

Indigenous Approaches to the HIV/AIDS Scourge in Uganda

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INDIGENOUS APPROACHES TO THE HIV/AIDS SCOURGE IN UGANDA

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ABSTRACT: The management of HIV/AIDS-related illnesses using existing drugs is very costly especially for poor households. Therefore, this study has focused on the role of traditional herbalists in the management and prevention of HIV/AIDS-related illnesses in Uganda. It has also examined the existing linkages between traditional herbalists, the government and other agencies working on HIV/AIDS and how these linkages can be enhanced, and the community's perception about traditional Herbalists in the management and prevention of HIV/AIDS-related illnesses.

A Participatory Rapid Appraisal (PRA) approach was used, involving focused group discussions (FGDs) with traditional herbalists and AIDS patients who were using traditional herbs to manage HIV/AIDS-related illnesses.

The traditional herbalists identified about six HIV/AIDS-related illnesses they manage, which include skin-related infections, persistent fever, cough, headache, chronic diarrhoea, and internal and external wounds. They also revealed that they do not carry out HIV testing on their own but rely on the presence and persistence of the most common symptoms and past histories of their clients to provide treatment for HIV/AIDS-related illnesses. The herbs used to manage HIV-related illnesses are administered in different forms. It was revealed that there could be a significant improvement within approximately 2-4 months of treatment.

The AIDS patients, caretakers and traditional herbalists reported that since the herbs are administered in their natural form, they exhibit no significant side effects. In addition, there are no problems of over-dosage even when their use is not well monitored. The traditional herbalists also provide counselling services to their patients.

The problems facing the traditional herbalists were structural (particularly the lack of physical infrastructure and simple medical equipment), financial, administrative, shortage of herbs in some cases, and the negative social stigma about use of traditional medicine.

The AIDS patients indicated a number of reasons for their choice of traditional treatment; for instance, traditional herbs are easier to administer and are relatively cheaper; traditional herbalists can provide treatment with part-payments or on credit; and traditional herbalists keep close contact with their patients through counselling, etc.

The AIDS patients identified three basic problems, i.e., shortage of finance; herbs may have to be changed several times before one that can effectively address a given illness is identified; and

AIDS patients are not allowed to use herbs in health units concurrently to treat opportunistic infections.

The collaborative linkages between traditional herbalists and other agencies working on HIV/AIDS are generally still weak because many traditional herbalists are not yet organized in associations or registered.

Some policy recommendations emerge from these findings. First, there should be systematic sensitization of the community about traditional medicine. Secondly, there is need to support traditional herbalists in terms of finance, training and patent rights to improve their services. Lastly, collaborative linkages between traditional herbalists and modern health practitioners need to be enhanced.

1. INTRODUCTION

1.1 Background

The situation of HIV/AIDS in Uganda is both one of the worst and one of the best experiences in the developing world. The human death toll due to AIDS has been high. An estimated 1.8 million people have died since the start of the epidemic, almost 10% of Uganda's 1998 population (Hutchinson 1999). By June 1992, Uganda reported 33,971 AIDS cases, and according to the HIV/AIDS Surveillance Report of 2001, 1,107,644 people were living with AIDS in Uganda by 2000, of whom about 90% are adults.

Although there has been significant progress in the fight against the epidemic (e.g., the prevalence rate has declined from 18.5% in 1995 to 6.5% in 2001), the socio-economic impact of HIV/AIDS on household welfare is still considerable (MoH 2002). Households must face the direct costs of treatment, the value of lost work time from illness or lower labour productivity. The loss of income earners, the direct costs of treating the HIV/AIDS-related illnesses, and the eventual burial costs to some households means a reallocation of household resources to cope with the effects of the AIDS epidemic, and, therefore, fewer resources would be available for other household needs. For example, the capacity of the affected households to provide for important needs such as school fees, farm or business inputs, and other medical services is generally reduced. The cost of treating HIV/AIDS-related illnesses remains high; yet, governments in developing countries and most of the affected households lack sufficient resources to get access to medical services.

With a per capita income of about US \$280 per annum, Uganda is among the poorest countries. According to the 2000 National Household Survey, 35% of the population are below the poverty line of per capita expenditure of one dollar a day. The Health and Demographic Survey (MoH 2001) shows that 51% of Ugandans live more than 5 km from a health facility, and that only 13% could afford proper medical care on their own. In addition to the widespread poverty, the health systems in Uganda are weak, with far too few doctors, nurses, medical facilities and beds. The low level of income for the majority of the households and the weak and poorly funded health services have made the treatment of HIV/AIDS-related illnesses using existing anti-retroviral drugs very costly.

The drugs cost an average of US \$5000 a year, including medical tests and consultation costs, which only about 1% of the people who are living with AIDS in Uganda could have access to (Foreman 2000). Likewise, according to the MoH report in the New Vision Supplement (2002), less than 30,000 people out of the slightly over one million with the HIV virus have access to anti-retroviral drugs.

Given the health effects of HIV/AIDS and the relatively high cost of pharmaceutical drugs, two options can be thought feasible. That is, either governments and pharmaceutical companies should provide sufficient subsidies and make the available anti-retroviral drugs affordable to the majority of the population or the patients have to explore alternative less costly methods of managing HIV/AIDS-related illnesses.

Indigenous approaches to the management of HIV/AIDS-related illnesses offer an alternative to the expensive anti-retroviral drugs and general palliative care for an AIDS patient. Traditional herbal medicine has become to be widely used by AIDS patients both in the rural and urban areas (see www.wbi0018.worldbank.org/AFR). Hutchinson (1999) shows that the choice of a traditional doctor as a health provider was 1.5% in rural areas and just under 1% in the urban areas in Uganda. About 80% of the population in the African region depend on traditional medicine for their healthcare needs (WHO 2000). Traditional healers/herbalists often outnumber doctors by 100 to 1 or more in African countries and provide effective treatment, sometimes on credit, or part-payments. This makes it easier for the patients to access treatment. The traditional herbalists are culturally linked to their clients, which makes communication about sexually transmitted diseases and related social issues easier.

Therefore, the indigenous methods, if well developed, are capable of managing HIV/AIDS-related illnesses, and providing palliative care to AIDS patients, and at the same time relieving households of the financial burden of the expensive pharmaceutical drugs and saving government resources.

1.2 Problem Statement

The management of HIV/AIDS-related illnesses using existing drugs from pharmaceutical companies is very costly especially for the poor households. According to Foreman (2000) at least 12 million people in developing countries are in urgent need of anti-retroviral drugs, which suppress HIV and postpone AIDS symptoms. But the vast majority of the AIDS patients are living in the world's poorest countries and cannot afford the estimated US\$5,000 required a year for the drugs, medical tests and consultations. Estimates show that in Uganda's case, providing anti-retroviral drugs to 400,000 people with AIDS would cost an equivalent of US \$1.9 billion (28% of the country's GNP) (Foreman 2000). Although there are mechanisms that allow countries to either import or manufacture drugs at competitive rates, it is still uncertain whether such mechanisms will enable developing countries to reach the 5-10% of current supply levels needed to bring the anti-retroviral drugs within reach of the vast majority of HIV/AIDS patients who need them.

From the viewpoint of lack of capacity by governments to provide sufficient subsidies on drugs, and the majority (rural and urban) poor to afford treatment on their own, effort to come up with

less expensive but effective methods of managing HIV/AIDS-related illnesses is very vital. It would increase the useful life years of the AIDS patient, and most importantly, save the household resources (e.g., high medical bills) for the provision of other needs. Indigenous approaches to the management of HIV/AIDS-related illnesses by traditional herbalists have the potential to meet this vital requirement if well developed. Therefore, this study focuses on the role of traditional herbalists in the management and prevention of HIV/AIDS-related illnesses in Uganda.

1.3 Objectives of the Study

The overall objectives of the study are to investigate the role of traditional/indigenous approaches in the management of HIV/AIDS-related health problems and examine how such approaches can be integrated into the wider program to fight HIV/AIDS epidemic in Uganda. The specific objectives of the study are to:

Identify the role played by traditional herbalists in management and prevention of HIV/AIDS-related illnesses,

Examine the existing linkages between traditional herbalists, the government and other agencies working on HIV/AIDS and how these linkages can be enhanced; and

Enhance community perception about traditional herbalists in the management and prevention of HIV/AIDS-related illnesses.

1.4 Research Questions

In order to achieve the research objectives, the following research questions were posed:

What are the services offered by the traditional herbalists to HIV/ AIDS patients?

What is the level of interaction that exists between traditional herbalists, the government and other agencies working on HIV/AIDS?

What do communities (i.e., patients and caretakers) perceive to be the advantages and disadvantages of seeking treatment from traditional herbalists in the management of HIV/ AIDS-related illnesses?

1.5 Rationale for the Study

This study seeks to create a better understanding of the roles of traditional herbalists in HIV/AIDS management and prevention. The study also identifies the existing linkages between the traditional herbalists and other agencies working on HIV/AIDS. Linking the pharmaceutical research findings and traditional treatment methods is an important component in the process of developing a cure for HIV, and can be enhanced by understanding the existing practices of traditional herbalists in the fight against the HIV/AIDS. The knowledge generated out of this

study could be used to initiate appropriate strategies to assist traditional herbalists in provision of healthcare in the management of HIV/AIDS-related problems.

2. AN OVERVIEW OF THE HIV/AIDS EPIDEMIC IN UGANDA

2.1 The HIV/AIDS Prevalence Rates in Uganda

The STD/AIDS control programme under the Ministry of Health monitors HIV infections using sentinel surveillance sites that are geographically distributed in different parts of the country. There are 20 sentinel surveillance sites based in antenatal clinics and in hospitals and one STD referral clinic in the country.

According to the June 2002 HIV/AIDS Surveillance Report, the overall antenatal prevalence rate for HIV/AIDS for the year 2000 was 6.1% (i.e., 8.1% and 4.2% for rural and urban, respectively) and for the year 2001, it was 6.5% (i.e., 8.8% and 4.2% for rural and urban, respectively)

It was further indicated that the AIDS cases reported as of December 31st, 2001 were 60,173 of which 55,707 (92.5%) were adults (i.e., 44.9% males and 55.1% females) and 4,466 (7.5%) were children aged less than 12 years. Similarly, the reported AIDS cases as of 31st December 2000 were 58,165 of whom 53,879 (92.6%) are adults and 4,286 (7.4 %) were children aged less than 12 years.

It should, however, be noted that these figures are from selected sentinel surveillance sites and they do not reflect the overall situation in Uganda. Moreover, many AIDS-related illnesses are not reported as AIDS, and many AIDS patients are not tested or they die without going to a health facility which implies that most cases are not documented. Table 1 shows the cumulative AIDS cases reported per year based on data from the sentinel surveillance sites.

Table 1. Cumulative reported AIDS cases

Year	No. of cases	Cumulative no. of cases
1983	17	17
1984	11	28
1985/1986	882	910
1987	2,914	3,824
1988	3,425	7,249
1989	6,090	13,339

1990	6,616	19,955
1991	10,235	30,190
1992	6,362	36,552
1993	4,641	41,193
1994	4,927	46,120
1995	2,191	48,312
1996	3,032	51,344
1997	1,962	53,306
1998	1,406	54,712
1999	1,149	55,861
2000	2,304	58,165
2001	2,008	60,173

SOURCE: MoH (2001).

Data on HIV prevalence rates from antenatal sentinel surveillance sites show that the prevalence rates have been declining over the last decade. Among males, the prevalence rate has declined from 11% in 1992 to 3.7% in 2001 while in females the prevalence rate has declined from 29% in 1992 to 10.1% in 2001.

Data on HIV prevalence rates from antenatal sentinel surveillance sites show that the prevalence rates have been declining over the last decade. Among males, the prevalence rate has declined from 11% in 1992 to 3.7% in 2001 while in females the prevalence rate has declined from 29% in 1992 to 10.1% in 2001.

According to the June 2002 HIV/AIDS Surveillance Report published by the STD /AIDS Control Programme in the Ministry of Health, the HIV infection rate is reported to be stabilizing. The findings of the Surveillance Report based on data from antenatal centres show that the overall prevalence rate for the year 2000 was 6.1%, slightly increasing to 6.5% in 2001. The report also indicates that the prevalence rate in urban areas was 8.7% in 2000, slightly increasing to 8.8% in 2001. In the rural areas, the prevalence rate was about 4.2% for both years.

2.2 Socio-Economic Impact of HIV/AIDS

In Uganda, AIDS locally known as (*slim*) was first identified in 1982 and by 1999 about 1.9 million people were living with AIDS. Currently, AIDS is responsible for up to 12% of annual deaths particularly among individuals aged 15-50 (Republic of Uganda 2000).

The most affected age group is 15-50 years, which occupies a very critical position in society. For example, it is estimated that Uganda's labour force will be about 2 million (or 12%) fewer than would be without AIDS by 2010 (Armstrong 1995). This represents a significant loss of labour and GDP to the economy. For instance, a survey done in Rakai District, southwestern

Uganda, shows that 25% of the households were cultivating less and less land, and of these, 35% attributed it to HIV/AIDS-related illnesses or death. These factors have threatened the food security of affected families and have led to a decline in cash crop production in general.

At the workplace, HIV/AIDS has caused employment insecurity and discrimination in the labour force. Infected employees are denied positions of responsibility, they are discriminated and job contracts may be terminated or not renewed on the basis of their serostatus (Republic of Uganda 2000). HIV/AIDS also affects work time and productivity during illness, and according to the Uganda National Serosurvey 1988, of those tested, the percentage of HIV-positive was higher among professionals (24.6%) and workers (21.3%), as shown in table 2.

Table 2. Uganda national serosurvey by occupation, residence and gender, 1987-8

	Tested	Positive (percent)
Occupation	487	24.6
Professional	296	21.3
Worker/driver	477	14.3
Unemployed	40	15.0
Unknown	1056	13.2
House wife	316	11.7
Student	744	8.3
Farmer/fisher		
Residence	1399	22.9
Urban	2027	8.7
rural		
Sex	1314	12.3
Male	2112	15.9
Female		

SOURCE: Uganda National Serosurvey, 1988 (in Armstrong 1995).

Uganda's health system is already under considerable strain due to the ever-increasing number of patients with AIDS-related illnesses. The annual population per hospital bed has risen to 800 and

the doctor to population ratio is as high as 1 to 4,300. Similarly, Armstrong (1995) shows that the resources used to treat 35% (about 350,000) of AIDS patients in Uganda would be sufficient to immunize one-third of all infants, or treat 2.5 million cases of malaria. Similarly, Foreman (2000) indicates that providing anti-retroviral drugs to 400,000 people with AIDS would cost US \$1.9 billion (an equivalent of 28% of Uganda's GNP). The allocation of resources towards the management of the AIDS epidemic implies that fewer resources would be available for other health services.

At the household level, the impact due to the death of a female member of the household, particularly the wife, is even greater. The Uganda National Serosurvey of 1988 reveals that women are 1.3 times more likely to be infected than men. Yet, female members are generally the principal caretakers of children. Therefore, the death of a woman has a greater negative impact on the development of children, both through her direct influence and the possibility that some children will have to forego or reduce their schooling to care for the household (Armstrong 1995). As a result of the AIDS epidemic, children or older women headed households are increasing, and many girls from poor families are becoming vulnerable to sexual exploitation in order to supplement family up-keep.

According to the World AIDS Day Supplement (*The New Vision*, 2nd Dec 2002), Uganda has over 1.77 million children orphaned by HIV/AIDS. This is the highest figure in the world according to the Uganda Aids Commission (UAC) report released in June 2001. As a result, the capacity of the African traditional system of extended families to cope with this increasing burden of orphaned dependents is being over-stretched. This is in terms of financial support for education, general welfare and health care. The older people have taken up too much responsibility of raising these orphans on limited resources, since most of the family resources get depleted during illness and upon death of the parents.

The loss of a principal income-earner in the household causes a significant change in the household (World Bank 1993). For instance, non-working household members must now work, household structures must shift, and households may have to draw on past savings or sell assets in order to survive. The surveys in Kagera, Tanzania, and Rakai, Uganda reveal that ownership of radios and bicycles increased among those households that had no death but decreased in those that had lost someone due to AIDS (World Bank 1993). This is a simple case of asset depletion to take care of the sick person, meanwhile leaving fewer resources for other family needs.

Therefore, HIV/AIDS has touched on every aspect of life and development including overall behaviour, function and role of the family and community, care and support systems and the economy.

2.3 Interventions in the Fight against HIV/ AIDS

Uganda has had one of the best approaches to the HIV/AIDS problem resulting in a significant reduction in HIV prevalence rate. Uganda adopted a multi-sectoral approach in the management of HIV/AIDS effects, and this approach is one of the success stories in the world. Following the intervention programmes pursued since the early 1990s, the prevalence rate has declined from

18.5% in 1995 to 6.5% 2001. Among males, the prevalence rate has declined from 11% in 1992 to 3.7% in 2001 and in females from 29% to about 10% over the same period (*The New Vision*, 2nd Dec. 2002). This is a reflection of the effective multi-sectoral approach adopted by the Ugandan government in the management of the HIV/AIDS epidemic

The approach ensures that every sector or individual has a role to play in the fight against the HIV/AIDS scourge. The National Strategic Framework for HIV/AIDS activities in Uganda, 2000/1-2005/6 highlights the National Policy on AIDS, the need for a multi-sectoral approach to HIV/AIDS, and overall goals of the multi-sectoral approach in the fight against HIV/AIDS.

2.3.1 The National Policy on HIV/AIDS

According to this policy, all Ugandans have individual and collective responsibility to be actively involved in AIDS control activities in a coordinated way at various grassroots levels. The fight against AIDS is not only directed at preventing of the spread of the HIV virus but also at addressing the active response to and management of all perceived consequences of the epidemic.

The process of preventing HIV infection and controlling its consequences by the various organizations and individuals in the country should be comprehensive and sensitive to all aspects of the epidemic, emphasizing capacity building for sustainable activities among sectors and individual organisations.

2.3.2 The Multi-Sectoral Approach to HIV/AIDS

During the early 1980s, when the HIV/AIDS epidemic was first reported, government and public response to the new disease was slow and ad hoc. As a result, the epidemic spread fast to most parts of Rakai District and the neighbouring district of Masaka. Later in 1986, the government of Uganda established an AIDS Control Program (ACP) in the Ministry of Health. Whereas the AIDS Control Program (ACP) made substantial progress in the areas of epidemiology, surveillance, health and AIDS education and blood transfusion services, the epidemic continued to be addressed exclusively as a health problem. It was, however, realized that the impact of the epidemic went beyond the domain of health and cut across all sectors. Therefore, in 1990, the government appointed a National Task Force to work out modalities for a Multi-Sectoral AIDS Control Approach.

The Multi-Sectoral AIDS Control Approach (MSAC) has five basic goals. First, it aspires to mitigate the adverse health and socio-economic impact of HIV/AIDS by promoting community level actions in order to reduce the impact of HIV/AIDS-related consequences, to provide health care for people with HIV and AIDS, and to cope with HIV/AIDS- related impacts.

Secondly, the approach is aimed at strengthening the national capacity to respond to the HIV/AIDS epidemic. This will be done through strengthening implementation capacities at the district and lower local levels, strengthening national and sectoral capacity for planning and policy development in relation to AIDS, and mobilizing resources both (human and financial) at

national and international levels. The third goal is to establish a national information base on HIV/AIDS by promoting appropriate data gathering and information access.

In addition, the multi-sectoral approach to AIDS control is to strengthen the national capacity to undertake research in HIV /AIDS. This is envisaged to be achieved through strengthening the national AIDS capacity for control, research and training; establishing quality control for HIV/AIDS-related research and monitoring and evaluation. It is also aimed at contributing to the international efforts in the development of cures and vaccines for HIV/AIDS, and promoting traditional healers/herbalists in the management of HIV/AIDS.

It is important to note that the success of the multi-sectoral approach is very much dependent on, among other things, the acceptability of the interventions by the community, availability of the capacity including human and financial resources for implementation and the cost-effectiveness and time feasibility of the intervention.

In essence, this approach has three distinct features. First, it advocates for the active involvement in HIV/AIDS control and prevention activities by all members of the society as individuals and collectively with systematic coordination at different administrative levels. Secondly, the approach seeks to address HIV/AIDS prevention while at the same time responding to the management of all perceived consequences of the epidemic. Thirdly, the approach emphasizes organizational capacity building among sectors and individual organizations for the sustainability of HIV/AIDS control activities.

2.4 Institutions Involved in Mitigating HIV/AIDS in Uganda

The number of actors in the national HIV/AIDS response has increased. New interventions or strategies on prevention, treatment/management and support for affected groups (e.g., widows and orphans) have been introduced.

The HIV sero-prevalence of 6.5% by 2001 needs further reduction and indicates that there are a number of people who have not yet been reached by the current interventions. Therefore, there is need to intensify existing interventions among the existing stakeholders or new partners in the fight against the HIV/AIDS scourge in Uganda.

The principal actor in the fight against HIV/AIDS in Uganda is the Uganda AIDS Commission. The Uganda AIDS Commission (UAC) is the reference point for formulation of plans, policies and national guidelines for HIV/AIDS control programmes and activities in the country. It coordinates these activities through periodic meetings of the advisory committees and technical committees. The UAC board consists of a Chairman, Vice Chairman, Director-General and 21 members all appointed by the President. This commission was established by statute no.2 of 1992.

An HIV partnership has been formed under the chairmanship of UAC aiming at minimizing duplication and pooling efforts for scaling up HIV prevention. It is an advisory body to the Uganda AIDS Commission (UAC) and provides a formal and representative forum for all stakeholders in the HIV/AIDS national response. Partners under the HIV/AIDS partnership fund

provide funds to coordinate these activities. The partnership committee has nine constituencies involved, and each constituency has an organization that coordinates the group activities. The constituencies are:

Government Line Ministries coordinated by the Ministry in Charge of Presidency for Government Line Ministries.

The decentralized levels coordinated by the Ugandan Local Authorities Association (ULAA).

The UN and Bilateral Development Group coordinated by the Department for International Development (DFID) with UNAIDS as the Secretariat.

The Networks Of People Living With HIV/AIDS (PLWA) coordinated by the National Guidance and Empowerment Network with National Community of Women Living with HIV/AIDS (NACWOLA)

The Private Sector Constituency coordinated by the Uganda Business Council on HIV/AIDS.

The research, academic and scientific community coordinated by the Makerere University Institute of Social Research

International NGOs' group coordinated by GOAL-Uganda

The private sector coordinated by the Uganda Network for AIDS Service Organization (UNASO)

The Faith Based Organizations coordinated by the Chair of the Inter-Religious Council of Uganda Networks on HIV/AIDS.

The UAC plays a leadership and coordination role for all the partnership groups and at the lower levels. Multi-Sectoral District AIDS Control committees are being established for effective coordination of AIDS control activities.

The agencies involved in the fight against HIV /AIDS include the AIDS Information Centre (AIC) which spearheads HIV testing in Uganda. AIC is a non-governmental organisation established in 1990 to provide voluntary counselling and testing services (VCT) for HIV. It also provides information and education, care and support for those affected. It offers services for tuberculosis, family planning and sexually transmitted diseases, e.g., syphilis. By 2002, AIC had established five main branches in Mbarara, Jinja, Arua, Kampala, Mbale Districts and had established 55 testing centres in 24 districts.

Another agency involved in the fight against HIV/AIDS is the Department for International Development (DFID), a British government department for promoting development and poverty alleviation in developing countries. In Uganda, DFID works in partnership with the government of Uganda and other donors to implement various government-led programs through the budget support modalities in order to provide support to civil society organizations, some of which are

involved in HIV/AIDS work. Under the Uganda's HIV umbrella programme, DFID (EA) has provided 6.2 Million pound sterling to support HIV/AIDS activities. These activities involve strengthening and mainstreaming HIV control throughout its programs, supporting the civil society and coordinating partners in HIV control. The organizations supported by DFID (EA) include; the AIDS Support Organization (ASO), AIDS Information Centre (AIC), Straight Talk Foundation, People Living with AIDS (PLWA) and employees infected by HIV/AIDS.

Uganda Network of AIDS Service Organisation (UNASO) is another organization working on HIV/AIDS-related activities. UNASO is a nation-wide network of NGOs, CBOs, faith, PLWA and other local communities involved in the response to HIV/AIDS in Uganda. UNASO coordinates HIV services that include quality care and support services through networking, information sharing and generation, and capacity building in terms of training for NGOs and CBOs. It is also involved in advocacy and lobbying for representation of AIDS service organizations at AIDS fora, and above all advocating for increased involvement of people living with HIV/AIDS.

Another agency involved in the fight against HIV/AIDS is the Straight Talk Foundation. It aims at improving the sexual and reproductive health status of adolescents in Uganda. The foundation helps adolescents to stay free from HIV infection, early unwanted pregnancies and sexual abuse, using a multi-media awareness approach. In this approach, a monthly 'Straight Talk' newspaper supplement is produced and distributed to secondary schools and higher institutions of learning. The foundation also distributes newspapers in six local languages (i.e., Luo, Ateso, Runyakole, Rukiga, Runyoro and Rutoro), and broadcasts radio shows on adolescent health over 10 FM radio stations in different parts of the country.

The AIDS Support Organization (ASO) is another agency involved in the fight against HIV/AIDS in Uganda. ASO was founded in 1987 to help volunteers affected or infected with HIV/AIDS restore back hope to stay alive, and to improve the quality of life of persons and communities affected by HIV/AIDS. Since then it has provided care to 67,000 clients, 64% of them females. ASO provides care and support to HIV/AIDS patients through counselling, providing medical care for opportunistic infections, providing home medical care for bedridden or very weak clients, offering outreach clinics, and providing information on family planning and STD management. In addition, ASO provides training services to AIDS workers for both national and international organizations. It also provides social support to some of the orphans of their deceased members. For instance, ASO currently pays school fees for about 85 children of ASO members to study carpentry, mechanical engineering, cookery, and tailoring. It further supports primary school children in schools such as Buddo and Buloba. So far, ASO has expanded its services to seven towns in Uganda, i.e., Kampala, Mpigi, Jinja, Tororo, Mbale, Masaka and Mbarara.

The other agency supporting several activities in different parts of the country in the fight against HIV/AIDS is GOAL-Uganda. Its programmes on HIV/AIDS began in 1999 primarily focusing on HIV/AIDS and street children. GOAL-Uganda has 3 main programmes, which include the Baaba project; a peer-led HIV/AIDS programme for street children; the Bugiri District HIV/AIDS Programme and a micro-projects programme offering technical and financial support to local organizations. Under the micro-projects programme, GOAL-Uganda offers assistance to

Hospice Uganda's model District Palliative Care Programme in Hoima, the Medical Missionaries of Mary Farm School Programme for Orphans in Masaka, and the Uganda Youth Development Link (UYDEL) HIV Prevention Education Programme in Kawempe. It also supports Mengo Hospital Club for AIDS-Affected Children, the Meeting Point for HIV/ AIDS Care and Support in Namuwongo, Kampala and Hoima, Kabarole Research Centre for HIV/ AIDS among the Youth, and *Engabo za Toro* (mainstreaming HIV/AIDS in Toro) among others.

Other organizations involved in the overall fight against HIV/AIDS include Federation of Uganda Employers, Hope for African Children Initiative, Mother-to-Child transmission and prevention programme, the National Community of Women with HIV/AIDS in Uganda (NACWOLA), and organizations for traditional healers/herbalists involved in the fight against HIV/AIDS.

2.5 Strategies for HIV/AIDS Prevention and Management

According to the Ministry of Health Statistics (2002), there are a number of strategies being used in the management and prevention of HIV/AIDS in Uganda. These include use of mass media for creating public awareness under the Ministry of Health, Ministry of Education and other ministries; currently public awareness about the means to control the spread of HIV/AIDS has reached to about 98% of the Ugandan population. HIV/AIDS education in schools has been promoted through collaborations between the Ministry of Health and Ministry of Education and Sports in which the HIV/AIDS handbook and messages for primary schools have been developed. Commercial sex peer education is another strategy that has also been adopted. This is where prostitutes are encouraged to engage in safe sex using condoms and are also counselled to abandon the practices and take on other income-generating activities.

Social marketing of condoms (both male and female condoms) has been promoted. Condoms are available at all retail shops at a cost ranging between 300-1000 Uganda shillings (about 16-50 cents of a dollar) for a packet of 3. And in higher institutions of learning, e.g., universities and some health organizations, condoms are distributed free of charge; as a result; there is a reported increase in the use of condoms in non regular sexual partners.

Treatment of sexually transmitted diseases, skin diseases, mouth rashes and tuberculosis can be obtained in all health centres, both public and NGO's; in addition, voluntary testing and counselling services are being scaled up to cover 56 districts and 2 outreach services have been established per district. Prevention of mother-to-child transmission under the PMTCT programme has also been launched in the 56 districts.

2.6 Available HIV/AIDS Management Methods

A. Anti-retroviral therapy

In treating opportunistic infections, anti-retroviral drugs are privately administered at authorized health centres and research institutions. It has been proven that these medications prolong life for people having AIDS, by reducing the viral load, boosting the immune and relieving pain. However, the dosage of anti-retroviral drugs per month cost about 1.5 million Uganda shillings

(an equivalent of US \$830), excluding monitoring costs. The drug access initiative currently being piloted by UNAIDS and Ministry of Health has lowered the cost to 700,000 Uganda shillings (about US \$380) per month per person, but this cost is still high and unaffordable to the majority of Ugandans (Republic of Uganda 2000). As a result, the majority of HIV infected people receive either no medical treatment or only palliative care to reduce pain and suffering. Among those using anti-retroviral drugs, some receive incomplete, unmonitored and inconsistent treatment due to the high costs involved. This is more likely to be disastrous because the virus develops resistance to the drug.

In general, the experimentally approved anti-retroviral drugs such as AZT, DDI, and DDC are expensive, usually not available when required, toxic at high doses and ineffective when the HIV develops resistance.

B. Management of HIV/AIDS with traditional herbal medicine

The use of traditional herbs as a form of therapy for AIDS is steadily increasing. The increased use of herbal medicine by people living with AIDS is an indication that local herbs are effective in the management of HIV/AIDS-related illnesses. As a result, funding agencies, the government and NGOs have supported research in herbal medicines through a collaborative effort between practitioners in herbal and modern treatment methods. An NGO called THETA (Traditional and Modern Health Practitioners Together against AIDS) was established to organize, monitor and supervise activities between the modern health care providers and traditional healers/herbalists (Republic of Uganda 2000).

The Ministry of Health (MoH) and Uganda AIDS Commission (UAC) through collaborative efforts of TASO and MSF-Switzerland established THETA in 1992. THETA was established to promote collaboration between traditional herbalists/healers and modern health practitioners in the area of treatment, care, support and prevention of STDs and AIDS (Homsy and King 1996). Although there are a number of agencies involved in the fight against HIV/AIDS and the prevalence rates have declined tremendously, AIDS is still a big problem in Uganda. In view of the high cost of the existing anti-retroviral drugs, their accessibility and related side effects, the contribution of the traditional herbs in the management of HIV/AIDS-related illnesses needs to be understood and enhanced.

3. PRACTICES OF TRADITIONAL HERBALISTS/HEALERS

3.1 The Practice of Traditional Healing

According to a report by Eden, Faull and Barak (2000) (available at www.writing.uct.ac.29/traditional.htm), the term “traditional healer” refers to a person involved in one of a broad range of practices including herbalism and spiritualism. These practices are not

part of the Western biomedical tradition and for the most part are ignored or frowned upon by that segment of society. Broken down into their simplest forms, traditional healers can be placed into four categories as illustrated in table 3.

Table 3. Categories of traditional healers

Class	Sub-class	Specialist within sub-class
i. Diviner-medium	<i>Diviner-medium, shaman, priest, witch identifier</i>	Oracle, spirit-medium, ceremonial specialist
ii. Herbalist	Herbalist	Children's disease specialist, bonesetter, traditional birth attendant
iii. Alternative healer	"Black bagger" injectionist	-
iv. Religious faith healer	Christian and Muslim faith healers	-

SOURCE: Eden, Faull, and Barak (2000).

The traditional herbalists interviewed during the study confirmed that the categorization of traditional practitioners exists in terms of class, sub-class and area of specialization as presented in table 3.

There are two distinct categories of traditional health practitioners, i.e., traditional healers and traditional herbalists. Traditional herbalists treat physical ailments such as fever, cancer, ulcers, syphilis, diabetes, chronic cough, etc. and they use local herbs in treatment. On the other hand, traditional healers deal with social and psychological problems and use spiritual powers to counsel patients, analyse the source of a problem and administer treatment depending on what the spirits require (e.g., offering animal sacrifice) or according to former experience with a similar case. Sometimes, traditional healers also administer herbs to their patients. The spiritual powers (commonly known as "*empeewo*" in Buganda) are believed to be of different types, namely: ancestral powers (*lubaale*), spirits (*amayembe*), mermaids (*emisambwa*), and ghosts (*emizimu*). However, there may not be very strict boundaries between the herbalists and healers, since traditional healers can also treat physical ailments as some traditional herbalists can also treat spiritual ailments.

While conducting the study, the traditional health practitioners revealed that the majority of them learn traditional medicine and practices from their ancestors through informal education (through experience and observation). Others get visions on what herbs to use for treating a particular ailment, while some others (mainly spiritualists, bonesetters, and herbalists) inherit the healing power handed down from generation to generation. Some traditional herbalists combine both biomedicine and traditional knowledge to treat patients with apparent success. One US based survey conducted in 1993 found that traditional healers treat an average of two thousand patients per year. Similarly, the use of traditional treatment in Uganda is high particularly in rural areas as given by Hutchinson (1999) (see table 4).

In Uganda, like in many other developing countries, the majority of the population has greater access to traditional medicine than modern health care services. In Uganda, the ratio of traditional herbalists/healers to the population is about 1:200, compared to 1:20,228 for doctors, 1:4,804 for nurses and 1:29,367 for medical assistants (Green 1994; Hutchinson 1999).

Table 4. Use of curative care by urban and rural residence in Uganda (in percentages)

Treatment sought	1992-93		1993-94		1995-96	
	Urban	Rural	Urban	Rural	Urban	Rural
None	2.1	6.4	4.8	10.6	6.3	17.3
Self-medication	26.2	37.2	27.1	30.5	25.3	19.1
Government	20.6	19.5	10.5	19.0	19.3	25.1
Private/NGO	49.8	34.3	57.5	36.5	48.2	36.4
Traditional	1.2	2.3	0.1	3.1	0.7	1.5
Other	0.1	0.4	0	0.3	0.3	0.6
Total						

SOURCE: MPED 1992-93 and 1996-97; MFEP 1993-94 and 1995-96 (from Hutchinson 1999, 19)

3.2 Organizational Structure of Traditional Herbalists/Healers in Uganda

All traditional herbalists/healers are recognized under the Ministry of Gender, Culture and Social Development and are represented by a chairperson assisted by an executive committee. There are both registered and unregistered traditional herbalists/healers in Uganda. Those registered have formed associations among themselves and those that are not registered in any of the associations exist without any formal recognized linkages to other traditional herbalists/healers. Thus, they cannot be easily accessed by agencies supporting traditional herbalists/healers in health care management for training, funding and other activities. Among the existing legally recognized

associations are Uganda N'eddagala Lyayo, NACOTHA (National Council of Traditional Healers/Herbalist Associations), Buligwanga N,ebyalyo, and Buganda N'ennonno Zaayo.

While conducting the study, it was discovered that there is no council unifying all traditional herbalists/healers associations in Uganda. Earlier efforts were made to establish one but eventually it collapsed due to internal misunderstandings. The council earlier formed was called NACOTHA (National Council of Traditional Herbalist/Healers Associations), which now exists as an association.

NACOTHA was formed in 1992 to oversee all traditional herbalist/healers' activities in the country. The council had 13 executive members from different herbalists and healers' associations, and it was registered under the Ministry of Gender, Culture and Social Development and the Ministry of Health. Before its disintegration, the council had 87 registered associations from different regions of Uganda and 3 associations from Kenya. Its headquarters were situated in Kampala City at Katwe in the Jubilee Park¹.

However, when the council collapsed, individual associations strengthened their establishments and according to the findings, membership in the existing traditional herbalists/healers associations is voluntary. Each association is supervised by a chairperson and an executive committee with a set of objectives and by-laws that govern members. Fees contributed by as membership fees, development fees or certificate fees financially support the respective associations. These fees range between 10,000 and 40,000 Uganda shillings (approximately US\$5-20) and are paid yearly or monthly depending on the association. Associations operating in gazetted areas like NACOTHA (whose majority of the members are operating from the Jubilee Park) ask visitors to pay an entrance fee of 200 Uganda shillings (10 cents of a dollar) to financially support the association.

In each association, members meet at the headquarters periodically to discuss finance, research, education, security, environment, publicity, and other technical issues. It is through these meetings that traditional herbalists/healers also organize to participate in seminars and workshops, such as national conferences on HIV/AIDS, global seminars on health, cultural shows and exhibitions, and educational training programs on modern health care management. They also share knowledge during these seminars on use of herbs from different regions.

3.3 Traditional Medicine and HIV/AIDS in Africa

According to the report from the International Conference on Medicinal Plants, Traditional Medicine and Local Communities in Africa (May 2000), the high cost and scarcity of many essential drugs, including anti-retroviral drugs means that most people with HIV/AIDS use traditional herbal treatments for HIV-related conditions including opportunistic infections (http://www.para55.org/caretreat/trad_med_mine.asp).

In light of these statistics, there is an urgent need for research into the efficacy and safety of the traditional medicines being used by the majority, and how they can be improved and developed.

The first international conference on traditional medicine and AIDS in Africa was hosted in March 1999 by the Association for the Promotion of Medicine (PROMETRA) in Dakar, Senegal, to respond to the need of promoting traditional medicine. The conference was followed by a series of presentations on traditional medicine, together with a parallel session, at the International Conference on AIDS and Sexually Transmitted Diseases in Africa (ICASA) in Lusaka, Zambia, in September 1999. At the ICASA meeting, it became clear that there is considerable political support from African leaders for research on traditional medicine.

The first important milestone in consolidating this emerging interest and support for research and development on traditional medicine and HIV/AIDS was the establishment of an eastern and southern Africa regional task force on traditional medicine and HIV/AIDS. This arose from a conference in Kampala in February 2000, where delegates from seventeen African countries met to review the role of traditional health practitioners in HIV prevention and care. The meeting was hosted by THETA and support was provided by UNAIDS and PROMETRA. The delegates focused on collaboration between the traditional and modern health sectors and identified projects that meet criteria for best practice responses to the AIDS epidemic in Africa. THETA agreed to serve as the Secretariat for the Task Force (inaugurated on 10th April 2000 in Kampala), whose members also include the Traditional Health Practitioners Association of Zambia (THPAZ), and the Zimbabwean National Traditional Healers Association (ZINATHA). There were also observer groups from Ghana, Nigeria and Cameroon.

At the Kampala meeting, the Global Initiative for Traditional Systems (GIFTS) of health, accepted the responsibility within the task force to lay the groundwork for a network of researchers and institutions. The research programme will identify, assess, and develop safe and effective local treatments for HIV/AIDS-related illnesses. This research initiative has subsequently been established and named the HIV/AIDS Research Initiative on Traditional Healthcare in Africa (HARITHAF).

The HIV/AIDS Research Initiative on Traditional Healthcare in Africa (HARITHAF) is to develop and apply simplified but controlled clinical protocols to conduct rapid evaluations of the safety and efficacy of promising herbal treatments for HIV/AIDS. The herbal medicines can either be used as immuno-stimulants and antiviral agents, or to combat opportunistic infections. A solid government research infrastructure, backed by international agencies, will need to be developed in order to move from positive preliminary findings to the stages of production and development of safe, effective and affordable medicines. The research initiative will emphasize, where applicable, the local production and dissemination of useful herbs at the national, community and family levels. It will build databases for information sharing on the successes and failures of local treatments. It will be grounded in an intellectual property rights framework to protect the rights of local knowledge holders, learning lessons from existing programs in Africa, and sustainable horticulture will be promoted for priority herbal species.

In view of these objectives, the International Conference on Medicinal Plants, Traditional Medicine and Local Communities in Africa, together with its parallel internet conference, was viewed as an appropriate forum for the launch of HARITHAF. The linkage between biodiversity and human health was especially apparent in the context of unsustainable global pressure on wild stocks of medicinal plants and the role of priority diseases in contributing to

pressure on selected medicinal plant species and their habitats. WHO/AFRO committed itself to providing a substantial increase in technical and financial resources for the development of traditional medicine in Africa.

4. ANALYTICAL FRAMEWORK

The analytical framework illustrates the linkages between supply of and demand for healthcare by households, and the factors which influence healthcare seeking behaviour of patients. The demand-side factors essentially relate to the patient (consumer) characteristics while the supply-side relate to the behaviour of healthcare providers, the existing body of knowledge, the code of practice in provision of healthcare services, and the overall set up of the health system. The behaviour of the healthcare providers, as the more informed agents in the market for healthcare services, predominantly influences the supply-side.

4.1 Determinants of Demand for Healthcare Services

The demand-side factors include household income, price, population dynamics, incidence of disease, socio-cultural factors, availability and proximity of health services to the communities.

Economic theory suggests that in the case of a normal good, there is a positive relationship between income level and the quantities purchased of that good. That is, a rational consumer will demand more quantities with each additional increase in income. Studies have shown that healthcare services, as a composite good, is a normal good for which consumers demand more with additional increase in income (Asenso *et al.* 1997; Cropper *et al.* 2000). For example, Cropper *et al.* (2000) report that a 10 percent increase in household income resulted in a 4.2 percent increase in demand for malaria treatment among females in Tigray region, Ethiopia. Hutchinson (1999) also reports that the number of patients who do nothing about their sickness was greater in the rural areas of Uganda than in the urban areas. This is partly due to the low-income levels (poverty) in the rural areas. Likewise, the proportion of the population seeking care from the more expensive private providers was greater in the urban than in rural areas. The patients' demand for healthcare is, therefore, positively correlated with household income, such that with an increase in household income, more quantities of or more expensive services will be demanded.

The price of healthcare services will influence affordability and, therefore, overall demand for healthcare. However, healthcare as a composite good is highly price inelastic since it has no close substitutes, particularly for emergency cases. This implies that any percentage increase in price will result in minimal (less than proportionate) decline in household demand for the service. For example, in the case of a bone fracture or labour pains, the question will not be whether or not to seek care but the choice of the source of care; that is, whether to go to a private or government hospital. Hence, price considerations are very negligible. In less emergency cases,

such as routine medical check-up or plastic surgery, however, price will negatively influence demand for healthcare.

Another factor that influences demand for healthcare is population dynamics in the form of educational level, age structure, family size and composition, and people with special needs. For example, a household with more children (and/or old people) will tend to have greater demand for healthcare than one whose members are mostly in their prime age and less vulnerable to common diseases such as malaria. Similarly, education will influence the choice of the healthcare provider, and the amount and quality of care demanded. Educated people are more likely to be of a high social standing with a wider social network. Therefore, they become aware of a range of healthcare providers through school and social interactions.

The incidence of disease is another factor that influences demand for healthcare. Although at the individual level the incidence of illness is quite a random occurrence, at the society level, illness can be highly predictable. The old and children below five years of age, the chronically ill such as the diabetic or people with asthma will have a higher probability of falling sick, and their demand for healthcare will be higher than average. Similarly, poor people with poor sanitation, low nutritional levels, and poor housing facilities are more vulnerable to sickness. Hence, the burden of disease for such vulnerable groups is higher and will demand more healthcare services than average.

Socio-cultural factors are associated with the demand-side and include beliefs and perception of illness, cultural norms and taboos, religious affiliation, and overall household social status influenced by location, education level and employment status. For example, a person who is well aware of the dangers of ill-health and desirous of treatment is likely to incur relatively large expenditures for preventive services but may incur lower expenditures for treatment of morbid physiological conditions because they have been prevented. On the other hand, one who tends to ignore the symptoms of diseases will have low expenditures for preventive services and care of non-critical conditions but may well spend more for treatment in the long run. Therefore, perception of illness greatly influences demand for healthcare. Cultural norms may also influence the patient's healthcare-seeking behaviour. For example, a patient who believes that the cause of illness is associated with spiritual powers will seek care from spiritual healers even in the case of diseases such as malaria, which are not associated with curses or bad spirits. The same applies to the saved people in the Christian faith who may rely only on praying for the sick as the only way of providing treatment.

Accessibility and proximity to healthcare providers and health facilities influence demand, since they affect the cost of seeking care in terms of transport costs and time. For example, Hutchinson (1999) shows that the proportion of people seeking curative care in Uganda is greater in the urban areas, where the majority of the population live within 5 km radius of a health facility/provider. In the rural areas, where the majority of the population live beyond 5 km radius to a health facility, the demand for healthcare is far less. The difficulty in accessing a health facility results in delays to seeking vital care or foregoing vital healthcare services altogether, with serious consequences to a patient's health and overall household welfare.

4.2 Determinants of Supply of Health Services

The supply-side factors largely include the existing body of medical knowledge in the management of disease, the code of practice governing the healthcare system, and the behaviour of healthcare providers.

One of the factors that limit a healthcare practitioner from providing a set of different treatment methods is the extent of his/her knowledge of the existing treatment methods. For example, when AIDS cases in Uganda were first identified in the early 1980s, there were few methods known in the management of HIV/AIDS-related illnesses and prevention of infection and re-infection. No anti-retroviral drugs had been developed by then and no herbal treatments were in use. Healthcare practitioners were, therefore, limited in their knowledge of providing treatment to AIDS patient and this in turn influenced the demand for healthcare by the patients. As new knowledge is generated, the choice of treatment methods is expanded. For example, the development of anti-retroviral drugs and discovery and development of more effective herbs has increased the choice of managing HIV/AIDS-related illnesses, which influences the patient's demand for healthcare.

The existing code of practice in the health system also influences the range of healthcare services and the demand for them. For instance, until the mid-1990s, traditional herbalists/healers in Uganda were not licensed and recognized by the medical council. Since the adoption of the multi-sectoral approach to the fight against HIV/AIDS, some traditional herbalists/healers have since been licensed under their associations and their operations have expanded. In addition, some traditional herbalists/healers under THETA have undergone training in providing counselling services, proper herbal usage, storage and preservation, and hygiene and sanitation. The formation of herbalists associations has promoted research into more effective herbs for the management of HIV/AIDS-related illnesses. It has also promoted collaboration with modern health practitioners in the fight against the HIV/AIDS scourge. Hence, changes in the medical code of practice influences the functioning of the supply-side of the health system.

The health economics literature suggests that the healthcare provider is more informed about the level of effectiveness of a given healthcare service than the patient but will act in the best interest of the patient while providing care, as a perfect agent. That is, before a given treatment procedure is administered, the healthcare provider will consider the effects of the treatment on the patient's health and the patient's well being. However, there are a set of considerations, such as professional ethics, time cost and the provider's own welfare, which the healthcare provider makes but do not concern the patient. Given these considerations, the healthcare provider may not always act as a perfect agent of the patient. For example, private healthcare providers, in their desire to maximize revenue by seeing more patients in a given time, may not perform certain treatment procedures that are time-consuming, yet these procedures could be more effective. Therefore, the behaviour of healthcare providers will influence the quantity and quality of services provided. Fig. 1 summarises the different demand-supply linkages in healthcare.

Fig. 1. Interactions between the demand and supply of health care

The interaction between the demand- and supply-side factors in turn influences utilization rates, choice of provider and choice of treatment in the management of a given health problem.

4.3 Methodology

A Participatory Rapid Appraisal (PRA) approach was used, involving traditional herbalists, AIDS patients seeking treatment from traditional herbalists and key informants among whom were AIDS patients and traditional herbalists. The PRA methodology was considered suitable since the study required data about the healthcare-seeking behaviour of AIDS patients, which is a highly sensitive matter in spite of the wide-spread campaigns against AIDS, which are believed to have considerably reduced the level of stigmatization about the disease. Hence, AIDS patients and their close relatives are very reserved about discussing their healthcare-seeking behaviour to outsiders other than counsellors and healthcare providers.

The PRA tool is appropriate because when the respondents are discussing together, the element of concealing information can be overcome and there is general consensus about an issue in the shortest time possible and the method is self-correcting as it initiates debate. In addition, the PRA is a protection tool for the researchers. It is capable of leading to a feasible policy recommendation for a problem, since such recommendations come via consensus from the concerned population as immediate beneficiaries. This way, the respondents envisage themselves as potential stakeholders in the implementation of the recommendations and avoid making suggestions that may not be feasible to the community.

4.3.1 Sample Selection

A sample of 47 traditional herbalists (15 females and 32 males) who are specialised in the management of HIV/ AIDS-related illnesses were selected. They are organized under NACOTHA and Buganda N'eddagala Lyayo Associations. Others were members of THETA from Kampala and Wakiso District. They represent different herbal stores including *Buligwanga N'ebyalyo, J.B.K.M. Research Centre, Uganda N'eddagala Lyayo, Traditional Medicine Centre, African Medicine Research, Bazaatusanga Babiri Amalgamated Traditional Herbalist Centre and Herbal Research Company, Mayinja clinic, Kireka Herbal Research Centre, Bwakedde Mpuliira Herbal Centre, and Bulamu Bwe Bugagga Research Organization.*

Overall, four focused group discussions (FGDs) were organized with the traditional herbalists. A sample of 30 traditional herbalists from NACOTHA was identified from different herbal stores in consultation with their chairpersons. They were then divided into two groups of 15. The first FGD was held in the Jubilee Park, and involved traditional herbalists working from within the Park. The second FGD involved traditional herbalists working outside the Jubilee Park. The third FGD involved a sample of 6 traditional herbalists from *Buganda N'eddagala Lyayo* selected in consultation with their National Secretary, and the fourth FGD composed of 11 traditional herbalists from THETA, and were met at THETA headquarters in Kamwokya during a speaker's bureau organized by THETA.

During the FGDs, the traditional herbalists were asked to give their experiences about the most common diseases suffered by AIDS patients, and to indicate the diseases they can manage using local herbs. They were also asked to provide information about the type, source, and method of administration and preservation of the herbs, and the dosage and cost of drugs. Information was sought about patients' characteristics, the benefits of using local herbs, existing linkages and the kind of support received (or desired) from the government and other agencies working on HIV/AIDS. The traditional herbalists also brainstormed on the overall constraints faced while providing treatment, particularly to AIDS patients. They were engaged into a brainstorming session but the issues were presented systematically, generating consensus on the responses given. Thus, reporting bias was considerably reduced at the same time allowing each experience to be correlated with others.

In addition, six key informants were interviewed to provide detailed information about their practices in the management of HIV/AIDS-related illnesses.

A sample of 38 AIDS patients was involved, divided into 2 focused group discussions. It was very difficult to get AIDS patients who were willing to disclose their experiences, particularly regarding the use of traditional medicine. Although attempts were made to mobilize the patients through their respective traditional Herbalists, many were still not willing to participate in the study and could not be persuaded by their traditional herbalists. That is why a small sample of only 38 respondents participated in the study, hence the small sample.

The AIDS patients were asked to give their views and experiences on the range of services received from traditional herbalists, and their reasons for choosing traditional herbalists instead of modern medicine. They also provided information regarding side-effects experienced in using local herbs and general constraints in using herbs to manage AIDS-related illnesses.

5. FINDINGS OF THE STUDY

The PRA sessions sought to determine a number of issues relating to the use of traditional herbs in the management of HIV/AIDS-related illnesses. These include identifying the advantages associated with using traditional herbs in the management of HIV/AIDS; identifying the treatment methods, payment modes and linkages between traditional herbalists and other agencies working on HIV/AIDS; and identifying problems encountered and how to enhance the role of traditional medicine in HIV/AIDS management.

5.1 Results from the PRA with Traditional Herbalists

During the focused group discussions with the traditional herbalists, the demographic characteristics of the AIDS patients who were seeking traditional treatment were documented with a view of understanding the unique features, if any, related to seeking treatment from traditional herbalists. It was revealed that the majority of the AIDS patients who seek such treatment are women. For instance, during the FGDs at the Jubilee Park, the traditional herbalists revealed that on average 6 in 10 of their patients are women, 26 out of the 38 participants of the FGDs with the AIDS patients were women.

Three basic reasons were given for this observation. First, it was noted that men are usually reluctant to use herbs, relating them to witchcraft; and those who seek treatment do so secretly. Secondly, men are not as responsible about their health as women are. Thirdly, men do not openly seek treatment from traditional herbalists for fear that rumours may spread that they are HIV positive and yet they may want to enter new relationships after contracting the virus. In addition, in a bid to address their socio-psychological problems concerning their families and marriages, women become more knowledgeable about traditional healing. Moreover, women tend to have fewer incomes and find it cheaper to seek treatment from the traditional herbalists who are willing to receive part payment and offer credits to their clients.

The traditional herbalists who took part in the FGDs at the Jubilee Park estimated that on average 7 - 15 patients seek treatment for HIV/AIDS-related illnesses per week. Of which, approximately 6 out of 10 patients seek treatment after the loss of a sexual partner, and about 2 in 10 patients seek treatment after recognizing HIV/AIDS-related symptoms. Approximately 4 out of 10 patients seek treatment after being tested HIV-positive and after having failed to register change in the use of modern healthcare services. At least 2 patients claim to have been bewitched yet their symptoms are actually very similar to those of AIDS.

5.1.1 HIV/AIDS-related Illnesses Commonly Managed by Traditional Herbalists

During the FGDs, the traditional herbalists identified about six HIV/AIDS-related illnesses they manage, which include skin-related infections, persistent fever, cough, headache, chronic diarrhoea, and internal and external wounds. Since the traditional herbalists do not carry out HIV testing on their own, they rely on the presence and persistence of the most common symptoms and past histories of their clients to provide treatment for HIV/AIDS-related illnesses. There are also instances when patients visit them after being aware of their serostatus. The traditional herbalists noted the following as the most common symptoms for HIV/AIDS infection and identified the type of herbs they administer in each case.

Skin-related infections, which include sores, skin itching and herpes zoster: In AIDS patients, the itching is accompanied with formation of painful blisters especially on the face, arms and legs. These blisters form black spots on drying and ash-like formation when scratched. The appearance and re-appearance of sores especially in the genital organs and around the chest is also another common skin problem. The other common skin infection is herpes zoster rash, which appears like burnt sores along the distribution of a sensory nerve.

The traditional herbalists indicated that they treat skin infections using extracts from a medicinal plant called *Clausena anisata* (*Muwo*). The plant leaves are dried and pounded into powder, which is mixed with Vaseline for external application to the infected area. In the case of herpes zoster, treatment is both external and internal because it is believed that the infection starts from inside the body. Externally, herbal extracts mixed in Vaseline are applied and for the internal infection, plant extracts are either boiled or squeezed in water for drinking.

Persistent fever with severe pain in the joints: Herbal extracts from *Vernonia amygdalina* (*Mululuza*) and *Erythrina abyssinica* (*Kigajji*) are used to treat the fever. Both of these plant extracts are mixed in water for drinking. In addition, persistent headaches are also a common problem among AIDS patients. The headache usually occurs in the forehead and is related to accumulation of heat and pressure in the brain. In such cases, herbs are used to prepare a steam bath for the patient.

Chronic diarrhoea and persistent cough: these symptom usually occur at later stages in the epidemic cycle. The cough is mostly associated with tuberculosis infection. It is usually lengthy, thick in appearance sometimes with stresses of blood and the patient experiences a lot of chest pain while coughing. The most common herb used is *Warburgia ugandensis* (*Mukuzannume*). The patient usually drinks these herbs until the condition improves.

Internal and external wounds: The internal wounds appear in the throat down to the abdomen and are very painful to an extent that the patient may be unable to eat. In treating the internal wounds, herbal extracts from a plant called *Chenopodium opulifolium* (*Mwetango*) are squeezed with water, with small amount of salt added, for the patient to drink at regular intervals. Bee honey is also used to treat wounds in the alimentary canal. External wounds are also common and usually affect the genital organs particularly in advanced stages of the infection. They are usually persistent and take long to cure. Herbal extracts from plants called *Alstonia boonei* (*Mubajjagalabi*) and *Hoslundia opposita* (*Kamunye*) are used to clean the wounds, and drain out pus.

The herbs are administered in different forms to the patient. Some herbs are pounded into powder form and mixed in food or drinks. Others are mixed in Vaseline for external use especially in the case of skin-related infections and external wounds. In addition, some of the herbs are boiled for drinking or steaming while others are squeezed raw in water for drinking or for bathing. In some cases, regular boiling is required to preserve the herbs for a longer period. And many herbal stores locally prepare herbal mixtures for their patients and the mixtures are collected for use at regular intervals to prevent the outbreak of HIV opportunistic diseases.

The herbs used in the management of HIV/AIDS-related infections boost the body immune system by making the HIV virus inactive to prevent multiplication. Some herbs also stimulate the production of blood cells in order to replace those destroyed by the virus. These herbs are also useful in repairing worn out tissues, restoring appetite, restoring lost body nutrients and cleansing out intoxicants from the body.

It was revealed that there could be a significant improvement within approximately 2-4 months of treatment if the patient seeks treatment early enough before the body immune system breaks down, and is active in taking the required dose. However, in case the condition does not improve, referrals are made to specialists among the traditional herbalists² or hospitals.

Since the herbs are administered in their natural form, patients seeking traditional treatment have not reported any significant side effects except the bitter taste and awful smell of some herbs. In addition, there are no problems of over-dosage even when their use is not well monitored.

Most of the herbs grow naturally in forests, bushes, and wetlands. However, many herbalists do grow herbs in their gardens, particularly those herbs that are rare or which have to be collected from distant places. The herbs are usually parts of the stems, roots and leaves of medicinal plants. In Uganda, herbs are mostly collected from Mubende, Rakai, Masaka and Mukono Districts because they have large forests and thicket cover. These herbs are also collected from neighbouring countries such as Tanzania, the Democratic Republic of Congo and Rwanda and other countries as far as Saudi Arabia, India and China.

Table 5 summarises the key findings of the in-depth discussions held with selected traditional herbalists as key informants.

Table 5. Information from key informants (traditional herbalists)

Informant	Patients' social status	AIDS-related illness treated	Treatment methods	Effect of treatment	Cost per dose (UG Shs.)	Contents in the dose	Herbal sources	Treatment centre & location	Affiliated Association
1	- Primary and tertiary educational level - Low and middle income groups	Chronic diarrhoea, fever, cough, sores and headaches	Syrups, powder, Vaseline and soap	- Boost the immune system	10000 per litre used whenever patient is ill	N/A	Own garden at Kabasanda and from Kasese, Busoga and Nakasongola	Bwakede Mpuliir a Herbal Center at Kiseka Market (Kampala)	Uganda Herbalists and Cultural Association
2	- Primary, secondary & tertiary educational level - Low, middle and high income group	Headaches, herpes zoster and diarrhoea	Syrup, Powder, Vaseline and soap	- suppressing the virus - stimulates production of blood cells	15000 per litter used every after 2 years	Achyranthes Aspera, (<i>Abukwasi</i>) Zanthoxylum Chaybeum, (<i>Entaleye ddugu</i>) and Allium Sativum (<i>Katungulu Kyumu</i>)	Own garden	Lukuli in Makindye division	THETA
3	- Primary, Secondary & Tertiary educational level - Low, Middle and high Income group	Chronic Diarrhea, Fever Cough, skin Cancer, herpes zoster, pneumonia and abdominal problems	Syrup and herbal soap	- Boosts the immunity - Cleanses out body intoxicants - Repairs worn-out Tissues	N/A	Psidium Guajava (<i>Mapeera</i>) Melicia-Excelecia (<i>Muvule</i>) Rose Carnina Wormwood and Mugwort	N/A	Katwe Jubilee Park at Bulamu Bwe Bugaga Herbal store	NACOT HA
4	- Primary, Secondary & Tertiary	Chronic Diarrhea, Fever Cough, Sores and	Syrup (AIDS Expectorate), Vaseline and Soap	Immune stimulant Prevents out-break of	10,000/= per litre of the AIDS-Expector	N/A	<i>N/A</i>	Katwe Jubilee park at JBKM Researc	NACOT HA.

	y educatio n level - Low, Middle and high Income group	Headaches		Opportuni stic infections	ate for 3 months			h Center	
5	- Primary, Seconda ry &Terti ary educatio n level - Low, Middle and high Income group.	Treats HIV/AIDS Opportuni stic infections	N/A	-Prevents out-break of Opportuni stic infections -Treats Opportuni stic infections	N/A	N/A	N/A	In Ndeeba at St Raphael Herbal Curativ e and Researc h center	N/A
6	- Primary and Tertiary educatio n level - Low and Middle income group	Sores, abdominal pains, Chronic Diarrhea, Fever	(Kalya Amagwa) Syrup Powder, Vaseline and Soap	- Stimulates production of blood cells - Treats Opportuni stic infections	5000 per litre and used when ill	<i>N/A</i>	N/A	At Kireka (Wakiso)	<i>Uganda N'eddagal a Lyayo</i>

SOURCE: Survey Data.

Note: The exchange rate is about 1800 Uganda Shillings per US Dollar.

5.1.2 Counselling Services

Apart from herbal treatment, traditional herbalists also provide counselling services to their patients. They have the advantage over the modern healthcare providers in that they spend more time with and keep good track of their patients by maintaining a close personal relationship. As a result, patients usually feel secure disclosing their experiences, including family matters, to the traditional herbalists. This enables the traditional herbalists to guide their patients on how to deal with the HIV opportunistic diseases and at the same time to cop with the demands of life.

Given their counselling skills, traditional herbalists have managed to persuade AIDS patients who claim to be bewitched, to take the HIV/AIDS tests and start regular treatment. For instance, it is estimated that approximately 2 out of the 7-15 AIDS patients received every week in the Jubilee Park claim to be bewitched and yet they have symptoms of HIV/AIDS sickness. Therefore, persuading them to take an HIV test in order to receive proper treatment is very challenging. Creating a close relationship is vital to win the patients' confidence to convince them to take the HIV test.

The traditional herbalists reported that most of them have received counselling skills through training workshops organized by NGOs, which include THETA (Traditional and Modern Health Practitioners Together against AIDS), Concern Worldwide, TASO (The AIDS Support Organization) and the Virus Research Institute in Entebbe.

In counselling, traditional herbalists advise the HIV/AIDS patients to avoid drinking alcohol and encourage them to eat bodybuilding foods to restore worn-out tissues. In general, HIV patients are advised to treat any opportunistic diseases as fast as possible, to stick to one sexual partner and use a condom to avoid infection and re-infection. In fact, some herbalists reported to be involved in distributing condoms and educating clients on how to use them. However, a number of the traditional herbalists interviewed claim that condoms are not effective in protecting against HIV infection since they do not entirely eliminate the sexual fluids from getting into contact during intercourse. According to them, the male condom can fully protect the female partner but not the male. There tends to be more sexual fluids from the female partner during sexual intercourse and there is a higher possibility of the fluid getting into contact with the unprotected parts of the man especially after shaving the pubic hair. In addition, female patients are advised to avoid getting pregnant in order not to stress and weaken the body, and avoid mother to child transmission of the virus.

5.1.3 Problems Faced by Traditional Herbalists

During the PRA, about 5 major problems were identified including structural and financial problems, negative social stigma due to limited sensitization about traditional medicine, shortage of herbs and administrative problems.

A. Structural problems

There are no centralized premises such as a resource centre where patients or their caretakers can seek information about the available range of treatment services. This information gap makes some patients delay in seeking treatment and or in identifying the appropriate service providers given their health conditions. Most of the time, patients or their caretakers get to know about these traditional herbalists from other patients who have sought treatment from a given herbalist or from friends and relatives. For instance, at the Jubilee Park, it is not easy to establish which traditional herbalist deals with a particular ailment, as a result of which patients may be misguided and exploited by unscrupulous herbalists.

In addition, many traditional herbalists lack adequate premises from where to operate. For instance, at the Jubilee Park, traditional herbalists operate from a small single room where herbs

are stored, patients are received and treated. There is no space for resting in case patients require resting. The traditional herbalists operating from their homes are constrained in instances where the patient has to stay for supervision and monitoring, or when he comes from a distant place and is unable to go back home after receiving treatment, since they have to share the family utilities like food, beds, toilets and bathrooms.

The other structural problem is the lack of scientific equipment such as stethoscopes, clinical thermometers and other laboratory facilities necessary to make simple scientific diagnosis of the patient's condition in order to provide appropriate treatment. In the absence of such equipment, traditional herbalists base themselves on the patient's history and their own past experience with similar cases to provide treatment. The other necessary equipment that many traditional herbalists lack is grinding machines used for synthesizing preserved herbs or herbs that are administered in powder form. Locally made grinders are used but they demand a lot of manual labour because apart from grinding, the herbs require sieving and regrinding into fine particles for proper use and storage.

B. Financial problems

Although a number of herbs are available free of charge from non-gazetted forests and wetlands, the traditional herbalist indicated that they incur costs for collecting the herbs in form of transportation and payment of their correspondents/botanists, who look for and collect the herbs from the forests, bushes and wetlands. In addition, there are synthesizing, packaging, storage and preservation costs involved. All these expenses require adequate financing, which the traditional herbalists lack. Financial problems arise because traditional herbalists do not benefit from external funding as in the case of modern healthcare, and may not adequately get funds from the fees they charge the patients. This is as a result of providing treatment on part-payment and sometimes credit resulting in non-payment because after a patient has received preliminary treatment and feels better, he/she may not complete treatment, particularly when there is a significant balance to pay to complete the dose. However, the traditional herbalists revealed that they practice price discrimination in order to cover unanticipated losses arising from default on payment. Prices are set differently depending on the patient's social status, need and relationship with the herbalist.

Traditional herbalists cannot afford to support research to establish the level of effectiveness for most of the herbs they use or to develop more effective herbs, which would manage HIV/AIDS-related illnesses. On the other hand, the chemotherapy laboratory at Wandegaya, which is supposed to test the effectiveness of herbal mixtures prepared by traditional herbalists, is largely not used for fear of losing patent rights to unscrupulous herbal dealers.

C. Negative social stigma about traditional medicine

The traditional herbalists revealed that there tends to be significant negative social stigma and resentment for traditional healing and use of herbs. First, the practice of traditional healing is associated with paganism and has been undermined since the introduction of western-based religion in Uganda. For example, in Christianity and many other religions, traditional healing is

viewed as an evil and satanic practice. Therefore, many people do not want to be publicly associated with it.

Secondly, there are some traditional herbalists who are involved in illegal practices such as human sacrifices in traditional healing. In addition, some people go to consult traditional herbalists with ill motives to bewitch others. This has greatly tarnished the image of traditional healing labelling all traditional herbalists as unscrupulous. Efforts to identify these unscrupulous herbalists under the on-going censoring program are futile because traditional herbalists are not registered country-wide to know who is genuine or not in a specific area.

Another factor that has tarnished the image of traditional medicine is that whereas traditional herbalists do have areas of specialization, this information is not available to the patients to know where exactly to seek care. Hence, herbalists who are not genuine may financially exploit some patients without any improvement in the patient's health condition. This tendency has led many people to doubt traditional treatment in general. Therefore, given the negative social stigma associated with traditional medicine, a number of patients actually seek herbal treatment as a last resort even though many herbs have been found to be effective in managing HIV/AIDS- related infections if used in time.

D. Shortage of herbs

As pointed out earlier, most of the herbs are collected from forests, bushes and wetlands but some useful herbs are either extinct or are very rare to come by. Yet, there is limited effort to preserve the rare herbs through botanical gardening on individual or association basis. For example, out of the 30 traditional herbalists met during the FGD at the Jubilee Park, only 3 had their own herbal gardens. The ban to deforestation also limits access to forests to collect herbs. Although herbs are leaves, stems or root parts and may not necessitate up-rooting the whole tree species, forest authorities do not give the herbal collectors access to forests without permits.

E. Administrative problems

Registered traditional herbalists in Uganda exist under different associations and the unregistered operate individually. But all traditional herbalists are represented by the chairperson of *Uganda N'edaggala Lyayo* Association (currently Ben Ggulu). There is no unifying council for traditional herbalists in Uganda where all could be identified as part of the medical system. All existing registered associations have their own agenda and objectives and no one is responsible for their activities especially in regard to the provision of healthcare because there is no mechanism in place to prove that what they are doing is genuine or not. Even illegal practitioners, like those involved in human sacrifice, are considered to be part of traditional herbalists.

5.1.4 Suggestions to Improve Traditional Herbalists' Practices

During the FGDs, the traditional herbalists came up with a number of suggestions to address the basic problems that are prevalent in traditional healing. They pointed out that the major problem is lack of awareness on traditional healing practices. There is, therefore, need to promote

traditional medicine through the following ways. First, traditional medicine should be promoted through the education system by incorporating it in the medical studies curriculum. This will legitimize traditional medicine as an effective medical treatment, and not rely only on modern medicine.

Secondly, seminars, workshops and exhibitions should be promoted as a way of creating awareness about the available herbal medicines, and the respective diseases/infections that can be managed using these herbs. The seminars and workshops will promote collaboration between the traditional herbalists and modern healthcare providers on one hand and cooperation among the herbalists on the other. In particular, training workshops will also harmonise efforts of the traditional herbalists and other stakeholders in the fight against the HIV/AIDS epidemic. For example, the recent international conference on traditional medicines, which took place in Kampala International Conference Centre in August 2002, aimed at bringing together traditional herbalists from different regions in and outside Uganda, and harmonizing the use of traditional medicine in the management of HIV/AIDS-related illnesses. In addition, publicity through the different media would also promote awareness about traditional healing practices and people will come to appreciate the role played by traditional herbalists in the management of HIV/AIDS.

The other suggestion made by Traditional Herbalists was to address the financial constraints they face. They indicated that financial assistance through a fund especially on HIV/AIDS management or micro-finance schemes should be provided to them. The financial assistance would enable them to conduct research into safe and effective traditional herbs, and therefore enhance the capacity of Traditional Herbalists in managing HIV/AIDS and other diseases. The research will for example be geared towards effective and improved herbs for HIV management, and enhancing knowledge on health practices as a means to standardize and improve the application of herbal medicine.

As part of the awareness campaigns, the financial assistance will also be used to initiate and promote outreach programmes that will coordinate Traditional Herbalists and modern healthcare providers in all regions of Uganda. That is, in sharing knowledge on traditional treatment practices and the standardization of herbal medicine to match World Health Organization (WHO) standards. Through such outreach programmes, censoring of Traditional Herbalists can be done to check traditional health practices, which are not compatible with healthcare regulations and eliminate illegal practitioners, in order to give credibility to traditional herbal practices.

The Traditional Herbalists recognized the need to preserve the available knowledge on traditional medicine for the future generations. They therefore suggested the establishment of a well-facilitated resource centre to keep such vital information. The resource centre will also serve as a source of information about existing and upcoming traditional medicines/treatment practices to the Traditional Herbalists themselves and other interest parties and researchers. The resource centre will provide information to the general public about the available registered traditional health practitioners, their location and areas of specialization. This will address the existing information gap between the health providers and the potential beneficiaries. In addition to a resource centre, there is need to preserve the rare and nearly extinct herbal medicines. The Traditional Herbalists suggested that local governments e.g. at sub-county level, should provide

land for botanical gardening to preserve the rare herbs. Individual Traditional Herbalists should also be encouraged to grow herbs in their own gardens.

5.2 Results of the PRA with AIDS Patients

Two FGDs were held with HIV infected patients seeking traditional treatment. Views were obtained on reasons for choice of traditional treatment, most common diseases treated as well as problems encountered and recommendations from the patients' viewpoint. The first FGD was held at Bwakedde Mpulira Herbal center, At Kisseka Market, Kampala involving 15 patients. The second FGD involving 23 patients was held at the Jubilee Park, Katwe.

5.2.1 Reasons for Choice of Traditional Herbal Treatment

According to HIV infected patients seeking traditional treatment, herbs have proved to be more effective in the management of AIDS-related opportunistic infections because from their past experiences, traditional herbs had cured ailments that had resisted pharmaceutical drugs. For instance, one of the participants who tested HIV positive in 1993, reported that he fell ill with fever for about 5 months, and consistently used chloroquine and Fasindah but the fever became chronic. A friend advised him to visit a herbal centre and receive treatment and since then he has not suffered from chronic fever. Another participant who had developed boils in her private parts in 1991 could not cure after a year of using pharmaceutical drugs from TASO. But when she started using herbs the boils cured. Other participants indicated they had suffered from chronic diarrhea, vomiting and fever and had used pharmaceutical drugs for a long time with no significant change. But upon using herbal treatment the illnesses become less frequent and easier to manage.

According to the participants in the Patients' FGDs, traditional herbs have limited side effects as compared to the existing pharmaceutical drugs for HIV management. Side effects like resistance to the herbs, body weakness and nerve damage, are not reported among patients using traditional herbs since most of the herbs are administered in their natural form and there are no chemicals added as preservatives or concentrates. Apart from curing opportunistic infections, the herbs also play a preventive role by strengthening the body immunity to resist infections, restore vital body nutrients, provide energy, restore appetite and prevent body wasting.

In addition, the participants reported that the traditional herbs are easier to administer. Some of the herbs are administered in liquid form therefore easier to drink or mixed with food or juice. In comparison the pharmaceutical tablets may be big and therefore difficult to swallow regularly and painful in case of patients with sores in the alimentary canal. The injections are also an inconvenience because they are usually many and require trained medical personnel to administer them to a patient. As a result, visiting a medical centre for injections becomes regular and expensive.

The patients revealed that the traditional herbs are relatively cheaper to buy compared to pharmaceutical drugs, and since some of the herbs are readily available in people's gardens, the patients can prepare some of the herbal medicine on their own and use them without any supervision. It is also common for the Traditional Herbalists to provide treatment with part-

payments or on credit, which benefits the poor patients. This implies that lack of money at hand is not a big limitation for one's access to treatment, especially for the long-time patients (existing/regular) patients whose debt payment record has been proved credible. For instance one participant reported that she tested HIV positive in 1993 and after the death of her husband (as a mother and housewife), she could not afford any treatment for skin rashes, abdominal pains and persistent vomiting which she experienced. But she received two bottles of syrup free of charge after approaching one of the Traditional Herbalists in the area.

The other benefits related to seeking treatment from Traditional Herbalists is the close contact they keep with their patients through counseling, and caring to know about the patients' other family issues. Patients also get an opportunity to establish close relationships among themselves, which helps them to share experiences, exchange ideas about the available effective herbs, and restore hope for positive living with AIDS. For example, one participant giving her experience said:

“I had lost hope, I didn't want to pay fees for my children or buy any thing new for myself or the children. However after meeting fellow AIDS patients and sharing experiences, I gained hope to live positively with HIV and give my children a future”.

The FGD participants further revealed that Traditional Herbalists are always available whenever they are needed and are easier to talk to because they play a guardian/counselor role in the community. There are also instances when the Traditional Herbalist offer financial assistance to the patients for transport, food and drinks.

The AIDS patients also engage in social activities such as drama, through which they transmit information about HIV/AIDS to the wider community. For instance, participants met at Bwakedde Mpulliira herbal store revealed that at one time they visited fellow AIDS patients in Mpigi and Buwama to interact and sensitize them about living positively with HIV/AIDS.

5.2.2 Problems Encountered by AIDS Patients

During the FGDs the AIDS patients identified three basic problems. One of the major problems is the shortage of finance to support patients, and their families. During illness, there is significant loss of productivity and the sources of income are limited. Yet they have got to carry on with their family responsibilities like feeding, clothing and housing, paying school fees for the children, medication for self and family, etc. The problem of finance to support the family tends to be more pronounced in the case of widows, because by the death of the husband, the family property may have been significantly depleted while meeting treatment costs. In other cases the family property may be taken over by the husband's relatives leaving the widow with no income sources or property to support the children as well as meet her medical expenses.

The other problem identified relates to the use of herbs whose effectiveness has not yet been proven. This results in instances where herbal types have to be changed several times before one that can effectively address a given illness is identified. Meanwhile the patient will have spent money and as a result the patient may lose confidence in using traditional herbs. Furthermore, modern healthcare providers have not yet recognized and appreciated the role of traditional herbs

in treatment of illnesses. For example, when AIDS patients are admitted to hospitals to receive treatment for AIDS infections, which the Traditional Herbalists cannot easily, address (e.g. theatre operation or blood transfusion) patients are not allowed to use herbs concurrently to treat opportunistic infections which may arise. Yet local herbs could treat such opportunistic infections more effectively.

5.2.3 Suggestions for Improvement

In the FGD participants made suggestions to address the problems identified above. First, they need financial support in form of soft loans to start off small businesses and get an income to support their families. This would enable them to access adequate medical care, afford better nutrition, pay school fees for their children and meet other requirements. They revealed that when they engage in income generating activities, it reduces their thoughts and worries about their serostatus, and empowers them for sustainable positive living with AIDS. Financial support would also address problems were widows have had to remarry in order address their financial needs, which has serious implications of infection and re-infection.

The other suggestion made was that traditional herbal medicine should be recognized and promoted through linkages between the Government, Traditional Herbalists and modern health care providers, in order to harmonize traditional and pharmaceutical treatment, in the fight against HIV/AIDS. Such a linkage would freely promote the use of herbal medicine even were possible concurrently with the pharmaceutical drugs for effective management of HIV/AIDS-related illnesses. It would also encourage AIDS patients not yet using herbs to start treatment as an alternative to manage HIV /AIDS related illnesses.

Campaigns about traditional treatment as an effective alternative for AIDS management should be supported and intensified. This is because an AIDS patients may neglect using herbal treatment due to lack of awareness about its effectiveness in the management of HIV/AIDS related illnesses. These campaigns should also advocate for research in local herbs, de-stigmatization of using local herbs, and promote Traditional Herbalists in the fight against HIV/AIDS.

5.3 Linkages between Traditional Herbalists, Government and other Agencies

5.3.1 Internal Linkages

Registered Traditional Healers/Herbalists have associations and most of these associations are in Kampala with members from different parts of the country (mainly from Districts of Kampala like Masaka, Mpigi, Iganga, Jinja, Mukono and Mityana). The registered associations include Uganda N'eddagala Lyayo, Nacotha, Buligwanga Ne'byalyo, African Medicine Research, Traditional Medicine Center, Herbal Research Company. These associations have executive committees responsible for finance, research, and education, security, environment, publicity and technical advice. They have a set of objectives and by-laws that govern members in the association. Financially members of each association have set up fees to be collected to assist in the functioning of the association. These fees range from 10,000-40,000 per year (about US\$ 6-21) and basically include membership fees, development fees, certificate fees or identify card

fee. The associations in gazetted areas of operation like the Jubilee park, visitors pay an entrance fee of 200/=.

In each association members meet at the headquarters periodically to discuss general issues to strengthen their operations and promote indigenous knowledge i.e on newly discovered effective herbs for HIV/AIDS management. Through these meetings Traditional Healers/Herbalists also organize to participate in seminars to build capacity in traditional treatment. They also organize workshops on to exhibit culture. They have also been involved in sensitization campaigns For instance in November 2001 members of the Uganda N'eddagala Lyayo association were called upon to sensitize parents in Mpigi District who had refused to take their children for malaria treatment thinking that the children had been be witched

Members in each association have also started establishing herbal gardens in different villages. These gardens though still at a small level, Traditional Herbalists are able to access herbs easily and distribute to other Traditional Herbalists. Medicinal plants like *Syzygium Cordatum* (Kanzironziro), *Vernonia Amygdalina* (Mululuza), *Acacia Hockii* (Kasaana), *Markhamia Lutea* (Munsambya), And *Combretum Molle* (Endagi) are grown at a substance level and distributed among Traditional Herbalists.

Traditional Herbalists revealed that they plan to set up a museum to promote and preserve indigenous knowledge and NACOTHA is planning to start-up a school, which will target all age groups. The school curriculum will be based on the needs of the students to enable the young generations to acquire knowledge about traditional health care management.

A clinic for both in-patient and out -patients meant to offer modern and traditional health care management to the community has also been established in Kisenyi at the headquarters of Uganda N'eddagala Lyayo Association. The clinic will have facilities to enable blood transfusion, and carry out operations. However, it is not yet equipped to offer the required services. Since Traditional Herbalists have been empowered with knowledge and skills in modern health care management, they can now use medical necessities on patients e.g. gloves. There has also been a reduction in unsafe traditional practices, improvement in herbal mixing and storage, and hygiene practices through routine inspections among members of the different associations.

5.3.2 External Linkages

During the FGDs, Traditional Herbalists indicated that the existing external linkage is primarily through THETA. Training programs have been designed specifically in hygiene and sanitation, First Aid, HIV management and counseling, prevention of sexually transmitted infections, condom use, proper nutrition, protection against high-risk medical practices that exposes traditional herbalists to patients body fluids, and record keeping.

THETA (Traditional and Modern Health Practitioners Together against Aids) is an NGO that has mostly spearheaded the training traditional healers/herbalists in Uganda. THETA was established in 1992 through collaborative efforts of TASO and MSF-Switzerland, by the Ministry of Health (MoH) and National AIDS Commission to promote collaborations between traditional

herbalists/healers and modern health practitioners in the area of treatment, care, support and prevention of STDS and AIDS (Homsy 1996). The original training curriculum was developed in collaboration with The Aids Support Organization (TASO). 17 healers were selected, for a 15 months training³ The training included oral and written tests, regular visits to the healers workplace, client follow up interviews and sit in sessions where the trainers observed a healer practicing. A participatory evaluation of the training program was conducted between 1997-1998 by THETA. And out of the 125 healers trained, 60% reported distributing condoms, 80% reported counseling patients, 82% reported educating the community on AIDS and 97% referred patients with complications to modern health care units

THETA reported 200 Traditional Healers /Herbalists who have been trained in 7 Districts since 1993 namely: Kiboga, Hoima, Kamuli, Katakwi, Mbarara, Mukono and Kampala (Rachel King UNAIDS 1999). The Traditional Healers/ Herbalists were trained in the following: HIV/STD transmission, prevention and care, Counseling, teaching, leadership and record keeping skills, Community AIDS education skills.

During the research I was able to attend one of the training in November 2001. it was conducted by the founder member of Hope Counseling Services (an NGO supporting HIV patients through counseling)(Doctor Maria Nannyoga a pediatrician at Nsambya hospital). The main issues covered in the training were First Aid and symptoms for referral cases.

In addition to training, THETA has also conducted a clinical survey⁴ with TASO to prove the effectiveness of herbs in the treatment of AIDS associated dermatological conditions which include herpes zoster and prurigo.

THETA has created a resource center for traditional medicine and AIDS. The center contains a library with materials on traditional medicine and AIDS. It has produced 2 videos and periodic newsletters to enable the public learn more about the application of traditional medicine.

Traditional Herbalists/Healers hold monthly meetings at selected sites under the guidance of THETA where both traditional and modern health care providers discuss and debate relevant topics. It is through these meetings that Traditional Herbalists/Healers get involved in internal and external AIDS and cultural exhibitions like the World AIDS Day where they exhibit herbs used for treatment, manuals, magazines and newsletters about their activities. Traditional Herbalists also get involved in the annual Youth anti AIDS Drama Festivals and the National Immunization Day Campaigns

THETA has also setup a demonstration herbal garden at Bujuuko, Mpigi district with over 80 species of potentially useful herbs in the treatment of HIV related diseases

As a result of THETA's effort to promote Traditional Herbalists, there are now more referrals to modern health care units, some Traditional Herbalists administer herbs to TASO patients during routine check ups. . For instance members of the Uganda N'eddagala Lyayo Association reported that in 1996/97 they were called upon to treat a sample of 50 HIV positive patients in Mulago hospital, with traditional herbs. A patient interviewed at TASO headquarters revealed that she tested HIV positive in 1992 and since then she uses both drugs from TASO and herbs.

Traditional herbalists also have access to test some of their herbal mixtures to prove their effectiveness at the Uganda chemotherapeutic laboratory in Wandegeya. The Uganda chemotherapeutic laboratory has also compiled a directory of traditional medicine. But many of the herbalists claim that this threatens their patent rights.

5.3.3 International Linkages

A report by the World Health Organization (Harare) Africa region (WHO/AFRO) for promoting the role of Traditional Medicine in Africa indicates that the African region is facing difficulties in ensuring equitable access to healthcare and only about half the population in the region have access to formal health services. This implies that a large proportion of the population relies on traditional medicine.

Traditional Medicine still maintains its popularity for historical and cultural reasons. In Benin and Sudan, for example 70 percent of the population rely on traditional medicine and about 30 percent in Uganda. A survey carried out in 1998 on the situation of Traditional Medicine in the African region showed that many countries have yet to develop and implement national policies on traditional medicine as part of their national health policies. They have to enact legislations, set up structures and develop codes of ethics and conduct for the practice of traditional medicine. Associations of traditional medicine practitioners should be created and closer collaboration forged between Traditional Herbalists' and the health system.

It should however be noted that this linkages between countries is still very weak and should be promoted given the growing body of knowledge in the effectiveness of traditional medicine in the management of HIV/AIDS- related illnesses.

6. CONCLUSION AND POLICY RECOMMENDATIONS

The study set out to examine the role of Traditional Herbalists in the management of HIV/AIDS, and the linkages between Traditional Herbalists and other agencies working on HIV/AIDS. It also examined the community's perception (i.e. patients and caretakers) about Traditional Herbalists. This is in view of the growing number of AIDS patients using local herbs as an alternative to the existing Anti-Retroviral drugs. The empirical findings and the literature review have shown the importance of using traditional herbs in the management of HIV/AIDS. This chapter summaries the basic findings, and the policy recommendations towards promoting Traditional medicine in the management of HIV/AIDS in Uganda.

6.1 Summary of the Findings

Traditional Herbalists are generally closer to society, and largely accessible for the provision of healthcare to the community. They spend more time examining the patient, which makes them

more suitable to provide counselling services. Appropriate and constant counselling is vital for the AIDS patients, who many times have to struggle with the physical illness and social tensions of the disease.

Traditional Herbalists are also less costly since they readily accept part-payments from their patients, and sometimes give credits. It is therefore fairly convenient for the relatively poor patients to receive timely treatment without being very much constrained. In contrast, the Anti-Retroviral drugs are unaffordable to the majority of the people in developing countries. At the same time, drug subsidies, which would improve accessibility of drugs to the poor, are unaffordable to most LDCs.

The other element is that local herbs generally exhibit limited side effects, even in cases of over-dosage, since they are used in their natural form. In addition, most local herbs can easily be available in home gardens, nearby bushes, etc, and once they become known, a patient could easily undertake self-medication and cut down on costs.

There is growing recognition of the vital role Traditional Herbalists play in the management of HIV/AIDS in the country i.e. the National Strategic Framework for HIV/AIDS activities in Uganda 2000/1-2005/6 recognizes the importance of traditional medicine in the management of HIV/AIDS-related illnesses. As a result, linkages with internal and external agencies with some Traditional Herbalists' associations have been initiated. Rockefeller Foundation and MSF-Switzerland are among the external agencies supporting training programmes for Traditional Herbalists in Uganda through THETA. However, the collaborative linkages between Traditional Herbalists and modern health practitioners are still rudimentary.

However, there are a number of problems facing Traditional Herbalists in Uganda. First, there are structural problems relating to lack of adequate premises to operate from and a resource centre to provide and preserve information about traditional treatment methods which are basically orally transmitted, and largely undocumented.

The other problem is the fact that Traditional Herbalists lack a joint institution due to limited cooperation and distrust among themselves and many are not yet registered, therefore screening out the unscrupulous practitioners becomes practically very difficult. This amorphous structure also makes it hard to provide assistance, e.g. financial or training to improve the practice of traditional medicine.

There is still considerable negative social stigma towards use of traditional medicine generally, and in the management of HIV/AIDS in particular. Yet, many local herbs have been found to be effective in combating certain HIV/AIDS-related illnesses. The negative social stigma is basically due to the existence of unscrupulous practitioners within Traditional Herbalists. This results in some patients delaying to use the available local herbs or using none at all. The findings to this study showed that this tendency is large among men than women.

There are also financial constraints facing Traditional Herbalists. This basically emanates from the small fees they charge their patients, non-payment by some patient who are offered credits, and lack of specific budgetary allocations from the Central or Local governments. Due to the

financial constraints, Traditional Herbalists are largely unable to invest in research into more effective herbs and treatment methods e.g. simple scientific equipment necessary to make simple diagnostic tests to provide appropriate care as well as better technology for preservation and storage of herbs.

In addition, many herbal species are getting extinct due to land degradation, over grazing, bush fires and destructive harvesting practices. Yet, there is no specific programme to replace and preserve the extinct herbal species.

6.2 Policy Recommendations

A number of policy recommendations emerge from the above observations. First, there should be systematic sensitization of the community about traditional medicine, and encourage their use in the fight against HIV/AIDS-related illnesses, where herbs have been proved to be effective. Reducing the negative social stigma through sensitization programmes will particularly benefit the low-income groups who cannot afford expensive Anti-Retroviral drugs. In addition, the media should positively promote activities of Traditional Herbalists by publishing positive research findings and ensuring that people with HIV/AIDS are fully informed of the results of the research. This will further raise the profile of traditional medicine

Secondly, there is need to provide support to Traditional Herbalists so as to improve their services. Financial support is particularly necessary so as to invest in better work premises including hygiene, and to provide simple scientific equipment. Training in better health practices, and undertaking research into safe and effective herbs and facilitating standardization of herbs to march world health standards is another form of support that should be provided. In fact, Traditional Herbalists need to be recognized by the Ministry of Health, and that of Gender, Culture and Social Development as another important category of health services providers, with specific budget allocations.

Collaborative linkages between Traditional Herbalists and modern health practitioners need to be enhanced. Through these linkages, the level of effectiveness of local herbs, as well as the appropriate dosage could be scientifically tested and verified. Cooperation among Traditional Herbalists themselves should be promoted by encouraging them to join Associations especially those from rural areas in order to develop comprehensive strategies for the sustainable management of HIV/AIDS.

The research also indicated that there is need for protection of intellectual property rights (Patent rights). Assistance should be given to Traditional Herbalists wishing to use Intellectual Property System to protect their knowledge. Traditional Herbalists should receive education and advice on intellectual property right issues and a systematic documentation procedure should be put in place and compile a database for reference for the future generations.

There is need for piece of land that could be used to grow and maintain local herbs A joint working group needs to be established for promoting, monitoring and assessing the conservation, management and sustainable use of herbal medicine in sustainable production and harvesting.

Lastly, a museum/cultural centre and a database should be established with the main purpose of preserving the available knowledge on indigenous healing.

¹This is a gazetted place located in Katwe near Kampala City where registered Traditional Herbalists/Healers have established stalls where patients can visit them for consultation on various diseases including AIDS-related illnesses.

²The re-known specialists in Wakiso and Kampala districts, include Dr. Musaasizi of J.B.K.M Herbal Research Center, Hajji Lutakoome of Bwakedde Mpuliira herbal center Dr. Kabahinda of Bulamu Bwe Bugagga Research Organization, Rev. Father Mwebe at Ndeeba, and Ms. Namukasa at Lukuli.

³The criteria used was based on: being recognized as a healers by their community and local authorities; Having regular patient attendance; Having a clinic or a shrine to receive and treat patients; Knowing how to prepare herbal and being registered in own association (THETA 1996).

⁴In the survey that took place at 4 traditional herbalists' clinics and at TASO in Kampala, 178 patients were enrolled, treated and followed up for 6 months. Those at TASO received calamine lotion for topical application, antihistamines for skin rash and antibiotics and those who visited herbal centers received treatment for skin rash prescribed by the traditional herbalist. Of the 104 patients who had severe itching at enrolment, 20% still had it 4 weeks after treatment. The majority of the patients who had a reduction in itching were more likely to be using herbal treatment than modern drugs.30% of the patients at TASO and one at one of the healer clinic had severe itching after 4weeks of treatment. King R, 1999

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