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Faith: Friend or Foe?

The Rise of Faith Healing in Tanzania and Its Impact on Community Understanding of HIV

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Abstract

Faith healing is the treatment of illness through religious belief or prayer rather than through modern biomedical practice (Hall, 2010). It is a well-established global phenomenon whose effect on global health initiatives in developing countries remains largely unknown. Though often dismissed by health organizations, the emergence and prevalence of faith healers in areas such as South America and East Africa has had an incomparable impact on the cultural understanding of disease and treatment. Indeed, the widespread notoriety of such figures often translates into a form of credibility, allowing their ideas to pervade popular culture (Hall, 2010).

Specifically, the recent rise to fame of Babu of Loliondo, a Tanzanian faith healer who claims to have the ability to cure HIV, has created a cultural and logistical crisis for NGOs and other health organizations working with rural communities in Tanzania, particularly in the area of education (Ibrahim, personal communication, 2011 July 9). The impact of Babu's faith healing on HIV education efforts in rural communities highlights the need for global health organizations to acknowledge faith-based phenomena. In turn, this will facilitate collaboration with these communities as how best to address the problems posed by Babu and similar faith-based figures.

This paper investigates the origin of Loliondo's faith healing movement and the factors leading to the popularization of Babu as a faith healer. Furthermore, it surveys the impact that the Loliondo phenomenon has had on a specific rural community's understanding of HIV and on the interface between biomedical and faith-based treatment interventions. Finally, it addresses potential community-based initiatives that NGOs and other health organizations can support to consistently and understandingly address this and similar situations.

Background

Approximately 1.5 million people in Tanzania are currently living with HIV/AIDS. 5.6% of Tanzanians between the ages of 15-49 are infected, and of Tanzania's 2.6 million orphans, 1.3 million were orphaned because of HIV/AIDS. Antiretroviral therapy is provided free of charge by the Tanzanian government, yet only 44% of those infected are currently receiving treatment; the majority of the untreated live in rural areas (UNAIDS, 2010). A major factor is the lack of knowledge about transmission and treatment, particularly in rural communities, which comprise 80% of Tanzania's population. Effective education programs in rural communities are a key component of any global health initiative, but they are especially important in the prevention of HIV in resource-limited environments. According to the World Health Organization, "Action on the sociocultural determinants of health is the fairest and most effective way to improve health for all people" (Labonte & Schrecker, 2007). Understanding cultural phenomena that limit or complicate education initiatives and engaging in open

discourse with rural communities should be priorities of health organizations.

Religion is a cornerstone of East African society, with approximately 35% of the Tanzanian population identifying as Christian, 35% as Muslim, and 30% as practicing indigenous religions (Central Intelligence Agency, 2011). Within the past ten years, several Christian religious movements have gained significant political and cultural momentum in East Africa, in part due to economic and infrastructural hardships that caused considerable anxiety among rural populations (Twesigye, 2010). From the Marion Movement to the Movement for the Restoration of the Ten Commandments of God, nearly all of these movements claimed the ability to cure the sick through faith and "the laying on of hands" (Twesigye, 2010). Their success and popularity were characteristic of the East African cultural traditions of faith healing but also indicative of the desperation felt by communities faced with few alternatives against the ravages of HIV, malaria, and other diseases. Indeed, the WHO estimates that 80% of people in low-income countries rely on non-allopathic healing for their primary health-care needs (UNAIDS, 2002). Given this cultural and historical context, it is not surprising that a Tanzanian faith healer could rapidly gain widespread notoriety and a legion of followers from around East Africa within a matter of months.

Ambilikile Mwasapile, a retired Evangelical Lutheran pastor from the rural village of Samunge located in Loliondo in northern Tanzania, has risen to prominence as a faith healer. According to a government-sponsored report by the National Institute of Medical Research in August of 2010, he claims to have been visited by God in a dream, in which he was told of a remedy for chronic illnesses such as diabetes, asthma, blood pressure, cancer and HIV/AIDS (Malebo & Mbwambo, 2011). The treatment involves boiling the root of the local black currant tree, known locally as Mugariga, and administering one cup of the liquid, known as kikombe. He began distributing the kikombe to locals later that year and rapidly gained notoriety when a local woman claimed that Babu had cured her of HIV, and that she had the taken the test to prove it (Malebo & Mbwambo, 2011). Although the woman was never identified and her story was never officially investigated, thousands of people from all over Tanzania traveled to Mwasa Pile in search of healing for a wide range of problems. The study estimates that in the three months after word began to spread, over 24,000 people had visited the healer, and a line of vehicles stretched over 15 kilometers along the dirt road leading to Loliondo (Malebo & Mbwambo, 2011). These numbers have since increased to nearly 1000 people a day, with followers traveling from Kenya, Uganda, and even South Africa. Reports of the benefits of his treatment (though undocumented) continued to grow, and Mwasapile came to be known simply as Babu, which means "grandfather" in Swahili.

Several factors contributed to the meteoric rise of Babu of Loliondo. First was the immediate involvement of media and the sensationalist reaction it created. Traditionally, healing is conducted at the level of local communities. However, recently media coverage has become accessible in rural areas, typically via radio broadcasts, and the combination of a newfound spread of information and the compelling language used to describe the phenomenon has greatly increased awareness and a willingness to participate. Second was the role of the Tanzanian government, particularly the Ministry of Health. While the government took immediate notice of the movement and launched an investigation of Babu and the kikombe, the report was inconclusive regarding the validity of his healing. The report further complicated the situation by outlining the possible anti-viral effects of the plant itself, based solely on descriptive accounts of those who have worked with it in the past (Malebo & Mbwambo, 2011). Furthermore, several well-known government officials, including the minister of natural resources and tourism and the mother of the president of the Democratic Republic of Congo, have themselves visited Babu, instances that were rapidly publicized by the media (Philemon, 2011). Government-issued security personnel have patrolled Loliondo to control crowds and protect Babu; in this sense, Babu has enjoyed a rare position of authority and security that most healers do not have. Together, these actions lent clear legitimacy to the healer despite the government's technically neutral position.

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Finally, Babu's strong association with monotheistic faith sets him apart from other healers working in East Africa. Most traditional healers in East Africa are strictly local, and their traditions are based on African indigenous beliefs and practices. These traditional healers are rarely linked to monotheistic religions, though many who visit these healers are Christians or Muslims (UNAIDS, 2002). The term "faith healer" refers to a different and less common group, who claim to draw their healing abilities from monotheistic religions, most often Christianity. Combining monotheistic religions with traditional healing practices to reach a wider audience (Twesigye, 2010), Christian faith healers practice worldwide but flourish in areas with a history of non-allopathic healing and limited access to medical care, both of which are present in East Africa (Twesigye, 2010). This practice has led to the success of previous Christian healing movements in East Africa (Twesigye, 2010). That Babu was a pastor, considering Tanzania's history of Christian faith healing, could have further contributed to his perceived legitimacy. This in turn could have promoted the unique response of the media and government to the Babu phenomenon, compared to their response to traditional healers. It is important to note that while Babu seems to invoke a Christian God in his descriptions of healing, the specific belief to which followers are ascribing is vague. Furthermore, in interviews and articles about his healing, Babu has emphasized that he welcomes all races and religions, expanding his appeal to non-Christians, as Yusuph Ibrahim recalls from his experiences with HIV patients (Ibrahim, personal communication, 2011 July 9).

Like many well-established faith healers, Babu employs treatment involving several strict regulations. Tanzanian employees of Support for International Change (SIC), an NGO providing HIV education, testing and support to rural Tanza-

nia, outlined the basic rules. Visitors must come with a specific ailment or problem in mind, without which they are not permitted to visit Babu. Furthermore, only Babu himself is allowed to prepare and administer the treatment – without his involvement the cure is considered worthless and may even be poisonous. The kikombe itself costs 500 Tanzanian shillings, or approximately 35 cents, but transportation by car or bus 400 kilometers along dirt roads from Arusha, the nearest city, can cost hundreds of dollars. The most important rule associated with the healing is the level of faith it demands. Babu claims that only those with complete faith will receive the full benefit of the cure, and thus the kikombe is incompatible with any other type of treatment, including anti-retroviral therapy (Ibrahim, personal communication, 2011 July 9). It is clear how such a mandate could create a significant problem from a public health standpoint – forgoing ARV therapy for as little as three days can have extremely severe repercussions including increased viral load, increased risk of transmission and overall lowered effectiveness of therapy (WHO, 2010). Considering the rate of HIV infection and the sheer number of pilgrims to Loliondo, the impact of this phenomenon is truly considerable.

The high level of uncertainty about discontinuing ARV therapy in favor of Babu also suggests that this faith is not absolute.

Indeed, organizations like SIC have already noticed an impact on their work. Yusuph Ibrahim, a field coordinator for the organization, noted that Babu had been brought up in nearly all of the recent community education presentations and often was a source of tension between educators and community members. Furthermore, dozens of the HIV-positive patients with whom SIC has been working in the past three months have gone to visit Babu, and several have chosen to stop their ARV therapy. The struggle facing public health education initiatives, then, is to successfully address the topic of faith healing from a place of understanding or risk losing the trust and cooperation of the communities with which they work. To promote the best interests of the population, health organizations must engage in an open discourse on a community level and form partnerships with community leaders, in this order.

Surveying the Impact on HIV Education

Methods:

In this study, 25 interviews were conducted in the village community of Sangaiwe, within the Mwada ward of Manyara, northern Tanzania. The study was sponsored by SIC, which had previously conducted a large-scale survey of five rural villages comprising the Mwada ward of northern Tanzania, focusing on general knowledge about HIV/AIDS transmission, prevention and treatment. This included surveying 75 heads of household over the age of 18 that were chosen randomly and distributed geographically among the ward's five villages. During the period that these interviews were conducted, SIC was preparing to organize an education and testing campaign for the Mwada ward, including the village of Sangaiwe.

The interviews in this study focused solely on the village community of Sangaiwe, randomly selecting 25 households (evenly distributed among the village's four geographic subvillages) and provided an explanation of the purpose behind the interview before soliciting for participation. This included starting from the geographical center-point of each sub-village, flipping a coin to determine which direction of the main road to walk down, and using a random-numbers chart to determine which houses were chosen for interviews. This continued until six interviews had been conducted in the subvillage, at which point the investigators would move to the next subvillage. In the last and most populous subvillage, Usole, seven interviews were conducted. Thirty-minute interviews were held with consenting men and women over the age of 18 at their households. Interview questions were initially written in English, but were translated and edited by Mr. Alex Herman, a Tanzanian teaching partner who works as a translator and HIV educator at SIC. Interviews were conducted orally in Swahili and again translated by Mr. Alex Herman. The interviews focused on knowledge of Babu and opinions on faith healing and education (Supplementary Table 1). Each of the questions was asked in a yes or no format, and for the descriptive questions (5,7), respondents were not prompted or asked to choose from a list of options but came up with responses independently. Though the data collected and presented was based on direct questions, the interview tone was informal and often included follow-up discussions or anecdotes. These were not included in the results section but were incorporated into the discussion and background.

Results:

The majority of respondents were Christian, of middle age, and had lived in Sangaiwe for their entire lives (Supplementary Table 2). 24 of the 25 respondents (96%) knew of Babu of Loliondo, and 19 (76%) said they knew someone who had gone to visit the faith healer. 92% first heard about Loliondo through some form of media, with most (72%) hearing through radio announcements. 88% also received more information about Loliondo from talking to others in the village (Supplementary Table 3).

The crucial content of the interviews, regarding belief in Babu and HIV, was contained in questions seven through ten. 20 of the respondents (80%) said they believed that Babu had some healing power, though 60% of those were unsure of the degree of healing he was capable of. For example, 17 (68%) believed he could cure or significantly improve either diabetes or asthma, but only six (24%) were as confident that he could cure or significantly improve HIV. Five respondents (20%) were confident that Babu could not cure HIV and the majority (14, 56%) were unsure. When asked why they believed or did not believe in Babu, 23 (92%) of the respondents referred to an individual they knew of whose condition either improved or deteriorated after visiting the healer as their primary reason. Of the randomly selected 25 respondents, seven (28%) had been to visit Babu themselves. Of these, five believed that it had helped their health in some way, but only two believed themselves to be completely cured.

Regarding ARV therapy vs. faith healing, respondents

were generally torn on the issue. Twenty-four (96%) claimed that, if diagnosed with HIV, they would take ARV therapy, while the other one person was unsure. However, 18 respondents (72%) felt that the efficacy of Babu's healing was based on the amount of faith a person had, and 17 (68%) said that they would go to visit Babu if they were diagnosed with HIV and had the resources to afford it. Nine (36%) claimed that they would continue ARV therapy while they went to visit Babu, three (12%) claimed they would discontinue ARVs if they visited Babu, and the rest were unsure if they would do so.

The final component of interviews was designed to identify possible targets for intervention by NGOs. When asked about the role of NGOs in educating about HIV, 24 respondents (96%) felt that NGOs should continue to educate rural communities about HIV transmission and prevention, and 23 (92%) felt that they should educate about ARV therapy as well. 23 respondents (92%) felt that NGOs should address the issue of Babu within their education programs, and 17 (68%) felt that Babu's healing should be incorporated into discussion of HIV treatment options.

Discussion:

In considering these results, there are several important trends of interest. Clearly, knowledge of Babu is highly prevalent in this rural community, even with limited access to media and communication technology. This is of particular interest considering the relative recency of the phenomenon, indicating the pervasiveness of this emergent faith healer. The number of people who first heard of Babu over the radio suggests that radio is one of the most powerful means of mass communication, and that the way information is presented over the radio can have a profound impact on the popular view of a cultural figure such as Babu. However, while the media may first introduce individuals to this phenomenon, it is by no means the deciding factor of public opinion. Every person who had formed an opinion on the legitimacy of Babu had done so by communicating with other members of their community: specifically, from hearing accounts of the experiences of others and sharing their own experiences. Based on these responses, it seems that these are not just isolated individuals and opinions but are indicative of a larger, community-level understanding in Sangaiwe. Therefore, engaging with this issue at the community level could be an effective means of both understanding and addressing the phenomenon.

Another trend among the responses is the level of uncertainty about the specific nature of faith healing. While the vast majority do believe that Babu can heal, there is nearly no established consensus regarding the specific diseases that are treatable, the importance of adhering to treatment guidelines or the possibility of combining Babu's method with traditional biomedical therapy. Each person interviewed had his or her uncertainties in different areas, and most were especially conflicted on the topic of HIV. Though many had heard rumors of people being cured of HIV, none of the respondents directly knew the individuals involved. The fact that the majority of respondents would travel to Liliondo if given an HIV diagnosis suggests a belief in a connection between Babu and well-being, but the high level of uncertainty about discontinuing ARV therapy in favor of Babu also suggests that this faith is not absolute. This uncertainty reflects an important opportunity for education programs to intervene in promoting safe lifestyle choices for rural communities.

While working in Mwada, SIC conducted a widespread household survey of general HIV knowledge among the five villages in the Mwada district. They found a generally high level of awareness of HIV – 100% knew what it was and 41% ranked it as a big or very big problem for their community (SIC, 2011). However, 18.5% of those surveyed claimed they did not know of any way to prevent HIV transmission, and 79.5% had never attended an HIV education activity (SIC, 2011). Given the previous insights on how the phenomenon of Babu of Loliondo has affected a community's understanding of HIV, the ultimate goal becomes incorporating cultural understanding of prominent figures like Babu into sustainable community education initiatives. It is essential to involve communities in discussions of culturally-based phenomena to promote an ethos of understanding and cooperation.

The results shown in this paper are based on interviews with a small subset of individuals from one community in rural northern Tanzania. The responses gathered were evaluated on a qualitative basis, lacking finite quantitative analysis because of the small sample size. Their general characteristics are typical for those living in rural east Africa – agrarian and herding lifestyles, Christianity, tribal identity and language, etc. But it is important to note that the information from these interviews does not necessarily represent true Tanzanians, or even those in the Mwada ward. The information does, however, provide an important set of insights that, along with other resources, can be used to better understand the Babu phenomenon. Furthering this work would include addressing these limitations by creating a wider-scale survey, incorporating increased religious diversity among participants, and performing quantitative analysis of the results. Taking this set of interviews as a case study on the impact of faith healing on rural understanding of HIV, we can explore the broader implications of this work for incorporating local belief into community education initiatives.

A large-scale means of addressing the phenomenon would be at a national level – working to change the way Babu is portrayed in the media and by the government of Tanzania. This would include working with the Department of Health and prominent media organizations to create and enforce stricter guidelines on Babu's portrayal and especially the Tanzanian government's stance on the issue. It could also involve establishing (or enforcing previously established) laws on practicing medicine without a license. Though potentially far-reaching, the feasibility of these tactics is doubtful. Given the popularity and widespread notoriety Babu has achieved, and the instrumental role that both media and government played in elevating him to such a position, it is unlikely that such momentum could be halted, let alone turned against such a culturally prominent figure.

A potentially more successful way to address the issue would be to create a middle ground with rural communities. Immediately and unequivocally dismissing Babu as ineffective, the initial tactic of many NGOs like SIC, created distrust among their rural audiences. This distrust often affected the way communities viewed the entire education curriculum, according to Ibrahim. Fostering this community involvement, then, is not just important in encouraging proper treatment of HIV, but it can have far-reaching effects on every component of an education campaign, including education on prevention.

Acknowledging that visiting Babu can be a beneficial experience for those struggling with chronic disease while maintaining that traditional biomedical therapy is the proven method of treatment ought to be a standard for education programs. Furthermore, having time allocated to specifically discuss this phenomenon and providing an open forum for discourse with community members about the topic will make important strides towards reaching a true understanding, which is the best platform on which to build sustainable behavior of change.

Part of this discourse should concern the nature of HIV, itself a highly contentious topic in rural areas of East Africa (Ibrahim, personal communication, 2011 July 9). The widespread notion that HIV is a "disease caused by sin" persists in rural communities to rationalize the spread of the disease and dismiss personal risk. A faith-based treatment goes hand-in-hand with this view, allowing those infected to absolve themselves of responsibility through a one-time miraculous panacea rather than accepting the long-term commitment to treatment that comes with a diagnosis of HIV. Indeed, Yusuph Ibrahim noted the prevalence of this moralistic view of HIV in the areas in which SIC works and its role in pushing HIV patients towards Babu's treatment (Ibrahim, personal communication, 2011 July 9). Addressing and providing information about HIV from a biological perspective could balance out this "disease of sin" view, and would likely make significant strides in bridging this gap in understanding.

The ultimate success could be achieved working with communities and affected individuals to construct a treatment regime that is more holistic in its outlook while adhering to the guidelines recommended by the WHO, such as a specific education campaign led by NGO-trained community health workers to widely address this issue and answer questions in community settings. Another option is working with community clinics to provide their HIV-positive patients with a holistic treatment program – ARV therapy, education, and open discussion about faith healing. Such a regimen would find its place among the biomedical regulations that are foreign to most rural Tanzanians. The next steps for such a project would be to expand the interviews to other villages and use village-specific information to address this issue uniquely according to the needs of each community. A past UNAIDS case study investigated the benefits of collaborating with traditional healers in East Africa through training and education programs to increase rural access to HIV testing and treatment. The study found a significant increase in both the number of patients gaining access to care and the overall satisfaction of those receiving care, proving to be a testament to the power of combinative practices (UNAIDS, 2002). Though faith healing and traditional healing are different phenomena, it is crucial to keep in mind the potential benefits of collaboration and to explore partnerships among the traditional healers in this and other communities. Given the cultural impact of a disease such as HIV, it would be wise to incorporate cultural understanding and mechanisms into any model of treatment and prevention.

Conclusion

This paper has sought to explore the phenomenon of Babu of Loliondo from several perspectives in order to come to a fuller understanding of how such events have affected one community's understanding of HIV. More specifically, it addresses the repercussions for community-based global health initiatives. Faith healing movements, particularly in the developing world, have long flown under the radar of global health organizations, but to allow these organizations to ignore such phenomena is a severe disservice to the communities and individuals of the area. Understanding the roots of such phenomena would allow organizations to address them appropriately and even utilize them in their community outreach initiatives.

To allow these global health organizations to ignore faith healing movements is a severe disservice to the communities and individuals of the area.

By doing so, traditional healers and faith healers would no longer be an enemy of global health initiatives but rather become an ally in reducing the impact of HIV/AIDS on the Tanzanian people.

Supplementary tables and figures for this article are available at JGH Online, www.ghjournal.org

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