**Introduction:** The Bridging Gaps Project (BG) was a 40 month intervention project. BG was designed to assess whether improved collaboration and communication between Biomedical Health Practitioners (BHP) and Traditional Health Practitioners (THP) could improve the quality of HIV and STI care in Zambia and Uganda. Here we report the first known use of the SCM to assess quality of HIV/AIDS care and support and the first known use of SCM among THP. Using data from the SCM we provide unique insight into some of the challenges and opportunities faced when attempting to scale-up ART in urban Zambia and rural Uganda.

**Methods:** The Simulated Client Method (SCM) has been widely used to assess quality of care in family planning and STI clinics. SCM uses trained research assistants to act as the patient of a standardized disease scenario. These patients then visit the health care provider as a normal patient would. After their consultation the simulated client’s experiences are recorded and analyzed. Simulated client visits (SCV) were conducted among BHP and THP in urban Zambia and rural Uganda between February and November 2005. SCV followed one of four standardized scenarios. Scenarios sought counseling and advice for Voluntary Counseling and Testing (VCT), Sexually Transmitted Infections (STI), ART, or Prevention of Mother to Child Transmission of HIV (PMTCT).

SCs were school leavers recruited from outside the study areas. SC training included expectations of care, normalizing the TPH experience, introduction & development of scenarios, colloquialisms, dress, researcher-patient balance, dealing with tricky questions/situations, extensive role playing, data capture tools, and field safety. SCs were debriefed by field supervisors as soon after their consultations as possible. Data was recorded qualitatively in short descriptive narratives and quantitatively through a structured questionnaire.

**Results:**

**Challenges:** In Zambia 2 of 12 (17%) and in Uganda 2 of 31 (6%) of female SC who consulted male clinic staff were sexually harassed as illustrated by this narrative of a female SC in Zambia:

*Narrative 1:* Then he really went off topic and started asking me how old I am and started proposing to me and saying, “you come and see me... I hope you won’t tell your sister that you are coming to see me. You have a nice face, nice hair”. He wanted to start touching me and came near me. I felt very uncomfortable. I said to him that I was uncomfortable and I quickly left. I would definitely not go back to that counselor... Imagine if it was a younger girl than me. I said during the manufacturing process they put a fluid was in the packaging. It is an extreme example of the generally poor interpersonal quality of care provided by BHP. This creates very tangible treatment seeking behaviour barriers. The most significant barriers that THP create for ART roll-out are the misconceptions and misleading advice that some TPH provide to their patients on condoms and HIV treatments (*Narrative 2*).

**Discussion:** Barriers to ART roll-out exist among both BHP and THP. Sexual harassment (*Narrative 1*) is an extreme example of the generally poor interpersonal quality of care provided by BHP. This creates very tangible treatment seeking behaviour barriers. The most significant barriers that THP create for ART roll-out are the misconceptions and misleading advice that some TPH provide to their patients on condoms and HIV treatments (*Narrative 2*). Still more worrisome was the widespread claim by THP that they could cure HIV/AIDS (*Table 1*).

The views of TPH and hence their impact on ART roll-out is very regional as illustrated by the differences between countries noted in Table 1. THP in Uganda do not use tattoos and therefore make no claim that they can prevent HIV infection in this manner (*Table 1*).

**Conclusions:**

- **Interpersonal quality of BHP’s care must be improved**
- **THP are influencing ART roll-out programs**
- **Local differences in THP views and practices must be accounted for when initiating ART roll-out programs.**

**Opportunities:** THP can play an important counseling and educational role in their communities as illustrated by this TPH’s comments to a male SC in Luwero, Uganda:

*Narrative 3:* “The youth are especially not talking about AIDS and they are given advice and still get into problems.” He said that sometimes they get into discussions and he joins in and the kids really listen to him. He said he had condoms but they were finished since he was sensitizing the youth... He told me where he goes for training, that they also say that parents who are positive can give birth to a child who is HIV negative.

**Further information** is available from Stephen Moore, stephen.moore@imperial.ac.uk.

**Acknowledgements:** This work was funded by the European Union and the DFID Knowledge Program. Many research assistants made the data collection successful and fun. Thanks to all.