German HIV Practice Collection

# Medical Dialogue:

## How to kick-start a joint AIDS response by health workers and traditional healers

gtz
Strengthening the German contribution to the global AIDS response

On behalf of
Federal Ministry for Economic Cooperation and Development

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# The German HIV Practice Collection

Peer-reviewed

The German HIV Practice Collection is edited by the German HIV Peer Review Group (PRG), an initiative launched in September 2004 by AIDS experts working in German and international development cooperation. The aim of this group is to collaboratively manage knowledge about good practice and lessons learnt in German contributions to AIDS responses in developing countries.

Based on a set of jointly defined criteria for 'good practice' (see text box), PRG members assess different ways of responding to AIDS that have been submitted to them for peer review. Approaches that meet the majority of the criteria will be documented, published and widely disseminated as part of this Practice Collection. While some of the documented practices cannot fully meet, as yet, the criteria for 'good practice" (i.e. several external evaluations and multiple replications in different countries), all of them represent examples of 'promising practice' that may inform and inspire other actors in the complex and dynamic fields of HIV prevention, AIDS treatment, impact mitigation, support and care.

### Selection Criteria

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

PRG members believe that collaborative knowledge management means **'getting the right people, at the right moment, to discuss the right thing'**. Through the peer review, discussion and dissemination of innovative approaches, German development cooperation supports essential principles of capacity development:

- The process is organised as a transparent and mutual learning experience involving AIDS experts of German organisations, their partner institutions in developing countries and AIDS experts working for multilateral organisations.
- It provides planners and practitioners with a range of practical, evidence-based programming models.
- It focuses on the results of the reviewed approaches, looking at their achievements, challenges and lessons learnt.

PRG membership is open to AIDS experts and development cooperation planners and practitioners with an interest in German contributions to the AIDS response in developing countries. For more information, contact the Secretary of the Peer Review Group at at aidsprg@gtz.de or go to http://hiv.prg.googlepages.com/home

# Summary

In many developing countries, people turn to traditional medicine not only because they believe it is effective but because it is readily available and affordable. By contrast, modern medicine or biomedicine is in short supply and requires out-of-pocket expenditures that many cannot afford. For those reasons, WHO and UNAIDS have long been recommending collaboration between biomedical practitioners and traditional healers and the integration of traditional medicine into public health care, including programmes to respond to AIDS.

Malawi is one of the world's nine countries most heavily burdened by AIDS but, so far, it has not achieved the collaboration and integration recommended by WHO and UNAIDS. Malawi's official national AIDS response draws exclusively on biomedical ideas about how to avoid and manage disease and ignores the fact that the majority of the Malawian people draw their understanding not just from biomedicine but also from traditional medicine.

Since 2004, GTZ has been supporting efforts to promote collaboration and integration through application of the "medical dialogue" method in one district, Kasungu. The method facilitates respectful dialogue, free of prejudice, among traditional healers, biomedical practitioners and people who turn to either or both for prevention, diagnosis and treatment. In Kasungu, as in the whole of Malawi, people who turn to both are in the majority and include even the well-educated and wealthy.

This publication provides background to the medical dialogue, a method that is based on the understanding that traditions are not static but constantly reinterpreted and adapted to a given context. The method's application in Kasungu began with training local moderators. They facilitated a series of focus group discussions in which traditional healers and biomedical practitioners talked about local sexual practices, beliefs and taboos and their ideas about illness, prevention, diagnosis and treatment. Both sides were encouraged to share their doubts and concerns about each other in ways in which both felt that their points of view were respected.

The focus group discussions provided information on which to base three-day medical dialogue workshops. Participants included equal numbers of traditional healers and biomedical practitioners chosen for their knowledge and communication skills and in order to create a mix of genders, ages and fields of work within traditional medicine and biomedicine. On the first day, traditional healers and biomedical practitioners met separately to prepare themselves. On the second day, they met together to air and discuss their different ideas and opinions. On the third day, they worked together on producing a mutually agreed plan of action that divided responsibilities between the two groups.

*Kasungu Task Force Team with TBAs*

*Patient transport to Kasungu hospital*

Over the following weeks, the traditional healers and biomedical practitioners established a Task Force Team, agreed on a mutual referral system, a referral form and a pilot area (Kasungu West) of manageable size. An evaluation one year later found that collaboration between the traditional healers and biomedical practitioners was working smoothly and that their patients were reaping the benefits. For example, maternal mortality in the project region had been reduced to zero in the project period because traditional birth attendants were now referring critical cases to the hospital in timely manner. Also, the district hospital was now providing them with the latex gloves they needed to protect themselves and their patients from HIV infection.

Such was the success in Kasungu West that the district medical health officer plans to use the medical dialogue method across the district and a large organization of traditional healers wants to test the method in an urban setting with an ethnically and religiously mixed population. The National AIDS Commission and the Ministry of Health have both expressed interest in the medical dialogue method as a tool that could help them build capacity to respond to AIDS and other disease through training, institutional development and establishment of a political and legal framework. Malawi already has a draft Traditional Medicine Policy in place and the success of the medical dialogue method could help move that draft toward ratification by Parliament.

# Introduction

*I would like to remind you of the United Nations circular letter, which advises that medical science and traditional healers cooperate with each other in the fight against AIDS.*
(Healer at the Kasungu dialogue workshop, 2006)

The rift between "modern medicine" or "biomedicine" and "traditional medicine" has a long history. During the colonial era, many governments accused traditional healers of witchcraft and legislated against them. Since then, most postcolonial governments have continued to support biomedicine while many of them oppose traditional medicine. Where healer organisations have gained government support, the cooperation often breaks down due to internal disputes between different healer organisations, sometimes resulting in one group pressing legal charges against another (Last and Chavunduka, 1986).

What are the differences between the two categories of medicine? The term "biomedicine" refers to that category's foundations in human biology and the closely related fields of physiology and pathophysiology (Hahn und Kleinman, 1983). Since it is the medicine most often recognized and supported by government, it is often referred to as the formal sector of medicine. Traditional medicine is often referred to as the informal sector and can be defined as "the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (WHO 2000).

What are the similarities between the two categories of medicine? Both are heterogeneous and hierarchical, with a variety of types of practitioner and a ranking of types. Malawi's biomedical practitioners include doctors, clinical officers, midwives, and health surveillance assistants. Malawi's traditional healers include traditional birth attendants (TBA), spiritual healers, herbalists and others. While "traditional" seems to imply unbroken continuity from past to present (Hobsbawn, 1992), traditional medicine is seldom static. Instead, it changes constantly through re-interpretation and adaptation to new circumstances.

In many developing countries, there are acute shortages of biomedical practitioners and the facilities, equipment and supplies they need to function. In addition, the costs of biomedicine are covered largely by out-of-pocket expenditures by patients and their families and many cannot afford these expenditures. As a result, people turn to traditional medicine not only because they believe it is effective but also because it is readily available and they can afford it.

In 1978, the International Conference of Primary Health Care in Alma-Ata recognized these realities and called for collaboration between the practitioners of biomedicine and traditional medicine and the integration of traditional medicine into public health care systems. In 1990, the World Health Organization's Traditional Medicine Programme and Global Programme on AIDS called for similar collaboration in the fight against AIDS. In 2000, UNAIDS called for mutual respect, the open exchange of information and ideas, and the fostering of partnerships among government authorities, biomedical practitioners and institutions and traditional healers (UNAIDS, 2000).

Malawi is one of the nine countries, all in southern Africa, that have the world's highest rates of HIV infection. In 2005, 14 percent of Malawian adults (15-49 years old) were infected with HIV. Only 31 percent of women and 38 percent of men used condoms for casual sex, and only 21 percent of women and 20 percent of men abstained from sex to avoid HIV (UNAIDS, 2006). Voluntary counseling and testing (VCT) services were seldom used, and then predominantly in cities by wealthier, better educated people (National Statistical Office, 2005).

In Malawi, as elsewhere, the primary objective of HIV prevention is to change sexual behaviour. Often prevention campaigns are based on biomedical thinking and presume that scientifically-derived information about modes of HIV transmission and methods of prevention will lead directly to changes in behaviour. Such a presumption fails to take into account that sex is tied up with fertility and reproduction (Rompel 2006) and that there are cultural attitudes and beliefs about both. There are also cultural attitudes and beliefs about how disease, including HIV, is transmitted and how it can be prevented or cured, and many of these correspond with biomedical thinking (Green, 1999; Wolf, 2001; Wolf, 2003).

Often testing and treatment campaigns are also based on biomedical thinking and presume that individuals will follow the advice of biomedical practitioners. This presumption fails to take into account that whole families may be involved in decisions for individuals and may decide which kind of institution or practitioner, whether biomedical or traditional, the individual will turn to for diagnosis and treatment (Janzen, 1978; Dilger, 2005).

Regardless of their level of education or economic status, most Malawians consult both biomedical practitioners and traditional healers. Biomedical and traditional approaches to HIV and AIDS co-exist and are not viewed as contradictory, per se. They may even be viewed as complementary or, at least, as two equally valid approaches both of which should be taken just to be on the safe side. Many biomedical practitioners disapprove of such views and may even, from their positions of greater power, talk down to both traditional healers and their patients. A more constructive attitude, however, would be to accept these views as given and to recognize traditional healers as potential allies in the fight against AIDS. This is especially so given that Malawi has a weak public health care system and suffers from acute shortages of qualified biomedical practitioners, facilities, equipment and supplies.

Yet even though WHO and UNAIDS strongly recommend collaboration between biomedical practitioners and traditional healers and integration of traditional medicine into public health care systems, neither of those things has occurred in Malawi. A Traditional Medicine Policy has been drafted but it has yet to be ratified by Parliament. However, three phenomena have given reason to hope for more action in the years ahead:

- WHO now has guidelines for research and evaluation of traditional medicine (WHO 2000) and a strategy to support traditional medicine (WHO 2002).
- Competition among Malawi's traditional healers has been eased by the establishment of an umbrella organization in which the presidents of the country's three major organizations of traditional healers hold key positions.
- The Government of Malawi has given the Ministry of Health responsibility for integrating traditional medicine into its brief.

Those three phenomena have leant support to the work described in this publication. By promoting communication and collaboration between the formal (biomedical) and informal (traditional) sectors of medicine, the medical dialogue method can make important contributions to national AIDS programmes in Malawi. It could result in new and culturally appropriate prevention programmes and in more take-up of opportunities for voluntary counselling, testing and treatment through an improved system of referrals. It could also help address the problem of Malawi's worsening health care drain, as biomedical practitioners take up more lucrative jobs abroad, by making it possible for traditional healers to fill some of the widening gap between the supply and the need for health care.

# Methods

## How the dialogue method originated

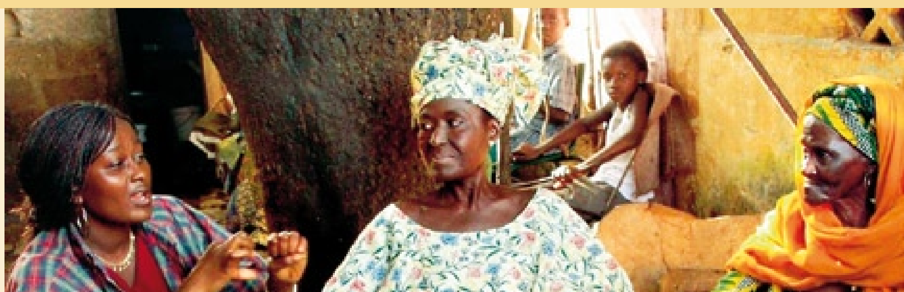
The dialogue method originated in 2002 in Guinea, where numerous government information campaigns have been informing the population about the negative health impacts of female genital mutilation (FGM) since the mid-1980s. Despite these efforts, a large proportion of all girls there are still subjected to FGM. Inspired by the Public Conversations Project (Public Conversations Project, 1999), representatives of local organisations, with the support of advisors from the GTZ project Promotion of Initiatives to End Female Genital Mutilation, decided to try a different approach. They made it their objective to attempt a respectful dialogue, free of prejudice, with proponents of FGM, so that the cultural and social reasons for its persistence might be better understood within the framework of an action research process, and so that interventions might then be adjusted accordingly.

> Find tool 1: PCP Dialogue Toolbox in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

Large numbers of community representatives took an active part in these discussion forums, which were organised for specific generation and gender groups. The open questions asked by the moderators, and their modus operandi, which stressed respect for the people and their values, led the older men and women to open up to the dialogue and to express, in addition to the many advantages of the "old days", their mixed feelings about FGM, which they know very well poses numerous risks to health. Many of the young women, for their part, expressed the desire to take part in this form of respectfully moderated discussion forum along with their parents and grandparents, whom they regard as the guardians of traditional customs and mores.

This is how the concept of the intergeneration dialogue, involving both older and younger generations came into being. The method enables local organisations not only to promote a coming together of traditional and "modern"[1] points of view and mutual respect and interest, but also to get these groups to agree on concrete resolutions for the future handling of controversial topics such as female genital mutilation, AIDS prevention and up-to-date sex education for young people (Roenne, 2003; GTZ, 2005). Since the method was first piloted in Guinea, the intergeneration dialogue has also been used in Mali and in Kenya, and in helping both younger and older persons in the eastern Congo to cope with war traumas.

The form and methods used in intergeneration dialogue workshops are chosen with the idea of allowing the specific knowledge and experiences of both generations to find equal expression. This means that in countries such as Guinea, Kenya and Congo, where the majority of the older generation have had little or no schooling, the dialogue must be held in the local language, and that written media and instructional material cannot be used at all. The room in which the dialogue takes place is decorated with local fabrics and furnished with both chairs and locally made straw mats, so that a comfortable atmosphere is created, with objects familiar especially to members of the older generation, for whom participation in such a seminar is something entirely new and alien. Local musical instruments are also at hand for music and dancing.



*Young and older women in Conakry, Guinea, discussing women's roles in past and present times.*

The exercises are introduced by moderators from the respective communities who have been trained in the dialogue method. They include discussion in small groups, role-playing and plenary discussion. Particularly the older generation continually contribute sayings, songs and dances to the dialogue. The exercise "life paths" highlights for all participants the main differences in the courses people's lives have taken, and in the values and challenges of the two generations. In this, both age groups make use of symbolic objects and of play-acting, songs and dances that illustrate the behaviour typical for their generation at various stages of life.

Find Tool 2: Generation Dialogue about FGM and HIV/AIDS in Guinea. Method, experiences in the field and impact assessment in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

Concrete outcomes of the intergeneration dialogue, to which well-known personalities and opinion-shapers are specifically invited, are, according to a study conducted by GTZ in 2003, not only markedly better relationships between the generations in the participating families but also greater commitment to dialogue between the generations in the areas in which participants are involved (schools, mosques, churches, local authorities).

*Girl in Labé, Guinea, interviewing her mother about girls' initiation in her time.*

*Dialogue facilitator team and consultant A. Wolf, August 2005*

## The Medical Dialogue in Malawi

In Malawi, the dialogue method was initially tested between representatives of the government health system and healers. As in a number of other countries, Malawi's general health care is split into a biomedical sector and a traditional sector. Some healers repeatedly claim to be able to cure AIDS, which has led to considerable tension between governmental offices and healers (Probst, 1999). The claims of the healers on the one hand and the claims to universal authority and the power of interpretation by biomedical representatives on the other made introducing the dialogue method particularly challenging in Malawi.

There are currently three large healers' associations in Malawi: the International Traditional Medicines Council of Malawi in the south of the country, headed by the healer Chipangula; the International Traditional Health Practitioners and Research Council of Malawi near the capital, Lilongwe, chaired by the healer Yohane, and the Herbalist Association of Malawi, in the centre and northern parts of the country, led by the healer Gangire. Recently these three organisations, after years of dispute, have joined forces within the national Malawian Traditional Healers Umbrella Organisation (MTHUO) and have agreed on the apportioning of offices within it. S. D. Yohane was ultimately accepted as president of the umbrella organisation, W. G. Chipangula as vice-president, and Gangire Phiri as senior advisor.

Based on existing GTZ contacts to the chairman of the Herbalist Association of Malawi, the healers' association in the central region of Kasungu, represented by Joseph Gangire Phiri, was selected as the partner organisation for this intervention. Besides, Kasungu, where 91 percent of the population have not been tested for HIV, also ranks last in the country in this key factor of effective HIV prevention (National Statistical Office, 2005).

The dialogue method was introduced in Kasungu in five steps:

- Preparation of facilitators for the dialogue
- Preparation of assistants for the focus group discussion
- Focus group discussions
- Dialogue workshop
- Identifying a public to participate in the new cooperation.

With the agreement of the district commissioner, clinic staff at the district hospital were informed of the approaching dialogue and asked to take part. In addition to the two clinical officers (CO) and several nurses, midwives and health surveillance assistants (HSA) were included as well. Local NGOs active in medical issues were also informed and invited. Herbalists and traditional birth assistants (TBA) were included in the focus group discussions from among the group of traditional experts, as were spiritual healers and rituals experts. Within two weeks, 18 focus group discussions were conducted in this way, with a total of 140 traditional experts. There were 40 participants in the five focus group discussions that took place with medical staff.

In the focus group discussions, people articulated their convictions about AIDS risk and preventive behaviour. In order to use this information later for a culturally adjusted prevention campaign, the discussions were recorded on tape, transcribed, and in part translated into English. Participants for the dialogue workshops were also selected from among the ranks of the participants in the focus group discussions.

Find Tool 3: Reader on Communication Skills in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

Not more than 15-20 persons should take part in a dialogue workshop at one time. Ideally, the workshops would be made up of 8 participants from each professional group. Moderators can select the participants on the basis of the recommendations of research assistants and in light of the following:

- A broad knowledge of health and tradition
- Good communications skills
- A balance in regard to age and gender
- Representation of all fields of work within the two professional groups.

Each dialogue workshop takes place on three successive days. On the first day the participants are prepared within their own professional groups. At this point they are to consider their own strengths and potential. On the second day, the two professional groups come together to familiarise themselves with the viewpoint of the other group and learn to respect their work. The third day is devoted to building consensus and finding a common ground for working together. Each day follows a prescribed programme. However, some flexibility is still important in order to allow room for unanticipated discussion as it arises.

- Day 1: Preparation of the dialogue with participants from each professional group
- Day 2: Dialogue between the two professional groups
- Day 3: Reaching consensus and shaping a common plan of action

*At the Kasungu dialogue workshop 2005*

The exercises for the three days, partially newly developed for this purpose and partially taken from the intergeneration dialogue, are:

- Introductions all around
- Curiosity Exercise (“an invitation to be curious”)
- Raising awareness Exercise
- Challenge Exercise
- Visions Exercise
- Consensus Exercise.

For the first exercise, pairs are formed made up of one representative of each side. The persons in each pair ask each other‘s names, origins and primary occupation, and about each other‘s contributions to their community‘s AIDS response. After 10 minutes, each of the partners can then introduce the other to the circle at large. This exercise establishes the first personal contact and shows the personal involvement and sympathies of each person in regard to the issue of AIDS.

**Find Tool 4: Full mission report: Medical Dialogue between Traditional Experts and Bio-medical Health Workers in Kasungu, Malawi in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue**

The **"Curiosity Exercise"** is intended to make the other professional group‘s handling of the issue of AIDS comprehensible. In this exercise, the representatives of both groups ask one another questions that they have had on their minds for some time but never asked one another before.

The **"Raising Awareness Exercise"** is designed to break down prejudices about the other group. Prejudices about and perceptions of the other group are frankly discussed so that in time common ground can be sought.

*Reading a poem during the Challenge Exercise*

The **"Challenge Exercise"** is meant to illustrate the contribution each professional group makes to the AIDS response. It is a good opportunity for each side to gain the respect of the other and to get their attention and be heard. Various equipment used by each profession – herbs, drums, hypodermic needles, testing kits, etc. – may be brought along and presented. Each side is asked to prepare a presentation. This can take the form of role-playing, poems, songs or other illustrative techniques. The presentation is then followed by a round of questions and discussion in the plenary.

The **"Visions Exercise"** at the close of the dialogue workshop offers an opportunity for the two groups to explore together possible forms of cooperation. In this they are assisted by concrete case studies, which they present as role-play and discuss in the plenary. For this purpose, the representatives of both groups are broken down into smaller, mixed groups. Then in the role-plays, they work on concrete cases together – cases in which, for example, patients take advantage of both traditional healing and hospital services and may thus have to find their way somehow between contradictory instructions.

During this process of role-playing, models for reciprocal referral of patients, new ideas for prevention, or other concrete forms of cooperation can be developed and tried out. Following each presentation a discussion is held in the plenary. The possibilities for collaboration thus developed during role-playing are ultimately converted into binding resolutions and a plan of action during the **"Consensus Exercise"**.

By means of these exercises, the dialogue workshops promote an exchange between the biomedical and the traditional sectors of medical treatment and patient care. They make it possible to consider potential terms of cooperation, then to discuss, plan and test these. The focus on so pressing a problem as AIDS makes communication easier and smoothes the way for the dialogue to actually take place. The essential element in its success is that the methodology is adapted to the worlds in which both groups live and that is characterised by mutual respect and esteem.

The Medical Dialogue method is a **gender-balanced approach** and ensures that women's voices are heard. When the teams for focus group discussion are formed, healers and midwives are to be included on an equal basis. Although male practitioners predominate in Malawi's healer organisations, women healers and TBA's care for a large number of patients. They are often involved in the sexual education of young women. Their voices can be lent added weight in advance, during the selection of participants by discussion assistants and facilitators. The same applies to the biomedical side, because nurses and midwives are usually the subordinates of male doctors and clinic officers. During the selection of discussion assistants and facilitators, too, care must be taken to ensure that both genders in all age groups are equally represented.

At the end of each dialogue workshop, it is crucial that the agreements between healers and biomedical health workers are **presented in public**. This ensures that the authoritative persons in each community are informed and integrated and that the two groups openly acknowledge their planned cooperation beyond the safe confines of the workshop, so that they can be held accountable. In Malawi, this public was created on three levels: in the city hall of the district capital of Kasungu, in rural areas of Kasungu with wide-spread participation of the village population and the contributions of theatre groups and the local masks association, as well as in the capital, Lilongwe, with a presentation of the results to representatives of the health ministry and medical faculty.

**Find Tool 5: Medical Dialogue Presentation in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue**

# Results

## Results of the focus group discussions

*Traditional midwives at a focus group discussion*

The focus group discussions that take place before the dialogue workshops, with groups of herbalists and midwives on the one hand and representatives of the state health system on the other, were significant in shaping the dialogue and the course it ultimately took. The result of the genuine interest displayed by the moderators and the respect they accorded both groups was that both the healers and the employees of the state health services felt that they were taken seriously and accepted, so that they then became open to a dialogue with the other group that would be moderated in this manner.

Find Tool 6: Full report on focus group discussions in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

In addition, these discussions alerted the moderators to both important potential conflict flashpoints for the dialogue and also to points at which cooperation between the two groups might be expedient and which might form a basis for culturally appropriate prevention campaigns:

### Prejudices held by the two groups

The focus group discussions showed a profound gap between biomedical and traditional health practitioners. There had been no cooperation between the two. Their mutual relations were characterised by mistrust, prejudice and misunderstanding. The health staff considered healers to be unreliable, gold-digging spreaders of infection. They were particularly outraged by the claim of some healers to be able to cure AIDS. The healers, for their part, considered the clinic staff to be condescending and lacking in respect: they said that they were often shouted at when they brought patients to the clinic. The focus group discussions provided important information about which prejudices would have to be dismantled step by step during the discussion process.

### The traditional connection between sexual behaviour and disease

During discussions with the healers, it became clear that this group used the term "mdulo" for typical AIDS symptoms such as coughing, diarrhoea, stomach pains and loss of weight, and that this was viewed as a complex of diseases with various causes all having to do with the breaking of sexual taboos. Magawagawa, also a communicable disease, was compared with AIDS as well. The healers were virtually unanimous in their view that indigenous sexual diseases might be prevented through sexual abstinence at particular times and with particular persons. Seen in this light, sexual abstinence is important for the protection of the family and the community. This local concept provides a very good entry point for a concept of disease and prevention to which both sides can subscribe, since it is based on an at least partly common understanding of abstinence as a way of preventing disease.

**Prejudices about condoms**

In a number of discussions the point was raised that condoms cannot be used by couples wishing to have children. Besides, in Malawi the father‘s sperm is credited with having a positive effect on the health of both mother and child (Kaspin, 1996; Wolf, 2001). Prevention campaigns in Malawi should take these points into account by making alternatives available to couples wishing to have children and by discussing with pregnant women the advantages versus the disadvantages of sexual contact with partners whose serostatus is unknown (UNFPA/WHO, 2006).

**Omission of useful traditional concepts in the 'official' discussion of AIDS**

The discussions showed once again that in the eyes of a number of Malawians, "modern ways of life" and the failure to observe traditional rules in regard to sexuality are the main causes of the spread of AIDS. The traditional concepts of magawagawa, which means "something shared" and is used to refer to sexually transmitted infections, and kanyera, which is the result of sexual intercourse during menstruation or too soon after childbirth, and which resembles AIDS in many respects, were addressed again and again.

*Kasungu healer with herbal medicine*

Instead of building on these concepts, the official government side had translated "virus" into the Chichewa term kachirombo, which means "small wild beast". This led to the assumption that the HI-Virus, like a small animal, might easily be "removed" or simply handed on, and that then one would be healthy once more (Wolf, 1996). Generally, it appears that the novel term EDZI (AIDS), introduced by the government side, was difficult to communicate culturally (Luanda, 2004). Although the biomedical virus model parallels other interpretations of disease, and the various notions of individuals, families, healers and communities are used according to the setting in which they occur or treated according to the given situation, the national health system has so far let slip this opportunity to use the concepts of disease that were already at hand on site to target HIV prevention.

## Direct results of the dialogue workshops

The dialogues achieved direct results in three important areas:

**The two groups reached agreement on the central conflict about their respective ability to treat or cure AIDS:**

Some healers claim that they can heal AIDS, since AIDS is understood as being equivalent to the local complex of symptoms known as kanyera, which can be treated. This claim is not accepted by the biomedical side. In the dialogue workshop, agreement could be reached on the treatment of coughing, diarrhoea, stomach pains and weight loss. Both sides acknowledged the competency of the other to relieve the suffering of patients through therapy treating symptoms and opportunistic infections.

**The interest and motivation of the two parties in communicating and collaborating with each other rose markedly:**

Both sides expressed regret at the lack of communication between them. The clinic staff criticised the failure of the healers to refer patients to the hospital in good time, for example, when patients were suspected of having tuberculosis or AIDS, or when complications arose in connection with childbirth. The healers noted that the lack of adequate patient transport and the disdain with which they were treated by hospital staff were inhibiting factors in timely referral.

*TBA examining patient*

**The state health workers acknowledged the important role of the TBA:**

During the dialogue process, through personal talks about conditions under which rural births take place, biomedical staff members came to adopt a better attitude toward TBA's. A discussion was initiated on the idea that respect for the traditional side become part of educational curricula for the health care professions.

The results of the dialogue workshops were readily translated into successful cooperative arrangements during the weeks that followed. Both sides resolved to cooperate and put the following steps into effect:

- A Task Force Team made up of five healers and five hospital staff members was set up in the district.
- It was agreed to hold regular meetings.
- A mutual referral system, including a referral form, was developed.
- A pilot area of a manageable size (Kasungu West) was agreed upon for cooperation.

Find Tool 7: Study presentation on focus group discussion in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

*TBA with latex gloves supplied by the district hospital*

## Results after one year

A year after the dialogue workshops, an on-site evaluation was conducted to monitor the results of this initiative (GTZ, 2006b). The evaluation team conducted interviews and focus group discussions with healers and government health workers, with health surveillance assistants (HSAs) at village level and with the district health officer at the district hospital. The team also took part in a meeting of a Task Force Team and visited a number of rural birth clinics operated by TBA.

The evaluation indicated that cooperation in the Kasungu pilot area between the 44 TBAs and healers on the one hand and the clinical officers (COs), nurses, midwives and HSAs on the other is now well established and operating smoothly. This positive impact is illustrated by three points in particular:

- Both groups confirm in talks and brief interviews that since the dialogue workshops the healers and TBAs regularly refer patients to the state health services for voluntary counselling and HIV testing.
- Since the intervention, TBAs and healers have been receiving disposable gloves free of charge from the district hospital so that they can protect themselves and their patients from HIV infection.
- The state health services see one particularly positive effect of the improved cooperation with the "traditional sector" in the fact that that since cooperation began there have been no instances of maternal mortality in the intervention area, because the TBAs now refer all critical cases to the hospital in good time.

The joint supervision visits to TBAs and healers by the Task Force Teams, which were made up of members of both groups, generated an impact that went beyond the scope of the dialogue workshops and strengthened cooperation between the two groups. Through these joint visits, respect grew on the side of the state health care staff for the work of the TBAs, in particular. They understood the need for disposable gloves and complied with this. The state health care staff, for their part, suggested to the midwives that they dig pits for placentas and other bodily tissue: the midwives accepted this recommendation and put it into effect.

The Task Force Team held meetings at which it defined both biomedical and traditional diseases according to their respective symptoms for purposes of reciprocal referral; it drafted a referral form for this purpose.

Despite these generally positive developments, points were also raised with the evaluation team about how cooperation might be improved:

Although the healers regularly referred patients to the hospital, the hospital did not refer any patients to the healers. The healers also expressed their regret that the follow-up return visits to healers that had been agreed upon in the dialogue after successful treatment at the state clinic, had yet to take place. The lower section of the form developed for this purpose has so far remained for the most part in the patient's file or at the hospital admissions office.

Despite these weaknesses, all sides regard the cooperation as successful. The decline in maternal mortality in the intervention area has been documented in the Maternal Death Audit, which is conducted throughout the country. Malawi has the highest rates of maternal mortality in the region. Because of declining rates in the project area and the success of the referrals, the district health officer is now in favour of extending the dialogue approach to the entire district.

Find Tool 8: Report on the Mid-Term Evaluation of the Dialogue Project in the internet toolbox for his approach at http://hiv.prg.googlepages.com/toolbox-medicaldialogue

# Prospects

### Extending this approach to the entire Kasungu district

The pilot area for cooperation between traditional healers and biomedical staff was in Western Kasungu. The district health officer would now like to see the dialogue concept extended to cover the entire Kasungu region. An application for project financing is currently being decided between the district and the National AIDS Commission.

### Introducing the dialogue approach in urban health care in Blantyre

The medical dialogue concept has to date to be tested in the predominantly homogeneous rural area of central Malawi. Now, however, the urban health care administration and the president of the International Traditional Medicines Council of Malawi, the largest healer organisation in the south of the country, have indicated their interest in testing these methods within an urban context with an ethnically and religiously mixed population; an appropriate intervention is now being prepared, once again with GTZ support.

*Task Force Team members meet interested colleagues in Blantyre*

### Creation of a legislative framework for cooperation between the state and the traditional sector

In Malawi no legislative framework or national policy on dealings with healers have yet been established. Parliament has not yet ratified the draft of a Traditional Medicine Policy. The difficulty is that without such regulation many hospital staff members are not prepared to engage in any form of cooperation that includes referrals to healers. Since it is the healers who increasingly work at home in the field of home-based care for AIDS victims and thus make a major contribution to the national AIDS programme, it is becoming increasingly important to lay legislative foundations of this kind. Both sides expect such a legislative framework to regulate their dealings with one another. The government is mainly interested in exercising some control over the practices of the healers, while the healers seek recognition of their activities and their status as a profession. Meetings with representatives of the Ministry of Health and the National AIDS Committee give us ground to hope that the Traditional Medicine Policy will be ratified in the near future.

### Integration of the approach into the national AIDS programme

Following the positive evaluation, the dialogue approach was presented to representatives of the National AIDS Commission and the Ministry of Health, who greeted it with interest. In this case, it was the question of future financing of the intervention that was at issue. Two possibilities were mentioned: For the introduction of the dialogue approach into new districts, applications could be made directly to the National AIDS Commission. Expenses incurred during the course of cooperation thus established would be covered by the budget of the district health administration.

# German HIV Peer Review

The German HIV Peer Review Group[2] has set out a number of criteria (see p. 3) that must be met to qualify GTZ-supported initiatives for its HIV Practice Collection[3]. The Medical Dialogue approach qualifies as 'promising practice' because it has demonstrated all of the following qualities:

### Effectiveness

In the project area, the medical dialogue method led to the first successful cooperation between traditional healers and midwives on the one hand and biomedical health staff on the other – and this a whole year after the original intervention. A Task Force Team made up of representatives of both groups is doing constructive work and meeting regularly, and there are numerous referrals from healers and TBAs for voluntary counselling and HIV testing. Finally, hospital staff unanimously credit the good cooperation with TBAs with the marked decline in maternal mortality due to complications during childbirth.

### Transferability

The method is based on the "intergeneration dialogue", which has been adapted for use in four different countries and in both rural and urban areas. Its transferability is thus clear. The instruments (manuals) for the focus group discussions and dialogue workshops of the medical dialogue are available and are soon to be adapted for use in the urban context in Malawi.

### Participation and empowerment

The contribution made by traditional healers to general health care among the population and to those afflicted with HIV and AIDS in particular is as yet accorded scarcely any public recognition in most African countries. Although it is generally known that the great majority of the population value and use such services, the "traditional sector" remains "invisible" and is marginalised because of the lack of a legislative framework and because it is simply left out of the planning, financing and implementation of public health programmes. The medical dialogue aims to create synergies between the two parallel and to some extent antipathetic systems by lending both sides a voice in a dialogue on equal terms.

### Cost effectiveness

*Patients waiting in front of a healer's clinic*

The immense costs of the AIDS epidemic to countries as severely affected as Malawi place a heavy burden on state health systems. Hospitals and decentralised health services are often largely preoccupied with caring for AIDS victims. In a situation such as this, the inclusion of the "traditional sector" would be indicated for economic reasons alone: with the support of healers, it is possible for many households to care for AIDS-afflicted family members at home, thus affording significant relief – including financial relief – to state services. By diagnosing risk (e.g., of an HIV infection or a high-risk birth) and making referrals in good time, healers help to reduce the costs to the economy occasioned by avoidable deaths. Finally, patients pay healers and traditional birth assistants directly and often in kind, according to a traditional fees system that places no burden whatever on the state health budget. In short, the promotion of cooperation between



2 http://hiv.prg.googlepages.com/home

3 http://hiv.prg.googlepages.com/reviewedpublications

the state health system and traditional healers pays off in every respect.

**Gender**

The medical dialogue is at pains to make the knowledge and skills of women healers, who are less active in the official healer associations than their male colleagues, more visible and to put them to better use. In order to achieve this, care is taken to ensure that healers of both genders enjoy numerically equal representation in focus group discussions and dialogues. The moderation method, which promotes mutual respect and attention, makes it possible for women to break with the cultural pattern of letting the men speak for them. One of the most prominent results of the medical dialogue in Kasungu District was recognition by the state health services of the important role played by TBAs.

**Sustainability**

The positive evaluation a year after the actual intervention indicates that the cooperation is sustainable. In order to create nationwide, sustainable cooperation between the state health system and healers, further steps are needed, however, and these have been initiated within the framework of this project. The National AIDS Commission has declared itself ready in principle to finance medical dialogue interventions in other parts of Malawi. The Ministry of Health also supports the project in Kasungu and recommends that the running costs of cooperation (e.g., meetings of the Task Force Team, sterile gloves for healers, supervision) become part of district health programmes and be integrated into their budgets.

The process of ratification of a legal regulation concerning traditional healers is gaining momentum once more. All of these constitute important contributions to creating sustainable improvements in the relations between the state and traditional health care sectors in Malawi.

*Task Force Team visiting healer*

# Tools

**The following tools and materials were developed in the course of this project and can be downloaded at**

http://hiv.prg.googlepages.com/toolbox-medicaldialogue

- Tool 1 : “PCP Dialogue Toolbox”, Public Conversations Project (1999), Watertown, Massachusetts
- Tool 2: “Generation Dialogue about FGM and HIV/AIDS in Guinea. Method, experiences in the field and impact assessment”, GTZ (2005), v. Roenne, A., Manguet, J., Eschborn.
- Tool 3: “Reader on Communication Skills. Developed for the Research Assistants of the Pilot Project Integration of Traditional Beliefs and Gender Roles in the HIV/AIDS Prevention Campaigns in Malawi”, GTZ (2005), unpublished handout compiled by Marion Baumgart dos Santos, Lilongwe.
- Tool 4: Full mission report: “Medical Dialogue between Traditional Medical Experts and Bio-medical Health Workers in Kasungu, Malawi”, GTZ (2006a), unpublished report by Angelika Wolf, Eschborn.
- Tool 5: “Medical Dialogue Presentation” by Angelika Wolf, presented on 13. 9. 2005 in Lilongwe
- Tool 6: “Full report on focus group discussions”, GTZ (2005a), unpublished report by Mabvuto Bowa and Vincent Jumbe, Lilongwe.
- Tool 7: “Study presentation” by Mabvuto Bowa and Vincent Jumbe presented on 13. 9. 2005 in Lilongwe
- Tool 8: “Report on the Mid-Term Evaluation of the Dialogue Project”, GTZ (2006b), unpublished report by Angelika Wolf, Eschborn.

# Bibliography

Baumgarten I, Finke E, Manguet, J, von Roenne A (2004). "Intergenerational dialogue on gender roles and female genital mutilation in Guinea", in: Sexual Health Exchange, 3-4/2004, pp. 17-20.

Dilger H (2005). *Leben mit AIDS. Krankheit, Tod und soziale Beziehungen in Afrika.* Frankfurt, New York.

Dos Santos M B (2005). Reader on Communication Skills. Developed for the Research Assistants of the Pilot Project Integration of Traditional Beliefs and Gender Roles in the HIV/AIDS Prevention Campaigns in Malawi. Unpublished handout compiled by Marion Baumgart dos Santos, Lilongwe. Available on CD-Rom with this report.

Green E C (1999). *Indigenous Theories of Contagious Disease*, Walnut Creek: Altamira Press.

GTZ (2005). Generation Dialogue about FGM and HIV/AIDS in Guinea. Method, experiences in the field and impact assessment, v. Roenne, A., Manguet, J., Eschborn.

GTZ (2006a). Medical Dialogue between Traditional Medical Experts and Biomedical Health Workers in Kasungu, Malawi. Unpublished GTZ Report by Angelika Wolf, Eschborn. Available on CD-Rom with this report.

GTZ (2006b). Report on the Mid-Term Evaluation of the Follow-Up of the Pilot Project Medical Dialogue between Traditional Medical Experts and Biomedical Health Workers in Kasungu, Malawi. Unpublished GTZ report by Angelika Wolf, Eschborn. Available on CD-Rom with this report.

Hertzig M (2003). "Starting a new conversation when debate is fruitless". Constructive Conversations. Public Conversations Project.

Hobsbawm E (1992). Inventing Tradition, in: Hobsbawm, E. and T. Ranger (Eds.), *The Invention of Tradition.* Cambridge, pp. 1-14.

Janzen J (1978). The Quest for Therapy. Medical Pluralism in Lower Zaire. Berkeley.

Kaspin D (1996). "A Chewa cosmology of the body", *American Ethnologist,* 23 (1996) 3: 561-78.

Last M and Chavunduka G L, eds (1986). The Professionalisation of African Medicine. Manchester.

Lwanda J L (2004). "Politics, Culture, and Medicine: An Unholy trinity? Historical Continuities and Ruptures in the HIV/AIDS Story in Malawi", in: Kalipeni, E. et al. (Eds.), HIV & AIDS in Africa. Oxford, pp. 29-42.

National Statistical Office and ORC Macro (2005). Malawi Demographic and Health Survey 2004. Calverton.

Probst P (1999). *"Mchape* '95, or, the Sudden Fame of Billy Goodson Chisupe: Healing, Social Memory and the Enigma of the Public Sphere in Post-Banda Malawi." Africa 67 (1): 108-38.

Public Conversations Project (1999). "PCP Dialogue Toolbox", Watertown, Massachusetts. Available at http://www.publicconversations.org/pcp/page.php?id=270 and on CD-Rom with this report.

von Roenne A (2003). "Empowerment of girls in Africa", in: E+Z, February, 30(2), February 2003, pp. 64-66.

Rompel M (2005). "Prevention is like telling people: Eh, stop loving". Ansätze und Problemfelder massenmedial vermittelter Aids-Prävention im südlichen Afrika, in: Drescher M und Klaeger S (Eds.), *Kommunikation über HIV/AIDS. Interdisziplinäre Beiträge zur Prävention im südlichen Afrika.* Münster: 219-235.

UNAIDS (2000). Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa. UNAIDS Best Practice

Collection. Geneva, Joint United Nations Programme on HIV/AIDS.

UNAIDS/WHO (2005). AIDS epidemic update: December 2005. Geneva, Joint United Nations Programme on HIV/AIDS. Available at http://www.unaids.org/epi2005/doc/EPIupdate2005_html_en/epi05_04_en.htm

UNAIDS (2006). 2006 AIDS Epidemic Update. Geneva, Geneva, Joint United Nations Programme on HIV/AIDS. Available at http://data.unaids.org/pub/EpiReport/2006/04-Sub_Saharan_Africa_2006_EpiUpdate_eng.pdf

UNFPA/WHO (2006). "Sexual and Reproductive Health of Women living with HIV". Geneva, United Nations Population Fund and World Health Organization.

WHO (2000). General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine. Geneva, World Health Organization. Available at http://whqlibdoc.who.int/hq/2000/WHO_EDM_TRM_2000.1.pdf

WHO (2002). WHO Traditional Medicine Strategy 2002-2005. Geneva, World Health Organization. Available at http://whqlibdoc.who.int/hq/2002/WHO_EDM_TRM_2002.1.pdf

WHO (2003). Resolution of the Executive Board of WHO, 24 January 2003. Geneva, World Health Organization. Available at http://www.who.int/gb/ebwha/pdf_files/EB111/eeb111r12.pdf

Wolf (1996). "Essensmetaphern im Kontext von Aids und Hexerei in Malawi". In: Wolf, A. and M. Stürzer (Publ.): *Die gesellschaftliche Konstruktion von Befindlichkeit. Ein Sammelband zur Medizinethnologie*. pp. 205-221. Berlin.

Wolf A (2001). 'AIDS, morality and indigenous concepts of sexually transmitted diseases in Southern Africa'. In: Africa spectrum 01 (1), 97-108.

Wolf A (2003). "Aids und Kanyera in Malawi: lokale Rezeption eines globalen Phänomens". In: Wolf, Angelika and Viola Hörbst (Publ.): *Medizin und Globalisierung: Universelle Ansprüche – lokale Antworten.* pp. 203-229. Münster.

Wolf A (2005). Medical Dialogue Presentation. Unpublished paper presented on 13. 9. 2005 in Lilongwe. Available on CD-Rom with this report.

# Glossary

**AIDS:** Acquired Immune Deficiency Syndrome

**CO:** Clinical Officer

**HIV:** Human Immunodeficiency Virus

**HSA:** Health Surveillance Assistants

**NGO:** Non-Governmental Organisation

**VCT:** Voluntary Counselling and Testing

**WHO:** World Health Organization

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