

Do No Cultural Harm: Malaria and Degedege in South Tanzania

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Biomedical initiatives for treating malaria have constantly run into problems in Tanzania, where locals often feel their children need to see traditional healers for a different disease called degedege. This has led initiatives in Tanzania to focus on educating individuals in hopes that their cultural beliefs can be changed and malaria can be prevented. However, bioethics should not take lightly the move of healthcare workers or researchers to educate local populations else, as the cultural imperialism argument goes, these peoples will have different belief systems pushed upon them. In order to prevent cultural harm or at least acknowledge it and work to mitigate its effects, bioethics must start considering cultural harm as an aspect of non-maleficence, to be weighed against other concerns in principlism.

To explain this idea of cultural harm and how it comes up in healthcare initiatives abroad, I want to look at the conflict between malaria and degedege in Tanzania. Malaria is the number one killer in Tanzania, affecting most drastically children and pregnant women. However, healthcare workers (HCWs) know that it is a preventable disease so long as the afflicted are brought to the hospital in a timely manner. Degedege is a “traditional malady” in Tanzania and the locals believed that it is caused by devils that often attack young children. Locals (mainly of those in the country’s southern region, which has seen far less development) see degedege as only treatable by traditional healers, though many of the symptoms of the two diseases are similar.

HCWs in South Tanzania ran into a large problem, the Tanzanians were bringing children with untreatable malaria to hospitals. They found the explanation to be that parents with a child sick with malaria thought the disease to be degedege and took their child to spiritual healers. Only after those healers were unable to treat malaria did parents bring their children, now past the point of viable care, to the hospital. HCWs also could not convince locals to bring their children to the hospital first; traditional healers argued that the treatments for malaria (the “needles” and “syrup”) would worsen the child’s degedege. How were HCWs to convince Tanzanians that children needed to be brought to the hospital before their prognosis was too severe to be treated?

Education seemed to be the best way to resolve the problem. If the locals understand that their children have malaria and what that entails then they will bring the children to the hospital. However, just educating the locals about the science would not be enough. Everyone already knows what malaria is and recognizes it as a disease spread by mosquitoes, cured by biomedical interventions. Degedege is a disease distinct from malaria, caused by entirely different phenomena that can’t be treated by western medicine.

Instead, HCWs embraced the idea of changing the behaviors of Southern Tanzanians, not just teaching them science. The idea, as has been explained in Gazinelli’s work in Brazil, is to change a local population’s perceptions, values, social representations, etc. Educating the people cannot entail only teaching science because the locals treat science as something other or secondary to their usual behaviors. Gazinelli showed that attempting to change perception could significantly change the behaviors of a locale, presenting a model to best help healthcare initiatives.

HCWs in Tanzania employed a similar methodology by making it an initiative to teach locals that degedege was malaria. As said in 2000 by Dr. Mwitwa, the coordinator for the National Malaria Control Program for the Tanzanian Ministry of Health, "They can know what convulsions are, that those are not evil spirits." Nurses started educating that both diseases were the same and children needed to be brought directly to the hospital. The convulsions that were thought typical of a child with degedege were newly explained; instead degedege meant convulsion and it was a symptom of malaria, not a disease in its own right. The hope was that this initiative would change the behaviors of parents so cases of malaria in children would be caught earlier when the malaria was still treatable.

Medical anthropologists such as Stacey Langwick have looked into this case and concluded that trying to change a locale's perceptions does not always work as well as biomedicine may expect. Langwick studied the southern Tanzanians who brought their children for treatment both at traditional healers and at the hospitals to understand their beliefs of malaria and degedege. Their behaviors were altered as shown by Langwick's case studies. Families often attempted to treat malaria and degedege side-by-side, alternating between bringing their children to the spiritual healer and to the hospital. However, the new beliefs that arose were not in line with the initiative pushed by HCWs, instead amalgam of previously held ideas and new ones.

Generally, when people think of imperialism the idea is centered on forcing others to submit. Medical imperialism is thought of as forcing others to abide by the ethical codes, and in this case 'empirical beliefs,' of the subjugator. An amalgam of beliefs as seen in Southern Tanzania might not be called medical imperialism. However, amalgamation is the actual result of imperialism. When the Spanish forced Catholicism on Latin America the natives didn't take one system or the other. They combined both systems and created something entirely new, though on the surface it often seemed close enough to Catholicism to fool the priests of their parishes. Langwick is describing this exact phenomenon with the Tanzanians. She notes that some of the locals, in response to the education attempts of HCWs, started believing their sick children had malaria. However if the child convulsed, which HCWs described as being the degedege symptom of malaria, parents would say the malaria has gone to the head and become degedege.

Byron Good, another medical anthropologist, has a simple answer for why this happens. Good writes that western biomedicine, like the medicine of the Tanzanian traditional healers, has a cultural language all its own. It is not simply empirical, as HCWs who claim natives mistake malaria for degedege like to believe. This means the actions of HCWs can stamp western cultural identity and beliefs into the identity of another culture without recognizing it, same as Catholicism (one set of cultural beliefs) was stamped into the various cultures of Latin America. An amalgam is likely to result and there's no way to know how locals will reinterpret and redefine their own beliefs after being introduced to new ones.

All that said, clearly bioethics cannot support the stopping of public health initiatives in Tanzania because of the risk of changing culture. I would agree with anyone who might give that critique and offer another solution: methodologies such as the one in this case (conflating degedege and malaria) must be evaluated as cultural harms. There is nothing wrong with trying to save more lives but specifically targeting and altering culture for the needs of biomedical science is a potential harm to the targeted populace. HCWs can't know how a change in culture will affect its people and while that alone should not stop public health initiatives it needs to be a risk that is taken into account and actively minimized. By placing the need to do no cultural harm under the principle of non-maleficence, studies and initiatives can be reminded that they need to be minimally invasive to a locale's culture.

Do no cultural harm could also be thought of as a part of beneficence, however this suggestion is flawed. If under beneficence do no cultural harm becomes a risk to be weighed against multiple benefits. However, there is no way of knowing what the cultural harms of research or a healthcare initiative might be. This means cultural harm could be overemphasized so that no good is done, or more likely it will be underemphasized or ignored entirely when compared to the benefits. Categorizing do no cultural harm under beneficence also makes it a risk, rather than a duty. HCWs and researchers know that 'do not kill' is a duty that is found within non-maleficence. Killing the patient (not the risk of death but active killing) is not a risk that can be outweighed by multiple benefits. To avoid the discussion of cultural harms becoming some utilitarian calculation by ethics committees it needs to be a proper duty that is sincerely accounted for and minimized under the principle of non-maleficence.

In conclusion, the lesson learned from healthcare's initiatives in Tanzania to combat malaria should show that 'do no cultural harm' is a duty bioethics needs to incorporate under the principle of non-maleficence. As a duty HCWs and researchers would need to take more seriously the effects of their work in other countries and work to mitigate the invasive nature of their initiatives. This doesn't mean that biomedicine should expect to never do cultural harms; only that non-maleficence has to be weighed against the other principles and properly balanced before research of a public health initiative is undertaken.

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