Development of a Medical Anthropology Curriculum in Mozambique

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Abstract

In the context of the project “Medicina Verde – Medicina Tradicional”, I was invited to develop and teach a medical anthropology curriculum at the bilingual (Portuguese/English) Beira Medical College and to give input in the communication for health curriculum, as well. In the process, not only did I gain deeper insight into local beliefs, attitudes, and practices concerning health and disease, but also discovered challenges that the students face when they try to integrate different concepts of health care within the Mozambican health care system and act as bridge builders between these worlds. In this paper I share about the content of the curriculum, the process of cross-cultural teaching, and what I learned along the way.
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Introduction of myself

I am Dora Carlos from Germany. I have been living and working with SIL in Mozambique with my husband and two children since 2005.

As many of the medical anthropologists, I also have a medical background. I am a trained nurse. This actually helped me gain the recognition and trust of the medical students, who were first wondering what this new discipline was about and if it might be of any use for their further career and practice.

UCM Beira

In 2007, I was asked by the Medical College in Beira to do a consultancy on how to include medical anthropology as a discipline into their “Problem-Based Learning” (PBL) curriculum of medicine.

At the end of 2006, the college had received a huge grant from the Kellogg foundation for a project called “Green Medicine – Traditional Medicine”. My proposal was accepted and the college offered me a part time job in the context of the project to design and teach the lectures and practical trainings I had proposed in my consultancy.

So, here I was, an anthropologist who had written an MA thesis on a medical anthro topic six years earlier, who had read everything about Medical Anthropology that I could find in my university library in Mainz during my study years. Period. I had no experience in teaching and was not really up to date with the developments in the discipline. However, I had heard before (and several times since then in Africa) that the answer to my doubts was: “If you don’t do it, no one else will. So, please, no further excuses.”

I taught the medical students from January 2008 – June 2009 and mentored a Mozambican Sociologist (Eugenio) to take over my teaching role during that period.

Teaching Approach of UCM

The medical college in Beira offers a bilingual curriculum in Portuguese and English. After my first practical skills training in English, I decided to only teach in Portuguese, since the level of English of most of my students was not sufficient to engage in a meaningful discussion or to extract meaning from an English text in a reasonable timeframe, especially for the students from the first year.

The PBL Curriculum is organized into thematic blocks. The core curriculum is centered around carefully formulated problems that are resolved by the students through a guided group process, as well as through independent self-directed learning and use of resources. Lectures and practical skills training complement the study program.

The challenge for me was to fit the learning goals I had for the students into the respective thematic blocks and to analyze how far I can refer to those formulated problems in the teaching process. You can have a look at the result in the appendix.

You can see that I used two different types of instruction: Lectures and practical skills training. In the lectures, I had students from a whole year (either year one, two, or three). In the practical skills training, the students of each year were divided into groups of ten to fifteen students, so that intensive group work and engaging students in deeper discussions was possible.

Desired Outcomes

Below are the goals (or desired outcomes) which guided me in designing the curriculum:

1. Students understand and respect the worldview and concepts of health and disease of their patients and relevant others and build a bridge between biomedical concepts and local concepts of health and disease.
One of the reasons why I stressed the doctor/patient relationship and respect for the perspective of others in general, was because I had heard complaints about the students from several professors. They said that many students tend to communicate in a top-down approach with their patients, act already like the all-knowing doctor, and call their patients or the poor population ignorant and unable or unwilling to learn. I will get back to that observation at the end of my presentation, when I talk about what I have learned.

2. Students are aware of the multiple global, national, and local factors (socio-cultural, socio-economic, politico-economic, educational, infrastructural, and environmental) that affect the health of a person, a family, or of a specific group in the population

Since those multiple factors were elaborated on in other disciplines, the students were already sensitized to it.

3. Students are aware of the influence that the world economy, their government, major NGOs, WHO, and pharmaceutical companies have on the decision making process in public health, and analyze critically public health programs and interventions in the areas of malaria, HIV, cholera, pregnancy management, use and distribution of Western pharmaceuticals, etc.

I developed this focus during my literature research for designing the teaching units. Rewarding discussions with the students were one of the results. They started enjoying the critical analysis, but found it challenging to come up with alternative approaches.

**Teaching Methods**

**Relevance**

To make the curriculum relevant for the students, I used as much research material as possible from Mozambique or the neighboring countries and I always started with a connector.

**Activate knowledge**

Whenever possible, I tried to build on their own knowledge, regularly having them work in groups, thus encouraging group discussions in the skills trainings.

I encouraged them to be self-reflective (ethnocentrism, cultural relativism, own body image, sex and gender concepts, communication style etc.). Most of them have never left Mozambique. The general teaching approach in Mozambique is frontal and rote learning. Analytical and critical thinking is not encouraged. That was one of the main reasons why the college chose to adopt the PBL curriculum from Maastricht.¹

**Critical thinking**

I challenged them to analyze critically the impact of biomedicine and its underlying worldview in Mozambique, given that at least 80 percent of the population use the services of local healers and health specialists.

I challenged them to also question if what they learn as medical students truly fits their context (e.g. communication curriculum, HIV/AIDS, and Malaria prevention campaigns, etc.).

At this point, I use a sample skills training and one lecture to demonstrate to you a little more of the curriculum:

**Skills training: Local taxonomies of diseases**

In this skills training, I first pose a problem to the students:

The government is taking steps to stem the effects of **malaria**, the deadliest disease in Mozambique. Between 2004 and 2007, 2.23 million mosquito nets were distributed, reaching 54.6 percent of pregnant women and children under five. Nevertheless, according to the latest joint review of the Mozambican government and donors, the country has registered an increase of maternal mortality of about 38 percent.

To demonstrate that globally designed health campaigns are not always successfully implemented locally and that anthropological research can improve the quality of planning, implementation, and evaluation of a program, I introduce the students to the Bagamoyo Bed Net Project (Southern coastal Tanzania), which is based upon the article of Peter Winch (1999).

While analyzing together the implementation and impact of the project, the students discover that there exist varying taxonomies for diseases in different cultures or language groups, which have consequences concerning the health behaviour of the population.

Categorizations which differ from the ones in biomedicine may lead to miscommunication and lack of cooperation with the agents of the professional sector.

The students are introduced to several anthropological rapid-research tools:

- Free listing, pile sorting, and seasonal calendars.

I want to underline the necessity of investigating, if possible, local concepts and categories of diseases in the mother tongue of the population, and to demonstrate that the population’s categorization of diseases is logical within their worldview, and based on empirical observations.

**Lecture**

This lecture is based on the book: “Social lives of Medicines” (2002), published by Susan Reynolds Whyte, Sjaak van der Geest and Anita Hardon, an excellent collection of articles on the topic.

Why did I include this lecture in the curriculum?

a) To explain which global powers and interests (WHO, pharmaceutical companies, associations of practitioners), as well as local and often divergent interests shape the distribution of Western pharmaceuticals in developing countries.

b) For students to realize that they need to investigate which sources of Western pharmaceuticals are available for their patients and how they use those for which purposes, as well as in each specific illness episode that the patient seeks help from the practitioner.

c) To demonstrate the rationality of local vendors and consumers concerning the use of these pharmaceuticals, which is often quite divergent from the biomedical rationality of global and national health planners, and may have negative effects on their health (e.g. Hausa and Zulu focus on the expulsion of the causing agent for the illness).

**What did I leave out?**

I did not include research methods because there was no time allotted for the students to do research in medical anthropology, and because I myself am not experienced in conducting research.
The family and community health curriculum of the faculty included the teaching of Participatory Action Research (PAR), and tried to put it into practice, with varying success, in small projects in a quarter near the faculty.

I did not give a systematic introduction into the history of medical anthropology and the strong shift to critical Medical Anthropology (MA) and political engagement and advocacy during the last decade, nor to interdisciplinarity. Nevertheless, in various lectures critical MA shines through in the critical analysis of the policy and the actions of global, national, and local players in the arena of health and economy.

**What I learned in the process**

Apart from what I learned by doing literature research and reading as a preparation for the teaching units and the socio-cultural knowledge that I received in the discussion with the students, I would like to mention a few others ...

I was reminded regularly that I live and teach in a society which is characterized by a high power distance (students are reminded every day that some are “more equal” than others, since they are supposed to use the back entrance of the university. The main entrance is reserved for faculty staff). Therefore I decided, for example, to dress according to my status.

I also learned that I live in a collectivistic society and that in this specific cross-cultural teaching context, it is best to let the students work and present their work as a group, never single anyone out, whether negatively or positively. Never react negatively or with criticism to any individual answer given. In other words, create a safe context for learning.

Let’s get back to the “top-down approach” of the students in their communication with their patients and relevant others, which some professors observed.

Since I also taught two of the communication curriculum units to the first year students, I asked them whether they could put the approach of “the patient as their partner” into the process of the therapeutic encounter in practice in such a high power distance society like Mozambique. They answered that their patients would not take them seriously if they treat them in the recommended way and if they ask too many questions. Their patients expect them to act in a superior way and to come up with a diagnosis quickly. Asking too many questions is interpreted as lack of competence.

Creative culturally-appropriate ways of communication with the patient and relevant others will need to be found.

I learned that conspiracy theories exist not only about HIV, but about any major public health intervention area (malaria, cholera, pregnancy management, etc.). What binds them together is the phrase “eles querem acabar consoco”, which means literally, ‘they want to finish with us, they want to kill us’. In general, the level of distrust within the society is immense concerning any interpersonal relationships in the family, neighborhood, or among colleagues, as well as towards powerful institutions and organizations. The tendency to interpret all kinds of calamities, disease, and death in the paradigm of witchcraft, sorcery, as well as ‘limited good’ is very strong. The other side of the coin is that being more successful than the average person as a farmer, student, co-worker, etc. can arouse the same suspicions. However, that would give enough material for another paper.

I learned that most of my students stand with one foot on the ground of biomedicine and the other on their local concepts of health and disease. After we had spent some sessions with one another, they opened up and told me that they are wearing amulets, believe in the power of curses and witchcraft, etc., and don’t trust their fellow students.

My guess is that in their professional life, they tend to deny “the other world” and play the role of the westernized doctor, but as members of their extended family and their wider social network, they will discuss (and probably be part of) such decision-making processes concerning the action to take when calamities strike their family or themselves.

Through constantly activating their knowledge from both worlds in our sessions and looking critically at both of them, I hope that more integration of the two worlds took place.

The students definitely identified reasons why certain biomedical approaches and public health care strategies and programs don’t have the desired impact in their context (e.g communication style, lack of
focusing on building trust with the community, not respecting their values, not knowing their concepts, taxonomies of diseases, etc.), but they struggled with coming up with alternative approaches and ideas. The time constraint of my curriculum was a negative factor. Three to four teaching units per year are not much. Medical Anthropology is a marginal subject in a medical faculty.

However, as the students engaged enthusiastically in our discussions, my hope is that they will continue to juggle the two worlds and build bridges between them in their own lives. That would be the best presupposition for them doing the same in their professional lives.

I also hope that some will continue to critically analyze the theoretical and practical knowledge they acquire during their studies, as well as the global developments which influence health care and will be innovative as future practitioners or administrators in the health sector.

I really enjoyed the teaching experience at UCM, and was probably the one who learned the most.

**Excursion PBL**

Problem-based learning (PBL) is a student-centered pedagogy in which students learn about a subject in the context of complex, multifaceted, and realistic problems (not to be confused with project-based learning). The goals of PBL are: to help the students develop flexible knowledge, effective problem solving skills, self-directed learning, effective collaboration skills, and intrinsic motivation.

In a problem-based learning (PBL) model, students engage complex, challenging problems and collaboratively work toward their resolution. PBL is about students connecting disciplinary knowledge to real-world problems—the motivation to solve a problem becomes the motivation to learn.

In problem-based learning (PBL), students use “triggers” from the problem case or scenario to define their own learning objectives. Subsequently, they do independent, self-directed study before returning to the group to discuss and refine their acquired knowledge. Thus, PBL is not about problem solving per se, but rather, it uses appropriate problems to increase knowledge and understanding. The process is clearly defined, and the several variations that exist follow a similar series of steps.

**Generic skills and attitudes**

Teamwork  
Chairing a group  
Listening  
Recording  
Cooperation  
Respect for colleagues' views  
Critical evaluation of literature  
Self-directed learning and use of resources  
Presentation skills

**Examples of trigger material for PBL scenarios**

Paper based clinical scenarios, experimental or clinical laboratory data, photographs, video clips, newspaper articles, all or part of an article from a scientific journal, a real or simulated patient, a family tree showing an inherited disorder

**PBL tutorial process**

*Step 1*—Identify and clarify unfamiliar terms presented in the scenario; scribe lists those that remain unexplained after discussion.
Step 2—Define the problem or problems to be discussed; students may have different views on the issues, but all should be considered; scribe records a list of agreed problems.

Step 3—“Brainstorming” session to discuss the problem(s), suggesting possible explanations on the basis of prior knowledge; students draw on each other’s knowledge and identify areas of incomplete knowledge; scribe records all discussion.

Step 4—Review steps 2 and 3 and arrange explanations into tentative solutions; scribe organizes the explanations and restructures, if necessary.

Step 5—Formulate learning objectives; group reaches consensus on the learning objectives; tutor ensures that learning objectives are focused, achievable, comprehensive, and appropriate.

Step 6—Private study (all students gather information related to each learning objective).

Step 7—Group shares results of private study (students identify their learning resources and share their results); tutor checks learning and may assess the group.

Staff development

Introducing PBL into a course makes new demands on tutors, requiring them to function as facilitators for small group learning, rather than acting as providers of information. Staff development is essential and should focus on enabling the PBL tutors to acquire skills in facilitation and in management of group dynamics (including dysfunctional groups).
## Appendix

### Overview of the Curriculum of Medical Anthropology

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<tr>
<th>Year</th>
<th>Block</th>
<th>Teaching Units of Medical Anthropology</th>
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| 1    | Introduction to Medicine | *Lecture: Introduction to Medical Anthropology*  
Concept of culture, emic versus etic view, cultural relativism, ethnocentrism, different factors which influence health and disease (apart from socio-cultural concepts), research methods, model of health care system (Kleinman).  
*Skills training: Introduction to concept of Explanatory Models* (EM’s, Kleinman), example childhood diarrhea, association with task 13 from block booklet. |
| 1    | Attack and Defense     | *Lecture: Use and distribution of (Western) pharmaceuticals in developing countries*  
Influence of interests of global and local agents in this field in the formal and informal sector.  
Inclusion of Western pharmaceuticals into local cultural categories for remedies and treatment. What is rational use of pharmaceuticals? |
| 1    | Balance and Imbalance  | *Lecture: Rituals*  
Theory on rituals, in general (Victor Turner, van Gennep).  
Closer look at rituals of reconciliation, using an example from Mozambique. |
| 2    | Birth and Growth       | *Lecture: Culture and Nutrition*  
Overview of socio-cultural classifications of foods.  
The influence of local socio-cultural concepts and social networks on malnutrition (undernutrition and obesity).  
Negative influence of global economic injustice and power of global players on nutrition in developing countries.  
Reflection on infant feeding practices in Mozambique and diet of breastfeeding mothers.  
*Lecture: Pregnancy management in Central Mozambique*  
The strategies of women to protect their pregnancy and fertility (planned). |
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<th>Health Determinants (Public Health)</th>
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<tr>
<td></td>
<td><strong>Skills training: sex and gender issues</strong></td>
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<td></td>
<td>Introduction to gender concept. Elaboration in groups of personal concept of masculinity/femininity and of societal stereotypes. Search for inconsistencies/contradictions in gender roles. Possible consequences for physical and mental health. Deconstruction and reconstruction of gender roles an option?</td>
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<td><strong>Skills training: Biomedical discourses on HIV/AIDS and local anti-discourses in Africa.</strong></td>
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<td>Discussion about extreme relevance of diverging EM’s (see block 1.1), differing values, and sex and gender issues in the case of HIV/AIDS. Antidiscourses in Mozambique. Present research of James Pfeiffer on PSI social marketing campaign of condoms in Chimoio in the 1990s. Analyze campaign critically. Make association with tasks 2a and 2b.</td>
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<td></td>
<td><strong>Mental Disorders</strong></td>
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<td><strong>Lecture: cross-cultural psychiatry</strong></td>
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<td>Socio-cultural factors influence strongly the perception and behaviour of patients as well as the reactions of the specific society or social group to certain behaviours. Introduce model to analyze concepts of normality Present three different approaches (biological, social labelling and combined approach) as basis for discussion, if biomedical categories of mental diseases can be employed universally. Present concept of symbolic healing. <strong>Lecture: PTSD and Rituals of reconciliation in Mozambique</strong> Introduction to Post traumatic stress disease. Post traumatic stress in Mozambique (example war traumatized population in Gorongosa and the local therapeutic answer to it, Gamba rituals (= a specific form of reconciliation rituals).</td>
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<td></td>
<td><strong>Fever and Infectious Diseases I or II</strong></td>
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<td></td>
<td><strong>Skills training: Disease taxonomies (Ex. Malaria)</strong></td>
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<td>There exist varying taxonomies for diseases in different cultures or language groups, which have consequences concerning the health behaviour of the population. Ex.: Analysis of a bed net distribution project in coastal Tanzania. <strong>Skills training: Biomedical discourses on Cholera and local anti-discourses in Mozambique</strong> (based on Carlos Serra 2003: Colera e Catarse, local newspaper articles, designed by Eugenio ).</td>
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<td><strong>Pain</strong></td>
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<td><strong>Skills training: Pain and culture</strong></td>
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References


