

**Medical Dialogue between Traditional Experts and
Biomedical Health Workers in Kasungu, Malawi**

Report for EPOS/GTZ/Aids Peer Review Group

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GLOSSARY OF TERMS.

AIDS: Acquired Immune Deficiency Syndrome.

Anankungwi: Traditional advisor

CGBVP – Combating Gender Based Violence Project

FGD – Focus Group Discussion

HIV: Human Immune Virus

Kachirombo: A Chichewa word denoting Human Immune Virus

Kanyera: sexually transmitted illness, occurs when a man has sex with a woman shortly after menstruation or birth

Magawagawa: Usually refers to Sexually Transmitted Illness. But now the term commonly refers to HIV/AIDS

Mapinga: Obstructed labour caused by infidelity of a husband or wife. Part of the treatment requires a husband confessing the number and names of women he had sex with

Mdulo: A complex of illnesses caused by not adhering to sexual taboos

MTHUO – Malawi Traditional Healer Umbrella Organisation

Mtengano: Medicine that a wife or husband seeks, in agreement or secretly, that once one party dies, the other should follow soon after. The term nowadays also refers to HIV/AIDS

P: Participant

Singanga, Chichewa for traditional healer

TH: Traditional Healer

TBA: Traditional Birth Attendants

TB: Tuberculosis

TDr.: Traditional Doctor in the sense of Traditional Healer

VCT: Voluntary Counseling and Testing.

I would like to remind you about the United Nations circular letter which advises that medical science and traditional healers should cooperate with each other in the fight against Aids. (Traditional Healer, Participant Dialogue Workshop 23rd August 2005)

1.0 Introduction

The aim of the Short Time Assignment was to develop, as a model for replication throughout Malawi and neighbouring countries, a method of “medical dialogue” between representatives of traditional experts and biomedical health workers to better fight HIV/AIDS in Malawi. The task had two steps:

1. to conduct a study in Kasungu district/Malawi on the integration of traditional beliefs and gender roles in HIV/AIDS prevention campaigns
2. to establish – based on the results of the study – a dialogue between traditional experts and biomedical health workers in Kasungu district/Malawi with the goal to better fight HIV/AIDS

1.1 Regional Context

Malawi is a landlocked country south of the equator in Sub-Saharan Africa. It is bordered by the United Republic of Tanzania; by the People’s Republic of Mozambique; and by the Republic of Zambia. It covers about 118.000 square kilometres including app. 24.000 sq km of inland water by Lake Malawi. It is densely populated with an estimated population of more than 12 million people, most of them predominantly rural.

More than 65 per cent of Malawi's population lives below the poverty line and in 2000, Malawi was among the bottom seven per cent of countries on the United Nations Development Programme's (UNDP) Human Poverty and Human Development indices (Unicef 2005). Malawi suffers a severe food crisis that combines with HIV/AIDS to form a vicious cycle: increased malnutrition weakens the resistance of people infected with HIV to opportunistic infections, thereby reducing the workforce available for agricultural and other work (Unicef 2005).

The pilot project was carried out in Kasungu, a district in the central region of Malawi. The Kasungu District lies about 100 kilometer North-west Lilongwe, the capital city of Malawi. It covers a land area of 7,878 sq kilometres. With a population of 480,659, it contains 4.8 % of the total population of Malawi (NSO 1998). Kasungu typifies the Malawian agro-based economy. Tobacco is the major cash crop grown in the district. Maize and groundnuts are the main staple crops.

The Chewa is the dominant ethnic group in the country as well as in the district. However, in the northern part of Kasungu, the Tumbuka become dominant.

1.2 Epidemiology

Malawi has an extremely high prevalence of HIV/AIDS, which affects an estimated 14.4% (range between 11.3%-17.7%) among the 15-49 year olds. This means, out of its 12 million people, it is estimated that over one Million are living with HIV/AIDS. HIV/AIDS patients occupy more than 50% of hospital beds. The high prevalence also accounts for some 70 % of hospital deaths. Currently, MOH is advocating palliative care of chronically ill AIDS patients. Therefore healers play an important role esp. in the field of home based care.

The epidemic is diverse and has not yet exhausted its potential for growth. Prevalence in rural communities is particularly high as is the prevalence among pregnant women, app. 20% among 20-24 years olds (UNAIDS 2005). Three quarters of AIDS cases are in the most productive age group with more females in the age range of 15-29 infected. Overall, more women are infected than men. However, prevalence is lowest among 5 – 14 year olds (NAC 2003). Still, some 400,000 children under age 15 have been orphaned by HIV/AIDS.

1.3 Relevance for the Country

In Malawi as in most of the other countries on the African continent healers are important custodians of traditional knowledge and they play a significant role in establishing medical understanding and HIV/AIDS relevant behaviour in the whole population. Traditional Healers (TH) are important key people for a change of sexual practices, as well as for modifying the beliefs and perceptions that are the basis of these practices.

Because of failing health systems and the growing prevalence of HIV/AIDS in developing countries, WHO as far back as 1974 has been urging developing countries to find novel solutions to their health problem. Encouraging greater involvement of Traditional Healers in health systems is one of the initiatives. In 1978 in Alma Ata WHO adopted a resolution to include traditional health practitioners in national health programmes. The WHO Traditional Medicine Programme and the WHO Global Programme on AIDS considered in 1990 ways to involve traditional health practitioners more actively in the prevention and control of HIV/AIDS. Healers are not only respected health care providers and opinion leaders in their communities; they also provide family counselling and promote social stability. UNAIDS (2000) urges that only a respectful attitude of open exchange of ideas and information can win trust and cooperation.

Unlike in other countries, Malawi has no policy on complimentary or alternative therapies. However, there is a drafted Traditional Medicine Policy that is currently awaiting the ratification of parliament. The policy includes a practitioners' bill as well as a code of ethics for traditional health practitioners of Malawi. However, despite the lack of legal policy, one collaborative project between traditional and biomedicine has been included into the UNAIDS Best Practice Collection. In the Chikwawa district of Malawi a baseline survey was conducted with 89 healers regarding their knowledge, attitudes, beliefs and practices surrounding AIDS (UNAIDS 2000). Using the results of the survey a curriculum for a one-day workshop was developed and two training programmes on community education and condom distribution were carried out. The evaluation six months later found that healers who participated in the programme

were more likely to distribute condoms than those who were not involved in the AIDS education (Berger and Porter 1994).

Among others, the UNAIDS Policy Position Paper for Intensifying HIV Prevention urges: “Address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission. Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment”. (UNAIDS/WHO 2005)

1.4 The Overall Situation

With the growing number of people affected by HIV/AIDS in Malawi, the necessity to include the traditional sector into consideration is obvious esp. when launching health relevant campaigns or when discussing home-based care. Since the epidemic has worsened the health service delivery system in Malawi HIV/AIDS affects traditional healers as well as health workers in the modern medical sector. Currently, there is an acute shortage of skilled cadres in the Ministry of Health (MOH), a major health service provider with coverage of over 67% countrywide. Staff attrition is largely due to emigration of skilled cadres abroad. Some retire from the public service to work in the more lucrative private sector. There is also an imbalance of geographic distribution of skilled workers. They shun rural areas in preference of urban settings. Inadequate financial and material resources further compound the Human Resource crisis. Medicaments are not adequate. Pilferage is high. Salaries are low¹. All these factors make the fight against the HIV/AIDS epidemic all the more challenging and calls for the integration of healers into the national medical system to better support people living with HIV/AIDS.

The campaigns to combat HIV/AIDS follow western logic, which assumes that the more informed the people are about the means of contracting and spreading of the disease, the greater the likelihood of achieving behavioural change, that is avoiding unsafe sex, and applying one of the ABC possibilities (**A**bstinence, **B**e faithful, use **C**ondom.) When these campaigns are designed in Africa, this logic is even adopted without scrutiny; only the method of the presentation is adapted to local circumstances and cultures (theatre groups perform in the local languages; local illustrators draw posters of specific context.) The priority of the campaigns, however maintains the bio-medical aspects of the disease. This approach is in conflict with

1. traditional descriptions and perceptions of diseases and illness, and ignores
2. important social and cultural factors underlying the spread of the disease.

Most Malawians in the rural areas depend on their tradition, that is their attitudes and behaviour are guided by traditional beliefs. Middle- and upper class Malawians often have changed their life styles through education and work, but still many of them were brought up in a traditional environment. Intellectually, they accept the modern or biomedical concepts, but it is no contradiction at all – particularly in times of crisis – to seek help in the traditional sector. Modern HIV/AIDS education and traditional HIV/AIDS explanation may co-exist mostly without any contradiction². Health workers and people working in health NGOs face the same situation: During their work, they

¹ Hornbay P., Ozcan S, *Malawi Human Resource For Health Sector Strategy Plan 2003-2013*, MOH, Draft.

² In the West as well people frequently may accept homeopathy, acupuncture or other treatment in addition or in some cases instead of Biomedicin (Wolf & Dilger 2003).

spread the modern HIV-messages that are often poorly understood. But their own behaviour and attitudes are in the same time often guided by traditional beliefs and understandings.

2.0 Objectives of the Intervention

Although the majority of the Malawian population is informed about the causes and the effects of HIV/AIDS, the prevention programmes run by both international and national development organisations have often not succeeded in effecting behavioural change and thereby preventing new infections. Services are rarely requested and new infections are not effectively prevented.

The study should provide answers to the following questions:

1. Which perceptions regarding AIDS, sickness/health, gender roles in relation to AIDS prevention and spread existed at the beginning of the research on the side of the healers and the “modern” actors, respectively? Have the two groups modified their views or attitudes during the course of the study, and if yes, how and why?
2. How can the modified perceptions, practices and attitudes towards one another, be translated into a more successful prevention strategy and into a more effective cooperation (e.g. mutual referrals) between the two groups in order to effectively contribute to HIV/AIDS prevention?
3. How can such a constructive dialogue process, including facilitated in-group discussions, cultural dialogues between the two groups and, as a result, agreed cooperation between them, be extended country-wide?
4. How can the traditional healers and midwives be adequately represented in, and work as a part of, the National AIDS Commission and in other *Country Coordination Mechanisms*?
5. How best can the pilot project become a model for the whole country and what are the funding options for the next steps?

3.0 Methodology

Definition of Dialogue

Dialogue in the arena of development approaches should be defined as: Animated conversation in the search for mutual understanding between two different groups in a certain field. The goal is to enhance communication between the groups and build up structures that are sustainable. To find agreements and solutions for further collaboration is anticipated.

3.1 The Dialogue Approach

The concept of the Dialogue Approach is based on Ideas of the *Public Conversations Project* in the USA (PCP 1999). It was further developed by GTZ as an Intergenerational Dialogue on 2 projects:

- Generational Dialogue about FGM and HIV/AIDS in Guinea (v. Roenne 2005)
- Generation Dialogue on FGM, HIV/AIDS and Reproductive Rights for Youths in Kenya

The Medical Dialogue between Traditional Experts and Biomedical Health Workers in Kasungu District/Malawi was to be the third experience of such an approach.³

The *Public Conversations Project* distinguishes between Debate and Dialogue. They contrast debate commonly seen on TV with dialogue the project seeks to promote. The main points are: Whereas debate operates with the constraints of the dominant public discourse, participants in a dialogue approach “are encouraged to question the dominant public discourse ... and to explore various options for problem definition and resolution” (PCP 1999:2). In a debate attacks and interruptions are also common, which is to be avoided in a dialogue process, where the atmosphere should be one safety and respectful exchange. Here, participants should speak as individuals from their own unique experience and not as representatives from a certain group. They also should speak to each other. Most important of all, participants in the dialogue listen to understand and gain insight into the beliefs and concerns of the others as opposed to the often rhetorical challenges or disguised statement in a debate. This means questions are asked from a position of curiosity on the other group (PCP 1999).

The concept of the PCP is based on written culture and other prerequisites of the US. The challenge was to adapt it to the Malawian situation. Instead of another project that educates and brings information *to* a community, part of the dialogue approach is to bring questions and learn *from* the target population. Hence, the Medical Dialogue between Traditional Experts and Biomedical Health Workers followed a „narrative choreography” enabling both sides to tell their stories, be respected and listened too, and give room for shared vision to emerge. The prerequisite for the dialogue therefore was a study on traditional beliefs and gender roles relevant for the perception of HIV/AIDS in the community.

A Study based on focus group discussions with participants of the different parts in the medical sector is a prerequisite to the dialogue workshop. It brings questions and shows the willingness to learn from the target groups.

Both, workshop and study would consider the environment of participants in relation to the language and used instruments. It follows a 4-step-structure:

- Preparing the facilitators of the workshop
- Preparing assistants for group discussion
- Conducting the research on knowledge and beliefs
- Conducting the Dialogue Workshop

³ A dialogue approach was also carried out by the Gender Based Violence Project in Malawi. It fostered a dialogue with leaders of the Islam Community in the South on issues of health and violence (Lit). However, it was not based on the same dialogue structure and concept.

3.2 The Topics for Dialogue

Since it is the goal of the dialogue to learn from participants no specific topics will be given. It should be the decision of the two groups to discuss issues that are relevant to them. In an ensuring atmosphere even peculiar questions will be addressed. However, the study provides a good opportunity to gain knowledge about important fields before the workshop starts. It may reveal in advance burning issues and thereby prepares the facilitators for upcoming conflicts (see also v. Roenne 2005).

In Malawi the relationship between traditional healers and the government is a difficult one. Mainly claims by the traditional healers to have found a cure against AIDS resulted in severe conflict with the government and the biomedical sector (Probst 1999, Lwanda 2003). For healers as well as for biomedical staff it is easier to overcome tension when they can talk about patients' stories and how to provide the best service a patient needs.

3.3 The Target Groups

The Combating Gender Based Violence Project of GTZ in Malawi had established good relationships with TDr. Gangire Phiri, head of *The Herbalist Association of Malawi* and one of the most influential traditional healers not only in Kasungu district, but in the whole country. Mr. Gangire is also committee member and senior adviser to the healers' umbrella organisation in Malawi (MTHUO). Based on this relationship the study and workshops were prepared with mutual effort. To get a broad range of traditional knowledge concerning matters of health, sexuality and prevention of disease not only herbalists should be consulted. It is also necessary to include other experts such as ritual advisers, TBAs and spiritual healers to the representatives of the traditional group. To allow a balanced composition of traditional experts, a strong and influential leader on the traditional side should therefore be involved.

With the consent of the DC in Kasungu District, the hospital staff was informed and asked for participation. Besides nurses and clinical officers Health Surveillance Assistants (HSA) and midwives represented the biomedical group.

Local NGOs working on medical issues were informed about the event and received invitations.

3.4 The Preparations

For the dialogue workshops it is important to have local facilitators. Some of them also should be able to supervise and train assistants for the study prior to the workshop.

3.4.1 Training of Facilitators

Local facilitators are necessary to adapt the dialogue-concept to the specific culture. Since the dialogue approach is new the facilitators themselves have to be trained. This is best done by discussing the difference between debate and dialogue developed by the PCP (1999), providing literature about already successfully implemented projects and including them into the preparation of the workshop.

The main task of the preparation is the training of ground rules for the dialogue:

- To pose open questions that encourage a free expression of views, values, worries hopes and visions
- To invite and encourage participants to connect their standpoints and views to personal experiences instead of making abstract statements
- To show the participants how to value and respect the other groups' contributions – whether they agree with them or not
- There is no right or wrong position
- Everybody's point of view will be listened to and respected
- To move the dialogue from a) listening to the way a problem is perceived to b) pointing out exceptions and unexpected behaviour of members of the other group to c) establishing a common way forward

Besides the training of the ground rules for the dialogue process local facilitators also have to be prepared for conducting the study. They should be involved in translating the questions of the study into the local language.

The local team consisted of

- a male professor of psychology with experience in qualitative research
- a female local Project Officer of the GTZ project with good relations to the local community and respected status as an elder lady
- an ambitious masters student

With this combination gender as well as age premises were fulfilled.

3.4.2 Training of research assistants

The dialogue method consists of a small study based on focus group discussions among the opposite groups and the dialogue workshops itself. Therefore in addition to the workshop facilitators research assistants have to be trained. It is important to choose assistants that have the necessary skills to conduct a guided study. At the same time they should be familiar with and accepted by the local community.

For the study, research assistants had to

- be trained in communication skills
- be prepared to conduct interviews and encourage discussion about a sometimes embarrassing topic
- be acquainted with the technical equipment
- be trained in transcription skills

The three-days training therefore should be divided into

- one day on self reflection about assistants' own education and own traditional beliefs
- a second day on developing listening and asking skills and
- a third day on discussing the questionnaires and making suggestions for proper translation

The best training is to experience as a participant. Assistants should do practical exercises on communication and documentation. In addition each assistant receives a reader on communication skills (Reader Communication 2005). The study should follow soon after the preparation. Still there should be one day between the end of the preparation and the beginning of the study to organise transport and sleeping facilities.

3.5 The Study

Prevention campaigns in Malawi have failed, the number of new infection has not yet exceeded its limit. One reason for this failing might be the focus on the bio-medical aspects of the disease with the promotion of condom use as a main point. The use of condoms may apply to the urban middle class, but for many others does not meet their concept of the human body and its implications (see Kaspin 1996). Also women are not in the power of demanding condoms: by 1997 only 27% of females had ever used condoms (Namate & Kornfield 1997). By traditional experts, church leaders and a majority of the general population condoms are not only rejected, but paradoxically linked to promiscuity.

The aim of the study was to assess different perceptions, beliefs, and attitudes regarding the causes and prevention of HIV/AIDS between biomedical and traditional experts. It was carried out separately *with* the participants on either side. Since the aim of such a project is not to bring information to the targeted groups but to learn from them, focus group discussion best fit the purpose.

*Focus Group Discussions are carried out together **with** the target groups. The aim is to gain local medical knowledge about health issues relevant to fight HIV/AIDS. In the same time it makes participants aware of shared or differing perceptions.*

The study was conducted in five selected TAs (Traditional Authorities) of Kasungu: Njombwa, Lukwa, Mwase, Khaphaizi, and Mawawa. Within two weeks 18 focus group discussions with traditional experts and 5 with biomedical health workers were carried out. The groups on the traditional side were usually composed by a mixture of 8 to 10 herbalists, spiritual healers, TBAs and custodians of tradition of different age and gender. The groups on the biomedical side consisted of 5 to 8 nurses, midwives, clinical officers and HSAs. All in all, a number of 140 on the traditional part and 40 on the biomedical side participated in the focus group discussion of the study.

Each focus group would take place on three consecutive afternoons:

- The discussion of the first day was on traditional concepts of health and sickness
- The second session focussed on sexuality and HIV/AIDS
- The third afternoon was dedicated to the relationship between tradition and HIV/AIDS. Another topic in the focus group discussion was the cooperation between the traditional and biomedical sector.

Traditional experts were eager to participate, arrived in great number and contributed with vivid discussion. Minor constraints occurred. In one group a village headman wanted to take part. It was the research assistants' impression that he rather wanted

to control the other participants. One focus group had to split when discussing matters of sexuality. This separation by gender was due to the fact that an aunt and her nephew participated in the same group, which was a culturally perceived clash by gender and age.

Within the group of biomedical experts the main problem was time constraints esp. with clinical officers and nurses. Generally HSAs were more eager to participate. Because of power relations HSAs were rather free to speak aloud and discuss when among their own kind.

Every focus group was assigned two research assistants who led the discussion by asking the prepared questions. They also recorded the sessions electronically and later transcribed them. The Professor and the PhD student organised the groups, controlled and evaluated the quality of the transcription and gave advice to the assistants. The international short time expert provided supervision. Supposed there was time, they would take part in some of the sessions.

3.6 The Workshops

Although the rate of school enrolment in Malawi is increasing, the majority of elder men and women in the rural areas have not received any schooling, a fact that has to be taken into account when planning the workshop. Most of the healers have acquainted their knowledge by oral tradition, but many of the health workers are as well familiar with learning by oral devices. To equally involve all participants, the local language is spoken. Thus, the Dialogue workshops make use of the African oral tradition and follow a “narrative choreography”. The main points are:

- The Workshop setting is adapted to the world of the participants
- Orality has priority
- Traditional wisdom is welcome
- Traditional methods of education like proverbs, songs, poems and religious quotations from among the participants are used.

The “narrative choreography” of the workshop takes into account African oral tradition. Proverbs, songs, dances, poems and religious quotations are used.

Thus the workshop should make use of oral techniques by posing questions to enhance discussion and by encouraging the use of songs, role-play and poems.

3.6.1 The Programme of the Workshops

The number of people participating in the workshops should not exceed 15, the ideal ratio is 7 to 8 people from each group, gender and age balance should be taken into account. The main criteria to integrate a person into the group of workshop participants were:

- In-depth knowledge about health and tradition

- Good speaking skills
- Good listening skills
- Variety of categories from within the two groups
- Balanced gender participation

Participants for the workshops were selected from among the participants of the study. The choice was made by the facilitators based on recommendations of the research assistants.

It is necessary to assure in advance the participation of all chosen members in the groups and to take into account professional responsibilities. Medical health workers should be taken from the roster, sleeping facilities should be provided for traditional experts coming from villages far away. However, time constraints might occur. This is one reason why each workshop should last three days. Another reason is that the dialogue process itself needs time: The facilitators create opportunities for the members of the different groups to come closer, to get to know each other, and to find their common ground as well as their differences. Once a basis is established more conflict-prone subjects can be addressed (see also v. Roenne 2005).

The Dialogue workshop in the Kasungu district of Malawi had the following structure:

- 1st Day: Preparation of the dialogue with members of the same group
- 2nd Day: Dialogue Process between the different groups
- 3rd Day: Consensus building and plan of action

We have structured the dialogue schedule in the form of three consecutive days in order to create a variety of opportunities for exchange between biomedical health workers and traditional experts. Each day follows a well defined plan, but flexibility is necessary to let room for unexpected discussions.

3.6.2 Questions and exercises on the 1st day

On the 1st day members of the same group meet. The goals are:

- To show that there is not one single opinion on the different issues discussed among members of the same group
- To show the variety of opinions on the same topic among members of the same group
- To reveal that opinion building is a process and that our view of things may constantly change due to new developments
- To explore on the complexity of the issue being discussed
- To clarify if participants agree that taking pictures and use tape recorder or video is one form of documentation
- To establish ground rules for the dialogue

Questions that could be asked in the peer reflection of the first day:

	Question	Remark	Exercise

1.	What are your motivations to fight HIV/AIDS?	<i>Opening round for introduction</i>	Pairs of two, then in Plenary
2.	How do traditional healers/biomedical health workers help the people in Malawi to cope with the HIV/AIDS epidemic?	<i>Each group has an opportunity to present themselves and their skills and knowledge with a sense of pride</i>	Discussion in Plenary
3.	What special strengths in fighting HIV/AIDS do you want to be acknowledged by the other group?	<i>Important for the dialogue: this is what the other group should acknowledge and respect, even if they see things differently</i>	Plenary Proverbs
4.	From your point of view, what can the other group contribute to the fight against HIV/AIDS in Malawi?	<i>Helps to find „exceptions“: to remember moments when they actually found something the other group had to offer</i>	Pairs of two Presentation in Plenary
5.	How do you see the collaboration between your group and the other group at the moment?	<i>Any exceptions to the overall negative picture are essential building blocks for the dialogue</i>	Small groups
6.	How could your different strengths be brought together to serve the people of Malawi in the fight against HIV/AIDS?	<i>Gives the possibility to talk about an “ideal collaboration”</i>	Plenary
7.	What could go wrong, and how could that be avoided?	<i>Strategy to focus on positive aspects and to express fears</i>	Plenary
8.	How do you want to be addressed by the other group?	<i>To express respect towards each other</i>	Plenary
9.	Establish ground rules for the dialogue	<i>To create an atmosphere of safety</i>	Plenary

Remarks: question 3 and 4 prepare for the following day whereas question 5 and 6 serve the requirements of the third day. At the end of the first day participants are asked to bring tools which they use for treatment or which can serve as a symbol for their profession. These tools may be used in the exercises of the next two days.

3.6.3 Exercises and role-plays on the 2nd day

On the 2nd day the members of the two different groups meet each other. The goals are:

- Getting to know each other
- To get curious about the work of the other group
- To clarify each group's contribution to the fight against HIV/AIDS
- To clarify the different approaches of each group in the fight against HIV/AIDS
- To find similarities between the two groups

Course of the second day

	Objectives	Exercises
1.	Clarifying Ground Rules for the Dialogue	Plenary Discussion
2.	Get more knowledge about each other	Pairs with members of other group Mutual presentation in plenary
3.	Get curious about the work and tradition of the other group	4 participants of own group collecting questions Mutual presentation: 4 people of the same group to 4 of the other group
4.	Challenges in the fight against HIV/AIDS and respective contribution of each group	Role play prepared by each group, poems, dances and songs Presentation in plenary
5	Raising awareness of differences and similarities, also about prejudices and perceptions	Small groups Proverbs Plenary discussion

Reminding the Ground Rules:

- A) There is no right or wrong – everybody's point of view will be listened to and respected.
- B) The facilitators' central task is to foster curiosity and respect for the other group's point of view.
- C) The objective of the dialogue is not to *convince* one another but to *learn more* about the perspective of the dialogue partner. There does not need to be agreement at the end, but an acknowledgement of and mutual respect for each side's contribution.

Exercises

To create a variety of opportunities for exchange the exercises require that the size and composition of the groups vary. At one time the traditional experts and resp. the biomedical health workers reflect and discuss among themselves, in another moment, the two groups meet in small formations to exchange ideas and to compare results. In the plenary meetings selected speakers present the results of their group. One of the main important tools in the dialogue process is role play esp. when demonstrating the present situation and when anticipating future solutions.

- A) **Mutual presentations** serve well to show the personal commitment in the fight against HIV/AIDS. After an opening prayer, the participants are asked to form pairs with a member of the other group. Each person should introduce him/herself by name, origin, why they participate, and their personal connection to the topic HIV/AIDS. After about 10 minutes, they will present each other to the plenary.
- B) The **Curiosity exercise** allows each group to gain an understanding of the other group's method of dealing with the disease, which they would never

have acquired otherwise. This is an exercise to be done in small groups of 3-4 members of the same group. The exercise begins with collecting about 4 questions that they are all interested in. Then two small groups, one biomedical, one traditional, come together and pose their questions, taking turns. The members of the other group can decide if, and who of them, wants to reply, so that no one is put under pressure.

- C) The **Challenge exercise** shows the contribution of each group in the fight against HIV/AIDS. This is an important exercise: the two groups are asked to each prepare a presentation, involving, if they want, role play or other visualisation, in which they present their contribution to the fight against AIDS to the other group. The idea is that here each group has a chance to be truly listened to by the other group. The presentation is followed by questions – whereby the ground rules are emphasized: show respect and appreciation – whether you share a point of view or not.
- D) The **Raising awareness exercise** will show prejudices and perceptions about the other group. It also depicts differences as well as similarities between the two groups. Because the main goal of the dialogue workshop is to enhance communication and collaboration between the traditional and the biomedical sector of health providers it is important not to neglect existing tensions. It is easier to deal with differences if they are clearly put on the table. Plenary meetings let room for discussing such controversy issues. But then it is important to find similarities in the work of each group. Members of the same group form small groups of 3-4 and brainstorm on situations or aspects of the other group’s contribution that they value. Afterwards they meet with a small group “of the other party” and they share these positive views of one another. They will tell each other about times and situations when they have appreciated the other group’s contribution to the fight against HIV/AIDS. Proverbs might help to express the mutual effort.

At the end of the day the facilitators should meet and identify main areas of possible cooperation. They also will prepare a scenario to be acted out by mixed groups in the last day. Generally in the meetings facilitators will adjust the schedule to the reality of the workshop.

3.6.4 Exercises and role-plays on the 3rd day

The goals of the 3rd day with the members of the two different groups are:

- To let emerge each group’s vision of an ideal collaboration
- To foster consensus building
- To find areas of collaboration
- To establish a plan of action for the near future

Course of the third day

	Objectives	Exercises

1.	Establish common understanding of HIV/AIDS and a vision on the ideal cooperation	Role Play Plenary presentation and discussion
2.	Consensus building and plan of action	Plenary Discussion

Exercises

- A) The **Vision exercise** will depict the ideal cooperation between the two groups. This time each of the two groups are divided into half. Each half of the same group will join one half of the other group. The two mixed groups will now work on a joint role play. They can be given a prepared scenario where a woman in a village is seeking help from her healer as well as from the health service, but is torn between the different pieces of advice that she has been given by either of them. Either the groups use this scenario or they come up with their own scenario of how good collaboration could work. Each play is presented in the following plenary session.
- B) **Consensus building**: the presentation of the two plays is followed by a plenary discussion. Participants will reflect on the plays and identify areas of collaboration in the everyday fight against HIV/AIDS. They also should be invited to come up with a number of concrete and realistic suggestions of what they could do within the next three months to improve their recommendations. The facilitators should try to formulate a few indicators that could be used to monitor any improvement in collaboration, such as mutual referrals, mutual consultations or else.

The workshops' aim is to bring about an exchange between the biomedical health workers and the traditional experts. To focus on one issue for dialogue - in this case Aids - will make communication possible. But the environment of the workshop as well as the methods and the exercises used are vital to the dialogue approach.

3.7 Going Public: Presenting the recommendations of the dialogue participants to community leaders and community members

At the end of the dialogue workshops, it is important to take the newly reached consensus and the recommendations that have been formulated out into the open. Otherwise there is a danger that this very fresh and young consensus will die a quick death outside of the safe space that the workshop created.

If both groups commit themselves publicly to certain steps, and if other community leaders, such as the District Health Officer, and important Chiefs, support their decisions, it is much more likely that the planned actions will be realized.

This could be done in form of a public presentation/declaration of dialogue participants at the end of the dialogue workshops: they may want to show a part of their role play. Each group may want to appoint a speaker who could present his/her group's perception of the workshop, what they have learned and what actions they have decided to take.

A DHO and a Chief could then do the official closing ceremony and give their public approval. Also, some members of the press could be invited to reach a larger audience.

4.0 Impact & Outcomes

4.1 Results of the Study

4.1.1 Traditional Concepts of Health and Sickness

The study unearthed concepts that traditional experts use to explain causes and prevention of various illnesses. Symptoms such as coughing, diarrhoea, painful belly button, and loss of weight were perceived as symptoms of *mdulo*. Other illness conditions such as difficulties during labour were attributed to a concept known as *mapinga*, which is part of the *mdulo* complex. *Mapinga* is obstructed labour caused by infidelity of the husband. Part of the treatment requires the husband to confess the number of women he had sex with.

Mdulo is a central concept in Chewa thought, and it has been discussed by various scholars from the beginning of the century until recently (Hodgson 1913, Marwick 1965, Drake 1976, Probst 1995, Morris 1996, Wolf 2001, 2003). In the context of the AIDS epidemic it gains new meaning. *Mdulo* has multiple causal factors all dealing with non-compliance of sex restrictions during certain times or violation of other traditions or taboos. Examples of conditions that lead to *mdulo* include the following:

- If a husband has sexual contact with other women and comes back to sleep with his pregnant wife. This wife will suffer from *mdulo*.
- If a girl has reached puberty, parents are supposed to abstain from sex for a certain time. This restriction is also extended to those involved into her initiation ceremony like the chief and the ritual expert (*nankungwi*). But if one of the partners has sex during this time, the initiate will contract *mdulo*.
- If one of the marital partners has sex outside the family before a traditional ritual officially marks the resumption of sexual relationship in a family after childbirth (known as *kuponya mwana kumphasa*), the child will suffer from *mdulo*.

All these restriction serve to ensure health conditions in a family and in the community. According to traditional experts *mdulo* is treated using traditional medicine. In some situations, for example *mapinga*, the treatment may not be effective until the guilty partner confesses the sexual misconduct and if it is the woman, she often dies during labour.

Other concepts which were used to describe HIV/AIDS by traditional experts are *mtengano* and *magawagawa*. Traditionally, *mtengano* refers to a man or woman who out of love for each other agrees to seek traditional medicine and in case that one dies, the other partner should soon follow. *Magawagawa* is a generic concept that embraces all sexually transmitted infections including HIV/AIDS. The concept denotes that HIV/AIDS is a disease that is passed on from one person to another.

4.1.2 Sexuality and HIV/AIDS

The study showed that traditional practices of sexuality are significant in the era of HIV/AIDS. One important contribution of the study is the discovery that unprotected sex is regarded as a beneficial activity in Malawian culture. Not only if a couple wants to have children, but exchanging of body fluids during sex is seen as beneficial to the health of the woman and the child. Sperms are considered to have a strengthening

role for the child both during pregnancy and postnatal period (*kudyetsera mimba*). Condoms are not used since sperms are believed to have a positive effect on the health of a child through the mother's breast-feeding. During the ritual *kuyika ku mphasa* the sperms are also smeared over the body of the child to strengthen his or her bones. In instances where the woman is not married, another man is identified to perform the tradition or a couple is requested to perform the *kuyika mwana kumphasa* on behalf of the woman.

The background to these practices is the belief that bodily fluids generate, sustain and strengthen life, the absence of fluids equals the absence of life (Kaspin 1996). Also people involved in sexual activity, their sexual fluids and their blood are classified as 'hot'. Since small children are perceived as 'cold', the child has to be integrated into the 'hot' world of his parents by a ritual. To bring the child into contact with the sperms is therefore a protecting measure and serves as health promotion. These beliefs about sexuality need to be considered when promoting messages about safe sexual practices such as condoms and even abstinence. It is imperative that HIV/AIDS messages and campaigns should resonate with culturally held beliefs about sexuality and health to achieve modification of sexual behaviours responsible for the spread of HIV/AIDS among local communities.

4.1.3 Relationship between Tradition and HIV/AIDS

There are two main points that link traditional concepts with HIV/AIDS: the illness termed *kanyera* and the word *kachirombo* used to describe the virus.

The illness *kanyera* occurs as a result of having sex with a menstruating woman or one who had an abortion. The symptoms of *kanyera* include elongated fingers through loss of weight, persistent fever, diarrhoea and a pale skin and they parallel to those of HIV/AIDS. This is one reason why *kanyera* is compared to AIDS. Another reason is epidemiology: in the beginning of the epidemic in Malawi more men were affected than women. Since *kanyera* is an illness which troubles men it can easily be linked to AIDS (Wolf 2003).

Also, AIDS is seen as a consequence of modernity. There is a moral discourse reflected in complaints of the healers about an inappropriate dress code among women, especially among young ladies. These ladies do not obey traditional rules anymore, most importantly they do not care about sex restrictions after menstruation and childbirth which leads – according to traditional people – to *kanyera/ AIDS*. Traditional experts insisted that the diminishing role of the ritual advisor, the *anankungwi*, as counselors to young people is an important reason of the misbehavior of young people.

Almost all participants in the study said that AIDS is caused by a virus which is transmitted via sexual intercourse with an infected person. The word virus has been translated as *kachirombo*, meaning little wild beast. Since the word is used in its singular form, in the public opinion AIDS soon became a curable disease: remove the beast and the disease is cured! Prevention campaigns barely made use of the plural form *tizirombo* (Wolf 2006). Nor did they include concepts like the mentioned *magawagawa*, which carries the connotation of "communicability via promiscuity" (Lwanda 2004: 35). To focus on a virus means to perpetuate a long held prejudice, that AIDS is culturally not communicable.

4.1.4 Cooperation between the traditional and biomedical sector.

There was no cooperation at all. The relationship between both groups was characterized by mistrust, prejudices and misunderstandings. The biomedical health workers perceived traditional healers as a source of infection, profiteers, fame seeking and untrustworthy. The traditional experts on the other hand experienced the biomedical staff as rough people who shout at them when they bring a patient and are not respectful to their profession.

4.2 Results of the Workshop

The study was very useful for the workshops. It prepared facilitators for upcoming conflicts such as the issue of treatment for AIDS, but also provided a basis for an easier communication about mutual referral between the two groups. To know some of the traditional concepts of sickness helped in the discussion about certain limits of biomedicine. The study also helped to understand why traditional experts rather support sexual abstinence than the use of condoms.

Two workshops on 'Cultural Dialogue between traditional experts and biomedical health workers' were carried out; each lasted 3 days. The results of the two workshops are similar: in the end a common ground of communication was established and a plan of action decided. Only the groups of the first workshop took more time until working together, but then quickly found solutions for cooperation. The groups in the second workshop were willing to work together from the start. They were more creative and besides the plays they came up with proverbs and poems.

4.2.1 Results of the Preparation for the Dialogue

One sometimes wonders if what they want is not to get our herbs, study them and then begin making pills out of them behind our backs. We can't allow that. (Traditional Healer, Participant Dialogue Workshop 22nd August 2005)

The first day was dedicated to prepare the next two days of dialogue. Each group was supposed to explore their own strength and contributions to fight against HIV/AIDS. Another issue was the current perception of collaboration between traditional experts and biomedical health-workers.

The traditional experts wanted to be acknowledged:

- Traditional Healers successfully heal some diseases that are symptomatic of AIDS like vomiting, coughing, diarrhoea. Herbal drugs are also available for people that have no appetite.
- Biomedical experts ought to give TH a chance to work hand in hand because there are other diseases that cannot be managed by conventional medicine. The diseases are *tsempho*, *kanyera*, *mapinga* among others. At the hospital these patients are told that they have no disease.

- People that have been bewitched cannot be healed or diagnosed at the hospital, they should be referred to TH.
- Traditional healers offer counseling and palliative care to HIV/AIDS patients.
- A referral system of patients from clinics of traditional healers to a hospital is problematic since transport is not provided.
- Biomedical experts ought to train and equip TH with skills and tools to administer medicine. For example, TH should be provided with calibrated tumblers for measuring herbal concoctions that are given to patients.
- TBAs have no gloves and no aprons to protect themselves against the virus. They use plastic bags from sugar, which is not hygienic.
- The loss of traditional values and the diminishing role of the ritual adviser contribute to the spread of HIV/AIDS

The biomedical health workers wanted to be acknowledged:

- One cannot distinguish *Kanyera* from AIDS only when going to the hospital and have a blood test.
- They do voluntary counseling and testing (VCT) and give advise to people in order to change their lifestyles.
- Kasungu is among the districts were distributing ARVs is free of charge.
- TH often bring a patient when her condition is already bad, because they do not want to admit that they have failed to heal the patient.
- Traditional beliefs may be helpful, only their explanation may cause a problem in preventing AIDS.
- To prevent HIV/AIDS, a person should abstain. If there is uncertainty a person should use a condom.
- Herbalists should accept the fact that they have got their areas and limits, just as we the hospital staff have our areas and limits.
- Some traditional doctors just want to earn money by claiming to have found the cure for AIDS.
- TH do not prescribe the right amount of drugs; sometimes the measurement is to high or sometimes it is less.
- There should be partnership and training for TH to know their limits.

Both groups perceived any existing cooperation as less functional and guided by mistrust, misunderstandings and prejudices.

4.2.2 The Curiosity Exercise

In small groups of the same profession four questions were collected. These questions were then presented to a small group of the other profession. The questions are supposed to gain knowledge about the work and tradition of the other group.

Some of the questions from the biomedical side are:

- How do traditional experts know that a patient has HIV/AIDS in your clinics?

- In your clinics, have you traditional healers ever received a patient with HIV/AIDS? How do you help them?
- Do traditional healers refer HIV/AIDS patients to hospitals?
- Is it true that traditional healers have drugs that cure HIV?
- Is there any difference between traditional medicine given to HIV people developing AIDS and people that are HIV negative?

Some of the questions from the traditional side are:

- How do you deal with Aids cases at the hospital?
- What are perceptions of people from the hospital on traditional beliefs regarding HIV/AIDS?
- Why does a HIV positive person who is on TB treatment still get thinner?
- How do medical personnel reconcile medical advice given to TB patients not to drink and smoke against adverts by Chibuku LTD that beer gives energy? And what is the connection between beer /smoking and TB?
- Why do medical people not refer an HIV patient to traditional experts?

Already in this first group-exercise, the issue of referral and treatment was put on the agenda, sometimes in a rather reproachful manner. Especially in the first workshop the questions immediately brought about a heated discussion. Such discussions cannot be avoided and should not be suppressed. In this case after a while the facilitators should refer to the more cooperative questions and give room to participants who provide solutions, like in the following example where a healer asks his biomedical colleagues:

- *What do you think about our forefathers' customs and practices? Don't you think these can actually help in the prevention area?*

Three participants from the biomedical side gave an answer (23rd August 2005):

P: Yes, of course. I feel these customs and practices can help a lot. There are customs which can help, but at the same time these are those which may worsen the spread of Aids. For example, customs such as "chokolo" (wife inheritance) and "kulowa kufa" – these can actually contribute to the spread of the virus.

P: Among those practices which help to control the spread of Aids is the one where a husband abstains from sleeping with his wife for a few months after the wife has delivered. At first, we thought this practice would help the spread of Aids. However, we are now of the view that it helps prevention. We have discovered that while the man is keeping away from having sex with the wife, he also keeps away from all other women. The (traditional) thinking is, that if he sleeps with another woman, he is going to harm the newly born baby. We feel this practice is helping to control promiscuity and therefore the spread of Aids.

P: In addition, there is that belief which stops pregnant women from being promiscuous. The belief is that if a pregnant woman is promiscuous she will die at her time of delivery. This practice also stops men whose wives are pregnant from sleeping with other women for fear that their expectant wives will have complicated deliveries. I feel such practices are helping in the control of Aids.

It turned out in the discussion that practices which the biomedical health workers had perceived as harmful actually could even serve to control promiscuity and therefore may help to control the spread of HIV. Since many cultural practices in Malawi deal with issues of sexuality, the study and the dialogue workshop contribute to find out which part of the concepts serve to ensure abstinence in cases where condom use is not accepted. For other practices it might be possible to find substitute solutions for example in the case of widow inheritance.

4.2.3 The Challenge Exercise

Using role-playing, each group will present their contribution to the fight against HIV/AIDS to the other group. In the first workshop we could not carry out this important exercise. We had time constraints (see 4.2.7) and many members of the two groups were still reluctant towards each other at this point of the workshop. However, in the second workshop each group brought about a role play and each a poem as well.

Plot of the play by traditional experts

- A woman who is pregnant visits a spiritual healer accompanied by her husband. In his diagnosis, the traditional healer discovers that the pregnant woman has complications. The healer says he will give the woman some herbs to treat some of the symptoms. He gives her a referral letter to go to the hospital.

Plot of the play by biomedical health workers

- A patient presents himself at a hospital with symptoms of coughing and diarrhoea. The doctor suggests he should undergo VCT. The results are positive. A CD4 count is done to determine the level of immunity. The patient is recommended for ARV's.

Whereas the biomedical group in their play focussed solely on hospital treatment the group of the traditional experts already included the possibility of transfer to the hospital. The same observation is true for the poems.

Poem of a traditional healer

- "Tigwirane manja" – Lets hold hands together

The poem praises the merits of collaboration with the hospital in the fight against HIV/AIDS and calls for care and a non-discriminatory attitude towards the suffering (Elliot Chindodah 2005).

Poem of a health surveillance assistant

- "Tadikira Kaye John." – Wait a little, John

The poem urges abstinence and shows how a young lady and young man try to resist seductive behaviour (Marko Chipeta 2005).

The challenge exercise helps to state each groups own position and provides a basis for the coming exercises.

4.2.4 The Raising Awareness Exercise

After the role play the awareness exercise will show differences as well as similarities between the two groups. Both workshops raised the issue of cure against AIDS. In the small groups they discussed controversy issues like a cure for AIDS.

- How do you detect Aids in a patient?

P: Well, I feel the most obvious points are the symptoms which the patient shows. For example, there are symptoms which accompany full blown Aids like diarrhea, frequent vomiting, shingles etc. However, when we give them medication they recover.

P: And just like you yourselves have already said, you cure only the secondary infections, so do we. We cure the secondary infections but unfortunately we have no equipment to check whether we have seen the HIV itself. This is one of the reasons for which we would like to work hand in hand with, hospital people.

P: As for me, Gangire, that is my specialty. A lot of patients write letters to me to tell me that they have been diagnosed HIV positive. I give them treatment and they recover. Even in the central region, people know that I treat and cure Aids. You, hospital people, can give me some of your patients if you want. You will see that they will recover.

It was important to see that not all traditional experts claim to be able to cure AIDS as it is the case in the last answer. The answers of the other healers show, that focusing on treatment of the symptoms is one point to take into account for collaboration. Proverbs helped to express the idea.

Proverbs of collaboration

- Lende n'kukankhana. *To swing you have to be pushed.*
- Mutu umodzi susenza denga. *One head can not lift a roof.*
- Chala chimodzi sichiswa m'sabwe. *You can not kill a lice using one thumb.*

All proverbs depict the idea of mutual effort: If one person wants to swing, she needs someone to push her. Only many people working together will manage to lift a roof. And two thumbs are necessary to crush lice on the head. These proverbs show how joint efforts help to find a solution for a problem one alone cannot solve.

4.2.5 The Vision Exercise

We know that some of our traditional customs and practice are bad. But then medical science, too, has some good and some bad practices. Therefore, we appeal to the government to select the good from our bad practices and mix them with their good ones. This is the way forward, let us cooperate! (Traditional Healer, Participant Dialogue Workshop 22nd August 2005)

The vision exercise is recommended at the third day of the workshop. Now the groups know each other and in an atmosphere of trust a vision of collaboration can be developed. The mixed groups were asked to portray an ideal cooperation between traditional experts and biomedical health workers. In both workshops this exercise was done with great enthusiasm and joy.

Plot of the vision exercise of the first workshop

- A husband is sick. Conventional medicine locally bought does not help. He suspects that he has malaria. With his wife, he goes to a traditional healer. He is given treatment plus instructions on uptake of the medicine. Yet he does not get better. Symptoms such as fever, coughing, diarrhoea persist. He goes again to the traditional healer. He is given a referral letter to hospital. At the hospital, his history is taken. The doctor recommends that on top of MPs and TB screening, the patient should also undergo VCT for HIV. The patient is diagnosed HIV positive. He receives counselling on what to do. He is also advised to see a traditional healer once opportunistic infections set in. He goes to a traditional healer where he is given herbal therapies. The Patient gets well. At a later date, he goes to the TH to tell him that he is feeling well. He shares the good news with the hospital staff.

First plot of the vision exercise of the second workshop

- A woman has fever, is vomiting, has a cough, she is also pregnant. She visits a traditional healer, seeking treatment. The healer refers the woman to the hospital because the pregnancy shows complications. She is given treatment for her ailments. She is referred to the hospital through the Health Surveillance Assistant. At the hospital, her history is taken. Her symptoms are diarrhoea and coughing. The clinician recommends VCT. She is given medication for her ailments, receives counselling and is tested for HIV.

Second plot of the vision exercise of second workshop

- A woman is pregnant. She goes to a TBA who is also a traditional healer and presents her symptoms of coughing, fever, and diarrhoea. She is given treatment but is also referred to the hospital. At the hospital, the doctor recommends VCT. She is diagnosed HIV positive. She is given medication for her ailments and receives counselling. She gives birth at a traditional birth

attendant. Because she is anaemic, she is again referred to the hospital. There, she is promptly assisted.

The plots of the sketches show the possibility of multiple referrals of one and the same patient. Depending on the situation traditional healers and TBAs may need the expertise of the hospital staff and vice versa. The plays emphasize that mutual referral should become a habit, a common thing in the district.

4.2.6 Consensus Building

In the plenary discussion after the plays participants reflected on the messages of the plays and identified areas of collaboration in the everyday fight against HIV/AIDS. In both workshops they found a common ground and came up with suggestions of further activities.

Common ground between traditional experts and biomedical health workers:

Both groups have the goal to uphold the health of people

Both disseminate preventive messages using different channels

Both have the capacity to admit patients in their clinics

Both are able to cure several illnesses i. e. diarrhoea, vomiting, pain, coughing, shingels.

Collaboration was built based on the common grounds. The **cornerstones** of the collaboration are:

- The cure of opportunistic diseases like diarrhoea etc.
- The wish for a referral system
- The wish for a dialogue on cultural beliefs to distinguish helpful from harmful practices concerning the spread of the virus.

At the end of both workshops a **plan of action** was discussed. It included:

- Briefing their seniors about the results of the workshops
- Meetings between representatives from both sides
- The creation of a referral form
- To choose areas and select healers for a pilot referral system
- To identify names and places of traditional experts, because hospital staff does not know where they live and work.

The observed changes in attitude can perhaps be explained by some of the following factors. Firstly, during the whole dialogue process the emphasis was put on the common issues in dealing with HIV/AIDS shared by the two groups. Through role plays and plenary discussions the similarities were uncovered and agreed upon. Secondly, the dialogue process provided an opportunity through which assumptions and prejudices about each other were challenged. While working in small mixed

groups, both sides were able to learn from each other about their work on HIV/AIDS and appreciated the challenges each group faced. Thirdly, there appeared to be a genuine desire on both sides to collaborate because previous attempt seemed not to have succeeded. This motivation perhaps led the biomedical experts to appreciate the areas in which traditional experts could make a significant contribution in HIV/AIDS prevention.

4.2.7. Challenges

The main challenges during the course of the workshops were a clash between the dominant representatives of each group, the refuse of one and the misunderstanding of another exercise, time constraints and the question of hierarchy and authority. How to address each other and avoiding to much writing had to be considered.

Clash of the dominant representatives

Most of the difficulties occurred in the three days of the first workshop. The second workshop was much easier in terms of cooperation between the two groups. However, the first workshop was a momentum to the whole idea of collaboration despite its difficulties. This is due to the fact, that the dominant representatives of each group took part in this first session. These representatives – two leading healers on the traditional side, and the vice DHO and a nurse on the biomedical side – defended their opinion, rank and position. When creating the small groups for mutual exchange, they refused to be together in the same group. One background to this was the claim of these healers to have a cure against HIV/AIDS whereas the nurse and the vice DHO strongly emphasized that AIDS is caused by a virus and no cure has been found yet.

Refusal of exercise

The first problem occurred right in the beginning of the second day of the first workshop when the two different groups came together. They are supposed to built pairs with members of the other group and introduce themselves to each other. After the talk in pairs, they should present each other in the plenary. All participants of the first workshop would refuse this exercise regardless whether they are healers or nurses. They would claim not to remember everything the other will say and they were afraid to make mistakes in the presentations. The refusal of the exercise was a real challenge to the facilitators, since it made clear the distance between the two groups. Mistakes are easier to cope with when there is trust and confidence. Participants insisted on presenting themselves individually, and we decided to accept their wish since they should not be forced to work together.

Misunderstanding of exercise

The aim of the curiosity exercise is to find out how the other group is dealing with the disease. Participants are asked to pose questions out of curiosity about the other profession. However, in both workshops there was a tendency to try to convince the members of the other group about ones own approach instead. In one case even accusations were made. Such situations cannot be avoided and should not be suppressed. But it is important to remind the ground rules participants have agreed on and to ensure mutual respect. After some time the facilitators should try to draw back attention to more cooperative issues.

Time constraints

To enable their attendance in the study as well as in the workshops, the DHO agreed to take nurses and clinical officers from the roster. This however appeared to be a challenging task: for the study we were not able to carry out all planned focus group discussions within this group. Also all days of the first workshop started behind time, since the hospital staff usually arrived late. Because of this time constraints nurses and clinical officers could only start at 1.30 p. m., whereas the traditional healers and TBA's had to leave at 4.30. Therefore, in the first workshop we had to let go a good deal of the exercises. And it was a demanding procedure to continuously adjust the schedule of the workshop. After discussing the situation with the DC and the DHO, the second workshop had a better start and hospital staff was able to come on time.

Hierarchy and authority

Generally, the healers were more interested in achieving collaboration than the biomedical staff. The biomedical health workers were rather ambivalent to collaborate with the healers. They also would refer to the health ministry since their activities are tied to the governmental authorities. Without authorization they were afraid to step into a new direction. After telling them about the draft on "Traditional Medicine Policy" and the "Legal Framework for Traditional Medicine" which are ready for ratification in parliament they were willing to support a proposition for the collaboration of the two groups. Still, when the first workshop came to an end and collaboration was decided, both groups emphasized to first reassure with their colleges and authorities, before giving a final consent.

Addressing each other

How to address each other as a group as well as on an individual level is a sensitive issue. In our team we decided to speak about the group of healers as traditional experts. In this way not only the healers but the ritual experts, traditional midwives and – in the case of the study - local authorities could be addressed properly. On the biomedical side the group consisted not only of people working in the hospital but also of HSAs living in rural areas. They all work in the realm of a medicine that is based on the biological concept of the human body. Therefore we decided on the term biomedical health workers. The decision also has a political connotation: healers often are not accepted as experts. Experts usually come from foreign countries or have a special education in the formal sector of the society. By addressing "traditional people" as experts means to consider their expertise in a field that is beyond the realm of biomedicine.

In the workshop the participants agreed to be called by their specific profession (*asinganga* for the healers, *azamba* for the birth attendants) or by their name. Healers did not insist on being called 'doctor' as it is the case in official papers like the framework of policy or in advertisement. One healer who participated in the launch of the results of the workshop even insists being addressed as Professor, since he is receiving healers from China who seek his expertise.

Oral tradition

Another challenge for a dialogue-workshop is the oral tradition, since the original idea of the dialogue approach in PCP-Project is based on written culture. So the required writings and the use of boards had to be exchanged with the elements of the oral tradition: play, songs, dances, poems or religious citations. The use of these elements was easy for the traditional experts, but the biomedical staff was as well

able to cope. Since it was not forbidden to use paper during the exercises, some questions or suggestions were written down. Interestingly, the main symbol of referral in the plays was a piece of paper and somebody writing on it – regardless if the person was a healer or somebody from the hospital.

4.3 Public Presentation

Two months later the results of the pilot project were presented to the public on three occasions:

- a presentation of the findings of the research in the Town Hall of the Kasungu District
- a launch of the cooperation between the traditional experts and biomedical health workers at the School/community ground in TA Njombwa
- a presentation of the study and the results of the workshop ‘Cultural Dialogue between traditional experts and biomedical health workers’ on the national level in Lilongwe

In the two months between the Dialogue-workshop and the official launch of the collaboration first steps towards cooperation in Kasungu had been taken:

- A Task Force Team had been established consisting of 5 biomedical and 5 traditional experts. Their aim is to operationalize the cooperation
- A Referral Form has been developed
- A List of traditional healers and TBA for referral has been compiled
- A Monitoring system was about to be established in order to measure the impact of the cooperation
- A Official launch of the cooperation in the Kasungu district lead by DC and DHO had been decided
- At the presentation in Lilongwe the DHO suggested to establish a similar dialogue between TBAs and hospital in order to reduce maternal mortality in the district

4.3.1 Presentation of the findings of the research in the Town Hall of the Kasungu District

Objective of the presentation

- Present the findings of the research to the participants of the focus group discussions and get feed back from them
- Sensitize other stakeholders, particular representatives from other associations of traditional experts, health NGOs and CBOs in the district.

Official Participants

- The District Commissioner
- The District Health Officer

- TDr. Domingo Yohane, Lilongwe; President of the *International Traditional Health Practitioners and Research Council of Malawi* and president of MTHUO
- TDr. Chipangula, Blantyre; president of the *International Medicines Council of Malawi* and vice president of MTHUO
- TDr. Gangire Phiri, Kasungu; President of the *Herbalist Association of Malawi* and senior adviser to MTHUO
- 15 traditional healers

4.3.2 Launch of the cooperation between the traditional experts and biomedical health workers at TA Njombwa

Objective of the Launch

- Familiarize the participants with the research/dialogue process and the outcomes
- Explain and disseminate the cooperation between traditional and biomedical experts
- Highlight the importance of that cooperation for the fight against HIV/Aids for the district as well for the Nation.

Official Participants

- The District Aids Coordinator
- The District Health Officer
- The Traditional Authority of Njobwa/Kasungu
- Approximately 200 people from the community

The launch was organized by the participants of the workshop in Kasungu, esp. by people around TDr. Gangire Phiri. After the speeches a theatre group of the hospital performed a play on the collaboration. Then local people would perform. Even the masks of the men's secret society (*nyau*) came to perform "the great dance" (*gule wamkulu*). The performance of the masks is the most important contribution to launch news to the local population.

4.3.3 Presentation of the results of the workshop on the national level in Lilongwe

The presentation of the results on the study "Integration of traditional beliefs and gender roles in the HIV/Aids prevention campaigns in Malawi" and the results of the workshop "Cultural Dialogue between traditional experts and biomedical health workers" was organized by the GTZ CGBV Programme and the GTZ Health Sector Support Programme. It took place in the Cresta Hotel in the capital city Lilongwe.

Objectives of the Presentation

- Disseminate the outcomes of the dialogue project
- Discuss the outcomes and their relevance with the participants
- Discuss possible ways forward

Official Participants

- Mr. Roy Hauya - Director of Planning and Policy (NAC)
- Mr. Mtota - responsible for traditional medicine in the Ministry of Health
- A colleague of the Health Sciences Department
- A representative of PSI
- A representative of MANET
- Dr. Stadler – GTZ Health Sector Support Programme

The results of the study “Integration of traditional beliefs and gender roles in the HIV/Aids prevention campaigns in Malawi” were presented by the Malawian facilitators from the college in Zomba (Bowa and Jumbe 2005). The new methodology on a medical dialogue and the results of the workshop ‘Cultural Dialogue between traditional experts and biomedical health workers’ were presented by the international short time consultant (see Wolf 2005).

4.4 Output

The study should provide answers to the above mentioned five questions.

4.4.1 Modification of perceptions and attitudes

The first question was:

1. Which perceptions regarding AIDS, sickness/health, gender roles in relation to AIDS prevention and spread existed at the beginning of the research on the side of the healers and the “modern” actors, respectively? Have the two groups modified their views or attitudes during the course of the study, and if yes, how and why?

The first part of the question is answered in the chapter above. This part deals with the second part of the question. During the study there were no changes in the two groups' concepts in explaining the causes of diseases in general and HIV/AIDS in particular. This would be too high an expectation for such a short time. However, noticeable changes were observed in the perception and attitudes towards each other during the course of the dialogue process. Three points are remarkable:

- The question of cure or treatment against AIDS
- The question of communication and collaboration
- The perception towards the role of TBAs

4.4.1.1 *The question of cure or treatment against AIDS*

Healers that claim to have a cure against AIDS will stick to this assertion. Since AIDS is compared with *Kanyera*, and healers are capable to cure *Kanyera*, some healers claim to be able to treat AIDS as well. This statement however is not accepted on the

biomedical side. But the dialogue process helped to find mutual acceptance in the question of treatment of the symptoms of AIDS like diarrhoea, vomiting, pain and loss of appetite. Healers as well biomedical staff may give relief to the suffering patient by curing the symptoms of AIDS and providing relief against opportunistic diseases.

This agreement is an important step towards better communication, since these two groups are having a long standing dispute about right or wrong treatment that traces back to colonial times. With the claim of some healers to be able to treat AIDS, the gap between traditional healers on the one side and biomedical staff and the government on the other side became wider. This claim had also caused a heated debate that lasts for years. To focus on the treatment of symptoms therefore is an important step into the right direction and will also serve the suffering.

4.4.1.2 The question of communication and collaboration

Both groups found the existing collaboration less successful and faced some challenges. They stated a lack of communication. In addition, there were some prejudices in the way traditional and biomedical experts perceived each other. Biomedical experts said that most of the traditional healers were often reluctant to refer cases, they had failed to treat, to the hospital in time, for instance HIV/AIDS and TBC. On their part, traditional experts said that lack of transport prevented them to make timely referral to hospital and hospital staff would treat them with disrespect.

The discussion of the draft on the “Traditional Medicine Policy” was one momentum for change. Another was the play in the mixed groups during the dialogue process. Also the importance of personal talks during the pause of the workshops, the dedication of the facilitators and the support of the international experts should not be underestimated. At the end of the dialogue workshop the two groups agreed on a meeting of representatives of both sides and the creation of a referral form.

4.4.1.3 The perception towards the role of TBAs

On the biomedical side it was generally felt that training programs had little impact on traditional birth attendants since referral of complicated pregnant cases to the hospital was not happening as expected. TBAs claimed the lack of transport. In addition, they lack material resources such as gloves, soap and aprons which made prevention of HIV/AIDS difficult in their work. During the course of the dialogue process respect for the work of TBAs would rise due to personal communication about work and care. In the end it was suggested that TBAs should be acknowledged separately in official papers by the government, and that respect for their work should be part of the curriculum of the Health Science Department. Traditional Birth Attendants were urged to come into the open. They should form an organization, and each should be known by their colleagues in the hospital.

4.4.2 Transfer into successful prevention strategy and more effective cooperation

The study should provide answers to the second question:

2. How can the modified perceptions, practices and attitudes towards one another, be translated into a more successful prevention strategy and into a

more effective cooperation (e.g. mutual referrals) between the two groups in order to effectively contribute to HIV/AIDS prevention?

There was no time and no possibility to develop another prevention strategy. This would be too high an expectation for such a short time. At the end of this paper the international short time expert will give recommendations and suggestions. But a great success is that traditional and biomedical experts decided to cooperate and:

- to develop a referral system and a corresponding referral form
- they agreed on periodical information meetings and mutual respect for the approaches and practices of the other
- to chose a smaller district as pilot area

4.4.2.1 Referral system

The healers and the biomedical staff agreed to jointly design a referral form. It has to be user friendly, that is, the illiterate traditional healers ought to be able to use it. It has to include other diseases that traditional healers are able to heal and not HIV/AIDS only. There are referral forms that home based care organizations are currently using. That model can be adapted when creating the referral form for traditional healers.

4.4.2.2 Information meetings

Both groups further suggested that there should be meetings between representatives from both sides. The agenda should be the creation of referral forms, what diseases to be included on the forms, and other areas of collaboration. Clear roles of the traditional experts and the biomedical health workers should be achieved through orientation meetings. It was mentioned that the referral system would work effectively if biomedical experts at the district hospital were personally acquainted with the traditional healers and the various diseases they are able to cure. At least they should be known to their nearest health post.

4.4.2.3 Pilot district

Another important decision was to choose a pilot area within the district of Kasungu. Selected healers and TBAs should cooperate with the hospital and their respective health posts to gain experience how to work together effectively and to test the new referral form. In this way it is easier to pilot the referral system before a full-fledged implementation in the whole district. Also an impact monitoring system should be established.

4.4.3 Country-wide extension of dialogue-process

The study should provide answers to the third question:

3. How can such a constructive dialogue process, including facilitated in-group discussions, cultural dialogues between the two groups and, as one result, agreed cooperation between them, be extended country-wide?

It is recommended:

- to conduct a second dialogue process in another region with other ethnic and religious population, preferable in an urban environment
- to develop a system of replication for the dialogue process
- to foster partnerships between traditional and biomedical health practitioners

The next step towards a nation-wide extension should be another small study and medical dialogue in the south of the country. The south is occupied by other ethnic groups and more Moslem compared to Kasungu live there. This second project of its kind is to reassure if the results are the same as in the Kasungu project or if there are differences in the concepts of disease esp. different perceptions of HIV/AIDS. The Kasungu project was carried out in a rather rural environment and with one of the four healer organisations in the country. For the sake of comparison the second project should not only work with another healers' association but also in an urban environment. It is recommended to carry out this second project in the town of Blantyre, the largest town in Malawi.

The most influential healer in the south of the country is TDr. Chipangula. He is the president of the *International Medicines Council of Malawi* and vice president of the *Malawi Traditional Healers Umbrella Organisation* (MTHUO). His office is based in Ndirande, a slum area of Blantyre. Like TDr. Gangire Phiri in Kasungu, he has many followers and is well networked with other traditional experts.

The president of the umbrella organisation is TDr. Domingo Yohane. He should not be neglected. But he is based in Lilongwe and Lilongwe is not far away from Kasungu. Also, the region is as well dominantly occupied by Chewa people. Studies carried out there (Probst 1999, Wolf 1996, 2001, 2003) show that the concepts of disease do not differ very much from the ones in Kasungu. He has connections to Chinese healers and companies, but rather seems to work on a more individual basis. His influence and connection to the government might relate to his clients from the upper class of Lilongwe.

After the second medical dialogue project a system of replication for the other districts in the country should be developed. Once the dialogue process has been extended to others districts partnerships on an individual basis between health practitioners working in the informal and formal medical sector should be fostered.

4.3.4 Representation of traditional experts in National AIDS Commission and Country Coordination Mechanisms

The study should provide answers to the fourth question:

4. How can the traditional healers and midwives be adequately represented in, and work as a part of, the National AIDS Commission and in other *Country Coordination Mechanisms*?

It is recommended:

- to urge the ratification of the *Traditional Medicine Policy*
- to incorporate midwives as a group on their own into the policy papers
- to provide resources for healers to let them internally prepare for official meetings

The most important step is to urge the ratification of the *Traditional Medicine Policy* in parliament. The policy includes a bill to provide the legal framework as well as a code of ethics for the collaboration with traditional health practitioners. Although the draft for the policy provides a basis of collaboration with healers it is strongly male-biased. In the umbrella organization female healers are subsumed under a “chairlady committee”, TBAs are only mentioned as being included in the term “Traditional Health Practitioner”. To give them a voice, they should be mentioned separately in all official documents.

Incorporation of traditional medicine into existing formal health care system is one step to enable traditional healers and midwives to participate in official commissions. Another is to ameliorate their general reputation by including the subject of respectful conduct between biomedical and traditional health practitioners into the curriculum of the polytechnic education centres.

Unlike representatives of the government healers do not have the structure and means to prepare for meetings of the NAC or to participate in the CCM. It is essential to provide financial resources for internal communication among healers to facilitate a coordinated preparation for official meetings.

4.3.5 Medical Dialogue as a model for the whole country

The study should provide answers to the fifth question:

5. How best can the pilot project become a model for the whole country and what are the funding options for the next steps?

Starting from Kasungu the dialogue process should be extended to other districts, so that communities there also benefit from the new approach. Therefore an open dialogue on the issue of collaboration between traditional and biomedical health practitioners should be encouraged. Within a decentralized health system it should be the responsibility of each District Commissioner to initiate this dialogue assisted by health care institutions and local NGOs.

It is suggested that the GTZ-adviser to the health ministry might link with the Chancellor College in Zomba to find out about their research programme and cooperation with traditional healers. He might interrogate on a possible cooperation for extending the dialogue process. Meetings with stakeholders, advocacy meetings with TAs and members of NAC are recommended. An impact monitoring system should be established.

Founding on this macro-level can only be provided by the NAC itself, probably through the Global Fund to fight AIDS, Tuberculosis and Malaria. The country is

already included into the Global Fund's antiretroviral treatment programme (WHO 2005).

5.0 Relevance of practice

- The overall situation in the health sector of Malawi is mentioned above. The governmental and formal health system is not capable to manage the health needs of the country's population. Healers are important actors in civil society. They provide a complimentary system which is self-reliant. To ensure efficacy and to better serve the sick, dialogue between traditional and biomedical health practitioners is highly recommended. The dialogue process seems to be the best method to serve the purpose esp. in the case of HIV/AIDS.
- There is no official national policy and no legal framework for traditional medicine. The drafted *Traditional Medicine Policy* is still awaiting the ratification of parliament. Only after ratification the process of elaborating a strategy at national, regional, district, TA and village level will start. The pilot project to enhance communication between traditional experts and biomedical health workers may therefore serve as a model for the whole country. It shows a way how to realize policy-aims within the health delivery system.
- The dialogue approach is genuine insofar as it is not a top-down but a bottom-up approach. Via the new method of *medical dialogue* cooperation develops from within the district.
- The combination of a FGD-study and the dialogue-method aids the development of a more successful HIV/AIDS prevention strategy. The study provides the cultural background for prevention messages on the community level. Once a dialogue between healers and representatives of biomedicine is established they may join to elaborate on an appropriate campaign which serves the concepts of both sectors.
- The dialogue approach fulfils the requirements of the UNAIDS Policy Position Paper. This paper urges to address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission (UNAIDS/WHO 2005).
- Also the dialogue approach fulfils another requirement of the UNAIDS Policy Position Paper: to support the mobilization of community-based responses throughout the continuum of prevention, care and treatment (UNAIDS/WHO 2005).

6.0 Suggestions and Recommendation

6.1 Recommendations concerning an appropriate Prevention Campaign

There are cultural practices that are useable in HIV/AIDS prevention. However, to launch a culturally appropriate prevention campaign it is necessary to wait for the results of the second study and workshop in the south. For a prevention campaign it is also necessary to conduct a third short study among the Tumbuka and the Ngoni in the north of the country. They differ from the dominant Chewa not only in the language but also in their social organisation. It is important to find out how their concepts overlap with central and southern Malawi and how these interfaces can be used in slogans.

Based on the results of this first study and the literature review, three issues should be considered in a future prevention campaign: the use of the term *kachiroambo*, the concept of *kanyera* and the question of abstinence. Another important point is to find a substitute for the use of semen in some rituals.

→ Use *Magawagawa* and *Chiwere were* instead of Virus or *Kachiroambo*

In Malawi the word virus was translated to the Chichewa term *kachiroambo*. *Chiroambo* means wild beast, *ka* is a diminutive, thus virus has been translated into “little wild beast”. Although many people meanwhile are familiar with the term *kachiroambo*, it evokes wrong ideas. In prevention campaigns and public conversation the term is used in its singular form which may suggest: remove the beast and the disease is cured. In future campaigns either the plural *tiziromo* should be used or Malawian concepts of *magawagawa* (‘something shared’) or *chiwere were* (promiscuity) should be applied (see 4.1.1).

Magawagawa is a common word when referring to STDs. *Chiwere were* is a word for the sound of an insect that flies from tree to tree. Thus, *chiwere were* evokes a picture of infidelity and promiscuity. Whereas *kachiroambo* is an adaptation of the biomedical virus-concept, the terms *magawagawa* and *chiwere were* are culturally understood. To communicate in rural areas it is recommended to adhere to the idea of “something shared” or of promiscuity.

→ Use the Concept of *Kanyera* – Contamination through unclean Blood

The idea of contamination is not alien to Malawian culture. The whole *mdulo*-complex is based on a concept of contamination that is caused by somehow illicit sexual contact (see 4.1.1). The concept is interrelated with perceptions of hot or unclean blood in the body. These perceptions are broader than the biomedical way of thinking about germs, as they include the idea of disobedience of social rules as a causal agent for disease.

Depending on the social aetiology, different sub-terms of *mdulo* such as *kanyera* are common (see 4.1.3). Because of the epidemiology at the beginning of the epidemic and the similarity of the symptoms between *kanyera* and AIDS, *kanyera* has been compared to AIDS. Moreover *kanyera* has strong moral implications since it refers to behaviour that is dangerous for the family and the community as a whole. The idea of dangerous behaviour should be used in prevention campaigns, although it should be clarified that the two diseases are not the same: there is a cure for *kanyera* but not for AIDS.

→ Give Priority to Abstinence

Prevention campaigns have propagated the use of condoms. Moreover, many posters in Malawi that advertise the use of condoms depict scenes with urban youngsters. Others portray scenes in bars or show ways of behaviour which is not accepted by the moral majority in the country (Wolf 2006). But they fit to the lifestyle of a certain part of the Malawian society. What is missing in the history of approximately 20 years of HIV/AIDS prevention messages in Malawi is an approach to the rather conservative part of the population. To meet their needs cultural concepts of abstinence should be applied.

Culturally prescribed abstinence at certain times serves to control promiscuity and therefore may help to control the spread of HIV. If one of the partners has sex outside the house when his wife is pregnant, she will have *mapinga* - obstructed labour. If the man is promiscuous while his wife is breast-feeding, their child will get sick with *tsempho*. Since many cultural practices in Malawi deal with issues of sexuality and abstinence concepts like *mapinga* and *tsempho* may serve to ensure abstinence in cases where condom use is not accepted. To propagate condoms or abstinence is a question of different lifestyles and how to address them accordingly.

→ Urge to substitute the symbolic Use of Semen with another white Liquid

Sperms are considered to have a strengthening role for the child both during pregnancy and the postnatal period (see 4.1.2). During the ritual the semen of the father is smeared over the body of the child to strengthen his or her bones. This practice is therefore seen as a protecting measure and culturally serves as health promotion. It might be possible to find substitute solutions like using milk or a liquid made of flour and water. Both liquids have a white colour; moreover, flour is also used in other rituals in Malawi. To deal with this case and to bring about change, the contribution of traditional healers, TBAs and ritual advisors is strongly recommended.

6.2 Suggestions concerning the Organisation of another Workshop

- Another study in the context of a medical dialogue can be carried out in only one or two days, but there should be more space between the study and the workshops to enable the facilitators to better prepare for the workshop.
- At least 3 days should be given between the study and the start of the workshops. This time will allow the facilitators to concentrate on the outcome of the study and to make use of the preliminary results.
- Recording and transcribing the Focus Group Discussions during the study turned out to be quite useful. Statements and concepts about health etc. of the participants are documented and can be used in prevention campaigns.
- Each workshop ends with a plan of action. To work on slogans for a more appropriate prevention campaign should be included into the plan of action. After the end of the workshops the facilitators should have a meeting with some participants of each group to work on a first draft for these slogans.

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