

BUILDING ON WOMEN'S TRADITIONAL HEALTH AND
MEDICINAL PLANT KNOWLEDGE IN MALAWI
*Opportunities for Support by the
Malawi Social Action Fund*
(MASAF)



REPORT OF A STUDY UNDER *GENFUND* PROVISION

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ABBREVIATIONS

CBO	Community Based Organization
DRF	Drug revolving fund
FGD	Focus Group Discussions
FRIM	Forestry Research Institute of Malawi
GENFUND	Norwegian Trust Fund for Mainstreaming Gender
HAM	Herbalists Association of Malawi
IEC	Information, Education & Communication
IPR	Intellectual Property Rights
ITMCM	International Traditional Medicines Council of Malawi
MASAF	Malawi Social Action Fund
MOH	Ministry of Health, Malawi
MGYCS	Ministry of Gender, Youth and Community Services
NHBG	National Herbarium and Botanic Gardens
NGO	Non-Governmental Organization
ORS	Oral Re-hydration Salts
OTC	Over the Counter
PRA	Participatory Rural Appraisal
STI	Sexually Transmitted Infections
TA	Traditional Authority
TBA	Traditional Birth Attendant
THK	Traditional Health Knowledge
UNICEF	United Nations Children's Fund
WHO	World Health Organization

GLOSSARY: COMMONLY USED LOCAL TERMS (Chichewa/Tumbuka)

chipatala	<i>lit.</i> ‘hospital’; but used in reference to any modern/biomedical health care facility
dambo	grass-covered plain which becomes flooded in the rains and retains moisture in the dry season
mankhwala	medicine; <i>mankhwala-chijipa</i> (<i>lit.</i> ‘black [African] medicine’ – <i>i.e.</i> traditional medicine; <i>mankhwala-yachizukungu</i> (<i>lit.</i> ‘White-men’s medicine’; <i>i.e.</i> ‘Western/biomedicine’)
mshalango	forest
mopane	indigenous woodland of lower altitudes
mtengo	tree
mzamba	traditional birth attendant
ndiwo	relish eaten with a main dish
ofunamankhwala	<i>lit.</i> ‘one who searches for medicines/ medicinal plants’; ‘herbalist’ (distinct from diviner/spiritual traditional healer known as <i>sing’anga</i>)
sing’anga; nganga (I)	diviner; spiritual traditional healer
uchire/ kuthengo	uncultivated grassland; woodland where naturally vegetated
uzuzu	mosquito

* (I) =: term in Tumbuka language; all others in the Chichewa

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ACKNOWLEDGMENTS
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BUILDING ON WOMEN'S TRADITIONAL HEALTH AND MEDICINAL PLANT KNOWLEDGE IN MALAWI

Opportunities for support by the Malawi Social Action Fund

I. BACKGROUND

Malawi remains one of the least developed countries of the world with more than 65% of its population of over 11 million falling below the poverty line. As in most countries in the region, biomedical health facilities and services are in very short supply, especially in the rural communities of Malawi which make up about 85% of its population. The HIV/AIDS epidemic has exacerbated the already strained scarce resources available within the health delivery system. Underlying these conditions is the prevalence of chronic food insecurity which continues to thwart the socio-economic development of resource-poor local communities. In the absence of adequate biomedical health services, most rural Malawians continue to rely on traditional health practices and the use of herbal medicines for meeting their primary health care needs. This study is concerned with the traditional health resources in rural Malawi, and particularly with the knowledge and home-based use of medicinal and food plant resources by local women.

Past research on traditional herbal medicine in Africa has focused on expert or specialist traditional health practitioners (i.e., traditional healers, herbalists, diviners and traditional birth attendants). It is also recognized, however, that the knowledge and skills which underpin the use of traditional plant medicines are also widely distributed among ordinary women and men in local communities. Moreover, it is increasingly appreciated that women are often among the main repositories and custodians of much traditional knowledge. This study set out to investigate the latter in the Malawian context.

The outcome of the study is intended to inform Phase III of the World Bank-supported Malawi Social Action Fund programme (MASAF III), and to recommend ways in which it might effectively target its development efforts in this area.

II. STUDY OBJECTIVES AND RESEARCH QUESTIONS

This study seeks to elucidate the extent to which local women rely on traditional health resources in meeting the health and nutrition needs of their families as well as their contributions to the relevant decision-making processes within rural Malawian households. Recognising that the effectiveness of women's contributions is generally likely to be dependent on the active involvement and support of men in local communities, the study adopts a balanced gender perspective in its assessment of traditional health knowledge, its distribution, application and transmission.

The specific research questions which guided this investigation fall under the following four interrelated topics:

- i. Distribution of traditional health knowledge in the 'popular' domain *vis-à-vis* knowledge of specialist traditional healers and medicinal plant vendors at local markets;
- ii. Characterization and sustainability of mechanisms for the inter-generational transmission of local traditional health knowledge;
- iii. Local medicinal plant supplies, distribution and sustainability of current use patterns; and
- iv. The overall significance and contribution of traditional knowledge and home-based use of medicinal and food plants to community well-being.

III. METHODOLOGY

A field-based qualitative and participatory research methodology was undertaken (during March 28 - May 6, 2004) among three rural communities selected (in consultation with MASAF) on the basis of the following criteria: (a) regional representation; (b) distances from major urban centers; and (c) previous or ongoing MASAF initiatives. The aim of the last criterion was to capture different case-scenarios upon which to base recommendations for future MASAF action. Accordingly, three communities were identified for the study: Chala Group Village, Malili, Lilongwe Rural (Central Region); Nation Nhelma Group Village, Nthwalo, Mzimba (Northern Region); Group Village Kantukule, Somba/ Blantryre Rural (Southern Region).

Six qualitative data-gathering instruments were employed, including focus group discussions (separate sessions with men and women, followed by mixed sessions involving both), and individual interviews of key informants identified through these sessions.

IV. MAIN FINDINGS

1. *The main health problems and perceived roles of traditional health practices and biomedical health services*

1.1. General findings: There was great similarity in the range of the most pressing health problems identified by focus group discussion (FGD) participants in the study communities. In addition to leading health problems recognized at the national level, i.e., malaria, HIV/AIDS, acute respiratory tract infections, diarrhoea and perinatal complications, a range of other commonly experienced ailments were recorded, including, *inter alia*, common dermatological conditions, symptoms associated with gastro-intestinal infections and bilharzia. Notably, a number of conditions exclusive to women were ranked by female participants among their most pressing health problems. However, their male counterparts were generally less inclined to discuss such problems, and were did not appear to be familiar with their specific traditional treatments.

The study affirmed that inhabitants of the three rural communities continue to routinely make use of home-based traditional herbal remedies as the first line of treatment for most common ailments and symptoms (e.g., stomach-ache; diarrhoea, relatively minor digestive problems; cough; localized pain; minor respiratory infections; various skin conditions). In most cases, informants reported having used a traditional herbal treatment as recently as a few days or a week ago. Some of the findings relating, in particular, to the major health problems are briefly indicated below.

1.2. Malaria: stands out as the single largest health problem in all of the study communities. A traditional medicinal plant known as *mpungabwi* cited as an effective mosquito repellent, is used to varying extents among the study communities. Severe cases of malaria are among illnesses for which seeking biomedical treatment is deemed the most effective solution by local people. The research participants were generally well-informed about the mechanisms of malaria transmission and effective preventive measures, but there were indications of uncertainty about the symptoms indicative of cerebral malaria in particular.

1.3. HIV/AIDS: Study participants generally demonstrated remarkable appreciation of the ways in which HIV/AIDS is transmitted. There were no traditional treatments (home-based or specialized) which were expressly cited as remedies for secondary infections associated with HIV/AIDS. However, the need for support for those households or groups caring for HIV/AIDS orphans was repeatedly brought up in discussions about pressing community health concerns

1.4. Diarrhoea: Some home-based herbal preparations believed to be effective for childhood diarrhoea are reportedly administered, notably with plenty of water and fluids. ORS were seldom reported as the first resort for managing diarrhoea in children.

1.5. Perceived advantages/disadvantages of biomedicine: Among health problems repeatedly identified by study participants as 'best treated at the hospital or local health center' were, *inter alia*, malaria, cholera, meningitis, pregnancy complications, rheumatic pain and TB. Biomedicine's diagnostic capabilities, the specificity of the modern drugs and the generally rapid recovery after treatment are perceived as the main advantages of biomedical treatment.

Distances to health facilities and the associated costs of transportation, consultation fees and purchase of medication, were cited as the main drawbacks. The difficulties experienced particularly by non-literate community members in following written prescriptions correctly were also indicated. Inefficiency of the government health system was cited as a disadvantage, with indications of preference for seeking care at one of the nearby private clinics with a view to getting faster attention and better access to medicines, albeit at additional costs.

1.6. Perceived advantages/disadvantages of traditional medicine: Among the perceived advantages of traditional medicines, are that they are accessible and they often cost nothing (especially, home-based treatments). A narrower range of 'more serious' conditions are often brought to the attention of specialists: e.g. STIs and reproductive health problems. In addition, traditional specialists particularly, *ofunamankhwala*, (secular herbalists) often offer flexible alternatives to the 'up-front' cash payments typically required at biomedical facilities (e.g., compensation in kind), and in most cases, only if the condition is cured or the patient shows visible signs of improvement after treatment.

Among the disadvantages reported were, that many traditional treatments are relatively slow to take effect, are at times not specific to the particular illness being treated, and their dosage is not always well measured. The very high fees that can be charged by some *sing'anga*, particularly (spiritual healers, often consulted for conditions believed to be caused by witchcraft) were also cited as a drawback.

The study also explored and identified gender differences involving the use of home-based treatments, harmful traditional practices, and complementarities of modern and traditional medicine.

2. The Knowledge-base: distribution and transmission of traditional health and medicinal plant knowledge

2.1 Different levels and types of knowledge and main knowledge sources

The research participants in all three study communities generally distinguished between three different levels of traditional health knowledge and practice: (a) knowledge held by ordinary men and women pertaining to widely available medicinal plants used as home-based treatments for a limited number of ailments; (b) knowledge that is relatively less widespread (often pertaining to treatments for a limited range of common health problems), generally restricted to individual families; and (c) the specialized knowledge and practices of well-known 'community herbalists' or particularly knowledgeable individuals known as *ofunamankhwala*, generally viewed as distinct from the *sing'anga* or spiritual traditional health practitioners; the *mzamba* or traditional birth attendants (TBAs), and herbal vendors at local markets (often themselves practising *sing'anga*).

2.2. Gender differentiation of knowledge and decision-making

Women reported that they are often the first to diagnose symptoms of illnesses at the household level. For relatively common symptoms, they generally, routinely assess the condition and administer the appropriate treatment on their own. A considerable number of men agreed that women are indeed, often the first to recognize symptoms and independently collect, prepare and administer traditional treatments at the household-level.

While men and women appeared to possess a comparable breadth of knowledge regarding the most commonly used traditional treatments, there was one notable exception: men generally tended to know very little about the traditional treatments used for women's health problems. However, it is noteworthy that local men generally claimed that they were the prime decision-makers at the household-level on matters pertaining to health care. Local women, on the other hand, tended to consider themselves as the ultimate arbiters in this regard, despite the fact that they often do have to consult with their husbands to obtain money for paying for biomedical or specialized traditional care.

Both male and female study participants generally demonstrated considerable appreciation for their local heritage of traditional health knowledge and skills. They also often made reference to the 'monetary' value of their

knowledge and medicines. Those recognized as *ofunamankhala* and *sing'anga* are also esteemed for their knowledge and treated with a degree of reverence.

2.3 Medicinal plant knowledge as private property and the culture of secretiveness

A 'culture of secretiveness' surrounding the knowledge and use of traditional herbal remedies was observed to varying degrees among the different study communities. Especially in group settings, some participants appeared to be reluctant to share knowledge of various home-based herbal treatments, apparently, for fear of losing some modest (usually, in kind) payment for providing traditional herbal treatments to fellow community members in need.

3. The Plants: classification, supplies and use patterns

The local names and specific applications of 70 plants of medicinal value were recorded throughout this study. This is clearly indicative of the wide range of plants in use among the study communities. It is also potentially among the most valuable outcomes of this investigation. Most of the plants identified are native trees. Among medicinal plants found to be most popular in at least two of the three study communities are: 'chizutu/'mvunguti'; '[sausage tree'](*Kigelia africana* (Lam) Benth); kamzota (*Bidens pilosa*); naphini/mujoyi (*Terminalia sericea*); and nthantanyerere (*Senna singueana* Del.).

The majority of locally-valued medicinal plants occur naturally in nearby *uchire* (uncultivated grasslands, where many native trees useful shrubs, herbs occur).

Study participants also cited on a range of locally-valued traditional wild and semi-domesticated vegetables and fruit species. However, little information could be gathered on the specific nutritive or health benefits of most of these plants. In general, many such species appear to be taken largely for granted among the rural communities with no apparent efforts made to manage or protect them.

V. MAIN CONCLUSIONS AND RECOMMENDATIONS

1. Main conclusions

1.1. Home-based plant-derived traditional treatments constitute a significant aspect of ordinary local people's routine health care efforts in rural Malawi. Among the study communities, such treatments are sought more frequently than the services of specialist local traditional healers or biomedical health facilities.

1.2. It was affirmed that local women are the principal providers of health care in the broadest sense encompassing general sanitation, nutrition and childcare at the household level. When it comes to the treatment of specific health problems using home-based plant medicines, their roles were found to be most pronounced in the realm of women's health problems and childcare. There were indications that local women were the most familiar with such treatments, although the range of traditional medicinal plants used specifically for pre-post-natal care appeared relatively limited.

1.3. While home-based health care is considered important among the communities, the need for poverty alleviation and for ensuring food security remain paramount concerns. This suggests the necessity for a strategy which on hand reflects a balance between health and nutritional requirements, and on the other, between protection and cultivation of medicinal plants and other species which promise greater income-generating opportunities.

2. Recommendations for MASAF action

Special efforts were made to elicit information on the community priorities for possible MASAF interventions in this field. Based on an assessment of the views expressed by the study participants in the context of MASAF III's service packages, a number of general propositions and areas for specific action were identified. A creative

approach of *'inter-packaging'* specific activities in support of traditional health knowledge and medicinal plant use within various service package components is recommended.

2.1 Development and articulation of a clear position statement and set of objectives in support of traditional health knowledge and practices which affirm *inter alia*, the potential role of home-based traditional health resources and the important role that is played by local women in this field.

2.2 Fostering coordination of the wide array of ongoing efforts in the field of traditional health knowledge and practices in Malawi which should include those of government agencies, CBOs, NGOs, and other institutions and actors in this field

2.3 Looking 'outside the health box', in devising innovative multi-sectoral approaches in directly and indirectly supporting traditional health knowledge and practices in different local contexts, with a view to building a diverse portfolio of experiences and replicable 'best practices'.

Among the specific recommendations made are the following:

2. 4. Gender and culturally-sensitive health IEC components should accompany *all* health sector initiatives, and wherever possible, should also be included in other projects. The possible role of indigenous or local networks and associations, such as the *namkungwi* women's groups or analogous church-based organizations for disseminating pertinent health information may also be considered.

2.5 The expansion and reorientation of the training of biomedical health staff through incorporation of traditional health topics such as the perceptions and classifications of various health problems by ordinary people, the complementary use of biomedical and traditional therapies, potentially hazardous traditional practices, etc. are also vital.

I. INTRODUCTION

This study is concerned with the traditional health knowledge which underpins the home-based use of traditional medicinal and food plant resources among local women in rural Malawi. Through a qualitative investigation of traditional health knowledge and the use of health protective and restorative plant species among ordinary women in selected rural communities in Malawi, this study aims to gain insight into the particular contributions of local women in this realm. Through the use of gender sensitive qualitative research methods, the study aims to elucidate the actual and potential contributions of such traditional knowledge and skills and how they might be strengthened and promoted for improving the health conditions of those who continue to depend on them. The outcome of the study is intended to inform Phase III of the Bank-supported Malawi Social Action Fund programme (MASAF III), and recommend ways in which it might effectively target its development efforts in this area.

The large majority of populations throughout sub-Saharan Africa and much of the developing world continue to depend on traditional, primarily plant-derived, medicines for their basic health care needs (Bannerman *et al.*, 1983; Lambert *et al.*, 1997). In Malawi, as in most African countries, this is partly due to economic circumstances which place Western biomedical services and pharmaceuticals out of the reach of the large majority. However, it is also attributable to the widespread belief in the effectiveness of many traditional therapies. Even where basic biomedical care is available, many people may still prefer traditional treatments for various conditions, suggesting that the latter will continue to play a significant role in health care of Africans into the future (Akerle, 1987; Anokbonggo, 1992; Sindiga, 1995; Muela, 2000). The socio-economic implications of such widespread and continued reliance on traditional therapies remains a major health development interest for countries such as Malawi. In a recent meeting held in Africa on the integration of traditional medicine into the health care system it was stressed that new directions should be sought as "...none of the African countries will meet, the Millennium Development Goals (MDGs) of eradicating poverty and reducing infant deaths with the worsening tuberculosis, HIV/AIDS and poverty in the continent." Possible options cited included, "...integration of herbal medicine into all areas of the health systems" (Country Watch, June 2004).

Although much research attention on traditional herbal medicine in Africa has focused on expert or specialist traditional health practitioners (i.e., traditional healers, herbalists, diviners and traditional birth attendants), the knowledge and skills which underpin the use of traditional plant medicines are also widely distributed among ordinary men and women in local communities. Indeed, some have noted that a significant part of African medical practices, consist of 'self-help', and home treatments, based on popular knowledge of herbs and other therapies, which may, in fact constitute the most valuable part of the continent's diverse medical traditions (van der Geest, 1997). In Malawi, as one researcher observed, virtually all rural inhabitants can be viewed as practising herbalists as they typically know of a variety of herbs to treat common ailments (Morris, 1986). Hence, while traditional healers undoubtedly occupy an important position in health care delivery throughout rural Africa, an understanding of the culturally-ingrained health knowledge and skills found among ordinary women and men in the local communities which they serve is also vital to efforts aimed at the promotion and development of traditional health knowledge and health care as a whole.

The knowledge about the uses of plant-based traditional home remedies can be viewed as a amalgamation of local ethnobotanical knowledge (including, knowledge about the distribution, classification and properties of plants, as well as the preparation of their therapeutic parts into medicines), and empirical understanding and perceptions about human health and diseases (including, illnesses classification and causation as well as appreciation of the role of good nutrition). Much of this local knowledge is transmitted through cultural learning mechanisms intrinsic to local socialization and enculturation processes (Ruddle, 1993). The extent and type of such knowledge held and put into practice by individuals within communities may vary considerably depending on a myriad of factors, such as kinship, gender, age, ethnicity and religious affiliation (Grenier, 1998). Gender roles and relationships, in particular, are believed to be among the most important factors involved in the differentiation of much traditional knowledge (Fernández, 1994).

It is increasingly recognised that women and elders are often among the main repositories and custodians of such knowledge. Women, in particular, are known to play special roles in health care, both in their capacities as mothers/primary care providers at the household-level, and often as the principal managers of home-gardens,

where a range of wild, weedy, semi-domesticated or cultivated medicinal and nutritious plants are likely to occur. Almost all rural children receive their first line of health care from their mothers. Such care often includes the use of home-based traditional treatments for common problems such as respiratory infections, diarrhoea, malaria and minor lesions. Although the continued extensive use of many traditional herbal medicines can in itself be viewed as an indication of their likely effectiveness, little is actually known (by the scientific community) about their specific modes of application, efficacy and safety. In some cases, women may also depend on harvesting medicinal species for sale. During periods of food shortage, rural women often revert to wild or semi-domesticated plant species for meeting the nutritional needs of their families. Despite these manifold contributions, rural women's knowledge and skills pertaining to the management and use of this valuable component of plant biodiversity remains a poorly documented resource.

Against this backdrop, chronic food insecurity, coupled with the HIV/AIDS crisis, continues to thwart the socio-economic development of resource-poor local communities throughout Africa. Especially in countries such as Malawi, where the epidemic has been among the most severe in the region, HIV/AIDS is disrupting the very social reproduction systems and traditional mechanisms through which valuable traditional health knowledge and coping strategies are transmitted through generations. Moreover, as the rural poor struggle to survive, ongoing deforestation and land degradation continue to pose major challenges to the survival and economic development of local communities, and more specifically, to the continued availability and use of many useful medicinal plants as well as wild and semi-domesticated food species. Little progress can be made in addressing these concerns and improving the health and living conditions of the vast majority without the mobilization of all available resources, including, most importantly, local people's own traditional health knowledge and skills.

There is thus, today heightened recognition of the need to document, disseminate and improve upon such traditional health knowledge resources, and to promote the valuation and incorporation of women's knowledge and skills in particular into broader development programmes (Ramphela, 2004). Understanding how the traditional health knowledge and skills of rural men complements that of women, and building on their collective knowledge-base offers an opportunity to empower rural communities to confront their most pressing needs in the realm of two vital aspects of poverty reduction and rural development: improvement of health and nutrition. Learning from women about their traditional skills and health care resources, and helping them to learn from each other in a more systematic manner can help strengthen local capacity, improve the effectiveness of development assistance, and ultimately the quality of people's lives in rural communities.

The remainder of this report is organized as follows. **Section II** sets out the study context, through a brief overview of ongoing initiatives in support of traditional herbal medicine in Malawi, and how the focus of this study relates to the priority areas identified in MASAF III's strategic plan. **Section III** outlines the study's conceptual framework, including its specific objectives and research questions. **Section IV** provides a description of the general research approach, and the specific qualitative data-gathering methods employed. In **Section V** the field research organization is described, including, notably, the criteria used for selecting the three study communities along with a brief description of each. **Section VI** discusses the main findings of the study under four broad topics: (a) the most pressing *health problems* experienced by local people and the remit and perceived value of home-based traditional practices *vis à vis* the range of biomedical health care resources available to them; (b) distribution and transmission of traditional health/medicinal plant *knowledge*; (c) classification, supplies and use patterns of *the plants* commonly used as medicine among the study communities; and (d) community-identified priorities for possible MASAF interventions. Discussion of the gender analyses carried out on the results of the FGD ranking sessions which focused on each of these themes form the core of this section. **Section VII** outlines the main conclusions of the study and distills some key lessons learned relating to methodological and substantive issues. Finally, **Section VIII** delivers some key recommendations for MASAF based on the priorities identified by the local people themselves.

II. STUDY CONTEXT

1. Traditional herbal medicine in Malawi: ongoing activities and the current policy environment

Malawi remains one of the world's least developed countries, and also figures among those most heavily affected by the HIV/AIDS epidemic. Today, the country is faced with the daunting challenge of meeting the health care needs of its rapidly growing population of over 11 million, an estimated 65.3% of which is below the poverty line (MASAF, 2003). As in most countries in the region, biomedical health facilities, modern pharmaceuticals and trained health care personnel are in very short supply in Malawi, especially in rural communities which make up about 85% of its population. The HIV/AIDS epidemic continues to exacerbate the poverty situation, placing further strains on the scarce resources available within the health delivery system.

In the absence of adequate biomedical health care services, most rural Malawians continue to rely on traditional health practices and the use of herbal medicines for meeting their primary health care needs. Recognising the continued significance of traditional medicine in the health care of the large majority of Malawians, the Ministry of Health and Population¹, recently reaffirmed its intentions to strengthen and promote the country's traditional health practices. Organised by MOHP, the inauguration of the "African Traditional Medicine Day" on December 6, 2003, brought together representatives of key organizations in Malawi which have been involved in research, development and information dissemination activities related to traditional health practices and medicinal plants, including the National Herbarium and Botanical Gardens of Malawi, the National AIDS Control Programme of MOHP (succeeded by the National AIDS Commission) and the World Health Organization. Also represented were Malawi's national associations of traditional medicine, including the International Traditional Medicines Council of Malawi and the Herbalist Association of Malawi. Women members outnumber men in both these organizations. Among the main concerns raised by MOHP at this gathering was the lack of a legal framework and regulatory mechanism to govern the practice of traditional medicine in the country. The development of appropriate legislation and the formation of a national regulatory body to institute and enforce quality and safety standards in the services provided by Malawi's diverse traditional health practitioners, were thus identified as key priorities. The MOHP reported having submitted a proposal to the WHO to support this endeavor. With a view to facilitating collaboration between government health services and the traditional health sector, the Minister of Health also urged Malawi's various national associations of traditional health practitioners (which currently appear to be operating independently), to unify under one national institution (Mthota, *Pers. Com.*, 2004).

There are, today, four registered associations of traditional medicine in Malawi: the Herbalists Association of Malawi (based in Kasungu, Central Region); the Yohane Herbalists Association of Malawi (based in Lilongwe, Central Region); the International Traditional Medicines Council of Malawi (based in Blantyre, Southern Region); and the Chizgani Ethnomedical Association (based in Mzuzu, Northern Region). Integration of these associations under a single national organisation remains a challenge, owing largely to administrative constraints, and discord with regard to appropriate leadership for the large diversity of traditional health specialists in the event of a merger (Mthota, *Pers. Com.* 2004). Nevertheless, even in the absence of an effective legal framework, these organisations appear to have formalized the practice of traditional medicine in the country to some extent. Established in 1964, the Herbalist Association of Malawi (HAM), was the first formally recognised consortium. Today, it remains the largest, comprising several thousand members (Phire, *Pers. Com.*, 2004).² Among HAM's main achievements to date, has been the establishment and ongoing maintenance of some ten natural medicinal plant gardens in different parts of the country³. HAM also issues registration certificates and organises various training workshops for its members. Likewise, recognizing the threats ongoing deforestation poses to their vocation, traditional health practitioners organised under the International Traditional Medicines Council of

¹ Note: In early 2004, the Ministry of Health and Population was reorganised into the 'Ministry of Health'; its previous responsibilities in the area of population planning are now subsumed under the mandate of the Ministry of Economic Planning and Development.

² It is also noteworthy that HAM was originally founded by a woman *sing'anga* (traditional 'healer' or 'doctor'), the late *Sing'anga* Agnes Chipatala (Mukandila, *Pers. Com.*, 2004).

³ This effort has been supported by four organizations, UNICEF, UNESCO, the Ministry of Research and Environmental Affairs and the National Aids Commission.

Malawi (IHCM) purchased a plot of indigenous forest land in Mwanza District (Southern Region) to serve as a medicinal plant botanical garden. Through ongoing afforestation initiatives and indigenous forest protection measures, the IHCM has been working to ensure the continued availability of the medicinal plant species upon which the trade of its members depends (CBNRM, 2002). With a membership of about 300 traditional health practitioners operating in the Northern Region of Malawi, the Chizgani Ethnomedical Association, established in 1994, is a much smaller group with relatively limited resources and activities.

Thus far, the Ministry of Health's efforts related to traditional medicine have focused mainly on providing training to traditional birth attendants (TBAs) and support to traditional health practitioners, through these various associations, specifically by the organization of a series of training workshops on the care and prevention of HIV/AIDS as well as the provision of basic training and supplies to traditional birth attendants (Smitt, 1994). In addition, in collaboration with UNICEF, the National AIDS Control Programme of MOHP produced a set of practical guidelines for home-based herbal treatment (derived from some 37 commonly available indigenous and exotic medicinal and food plants) of some nine HIV/AIDS related symptoms and infections (NACP, 1998). However, ground-breaking as this initiative appears to have been the extent to which the guidelines have since been actively promoted by MOH and effectively implemented by the intended users (i.e., health workers and home-based care providers), remains unclear.

Neither is it clear to what extent the efforts of the various other organizations involved in activities related to traditional medicine and medicinal plants are coordinated at the national level. Indeed, it appears that Malawi currently lacks a clear policy framework with regard to work in support of traditional health knowledge and practices.

A Ministry of Health official identified two of the major challenges faced by decision-makers at the national level in strengthening traditional health practices: persistence of negative perceptions of traditional health practices among biomedical professionals; and the current 'policy vacuum'.

Many biomedical practitioners view traditional practices/treatments as largely ineffective and hence as a factor which 'wastes time' and causes undue delay in seeking 'proper', i.e. biomedical care. As indicated above, there are no national regulatory policies and legislation governing the practice of traditional medicine in Malawi and hence, the public remain unprotected. Neither is there a clearly defined national direction as to how to strengthen their contribution to health care delivery (Mthota, *Pers. Com.*, 2004). Nevertheless, various national organisations, non-governmental organizations (NGOs), and individual researchers have pursued work on traditional medicine and Malawian medicinal plants, albeit with limited coordination of their efforts. The three main areas of focus which can be discerned are: (i) conservation of traditional medicinal and food plants through forest protection and cultivation; (ii) promoting utilisation of local, culturally accepted food and medicinal plant resources to provide affordable HIV/AIDS prevention and care; and; (iii) collaborative applied research and training involving traditional healers, and to some extent, documentation of community-based traditional health knowledge pertaining to the uses of Malawian medicinal plant species.

The National Herbarium and Botanical Gardens of Malawi has led a series of community-based ethnobotanical studies focused on collecting specimens of native medicinal plant species and documentation of indigenous knowledge about their uses, mainly in the Southern Region of Malawi. It has also supported the establishment of community herbal gardens in some areas and collaborated with TRAFFIC International on herbal market surveys. Also noteworthy is a collaborative initiative (funded by the International Development Research Centre, IDRC), involving the University of Malawi's Centre for Social Research, based in Zomba, and the Lilongwe Central Hospital, a WHO Collaborating Centre for the Prevention of Blindness, for investigating local people's use of traditional plant-derived eye medicines and how traditional healers can collaborate with biomedical practitioners in improving eye care services (Gangon, 2000). Action Aid has also been encouraging the use of nutritious traditional plants and herbal medicines in HIV/AIDS prevention and treatment programmes, while the US Peace Corps/Malawi has been advocating the establishment of 'permanent nutrition and medicinal gardens' and is currently discussing an initiative to document indigenous knowledge of Malawian plants in collaboration with the Food and Agriculture Organization.

Other organizations implementing traditional food and medicinal plant gardening schemes in different parts of Malawi include, *inter alia*, the Lighthouse Centre in Lilongwe, which established herbal gardens in 2003 for use in its HIV/AIDS home-based care programme; the longstanding traditional food and medicine gardens of the Hope Humana Project; and the Chifundo Projects Herbal Garden based in Balaka (Southern Region). The latter is a clinic focused on home-based care and herbal treatment. In addition, with technical support from US Peace Corps, the Nkhotakhota AIDS Service Organization has recently embarked upon a project to document traditional medicines in Malawi (US-PC, 2004).

It is clear even from the above cursory review, that there are today, a diversity of organizations with active interest in the promotion of traditional herbal medicine in Malawi. However, few appear to have given express priority to the active engagement of local communities in defining the focus and approach of their programmes. Indeed, none of the ones mentioned above appear to have paid particular attention to the role of ordinary local women in the provision of traditional health care at the household level. This may well present opportunities for MASAF in planning its contribution to this area. By forging partnerships, especially with organizations operating at the community level, MASAF can capitalise on its community-driven approach to development in drawing attention to and supporting the particular contributions of local women in this realm.

2. MASAF and community health development: opportunities for building on past gains through a focus on indigenous knowledge and gender

Malawi embarked upon Phase III of the World Bank-supported social action fund programme (MASAF III) in November, 2003. The programme is a social protection operation which targets poor communities, individual households, vulnerable and disadvantaged social groups in both rural and urban areas. In Phases I and II (1995-2002) MASAF's operational objectives included:

- provision of additional resources and ensuring sustainable use of such services;
- capacity building and direct involvement of communities in project preparation and management;
- encouraging government agencies, NGOs and private institutions to assist community poverty alleviation efforts; and
- transfer of cash incomes through employment in labor-intensive public works, with a view to establish a social safety net.

MASAF III seeks to build on the gains made by its Community Driven Development (CDD) approach during MASAF I and II, with respect to infrastructural development, capacity building and community empowerment through its five basic services packages (*see Table 1*).

In the health sector and the allied areas of water supply and sanitation, assistance to communities and districts with infrastructural development (especially, construction of health units and clean water supplies from protected wells or boreholes) accounted for a considerable amount of investments during MASAF I and II (Lenneiy, 2003). Malawi's Demographic and Health Survey completed in 2000, reported that 65% of Malawian households had access to clean water sources compared to only 47% in 1992. Improved access to potable water was noted as one of the most important public health advances in Malawi during the 1990s, and may well, at least partly, account for declines in mortality among young children over the same period (NSO, 2000:17). However, by and large, other improvements in physical infrastructure have yet to translate into tangible improvements in health conditions and significant poverty reduction in rural communities. Closer attention to two issues critical to community participation – indigenous knowledge and gender – can facilitate MASAF III's efforts to complement the construction of physical infrastructure with the provision of additional inputs that can help achieve significant improvements in community health development.

Throughout Phases I and II, MASAF has effectively employed a range of strategies for encouraging the participation of women in its various projects. These included: (a) the establishment of quotas for women's participation; (b) targeting female-headed households, which account for some 30% of rural Malawian households; (c) directing project information, dissemination and communication efforts to the specific needs of women; and (d) tracking women's participation through a monitoring and evaluation system (Kuenhast, 2003).

A recent assessment of MASAF's gains with regard to gender equity noted that there has been significant success in improving gender representation and participation, with most project management committees meeting the minimum required number of women members and many achieving an optimum gender balance. It was noted, however, that the focus thus far, has been on *quantitative* measures and that the effectiveness and *quality* of women's participation in development initiatives needs to be improved. In reality, women had few opportunities for assuming leadership positions on project management committees. Targeted Information, Education and Communication (IEC) interventions based on gender analysis, and capacity building initiatives addressing the specific needs of women were identified among the key strategies for improving the effectiveness of their participation (Ndeti, 2003).

MASAF III's plans to expand the support of productive and income generating activities, with a particular focus on women and poorer segments of local communities, may provide good opportunities for enhancing the effectiveness of women's participation. Such activities which could include, e.g., horticulture and natural resources management, aim at generating cash income or savings but could also focus on food security and related initiatives. Making greater use of indigenous knowledge and resources in the implementation of its various projects is also identified as one of MASAF III's strategies (MASAF, 2003).

In this context, attention to rural women's role in traditional health care at the household level – an area where they are believed to be the principal contributors – may present MASAF with a prime opportunity for building their capacity for participation and empowering them through valuation and support of their traditional health knowledge. In line with its CDD principles, this may also enable MASAF to improve the effectiveness of its health related IEC efforts by building on various traditional means of communication.

Social funds, such as MASAF finance a wide variety of demand-driven projects to meet the particular needs of poor and vulnerable populations. A study which examined eight social funds to assess their impact on women's empowerment and women's health, suggested that the demand-driven aspects of social funds produce a significant relationship between women's empowerment and health development. Women's empowerment is defined as an increased level of decision-making as a result of women's participation in development projects. Some studies have shown that where there is more women's empowerment, there is a greater emphasis on health and education projects that can advance the lives of women as well as the larger community (Johnson, 1999).

Three particular aspects of this study's approach are expected to yield pertinent information that can help MASAF to determine how best it can harness local communities' traditional health knowledge and resources in assisting them to improve their own health conditions:

- (a) The study's particular attention to the 'non-specialised' or 'popular' domain of traditional health knowledge and skills among communities, which it posits to be as significant as the knowledge and contributions of specialist traditional health practitioners;
- (b) Its explicit focus on the investigation of gender differentiation of traditional health knowledge and medicinal plant use, with special attention to the particular roles of women as primary health care providers, as well as key contributors to decision-making regarding health care choices at the household level; and
- (c) The broad perspective it adopts in seeking to understand the overall position and contribution of home-based traditional health care efforts, within the context of:
 - the range of health care options available to local communities (including 'formal' traditional health care provided by specialist traditional health practitioners as well as modern/biomedical services); and
 - the most pressing health problems currently experienced by local people.

These three dimensions are consolidated in the study's conceptual framework outlined in the next section.

Table 1: MASAF'S 5 BASIC SERVICES PACKAGES

ESSENTIAL HEALTH CARE PACKAGE	<p>Training of TBAS; Senior Health Surveillance Assistants; Nurses; and Midwives</p> <p>Establishment of Drug Revolving Fund (DRF)</p> <p>Anti-malaria programme</p> <p>Family planning services</p> <p>Rehabilitation, construction and maintenance of health centres</p>
WATER & SANITATION PACKAGE	<p>Implementation of new water and sanitation projects and maintenance of wells, boreholes, piped water schemes, earth dams, valley tanks and water kiosks</p> <p>Rehabilitation of community water points</p> <p>Promotion of general sanitation including sanitation platforms in latrines</p> <p>Water hygiene education</p>
EDUCATION SERVICE PACKAGE	<p>Rehabilitation and maintenance of educational facilities</p> <p>Improvement in the learning environment through the provision of good quality classrooms, water points and sanitation facilities</p> <p>Providing teachers' houses with water and sanitation facilities</p> <p>Promoting community participation in school governance</p> <p>Institutionalisation of school committees and parent-teachers associations; review of school statistics</p>
TRANSPORT & COMMUNICATION SERVICE PACKAGE	<p>Improvement of the transport and communication infrastructure</p> <p>Construction of social-economic assets such as community access roads, bridges, footpaths, and community land soil and water resources management facilities.</p>
HOUSEHOLD FOOD SECURITY SERVICE PACKAGE	<p>Empowering and building capacities of individuals, families and communities caring for vulnerable groups, to increase their incomes to mitigate the risks of household food insecurity</p> <p>Crop diversification; and community compost manure making</p> <p>develop woodlots;</p> <p>Setting up crop and produce marketing co- operatives</p>

III. CONCEPTUAL FRAMEWORK: STUDY OBJECTIVES & RESEARCH QUESTIONS

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1. Conceptual framework

A focused literature review covering research on traditional health knowledge and medicinal plant use in Malawi and other African countries reveals three broad propositions which guided this study. These are:

- (a) The use of home-based health protective and restorative plant-derived traditional treatments accounts for a significant part of ordinary local people's routine health care efforts at the household level. Local people make use of such home-based treatments more frequently than they seek care from specialist local traditional healers or at biomedical health facilities.
- (b) The use of such home-based treatments constitutes the first, and often the last, resort in dealing with the majority of common health problems experienced by local people.
- (c) As mothers and primary health care providers, local women's traditional knowledge pertaining to the use of such health restorative and protective plant species is likely to be both qualitatively and quantitatively different from that of men at the household level.

These insights provide the general background and context within which the specific objectives and research questions for this study were framed.

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2. Objectives

This study aims to elucidate the nature and scope of rural Malawian women's traditional health knowledge and practices pertaining, in particular, to the use of home-based plant medicines and traditional food plants. It seeks to assess the extent to which local women rely on such resources in meeting the health and nutrition needs of their families as well as their contribution to the relevant decision-making processes within rural Malawian households.

While the central concern of this study is with the particular knowledge and practices of local women it cannot disregard the contributions of their male counterparts in this realm. Recognising that the effectiveness of women's empowerment and capacity building is largely dependent on the active involvement and support of men in local communities, the study adopts a balanced gender perspective in its assessment of traditional health knowledge. In this context, attention is focused on how men and women interact, make decisions and complement each other's efforts in a variety of roles and responsibilities pertaining to health care (Kuenhast, 2003).

The study seeks to contribute specific contextual information on the distribution and transmission of traditional health knowledge among ordinary local women *and* men in selected rural Malawian communities, as well as the range, availability and various applications of the locally-valued health protective and restorative plant species commonly used at the household level.

The outcome of the study is intended to inform MASAF III, and recommend specific ways in which it might effectively target its development efforts in support of women's indigenous knowledge resources in this area.

3. Research questions

Four sets of interrelated research questions have been formulated, in order to assemble the information required for testing the central hypothesis:

(i) *Distribution of traditional health knowledge in the ‘popular’ domain vis-à-vis knowledge of professional traditional healers and medicinal plant vendors at local markets:*

How is traditional health/medicinal plant knowledge distributed among ordinary men and women in the study communities?

What are the particular roles of the different types of specialist traditional health practitioners (female and male) found within communities? What type of health care services do they typically provide to local community members? How does the nature and scope of their knowledge regarding medicinal plants differ from that of lay women and men at the household-level?

How does the nature and scope of medicinal plant knowledge among herbal vendors at local markets differ from that of ordinary local men and women? Are more women or men engaged in this occupation? What are the main sources and types of medicinal plant products typically sold in local markets and how do these differ from those commonly used as home-based treatments by local people?

(ii) *Characterisation and sustainability of mechanisms for the inter-generational transmission of local traditional health knowledge:* How is this ‘popular’ domain of traditional health knowledge generally acquired by local men and women and how has it been transmitted over generations? What are the potential impacts of various forces of modernization (including, e.g., urbanization, formal education) on the continuity of this process?

(iii) *Medicinal plant supplies, distribution and sustainability of current use patterns:* Are current local patterns and levels of medicinal plant use sustainable? To what extent do parallel forces, such as deforestation, over-harvesting and/or habitat destruction affect the supplies of useful medicinal and traditional food species in the study communities?

(iv). *The overall significance of popular traditional knowledge and home-based use of traditional medicinal/food plants:* What is the overall position of home-based traditional health practices and knowledge of medicinal plants within the context of the prevailing pluralistic patterns of health care utilisation? To what extent do home-based use of remedies serve as the first and/or the last resort for treating common health problems?

Each of the above questions is linked to one or more of the study’s five methodological components which are elaborated below.

IV. METHODOLOGY: SIX RESEARCH COMPONENTS

The fieldwork for this study draws on a combination of qualitative research methods, which have been used to design six data-gathering instruments. These six methodological components are elaborated below, along with their particular aims and the specific types of data they were expected to yield.

1. Focus Group Discussions (FGD)

Following introductory discussions with community leaders/representatives (i.e., the village/group village headman and/or deputy), the main phase of the fieldwork programme in each community started with three focus group discussion (FGD) sessions: (a) FGD with women; (b) FGD with men; and (c) a wrap-up FGD discussion with a mixed group of men and women.

1.1. Women's focus group discussions

With the assistance of MASAF staff and local community representatives/development agents⁴ (and the approval of community leaders), a diverse group of 15-20 ordinary women community members (of varying age, marital status/household-headship; formal education/literacy levels) was convened in each community. The women's focus group discussion was envisaged as a means of allowing women to freely and informally discuss matters of health amongst themselves, without any socio-cultural inhibitions they might otherwise feel if men were to be included in the group.

Village mapping: This group interactive exercise was intended both as an 'ice-breaker' and as a means of getting participants to start thinking about health matters and the health-related resources available to them. Its aim was to get a rapid overview of what participants view as their main health care and related resources, while at the same time noting any comments made about these (e.g., how far various facilities are from key landmarks, means of transportation available, etc.). Participants were encouraged to start with key landmarks such as the village centre, churches, schools etc., and map the following types of resources around these: the homes of community traditional healers, TBAs; the closest biomedical health care facilities (closest government health centre, district hospital, frequently used private clinic(s)); local markets where herbal medicines are available for sale; village shops where modern OTC pharmaceuticals or anti-malarial drugs might be bought; areas in the community where most medicinal plants can be found (home-gardens, farm borders, nearby hills, uncultivated natural areas, forests, etc.); safe water sources (boreholes, protected wells, other water sources used).

Discussion questions: Upon completion of the village mapping exercise, the six sets of 'probe' questions (detailed in **Appendix I**) were introduced to facilitate discussions centred around community health matters in general, and the study's main concern of traditional health knowledge and home-based use of medicinal plants, in particular.

1.2. Men's focus group discussions

A diverse group of 15-20 male community members (of varying age, marital status/household-headship; formal education/literacy levels) was convened in each community. The group was first asked to comment (add to or correct as deemed fit) the village map drawn earlier by the women's group. Any modifications made were noted. The same discussions questions used in the women's FGD were then raised to facilitate discussions, noting in particular, any significant differences/contradictions in the types of responses obtained from the men's group from those obtained through the women's FGD.

⁴ The following individuals served as liaisons with community members, helped organize the focus group discussions, and provided background information on the community: Mr. Enoch Amuthe, Materazi Maize Mill Project Committee Secretary, CHALA; Mr. Mfunic Stembidge, Health Surveillance Assistant, Under Fives Clinic, Ministry of Health – JOMBO; and Mr. Jafali Chisale, Community Development Agent, Ministry of Gender, - MPEMBA.

1.3 Focus group discussions: mixed group of men and women

These sessions started with a discussion of any significant differences in responses and observations noted between the outcomes of the women's and men's group discussions.

Participatory ranking: Based on a summation of the results from the previous two discussion groups, men and women were asked to participate in a series of ranking exercises. In preparation, the results from the previous discussions were consolidated into three lists as outlined below:

(a) Compilation of all the main health problems cited (highlighting those mentioned exclusively by women/men). These were ranked (*1: high/2: moderate/3: low*) according to the following criteria:

- the perceived seriousness (life-threatening or widespread and severely debilitating) of the health problem;
- perceived effectiveness of any treatments of the health problem provided by traditional healers;
- perceived effectiveness of any home-based traditional treatments for the health problem; and
- perceived effectiveness of any modern/biomedical treatments of the health problem

(b) List of all the medicinal plants cited (highlighting those mentioned exclusively by women/men). The overall local value ascribed to the various medicinal plants was ranked (*1: high/2: moderate/3: low*) according to:

- their perceived effectiveness, frequency of use;
- availability: most scarce in the local area; and
- their overall socio-economic and/or cultural value.

(c) A set of possible types of initiatives which could be supported by MASAF (based on the concerns identified through the previous discussions) was also outlined and ranked (*1: high/2: moderate/3: low*) according to their perceived relevance and priority.

2. Semi-Structured key informant interviews

The aim of this component was to obtain more detailed information on the use of home-based medicinal plant treatments from particularly knowledgeable women and men community members identified by the participants of the women and men focus group discussions, respectively. It also allowed for a general comparison of the breadth and depth of knowledge possessed by those deemed 'most knowledgeable' by women with those identified by men. The interview schedule included both closed and open-ended questions, covering the following:

- Background information: informants' personal data (including, name, age, gender, marital status, occupation, literacy/level of formal education, sources of income);
- Information on plants used to treat a range of common ailments (respiratory infections; dermatological problems, digestive problems, acute pain, and others mentioned by the informants) including (their local names, sources, therapeutic part(s) and descriptions of their preparation and administration);
- Information on home-garden composition (particularly, cultivation or maintenance of medicinal species);
- Informants' general health care seeking strategies; and
- Perceptions and knowledge of major health problems in the area (malaria; HIV/AIDS), including information on any traditional treatments.

3. Interviews with village female/male traditional healers

Individual interviews were held with community identified (including, both women and men) traditional health practitioners operating in the local area. The questions included in these interviews, aimed to gain insight into:

- the background/training and area of expertise/specializations of the traditional practitioners,
- their perspectives regarding major health problems in the area; and
- their views regarding the knowledge and use of traditional medicinal plants by ordinary local people.

If traditional healers were willing to talk about the herbal treatments they provide, these were also recorded following the same format used for interviews with knowledgeable key informants. In addition, similar interviews were conducted with the chairpersons or representatives of the various traditional healer associations in Malawi.

4. Semi-structured interviews with traditional birth attendants

This research component focused on the medical plant knowledge and health practices of community traditional birth attendants (TBAs). The interview format was similar to that used in key informant interviews, with one notable distinction, namely, the inclusion of questions pertaining specifically to their medicinal plant knowledge and use in pre- and post-natal traditional health care. In addition this instrument gathered information on:

- their main sources of knowledge and skills and number of years of working experience as a TBA
- their mode of operation, including the reach of their services (number of villages which they served);
- most frequently encountered (women's/maternal and child) health problems;
- how they were compensated for their services;
- the type of basic biomedical-based training they may have received; and
- the major problems and constraints they faced in providing child birth; pre/post-natal services,

5. Semi-structured interviews with village elders

Individual interviews were held with widely-recognized elders in each research community (2-3 men and women, respectively). The key informants for this component of the study were identified in consultation with community members. The aim of these discussions was to gain insight into:

- the overall historical perspective of the local culture and traditions;
- changes in the local natural environment, the extent of habitat conversion and changing land use patterns over the years, including any losses of locally-valued medicinal and food plants; and
- local perspectives regarding the pressing health problems faced by the community as well as and the advantages and drawbacks of traditional medical practices as compared with biomedicine.

6. Semi-structured interviews with herbal vendors at local markets

Semi-structured interviews were conducted with herbal vendors (where available, both men and women vendors) at the local market closest to each study community. The aim of this was to elucidate any significant differences between the medicinal plant knowledge held by this particular group of people (compared to that possessed ordinary local men and women). In addition, a general assessment was also made of the types of medicinal plant products they offered for sale.

The information generated by means of the above instruments was complemented by data from various secondary sources and through informal discussions with key resource persons and representatives from various organizations involved in work related to traditional herbal medicine. In addition, the plant-specific information obtained through the various research components described above was organized into a comprehensive matrix. The local names of plants were listed alongside the health problems for which they were used as treatments. The collaboration of experts at the National Herbarium and Botanical Gardens, was sought in determining the corresponding scientific botanical designations, of the most frequently cited species (wherever feasible), using photo images, which were collected throughout the fieldwork.

V. FIELDWORK PLANNING AND ORGANISATION

The fieldwork for this study was carried out over a period of about six weeks (March 28 – May 7, 2004). Below, is an outline of the work programme followed:

1. Fieldwork preparatory phase and practicalities

Through consultations with MASAF and Bank staff a fieldwork plan was outlined, which included identification of relevant organisations/key resource persons to consult, criteria for the selection of study communities, as well as logistical arrangements for local transport and requirements for fieldwork support.

Discussions with representatives of various organisations involved in work related to traditional medicine including, representatives of the Ministry of Health, the Ministry of Gender and Social Services, the College of Health Sciences and the National Herbarium and Botanical Gardens, (*see Appendix II for list of organisations consulted*) helped sharpen the research questions and general approach of the study.

Also during this preparatory phase, some site visits were made to rural communities outside Lilongwe (Malili Traditional Authority, Central Region). Informal conversations about the study objectives and the uses of various traditional home-based plant medicines with the various community members and representatives met during these visits helped in refining the specific questions included in the various research instruments to be employed.

In consultation with various resource persons, a local counterpart researcher was identified. Ms. Lexa Kawala, who is a qualified nurse (currently a Lecturer at the College of Nursing in Lilongwe) brought to the study her biomedical training and varied experience with participatory research approaches in rural Malawi. Her experience as a nurse in Malawi has proved particularly useful, especially in interpreting the biomedical approximations of the local terms of various symptoms health problems. Ms Kawala's native language is Chichewa, spoken in much of the Central and Southern Regions. She also has a good understanding of Tumbuka which is the native language in many rural areas in the Northern Region, including, as discussed below, in one of the selected study communities.

2. Selection of study communities

In close consultation with MASAF staff and various resource persons from other organisations with mandates relevant to the objectives of this study, three practical criteria were arrived at for selecting the study communities.

(a) Regional representation: It was repeatedly recommended that the fieldwork for this study include at least one rural community from each of Malawi's three administrative regions, i.e. the North, Central and Southern regions respectively. Clearly, it would be difficult to select a single community to represent the diverse socio-economic, cultural and eco-geographical conditions found within each region. Indeed, traditional health knowledge, and particularly knowledge pertaining to medicinal plants is necessarily intrinsic to the socio-cultural heritage of a given people, which is, in turn, shaped by the particularities of their local natural environment. As such, traditional health practices in Malawi are likely to be as diverse as the socio-cultural and environmental variations found among the local communities in which they persist. This necessarily limits the extrapolations that can be made from the findings of this study. Nevertheless, it was agreed that including one community from each region would at least enable a modest appreciation of some of the relevant broad differences between the regions, while also allowing instructive comparisons between the traditional health knowledge and range of medicinal plants used among three culturally, eco-geographically and socio-economically distinct communities.

(b) Distance from a main urban/town center: It could be expected that the farther away a rural community is from an urban/town center (where relatively ample biomedical services are usually more readily available), the greater the reliance of its inhabitants on traditional health care resources. Based on this premise, it was agreed

that the selected study communities be located at least 25 km. outside the main urban center in each region (Lilongwe, Central Region; Mzuzu, Northern Region; and Blantyre, Southern Region). It was also decided that the selected communities be no more than 40 km. away from an urban centre, in order to ensure that daily commutes to the communities are practicable.

(c) **MASAF initiatives:** Finally, it was agreed that it would also be useful to take into consideration MASAF's previous involvements in the particular communities selected for the study. The aim of this was to provide MASAF with a broad picture of the extent of reliance on traditional health practices among communities where it has had different levels and types of involvement, and to assess any relevant differences in local men's and women's main priorities and concerns in each type of setting. Accordingly, in consultation with the respective MASAF Zonal PRA Officers,⁵ the study attempted to capture three different scenarios by ensuring that the communities selected include:

- a community where MASAF has supported a project of direct relevance to health development;
- a community where MASAF has supported a 'non-health related' initiative; and
- a community where MASAF has not supported any initiatives, to date.

3. Profiles of the three study communities

Table 2. below provides a summary of the main characteristics of each of the three study communities selected based on the criteria cited above.

Table 2: PROFILES OF THE THREE STUDY COMMUNITIES

	CENTRAL REGION	NORTHERN REGION	SOUTHERN REGION
LOCAL NAME OF COMMUNITY/STUDY AREA	<i>Chala</i>	<i>Jombo</i>	<i>Mpemba</i>
GROUP VILLAGE (GV)	Chala GV	Nation Nhelma GV	Kantukule GV
CENTRAL VILLAGE	Chala	Kamnthambani	Mpingo
TRADITIONAL AUTHORITY (TA)/ DISTRICT	Malili/ Lilongwe Rural	Nthwalo/ Mzimba	Somba/ Blantyre Rural
DISTANCE FROM MAJOR URBAN CENTRE	27km (South of central Lilongwe)	40km Mzuzu	25km (S.E of central Blantyre)
TOTAL POPULATION	1400	1230	1202
MAIN LOCAL LANGUAGE	Chichewa	Tumbuka	Chichewa
SOCIAL ORGANIZATION	matrilineal	patrilineal	patrilineal
MASAF INVOLVEMENT	'non-health initiative': Materezi Maize Mill Project (since 2002)	'health initiative' : construction of under-5s health unit, staffed by 1 Health Surveillance Assistant.	'no initiatives to date'
CLOSEST GOVERNMENT HEALTH CENTRE	CHITEDZE GOV'T HEALTH CENTRE 2-3hrs walk/ 11 km	Kamnthambani village center (see above)	MPEMBA GOV'T HEALTH CENTRE 2hrs walk/ 10.5 km
CLOSEST HOSPITAL(S)	- LIKUNI HOSPITAL (Private/Missionary) (since 1940s) 2-3hrs walk/ 11 km	-EKWENDENI HOSPITAL(Private/Missionary) 2hrs walk/ 10 km - RHUMPI GOV'T. DISTRICT HOSPITAL:27km	QUEEN ELIZABETH CENTRAL HOSPITAL (Urban Center) 28 km

⁵ MASAF Zonal PRA Officers: Ms. Leonessa Mukaka (MASAF, Lilongwe); Mr. Stewart Kazira (MASAF Mzuzu); and Mr. Adack Chidumu (MASAF, Blantyre) assisted in the selection of the study communities in the Central and Northern and Southern regions respectively.

The respective local or informal designations of the general areas in which the three study communities are located will be used in reference to each throughout the remainder of this report, i.e. Chala, Jombo and Mpemba for the study communities in the Central, North and Southern Regions respectively.

3.1 Distinguishing features

Chala

Residents of Chala which belong to the Chichewa-speaking Achewa ethnic group are traditionally described as a matrilineal society⁶ (unlike the other two communities which are patrilineal). However, nowadays they are influenced by both matrilineal and patrilineal leadership. Settlement patterns in Chala appeared to follow matrilineal lines.

Subsistence farming is the main livelihood in Chala tobacco (*jodya*); groundnuts; vegetables (sweet potato, tomatoes etc). Christianity is the dominant religion though it is noteworthy that, at least in Chala village a significant minority are adherents of the traditional belief system revering ancestral spirits known as *nyaw*.

Jombo

The Nationi-Nthelma and Enkweni area is also locally referred to as 'Jombo'. The local inhabitants are predominantly (Presbyterian) Christians. Literacy is almost universal (among men and women) in the area (estimated over than 90%), with most having primary level formal education.

MASAF has supported the construction of a biomedical clinic in Kamnthambani village to serve primarily as an under-fives clinic. Construction of the building started in 1995 and took approximately 2 years. Polygamy is more common in Jombo where Christianity arrived relatively late. Whereas the practice is still acceptable in principle and left to individual choice, most believe it is on the wane, as difficult socio-economic circumstances are making it increasingly difficult to support more than one wife/family.

Mpemba

The Mpemba community is situated on particularly difficult terrain: steep hills and narrow dirt roads make it very inaccessible. The majority of the local people rely on production of charcoal for sale in the urban center as their main source of income. Unlike in the other communities, there is no tobacco production in Mpemba and surrounding areas, as soils are reportedly unfavourable. Ongoing deforestation (mainly for charcoal production) is a notable problem. No afforestation programmes have recently been implemented.

Local people can purchase basic modern drugs such as anti-malarials and antibiotics from trained community representatives through a Drug Revolving Fund (DRF) scheme recently established three months prior to our visit.

3.2. Range of health care resources available

As indicated in **Table 2**, the three study communities have a similar range of biomedical health care resources available to them. On face value, with a recently constructed under-fives clinic through MASAF support, Jombo residents may appear to be better-off than the others. But as will be discussed later on, the services provided at the health center remain inadequate. In Chala FGD participants noted that a mobile clinic from Likuni hospital makes regular rounds every month to immunize children under five, to conduct antenatal monitoring and to administer any other treatments required.

Each community typically has a 'village grocery' or shop where modern drugs (mainly OTC pain-killers, such as panadol, and antimalarials such as fansidar) are occasionally available for sale. Few people in Chala and Mpemba village have latrines, while many households have functional latrines in Jombo.

⁶ The matrilineal sorority group of the Chewa people, traditionally consisted of a group of sisters and their children overseen by an elder brother or uncle. The brother-sister tie is particularly strong. When women get married, they usually, stay close to their mothers, sisters and aunts, while maintaining separate dwellings with their husbands and young children (Vaughn, 1987: 134).

3.3. Livelihood strategies

The large majority of residents in the three study communities are subsistence farmers. In Chala and Jombo (Central and Northern regions respectively), the main crops grown are maize (which is the preferred staple in most parts of Malawi) and tobacco. Tobacco is a relatively profitable cash crop, which earns local farmers a significant income. However, due to unfavorable soil types, tobacco is not cultivated in the Mpemba community of the Southern region. Indeed, the large majority of Mpemba residents appear to have no alternative livelihood strategies outside of subsistence maize production and, notably, logging for the production of charcoal. The detrimental effects of the increasing reliance on charcoal production on the local natural resource base in and around Mpemba has not gone unnoticed by the local people themselves.



Chala: Women's focus group discussion



Jombo Men's focus group discussion



Mpemba: 'The Fundeni's'

Bambo Macray Fundeni (center) – a community recognized *ofunamankhwala* & carpenter (Key Informant) and parents

VI. MAIN FINDINGS

This section sets out and discusses the main findings of the study under four broad topics: (a) the most pressing *health problems* experienced by local people and the remit and perceived value of home-based traditional practices *vis à vis* the specialist traditional practitioners and the range of biomedical health care resources available to them; (b) distribution and transmission of traditional health/medicinal plant *knowledge*; (c) classification, supplies and use patterns of *the plants* commonly used as medicine among the study communities; and (d) community-identified priorities for possible MASAF interventions. The ensuing analyses draw heavily on information compiled through the focus group discussions (nine sessions in total) held in the three study communities. Relevant information elicited through the other research instruments is also used to complement the key findings distilled. Following are a few observations about the composition of these groups (summarized in **Table 3**) can enable an appreciation of the validity of the information gathered.

Table 3: COMPOSITION OF FOCUS GROUPS IN THE 3 STUDY COMMUNITIES

	CHALA		JOMBO		MPEMBA	
	WOMEN	MEN	WOMEN	MEN	WOMEN	MEN
TOTAL NUMBER	26	15	24	23	18	19
AGE GROUPS (MAJORITY approx %)	80%: 30-65 yrs.	61% < 30 yrs	75% <=45 yrs	57% > 45yrs	78% 30-65 yrs.	68% > 45yrs
M: MARRIED H:HOUSEHOLD HEAD	70% M 30% HHH	<i>all</i> M/HHH	80% M 30%HHH	<i>all</i> M/HHH	72% M 28% HHH	<i>all</i> M/HHH
approx. % LITERATE	<10% (<i>only 2 literate</i>)	26% (<i>only 4 literate</i>)	> 90%	> 90%	28%	> 90% (<i>only 1 non-literate</i>)

On the whole, all the focus groups were deemed sufficiently diverse. The representation of women was deemed satisfactory, both in terms of their total numbers as well as their heterogeneity (different age-groups; married and divorced/widowed household heads). The particular composition of some of the groups which may have had an effect on the information elicited should be noted. For example, the men's group in Chala was a remarkably young one with the majority of participants younger than 30 years of age, of whom only four were literate. Also, significant differences were noted in the levels of literacy among women and men participants of Mpemba (although this did not appear to compromise women's participation). Almost all FGD participants in Jombo were literate. This inevitably had a notable impact on the dynamics of the discussions compared to the sessions in the other two communities (e.g., some women were observed taking their own notes during the discussions).

In general, local people in all three study communities were found to be assertive; it is noteworthy that women were generally found to be remarkably so, irrespective of their literacy levels, marital status or household-headship, not just during the women's discussion sessions but also during the mixed sessions, which included men. Except for showing some reluctance in divulging their traditional knowledge of specific herbal preparations, both men and women articulated their concerns without inhibition both during individual sessions as well as in the focus group discussions.

1. The main health problems: the remit and perceived value of traditional health knowledge and practices vs. biomedical health care resources

1.1. The main health problems experienced by the study communities

There was considerable similarity in the range of the most pressing health problems identified by FGD participants in the study communities. A consolidated overview of these is provided in **Table 3**. Approximate biomedical interpretations of the symptoms corresponding to the various conditions identified by local terms are detailed in **Appendix III**.

Table 3 : SUMMARY OF THE MAIN HEALTH PROBLEMS IDENTIFIED
(COMPILATION OF 'TOP 15' MOST FREQUENTLY CITED)

1.	malaria /cerebral malaria
2.	HIV/AIDS
3.	STI (gonorrhoea; genital ulcers/bubos)
4.	pneumonia ('chilaso'/'chibayo')
5.	diarrhoea (neonates /children)
6.	'mawuka' (acute febrile illness in neonates/young children)
7.	stomach-cramps (often associated with diarrhoea or dysentery)
8.	skin infections (scabies; abscess)
9.	TB; cough (persistent/chronic)
10.	migraine
11.	rheumatic pain
12.	bilharzia
13.	pregnancy/child-delivery complications
14.	menstrual cramps
15.	eye-infections (conjunctivitis, <i>esp. young children</i>)

Traditional health knowledge and practices and local perceptions surrounding the management of four of the above health problems, namely malaria, HIV/AIDS, childhood diarrhoea and peri-natal complications, which feature among the leading causes of mortality and morbidity at the national level are briefly highlighted below.

Malaria

Malaria stands out as the single largest health problem in all of the study communities. In general, participants in all three communities appeared to be well-informed about the mechanisms of malaria transmission and effective preventive measures. The use of modern anti-malarial drugs, purchased without prescription from village shops is also a widespread practice. It appears that local people tend not to view the symptoms associated with *cerebral malaria* (especially convulsions) as malaria. Indeed the symptoms seem to be often confused with epileptic seizures or viewed as a wholly different condition known as '*kugnu*.' This points to the need for targeted health education efforts on malaria symptom recognition.

Provision of basic hands-on training to better enable local people, especially mothers, to detect and treat malaria at home in a timely manner can also expand the severely constrained human resource-base of rural government health facilities, and help to engender real community participation. Such a strategy would be directly in line with the recommendations of the WHO-led 'Roll Back Malaria', which, *inter alia*, emphasizes the need for prompt diagnosis and treatment of malaria within or as near as possible to the home (Anonymous, 2000; Banda, 2000).

While most were aware of the use of bed-nets and how they could be obtained, the use of bed-nets appeared to be most widespread among the study community in the Northern region; all FGD participants use bed-nets. For many, especially those in Chala village, 100 K for a bed-net is deemed too expensive, but if available for free many claimed they would certainly use it. On the other hand, anecdotal evidence suggests that bed-nets (especially, in cases where they have been provided free of charge by certain NGOs) have often been appropriated for a different purpose - use as fishing nets. Understandably, the communities give priority to food, rather than malaria prevention through use of bed-nets.

Box 1. SUMMARY OF TYPICAL HEALTH-CARE SEEKING STRATEGIES FOR MALARIA CASES AS DESCRIBED BY FGD PARTICIPANTS AND KEY INFORMANTS	
Step 1: use of modern pain relief drugs or anti-malarials purchased from local vendors or village shop	often, following routine self-diagnosis (with little consultation), or in the case of children, recognition of symptoms by mothers
Step 2: if symptoms persist, seek treatment at modern health facility	following consultation with/ approval of house-hold head
Step 3: if treatment at modern health facility fails	further consultation typically often involving others outside the household)often resulting in 're-diagnosis' of condition as 'witchcraft-inflicted'
Step 4: if determined to be caused by witchcraft	resort to elaborate set of cultural practices which are believed to break the spell

HIV/AIDS

The local expression: “*Edzi irimufa!*” meaning, “[HIV/AIDS is in the maize flour!” (i.e., it is widespread and, hence, very difficult to avoid), denotes acute local awareness of the prevalence and threat of the disease. In all three study communities, both men and women informants appeared generally well-informed about HIV/AIDS, its main modes of transmission and most effective ways of prevention. The only notable exception was that FGD participants in Chala village insisted (despite what they had learned from biomedical health personnel) that the only mode of transmission was sexual intercourse. Informants in Jombo and Mpemba cited other ways, in addition to sexual contact, in which HIV/AIDS can be contracted, including during treatment at modern health facilities through contaminated needles and blood transfusions as well as repeated use of contaminated razor blades in administering various traditional treatments.

There were no traditional treatments (home-based or specialised) which were expressly cited as remedies for secondary infections associated with HIV/AIDS. Indeed, most participants seemed to think that seeking any type of care for HIV/AIDS was futile.

Among the main sources of HIV/AIDS information cited by Jombo residents were, the radio, educational dramas organized by various youth groups and local biomedical personnel as well as outreach programmes sponsored by churches, organizations such as UNICEF, the National Youth Council of Malawi. Overall, the general knowledge of local people regarding the disease would suggest that ongoing HIV/AIDS prevention education campaigns have made significant in-roads in rural areas. It should be noted in this connection, that all three communities have a significant number of HIV/AIDS orphans, and support for those caring for them was repeatedly brought up in discussions about pressing community health concerns.

Childhood diarrhoea

In some traditional health systems, limiting fluid intake is recommended as part of the treatment of diarrhoea (Olango and Aboud, 1990). This, of course, can exacerbate the condition by bringing about fatal levels of dehydration especially in infants and young children. This does not appear to be the case among the study communities, most mothers affirming that diarrhoea treatments are administered with plenty of water and fluids. It is not altogether clear, however, whether this practice is part of the traditional culture or whether the messages from biomedical health education initiatives have been incorporated into local people's traditional strategies of coping with diarrhoeal diseases.

Only the women in Mpemba made reference to the use of Oral Rehydration Salts (ORS), locally referred to as *Thanzi*, as one of the first options for treating childhood diarrhoea. Some noted that whereas they previously relied solely on traditional remedies, nowadays they resort to traditional herbal preparations only when ORS treatments fail. Indeed, large permanent advertisement of ORS treatments can be seen on the sides of buildings in the roadside market centers visited *en route* to the rural villages.

Pregnancy/child delivery complications

In addition to a range of pregnancy complications, women repeatedly cited menstrual pain and vaginal infections as among their main problems. Consistently, men participants were found to be uncommunicative when these were raised.

It is also worth noting that symptoms approximating rectal prolapse, a condition which is known to be more common in women than men (usually associated with the stresses involved in childbirth) were also described by two female key informants (specialist *ofunamankhwala*) in Mpemba who contended that the condition, although not very common, is experienced by some older local women. Both these specialists said they knew of, and have on occasion, provided effective traditional plant treatments for it.

Table 4. MAIN HEALTH PROBLEMS AFFECTING DIFFERENT GENDER-AGE GROUPS IN THE 3 STUDY COMMUNITIES

INFANTS/YOUNG CHILDREN	YOUNG ADULTS (REPRODUCTIVE AGE)		MIDDLE-AGE ADULTS		ELDERLY
	FEMALE	MALE	FEMALE	MALE	
	pregnancy complications	'sila'	pregnancy complications		
	'tcheka'/'chamimba' (menstrual pain)	undescended testicles	vikanga		
			'tcheka'/'chamimba' (menstrual pain)		
			'mawuka' (vaginal infection)		
			rectal prolapse		
	back-ache				
malaria/cerebral malaria	malaria/cerebral malaria		malaria/cerebral malaria		rheumatic pain
diarrhoea	HIV/AIDS		HIV/AIDS		
'chiripu' (persistent vomiting + diarrhea)	TB		TB		
'kutuba' (symptoms of severe malnutrition)	STI (gonorrhoea; genital ulcers/bubos)		STI (gonorrhoea; genital ulcers/bubos)		arthritis
luwombo (abnormal fontanel/neonates)	bilharzia		'chibayo' (pneumonia)		
'mawuka' (acute febrile illness)	chicken pox		migraine		back-ache
cough (persistent/chronic)	skin infections (scabies/ abscess)		shingles		
'bambala' (splenomegaly)	toothache		meningitis		
measels	diarrhoea/dysentery		diarrhoea/dysentery		tooth-ache
meningitis	abscesses		arthritis		
'mpere' (skin infections/scabies)	'mpere' (skin infections/scabies)		rheumatic pain		
'chibayo' (pneumonia)					
oral thrush					
eye infections/conjunctivitis					
ear infections/otitis					

1.2 Local perspectives: Biomedicine vs. traditional medicine

Perceived advantages and disadvantages of biomedicine

Table 5 shows the range of health problems for which men and women FGD participants in the three study communities are generally inclined to seek biomedical care.

Table 5: HEALTH PROBLEMS BELIEVED TO BE MOST EFFECTIVELY TREATED BY BIOMEDICINE (ALL RANKED EQUALLY HIGHLY)

1.	Arthritis (S)
2.	Asthma (N)
3.	Bilharzia (S)
4.	Cholera (C/N/S)
5.	Diabetes (S)
6.	Diarrhoea (children) (C/N/S)
7.	Ear-infections (N/S)
8.	Eye-infections/ conjunctivitis (C/S)
9.	HIV/AIDS [2 ^o infections] (C/N/S)
10.	Malaria (C/N/S)
11.	Measles (C)
12.	Meningitis (N)
13.	Migraine (S)
14.	Pneumonia (S)
15.	Pregnancy complications (C)
16.	Rheumatic pain (C)
17.	Shingles (S)
18.	Skin infections (C)
19.	TB (C)
20.	Tooth-ache (S)
*(C), (N), (S): identified by FGD participants in the study communities: Central (Chala), Northern (Jombo) and Southern (Mpemba) regions respectively	

Advantages: Biomedicine's diagnostic capabilities, the specificity of the modern drugs and the generally rapid recovery after treatment are perceived as the main advantages of biomedical treatment.

Disadvantages: The distance to the hospital and the associated costs of obtaining treatment (including, costs of transportation, consultation, purchase of medication) were cited as the main drawbacks. In Chala, women FGD participants stressed that while they believed that the biomedical treatment for these problem was the best option, they lamented the high costs of transport, consultation and treatment entailed which can often exceed 2000 MK (about USD 20).

Another important drawback observed by Jombo residents was the complications that can arise from inappropriate use of modern pharmaceuticals. They noted that non-literate community members in particular often have trouble following written prescriptions correctly.

Inefficiency of the government health system was also cited as a disadvantage. Most FGD participants in (men and women) in Jombo, indicated a preference for seeking biomedical care at one of the private clinics located at the nearest rural market center rather than at the local government health center. Despite the additional direct and indirect costs entailed (i.e., the unavoidable consultation fees charged by private clinics, transportation costs, as well as precious time away from productive activities), informants in this group said they still preferred private clinics, mainly because of the prompt medical attention they receive at such facilities. They contended that by

going directly to private clinics, they can effectively avoid the long queues and often, protracted referral process in the government health system and can also get more ready access to the required medication.

Perceived advantages and disadvantages of traditional medicine

The study affirmed that inhabitants of the three rural communities continue to routinely make use of home-based traditional herbal remedies as the first line of treatment for most common ailments and symptoms (e.g. stomach-ache; diarrhoea and other minor digestive problems; cough; localized pain; minor respiratory infections; various skin conditions).

Traditional medicinal plant use continues to be an integral part of local people's daily lives. FGD participants and key informants typically reported having used various traditional home-based treatments as recently as just a few days to a week, prior to the discussion/interview session: Some made specific reference to particular plants they had recently used, e.g. in Chala village, *ndima* (for childhood diarrhoea); *mwimbi* and *mbwaze* (for rheumatic pain). A participant in the women's focus group discussions in Jombo, said that the very same morning, she had prepared and administered a plant treatment for her child who was suffering from a persistent cough.

Advantages: Among the perceived advantages of traditional medicines, is that they are accessible and they often cost nothing (esp. home-based treatments). In addition, traditional specialists often offer flexible alternatives to the 'up-front' cash payments typically required at biomedical facilities (e.g., compensation in kind, and in most cases only, if the condition is cured or the patient shows visible signs of improvement after treatment).

Disadvantages: It was noted however, that many traditional treatments are relatively slow to take effect, are usually not specific to the particular illness they are prescribed for, and their dosage is often not standardized.

Also, payments to traditional healers especially *sing'anga* can sometimes be very high; according to Mpemba residents treatments can cost as much as 1000K (USD 100) in addition to a goat (!), depending on the type of treatment (fertility treatments, formulations for bringing about good-fortune, business prosperity being the most expensive); the amounts charged by village *ofunamankhwala* (a chicken or up to 50K are relatively modest but not deemed negligible).

Women in the FGD in Jombo noted that special care is taken in measuring the appropriate dosage of traditional treatments administered to children, while much less attention is paid to the dose for treatments given to adults.

Table 6 provides a summary of the range of conditions believed to be most effectively treated by home-based or specialized traditional medicines provided by expert practitioners.

Table 6. HEALTH PROBLEMS BELIEVED TO BE MOST EFFECTIVELY TREATED BY TRADITIONAL MEDICINES

	HEALTH PROBLEM	(A) HOME-BASED HERBAL REMEDIES (B) TREATMENTS PROVIDED BY SPECIALIST PRACTITIONERS	COMMUNITY IN WHICH IDENTIFIED
1.	abscesses	A	N
2.	back-ache	B	N
3.	<i>bambala</i> (splenomegaly)	A	N
4.	<i>chamimba/tcheka</i> (menstrual pain)	A	N/S
5.	<i>chibayo/chilaso</i> (pneumonia?) *	B	N
6.	conjunctivitis/eye infections	A	C
7.	cough persistent/chronic	A	N/S
8.	diarrhoea	A	N/S
9.	dysentery	A	N
10.	<i>kugnu</i> (cerebral malaria?)*	A/B	N
11.	<i>likodzwa</i> (bilharzia)	A	C
12.	<i>luumbo</i> (abnormal fontanel in neonates)*	A	C/ S
13.	<i>mawuka</i> (acute febrile illness in children?) *	A/ B	C/S
14.	<i>mimba</i> (stomach-cramps/ colic)	A	N
15.	<i>mudu</i> (migraine)	A	C
16.	<i>rinjirinjiri</i> (epilepsy)	B	C
17.	<i>sila</i> (cerebral malaria ?) *	A	N
18.	STI (gonorrhoea; genital ulcers/bubos)	A/B	C/N/S
19.	undescended testicles	A	N
20.	vikanga (vaginal infection)	B	N

(C), (N), (S): identified by FGD participants in the study communities: Central (Chala), Northern (Jombo) and Southern (Mpemba) regions respectively
 [*] denotes uncertainty among FGD participants regarding nature of condition or significant gender differences in perception of health problem/ appropriate treatment

1.3 Some gender differences

Some important gender differences in the perception of particular health problems and their most appropriate and effective treatments should be highlighted. There were some general indications that women and men tend to judge the severity of different health problems affecting children somewhat differently. For example, women tended to think that eye-infections in children could be effectively treated through the use of various home-based remedies, while men generally indicated that biomedical care should be sought for such conditions (generally consistent with findings of a study which looked into traditional eye-treatments in Malawi: see Courtright *et al.*, 2001).

Knowledge about the treatment of 'luumbo' – a condition affecting neonates, described as abnormal fontanel formation (see Appendix III) – also seems to be generally the reserve of women. In all the mixed FGD sessions, men participants deferred questions about this condition to their female counterparts

In general, women prefer to seek care from female *ofunamankhwala* for various reproductive health problems. Most men claimed not to have any particular preference. In Chala village, men agreed that in just the way they have no qualms about being examined/treated by a female biomedical professional, they would have no problems seeking the assistance of a female *ofunamankhwala* known to have effective medicines for STIs.

There was general consensus between men and women that STIs, such as genital ulcers (bubos) and certain gynaecological problems (e.g. excessive vaginal bleeding) are best treated using various traditional medicines provided by recognized village *ofunamankhwala* (secular herbalists).

1.4. Harmful traditional practices

Some harmful practices were repeatedly cited by FGD participants. Misdiagnosis by *sing'anga* – claiming that the 'wrong' people in the community have caused illness through witchcraft – can bring about perpetual social conflicts which can lead to more harm.

In some cases, traditional medicines might be repeatedly used but may fail to bring about relief; if this is not recognized and alternatives sought in time (e.g. specialized traditional treatments or biomedical care as appropriate), the illness is prolonged and can result in further complications.

Too much of any medicine can also be harmful, especially in cases where treatments must be administered on an empty stomach. The practice of not measuring and standardizing the dosage of traditional medicines is therefore a potentially dangerous one.

Some in the community are also known to deliberately inflict harm on those whom they dislike or have conflicts with by secretly poisoning them, often with poisonous plants.

It is noteworthy that certain women's cultural health practices that have been identified as problematic by the biomedical community, were rarely discussed by local people. In the rare instances they were raised, they were not considered as harmful.

Three types of traditional herbal treatments surrounding pregnancy and childbirth with potentially severe side-effects are recognized by the biomedical community:

Traditional abortifacients: Studies have documented the widespread use of traditional abortifacients (often obtained secretly through family networks); because of the secretiveness surrounding their use, their possible side effects of these remain unknown.

Child-delivery labor facilitating treatments: various herbal products are used to facilitate labor and speed up child delivery (these are dubbed 'traditional pitosin' by local biomedical practitioners). Such products are commonly misused (e.g. administered in excessive amounts) thus leading to serious complications such as rupturing of the uterus.

Herbal products used in cultural practices surrounding sexual activity: The use of herbs (as well as other products) as vaginal drying agents is a common practice in Malawi and has been reported in several other African countries. The use of such agents may increase women's risk of HIV or other STD infection when these practices result in genital irritation and inflammation (Kun, 1998; Shaba, *Pers. Com.*, 2004). The mixed gender FGD in Jombo provided an opportunity to discuss this issue at length. Both men and women FGD participants who initially appeared completely unaware of the likely negative consequences of this practice expressed appreciation of the explanations and insights offered, but stopped short of proposing any solutions for preventing them.

Reproductive health education and disease prevention initiatives can only be effective if they take such culturally-ingrained practices into account and approach discussion of their likely drawbacks in a culturally sensitive manner (Kun, 1998). In this connection, it is important to note that in all three communities the existence of indigenous women's groups known as *namkungwi* was reported; these may well have a role to play in disseminating pertinent information on reproductive health. Traditionally, such groups comprise several, often well-recognized older women residents, whose main task is to oversee the initiation of young women into adulthood. When a young woman comes of age, *namkungwi* members are responsible for counselling her about married life and her expected social conduct, and notably, introduce her to vital issues pertaining to sexuality and reproductive health.

It appears, however, that these groups convene only on the occasion of an initiation in the village, remaining as largely inactive informal networks at other times. According to informants, it is also common nowadays to have similar church-based women's groups guided by Christian values, as an alternative to the *namkwanjwi* grounded in indigenous spiritual and ritual practices.

Despite this there may be opportunities for strengthening, formalizing and building on both such groups with a view to fostering women's empowerment. With appropriate backing, they can serve as conduits for disseminating vital health promotive information which can help improve the beneficial aspects of traditional health practices and affect positive change in those found to be problematic or no longer relevant (see Hickey, 1997).

1.5. Complementarity of modern traditional medicine

The traditional practitioners interviewed expressed appreciation of biomedical methods (especially diagnostic capabilities) and therapies, viewing them as essentially complementary to traditional forms of health care. For the most part local people concur with this view.

1.6. Christianity and traditional medicine

Christianity is the dominant religion in all three communities. In the Mpemba village alone there are five churches of different Christian denominations. The practices of traditional diviners or *sing'anga* are generally not accepted by church teachings. Historically, the practices of the *sing'anga* have historically been branded as witchcraft by Christian missionaries and this message appears to have had an impact on local people's ambivalent perspectives regarding traditional medical practices. Although those who identify themselves as church members may on occasion consult *sing'anga*, they generally tend to do so covertly. In Mpemba, the village chief's brother who initially introduced himself as an *ofunamankhwala*, later revealed that he is, in fact, a *sing'anga* and possesses divinatory powers which he chooses to keep secret. As an active member of his church, he accepts that he cannot serve openly as a *sing'anga*, as the spiritual beliefs underlying his divinatory powers are not compatible with the church's teachings. He explained however that the church is more accepting of *ofunamankhwala* who simply provide herbal medicines to those in need.

But not all *sing'anga* encountered perceive contradictions between traditional divinatory practices and Christian teachings. For example a *sing'anga* –herbal vendor interviewed at Likuni market, attributed the acquisition of his divinatory powers to special dreams which in some instances directed him to particular verses in the Bible.



Jombo: one of several local churches;
Background: naturally vegetated areas where many locally used medicinal plants are said to be found

1.7. *Traditional preventive practices*

There appear to be few preventive home-based remedies or traditional health practices among the study communities. With the exception of a preventive ante-natal herbal treatment provided by TBAs to protect against eventual pregnancy complications, no prophylactics or other preventive treatments provided by traditional specialists were reported. It should also be noted that few local food plants appear to be specifically recommended for the diet of pregnant women, the only ones reported were cultivated species, such as pumpkin leaves (believed to be 'good for the blood') and turnips.

2. The Knowledge-base: distribution and transmission of traditional health/medicinal plant knowledge

2.1. *Different levels /types of knowledge and main knowledge sources*

Local people in all three study communities, generally distinguish between three different levels of traditional health knowledge and practice: (a) knowledge held by ordinary men and women pertaining to widely available medicinal plants used as home-based treatments for a limited number of common ailments; (b) knowledge that is relatively less widespread (often pertaining to treatments for a limited range of common health problems) and is generally restricted to individual families; and (c) the specialized knowledge and practices of well-known 'community herbalists' or particularly knowledgeable individuals known as '*ofunamankhwala*' (lit. one who searches for plant medicines), who hold knowledge of herbal treatments for a discrete number of relatively more serious conditions. It is noteworthy that the *ofunamankhwala* (who are themselves often ordinary farmers), are generally viewed as distinct from the *sing'anga* or spiritual traditional health practitioners. As indicated above, the latter are believed to possess special divinatory powers which enables them to can diagnose and treat a potentially unlimited range of conditions. It appears that services of the *sing'anga* are generally sought for conditions believed to be caused by 'human agents' rather than illnesses perceived as having naturalistic causes.

Ofunamankhwala and sing'anga

In each village there are a number of well-known *ofunamankhwala* who acquire their specialized knowledge of traditional plant medicines in a variety of ways. They often concentrate their efforts on the treatment of a discrete set of 'serious' conditions, for which they are widely recognised as having special expertise. By contrast, a generally much larger range of conditions (albeit, generally relatively minor) are treated at the household-level. In general, there appeared to be fewer *sing'anga* operating in and around the study communities.

In all three study communities, participants believed that *sing'anga* and *ofunamankhwala* derive medicines from many of the same plants known to ordinary people. However, it is also notable, that the specialists interviewed cited a few plants, which were not mentioned during the focus group discussions.

Female *sing'anga* are generally more trusted by men of Mpemba, who generally seem to view women as more honest than men. As one FGD participant put it, "...a female *sing'anga* is likely to give you the correct medicine; if it is a man, however, he'll usually try to swindle you!"

It appears that many herbal treatments prescribed by specialists are composite treatments, comprising products of several different medicinal plants, while those most widely used among ordinary local people tend to be simpler single-plant preparations.

Notably, all the professionals interviewed had relatively extensive travel experiences (compared to ordinary community members) which they said enabled them to benefit from exchanges with experts in other regions.

Traditional birth attendants (TBAs)

Some examples of local medicinal plants used by TBAs to treat various peri-natal complications are shown in Table 7.

Table 7. MEDICINAL PLANTS USED IN PRE/POST-NATAL CARE CITED BY TBAs

LOCAL NAME	SCIENTIFIC NAME	PLANT PART USED
bamboo	<i>Oreobambus</i> spp.	stems
chipembere	<i>Catunaregam spinosa</i> (Thunb) Tir	roots
mkuwikuwi	<i>Cucumis hirsutus</i>	roots
mbwabwa	<i>Cussonia arborea</i> Hochst ex. A Rich	[not disclosed]
mpoza	<i>Annona senegalensis</i> Pers.	bark

It is noteworthy that not all deliveries that do not occur at a modern health facility are handled by traditional birth attendants. While the assistance of experienced TBAs is preferred and often sought, study participants noted that (especially in urgent cases) many deliveries occur at home (often under the supervision of a closely related older woman, e.g. mother, mother-in-law, aunt etc.). As such, among closely related women, child-delivery can be dealt with through a mutual support network, in which the necessary practical skills are acquired, developed and transmitted through observation and participation.

Herb vendors at local markets

Four local market centres were visited during this study: Likuni market, Mzuzu central market, Blantyre central market and Chadzunda market (approx. 12 km from Mpemba). Surprisingly no herbal vendors could be found at the Chadzunda roadside market. A vegetable vendor at the market informed us that there were usually a couple of stalls of herbal medicines on Saturdays but the vendors had been coming rather sporadically over recent weeks. It was thus decided to visit the Blantyre central market instead.

In general, local herbal vendors appear to have a more extensive medicinal plant knowledge than ordinary local men and women. Indeed, four of the six herbal vendors interviewed identified themselves as *sing'anga*. It is also notable that all those encountered described this occupation as their main source of livelihood.

According to informants in all three study communities, medicinal plant products typically available at local markets include:

- (a) those that are gathered from distant wild areas/forests; and
- (b) those no longer readily available locally, e.g. *kakome* (previously readily available in Mpemba area but has disappeared in recent years, due to over-harvesting for charcoal production).



Herb vendor at Likuni market (Rural Lilongwe) displaying wide array of medicinal plant products dominated by roots



Herbal products at Blantyre market

Marshall (1998) noted that countries, such as Malawi and South Africa supply certain wildlife-medicinals to neighbouring countries. According to Mr. Gangire Phire, Chairman of the Herbalist Association of Malawi, at present international trade of Malawian medicinal species remains relatively small-scale, and is dominated by individual plant collectors and traders who travel between Malawi and neighboring countries in search of saleable medicinal plant products. This observation concurs with the information obtained from interviews with the herbal vendors.

2.2. Gender differentiation of knowledge and decision-making

Special attention was paid to significant gender differences which were recorded throughout FGD sessions and especially during the ranking exercises.

In all three study communities, there appeared to be significant overlap between the most pressing health problems cited by women and men, including (wherever applicable) the appropriate home-based plant remedies used to treat them. Most women participants identified themselves as being the first to diagnose symptoms of illness at the household level. While men and women appeared to possess a comparable breadth of knowledge regarding the most commonly used traditional treatments, there was one notable exception: men generally tended to say very little about women's health problems and did not appear to be familiar with the traditional treatments mentioned by women.

Gender differences noted in the various aspects of medicinal plant knowledge and use are highlighted below:

Illness diagnosis

The first step involved in medicinal plant use is identification of the particular condition or symptoms to be treated. Among the study communities, illness diagnosis appears to be a concerted effort in most cases. Both men and women informants indicated that the characterization of symptoms usually draws on the collective experiences and opinions of the adult members of a household. Often, the 'second opinion' of others outside the household who may have had relevant previous experiences are also sought (e.g., neighbors who are often also close relatives, as well as other close acquaintances). The empirical nature of traditional health knowledge is

perhaps most evident at this stage, as the opinions and recommendations of close associates who claim specific prior experience with similar cases, are generally given the most weight. While consultation appears to be the generally preferred procedure, conditions and symptoms deemed relatively common and 'unambiguous', can be routinely detected and treated by individuals with little discussion. It is noteworthy that there is reportedly extensive consultation of this type in assessing unfamiliar symptoms and often in determining that a particular condition has been caused by witchcraft. (*see also similar findings elsewhere in Africa, Fassil, 2003*).

As primary care providers at the household-level, women affirmed that they are often the first to observe symptoms of illness in children. For relatively common symptoms, such as 'stomach cramps' – for which the most widely used treatments tend to be fairly simple, single plant preparations – women noted that they would routinely assess the condition and administer the appropriate treatment on their own. Men in Jombo were the only ones who explicitly and unanimously agreed to this claim. They observed that especially in cases of sudden onset of illness, women are the first to generally diagnose the problem and often independently collect, prepare and administer traditional treatments at the household level. One young man went as far as saying: "*Let's be honest... our women are the ones who do almost everything!*" None of his fellow focus group members disagreed!

Plant identification, collection and treatment preparation and administration:

Knowledge and skills pertaining to plant identification and collection do not in most cases appear to be differentiated by gender. The task of plant collection is one that depends on: (a) who in the household is ill; (b) how the illness is perceived and the type of treatment deemed necessary; and (c) whether the required medicinal plant is readily available in the vicinity.

In Chala village women indicated that they, rather than their husbands, would often be the ones to gather the medicinal herbs required. However, men may also take on this task on occasion, especially when the woman of the household is the one who is ill, or when they are more familiar with the treatment required (i.e., the particular botanical identity, growth habit and application of the required medicinal plant); or when the plant required is found only in distant areas.

Decision-making at the household-level

There were also differences in the perceptions of men and women regarding their respective involvements in household decision-making surrounding health. During the separate men's FGD sessions, local men, who generally have more control over household assets and resources, claimed that they maintain more power during all critical household decision-making, including in the area of health. Clearly, women who are household-heads will, in principle, have much more control on how household resources are allocated than married women. While married women may take the initiative to use home-based treatments and other traditional treatments available free of charge (e.g., for treatment by a knowledgeable neighbour or relative), they are generally expected to consult with their husbands before purchasing any treatments (traditional or biomedical) or paying for transportation to obtain treatment.

But local women tend to view the power balance differently. For example, women in Jombo (both married and widowed/divorced household heads) reported that they have considerable decision-making influence over matters pertaining to health care choices at the household level. Indeed, most were convinced that they were the final arbiters in this respect. This is despite the fact that in most cases women do have to obtain money for paying for specialized (traditional/biomedical care). In their view, the fact that they have to consult with their husbands in order to obtain money, does not diminish their decision-making power. On the other hand, men are adamant that they are the ultimate decision makers and their wives merely act on the decisions they make. This observation concurs with the findings of other similar studies in Malawi (Courtright, *et al.*, 2001).

2.3 Local valuation of traditional health knowledge: source of income and social esteem

Both male and female study participants generally demonstrated considerable appreciation for their local heritage of traditional health knowledge/skills. Indeed, they often made reference to the monetary value of their knowledge and medicines:

- One key informant, Lunya Staniel (elderly female resident, Chala) reported: “We tend not to disclose our knowledge of medicines to others in the community as it serves as a supplementary, although small, source of income.” Most families have a secret medicine. The cultural term *chitsyuka maso* (lit: “[for soap] for washing your face”) is used to refer to cash payments or in kind compensation for medicines provided by a knowledgeable community member.
- Another interviewee, Amuthe (Village Headman and *ofunamankwala*, Chala) reported: “We do not divulge our specialized herbal recipes as many of us often have had to pay to acquire our knowledge. Some of the medicines I know I learned through exchange with others, some I ‘purchased’ during my travels to South Africa as a migrant mine worker”.
- The Mpemba Village Chief’s brother (a clandestine *sing’anga*) claimed to have paid a substantial sum to acquire his knowledge and divinatory powers.

Those recognized as *ofunamankwala* and *sing’anga* are also esteemed for their knowledge and treated with a degree of reverence.

2.4 Medicinal plant knowledge as private property and the culture of secretiveness

A ‘culture of secretiveness’ surrounding the knowledge and use of traditional herbal remedies was observed to varying degrees among the different study communities. Especially in group settings, some participants appeared reluctant to share knowledge of various home-based herbal treatments for fear of losing some modest (usually, in kind) payment for providing traditional herbal treatments to neighbors and fellow community members in need. While the need for systematic documentation of traditional health knowledge and herbal recipes could be readily appreciated, this culture of secretiveness makes this a particularly problematic area for intervention.

Men in Jombo were the most reluctant to discuss their knowledge of traditional herbal preparations in the focus group discussion setting. As one participant put it: “This medicinal plant knowledge each of us guard, is our means of getting an extra chicken!” Most of those who volunteered or accepted the group’s nomination to participate in individual interviews, were, however, found to be remarkably open and eager to share their knowledge of various traditional treatments.

Secretiveness, surrounds particularly the following:

- valued special personal/family herbal recipes;
- treatments used for ‘socio-culturally unacceptable’ procedures (e.g. abortifacients);
- secretiveness of *sing’anga* who choose to keep their divinatory powers under cover;
- secretiveness of women/men about love-potions and gender-specific traditional treatments to remedy; sexual dysfunction or plant products with aphrodisiac properties; and
- secretiveness about treatments used for stds.

Sing’anga Shaba of Jombo, for example strongly supports the idea of documenting traditional plant derived medicines. He believes that by being open about their traditional medicinal plant knowledge, especially with researchers and organizations such as MASAF, traditional specialists like himself and local people can focus attention on and improve appreciation of the value of their traditional knowledge and practices. He observed that this can only ultimately benefit the community. Not very many appear to share his sentiments however.

As another *sing’anga* put it: “Those who have ‘inherited’ their knowledge of particular herbal recipes from their parents consider this knowledge their private property, “..like their clothes..” or other such personal effects. It is therefore, only natural that they should seek to safeguard it by keeping it secret.

Paradoxically, some of the specialist traditional practitioners (often known to be especially secretive about their *materia medica*, upon which they depend for deriving income), were found to be remarkably more open with their knowledge, and showed no reluctance in divulging detailed herbal recipes.

2.5 Main sources and transmission of knowledge

Among the differences between home-based and specialized traditional medicine is also the mechanism through which the relevant knowledge and skills are acquired. The skill for the preparation and application of most home-based plant-derived medicines, is often acquired from parents or close relatives. Specialist *ofunamankwala*, acquire their knowledge through more extensive exchanges with other knowledgeable persons (often encountered while travelling to distant areas), while *sing'anga* generally say that they acquire their divinatory powers and plant knowledge through 'spiritual intervention'.

Moreover, as specialist practitioners generally do not disclose the identities of the specific plants used to prepare medicines, their lay clients usually have little knowledge about them. Specialist traditional health practitioners also typically keep a diverse stock of medicinal plant products at hand, whereas storage of medicinal plant parts for future use is a rare practice among ordinary community members.

During discussions about the transmission of traditional medicinal plant knowledge, some older residents in Jombo, lamented that young people are generally not interested in learning about traditional treatments as they think of traditional medicine as 'a thing of the past'. In particular, those who have had some formal schooling, generally prefer to seek health care at a modern health facility or purchase modern drugs when needed. In the light of the above, the initiatives taken by individual community members to record their traditional medicinal plant knowledge (made possible by the high levels of literacy in Jombo) can be viewed as a highly auspicious development, worthy of support.

Also encountered was the view that some traditional practices and treatments are not sufficiently 'modern' or have become obsolete, especially where effective biomedical alternatives have been introduced and have gained wide acceptance. A prime example is the use of the *mpungabwi* plant to ward off mosquitoes. In Jombo (where pertinently, literacy was the highest and local people appeared more influenced by urbanization), participants in the mixed FGD session were generally dismissive about the usefulness of *mpungabwi*, even when it was suggested to them that it might prove to be an effective complement to the use of 'modern' bed-nets. Whereas they acknowledged that *mpungabwi* was widely used in the past and is still in principle viewed as an effective measure, the availability of mosquito bed-nets (deemed even more effective, and convenient by most) has meant that the plant is rarely used by Jombo residents for this purpose. They explained that the use of *mpungabwi* was not deemed in line with '*chitukuko*' (which in Tumbuka, lit. translates as 'modernisation' or 'development'. When asked whether they would consider using an improved '*mpungabwi* mosquito-repellent', were it possible to produce it in a spray-can form through laboratory research of extracts from the *mpungabwi* plant, study participants responded in the affirmative unanimously and with great enthusiasm.

It is notable, however, that inhabitants of Chala and Mpemba, where only a minority reportedly have access to bed-nets, do still use the *mpungabwi* plant for mosquito control.

3. The Plants: classification, supplies and use patterns

3.1 Overview of the medicinal plants inventory

On average, about 20-30 commonly used medicinal plants were cited in each of the communities. In collaboration with experts at the *National Herbarium and Botanical Gardens* (Zomba, Malawi), the scientific botanical identities of most of these species could be determined (at least to the genus level) using photo images of the plants collected throughout the fieldwork. Many of the most popular plant remedies are derived from native trees. The continued availability of such species is increasingly endangered by ongoing land-clearing, deforestation and in some cases, over-harvesting.

While the main focus of this study was on traditional herbal medicines, a relatively limited range of wild or semi-domesticated vegetables were also cited among the local plant species recognized as having health protective benefits. Among these, are plants which are often used during times of food shortage.

The local names, corresponding scientific designations⁷ and specific applications of 70 plant species (representing 44 families) of medicinal value were recorded throughout this study. This is clearly indicative of the wide range of plants in use among the study communities. A comprehensive compilation of the traditional applications medicinal plants cited by at least two different individuals or groups of informants is provided in **Appendix IV**.

It is notable that all of the treatments mentioned are derived from plants viewed as being relatively abundant and are readily available in the local area.

It is important to note the limitations of this plant catalogue which is only intended as a preliminary index:

(a) the specific identities of some plants (those which could not be photographed) have yet to be determined; for these only the local names and uses have been recorded for, wherever possible, along with suggestions of their likely scientific names derived by consulting existing key references: (Binns, 1972); (Pullinger and Kitchin, 1982); and (Williamson, 1972).

(b) biomedical interpretations of the health problems which the plants are reportedly used to treat are all tentative interpretations (arrived at through consultation of local biomedical personnel as well as the advice of the local research partner who is a trained biomedical nurse); and

(c) inconsistencies in local plant nomenclature are also problematic; in some instances, the same local name can be used to refer to different species within the same genus or even to entirely different plants; this is further compounded by the fact that many plants have entirely different local designations in the Chichewa and Tumbuka languages.

3.2 Significance of the study communities' medicinal plant repertoire

Malawi is known to be exceptionally rich in plant biodiversity. Significant differences are believed to exist in the medicinal flora within and between the Central, North and South regions (Phire, *Pers. Com.*, 2004). As such, the findings of this study are likely to represent a mere 'snap-shot' of the wide array of plant species used by local people in different parts of Malawi. It is noteworthy that a much more in-depth study carried out over a considerably longer period, yet focused solely on traditional plant medicines used to treat eye diseases in two districts of Malawi, compiled information on more than 105 plant species (Courtright *et al.*, 2001). Also of note, is that similar to the findings of the latter study, the current investigation found little overlap between the range of plants species most frequently used in each of the study communities. **Tables 8 and 9** provide summaries of the 'most popular' medicinal species used in the study communities. The 30 most highly valued plant species (as ranked by the mixed FGD participants in the three study communities) are listed in **Table 10**.

⁷ identified with reasonable confidence by experts at NHBG (NB. but based only on photo images); further work, including collection of voucher specimens would be needed to confirm identities.

Table 8: TOP TEN 'MOST POPULAR'⁽¹⁾ MEDICINAL PLANTS IN THE 3 STUDY COMMUNITIES (CONSOLIDATED LIST/ ALL RANKED EQUALLY HIGHLY)

LOCAL NAME	SCIENTIFIC NAME
chawayi (N)*	<i>Crotalaria</i> sp.
chewe; mawope (C)/(N)	<i>Sesamum angolense</i> Welw.
chipembere (S)	<i>Catunaregam spinosa</i> (Thunb) Tir.
chizutu (N) [mvunguti; sausage tree]	<i>Kigelia africana</i> (Lam) Benth
futsa (C)	<i>Veronia amygdalina</i>
jerejere (C); [njjejele]	<i>Sesbania sesban</i>
jinkha (C)	<i>Friesodielsia obovata</i> (Benth) Verdc.
katope (S)*	<i>Syzygium</i> sp.
kangaluhe ⁸ (C)/(S)*	<i>Zanba africana</i> [?]
kanufu (N)	<i>Ocimum americanum</i> L.
kasungula (N)*	<i>Asparagus</i> sp.
kaufiti (C)	<i>Striga asiatica</i> L.
likodza (C)	<i>Clerodendrum uncinatum</i> Schinz.
mbanga (S); muwanga (N)	<i>Pericopsis angolensis</i> (Bak) Van Meeuwen.
mbwaze (C)	<i>Securidaca longepedunculata</i> Fresen.
mdima; ndima (C)*	<i>Diospyros</i> sp.
moloji (N)	<i>Adenia gummifera</i> (Harv) Harms
mpoza (S)	<i>Annona senegalensis</i> Pers
mpungabwi (S)	<i>Ocimum americanum</i> L.
mtombozi (S)	<i>Diplorhynchus candylocarpon</i> (Mull. Arg.) Pichon
mtunduluka (N) *	<i>Ficus</i> sp.
mubabani (N)	<i>Cassia abbreviata</i> Oliv.
mwimbi	<i>Rauvifolia caffra</i> . Sond.
nandolo (N)	<i>Cajanus cajan</i> (L.) Millsp.
nkhadze (S)	<i>Euphorbia tirucalli</i> L.
nsolo (S)	<i>Choristylis rhamnoides</i>
ntanthanyerere (S)	<i>Senna singueana</i> Del

*(C), (N), (S) cited by study community in the Central, Northern and Southern Region, respectively
(1): 'Most popular' means those ranked as the most frequently used/most effective by participants in the mixed FGDs
[*]: indicates plants the taxonomical designation of which is uncertain (guesstimates indicated here arrived at through consultation of key published sources: [1: (Binns, 1972); 2: (Pullinger and Kitchin, 1982); 3:(Williamson,1972)].

⁸ Unfortunately, despite its popularity in all three communities, this plant was not encountered during the fieldwork, and hence, could not be photographed in order to determine its botanical identity. Its local name does not appear in any of the key references consulted. From the general description of the plant and its common application provided by informants, NHBG experts speculate that it is likely to be '*Zanba africana* (Sapindaceae)', stressing however, that this was only a very tentative conjecture (Malinichi-Nyirenda, *Pers. Com.*, June 2004).

Table 9: SUBSET OF THE 'MOST POPULAR' SPECIES CITED IN AT LEAST TWO OF THE STUDY COMMUNITIES

LOCAL NAME	SCIENTIFIC NAME
chewe; mawope	<i>Crotalaria florida</i> (1)
chizutu/ mvunguti; [sausage tree]	<i>Kigelia africana</i> (Lam) Benth
kamzota	<i>Bidens pilosa</i> L.
kangalucho	[?]
naphini/ mujoyi	<i>Terminalia sericea</i>
mfula/mbula	<i>Parinari curatellifolia</i> Planch. Ex Benth
ntanthanyele /nthantanyerere	<i>Senna singueana</i> Del.
umpoloni	<i>Steganotaenia araliaceae</i> Hochst.

[?]: taxonomical designation could not be determined.



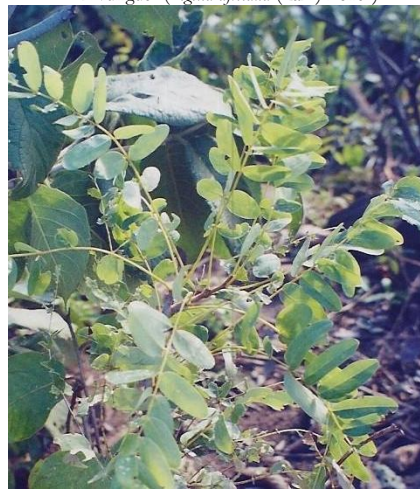
'mbula' (*Parinari curatellifolia* Planch. Ex. Benth)



'mvunguti' (*Kigelia africana* (Lam) Benth)



'naphini' (*Terminalia sericea* Burch)



'nthantanyerere' (*Senna singueana* Del.)

Table 10: TOP 30 MOST VALUED SPECIES: PLANTS RANKED AS 'MOST USEFUL' *
(ALL RANKED EQUALLY HIGHLY)

	LOCAL NAME	SCIENTIFIC NAME	PLANT TYPE	USES (OTHER THAN MEDICINAL)
1.	Bamboo (S)	<i>Oreobambus spp</i>	tree	construction, baskets/handicrafts
2.	Cederela (S)	<i>Toona cilata/Cederela toona</i>	tree	introduced species: commonly used in afforestation schemes
3.	Chewe (C)	<i>Sesamum angolense</i> Welw	shrub	traditional wild vegetable
4.	Chigwada (C/S)	<i>Manihot esculenta</i>	food crop	edible tuber
5.	Chipombola (N)	<i>Cussonia kirkii</i>	?	?
6.	Chisoyo (N)	<i>Veronia bracteosa</i>	shrub	?
7.	Chivumulo (N)	<i>Crassocephalum bojeri</i> (DC) Robyns	shrub	?
8.	Futsa (C)	<i>Veronia amygdalina</i>	shrub	fuel-wood; tooth-stick; beer brewing
9.	Guava (N/S)	<i>Psidium guajava</i>	tree	edible fruit
10.	Jinkha (C)	<i>Friesodielsia obovata</i> (Benth) Verdc.		fuel-wood; construction; maize storage
11.	Kamzota (C)	<i>Bidens pilosa</i> L.	shrub	traditional leafy green vegetable
12.	Kangaluhe (C/N/S)	[?]	tree	
13.	Kasungula (N)	<i>Asparagus</i> sp.	shrub	
14.	Katope (S) [?]	<i>Syngium</i> sp.	tree	edible fruit/ carpentry
15.	Mangana	<i>Cucumis hirsutus</i>	shrub	traditional leafy green vegetable
16.	Mango (S)	<i>Mangifera indica</i> L.	tree	edible fruit/leaves
17.	Mateme (S)	<i>Strychnos spinosa</i> Lam	tree	edible fruit
18.	Mbwaze (C)	<i>Securidaca longepedunculata</i> Fresen.	shrub /small tree	fuel-wood, construction
19.	Mkalakati (N)	<i>Turraea nilotica</i> Kotschy & Peyr.		
20.	Mlombwa (S)	<i>Pterocarpus angolensis</i> DC.	tree	construction/ carpentry
21.	Mlozi (N)	<i>Adenia gummifera</i> (Harv) Harms	tree	traditional leafy green vegetable
22.	Mpoza (C/N/S)	<i>Ammonia senegalensis</i> Pers	tree	edible fruit
23.	Mthombozi (N/S)	<i>Diplorhynchus candylocarpon</i>	tree	fuel-wood, glue
24.	Muowani (C)	<i>Cassia abbreviata</i> Oliv.	tree	multiple medicinal applications
25.	Muwanga (S)	<i>Pericopsis angolensis</i> (Bak) Van Meeuwen.	tree	
26.	Mwavi (N)	<i>Erythrophleum suaveolens</i>	tree	construction
27.	Mwimbi (C)	<i>Rauvifolia caffra</i> .	tree	carpentry; fuel-wood
28.	Naphini (S)	<i>Terminalia sericea</i> Burch ex DC.	tree	construction, carpentry (making farm implements)
29.	Ndimba (C/N)	<i>Diospyros</i> sp.	shrub	fuel-wood; construction; maize storage
30.	Ntanthanyerere (S)	<i>Senna singueana</i> Del.	shrub	edible pods
* MEDICINE AND/OR MULTI-PURPOSE SPECIES/ HIGHEST SOCIO-ECONOMIC/CULTURAL VALUE				
(C), (N), (S): identified by FGD participants in the study communities: Central (Chala), Northern (Jombo) and Southern (Mpemba) regions respectively				

3.3 Main medicinal plant types, supplies and use patterns

As noted above, most of the locally-valued medicinal plant species documented are trees.

The majority of locally-valued medicinal plants occur naturally in nearby *uchire* (uncultivated grasslands, where many native trees useful shrubs, herbs and native trees occur naturally). Local people in all the study communities generally made reference to one particularly extensive area of natural vegetation as the main source of most traditional medicinal plants. However, in some cases smaller patches of natural vegetation around the homestead, often flanking farm-plots, other times located at a distance from settlements were the main sources indicated.

Chala residents only have to walk about 20-30 minutes to find many of the plants frequently used in home-based preparations. In Jombo, smaller patches of natural vegetation flank farm-plots and some residents need only to walk a few minutes outside their backyards in search of naturally occurring medicinal shrubs, and trees. For residents in Mpemba, however, where deforestation has reportedly been the most severe in recent years, the closest '*uchire*' is reportedly about an hour away on foot.

Ongoing habitat destruction and land degradation no doubt pose major challenges to the survival and economic development of the local communities. Of particular concern to this study are the implications of these processes for the continued availability and use of traditional plant medicines. As already stated, while ongoing deforestation is a problem in all of the study communities, it appears to be one that is most pronounced in Mpemba. In Mpemba, FGD participants and key informants expressed great concern regarding the impact of this widespread practice on their local environment, citing the increasing scarcity of certain locally-valued indigenous trees. At the same time, they also lamented the lack of viable income-generating alternatives.

Some of the medicinal trees cited were noted as becoming increasingly scarce, especially because they are also favored as sources of fuel-wood.

Cultural practices in support of biodiversity conservation

Certain cultural practices and taboos, such as the protection of plants occurring in and around graveyards can also be viewed as effective traditional mechanisms for safeguarding plant biodiversity. Community burial sites are typically distinguished by thick groves of indigenous trees and natural vegetation, often including medicinal species. Cutting down any trees or plants from these 'traditional reserves' is deemed disrespectful to the deceased and hence, prohibited. It is notable that this restriction is observed by all, even under high population densities and considerable demands for arable land.

Within the precinct of their communities, village chiefs also prohibit the clearing of certain natural areas for cultivation. However, fuel-wood is often obtained from the same 'reserved' natural grassland area. Local people recognize that, in the absence of regular replanting or non-destructive harvesting methods, this is not sustainable and can lead to losses of valuable medicinal species over the long-term

Most frequently used plant parts

The particular plant part which is valued therapeutically often has important implications for the continued availability of naturally occurring species. Harvesting of aerial parts such as leaves, shoots and branches can often allow plants to regenerate. On the other hand, conservationists recognise that natural populations of particularly popular medicinal plants, primarily valued for their root parts, as well as those which are intensively harvested for their bark, often tend to be the most threatened by over-exploitation (Sheldon *et al.*, 1997).

The most frequently cited therapeutic plant parts were the roots and bark. Some highly valued medicinal species are also threatened by unsustainable (bark or root) harvesting practices. For example, the *mmavi* tree (included in **Table 10**) which is valued as a source of a diversity of medicines is known to have disappeared from certain forest reserves elsewhere in Malawi (FRIM, 2003).

The development of practical guidelines for sustainable bark/root harvesting of such species and even more pertinently, the documentation of traditional knowledge pertaining to useful safe plant collecting methods are among the objectives of an ongoing research project being implemented by the Forest Research Institute of Malawi (*op. cit.*).

Table 11: TOP 10 MEDICINAL PLANTS RANKED AS ‘SCARCE’ OR ‘BECOMING INCREASINGLY SCARCE IN LOCAL AREA

	LOCAL NAME	SCIENTIFIC NAME	PLANT TYPE	CORROBORATED BY SPECIALIST TRADITIONAL PRACTITIONERS
1.	Katope (S)	<i>Syzygium</i> sp. [?]	tree	--
2.	Kangaluche (C/N/S)	[?]	tree	--
3.	Kapanthi (N)	<i>Manihot glaziovii</i> Muell. Arg	tree	--
4.	Mateme (S)	<i>Strychnos spinosa</i> Lam	tree	--
5.	Muwanga (S)	<i>Pericopsis angolensis</i> (Bak) Van Meeuwen.	tree	(Chipangola, <i>Pers Com</i> , 2004)
6.	Mlombwa (S)	<i>Pterocarpus angolensis</i> DC.	tree	(Phire, <i>Pers. Com</i> , 2004)
7.	Muowani (C)	<i>Cassia abbreviata</i> Oliv.	tree	(Phire, <i>Pers. Com</i> , 2004)
8.	Naphini (S)	<i>Terminalia sericea</i> Burch ex DC.	shrub	--
9.	Nkhalanjiwa (N)	<i>Ilex mitis</i> ⁽¹⁾ [?]	?	--
10.	Nsolo (S)	<i>Choristylis rhamnoides</i>	shrub/small tree	--

***(C), (N), (S):** identified by FGD participants in the study communities: Central (Chala), Northern (Jombo) and Southern (Mpemba) regions respectively.

Table 11 provides a compilation of the most ‘threatened’ medicinal species identified through the FGDs in the three study communities. An important caveat to this list, is that most people tend to be most familiar with and rely most heavily on plants which occur in their immediate local surroundings and as such, may often not be aware that certain species that might be difficult to find in their neighborhoods might occur abundantly in not too distant areas. Indeed, as noted by other studies (Courtright *et al.*, 2001), in some cases, a plant thought to be scarce or rare in one village may well be found to be readily available in the next.

On the other hand, it is worth noting that scarcity (throughout Malawi) of three of the trees on the above short-list was corroborated by two prominent *sing’anga* (the chairmen of two main national traditional healers associations).

- ‘muwanga’ (*Pericopsis angolensis* (Bak) Van Meeuwen);
- ‘mlombwa’ (*Pterocarpus angolensis* DC.); and
- ‘muowani’ (*Cassia abbreviata* Oliv.).⁹

Given that these species were also included among those with high local socio-economic/cultural value (see **Table 10**) it may well be worthwhile to consider their prioritisation in afforestation initiatives.

⁹ ‘muowani’ was also cited by a herbal vendor/*sing’anga* at Likuni market who said that he currently has to travel to a different district (Madisi) to obtain roots of the plant, whereas the plant was previously readily available in the local area.



Modes of treatment, preparation and administration

Water decoctions (prepared by simply simmering larger pieces of the herb, such as bark, roots, in a pot of water) and cold infusions (diluting the juice extracted from crushed fresh leaves with water) are the most commonly cited types of herbal preparations. Many herbal treatments are also mixed with food, especially maize porridge.

Another commonly cited practice worth noting is the rigorous scratching-bleeding (believed to facilitate absorption of the medicine) that often precedes topical application of treatments for various skin infections such as 'mphere'.

Cutting, i.e. making incisions on the body (using a razor blade) into which herbal medicines are applied directly into the blood stream, is also common practice for the treatment of acute localized pain (rheumatic pain, back-aches, severe head-ache/migraine). Participants in the women's FGD in Chala village noted that most prefer this traditional treatment procedure for pain relief rather than going to the health center where they believe injections (paradoxically, dreaded by most) are likely to be prescribed. Pain relief treatments (most notably, that derived from a plant known as *kangalucho*), administered using the cutting method are deemed among the most effective traditional medicines. Some recognize that the cutting method can often result in excessive blood loss. Despite this, the practice continues to persist among men and women in all three study communities and appears to be especially favored by older residents.

3.4 Wild food plants and traditional vegetables

As noted earlier, this study also sought to compile information on locally-valued traditional wild vegetables and fruit species. Those mentioned are listed in **Table 12**. Invariably, however, informants would simply cite these species, but had little to say about their specific nutritive and health benefits (other than generally describing them as 'good foods') except in cases where they have specific medicinal applications. Both the focus group discussions and key informant interviews elicited more interest and hence, more information on medicinal plants. Many traditional vegetable and fruit species have already been well-documented in Malawi (*see, e.g.* Williamson, 1972). A number of traditional leafy vegetables remain popular even among urban communities, commonly grown in urban home-gardens, and often available at urban markets. Among the rural communities however, such plants appear to be taken very much for granted. Some of the species such as *chene* (leaves eaten as

vegetable side-dish or '*ndvivo*'; also has some specific medicinal applications) can be commonly seen growing on farm borders and roadsides, with no apparent efforts to manage and protect them.

Table 12: LOCAL NAMES OF SOME WILD, SEMI-DOMESTICATED AND CULTIVATED TRADITIONAL FOOD PLANTS RECORDED IN THE STUDY COMMUNITIES

bonongwe (bereketi)	mfula
chewe (nyolo-nyolo; mawope)	mlozi
chidwokho	mphulula
chisoso	mpoza
fwifwi /mamun alungome)	ndwozi
guava	njenje
impiru (turnips)	nthuza
kabata	papaya
kankhande	psipsa
katope	telele
masuku	tengere
mavilo	uchi
maye	yembe [mango]



'chewe' / 'mawope' (*Sesamum angolense* Welw.): locally-valued as food and medicine

Finally, it should be mentioned that while the importance of traditional knowledge pertaining to the use of medicinal plants was well-acknowledged during all the FGD sessions, participants invariably brought up other issues both directly and indirectly related to health, such as the problem of food insecurity, which they viewed as areas where interventions were required much more urgently. For example, a member of women's discussion group in Jombo, who requested to make a concluding remark at the end of the session, stressed that whereas, the discussion had been useful for all involved and raised participants' awareness about a number of important issues, the most pressing concern faced by the community at the moment was chronic food insecurity and the looming threat of hunger as a result of maize crop failure during that season: "*How can we even worry about health or walk to the 'chipatala' to get treatment if we are already so weak because we do not have enough to eat? What can MASAF do to help us with that?*" she asked.

Indeed, such remarks, and the ability of local people to identify and clearly vocalize their most pressing concerns further supports the necessity and effectiveness of MASAF's community-demand driven approach to development. Subsistence and food-security concerns consistently tend to outweigh the priority given to health protection and disease prevention measures, the results of which are often not as tangible or as immediately evident (e.g., as in the case mentioned earlier, about the use of malaria prevention mosquito bed-nets as fishing nets).

4. Community-identified priorities: areas for possible MASAF intervention

During the final mixed gender FGD sessions in each community, participants were first presented with a list of possible interventions in support of health in general, and traditional health knowledge and practices, in particular. To these, they were asked to add other priorities. They were then asked to rank the importance of each item on the consolidated list relative to all other possible interventions.

Table 13 provides a summary of the results from these sessions, highlighting the interventions which were unanimously assigned the highest ranking score. There is considerable commonality between the types of activities deemed most of highest priority in each community.

Invariably, construction of more boreholes (or rehabilitation of ones that exist) featured among the most pressing needs identified. There was also strong support for planting medicinal species, but only through afforestation schemes which give special priority to multipurpose species. Such schemes were consistently ranked higher than the ‘establishment of community medicinal plant gardens’ – an item that was included in the original list of proposals. The latter did not feature among the highest priorities in any of the communities. Among those consistently ranked lower were:

- systematic documentation of traditional medicinal plant knowledge/ herbal recipes (mainly due to the culture of secrecy surrounding medicinal plant knowledge, discussed earlier);
- improvement of methods for measuring dosage of traditional medicines (although there were a few individuals who felt particularly strongly about this, the groups as a whole did not rate it as a main priority);
- incorporation of study of traditional medicinal plants/ awareness of value of traditional medicine into primary school curricula (this was generally considered a ‘nice idea’ but most were sceptical about its practical usefulness); and
- training of mothers to better diagnose disease (e.g., malaria in children).

4.1 Community-identified requirements for tree planting

Chala community members, and particularly the men focus group participants (including the Group Village Chief) who were particularly keen about tree planting, went even further in articulating their particular requirements for undertaking such an initiative, *niŵi*:

- support for acquisition of tools and supplies: hoes, wheel-barrows, seeds/seedlings, fertilisers;
- technical training in plant propagation methods; and
- watering and irrigation systems.

4.2 Malaria prevention programs

While malaria was identified as among the most pressing health problems, ‘malaria prevention programmes’ were ranked highest only in Jombo, where paradoxically, protective mosquito bed-net use is almost universal. This may well be because local people’s experience with the use of bed-nets may have enabled them to appreciate the benefits of malaria preventive strategies. ‘Malaria prevention programmes’ were also ranked relatively highly in Chala and Mpemba, although it did not feature among the highest priorities. It is noteworthy, that in Mpemba plans are underway for introducing bed-nets through the drug revolving fund (DRF) programme.

Table 13: COMMUNITY-IDENTIFIED PRIORITIES & POSSIBLE INTERVENTIONS FOR MASAF SUPPORT
(ALL RANKED EQUALLY HIGHLY)

POSSIBLE INITIATIVES FOR MASAF SUPPORT			
	CHALA	JOMBO	MPEMBA
	Clean water supplies: boreholes <i>(including rehabilitation of existing borehole)</i>	Clean water supplies: boreholes	Clean water supplies: boreholes
	Planting trees/afforestation schemes prioritizing native multipurpose trees, especially those with medicinal value <i>(including training in plant propagation methods, assistance with tools/supplies)</i>	Planting trees/afforestation schemes prioritizing native multipurpose trees, including those with medicinal value	Planting trees/afforestation schemes prioritizing native multipurpose trees, including those with medicinal value/ <i>(including forest protection measures: guards/restrictions on cutting down trees)</i>
	Training of village TBAs	Training for village TBAs	Training for village TBAs + <i>construction of child delivery center</i>
	Construction of a village (biomedical) health centre	Improved access/supply of modern medicines + expansion of services provided by under-fives health centre (including more trained biomedical staff)	Road construction <i>(*under-fives clinic currently being constructed through support of local NGO – Malawi Hunger Project)</i>
	Health education programme (e.g. hygiene / HIV/AIDS prevention) Alternative income generation activities	HIV/AIDS orphan care programme Malaria prevention programme	Alternative income generation activities (e.g. loans for carpentry establishment of community maize mill) – <i>*recognised as the only viable way to stop deforestation</i>

4.3 Improvement of biomedical services

Also, in Jombo, where an under-fives health clinic has already been constructed through MASAF support, (recently supplemented by the construction of child-delivery center next door) community demands appear to have shifted from physical infrastructure to the scope and quality of actual services provided (i.e., to more medicines, trained staff/services).¹⁰

4.4 HIV/AIDS orphan care programs

Support for the establishment of a community HIV/AIDS orphan care program was independently raised by FGD participants in both Jombo and Mpemba. (Such a programme already exists in Chala, linked with the Maize Mill project). The design of such programmes allows for a great deal of flexibility and innovation. There is strong local support for them and, as discussed in the next section, may provide a good entry point for initiatives aimed at promoting traditional health knowledge.

4.5 Other non-health initiatives

The participatory ranking exercise proved most challenging in Mpemba (Southern Region) community which, to date, has not benefited from MASAF support. There were many competing demands, and it was difficult for participants to reach a consensus regarding their relative importance. There was one instance in which a participant expressed his reluctance to rank 'documentation of traditional medical knowledge' as a high priority because he feared that this might detract attention from the much needed health center that was also ranked among the most pressing community needs. All agreed however on the two most pressing problems faced by their community:

- (a) severe ongoing deforestation (hence, land degradation and attendant losses of many valuable species) mainly due to ever-growing reliance on charcoal production; and
- (b) the lack of roads (which renders access to the community extremely difficult especially during the rainy season).

Road construction and afforestation, accompanied by controls on the use of forests and natural vegetation, were thus, greatly emphasised. Both men and women participants viewed alternative income-generating activities as a key way of arresting deforestation. They cited skill-building and micro-financing schemes for carpentry and handicrafts/basket-ware production, by men and women respectively, as potentially viable programs. Perhaps more so than in the other study communities, FGD participants in Mpemba tended to be more concerned with basic developments which fall outside the 'health' sphere, viewing these as essential prerequisites to all other developments.

¹⁰ This shift in demand affirms the appropriateness of MASAF III's current focus. Recognising that much emphasis was placed on construction of health facilities during the first two phases its programme implementation, MASAF has prioritised improvement of the quality of services provided by health facilities in its strategic plan for the implementation of its current phase.

VII. MAIN CONCLUSIONS AND LESSONS LEARNED

1. Main conclusions

The main conclusions of this study are outlined below.

1.1. Consistent with findings elsewhere, home-based plant-derived traditional treatments constitute a significant aspect of ordinary local people's routine health care efforts in Malawi. Among the study communities, such treatments are sought more frequently than the services of specialist local traditional healers or biomedical health facilities.

These basic findings counter the underlying assumptions of ongoing national research and development strategies and policy frameworks, which, to date, have focused mainly on the expert knowledge of specialist traditional practitioners. The traditional health knowledge and practices of lay people in local communities have largely been disregarded.

The study's findings are also supportive of a perspective which regards ordinary people's knowledge and use of such traditional home remedies, not only as a fundamental part of 'traditional' health care, but as an integral aspect of a much broader and evolving amalgam of local cultural health knowledge. Thus, local health knowledge is viewed not simply as that which pertains to the use of 'traditional' home remedies, but as the totality of local people's evolving cultural perspectives regarding the causes of different illnesses and their experiential understanding and use of both specialised traditional and biomedical treatments available to them.

1.2. It could be readily appreciated from the clear differentiation of traditional gender roles and responsibilities among the study communities that local women are indeed the principal providers of health care (i.e., in the broadest sense: sanitation, nutrition, childcare) at the household level. But when it comes to the diagnosis and treatment of specific health problems using home-based plant medicines, their roles were found to be most pronounced only in the realm of maternal and childcare. There were indications that local women were the most familiar with such treatments, although the range of traditional medicinal plants used specifically for pre-post-natal care appeared relatively limited.

The home-based diagnosis and treatment of the wide range of conditions affecting adults, however, do not appear to be the specialised domain of either women or men. Hence, it appears that local women's greater traditional responsibility in the provision of care at the household-level, in itself, does not necessarily translate into quantitative differences in knowledge, i.e., women having knowledge of a considerably greater number and variety of medicinal plants than men, but rather, perhaps, in more in-depth knowledge and practical experience with particular *aspects* of medicinal plant use and the handling of particular health problems. It was also noted however, that women are likely to have greater practical experience and skills with regard to the preparation and administration of those plant treatments requiring considerable processing.

While women are usually the first to recognise and treat symptoms in children, it appears that diagnosis of most other common ailments affecting adults can be undertaken by either men or women, as can their home-based traditional treatment (if deemed the appropriate action), which often involves the use of simple formulations requiring little processing.

1.3. As a more general conclusion, it should be emphasised that the reliance on traditional plant remedies for certain illnesses, does not necessarily imply a sound local understanding regarding their root causes and modes of transmission. Indeed, the need for community health education is paramount with respect to all of the leading health problems in the study area, as neither their prevention nor their treatment can be effective without the real engagement of local people. But for health education efforts to have any impact at all, they must be based on a broad understanding of both the strengths and shortcomings of cultural perceptions and practices which surround the management of various illnesses. Only through such an understanding can effective measures be devised for the dissemination of pertinent health information in ways that are *meaningful* to local people and can hence, be incorporated and actively operationalized by local communities themselves, in ways which are compatible with their socio-economic and cultural realities.

1.4. Despite its limited time frame, this study has managed to gather a great deal of information on local traditional medicinal plant practices in Malawi. It is hoped that this report will serve as useful reference for studies and initiatives concerned with health in particular as well as those focused on traditional knowledge systems and local plant biodiversity in Malawi. The sustainability and potential for upgrading and better integration of home-based into the formal health system will depend on safeguarding the mechanisms for the transmission of traditional knowledge and the protection of local plant biodiversity.

1.5. This study has revealed that while home-based health care is central, the need for poverty alleviation and ensuring food-security is paramount within the study communities. This suggests the necessity for a strategy which on hand reflects a balance between health and nutritional requirements, and on the other, between protection and cultivation of medicinal plants and other species which promise greater income-generating opportunities.

2. Key lessons learned

2.1 The central research instrument employed in this study, i.e. focus group discussion, was not always found to be the best way of eliciting information on *specific* plant treatments. Given the culture of secrecy surrounding traditional health knowledge individual interviews proved a more ‘culturally appropriate’ method in this study.

2.2 The main strategic challenge faced by MASAF is how to effectively realize the community demand-driven (CDD) approach within the domain of advancing traditional health knowledge and practices. This study concludes that the key to this is the provision of pertinent, concise, easy to use information to communities. At the very basic level, communities (as was observed in the Mpemba community of the Southern Region) require assistance in accessing information on how to put together project proposals which would qualify for MASAF III funding support. It has been observed, moreover, that without careful provision of clear, consistent and complete information, there is a danger of conveying mixed messages. For example, it was not uncommon for community members to make comments like: “...but we hear on the radio that traditional practices are not useful, and that we should just go to the hospital”.

2.3 Finally, implementation of this study has highlighted the sheer complexity of this area of work and raised several issues of which MASAF should be cognizant. These issues, *inter alia* encompass the questions regarding the efficacy of herbal treatments, the potential long-term side effects they might have, effects of their interactions with modern drugs, the real rates at which valuable medicinal plant species might be disappearing due to ongoing deforestation. MASAF should also be cognizant of intellectual property rights (IPR) issues surrounding knowledge and use of medicinal plants and seek to assist communities to safeguard their traditional plant-based medical heritage.

VIII. RECOMMENDATIONS FOR MASAF ACTION

“*Dzanja limodzji silikumba mankhwala*”
[Lit. “One hand alone cannot dig up medicinal herbs”]
A popular Chichewa proverb

Despite local people’s continued reliance on, and high regard of traditional medicine, project proposals aimed *expressly* at the improvement of traditional medicines and health practices *per se* are unlikely to ‘naturally’ emerge as the most pressing among the many competing community demands for MASAF support, such as the construction of boreholes and community health centres.

In light of this, MASAF III would need to adopt a variety of proactive and indirect strategies for harnessing and strengthening traditional health knowledge and practices through its various programs. This section sets out some general and specific action-oriented recommendations for MASAF to consider in shaping its strategic approach to this area of work. Particular attention is paid to specific components within MASAF III’s *Community Service Packages* which are of direct relevance to the priorities identified through the FGDs in the study communities.

1. General strategic recommendations

(a) Development of a clear position statement and set of objectives in support of traditional health knowledge and practices

Firstly, should MASAF resolve to take specific proactive measures for incorporating activities in support of traditional health knowledge and practices into its programs, it would be important for it to start by clearly articulating its relevant perspectives, key concerns and objectives, possibly in the form of some general ‘guiding principles’. As discussed earlier, given the wide range of ‘unknowns’ in this field, there is a real danger of conveying confusing messages, and indeed, in some cases, inadvertently reinforcing potentially harmful traditional practices, even by simply initiating discussions about traditional health knowledge and practices with communities. On the other hand, this study has also shown that MASAF’s mere interest and preliminary inquiry into this area, can in itself serve to enhance the empowerment of communities, as it immediately signals appreciation of the their traditional skills, resources and efforts in the critical area of health, which in turn engenders their own valuation of the same. At the same time, MASAF’s proactive support, can just as easily be misconstrued as an indiscriminate endorsement of all traditional health practices.

It is therefore, vital that MASAF clearly communicate its intentions both for the benefit of communities as well as potential partner organizations. Articulation of such guiding principles to direct MASAF’s own involvements in this area, can also pave the way for the development of clearer policies on the role of traditional medicine in primary health care development at the national level.

Following are some key issues which could be addressed by MASAF in developing such guiding principles:

- recognition of women’s special contributions in the provision of health care and relevant decision-making as a whole, and in particular aspects of home-based and specialised (e.g., TBAs) traditional health care delivery;
- recognition that women’s traditional health knowledge/skills cannot be considered in isolation and that improvement of local men’s active engagement, especially in maternal and child health concerns, is vital for supporting women’s health care efforts;

- willingness to work closely with other organizations involved in various aspects of traditional medicine, and to link communities with such organizations, including those with interest in investigating the efficacy of traditional medicines and health practices;
- recognition that not all traditional health practices are necessarily beneficial, and that culturally-sensitive approaches are needed to assist communities in identifying and modifying those with potentially adverse effects on health;
- recognition of the essential complementarity between traditional and biomedical health care approaches;
- recognition of the important IPR concerns surrounding local people's traditional medicinal plant knowledge, the need to raise local awareness of these issues and to assist communities to both safeguard and develop their knowledge for improving their health conditions;
- affirmation of the significance of traditional health and medicinal plant knowledge and use at the household-level and the need to focus attention on *the home* not only because it is a vital source of health care, but also the prime locus of knowledge and critical decision-making regarding the use of all other health care resources available; and
- articulation of how important players in the field of traditional medicine, notably, specialised traditional health practitioners (herbalists, TBAs and spiritual healers, operating within rural communities as well as those based in urban areas/ formally organized under the various national traditional healers associations) as well as herbal vendors at local markets, fit into MASAF's community-demand driven approach.

(b) MASAF is well-positioned to foster coordination of the wide array of ongoing efforts in the field of traditional health knowledge and practices in Malawi.

Promotion of traditional health knowledge and medicinal plant use is a complex and multi-faceted area, which typically attracts a remarkably wide range of players. This study has revealed that while there is certainly no dearth of interest in this area in Malawi, what is conspicuously lacking is a mechanism for coordinating the efforts of the diversity of organizations actively engaged in initiatives in support of traditional herbal medicine throughout the country.

Moreover, few organizations involved in this area appear to have given priority to the active *engagement of local communities* in defining the focus and approach of their programmes. Indeed, few have a broad enough mandate, capacity, and an adequately flexible multi-sectoral approach to address concerns about traditional health knowledge and medicinal plant use and local health development in an integrated manner.

Given its central community-demand driven approach, MASAF may well have a key advantage in all these respects. It stands to make a significant impact by seeking ways to foster coordination and collaboration between the efforts of government agencies, CBOs and NGOs working in support of traditional health knowledge and practices within the health, education, biodiversity/natural resources sectors. Only by working with others can MASAF enable communities to undertake meaningful activities which stand to have a real impact on improving on their traditional health knowledge/practices.

MASAF is well-positioned to identify key partners in this area, to gather information on their respective areas of focus and scope of activities which it can then make available to communities. It can also encourage such organizations to collaborate amongst themselves, to strengthen their community-based efforts and to promote participation of local men and women in their programs. More specifically, it can seek ways of linking communities with such organizations, many of which might be able to support focused research and/or provide hands-on training, or technical support in particular areas, by actively seeking their collaboration on specific components pertaining to traditional health knowledge and plant use within community proposed projects.

(c) MASAF should seek to devise innovative multi-sectoral approaches in directly and indirectly supporting traditional health knowledge and practices in different local contexts, with a view to building a diverse portfolio of experiences and replicable ‘best practices’ in each of these areas.

The results of the FGD sessions have shown that it is necessary to think beyond ‘traditional medicine’ *per se* and indeed, ‘outside the health box’ as a whole, in search of innovative ways to support traditional health knowledge and build upon local people’s home-based health care efforts. The solutions of many of the most pressing problems surrounding local people’s health depend upon fundamental developments in other sectors, the most obvious being the water and environmental sanitation sector.

Indeed, many of the ailments for which local plant medicines are used can be linked to consumption of contaminated water and poor environmental sanitation. But in addition to the construction, and more effective use of latrines and improving the effectiveness of water hygiene and sanitation education, basic developments in other sectors can also have a positive impact on traditional health practices. A number of such areas for action highlighted by this study and are outlined under the specific recommendations below.

By considering three different communities, with distinct environmental and socio-economic concerns, this study has also shown that certain actions are likely to have greater impact in terms of supporting local health knowledge and practices in communities with particular circumstances. In essence, ‘one size *does not* fit all’. This in itself can be viewed as an opportunity to rapidly build experience and generate ‘best practices’ for replication and refinement in other appropriate local contexts. As such, the information gathered by this study can be utilized by MASAF in two complementary ways:

Firstly, the information specific to the particular study communities, can serve as useful background in evaluating *all* future projects which might be proposed by these same communities (be these directly or indirectly related to health), with a view to incorporating appropriate actions in support of traditional health knowledge/skills.

Secondly, each of the three study communities can be viewed as ‘case-scenarios’ with broader implications. Their distinguishing sets of socio-economic/cultural characteristics, and in particular, the range of health care resources accessible to each and the key priorities identified, through the respective FGD sessions, can serve as a practical means of classifying different types of communities, when approaching the area of plant-based traditional health knowledge and practices.

3. Specific recommendations

The key areas and approaches for action proposed in this section are based on the priorities identified through the mixed FGD sessions in the three study communities. Examination of each of these priority areas against the relevant contents of MASAF's current Community Service Packages **Table 14** reveals remarkable congruency between the two, especially in the health and water/sanitation sectors. It also brings to light the need for: (a) targeted gender and culturally-sensitive IEC initiatives that cut across all health sector and closely-allied initiatives; and (b) some possible entry points for integrating multi-sectoral activities in support of traditional health knowledge/practices into MASAF supported projects. Each of these is discussed briefly below.

3.1 Gender and culturally-sensitive IEC component to accompany all health sector initiatives.

Based on the findings of this study, it is recommended that greater emphasis be placed on health education and promotion efforts in general throughout the implementation of MASAF-III. The possible role of indigenous/local networks and associations, such as the *namkungwi* women's groups or analogous church-based organizations in disseminating pertinent health information should also be considered. Specific initiatives targeting different groups and focusing on the following key areas are suggested.

Expanding local health services & training/deployment of local biomedical health staff

As discussed earlier, for health education efforts to have any impact at all, it is paramount that they be based on a broad understanding of both the strengths and shortcomings of cultural perceptions and traditional practices which surround the management of various illnesses.

Gender and culturally-sensitive IEC initiatives accompanying the introduction of family planning/ reproductive health services (targeting both ordinary local community members and TBAs), should include as key discussion topics: gender-specific home-based and specialised traditional treatments which impact upon reproductive health, including, peri-natal traditional practices (fertility treatments, abortifacients, sexual dysfunction remedies, etc.). In particular, a vital area where targeted IEC interventions are required is in raising awareness and understanding among local men regarding women's health problems.

Incorporation of traditional health topics in training of local biomedical health providers

Communities' demand for expansion of services will in most cases require more staff, and MASAF's prioritization of the training and deployment of Senior Health Surveillance Assistants, Nurses and Mid-wives provides a vital opportunity to effect positive change in support of traditional health knowledge and practices. Especially in rural areas the 'socio-cultural distance' between biomedical practitioners and their largely non-literate patients limits effective communication between them. This is further compounded by the widespread scepticism among biomedically-trained practitioners regarding traditional forms of therapy. The most open-minded of practitioners might accept the validity of some treatments provided by recognised specialists, but very rarely of the home-based health practices of their lay patients. Indeed, this situation is hardly conducive to the effective delivery of even biomedical care, much less to participatory processes essential for the understanding and promotion of local health knowledge and practices.

For health programmes to be effective, a genuine interest in understanding local people's cultural health perceptions, knowledge and practices must be prevail throughout the formal national health system. Among practitioners already in service, such a perspective can be promoted through focused training workshops. But a more effective and enduring reorientation towards a concern with the vital socio-cultural aspects of health care delivery can best be achieved by broadening the conventional training curricula of local health staff. Such training programmes, could, *inter alia*, aim to raise trainees' awareness about:

- (a) local perceptions and classifications of various health problems (supported through, e.g. the development and use of an evolving glossary of common local disease/symptom terms and their biomedical approximations¹¹); and
- (b) the widespread successive and/or concurrent use of various traditional forms of therapy and biomedical treatments among local communities and the implications of this (WHO, 2002: p.27).

¹¹ The preliminary glossary compiled through this index might serve as a useful start to be further improved upon through expert consultation and empirical validation.

Finally, while drawing due attention to the positive aspects of traditional therapies and the significance of local people's home-based health care efforts, MASAF-supported training of biomedical practitioners to staff rural health centers, should also address traditional health practices deemed potentially hazardous. The propensity of biomedical practitioners has been to condemn such practices and to urge local people to abandon them, with little consideration of the broader socio-cultural contexts in which they persist. A balanced perspective is thus, vital.

Focus on the training of TBAs

Firstly, it should be noted that following recent consultations with its various collaborating partners, including, most notably, UNICEF, MASAF is currently reviewing the objectives and approaches of this particular component of its Essential Health Service Package (Mandala, C. *Pers. Com.*, May, 2004). It appears that UNICEF and WHO, both of which have historically been engaged in the training of TBAs are currently reconceptualizing the role of conventional TBA training programmes, especially with respect to their effective contributions in reducing maternal mortality in rural areas (Muita, J, *Pers. Com.*, May, 2004).¹² MASAF's involvement in this area will, therefore, need to take into account the outcome of the current deliberations.

MASAF should seek to actively participate in these discussions, as re-shaping the objectives and contents of TBA training programmes, may well present valuable opportunities for incorporating activities in support of, e.g. systematic documentation of their own specialised traditional health and medicinal plant knowledge and other common traditional practices surrounding reproductive health. These discussions should also take note that *the* greatest constraint consistently identified by all the TBAs interviewed in this study, was the lack of reliable transportation to health facilities, which they believe severely limits their contribution to averting peri-natal mortality (i.e., through timely diagnosis and referral of problematic pregnancies).

One possible strategy which MASAF might explore is combining certain components of the training of TBAs with that of local biomedical health staff through focused training workshops, which can facilitate valuable dialogue and learning between the two groups.

Finally, it should be added that the problem noted by all TBAs interviewed regarding the recurrent shortage of supplies, may well be effectively resolved by the expansion of the relatively recently devised strategy, which involves distributing child delivery kits (including, essential sterile supplies, such as disposable gloves), directly to expecting mothers (Muita, J. *Pers. Com.*, UNICEF 2004). The fact that utilization of antenatal care services provided at biomedical facilities is particularly high in Malawi, makes this a very promising approach (UNICEF/WHO/MALAWI, 2001: 105-6).

Community health education and hands-on training: focus on key health topics

MASAF can support local people's home-based health care efforts and relevant decision-making by focusing on gender and culturally sensitive health IEC programmes on the following specific topics:

MASAF's disease-focused IEC efforts would be best targeted at major health problems where symptom recognition was found to be problematic: notably, malaria; acute febrile illnesses and acute respiratory infections, such as pneumonia.

Malaria: Provision of basic 'hands-on' training to enable local people, especially mothers, to better prevent, detect and treat malaria at home in a timely manner, is a much needed intervention among the study communities. This need is likely to be common to many rural communities in Malawi. MASAF-supported health education efforts

¹² In many developing countries, including in Malawi support for traditional health practitioners has historically been focused largely on training of TBAs. This strategy was shaped in large part by WHO recommendations on traditional medicine promulgated following the adoption of the Primary Health Care Strategy (PHS) in the late 1970s. The PHS gave particular priority to TBA training programmes, viewing these as a way of reducing maternal/child mortality and morbidity (Maglacas and Mangay, 1986). Although many of these efforts were initially thought to be 'successful' (based merely on quantitative indicators such as 'numbers of TBAs trained'), more rigorous evaluations of TBA training programmes in various countries have recently shown that their impact has been marginal (Smith *et al.*, 2000; Goodburn *et al.*, 2000).

in this area should give priority to (a) distinguishing other common acute febrile illnesses from malaria; and (b) recognition of the particular symptoms associated with cerebral malaria, which as suggested by the findings of this study, may often be confused with epileptic seizures or interpreted as wholly different problems for which traditional treatment is routinely prescribed. Such programmes would be best delivered in the form of 'mutual learning exercises' wherein, local biomedical health providers can be encouraged to learn from local people about the various cultural constructs underlying conditions referred to *kugnu/ rinjirinjiri* or *sila*.

Acute respiratory infections: Likewise, hands-on training programmes (again, targeting especially mothers), should seek to equip local people with skills to detect and seek timely biomedical treatment for serious conditions such as pneumonia, given the finding that the local terms of the associated symptoms, i.e. *chibayo/chilaso* may also in some instances, be used in reference to conditions associated with witchcraft which are not normally brought to the attention of biomedical providers.

Water-borne diseases: MASAF should ensure that the water-sanitation education programmes built into its Water & Sanitation, package focus on common water-borne conditions commonly treated with home-based herbal remedies, including especially bilharzia; and diarrhoea/dysentery causing infections. IEC interventions (especially, targeting mothers) should also focus on the dangers of dehydration in childhood diarrhoea and the need for ensuring regular fluid intake into home-based treatment strategies. Information on the usefulness of ORS (which appeared not to be commonly used among the study communities), including recommendations on how they can be obtained.

Pre/post-natal nutrition: This is an area that does not appear to be given much regard in traditional health practices; IEC efforts should draw on existing research evidence, in raising local awareness regarding the value of various micronutrient-rich traditional wild and semi-domesticated food plants, e.g., especially leafy green vegetables rich in vital micronutrients such as iron and vitamin A (Chweya, 1999, Fassil *et al*, 2000).

3.2 Outside the 'health package': opportunities for integrating traditional health knowledge-supportive activities into MASAF's other service packages

Construction/rehabilitation of community health and child delivery centres

New community proposals for the construction of local health facilities can serve as a means of introducing initiatives, such as the establishment of permanent traditional vegetable/fruit and/or medicinal gardens on communal land-patches around health centers (Village schools and church-yards may also be considered as possible sites for establishing such community gardens). In addition, locally-valued and/or 'threatened' species can be included among those planted in replenishment woodlots which accompany such construction projects. Strong community support and clear consensus regarding communal access and use of the replanted species would, of course, be needed for the success of such initiatives. There may be an opportunity for testing this approach in **Chala**, in the event that MASAF supports construction of a community health center in/around that community.

Developing transportation and communication infrastructure

Building roads can, no doubt, significantly improve access to health care facilities. In communities where land is particularly scarce, road construction may be combined with roadside planting of medicinal/edible fruit species, especially in cases where vegetation clearing is necessary in order to build the road. In communities situated on particularly difficult terrain, even basic clearings and levelled foot-paths within villages can make the lives of local women much easier by facilitating their regular trips to community water points.

MASAF may also explore other ways of improving communication between communities (especially, TBAs) and biomedical health providers in rural areas. In this respect, lessons learned from a recent successful initiative in rural Uganda where walkie-talkies were used by village TBAs to request the nearest health unit or referral hospital for urgent dispatch of transport, in cases of obstetric emergencies, could be well considered by MASAF (Musoke, 2002).

Linking medicinal plant cultivation to income generating activities, improved nutrition and health

The Household Food Security service package is one that allows for a great deal of flexibility and innovation in designing multi-sectoral community self-help initiatives. In this context, it is recommended that MASAF seek to

capitalise on opportunities for linking afforestation and crop-diversification schemes with income-generating activities and/or support to those caring for vulnerable segments of the community.

- Community afforestation schemes represent a viable way of supporting traditional health practices through improved medicinal plant supplies. They can serve as a conduit for actively encouraging the cultivation of locally-valued medicinal species, and especially those identified as becoming scarce due to over-harvesting or ongoing deforestation (possible candidate species among the study communities, include native trees such as, 'muwanga' (*Pericopsis angolensis* (Bak) Van Meeuwen); 'mlombwa' (*Pterocarpus angolensis* DC.); and 'muowani' (*Cassia abbreviata* Oliv.). It is recommended that MASAF seek partnerships with organizations such as, the Forestry Research Institute of Malawi (FRIM), the National Herbarium and Botanical Gardens (NHBG), the Biology and Chemistry Departments of Chancellor College (see **Appendix II.** for contact information). These organizations are interested and well-positioned to collaborate with communities by providing relevant expertise for specific projects involving the research, conservation and sustainable use of traditional Malawian medicinal plants. In close collaboration with such partners, it is also recommended that MASAF consider developing a practicable research agenda which will enable it to generate pertinent information to strengthen its involvements in this area. In **Mpemba**, an afforestation scheme, prioritizing multipurpose native trees, especially locally-valued medicinal/ hard-wood species, and linked to alternative income generation initiatives is most likely to be met by strong community support. The capacity building component might focus on supporting local carpentry (primarily for men) and introducing basket-ware/handicraft production skills (targeting women) possibly, in partnership with MoGYCS which is supporting similar initiatives in neighboring areas (Chifali, *Pers. Com.* May, 2004).
- Crop-diversification can provide a special opportunity for building on local women's knowledge of traditional wild/semi-domesticated fruit and vegetable plants, and can serve to promote the valuation of such species, ultimately improving household nutrition and health. Such an initiative can also allow for focused attention on the role of improved nutrition in the management of the disease. It can provide a channel for disseminating vital information on the importance of a diverse diet in boosting the immune system and how certain micronutrient deficiencies may also increase susceptibility to HIV/AIDS (Green, 2004). Ascertaining the nutritive value of particular traditional food plants (both by assembling existing literature or through small focused studies involving local people), could strengthen IEC efforts.
- Cultivation of communal food and medicine gardens, can both support the provisions of those caring for HIV/AIDS orphans and other vulnerable groups, at the same time as reducing pressures on wild stocks of such useful species. The experiences of organizations implementing HIV/AIDS programmes based on the 'home-based care' approach are most relevant in this context (NACP,1998). **Jombo** residents, who identified HIV/AIDS orphan care programmes among their priorities, are likely to be particularly in favour of such integrated self-help projects.

Enhancing the relevance of the Education Service Package in support of traditional health knowledge and medicinal plant use

At least on face value, MASAF's Education Service package appears to be the only one where new components might be required in order to more readily incorporate relevant activities supportive of traditional health knowledge and skills. It is not clear, for example, to what extent MASAF has to date, supported community literacy programmes linked to the establishment of village primary/secondary schools or programmes aimed at developing learning materials adapted to the local realities of rural communities. In this respect, possibilities which might be explored by MASAF and partner organizations include: (a) the use of 'contextualization of learning' approaches aimed at making formal schooling more relevant to the practical life experiences of rural pupils (Kallaway, 2001; Taylor and Mulhall, 2001), e.g. through practical activities focused on identifying, classifying, drawing and recording the uses of local plants supported by the development of appropriate development of learning materials; and (b) encouraging the establishment of medicinal plant gardens in school yards, which can support the above approach, while also serving to enhance the learning environment and contributing to community-based biodiversity conservation efforts.

Finally, the far-reaching benefits of community literacy programmes (which can be linked to support for village schools) should be emphasised. Basic literacy programmes can empower communities by enabling them both to record their traditional health knowledge as well as to better access and utilize vital health information, resulting, *inter alia*, in improved treatment compliance with biomedical treatment regimens. Especially given the culture of secrecy surrounding medicinal plant knowledge, support for community literacy programmes, represents a vital strategy for safeguarding traditional health knowledge through systematic documentation by local people themselves.

Those prized, well-worn notebooks in which women *and* men in Jombo had, *on their own initiative*, recorded their traditional herbal medical recipes, are a striking illustration of what communities can achieve for themselves when they have the most basic of tools in their hands.

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“...I started writing them down years ago... so I wouldn't forget...”

Mai Eunice Qongwani (Key Informant, Jombo)
Demonstrating her notebook of herbal recipes

Table 14: SUPPORTING TRADITIONAL HEALTH KNOWLEDGE: TARGETED IEC INITIATIVES & 'INTER-PACKAGING' OF MASAF's SERVICES

COMMUNITY IDENTIFIED PRIORITIES	RECOMMENDED IEC COMPLEMENTS & SUGGESTED APPROACHES	RELEVANT COMPONENTS OF MASAF's SERVICE PACKAGES	
-Expansion of services provided by village health centres - More trained health personnel	- gender/culturally-sensitive reproductive health education - sensitisation of trainees to key traditional health practices - development/inclusion of (traditional-biomedical) glossary of symptom/disease terminology in training syllabus	- FAMILY PLANNING SERVICES - TRAINING/DEPLOYMENT OF: SENIOR HEALTH SURVEILLANCE ASSISTANTS; NURSES; MIDWIVES	ESSENTIAL HEALTH CARE
Training of TBAs	maternal/child nutrition education emphasising value of micro-nutrient-rich traditional food plants	TRAINING OF TBAs	
Construction of village health centre/ child-delivery facility	- inclusion of locally-valued/'threatened' species in replenishment woodlots planted as part of construction projects; - establishment of permanent food/medicinal gardens on communal land-patches around health centres	REHABILITATION CONSTRUCTION/ MAINTENANCE OF HEALTH CENTRES	
Improved access/supply of modern medicines	Hands-on training:	DRUG REVOLVING FUND (DRF)	
Malaria prevention	- prevention, apt. use of anti-malarial & other drugs; improved/timely diagnosis of symptoms (<i>esp.</i> targeting mothers) addressing traditional practices surrounding malaria management (<i>esp. cerebral malaria</i>)	ANTI-MALARIA PROGRAMMES	
Construction of new boreholes/ rehabilitation of existing one	culturally-sensitive water hygiene/sanitation education; focus on common water-borne conditions commonly treated with home-based herbal remedies: <i>e.g.</i> bilharzia; diarrhoea/dysentery causing infections	NEW WATER/SANITATION PROJECTS; MAINTENANCE/REHABILITATION OF BOREHOLES/COMMUNITY WATER POINTS/ WATER HYGIENE EDUCATION	WATER & SANITATION
Road construction	<i>e.g.</i> combined with roadside planting of medicinal/edible fruit species / <i>esp.</i> in cases where vegetation clearing is necessary; community saving schemes for purchasing bicycles	IMPROVEMENT OF TRANSPORT/ COMMUNICATION INFRASTRUCTURE	TRANSPORT & COMMUNICATION
- Alternative income generation activities - Planting trees/afforestation schemes prioritizing native multipurpose trees, especially those with medicinal value (<i>including training in plant propagation methods, assistance with tools/supplies</i>) - HIV/AIDS orphan care programme	<i>e.g.</i> : - skill-building for (handicraft/basket production /carpentry) supported by planting mixed woodlots of multi-purpose species of medicinal value (for raw materials); - generate provisions/funds for HIV/AIDS Orphan Care programmes through planting/use/sale of medicinal & nutrient-rich traditional fruit/vegetable species	- BUILDING CAPACITIES TO INCREASE INCOMES/ FOOD SECURITY OF THOSE CARING FOR VULNERABLE GROUPS - SETTING UP OF CROP & PRODUCE MARKETING CO- OPERATIVES - DEVELOPMENT OF WOODLOTS	HOUSEHOLD FOOD SECURITY

BIBLIOGRAPHY

- Akerele, O. (1987). The best of both worlds: bringing traditional medicine up to date. *Social Science and Medicine*, 24 (2), 177-181.
- Anokbonggo, W. W. (1992). The role of African traditional medicine in health care delivery alongside modern medicine. *Botany 2000: East and Central Africa NAPRECA*, 5, 25-35.
- Banda, J. J. (2000). *Roll Back Malaria Action at Country Level: Country Updates: Ethiopia (October 1998- June 2000)*. Geneva: World Health Organization.
- Bannerman, R. H., J. Burton and C. Wen-Chen (eds.). (1983). *Traditional Medicine and Health Care Coverage*. Geneva: World Health Organization.
- Binns, Blowden. 1972. *Dictionary of Plant Names in Malawi*. University of Malawi. Zomba: Government Printer
- Bullough, C.H. and W.P. Leary, W.P. (1982). Herbal medicines used by traditional birth attendants in Malawi. *Trop. Geogr. Med.* 34(1):81-5
- Caldecott, J. and E. Lutz. (eds). 1996. Decentralization and Biodiversity Conservation. The World Bank, Washington D.C.
- CBNRM. (2002). Best Practices and Model Sites in Malawi: Traditional Herbalists in Malawi Take Steps to Protect Indigenous Medicinal Trees. 1994. Global Environment Facility.
- Chisale, Jafali *Pers. Com.* (April 2004). Community Development Agent, Ministry of Gender, Youth & Community Services, Mpemba, Rural Blantyre.
- Chweya, J.A. and P.B. Eyzaguirre (eds.). 1999. The Biodiversity of Traditional Leafy Vegetables. International Plant Genetic Resources Institute (IPGRI). Rome, Italy.
- Country Watch (June, 15, 2004). Rogo, K. , Lead Specialist, Reproductive Health, Human Development, Africa Region, World Bank quoted in “*World Bank and World Health Organization warn Africans to stop ignoring herbal medicine*” Country Watch. Available:
http://aol.countrywatch.com/aol_wire.asp?vCOUNTRY=169&UID=1133877
- Courtright, P. (1995). ‘Eye care knowledge and practices among Malawian Traditional Healers and the Development of Collaborative Blindness Prevention Programmes’. *Soc.Sci.Med.* 41(11):1569-1575
- Courtright, P. T. Bisika, R. Geneau, M. Chirambo. (2001). *Traditional Eye Medicines in Malawi: Biodiversity and Utilization*. Final Narrative Report: IDRC-supported Project (Project No. 003955). University of British Columbia, Canada and Centre for Social Research, University of Malawi, Malawi.
- Easton, P and M. Ronald. (2000). Seeds of life: Women and agricultural biodiversity in Africa IK Notes. No. 23. August, 2000. World Bank.
- Fassil, H, L. Guarino, S. Sharock, BhagMal, T. Hodgkin and M. Iwanaga. 2000. Diversity for Food Security: Improving Human Nutrition through Better Evaluation, Management and Use of Plant Genetic Resources. *Food and Nutrition Bulletin*. Vol 21(4): 497-502. Special Issue on Improving Human Nutrition through Agriculture.
- Fassil, H. 2003. “*We Do What We Know*”: Local Health Knowledge and Home-based Medicinal Plant Use in Ethiopia. Unpublished PhD Dissertation. International Development Centre, University of Oxford, Oxford UK.
- Fernández, M. E. (1994) ‘Gender and indigenous knowledge’. *Indigenous Knowledge and Development Monitor*, 2(3).
- FRIM. (2003). Developing biometric sampling systems and optimal harvesting methods for medicinal tree bark in Southern Africa: A FRIM research project. Forest Research Institute of Malawi (FRIM).
- Gagnon, L. (2000). Investigating traditional eye medicines in Malawi. IDRC Project Number 970019. International Development Research Centre (IDRC), Canada.
- Green, E. (2004). Indigenous Responses to AIDS in Africa. In *Indigenous Knowledge: Local Pathways to Global Development. Five Years of the Indigenous Knowledge for Development Programme*. Woytek, R., Shroff-Mehta, P., Mohan, PC (eds.) IK Book Volume I: pp.24-30. The World Bank, Washington, DC., U.S.A.
- Grenier, L. (1998). *Working With Indigenous Knowledge: A Guide for Researchers*. Ottawa, Canada: International Development Research Centre (IDRC).
- Goodburn, E. A., M. Chowdhury, R. Gazi, T. Marshall and W. Graham (2000). Training traditional birth attendants in clean delivery does not
- Johnson, T. L. (1999). *Social Funds: Examining Women’s Reproductive Health and Women’s Empowerment*. U.S. Department of Health Human Services. Health Resources Services Administration. Bureau of Primary Health Care. Human Development Network Population and Reproductive Health Group. Poverty Reduction and Economic Management Network. Gender Division. The World Bank.

- Kallaway, P. (2001). The need for attention to the issue of rural education. *International Journal of Educational Development*, 21(21-32).
- Keuhnast, K. (2003). *Gender and Social Funds: Challenges and Opportunities*. Social Funds Unit, Social Protection Department, Human Development Network. SP Discussion Paper No. 0309. World Bank.
- Kun, K. E. (1998). Vaginal drying agents and HIV transmission. *Family Planning Perspectives* 24 (2): 93-94.
- Lambert, J.-J., Srivastava and N. Vitmeyer (1997). *Medicinal Plants: Rescuing a Global Heritage*. World Bank Technical Paper No. 355. Washington D. C. World Bank.
- Lenneiyee, N.M. (2003). "Integrating MDGs into the Malawi Social Action Fund" *Findings*: 233, December, 2003. Human Development. The World Bank.
- Maglacas, A. and J. S. Mangay. 1986. *The Potential of the Traditional Birth Attendant*. WHO Offset Publication. (Vol. 95). Geneva: World Health Organization of the United Nations.
- Malinichi-Nyirenda, C. P. *Pers. Com.* (June, 2004). National Herbarium and Botanic Gardens of Malawi P.O.Box 528, Zomba.
- Mandala, C. *Pers. Com.*, (May, 2004) Director, Research & Training, MASAF. Private Bag 352. Red Cross House, Area 14, Lilongwe 3 Malawi
- Marcus, R. (1993). *Gender and HIV/AIDS in Sub-Saharan Africa: The Cases of Uganda and Malawi*. Centre for Development Studies, University College of Swansea Bridge: Briefings on Development and Gender.
- Marshall, N. T. (1998). *Searching for a Cure: Conservation of Medicinal Wildlife Resources in East and Southern Africa*. Species in Danger Series. Cambridge: TRAFFIC International.
- MASAF. (2003). *Community Empowerment and Development Project (CEDP)/Malawi Social Action Fund: Operational Manual (OM)*
- MASAF. (2004). "MASAF now ready to disburse." Malawi Social Action Fund. Press Release. *Weekend Nation*: 1-2 May 2004.
- MOH. (2004). *Health Management Information System (HMIS)*. Planning Department. Ministry of Health.
- MOHP and JICA. (2003). Malawi: National Health Facility Atlas: Preliminary Analysis of the Health Facility Database (status of health facilities November 2002-January,2002) . Ministry of Health and Population, Malawi and Japan International Cooperation Agency.
- MOHP. (2003). Key note speech delivered by the Minister of Health and Population. Inauguration of the African Traditional Medicines Day, 6th December, 2003.
- Moran, K. (1999). Health: Indigenous knowledge, equitable benefits. *IK Notes* No. 15. December, 1999. World Bank.
- Morris, B. (1984). Botanical and herbal folk knowledge among the Chewa of Malawi. *Herbal Rev.* Spring. 5.
- Morris, B. (1986). Herbalism and divination in southern Malawi. *Soc. Sci. Med.* 23(4): 367-77
- Morris, B. and J.D. Msonthi. (1996). *Chewa Medical Botany: A Study of Herbalism in Southern Malawi*. Hamburg: Lit Verlag; London: International African Institute.
- Msonthi, J.D. (1988). The status of medicinal plant research and traditional medicine in Malawi.
- Msonthi, J.D. (1985). Medicinal Herbs in Malawi and their Cures. Chancellor College, University of Malawi. 1985. Unpublished
- Msonthi, J.D. 1970. A Survey on Traditional Medicinal Plants of Malawi. Zomba: University of Malawi, Chancellor College, Chemistry Department.
- Msonthi, J.D. and D. Magombo. 1980/9? Traditional medicine in Malawi. Zomba: University of Malawi, Chancellor College, Chemistry Department.
- Mtotha, D.M. *Pers. Com.* 2 April, 2004. Deputy Director of Clinical & Population Services (Curative) Clinical Services Department, Ministry of Health, Lilongwe, Malawi.
- Muela, S. J., A. K. Mushi and J. M. Ribera (2000). The paradox of cost and affordability of traditional and government health services in Tanzania. *Health Policy and Planning*, 15(3), 296-302.
- Muita, J. (4 May 2004). *Pers. Com.* Project Officer HIV/AIDS, United Nations Children's Fund P.O. Box 30375 Lilongwe Malawi.
- Mukandila, G, *Pers. Com.* (14 April, 2004). Women's Representative, Herbalist Association of Malawi, Kasungu, Malawi.
- Mungai, R. and X.Ye. (2003). Malawi Integrated Household Survey. 1997. *Findings* 26589. Standardised Survey Bulletin 3.
- Musoke, Maria G.N. 2002. "Maternal Health Care in Rural Uganda: Leveraging Traditional and Modern Knowledge Systems" *IK Notes*. No. 40. January 2002. World Bank.
- NACP. (1998). *Home-based Care Herbal Treatment Guideline*. National AIDS Control Programme (NACP). Lilongwe: Ministry of Health and Population.

- Ndeti, M. (2003). Gender in Community Participation: An Assessment of the Malawi Social Action Fund (MASAF). African Region Human Development. AFTH1. The World Bank.
- NSO. (2001). *Malawi Demographic and Health Survey*. National Statistical Office. Zomba, Malawi. ORC Macro Calverton, Maryland, USA.
- OAU/STRC (1997). *Medicinal Plants and Herbal Medicine in Africa: Policy Issues on Ownership, Access and Conservation*. Report and Recommendations of the First Scientific Technical and Research Commission of the Organization of African Unity (OAU/STRC), Development Partners (DEPA) and KIPO, Kenya 14-17 April, 1997. Nairobi, Kenya.
- Olango, P. and F. Aboud (1990). 'Determinants of mothers treatment of diarrhea in rural Ethiopia'. *Social Science and Medicine*, 31(11), 1245-1249.
- Phiri, Gangire, *Pers. Com.* (14 April, 2004). President, Herbalist Association of Malawi, Kasungu, Malawi.
- Phuka, J. and S Tauro M. M. Faye. 2003. *Malawi Multi-sector AIDS Programme Project: Environmental Assessment*. Vol.3 Report no. E714. 2003/07/04.
- Picazo, O. (2002). Better Health Outcomes from Limited Resources. Focusing on Priority Services in Malawi. World Bank. Africa Region Human Development Working Paper Series. Report No. 24132 April, 2002.
- Pullinger, John S. and A. M. Kitchin. 1982. *Trees of Malawi with Some Shrubs and Climbers*. Blantyre: Blantyre Print.
- Ramphela, M. (2004). Women's indigenous knowledge – building bridges between the traditional and the modern. In *Indigenous Knowledge: Local Pathways to Global Development. Five Years of the Indigenous Knowledge for Development Programme*. Woytek, R., Shroff-Mehta, P., Mohan, PC (eds.) IK Book Volume I: pp.24-30. The World Bank, Washington, DC., U.S.A.
- Ruddle, K. (1993). The transmission of traditional ecological knowledge. In *Traditional Ecological Knowledge: Concepts and Cases* Inglis, J. (ed.) pp. 17-31. Ottawa, Canada: International Programme on Traditional Ecological Knowledge, International Development Centre, Canada.
- Scholz, U. and S. Chimatiro. (2004). Malawi: Institutionalizing traditional community-based natural resource management. *IK Notes* No. 64. January, 2004. World Bank.
- Shaba, M. *Pers. Com.* (1 April, 2004) Ministry of Gender, Youth and Community Services, Lilongwe, Malawi.
- Sindiga, I. (1995). African ethnomedicine and other medical systems. In *Traditional Medicine in Africa* Sindiga, I., C. Nyaigotti-Chacha, and M. P. Kanunah (eds.) pp. 16-29. Nairobi: English Press Ltd.
- Smith, J. B., N. A. Coleman, J. A. Fortney, D. J. Johnson, D. W. Blumhagen and T. W. Grey (2000). The impact of traditional birth attendant training on delivery complications in Ghana. *Health Policy and Planning*, 15(3).
- Smitt, J.J. (1994). "Traditional birth attendants in Malawi". *Curationis* 17(2): 35-8
- Tella, A.A. (1987). WHO Mission to Advise the Government on Malawi on Traditional Medicine WHO Mission to Malawi, Lilongwe, 1987.
- Taylor, P. and A. Mulhall (2001). Linking learning environments through agricultural experience -- enhancing the learning process in rural primary schools. *International Journal of Educational Development*, 21, 135-148.
- UNEP (1994). *Convention on Biological Diversity. Text and Annexes*. Geneva: United Nations Environment Programme (UNEP).
- UNICEF/WHO/MALAWI GVT (2001). *Household Baseline Survey on Key Community Child Care Practices in Selected Districts of Malawi. Community IMCI Baseline Survey in Malawi*. E. Wansi, D. Mtango, E. Maganga, E. Banda and T. Msiska. (eds.). United Nations Children's Fund/ World Health Organization. Government of Malawi
- US Peace Corps, Malawi. (2004). "Malawi is rich!: Permanent nutrition and medicinal gardens using local resources". Compiled for the National HIV/AIDS Policy. Chapter 3. Promotion of HIV/AIDS Prevention, Treatment, Care and Support.
- van der Geest, S. (1997). Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. *Tropical Medicine and International Health*, 2(9), 903-911.
- Vaughan, M. 1987. *The Story of an African Famine: Gender and Famine in Twentieth-Century Malawi*. Cambridge: Cambridge University Press.
- Woytek, R., Shroff-Mehta, P., Mohan, PC (eds.) 2004. *Indigenous Knowledge: Local Pathways to Global Development*. IK Book Volume I. World Bank, Washington, DC, USA.

- WHO (1995). *Traditional Practitioners as Primary Health Care Workers: Guidelines for Training Traditional Health Practitioners in Primary Health Care*. Geneva: World Health Organization
- WHO. (2002). *WHO Traditional Medicine Strategy 2002-2005*. Geneva: World Health Organization.
- WHO. (2003). *Guidelines on Good Agricultural and Collection Practices for Medicinal Plants*. Geneva: World Health Organization.
- Williamson, Jessie. (1972). *Useful Plants of Malawi*. Limbe: Montfort Press University of Malawi
- World Bank/GEF. (1994). *Republic of Malawi, Lake Malawi/Nyasa Biodiversity Conservation* Global Environment Facility (GEF) Project Documents. Report No. 13044 MAI . December, 1994.
- World Bank. 1995). *Development in Practice. Priorities and Strategies for Education. A World Bank Review*. Washington, DC: World Bank.
- World Bank. (2003). *Malawi. Third Social Action Fund*. Project Appraisal Document on a Proposed Credit to the Government of the Republic of Malawi for a Third Social Action Fund in Support of the First Phase of the Community Empowerment and Development Programme. Report No. 25562-MW

FOCUS GROUP DISCUSSION GUIDE: QUESTIONS

(i) *Home-based vs. specialized traditional health knowledge/practices:*

Do community members make a distinction between home-based traditional health knowledge and practices and traditional medicine provided by traditional healers? If so, what are the main perceived differences? How is this expressed in local language? What are the local terms for 'traditional healer'; 'traditional medicines used at the household-level'; 'modern/biomedicine'?

(ii) *Main health problems:*

What are the major health problems commonly experienced by the community as a whole/ by different age groups of women and men? And what are the perceived most effective (specialized or home-based traditional, or biomedical) treatments for these?

Major illnesses/health problems affecting different age groups: infants and young children; young men/women (adolescents); adult-middle-aged women (including pre/post-natal problems and problems during child-birth); adult men; elderly women and men.

General perceptions regarding major health problems: malaria; HIV/AIDS. What are the perceived causes modes of transmission and the most effective prevention measures and treatment(s)?

(iii) *Health care utilisation patterns: Modern/biomedical care vs. specialized traditional health care vs. home-based traditional health care*

Modern/biomedical care: For what particular types of health problems is care at the local health centre/clinic/hospital usually sought? What particular illnesses are believed to be treated effectively only through modern medicine? To what extent are cost of treatment and cost/availability of transportation a consideration in deciding to seek modern/biomedical care? What are the perceived general advantages/disadvantages of health care provided at the local health centre/clinic/hospital.

Traditional healers: For what particular type of health problems are the services of local traditional healers usually sought? What particular illnesses can only be treated effectively using traditional treatments?

Is cost of treatment a main consideration? Do most traditional healers provide treatment for the same/similar or a significantly different range of health problems?

How are female traditional healers different from male traditional healers? How many of each are found in and around the community? Do more male or female patients typically go to female traditional healers? – and to male traditional healers? What are the perceived advantages/disadvantages of traditional health care provided by traditional healers?

Home-based traditional health care: What type of health problems are treated at the household level with herbal medicines? What are the most commonly used home-based traditional treatments? Which particular types of medicinal plants are cultivated if any? Which types of medicinal plants occur naturally around the home/farm? Which types of medicinal plants are only found in nearby uncultivated/natural areas? distant forests or wild areas? Which types of medicinal plant products are typically purchased/only found at the local market?

(iv) *Differential roles of women/men in home-based health care and decision-making processes regarding health care choices*

How are decisions regarding health care choices made at the household level?

Who usually diagnoses illness at the household level? Who usually decides what action to take? Who collects medicinal plant materials for home use? Who prepares/administers home-based traditional medicines? Who provides the payment for treatment outside the home (modern/biomedical or traditional)?

(v) **Preventive health care/food-based medicines:** What type of preventive home-based traditional treatments are routinely used and what are they intended to protect against? Which types of foods/food crops are believed to 'restore strength' or prevent illness? What type of preventive treatments are provided by traditional healers?

(vi) **Problematic traditional health practices/treatments:** Which particular traditional (home-based/specialized) health practices are believed to be problematic or harmful? How could these be ameliorated?

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**GLOSSARY OF LOCAL TERMS FOR COMMON AILMENTS / SYMPTOMS:
DESCRIPTIONS & BIOMEDICAL APPROXIMATIONS**

<i>bambala; chitafya</i>	abdominal swelling, often affecting young children; most probably ‘splenomegaly’, i.e. swelling of spleen, often as a result of repeated exposure to acute/chronic infectious diseases.
<i>chibayo; chilaso</i> (I)	pneumonia (<i>see also</i> , UNICEF/WHO/MALAWI, 2000: p.21); but also at times interpreted as condition inflicted by witchcraft for which traditional treatment is sought
<i>chifuwa; chikoso</i> (I)	cough (primarily in infants/young children)
<i>chifuwa-chachikulu</i>	persistent/chronic cough; indication of TB
<i>chikuku</i>	measles
<i>chipere</i>	ring worm
<i>chirupu</i>	diarrhoea accompanied by vomiting (esp. in young children)
<i>dzino</i>	(<i>lit.</i> teeth) toothache
<i>gozole</i>	sexually transmitted infections (STI)
<i>kuchepa ndopa</i>	anaemia
<i>kusanza</i>	vomiting
<i>kutupa</i>	symptoms associated with severe malnutrition in children
<i>kutsegula mimba</i>	diarrhoea
<i>kugnu</i>	epilepsy
<i>luwombo</i>	‘abnormal fontanel’ in neonates: possibly one of the following types of problems – (a) <i>delayed fontanel closure/formation</i> , often caused by malnutrition, hypothyroidism, achondroplasia, Down’s syndrome, increased intracranial pressure, or rickets; (b) <i>sunken fontanel</i> usually a sign of dehydration.
<i>magazintupi; ndopa</i>	anaemia/anaemic
<i>zingamala</i>	conjunctivitis
<i>malungo;</i>	malaria
<i>mpugnu</i> (I)	
<i>mpengha</i>	otitis (ear infection)
<i>mathenda; opadsirana;</i>	sexually transmitted infections (STI)
<i>ogonana</i>	
<i>mawuka</i>	(a) condition affecting primarily infants and young children characterised by high/persistent fever; ‘low levels of blood’ (anaemia?) <i>acute febrile illness</i> ; (believed to be a seasonal condition, which often occurs right before the harvest of maize); (b) also used to refer to genital irritation/ affecting women
<i>mimba</i>	stomach-cramps; <i>kutsegula mmimba</i> (<i>lit.</i> ‘open stomach-cramps’): diarrhoea (<i>see also</i> ‘ <i>umpungulire</i> ’)
<i>mphere</i>	scabies
<i>muu</i>	severe head-ache / migraine
<i>njere-were</i>	warts
<i>nyamakazi</i>	rheumatic pain
<i>rinjirinjiri;</i>	condition characterized by high fever and severe convulsions (most likely cerebral malaria) but often confused with <i>kugnu</i> , i.e., epilepsy.
<i>chikoko</i> (I)	
<i>umpungulire;</i>	diarrhoea
<i>pamoyo</i> (I)	
<i>vimbokoli</i> (I)	conjunctivitis

* (I) =: term in Tumbuka language; all others in the Chichewa

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<i>pamoyo</i> (I)	
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