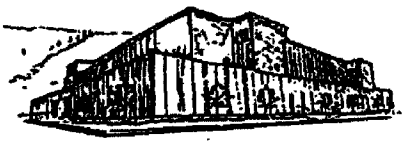
2004

Traditional healers as agents and leaders of change : an examination of the role of the healer in the time of AIDS

Allison Elizabeth Fissel
The University of Montana



Maureen and Mike
MANSFIELD LIBRARY

The University of
Montana

TRADITIONAL HEALERS AS AGENTS AND LEADERS OF CHANGE: AN EXAMINATION OF THE ROLE OF THE HEALER IN THE TIME OF AIDS

by

Allison Elizabeth Fissel

B.A. Drew University, 2002

presented in partial fulfillment of the requirements

for the degree of

Masters of Arts

The University of Montana

May 2004

Approved by

Chairperson

Dean, Graduate School

5-14-04

Date

Fissel, Allison E. M.A., May 2004 Anthropology

Traditional Healers as Agents and Leaders of Change: An examination of the Role of the Healer in the Time of AIDS.

Director: Kimber Haddix McKay, Ph.D.

In a region of the world where HIV/AIDS is rampant, Uganda has struggled to survive. However, in the last 10 to 15 years the country has significantly lowered its incidence of HIV. Recent debates in the anthropological and public health fields have emerged, focused on Uganda's success in dealing with HIV/AIDS prevalence and treatment. For the most part, this debate has remained polarized and has been largely focused on the behavioral and social explanatory paradigms. Using the diffusion of innovations theory, this thesis attempts bridge the behavioral and the social, and highlight the important role of traditional healer within this system. A hybrid diffusion model is used to illustrate how important innovations such as drugs, services, and information flow throughout the social system and change in individual behavior.

Acknowledgements

I would like to thank the members of my thesis committee: Dr. Herbert Swick, who has offered his time and insight; Dr. Greg Campbell, who has provided me guidance and encouragement throughout my course of study here at the University of Montana; Most importantly, Dr. Kimber Haddix McKay who introduced me to the wonderful country of Uganda, and was instrumental in getting me there! Dr. Haddix McKay has been both a mentor and friend. Above all else, she has greatly influenced my desire to work in applied anthropology.

Other individuals within the department should be mentioned as well. I would like to thank my research partner Stacy Russell. While we were not working on the same project, traveling together and sharing the experience of Uganda will never be forgotten. A most gracious thank you goes to Eileen Flannigan for her encouragement and hours of excellent editing skills. I would also like to than Betty Matthews, Jessica Bochart and Ryan Reeves for their daily encouragement and support.

It is also important for me to thank individuals in Uganda, whom without their insight this thesis would not be possible. It should be noted that real names of informants have been used with their permission. I am most thankful to the members of PROMETRA-Uganda, who spent a great deal of their time with me and are the primary reason for my decision to stay in Kampala. THETA, another organization in Kampala should also be thanked for allowing me to use their 'library' of resources, and also for their time spent with me. I would also like to thank my driver and friend, James, who without, I would have never made it around Kampala!

Finally I would like to thank my family and friends, who have supported me throughout my journeys, across the globe and throughout life.

Table of Contents

List of Map and Tables

Maps

Tables

List of Figures

Figures

"The information about AIDS used to be rumours in my ears; today, I got the privilege to hear from my healers some information that is going to help me save my life" –Community member, Katakwi. (UNAIDS Case Study 2002).

INTRODUCTION
Traditional Healers and Uganda's Success

This project addresses and advances the recent anthropological debate about Uganda's success in dealing with HIV prevalence and treatment, which has to date been framed between the behavioral and social explanatory paradigms, and which questions the level at which change is occurring. Research was conducted in and around Kampala, Uganda in June of 2003. Subjects included various NGO/INGO groups, as well as individual traditional healers, either in markets or from within larger traditional healer networks. Key informants were the leaders of major traditional healer organizations in Kampala, some traditional healers themselves, others nontraditional healers.

Ultimately, this thesis addresses the question, 'what happened to the HIV/AIDS prevalence rate in Uganda?', and asks: 'What role do traditional healers play in providing drugs, services and information in Uganda, and how does their role affect the changes and successes in dealing with disease, specifically in the context of HIV/AIDS?' My intent is to answer this question and, contribute to discussions regarding HIV/AIDS in Uganda which have surfaced within the anthropological and public health fields. Using the diffusion of innovations theory, I hope to show that Uganda has a complex social system in which services drugs and information diffuse throughout the country among local, national, and international organizations. The networks linking traditional healers play an effective and culturally meaningful part in this system. I analyze this using a

hybrid diffusion model to illustrate how innovations flow throughout the social system and ultimately change individual behavior.

I originally began my research for this thesis investigating the relationships between traditional healers and Western medical doctors in Luwero district, Uganda. However, as I'm sure many an anthropologist may empathize with, when I got into the field, my research shifted direction based on the plethora of resources in and around Kampala and my interest in traditional healer organizations that existed there. I had already spent some time in Kampala, the capital of Uganda. As planned, I had met with and interviewed two NGO groups, *Promotion des Medecines Traditionnelles (PROMETRA-Uganda)* and *Traditional Healers and Modern Practitioners Together Against AIDS (THETA)*, prior to leaving for the bush. These meetings were initially set up to provide me with background information on traditional healer practices. The two groups were also chosen because of their well-known and successful implementation of programs which have developed collaborative relationships between indigenous and modern health practices. I found both groups to be extremely significant resources.

Through literature research and my own research in Kampala, Uganda, I have come to better understand the utter importance of traditional healers within their communities. Even more specifically, I have found that traditional healers play an important role in dealing with HIV/AIDS prevention, as well as day to day treatment in a country that has limited resources and access to antiretroviral drug treatments.

Over the past year, anthropological discussions about HIV/AIDS in Uganda have become heated. These discussions have arisen in part because of Uganda's success in its

fight against HIV/AIDS prevalence and treatment. Primarily, discussions revolve around a behavioral versus social paradigm and question the level at which change is occurring.

This is an important issue for a number of reasons, most notably because Uganda *has* successfully reduced its seroprevalence and increased its HIV/AIDS treatment. Thus, it may serve as a model for other African nations in the fight against HIV/AIDS. Even more importantly it may provide a model for other nations throughout the world. As HIV/AIDS continues to be a prominent threat for first and third world countries alike, it would do government and public health workers much good to understand what exactly has occurred in Uganda. In addition, the U.S. government has recently promised $15 billion for HIV/AIDS funding, intended for Africa and the Caribbean.

While in Uganda myself, I witnessed the traditional healer networks, both small and large scale, that deal with the health needs of their communities. I visited traditional healer markets and talked with healers who supply herbal and spiritual medicines and paraphernalia to the city of Kampala. I also spent a great deal of my time in Uganda with the traditional healer network, PROMETRA, which provides an organization of collaboration among traditional healers from Kampala, and nearby villages. Through casual observation, I noticed that HIV/AIDS health related issues were the prominent concern and topic of discussion.

Due to the importance of understanding the cause of Uganda's success in dealing with the HIV problem, and considering the committed and dynamic presence of traditional healers that I observed and have read about, I argue in this thesis that traditional healers' roles in Uganda's health system (particularly dealing with HIV/AIDS

prevention and treatment) are absolutely critical. Further, I believe that anthropological research on traditional healers in Uganda needs to be extended.

Chapter One offers a background of Uganda, both historical and ethnographic, which I feel is important to unravel before embarking on the deeper underlying questions. In addition to cultural background, this chapter will offer a background of the HIV/AIDS epidemic. The purpose of this chapter is to set the stage for understanding Uganda's social system.

Chapter Two focuses on the current debate regarding methods and theories concerning change in the Ugandan system and asks, at what level has change occurred in Uganda? This includes an analysis of recent publications revolving around the issue, which primarily focus on a behavioral versus social approach. My intent here is to show the importance of the debate, while at the same time questioning whether or not this debate is on target or missing the point. In other words, is the current debate influencing policy change for the better, or simply focusing around personal agendas?

Following this, Chapter Three discusses the theoretical paradigm I relied upon, as presented by Rogers (1995). The theory of the *diffusion of innovations* adds an important dimension to the overall questions and concerns regarding HIV/AIDS in Uganda. In addition, I believe this theory adds an important dimension to the social versus behavioral theoretical debate, which may have been overlooked, if not forgotten altogether, in previous discussions. This chapter highlights the four major elements in the diffusion model and offers a brief discussion of each. Ultimately, this chapter is intended to provide a background of the diffusion theory, which will later be used to discuss the Ugandan social system and the possibility of traditional healers as agents of change.

Chapter Four addresses Uganda's complex communication and social structures, which ultimately provide drugs, services and information throughout Uganda. This chapter includes an analysis of Uganda's structures using Rogers' diffusion of innovation theory. I will examine the various patterns of relationships, including a discussion of the major roles involved in the diffusion process. In this chapter, I highlight the most significant roles pertaining to this discussion: leaders of traditional healer organizations, traditional healers, and individual community member.

Chapter Five examines the role of traditional healer, particularly within the Ugandan system, as well as an examination of their legitimization and overall effectiveness. This is the most in-depth chapter, as it deals with the crux of the debate. I include interviews with traditional healers and leaders of traditional healer networks which I feel highlight the important role of traditional healer as change agent.

Chapter Six continues the discussion of the significant role of traditional healers in and out of Uganda and, returning to the diffusion theory presented in Chapter Three, takes the diffusion model one step further, applying it to traditional healers in the Ugandan context. My purpose in this chapter is to argue the notion that the diffusion model may be applied to the Uganda model and effectively bridge the discussions presented by Green, Farmer and colleagues. In this chapter, I attempt to tie all of the information presented in this thesis together, and most importantly, illustrate how traditional healers are central in the discussion of diffusion, and have an important role as change agents and opinion leaders in providing information, drugs and services to community members

In addition to extensive literature research, findings from my time in Uganda make up a large part of this study. I focused the majority of my time with specific traditional healer organizations. Four organizations were singled out for exploration; one in particular, PROMETRA, was the most accessible. I followed a method used by Edward Green in *Indigenous Theories of Contagious Disease* (Green 1999:30), who found that "most information derived from health surveys, particularly if it sought to answer the "why" questions, was superficial at best and often of dubious validity". Thus, he turned to interviewing the traditional healers through in-depth interviews, and found the results to be of "much higher quality". In addition, Green points out that, "healers presumably represent the beliefs of clients who consult them and they are often better able than their clients to explain such beliefs, both because of their specialized knowledge and because their status in the community makes them less likely to be intimidated by an interviewer" (1999:30). Like Green, I focused my interviews on the traditional healers (especially leaders of the traditional healer organizations), hoping that they would have insight into the needs of their clients, and other traditional healers and be more open and willing to talk with me. I found this to be the case, and this method was successful.

At the time, I was more interested in understanding the general practices of traditional healers, and their organizations, including their relationships with the local hospitals and doctors. I found that more often than not, my "semi"-structured interviews became "un"-structured and open ended interviews that often took off in the direction of the interviewees. I allowed for this, as I reasoned that the traditional healers themselves knew more about what I needed to know than I did. I was still able to collect the information I set out to obtain, however I finished my fieldwork with a much broader

understanding of the organizations and traditional healers themselves than I initially anticipated. In addition, and as mentioned above, I began to see traditional healers' significant role in dealing with the HIV/AIDS epidemic.

Because of their significant knowledge base, and overall enthusiastic energy, I conducted several follow up interviews with the staff at PROMETRA, a local NGO, including interviews at their main office in Kampala, as well as interviews with traditional healers at their weekly meetings in Buyijja village about an hour's drive from Kampala. In addition to interviews, during my time in Buyijja, I was allowed time for participant observation, which included sitting in on classes (with translators as I don't speak Lugandan), as well as taking part in discussions regarding spirits with a class of spiritualists. Thus, I was able gain knowledge through interviews, observation, and participation.

I also met with THETA, another local NGO, who did not have as much time to spend with me, though I did learn some information about their organization, and they were kind enough to offer me access to their extensive library of materials on traditional healers and health care from around the world. MAKOHA, a traditional healer organization, was another group I met with. Most of my time was spent with the chairman of the organization. Additionally, I was introduced to a number of members from the group, whom I also interviewed. Incidentally, one of the members of the group was also a prominent traditional healer himself and ended up taking me to his hospital center about 30km from Kampala. In addition to these key informants, I spoke with a variety of other community members from various levels including: market vendors

(some of whom were traditional healers selling herbs), major researchers and prominent directors from the country.

I was very fortunate and am very indebted to the time and energy put out by all of my informants. I found the people in Uganda I spoke with to all be extremely knowledgeable and giving. Every group and individual went out of their way to assure that I was accessing the correct information and as much of it as possible in my short time there. I suspect that if it was possible, my informant friends would have had me working 24 hours a day 7 days a week, as those seem to be the hours they all work!

As my research shifted from an examination of collaboration among traditional and allopathic healers to a study of traditional healers as agents of change in a time of AIDS, I found that a majority of the information presented to me this past summer contributes significantly to the current anthropological discussions regarding the cultural importance and efficacy of traditional healers in community systems. Furthermore, intensifying debates among anthropologists this past fall have all led me to the conclusion that I must present my analysis of traditional healers, and place this knowledge in the context of HIV/AIDS. Ultimately, I hope to return to Uganda and continue researching traditional healers, as well as their relationship with Western medicine. However, for now I turn to the question presented at the beginning of this introduction: What role do traditional healers play in the provisioning of drugs, services and information in Uganda, and how does their role affect the changes and successes in dealing with disease, specifically in the context of HIV/AIDS?

CHAPTER ONE
A Shifting Country

The purpose of this chapter is to provide the reader with a solid background of the research site. It is important to understand the history of the area and such cultural components as language, ethnicity, and political structures that make up a society. In this chapter, I will first include information on cultural and political make up, specifically dealing with language, history, and general demographics of Uganda and its health care infrastructure. Next, I will take a look at HIV/AIDS in Uganda, including an analysis of prevalence rates, and comparison with other countries in Sub-Saharan Africa and the world. Finally, I will conclude with a statement as to why this discussion is fundamental to the following chapters, as I begin to tackle the underlying question regarding the role of traditional healers in Uganda.

Research Setting

Uganda is a landlocked country located just on the equator, bordering Kenya to the east, Tanzania and Rwanda to the southwest, Zaire in the west and Sudan in the north. The country's landscape reflects the diversity of the people. Whereas the North is dry and arid, the South, near the lakes region, is tropical and rain is plentiful. The country also includes plateaus, hills and mountain ranges. And of course, Uganda includes the source of the great Nile River, flowing from Lake Victoria.

As mentioned previously, I spent my time in Uganda in and around the capital city of Kampala. Considered a war zone for quite sometime, Kampala has begun to rebuild itself into a beautiful, bustling African city. While some buildings still bear the

scars of bullets and explosions, most have been restored and even newer, more modern buildings are being constructed.

From a modern shopping mall complete with food court and movie theater, to local markets which includes fresh produce, meat, crafts, clothing, traditional herbs and more, Kampala today offers most all of the modern amenities one might need, as well as a variety of methods of obtaining them. I visited several markets (for a variety of purposes) including: Nakasero market, Uganda Arts and Crafts Village, Katwe, and most important to our research, Owino Market.

Owino market is a hot, sticky, crowded maze, filled with clothing, luggage, baskets, kitchenware, you name it. Most importantly, Owino has its own traditional healer area, somewhat like a pharmacy within a drug store. Owino market proved not only to be the most fruitful in terms of shopping, but also for interviews and information.

Demographics

Uganda is a country made up of over 25,632,794 people, as of July 2003 (CIA World Fact Book online), all of whom may speak one of 12-plus native languages, from four major language groups: the Bantu, Luo, Atekerin and Sudanic, as well as English, which is considered the official "national" language. This great diversity of languages is very revealing. As Nzita and Niwampa point out in *Peoples and Cultures of Uganda*, "There is no one Ugandan culture." (Nzita and Niwampa 1997:iii).

My own time in the field was primarily spent in the capital city of Kampala and the surrounding area. In the middle of the 1900's Kampala became an epicenter of diversity. In Harold Ingram's ethnography, *Uganda*, he observes that "Kampala, with a

comparatively large number of Europeans is the only place in Uganda where a genuine mixed society is growing up...In Kampala people from two worlds live together, more or less cheek by jowl."(sic Ingram 1960:302). Today that holds true, with more and more people from around the country moving to Kampala for job opportunities. Wallman purports that "in many African countries economic stagnation or decline in the 1970's and 1980's has combined with rapid overall population growth (around 3 percent per annum in the 1980's) to worsen the situation of ordinary people in both rural and urban areas" (1998:9). With so many people moving to Kampala, a great competition for jobs emerges, and the job market becomes tough in that "The real wages of urban workers have fallen sharply, the earlier relative security of formal work has largely gone, and the rural urban gap has narrowed markedly if not altogether vanished." (Jamal and Weeks 1998:9-10).

I observed this problem every day while I was in Uganda. The overpopulated city houses people from all over the country that have come to the city to find work, hoping to send money home to their families while still trying to feed and shelter themselves. The people not only struggle to find work, but also manage on non-living wages. One informant mentioned how lucky he was to have a job at all, and that his brothers back home (a village five hours away) depended on him to send money to pay for school fees. Another informant, who had a job while I was there, has written to inform me that he is unemployed and struggles to find work.

Ethnographic Background

Who are all these people moving to the city? Kampala residents represent a great diversity in backgrounds. This diversity include people from various language groups, as mentioned above, as well as specific ethnic backgrounds as can be seen in Table 1.1. These mixed backgrounds together with a powerful history, make for quite the melting pot.

Table 1.1. Ethnic Diversity found in Uganda as reported by The CIA World Fact Book Online

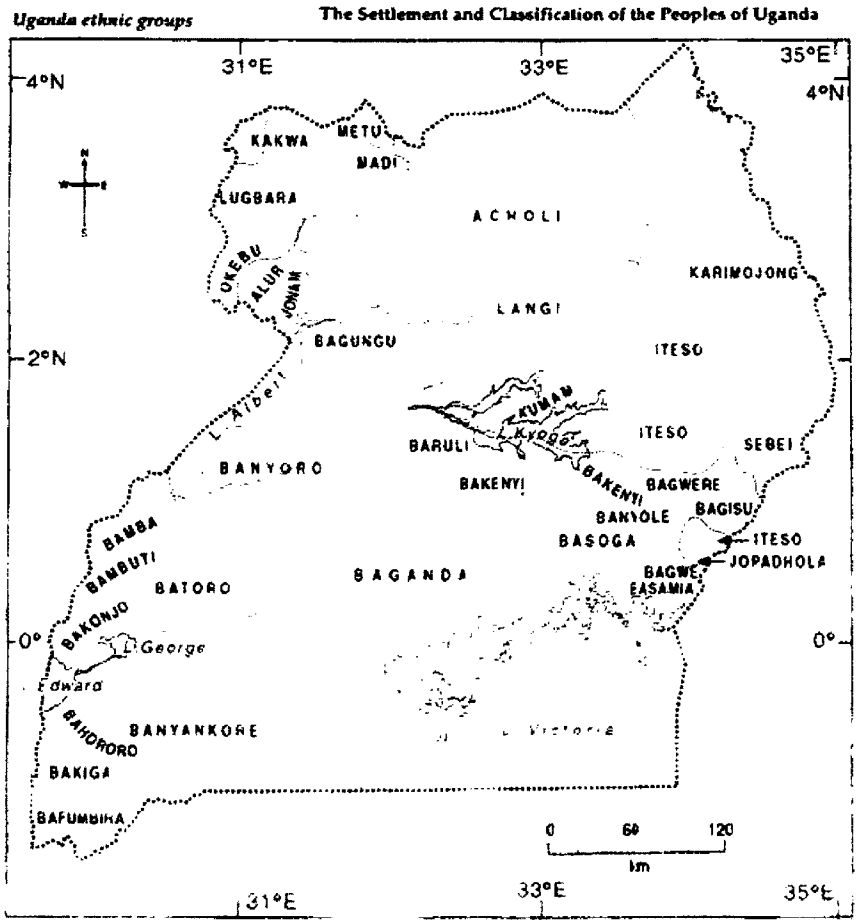
Ethnic Background:	Percentage
Baganda	17
Ankole	8
Basoga	8
Iteso	8
Bakiga	7
Langi	6
Rwanda	6
Bagisu	5
Acholi	4
Lugbara	4
Batoro	3
Bunyoro	3
Alur	2
Bawere	2
Bakonjo	2
Jopodhola	2
Karamojong	2
Rundi	2
Non-African	1
other	8

Various tribes and backgrounds were forced together into confined borders under British colonial rule in 1890 and made into the country, Uganda. Prior to this time, the current boundaries of the country did not exist. Groups of people who were historical enemies were forced to converge into one country under one rule. In a 1961 paper on *Ideology and Culture in Uganda Nationalism,* Lloyd Fallers points out that the "colonial territories into which the continent was divided during the 19th century usually have little

community of language or culture" (Fallers 1961: 677). Fallers discusses the difficulties of African nations that were forced to form allegiances and thus began seeking independence from British rule, yet have very little "personality" of their own. In other words, who or what exactly makes up "Uganda"?

Many cultural backgrounds have formed this diverse country. The major division is by language groups (Bantu, Luo, Atekerin and Sudanic), which then break into kingdoms (see Map 1). The Buganda make up the largest population as a culture group, although other groups remain prominent. Other neighboring tribes and migrant groups make up the rest of the ethnic backgrounds.

Map 1. Language Classification in Uganda (Nzita and Mbaga-Niwampa 1997:3)



The Buganda have been the major kingdom since British rule, in part because the Buganda joined with the British in conquering and adding territories to contemporary

Uganda. The Buganda also "contained both the capital and the commercial center of the Protectorate and consequently the new political and economic institutions which have grown up during the association with Great Britain have their locus in Buganda" (Fallers 1961:678). In *The Peopling of Africa,* Newman (1995) mentions that the Bunyoro, located in northern Uganda, were once the dominant power, until the 19th century when both the Buganda and the Ankole took control. He claims that "Control of intraregional trade, primarily of salt, iron hides and skins, and agricultural produce, was the prize in question." (Newman 1995:16).

Early 20th century ethnographies of non-Buganda kingdoms refer to Baganda as both important, perhaps even opportunistic (Winter 1959), and as historical enemies, engaged in constant wars (Beattie 1960). Fallers supports this in his statement: "the other peoples of Uganda tend to regard the Baganda with a mixture of admiration and resentment" (1961:685). Yet Buganda has continued to remain dominant and even today makes up the largest ethnic group percentage-wise.[1]

In addition to ethnic background, the people of Uganda also represent a large spectrum of religious practices. Table 1.2 shows the different religious practices found in Uganda. This table shows that the majority of the population is Christians. Muslim and Indigenous practices are practiced by most of the remaining population, and only a small percentage follows other religions. In Uganda, I met with Christian, Muslim, Indigenous, and non-practicing traditional healers. In some instances healers from various religious backgrounds were collaborating together.

[1] Following Beattie (1960) I should note the make up of how the people understand themselves: The people speak of themselves as *Baganda,* their kingdom as *Buganda*, and their language as *Luganda*. Similarly for other ethnic groups, such as the *Banyoro people*, from the *Bunyoro* kingdom, and speak *Lunyoro*.[1]

Table 1.2. Religious Practices found in Uganda as reported by The CIA World Fact Book Online

Religion:	Percentage
Christianity	66
Muslim	16
Indigenous	16
Others	2

Most of the people I met and spoke with were Baganda, and spoke Luganda. The majority of the people I met with also spoke English. Looking at these differences, I think it is important to emphasize researchers' tendencies to generalize Ugandan cultural beliefs and practices. What may be the case for the southern people may very well not be the case for those in the North. Furthermore, throughout this paper, while I make generalizations about Ugandan health practices and traditional health practices, there is regional variation deserving of further study. However, for the purposes of this research project, I make certain generalizations as is the convention in most HIV/AIDS research in the area.

Historical Background

A detailed political history of Uganda would be a full thesis project in and of itself, for Uganda holds claim to one of the most brutal civil wars in history. However, a brief outline discussing key points in history is essential to understanding Uganda today. A short history is also important in understanding the rise and fall of its health infrastructure, which in turn, is critical to the HIV/AIDS discussion.

Because Uganda as a 'country' was established under British rule, it, as a 'country', does not have a collective history before the late 1800's. Thus, in this section concerning Uganda's history, I will begin at the end of British rule. British rule

continued until Independence in 1962. Unfortunately, despite the notion of 'independence', this led to a series of corrupt leaders and devastating results. Since independence, three men have held power (one man twice) and turmoil has resounded. Even today, despite the many positive impacts of Uganda's current President, Museveni, civil war continues in the North under rebel leader Joseph Koney. These difficulties may be the effects of merging various tribes and backgrounds. However, while internal tensions have fueled the fire, the ultimate human indecencies shown here are most likely due to various corrupt governments and individuals.

In the beginning there was a great deal of tension as to who would take over control following the departure of the British. In 1966, Uganda's two major leaders were a Baganda separatist named Kabake Yekka (KY) and Milton Obote, who formed the Uganda People's Congress (UPC). Ultimately Obote's party became the primary ruling government; however, they often catered to the demands of the KY party (Library of Congress 1992). Despite his upfront cooperation, by the end of his rule, Obote's intentions to destroy the Buganda kingdom became clear to the public (1992). This, for obvious reasons, upset the Baganda and led to more tension and conflict. Obote's corrupt party came to an end in 1971 when armed forces commander for the UPC, Idi Amin Dada, led a political coup overturning Obote and taking over the presidency.

The period of Amin's presidency was no better, if not worse than that of Obote. The Library of Congress Country Study explained his rule very well: "Amin's military experience, which was virtually his only experience, determined the character of his rule...the army itself was an arena of lethal competition, in which losers were usually

eliminated." (1992:26). Along with military personnel, Amin also sought to eliminate certain ethnic groups. Gwyn describes this time period:

> Amin's killings (both in method and extent) generate a degree of fear that is impossible to overstate. And his use of scapegoats to justify or divert attention from the killings has the effect of keeping people of Uganda perpetually off balance. In effect, every tribe, every district, every arm of the government, every religious sect is potentially at risk. (Gwyn 1977: 126)

The next eight years proved deadly, incurring a great deal of "economic decline, social disintegration, and massive human rights violations" (Bureau of African Affairs 2003). Amin exiled and killed many Acholi and Langi, not to mention the large Asian population which had migrated to Uganda and built a successful community. In addition, he also had a great hatred of Europeans so they, for the most part, were driven out of the country. As Amin built his army up, his country was falling to pieces. In 1978 Uganda's army invaded Tanzania and took control of a small section of the country. Greatly upsetting Tanzania, this invasion began Amin's down fall and by April of 1979 he was overthrown and exiled to Libya. An American primatologist, Robert M. Sapolsky, was conducting research in East Africa during the fall of Amin and describes an experience in Kampala shortly thereafter:

> Everyone went bonkers in Kampala. Dancing in the streets, the radio said. A new government, and end of fear, emptying of the jails and the torture chambers...One day, I walked in downtown Kampala, near the palace of the new president...A busy crowd of people, going about their business. Something subtle happened, and it triggered the gears of fright in everyone's head. I would guess that three or four people, independently, just happened to stop on the same block at the same time...Some psychological critical mass had been reached, enough people were standing still. Everyone stopped dead. It spread, until the whole downtown, everyone was standing still. We all stared at the presidential palace, everyone breathed tensely, families

> huddled together. Oh my god, what is about to happen? everyone was thinking. We all stood there in silence, waiting for the next trouble for maybe five minutes, until Tanzanian soldiers came and yelled at everyone to start moving again. (sic Sapolsky 2002:87-89)

The Tanzanian government held control for a short time before handing the country over to the Uganda National Liberation Army (UNLA). The following years included a number of different individuals in power, each one ousting the next, until 1980 when Uganda held official elections and Milton Obote was put back in power under the UPC. Again, this period under Obote proved to be no better than that of Amin. More human rights violations occurred, and once again, the country experienced ongoing destruction and devastation. During this time, many insurgent groups, including that of the current president Museveni laid grounds for overthrowing Obote. Consequently, this fueled Obote's fire, and the government "laid waste to a substantial section of the country, especially in the Luwero area north of Kampala" (US Department of State online). A paper by Liebling and Kiziri-Mayengo graphically describes this time: "Torture took various forms including defilement, gang rape and forced marriages. Pregnant women had their abdomens opened up and their heads banged against stones, whereas others were shot at, mutilated or had their bodies burnt using melted plastic" (2002: 553). From images like this one, it is clear that people suffered, and had been suffering for quite some time now. Trapped in a rollercoaster of corruption, it appeared Uganda had no relief in sight.

Obote's second presidency lasted five years, and by 1986 the government was handed over to Museveni and the National Resistance Movement (NRM). For the most part, Museveni has played a large part in ending many of the human rights violations and

has worked to restore peace and stability to this civil war torn nation. Despite his efforts, conflict still continues in the north under the Lord's Resistance Army (LRA) led by Joseph Kony. While southern Uganda is finally experiencing some relief from the hardships of the past 30 years, people in the north are now facing rebel army attacks, murder, kidnapping and devastation. While I was in Uganda, daily articles in the newspapers portrayed extreme helplessness, brutal human rights violations and, as a reflection of the past, instability.

Existing Health Care System: HIV/AIDS in sub-Saharan Africa

Because of the extreme conditions Ugandans have lived with for so many years, it should come as no surprise that Uganda was once one of the most HIV/AIDS inflicted countries in the world. In 1986, following Museveni's newly appointed presidency, he sent 60 of his top officers to Cuba for training. Museveni shares the story of how 18 out of the 60 officers were HIV positive, and Fidel Castro told him, "Brother, you have a problem." (Allen 2002). This statement sent Museveni and Uganda on a mission to fight the disease.

Since Castro's alert, Uganda has been effectively fighting the disease. In the last 10-15 years, Uganda significantly lowered its prevalence rates down from above 30 percent to approximately 6.2 percent (USAID 2002; UNAIDS 2003). However, a UNAIDS case study points out that prevalence rates vary between 2% to 25% depending on areas and populations in Uganda (2003). The rise and decline in prevalence rates is a result of various factors including the health care system within Uganda.

The existing health care system plays an important role in the care and treatment of AIDS patients. Political unrest has contributed to the decline in health care, and no doubt the rise and spread of HIV/AIDS prevalence. Table 1.3 is modeled from a table in Wallman (1996:5), which sketched the rise and fall of Uganda's economy parallel to its political sequences. Adopted for the purposes of this research, it is interesting to compare health care infrastructure to Uganda's wavering political history.

Table 1.3. Progression of health care in Uganda throughout different political time periods

Time Period	Political Sequences	Health Care Overview
-- 1893	Independent Kingdoms	Relied on traditional health care
1893	British Rule	Establishment of British supported Colonial health system
1962	Independence	
1966	Obote	The beginning of the collapse of health services.
1971	Amin Coup	Government health infrastructure destroyed.
	Obote II	No money for health care.
1986	Museveni	Rehabilitation begins slowly.
1990	----------	Emphasis on donor dependency.
Current	----------	Decentralized health care NGO sector plays key role Access to heath care is limited

Beginning with Obote and Amin, the Ugandan health care system virtually collapsed. Wallman states that "government hospital infrastructure and many health centers were destroyed, leaving formal health care mostly in the hands of non-governmental organizations, missionaries and private practitioners" (1996:7). By the

time Museveni was placed into office in 1986, it remained almost non-existent and the "value of public health budget was only 6.4 per cent of its 1970's levels (Kapoor et al. 1993; in Wallman 1996:7). Finally, under Museveni, hospitals have begun rehabilitation. Yet there is still increased reliance on donor dependency as well as the NGO sector (Wallman 1996 and Pearson 2000).

A strong health care system is necessary in a country that is continuously fighting major health epidemics such as HIV/AIDS. Despite its success in lowering its HIV prevalence rates, Uganda is still struggling with the disease. According to a UNAIDS case study "Between 1 and 2 million of Uganda's 22 million people are thought to be HIV-infected. Of these, between 100,000 and 220,000 are in need of antiretroviral treatment". (sic UNAIDS 2003:41). Given the cost of these anti-retroviral treatments, US$42 a month per person (UNAIDS 2003), the current government alone can hardly afford treatment for every individual.

Conclusion

This chapter has outlined general language, history and demographics of Uganda. This chapter has also discussed Uganda's basic health care infrastructure as it has existed over periods of the various governmental rules. Following British rule, Uganda experienced a great deal of suffering and turmoil. This ultimately led to the destruction of its health care system. Uganda, situated in sub-Saharan Africa, home of the majority of the worlds AIDS population, has suffered significantly because of its lack of health care. As Museveni has begun to restore the country, health care has also begun to

rehabilitate; however, there is still substantial need in the form of providing drugs, services and information.

This chapter is fundamental to the following chapters in that it has provided a background into the people that I have studied. I have shown that Uganda is a country made up of multiple ethnicities, religions and histories. As there is no one culture group in Uganda, there can be no one answer to the HIV/AIDS and health care problem. Understanding this is imperative for all health care workers engaged in the fight against HIV/AIDS.

CHAPTER TWO
The Current Debate

As Uganda has become internationally recognized as successfully fighting HIV/AIDS prevalence and treatment, various debates have surfaced, primarily centered on the popular ABC approach, which stands for: Abstinence, Be faithful, use a Condom. Ultimately these debates revolve around a behavior versus social paradigm, questioning at what level change is occurring in Uganda. This chapter starts by clarifying the debate through a review of the current literature surrounding the ABC model, specifically looking at two prominent researchers in the field: Edward Green, who supports the ABC model and favors a behavioral analysis, and Paul Farmer, who calls on Green to make his analysis more social and add PC, for Political Commitment, to the ABC model. Within this chapter, I will look at ways that individual behavior is influenced by social aspects. I will also suggest that perhaps the behavior and the social paradigms might be a successful approach working side by side. In addition to Green and Farmer, I also present the arguments of Douglas Feldman. Feldman questions the ABC approach as a whole, and argues that models like the one in Uganda are a plug for religious fundamentalisms and that they minimize the effectiveness of condom distribution in favor of programs which support abstinence and fidelity. At the end of this chapter I question whether this debate is on target or perhaps missing the point of the matter and I ask: are we successfully advancing our understanding of the AIDS epidemic through the current debate?

Clarifying the Debate

Last fall (2003) a discussion revolving HIV/AIDS in Uganda appeared in *Anthropology News*. The discussion revolved around Uganda's success in dealing with HIV/AIDS prevalence and treatment. The discussion soon developed into a debate among scholars, and become more centered on the popular ABC approach. The crux of the debate seemed to revolve around a behavior vs. social paradigm and questioned the level at which change is occurring. This debate has by no means been resolved and researchers continue to ask, what has been happening in Uganda? In this section I begin by attempting to clarify the debate by identifying key respondents involved and their arguments. I then explore the notions of behavioral versus social theoretical approaches, including a discussion of condom distribution.

ABC and Behavioral vs. Social

This debate has remained complex and has often times become personal. As mentioned above, the ABC approach is most widely known to stand for Abstinence, Be faithful, use Condoms; although, in other circles ABC may stand for other things such as C for care, compensation and controversy. Additionally, other methods add letters such as D for delay. E and F for Empowerment of women through Financial independence. And even go so far as to add G for getting tested and I for innovation (USAID 2002). One of my Ugandan informants mentioned that some people are now adding D, for death, the last option! (Personal Communication) For the purposes of this research I will only deal with the letters ABC.

In the fall of 2003, the American Anthropological Association's monthly publication, *Anthropology News*, became an arena for strong back and forth deliberation. Green began in September with an article discussing "New Challenges to the AIDS Prevention Paradigm". He introduced the term "primary behavior change" (PBC), as originally purposed by John Richens. He argues that PBC

> denote[s] fundamental changes in sexual behavior, including partner reduction, that do not rely on devices or drugs. He (Richens), and I and a very few others have suggested treating AIDS as a behavioral issue that calls for behavioral solutions, although not to the exclusion of risk reduction remedies. The dominant paradigm model treats AIDS as a medical problem requiring medical solutions. PBC deals with the problem itself, getting at what is needed for primary prevention, while the medical model deals with symptoms. (Green 2003a:5)

Green views the AIDS problem as a behavioral problem, in that certain behaviors, like risky sexual activities, lead to AIDS. Changing those behaviors will ultimately change the course of the diseases. Green's focus is centered around the individual, and his school of thought includes changing the individual's behavior.

Farmer, on the other hand, argues that the decline in prevelance has little to do with behavior change, and more to do with issues of politics and social events, such as war (people will die off), as well as increased access to HIV/AIDS drugs. Farmer asserts that AIDS is a "social problem with a social solution" (Farmer 2003:7). I believe Farmer gets to the core of his critique when he surmises that when discussing behavior (and the individual), we must talk about the behavior of the powerful, because, he argues, "what the have-nots lack is agency" (2003:7).

Green and Farmer both illuminate important dimensions in the fight against AIDS, in that the *individual* is key. They point out the importance of the individual

behavior on the one hand, and the question of agency, on the level of the individual, on the other, whether that be the individual community member (powerless), or community leaders or government officials (powerful). While Green is primarily focused on the level of the individual, Farmer indicates that individual behavior has to be understood in the context of social structures and the devolution of power. That devolution of power (and thus agency) is disseminated through many layers of the social system.

Paul Farmer's emphasis on the examination of HIV/AIDS through a social paradigm addresses notions of power and inequalities, as mentioned above. In his book *Infections and Inequalities*, Farmer argues that "*HIV tracks along steep gradients of power.* In many settings, HIV risks are enhanced not so much by poverty in and of itself but by inequality." (Farmer 1999:91, in original). Farmer's statement regarding power suggests that in societies where inequalities exist, HIV may be more prevalent. In low-income countries like Uganda, inequalities are inevitable. Thus behavior changes focused on prevention may not be enough. He argues, "If indeed inequality is an important co-factor in this pandemic, then stopping AIDS will require a more ambitious agenda, one that calls for the fundamental transformation of our world." (Farmer 2003b:93). Farmer indicates that in order to curb the infections, (as well as change behavior) is to make changes in social structure and "scrutinize the behavior of the powerful" (Farmer 2003a:7).

Farmer believes that because there has been such an emphasis on prevention, *treatment*, is often left out of programs where *prevention* is the primary focus (Farmer 1999, 2003a, 2003b), such as the current focus on the ABC model. In his book *Pathologies of Power*, Farmer refers to an individual who mentioned that "prevention

comes too late for people who are already sick and immiserated" (Farmer 2003b:206). Throughout his discussions, Farmer does not ignore the notion of the importance of behavior, but instead focuses on ways in which the social system influences individual behavior.

Edward Green's work is strong in its behavioral analysis, and his devotion to the ABC model. Green argues that it is the behavior change that most people chose for themselves, whether or not it is promoted. However, "When PBC is actively promoted, even more of this type of behavioral change seems to result than when it is not." (Green 2003b:9). I would argue that Green does not completely dismiss some of what Farmer and the others who are focused on the social aspects are arguing. In his book *Rethinking AIDS (2003)*, Green goes into great detail regarding the political and social actions occurring in Uganda, from the top (such as donor agencies and the president) to localized governments, to individual community leaders, and finally to the individual. Each of these individuals or groups has contributed to Uganda's success. Green reflects on behavioral researchers as a whole, recognizing that "complex health behaviors, such as those involving sexual intercourse, take place on a social and cultural context" (Green 2003b:206). Green's recognition of the social system leads me to suggest we look at the Uganda model in a slightly different way, incorporating behavioral change *and* the social system.

Behavioral Change *and* the Social System

Instead of contrasting the behavioral and the social paradigms, perhaps it is best to examine the Uganda model using a behavioral *and* social paradigm and notice how the

social system influences individual behavioral change. Sweat and Denison (1995) point out that, "Complex health behaviors, such as those involving sexual intercourse, take place in a social and cultural context. Therefore social and cultural factors surrounding the individual must be considered in designing, preventative interventions" (in Green 2003:206). In other words, an individual must have the agency through which to change, and thus social factors do play a role. The cultural ultimately affects the individual, thereby making change necessary from a social and behavioral theoretical approach.

What, then, makes Uganda unique in the social realm? The following table is presented by Green et al. (2002), showing actions that have affected Uganda, and are absent or less prevalent in other African countries (such as Zimbabwe, South Africa, Botswana, Kenya, and Malawi), all of which have not seen the significant decline in prevalence rates that Uganda has seen (see Table 2.1).

Table 2.1. HIV/AIDS action seen occurring in Uganda. Adapted from Green et al. (2002)

Epidemiological, Socio-cultural, Political Elements Which have Affected Prevalence Rates in Uganda
1. High-level political support with multi-sectoral response set the tone
2. Decentralized planning and implementation for behavior change communication (BCC) reached both general populations and key target groups.
3. Interventions addressed women and youth, stigma and discrimination.
4. Religious leaders and faith-based organizations have been active on the front lines of the response to the epidemic.
5. Africa's first confidential voluntary counseling and testing (VCT) services opened in Kampala in 1990.
6. Condom social marketing has played a key but evidently not the major role.
7. Sexually transmitted infections (STI) control and prevention programs have received increased emphasis.
8. The most important determinant of the reduction in HIV incidence in Uganda appears to be a decrease in multiple sexual partnerships and networks.

From this list, it is evident that the level of political and social support for HIV/AIDS education, and care for those who have the disease, has been remarkably present and widespread. Notice that the majority of items in this list do in fact deal with social elements, involving support and agency. This shows Uganda's reliance on social aspects of the fight against HIV/AIDS, such as political support, condom marketing, and prevention programs. However, I would suggest that perhaps the most important element is number eight, which states: "The most important determinant of the reduction in HIV incidence in Uganda appears to be a decrease in multiple sexual partnerships and networks." (2002), and thus points to the importance of individual behavior. These eight elements which have shown to affect prevalence rates incorporate aspects of both the behavioral and the social paradigms.

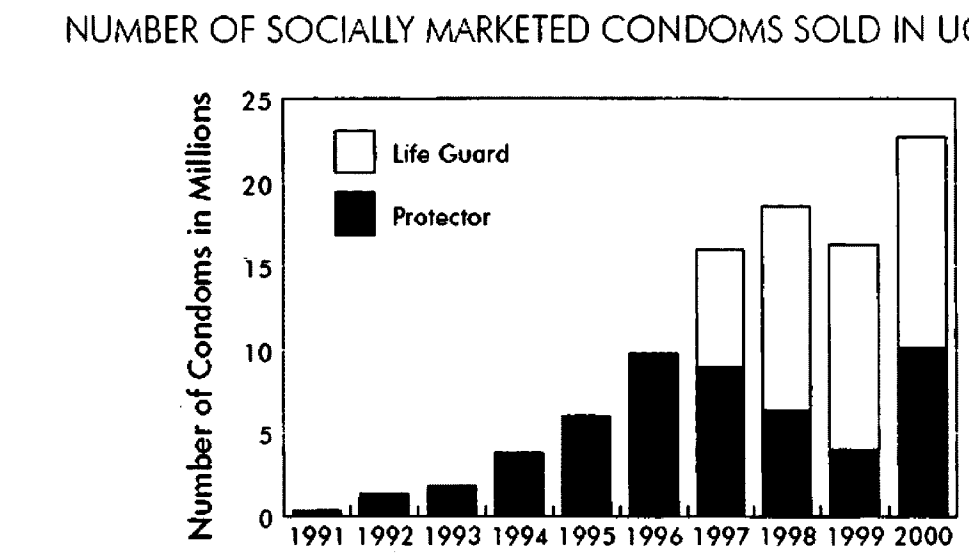
Condom Conundrum

Included in the debate over the behavioral vs. social paradigms, and often one of the most passionately debated, is that of the condom, the C in ABC. The debate over the importance of stressing condom distribution and condom use has caused quiet a stir here in the United States, and throughout the world. Researchers and health policy makers seem to be implementing policies that are modeled on the United States experience. This becomes dangerous and often times ineffective, as matters of cultural-relativity need to be considered. In other words, in some cultures, the condom is not understood or well accepted and thus fails as a program. In addition to creating policies modeled after the United States experience, the debate also stems from a long-standing fear of the Christian conservatives, who are often the proponents of Abstinence Only programs here in the

United States. Furthermore, the condom debate has become a significant aspect of the behavioral vs. social debate. Condom distribution, if implemented, must be done so in a manner that best fits that particular social system. In addition, condoms must then be made available at all times (not sporadically, or made difficult to obtain). Most importantly, if condom distribution is to take place, a change in behavior needs to occur as well. Thus, the condom conundrum lies on both a behavioral and social level, and in Uganda, may not be the best answer altogether. This section outlines the debate over, and presence of, the big C in the ABC method, as applied to Uganda, and examines the use and implementation of condoms in the country.

Many people may believe that distributing condoms in Africa has been, or could be, fundamental to curbing HIV/AIDS prevalence. Yet for Uganda, "Condom promotion was not an especially dominant element in Uganda's earlier response to AIDS, certainly compared to several other countries in eastern and southern Africa...[see Figure 2.1] Nearly all of the decline in HIV incidence (and much of the decline in prevalence) had already occurred by 1995." (Green et al. 2002: 7-8). While a high incidence of change occurred before 1995, looking at the graph we see that there was not a significant amount of condom distribution occurring at that time period. Instead, the primary behavioral change was partner reduction (Green 2003b). By 2000, there was in fact, a significant distribution of condoms, and thus may perhaps be contributing to the lowering of prevalence rates. Reflecting on behavioral change and the social system, and putting the condom question into the Ugandan context: historically, behaviorally, and socially, condoms have not been a part of the equation.

Figure 2.1. Number of socially marketed condoms sold in Uganda. (Green et al. 2002)



Source: Deloitte Touche Tohmatsu, Commercial Market Strategies, Uganda Report, 2001.

In addition, Green discusses condoms as a resource that is not always available to communities. He argues that:

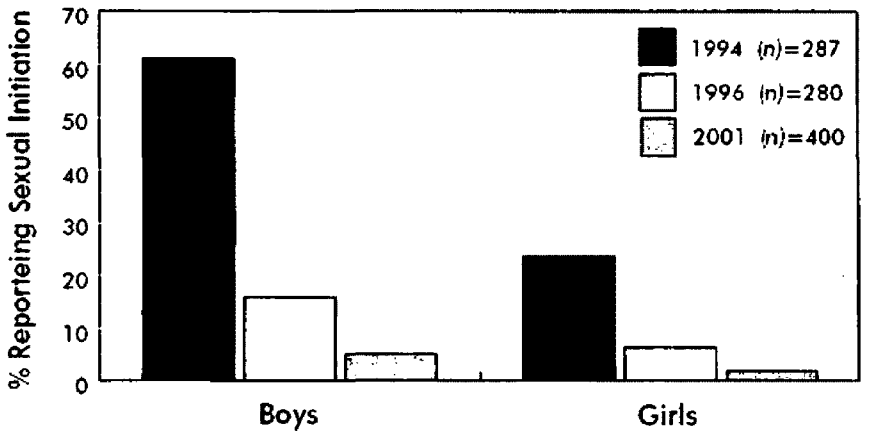
> It makes pubic health sense to build upon what people already do rather than put all or most of AIDS prevention resources into promoting an alien technology, something that involves monetary costs to the target audience and that needs to be constantly resupplied in vast quantities. At least this makes sense if promotion of PBC can be shown to reduce HIV transmission significantly." (Green 2003b:9)

Building upon Green's argument, it appears that the data collected throughout the years do point towards a behavioral change, rather than condom use, at least during the years of significant change in prevalence rates (from the years 1991-1995). Referring back to Figure 2.1, one can see that there was not a considerable amount of condom distribution in the earlier years (1991-1995). Compare this information with Figure 2.2, which indicates changes in sexual debut, and notice the significant changes in both boys and

girls in behavioral change regarding changes in sexual behavior. This figure shows a considerable change in behavior from 1994 to 1996, especially among boys. A drop off in sexual debut may point to an increase in changed behavior as a result of increased education about HIV/AIDS.

Figure 2.2. Delayed Sexual Debut Among Primary School Pupils. (Green et al. 2002)

DELAYED SEXUAL DEBUT AMONG PRIMARY SCHOOL PUPILS (13-16 YEARS) FOLLOWING IEC (Soroti District, Uganda)



Source: The Effects of the Katakwi/Soroti School Health and AIDS Prevention Project, AMREF Report, Kampala, August 2001.

Why then are public heath workers so adamant about condom distribution? Often times Western researchers and policy makers bring cultural baggage into their programs. In other words, the abstinence only versus condom promotion debate rages on in United States health policy and thus carries over to international health policies. This seems to be the case for the current debate.

In the October issue of *Anthropology News,* Douglas Feldman joined the discussion. He argued that Green's Uganda model, including the ABC approach, is entirely a politically conservative, religious fundamentalist approach. Feldman purports

that "there is no question that if everyone in Africa who is sexually active, and not actively seeking to have children with their partner, were to use condoms properly every time, the HIV epidemic would substantially diminish throughout the continent" (Feldman 2003:6). Perhaps Feldman doesn't take into consideration the factor of accessibility. Accessibility includes the level of education involved in properly using the condoms, not to mention the level of agency involved in supplying and distributing this non-sustainable commodity.

In many other countries, condom distribution has not succeeded, if it has not altogether failed. This may be due to lack of training of local health workers, lack of education of the individual using, or choosing to use, the condom, or simply lack of availability of the product. An article in the American Journal of Nursing described a condom distribution program that occurred in South Africa in 2000 during National Condom Week, in which free condoms were stapled to a card and then handed out for free. As a result of the staples, all of the condoms were defective (Giarelli and Jacobs 2003:39). Elizabeth Onjoro points out that, strategies which are centered on providing condoms to the public have not been effective in many African nations. She attributes this to the programs not taking cultural factors into account. She states that "Initiatives in Botswana and Kenya provide vivid examples of the failure of a mainly condom strategy." (Onjoro, 2003: 4).

Onjoro continues the discussion in the November issue of *Anthropology News*, arguing strongly for methods which are culturally relevant, and perhaps condoms are not. She states:

> It is no surprise that ABC has been at the center of effective HIV/AIDS prevention in Senegal and Uganda. The ABC strategy in each country is tailored to fit that country's

> cultural reality. Among the driving forces behind the strategy's successes are strong political leadership, sound public health practice, integration of cultural knowledge and environmental reality. This points to what many Western researchers and policy makers do not like to hear: effective HIV programs must integrate a cultural framework of health and healing, treatment and prevention messages. *Prevention messages that are perceived as best and effective in the West may not necessarily be equally effective in the African context* [emphasis my own]. Given the myriad driving forces that can have a profound effect on HIV infection rates, more funding needs to focus on strengthening these elements and our understanding of them; even if it means reducing funds available exclusively for condoms. (Onjoro 2003:4)

Onjoro points to a particular problem within public policy and research in the public health field. As anthropologists, we should know there are a great number of differences among culture groups, in addition to differences in solving those problems.

Nevertheless, Feldman continued his argument, motivated by what he perceives as conservative American policies implemented in Africa. He stated that "HIV prevention programs, especially in rural areas, need to be tailored for the Buganda, Bemba, Lozi, Mossi, Igbo, Yoruba, Maasai, Turkana, Azande, Shona, and many others, rather than pre-packaged in the state of Texas" (Feldman 2003:6). However, Uganda, and other African nations have held certain beliefs, which Feldman might consider "conservative". These beliefs are presented by Onjoro on an online bulletin board focused on the discussion of AIDS and Uganda. Onjoro rejects Feldman's notion of religious fundamentalism taking control, and, speaking of growing up in Africa, she adds that she has a "totally different belief of what Africans' sexual behaviors are. Abstinence is buil[t] into many African cultures as part of various rituals. The term or practice did not [come] to Africa from the conservative Christian wing as it seems to be the case here in America" (Onjoro 2003: online discussion). It is interesting to note that Feldman views notions of abstinence and

other such behaviors, as "Western policy", but does not consider condom promotion as such.

With so many varying views on the matter, perhaps we should get back to looking at the facts. Table 2.2 was presented by Green in a presentation to the House Committee of Energy and Commerce Subcommittee on Health on March 20th, 2003.

Table 2.2. Available condoms in African countries (adapted from Green 2003c)

Average number of condoms per male 15-49 in African countries for which data are available. Source: DKT				
Country	Average annual condoms 1989-2000	Males 15-59 (in thousands) 1995	Average annual condoms/male 15-59	HIV/Prevalence (%)
Ghana	9,901,068	4,424	2	3.6
Benin	4,065,408	1,263	3	2.45
Senegal	5,513,517	2,091	3	1
Cameroon	10,378,900	3,280	3	8
Uganda	16,702,846	4,740	4	6
Tanzania	27,217,215	7,603	4	16
Zambia	12,131,695	2,280	5	20
Kenya	42,391,034	6,666	6	14
Botswana	2,436,232	356	7	36
South Africa	76,284,892	11,645	7	20
Zimbabwe	29,149,405	2,826	10	25

Here we see a trend indicating that in countries like Uganda, where annual condom distribution is relatively low, prevalence rates also remain low. In Uganda 16,702,846 condoms were available between 1989 and 2000. In a place where 4 condoms per year per male were available, the HIV prevalence is 6%, compared with South Africa which has nearly twice as many condoms available per male, yet almost 4 times the prevalence

rate. Table 2.2 shows that in South Africa, the average a man can only have sex safely with a condom 7 times a year, whereas in Uganda, a man can only have sex safely with a condom 4 times a year. This chart shows that despite Uganda's relatively significantly low supply of condoms, prevalence rates are relatively low thereby suggesting that success may not be due to condom use.

President Museveni himself, while instrumental in providing health services, has not always supported condom distribution. It has only been since recent pressure from outside funding groups that he has had to include condom promotion in his program (Green 2003). In 1991, Museveni spoke out against condoms stating, "In countries like ours, where a mother often has to walk twenty miles to get an aspirin for her sick child or five miles to get any water at all, the question of getting a constant supply of condoms may never be resolved" (Museveni, 2000: p. 252; in Green 2003:153). The point that Museveni is trying to make is that countries like Uganda cannot rely on condom availability. It must be remembered that not all people live in or near major cities, and a great number of the population lives in rural settings where access to condoms is not an option.

What is the purpose of condoms? As Edward Green pointed out in his address to the United States House Subcommittee on health, one of the aspects of the ABC program is in fact C for Condom, and this program recognizes that "some people cannot or will not avoid risky sex, and so they need to reduce their risk with condoms". In addition to Green's observation, some of the traditional healers I interviewed spoke about condoms. One individual stated, "Condom use is known to all Ugandans including traditional healers. ...about abstinence, people prefer using condoms" (personal communication

2003). While this does not necessarily mean that people *are* using condoms, it does suggest that people in Uganda may be more likely to have sex and use condoms, than to abstain from sex, in this person's opinion.

The question of condom distribution ultimately comes to a need for social agency and behavioral change of individuals. Without access to the condoms provided by social networks, the individual cannot get the condom resource, and without the knowledge base, the individual does not have the tools to change behavior and use the condom, let alone use it correctly. Thus condom usage, embedded in a social and behavioral context, proves to be a complex resource and variable to the significant decline in HIV/AIDS.

On Target, or Missing the Point: Concluding Thoughts

In this chapter, I have reviewed the various debates surrounding Uganda's success and the questioning of at what level change is occurring. I have attempted to show that discussions in the literature emphasize the importance of understanding the individual behavior in the context of the social system. While both behavioral and social elements are important to understand, I would argue that too much emphasis is being placed on an either/or issue, when in fact, we should look at how the two work together. In addition, I believe that we, as researchers, need to stay away from matters concerning values, beliefs, and political positions drawn from our own culture, and instead look at those of the culture in question. It is imperative that we understand the culture in its own context before we can understand how to assist in implementing change, especially where HIV/AIDS is concerned.

The overall understanding to be gathered from this debate reflects the need to look at behavior change in the context of the social system, especially when discussing issues such as condom distribution and those involving sexual behavioral choices. Edward Green points out that, while there are many aspects to take into consideration, such as political and social support, the most important thing to remember is that "Sexual behavior itself must change in order for seroincidence to change." (Green et. al. 2000:11). This statement highlights the importance of the social system, including governmental, nongovernmental and local community roles, in dealing with HIV/AIDS, while emphasizing that change must ultimately come from the individual

The current anthropological debate has given particular focus to recognizing the duality of roles between social elements and behavioral choices when dealing with HIV/AIDS. While the debate has remained polarized, I have suggested that the two theoretical paradigms may in fact work together. In the following chapter, I will present a theoretical model that bridges the behavioral and the social paradigms and highlights the facilitation of individual change through certain social systems. This theory will later be applied to the Ugandan context, where I will demonstrate the role of the traditional healer and leaders of traditional healer organizations, as part of the social network, and how they are actively engaged in providing information drugs and services to the community and individuals within a community, which in turn, through a diffusion process, falls within the realm of both the social systems and individual behavioral change.

CHAPTER THREE
Theoretical Position

The purpose of this chapter is to explore Everett Rogers' *diffusion of innovations* theory, while applying it to the Uganda context. In the previous chapters, I have sketched a brief background of Uganda, including the structure of the country today, its political background, and current health care infrastructure. In addition, I have identified and discussed the major theoretical constructs argued by current researchers, primarily Edward Green, Paul Farmer and Douglas Feldman, whose research primarily revolves around a social vs. behavioral paradigm. Recalling these theoretical constructs, this chapter attempts to bridge the two, using a *diffusion of innovations* model as presented by Everett Rogers (1995). Researchers are asking the question how and why has change occurred in Uganda, and I believe the diffusion model may be able to help answer these questions. Furthermore, this model illustrated how innovations such as information, drugs and services are made available to individuals through a social process.

What I am trying to argue here is that, in Uganda, traditional healers and leaders of traditional healer organizations play important roles in a diffusion process. As part of the social system, these leaders and individual healers effectively communicate with potential adopters of these innovations (community members), and are thus facilitating behavioral change within the social system.

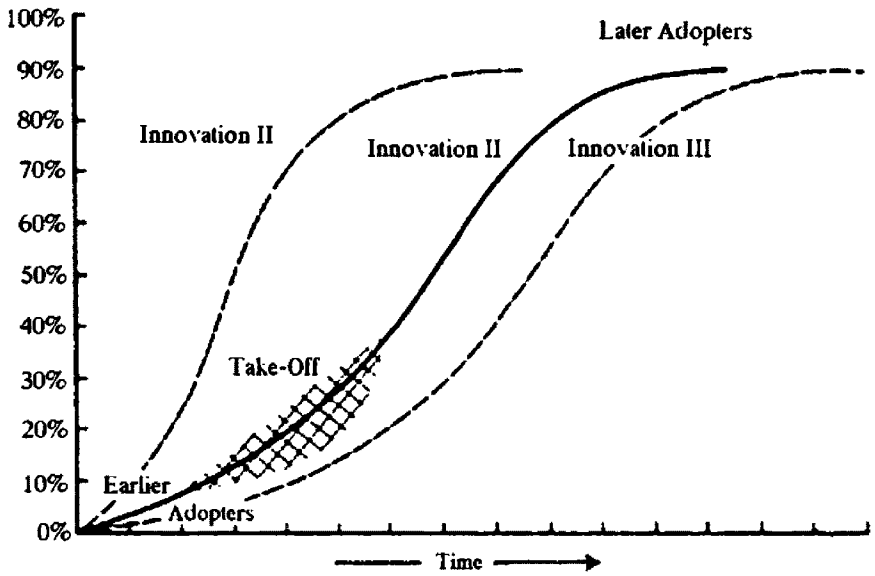
In his book, *Diffusion of Innovations* (1995), Everett Rogers, the father of the diffusion of innovations theory, defines *diffusion* as "the process by which an innovation is communicated through certain channels over time among the members of a social system"(1995:5). In reference to the idea of communication, communication is further

defined as "a process in which participants create and share information with one another in order to reach a mutual understanding" (1995:5-6). Moreover, the diffusion discussed here is a "kind of *social change*, defined as the process by which alteration occurs in the structure and function of a social system" (1995:6). In sum, diffusion of innovations is a social process in which members of a group are engaged in communication, which in turn changes the system.

Diffusion of innovations theory is known for showing how a certain type of new idea, technology, or method is diffused throughout a system. The diffusion of innovations theory has been used in a variety of studies ranging from the diffusion of agricultural methods, as exemplified in hybrid corn adoption, to keyboard manufacturing in computer technology, and community health matters such as water boiling and prescription drug choices. The areas applicable to the diffusion of innovation model cover a broad spectrum and therefore can be applied by multiple disciplines. I have selected this theory not only because of its wide applicability but also because of its use of the social system and individual components, such as behavior of individuals.

This chapter will look at the main tenants of the diffusion model. These include: *innovation, communication channels, time,* and the *social system*, as seen in Figure 3.1 taken from Rogers (1995). Within the discussion of these elements, I will give particular focus to prevalent aspects of the communication channels, as well as the social system, as appropriate to this particular thesis. It is important to keep in mind that all four of these elements are complex factors, and that they are only briefly summarized below. I will provide examples from Uganda to illustrate each element; however, a more in depth discussion will tie this model to the Ugandan context in subsequent chapters.

Figure 3.1 Rogers' Diffusion Model (Rogers 1995:11)



The Innovation

The innovation is perhaps the most fundamental of the four elements presented, for it is the innovation that must be diffused throughout the system, over time, through the communication channels. *Innovation* is defined as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption" (Rogers 1995:11). Examples of innovations within the Ugandan context might include:

An idea: 'HIV/AIDS is deadly'

A practice: Abstinence, Be faithful

An object: Condoms

With that in mind, the ABC model encompasses all of these examples of innovations, the idea that HIV/AIDS is deadly, therefore, one should practice abstinence and be faithful, and if all else fails, use the condom. Other more basic innovations are diffused as well, including more general education on HIV/AIDS transmission and treatment.

Rogers points out five major characteristics of innovations. To begin with, the innovation in question must have some sort of *relative advantage* (1995), or perceptional advantage. It matters more that an individual believes the innovation to be advantageous, rather than the degree to which an innovation is actually advantageous. Ultimately, "The greater the perceived relative advantage of an innovation, the more rapid its rate of adoption will be." (1995:15). In other words, if individuals feel a certain drug or treatment option would be beneficial to their heath, regardless of its actual advantage, they would be more likely to adopt the drug than if they believed it to be ineffective.

The next characteristic is concerned with *compatibility,* specifically involving values, norms and beliefs pre-existing within the system the innovation is potentially being diffused in. An innovation that is not compatible with the norms of a system will take longer to diffuse. For instance, using condom promotion as an example of an innovation, in an African community which holds pre-existing notions of abstinence, this innovation may not be compatible and may fail or appear to have failed. In comparison, in a community where abstinence may not be the norm, the innovation might be more likely to take off.

A third characteristic of innovations to consider is the notion of *complexity.* This refers to the level of difficulty in understanding and adopting an innovation. As expected, the more difficult an innovation is to understand, the slower its adoption rate will be. For example, if the innovation is too abstract, and the individual doesn't have the knowledge background to decipher the meaning and proper use of that innovation, typically the case of the C in the ABC model, then the innovation may not be successful. However, in some African countries, where abstinence has shown to be an underlying

practice in their culture (as pointed out by Elizabeth Onjoro in Chapter Two), the A for abstinence may be a more appropriate and effective innovation. By introducing simple, less complex innovations, individuals may be more likely to change their behavior and adopt new innovations.

Trialability is a fourth characteristic, which is basically the degree to which an individual may experiment with the innovation, which in turn affects rates of adoption. For example, if condoms are freely distributed, and an individual is able to try this product and decide whether to adopt this method, that person may be more likely to adopt condom use into his lifestyle than one who needs to seek the resource on his own. This is similar to the final characteristic, which is *observability.* Observability refers to the degree to which the innovations are visible to others. Individuals are more likely to adopt an innovation that they can clearly observe as being successful. This characteristic often includes the observations of friends, neighbors, and peer groups.

All of these characteristics of innovations are important for those involved in initiating change to consider. As mentioned previously, the innovation is fundamental to the process of diffusion. In Chapter Six, I will point out ways in which traditional healer organizations and traditional healers are involved in dealing with issues of *relative advantage, compatibility, complexity, and trailability*, and in turn work to provide the innovation (information, drugs, and services) to individuals within their social system.

Communication Channels

Communication channels are integral in the process of diffusion of innovation, in that these channels are the means by which the innovation flows throughout the system. These channels carry messages concerned with the idea, practice, or object. The process of communication within the diffusion process typically involves the following:

(1) an innovation
(2) an individual or other unit of adoption that has knowledge of the innovation or experience with using it
(3) another individual or other unit that does not have experience with the innovation, and
(4) a communication channel connecting the two units. (Rogers 1995:18)

To clarify, this process includes those who have specific knowledge or expertise, or who have already adopted (adopters) the innovation, and those who do not have the knowledge or have not adopted. These individuals are connected through communication channels which act as pathways or networks. These pathways or networks may include public, multi-individual approaches, often called "mass media channels". Examples may be radio, television, and newspapers. Communication channel pathways may also incorporate a more personal approach by means of interpersonal channels which usually occur face to face with smaller numbers, but including at least two individuals. In Uganda, the HIV/AIDS education and prevention messages are presented using both channel approaches (mass media and interpersonal) as demonstrated by the use of billboards and broadcast radio announcements, while at the same time, sending 'experts' to local areas for face to face counseling and education as a more personal approach.

While both of these approaches seem to be successful, Rogers points out that, "the dependence on the experience of near peers suggests that the heart of the diffusion

process consists of modeling and imitation by potential adopters of their network partners who have adopted previously" (Rogers 1995:18). Rogers concludes by saying, "So diffusion is a very social process." (1995:18). Understanding the role of the peers and network partners has become an important tool for researchers. There are multiple dimensions of the social process, some of which will be pointed out later in this chapter when discussing *social structure,* one of the four elements of diffusion. Continuing the discussion of communication channels I will distinguish between notions of homophily and heterophily which are relevant to communication between individuals.

Homophily refers to the "degree to which two or more individuals who interact are similar in certain attributes" (1995:19), whereas heterophily would be the opposite, describing the degree to which individuals are different. Members inside the same social system are homophilious. Their homophily occurs because they share the same language, customs, values, and beliefs, thereby allowing for communication to flow freely. There are often language and cultural constraints in heterophily groups which may hinder or prevent communication altogether. Rogers also points out that there is a positive relationship between change existing in homophilious groups, and as a result, problems often arise in situations where members of a system are heterophilous (1995).

Heterophily and homophily are important principles to this discussion as traditional healers are compared to other outsider or heterophilous health care providers. I will return to these principles when discussing change agents, both in this chapter, and again in chapter six. However, for now, I will continue outlining the major elements of the diffusion model.

Time

As an innovation passes through the communication channels, it requires a certain amount of time to diffuse. Certain time dimensions must be taken into consideration

> (1) in the innovation-decision process by which an individual passes from first knowledge of an innovation through its adoption or rejection,
> (2) in the innovativeness/lateness with which an innovation is adopted-compared with other members of a system,
> (3) in an innovation's rate of adoption in a system, usually measured as the number of members of the system tat adopt the innovation in a given time period. (Rogers 1995:20)

In other words, the basic dimensions of time are measured as first, the process of adoption or rejection, second, the innovation of the individual comparatively in the group, and finally, the total number of adopters in a system in a given time, which can also be considered as the speed in which an innovation is adopted. This third variable can be seen by looking again at the S-shaped curve in figure 3.1. Everett Rogers points out that the unit of analysis here is the innovation in a system, not the individual, which is used to measure rates of adoption. In the instance of ABC adoption, the unit of analysis over time might be the condom, but not those individuals selecting the condom, as one might suspect.

The Social System

Social systems are defined by Rogers as "a set of interrelated units that are engaged in joint problem-solving to accomplish a common goal" (1995:23). This definition seems somewhat limited to only those members who are aware of a problem and actively pursuing a solution. I would add to his definition the idea that all levels of involvement and action should be taken into consideration, including those less involved in problem solving but willing to adopt new innovations. This is important because it is at the level of final adoption which completes the diffusion process. In addition, in some instances, feedback from individuals, regardless of their participation in 'problem solving', is necessary for further implementation of innovations (see Chapter Four).

With that in mind, throughout the social system, one finds a certain degree of *social structure*, or the "patterned relationships among the members of a system" (199:24). In addition, one finds, *communication structures*, which are "elements that can be recognized in the patterned communication flows in a system" (1995:24). Both of these elements may work either for or against an innovation's diffusion process. In addition to the patterns which occur in the system, there are specific positions that are taken on within the system. There are two major roles that occur in social systems, *opinion leaders* and *change agents,* which ultimately bring the innovation to the individual. These are key roles to this discussion as traditional healers may serve to fill one, if not both, of these roles.

Rogers defines *opinion leadership* as the "degree to which an individual is able to influence other individuals' attitudes or overt behavior informally in a desired way with relative frequency" (1995:27). He states that, "Opinion leadership is earned and

maintained by the individual's technical competence, social accessibility, and conformity to the system's norms." (1995:27). As members of a community, traditional healers are often awarded the title of specialist, or health expert in the community, while at the same time those members of the community are very connected and rooted to their systems norms. Opinion leaders serve as excellent representatives of a system and are thus key members to influence when attempting to change or diffuse patterns within a system.

In addition to opinion leaders, social systems may also include *change agents*. A change agent is defined as an "individual who influences clients' innovation-decisions in a direction deemed desirable by a change agency" (1995:27). In this case, traditional healers who are engaged in traditional healer organizations may be labeled as change agents, more specifically, the leaders of the organizations. The change agency may be considered simply the traditional healer organization, or perhaps when broadening the scope of the social system, the agency may be the government, or multilateral groups such as the World Health Organization or UNAIDS. A more in depth discussion of traditional healers as opinion leaders and change agents will follow in Chapter Six.

Conclusion

Looking at the different elements of the diffusion model, including the *innovation* itself, *communication channels*, *time*, and *the social system*, it is apparent that the process of diffusion is a complex and yet fairly structured model. When discussing the current debate regarding the behavioral and the social paradigms, many researchers get caught up in looking at only one approach. With the diffusion of innovations approach, diffusion is explained using both the social system and individual behavior. Both are shown to be

interconnected and may have direct or indirect influence over each other. Thus, this model may be used to bridge the gap that exists in the current literature, and furthermore, may be used to explore ways in which change is occurring in Uganda. Finally, traditional healers may play significant roles in the process of diffusion in Uganda.

Throughout this paper, I have been looking into the recent debate in anthropology about Uganda's success in dealing with HIV/AIDS, and have been interested in at what level change is occurring. Furthermore, I have been interested in the role of traditional healer in this success. Following a review of the current anthropological debate regarding behavioral and the social paradigms in the context of Uganda, I have chosen the diffusion of innovations model to illustrate how information, drugs and services are provided to individuals though traditional healers and traditional healer organizations.

In the next few chapters I will further explore the Ugandan social system, specifically the networks that are involved in the provisioning of drugs, services, and information. I will then turn to a discussion of traditional healers and show how they are engaged in an effective practice which ultimately spans the various levels mentioned above. Finally, in Chapter Six I will return to the diffusion of innovations theory and discuss how this theory may be applied to the Ugandan social system and most importantly, demonstrate how traditional healers are applied to the model.

CHAPTER FOUR
A Social System

Through a complex system of communication channels, Uganda's social system is engaged in a process of diffusion of innovations that to date has shown to be successful in its rates of adoption of various innovations. This process has cumulatively led to a decrease in prevalence rates. As mentioned in the previous chapter, Rogers suggests that there are certain patterns which exist in social systems, including the social structure and communication structure. In addition to these patterns, there are certain roles that exist within the system, including opinion leaders and change agents. It is my suggestion that traditional healers and leaders of traditional healer organizations fill these roles, respectively.

This chapter explores Uganda's social structure and the communication channels which pave the way for the innovations to flow throughout the system. Using examples from my research and a hybrid diffusion model to highlight the important roles of traditional healer and leader of traditional healer organizations, I will show how innovations diffuse throughout the Ugandan social system. First, I will look at the structure of the social system including the patterns and pathways and the individual components which make up the Ugandan system. This will include an analysis of the social network using the diffusion of innovation model and will suggest the type of diffusion system as well as communication channels that exists in Uganda. Next, I will describe in more detail each of the roles within the system, specifically those engaged in HIV/AIDS prevention and care.

There are two major types of diffusion systems outlined by Rogers (1995), *centralized* and *decentralized* systems. In general, the classic centralized system begins at the center point and diffuses out. This can be compared to a decentralized system "in which innovations originated from numerous sources and then evolve as they diffuse via horizontal networks" (Rogers 1995:354). However, in some cases, hybrid systems are formed (1995) which combine aspects of both, and may perhaps be more successful given the multidimensional approach. I suggest that this type of hybrid diffusion system may be the case in Uganda.

In general, centralized systems are more of a top down approach where perhaps the government or single agency is in control. Many times countries consist of centralized systems, particularly those poorer countries which depend on large donor agencies and multilateral and bilateral organizations like the World Bank. In these instances, when diffusion of an innovation is needed, control begins with organizations such as the World Bank and diffuses down to the people. In this system, individuals at the local level have little power. On the contrary, decentralized systems afford more power on the individual level and smaller localized systems. This type of system usually involves peer networks and other lower level networks. In some instances, individuals control their own diffusion system.

Rogers (1995) points out that decentralized systems are primarily utilized in situations where adopters are highly educated, or experts, or where the innovation is not complicated. An example of this might include health concepts, including condom distribution and disease awareness. Rogers argues that these types of innovations do not work well in decentralized systems and specifically states that "decentralized diffusion

systems for contraceptive innovations do not exist in Latin America, Africa, and Asia" (1995:369). He suggests, instead, that a more centralized system would be best utilized.

As part of its 1995 National Constitution, Uganda decentralized its health care sector. As a result, individual districts now tackle the role of various health programs, and services (WHO 2001; Pearson 2000). And the Ministry of Health is now "focused on providing technical support, supervision and monitoring, setting norms and standards, mobilizing resource and donor coordination" (Pearson 2000). This implementation came largely out of stipulations from the World Bank, as per loan requirements to Uganda for AIDS prevention (Green 2003b). Because of these changes, a "great deal of training and face to face AIDS education was going on at district and lower levels" (Green 2000). In general, the government has been extremely active in implementing and supporting district and other lower level programs.

According to a USAID case study (Green et al. 2002), a reported 700 agencies- government and nongovernmental- were working on HIV/AIDS issues through Uganda in 2001. As Pearson suggests above, the NGO sector is key in the health system. At the same time, Sandra Wallman points out that "Since 1986, most of the health resources have been used to support single focus vertical programmes, such as control of diarrhoeal diseases, and to rehabilitate hospitals and heath centres." (Wallman 1996:7). The condition of Uganda's social system looks to be somewhere in between controlled centralized programs and local decentralized programs.

Everett Rogers would describe this type of system as a "hybrid diffusion system [that combines] a central-type coordinating role, with decentralized decisions being made" (Rogers 1995:369). I consider Uganda's system, in which drugs, services and

information are disseminated, a *hybrid diffusion system.* Furthermore, I believe the key to Uganda's success in dealing with the HIV/AIDS epidemic is this hybrid diffusion system. In Uganda, multiple players serve as the central role, from which patterns of relationships diffuse to the level of the individual. Yet, at the same time, there is a great deal of local initiatives like traditional healer organizations. Thus, a merger of the two systems working together can be seen to form a holistic and exceptional method of providing information drugs and services.

Figure 4.1 and Figure 4.2 depict Rogers' centralized and decentralized diffusion systems (1995:367). In Figure 4.3 I have incorporated the two systems to illustrate a hybrid model of the Ugandan system.

Figure 4.1. Rogers' Centralized Diffusion System

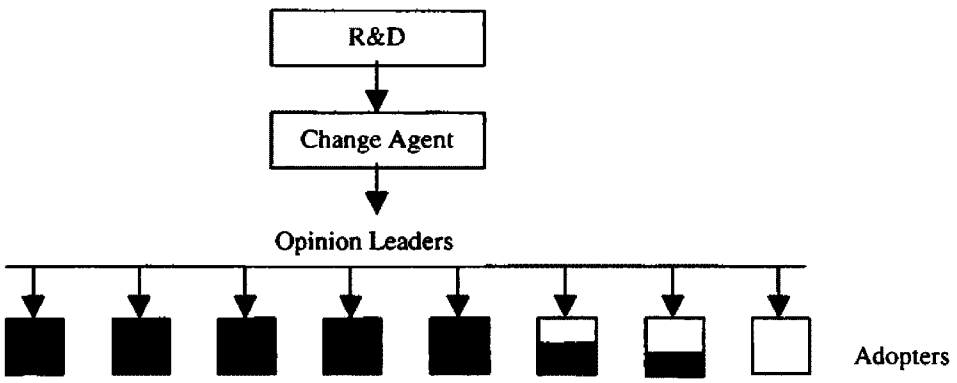


Figure 4.2. Rogers' Decentralized Diffusion System

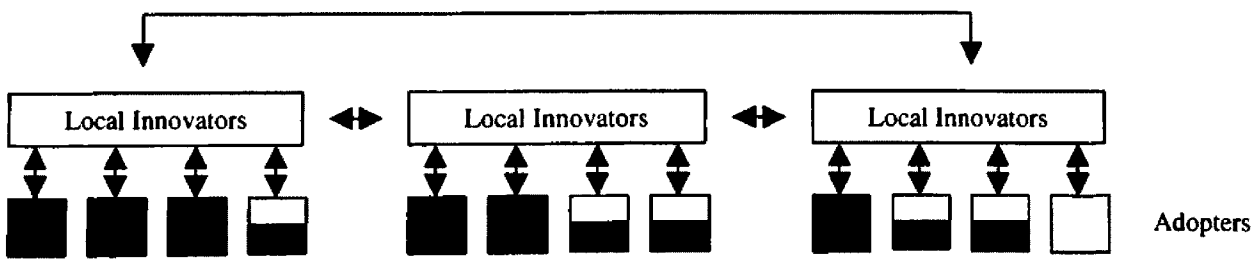
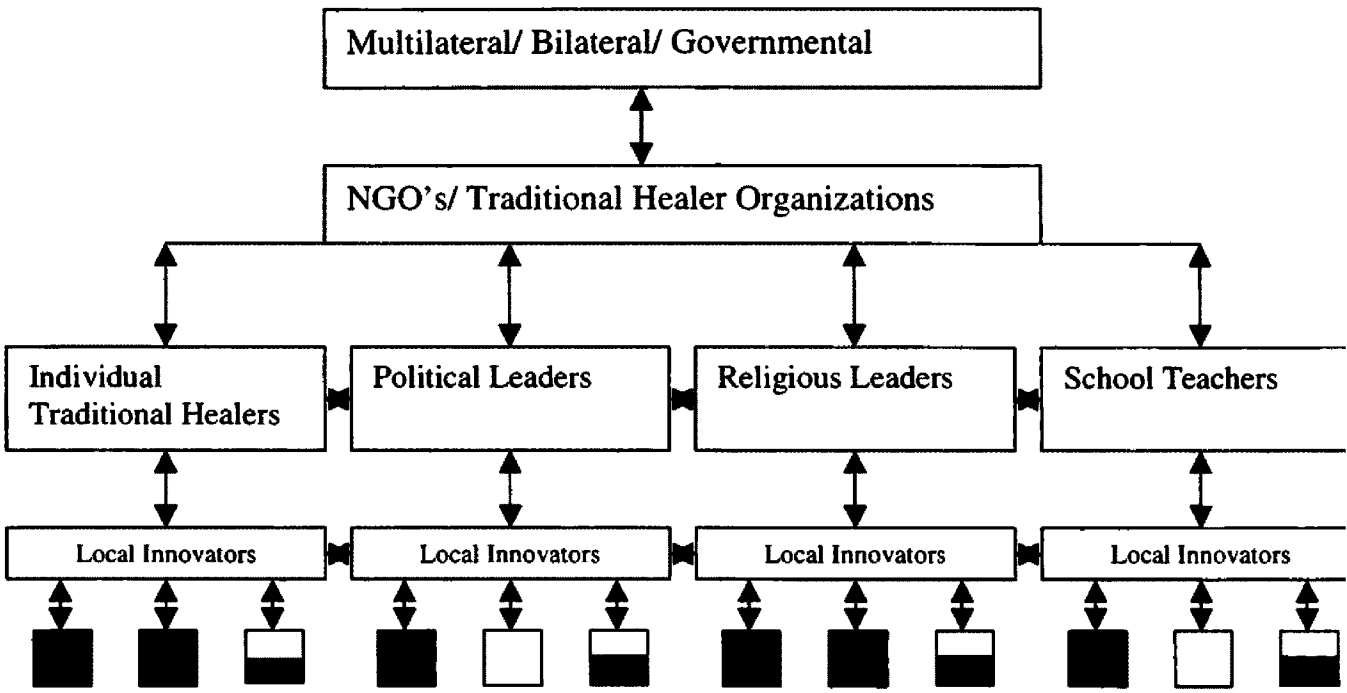


Figure 4.3. Possible Hybrid Diffusion System as Seen in Uganda



In the first two figures, presented by Rogers, various roles may be inserted. For instance, R&D (research and development) may be replaced with governmental or donor agencies. Change agents, opinion leaders, and local innovators may be replaced with various leaders of communities (including traditional healers), or individual community members themselves who show particular receptiveness to the innovation. In both systems, the flow of diffusion ultimately reaches the individual adopters, who may immediately adopt the innovation, as indicated by the blackened squares, take some time to adopt, as indicated by the half blackened squares, or not adopt at all, as indicated by the blank squares.

Notice in Figure 4.1 that all innovations flow in one direction, from the top down. In this type of system, decisions regarding innovations, as well as management of the flow of the innovation come from "experts", usually those in positions of power (Rogers

1995). Recalling the debate, this model may show Farmer's impression of power and inequality. In in-equalitarian societies, as in this model, power clearly resides at the top. In addition, this model may also clarify Farmer's statement regarding the importance of changing the behavior of the powerful. Theoretically, a change in the top position would then be diffused throughout the system, eventually reaching the level of the individual.

Figure 4.2 represents a different type of system in which power is shared among all members of the system. This includes much more localized programs, and involvement of local individuals. This system is applied when localized problems arise, and individuals themselves seek and create innovations (Rogers 1995). A decentralized system includes local innovators and adopters, whereas local innovators were the first adopters within the system. Rogers points out that local innovators (in Figure 4.2) are often mistaken for opinion leaders (in Figure 4.1), however the differences reside in the fact that "Opinion leaders have followers, whereas innovators are the first to adopt new ideas." (Rogers 1995: 354). In other words, opinion leaders are already established leaders in the community, versus innovators that are regular community members.

Figure 4.3 shows a possible hybrid diffusion system, which may be seen in Uganda. This system reflects the decentralized programs describe above, while also recognizing that overall support and supervision do come from the top, including multilateral, bilateral and governmental organizations. NGOs and traditional healer organizations represent the change agent role, serving as mediators between the top roles and the ones found below. Individual healers, school teachers, political and religious leaders all serve as opinion leaders in this model. They provide the pathways between the opinion leaders and local innovators and individual adopters. The crucial aspect of

this hybrid model is that it "[combines] a central-type coordinating role, with decentralized decisions being made about which innovations should be diffused" (1995:369). Furthermore, power is shared on multiple levels of the system, including the lower levels.

Governmental/Bilateral/Multilateral

Uganda's President, Yoweri Museveni, has been praised for his political support in dealing with health care and the HIV/AIDS crisis. With political emphases geared towards reducing stigma, as well as increasing aid and education, the government has done a lot to change HIV/AIDS in Uganda. Last summer, as part of his seven country tour of Africa, President Bush traveled to Uganda. While there, Bush praised Uganda and Museveni for "working to remove the stigma of AIDS and aggressively pursuing a program that includes drug treatments, as well as promoting abstinence, condom use and education about the disease" (Stevenson 2003:A4). This notion is similar to other international praise and recognition for the country and the government.

Museveni's approach to the nationwide problem included the launching of a national awareness campaign which involved face-to-face communication and the implementation of the various levels of opinion leaders. Most importantly, Museveni's approach, unlike others in Africa (Green 2003) focused more on a decentralized system, and on the local community level. Beginning primarily in October 1986, Museveni established an AIDS Control Program. This was considered "the first of its kind in the world" according to a World Bank Study. This included the organization of international donors and other governmental groups like the Uganda AIDS Commission which was set

up in 1990. The World Bank Study outlines a few of the major tasks which have been taken on by such governmental organizations:

- Development and distribution of guidelines for AIDS prevention and control
- Increase in the number of personnel trained to plan, implement, co-ordinate and undertake research related to HIV/AIDS
- Ongoing multi-sectoral approach to planning HIV/AIDS activities
- Establishment of national and regional networks related to HIV/AIDS for PHAs, Law and Ethics, Youth, Traditional Healers and AIDS Service organizations
- Establishment of a legal framework for co-ordinating the national AIDS control programme
- Establishment of research institutions related to HIV/AIDS such as the National Blood Bank and Joint Clinical Research Council (Republic of Uganda, 2000) (Hyde 2002)

Large donor organizations, including multilateral and bilateral organizations, like The World Bank, USAID, UNAIDS, and The World Health Organizations (WHO), play a major role in research and development in Uganda, and other African nations. While it is apparent that these organizations have a major focus on condom promotion (Green 1999), they have also served as genuine supporters in tackling the AIDS crisis. In addition, they are supporting a great number of studies throughout the country which have led to increased awareness of models that work, and those that do not work. These studies examine the role of behavior change, condom distribution, involvement of religious groups as well as a number of other things. To further increase the diffusion of knowledge, most all of these reports are documented online and are accessible to the general public.

As mentioned in Chapter Two, despite Museveni's initial reluctance to include condom promotion, it has now become a part of the Ugandan model. Mostly due to

outside donor funds coming into Uganda, in 1992 Museveni changed his program slightly, including an increase in condom promotion (Green 2003b). It is interesting to note the influences of these donor agencies, and at the same time, question their ability to assume what is right for a nation not their own. Green (2003b) notes that many programs which have focused around primary behavior change (like the ABC program) have since diminished due to an increase in dependency of outside donor groups (like UNAID). He argues that current Ugandan programs are beginning to resemble those of other African countries, for instance the promotion of condoms. While in the country myself, I was never directly confronted with the ABC program. I saw no billboards, radio or TV announcements, nor did any informants address the program. However, when I asked about the program, informants confirmed their understanding of the ABC.

Museveni's program, despite the involvement of international agencies like the World Bank and WHO, is still primarily in control of how certain funds are spent, and thus a certain degree of the programs that exist. By involving individuals within the country, the organizations were more equipped culturally to serve the people. Green suggests that: "It appears that these [district health officials] had a better idea—certainly than foreign donors—of what was needed, what was feasible, and what had worked to date in prevention." (2003:155). Working together, the Ugandan government, bilateral, and multilateral organizations, are involved in funding, planning and overseeing various programs of innovation within the Ugandan system.

NGOs and Traditional Healer Organizations

At the local level, there has been an increased emphasis on community leadership, including the education and training of opinion leaders and change agents. Green points out that "this seems to have resulted in the awareness and subsequent involvement in AIDS education of not only health personnel and traditional healers as well as traditional birth attendants, but influential people normally not involved in health issues, such as political and religious leaders, teachers, traders, leaders of women's and youth associations, and the like" (Green 2003: 174). There is always a limit to what a government can accomplish, especially given monetary constraints, as is the case in Uganda, as well as many developing countries. This need has prompted the activation of roles such as NGOs and those mentioned by Green above.

The level of NGO and Traditional Healer organizations found on Figure 4.3 includes various groups that work within Uganda. Green points out that there are over 1,100 NGOs (Nongovernmental Organizations) and CBOs (Community Based Organizations) in Uganda (2003b). NGOs in Uganda organizations both large and small, international, national and local.

Beginning in 1987, The AIDS Support Organizations (TASO) is one of the most significant NGOs in the country and was included in President Bush's visit to Uganda. In a report titled "HIV AIDS Education in Uganda: A Window of Opportunity", Hyde et al. illustrate the message of TASO as follows:

> The TASO slogan of "Living Positively with AIDS" is a call to everyone in society, infected or not infected. It calls on those infected to live responsibly with the HIV infection and to face up to the infection as a starting point; to recognize their responsibility to society, the responsibility to retain the amount of virus they have in their blood, and not to spread it around to others; to look after themselves better; and to

> remain actively involved in society. It also calls upon the rest of the community to support people infected with HIV. It calls on the uninfected or those who don't know that they are infected, to accept people with AIDS, to recognize that one cannot catch AIDS through casual contact. Acceptance of people with HIV/AIDS within the community is a very important starting point for dealing with the problem. (Hyde et. al. 2002: 18-19)

This statement reflects TASO's involvement in making individuals within their community responsible for their own protection and care. At the same time, TASO is involved in assisting them in this task. In addition to education and care, they are focused on reducing stigma, which may in turn increase overall awareness of the disease.

Some traditional healer organizations are also considered to be NGOs. I define traditional healer organizations as those engaged in the promotion of traditional healer practices, collaboration between healers and allopathic healers, as well as providing education and standardization of traditional healers. In Uganda, especially in Kampala, traditional healer organizations have become well-established among communities.

Traditional healers in general are important to the diffusion of information, drugs and services, in that many individuals rely on them as health care providers, as well as community leaders. Green provides a statement from Professor John Rwomushana, a member of the Uganda AIDS Commission:

> Through mutual education and training, Traditional Healers have been successfully involved in HIV/AIDS prevention through community mobilization, care, counseling, social support and research. They are encouraged to use their own traditional approaches and methods. Collaboration, rather than integration, strategies are applied in joint interventions. (Green 2003b:201).

Rwomushana's description of the traditional healer's role shows that traditional healers are engaged in various aspects of community health care ranging from prevention, to research.

Several NGOs in Kampala are actively involved in promoting the type of traditional medicine mentioned above. I had the opportunity to meet with two of the major recognized organizations in Kampala: Promotion des Medecines Traditionnelles (PROMETRA-Uganda) and Traditional Healers and Modern Practitioners Together Against AIDS (THETA). Both of these organizations have established a successful approach to meeting the needs of the people, as well as combating the difficulties of HIV/AIDS. What follows is an introduction to these two organizations, representing significant NGOs engaged as change agents within the diffusion system. A more in depth discussion of the organizations' roles will occur in Chapter Six.

PROMETRA- Uganda is an affiliate of PROMETRA International. PROMETRA is engaged in strengthening and promoting traditional knowledge. In addition, their vision is to have a healthy and informed population (Personal Communication 2003). PROMETRA-Uganda is engaged in a variety of activities which are aimed at improving the community's health. Much of their work is geared towards research and training. Training involves demonstrations and practical lesions. Research includes investigation of certain treatments, for example, the making of HIV-medicated vaseline and anti-malarial drugs. In addition, PROMETRA is actively engaged in collaboration, not only among local traditional healers, but also with the government, research organizations, other NGOs (such as THETA).

I was impressed with PROMETRA's active role in Uganda. One of their major programs is a traditional healer association called PROMETRA BUYIJJA. PROMTRA Buyijja is a "training forest centre" (personal communication) which meets weekly in Buyijja, a village some 60Km out of Kampala. The association is a group of traditional healers who collaborate together in order to increase their knowledge concerning traditional medicine. Traditional healers travel from many villages to meet in the PROMETRA training center and take part in the association's weekly classes. In addition to this association, PROMETRA has become involved in part of the design process in setting up Nakasee University in Luwero. In addition, PROMETRA has developed a training model (FAPEG), which is geared towards training about prevention of sexually transmitted disease and HIV/AIDS and infant oral re-hydration and natural family planning (Oladele 2003, PROMETRA website).

THETA, a second NGO in Kampala, believes that "building viable partnerships between traditional healers and biomedical health workers is the most culturally appropriate and economically sustainable way to create more universal access to STD/AIDS prevention, care and support" (THETA 2004: website). In addition, THETA's mission looks "towards improved health care and health promotion in partnership with traditional healing systems, biomedicine and the larger community". Established in 1992 by Doctors Without Borders and The AIDS Support Organization of Uganda, THETA recognizes the "cultural roots" of traditional healers as well as their vital role in the community (Engle 1998; Green et al. 1998). THETA began with a clinical study comparing traditional herbal treatments and modern medical treatments in two groups of 500 AIDS patients (Engle, 1998). In addition, THETA conducts

workshops throughout Uganda geared towards sharing knowledge of both modern AIDS prevention and traditional herbal medicine. Its success has led to continued involvement with traditional healers, and subsequently noteworthy training and education in HIV/AIDS care, as well as the collaboration between traditional and non traditional care providers (Green et al. 1998). THETA's outreach efforts in training and education have reached 10 districts across Uganda. THETA also Tracks and evaluates treatment in HIV patients who have used herbal medicines and traditional healers (Burton and McCarthy 1999), which has led to an increased awareness of these treatment options. Finally, THETA calls for "a mutually respectful collaboration between traditional healers and conventional health practitioners in the fight against AIDS and other diseases" (Engle, 1998), which in turn has created an improved and more open relationship between traditional and allopathic healers in Uganda. In sum, THETA has proved to be an important organization in the community both for traditional healers and the community at large.

Both THETA and PROMETRA have been successful in their implementation of programs which are engaged in diffusing information, drugs and services, especially in the context of HIV/AIDS. In addition, both PROMETRA and THETA are recognized and supported by governmental and international organizations such as the World Health Organization, the National AIDS commission, UNAIDS and others (Bodeker et al. 2000; Nakyanzi 1999). While governmental and international organizations have served the role of research and development as per Roger's model, TASO, THETA and PROMETRA further diffuse the information to local opinion leaders and their communities.

Traditional Healers and Other Opinion Leaders

Opinion leaders are located below change agents on the diffusion model shown in Figure 4.1. Despite their location towards the bottom, opinion leaders are some of the most important individuals within the system. These individuals include, but are not limited to: individual traditional healers, political leaders, religious leaders, and school teachers, as shown on the hybrid diffusion model in Figure 4.3. Opinion leaders often receive information and assistance from other roles within the system; however, they also may create or modify their own methods of implementing behavior change in their promotion of an innovation. Opinion leaders may also be adaptors who have been influenced by others in the network, and are then able to reach a larger number of individual adopters in both culturally and socially meaningful ways.

School teachers are significant innovators in that they reach out to individuals beginning at a young age. Because of this they are able to teach the importantance of understanding HIV/AIDS and certain behaviors that will lead to possible transmission of the disease early in a child's life. HIV/AIDS education has been implemented in the Uganda schools since 1987. According to Green, this initiative began through the School Health Education Program (SHEP) and was supported by a Swedish AID agency (SIDA), Danish AID (DANIDA) and UNICEF (Green 2003b). However, in study conducted by Hyde et al. assessing the HIV education sector in three countries (Uganda, Malawi and Botswana) found that in Uganda there was actually very little mention of HIV/AIDS in the curriculum and for the most part, schools relied on outside sources (like TASO) and to provide the students with AIDS information. This study suggested improving the education and skills of the teachers as well as enhancing the curriculum. (Hyde et al.

2002). Hyde et al. show the overall importance of teachers as opinion leaders. It also sheds light on the fact that there is still a large gap in the education system regarding HIV/AIDS education.

Religious leaders are also recognized as influential innovators within the diffusion system. A UNAIDS case study in 1998 showed the importance of the role of religious leaders in diffusing HIV/AIDS education. This case study acknowledged the Islamic Medical Association of Uganda (IMAU), which by 1998 had already trained 8,000 religious leaders, cumulatively reaching over 100,000 families in 11 districts (UNAIDS 1998). Those figures are outstanding, especially considering the small percentage of practicing Muslims in the country (see Chapter One).

> Research carried out by IMAU in their project areas found a similar trend. A follow-up survey in project areas showed that two years after IMAU began their AIDS education effort, community members showed a significant increase in correct knowledge about HIV transmission and methods of preventing HIV infection.
>
> The survey also found changes in high-risk behavior, showing a significant reduction in sexual partners among respondents under 45 years of age and a significant increase in self-reported condom use. (UNAIDS 1998:9)

This study reflects the value of training and utilizing religious community leaders. In addition, it provides results of the leader's work, showing changes in individual sexual behaviors.

The same UNAIDS case study also reported that religious leaders in Kampala are trained by an organization known as The Community Action for AIDS Prevention Project or CAAP. This organization is engaged in training local religious groups as well as market vendors and taxi drivers. These people then pass on information to their clients (1998: 22). At the time this report was issued in 1998, CAAP had reached 19 mosques,

29 Catholic and Protestant churches, four born again churches, 16 local council parishes, one group of boda boda (taxi bikes) boys, and one group of market vendors. Considering the information was further diffused via their particular religious organizations and work channels, this method appears successful in disseminating knowledge throughout communities.

Political leaders can also be considered opinion leaders. The Uganda AIDS Commission website describes the role of political leaders in Uganda as follows: "The role of elected political leaders in the fight against HIV/AIDS cannot be underestimated. Besides ensuring a conducive policy environment for implementing national priorities and resource management, members of Parliament have a role to play in mass mobilization and sensitization against the epidemic." (Uganda Aids Commission: website). While some political leaders may fall under the government sector, others may serve as local opinion leaders. These roles range from leaders in parliament the Ministry of Health, and the Ministry of Agriculture, to name a few.

One aspect of HIV/AIDS care political leaders are focusing on is the integration of traditional medicine, as well bridging collaborative methods between traditional and modern medicine. When in Uganda, I spoke with the Deputy Director of General-Research for the National Agricultural Research Organization (NARO). NARO was set up in 1992 and is comprised of various governmental ministry research organizations. This program is primarily focused on agricultural research; however, as AIDS has touched every aspect of every life in Uganda, it has touched the agricultural sector as well. The deputy director stated that in previous years HIV/AIDS was seen as a health issue, but now it has become more of a socio-economic issue. His organization is

engaged in introducing new technologies which will benefit local communities. Many of these technologies are geared towards determining which crops will provide nutrition and medicines for those who cannot afford the expensive medicines[2]. Programs like this, and other grassroots governmental programs, provide ways in which information, drugs and services can reach access the people. At the same time they are close enough to the community that they are able to identify and respond to the needs of the people, whether that be the implementation of certain crops, chickens, or schools.

Traditional healers also serve as opinion leaders. In a country where many individuals are not able to access modern health care, the traditional healer may be the only option. In addition, traditional healers are often the preferred option over Western medicine, as they provide culturally meaningful approaches. Individual traditional healers play a fundamental role in Ugandan culture through which information, drugs and services are provided to the people in their communities. Traditional healers who undergo training and collaborative partnerships with organizations such as PROMETRA and THETA become even more beneficial to the community. After training, they possess more accurate knowledge about HIV/AIDS, as well as additional methods of treatment, care, and prevention. There are a variety of reasons traditional healers are thought of as effective primary health care providers, which will be discussed in detail in the following chapter. Most important to this discussion, traditional healers have access to and are accessed by the majority of Ugandans, and because of this, they play a significant role as opinion leaders. At the same time, while engaged in training programs such as those set

[2] NARO, as an organization itself is an excellent example of a smaller scale hybrid diffusion system. With an emphasis on research and development, including a variety of "experts", the program also focuses on direct contact with research staff and community members to "ensure that technologies acceptable to farmers are identified, developed and disseminated." (NARO website). For a more detailed summary of NARO see their website.

up by THETA and PROMETRA, they are engaged in sharing knowledge with each other. They also offer the opinions and views of the people in their communities, when sharing knowledge with change agents, the government, and international organizations. Thus, information regarding individual community members diffuses upward and throughout the system, as the model of the hybrid diffusion system suggests. As health care providers, traditional healers play an additionally important role as opinion leaders. A background on traditional healers will follow in Chapter Five, and the diffusion of innovations theory will be applied to traditional healers in Chapter Six.

Communication Channels

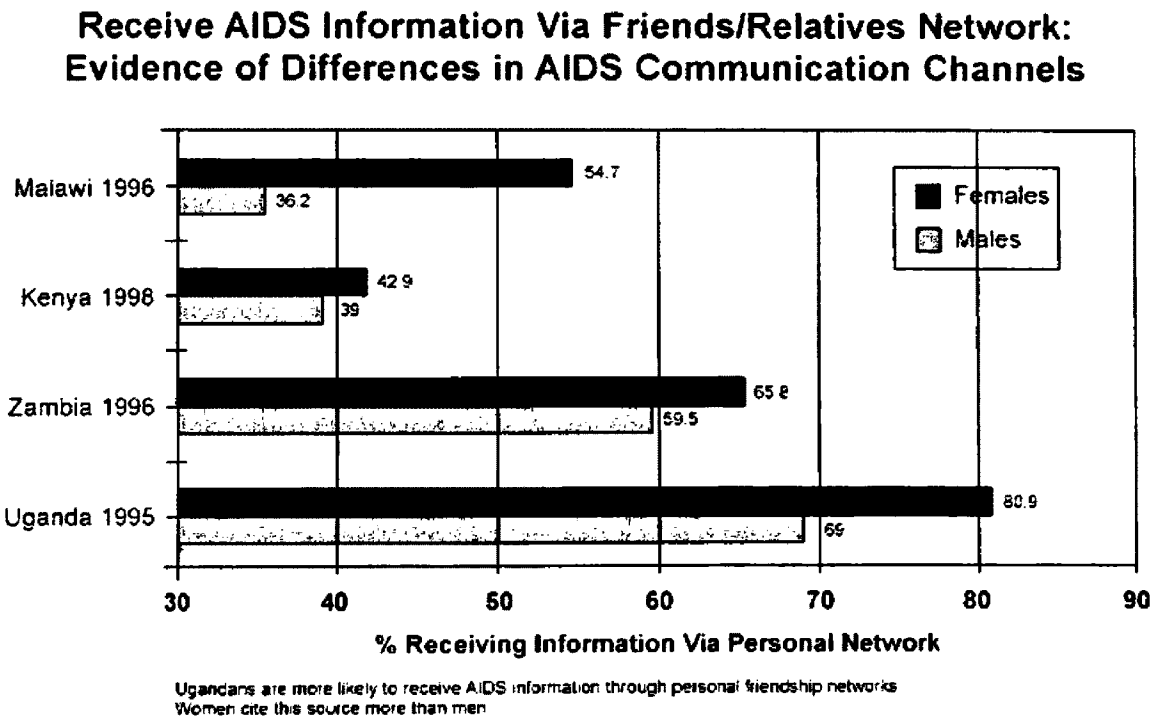
Using Rogers' diffusion model (1995), I have outlined important roles that appear in Uganda's diffusion system. I turn now to the communication channels that exist to diffuse such innovations. As mentioned in Chapter Three, communication channels are the pathways which connect individuals within the social system. These channels may involve public or personal approaches, both of which are used. Public approaches include mass communication like television and radio. Personal approaches include more face-to-face communication, for example, traditional healer-to client information sharing. I suggest that the use of multiple systems has added to Uganda's success.

A USAID report on "The ABCs of Prevention" showed that Uganda was unique compared to other African countries in methods of disseminating knowledge.

> As the acceptance of partner reduction in Uganda occurred before interventions such as condom promotion, social marketing, and VCT were implemented, the country's success appears to have taken root from the behavior changes motivated by this communication-based, community-level response to the epidemic. (USAID 2002:3)

This statement, followed by Figure 4.4, which shows the percentage of females and males in four African countries who receive AIDS information via personal networks, suggests that in Uganda, changes in sexual behavior seem to be a result of the personal face-to-face information sharing which occurs in personal communication systems. Notice on this graph that Ugandans had the highest percentage of both males and females who received information from friends and relatives. Due to Uganda's success, it may be suggested that receiving information through personal communication channels via face-to-face communication is a successful method of communication.

Figure 4.4. Information Received Via Personal Networks (USAID 2002:3)



Public, mass communication channels are also operating in Uganda. Green notes that "The USAID funded DISH project in the latter 1990s feels that its radio campaign has also been able to directly motivate behavior change, especially condom adoption." (Green 2003b:200). While mass media channels are not as personal, they are still able to

reach community members and, as Green mentions, affect behavior change. But what might be the most effective model is one which includes both types of channels.

"The ABCs of Prevention" report mentioned above also mention that "The role of mass media should not be overlooked. Interpersonal communication may act as a catalyst for individuals to absorb mass media messages." (USAID 2002:6). In other words, through mass media, an idea or general knowledge is introduced to an individual, then through personal communications, for example with traditional healers, individuals are more familiar with the ideas regarding HIV/AIDS.

Conclusion

Using Rogers' diffusion of innovations mode, I have shown certain patterns which exist in the Ugandan social system, including the social structure and communication channels. In the social system of Uganda, there are various roles that exist such as opinion leaders and change agents. Uganda's social system includes active participation from all levels including outside international organizations, as well as governmental leaders and programs, and a wide variety of NGOs. In addition, Uganda has a complex system of opinion leaders including the important role of traditional healer. Through various communication channels, public and personal, these individuals are involved in providing a successful diffusion of information, drugs and services.

CHAPTER FIVE
Traditional Healers

Traditional medicine, and traditional healers themselves, bring with them much controversy, and their place in the social system in which they provide services, drugs and information is often questioned or overlooked. Reflecting on my research of the literature, as well as my time in Uganda, I argue that traditional healers and traditional healers' networks provide an effective and culturally meaningful bridge that spans the various levels at which drugs, services, and information are available to individual Ugandans. Furthermore, I suggest that their role has had a positive effect in individual changes and successes in dealing with disease, specifically HIV/AIDS.

The role of traditional healer is a multifaceted role, in which various types of healers fit into an often times singular definition. My intent in this chapter is to provide a background of traditional healers and traditional healer organizations. This chapter first looks to deconstruct the notion of traditional healer, both in Uganda and throughout the world. Next, this chapter examines their overall effectiveness as health care providers. I highlight traditional healer organizations, as well as a few individual healers as examples of those involved in the Ugandan diffusion process. Finally, I examine traditional healers' notions of HIV/AIDS, and disease.

Deconstructing the Notion of Traditional Healer

This section is intended to provide the reader with a better understanding of what a traditional healer is. I will include the concepts of traditional healers as defined at the local level and international level. Both notions are important to take into account as

both are called upon when negotiating communication within a society's diffusion process.

According to the World Health Organization (WHO), traditional healers are defined as "those recognized in their communities as skilled and knowledgeable in the use of indigenous medications (herbal, animal, or mineral substances) and therapies (such as acupuncture and qigong) that are considered alternative or complementary in Western health care." (WHO 2003; in Giarelli et al. 2003: 40). Furthermore, the WHO defines traditional medicine as "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being" (WHO 2003). These definitions help to change outdated notions like witch doctor, towards ones focused on the use of the traditional healer as primary health care provider. I believe the newer language used to describe traditional healers connotes generally positive and effective practices.

> On the ground in Uganda, THETA defines a traditional healer as one who is recognized by his community and uses indigenous (native) knowledge that is handed down from generation to generation either orally or through spiritual means (communication with ancestral spirits usually through dreams, possession) to alleviate all forms of human suffering. (sic THETA, 2002).

This definition differs slightly from the umbrella definition provided by the WHO. The significant difference in this definition is that the healer must be "recognized by his community". I would suggest that this statement touches on one of the most important factors contributing to the success of the traditional healers in dealing with HIV/AIDS. I

would also suggest that their link to the community is as key, or perhaps even more so, than their treatment. Both the WHO and THETA's definitions address the notion of knowledge. The WHO places emphasis on a variety of treatment, whereas THETA's definition does not.

Throughout history, traditional healers have been romanticized, demonized, but above all else, utilized. Anthropologists often find themselves drawn to cultures which continue to practice age old customs, and who are thought of as "unchanged". The idea of "traditional healer" may bring up notions of unchanging customs. One image that might come to mind is that of an African healer wearing masks, throwing curses, etc. Traditional healers are often associated with mysticism, voodooism, and other romanticized notions. In addition, researchers of the past, primarily white Christian men, have demonized healers, coining them as 'witch doctors' and quacks. Using extremely value ridden language, as well as terms like 'superstitions', indicating the untruthfulness of such practices and beliefs; such depictions have cast a shadow over a vital role in many societies. African governments themselves tend to be ashamed of such practices, Edward Green points this out in his research.

> African government officials tend to regard indigenous practitioners as a somewhat embarrassing anachronism, especially when dealing with donor organization officials or other outsiders. Traditional healers in particular project an image of the backward, the primitive, the heathen, even of the illegal. (Green 1988:1127)

In addition to this statement, Green also refer to misconceptions of traditional healers, this time indicating that anthropologists themselves often times fuel misconceptions and witchcraft stereotypes, even so far as to proclaim them, erroneously,

as "dangerous" (Green, 1999:18). These notions misrepresent the true traditional healer, as well as devalue the importance of their role in the primary health care.

In his book *Indigenous Theories of Contagious Disease,* Edward Green illustrates how many people feel about traditional healers. He quotes a clinician who had written in *Tropical Doctor:*

> The assumption that traditional healers should be included in counseling and encouraged to treat AIDS sufferers is where many of us involved in the war against AIDS would part company with Dr. Staugaard [who had suggested this]. We should not assume that we could work as a team with those among traditional healers whose world view is that there are no pathogens in the universe, and that AIDS is caused by a broken taboo perhaps having no direct relationship with promiscuity. The view of our traditional health workers is that everything is curable if the offended spirits are placated and the proper corrective applied. (Green 1999: 268)

This doctor reveals a largely debated view of healers' notions of disease, including the notions of disease and knowledge of treatment.

While allopathic doctors continue to be wary of traditional healers, traditional healers are beginning to refer their patients to a clinic or hospital if they feel they cannot treat the patient. I found this to be the case with most of the people I interviewed; in addition, some had been to a Western trained doctor at least once themselves. One woman pointed out, "I took problem, came back without it, how could I *not* like it?" (Personal Communication). While another informant mentioned that he had been treated by allopathic medicine before he became a healer, but now that he has become a healer (for the past nine years), he has not.

In a study of traditional medicine in Bulamogi county, Uganda, Tabuati et al. found that "Some [traditional healers] (50%, n=47) refer patients to hospitals for conditions they feel they cannot cure, or some [traditional healers] specialized in treating

spiritual conditions will treat the non-clinical aspect of a disease and refer the clinical conditions to biomedical workers" (Tabuati et al. 2003). These researchers also found that a small percentage of traditional healers reported hospitals referring patients to them. This study indicates an unbalanced referral system.

Why the lack of support from doctors? Some allopathic healers feel that traditional healers do not recognize that their treatments are not working until it is too late. This is "a frequent source of complaint from orthodox medical practitioners against traditional healers" (Anokbonggo et al. 1990). In addition, "A health official might be reluctant to put itself in the position of appearing to reinforce a belief in sorcery." (Green 1994: 17). Regardless, lack of support from the side of Western medicine has largely impeded collaborative work between traditional and allopathic healers.

Green argues that "undue focus on witchcraft beliefs and practices by anthropologists and others has not contributed to the incorporation of ethnomedical findings in public health programs...we are more likely to see health programs informed by ethnomedical research if we place more emphasis where it deserves to be: not on witchcraft beliefs—which is probably the area of least compatibility between indigenous medicine and Western public health—but instead on naturalistic understandings of contagious illnesses" (Green 1999:270). In other words, Green points out that we should move past an emphasis on the "harmful" practices of witchcraft, and the traditional studies of anthropologists. Instead we should focus on how traditional healers understand disease, what they are doing that is successful, and perhaps how they can be incorporated into public health programs (as have already begun).

Variations Among Traditional Healers in Uganda

Traditional medicine serves other purposes as well as treating specific diseases. There are various types of healers ranging from herbalists to bone setters. A study conducted by THETA (2002), showed that the main traditional healing practices in Uganda included those seen in Table 5.1

Table 5.1. THETA Research Showing the Main Traditional Healing in Uganda (THETA 2002)

Practice:	Percentage
Herbalist	42%
Spiritualists	44%
Bone setters	33%
Traditional birth attendants	12.3%

Notice the sum of percentages in Table 5.1 total above 100%. This is most likely due to the fact that many traditional healers view themselves as practicing more than one type of healing. For instance, I met with healers that were practicing spiritualists, but were also treating patients with herbal remedies. These individuals would fall under both categories.

When discussing traditional healers at any level, it is important to understand that not all traditional healers are the same. They range in age, gender, socio-economic and culture groups. Just as a traditional healer from India might differ from African traditional healers, due to the great diversity found throughout Uganda, as mentioned earlier, a great deal of variety among Ugandan healers occurs as well. In fact, even healers from closely situated villages may use different techniques, recipes, or even different methodologies in treatment and care of their patients. There are multiple practices, or specialties of traditional healing, just as there are specialties here in the United States (i.e. cardiologist, ophthalmologist, pediatrician). In addition, rural healers may be very different from urban healers. Located in densely populated areas, urban

healers are able to "set up shop" and access a larger client pool. Comparatively, rural healers, located in villages and other less populated areas, have more personal connections with their clients and may be more likely to accept methods of payment other than cash. What follows is an outline of the variations that occur among healers.

Herbalists

In Africa, more than 80 percent of the population relies on medicinal plants for its health care (IDRC 2000). This would indicate that the role of the herbalist is essential to the African population. I would compare the practice of herbalists to that of a pharmacist. They both work with various recipes and solutions, adding and subtracting ingredients, ultimately hoping to treat an ailment.

When observing the class of PROMETRA herbalists, I realized just how important it becomes for the healers to know the properties and uses of every plant in the forest. While walking through the forest, and receiving an introduction of each to the different plants, my research partner reached out to touch a plant. Our guide sternly said "please don't touch that, its poisonious [poisonous]". He explained that all of the healers there had to learn the different names of the plants and their uses, as some of them can be very deadly. As this instance demonstrates, herbalists have the important job of knowing which plants are effective, and which plants can be fatal.

Spiritualists

A second category of healer is distinguished as Spiritualists. Spiritualists are also known as diviners and are defined by THETA as those who "diagnose and treat patients

by spiritual and divination practices. Some of them use ancestral worship and report possession by a number of traditionally known healing spirits and deities. Their healing activities are usually performed by the healer as the spiritual mediator. They mainly attend to the psycho- socio-cultural issues." (THETA 2001:15) This seems to be a widely accepted description of spiritualists, and matches my observations from the field.

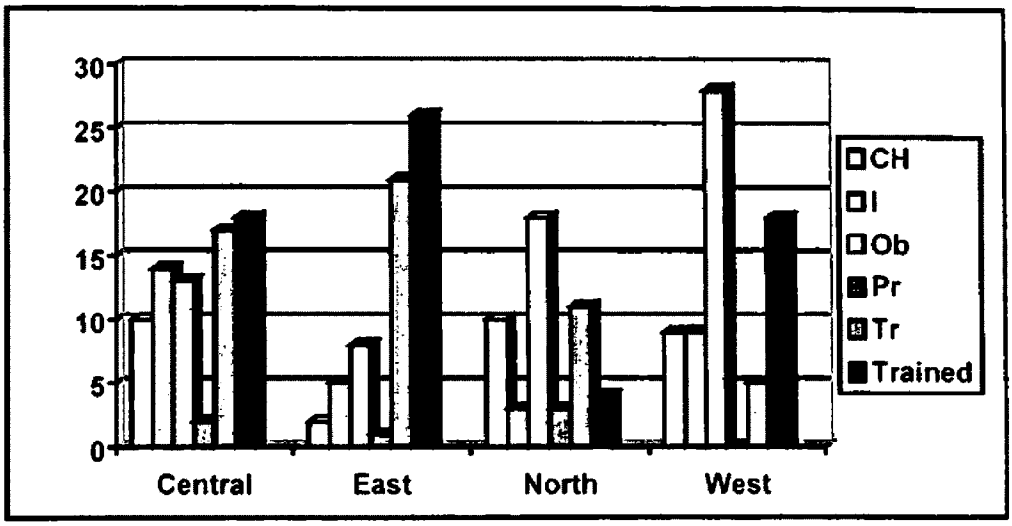
When I met with PROMETRA Buyijja in the forest center, I attended a meeting of the spiritualist class. When I arrived they were engaged in a discussion revolving around spirits and ghosts. I was asked if there were ghosts in my culture. Afterwards, a discussion arouse regarding the difference between being "sick in the head" (psychological problem) versus dealing with a spiritual being which possesses an individual. I was told that a spirit may paralyze someone until their family makes a sacrifice. Spiritualists deal with all of these problems (ghosts, psychological, and spirit possession). Because of their versatile practices and time spent with clients, if educated properly, spiritualists may play a significant role in the education of individual community members.

Just as there are variations in healer types, there are also differences in the processes of becoming a healer. Some healers are born into a healing family and later inherit the skills or practices. Others learn by working with another healer, or through their own observation (trial and error). Figure 5.1 was presented by THETA in a baseline study. This figure shows some of the ways traditional healers have begun practicing. This graph indicates that in the central region (where Kampala is located), many individuals become healers through training in the preparation of herbs. Becoming a healer after becoming ill and being treated is a second process widely seen in the central

area. Working alongside another traditional healer, otherwise known as apprenticeship, is not as commonly practiced in this region. Comparatively, a significant decline in trained traditional healers is present in the Northern region. In this region, learning through observation seems to be most common.

Figure 5.1. Processes of becoming a healer in Uganda (THETA 2001:17)

Bar graph showing the process of becoming a healer by region.



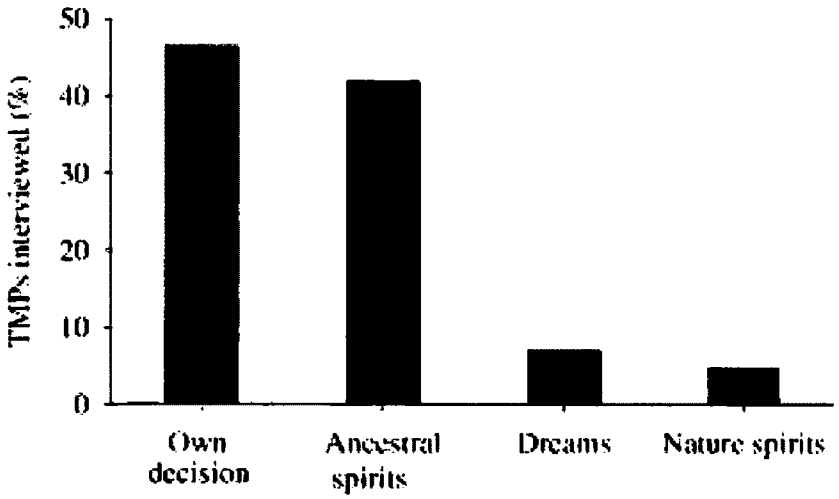
CH: Through Collecting herbs **Tr:** First became ill, was treated & became a healer
I: Inherited **Ob:** Through Observation **Pr:** Working alongside the TH
Trained: Trained to prepare herbs

Central: Kampala, Mukono & Kiboga **West**: Hoima & Mbarara
East: Moroto, Kamuli & Katakwi **North**: Apac & Adjumani

In addition to *how* individuals became healers, the other variable to consider is *why*. In other words, did they grow up knowing they would be healers, was it something that came to them in a dream, or did they become interested or in need of the practice? Figure 5.2 shows results from a study conducted in Bulamogi county indicating the various reasons, or why, traditional healers took up healing. This figure shows that in this county a majority of the healers have decided for themselves to become traditional

healers, this may be due to diseases encountered by family members, or simply have the desire to work with medicine. In addition, ancestral spirits are also a major cause traditional healers in Bulamogi have begun practicing.

Figure 5.2 Various Reasons for Becoming a Traditional Healer in Bulamogi County (Tabuti et al. 2003)



Below are a few personal stories that were shared with me that best illustrate the process of becoming a healer.

Profile
Males Moses

Males Moses is a 30 year old herbalist, currently the chairman of MAKOHA. Moses' father and grandfather were herbalists. His mother was a traditional birth attendant. Moses tells the story of how his grandfather was a hunter. His grandfather asked, 'Why can these animals do very well with out seeing a doctor?' He began to watch the animals and observe what they were eating. He noticed that they ate the plants that were healthy for them, or would treat any problems they had. He believed humans could do this too! Through observation, his grandfather became a healer for both people and animals.

Males Moses' story is an example of a traditional healer family. The grandfather began practicing traditional medicine through observation, and then passed down his knowledge through the generations. However, as Figure 5.1 indicates, this is not the only method of becoming a traditional healer. Another process is profiled below.

Profile
T/dr. Konde

T/dr. Konde, the chairman of PROMETRA Buyijja, received a calling to become a traditional healer when he was 7 years old. Years later, when he joined the army spirits told him to leave because he was involved in killing. In 1986 he finally became a healer. He studied with a 'jjaajja' or 'grandfather' [this is a term used for traditional healer, not necessarily a related grandfather]. According to Dr. Konde, you can't teach your own children, and you shouldn't learn from a relative.

T/dr.[3] Konde's story shows the importance of spiritual callings to become healers. This process was not addressed in either the THETA or Tabuti et al. study. Dr. Konde's story also shows that even those who receive callings need training. Dr. Konde's beliefs about who should train you differ from Moses' example regarding training by a relative. This highlights the fact that there is great variation among healers and their beliefs, even among those of similar cultural backgrounds.

Some healers grow up knowing that they will learn the practices of their relatives; however, to others it becomes something learned later in life, out of interest, or out of "calling" as mentioned above. A THETA report explains that some traditional healers are possessed by ancestral spirits. The report gives the example of a woman who stated:

[3] Dr. Sekagya specifically advised me to title Konde as "T/dr." which refers to traditional healer or traditional doctor.

"I met the spirit by the road side in the form of a woman. The spirit told me to invite her to my home. When we reached home the spirit disappeared and left only footprints. Since that day I have been possessed by certain spirits." (THETA 2002:19). Dr. Sekagya, the director of PROMETRA, who is also a medically trained doctor, said that he is a "dentist by training, traditional healer by call". He explained the process of his calling, which involved days of sickness. He learned that he must answer his calling and become a traditional healer. Another healer said that she did not receive a calling. She simply became interested in traditional medicine and received her training from "the director" [most likely she means she received her training from the weekly classes held by PROMETRA, which the director runs]. This woman's response appears similar to that of many allopathic doctors who first become interested in health and treatment, go for training (medical school) and then become healers.

Thus, I have outlined a few of the various categories of healers that reside in Kampala and the surrounding area. I have also shown ways in which healers begin their practice. Next I will discuss the legitimization of traditional healers, including their ability and authority to treat individuals in their community.

Legitimization of the Traditional Healer

As in any city, Kampala has its fair share of false healers. Wallman points out that in Kampala there is "a plethora of different categories of 'healer'-some legitimate, others charlatan" (Wallman 1996:114). I also met healers that were pointed out as not legitimate, and others which were most likely not true healers. It is difficult, though, to quickly recognize charlatan healers. Even the most experienced and well-respected

healer may look like any other man or woman on the street.[4] I found that the easiest way for someone like me to learn about a healer's legitimacy would is by word of mouth, and the same would most likely be true for local people as well.

Another method of determining legitimacy would be to ask to see a certificate. While the training and certification is not institutionalized (UNAIDS 2000), some traditional healer organizations have begun certification programs which demonstrates that healer has gone through training and are in fact true healers. Both PROMETRA-Uganda and THETA have begun training and certification programs. THETA began its training and certification program in Kampala. Because of its popularity, this program has since spread to many other districts. According to a June, 2002 UNAIDS case study, "by April 2001, nearly 1000 healers from seven rural districts had participated in a three-day AIDS awareness workshop, and nearly 300 traditional healers had gone through an intensive two year training and certification programme in STI/AIDS counseling and education" (UNAIDS 2002: 31). A typical THETA certification process includes: training, monitoring, evaluation, and follow up studies (2001). This training process occurs over a period of two years, following which THETA "holds a formal certification ceremony for healers, where community leaders are invited and healers have a chance to demonstrate what they have learned in the form of stories, personal testimonies, song, dance and drama" (2001:37)

These training processes may initially seem tedious and or unnecessary to the healer, as it is not required by law. But certification provides the healers, with "official" legitimacy and also with respect and ultimately higher value within their community. In

[4] Wallman provides an example of a traditional healer "clinic" where attendants wore white coats which "gave the impression that they were medically trained". (Wallman 1996: 123),

addition to legitimizing healers in the eyes of their community, these training programs also help diffusion of knowledge and skills to the traditional healers who later spread the knowledge throughout their community.

There has been an increase in promotion of collaboration between traditional and allopathic healers which helps legitimize the healers, particularly in the eyes of other allopathic healers and other researchers. Researchers and larger organizations have begun working on promoting traditional health practices, as well as incorporating methods used by healers into their own practices. The WHO has launched "the first global strategy" on promoting traditional or complementary/alternative medicine (TM/CAM) (WHO 2002b: online). This program will:

- develop national policies on the evaluation and regulation of TM/CAM practices:
- create a stronger evidence base on the safety, efficacy and quality of the TM/CAM products and practices;
- ensure availability and affordability of TM/CAM, including essential herbal medicines;
- promote therapeutically sound use of TM/CAM by providers and consumers

Through programs like THETA and the WHO, which are engaged in developing collaboration, education, and policy issues, traditional healers are becoming more recognized as legitimate healers. However, even with the support of allopathic healers, and local and international organizations, traditional healers must first be recognized as legitimate health care providers by the members of their own community (or client pool).

Wallman points out: "The WHO definition of legitimacy matches the popular Kampala version very closely. Both have confidence in a traditional healer who is recognized as such by local people and can be trusted to the extent that he or she is embedded in networks of local relations" (Wallman 1996: 114). In other words, a

legitimate healer is one that is recognized in its community as being effective. The next question to consider then is efficacy. The following section of this chapter outlines ways in which traditional healers are effective health care choices.

Efficacy

While many perceptions of health care are influenced by Western medicine, traditional healers still prove to be an effective and beneficial service in primary health care delivery in Africa (Green 1994), and beyond. This has certainly shown to be the case for Uganda. As Western medicine has been encroaching on less developed countries slowly, oftentimes researchers are perplexed at why individuals continue to see traditional healers while Western medicine is available. In this section, I point out four major reasons why traditional healers remain effective primary health care choices: *accessibility*, *economic constraints*, *homophily*, and *effectiveness* of treatments.

Accessibility

Research has shown that access to allopathic health is limited in most third world countries, especially in certain regions of these countries. Despite the resources found within Kampala, individuals who live outside of the city may have to travel great distances to access an allopathic doctor. Green showed in 1994 that there was only one doctor for every 20,000 people in the country. Comparatively, there was one traditional healer for every 200-400 people. More recent information suggests that there is only one allopathic medical doctor for every 10,000 people in urban areas, and only one doctor for every 50,000 people in urban areas (IK Notes 2003). In a base line study conducted by

THETA, statistical estimates show that "there could be as many as 150,000-200,000 traditional healers country wide" (2001). With a limited number of allopathic doctors available to third world countries, traditional healers are often the only option. Thus, location of healers is critical to receiving health care. Location, however, is not the only component of accessibility; economic resources often come into play regarding health choices as well.

Economics

Even for those individuals and families who do have local access to Western medical hospitals and clinics, there is a good chance that they are not able to afford treatments. The GNP for Uganda in July 2001 was $300 US. In addition, "46% of the population live below absolute poverty lines that is less than $1 per day" (WHO/AFRO, 2001: online). Consequently in countries like Uganda, the costs of health care can be quite burdensome and not easily attainable.

Raphael Ngong Teh notes that, "the most effective way of extending benefits without great cost is to use and develop local resources (Teh 1998). As Teh points out, in a country like Uganda, where the cost of foreign drugs is high, local traditional remedies are more affordable, and therefore more accessible. According to Dr. Amai, senior research officer at the National Chemotherapeutics Research Laboratory, in Uganda, "Herbal medicines are often free, or can be paid for in kind." (Personal Communication 2003). In addition to allowing for affordable services to the public, money or services stay within the local economy, instead of going to the big drug companies (outside of the local economy).

In heavily populated areas like Kampala, traditional medicine has become more competitive. However, this is not necessarily the case for more rural villages where treatment is more communal. In these instances, "treatment is nothing to do with money" (Personal Communication). Dr. Sekagya explains: "You are not competing for patients to come. It's not a business, traditional healers are not rich to any standards, they know they are not treating using their own energy. They are only messengers [from God] and the messenger does not own the message." (Personal Communication).

In the above statement, Dr. Sekagya describes a key difference between traditional and allopathic medicine, particularly allopathic medicine concerning large drug companies. T/dr. Konde supports this, stating that he doesn't look for money. He informed me that payment may come in the form of money; however, it may also come in the form of presents, perhaps a coat, or other items.

Some of the healers I spoke with had similar responses including one woman who primarily treats her family and neighbors. She offers her treatment for free, or she will show the proper leaves to use and the individual can treat themselves. A second man I spoke with treats roughly 10 patients a day. He said he usually receives money, however, if they don't have money, he still treats them and tells them to bring the money later. Wallman identified a variety of payment options, ranging from money only, to similar payment methods indicated above, as well as payments in the form of gifts. Wallman mentions one healer who said "she could not refuse to treat because of lack of money, especially when, as she put it, it is for the children of the Nation and the mothers cry..." (Wallman 1996: 131). This statement depicts not only an image of despair, but also one of compassion.

Interestingly, one of my key informants suggested that the "poor" have more access to traditional healers because they live in communities that have traditional healers, whereas, the "rich" tend to go to the hospital first, then later, they go back home to the village to see the traditional healer when they are ready to die. This healer's attitude is very similar to other attitudes I encountered regarding access to health care and the economic divide. I was told that many times "People who have money and education wait, and then its too late." (Personal Communication) It was explained to me that this usually happens to those living in the city and when they go home to their local healer, there is no hope in treating the problem. These statements from two different healers suggest that access to a traditional healer is considered important, and perhaps even advantageous. This seems to occur mostly with those living in the city. Then when they go home to their local healer, there is no hope in treating the problem.

Cultural Attachment

A paper titled *Bridging gaps between public and traditional health care sectors*, comments that "A health care system is socially and culturally constructed. It includes beliefs about the causes of illness, and norms governing choices and evaluation of treatment." (EC funded paper). With that in mind, there is also a certain level of cultural attachment associated with the use of traditional medicine. This concept is similar to the notion of homophily. As presented in Chapter 3, homophily refers to the degree to which pairs of individuals are similar in certain attributes, such as beliefs, values, education, social status and the like (Rogers 1995). Traditional healer systems are homophilious

systems which may be more attractive to certain populations, especially in traditional societies.

Wallman points out that "the importance of social/cultural values can outweigh monetary costs, and the choice of health practitioner depends upon the degree of homophily between the patient or treatment seeker and the treatment options available (Wallman1996: 113). In this case, traditional healers who hold similar beliefs and values of their patients, in addition to understanding the cultural practices which may affect treatment options, may be seen as the better choice by the individuals seeking the treatment.

Irwin Press notes that "cultural healing and symbolic manifestation of disease are characteristic of all human episodes of sickness" (Press 1982:181). In other words, in all cultures around the world individuals hold complex notions of disease. Healer/Client relationships function much better when the two have similar concepts of disease and are homophilious. This in turn, ultimately leads to better treatments. One of the most common examples of this is the notion of hot/cold treatments.

> If, for example, your patient believes that diarrhea is a "cold" disease, and that penicillin is a "cold" – and therefore inappropriate – medicine, then by dissolving penicillin in a "hot" substance (such as orange juice or chocolate), the ostensible exacerbating effects of penicillin's "coldness" can be moderated (Logan 1973). But this is a highly specific phenomenon. It may be meaningless to many Latinos who were raised with different hot/cold beliefs or none at all. (Press 1982:183)

Another example of differing cultural notions of disease is presented by Green et al. 1994), in the paper *The Snake in the Stomach: Child Diarrhea in Central Mozambique.* This paper explores ethnomedical notions of disease. Here, researchers found various notions of disease which included the belief in contamination, social disharmony, and

transgression of rules (including certain sexual behaviors). These concepts are mostly related to social events which occur within the society, thus disease becomes culturally tied.

In these instances, and countless examples throughout the world, doctors who do not understand specific cultural notions of disease pertaining to the culture in which they work may prescribe treatments that patients either do not understand, or will not take. This is often a result of different understandings of the disease. Misunderstandings, of both the healer and the patient, ultimately lead to ineffective treatment. Traditional healers usually treat patients from within the culture they reside in, and therefore already hold similar notions of disease. It is because of this homophily that traditional healers may by better able to effectively treat the patients.

Expanding on the importance of culturally meaningful treatments, the example of hot/cold healing beliefs is further explained by Price's explanation of symbolic healing. He states that "Every patient conceptualizes and expresses sickness in a symbolically laden manner. Every named and known disease comes equipped with an image and reputation that affects the sufferer's response in some manner or other." (Press 1982:180). In other words, Press describes the following: **conscious thought = symboling (a cultural act).** Press also suggests that half of the effectiveness of a given treatment is due to "general medical treatment" (i.e. symbolic recognition of the healing act), while the remaining half is due to actual active medication, thus: **treatment or "care" + medication = effective treatment**. (Press 1982)

Press' argument is reinforced by Raphael Teh's statement regarding treatment. Teh states that "The traditional medical practitioners have a deep knowledge of the

culture and they are very familiar with the cultural traditions, the fears and the wishes of their clientele, so they utilize such knowledge in their diagnosis and curative skills, in a form of psychotherapy." (Teh 1998). These forms of ethno psycho-social-therapy, usually accompanied with medications (often in the form of plants and herbs) together serve as effective treatment.

Efficacy of treatment

Another important reason patients continue to seek out traditional healers, regardless of location, cost, and cultural attachment, is fact that certain remedies are shown to be successful. Some of these effective results may be due to psychological reasons, as mentioned in the section concerning cultural attachment (i.e. if you believe a treatment is going to work, it may work). But scientific researchers are also beginning to see results in studies showing the positive effects of the herbal medicines. Unfortunately, the research has been minimal, and therefore lacking a great deal of support.

Currently, 25% of the modern medicines used by allopathic healers are made from plants traditionally used by healers (WHO 2003). In general this is due to the fact that certain plants have pharmacological properties, and thus provide beneficial remedial effects (Anokbonggo et al. 1990). This is also a major reason why traditional healers are distrustful of sharing their information, for fear of "selling out" their remedies to pharmaceutical companies (Personal Communication).

In my research I have found a variety of studies which serve as examples of effective herbal treatments from around the world. Table 5.2 represents some of these

examples[5]. Notice that many of the plants or herbs can be used to treat various symptoms. While sitting in on an herbalist class, with PROMETRA herbalists, one herb alone was discussed treating over 8 different diseases. The importance of the traditional healer is not only to know what plant to use, but then how to prepare and how to use it properly.

Table 5.2. Herbal Chart Showing Various Herbs Used to Treat Specific Ailments.

Country	Plant or Herbal Remedy	Use	Expanded Benefits	Source
South Africa	Sutherlandia	Treating AIDS patients	Traditionally used as a tonic, increases energy, appetite and body mass	WHO 2003
China	Artemisia annua	Malaria	Could prevent almost 1 million deaths annually	WHO 2003
Uganda	Nongo (mixed with other plant stems)	Bloody diarrhea	Can be mixed with shavings from another plant, and used for a hurt foot	Personal Communication
Uganda	Bananas	-Asthma -Antidote for poison -flue/colds -skin treatments -T.B.	There are just a few of the uses mentioned. Most uses require processing of the banana	NARO Bulletin 2001
Uganda	Maize	- respiratory illnesses - measles -body odor	Same as above	NARO Bulletin 2002a
Uganda	Cassia Sieberiana	-diarrhea - ulcers -toothaches	Same as above	NARO Bulletin 2000
Uganda	Cassave	-Measles -Asthma -T.B.	Same as above	NARO Bulletin 2002b
Uganda	Eutungo	-Paralysis -Dizziness -skin rash for babies -scabies	Same as above	Personal Communication

[5] Not all of these "effective treatments may qualify under the specific guidelines of the WHO in evaluating traditional medicine. See General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine, WHO/EDM/TRM/2000.1, WHO Geneva, 2000 to view these guidelines.

A study conducted by THETA examined treatment of an herbal remedy applied to Shingles (Herpes zoster), a virus associated with the chicken pox virus, and one often associated with HIV/AIDS. "The results suggests that herbal treatment offers an important local and affordable primary care alternative for the management of herpes zoster in HIV-infected patients in Uganda and that it would prove effective if used in similar settings." (Homsy et. al 2000: online) Additional studies like this are being conducted in Uganda by THETA, PROMETRA, and other organizations such as the International Development Research Center (IDRC) and the National Chemotheraputics Research Center, which is involved in research, development, and most importantly, paving the way for effective traditional medicine to be incorporated into the health care system.

Green points out that "even in the absence of evidence that the herbal medicines in use are effective against opportunist infections, or against HIV infection itself, we can see there is value in such treatment and advice to PLWHAs [People Living With HIV AIDs]" (Green 2003:135). Green brings up an interesting point that while we still may be lacking scientific evidence on specific herbal remedies, or treatments that may or may not "qualify" as effective yet, we as social observers can see the positive effects of traditional healers. These treatments are especially important now in the time of AIDS.

Traditional Healers Concepts of HIV/AIDS

Many traditional healers' explanations of STDs, HIV/AIDS vary regarding 'transmission' of these diseases" (King 2000). The varying explanations leads to one of the benefits of traditional healer organizations such as PROMETRA and THETA, and others which serve to promote knowledge-sharing among healers, make for more

educated and disease-minded healers. Despite efforts to educate traditional healers in matters concerning HIV/AIDS, questions often arise concerning their knowledge and understanding of HIV/AIDS. The concern is that if they do not understand HIV/AIDS, then how will they effectively educate and treat their clients?

A study conducted in South Africa in 1992 asked traditional healers questions about HIV/AIDS, including their knowledge, beliefs and practices. "The results indicated that many healers were somewhat knowledgeable about AIDS symptoms, HIV transmission patterns, and causes of the disease. Yet a majority didn't know if AIDS could be prevented, and 50 % maintained that AIDS could be 'cured by either traditional or Western medical treatments'" (Giarelli and Jacobs 2003:41) This lack of significant knowledge presents a problem for many people, especially allopathic doctors who are concerned that individuals seeking help from traditional healers are not receiving proper care and education.

Regarding disease diagnosis, Dr. Sekagya, the director of PROMETRA-Uganda, explained that the issue is not the *wrong diagnosis*, the issue is *can he treat it.* (Personal Communication). For instance, if a healer diagnoses a disease as "Disease A", and a allopathic healer diagnoses the same disease as "Disease B", but both doctors adequately treat the disease, then both were successful. Therefore, it should not be important that different healers treat patients in different ways, whether that be different healers from different cultures (Western or non-Western), or even two healers from neighboring communities.

Dr. Sekagya points out, however, that this difference in understanding becomes a problem between traditional healer and "scientist" when we are talking about HIV/AIDS.

He argues that "Really we are talking about the same thing, only understanding it differently." (Personal Communication) Often times when HIV is concerned, a Western doctor might say, 'there is no cure'. A traditional healer he might ask, 'what's your problem' (i.e. rash, fatigue, weight loss). In other words, Dr. Sekagya explains, "to a healer you are not a patient until you have an ailment, so if you have HIV but no problem, you are not a patient, so by the time you go to the healer for a problem you have AIDS" (Personal Communication. 2003). This example illustrates one of the reasons healer organizations are beneficial to the traditional healer community in that they educate traditional healers. But while traditional healers have become involved in learning allopathic concepts of disease, Dr. Sekagya wonders how much the doctors understand and accommodate the healers' views.

Dr. Sekagya addresses an interesting point. Communication also plays an important role in understanding traditional healer's concepts of disease, as well as properly training them. While in Uganda, I was reminded by my informants over and over again that the PROMETRA meetings were a sharing of knowledge, not Western doctors training traditional healers.

Scientific jargon will not work, nor will overlooking their notions of disease. A WHO article published a report on "Planning for costs-effective traditional health services in the new century", and discussed one of the challenges of moving beyond training, to information sharing. This article stated, "removing communication barriers such as these [scientific jargon] is a necessary first step in ensuring that training is an effective tool in mobilizing traditional health practitioners as partners in AIDS control" (WHO 2002a: online). The paper also presented a case study conducted in Brazil where

local "language, codes, symbols and images" (2002a: online), along side scientific medicine were used to present information about HIV/AIDS to traditional healers. The study found "significant increases in AIDS awareness, knowledge about risky HIV behavior, information about correct condom use, and acceptance of lower-risk, alternative ritual blood practices" (2002a: online). This study points toward the idea that what is most important in the diffusion of knowledge is not necessarily teaching new concepts, but sharing information in a culturally meaningful way.

Conclusion

This chapter has given a background into one of the most important roles in the diffusion of innovations model, the traditional healer. While not always thought of as a legitimate practice, traditional medicine has begun to show itself as an effective primary health care choice. This is especially the case in countries that have limited access to health care. Through collaborative programs, NGOs like PROMETRA and THETA are engaged in training and monitoring traditional healers in practices that concern HIV/AIDS and other health issues. These programs support traditional healers, who are then able to disseminate their learned knowledge and skills throughout their community. Chapter Six continues this discussion applying Rogers' model of diffusion to the traditional healer community.

CHAPTER SIX
Traditional Healers as Agents of Change

This chapter takes a more in depth look at the social structures within Uganda that utilize traditional healers. Chapter three presented the underlined theoretical approach to this research project. I introduced the diffusion of innovation model, as presented by Rogers (1995). Chapter four suggested a possible framework in which the diffusion model can be applied in Uganda, leading up to the important role of traditional healer. Chapter five looked at the general role of traditional healer, primarily in Uganda. Continuing the discussion of diffusion, in this chapter I will examine the role of change agent and opinion leader as they fit into the model. As examples I will include various case studies from Uganda and other countries in which traditional healers serve as change agents and opinion leaders. I use examples from other African countries to show that traditional healer organizations and traditional healers are important not just in Uganda, but in other social systems as well. In doing so, I intend to bring all of this information together to show ways in which traditional healers serve the important role as change agents and opinion leaders. Through a complex social system, these individuals are successfully involved in diffusing drugs, services, and information throughout Uganda. Ultimately, in this chapter I hope to show that traditional healers may be critical to understanding HIV/AIDS decline in the country. In addition, it is my intent to demonstrate that a great deal of behavioral change is occurring at the level of the traditional healer.

Change Agents

The change agent, as defined in chapter three, is one who influences other's decisions in a direction usually enforced or "deemed desirable" (Rogers 1995:27) by a change agency. Rogers stresses that "one of the main roles of a change agent is to facilitate the flow of innovations from a change agency to an audience of clients" (1995:336). As suggested in chapter three, certain traditional healers, or leaders of traditional healer organizations may fall under the category of change agents. Furthermore, the traditional healer organization may serve as the change agency from which the change agent himself serves. In the Ugandan model, the innovation the change agent is diffusing pertains to health practices, treatment and care. More specifically to this argument, the innovation refers to drugs, information and services regarding HIV/AIDS.

Figure 4.3 shows a diffusion model that may be applied to Uganda. Notice the level of NGO and Traditional Healer Organizations; this is also the level of change agent. Rogers outlines a sequence of seven roles of a change agent which occur throughout the innovation process. His roles are as follows:

1. To develop a need for change:
2. Establish an information-exchange relationships.
3. To diagnose problems.
4. To create an intent in the client to change
5. To translate an intent to action.
6. To stabilize adoption and prevent discontinuance.
7. To achieve a terminal relationship.

Traditional healers are engaged in these roles as change agents. Applying these roles to Rogers model, it can be shown that leaders of traditional healer organizations do in fact

undergo these roles. They first begin by helping individual traditional healers *develop the need to change* their behavior as related to HIV/AIDS. Next they help them understand the need to be more educated about HIV/AIDS in their community. In the next step, leaders of the organizations *develop relationships* with healers. This often takes place in the form of healer associations, like with PROMETRA, or in workshops, as THETA conducts. In addition to organization of these relationships and meetings, change agents must assess the situation, and *diagnose a problem.* Dr. Sekagya, a PROMETRA change agent stated that it is important to "understand their concepts, and fill in the gaps" (Personal Communication). This step includes extensive research and collaboration on the part of the change agent and change agency.

The following step involves *creating intent to change.* In this case the change agents seek to motivate their clients. I observed many methods of motivation, including songs and dances, which are later handed over to the healers to bring to their communities. Traditional healers are recruited and encouraged to take part in workshops and healer associations. Sometimes traditional healers seek out the assistance of these change agencies, perhaps to enhance their own skills, or possibly they have a family member or client who has a disease they do not know how to treat.

As agents of change move on to *translate intent into action*, the individual traditional healers themselves now begin the role as opinion leaders, and the change agent works indirectly through the opinion leaders (traditional healers) to reach out to communities. In this case it involves disseminating information about HIV/AIDS.

The last two roles involve *stabilizing adoption* and *developing a terminal relationship*. Traditional healer organizations that continuously meet, like PROMETRA,

allow for a steady knowledge base and serves to reinforce concepts already learned. However, healers may only attend these meetings for a short while, and it is the hope of the change agent, that these individuals have gained enough information to further disseminate knowledge on their own.

These examples illustrate how leaders of traditional healer organizations and traditional healers themselves may be applied to Rogers' model of change agent roles. Furthermore, they appear to be significant examples of change agents and opinion leaders. As healers will most likely always be culturally attached to their communities, the network of healers and healers themselves are important resources for providing drugs services and information.

Rogers states that in general, change agents are heterophilous (the degree to which two or more individuals who interact are different) (Rogers 1995:18). In most cases, a change agent is considered an "educated expert". Sometimes this role is filled by someone with masters or doctoral degrees. Rogers explains that "their superior know-how makes it difficult for them to communicate directly with clients. Accompanying their heterophily in technical competence usually is heterophily in subcultural language difference, socioeconomic status, and beliefs and attitudes" (1995:336). This trend is often seen in developing countries where outside developers, allopathic doctors or "experts" come into the country. In addition, Rogers states that

> change agents, even though they link the two systems, may be quite heterophilous in relation to both their client and to the technical experts in the change agency. This heterophily gap on both sides of the change agent creates role conflicts and certain problems in communication. As a bridge between two differing systems, the change agent is a marginal figure with one foot in each of two worlds. (Rogers 1995:336).

However, when the change agent is from within the same culture or group (homophilious), as is the case with most of the leaders of the traditional healer organizations, many of these communication barriers are resolved and communication may be enhanced. The problem or role conflicts may also be solved because leaders of these organizations are, in most cases, not only homophilous with their clients, or community adopters, but they also tend to be linked to outside "experts" or the R&D groups. Furthermore, they may even be considered "experts" themselves, as may are becoming increasingly involved in their own research and development, self-improvement, and policy implementation.

Another important aspect of the change agents' success includes empathy. Empathy is described as "the degree to which an individual can put himself or herself into the role of another person" (1995: 342). When the change agent comes from within the same culture as the client pool itself (as most traditional healers most often come from within the community they serve), they can more easily relate to the client's role than if they were outsiders. Rogers believes that empathy is positively related to change agent success (1995). If this is true, then the leaders of traditional healer organizations are positively related to success. Perhaps this is an indication as to why Uganda has been so successful in dealing with HIV/AIDS.

Three organizations are outlined below, THETA, TAWG and PROMETRA, which may serve as change agencies. The leaders of these organizations thus serve as change agents. In this section of this chapter I will show ways in which traditional healer organizations serve as change agencies, and leaders of these organizations become change agents.

Profile
THETA-Change Agency

THETA (Traditional and Modern Health Practioners Together Against AIDS and other diseases) was Established in 1992 by Doctors Without Borders and The AIDS Support Organization of Uganda. THETA is engaged in many activities focused around supporting the collaboration of traditional and modern health practices. THETA has become actively involved with the treatment and education of HIV/AIDS, primarily in the training of traditional healers. THETA conducts Workshops geared towards sharing knowledge of both modern AIDS prevention and traditional herbal medicine (WHO 2002), which has lead to successful diffusion of information in various directions. THETA's knowledge base has diffused to the level of the traditional healer, who then is able to take that information to the individual community member (as opinion leader). THETA has also provided research for traditional remedies that may treat HIV/AIDS symptoms. These innovations are therefore diffused upward, and horizontally throughout the system (see Figure 4.3).

THETA, as an NGO, serves as an excellent example of a change agency. Initiated by research and development groups like Doctors Without Borders and The AIDS Support Organization of Uganda, THETA has taken the lead in local community mobilization and facilitation of innovativeness. Through collaborative programs, THETA leaders have demonstrated to traditional healers the importance of change. Once healers have been through the program they hopefully have become knowledgeable enough to then pass on the information to their communities (as opinion leaders).

TAWG-C Profile
Change Agency

TAWG (Tanga AIDS Working Group) is a result of collaboration among traditional and allopathic healers in the United Republic of Tanzania, who had been collaborating together since the late 1980's. This collaboration led to respect and sharing of treatment, care, and prevention of HIV/AIDS patients (King 2000). TAWG currently works with another program (CHICC), which offers services and information regarding HIV/AIDS. Together, these programs target various opinion leaders such as "health care workers, teachers, students, workers in high risk areas and traditional healers" (UNAIDS 2002:23). A UNAIDS final analysis of the program indicated that individuals who met with trained healers reduced their "risky business" (2002:29).

The TAWG example illustrates a change agency's direct involvement with opinion leaders in local communities. Part of TAWG's initial strength may be contributed to its collaboration between traditional and allopathic healers. Its continued success is most likely a result of its focus on community and traditional knowledge. Both TAWG and THETA are examples of change agencies. PROMETRA is also a change agency involved in the diffusion process. The following profile is of a leader of PROMETA. A traditional and allopathic healer, this leader serves as a change agent.

Profile

Dr. Sekagya: Change Agent

Dr. Sekagya is the director and leader of PROMETRA-Uganda. A Ugandan native, he is a dentist by training, but a traditional healer by calling. Dr. Sekagya is a frontrunner in the community who engaged in promoting collaboration relationships between traditional and Western medicine. In addition, he is involved in facilitating the sharing of knowledge between and among Western and traditional healers.

Dr. Sekagya emanates an air of competence and respect, and is never without a smile. A busy man for sure, he is also one of proficiency and direction. In his PROMETRA office he met with me just one day after returning from a business trip. I asked Dr. Sekagya to describe his daily work routine and he laughed and responded with "now-which day?!". Dr. Sekagya is involved in many activities that run alongside PROMETRA. He is also the director for a clinic/nursing home in Uganda which operates next door to the PROMETRA facility. There he sees and treats patients using combined methods from his two medical backgrounds. He in involved in training in herbal medicine for terminally ill patients and AIDS patients. Dr. Sekagya also serves on a committee that is designing a University in Luwero district, where traditional medicine will be taught. In addition to these many roles, Dr. Sekagya is also involved with his own training in Buyijja, with the PROMETRA Herbalist Association. He explained to me the important notion that it is a two way training. While he is training traditional healers with his knowledge, he is also being trained (by the healers), and gaining knowledge.

Profile-continued

In the Buyijja, Dr. Sekagya, was dressed in traditional Ugandan attire, and served as both student and teacher. As a teacher, he took healers out to the gardens of the forest to examine the plants. Observing from a distance, his field lecture looked much like any practical lab class in the United States might. As a student, Dr. Sekagya sat in on classes just like other healers.

In most cases, a typical class includes a facilitator, and or members of the class who bring a specific plant or disease to the table for discussion. Individual healers will offer their uses and directions for a plant, or cure for a disease. Then a discussion of different treatments will take place. I was told, if four healers each come to the meetings with one method of treating a disease, and they walk away with four, they have just greatly enhanced their practice. This was demonstrated as each healer in the group presented their different uses of a plant.

Dr. Sekagya pointed out a problem when dealing with traditional healers and AIDS. He explained, to a healer you are not a patient until you have an ailment, so if you have HIV but you are not transformed to AIDS you are not a candidate to a healer, so by the time you present to the traditional healer, then its not HIV, it has manifested into AIDS. In general, traditional healers claim to treat AIDS because they treat the opportunistic infection, and if that goes away, then the patient is cured. In other words, to traditional healers, AIDS exists, but HIV doesn't. He explains that traditional medicine involves the five sense, but HIV needs conceptualization (it cannot be seen, touched etc.). Dr. Sekagya said, "He [the traditional healer] doesn't know about it. So we go into teach about HIV".

Dr. Sekagya's explanation of traditional healers' understanding of HIV/AIDS is one of the many reasons the PROMETRA organization is so important, as well as the weekly meetings of the PROMETRA herbalists association that meets in Buyijja. Dr. Sekagya said that the traditional healers that meet in Buyijja have a good response, mostly because they are willing to learn. This profile presents a change agent who is deeply rooted in his local culture, but also sees need to change and enhance certain practices in traditional medicine. He has created a successful information sharing relationship with other members of the herbalist association. In addition, Dr. Sekagya is involved in collaboration methods which lead to adoption of new ideas and practices of

many traditional healers, and ultimately individual community members throughout Uganda.

Profile
South African Traditional Healers

Green, Zokwe and Dupree (1995) presented a paper on "The experience of an AIDS prevention program focused on South African Traditional Healers". This program recruited and trained an initial group of traditional healers, selected from formal traditional healer associations. From there, the trained healers went out and trained additional healers, through workshops similar to the ones they attended. The results showed the second group of healers seemed as well trained as the first group. Next, the research team investigated the healers' involvement within the community. In addition to increased status with local medical personnel, the training influenced healers to counsel and provide sex education with their patients. Healers were also educating friends and family, as well as other members of the community, not just their patients.

The South African profile resembles some of the programs implemented in Uganda, and transitions into a discussion of the important role of traditional healer as opinion leader. Traditional Healers, trained and collaborating with change agencies, are later able to go out into their communities as opinion leaders. Below are some examples of traditional healers in Uganda who are now taking on the role of opinion leader when they go back to their communities and patients. What follows are several profiles of traditional healer success as opinion leader.

Opinion Leaders

Opinion leaders are similar in nature to change agents. According to Rogers, opinion leadership is the "degree to which an individual can informally influence other individuals' attitudes or overt behavior in a desired way with relative frequency" (Rogers 1995: 354). As discussed in Chapter Four, opinion leaders may be adopters who have been influenced by change agents, or others, and make the decision to promote the

innovation further. Various leaders in Uganda serve as opinion leaders, such as school teachers, religious and political leaders, and traditional healers. As a general rule, opinion leaders tend to have followers, which in turn adopt the innovation. Traditional healers as opinion leaders already have a large following, as more than 80% of Africans seek traditional medicine (WHO 2002). By utilizing individuals who have access to a large population, innovations are easily diffused. In this manner, drugs, services and information are provided to the community. This section profiles training that traditional healers undergo and ways in which healers are using that training to diffuse information further in their communities.

In 1999, Green reported on his research conducted in Mozambique. This study "sought to take advantage of the prestige, credibility, widespread availability, and authority of traditional healers to promote behavior change and the adoption of new technology such as condoms among those who consult healers for STIs [sexually transmitted infections] and other illnesses" (Green 1999:136). In doing so they wanted to include traditional healers, as they tend to see many, if not most of the health cases in Africa. By including those healers who consult STI and STD patients, they were including a large group of those with HIV/AIDS as well. This program sought to "reduce STD incidence and thereby HIV seropositivity by means of behavior change on the part of traditional healer (in their treatment and referral practices) and—through them—their clients (1999:136). This study is a good example of using traditional healers as opinion leaders, which reflects the Uganda case as well.

Profile
THETA
Traditional Healers

According to THETA, there are currently nine traditional healers' associations and eight support groups that have been developed by traditional healers trained by THETA. These groups are involved with HIV/AIDS care and prevention, and are involved in "education, stigma reduction and orphan support". (THETA personal communication)

Traditional Healers trained by THETA have incorporated their training into their counseling and patient care. In addition, they are engaged in HIV prevention. Traditional healers become trained as HIV and STD educatiors, and also skilled at clinical diagnosis. (UNAIDS 2002; Burton and McCarthy:1999)

Like PROMETRA, THETA healers have also used music and dance to transmit the message of HIV/AIDS. In addition, they have used story telling, personal testimonies of HIV-positive people" and other methods for community education. (Personal Communication; Nakyanzi 1999)

"In the end-of-programme survey in Hoima, 93% of traditional healers said that they talk to their patients about AIDS, compared to 81% before the programme began. The most common information given to patients, both before and after the programme, is related to taking HIV tests" (UNAIDS 2002).

This profile illustrates some of the methods traditional healers have integrated their training into the care and education of their clients. As opinion leaders, they have demonstrated their general understanding of HIV/AIDS, and then take on the responsibility of diffusing the innovations related to the disease, such as education and treatment, into their community through entertainment, counseling, and overall care. Follow up studies like the 2002 UNAIDS study indicate that these programs are successful and information regarding HIV is being passed from healer to client. In addition, this profile shows that traditional healers are being trained to diagnose HIV and recommend HIV testing, which is an important first step before treatment.

Profile
PROMETRA-Buyijja
Traditional Healers

Visiting Buyijja, I witnessed one method of HIV training, which included a brilliant routine of song and dance. They began with a traditional Buganda cultural dance, including rapid rhythmic drumming and incredible dancing. They also sang songs about HIV awareness that was sung in both English and Lugandan. These songs and dances serve as communication channels which serve not only as entertainment, but also provide education and knowledge about HIV/AIDS. This method initially serves as training for the traditional healers, however, they are then able to bring these songs back to their community, thereby transferring the knowledge.

PROMETRA Buyijja healers' songs and dances demonstrate effective personal communication channels which diffuse information regarding HIV/AIDS. Because the traditional healers incorporate local customs into the songs and dances they are more culturally relevant to the people observing them. Therefore, community members may be able to understand the message of a song or dance over that of a public health worker simply lecturing about HIV/AIDS.

Profile
Botswana (King 2000)

Botswana programs similar to THETA and PROMETRA, which include seminars and training programs for traditional healers on AIDS. The Botswana Dingaka AIDS Awareness and Training Project was established with the idea that once traditional healers were trained, they would then train additional groups of traditional healers. Unfortunately, as is often the case in Africa, the money for the workshops ran out, and the project was ended. Follow up evaluations on the successfulness of the programs did occur however. Studies in 1994 and 1995 indicated that some healers had made changes in their practices, promoted condoms, and "disseminated information to their community" (King 2000:15), however not all healers saw themselves "playing a role in home-based care for persons living with HIV/AIDS".

The Botswana profile shows traditional healers acting as opinion leaders. Despite the lack of long term training, traditional healers took what they learned from the original training sessions and further diffused the information, including information and condom promotion. Unfortunately, this case study also showed that not all healers were completely aware of all HIV symptoms, nor did they see themselves in the opinion leader role. This is a problem encountered in Uganda as well (Personal Communication), and one of the reasons traditional healer organizations like THETA and PROMETRA are so important.

Profile
Moses Male: Chairman of MAKOHA

MAKOHA is an herbalist association originally started by Male's grandfather. MAKOHA is primary objective is to improve health care through the development of herbal medicines. I met with Male, a traditional healer himself, and discussed some of the many issues regarding traditional medicine he is involved in. One aspect of his program is to promote sustainability of certain plant life that is critical to treating HIV/AIDS. He has held seminars in plant conservation and maintenance.

In addition to plant conservation, Male sees and treats patients with a variety of ailments. He sees patients at three different centers. By 9am the morning I met with him, he had already seen 10 patients. Looking back in his records, he recorded a total of 45 patients in May.

While visiting with him, an HIV patient came to his door seeking additional medicine for his skin problem. The patient asked Male some questions, and Male examined his skin. He told him the medicine he needed to take, how much, and for how long he needed to take it for. Then he gave him some herbs. The patient left without payment, for he couldn't afford the medicine. I was told this patient had been treated for 8 years, and is still "very healthy".

Males Moses' profile illustrates a traditional healer's knowledge regarding the treatment and care of HIV/AIDS patients. Serving as both a counselor and healer, patients from all over Kampala rely on his services. Patients, like the one I met, are examples of successful traditional treatment. Given Male's involvement in his

community both in treatment of HIV patients, as well as community training in plant conservation I would consider him an opinion leader within his community. Furthermore, he is involved in linear as well as horizontal diffusion directions, in that he shares his information with the community, as well as change agents such as THETA, and larger organizations such as research and development teams ranging from governmental organizations, to multilateral organizations like the World Bank. Male is an excellent model for the hybrid diffusion system as suggested for Uganda.

These case studies reflect how traditional healers become empowered with better knowledge and understanding of HIV/AIDS and are then able to influence other individuals in the adoption of certain innovations. They first learn skills in diagnosing problems, and effective treatment. Upon completion of training programs, they see the need to education and serve the people in their community. Traditional healers have become actively involved in their community educating and providing necessary services to the people. Because they are respected and trusted in their community, their word is often take more seriously than that of an outsider. Thus, in this context, they serve the role as opinion leader.

Conclusion

This chapter has analyzed traditional healer organizations and individual traditional healers using elements from a hybrid diffusion of innovations model. I have discussed the roles of change agent and opinion leader and applied these roles to the Ugandan context. Using Rogers (1995) model of the role of the change agent, the process begins with the change agent's development of a need to change, as well as establishment of an information-exchange relationship. Change agents also create intent

to change on the part of the traditional healer, following which, the traditional healers themselves take on an active role in the diffusion process. As change agents, leaders of traditional healer organizations, in Uganda and elsewhere, have provided education, training, and collaborative opportunities for traditional healers. Through these programs, traditional healers have not only gained knowledge and adopted new concepts and treatment methods; they have also taken on the role of opinion leaders who then serve their community. Together, these networks of healers are involved in providing drugs, services and information throughout Uganda's social system, resulting in overall behavior change in individual community members.

CONCLUSION

In a country where health care is limited, traditional healers offer an effective and culturally meaningful link in the Ugandan system of diffusion. Because of accessibility issues, including location and economic constraints, traditional healers are often the only option as health care providers. Health care is a social construct, in that certain beliefs and practices are important to the health care seeker. Traditional healers typically hold similar cultural beliefs and practices as the individuals in their community seeking health care. Traditional healers also provide certain treatments that have been proven to provide beneficial pharmacological properties. Therefore, even when allopathic medicine *is* available, traditional healers may still be the preferred choice.

Many traditional healers are linked within the larger Ugandan social system through traditional healer organizations like PROMETRA and THETA. These organizations are involved in the training and collaboration of traditional healers, specifically dealing with HIV/AIDS information and treatment. In addition, both of these organizations provide the resources for traditional healers to go out into their communities and teach HIV/AIDS awareness and safe practices.

This thesis inquired about the popular anthropological question 'what happened in Uganda', and asked what role traditional healers play in providing drugs services and information in Uganda. This thesis also questioned how traditional healers' roles affect changes and successes in dealing with disease, specifically in the context of HIV/AIDS. Using Rogers (1995) diffusion model, I have applied traditional healers to the role of opinion leader, and leaders of traditional healer organizations as change agents.

As this thesis has argued, Uganda has a complex social system in which services, drugs and information diffuse throughout the country among local villages, national, and international organizations. As I have shown using a hybrid diffusion model, the networks of traditional healers provide an effective and culturally meaningful role in this system, in which innovations flow throughout the social system and ultimately change individual behavior.

Rogers' (1995) diffusion of innovations model, specifically a hybrid model, offers an explanation to the popular question: what happened in Uganda? I have used this model to show that leaders of traditional healers serve as effective change agents, as they are culturally tied to the community in which they serve. PROMETRA-Uganda and THETA are two examples which have proven to be instrumental in the diffusion of drugs services and information about HIV/AIDS. Traditional healers in Uganda are influenced by these change agents mentioned above. After undergoing training programs, certain traditional healers serve the role as opinion leaders, further facilitating change among local community members.

Government, multilateral and bilateral organizations also play a part in the diffusion process. However, these groups primarily serve as research and development organizations. Their main roles appear to be monitoring and supporting local health care initiatives, like those set up by PROMETRA and THETA, and play less of a direct role in behavior change.

Government, multilateral and bilateral organizations, along with traditional healer organizations and individual traditional healers, utilize various communication channels which have shown to be successful in the diffusion process. Research has indicated that

mass communication channels do affect behavior change, as well as increase overall knowledge about HIV/AIDS. However, personal communication networks, including face-to-face information sharing, seem to be the most successful. I have suggested that the use of both communication systems has contributed to Uganda's success.

As Press (1982) illuminates, it is important for allopathic doctors, researchers and policy makers to understand cultural notions of disease and healing. Oftentimes misunderstandings occur between these individuals and their clients. Relationships between healer/client are more successful when operating as homophilious relationships. As homophily usually occurs between traditional healers and their clients, traditional healers may be more effective. Educational workshops involving healers have also proven to successfully diffuse information regarding HIV/AIDS to communities in culturally meaningful ways.

Traditional healer roles have greatly affected the changes and successes seen in Uganda's HIV epidemic. Understanding the role of traditional healer and working towards increased collaboration programs can only further enhance the diffusion of drugs services and information already occurring in Uganda. Given their significant contribution to the health care sector, traditional healers are becoming more recognized as legitimate health care providers. Despite the current research which has shown benefits of traditional healers, a greater emphasis on research on the promotion of traditional medicine and the role of the traditional healer and their programs is still needed, and is necessary to further enhance the diffusion of innovations such as drugs information and services.

PROMETRA has a wonderful metaphor used for their program that could also be applied to the Ugandan diffusion system as a whole. They call this metaphor "The Philosophy of the Pot". It was explained that a pot is very important to their culture; it can hold many things, including water, which is very important to life. PROMETRA displays a pot that has holes in it. "Just like this pot", they explain, "traditional healers are important to their culture. But just like the pot, traditional healers are full of holes. PROMETRA is engaged in filling those holes" (Personal Communication). Through a complex social system, PROMETRA, other traditional healer organizations, and individual traditional healers themselves, are involved in filing holes in traditional healers' practices and the health care system as a whole. By filling these holes, these individuals are engaged in the diffusion of drugs, services, and information throughout Uganda, which has played an effective part in Uganda's success in dealing with HIV/AIDS.

References Cited

Allen, Arthur
2002 Uganda v. Condoms. Sex Change. The New Republic Online. Electronic Document. http://www.tnr.com/docprint.mhtml?i=20020527&s=allen052702

Anokbonggo, W.W., R. Odoi-Adome, and P.M. Oluju.
1990 Tradtitional methods in management of diarrhoeal disease in Uganda. Bulletin of the World Health Organizations, 68(3):359(5).

Beattie, John
1960 Bunyoror: An African Kingdom. New York: Holt, Rinehart and Winston INC.

Bodeker, Gerard, et al.
2000 A regional task force on traditional medicine and AIDS. The Lancet 355(i9211):1284.

Bureau of African Affairs
2003 Background Note: Uganda. Electronic Document. http://www.state.gov/r/pa/ei/bgn/2963.htm Bureau of Public Affairs, U.S. Department of State.

Burton, Timothy and Tim McCarthy
1999 Profile Medicine Woman. Electronic Document. http://www.pox.com/archive/july1999/inside/medicinewomean.html

Byrnes, Rita M.
1992 Uganda: a country study. Federal Research Division, Library of Congress. Area Handbook Series. Washington D.C.: U.S. Government Printing Office.

EC funded paper.
No date Bridging gaps between public and traditional health care sectors - testing a model to improve quality of STI/HIV/AIDS care in sub-Saharan Africa. Electronic document. http://www.ki.se/hcs/doktorand/pdf/faxelid.pdf

CIA World Fact Book. Uganda. Electronic Document. http://www.odci.gov/cia/publications/factbook/geos/ug.html

Carpenter, Frank G.
1924 Uganda to the Cape. Carpenter's World Travels,12. New York: Doubleday, Page and Company.

Fallers, Lloyd A.
1961 Ideology and Culture in Uganda Nationalism. American Anthropologist 63:677-686.

Feldman, Douglas
2003 Problems with the Uganda Model for HIV/AIDS Prevention. Anthropology News 44(7):6.

Engle, Laura
1998 Traditional Healing in a Modern Epidemic. Body Positive 11(10).

Farmer, Paul
1999 Infections and Inequalities. Berkeley, California: University of California Press.

2003a AIDS: A Biosocial Problem with Social Solutions. Anthropology News 44(6):7.

2003b Pathologies of Power. Berkeley, California: University of California Press.

Giarelli, Ellen, and Linda A. Jacobs
2003 Traditional Healing and HIV-AIDS in Kwazulu-Natal, South Africa. American Journal of Nursing 103(10):36-46.

Green, Edward C.
1988 Can Collaborative Programs Between Biomedical and African Indienous Health Practitioners Succeed? Soc. Sci. Med. 27(11):1125-1130.

1999 Indigenous Theories of Contagious Disease. Walnut Creek: California: AltaMira Press.

2000 Traditional Healers and AIDS in Uganda. Journal of Alternative and Complementary Medicine 6(1):1-2.

2003a New Challenges to the AIDS Prevention Paradigm. Anthropology News 44(6):5.

2003b Rethinking AIDS Prevention: Learning from Successes in Developing Countries. Westport, Connecticut: Praeger.

2003c "HIV/AIDS, TB, and Malaria: Combating a Global Pandemic". Prepared Witness Testimony: The House Committee on Energy and Commerce.
http://energycommerce.house.gov/108/Hearings/03202003hearing832/Green1379.htm

Green, Edward C., et al.
1992 The Snake in the Stomach: Child Diarrhea in Central Mozambique. Medical Anthropology Quarterly 8(1)4-24.

Green, Edward C. et al.
2002 What Happened in Uganda? Declining HIV Prevalence, Behavior Change, and the National Response. Project Lessons Learned Case Study. USAID/Washington and the Synergy Project.

Green, Edward C., Bongi Zokwe and John David Dupree
1995 The Experience of an AIDS Prevention Program Focused on South African Traditional Healers. Soc. Sci. Med. 40(4):503-515.

Gwyn, David
1977 Idi Amin: Death-Light of Africa. Boston: Little, Brown and Company.

Hyde, Karin A. L. et.al
2002 HIV/AIDS and Education in Uganda: Window of Opportunity? World Bank. Electronic Document. http://www.worldbank.org/children/Uganda%20Report.pdf

Homsy, J., and R. King
1996 The role of traditional healers in HIV/AIDS counseling in Kampala Uganda. Sociétés d'Afrique & sida. 13:2-4.

IDRC
2000 Canada to Participate in the Decade For African Traditional Medicine. Ottawa, Canada: IDRC.

2001 From hospitals to herbalists: Rx herbal medicines. Ottawa, Cananda: IDRC.

IK Notes
2000 Traditional Medicine and AIDS, 26. World Bank.

2003 Traditional Medicine Practice in Contemporary Uganda, 54. World Bank.

Ingrams, Harold
1960 Uganda: A crisis of nationhood. London: Her Majesty's Stationary Office.

Ingstad, Benedicte
1990 The Cultural Construction of AIDS and Its Consequences for Preservation in Botswana. Medical Anthropology Quarterly, New Series, Culture and Behavior in the AIDS Epidemic 4(1):28-40.

International Health Library
2001 Health Problems Shingles (Herpes Zoster). Internet Health Library. Electronic Resource.
http://www.internethealthlibrary.com/Healthproblems/Herbal_medicine&Shingles.htm

King, Rachel and Jacques Homsy
1997 Involving traditional healers in AIDS education and counseling in sub-Saharan Africa: a review. AIDS 11(A):S217-S225.

King R. et. al.
1994 Traditional Healers as AIDS educators and counselors in Kampala, Uganda. *International Conference on AIDS (abstract PDO247).* Electronic Document. http://www.aegis.com/conferences/10wac/PD0247.html

Library of Congress
Current. Uganda A Country Study. Electronic Document. http://lcweb2.loc.gov/frd/cs/ugtoc.html

Liebling, Helen and Rebecca Kiziri-Mayengo
2002 The Psychological effects of Gender-Based Violence Following Armed Conflict in Luwero District, Uganda. Feminism & Psychology 12(4):553-560.

Nakyanzi, Teopista
1999 Promoting collaboration. AIDS Action 46:4.

NARO
2000 Useful tree – Cassia Sieberiana. NARO Bulletin 5(9):11.

2001 What you did not know About Bananas. NARO Bulletin 6(1):10.

2002a Maize (zea mays) as medicine and food. NARO Bulletin 9(7):9.

2002b What you did not know about cassava. NARO Bulletin 8(6):9.

2004 National Agricultural Research Organization. Electronic Document. http://www.naro.go.ug/about/welcome.htm

Nzita, Richard and Mbaga-Niwampa
1997 Peoples and Cultures of Uganda. 3rd Edition. Kampala, Uganda: Fountain Publishers Ltd.

Oladele, Alawonde
2003 HIV, There is Hope Tradtional Medicine Meets Modern Medicine. Complementary Alternative Medical Association. http://www.camaweb.org/library/infectious_disease/hiv_there_is_hope.php

Onjoro, Elizabeth
2003 Cultural Integration for Effective AIDS Prevention. Anthropology News 44(8): 4-8.

Onjoro, Elizabeth
2003 "AIDS Prevention and Paradigms: An Electronic Discussion". *AIDS and Anthropology Research Group.* Electronic Document.
http://puffin.creighton.edu/aarg/prevention.html

Pearson, M.
2000 Uganda Country Health Briefing Paper. Department for International Development Health Systems Resource Center. London: IHSD Limited.

Press, Irwin
1982 Witch Doctor Legacy: Some anthropological implications for the practice of clinical medicine. *In* Clinically Applied Anthropology. Noel J Chrisman and Thomas W. Maretzki eds. Pp. 179-198. Dordrecht, Holland: D. Reidel Publishing Company.

Rogers, Everett M.
1995 Diffusion of Innovations. 4th Edition. New York: The Free Press.

Ross, Michael W., and Mark L. Williams
2002 Effective Targeted and Community HIV/STD Prevention Programs. The Jouranl of Sex Research 39(1):58-62.

Sapolsky, Robert M.
2002 A Primate's Memoir: Love, Death an Baboons in East Africa. London: Vintage.

Stevenson Richard W.
2003 Bush Has Praise for Uganda In Its Fight Against AIDS. The New York Times, July 12: A4.

Tabuti, J.R.S., S.S. Dhillion and K.A.Lye.
2003 Traditional medicine in Bulamogi county, Uganda: its practitioners, users and viability. Journal of Ethnopharmacology 85(1):119-129.

Teh, Raphael Ngong
1998 The Role of Tradtional Medical Practitioners: in the Context of the African Tradtional Concept of Health and Healing. International Mental Health Workshop. Electronic Document. http://www.globalconnections.co.uk/pdfs/HealersMentalHealth.pdf

THETA
2001 Contributions of traditional medicines to health care delivery in Uganda. Ministry of Health Public-Private Partnership Office.

Uganda AIDS Commission
Parliamentary response. Electronic Document.
http://www.aidsuganda.org/response/govt_sectors/parliament.htm

Wallman, Sandra
1996 Kampala Women Getting By: Wellbeing in the time of AIDS. London: James Curey.

WHO
2002a Planning for cost-effective traditional health services in the new century-a discussion paper. WHO KOBE Centre.

2002b WHO Launches the First Global Strategy on Traditional and Alternative Medicine. Press Release WHO/38. Electronic Document.
http://www.who.int/inf/en/pr-2002-38.html

WHO
2003 Traditional Medicine. Fact Sheen, 134. Electronic Document.
http://www.who.int/mediacentre/factsheets/2003/fs134/en/print.html

WHO/AFRO
2001 Uganda Health Profile: Overview. Electronic Document.
http://www.afro.who.int/uganda/overview.html

UNAIDS
2003 Stepping back from the edge: The pursuit of antiretroviral therapy in Botswana, South Africa and Uganda. Best Practice Collection. Geneva, Switzerland: UNAIDS.

UNAIDS
2002 Ancient Remedies, New Disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa. Best Practice Collection. Geneva, Switzerland: UNAIDS.

UNAIDS
2000 Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan African. UNAIDS Best Practice Collection: A Literature Review. Genevea, Switzerland: UNAIDS.

UNAIDS
1998 AIDS Education Through Imams: A Spiritually Motivated Community Effort in Uganda. Best Practice Collection. Geneva, Switzerland: UNAIDS

USAID
2002 The "ABCs" of HIV Prevention: Report of a USAID Technical Meeting On Behavior Change Approaches To Primary Prevention of HIV/AIDS. Washington D.C. USAID.

Wallman, Sarah
1996 Kampala Women Getting By: Wellbeing in the time of AIDS. London: James Currey.