# Involving traditional healers in AIDS education and counselling in sub-Saharan Africa: a review

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## Introduction

At the last International Conference on AIDS in Africa, Father Mwebe, a traditional healer in Kampala, opened his presentation to a crowded room of delegates by declaring, 'Traditional medicine is the mother of all medicines...', adding for the benefit of the numerous medical doctors in attendance, 'We are your fathers; you owe us respect...' [1]. Father Mwebe, an educated, articulate Ugandan architect and priest, may not represent the 'typical' traditional Ugandan healer, if such an average exists, but his words perfectly summarized the position and expectations of traditional healers in his country, and possibly throughout sub-Saharan Africa. His participation and the presence of several other healers at the conference, where a surprisingly large audience attended the sessions on traditional medicine, exemplified a gradually increasing trend of collaboration between traditional and modern biomedical health practitioners for AIDS in the region.

Africa, being the continent hardest hit by HIV and the poorest in modern health resources, should be an obvious place for such collaborations. However, despite the plethora of health challenges affecting the African people, very little action has been taken to actually work with healers since the recognition by the World Health Organization (WHO) of the importance of traditional medicine to primary health care and of the need to include healers in national health strategies and policies [2–7]. Undoubtedly, considerable prejudice remains ingrained among western health practitioners about the justification, validity and integrity of traditional medical practices. One important reason is the almost complete absence of serious certification systems and regulations governing the practice of traditional medicine in Africa, which makes it easier for charlatans to infiltrate this profession and abuse its reputation and clients. Nevertheless, the WHO recommendations are based on the premise shared by many researchers that, as a highly respected, widely distributed and often consulted group of health practitioners, recognized traditional healers have the cultural knowledge and skills to make an impact on disease prevention, health promotion and care including AIDS [8–13]. Indeed, the African healer is often consulted as a marriage counsellor, social worker, religious and spiritual guide, and legal and political advisor [14]. In addition, sexually transmitted diseases (STD) are among the most common reasons for a visit to the healer in many sub-Saharan countries where a majority of people believe that, whereas biomedicine can effectively cure physical symptoms of 'modern' diseases, healers are expected to completely heal the body, spirit and soul, and to cure diseases considered distinctly 'African' (i.e. believed to be due to forces beyond modern medicine's comprehension) [8–15]. Finally, women, whose social position in Africa makes them particularly vulnerable to STD and AIDS, often constitute the majority of healers' clients [16].

Undoubtedly, and ironically, it is primarily because of the unprecedented shock AIDS dealt to the developed world and to modern medicine that a renewed interest has emerged in supporting collaborations with traditional healers in the hope of finding new, more effective ways to fight and prevent this disease. Initially, several projects attempted to assess the value of traditional herbal remedies for the treatment of illnesses associated with AIDS [17–31]. At the same time, a number of studies were conducted on healers' perceptions of STD, HIV and AIDS. Based on these, most collaborative efforts have focused on training healers as educators and counsellors to disseminate HIV/AIDS information and prevention practices among their peers and communities. Finally, involving healers further, some projects have also encouraged healers to empower and provide emotional support to clients living with HIV and AIDS. Except for herbal and clinical studies, this review will look at the outcomes and

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challenges of these initiatives, and will attempt to draw initial conclusions about the advantages and difficulties inherent to the approaches used.

## Healers' perceptions on STD, HIV and AIDS

Traditional healers represent a broad range of practitioners including herbalists, spiritualists, diviners, priests and faith healers. Although many of the initiatives reviewed did not differentiate between them, the term 'traditional healer' used herein refers to either herbalists, spiritualists, or to the great majority of traditional healers very often involved in both practices.

African traditional healers mirror the great variety of cultures and belief systems existing on the continent, and possess equally heterogeneous experience, training and educational backgrounds. This diversity is further enhanced by their ability, often imperative, to adapt to the dramatic social changes that have affected most of the region since colonization, such as urbanization, population migration or displacement, and wars [32]. Thus, whenever African healers' knowledge, attitudes, beliefs and practices about STD and AIDS have been explored, findings have reflected both the stage of the epidemic, the amount of information that healers have been exposed to, and their pre-existing beliefs regarding diseases in general and STD/AIDS in particular.

Most healers have treated STD for generations, but their explanations of STD and AIDS vary considerably 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 STD which healers in most settings, whether rural or urban, almost universally ascribe to transgressions of sexual taboos related to birth, pregnancy, marriage and death [10,12,33]. These include having sex with an uncleansed widow or a woman who has had an abortion, as well as violations of moral codes, such as adultery or having sex with animals [11,33,34]. Other common causes reported from widely different settings include promiscuity and 'pollution' through stepping in urine or wearing clothes of an infected or sick person, or direct contamination by 'dirt', insects and microscopic agents, or through spirits, sorcery and poisoning [9–11,34].

While social research has shown that in many countries healers could name and describe numerous types of STD (which do not always correspond to the modern definition of STD), few of them considered AIDS an old 'African' disease [10,11]. In some cases, however, AIDS has been confused with known STD that mimic AIDS symptoms, such as *Boswagadi* in Botswana, a traditional STD considered lethal and consisting of oedemas and profuse diarrhoea (C. Oja, personal communication, 1994), or *Kalyonde'onde* in Zambia, a condition traditionally referring to wasting, oedemas and diarrhoea, but believed to be curable (unpublished data).

Beliefs related to the prevention of STD or AIDS follow the logic of transmission and causation, and therefore 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 [10,11,34,35]. In many cases, condoms have been acceptable to healers especially when they could be justified within their belief system. For example, many African healers consider semen a vital element to nurture a pregnant woman's fetus and maintain her health and beauty, but their concern for family and cultural survival can override this belief and allow them to promote condom use [11,35].

## Training healers as AIDS educators and counsellors

With the realization that traditional healers could become effective change agents for AIDS prevention, given their *de facto* roles as educators and counsellors, a number of projects started training healers in HIV/AIDS as early as the late 1980s [8,11,12,35]. Most initiatives have found that 'training' healers, however, implies a different approach than that used with conventional health workers to whom knowledge is often imparted unidirectionally. With traditional healers, only a respectful attitude of open exchange of ideas and information can win their trust and cooperation. The initiatives we have reviewed here are those where such an approach has been used and for which a minimum of follow-up data was available. As a guide to these and other less documented projects, we have summarized the data available on the nature, achievements and findings of collaborative initiatives in Table 1.

### Zambia

In Zambia, where HIV prevalence is one of the highest in the world (estimated at around 24% in Lusaka [36]), the Ministry of Health (MOH), designed in 1987, a workshop to train healers on AIDS [37]. Forty healers attended and their knowledge about the cause of AIDS and HIV transmission, and their attitudes about people living with HIV and AIDS (PWA) improved after the workshop. However, the proportion of healers claiming AIDS had a cure only decreased from 75 to 48% after training, whereas 43% of them still believed that abortion could cause AIDS (down from 58%).

This effort was not followed up until 1994, when the Zambian MOH Traditional Medicine Unit developed an STD/AIDS training programme for healers consisting of 3-day workshops and emphasizing follow-up

**Table 1.** A summary of documented collaborations with traditional healers for sexually transmitted disease (STD)/AIDS prevention in sub-Saharan Africa (1987–1996).

| Project [refs] | Initiated/supported by | Status | Achievements/findings |
|---|---|---|---|
| Botswana* [5,45] (King 1995) | | | |
| Seminars for TH on AIDS | MOH | Ongoing | Seminars held sporadically with TH on various diseases including AIDS. |
| Dingaka AIDS Awareness*, 1991–1993 | CIDA, WHO, MOH | Terminated | Two-week TOT held with 12 TH on AIDS, video produced. |
| Cameroon [5,71] | | | |
| KABP survey of TH, 1990 | MOH | Completed | No data available. |
| TH guide for AIDS, 1994 | Ministry of Public Health, National Commission for AIDS | Completed | Manual on AIDS for TH produced by one TH. |
| Central African Republic [53,54] (Somsé 1995) | | | |
| Action to Define, Broaden, and Strengthen the Role of Traditional Practitioners (ADERT), 1995 | MOH, University of Bangui, World AIDS Foundation, CDC, CIDA, University of Washington (USA) | Completed | KABP survey on AIDS of TH, 6-day training completed for 103 TH; TH knowledge improved except for own risk practices; repetitive rather than single training model suggested. |
| Ghana [5] | | | |
| Establishment of a MOH unit for TM, 1990 | WHO, MOH | Completed | Recommendations for involving TH in management and treatment of AIDS. |
| Liberia [10,12] | | | |
| Anthropology Research on STD, 1988 | SOMARC/USAID, Johns Hopkins University (USA) | | TH advise against prostitutes, should be taught STD diagnosis and referral, because people believe in TM for STD |
| Malawi* [47] | | | |
| Training on AIDS for TH, 1992 | International Eye Foundation, UK Malawi International Centre for Eye Health | NA | One-day training for 334 TH on AIDS; increase in community education, condom distribution, and patient counselling. |
| Mozambique* [11,12,49] | | | |
| Anthropology research on TM, STD and HIV, 1991–1994 | MOH, Swiss Cooperation | Completed | Developed culturally appropriate strategy for the NACP involving TH for STD; workshop on STD, 1991; 1994 follow-up: increased knowledge on HIV transmission, condom use and promotion. |
| Rwanda [72] | | | |
| Research on health-seeking behaviour among women in an HIV/AIDS prospective cohort (Project San Francisco), 1990 | University of California, San Francisco (USA), MOH | Completed | Majority of women used both biomedical and traditional systems and believed in the greater effectiveness of TM for certain AIDS symptoms. |
| Sierra Leone [69] | | | |
| Counselling training for TH, 1992 | National STD/AIDS Control Programme | Completed | 150 TH trained in HIV/AIDS counselling; 80% of people with HIV/AIDS prefer TM treatment. |
| South Africa* [12,29,50–52] | | | |
| TOT for TH, 1992 | AIDSCAP, MOH | Ongoing | 630 TH trained by 28 trained TH on basic AIDS facts; 7-month follow-up: ≥ 80% retained correct STD/AIDS information and practised counselling. |
| Pilot survey of TH to assess their potential for AIDS prevention and care, 1992 | Centre for Natural and Traditional Medicine, Washington, DC (USA) | Completed | Survey found TH had high knowledge about AIDS and were treating symptoms of AIDS. |
| Tanzania [12] | | | |
| Anthropological research, 1993 | E. Green | Completed | TH advise positive living and partner notification, and give physical therapy to PWA. |
| Uganda* [16,28,39,41–44] | | | |
| Traditional and Modern Health Practitioners Together against AIDS (THETA), 1992 | Doctors without Borders, The AIDS Support Organization, NACP, MOH, Uganda AIDS Commission | Ongoing | Training of TH in AIDS community education and counselling; preliminary results show increased counselling by trained TH and increased knowledge and condom use among women clients of trained TH. |
| Community-based home care, 1993 | CONCERN†, MOH | Ongoing | TH trained 68 volunteers involved in home care and support to distribute herbs for common AIDS symptoms. |
| Zaïre* [35,56,68] | | | |
| Action research and two workshops with TH, 1989 | CONNAISSIDA, Zaïre Traditional Healers Association | Completed | Demonstrated TH pragmatism and the role they can play in promoting behaviour change for safer sex practices. |
| Zambia* [34,37,38] | | | |
| AIDS workshop, 1987 | Traditional Practitioners Association of Zambia, MOH | Completed | 40 TH attended; knowledge increased after training, misconceptions still strong. |
| AIDS research, training and follow-up, 1994–1996 | MOH, USAID, Morehouse University School of Medicine (USA) | Terminated | 2000 TH trained on AIDS facts and 120 TH trained in community education; knowledge increased, TH selling condoms through a social marketing programme. |
| Zimbabwe [5,67,73] | | | |
| AIDS workshops, 1988 | ZINATHA, MOH | Ongoing | Workshops organized to train TH in AIDS and counselling, pamphlet in local language designed for TH and AIDS. |
| Baseline data collection for STD/AIDS training programme of TH, 1995 | McMaster University (Canada) | NA | Designed an educational strategy merging biomedical and TM belief systems. |

*Projects discussed in the text; †a non-government organisation in Ireland. NACP, National AIDS Control Programme; CDC, Centres of Disease Control and Prevention; CONNAISSIDA, National AIDS Control Program Project in Zaïre; USAID, United States Agency for International Development; SOMARC, Condom Social Marketing Programme; TH, traditional healers; CIDA, Canada International Development Agency; TM, traditional medicine; KABP, knowledge, attitudes, beliefs and practices; TOT, training of trainers; MOH, Ministry of Health; WHO, World Health Organization; ZINATHA, Zimbabwe National TH Association; NA, information not available.

through healers trained in community education [38]. Over 18 months, the project trained about 2000 healers in basic STD/HIV/AIDS facts and 120 healers in community education. The curriculum, adapted from the Ugandan project discussed below [39] with Zambian traditional healer input, included STD/AIDS transmission and prevention, HIV testing, and condom social marketing [34,38]. Monthly follow-up meetings were led by healers trained in community education together with health centre staff.

Results of a mid-term survey showed that trained healers scored significantly better than non-trained healers on 13 out of 17 impact measures [38], including knowledge about HIV transmission and prevention, advice to give PWA, and condom use and storage. By then, 250 trained healers reported selling condoms to patients and community members through a social marketing programme. Trained healers were also more likely to have discussed the following with their clients: HIV and STD prevention, HIV testing, condom use and caring for PWA. Most of the healers' patients interviewed confirmed that their trained healer 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 [38]. Unfortunately, this project was terminated in 1996 due to lack of funding.

## Uganda

In Uganda, where HIV seroprevalence is also among the highest, two non-governmental organizations (NGO), the MOH and the National AIDS Commission launched in 1991 the Traditional and Modern Health Practitioners Together against AIDS (THETA) initiative with the aim of promoting active collaboration between traditional healers and modern practitioners in the area of treatment, care, support and prevention of STD and AIDS [16]. The first THETA project was a collaborative clinical study to evaluate herbal treatments for HIV/AIDS symptoms for which few or no therapeutic alternatives were available in the region [28]. During this study, healers were reluctant to discuss AIDS with their clients because they feared scaring them away with this potentially terminal diagnosis. This generated momentum for a second study to empower healers for STD/AIDS counselling and education, with a particular emphasis on their women clients in Kampala, where the prevalence of HIV had levelled at around 30% in pregnant women [40].

For this second 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 STD and AIDS [33]. Following this survey, 17 healers were recruited to participate in a 15-month 'training' programme including an average of three training days per month. The training curriculum was developed with the AIDS Support Organization and regularly updated with the input of both healers and community women. Content focused specifically on STD and AIDS, but also covered general topics such as cultural beliefs and practices, counselling, leadership, sexuality, gender, and legal issues [39].

The overall performance of healers was evaluated systematically, using various indicators with the healer, his/her clients and the community, including oral and written tests, regular visits to the healer's workplace, client follow-up interviews, and sit-in sessions (where a trainer observed a healer practising education or counselling) [39,41,42]. Each healer was found to have applied the training differently, some using their new skills for community education, others for counselling or initiating PWA youth or women's support groups [16]. Community education by healers proved to be a very interactive process where healers developed and used unique approaches such as story-telling, PWA personal testimony, music, dance, poetry and drama to convey their messages. A preliminary assessment was conducted 1 year after the end of the training programme comparing three communities where healers had completed the THETA curriculum with one community where healers had not been trained. The communities with trained healers showed increased knowledge about HIV/AIDS and reported increased condom use (50 versus 17% where the healer was not trained) and reduced risk behaviour [43].

Healers' counselling was evaluated by interviewing 180 women who had consulted nine trained healers for HIV symptoms, STD, or 'love' problems and following them up 3 and 6 months later (follow-up I and II, respectively) [42]. Both the proportions of women who reported having received counselling from their healer (45–72%) and having been tested for HIV (46–64%) had risen significantly by follow-up II. During counselling, women said healers discussed facts about AIDS, positive living, condom use, and demonstrated and offered condoms [42]. Condom knowledge, attitudes and use were found to significantly increase over time among these women, as was the increase in condom negotiation by women with their sex partners. However, at follow-up II, eight (21%) out of 39 women still said that one could tell someone had AIDS by 'pale skin or eyes'. Finally, three of the trained healers spontaneously initiated the formation of PWA support groups for their clients, some of whom achieved local notoriety for their educational songs, drama and dance on AIDS [44]. Based on these results, the THETA initiative has been expanded to four rural districts of Uganda using the framework developed in the Kampala pilot study.

## Botswana

In Botswana, where the 1994 national serosurveillance data showed an HIV prevalence of 22.5% among pregnant women, the government has had a policy of actively promoting cooperation between modern and traditional medicine for more than 16 years [5,14]. Activities of the MOH with traditional healers have included seminars on various health conditions including AIDS, facilitating

referral, and implementing the Botswana Dingaka AIDS Awareness and Training Project. This project took place between 1991 and 1993 with the objective of training healers as AIDS trainers who would pass the information on to other healers in selected pilot areas. The original training of trainers lasted 2 weeks and involved 12 healers (group 1) in six districts of Botswana. Trained healers were then to travel together to other districts to train about 40 healers (group 2) in each district. Once trained, group 2 healers were expected to train additional healers, collect condoms from health centres and distribute them [45].

Four of the five workshops planned for the group 2 healers took place, but funding was terminated after the first phase of the project, so neither group 1 nor 2 healers were followed up extensively. However, three of the 12 group 1 healers interviewed 2 years after training said they were able to disseminate information in their communities, they referred patients to the hospital when their treatments failed, and that they had no hesitation distributing condoms or talking about sexual issues with clients [46]. All three also claimed they had many STD patients, yet had never had a patient whom they suspected of having AIDS. When asked how they would react if such a patient came, they all said there was nothing they could do, since they did not have a treatment for AIDS. They were not confident with the clinical case definition of AIDS, or for referring clients for HIV testing and counselling, and did not see themselves playing a significant role in home-based care [46]. A further evaluation of the MOH's involvement with healers was designed in 1995 and awaits implementation.

## Malawi

In the Chikwawa District of Malawi, which has an estimated HIV seroprevalence of 31%, 89 healers were interviewed in 1991–1992 regarding their knowledge, attitudes, beliefs and practices surrounding AIDS, and 334 participated in a 1-day workshop emphasizing community education and condom distribution [47]. When 85 of the 89 healers were re-interviewed 18 months later, 43 (50%) had received the training, and of these, 21 were conducting community education, distributing condoms and counselling patients. Trained healers were found to be 2.5 times more likely to report having counselled their patients than their untrained counterparts, although no data was available on the content of counselling. However, the proportion of healers reporting witchcraft as a main mode of transmission increased from 2 to 11% after training. Based on these results, authors stated that although 'no training is likely to change the belief in witchcraft in African societies', even short-term training can have a beneficial effect on healers' knowledge and practices on AIDS [47].

## Mozambique

By 1992, Mozambique had an official overall HIV prevalence of 2.5% [48]. A year earlier, a 3-year programme was started by the MOH Department of Traditional Medicine with the aim of decreasing the spread of HIV by reducing the incidence of STD through a collaborative effort with a local traditional healers' organization [11,12]. Preliminary qualitative research conducted on healers' perceptions of STD and AIDS revealed a strong underlying belief that modern practitioners 'do not understand the true cause of STD' and showed that all healers had heard of AIDS, had complete faith in their medicines, advised avoiding biomedicine for STD, and believed a number of illnesses (but not AIDS) to be sexually transmitted [11]. Based on these findings, a training strategy was proposed whereby new concepts such as promoting condom use would be integrated or 'translated' into existing notions of protection, traditional precepts (such as discouraging sex outside marriage or promoting sexual abstinence during STD treatment) would be reinforced, whereas traditional practices such as vaccination involving healer-to-patient or patient-to-patient blood contact would be discouraged [9,49]. Based on this strategy, two 1-week workshops were conducted for 30 healers in two provinces of the country in 1991 and 1994. An assessment of the 1994 workshop found that most healers had learned about the sexual transmission of HIV, 75% reported condom use as a method to avoid AIDS, and 18 (80%) out of 22 claimed to have promoted condoms. However, confusion remained as to the relationship between STD, HIV and AIDS and about whether AIDS is curable (E. Green, personal communication, 1995).

## South Africa

In South Africa, where traditional medicine has remained an important component of health services despite a high rate of modernization, a traditional medicine and AIDS project was started in 1992 to train 27 000 traditional healers nationwide in three successive cycles [12,50–52]. The strategy was to train 30 healers as trainers who would each train a second group of 30 healers who would repeat the cycle once more. The initial 5-day training session covered topics similar to those described in other programmes mentioned above in addition to the issue of death and dying.

Seven months after the first training, 18 of the first 28 trained healers reported having trained 630 second-generation healers in diverse parts of the country. A preliminary assessment of this second generation focused on 70 trained healers selected from 10 geographically representative sites [50]. Ninety per cent of them thought that the demonstration of proper condom use was the most useful lesson learned at the workshop. These healers had correctly retained basic information on gonorrhoea, HIV as an infectious agent, HIV symptoms, and modes of transmission and prevention. Three out of 18 healers who said they had treated cases of AIDS, mentioned giving advice and counselling to their clients without being prompted [50]. When prompted, the other 15 most frequently described promoting positive attitudes or show-

ing care and understanding as the type of advice or counselling given (20 out of 48 answers), whereas eight mentioned advising condom use [50].

Addressing the challenge that healers were facing in promoting behaviour change, one healer commented that, 'in former times, elders took boys to the bush to educate them about proper behaviour ... [which included] intercourse where there is no penetration' [50]. He added that the practice had become increasingly rare, practically unknown to young people in some towns, and noted that in rural areas, 'even the youngest people want penetrative sexual intercourse'. The assessment concluded that the first generation of trained healers selected and trained their peers for the second cycle more effectively than the western trainers of the first generation, as the healers' selection was less politically oriented and the training more culturally relevant [50].

### Central African Republic

Finally, a 1-year project to increase healers' ability to deliver preventive messages, provide support to PWA, 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 [53]. Over a 2-month period, 103 healers received 6 days of training on general STD/AIDS information in addition to community education [53,54]. By the end of the training, healers' knowledge had significantly improved regarding the notion that STD increase risk for HIV, that condoms protect against HIV, the causes of genital discharge and ulcers, STD complications, and modes of HIV transmission and prevention (P. Somsé, personal communication, 1995). Some variables such as knowledge of the most common STD, the lack of a cure for AIDS and the perception of risk scored high to begin with, thus had little room for improvement. Knowledge and attitudes regarding 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.

## Outcomes and challenges

Although advocacy for traditional medicine and attempts to involve healers in primary health care had been undertaken well before the AIDS epidemic in several African countries [15,55–64], there are still few collaborative efforts between traditional healers and modern practitioners for AIDS prevention or care. Nevertheless, the initiatives reviewed here confirm that there is certainly no lack of enthusiasm on the part of healers to collaborate with their western-trained counterparts and learn from them about STD and HIV/AIDS [9,12,65,66]. Experiences across countries show that modern and traditional belief systems are not incompatible and if we accept with Green that traditional healers (in Africa) 'are unlikely to abandon their way of interpreting STD and other diseases as a result of any education ... directly confronting existing beliefs' [11], then collaborations can create understanding and respect for both cosmologies so that they become complementary and the interpretations healers make of them are beneficial for their clients and communities infected and affected by HIV [35]. The initiatives described above show that, once a dialogue is established, it is possible to work with traditional healers and design, plan and implement collaborative approaches for AIDS education and counselling [1,47,66–68].

Most projects reviewed here have used a scheme whereby a core group of healers is trained as trainers for periods ranging from 1 day to 15 months. These healers are then given the mission to educate communities or train their peers [12,16,38,47]. Some projects have also supported healers in developing educational materials [5,39,46], condom social marketing [38], or giving basic counselling [38,41,42,69]. Counselling is probably one of the most fundamental services healers have traditionally provided to their communities, and since the AIDS epidemic, counselling has been an integral component of both STD/AIDS prevention and care strategies promoted worldwide. However, only three of the projects reviewed above have reported on the effect of training on healers' counselling ability for STD and AIDS [16,47,50].

Preliminary assessments of some projects have shown that, although in most cases 'trained' healers quickly assimilate the new knowledge and integrate it into their practices and messages they deliver to communities, misconceptions remain, especially after short-term training [16,42,53]. Only a few projects have planned or have had the means to systematically follow-up healers after their initial 'training'. However, an important reason for providing long-term support to healers is that, despite being natural counsellors [16,41,50], healers can face real difficulties in dealing with the issues of condom use, care and support, and death and dying elicited by AIDS. How can healers give their clients a diagnosis of AIDS when it may mean losing their business? How can a healer, the traditional guarantor of the clan's fertility, counsel an HIV-positive woman who wants to have a child? The THETA initiative indicates that, once left on their own, healers who have been regularly supported after training have sustained their STD/AIDS activities in the community longer and more intensively than those who only participated in training [43].

Most assessments however have been sporadic, spaced over long periods of time, and relied too often on healers' surveys alone. None of the projects reviewed has completed a comprehensive evaluation of the different approaches used and 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 the impact on the healers' clients and communities. Systematic and more in-depth evaluation 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 collaborations.

## Conclusion

In her case study of traditional Ghanaian medicine, Fink stated that, 'medical pluralism views all medical fields as coexisting parts of a connected system, [made of patients] who simultaneously or successively use different types of medicine' [15]. This pluralism can be interpreted as a means of survival which is all the more compelling when disease pressure is high and health resources are scarce or ineffective. The bridge between alternative and biomedical health care is generally built by the client rather than the provider, as has been the case for AIDS. The multiple use of different medical systems by AIDS patients, whether symptomatic or not, has forced the interest of the biomedical sector in potentially valid alternatives. Eventually, this process can promote collaboration between the various health sectors, especially in resource-poor environments and for conditions which have no cure. But collaboration should not be a forced alternative just because an effective cure or vaccine for AIDS is not available. Nor should it be needed out of respect for the long-established healers, but out of necessity. Traditional healers remain the vast majority of preferred and universally accessible care providers in Africa. If they are left out of the AIDS struggle, the social, behavioural and cultural factors that allowed the AIDS pandemic to flourish on this continent will never be eliminated, even in the idealistic situation where an effective drug or vaccine reaches the majority of the African people.

Father Mwebe's quote at the beginning of this article reminded his audience of what traditional healers expect from any collaboration: recognition and respect. As simple as this may sound, these demands are still too rarely met, and even if collaborations may seem easy to initiate, they demand constant dialogue and systematic support and follow-up to achieve the results expected of them. Western and traditional African medicines are based on concepts, languages and cultural constructs that are too distant for a simple mixing to automatically achieve positive results [14,70]. Even when traditional or modern health concepts are translated in an attempt to bridge the gap between the two medical worlds [11], the lack of solid evaluations together with a still pervading scepticism among modern biomedical practitioners against 'unscientific' approaches cause collaborations to enter a vicious circle where the lack of data justifies the lack of funding, and *vice versa*.

These limitations exemplify the imbalance inherent in the colonial heritage of public health in Africa; collaborations are almost always initiated, and terminated, by the western sector because this is where the funds are. Yet, despite these difficulties, the projects reviewed here highlight that healers are capable of performing at least as well, if not better than their biomedical counterparts in their new roles as AIDS educators and counsellors. This observation alone should prompt national, international organizations and NGO as well as communities to plan, design and implement programmes to support traditional health practitioners as educators and counsellors for STD and AIDS on a large scale in Africa. For this to occur, however, a fundamental shift in attitude and approach of the biomedical elite to traditional medicine is crucial. If we truly care about the underserved communities of Africa and elsewhere, then we have no choice but to face the cultural challenge of working together with those who have the language and the respect of these communities. In short, a true dialogue is needed, but cannot happen until traditional medicine is fully recognized and respected *a priori*, so that long-term collaborative projects can be carefully planned, seriously funded and evaluated in order to empower traditional healers for the prevention and care of AIDS and other diseases in the region.

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