



Collaboration with  
traditional healers in  
**HIV/AIDS** prevention and care  
in sub-Saharan Africa  
A literature review



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# Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa

## A literature review



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Traditional healers develop training materials in Mukono, central Uganda.



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# Introduction

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HIV/AIDS is now the number one overall cause of death in Africa, and has moved up to fourth place among all causes of death worldwide, according to the latest annual *World Health Report*.

As the epidemic continues to ravage the developing world, it becomes increasingly evident that diverse strategies to confront the wide-ranging and complex social, cultural, environmental and economic contexts in which HIV continues to spread must be researched, tested, evaluated, adapted and adopted. The majority of populations in developing countries have access to traditional health care and it is widely accepted that about 80% of people in Africa rely on traditional medicine for many of their health care needs. Traditional healers are well known in the communities where they work for their expertise in treating many sexually transmitted diseases<sup>1</sup> (Green, 1994). Consequently, the World Health Organization (WHO) has advocated the inclusion of traditional healers in National AIDS programmes since the early 1990s.

The aim of this report was to give a brief update on AIDS and traditional medicine in Africa, and to review initiatives that have attempted collaboration between traditional and biomedical practitioners for AIDS prevention. There is, however, a dearth of research actually testing the impact of involving traditional healers in AIDS prevention efforts. Most reports—even evaluation reports—often state only achievements and findings. This review first looked as broadly as possible at all interventions involving traditional healers in AIDS prevention and care in sub-Saharan Africa. Eight projects that most closely met UNAIDS Best Practice criteria (*effective* and *ethical* interventions that are *efficient*, *sustainable*, and *relevant* for AIDS prevention in the resource-constrained settings of sub-Saharan Africa) were then selected and compared.

In addition to the UNAIDS criteria, supplementary standards were defined that are specific to traditional medicine/biomedicine collaborative projects. Data were collected through published and unpublished literature, through personal contacts, e-mail correspondence, circulation of a questionnaire and by attending the First International Conference on AIDS and Traditional Medicine in Dakar, Senegal, in March 1999.

The report is organized into four sections. The first section gives a brief update on AIDS in Africa and is followed by background information on African traditional medicine. This includes strengths and limitations of traditional medicine and healers with respect to collaboration with biomedicine, and the continuing policy debate on the integration, cooperation, and collaboration of traditional medicine with national health care systems. The second section reviews collaborations between traditional medicine and biomedicine for AIDS prevention, including a comprehensive table of collaborative initiatives. The third section analyses traditional medicine/biomedicine collaborative projects with reference to the UNAIDS Best Practice Criteria of effectiveness, efficiency, relevance, ethical soundness and sustainability, and adds suggested specific criteria for these types of projects. As many projects had not reported specifically on these criteria, a list of issues to consider in order to conform to Best Practices was included in each subsection. Finally, since this continues to be an extremely exploratory field, the last section identifies needs for further research on collaboration between health sectors.

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<sup>1</sup> Researchers in some countries have noted that some other illnesses and conditions not classified as sexually transmitted in biomedical nosology may be locally regarded as such by traditional healers and their clients (Green, 1994).

# *AIDS and traditional medicine in Africa*

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## Background

Since the beginning of the epidemic, an estimated 34 million people living in sub-Saharan Africa have been infected with the virus. In 1998, 70% of the people who became infected with HIV and four-fifths of all AIDS deaths were in sub-Saharan Africa. In addition, at least 95% of all AIDS orphans have been African<sup>2</sup>. AIDS was responsible for an estimated 2 million African deaths, which could account for 5,500 funerals a day. And despite the scale of death, today there are more Africans living with HIV than ever before: 23.5 million adults and children (UNAIDS, 1999).

The majority of new infections continue to be concentrated in Eastern and Southern Africa, though no country is spared. In Botswana, Namibia, Swaziland and Zimbabwe, current estimates indicate that between 20% and 26% of people aged 15–49 are living with HIV or AIDS. Zimbabwe for example, is very hard hit. In 23 of 25 surveillance sites, over 20% of all pregnant women were found to be infected. About one-third of these women are likely to pass the infection on to their babies. In Central African Republic, Côte d'Ivoire, Djibouti and Kenya, at least one in ten adults is HIV-infected. In Rwanda, the median prevalence among women attending antenatal clinics in major urban centres was about 28% and, in Uganda, the prevalence has dropped in recent years to 15% in the same population. West Africa is generally less affected by HIV than Southern or Eastern Africa (UNAIDS, 1998).

Today, interventions to stem the spread of HIV/AIDS throughout the world are as varied as the contexts in which we find them. Not only is the HIV epidemic dynamic in terms of treatment options, prevention strategies and disease progression, but sexual behaviour, which remains the primary target of HIV/AIDS prevention efforts worldwide, is widely diverse and deeply embedded in social and cultural relationships, as well as environmental and economic processes. This makes prevention of HIV/AIDS very complex.

Most preventive interventions have relied on giving correct information about HIV transmission and prevention and imparting practical skills to enable individuals to reduce their risk of HIV infection. More recently, sociocultural factors surrounding the individual have been considered in designing prevention interventions. In addition, beyond the individual and his or her immediate social relationships, larger issues of structural and environmental determinants also play a significant role in sexual behaviour and thus are addressed in intervention design and implementation.

Monitoring and evaluation of prevention programmes have shown that prevention does work. In countries that have implemented quick, well-planned efforts with support from political and religious leaders, including sex education in schools, treatment of STDs (sexually transmitted diseases), and widely promoted condom use, HIV prevalence has been kept consistently low and has even decreased in some countries in the last five years (UNAIDS, 1998). Yet, cases of decreased HIV prevalence are still the exception and many developing countries are struggling to find innovative, cost-effective strategies that are relevant to their AIDS situation. In resource-constrained settings, one avenue that has still been rarely travelled is cooperation with the indigenous health system.

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<sup>2</sup> UNAIDS defines AIDS orphans as people who lost their mother or both their parents to AIDS when they were under the age of 15.

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## The role of traditional medicine

Traditional healers represent a broad range of practices, including herbalism and spiritualism, as well as a range of individuals who call themselves diviners, priests and faith healers, among other terms. Although many of the initiatives reviewed here did not differentiate between these categories, the term 'traditional healer' used refers to either herbalists, spiritualists, or to those (the great majority of healers) involved in both practices.

African traditional healers mirror the great variety of cultures and belief systems on the continent, and possess equally heterogeneous experience, training and educational backgrounds. This diversity is further enhanced by their adaptations to the dramatic social changes that have affected much of the region since colonization, such as urbanization, population migration and displacement, and civil conflict (Good, 1987). The cost of traditional medical care varies with the nature of treatment, the type and severity of ailment and the relative wealth of the client (Porter, 1996; King et al, 1992). Whenever African healers' knowledge, attitudes, beliefs and practices about STDs and AIDS have been explored, findings have reflected the stage of the epidemic, the amount of information traditional healers have been exposed to, and their pre-existing belief systems about health and disease in general, and STDs and AIDS in particular.

Many traditional healers have treated STDs for generations, but their explanations of STDs and AIDS vary considerably across ethnic backgrounds with regard to the nature, causes and modes of transmission of these diseases. However, the concepts underlying these explanations appear remarkably similar across national and cultural boundaries. Perhaps the most striking example is the origin of STDs: healers in many settings, whether rural or urban, often ascribe these to transgressions of taboos related to birth, pregnancy, marriage and death (Green, 1992, 1994; King et al, 1993). At the same time, some of Africa's most serious diseases, including AIDS and other STDs, are often understood within a framework of contagion which could include invasion of the body by dangerous microorganisms, pollution or environmental dangers (Green, 1999).

While social research has shown that, in many countries, healers could name and describe numerous types of STDs (which do not always correspond to the biomedical definition of STDs), few of them consider AIDS an 'African' disease (Green, 1992a; Green et al, 1993). Traditional beliefs about the prevention of STDs or HIV/AIDS follow the logic of transmission and causation, and include limiting the number of sexual partners, wearing protective charms or tattoos, having 'strong blood', using condoms to reduce the risk of 'pollution', or undergoing a 'traditional vaccination' consisting of introducing herbs in skin incisions (Green, 1992a; Green et al, 1993; Nzima et al, 1996; Schoepf, 1992). In numerous cases now, condoms have been acceptable to traditional healers, especially when they fit into their belief system. For example, many African healers consider semen an important element to nourish a growing foetus and maintain the mother's health and beauty, but their concern for family and cultural survival can override this belief and allow them to promote condom use (Green et al, 1993; Schoepf, 1992).

## Health policy and traditional medicine in sub-Saharan Africa

With growing interest and increasing need for expanded health care in the past 20 years, the governing bodies of WHO have adopted a series of resolutions. Policies regarding collaboration with traditional medicine have been shifting since the late 1970s. As early as 1974, the WHO Regional Committee for Africa decided that the topic for the technical discussions at its upcoming twenty-sixth session would be "Traditional medicine and its role in the development of health services in Africa." Three years later, the World Health Assembly adopted a resolution

promoting training and research related to traditional medicine. In 1978 in Alma Ata, WHO and UNICEF adopted resolutions supporting the use of indigenous health practitioners in government-sponsored health programmes.

In 1984, 1989 and 1990, further resolutions were adopted, encouraging specific measures governing the practice of traditional medicine to be incorporated within national health legislation, adequate budgets to allow promotion of traditional medicine, the development of traditional medicine systems, effective launching of these programmes, and inventories of medicinal plants. In 1990, the WHO Traditional Medicine Programme and the WHO Global Programme on AIDS came together in Botswana to consider ways to involve traditional health practitioners more actively in measures to prevent and control HIV infection and AIDS in African communities. In 1994, the WHO offered further observations and direction regarding traditional healers, suggesting that upgrading their skills made more sense than training new groups of health workers, such as village health workers.

Since then, changing policies and a growing body of data concerning cooperation with traditional healers have fuelled an ongoing debate on the public health relevance of investing in efforts for partnership with traditional healers. In this debate, the following points are made in favour of collaboration:

- Traditional healers often outnumber doctors by 100 to 1 or more in most African countries. They provide a large accessible, available, affordable trained human resource pool.
- Traditional healers possess many effective treatments and treatment methods.
- Traditional healers provide client-centred, personalized health care that is culturally appropriate, holistic, and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues. This is especially important in the case of STDs.
- Traditional healers often see their patients in the presence of other family members, which sheds light on the traditional healers' role in promoting social stability and family counselling.
- When traditional healers engage in harmful practices, there is a public health responsibility to try to change these practices, which is only possible with dialogue and cooperation. Research has shown that traditional healers abstain from dangerous practices when educated about the risks.
- Traditional healers are generally respected health care providers and opinion leaders in their communities, and thus are treating large numbers of people living with HIV/AIDS. Healers have greater credibility than village health workers (who are often their counterparts in village settings), especially with respect to social and spiritual matters.
- Since traditional healers occupy a critical role in African societies, they are not likely to disappear soon. They survived even strict colonial legislation forbidding their practice. Even with the rapid sociocultural changes occurring in many African societies, traditional healers continue to play a crucial role in addressing the variety of psychosocial problems that arise from conflicting expectations of changing societies.
- Numerous studies (see below) document traditional healers' enthusiasm for collaborating with biomedical health providers and show that their activities are sustainable as they generate their own source of income.

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- Many biomedical health providers want such collaboration (Oja & Steen, 1996).
  - Especially since the 1980s, healers have been organizing themselves into traditional healers' associations, which makes it easier to establish collaborative programmes.
  - Efforts at collaboration seem to improve health delivery in a number of ways:
    - increased knowledge and skills of traditional healers
    - increased confidence in their practice
    - increased openness (transparency) towards the community within their work
    - earlier referral to hospital or health centre

Points against, or weaknesses of, collaboration include:

- The training and licensing of healers is not institutionalized, which makes it difficult to reach and train them regularly in a standardized manner
- Quality control of healers is difficult in the absence of officially recognized licensing procedures
- There is no general monitoring of healers' activities or claims
- Traditional healers lack detailed anatomical and physiological knowledge
- Traditional healers may engage in some harmful practices or cause delays in referral to biomedical facilities
- Promotion and improvement of traditional methods may undermine efforts to increase access to biomedicine
- The effects of combining traditional and biomedical treatments are not known and may be harmful
- Official recognition of traditional medicine gives legitimacy to traditional healers when their treatments and methods are still largely untested
- Opening up collaboration with traditional healers raises their expectations of greater recognition from government, which governments may not be able to give.

Many public health experts involved in this ongoing debate have concluded that, despite the limitations, it makes sense to at least attempt collaboration, given the vast health needs in developing countries and the numerous realistic and practical advantages. The following section discusses eight projects that have developed collaboration between biomedical and traditional health practitioners for AIDS prevention and care. In addition, Guinea is also discussed as a supplementary case, since the government has tried to integrate traditional healers into many different aspects of health care, though not specifically AIDS.

A healer tends a herbal garden in Mbarara, western Uganda.



## *Selected examples of collaboration in AIDS prevention and care*

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The African continent, being the region most affected by AIDS and the poorest in modern health resources, should be an obvious place for collaborations between traditional and biomedical health care. However, despite the multitude of health challenges affecting the African people, very little action has been taken to actually work with healers since the WHO's recognition of the importance of traditional medicine to primary health care, and of the need to include healers in national health strategies and policies (WHO, 1977, 1978, 1991). Certainly, considerable prejudice remains ingrained among many biomedical health practitioners about the justification, validity and integrity of traditional medical practices and practitioners. An important reason for this is the absence of regulatory bodies governing the practice of traditional medicine in most of Africa, which makes it easier for charlatans to infiltrate the profession and abuse its reputation.

Nevertheless, the WHO recommendations are based on the premise shared by many researchers, physicians and public health experts that, as a highly respected, widely distributed and highly consulted group of health practitioners, recognized traditional healers have the cultural knowledge and skills to make an impact on the prevention of disease (including AIDS), as well as on health promotion and care (Staugaard, 1991; Green, 1992a,b, 1993, 1994, 1995). The traditional healer is frequently consulted as a religious and spiritual guide, legal and political adviser, and marriage and family counsellor (Staugaard, 1985). In addition, STDs are among the most common reasons for visiting the traditional healers in many African countries where many people believe that, while biomedicine can effectively cure physical symptoms of 'modern' diseases, healers are expected to completely heal the body and spirit, and to cure diseases considered distinctly 'African' (i.e. believed to be due to forces beyond modern medicine's comprehension) (Staugaard, 1985,1991; Green, 1992a,b, 1994, 1995; Green et al, 1993; Fink, 1990). In fact, many people in Africa believe that biomedical health practitioners cannot effectively and completely cure STDs (Green, 1999). Finally, women, whose social, cultural and economic position in Africa makes them especially vulnerable to STDs and AIDS, often constitute the majority of traditional healers' clients (Homsy & King, 1996).

Since the beginning of the AIDS epidemic, there has been a renewed interest in collaboration with traditional healers in the hope of finding new, more effective ways to fight and prevent this disease. Initially, a number of projects attempted to assess the value of traditional herbal remedies for the treatment of illnesses associated with AIDS (Musinguzi & Twa-Twa, 1991; Akerele et al, 1993; Ssenyonga, 1994; Ssenyonga & Brehony, 1993a; Ssemukasa & Brehony, 1993; Sofowora, 1993; Homsy & King, 1996; Lynde, 1996). Other studies were conducted on traditional healers' perceptions of STDs, HIV and AIDS. With these results, collaborative efforts have created programmes that trained traditional healers as educators and counsellors to disseminate HIV/AIDS information and prevention practices among their peers and communities. As a means of involving traditional healers further, some projects have encouraged healers to empower and provide emotional support to clients living with HIV and AIDS.

With the realization that traditional healers could become effective health workers for HIV/AIDS prevention, given their traditional roles as educators and counsellors in their communities, a number of projects started training healers in HIV/AIDS as early as the late 1980s (Staugaard, 1991; Green et al, 1993, 1994; Schoepf, 1992). Some initiatives have noted that

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'training' healers implies a different approach than that used with conventional health workers, to whom knowledge tends to be imparted unidirectionally. With traditional healers, only a respectful attitude of open exchange of ideas and information can win trust and cooperation. The projects reviewed below used that approach. Few have any follow-up data.

This report addresses initiatives (in alphabetical order) that attempted a collaboration between traditional and biomedical health practitioners for HIV/AIDS prevention, education and counselling. It does not include collaborative projects solely focusing on herbal remedies for HIV infection. The nature, objectives, methods, achievements and findings of these initiatives are summarized in the annexed Table 1.

## BOTSWANA

In Botswana, where the 1997 national serosurveillance data showed an HIV prevalence of 38.5% among pregnant women in urban areas, the government has had for more than 18 years a policy of actively promoting cooperation between modern and traditional medicine (WHO, 1991; Staugaard, 1985). Activities of the Ministry of Health/National AIDS Programme for traditional healers have included seminars on AIDS, and implementing the Botswana Dingaka AIDS Awareness and Training Project. This project took place between 1991 and 1993 with the objective of training traditional healers as trainers who would pass AIDS information on to other traditional healers in selected pilot areas, and promoting cooperation and collaboration between traditional and biomedical health services (see Table 1). The original training of trainers lasted two weeks and involved 12 healers in six districts of Botswana. Trained healers were then to travel together to other districts to train 40 other healers in each district. Once trained, newly trained healers were expected to train more healers, obtain condoms from health centres and distribute them to their clients and communities (Mbongwe & Mokganedi, 1993).

Four of the five workshops planned for the second-generation healers took place. However, funding was terminated after the first phase of the project, so neither group of healers was followed-up or formally evaluated for effectiveness of the training or for accomplishment of stated objectives within the duration of the project. However, an independent assessment of the Botswana Dingaka AIDS Awareness and Training Project, conducted in 1994, interviewed 32 traditional healers, 19 nurses and 20 medical doctors; 72% of the traditional healers interviewed stated that they had changed something in their practice in relation to the new information on AIDS and 80% said that, after training, they recommended condoms to their patients, while 31 of the 32 stated that they referred patients to clinics or to the hospital (Oja & Steen, 1996). Interestingly, 17 of 19 nurses interviewed claimed that they also referred patients to traditional healers, but only 7% of the medical doctors reported doing the same.

In a second assessment in 1995, three of the 12 first-generation healers interviewed said they were able to disseminate information in their communities, had referred patients to the hospital when their treatments failed, and had no hesitation in distributing condoms or talking about sexual issues with clients (King, 1995). All three healers also claimed they had many STD patients, yet had not, so far, had a patient whom they believed had AIDS. When asked how they would manage a person with AIDS, they all said there was nothing they could do, since they didn't have a treatment for AIDS. They were not aware of the clinical case definition of AIDS, and were not referring their clients for HIV testing and counselling. They did not see themselves playing a role in home-based care for persons living with HIV/AIDS (King, 1995).

## CENTRAL AFRICAN REPUBLIC

A one-year project to increase traditional healers' capacity to deliver preventive messages, provide support to persons living with HIV/AIDS, and modify their own risk practices was started in 1995 in the Central African Republic, where HIV seroprevalence among adults was estimated at 15% in Bangui and 4% in rural areas (Johnson, 1996). Over two months, 103 healers in four locations received six days (36 hours) of STD/AIDS information and training on community education (Somsé et al, 1995; Johnson, 1996). At the end of training assessment, traditional healers' knowledge had significantly improved regarding:

- the role of STDs in increasing risk of HIV infection
- condoms protecting against HIV
- the causes of genital discharge and ulcers
- STD complications
- the modes of HIV transmission and prevention (Somsé et al, 1995).

Knowledge and attitudes regarding traditional healers' risk practices of transmitting HIV and towards condom use did not improve. The authors suggested that attitudes towards condom use may not have changed because of the conflict with the desire to have children, but did not suggest reasons as to why healers' knowledge did not change with regard to appropriate modes of care.

The objectives of supporting persons living with HIV/AIDS and changing healers' practices were not measured in detail in the first analysis. However, of the traditional healers who reported seeing STD cases, 76% reported integrating partner referral into their STD treatment.

## GUINEA

In 1979, the Ministry of Public Health and its Department of Traditional Medicine began to collaborate with traditional healers on primary health care in Guinea. In the 1990s, when the prevalence of HIV was still below 1.5% among women in prenatal care, an initiative was aimed at identifying how traditional medicine could increase the effectiveness of the National AIDS Programme and answer the following questions:

- For what STDs are traditional healers consulted?
- How do traditional healers diagnose and treat STDs?

A survey implemented by the Department of Traditional Medicine and a research study completed by ORSTOM (Institut français de recherche scientifique pour le développement et coopération) both indicated that gonorrhoea was the STD most frequently diagnosed by the traditional healers.

In addition, the National AIDS Programme financed two training workshops for traditional healers with the objective of increasing knowledge about AIDS transmission and prevention, clinical manifestations of AIDS, and AIDS care. Unfortunately, further training could not continue due to lack of funding. Investigators suggested that educational messages should be specifically designed to reinforce, and not to contradict, traditional concepts of disease and

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illness (e.g. using the same names of diseases, which helps to gain the interest and trust of traditional healers). The objectives were "to bring traditional healers as effective educators at the community level, to give quality treatment, and to refer in time for all conditions he/she cannot treat." In one district of the country, the AIDS office, in collaboration with healer associations, organized training sessions for healer association members. It was realized that healers could play a significant role in health education, promotion and distribution of condoms, treatment of opportunistic infections, early referral, and participation in research on AIDS and STDs. In addition, traditional healers are involved in other primary health care issues such as immunization, nutrition education and sanitation. The district also did significant research and documentation on plants used in STD and AIDS treatment by traditional healers (Traditional Medicine and AIDS report, Ministry of Health, Guinea, 1998).

## MALAWI

In the Chikwawa District of Malawi, which in 1996 had an estimated HIV seroprevalence of 30.5% among women in antenatal care clinics in major urban areas (UNAIDS, 1998), a series of orientations and focus group discussions were held with groups of traditional healers. In 1993, based on requests from traditional healers, AIDS activities were initiated within an already established eye care programme with the following objectives:

- to better understand the practices and roles of healers in their communities
- to promote greater communication between traditional healers and the 'formal' health sector
- to educate traditional healers about HIV/AIDS and STD transmission and prevention
- to encourage community-based HIV/AIDS prevention and care activities by traditional healers.

A baseline survey was conducted with 89 healers regarding their knowledge, attitudes, beliefs and practices surrounding AIDS. Using the results of this survey, a curriculum (including modes of HIV transmission, condom use, and AIDS education messages) was developed for one-day workshops in 14 sites emphasizing community education and condom distribution (Berger & Porter, 1994; Porter, 1996). Healers were selected through recommendations from community leaders to participate in training sessions. A total of 352 healers were reached in the first of 2 training programmes. Six months after the first training, 61 healers were randomly selected for an evaluation of the training sessions. The evaluation found that 64% of the healers had conducted AIDS educational sessions and 89% had distributed condoms. Those conducting educational sessions were more likely to distribute condoms compared to those who were not involved in AIDS education. Unfortunately, when traditional healers ran out of condoms, many did not seek out health centres to replenish their supply. Moreover, the authors comment that changing community and traditional healers' values about STDs is more challenging than changing those about AIDS. Though the aspect of collaboration was not formally evaluated, investigators suggest that more collaborative referral networks need to be encouraged.

## MOZAMBIQUE

In 1996, Mozambique had an official overall HIV prevalence of 5.8% in major urban areas and 19.2% outside of urban centres (UNAIDS, 1998). As early as 1991, a three-year programme was initiated by the Ministry of Health's Department of Traditional Medicine with the aim of

decreasing the spread of HIV by reducing the incidence of STDs through a collaborative effort with a local healer organization (Green et al, 1993; Green, 1994). Preliminary qualitative research on traditional healers' perceptions of STDs and AIDS revealed a strong belief that biomedical practitioners "do not understand the true cause of STDs." The survey also showed that all traditional healers had heard of AIDS, had complete faith in their medicines, advised avoiding biomedicine for STDs, and believed a number of illnesses (but not AIDS) to be sexually transmitted (Green et al, 1993). A training strategy was proposed whereby new concepts such as promoting condom use would be integrated into existing notions of protection, and traditional principles (such as discouraging sex outside marriage or promoting sexual abstinence during STD treatment) would be reinforced. At the same time, old practices, such as traditional vaccination involving healer-to-patient or patient-to-patient blood contact, would be discouraged (Green, 1992a; Jurg et al, 1992).

Based on this strategy, two one-week workshops were conducted for 30 healers in two provinces of the country, in 1991 and 1994. An assessment of the 1994 workshop included 70% of the trained healers and eight patients of trained healers. The evaluation found that most traditional healers had learned about the sexual transmission of HIV, 75% reported condom use as a way to avoid AIDS, and 81% claimed to promote condoms with at least their STD patients. However, confusion remained as to the relationship between STDs, HIV and AIDS and about whether AIDS is curable (Green, 1995a).

## SOUTH AFRICA

In South Africa, HIV seroprevalence has been rising rapidly in the past few years, reaching 15% in 1997 among women in antenatal clinics in urban areas and 18% in more rural antenatal clinics. Traditional medicine has remained an important component of health services, despite a high rate of modernization. A project was started in 1992 to train 27,000 traditional healers nationwide about AIDS in three successive cycles (Green, 1994, 1995b; Mgiba et al, 1993; Mancini et al, 1993). The strategy was to train 30 healers as trainers, who would each train a second group of 30 healers, who would then repeat the cycle. The initial five-day training covered topics similar to those described in other programmes above, in addition to the issue of death and dying.

Eighteen of the trained traditional healers reported having trained 630 second-generation healers in different regions of the country seven months after the first training. A preliminary evaluation of this second generation focused on 70 trained healers selected from 10 geographically representative sites (Green, 1995b). Ninety percent of them thought that the demonstration of correct condom use was the most useful aspect of the workshop. These healers had correctly retained basic information on gonorrhoea, HIV as an infectious agent, HIV symptoms, and modes of HIV transmission and prevention. Of 18 healers who said they had treated cases of AIDS, three mentioned giving advice and counselling to their clients without being prompted (Green, 1995). When prompted, the other 15 described promoting positive attitudes about people with AIDS, or showing care and understanding as to the type of advice or counselling given, while eight mentioned advising on condom use (Green, 1995). The assessment concluded that the first generation of trained traditional healers selected and trained their peers for the second cycle more effectively than the western-trained trainers of the first generation, as the traditional healers' selection was less politically directed and the training more culturally appropriate (Green et al, 1995).

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## UGANDA

HIV seroprevalence is among the world's highest in Uganda. In the early 1990s, two NGOs, the Ministry of Health and the National AIDS Commission launched an initiative called Traditional and Modern Health Practitioners Together against AIDS (THETA). The aim was to promote a true collaboration between traditional healers and biomedical health providers in the area of treatment, care, support and prevention of STDs and AIDS (Homsy & King, 1996). In 1992, the first THETA project attempted a collaborative clinical study to evaluate herbal treatments for HIV/AIDS symptoms for which few or no therapeutic options were available in the region (Homsy et al, 1995). When this study began, healers were unwilling to discuss AIDS with their clients because they feared losing them with this terminal diagnosis. These challenges motivated a second project to empower traditional healers to provide STD/AIDS counselling and education. The project had a particular emphasis on the healers' women clients in Kampala, where the prevalence of HIV had levelled around 30% in pregnant women at that time<sup>3</sup> (Ugandan Ministry of Health, 1996).

For this study, 48 Kampala healers were selected through home and clinic visits to answer a baseline questionnaire related to their knowledge, attitudes, beliefs and practices surrounding STDs and AIDS (King, 1994a). Following this survey, 17 healers were recruited to participate in a 15-month 'training' programme including an average of three training days a month. The original training curriculum was developed in collaboration with The AIDS Support Organization (TASO) and with the input of both healers and community women. Content focused specifically on STDs and AIDS, but also covered general topics such as cultural beliefs and practices, counselling, leadership, sexuality, gender, and legal issues (King, 1994b).

Healers' overall performance was evaluated systematically using various indicators with each traditional healer, his/her clients and the community. Research methods included oral and written tests, regular visits to the healers' workplace, client follow-up interviews, and sessions in which a trainer observed a healer practising education or counselling (King, 1994b; Nshakira et al, 1995; Nakyanzi et al, 1996). Each healer was found to have applied the training differently, some using their new skills for community education, others for counselling and/or initiating persons living with HIV/AIDS, youth or women's support groups (Homsy & King, 1996). Community education by healers proved to be a very interactive process whereby traditional healers designed their own training materials, and developed and used unique approaches such as story-telling, personal testimonies from persons living with HIV/AIDS, music, dance, poetry and drama to convey their messages. A preliminary assessment was conducted one year after the end of the training programme, comparing three communities where healers had completed the THETA curriculum with one community where traditional healers had not been trained. The community members with trained healers showed increased knowledge about HIV/AIDS and reported increased condom use (50% versus 17% where the traditional healer was not trained) and reduced risk behaviour (Nshakira et al, 1995).

Healers' counselling was evaluated by interviewing 180 women clients consulting for HIV symptoms, STDs, or 'love' problems, with nine trained healers and following them up three and six months later (King, 1994b). The proportions of women who reported having both received counselling from their healer (45 to 72%) and been tested for HIV (46 to 64%) had risen significantly by the second follow-up. During counselling, women said healers discussed facts about AIDS, positive living, condom use, and had demonstrated and offered condoms (King,

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<sup>3</sup> HIV seroprevalence has since declined in Uganda—to a level of 14.7% in antenatal clinics in major urban areas in 1997.

1994b). Condom knowledge, attitudes and use were found to significantly increase over time among these women, as did condom negotiation by women with their sex partners. However, at six months, eight out of 39 (21%) women still said that one could tell someone had AIDS by "pale skin or eyes".

Finally, within the first year of training, three of the trained healers spontaneously initiated the formation of 'persons living with HIV/AIDS' support groups for their clients, some of whom achieved local renown for their educational songs, drama and dance on AIDS (Lattu et al, 1994). Based on these results, the THETA initiative has been expanded to six rural districts of Uganda, using the framework developed in the Kampala pilot study. A participatory evaluation of THETA conducted in 1997-1998 showed that:

- 125 healers were trained in the first five districts selected
- 60% of trained traditional healers (compared to 9% of untrained traditional healers) reported distributing condoms
- 80% of trained traditional healers (compared to 40% of untrained traditional healers) reported counselling patients
- 82% of trained traditional healers (compared to 42% of untrained traditional healers) reported giving AIDS community education
- cross-referral of patients increased, with 97% of trained healers referring patients.

Other benefits of training included: better hygiene, initiation of record keeping, decreased fees, initiation of patient support groups and improved collaboration with biomedicine (THETA, 1998).

In addition to training activities, THETA conducts clinical activities and has initiated the creation of a resource centre for traditional medicine and AIDS. Clinical activities have included a study assessing herbal treatments of traditional healers for specific HIV-associated symptoms, and training for traditional healers on basic clinical diagnosis. The resource centre contains a library with material on traditional medicine and AIDS, and has produced two videos and a newsletter that comes out three times a year. It also conducts a monthly speakers' bureau where topics relevant to traditional medicine and AIDS are discussed and debated among practitioners of traditional medicine and biomedicine, as well as patients of both systems.

## UNITED REPUBLIC OF TANZANIA

HIV seroprevalence reached 13.7% in 1996 in antenatal clinics in urban centres in the United Republic of Tanzania. In 1989, the impact of HIV motivated collaboration between traditional and biomedical health workers in the Tanga region of North Eastern Tanzania. During early collaborative meetings between traditional healers and biomedical physicians, a spirit of mutual respect was established, and experiences were shared on care and prevention of HIV/AIDS as well as other mostly infectious diseases (Scheinman et al, 1992). Due to the enthusiasm of both sides of the partnership, the collaboration spread to the rest of the region, influencing the formation of the Tanga AIDS Working Group (TAWG) in 1992. The main goal of the organization was to stop the spread of HIV and other STDs and to reduce the impact of the disease in the region (Scheinman et al, 1992). With the assistance of existing village health projects and sensitization meetings with local leaders and the community, TAWG has been collaborating with about 120 traditional healers in two districts of Muheza and Pangani. Training

of traditional healers included basic information about STDs, HIV and AIDS, and information on AIDS counselling and care, condom promotion and community behaviour change. In addition, traditional healers were trained in hygiene and sterile procedures for their equipment. Field supervision and monitoring followed training.

The results reported by TAWG showed that 60 traditional healers and 60 traditional birth attendants have been trained and have:

- conducted home visits to 237 persons living with HIV/AIDS
- made 1,600 referrals for HIV testing
- made 5,400 referrals of biomedical health workers to TAWG for counselling
- organized 1,241 educational sessions conducted by traditional healers and biomedical health providers as a team, reaching more than 19 290 people
- promoted and sold condoms (Salama Condom sales increased by 50%).

Based on the lessons learned in Tanzania, which may be useful to other countries attempting similar collaborative efforts, TAWG makes the following recommendations:

- Sensitization of biomedical and traditional health practitioners, as well as community leadership, is essential for establishing mutual trust and understanding of roles and expectations among the key players.
- Specific training on STDs and AIDS for particular groups, such as biomedical and traditional practitioners, is essential not only in imparting badly needed information and skills related to their practice, but also to improve their confidence.
- The existence of local medicines for treatment of opportunistic infections provides a basic ingredient in home-based care services provided by counsellors.
- Involvement of traditional healers in identifying community needs for AIDS education leads to culturally grounded messages that are relevant, culturally sensitive and have the best potential for influencing behaviour change (Mberesero et al, 1995).

## ZAMBIA

HIV prevalence in Zambia is now one of the highest in the world, and was estimated at around 26.5% in Lusaka (UNAIDS, 1998). In 1987, the Ministry of Health designed a workshop to train healers about AIDS, which 40 healers attended (Chirwa & Sivile, 1989). It was found that their knowledge about HIV transmission, and their attitudes about people living with HIV and AIDS improved after the workshop. However, 43% of traditional healers still believed that abortion could cause AIDS (compared to 58% before training).

AIDS prevention activities with traditional healers were not followed up until 1994, when the Zambian Ministry of Health Traditional Medicine Unit, supported by the Morehouse University School of Medicine (USA), developed an STD/AIDS training programme for traditional healers. This consisted of three-day workshops and emphasized follow-up through healers trained in community education (Anyangwe et al, 1995). In 18 months, the project trained about 2000 traditional healers in basic information on STDs and HIV/AIDS and 120 in community

education. The curriculum, adapted from the THETA Uganda project (King, 1994b) with Zambian traditional healers' input, included STD/AIDS transmission and prevention, HIV testing, and condom social marketing (Nzima et al, 1996; Anyangwe et al, 1995). Traditional healers trained in community education, together with health centre staff, led monthly follow-up meetings.

Mid-term survey results showed that trained traditional healers scored significantly better than non-trained traditional healers on 13 of 17 impact measures, including knowledge about HIV transmission and prevention, advice for persons living with HIV/AIDS, and condom use (Anyangwe et al, 1995). At the time of the mid-term review, 250 trained healers reported selling condoms to patients and community members through a social marketing programme. Trained traditional healers were also more likely to have discussed with their clients HIV and STD prevention, HIV testing, condom use and caring for persons living with HIV/AIDS. Most traditional healers' patients interviewed confirmed that their trained traditional healers had taught them basic facts about AIDS, but they showed poor knowledge about how HIV is *not* spread, HIV testing, the difference between HIV and AIDS, and AIDS symptoms (Anyangwe et al, 1995).

## Conclusions

Although advocacy for traditional medicine and attempts to involve traditional healers in primary health care had been undertaken well before the advent of AIDS in several African countries, there are still few collaborative efforts between traditional healers and biomedical health providers for AIDS prevention or care on this continent (Fink, 1990; Bibeau, 1982; Warren et al, 1982; Hoff & Maseko, 1986; Fassin & Fassin, 1988; Last, 1990; WHO, 1991). Nevertheless, the initiatives reviewed here confirm that there continues to be great enthusiasm on the part of traditional healers to collaborate with their western-trained counterparts and learn from them about STDs and HIV/AIDS (Green, 1994; O'Rourke, 1996; Kabatesi et al, 1994). Experiences across countries show that modern and traditional belief systems are not incompatible but complementary. And if we accept with Green that, "traditional healers (in Africa) are unlikely to abandon their way of interpreting STDs and other diseases as a result of any education (...) directly confronting existing beliefs" (Green et al, 1993), then collaboration can create understanding and respect for *both* cosmologies so that they become harmonizing, and the interpretations healers make of them are beneficial for their communities infected and affected by HIV (Schoepf, 1992). In other words, once a common language is established, it is possible to design, plan, implement and evaluate a collaborative project, as long as traditional healers' views and concepts are included.

Many of the programmes reviewed here have used a strategy whereby a core group of traditional healers is trained as trainers for periods ranging from one day to 15 months. These traditional healers are then empowered to educate communities and/or train their peers. Additionally, some projects have also supported traditional healers in developing educational materials (King et al, 1994b; King, 1995), condom social marketing (Anyangwe et al, 1995), or giving basic counselling (Anyangwe et al, 1995; Nakyanzi et al, 1996; Nshakira et al, 1995; Kosia et al, 1993). Counselling may be one of the most essential services traditional healers have traditionally provided to their communities; since the AIDS epidemic, counselling has been an integral component of both STD/AIDS prevention and care strategies promoted worldwide. Counselling provides a bridge between prevention and care projects. Yet, only a few of the projects reviewed above have reported on the effect of training traditional healers in counselling skills for STDs and AIDS (Homsy & King, 1996; Berger et al, 1994; Green et al, 1995). And the information available in these reports is still too limited to compare the elements involved in the counselling components of the training.

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Preliminary assessments of some projects have shown that although, in most cases, 'trained' traditional healers quickly assimilate the new knowledge and 'integrate' it into their practices and the messages they deliver to communities, misconceptions remain, especially after short-term training (Homsy & King, 1996; Nshakira et al, 1995; Johnson, 1996a). Few projects have planned, or have had the means, to systematically follow up healers *after* their initial 'training'. Yet, it is important to provide long-term support to healers because, despite being natural counsellors, traditional healers can face significant difficulties in dealing with the issues of condom use, care and support, and death and dying elicited by AIDS (Homsy & King, 1996; Nakyanzi et al, 1996; Green et al, 1995). How can healers give their clients a diagnosis of AIDS when it means possibly losing their business? How can a traditional healer—the traditional advocate of the clan's fertility—counsel an HIV-positive woman who wants to have a child? And how can a traditional healer turn away a sick patient who has become dependent on his or her care and support? (Green, 1994; Nakyanzi, 1999, personal communication). The THETA Uganda initiative indicates that, once left on their own, healers who have been regularly supported after training have sustained and even increased their STD/AIDS activities in the community longer and more intensively than those who only participated in training (King, 1994b).

Evaluations have been infrequent, spaced over long periods of time, and relied too often on healers' surveys alone. Only one of the projects reviewed here has completed a comprehensive evaluation of the different approaches used and of their real impact on the population. Critical evaluations would be vital not only to assess the effectiveness of these strategies but also to examine the determinants of their success, or failure. For example, many projects found that traditional healers did carry out the education and counselling activities they were 'trained' for, but few document the content of these activities and analyse how they impact on traditional healers' clients and communities. Not one evaluation included measures of cost-effectiveness of the programme. Systematic, more in-depth and longer-term evaluations would also help answer the question of sustainability of traditional healers' involvement in AIDS prevention and care, which is one of the main assumptions behind these collaborations.

Biomedicine and traditional African medicine are based on concepts, languages and cultural constructs that are too distant for a simple mixing to automatically achieve positive results. Even when traditional or modern health concepts are translated in an attempt to bridge the gap between the two medical worlds (Green et al, 1993), the lack of solid evaluations, together with a still-pervading scepticism among biomedical health providers against 'unscientific' approaches, cause collaborations to enter a vicious circle whereby the lack of data justifies the lack of funding, and vice versa. Yet, despite these difficulties, the projects reviewed here highlight that traditional healers are capable of performing at least as well as, if not better than, their biomedical counterparts in their new roles as AIDS educators and counsellors.

## *Selected projects reviewed according to UNAIDS Best Practice criteria*

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Among the 25 projects reviewed in Table 1, eight with the most evaluation data were selected. These eight projects are compared in Table 2 with reference to the UNAIDS Best Practice Criteria (effectiveness, ethical soundness, efficiency, relevance and sustainability). Below is a discussion of these projects with respect to each of the criteria, as well as a list of issues that collaborative projects should consider using to assess their performance. Following this discussion is a section with suggested additional criteria specific to initiatives involving traditional medicine and AIDS.

### Effectiveness

Very few projects on traditional medicine and AIDS reviewed in this report have been assessed thoroughly for effectiveness. Effectiveness is an activity's overall success in producing desired outcomes and reaching overall objectives. Thus, to identify a project's effectiveness, one needs to know objectives and outcomes, as well as what changed during the time the activity was implemented and why the change occurred.

Whenever present, stated objectives varied widely, as did reported effectiveness measures (see Tables 1 and 2). Some projects aimed simply to train healers and measured their effectiveness by the number of healers trained and the information understood by healers. Others aimed to train traditional healers to reach fellow-healers, or the community served by healers, with AIDS information. Other projects aimed to change the sexual practices of healers' clients or community members. Lastly, an objective of many projects was to increase collaboration between traditional healers and their biomedical counterparts. Measures of effectiveness in each of these cases included numbers of healers or community members trained by trained healers, behaviour change among healers' clients and/or community members, and collaboration indicators such as referral between healers and biomedical health facilities or links built between healers and health structures.

Of the eight projects compared in this report, all described a significant increase in knowledge among trained healers regarding symptoms of HIV disease, HIV transmission and prevention and whether or not AIDS was curable. One project in South Africa reported an increase in positive attitudes about AIDS.

Other effectiveness measures included detailing how much of the information trained healers passed on to fellow-healers or clients and community members. In Botswana, healers trained in a two-week 'peer education' programme not only recalled information they learned two years after training, but they claimed to be training fellow-healers and community members as well. In Mozambique, South Africa, and Uganda, evaluation showed that traditional healers were counselling clients in AIDS prevention and care. In Malawi, Uganda and the United Republic of Tanzania, trained healers were reported to be giving dynamic AIDS education, some using drama, song, and dance and many developing their own training materials.

In all but one of the eight projects reviewed here (the exception being Central African Republic, where investigators only measured change in knowledge), traditional healers were reported to be active condom promoters and distributors. Even after one-day training sessions, healers in Malawi reported having open discussions about condoms, and female traditional healers reported distributing condoms as frequently as male traditional healers.

The objective of increasing collaboration between the two health systems can be difficult to measure and few data were available. Projects reported increasing patient referral from healer to health centres, and strong links with local hospitals. In Uganda, healers have become involved in policy-making bodies such as the National Drug Authority.

In summary, even though most projects showed signs of at least short-term effectiveness, few completed comprehensive evaluations of long-term impact on traditional healers and/or communities. For this reason, it is difficult to assess whether they meet the UNAIDS Best Practice criteria for effectiveness. In order to do so, future projects should use indicators and tools to address and evaluate the issues shown in Figure 1.

### Figure 1. Effectiveness issues

#### ***Traditional healers' knowledge about AIDS and STDs***

- What are the measurements of traditional healers' knowledge?
- Is there a measurable change in traditional healers' knowledge on AIDS and STDs after training?

#### ***Client /community AIDS knowledge***

- Is there a measurable change in client and/or community knowledge on AIDS and STDs after traditional healer training?
- What are the measurements of this knowledge?

#### ***Traditional healers' coverage***

- How wide is the coverage of traditional healers reached by training?
- How wide is the coverage of trained traditional healers' clients and/or community members (i.e. final beneficiaries)?

#### ***Traditional healers' skills in AIDS counselling and community education***

- Do traditional healers show a change in AIDS counselling and community education skills after training?

#### ***Traditional healers' skills in training fellow traditional healers***

- Do traditional healers show the capacity to train other traditional healers in AIDS and STDs (including capacity for mobilization, organization, teaching skills and transmission of correct information)?

#### ***Client/community risk behaviour***

- Is there a measurable change in client and /or community risk behaviour after traditional healers training?
- What are the measurements of this behaviour change?

#### ***Traditional healers' risk behaviour***

- Have traditional healers shown a measurable change in personal and/ or professional risk behaviour?

#### ***Condom promotion/distribution***

- Are traditional healers willing and able to promote and/or distribute condoms to clients and community members?

***Persons living with HIV/AIDS support***

- Do traditional healers show the willingness and capacity to provide care and support to persons living with HIV/AIDS?

***Collaboration between traditional medicine and biomedicine***

- Has the project set up a formalized referral system between traditional and biomedical health services?
- Has the project set up mutual visits between health practitioners?
- Has the project addressed any policy obstacles to recognition of traditional healers?

***Changes in overall health impact in the communities surrounding traditional healers***

- Are there any measurable changes in AIDS morbidity or mortality in the project intervention sites?
- Can any of these changes be attributed to the activity of the traditional healers?

## Ethical soundness

Ethical soundness is measured according to principles of appropriate and acceptable social and professional conduct. Important concepts to be considered regarding ethical soundness include: confidentiality, mutual respect, community and government participation, and informed consent.

Measures of ethical soundness adopted by many of the eight projects reviewed here included establishing a climate of mutual respect between traditional healers and biomedical health practitioners, signing agreements or working closely with hospitals or the Ministry of Health, and ensuring confidentiality of patients. Most projects had some connection with the Ministry of Health, but only two of them reported that they informed traditional healers and their communities of the projects' results (i.e. provided feedback). The Malawi project specifically addressed issues related to the negative or positive images relayed in awareness messages. Some projects also paid special attention to tailoring their messages to fit the understanding of traditional healers, or to strengthening resources in disadvantaged communities.

Two issues of particular concern to traditional medicine projects are: (1) whether any patients experience harmful effects due to traditional methods or treatments; and (2) respect of the proprietary rights of traditional healers over their herbal preparations. In the survey mailed to project leaders to gather information for this report (see Annex), none of the respondents reported any harmful effects of herbal remedies and only one project discussed the measures in place to protect healers' rights over their treatments.

The projects reviewed here generally met the UNAIDS Best Practice criteria for ethical soundness. However, ethical soundness issues were not necessarily addressed as part of a systematic plan, but rather out of concern and respect for traditional healers, their clients and communities. A systematic plan to approach ethical soundness could include the issues in Figure 2.

Figure 2. Ethical soundness issues

***Approval by scientific and ethical committees***

- Has the project been approved by scientific and/or ethical committees nationally or locally?

***Equity of participation***

- Has the selection of traditional healer participants been balanced geographically by gender and by type of practice?

***Informed consent***

- Were all project participants (traditional healers and clients/community members) sufficiently informed of the objectives and implications of the intervention before they agreed to participate?

***Patient confidentiality***

- Do trained traditional healers understand the principles and importance of confidentiality?
- Has the project set up a system of patient confidentiality with traditional healers?

***Safeguards of traditional healers' proprietary rights to their treatments***

- Has the project ensured that proprietary rights remain in the possession of traditional healers?

***Harm from traditional healers' treatments***

- Has there been any indication of harm from herbal or spiritual traditional healers' treatments?
- If so, how has the project dealt with it?

***Feedback of results***

- Has the project included sufficient time and resources to adequately feed back results to traditional healers, community members and other key players?

## Efficiency

Interest in efficiency has grown in recent years with the realization that resources are scarce and need to be used in the most cost-effective manner. The basic meaning of efficiency is the ability to produce the desired results with a minimum expenditure of energy, time, or resources. There are many economic evaluation techniques concerned with measuring cost-effectiveness, but they all involve knowing the costs involved in project implementation and concrete measures of effectiveness. Unfortunately, as most of the projects reviewed did not describe measures of efficiency, costs involved in various activities, or clear measures of effectiveness, it is difficult to compare and thus to conclude on this aspect.

Of the projects that measured efficiency, indicators included:

- cost of training per healer and per client or community member reached<sup>4</sup>
- number of traditional healers' clients and community members reached by healer initiatives (community AIDS education, drama, counselling)
- number of persons living with HIV/AIDS reached during home-care visits
- number of fellow healers trained by trained traditional healers
- financial control
- regularity of activity and financial reports.

In the three projects that reported on cost of training, the figures varied, but not significantly. In Zambia, training costs were US\$35 per day per traditional healer, in Botswana US\$22, and in Uganda US\$20. Figures available show that healers are able to attract large numbers of people to

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<sup>4</sup> Calculations described in Table 4

their community AIDS events, which translates into very large numbers of people reached for education, once healers are trained. The Tanzania AIDS Working Group estimated that, in three years, some 27,000 community members were reached in educational sessions, 4,300 persons living with HIV/AIDS in home visits and 450,000 people in drama groups. THETA Uganda estimates that it reaches between 150,000 and 400,000 beneficiaries per year (thus between 450,000 and 1,200,000 in three years). In comparison, another AIDS educational strategy in Uganda—the AIDS education through Imams initiative—states that they have reached 100,000 homes in five years (UNAIDS, 1998a)—a similar level. The cost per beneficiary was only available for THETA Uganda, where it was estimated to be between US\$0.24 and US\$0.71 per year (see Table 4).

One analysis in Botswana estimated that 30% of persons living with HIV/AIDS would be admitted to a hospital over the course of their illness. Each user would average one re-admission, with each stay averaging 8.2 days and costing US\$42 per day. Without home- or healer-based care, hospital treatment would cost US\$241 per person living with HIV/AIDS (Cameron et al, 1994).

Indicators that efficiency issues were being addressed included the existence of reporting and control of finances and administration. At THETA Uganda, accounts are audited annually and activity and financial reports are produced quarterly. Financial administration is tightly controlled. More details on finances and administration were difficult to acquire for other projects.

In conclusion, the only efficiency data available were from projects where the author was personally involved. In-depth cost-effectiveness analysis would therefore require specific studies whereby projects would be visited. Some project leaders reported that they did not have the expertise, resources or time to prioritize cost-effectiveness analysis. Ideally, efficiency evaluation should be planned for, budgeted and supported by funders from the very initial phase of project design. Such a plan should address the points summarized in Figure 3.

Figure 3. Efficiency issues

***Monitoring and evaluation***

- Do all project activities have a monitoring and evaluation component that has been thoroughly thought out and is realistic according to project timeline and human and financial resources?

***Cost-benefit measures***

- Does the project have adequate tools and plans to calculate its costs relative to the benefits provided to its target audience?

***Numbers of traditional healers reached***

- Does the number of traditional healers reached by the intervention justify the amount of resources used?

***Numbers of clients/community members reached***

- Does the number of clients and/or community members reached justify the amount of resources used?

***Use of resources***

- Were the human, material and financial resources used in a timely and effective manner?

***Flexibility to changing circumstances***

- Has the project recognized the changes in the AIDS situation or in the policy of traditional healers over time and rethought its objectives accordingly?

***Record keeping and reporting***

- Are records of activities and finances adequately kept? Are financial and activity reports distributed regularly and in a timely manner?

***Financial control***

- Are finances regularly audited by an outside agency?
- Are there internal checks and balances in the project's finances?

## Sustainability

Sustainability can be seen as the ability of a programme to carry on with a certain degree of autonomy and to continue being effective over the medium-to-long term. For the projects reviewed here, sustainability was assessed by finding out whether the information and skills passed on to healers were remembered, and whether these skills were used over time. For example, an assessment was made of whether healers were continuing to practise counselling, condom distribution, and community AIDS education, and whether they were still collaborating with biomedical health practitioners.

The eight projects generally attempted to ensure sustainability by building relations with health structures so that traditional healers could continue to receive support for their educational activities—including condoms for distribution—after completion of the intervention. None of the projects reported paying healers' salaries, but they often reimbursed expenses such as transportation costs to reach training sites. Many projects assumed that even if project activities were to officially end, healers had gained enough information and skills to continue to use that information in their practices. This point has been verified by a number of different projects. Interviews conducted in Botswana, Central African Republic and Zambia, years after the completion of training projects, showed that healers recalled information imparted in training and that they claimed to be still using it through counselling and by educating clients and communities, as well as referring patients to hospitals and clinics. The South African healers who were trained by fellow-healers felt they were ready to train a third generation of healers, but some of them preferred to have the assistance of a project facilitator during training. Project design generally included information in their curricula, but often failed to recognize the importance of incorporating into training the necessary skill-building sessions that would enable traditional healers to teach fellow-healers.

In Uganda, healers who were trained in 1993-1994 continued to give education sessions in their communities and even started formal training of fellow healers on their own initiative. Though THETA is no longer training the same healers it trained in 1993-1994, it is available to act as a guarantor for traditional healers' fundraising, or to facilitate occasional workshops organized by healers.

Sustainability is one of the most challenging issues facing AIDS prevention efforts in general, and traditional medicine collaborative projects are no exception. One major problem is the definition and importance of sustainability given by different funders. This review has shown that it has been extremely difficult for the majority of projects to remain active or to follow up with participating traditional healers over the long term, even though traditional healers remain active independently. A more systematic and standardized approach to sustainability is needed in order to design long-term projects and measure their impact over time. Figure 4 lists the issues to consider in developing such plans.

#### Figure 4. Sustainability issues

##### ***Sustainability of results***

- Are the results of the intervention permanent or temporary?
- Will new knowledge and activities (such as counselling and/or community education) continue even after training has ceased?

##### ***Funding***

- Is the project completely dependent on external funding?
- Would the project continue if external funding were cut?
- Are there any income-generating activities within the project?
- Has there been any input of local resources, including volunteer labour or donations?

##### ***Capacity-building***

- Are there any measures of capacity-building within the project's goals/objectives?
- Have traditional healers participated in design, implementation, or evaluation of project activities?

##### ***Local ownership***

- How do the staff and community feel about the success or failure of the project?
- Is there a feeling of personal investment in the project by staff and community?

##### ***Links with local health or community systems***

- Has the project built links with the hospital or clinics within the project area?
- Has the project created links with other community systems?
- How will these link be maintained over time?

## Relevance

It has been formally recognized since the late 1970s that, for developing countries, it is imperative to include traditional healers in primary health care (WHO, 1978). As discussed above, since the early 1990s, the same has been agreed upon for AIDS, especially in sub-Saharan Africa, where ministries of health cannot pay for adequate health care services. In addition, the debilitating direct and indirect costs associated with AIDS in many countries make the prospect of cooperating with traditional healers all the more appealing. In general, the basic fact underlying this approach is that African healers are accessible, affordable, and culturally appropriate and acceptable, thereby fulfilling the major criteria for low-cost, effective health care service delivery in most sub-Saharan African settings. Thus, the relevance of the overall approach of working with healers will be taken as a given; instead, it is the relevance of specific strategies used by particular projects that will be assessed.

Relevance is about how closely a project is focused on the HIV/AIDS response in the context of the society in which it is implemented. Issues such as cultural and political factors are usually considered. For the projects compared here, the emphasis was placed on how appropriate the particular strategy of each project was to the HIV/AIDS situation and how project objectives related to the prevalence of HIV, needs assessments and the priorities of the National AIDS Programme. For instance, countries with a mature epidemic should combine prevention with counselling and care, as was done in the project in the United Republic of Tanzania.

In the projects reviewed in Table 2, objectives were defined following baseline research with traditional healers, carried out either through surveys or focus group discussions. In only a few projects was it mentioned that needs were assessed according to the larger political context—specifically with reference to the AIDS epidemiology—or the surrounding community needs. However, in almost all the countries in this review, the prevalence of HIV was already high when the projects were initiated. The differences in political will to work with traditional healers between countries can play a strong role in the overall success of this type of collaborative project, but this was rarely mentioned in project literature.

THETA Uganda may be the only project that carried out needs assessment in communities surrounding the traditional healers. Three projects stated that their objectives were directly based on National AIDS Programme priorities. The Malawi project noted that its objectives changed as the AIDS situation did. In the Central African Republic, it was noted that the content of the training curriculum was relevant to all types of healers trained, as the magnitude of knowledge and attitude change was not related to traditional healers' characteristics.

Measures of relevance therefore varied widely in the different contexts of the projects reviewed. Where the relevance of involving traditional healers in AIDS control efforts is no longer in question, it is essential that the objectives and strategies used by each project be appropriate for a given context. This will have a considerable impact on effectiveness. Issues to consider are listed below.

#### Figure 5. Relevance issues

##### ***Needs assessment***

- Did the project carry out a needs assessment study before developing objectives?

##### ***HIV/AIDS context***

- Did the project take into consideration the local HIV prevalence, incidence and other AIDS interventions?

##### ***Relevance to National AIDS Programme priorities***

- Did the project take into consideration the priorities of the National AIDS Programme?

##### ***Political context***

- Did the project consider the political, social and cultural context surrounding traditional medicine, AIDS and other STD issues?

## *Additional criteria for collaborative projects*

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In addition to the UNAIDS Best Practice criteria, which are general criteria used to assess a wide variety of AIDS-related projects, the following are considerations which apply specifically to collaborative projects between traditional medicine and biomedicine. (For a summary, see Table 3 at the end of the review).

### Criteria for selecting 'genuine' or 'authentic' healers

Due to the lack of regulatory bodies for traditional healers in most countries, selection of 'genuine' or 'authentic' healers can be a challenge for most new projects.

In general, these eight projects generally consulted community leaders, traditional healer associations and the ministries in charge of traditional healer activities for approval and for recommendations of genuine or authentic healers. Many project leaders commented on the extensive time needed to select genuine traditional healers who were truly interested in collaboration.

In Senegal, criteria for selection were initially based on healers' reputations. The selection was enhanced by the use of children, considered innocent and unbiased. They were asked to which healer in their community they would refer someone with an ailment.

In South Africa, the project first contacted five traditional healers' associations to select healers for training. However, in the second round of training, it was found that the trained healers were much more effective at selecting genuine healers than the traditional healers' associations were.

Other initiatives also noted that it was preferable to avoid traditional healers' associations, as the internal politics of these associations can sometimes interfere with selection, training, or other project objectives. Such was the case in Uganda, where the criteria for traditional healers' selection used by THETA are the following:

- being recognized as healers by the community and local authorities
- having regular patient attendance
- having a clinic or shrine to receive and treat patients
- knowing how to prepare herbal remedies.

The list in Figure 6 can be useful in selecting healers to participate in collaborative projects.

Figure 6. Issues in selecting 'genuine' or 'authentic' healers

#### ***Community recommendations***

- Did the project consider the community recommendations for genuine or authentic healers?

#### ***Traditional healers' associations***

- Did the project consider traditional healers' association recommendations critically?

**Ministry recommendations**

- Does the country have an office in the ministry under which traditional healers' activities fall?
- If so, did the project collaborate with this office in the selection of traditional healers?

**Patient attendance**

- Do the traditional healers selected have regular patient attendance?

**Herbal preparations**

- Do the traditional healers selected prepare herbal treatments?

**Taking time**

- Has the project budgeted enough time to select genuine traditional healers?

## Approach used to establish trust with traditional healers

Discussion, interviews and listening to traditional healers' needs were the most common methods used for building trust with traditional healers, and it was agreed that doing this slowly, without rushing the traditional healers, was important.

In Uganda, explicit recognition of healers' rights to their treatment secrets was emphasized in order to help gain trust in setting up the initial collaborative clinical research on herbal treatments for opportunistic infections. In both the United Republic of Tanzania and Uganda, a series of workshops were held after initial contacts to share ideas between representatives of the two health care systems. Other initiatives used repeated visits to healers' homes/clinics or focus group discussions as a way of establishing trust.

Figure 7 lists issues to be considered in building trust.

### Figure 7. Issues in establishing trust with traditional healers

**Taking time**

- Has the project budgeted enough time to build strong and lasting relationships with traditional healers?
- What methods will the project use to build trust (focus group discussions, visits to traditional healers' homes/clinics, etc.)?

**Fostering respect**

- Does the project treat traditional healer participants with respect?

**Recognizing traditional healers' rights to their treatment secrets**

- Does the project recognize traditional healers' proprietary rights to their treatments?
- How has this recognition been conveyed to traditional healers?

## *Lessons learned*

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### Training methods

The Government of South Africa recently hired a traditional healer to regularly train fellow-healers. With her many years of experience, this traditional healer suggested that traditional healers need a participatory approach to training, and need to be shown the utmost respect. She advised, "Let them burn their incense in training", meaning that if the project respects the traditional healers' customs, the training will be successful. In addition, she emphasized the importance of using fellow-healers to train others, as healers are more receptive to hearing new things from their peers. She cautions against talking about traditional healers' associations in training as the politics will distract healers from the training session (Manci, 1999, personal communication). Other project leaders agreed with Manci about the issue of respect and some specifically emphasized the importance of respecting healers as professional health care providers.

With regard to content of training, most initiatives have had little difficulty with issues around AIDS symptoms, HIV transmission and prevention, condom use, condom promotion and distribution. The areas that provided the biggest obstacles were home care, death and dying, mother-to-child HIV transmission and, in the Central African Republic, condom use, which the authors linked to a high desire to have children.

### Collaboration

Healers in Uganda and the United Republic of Tanzania have been given access to hospitals, which has motivated them greatly. One project leader in the United Republic of Tanzania suggested establishing a cooperative relationship with a hospital or clinic to facilitate collaboration (Scheinman, personal communication). THETA Uganda leaders noted as well that developing a lasting collaboration between the two health systems involves much effort on both sides of the collaborative relationship. Collaborative project designs cannot emphasize only the efforts required by healers and assume that the biomedical health workers will follow without as much time and energy input. In Malawi, similar lessons were noted, and authors suggested that more collaborative referral networks need to be encouraged between traditional healers and the formal health sector (Porter, 1996). It may be that what is needed is simply a change of attitude within the biomedical health structures and among personnel. The key is a true dialogue (Webb, 1997).

Finally, THETA has suggested that the type of collaboration they have created in Uganda could be extended nationwide if emphasis were placed on building strong links at the community level with local leaders, health authorities, government and nongovernmental key players. These links ensure sustainability, reduce programme costs and increase healer recognition in their own communities.

### Project design and implementation

One of the most important lessons learned is not only that collaboration is possible, but that it has yielded valuable public health benefits. As longer-term projects have revealed, it is often not

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until after training that trained healers devise innovative initiatives for AIDS prevention. For example, in Mozambique, it was noted that some trained traditional healers shared the information they gained from one workshop with other healers in their traditional healers' association. This may be evidence that the training was valued enough that some healers expanded the training without asking for resources. It is therefore critical to plan and secure funding for long-term monitoring, evaluation and follow-up of collaborative projects.

Given the changing epidemic and the dynamic relationship between the two health sectors, this issue becomes even more crucial if we are to take advantage of, and learn from, this exploratory field.

## *Further research and action*

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More systematic evaluation of collaborative projects is urgently needed, especially to assess determinants of success and/or failure. Since many of these projects are still in an experimental phase, the information collected could be used to improve existing endeavours and help develop new ones. A multiplicity of variables needs to be assessed and it is only with systematic and repeated evaluations, using a variety of methods, that we can hope to answer some of the crucial questions we are faced with. There is a dearth of rigorous, long-term measures of effectiveness and sustainability. Of particular interest is the question of cost-effectiveness; not one of the projects reviewed here officially reported on the efficiency of training with respect to cost-effectiveness. Unfortunately, without cost-effectiveness data it is easier for funding agencies to deny the usefulness of such projects.

Research, not only into the methods that traditional healers use and the impact of training projects, but also into the relationship between the traditional and biomedical health care systems, is crucial if we hope to answer questions about collaboration between the two systems. Interesting questions, such as how each health system influences the other, and how the relationship could be mutually beneficial, deserve an in-depth analysis in order to build a sustainable link between the two sectors.

With greater emphasis on home care since the advent of AIDS, it is possible that traditional healers may act as a critical link in the continuum of care from hospital to home. Research into the healer approach to care is another neglected area of research that shows great potential. In particular, an in-depth analysis of the counselling provided by traditional healers, and how they integrate biomedical concepts into their traditional belief system and methods of practice, is still untouched by research. But it is crucial to our understanding of the impact traditional healers could have in both care and prevention of STDs and AIDS.

In the continuing struggle to provide comprehensive health care to a wider population, research into the role of traditional healers might result in the development of innovative new strategies. For example, since the mid-1990s, traditional healers have played an increasingly important role in the promotion of condoms in a few countries in Africa. It is thus possible for them to play a role in providing greater access to other health care options such as family planning. This area has been looked at in some countries for primary health care, but has not been expanded to other areas of health or assessed on a large scale. The goal of maximizing availability of drugs in poor countries makes research on herbal medicine especially important today.

The question of standardization and regulation of traditional medicine training and traditional healers' practice has been debated with respect to creating national policies. Consensus has not yet been reached, but the issues are complex as recognition often depends on organization of traditional healers. There is a danger that regulation and standardization of traditional healers' practices will cause a loss of diversity within these practices. However, many traditional healers are still interested in recognition by the biomedical structure and welcome official policy changes to this end.

Collaborative projects have much to learn from each other. An improved system of communication among traditional healers, as well as within and between countries, would be useful. Regular meetings and networking would benefit not only the projects concerned but their beneficiaries as well.

## *Annexes*



## Questionnaire given to project leaders to determine Best Practices

### I. In terms of ethical soundness:

In your project, are there safeguards for confidentiality of patient information?

Has your research/intervention been approved by scientific and ethical review committees at the national or local levels?

Have you had any examples of harm from any of the herbal preparations? If so, how did the project/organization deal with it?

Do you disseminate (feed back) results of your research/intervention to the community? If so, how?

### II. Effectiveness

Do you have any idea about the coverage of the project in the communities that you are working in (i.e. how many healers do you work with compared to the estimated total number in the area, and is there an estimate of the number of clients/community members seen by traditional healers)?

Do you have any measures of effectiveness of the counselling or prevention activities of the traditional healers that you collaborate with?

Have you done any social science research with your healers (or healer clients/community members), looking at outcomes such as: increased awareness, increased skills, reduction of risk behaviour? If so, are there any results available?

Are there any results of overall impact, i.e. change in health status, change of HIV/AIDS/STD morbidity or mortality?

### III. Efficiency

Do you have any measures of cost-benefit analysis, or any way to measure efficiency?

How are records kept? Is the information collected used in running the programme?

Are there any systems of monitoring and evaluation set up in the project? If so, what are the indicators? Are there results available?

Has the project had to change course due to changing circumstances? If so, how was the process managed?

### IV. Sustainability

Do you think your project is completely dependent on outside funding sources? Would it continue without outside funding?

Is there a feeling of local ownership of the project?

How strong are the links between the biomedical health facilities and the healers? Is the project's intervention required for continued collaboration?

In general, what would you say are the lessons you learned with regard to working with traditional healers for AIDS prevention and care?

Table 1: Summary of documented examples of collaboration in sub-Saharan Africa (1987-1999)

Shading indicates selection for Best Practice comparison in Table 2

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
Botswana	Seminars for traditional healers on AIDS, 1993	Ministry of Health	<ul style="list-style-type: none"> <li>- Sensitization of traditional healers to AIDS</li> <li>- To coordinate activities of traditional healers with district health teams</li> </ul>	<i>No information</i>	Seminars held sporadically with traditional healers on various diseases including AIDS
	Botswana Dingaka AIDS Awareness and Training Programme, 1991-1993	CIDA, WHO, Ministry of Health	<ul style="list-style-type: none"> <li>- <i>Providing a forum for exchange of information and experiences between traditional healers and biomedical health practitioners</i></li> <li>- Promoting cooperation and collaboration for health services</li> <li>- Creating awareness on AIDS among traditional healers</li> <li>- Training core trainers who will, in turn, pass on the information to other traditional healers in selected pilot areas</li> </ul>	<ul style="list-style-type: none"> <li>- 2-week TOT held with 12 traditional healers on AIDS from 6 districts of Botswana</li> <li>- Independent evaluation interviewed 32 traditional healers, 19 nurses and 20 medical doctors</li> </ul>	<ul style="list-style-type: none"> <li>- Trained traditional healers trained, on average, 45 other traditional healers per district in 2 years</li> <li>- 72% of traditional healers said they had changed something in their practice in relation to AIDS training</li> <li>- 80% said they recommend condoms</li> <li>- Educational video produced</li> <li>- Flip chart addressing practices of traditional healers produced</li> </ul>
Cameroon	KABP survey of traditional healers, 1990	NACP National traditional medicine programme	<ul style="list-style-type: none"> <li>- To sensitize and introduce traditional healers to AIDS control.</li> </ul>	<ul style="list-style-type: none"> <li>- National seminar on traditional medicine and AIDS to be conducted</li> </ul>	No information
Central African Republic	Action to Define, Broaden, and Strengthen the Role of Traditional Practitioners (ADERT), 1995	Ministry of Health, University of Bangui, World AIDS Foundation, CDC, CIDA, University of Washington, USA	<ul style="list-style-type: none"> <li>- To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those that have negative health impacts</li> <li>- To enable traditional healers to deliver preventive messages, support persons living with HIV/AIDS and modify their own risk practices</li> </ul>	<ul style="list-style-type: none"> <li>- Focus groups to identify training topics and methods</li> <li>- Working group of traditional healers and Ministry of Health staff to develop curriculum</li> <li>- 103 traditional healers at 4 locations (urban and rural) completed 6-day training</li> <li>- 96 traditional healers completed pre- and post- KABP questionnaires</li> </ul>	Traditional healers' knowledge improved, except with regard to their own risk practices. Repetitive rather than single training model suggested.

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
Ghana	Unit for traditional medicine established in Ministry of Health, 1990	WHO, Ministry of Health	- To involve traditional healers in primary health care.	- Establishing a dialogue with traditional healers	Recommendations for involving traditional healers in management and treatment of AIDS
	Training manual for traditional healers	Save the Children	- To produce a document to systematically train traditional healers in AIDS prevention and care	- Production of training manual	No information
Guinea	Ministry of Health, traditional medicine unit. Integration of traditional healers into health activities, 1985.	Ministry of Health	- To identify the factors within traditional medicine that can increase the effectiveness of the fight against AIDS in Guinea - To increase traditional healers' knowledge of modes of HIV transmission and prevention, clinical manifestations, care and support.	- Survey of STDs known to traditional healers - Research on traditional treatments for fertility, AIDS, STDs - Baseline survey of traditional healers' knowledge of AIDS - 2 workshops organized for traditional healers - Each district has a physician in charge of traditional medicine	Traditional healers are registered with Ministry of Health. Research on 898 traditional healers since the beginning of the programme found that increasing numbers of traditional healers refer to health centres (using referral forms), hospitals and other traditional healers for diagnosis and treatment. Biomedical health providers also refer back. Traditional healers keep records on numbers of cases and treatment.
Liberia	Anthropological Research on STDs, 1988	SOMARC/USAID, Johns Hopkins University, USA	- To learn how to promote condoms to limit the spread of HIV	- Focus group discussions with 53 participants - Conducted interviews with 103 traditional healers	- Traditional healers advise against prostitutes. - Traditional healers should be taught STD diagnosis and referral because people believe in traditional medicine for STDs.

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
Malawi	Training on AIDS for traditional healers, 1992	International Eye Foundation, Malawi International Centre for Eye Health, UK	<ul style="list-style-type: none"> <li>- To better understand the practices and roles of healers in their communities</li> <li>- To promote greater communication between traditional healers and the formal health care sector</li> <li>- To educate traditional healers about HIV/AIDS and STD transmission and prevention</li> <li>- To encourage community-based AIDS prevention and care by traditional healers.</li> </ul>	<ul style="list-style-type: none"> <li>- Series of orientations and focus group discussion were held with traditional healers</li> <li>- An eye care programme formed the initial base of contact and collaboration between project staff and traditional healers</li> <li>- Baseline and follow-up (6 months post-training) were conducted with 89 traditional healers</li> <li>- One-day training sessions were held in 14 sites in one district (334 traditional healers)</li> </ul>	<ul style="list-style-type: none"> <li>- Increase in community education, condom distribution, and patient counselling activities 6 months post training.</li> </ul>
Mozambique	Anthropological research and training on AIDS and STDs for traditional healers, 1991-1994	Ministry of Health, Swiss Cooperation	<ul style="list-style-type: none"> <li>- To improve intersectoral cooperation in the prevention and treatment of STDs</li> <li>- To identify and reinforce aspects of traditional medicine believed to promote public health, while discouraging those believed to have negative health impacts</li> </ul>	<ul style="list-style-type: none"> <li>- Conducted interviews with 51 traditional healers specializing in STDs to develop training strategy</li> <li>- 5 focus group discussions were held, with 7 traditional healers per group</li> <li>- 2 one-week workshops in 2 provinces</li> </ul>	<ul style="list-style-type: none"> <li>- Developed culturally appropriate strategy for the NACP involving traditional healers for STDs.</li> <li>- 30 traditional healers participated in workshop on STDs in 1991. In 1994, follow-up with 21 traditional healers; 8 clients were interviewed and showed increased knowledge on HIV transmission, condom use and promotion.</li> </ul>
Namibia	Anthropological research on traditional medicine, 1995	PhD thesis fieldwork	<ul style="list-style-type: none"> <li>- To analyse traditional healers' patients' health-seeking behaviour for illness in general</li> </ul>	<ul style="list-style-type: none"> <li>- Quantitative and qualitative methods</li> </ul>	No information
Rwanda	AIDS research project (Project San Francisco), 1990	University of California, San Francisco, USA; Ministry of Health	<ul style="list-style-type: none"> <li>- To analyse health-seeking behaviour of women patients with regard to AIDS and traditional medicine</li> <li>- To analyse knowledge, attitudes, practices surrounding AIDS and STDs</li> </ul>	<ul style="list-style-type: none"> <li>- Quantitative and qualitative methods including questionnaires, and in-depth interviews among 40 women involved in a prospective cohort study</li> <li>- 25 traditional healers interviewed on KABP on AIDS</li> </ul>	<ul style="list-style-type: none"> <li>- Majority of women used both biomedical and traditional systems and believed in greater effectiveness of traditional medicine for certain AIDS symptoms.</li> <li>- All traditional healers had heard of AIDS, knew modes of transmission, signs and symptoms and that there was no treatment or vaccine.</li> </ul>

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
Senegal	Promotion of Traditional Medicine (PROMETRA), 1981	Centre for Experimentation of Traditional Medicine, Senegal  Tulane School of Public Health, USA  Morehouse School of Medicine, USA	- To promote traditional medicine	- 383 healers organized into an association called PROMETRA  - Conducted training on diarrhoea and family planning, but not yet on AIDS  - Needs assessment conducted prior to training.	- 87% of interviewed patients were satisfied with traditional healers' services.  - 67% physicians interviewed stated they referred patients to traditional healers.
Sierra Leone	Counselling training for traditional healers, 1992	National STD/AIDS Control Programme	- To train traditional healers in HIV/AIDS counselling	1-day training held with 150 traditional healers.	- 150 traditional healers trained in HIV/AIDS counselling  - 80% of people with HIV/AIDS prefer traditional medicine treatment.
South Africa	Training of trainers for healers, 1992	AIDSCAP, USA AIDSCOM, USA Ministry of Health, South Africa	- The initial goal was to determine the level of interest, knowledge, and skills of traditional healers in HIV prevention and whether they could serve as effective agents of behaviour change.  - The ultimate goal was to engage traditional healers in combating HIV/AIDS in South Africa through training other healers and incorporating HIV/AIDS prevention into their practices.	- 1-year feasibility study  - Preliminary 5-day workshop (Nov. 1992) 28 traditional healers  3 follow-up workshops (July 1993, Nov. 1993, July 1994)	- 630 traditional healers trained by 28 trained traditional healers on basic AIDS facts.  - 7-month follow-up: ≥80% retained correct STD/AIDS information and practised counselling.
	Pilot survey of traditional healers, 1992	Centre for Natural and Traditional Medicine, Washington, DC, USA	- To assess traditional healers' potential for AIDS prevention and care	No information	- Survey found traditional healers had high knowledge about AIDS, were treating symptoms of AIDS; and concluded that, "traditional healers are a force that cannot be ignored in the fight against HIV/AIDS".

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
	Training programme for traditional healers in KwaZulu-Natal, 1994	AIDS Foundation of South Africa, National Traditional Healers' Association of South Africa	<ul style="list-style-type: none"> <li>- To increase AIDS prevention, education and management in KwaZulu-Natal by providing training and resources to traditional healers</li> <li>- To help trained traditional healers become accepted by the biomedical system in KwaZulu-Natal</li> </ul>	<ul style="list-style-type: none"> <li>- Project emphasized strengthening resources in disadvantaged communities.</li> </ul>	<ul style="list-style-type: none"> <li>- Traditional healers could identify signs and symptoms of AIDS after training.</li> <li>- Traditional healers identified need for rural AIDS hospices and trained home-care personnel to care for persons living with HIV/AIDS.</li> <li>- 75% traditional healers believed they could cure AIDS before training, none after</li> </ul>
	Training of traditional healers in HIV prevention and collaboration, 1998	Government of South Africa	<ul style="list-style-type: none"> <li>- To train traditional healers in every province of South Africa on AIDS prevention</li> <li>- To build collaboration between traditional and biomedical health systems</li> </ul>	<ul style="list-style-type: none"> <li>- 3-day workshop for traditional healers in every province of South Africa, using participatory methods</li> </ul>	<ul style="list-style-type: none"> <li>- Prevention training was successful, but collaboration was not. Recommends using traditional healers to train traditional healers because traditional healers respect their fellow-members.</li> </ul>
Uganda	Traditional and Modern Health Practitioners Together against AIDS (THETA), 1992	Doctors without Borders, The AIDS Support Organization, NACP, Ministry of Health, Uganda AIDS Commission, Rockefeller Foundation	<ul style="list-style-type: none"> <li>- To provide training for traditional healers in community counselling and HIV/ AIDS education, basic clinical diagnosis and patient management</li> <li>- To provide a resource centre for information sharing on traditional medicine and AIDS</li> <li>- To advocate for traditional medicine among health professionals and other scientists in order to build a true collaboration</li> </ul>	<ul style="list-style-type: none"> <li>- Community mobilization, traditional healers training in AIDS education and counselling in 7 districts in Uganda, with 40 traditional healers per district since 1993</li> <li>- Traditional healers' training in patient management with 30 traditional healers in Kampala in 1 year</li> <li>- Resource centre collects and disseminates information on traditional medicine and AIDS</li> <li>- Promoting collaboration between traditional medicine and biomedicine</li> </ul>	<ul style="list-style-type: none"> <li>- Increased counselling and AIDS education by trained traditional healers and increased knowledge and condom use among clients of trained traditional healers</li> <li>- Over 120 traditional healers trained and more than 96,000 persons benefited in 2 years</li> <li>- Collected a wide variety of materials on traditional medicine and AIDS</li> <li>- Produced 2 videos in Uganda and English for educational and informational use</li> </ul>
	Community-based home care, 1993	CONCERN, Ireland Ministry of Health, Uganda	<ul style="list-style-type: none"> <li>- To train volunteers to provide care and support to the sick using a primary care herbal kit developed by the project</li> <li>- To disseminate information on herbs and disease</li> </ul>	<ul style="list-style-type: none"> <li>- Workshops centred on skills and confidence-building in giving out herbal medicine</li> </ul>	<ul style="list-style-type: none"> <li>- Traditional healers trained 68 volunteers involved in home care and distributing herbs for common AIDS-related symptoms</li> </ul>

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
United Republic of Tanzania	Tanga AIDS Working Group (TAWG), 1990	Initiated by a physician and traditional healers. Family Health International, Shaman Pharmaceutical Company, Evangelische Zentralstelle für Entwicklungshilfe, GTZ	- Raise HIV/AIDS/STD awareness among traditional practitioners in 3 districts to safeguard both practitioners and clients from being infected during practices - Train traditional healers as community-based HIV/AIDS/STD educators and home-care providers for persons living with HIV/AIDS and their families - Promotion of community-based condom distribution	- Series of sensitization meetings between local govt, district PHC committees, village health committees, communities and traditional healers - 2 types of participatory approaches— ZOPP and LEPSA—were used to identify and train key people at the grassroots level - TAWG trained 120 traditional healers in 3 districts in 1994 - Health personnel at each health facility were trained to support the programme	- 160 traditional healers have been trained in HIV/AIDS and health information. - Healers are involved in collaborative clinical work, AIDS education, counselling, home visits and village theatre groups. - Training manual produced
Zaire	Workshops with traditional healers, 1989	CONNAISSIDA, Zaire Traditional Healers' Association	No information.	- Action research using 2 experimental risk-reduction workshops with women in low-income area.	- Demonstrated traditional healers' pragmatism and the role they can play in promoting behaviour change for safer sex practices
Zambia	AIDS workshop, 1987	Traditional Practitioners' Association. of Zambia, Ministry of Health	- To exchange ideas and experiences on AIDS and gain traditional healers' support in fighting its spread.	- Dialogue between the Ministry of Health Education Unit and the secretariat of the Traditional Practitioners' Assn. of Zambia - Workshop held with 40 traditional healers	- 40 traditional healers attended - Knowledge increased, misconceptions still strong
	AIDS research, training and follow-up 1994-1996	Ministry of Health, USAID, Morehouse University School of Medicine, USA	- To educate traditional healers about HIV/AIDS and STD transmission, prevention and care - To enable traditional healers to educate their patients about these issues and motivate them to avoid high-risk behaviour	- 25-40 prominent traditional healers selected to participate in 3-day workshops on AIDS between June 94 and Nov. 95. - Trained traditional healers attended monthly or alternate month follow-up meetings led by health centre staff	- 2000 traditional healers trained on AIDS facts and 120 traditional healers trained in community education. - Knowledge increased, traditional healers started selling condoms through a social marketing programme.

Country	Project/ institution	Initiated/ supported by	Objectives	Methods	Achievements/findings
Zimbabwe	AIDS workshops, 1988	Zimbabwe National Traditional Healers Association (ZINATHA), Ministry of Health	No information	No information	- Workshops organized to train traditional healers in AIDS and counselling. - Pamphlet in local language designed for traditional healers and AIDS

Abbreviations:

AMREF	African Medical Research Foundation	NACP	National AIDS Control programme
BHP	Biomedical health practitioners	PHC	Primary health care
CDC	Centres for Disease Control and Prevention	SOMARC	Condom Social Marketing Programme
CDD	Control of diarrhoeal diseases	TH	Traditional healers
CIDA	Canadian International Development Agency	TM	Traditional medicine
KABP	Knowledge, attitudes, beliefs and practices	TOT	Training of trainers
MOH	Ministry of Health	WHO	World Health Organization

Table 2: Review of examples of collaboration according to UNAIDS Best Practice criteria

Project*	Effectiveness	Ethical soundness	Efficiency	Sustainability	Relevance of approach
Dingaka AIDS Awareness, <b>Botswana</b> 1991-1993	<ul style="list-style-type: none"> <li>- Trained traditional healers passed on information to clients and fellow-traditional healers</li> <li>- 80% of traditional healers recommend condoms to patients</li> <li>- 31/32 refer patients</li> <li>- Nurses refer to traditional healers</li> </ul>	<ul style="list-style-type: none"> <li>- Programme worked with Ministry of Health</li> </ul>	<ul style="list-style-type: none"> <li>- Estimated cost US\$22 per traditional healer trained per day</li> <li>- Traditional healers trained, on average, 45 other traditional healers per district</li> </ul>	<ul style="list-style-type: none"> <li>- Not sustainable as a project, but healers have continued to use the information they gained.</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated, and relevant to the AIDS situation, but TOT and collaboration aspects of the project ambitious for time and resources allocated.</li> </ul>
Action to Define, Broaden, and Strengthen the Role of Traditional Practitioners (ADERT) <b>Central African Republic</b> 1994	<ul style="list-style-type: none"> <li>- Significant improvement in traditional healers' knowledge on STD risk, condom use, and HIV transmission after training</li> <li>- 76% of traditional healers with STD cases report integrating partner referral into their STD care treatment.</li> </ul>	<ul style="list-style-type: none"> <li>- Programme worked with Ministry of Health</li> <li>- Specific attention to appropriateness of training topics and methods for traditional healers</li> </ul>	<ul style="list-style-type: none"> <li>- 103 traditional healers trained in 4 locations over 2 months</li> <li>- No cost-effectiveness measures</li> </ul>	<ul style="list-style-type: none"> <li>- No measures taken to ensure sustainability; activities ceased when funding stopped.</li> <li>- One healer interviewed in 1999 said he was eager to be involved in another project and he was still using the information gained.</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and relevant to needs assessed through baseline focus group discussion and working group of traditional healers and Ministry of Health staff.</li> <li>- Magnitude of knowledge and attitude change was not related to traditional healers' characteristics, indicating that impact of training was uniform among practitioners. This implies that specific types of practitioners do not need targeting, and training content was relevant to all traditional healers in that setting and context.</li> </ul>

Project*	Effectiveness	Ethical soundness	Efficiency	Sustainability	Relevance of approach
Training on AIDS for traditional healers <b>Malawi</b> 1992	<ul style="list-style-type: none"> <li>- Increase in traditional healers' knowledge</li> <li>- 64% conducted AIDS education events</li> <li>- 89% distributed condoms</li> <li>- No evaluation of collaboration.</li> </ul>	<ul style="list-style-type: none"> <li>- Collaboration with Malawi NACP</li> <li>- The purpose of the study was clearly explained to each traditional healer</li> <li>- Specific attention to positive images in educational messages</li> </ul>	<ul style="list-style-type: none"> <li>- In 6 months, 3000 community members reached in AIDS education</li> </ul>	<ul style="list-style-type: none"> <li>- Most healers within walking distance of training.</li> <li>- Traditional healers encouraged to acquire condoms from health centre.</li> </ul>	<ul style="list-style-type: none"> <li>- Goals and objectives clearly stated and relevant to needs assessed through baseline survey.</li> <li>- Project changed significantly in response to changes in AIDS situation.</li> <li>- Strategy did not include specific emphasis on biomedical health sector.</li> </ul>
Ministry of Health/traditional healers' association collaboration <b>Mozambique</b> 1991-1994	<ul style="list-style-type: none"> <li>- 85% traditional healers able to describe HIV symptoms</li> <li>- 85% knew AIDS transmitted by sex</li> <li>- 81% traditional healers promoting condom use</li> <li>- traditional healers advise clients to avoid having many sex partners</li> </ul>	<ul style="list-style-type: none"> <li>- Programme started by Ministry of Health</li> </ul>	<ul style="list-style-type: none"> <li>- 47 traditional healers trained</li> <li>- No information on cost-effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>- At least one follow-up workshop for traditional healers organized by the Provincial Health Dept within 10 months of the initial workshop.</li> <li>- Traditional healers reported distributing condoms and cooperating in other areas with health department</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and based on preliminary ethnomedical research, taking into consideration the national and local STD/AIDS programme priorities, as well as the political situation.</li> </ul>
Training of trainers <b>South Africa</b> 1992	<ul style="list-style-type: none"> <li>- Traditional healers training other traditional healers, counselling clients, promoting condoms.</li> <li>- Increased positive attitudes</li> </ul>	<ul style="list-style-type: none"> <li>- Collaboration with traditional healers' associations</li> </ul>	<ul style="list-style-type: none"> <li>- 1510 traditional healers trained, all but 28 by fellow-traditional healers in almost 1 year</li> </ul>	<ul style="list-style-type: none"> <li>- Second-generation traditional healers were prepared to train third-generation healers with minimal assistance</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and based on feasibility of engaging traditional healers in the fight against AIDS</li> </ul>

Project*	Effectiveness	Ethical soundness	Efficiency	Sustainability	Relevance of approach
<p>Traditional and Modern Health Practitioners Together against AIDS (THETA) <b>Uganda</b> 1992</p>	<ul style="list-style-type: none"> <li>- 200 traditional healers trained in 7 districts since 1993</li> <li>- Traditional healers gained knowledge in HIV and STD transmission, prevention and care</li> <li>- Traditional healers gained counselling, teaching, leadership and record-keeping skills.</li> <li>- Trained traditional healers providing regular community AIDS education</li> <li>- Traditional healers distributing condoms</li> <li>- Traditional healers make increased referrals to biomedical health providers</li> <li>- THETA produces a newsletter, initiated a speakers' bureau, contains a library on traditional medicine and AIDS, and produced 2 videos</li> <li>- Conducted a study on the effectiveness of herbal treatment for opportunistic infections.</li> </ul>	<ul style="list-style-type: none"> <li>- Research results are fed back to healers and community</li> <li>- Patient confidentiality is emphasized in training programmes</li> <li>- Agreement signed with Ministry of Health</li> <li>- Traditional healers have worked within the hospital for herbal study</li> <li>- Patients sign informed consent form</li> <li>- Mutual respect is emphasized from the beginning</li> </ul>	<ul style="list-style-type: none"> <li>- Admin. tightly controlled and reports produced quarterly</li> <li>- Costs per traditional healer client range between US\$0.24 and US\$0.71</li> <li>- US\$21/day per traditional healer trained</li> <li>- Estimated total number of beneficiaries range from 150, 000 to 400,000 per year *</li> </ul>	<ul style="list-style-type: none"> <li>- Healers don't receive salaries</li> <li>- Strong links are built with community leaders in each district (i.e. local council, secretaries for women, etc) for supporting continuing healer activities</li> <li>- Traditional healers involved in the training have formed their own associations that undertake various activities, including community AIDS education and drama, training of fellow-healers, and 'persons living with HIV/AIDS' support groups</li> <li>- THETA trained traditional healers involved in national policy bodies (National Drug Authority)</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and based on baseline traditional healers' surveys and community baseline assessments</li> <li>- Objectives and implementation follow the National AIDS Programme strategy</li> <li>- Implementation of district activities is area-specific and based on feasibility assessments carried out in several possible sites before each new district is chosen</li> </ul>

Project*	Effectiveness	Ethical soundness	Efficiency	Sustainability	Relevance of approach
Tanga AIDS Working Group, (TAWG) <b>United Republic of Tanzania</b> 1990	<ul style="list-style-type: none"> <li>- 120 traditional healers trained since 1994</li> <li>- Drama group reached 55,000 people in 4 months</li> <li>- 1997 survey showed traditional healers had increased awareness of HIV/AIDS</li> <li>- Clients who were counselled reduced risky behaviour</li> </ul>	<ul style="list-style-type: none"> <li>- Mutual respect is a main TAWG principle</li> <li>- Counsellors are given code numbers and confidentiality is assured</li> <li>- Ministry of Health authorised research; offices within hospital</li> <li>- Research results fed back to healers and NGO</li> </ul>	<ul style="list-style-type: none"> <li>- Traditional treatments are free for patients</li> <li>- In 3 years: 27 000 community members reached in education sessions</li> <li>- 237 persons living with HIV/AIDS reached in 4,300 home-care visits</li> </ul>	<ul style="list-style-type: none"> <li>- As permanent members of the community, traditional healers will continue to practise their new research and counselling skills even if the NGO is not present</li> <li>- Healers don't receive salaries</li> <li>- NGO office is in the hospital; links between hospital and NGO are strong</li> <li>- 17 supervisors from the health facilities were trained to monitor and support traditional healers.</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and based on 7 years of experience working with traditional healers.</li> <li>- Linking prevention and care provides a culturally relevant approach for the Tanga region.</li> </ul>
AIDS research, training and follow-up <b>Zambia</b> 1994-1996	<ul style="list-style-type: none"> <li>- 250 traditional healers promoting and selling condoms</li> <li>- Traditional healers counselling on HIV and STD prevention, HIV testing and caring for persons living with HIV/AIDS at home</li> </ul>	<ul style="list-style-type: none"> <li>- Ministry of Health agreement</li> <li>- Project planned for feedback of results to province, district and local levels</li> </ul>	<ul style="list-style-type: none"> <li>- US\$35/day per traditional healers trained</li> </ul>	<ul style="list-style-type: none"> <li>- Links built between traditional healers and local biomedical health practitioner and health facility</li> </ul>	<ul style="list-style-type: none"> <li>- Objectives clearly stated and based on preliminary assessments and national AIDS programme priorities.</li> </ul>

\* For ongoing projects, only starting date given.

\* Calculations are explained in Table 4.

Table 3: Specific criteria/approach for collaboration

Country	Criteria for selecting 'genuine' or 'authentic' healers	Approach used to build trust	Lessons learned
<b>Botswana</b>	- Leaders from different traditional healers' associations in 6 districts selected 12 traditional healers for training	- Discussions and seminars with traditional healers	- Condom promotion easily integrated into traditional healers' practice - Home care difficult to integrate into traditional healers' practice - Follow-up necessary to sustain the intervention - Traditional healers see doctors as their counterparts - The legal status of traditional healers should be dealt with in order to improve organization of traditional healers and ultimately improve cooperation between health sectors - Biomedical health practitioners should be trained to acknowledge that patients share traditional and modern beliefs and values
<b>Central African Republic</b>	- The most influential traditional healers were selected by village leaders from a census list of traditional healers	- Central African Republic physician employed persistence, rapport building, and mobilizing skills to slowly gain trust. - Traditional healers slowly found that collaborating with Ministry of Health would legitimize them in the eyes of the government.	- Attitudes towards condom use did not change. Investigators linked this information to a high desire to have children. - Authors found that careful design of curriculum adapted for training of traditional healers is useful for traditional healers' increase in knowledge; a one-time training cannot achieve a significant level of change in traditional healers' practice. Rather a repetitive model would be most effective for promoting cognitive, attitudinal and behavioural change.
<b>Malawi</b>	- Older healers were reported to have more credibility with village leaders - Community leaders were consulted to gain approval and to recommend the most respected and most active traditional healers in their areas	- Focus group discussions were held with groups of traditional healers to build relationships between healers, Ministry of Health and project.	- Traditional healers were open to condom promotion - Need for greater collaboration between health centre staff and traditional healers to maintain community-based education and condom distribution

Country	Criteria for selecting 'genuine' or 'authentic' healers	Approach used to build trust	Lessons learned
<b>Mozambique</b>	- Traditional healers' association assisted in selection of traditional healers, seeking to provide balance by gender, age and district.	- In-depth interviews and focus group discussions over 9-month period before training.	- Much public health knowledge and practice is already found in beliefs and practices of traditional healers. Difficult to interview patients of traditional healers due to stigma of STDs. The use of indigenous disease names proved a great facilitator of communication as it was taken as a sign of respect.
<b>Senegal</b>	- Selection based on healers' reputation, and preschool children 4-6 years old were asked to identify traditional healers known for specific conditions	- Consent of local authorities - Series of contacts that lasted from several months to years - Healers provided names and addresses of other healers	- PROMETRA considers its work to be cultural research, medical practice, and views itself as an integral partner in dissemination of scientific information to a large community.
<b>AIDS Foundation, South Africa</b>	Traditional healers themselves selected traditional healers to be trained	- Traditional healers approached the AIDS Foundation of South Africa for training	- Traditional healers identified the need for rural AIDS hospices and trained home-care personnel - More work needs to be done to eliminate the tenuous and strained aspect of the relationship between traditional healers and biomedical practitioners.
<b>Training of Trainers, South Africa</b>	- 5 national traditional healers' associations selected traditional healers for first workshop based on gender and geographical balance. - Trained traditional healers selected healers for future workshops.	- In-depth interviews and focus group discussions over 1-year period.	- Misconceptions about AIDS are easily dispelled - Second-generation traditional healers were as well, if not better, trained than first-generation healers due to better selection of trainees by traditional healers - Training on death and dying was not liked by traditional healers. - It was advised to discontinue work with traditional healers' organizations to avoid political conflicts - Traditional healers wanted explicit condom demonstration - As traditional healers had access to intimate details of patients' physical emotional and spiritual lives, they experienced few problems influencing behaviour in sex and sexuality

Country	Criteria for selecting 'genuine' or 'authentic' healers	Approach used to build trust	Lessons learned
<b>Uganda</b>	THETA selection criteria: <ul style="list-style-type: none"> <li>- Being recognized as healers by their community and local authorities</li> <li>- Having regular patient attendance</li> <li>- Having a clinic or shrine to receive and treat patients</li> <li>- Knowing how to prepare herbal remedies</li> <li>- Questionnaire answered by each healer</li> </ul>	<ul style="list-style-type: none"> <li>- Emphasis on healers' right to ownership of their treatments.</li> <li>- Initial contact through the Culture Officer of the Ministry of Gender and Community Development as well as through a TASO doctor and personal visits to traditional healer's clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Research with traditional healers requires mutual respect and collaboration with biomedical health practitioner</li> <li>- Collaborative work requires time to build trust and continuous follow-up to monitor and evaluate a changing epidemic, and a dynamic relationship between the 2 health sectors</li> <li>- Traditional healers can come up with innovative ideas for AIDS prevention long after training is completed</li> <li>- This type of collaboration can extend nationwide if strong links are built at the community level with local leaders, government and nongovernmental key players and health authorities</li> </ul>
<b>United Republic of Tanzania</b>	<ul style="list-style-type: none"> <li>- Two types of participatory approaches were used to identify key traditional healers and health personnel to participate in the training workshops.</li> </ul>	<ul style="list-style-type: none"> <li>- Meetings were arranged between expatriate physician and traditional healers. Healers enjoyed being taken seriously and being treated like fellow professionals. Initial dialogues evolved into a series of workshops on patient care, treatment, education and cooperation between biomedical and traditional health practitioners.</li> </ul>	<ul style="list-style-type: none"> <li>- Traditional healers should be respected as health professionals</li> <li>- Give traditional healers access to hospitals, clinics, and patients</li> <li>- Involve them in home care and training</li> <li>- Healers care about their patients and want to learn more</li> <li>- Traditional healers are keen students.</li> <li>- Traditional healers love learning about research</li> <li>- Traditional healers enjoy mutual referral between them and hospital / clinics</li> <li>- Develop a cooperative and collaborative relationship between traditional healers and hospital/ clinic</li> </ul>
<b>Zambia</b>	<ul style="list-style-type: none"> <li>- Traditional leaders assisted health centre staff in selection process.</li> <li>- Professional reputation within the community, willingness and ability to learn and communication skills.</li> </ul>	<ul style="list-style-type: none"> <li>- Training was highly participatory</li> <li>- Health workers facilitating workshops underwent training in participatory methods</li> <li>- Effort was made to find terms that are more familiar to traditional healers' understanding of health and disease rather than using biomedical terminology</li> </ul>	<ul style="list-style-type: none"> <li>- Traditional healers came up with symbolic alternatives to high risk practices</li> <li>- After culturally appropriate exposure to explanations of public health, traditional healers can modify ritual practices</li> </ul>

Table 4: Efficiency calculations for THETA Uganda

Population in the districts targeted by THETA (1991)*	Rural	Urban	Total
Mbarara	884,156	46,616	930,772
Mukono	725,869	98,735	824,604
Kamuli	473,200	8,262	481,462
Soroti	384,116	46,274	430,390
Hoima	193,300	4,616	197,916
Kiboga	136,330	5,277	141,607
<b>Total</b>	<b>2,796,971</b>	<b>209,780</b>	<b>3,006,751</b>
Total Ugandan population 1991*			16,671,705
Estimated total Ugandan population 1998			22,000,000
Estimated population growth 1991-1998			32%
<b>Estimated 1998 population of the 6 districts targeted by THETA</b>	<b>3,690,886</b>	<b>276,826</b>	<b>3,967,712</b>

Traditional healer population estimates			
No. of traditional healers in the 6 districts targeted by THETA**			1,407
No. of traditional healers trained by THETA in all 6 districts (40 per district)			240
Percentage of traditional healers trained by THETA in all 6 districts			17%
Estimated beneficiaries			
	Rural	Urban	Total
Total estimated 1998 pop. of the 6 districts targeted by THETA	3,690,886	276,826	3,967,712
Estimated % population using THs	Low estimate***	29%	20%
Estimated number of people based on	Low estimate***	1,070,357	55,365
Estimated % population using THs	High estimate***	85%	75%
Estimated number of people based on	High estimate***	3,137,253	207,619
Estimated 1998 client population of THETA trained THs (17% of traditional healers trained by THETA)			
Based on low estimate of pop. using THs	182,577	9,444	192,021
Based on high estimate of pop. using THs	535,139	35,415	570,554

Estimated costs per beneficiary:	
Training programme costs per year (1998 figure)	US\$ 128,722.00
Cost per trained traditional healer per year of training (240 traditional healers)	US\$ 536.34
Cost per trained traditional healer per day of training (26 days/year)	US\$ 20.63
Cost per trained traditional healer per year of practice post-training assuming 5 years of practice post training	US\$ 107.27
assuming 10 years of practice post training	US\$ 53.63
Cost per traditional healer client, based on low estimate of pop. using THs-	US\$ 0.71
based on high estimate of pop. using THs	US\$ 0.24

\* Based on the 1991 National Population and Housing Census. \*\*Based on figures submitted by community at county level for "individuals known to treat people spiritually or with herbs". \*\*\*Based on references: Scheinman, 1997 (personal communication); Dupree et al, 1992; Barton & Wamai, 1994

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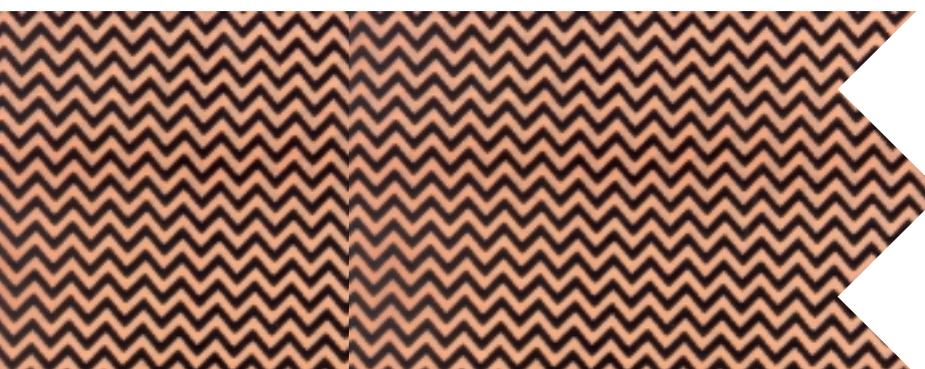
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