. Educational standards/institutions (i.e., Zimbabwe)
 - c. Recertification
 - d. Ethics
 - e. Intellectual property rights
 - f. Malpractice
 - g. Role/importance of research
 - h. Punishments, self-enforced
 - i. Record keeping, management importance (urban/rural difference)
 - j. Role/importance of protecting environment
 - k. Government's role in making the option available in hospitals
 - l. What specific things are you looking for?
- (3) The Process
 - a. What steps have been taken?
 - b. What are the stumbling blocks?
 - c. What is prognosis?
 - d. What can people realistically expect?
 - e. What are the biggest threats to the profession?

PART FIVE: MISCELLANEOUS

- (1) AU calls 2001-2010 the Decade of Traditional Medicine, thoughts, support from AU, what can you expect?
- (2) What kind of support are you looking for from organizations like World Bank, UN?
- (3) Western pharmaceutical companies have vested interest—marketing
 - a. Ghana opens TM factory—econ benefit to country, thoughts

- b. Relationship with pharmaceutical companies
- (4) Role of NGOs like THETA and Prometra in bridging gap between biomedicine and traditional medicine—desired? Helpful? Effects?

PART SIX: CONCLUSION

- (1) Any further comments on anything we've discussed or additional?
- (2) Thank you
- (3) Give contact information (new info, questions, concerns)

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