



Building on Traditional Medicinal Plant Knowledge and Home-based Health Care Efforts in Rural Malawi

Malawi remains one of the world's least developed countries, with more than 65 percent of its population of over 11 million 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—about 85 percent of its population. The HIV/AIDS epidemic has exacerbated the already strained scarce resources available within the national health delivery system. In the absence of adequate biomedical health services, most rural Malawians continue to rely on traditional, largely plant-derived treatments for their primary health care needs.

As observed by one researcher, virtually all rural Malawians can be viewed as practising herbalists, as they typically know of a variety of herbs to treat common ailments (Morris, 1986). Indeed, while traditional healers undoubtedly occupy an important position in health care delivery throughout rural Africa, it is increasingly appreciated that ordinary local people and women in particular, are often among the main custodians of much traditional knowledge.

Through support provided by GENFUND¹, a field-based study carried out in three rural communities² in the Central, North and South regions of Malawi respectively (April-May, 2004)

investigated local women's knowledge and use of home-based plant medicines. An attempt was also made to understand women's particular contribution to the relevant decision-making processes at the household level. Gender-sensitive qualitative and participatory research methods, including focus group discussions (FGD) and semi-structured key informant interviews were employed. The study recommends specific ways in which the World Bank-supported Malawi Social Action Fund (MASAF III) might effectively target its community demand-driven (CDD) development efforts in support of local women's knowledge and skills in this area (MASAF, 2003). Some of the main findings are highlighted below.

IK Notes reports periodically on Indigenous Knowledge (IK) initiatives in Sub-Saharan Africa and occasionally on such initiatives outside the Region. It is published by the Africa Region's Knowledge and Learning Center as part of an evolving IK partnership between the World Bank, communities, NGOs, development institutions and multilateral organizations. The views expressed in this article are those of the authors and should not be attributed to the World Bank Group or its partners in this initiative. A webpage on IK is available at // www.worldbank.org/afr/ik/default.htm

Ongoing activities in support of traditional health knowledge and practices

There are, currently, four registered associations of specialist traditional health practitioners in Malawi: the Herbalists Association of Malawi (HAM, based in Kasungu); the Yohane Herbalists Association of Malawi (Lilongwe); the International Traditional Medicines Council of Malawi (ITMCM, Blantyre); and the Chizgani Ethnomedical Association (Mzuzu). Thus far, the Ministry of Health's (MOH) efforts related to traditional medicine have focused mainly on providing support to traditional health specialists, through these associations, e.g., through training workshops on HIV/AIDS prevention and care. The ministry has also supported the provision of basic supplies and ongoing training for traditional birth attendants (TBAs), although the findings of this study suggest that resource constraints have limited both the reach and consistency of such programmes (Smitt, 1994).

Two major challenges faced by national decision-makers were noted by key informants: the persistence of negative perceptions of traditional health practices among biomedical professionals; and the current 'policy vacuum' surrounding the use of traditional therapies. Despite the lack of a clearly defined national policies regarding the development of traditional medicine, various national organisations, non-governmental organizations (NGOs), and individual researchers have pursued work on traditional health practices and Malawian medicinal plant use, albeit with limited apparent coordination of their efforts.

The knowledge base: local distribution of medicinal plant knowledge

Local people generally distinguished between: (a) knowledge held by ordinary men and women pertaining to widely available medicinal plants used as home-based treatments for common ailments; (b) special herbal recipes restricted to individual families; and (c) the knowledge and practices of specialists: community 'herbalists' known as *ofunamankhwala*, generally viewed as distinct from the *sing'anga* (spiritual diviners/healers), the *azamba* or TBAs and herbal vendors at local markets (often themselves practising *sing'anga*).

At the household level, knowledge and skills pertaining to plant identification, collection, preparation and administration of most commonly used traditional herbal treatments generally do not appear to be clearly differentiated by gen-

der. It is noteworthy however, that local women reported that they are generally the first to diagnose symptoms of illnesses in children. There was also one notable exception: men generally demonstrated little knowledge about the women's health problems and their appropriate traditional treatments, pointing to the need for targeted health education interventions in raising awareness and understanding among local men regarding such conditions. The importance of this becomes all the more compelling when considering that local women, despite considering themselves as the prime decision-makers on health matters at the household level, often depend on their husbands for money for biomedical or specialized traditional care.

On the whole, both male and female study participants generally demonstrated considerable appreciation for their local heritage of traditional health knowledge and skills, which they value both as a modest source of income and social esteem. The skills for preparing and administering most home-based plant-derived medicines are often learned from parents or close relatives. Specialist *ofunamankhwala*, reportedly acquire and develop their herbal recipes through more extensive exchanges with other knowledgeable persons (often encountered while travelling to distant areas), while the *sing'anga* interviewed claimed that they attained their divinatory powers and plant knowledge through 'spiritual intervention'.

Focus group discussions revealed considerable local appreciation for the need to systematically document traditional health knowledge as a whole, and particularly herbal preparations commonly used at the household level. However, a perceptible culture of secretiveness surrounding the knowledge and use of traditional herbal remedies may render this a particularly challenging area for intervention. Given the prevailing preference among local people for recording traditional herbal recipes at the household level rather than through a concerted communal effort, it was suggested that support for community literacy programmes may represent a vital strategy for safeguarding traditional health knowledge.

The main health problems: local views of traditional therapies and biomedicine

The study affirmed that inhabitants of the three communities continue do routinely make use of home-based traditional herbal remedies as the first line of treatment for most common ailments. Such treatments appear to be used more frequently than the services of local traditional specialists or

biomedical health facilities. Many informants reported having used a traditional herbal treatment as recently as a few days or weeks ago.

There was considerable similarity in the range of the most pressing health problems identified by 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, common dermatological conditions, symptoms associated with gastro-intestinal infections, various forms localized pain and bilharzia.

Key findings relating to the major health problems are summarized below.

Malaria: stands out as the single largest health problem in all of the study communities. A local wild shrub cited as an effective mosquito repellent, is used to varying extents among the study communities. Biomedical treatment is deemed the most effective solution by local people for severe malaria. Participants were generally well-informed about the mechanisms of malaria transmission, but there were indications of uncertainty about the symptoms indicative of cerebral malaria in particular.

HIV/AIDS: Study participants generally demonstrated remarkable appreciation regarding HIV/AIDS modes of transmission. There were no traditional treatments which were expressly cited as remedies for secondary infections associated with HIV/AIDS. However, the need for support for those households caring for HIV/AIDS orphans was repeatedly brought up in discussions about pressing community health concerns.

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.

Perceived advantages/disadvantages of traditional medicine and biomedicine: Local people generally view biomedicine as complementary to both specialized and home-based traditional forms of health care. Among the perceived advantages of traditional medicines, are that they are accessible and often cost nothing (especially home-based treatments). 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 that their dosage is not always well measured. The very high fees that can be charged by some specialist *sing'anga*

(often consulted for conditions believed to be caused by witchcraft) were also cited as a drawback.

Biomedicine's diagnostic capabilities, the specificity of modern drugs and the generally rapid recovery after treatment are perceived as its key advantages. 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 noted.

The plants: classification, supplies and use patterns

The local names, corresponding scientific designations³ and specific applications of 70 plant species (representing 44 families) of medicinal value were recorded by this study. This is indicative of the wide range of plants in use among the study communities. It is notable that all of the treatments mentioned are derived from plants viewed as being readily available in the local area.

The majority of locally-valued medicinal plants occur naturally in nearby *uchire* (uncultivated wooded grasslands). However, in some cases, smaller patches of natural vegetation around the homestead, often flanking farm-plots appeared to be the main sources of medicinal species.

Many of the most popular 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. The most frequently cited therapeutic plant parts were the roots and bark. Some highly valued medicinal tree species appear to be threatened by unsustainable (bark or root) harvesting practices. For example, 'mwavi' (*Erythrophleum suaveolens*) a tree noted as being 'scarce' and valued as a source of several medicines among the study communities, is known to have disappeared from certain forest reserves elsewhere in Malawi (FRIM, 2003).

Way forward: seeking community-demand-compatible strategies

The study concluded that despite local people's continued reliance on, and high regard of traditional forms of therapy, project proposals aimed *exclusively* 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 support by social fund projects such as MASAF. Among the study communities, support for the construction of boreholes and community health centres consistently took precedence.

In light of this, projects such as 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. The key recommendations made to MASAF in shaping its strategic approach to this area of work are: (a) foster coordination of the wide array of ongoing efforts in the field of traditional health knowledge and practices, through *inter alia*, encouraging collaborative efforts at the community level; (b) devise multi-sectoral approaches, in supporting traditional health knowledge and practices, through, e.g. the establishment of herbal gardens and afforestation schemes targeting threatened medicinal plants as adjuncts to diverse projects; (c) incorporating gender and culturally-sensitive health education efforts on key topics (e.g. reproductive health, malaria prevention and treatment), with a view to building critical symptom recognition skills and supporting health care efforts and decision-making at the household level; (d) exploring innovative ways of disseminating vital health information, e.g. through indigenous networks, with a view to improving the beneficial aspects of traditional health knowledge and affecting positive change in those practices identified as problematic or no longer useful.

Finally, it should be noted that while the importance of traditional medicinal plant knowledge was well-acknowledged in all the FGD sessions, invariably, other pressing issues both directly and indirectly related to health were raised. Not surprisingly, subsistence and food-security concerns consistently outweighed the priority given to health care. This is illustrated by the following pointed remark made by a local woman at the end of a FGD session: “*How can we even worry about health or walk to the health center ... if we are already so weak because we do not have enough to eat?*”

References

- 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).
- MASAF(2003). *Malawi Social Action Fund Phase III - Community Empowerment and Development Project (MASAFIII /CEDP): Operational Manual (OM)*. Government of Malawi. Office of the President and Cabinet (OPC).
- Morris, B. (1986). Herbalism and divination in southern Malawi. *Soc. Sci. Med.* 23(4): 367-77
- Smitt, J.J (1994). “Traditional birth attendants in Malawi”. *Curationis* 17(2): 35-8.

- 1 Norwegian Trust Fund for Mainstreaming Gender (GENFUND).
- 2 Chala Group Village, Malili, Lilongwe Rural (Central Region); Nation Nhelma Group Village, Nthwalo, Mzimba (Northern Region); and Group Village Kantukule, Somba/Blantryre Rural (Southern Region).
- 3 The botanical identities of most species could be determined with reasonable confidence by experts at the *National Herbarium and Botanical Gardens* (at least to the genus level) using photo images of the plants collected throughout the fieldwork.; further work, including collection of voucher specimens, would be needed to confirm taxonomies.