
**TRADITIONAL MEDICINE PROGRAMME &
GLOBAL PROGRAMME ON AIDS**

**REPORT OF
THE CONSULTATION ON AIDS
AND TRADITIONAL MEDICINE:
PROSPECTS FOR INVOLVING
TRADITIONAL HEALTH PRACTITIONERS**

FRANCISTOWN, BOTSWANA

23-27 July 1990



World Health Organization



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CONSULTATION ON AIDS AND TRADITIONAL MEDICINE:
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1. INTRODUCTION

1.1 Background of the consultation

The acquired immunodeficiency syndrome (AIDS) was first identified in June 1981. By December 1990, a global total of approximately 307 000 cases of AIDS had been officially reported to the World Health Organization (WHO) by 156 Member States. Of these reported cases, about 80 000 have been in sub-Saharan Africa.

However, it is believed that these reported figures represent only a fraction of the actual number of AIDS cases. Worldwide, WHO estimates that there may have been a cumulative total of as many as 1 000 000 cases, with 700 000 of these having occurred in sub-Saharan Africa. Some 8-10 million adults throughout the world have been infected with the human immunodeficiency virus (HIV). WHO projects a total of 8-10 million cumulative AIDS cases by the year 2000.

The AIDS pandemic has had a significant impact on individuals and communities everywhere in the world, particularly in the African Region. Modern medicine has so far been unable to contain the spread of HIV infection; therefore, renewed attention has been drawn not only to the potential of traditional medicine but principally to the major role that traditional health practitioners can play in the implementation of national strategies for the prevention and the control of HIV infection and amelioration of symptoms caused by opportunistic infections and AIDS.

In 1976, the World Health Assembly acknowledged the potential value of traditional medicine in expanding health services by calling attention to the manpower reserve constituted by traditional health practitioners (resolution WHA29.72). In the following year, a Health Assembly resolution (WHA30.49) urged countries to utilize their traditional systems of medicine. Another resolution was passed in 1978, in which the Organization was called upon to develop a comprehensive approach to the subject of medicinal plants (WHA31.33). Nine years later, in 1987, the Fortieth World Health Assembly reaffirmed the main points of the earlier resolutions, as well as related recommendations made at the International Conference on Primary Health Care, held in Alma-Ata, USSR, in 1978 (WHA40.33).

The Forty-first World Health Assembly drew attention to the Chiang Mai Declaration (1988): "Save Plants that Save Lives" and endorsed the call for international cooperation and coordination to establish a basis for the conservation of medicinal plants, in order to ensure that adequate quantities be available for the use of future generations (resolution WHA41.19).

In 1989, a resolution was passed (WHA42.43) that recalled earlier resolutions on traditional medicine, traditional health practitioners, and traditional remedies and affirmed that together they constitute a comprehensive approach to the utilization of medicinal plants in the health services.

This resolution provided a fresh mandate for future action in promoting effective collaboration between the traditional and modern health care sectors in WHO's Member States. The adoption of safe and useful traditional medicine practices in the design and implementation of national health systems makes good sense in terms of economics and cultural acceptability.

Given the paucity of human and material resources available to African governments and the extremely high number of AIDS cases in the region, there is an urgent need to devise new approaches that would contain the further spread of this dread disease. These new approaches should not only be developed within the framework of national strategies for delivering primary health care, but should also take into consideration the fact that in many countries, especially those in the African Region, traditional medicine is part of the health practices of individuals and communities; a form of private practice, outside the formal health system. Governments, therefore, have a responsibility to

ensure that traditional medical practices are not harmful and to foster what is effective and beneficial, in keeping with the beliefs of the people. These positive practices can be crucial in meeting the challenge of the present crisis.

In responding to the gravity of the situation caused by AIDS, many African countries have developed national AIDS control plans. For example, Botswana, Kenya, United Republic of Tanzania, Uganda, and Zimbabwe have identified programme areas that are appropriate for involving traditional health practitioners in community health activities; these include community-based care, health education, counselling, and the relief of certain symptomatic conditions. In addition to these areas, there is also a potential for involving traditional health practitioners in providing the community with culture-specific information on sexual behaviour and in formulating and channelling specific health promotional messages. So far, these efforts have not been coordinated, and therefore there is no basis for a comparison of their effectiveness. However, there is no doubt that, properly motivated and involved, the traditional health practitioner can act as a valuable link to the majority of the population, who may be difficult if not impossible for modern health workers to reach.

1.2 Purpose and objectives of the consultation

The consultation was held to consider ways and means to expand the important role of traditional health practitioners, including traditional midwives, in the delivery of health services in African communities by involving them more actively in measures to prevent and control HIV infection and AIDS.

The specific objectives of the consultation were as follows:

1. To explore and identify the best ways to involve traditional health practitioners in the prevention and control of AIDS in Africa.
2. To draft guidelines on approaches that countries could use to secure the involvement and continued participation of traditional health practitioners.
3. To examine the need for, and to define, health services operational research in traditional medicine that is relevant for developing and implementing strategies for AIDS prevention and control and for solving other public health problems.
4. To formulate recommendations to WHO and to governments in the African Region on the appropriate steps to be taken in order to facilitate the involvement of traditional health practitioners in AIDS prevention and control.
5. To produce a report that can be used as a practical instrument for Member States who wish to strengthen AIDS prevention and control activities through the involvement of their traditional health practitioners in national AIDS programmes.

1.3 Organization and proceedings of the consultation

In preparation for this consultation, the participants were asked to prepare country reports that would outline the most significant issues stemming from experiences in involving traditional health practitioners in national AIDS programmes.

Fifteen experts and members of the WHO Secretariat took part in the deliberations. The participants, representing a wide range of technical disciplines, included anthropologists, educators, health policy-makers, pharmacognocists, pharmacologists, and traditional health practitioners, as well as managers of national AIDS programmes (see Annex 1).

During the opening ceremony, the Mayor of Francistown, Mr M. I. Ebrahim, formally welcomed the participants of the consultation. Mr M. Tshipinare, the acting Minister of Health, then added his words of welcome to the participants and described Botswana's medium-term plan for the prevention and control of AIDS (see Annex 3).

The consultation was formally opened by Dr G. L. Monekosso, Regional Director for Africa. In his inaugural address, Dr Monekosso reminded the participants of the gravity of the AIDS pandemic and how it has particularly affected the African Region (see Annex 4).

Dr O. Akerele, Manager of WHO's Traditional Medicine Programme, next addressed the group and outlined to them the purpose and expected outputs of the consultation. He also described to them the objectives and activities of WHO's programme, including recent collaborative work with the Biomedical Research Unit of the WHO Global Programme on AIDS, to assess the potential anti-HIV activity of traditional remedies (see Annex 5).

Next followed the nomination of officers: Dr E. Maganu, Chairman; Dr G. L. Chavunduka, Vice-Chairman; and Dr P. Marshall and Dr Debrework Zewdie, Rapporteurs.

The participants then adopted the proposed agenda and began their deliberations (see Annex 2).

The programme began with a review by Dr B. Nkowane of the current status of the AIDS pandemic, including global preventive and control strategies (see Annex 6). This was followed by the country reports (see Annex 7) and two days of group work, during which the participants were expected to identify the most practical ways to involve traditional health practitioners in AIDS prevention and control, giving consideration to policy formulation, training, teaching/learning materials, and research priorities. Plenary sessions were held towards the end of the consultation to summarize the discussions, consider recommendations, and adopt a draft report.

2. APPROACHES FOR INVOLVING TRADITIONAL HEALTH PRACTITIONERS IN AIDS PREVENTION AND CONTROL

2.1 Guidelines for formulating policies on training, research, and ethical issues in traditional medicine and AIDS

Countries should themselves decide which types of traditional practitioners they would want to involve in their national AIDS prevention, control, and care activities. While it is important to distinguish between different types of practitioners, it is understood that all types of traditional health practitioners recognized by their communities may well have important roles to play in AIDS prevention, counselling, and care and in community leadership.

2.1.1 The purposes of a policy on traditional medicine are:

- (a) to protect the patient from substandard care;
- (b) to recognize the role of traditional health practitioners and define their rights, privileges, and responsibilities as health care providers;
- (c) to educate and guide the practitioners and the community;
- (d) to correct the serious neglect in the education and training (including continuing education) of traditional practitioners and in research on the effectiveness of their practices;
- (e) to protect the traditional health practitioner from malpractice suits and prosecution under existing and proposed penal laws;
- (f) to protect individuals and the community from charlatans.

2.1.2 The goals of policy formulation include:

- (a) the improvement of the health and welfare of the population;
- (b) elaboration of a framework enabling the formulation of appropriate legislation and regulations for operational traditional medicine programmes;
- (c) the provision of a basis for the consideration of key ethical issues:
 - respect for the person as an individual and respect for the community as a whole;
 - promotion of the beneficial effects of traditional medical care and elimination of the harmful ones;
 - promotion of social justice through ensuring safe, culturally acceptable, and cost-effective traditional medical care to individuals and communities.

2.1.3 A policy on traditional medicine should provide guidelines for the following major areas: legislation and regulation; education and training; research and development; ethical issues; and allocation of financial and other resources.

(a) Legislation in traditional medicine should: enable the recognition of traditional health practitioners; define and standardize basic concepts of traditional medicine; define areas of practice; state the rights, privileges, and responsibilities of traditional health practitioners; provide a basis for their recruitment and registration, as well as the modalities for their utilization in health systems. Legislation drawn up by peers should provide the basis for ordinances and standards of reference to determine malpractice. Provision should be made for enactment of laws to protect the practice of the profession, as well as to stipulate the appropriate materia medica upon which traditional medicine should depend for its growth and survival.

(b) Education and training in traditional medicine should promote its acceptance and recognition as an integral part of the cultural heritage of the people, and it should facilitate collaboration between the modern and traditional systems. Information about traditional health care and its practitioners should be introduced into medical, nursing, and other health sciences curricula, as well as in social and behavioural sciences. Students of both systems should be involved in multidisciplinary action research in traditional and modern medicine. Appropriate information about the philosophy, principles, history, and cultural value of traditional medicine (merits and limitations) and the role of its practitioners should be included in secondary school curricula and introduced in the training courses for teachers. Prominent traditional health practitioners should be invited to explain and discuss their work. The complementary aspects of the modern and traditional health systems within a community must be emphasized to the practitioners of both systems in order to promote mutual professional respect. The following are educational activities that might promote the involvement of traditional practitioners in community health care:

- joint seminars and workshops should be organized for practitioners of modern and traditional medicine as well as for scientists of relevant disciplines;
- special courses of various grades and duration should be organized for traditional health practitioners, and, eventually, schools of traditional medicine should be developed, as was done in China and India.

Special training of traditional health practitioners for their participation in certain primary health care programmes must be emphasized. Appropriate entry points for their involvement in primary health care activities could be:

- oral rehydration therapy;
- traditional midwives for primary health care centres;
- family planning programmes;
- control of sexually transmitted diseases and AIDS;
- integrated AIDS and family planning programmes;
- endemic disease control such as of leprosy and tuberculosis;
- expanded programme on immunization;
- nutritional education;
- breast-feeding;
- elaboration of national traditional medicine pharmacopoeia;
- needs assessment through KAP surveys on AIDS (knowledge, attitudes, beliefs and practices);
- collection and dissemination of information and simple statistics on health care.

(c) The importance of research as the source of new information for establishing community diagnosis, determining needs, and resolving community health problems must be emphasized in the development of a policy for the promotion of traditional medicine. Multidisciplinary action research should be recommended as the best means to promote traditional health care and the utilization of traditional health practitioners in primary health care at the district level. Traditional health practitioners should be represented in all formal national research bodies for traditional medicine. They should also be involved in the planning and implementation of research and in the discussion and evaluation of results for feedback. In all of this they should be treated with respect, adequately compensated for their participation, and duly acknowledged. University faculties and research institutions should be encouraged and funded to take an initiative in these efforts. Various kinds of research are necessary for a full and balanced development of traditional medicine. The following are some examples:

- (i) operational or applied research that seeks to discover the strengths and weaknesses of traditional medicine practices in order to propose and offer solutions for improvement;
- (ii) research to explore new remedies for health problems and diseases such as AIDS;
- (iii) research on how to improve traditional medicine resources, such as the cultivation of medicinal plants, the breeding of animals, and the preservation and improvement of well-tested remedies;
- (iv) research on traditional remedies to evaluate their physiological activity, pharmacological properties, toxicity, and, whenever possible, to determine their chemical structure;
- (v) research on traditional health practitioners' concept of health, disease, treatment, and care;
- (vi) research on the sociodemographic, epidemiological, and professional profiles of traditional health practitioners;

(vii) research on the modalities of cooperation between modern and traditional health systems.

Research priorities would need to be defined on the basis of affordability, cost-effectiveness, and feasibility. Research results should be carefully reported and disseminated to policy- and decision-makers at local and national levels. They should also be disseminated to the public for their information and educational purposes. All research must respect established ethical principles.

(d) It is important that all existing traditional or customary beliefs, norms, taboos, rules, and attitudes be considered in elaborating a code of ethics for the practice of traditional medicine, whether at district, regional, or national level. To ensure that the practice of traditional medicine be respectable, fundamental human rights must be codified and adhered to. These should include:

- protection of the individual;
- confidentiality in practice;
- informed consent in studies and drug trials;
- avoidance of prejudice against patients (e.g., those with AIDS, other sexually transmitted diseases, leprosy);
- respect for the dead;
- respect for proprietary rights and intellectual property;
- adequate compensation (for practitioners' services, malpractice suits);
- promotion of national resource regeneration and conservation.

The national body responsible for the regulation of traditional medicine, the various associations of traditional health practitioners, and the national body responsible for the protection of human subjects in research should be in charge of ensuring ethical conduct in the practice of, and research in, traditional medicine.

(e) Financial resources should be made available for public education and information and for the training of traditional health practitioners through both the formal health system and associations of traditional health practitioners. Budgetary allocation should be provided for traditional medicine in national health budgets, as well as in national AIDS programmes.

Adequate financial support is a key factor in the effective implementation of policies, programmes, and projects aimed at promoting the utilization of traditional health practitioners in the prevention and control of AIDS.

2.2 Identification of relevant programme areas for involving traditional health practitioners in AIDS prevention and control

The role of traditional health practitioners as community leaders and health care providers is recognized and accepted by the majority of the population in most African countries. Their communication skills in health and social issues are a vital resource that can be tapped and utilized in a variety of crucial areas of AIDS prevention and control. A multisectoral approach has been recognized as the key to containment of the HIV/AIDS pandemic.

2.2.1 Information, education, communication, and counselling

Traditional health practitioners should be involved in activities aimed at creating and sustaining awareness about AIDS and sexually transmitted diseases by having them

inform, educate, and counsel their communities in general and their clients in particular.

- (a) Community leaders, including traditional health practitioners, should be mobilized and sensitized to support the AIDS control programme.
- (b) Traditional health practitioners should be provided with basic information about AIDS; they can then transfer this knowledge to their clients and their community. Their understanding of the epidemiology of the disease would be useful in attempts to prevent transmission of HIV through sexual contact and other high-risk practices.
- (c) Many traditional health practitioners and traditional midwives have expertise in providing marriage guidance and counselling and in discussing issues of family life and sexuality with specific target groups such as pregnant women and adolescent girls. They can, therefore, successfully reach them with appropriate information about AIDS and sexually transmitted diseases.
- (d) Traditional health practitioners should encourage condom use. Condom disposal techniques (e.g., to tie and throw into a pit-latrine, burying, burning, etc.) must be clearly explained to the traditional health practitioners so that their clients can be correctly informed.
- (e) Traditional health practitioners, as community opinion leaders, are in a unique position to participate in education programmes aimed at changing customs and traditions that are high-risk factors in the spread of HIV.

2.2.2 Prevention of HIV transmission through skin piercing practices, including circumcision

- (a) In a collaborative dialogue with modern health practitioners, traditional health practitioners should be alerted to the potential danger of some of their practices as high-risk factors for HIV transmission to their clients and to themselves. They should be advised to identify alternative and safe methods in the management of their patients' illnesses.
- (b) Traditional health practitioners should be taught basic hygiene practices as an important and key factor in the prevention of communicable diseases. Discussion groups and seminars should be organized where safety procedures are emphasized.

2.2.3 Prevention of HIV transmission through blood and blood products

The risk of transmission of HIV among traditional health practitioners, especially traditional midwives, poses a real problem. This risk can be reduced through education about safe practices.

- (a) Efforts should be made to identify and build on beneficial practices that could prevent and control HIV transmission.
- (b) An adequate and sustained supply of protective clothing, including gloves, should be ensured for both modern and traditional health workers when establishing a national AIDS control programme.
- (c) Efforts should be made to elaborate training for all health workers in obstetric techniques, especially traditional obstetric procedures, to ensure minimum exposure to blood.
- (d) Traditional health practitioners manage certain conditions by bleeding their patients. The risk of such practices should be explained in order to discourage their continuation.

(e) This situation can be used to advantage by correcting the misleading impression in African societies of the alleged superiority of injection over other forms of therapies.

2.2.4 Prevention of perinatal transmission

Traditional midwives have a crucial role to play in the education of women of childbearing age. By the nature of their role, they can discuss issues related to family life and sexuality that are important in initiating and motivating behaviour change, as well as encouraging safe sexual practices. They are also in a good position to counsel women of childbearing age who are at risk of HIV infection and inform them about preventive measures.

2.2.5 Clinical management and counselling

(a) Traditional health practitioners form a strong network of community health workers and provide support to individuals and families. National AIDS programmes should take advantage of this situation by fully involving traditional health practitioners in the information, education, and communication components of their programme and in the clinical management and counselling of AIDS patients. An appropriate mechanism to develop and facilitate this should be established by the district/village health team, including traditional health practitioners, as part of the national AIDS programme. This activity should be supported by appropriate focus-group discussions and seminars at those levels.

(b) Traditional health practitioners are experienced in providing psychosocial support to the terminally ill and in counselling bereaved families. Traditional health practitioners are an important source of alternative care for AIDS cases, and their position as community leaders should be capitalized upon in developing and soliciting community support for the care of AIDS patients.

2.2.6 An outline of ways to involve traditional health practitioners in national AIDS programmes

There is no simple or single approach to involving traditional health practitioners in national AIDS programmes; however, this should be based on mutual trust and collaboration between all health care workers.

(a) Where there is formal recognition of traditional health practitioners, with established specific organizational structures, they should be represented on national, provincial, and district AIDS committees. This could be an initial step towards recognizing their role and soliciting their support in national AIDS programmes.

(b) Where there is neither a national organization for traditional health practitioners, nor a specific policy on traditional medicine, statements on their important role in national AIDS programmes should be issued by the highest political authorities in the country until such time as a national policy is formulated and implemented. This will create an atmosphere conducive to meaningful dialogue between the traditional health practitioners and other health care workers at village and district levels.

(c) The existing primary health care administrative structure at village and district levels should be utilized to initiate contact with traditional health practitioners. When dialogue has been established, small focus-group discussions should be organized where issues relating to AIDS prevention and control are taken up and the role of traditional health practitioners is highlighted. These discussions should be followed by seminars at district, provincial, and central levels.

(d) Traditional health practitioners should be encouraged to express their perception of HIV infection/AIDS, including views on management and treatment, through their participation in focus-group discussions and seminars. Positive aspects of their understanding should be used when involving them in national AIDS prevention and control activities.

(e) Focal points should be identified that would serve as links between traditional health practitioners and other health care workers at different levels of the health system. These links should also be strengthened and extended so as to coordinate collaborative activities to prevent and control AIDS and sexually transmitted diseases with other primary health care activities.

(f) Traditional health practitioners should be involved to the extent possible in all stages of designing, implementing, and evaluating AIDS prevention and control activities. They should be involved in established community-based activities (e.g., drama and other groups) that could be used to portray the consequences of AIDS as part of health education programmes.

(g) A mutually acceptable referral system between traditional health practitioners and other health practitioners should be established. This needs to be supported by a system of continuing education to equip traditional health practitioners with the information and skills necessary to better manage and care for patients in the community.

(h) Traditional health practitioners should be involved to the extent possible in collaborative studies with modern health workers to evaluate the safety and efficacy of traditional remedies, especially medicinal plants, used in the treatment of opportunistic infections and AIDS symptoms. They could also be effective in motivating communities to participate in these studies. In order to facilitate this and to create an atmosphere of mutual trust, countries would have to consider developing patent laws to protect the rights of traditional health practitioners and to ensure equity in the distribution of income derived from drugs developed from traditional remedies.

(i) There should be a provision in the budgets of AIDS control programmes specifically for the active involvement of traditional health practitioners in AIDS prevention and control. When traditional health practitioners first begin to participate in these programmes, it would be necessary to make funds available for a number of activities, including seminars and the production of education materials, and for the remuneration of national and provincial focal points/coordinators, since they will devote most of their time to organizing their members and developing and coordinating different identified activities.

2.3 Identification of target groups of traditional health practitioners for training, development of training methodology, and identification of training materials

2.3.1 Efforts should be made to train all categories of traditional health practitioners in AIDS prevention and control, whether or not they are part of the formal health system. They will, in turn, become trainers for their client population, thus promoting a multiplier effect.

2.3.2 Prior to the development of the methodology and content of such training, it is imperative that the background and learning needs of the practitioners be determined. Furthermore, it is essential that extreme care be used in identifying "trusted intermediaries" who will act as training providers (educators and modern medical health practitioners and workers who believe in traditional medicine as well as in modern medicine) to ensure that the trainees have maximum confidence in their trainers.

2.3.3 The very first step in training must be the establishment of good rapport between the educational providers and the recipients by: (a) emphasizing that "AIDS" is a new disease, for which neither modern nor traditional medicine has yet discovered a cure and

(b) by informing the traditional health practitioners that they can play a vital role in the prevention and control of AIDS and in patient care. Training programmes organized at community level should emphasize that all kinds of health professionals (modern and traditional) should work together against a major, serious health problem that is not only of local, but of national and global concern. It must be stressed that cooperation on AIDS between traditional health practitioners and modern medical practitioners is very important and could be of mutual benefit. While modern medicine is needed for the accurate diagnosis of AIDS, it is the traditional health practitioners who would probably be the primary care providers and in the front line in the prevention and control of the spread of this disease.

2.3.4 Once rapport and confidence have been established, modern and traditional health practitioners should share their perceptions of AIDS and AIDS-related diseases. Where possible, national/provincial traditional health practitioner leaders should be included as members of the training team. The trainers should then proceed with a seminar/workshop to present relevant information on AIDS transmission, prevention, control, and patient care in a way that minimizes resentment and resistance among the trainees. Appropriate curricula on the subject of traditional medicine in general, and AIDS in particular, should be developed in collaboration with traditional health practitioners and taught at medical schools and at other schools of health sciences.

Examples of possible training methods include:

- group discussion rather than a lecture approach at both national and local levels;
- a problem-solving and case-study approach in small working groups;
- use of audiovisual aids, such as films and slides on specific AIDS cases, in the language of the trainees;
- demonstrations of beneficial therapeutic practices;
- role-playing (dramatization, etc.).

2.3.5 The development of training materials for traditional health practitioners should include:

- (a) motion pictures, audiovisual aids, pamphlets, posters, cartoons, and leaflets with drawings illustrating basic facts on AIDS and AIDS-related diseases;
- (b) for the education of the general public by the trained traditional health practitioner, the following materials could be made available: scripts of theatrical plays, songs, radio jingles, short stories, poems, well-known myths, legends, and folklore (adapted as needed); posters, cartoons, and audiovisual aids (where appropriate).

2.4 Identification of research priorities

Research priorities are defined in the context of the traditional health practitioner's role in the prevention and control of AIDS. These include:

- traditional health practitioners' perceptions of AIDS (diagnosis, prevention, treatment, patient care, and "cure");
- the community's perception of the traditional health practitioner's role and activities in AIDS prevention and control;
- relationship between modern health practitioners and traditional health practitioners in the delivery of primary health care;
- identification of the traditional health practitioner's clientele;

- specific traditional practices that could lead to HIV transmission to patients and/or to the traditional health practitioner;
- existing legal and ethical frameworks of traditional medical systems practice;
- counselling techniques of the traditional health practitioner;
- ways to promote cooperation of traditional health practitioners in scientific research on traditional medicine and AIDS;
- the best ways to inform traditional health practitioners and the general public about AIDS;
- ways to involve traditional health practitioners in epidemiological surveys and surveillance.

Present research policies in most countries do not reflect the role of traditional medicine in the delivery of health care. New research and development policies could greatly assist institutions in addressing the critical problem now being faced throughout the world of controlling and preventing the spread of AIDS.

3. RECOMMENDATIONS

In recognition of the vital role that traditional health practitioners have to play in national AIDS prevention and control activities, the consultation made the following recommendations to countries:

3.1 Policy and legislation

- 3.1.1 All countries should formulate a national policy on traditional medicine. Such a policy should be aimed at improving the overall health and welfare of the population within the framework of national primary health care programmes.
- 3.1.2 A national traditional medicine research policy should be formulated and implemented by a multidisciplinary traditional medicine research council that includes traditional health practitioners among its members.
- 3.1.3 Countries should consider establishing policies that would guarantee the intellectual property and patent rights of individuals and institutions involved in research and development of new drugs from traditional remedies. Such a policy should indicate how income potentially arising from these discoveries should be distributed.
- 3.1.4 A policy should be formulated to provide adequate funding from national budgets to ensure the active involvement of traditional health practitioners. External sources of funding should only be considered as secondary or supplemental resources to the normal government expenditure.
- 3.1.5 A well-defined policy should be followed by legislation that defines and standardizes basic elements of prevailing traditional medicine practices. Such legislation should clearly state the rights, responsibilities, and privileges of traditional health practitioners. Conversely, the public should be educated as to what standards of safe health care they should expect from their traditional health practitioners, including guidance on payment of consultation fees. Ordinances should also be established that ensure codes of professional ethics, as well as penalties for their violation. The legislation should also be directed towards the conservation and rational utilization of traditional medical resources, including vegetable, animal, and mineral products, upon which many traditional health practitioners depend. There should also be legislation to ensure equity in the distribution of income generated from the sale of drugs developed from traditional sources. A review of existing legislation is needed in order to revise it to conform to the new national policies.

3.2 Education and training

3.2.1 Courses on the elements of traditional medicine should be introduced early in the curricula of all modern health workers so as to ensure their awareness of the importance of traditional medicine in the context of their cultural settings.

3.2.2 Elements of modern medicine, such as hygiene, anatomy, and physiology, should also be taught to traditional health practitioners in order to make their work more effective.

3.2.3 Special continuing education courses at different levels and of varying duration should be organized for traditional health practitioners and eventually lead to the development of schools of traditional medicine.

3.2.4 To ensure the dissemination of accurate information, national governments, national AIDS programmes, and national AIDS committees should devise strategies for developing rapport with the media in order to continuously and correctly inform and educate the public on the AIDS pandemic.

3.2.5 Countries should develop national education activities aimed at fully involving traditional health practitioners in national AIDS prevention, control, and patient care programmes and making them fully aware of the risk to themselves and all their patients of HIV transmission in their practices.

3.3 Research

3.3.1 Resources, both human and material, should be made available for undertaking research in the priority areas identified by the consultation.

3.3.2 Technology transfer should be an integral part of any research agreement with foreign investigators/institutions, so that national research capabilities can be strengthened.

3.3.3 Countries should make efforts to involve traditional health practitioners in epidemiological surveys and in the surveillance of HIV infection and AIDS.

3.3.4 Traditional health practitioners should be involved in AIDS research in collaboration with modern health workers, as this would accord them the opportunity of biomedical testing and follow-up of their patients through the referral system.

3.3.5 Multidisciplinary, action-oriented research should be undertaken as the best means of promoting traditional medicine and utilizing traditional health practitioners in primary health care, especially in the prevention and control of AIDS and HIV infections. Involvement of local personnel in research teams (e.g., traditional health practitioners, community health workers, nurses, modern medical practitioners, botanists, chemists, pharmacologists, etc.) should be encouraged. Feedback of research results to all personnel and institutions involved in the project should be ensured.

3.3.6 Research priorities, as defined by national AIDS programmes in conjunction with the national body responsible and with the involvement of traditional health practitioners, should be based on affordability, cost-effectiveness, and feasibility. Research results should be carefully reported and disseminated, especially to health policy-makers and decision-makers at national level, as well as to the public, for information and education. All research must respect ethical principles.

3.3.7 National authorities should develop a mechanism for screening claims of "cures" in order to verify their authenticity.

3.3.8 National authorities should support multidisciplinary clinical studies on the safety and efficacy of traditional remedies in the treatment or management regimens of HIV infections and AIDS. Additional studies should explore social and behavioural issues surrounding beliefs and perceptions of HIV infections and AIDS.

3.4 Involvement of traditional health practitioners in national AIDS programmes

3.4.1 The guidelines formulated by the consultation should be adapted by national authorities to further develop activities to involve traditional health practitioners in the prevention and control of HIV infections and in the care of AIDS patients.

3.5 Recommendations for WHO follow-up action

3.5.1 WHO should urgently forward the Report of the Consultation to the Regional Committee for Africa and to countries in the Region, so that the recommendations made can be considered.

3.5.2 WHO should support countries to implement the recommendations made to them through:

- mobilizing extrabudgetary funding to ensure that resources be made available that are required to support the training and utilization of traditional health practitioners for primary health care, for the prevention and control of HIV infection, and for the care of AIDS patients;
- organizing workshops in countries to study the contributions of traditional health practitioners and to examine their training programmes in order to accelerate their articulation with the national health system, as well as to systematize their practices in primary health care, including the prevention and control of HIV infection and the care of AIDS patients;
- undertaking action research on traditional medicine in research and training centres, especially those centres involved in HIV/AIDS research and training.

3.5.3 WHO should support technical cooperation through the exchange of information, training, and research personnel between countries in order to facilitate the sharing of knowledge and experiences of traditional medicine and AIDS research.

3.5.4 WHO should initiate operational research, which could include research on the successes and limitations of collaboration between traditional and modern health workers, especially the involvement of traditional health practitioners in selected strategies for preventing HIV infection and for counselling and caring for AIDS patients. WHO should develop research protocols, for adaptation by different countries, to facilitate evaluation, comparison, and follow-up of research results.

ANNEX 1

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WELCOMING REMARKS BY MR M. TSHIPINARE

It is indeed an honour and privilege for me to welcome you to our beautiful country, on behalf of the Government of Botswana, on my behalf as the acting Minister of Health, and on behalf of the health staff, not only in Francistown, but throughout Botswana.

We appreciate the decision of the World Health Organization to have chosen to hold this important meeting in our country. We are very proud to host this meeting.

Like all other nations, we too are very concerned about the global pandemic of AIDS, which is spreading very fast. We hope and pray that a cure for this disease will be discovered soon.

Botswana, with the assistance of WHO, formulated a Medium-Term Plan for the prevention and control of AIDS. This was followed by a resource mobilization meeting at which multilateral and bilateral agencies made generous pledges to support our government, both financially and technically, to prevent and control AIDS in Botswana. This support has facilitated the implementation of the Medium-Term Plan. We are very grateful to the donor community and to WHO for having made it possible for our AIDS control programme to take off.

As I mentioned earlier, we are anxiously waiting for the day when the discovery of a cure will be announced. In this direction we appreciate the efforts of WHO to convene a consultative meeting on AIDS and traditional medicine. Who knows, perhaps the cure for AIDS is still hidden in traditional medicine.

While wishing you very fruitful discussions, we hope you will be able to discover areas of interest in Botswana during the meeting. Better still, some of you may prefer to stay on for a few days after the meeting. Alternatively, you may choose to come back at a later date and visit our country. Whatever you decide, you will always be welcome.

Finally, let me wish you the best of success in your deliberations. We wish you all a pleasant stay in Botswana and a safe journey home.

INAUGURAL ADDRESS BY DR G.L. MONEKOSSO, DIRECTOR,
WHO REGIONAL OFFICE FOR AFRICA

It is a great pleasure for me to be here in Francistown for the opening of this Consultation on AIDS and Traditional Medicine. I should like to express my sincere thanks to everyone who worked to make this consultation possible. In particular, I should like to thank the Government of Botswana for their full cooperation and support, and for their generous and kind offer to host this meeting.

AIDS was first identified as a devastating syndrome in June 1981. Since then, HIV infection and AIDS have weighed heavily on all our consciences. We have watched with grief in our hearts the uncompromising human suffering that the disease has unleashed on the world, and which it has continued relentlessly to do, even today.

As of mid-1990, a global total of 266 098 cases of AIDS have been officially reported to the World Health Organization by 156 Member States. However, it is believed that this figure represents only a fraction of the actual number of AIDS cases worldwide. It has been estimated that at present there may be as many as 700 000 AIDS cases, and six to eight million HIV-infected persons throughout the world. WHO has projected more than one million cases of AIDS worldwide by the early part of the 1990s, and some five to six million cumulative cases by the year 2000.

No region of the world has been spared the misery brought about by AIDS and HIV infection; and Africa is no exception. Of the total number of AIDS cases that I have just mentioned, about 65 000 cases have been reported in sub-Saharan Africa alone, representing roughly 24% of the world's total cases.

Given the paucity of resources available to African governments and the extremely high number of AIDS cases that I have just quoted, there is an urgent need for designing new approaches to contain further the spread of this dread disease. This consultation, with its singular objective of exploring new and innovative ways of involving traditional health practitioners in global efforts to control and prevent AIDS comes, therefore, at a most appropriate and opportune time.

We expect traditional health practitioners to contribute positively to the control and prevention of AIDS for a number of important reasons:

- Traditional medicine has been playing a very significant and increasing role in meeting the primary health care needs of all our people.

- The achievements of WHO's Member States in expanding and improving health services within the last decade, to both urban and rural populations, have been remarkable. These achievements - in this brief span of time - are in part the results of collaborative efforts between WHO and its Member countries. Many of these efforts have explored ways to integrate the positive and effective elements of traditional medicine into primary health care activities.

- In most developing countries, between 60 and 80% of the population live and work in the hinterlands. To most people in rural environments and the deprived groups in the urban areas, access to any form of health care has been mostly through the traditional health care delivery systems. The men and women who practise traditional medicine are usually well-distributed throughout a country, and they can be found in every single village and hamlet. Since 60% of deliveries take place outside medical establishments, there is no doubt about the unique and important services provided by traditional birth attendants in most countries within the framework of their primary health care programmes.

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- Traditional health practitioners enjoy respect and esteem in their communities. Traditional medicine has always been an inseparable part of the history and culture of all peoples. It is the culmination of the experiences of people in their struggle against disease and in maintaining healthful practices. By virtue of being at the front line of the struggle to prevent and cure diseases, traditional health practitioners have acquired considerable knowledge about the community and the people who live in it. They have a deep understanding of the culture in which they operate. They are well-placed to understand the dynamics of health in relation to man and his total environment. This has led to the profound respect that they enjoy from the members of the community in which they live and work.

- The sheer numerical strength of traditional health practitioners, coupled with the fact that they are already fully integrated into their communities, make them an important singular resource for delivering health care to every part of the country. They constitute a credible and powerful institutional network for reaching both urban and rural populations with well-formulated health messages. The success of the Chinese and other country experiences in integrating traditional medicine into primary health care programmes and activities as a viable option to achieve the fullest coverage of vast rural populations are well documented. The involvement of traditional health practitioners in efforts to control and prevent AIDS could, therefore, be a significant and critical issue.

There are, of course, other reasons why traditional health practitioners can contribute positively to the fight against AIDS. But the ones I have just touched upon here are what I consider the major reasons for supporting the efforts of WHO's Traditional Medicine Programme and its Global Programme on AIDS to bring all of you together to deliberate on the timely and important issue of how to involve traditional health practitioners in AIDS control and prevention.

Some important questions to be answered during these few days of consultation are the following:

1. What is the current situation of the traditional health practitioner in the national health care delivery system generally and, specifically, what is their role and involvement in HIV/AIDS control and prevention?
2. What is the present level of their knowledge about HIV infection and AIDS?
3. How can the educational infrastructure be adapted to accommodate the preparation of traditional health practitioners to effectively participate in national activities for the prevention and control of HIV infection and AIDS?
4. What kind of educational programmes will need to be developed, in terms of course content, methods, teaching/learning materials, etc.?
5. How do we assess the traditional health practitioners' understanding of their role and functions in national AIDS control and prevention activities?
6. How do we supervise traditional health practitioners when they carry out these prevention and control activities in their communities?

At this time, we have only partial answers to some of these questions. We know that the short- and medium-term national plans that we developed in collaboration with Member States have given the highest priority to AIDS education of health personnel, including physicians, technicians, and, where appropriate, a broad range of other health workers such as traditional birth attendants and traditional health practitioners. We are aware that countries are according the highest priority to using all elements of the health system in HIV/AIDS prevention and control. However, we still do not have a clear understanding of the form and content of educational programmes for traditional health

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practitioners. We have as yet no definite idea about how to monitor and evaluate their training. The answers to these questions will be necessary in order to enable us to develop educational activities that will ensure the full and continued involvement of traditional health practitioners in the AIDS control and prevention efforts.

I am sure that in the course of your deliberations more questions will be raised, to which you will have to find appropriate answers.

Unfortunately, today, there is no cure for AIDS nor is there a vaccine against the disease. As we continue to make progress towards finding a biomedical solution to the problem, our only hope at this time is to intensify our efforts to control this scourge by capitalizing on the only known weapon we have against the disease: EDUCATION for behavioural change. We emphasize education, information, and communication as our most effective weapons. Why? Because we know that individual behaviour and practices are mainly responsible for most HIV transmission.

Therefore, by involving traditional health practitioners in the educational process, we are providing them with the necessary information to guide them in making decisions to modify or abandon those practices that expose them and their clients to the risks of HIV infection and other public health hazards. When they have become better informed, traditional health practitioners can, in turn, inform and educate their communities about AIDS and HIV infection and other diseases; this would be especially effective when the messages are translated and adapted to local languages and cultures. As informed partners in the provision of health care (whether or not they are part of the formal health system), traditional health practitioners could be instrumental in promoting social and cultural support for those practices that spell good health.

The African Regional Office has always welcomed with open arms any practical and constructive suggestions for improving and extending health services to all of our people. Our office, along with the other regional offices, welcomes this consultation for the important contribution it could make to the ultimate goal of strengthening the primary health care approach through the meaningful involvement of traditional health practitioners.

We all know that traditional medicine has from time immemorial been a key resource to meeting the health needs of peoples in developing countries. This recognition is evident in the efforts that we have made from time to time to explore ways to further strengthen our health care delivery systems.

For example, national AIDS control plans in many African countries, including Botswana, Kenya, Tanzania, Uganda, and Zimbabwe, have already defined programme areas such as community-based care, counselling, and certain symptomatic treatments as suitable for involving traditional health practitioners.

However, action-oriented and decision-linked research on knowledge, attitudes, beliefs, and practices involving traditional health practitioners in the prevention and control of AIDS is needed and should be given high priority during your deliberations.

The experience gained from such research will enable all national AIDS programmes in the African Region to formulate country-specific, innovative, and effective strategies to prevent and control this disease.

These research results may also serve to illustrate to what extent traditional health practitioners, including traditional birth attendants, can contribute to community health development.

Another example of our attempts to strengthen the use of traditional medicine in the health services is the recent meeting of experts from developing countries on traditional medicinal plants. They met in Arusha with the objective of exploring all practical ways

of strengthening overall South-South cooperation on the rational utilization of medicinal plants in the health services. Among other things, the meeting helped to reinforce the recognition of traditional medicinal-plant remedies as an important component of primary health care programmes in the countries of the South.

We are gathered here today, in this beautiful city of Francistown, for a few days of deliberation on the subject of AIDS and traditional medicine. I am sure that the recommendations and conclusions of this consultation will point us in the right direction towards ensuring the involvement and continued participation of traditional health practitioners in the global efforts to control and prevent the spread of HIV infection and AIDS. The challenge facing us is enormous, but we have the calibre of experts who are equal to the task at hand.

Once again let me express my deep appreciation and thanks to all of you here, and, in particular, to the Government of Botswana for all the preparations that have been made to ensure that our stay is not only productive, but also enjoyable.

I now have the pleasure of declaring open the First Consultation on AIDS and Traditional Medicine: Prospects for Involving Traditional Health Practitioners.

Thank you.

TRADITIONAL MEDICINE AND AIDS: PROSPECTS AND PERSPECTIVES

by

Dr Olayiwola Akerele, Programme Manager,
Traditional Medicine, WHO Geneva

It is a pleasure to add my welcome to that of the distinguished personalities who have addressed you this afternoon, and, at the same time, to express to our Botswana hosts and colleagues our deep appreciation for the consideration, kindness, and generosity they have shown in hosting this consultation. I am sure that it is obvious to all of us how much care, thought, and hard work have gone into the preparations they have made to ensure that our visit to their beautiful country will be not only pleasant but highly rewarding and full of interest.

The purpose of our consultation is to:

- (i) explore the best ways of involving traditional health practitioners in the prevention and control of AIDS in Africa;
- (ii) draft guidelines on approaches that countries could use to secure the involvement and continued participation of traditional health practitioners;
- (iii) examine the need for health services operational research in traditional medicine that is relevant to developing and implementing strategies for AIDS prevention and control and other public health problems.

I am delighted to have this opportunity to work with you in finding the best ways and means to maximize the utilization of traditional health practitioners in preventing and controlling AIDS. I do not need to make a case for the important role of traditional medicine in primary health care, since all of you are experts in this field. I know that you are as convinced as I am that it is only logical for us to take the next step and consider the most appropriate measures to involve traditional health practitioners in community health activities, and, in particular, to accentuate and accelerate the work that needs to be done in AIDS prevention and control.

What I should like to do now is give you a brief outline of the objectives and activities of the WHO Traditional Medicine Programme. In our work in traditional medicine, the World Health Organization encourages and supports countries to identify and provide safe and effective remedies and practices for use in the formal and informal health systems. WHO's priorities in its Traditional Medicine Programme are reflected in a number of activities; these are grouped into five main areas of concern:

NATIONAL PROGRAMME DEVELOPMENT
HEALTH SYSTEMS AND OPERATIONAL RESEARCH
CLINICAL AND SCIENTIFIC INVESTIGATIONS
EDUCATION AND TRAINING
EXCHANGE OF INFORMATION

In the area of national programme development, WHO collaborates with its Member States in the review of national policies, legislation, and decisions on the nature and extent of the use of traditional medicine in their health systems. This includes assisting ministries of health in establishing policies and appropriate mechanisms for introducing traditional remedies and practices into primary health care programmes.

Research is a broad area of endeavour that includes health systems, clinical, and scientific research. Health systems and operational research involves: studies on the potential and limitations of the use of traditional health practitioners in primary

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health care in district health systems, surveys of traditional medical practices, and inventories of medicinal plants and other natural substances used. Comparative studies of modern and traditional medicine evaluate the relative advantages, such as clinical efficacy and cost-effectiveness, as well as the cultural acceptability of the two systems to the consumers.

Clinical and scientific investigations are also needed to ensure safety and efficacy, as they are done for modern medicaments, especially for manufactured products moving in international commerce. Within the context of an overall health research strategy, national research establishments are continuing to investigate the safety and efficacy of many of the remedies used by traditional health practitioners from the point of view of ethnobotany, medical anthropology, experimental pharmacology, and clinical practice, as well as to conduct epidemiological studies. These institutions are undertaking clinical evaluation of traditional methods of treatment and pharmacological and toxicological studies on commonly used medicinal plants. They also undertake to standardize and improve traditional formulations destined for pharmaceutical production.

In the area of education and training, WHO promotes the acquisition of new knowledge and skills of all health personnel, including traditional health practitioners. In advocating training for them, WHO emphasizes the further development of their competence and skills within the framework of primary health care so as to afford them an opportunity to share their experiences with others. Incorporation of elements of traditional medicine into training schemes for other health workers is also being pursued by countries. Providing communities with educational material about valid traditional health practices is also being actively implemented.

Finally, the exchange of information is a vital role that WHO plays, not only in traditional medicine, but in virtually every aspect of public health. In this, it is ably supported by some national reference centres and by WHO collaborating centres. The International Traditional Medicine Newsletter, published by the Chicago Collaborating Centre for Traditional Medicine, provides an opportunity for exchange of information on the subject, reporting both on the work of other collaborating centres and also on country experiences. This newsletter has been playing a valuable role by providing individuals and institutions with a means of keeping in touch with developments in other parts of the world.

In recent years, we have witnessed the development of WHO collaborating centres for traditional medicine. The first such centre was designated in February 1979 in Italy. This was the Istituto Italo-Africo in Rome and, in the early 1980s, a number of other centres were designated. Today, we have 26 collaborating centres for traditional medicine throughout the world: five in the African Region, three in the American Region, one in the Eastern Mediterranean Region, two in the European Region, three in the South-East Asia Region and twelve in the Western Pacific Region.

In many countries, there are institutions supported by national and international bodies. These can be mobilized to participate in the activities that we will outline during the course of this week.

That traditional medicine and its practitioners have a useful role to play in AIDS prevention and control, particularly in the African Region, is no longer open to doubt. However, this role needs to be explored in more detail; but first there are three important areas that lend themselves to immediate consideration:

- (1) putting traditional health practitioners fully into the picture about the AIDS situation, the threat it represents to the population and to themselves, and the strategies available for its prevention and control;

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(2) involving traditional health practitioners in enlisting community participation in, and support for, various aspects of national AIDS programmes, e.g., condom distribution, health education, epidemiological studies, and contact tracing;

(3) securing the collaboration of traditional health practitioners to share their knowledge and experience in the use of traditional remedies that may have antiviral, particularly anti-HIV, activities, and those that are used for conditions related to AIDS, e.g., opportunistic infections and Kaposi's sarcoma.

In this context, I should like to briefly mention an activity in biomedical research. One of the key issues to be addressed by WHO and its Member States is how to formulate an up-to-date research and development policy in traditional medicine. Why? Because at present research policies in most countries do not reflect the role of traditional medicine in health services. New research and development policies could greatly assist institutions in addressing the critical problems now being faced. One recent development is the investigation of traditional medicinal plants considered to have antiviral properties or activity against opportunistic infections occurring in patients with AIDS. For viral diseases or syndromes for which no vaccines are available, such as AIDS, therapeutic agents that are capable of selectively blocking the replication cycle of HIV are clearly needed.

A number of natural products have demonstrated an anti-HIV or anti-reverse transcriptase activity in vitro; for example, castanospermine, derived from the Australian chestnut tree, and glycyrrhizin, derived from liquorice. Such natural products have also been tested in limited clinical trials. To this end, a meeting was organized in collaboration with the Biomedical Research Unit of the WHO Global Programme on AIDS (1989) to consider the systematic and scientific assessment of potential anti-HIV activity for further clinical evaluation. A memorandum on the meeting is available for those of you who are interested.

With respect to the first consideration, we have to continue to find innovative ways to make traditional health practitioners fully aware of the AIDS pandemic and its consequences because in many developing countries they are often the first to be contacted in sickness and the last recourse for the desperate and chronically ill.

With AIDS patients, this puts them at special risk, but at the same time it places them in an opportune position to participate in the struggle against AIDS and in programmes aimed at health promotion. Traditional practitioners have to be informed of the risks for them personally and of the methods to reduce exposure to HIV infection for the population in general.

Given the potential importance of traditional medicine in the fight against this dread disease, our consultation should consider developing general guidelines that national AIDS programmes may adapt and use to secure the full collaboration and involvement of traditional health practitioners in AIDS programmes.

The guidelines that we develop would prepare nationals to develop and implement, in their respective countries, programmes for training traditional health practitioners. It is expected that countries will initiate a series of activities at district level for both modern health staff and traditional health practitioners in an effort to engage their collaboration in AIDS prevention and control.

Our consultation should also consider the opportunities and possibilities for an expanded role for traditional health practitioners, emphasizing their close involvement in health services, as well as their active participation in operational health programmes, especially at the community and district levels.

We should also give some thought to what form cooperation between the formal and the traditional health sectors might take and to what kind of additional support may be

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required in the nature of training, equipment, information exchange, networking, and the like.

The WHO Traditional Medicine Programme is, by its very nature, a multi-disciplinary and multi-institutional arrangement, and this is closely reflected in the disciplines represented here today.

The fact that we are all here to discuss modalities of cooperation with traditional health practitioners means that they are still a very relevant factor in the health equation.

This is a rather paradoxical situation, but one that illustrates very well our conviction of the immense potential that traditional health practitioners have for improving the health of all our communities.

I thank you.

ANNEX 6

A REVIEW OF AIDS EPIDEMIOLOGY WORLDWIDE

by

Dr Benjamin M. Nkowane, Medical Officer,
Global Programme on AIDS, WHO, Geneva

Ever since the acquired immunodeficiency syndrome (AIDS) was first recognized among unrelated homosexual men in San Francisco in 1981, it has been identified as a severe and devastating disease worldwide. AIDS has weighed heavily on all our consciences. We have all watched, with grief in our hearts, the uncompromising human suffering this disease has unleashed on the world. No region of the world has been spared the misery brought about by AIDS and HIV infection, and as of July 1990, a total of 266 098 cases of AIDS had been officially reported to the World Health Organization by 156 Member States. In this presentation I will review the main epidemiological features of the disease worldwide and discuss the current strategies for prevention and control, as well as the possible impact HIV/AIDS has had and will have in the 1990s.

AIDS epidemiology

Cases have been reported from all continents; the numbers continue to change as infections with the virus HIV are introduced and spread in the unaffected communities. To date, the largest numbers of reported cases have been from the Americas, accounting for just over 162 000 cases and Africa with 64 000 cases.

The reported cases, however, represent a gross underestimate of the cases that have occurred. The global data on AIDS are biased by wide intercountry and interregional variations in case detection and reporting. Completeness of reporting is thought to vary from 80% in some industrialized countries to less than 10% in some African countries. Overall, therefore, we believe that the 266 000 cases that have been officially reported to WHO represent only 40% of the cases that have occurred worldwide. In addition, because of difficulties in diagnosing AIDS in children, these cases are not reported in many countries.

Magnitude of the epidemic

The use of reported cases of AIDS cannot be relied on to accurately assess the magnitude of the epidemic. It is clear that the cases of AIDS that are occurring now are due to HIV infections which were spread silently and extensively in the late 1970s and early 1980s. Since HIV infection precedes the development of AIDS by many years, an optimal understanding of the patterns of AIDS must be obtained from analysis of both reported cases and surveys of infection with HIV. Three distinct global patterns of HIV infection and AIDS have been described. The explanation for these patterns includes differences in temporal spread of HIV among different populations.

HIV infection throughout the world has continued to be limited to three primary modes of transmission: (1) through sexual intercourse; (2) through infected blood or blood products; and (3) from an HIV-infected woman to her fetus or infant. Because of these modes of transmission, the majority of cases continue to be transmitted by voluntary human behaviours; predominantly sexual intercourse and intravenous drug use. Consequently, HIV infections are not uniformly distributed in any population, but disproportionately affect certain identifiable groups of individuals whose behaviour places them at greater risk of HIV infection. Such individuals therefore are likely to be the major source of propagation of the epidemic.

Global patterns of HIV infection and AIDS

Three global patterns are described. Epidemiologic pattern I is found in North America, Western Europe, Australia, New Zealand, and parts of Latin America. In this pattern, HIV spread extensively in the late 1970s and early 1980s, with most cases being in homosexual or bisexual men and intravenous drug users and only a small percentage of cases being transmitted heterosexually. Recent trends, however, indicate that the incidence of new infections among certain groups of homosexual men has slowed down. The full significance of such data is difficult to assess, as there are many groups and subgroups of populations at risk who have either not received much public attention or have not been researched as extensively. Furthermore, in most places, including the United States of America, the size of the populations at risk of infection remains incompletely established. In addition, HIV infection continues to spread in the most socially and economically vulnerable segments of society.

Epidemiologic pattern II is seen in sub-Saharan Africa, Latin America, and the Caribbean. Within areas currently classified in this pattern, transmission continues to be predominantly heterosexual, and the incidence of HIV infection continues to rise. Today, HIV prevalence among women attending antenatal clinics in many urban areas in sub-Saharan Africa ranges from 10% to 30%, while HIV seroprevalence among adults may be as high as 12% in the highly populated areas. Rural areas of many pattern II countries still have low seroprevalences. However, there is still concern that the greater population in these rural areas includes a large pool of individuals whose practices and behaviour place them at risk of HIV infection.

Pattern III areas are areas where few cases of HIV infections have occurred. The HIV pandemic has, however, continued its geographical expansion and has reached these areas and regions previously only slightly affected. Pattern III areas are characterized by the recent onset of the HIV/AIDS pandemic, in the late 1980s. Most countries that exhibit this pattern have not yet shown the predominant modes of transmission.

This, however, changes rapidly; for example, in Bangkok, Thailand, extensive spread of HIV infection among intravenous drug users since early 1988 has been documented, and HIV prevalence estimates rose from about 1% in late 1987 to over 40% in early 1989. A similar rapid rise appears to have occurred in some groups of intravenous drug users in Burma.

HIV prevalence rates

Up to the end of June, WHO estimated that worldwide, 6-8 million persons had become infected with HIV. Recently, WHO revised the global estimates of HIV infection to 8-10 million people around the world. These new figures reflect the continued worsening of the epidemic of HIV/AIDS in developing countries, especially in sub-Saharan Africa and Asia. The new estimates indicate the following trends.

Sub-Saharan Africa: WHO estimates of persons infected in sub-Saharan Africa have increased from 3 million to about 5 million. In 1987, most HIV-infected people were in urban populations. Now, however, extensive spread is being documented in rural areas. It is estimated now that about one in every 40 adult men and women is infected with HIV.

Asia: Serological data for 1988 and 1989 for South-east Asian countries, including Thailand and India, indicate marked increases in HIV infections among intravenous drug users and female prostitutes. HIV was introduced into Asia only in the early- to mid-1980s, and up to the end of the 1980s the numbers of both AIDS and HIV infections were low. Recent data indicated that the total number of HIV-infected persons in Asia has risen from virtually nil two years ago to an estimated current total of at least 500 000, a much more rapid increase than projected even a year ago.

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What does the future hold for AIDS?

During the first decade of the pandemic, AIDS/HIV has caused an estimated 500 000 cases in women and children, most of which have so far been unrecognized. During the 1990s, the pandemic will kill an additional 3 million or more women and children throughout the world, and it is estimated that up to 1 million uninfected children will have been orphaned because their HIV-infected mothers and fathers will have died from AIDS.

For the 1990s, AIDS may take other important turns - there may be growing complacency among policy-makers and an eventual decrease in funds for control and prevention activities.

However, more cases of HIV infection will continue to occur worldwide, and there will be a continued increase in sick persons to be taken care of by already overstretched health care systems. Numerous challenges still exist in prevention and control of AIDS worldwide:

Firstly, the commonest mode of transmission, sexual transmission. It is well recognized that to prevent sexual transmission requires: (1) initiatives from persons at risk, and (2) identification of factors that may increase the risk of transmission, such as other sexually transmitted diseases.

Secondly, although blood and blood product transmission is relatively easy to prevent, there still exists marked potential for transmission, especially in any situation where there is exchange of blood, as seen in intravenous drug users and hospital settings where reuse of needles and syringes is common practice. This has been shown in Romania and the Soviet Union.

Thirdly, transmission from infected women to their infants is also difficult to prevent, and the problem of transmission will continue to become bigger. Potential interventions however include: (1) safer sexual behaviour/family planning; (2) voluntary antenatal screening; (3) possibly pharmaceuticals; and (4) pregnancy termination.

Conclusion

The challenge that still remains, however, in AIDS prevention and control is to assure an appropriate balance of (1) prevention services, and (2) control of the impact of AIDS on HIV-infected persons and their families and friends.

There is a difficult task ahead. AIDS is revealing the many inadequacies in our societies today, and we must continue to fight and avoid complacency as the epidemiology of the disease and future trends only indicate a worsening problem. Effective prevention and control efforts will require a concerted multidisciplinary approach, which should include all sectors of the health care system.

COUNTRY PROFILES

BotswanaIntroduction

It has been the policy of the Botswana Government to actively promote collaboration and cooperation between the traditional and the formal health sector for more than 10 years now. Attempts to integrate the two systems have not been actively pursued, since it is felt one or the other of them might suffer in the process; instead, parallel development is encouraged.

Although collaboration was initiated and formalized by the Ministry of Health, activities with traditional health workers are now carried out by district health workers, mainly with support from the Health Education Unit. Collaboration has involved the following activities:

- seminars and discussions with traditional healers, which take up cooperation and two-way referral, the management of different diseases, and prevention and control of the main public health problems;
- facilitating self-referral by patients from the modern health care centre and encouraging follow-up by the traditional health practitioner after completion of treatment;
- informal arrangements whereby traditional health practitioners treat their clients/patients in modern health facilities.

Legislation/registration

A law has been drafted and is now ready for presentation to the Cabinet that essentially seeks to regularize the registration and licensing of traditional health practitioners. This will be done under the umbrella of the associations through which traditional health practitioners are registered with the Ministry of Home Affairs.

Collaboration with traditional health practitioners

District medical officers, health education officers, and other community health workers in all the health districts in Botswana hold regular seminars with traditional practitioners. These are routinely planned and budgeted for under a local government fund for community leaders' seminars.

At these seminars, views are exchanged with traditional health practitioners about the probable etiology of various diseases, their management, and the prevention of public health problems. Traditional health practitioners have been successfully involved in the management of diarrhoeal diseases and tuberculosis in Botswana; the latter might form a useful model for their involvement in the management of HIV/AIDS prevention and control activities.

Traditional health practitioners have also extended invitations to modern health practitioners to attend and speak at their meetings.

The response of traditional health practitioners to the attempts of the modern health sector to accelerate collaboration has, on the whole, been positive, particularly if it is carried out in an atmosphere of mutual respect and genuine exchange of ideas and expertise. They have also suggested the adoption of a standard format for use in the referral of patients from traditional health practitioners to modern health facilities. However, traditional health practitioners feel that referral of patients is generally

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one-sided; they have suggested that more patients be referred to them by modern health workers.

Involvement of traditional health practitioners in HIV/AIDS prevention and control - the traditional health practitioners' perceptions of HIV/AIDS

No systematic research has been done to assess the traditional health practitioner's knowledge and ideas about HIV/AIDS. However, during discussions at seminars and meetings, a variety of views about HIV/AIDS have been expressed by them, ranging from claims to have known and been able to cure the disease for a long time, to admissions that AIDS is a new and unknown disease about which they have to gain more knowledge.

The most commonly expressed view is that AIDS is "baswagadi", an illness caused by the failure to observe certain taboos and go through cleansing ceremonies following bereavement. AIDS is also attributed to mixing one's blood with that of strangers who do not observe the same taboos; in essence, having sexual contact with strangers. This view has interesting parallels with the known risk factor of having multiple sexual partners and has possibilities for development and incorporation into health education messages. Research is needed to collect more comprehensive and detailed knowledge about traditional health practitioners and, therefore, the community's perception of the etiology and pathogenesis of HIV/AIDS.

Seminars on HIV/AIDS for traditional health practitioners

District and local seminars on HIV/AIDS are becoming increasingly important as a way to disseminate and discuss information on this topic. Traditional health practitioners are being informed about HIV/AIDS from their perspective as health care providers. Information about the risks related to certain practices and to the practitioner and the client is given with special emphasis on midwifery, bleeding, and scarification. Traditional health practitioners are taught about hygienic practices to avoid infection and the need, in all cases, to use a new razor blade with each client for the practice of scarification.

Seminar attendants subsequently inform their colleagues in their own association meetings.

Condom promotion

A pilot activity has been carried out in several districts where, after being informed about HIV/AIDS, traditional health practitioners agree to distribute condoms to their clients, particularly those with sexually transmitted diseases. This has been continued successfully with a few traditional health practitioners but has failed in some cases, mainly because of poor support from modern health workers. Attempts are being made to restart and sustain these activities.

Counselling

Traditional health practitioners have been recognized as a valuable counselling resource in the community because they already manage a variety of health, family, and social problems as part of their work. A study is being carried out in one district to collect information about the counselling methods of traditional health practitioners for incorporation into the training of modern health workers in counselling.

Future activities

It has become clear that traditional health practitioners in their roles as community leaders and health care providers have an important part to play in most of the components of the National AIDS Programme. Activities will be developed to strengthen their involvement in information and education, counselling, condom promotion, prevention of infection during health care, and research.

Cameroon

Introduction

From colonial times, all traditional medicine was wrapped up in the same package and banned. The law banning it has not yet been lifted. Indeed, a draft bill to recognize traditional medicine is now being discussed. So, traditional medicine has survived, but clandestinely.

However, the official attitude has gradually changed with time, thanks to research efforts, censuses of traditional healers, and pressure from traditional health practitioners, who formed ephemeral semi-national associations; WHO's multilateral push; and the Alma-Ata Declaration. The public institutions that have accumulated information over the last 20 years include:

- the National Medical School (Centre universitaire des Sciences de la Santé, Université fédérale du Cameroun);
- the Faculty of Science of the University of Yaoundé;
- the Institute for Medical Research and Study of Medicinal Plants;
- the Ministry of Public Health's National Commission for the Study of Traditional Medicine;
- the people themselves through popular usage;
- the national newspapers;
- experiments carried out in Yaoundé National Central Hospital on the cooperation of traditional medicine and modern medicine.

Recognition of traditional medicine in primary health care

Thanks to the Declaration of Alma-Ata (1978), the National Five-Year Development Plan, 1981-1986, included a programme on traditional medicine in primary health care activities.

Utilization of traditional health practitioners in primary health care

Traditional midwives have now been widely assimilated into primary health care teams. The use of traditional psychiatrists, doctors, and their "bush hospitals" is now being discussed in the planning of services for the new director of maternal and child health and mental health, created by the 1989 decree reorganizing the Ministry of Public Health.

Potential contribution of traditional medicine to AIDS control

The national coordinator of traditional medicine, who has been conducting the census of traditional health practitioners since 1983, is also the team leader for the WHO Regional Centre for Exchange of Didactic Material and Information for AIDS Control in Francophone Africa and, as such, acts as a suitable bridge between the National AIDS Control Committee and the National Traditional Medicine Programme. A knowledge, attitudes, beliefs, and practices (KABP) survey has already been conducted, which has sensitized and initiated traditional health practitioners in AIDS control. Resources are needed to keep these initiatives going. What has been done so far can be followed up by a national seminar with traditional health practitioners on how to control HIV/AIDS, in collaboration with other action programmes, especially those of the Ministry of Public Health and the private health sector.

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- (k) Do you refer cases suspected of [being] AIDS to modern hospitals? YES / NO
- (l) Does any person (healer or not) refer AIDS cases to you? YES / NO
- (m) Do you know some expert healers who cure AIDS? YES / NO
- (n) If yes, name them: ...
15. What are the signs that an AIDS patient has been cured? [7 blanks]
16. How many AIDS patients have died in your healing home? ...
17. How did you know that they were AIDS patients? ...
18. Are there other diseases that present with the same signs and complaint as AIDS? YES / NO. If yes, what are these diseases? ...
19. When you see a case of AIDS in your clinic, what advice do you give to him or her? [4 blanks]
24. Has the news about AIDS changed the behaviour of people in your village or community? YES / NO. If yes, in what way? ...
25. Are you willing to join the Ministry of Health and the World Health Organization to fight against AIDS? YES / NO

Annex 7EthiopiaIntroduction and background

Before going into the role of traditional health practitioners in AIDS control in Ethiopia, it would be appropriate to go through the history of traditional health practitioners in Ethiopia. The inadequacy and inaccessibility of modern health services have been partly responsible for the continued reliance of over 80% of the rural population on traditional medicine (Ministry of Health, 1980). Even in cities where the services for modern medicine are adequate, many people continue to go to traditional health practitioners for various reasons. Traditional medicine in Ethiopia is as diverse as its culture, but there are two most fundamental features common to the different traditional medicine systems. They are (a) the holistic approach to human problems and (b) the overlap between "mystical" and "empirical" medical beliefs.

Healing in Ethiopian traditional medicine is more than the curing of disease. It is concerned with the protection and promotion of human physical, spiritual, and material well-being (Bishaw, 1989).

The more recent contact with the industrialized world has also influenced Ethiopian traditional medicine. Because of the attraction that modern medicine has had for the people, traditional health practitioners have in some cases mixed the two and become more popular. Some have even become "injectionists".

The first legal provision for traditional medicine in Ethiopia came with the 1957 penal code, which more or less remained on paper. It was only after 1979 that the Ministry of Health appointed a committee of experts to plan and coordinate the promotion of traditional medicine in the country. This was then followed by the opening of a coordinating office. The purpose of establishing the coordinating office was to (a) organize, train, and register healers; (b) coordinate and encourage research into traditional medicine and conduct seminars and workshops for both traditional and modern medical practitioners; (c) identify, describe, and register those traditional medicines and healers with actual or potential usefulness; (d) explore the possibilities of establishing herbariums and museums for traditional medicinal plants and artifacts; and (e) pave the way for the final integration of traditional medicine into the formal health care system.

These goals were sanctioned by the government, and international meetings and workshops were organized that brought together traditional health practitioners and modern medicine practitioners. The intention of promoting and utilizing traditional medicine was incorporated into the ten-year perspective plan. The reasons behind the need to promote traditional medicine were (a) traditional medicine was part of the culture, used by about 80% of the population; (b) many traditional medicines were known to be efficacious; (c) traditional medical practice is not expensive; (d) provision of adequate health services would take a long time, considering the country's economic resources; and (e) the utilization of traditional medicine would be a step forward in self-sufficiency.

Considerable achievements have been made since 1974 towards the promotion of modern health services; however, the lag in policy implementation in the promotion of traditional medicine is marked. There are only a few places where traditional healers have been organized, and in most of these cases the lack of support and guidance has become a source of serious misgiving among healers about the sincerity and intentions of the Ministry of Health. The organization and registration of healers, which began after the creation of the coordinating office, have met with problems. So far, over 6000 healers have been registered from various parts of the country. In a number of places, healers have formed their own professional associations. These associations, however, lack guidance, funds, and personnel needed to move forward.

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One other important factor that has created resentment between the coordinating office and the traditional health practitioners is the exclusive emphasis that continues to be placed on research into herbal medicine. The coordinating office has expended its limited resources on getting traditional healers to provide detailed information on the medicines they use in the treatment of illness. Thus traditional health practitioners argued that no one had the right to take away an important means of their livelihood without any assurance of involving them both in the testing of their drugs and in the sharing of the possible benefits should these medicines be found useful enough for mass production and marketing.

Traditional health practitioners and AIDS control

In the last couple of years a tremendous effort has been made to involve traditional health practitioners in the control of AIDS. Traditional health practitioners came to the programme claiming that they could cure AIDS. The technical advisory committee to the national AIDS programme in Ethiopia discussed the issue thoroughly and was sceptical at first. Two of the most important questions in the discussion were "Is it ethical to send patients to the traditional practitioner without knowing anything about the content of the drug and its possible toxic effect?" and "Are we in a position to do even a crude toxicity study on animals?".

While the issues are being debated and because of pressure from different sectors, a few patients (AIDS patients that satisfied both the clinical and laboratory diagnosis criteria) were sent to two traditional healers. These were patients at different stages of the disease. Whenever possible, blood samples were taken before and after the patient had completed a seven-day course of the traditional medicine. In a few of the patients who had diarrhoea, the diarrhoea stopped and they developed a voracious appetite and, as a result, a marked weight gain. Some of these patients relapsed and died, but others continued to survive. In all cases where we have managed to collect blood specimens before and after the administration of the traditional medicine, there was no change in the Western blot pattern and all were culture-positive. In the meantime, the AIDS control programme and one traditional health practitioner came to an agreement that the traditional health practitioner would be given access to a clinic where he could administer the drug while a toxicity study on mice would be done simultaneously.

An acute-toxicity study was carried out on a few mice, but the entire toxicity study had to be abandoned because the traditional health practitioner would not allow anything to be done to the medicine out of his sight. All attempts to reassure him that all benefits would go to him if the medicine turned out to be useful failed.

A number of other traditional health practitioners have approached the AIDS control programme since then. A research committee, formed to look into the problem after the first experience, made its primary task the drawing up of an agreement between traditional health practitioners and the Ministry of Health, which would stand in a court of law. This agreement, which clearly states what is required of the traditional health practitioner, the Ministry of Health, and the AIDS control programme, have been given to traditional health practitioners for comment. Some automatically rejected it on the basis of disclosure of the contents of the medicine. Others said they would be able to provide everything required. At present, the agreement is in the process of being delivered to the Council of Ministers for endorsement. Once that is done, meaningful research into traditional medicine for AIDS can be embarked on.

As was pointed out earlier in the introduction, one of the difficulties in dealing with traditional health practitioners has been the mystification of the entire traditional medicine issue. In the Ethiopian context, the skill of a traditional health practitioner is given by God, and it may only be transferred to a favourite (usually male) child. That being the case, a traditional health practitioner would find it very difficult to part with his/her knowledge to a researcher whom he/she does not trust. From the modern medical practitioner's side, very little effort is made to understand

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traditional health practitioners for that same reason. The modern health practitioner in Ethiopia thinks that there is no logic to whatever traditional health practitioners do. Hence, ignorance on both sides makes the effort almost impossible.

Despite problems, a lot of progress has been made towards utilizing traditional health practitioners in Ethiopia. With the adoption of primary health care and with 80% of the population still going to traditional health practitioners for various purposes, the Ministry of Health has been giving various types of short-term retraining courses in an effort to make traditional practice a little bit more modern. The best example of this is the 11 500 traditional birth attendants who have been trained by the Ministry of Health and who are being given refresher courses so that they can take care of themselves and, at the same time, teach the community about the transmission and control of AIDS.

Apart from providing treatment, traditional health practitioners could be used to take care of AIDS patients. As was mentioned earlier, not only 80% of the rural population, but also the urban population go to traditional health practitioners, even if they have access to modern medicine. It is for this reason that gaining the confidence of traditional health practitioners and establishing a good relationship with them becomes crucial. In many African countries, including Ethiopia, with the increasing problems of the disease, the existing health infrastructure will not be able to cope with the problem in a few years.

Conclusions

- (a) In countries where primary health care is being practised, efforts to include traditional health practitioners have to continue at an accelerated rate and in an integrated manner.
- (b) In cases where traditional health practitioners are involved in the cure of the disease AIDS, a clear indication has to be given of their legal right to the benefits emanating from their medicines. This would bring traditional health practitioners closer to researchers and modern health practitioners.
- (c) The effort that has been made in retraining traditional birth attendants in many places in Africa and that of teaching reasonable care to both patients and traditional health practitioners when it comes to administration of medicine has to be emphasized so as not to contribute further to the spread of the disease.
- (d) Health education efforts should be directed toward traditional health practitioners in a meaningful way, rather than in the derogatory manner that is practised at present.

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Ghana

In Ghana, there has been an interest in the work of traditional healers since independence in 1956. Specifically, in 1962 the Ghanaian Government appointed a scientist to study the practice of traditional healers. This was done for several reasons:

- (a) interest in re-awakening traditional institutions as a sign of independence;
- (b) lack of financial and other resources to reach the hinterland; and
- (c) the need to draw on the resources of all health practitioners in the treatment and prevention of infectious and other diseases.

Four types of traditional health practitioners were identified:

- (a) traditional midwives;
- (b) herbalists;
- (c) spiritualists; and
- (d) faith healers.

In 1974, WHO came to the assistance of Ghana by providing funds to open the Centre for Scientific Study into Plant Medicine.

In 1990, the Ministry of Health of Ghana agreed to establish a unit for traditional medicine in the Ministry. The aim is to get traditional health practitioners to cooperate with primary health care programmes.

This will offer the Ministry the opportunity to have a dialogue with traditional healers and to seek their cooperation in the prevention and control of AIDS.

Traditional healers operate in rural and outlying areas. They have many clients; therefore, their cooperation is needed to get them to understand the mode of transmission of the AIDS virus in an attempt to control the spread of the disease.

The dangers of the illegitimate use of needles, not wearing protective garments in the delivery process, etc., must be made known to traditional health practitioners.

The modern medical practitioners and the Ministry of Health will also be able to learn from traditional approaches to preventing and controlling the spread of AIDS.

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Kenya¹

Introduction

AIDS was identified in 1981 by researchers at the Centers for Disease Control in the USA, in homosexual men (CDC, 1981). A review of the medical literature (D. Huminer et al., 1987), however, revealed that at least 19 cases had occurred between 1950 and 1981. In this review, AIDS was found to have occurred in people in North America, Western Europe, Africa, and the Middle East. It would be logical to assume that more than 19 cases of the disease could have occurred, but only these were found in the literature and hospital records.

If the AIDS disease had been around before the AIDS era, from 1981 to the present, it would also be logical to say that traditional health practitioners would have come across it and would have attempted to treat it. A recourse to the ancestral medical armamentarium may, therefore, reveal some preparations that could be of value in the management of AIDS.

This paper will be restricted to the role the African traditional health practitioner, in general, and the Kenyan traditional health practitioner, in particular, can play in the prevention and control of AIDS. This is because cultural practices as they relate to traditional medicine vary from place to place; however, it should be possible to adapt the concepts to other areas of the world.

Cultural concepts in the management of disease

I would like to mention very briefly the relevance of cultural concepts as they relate to the present discussion. Traditional African medicine has been defined as: "The sum total of practices, measures, ingredients, and procedures of all kinds, whether material or not, which from time immemorial had enabled the African to guard against disease, to alleviate his sufferings and cure himself" (WHO, 1978). Traditional medicine, therefore, is derived from a people's culture, and culture is defined as: "All the historically created designs for living, explicit and implicit, rational, irrational, and nonrational, which exist at any given time as potential guides for the behaviour of men" (Von Mering & Kasdan, 1970). The integrated nature of culture and traditional medicine is therefore evident. Society means people, and culture means the behaviour of people. Culture is dynamic and is constantly evolving; consequently, traditional health practices also undergo evolutionary changes. It is in line with these concepts that we shall examine the role of contemporary traditional health practices in the management and treatment of AIDS.

Traditional concepts of disease

In many African communities, disease causation is invariably ascribed to external and, indeed, supernatural forces. The disease AIDS is no exception. However, because modern science has ascribed it to sexual transmission, many traditional health practitioners equate the disease with either syphilis or gonorrhoea. This view is difficult to change, and it is against this background that the involvement of these practitioners will be discussed.

¹ This country profile was prepared by Dr W.M. Kofi-Tsekpo, PhD., Chief Research Officer and Director, Traditional Medicine and Drugs Research Centre, Kenya Medical Research Institute, P.O. Box 54840, Nairobi, Kenya; Dr Kofi-Tsekpo was unable to attend the consultation.

Traditional health practitioners

There are two main types of traditional health practitioners: (1) traditional medical practitioners, which include herbalists, diviners, spirit mediums, defenders, rain makers, etc., and (2) traditional midwives, who are often derogatorily referred to as traditional birth attendants. These people do in fact provide health care much more than child delivery, and the name birth attendant, which refers specifically to the act of child delivery, is inappropriate.

Both traditional health practitioners and traditional midwives are herbalists to various degrees. The extent of the use of herbs is determined by the specialization of the practitioner.

The role of traditional health practitioners in the prevention and management of AIDS:

The traditional health practitioner can be useful in two major areas in the control of AIDS, namely: (1) the prevention of AIDS and (2) the management and treatment of AIDS.

1. The prevention of AIDS

The traditional health practitioner is an influential member of his/her community. His role in educating members of the community on the disease and its prevention cannot be overestimated. He is able to reach the people through the right medium (not necessarily language) to get the message across. In certain cases, even the highly educated can be reached this way much more easily.

Ethical decisions often have to be made when HIV tests are to be done, or have been done, on someone (Zuger, 1990). The traditional health practitioner would be most useful where counselling is necessary. In all instances, the fundamental requirement would be that the traditional health practitioner is himself adequately trained to provide the required service and information. This point will be further discussed later.

2. The management and treatment of AIDS

The traditional health practitioner would be most useful at the rural community level in the counselling of people who have either been found to be HIV-positive or who have developed HIV disease. Since it is sometimes difficult to convince such patients that they have not been bewitched, the message would be delivered better by a traditional health practitioner. In the use of currently available drugs, the practitioner would prove very useful in counselling and in giving instructions for their use in the rural setting. He may be able to explain why this medicine, rather than his own, should be used at this time; this may not, however, be easy.

The chemotherapy of AIDS with traditional medicines

Many agents, synthetic and natural products, for use against AIDS are currently under clinical study in many parts of the world. Notable among them is AZT (or zidovudine). This is the most commonly used drug at the moment. AZT has some limitations in terms of toxicity and high cost because the drug has to be taken over a long period. Soon to be introduced for clinical study is the new drug KEMRON, developed at the Kenya Medical Research Institute. It is used as a sublingual medication and has shown no side-effects so far. It is also expected to be reasonably cheap. Some other compounds of interest currently under study are TIBO derivatives, which are synthetic benzodiazepine derivatives (Pauwels et al., 1990). DITHIOCARE, which is a synthetic inorganic compound (Reisinger et al., 1990), a well-known alkaloid, PAPAVERINE (Turano et al., 1989), and CASTANOSPERMINE, an indolizine alkaloid from the seeds of Castanospermum australe (Ruprecht et al., 1989). A number of medicinal plants have also been mentioned as potential sources of agents for the treatment of AIDS (WHO, 1989).

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It would be desirable to continue looking for medicines against AIDS from among the traditional cures of the traditional health practitioners. If, as has been noted above, HIV disease has been occurring in Africa and other parts of the world in the past, there could be some medications that would be worthy of investigation.

The involvement of the traditional health practitioner in the management and treatment of AIDS

The most practical way of involving the traditional health practitioner in this process of health delivery is on a collaborative basis. This collaboration must emphasize equality in health care delivery. However, it will soon become apparent that this collaboration will involve a kind of mutual learning. The traditional health practitioner must be made to understand and feel this mutual relationship. The following steps will be useful to take:

1. Establish a relationship that involves your own desire to understand the cultural values under which the traditional health practitioner carries out his practice.
2. Give him/her the opportunity to understand the nature of modern medical practice and its complementarity to the traditional practice.
3. The traditional health practitioner of today has a strong commercial angle to his practice. This should be recognized. No attempt should be made to buy information directly or indirectly; but the practitioner should be made to feel that the interaction would be beneficial to his practice.
4. It would be desirable to develop a project on the prevention and management of AIDS, and involve up to five traditional health practitioners. More than five may become unmanageable. The selection of traditional health practitioners in such a group should be carefully done, and people with similar age, same sex, and experience should be in one group. This is important from the African cultural point of view.
5. Continuing education on health matters and the disease should be informal and on an information-exchange basis; it should not be didactic.
6. Wherever possible, learning should come from actual examples, such as HIV/AIDS patients in the hospital setting or in the traditional health practitioner's clinic.
7. Whenever possible, the traditional health practitioner should be given an opportunity to talk about his/her own practice.
8. Whereas it is desirable to limit incentives of financial gain at the beginning, later token payments of transport, meals, and honorariums are essential benefits that should be considered.
9. Typical topics to be covered in learning activities should include:
 - the causation and transmission of AIDS;
 - the distinction between AIDS and other STDs;
 - counselling of patients with AIDS: here the practitioner should be encouraged to suggest alternative methods of counselling;
 - the drugs currently used in the management of AIDS and their limitations;
 - methods of preventing HIV transmission.

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10. If the traditional health practitioner feels that he has a drug for the treatment of the disease, every attempt should be made to have the medicine investigated.
11. In the development of the project with traditional health practitioners, a multidisciplinary team of "modern" health practitioners should be involved. Such people should themselves be adequately tutored in the traditional approach to dealing with elders in the African cultural environment.

Conclusion

The ultimate aim of the above process is to establish the traditional health practitioner as an integral part of the health team in the fight against AIDS. But, above all, such a health practitioner should have improved in all other aspects of health care delivery so that his/her role in the community would have been further emphasized, and his own traditional practice should have also improved in terms of modern health science. Such a traditional health practitioner would then become a valuable asset, especially in the delivery of primary health care in the rural setting, where modern health facilities may be scarce.

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Nigeria

The situation with traditional medicine in Nigeria has not changed much from the account of Oyebola (1986). There is no official government policy on traditional medicine in Nigeria. The call by traditional health practitioners for the recognition of their profession has persisted.

Officials of the traditional medicine associations were scheduled to meet with the Minister of Health in Lagos in 1988. Unfortunately, on the day of the meeting, one of the more prominent members of the traditional health practitioners collapsed in the Federal Ministry of Health and died; this resulted in a panic situation and the meeting could not be held. Since then, another meeting with the Minister of Health has not been scheduled. The minister, who is a professor of paediatrics, has consistently maintained, however, that unless the traditional health practitioners are prepared to make their remedies available for scientific evaluation, it will be difficult for the government to grant a blanket recognition to a practice about which the government has limited information.

In 1988, however, the Federal Ministry of Science and Technology, following a ministerial directive, set up a National Committee on Traditional and Alternative Medicine. The membership of this committee included university lecturers/professors, scientific doctors, traditional health practitioners, practitioners of alternative medicine, and senior officials from the Ministry of Science and Technology and the Ministry of Health. This committee was to examine traditional and alternative medicine in all its ramifications and make appropriate recommendations to the government on how best to incorporate this group of practitioners into the national health care delivery team. This committee produced a document containing far-reaching recommendations on how to harness the potentials of traditional and alternative medicine for the improvement of national health care delivery. The document was to be presented by the Minister of Science and Technology to the Council of Ministries for debate and approval. Unfortunately, before this was done, there was a cabinet reshuffle and the minister was dropped from the cabinet.

Traditional healers have been used by the government mainly as traditional birth attendants, whose training and utilization many state governments and the federal government have encouraged. The village concept of care of psychiatric patients, fashioned along the approach of community care used by traditional health practitioners, initiated by Professor Adeoye Lambo almost three decades ago, is still very much applied.

The specialities that exist in traditional medicine in a part of Nigeria and the professional associations of the healers were the subjects of two publications (Oyebola, 1980 (a), and (b)).

The traditional health practitioners have not been involved in the prevention and control of HIV/AIDS in Nigeria. The government has not made any pronouncement as to whether traditional health practitioners can participate or not in AIDS prevention and control.

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Uganda

In Uganda, there is a general law covering medical practice. In addition, there are specific laws covering the practice of modern medical and dental practitioners, pharmacists, nurses, and paramedical personnel. But there is nothing specific in the laws of Uganda that governs the activities and practices of traditional healers. Their practices are therefore being governed by an amorphous type of law, which does not spell out the specific responsibilities and limits of their activity. In a situation such as this, it is not possible to organize the traditional health practitioners into a legal entity, as their recognition by the government is not clear, which makes their health care activities unrecognized and unappreciated.

However, our study of the role of traditional healers in the management of diarrhoeal diseases has revealed that in every village in Uganda there are two or more traditional health practitioners. There is therefore a large number of healers in the country looking after the health of more than 80% of the population. Because of the confidence that people continue to have in them, traditional health practitioners in Uganda have a unique place in society and an important role to play in the prevention and control of AIDS, once the government decides to mobilize them to participate in the AIDS control campaign. They are there, and it is thought that they could be used effectively, not only in the control and prevention of AIDS, but also in finding practical solutions to problems in the control of other communicable diseases.

Annex 7Zimbabwe

The Zimbabwe National Traditional Healers Associations (ZINATHA) was established in July 1980. In 1981, the Government of Zimbabwe passed a law known as the Traditional Medical Practitioners Act, which has assisted the development of traditional medicine in Zimbabwe in a number of ways. First, the Act recognized ZINATHA as the legal association to which all traditional health practitioners should belong. This status enabled them to organize themselves more openly and more effectively than in the past. Second, the Act established, in addition to the association, a traditional medicine council, officially known as the Traditional Medical Practitioners Council.

The establishment of ZINATHA and the Traditional Medical Practitioners Council has made research into traditional medicine in Zimbabwe easier than in the past. Many traditional health practitioners are now more willing to discuss their work than in the past. The stigma attached to traditional medicine during colonial times has largely been removed.

The year 1981 was also a major turning point in the history of antagonistic relationships between modern and traditional healing systems in Zimbabwe. Cooperation between the modern and the traditional medical systems is now possible and in fact encouraged. Although the State is officially concerned only with the modern sector, it has allowed the traditional sector to develop on its own without much government control. Traditional health practitioners were given, through their association and council, the main power in the selection and control of their activities.

The number of registered traditional health practitioners in ZINATHA is about 24 000. Registration is, however, continuing.

The basic organ of ZINATHA is a branch; the executive committee of a branch has 10 elected officials. At present there are 312 branches throughout the country. Between the branches and the national leadership is the district executive committee. In every administrative district of Zimbabwe there is at least one district executive committee of ZINATHA. Most administrative districts have two district executive committees of ZINATHA. The district executive committee has 10 members, who are also elected. There are at present 104 district executive committees. Above the district executive committee is the national executive committee, consisting of 16 elected officials, including the president of the association. National officials are elected every 5 years by all registered traditional health practitioners at a congress of the association. ZINATHA has five departments: finance, research, education, legal affairs, and AIDS education, which was established in January 1990.

Traditional health practitioners and AIDS control

ZINATHA joined the fight against the spread of AIDS in 1988. In collaboration with the Ministry of Health, the association organized two workshops in 1988. These workshops were mainly for members of the ZINATHA national executive committee and members of the council. A few district officials also attended. Again, in collaboration with the Ministry of Health, the association held four workshops in 1989. These workshops were mainly for ZINATHA district officials. In January 1990, ZINATHA embarked on a comprehensive community-based health education programme for HIV/AIDS awareness, prevention, and care, with some financial assistance from donors.

The programme has three main objectives. First, it seeks to educate traditional health practitioners on AIDS/HIV awareness, prevention, and care and to encourage them to share their knowledge with the communities in which they work. Second, the programme hopes to increase awareness regarding the medical practices of the health practitioners themselves, in terms of their capacity both to transmit the virus and to become infected with HIV. Third, it seeks to promote greater communication and cooperation between traditional and modern forms of medicine.

Annex 7

A base-line survey of the programme was conducted between March and May 1990. The survey had three main objectives. First, to understand where the programme begins in terms of knowledge, attitudes, and practices, in order to monitor the impact of the provision of new information through the workshops. Second, to identify the most important information gaps, misconceptions, and requirements among participants and to advise on relevant workshop content. Third, to provide some indication of appropriate and effective means of providing this information.

The results of the survey indicated low levels of education and literacy, which means that workshops would have to concentrate on oral and pictorial methods of imparting information. A simple pamphlet in local languages was designed, containing basic information on HIV/AIDS and showing how the disease relates particularly to traditional health practitioners. Ten workshops for ZINATHA members are now being planned. Follow-up research will be carried out after the workshops have been held. Topics for workshops include the following: What is AIDS? How is AIDS spread? How healers might be at risk of contracting or transmitting the virus. How healers can protect themselves from contracting the disease or from spreading it. Signs and symptoms of HIV infection and AIDS. How it feels to be HIV-positive or have AIDS. Support that healers can give to HIV/AIDS sufferers and their families. The role that healers can play in HIV/AIDS diagnosis, referral, treatment, care, and counselling. The role that healers can play in HIV/AIDS education and awareness.

More workshops will be mounted in 1991 if funds are available, either from the Ministry of Health or from donors or both. ZINATHA cannot set up workshops on AIDS from its own resources.

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