Appendix A

A growing number of African countries have established structures, budget and training in TM

Country	A legal framework for TM	A national management or coordination body	Association(s) of traditional practitioners	Directory of traditional practitioners	National budget allocation for TM
Angola		●	●	●	
Botswana			●		
Burkina Faso	●	●	●		
Cameroon			●	●	
Côte d'Ivoire	●	●	●		●
Dem. Rep. of the Congo	●	●			
Equatorial Guinea	●	●	●		
Eritrea					●
Ethiopia	●		●		●
Gambia				●	
Ghana	●	●	●		●
Lesotho	●	●	●	●	
Madagascar	●	●	●	●	
Malawi		●	●		
Mali	●	●	●	●	●
Mauritania			●		
Mozambique	●		●		
Namibia	●	●	●		
Niger	●	●	●	●	
Nigeria	●	●	●		●
Rwanda		●	●	●	●
Sao Tome & Principe	●	●	●		
Senegal			●		●
Zambia	●	●	●	●	
Zimbabwe	●	●	●	●	

Source: World Health Organization, 2000.[3]

From: *Traditional Medicine Strategy 2002-2005*

World Health Organization

WHO/EDM/TRM/2002.1

Geneva

p.14

Appendix B

Recommendations

The workshop participants stressed the important role of traditional medicine in developing countries and reiterated that countries should develop a national traditional medicine policy. This national traditional medicine policy should include the issue of R&D in the area of traditional medicine, the formal recognition of traditional medicine systems and the integration of traditional medicine in the national health care system.

The meeting noted that many activities and products based on traditional knowledge are important sources of income and health care, as well as environmentally sustainable routes to economic development for large parts of the population in many developing countries. The use of traditional medicine and the vast majority of plant genetic resources and other forms of biodiversity are found in, or originate from, developing countries. Access to these resources and the associated traditional knowledge can provide substantial benefits to companies and scientific research centres in both developed and developing countries. There is concern that traditional knowledge is at times appropriated, adapted and patented by scientists and industry, for the most part from developed countries, with little or no compensation to the custodians of this knowledge and without their prior informed consent. This is a trade issue, as traditional knowledge and products derived from traditional knowledge often cross international borders. Developing countries should rally their concern for fair and equitable sharing of benefits.

In view of the above, the workshop made the following recommendations:

- Countries should have a national policy on traditional medicine as part of the national health policy and countries should develop and utilize traditional medicine in a meaningful manner in the national health care system.
- Organizational infrastructure of traditional medicine should be developed and/or strengthened and official recognition accorded to it.

- National and regional strategies should be developed for the protection of traditional medicine with the support of WHO and other international agencies.

- Ways and means need to be devised and customary laws strengthened for the protection of traditional medicine knowledge of the community from biopiracy.

- Simultaneously, efforts through technical cooperation among countries need to be made to add value through innovation for public health. Indigenous and local communities should be involved in devising these models.

- Traditional knowledge which is in the public domain needs to be documented in the form of traditional knowledge digital libraries in the respective countries with the help of WHO to WIPO's work in this area. Such information needs to be exchanged and disseminated through systems or mechanisms relating to intellectual property rights.

- WHO, in cooperation with other agencies including UNCTAD, needs to support the initiatives taken by governments of Member States for capacity building, implementation and enforcing the legislation to protect and promote traditional medicine knowledge through training, seminars and workshops. International cooperation should be increased in this area.

- Governments should develop and use all possible systems including the *sui generis* model for traditional medicine protection and equitable benefit sharing.

- Countries should develop guidelines or laws and enforce them to ensure benefit sharing with the community for commercial use of traditional knowledge.

- Traditional knowledge should be recognized in the form and concepts of the traditional medicine system of a particular country, and not necessarily on a Western model.

- Efforts should be made to utilize the flexibility provided under the TRIPS Agreement with a view to promoting easy access to traditional medicine for the health care needs of developing countries.

- *Report of the Inter-regional Workshop on Intellectual Property Rights in the Context of Traditional Medicine*

WHO

Bangkok,Thailand

6-9 December 2000

WHO/EDM/TRM/2001.1

p.34—35

Appendix C

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

- 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.

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.

    - 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.

- “Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: A Literature review”

UNAIDS Best Practice Collection

September 2000

p.10-11

Appendix D

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[3] (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,

[3] 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.

- Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: A Literature review"

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Appendix E

Selected projects reviewed according to UNAIDS Best Practice criteria

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 HIV/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[4]
- 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.

[4] Calculations described in Table 4

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 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 -ealers 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 HIV 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 links 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 HIV/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?

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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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Appendix F

Develop and strengthen traditional medicine

Governments need t recognize the importance of integrating traditional medicine in national health systems and creating an enabling environment for optimizing its use. There is need to mobilize political leaders and policy makers, traditional medicine practitioners, non-governmental organisations, professional health associations, the community, teaching and training institutions and other stakeholders. Advocacy, social marketing, participatory methods and legal frameworks can be used to integrate traditional medicine into health systems.

It is essential to strengthen structures of traditional medicine through analysis of the prevailing systems and with the involvement of traditional health practitioners and communities. Some of the organizational requirements include the establishment of a national multi-disciplinary body responsible for the co-ordination of traditional medicine; formulation of a policy and legal framework; allocation of adequate resources; development of regulations for the local production and rational use of traditional medicines; and protection of intellectual property rights. The strategy for integrating traditional medicine adopted by health ministers and the declaration by heads of state provide orientations on how best to move forward in this important area.

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Available http://www.touchtech.biz/nepad/files/documents/115.pdf

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