Traditional medicine in Bulamogi county, Uganda: its practitioners, users and viability

J.R.S. Tabuti a,b,∗, S.S. Dhillion a,c, K.A. Lye a

a Department of Biology and Nature Conservation (IBN), Agricultural University of Norway, P.O. Box 5014, N-1432 Ås, Norway
b Department of Botany, Makerere University, P.O. Box 7062, Kampala, Uganda
c Centre for Development and the Environment (SUM), University of Oslo, P.O. Box 1116; Blindern, N-0317 Oslo, Norway

Received 14 March 2002; received in revised form 27 November 2002; accepted 27 November 2002

Abstract

Traditional medicine (TM) in Bulamogi (Uganda) is holistic, providing treatments for physical illnesses as well as psycho-spiritual ones. People use it to prevent and eliminate the effects of witchcraft, to appease spirits and to cure chronic illnesses. The traditional medicine practitioners (TMPs) are numerous and have extensive experience of traditional healing. They serve as important depositories of traditional knowledge of healing. The health seeking behaviour of the Bulamogi is biased towards orthodox medicine (OM), because the people believe it to be more effective than TM. Local people prefer the exact diagnosing methods of orthodox medicine practitioners. The functional values of OM and TM are different in that they serve different health needs in the society. We suggest that they are compatible and complementary as a reliance on both systems is observed. The TMPs, upon additional training, are seen by authorities as a ready source of manpower to provide primary health care services. Some effort has been taken to recognise and integrate TM into the mainstream health care delivery system of Uganda.

© 2002 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Traditional medicine; Traditional medicine practitioners; Orthodox medicine; Disease; Traditional knowledge; Health care; Biodiversity; Uganda

1. Introduction

Traditional medicine (TM) occupies an important place in the health care systems of developing countries. The World Health Organization (WHO) estimates that more than 80% of health care needs in these countries are met through traditional health care practices. The people in developing countries depend on TM, because it is cheaper and more accessible than orthodox medicine (OM) (Sofowora, 1993; Luoga et al., 2000; World Health Organization, 2002). Traditional medicine is also more acceptable than OM because it blends readily into the peoples’ socio-cultural life.

Traditional medicine is the total knowledge, skills and practices based on the theories, beliefs, and indigenous cultural experiences, whether explicable or not, used in the maintenance of health, diagnosing, preventing, or eliminating physical, mental or social diseases. Such knowledge may rely exclusively on past experience and observations handed down from generation to generation, verbally or in writing (Sofowora, 1993; Diallo and Paulsen, 2000; World Health Organization, 2000, 2002). The TM system is holistic in that its application usually covers the mind, body and soul (e.g. World Health Organization, 1978, 2002; Johns et al., 1990). The concept of illness in traditional medicine includes health conditions caused by both seen and unseen forces such as ancestors, spirits and enemies (Gessler et al., 1995; Felhaber and Mayeng, 1997; Madge, 1998; Teh, 1998; Erdtsieck, 2000; Juntunen, 2001). For most Africans, good health means not only physical health, but also a healthy situation in everything that concerns them (Cocks and Dold, 2000). According to the users, TM cures both the physical/organic causes of a disease as well as its underlying causes, such as aggrieved ancestors or a neighbour’s wrath and therefore it provides a complete cure, which is why people trust it (Anokbonggo et al., 1990). Traditional medicine practitioners (TMPs) are people recognised by their community as competent to provide health care by using biotic and abiotic substances and certain other methods (Sofowora, 1993), and even with the expansion of modern medicine, TMPs command higher...
frees than orthodox medicine practitioners (Obbo, 1996; Leonard, 2001). In addition to supplying herbal remedies, TMPs can also act against aggrieved ancestors, evil spirits or charms from one’s enemies. The TMPs remain popular also because of the personal way they provide medical care (Gessler et al., 1995; Caney et al., 1996; Tsey, 1997; Teh, 1998), as contrasted to the OM system where care is often much more impersonal. In Tanzania some of the reasons people gave for visiting TMPs included too short consultations with doctors or hospital staff often of less than 5 min, little opportunity to express their own concerns, and being given medicine without any explanation as to the cause of their illness (see Gessler et al., 1995). Traditional medicine practitioners are experts at counselling and take time to get involved in the patients’ illness. This could explain why they are considered effective against psychological maladies (Teh, 1998).

The orthodox health service in Uganda is underdeveloped, and poverty is the underlying cause of poor health in the country (Ministry of Health, 2000). The country has a heavy burden of disease, inadequate health services infrastructure and insufficient human resources (Ministry of Health, 2000). There are few hospitals and physicians; the ratio of doctors to people is 1:25,000. Many trained health workers are working abroad or are in private practice, and doctors are substituted for by trained medical assistants (The Economist Intelligence Unit, 1999). On the other hand, there are many TMPs in the country, and it is believed that these, if integrated into the health care delivery system, would improve health delivery in the country. By integrating TM and OM into the official health care system there would be an increase in manpower that could provide a higher degree of health coverage (World Health Organization, 1978). The most effective way of extending benefits without great cost is to use and develop local resources (Teh, 1998). To integrate these two medical systems, there would be need for the TMPs to undergo basic training in orthodox health care practices.

Under colonial times, TM was frequently outlawed (Bodeker, 1994; Obbo, 1996; Dhillon and Paulsen, 2000; Svarstad and Dhillon, 2000; Juntunen, 2001) and in many countries, official recognition is given to modern medicine whilst TM and its practitioners are merely tolerated. In others such as Cuba, TM is illegal. In a few countries, for example Thailand (Dhillon and Ampompan, 2000), TM is being integrated into the mainstream medical system. In some countries, however, TM is recognised and respected. In China and Bhutan it has been integrated in the officially recognised health care delivery system, while in India, Sri Lanka, Tanzania (World Health Organization, 1987; Sofowora, 1993) and Mali (Dhillon and Paulsen, 2000) TM is co-recognised and practised in parallel to OM. Uganda intends to recognise and promote traditional medicine and a draft Bill for a law to recognise, coordinate and regulate the practice of TM in Uganda will be drafted soon (Ministry of Health, 2000). There have also been efforts to encourage collaboration between TM and OM practitioners by the organisation “Traditional and Modern Health Practitioners Together Against AIDS (THETA).”

Traditional medicine encompasses a body of knowledge linked to natural resources, specifically biodiversity. The greater part of the world’s biodiversity is found in the tropics. Local communities in the tropics have an intimate relationship with nature and possess abundant indigenous knowledge on the use of plants as well as a good knowledge of the biology and ecology of the species that they use (Etkin, 1999, 2002; Dhillon and Amandisen, 2000). The recognition of traditional knowledge and associated biodiversity use is important in the conservation and sustainable use of biodiversity. The Convention on Biodiversity (CBD) requests that such knowledge be protected, respected and preserved (http://www.biodiv.org/; article 8(j) and related provisions). Uganda ratified the CBD in 1993 and various efforts to develop a CBD-related legislative systems are underway.

Successful integration of TM into the mainstream health care delivery system requires an understanding of TMPs recruitment modes and practices. Local people’s attitudes towards TM and its practitioners need to be studied to assess the status of TM and its viability. Furthermore, detailed studies of TM are especially important to inform health policy makers of the role of TM in order to promote it (World Health Organization, 1978). Here we explore the practice of and the role of TM in a local community of Bulamogi, in Uganda.

1.1. Study area

Bulamogi county is found in Kamuli district of Uganda between 33°20’–33°38’E and 0°58’–1°18’N at an altitude of 1052–1098 m (Uganda Government, 1963). It covers an area of ca. 870 km². Bulamogi county lies ca. 200 km northeast of Kampala, the capital city of Uganda. Within Bulamogi county are five subcounties, viz. Nawaikoke, Gadumire, Namwiwa, Bumanya and Namugongo. Within each subcounty are several parishes, each made up of a number of villages.

The county has an estimated population of about 150,000 people and a population density of approximately 170 people/km² based on the population census of 1990 (Statistics department, 1992). Nawaikoke and Namwiwa have the lowest population densities in the county of 100–149 people/km², the other subcounties have population densities of 150–199 people/km² (Statistics department, 1992). The people of Bulamogi are subsistence farmers, and agriculture is their main source of livelihood. Gross domestic product per capita for Uganda is estimated at USD 332 (The Economist Intelligence Unit, 1999).

The orthodox health care delivery system is underdeveloped. Bulamogi county as a whole has six health centres. One of the health centres is a Health centre level IV, that is,
it can be classified as a small hospital. It has an operation room and a few beds for in-patients. The whole county has 1 government doctor, 1 dental assistant, 6 clinical officers, 10 registered midwives, 10 enrolled nurses, and 18 nursing aides (Traditional and Modern Health Practitioners Together Against AIDS, 2000). There are probably a few more private visiting-doctors. The number of patients attending outpatient clinics is low and continues to decline. Per capita out patient attendance, i.e. number of patients attending outpatient clinic as a proportion of the total population of the district, declined from 40 to 30% in the period 1997–1999 (Uganda Bureau of Statistics, 2000).

2. Methodology

Fieldwork for this study was carried out between June 2000 and June 2001. A combination of biological and social science approaches were used to collect the data: semi-structured interviews, questionnaires, direct observations, and transect walks in wild plant medicine collection areas. Prior to any contact with the local community this study was introduced to the County Officer—this introduction was always repeated when entering a new administrative area (e.g. a subcounty or a village). Two research assistants were hired. The research assistants had grown up in the area and aided in interpreting the cultural norms and meanings behind the comments expressed during interview. The research assistants were also important in winning the trust of respondents and establishing rapport; respondents were less suspicious of the motives of the interviewer when interviewed in the presence of someone they knew.

A pilot study lasting 3 weeks was conducted at the very beginning of the study. In the pilot study, key informants were identified by the help of the assistants and local politicians. Semi-structured interviews were conducted with 23 key informants. During the pilot study, we gained a good understanding of the study area and the people, and refined the questionnaires. In the same pilot study we made a census of the TMPs.

Following the pilot study, a detailed survey using a mixture of open- and close-ended questionnaires during face-to-face interviews was conducted. Interviews were conducted in the local language, the KiLamogi. Traditional medicine practitioners were selected based on their reputation, while household respondents were chosen through stratified sampling. In each subcounty, a respondent was randomly chosen from at least one village from each parish in the subcounty until at least 30 respondents had been included in the survey in each subcounty. Respondents included the head of household or the wife or the older children. Altogether 47 TMPs and 126 household respondents were interviewed in the survey. TMPs survey questions addressed the following issues: how TMPs learnt the art of healing; how long they had practised; whether they belonged to traditional healer associations. Interview questions also included: how they use plants to treat their patients; how many patients they receive; the level of cooperation between practitioners of traditional medicine and orthodox medicine (OM); and aspects of traditional herbal knowledge on harvesting and management. Household interview questions were designed to discover which of the two medical systems, TM and OM, people preferred; what common ailments afflict the people; and indigenous knowledge of herbal plants. Translations of the local diseases names into their English or western-medicine equivalents were provided by Mr. M. Wambuzi, the Medical Assistant in-charge of Bulamogi subcounty health centre. These were later confirmed by a physician originating from Bulamogi county, Dr. P. Waako.

The interviews were supplemented by direct observations and transect walks. During the transect walks plants used by the TMPs were ‘identified’ in the local taxonomy. Plant voucher specimens were collected and taken to Makerere University Herbarium, for identification. Data on the used herbal plants will be reported in a separate paper.

Data from the field study was analysed both qualitatively and quantitatively. Responses from open-ended questions were grouped into classes that expressed similar ideas while percentages, based on valid responses only, were calculated from close-ended questions.

3. Results

3.1. The traditional medicine system

The traditional health care system of Bulamogi is both herbal and animal based, and holistic. The TMPs employ plant and animal parts, as well as other material to effect cures. Clients are treated for physical ailments and psycho-spiritual conditions such as bewitchment. Respondents in the study reported 97 physical illnesses and 26 magical, spiritual or ritual conditions (see Tables 1 and 2). There are more than 340 TMPs in the county, and these are specialised as herbalists, traditional birth attendants (TBAs), bonesetters, diviners and spiritual healers ‘muswezi’ or faith healers ‘Seeka/Mwalimu’, although many of them can belong to several of these categories.

The practice of TM is dominated by mature men. In this study 85% (n = 47) of the healers were men aged 40 years (78%, n = 46) or more, none was younger than 25 years of age. The healers have extensive experience and 88% of them had practised TM for more than 10 years (Table 3). The TMPs are mainly Christian and educated up to primary level. Traditional medicine practitioners are registered with traditional medicine healers associations, and they are commonly registered with the association known as ‘Uganda ne dagala lye kinansi’ (UDK) (Table 3). Membership fees amount to U Shs 50,000 (ca. USD 30). In addition they...
pay an annual tax to their respective subcounties, of U Shs 12,000 (ca. USD 7). The healers do other work besides healing in order to earn an income (65%, n = 33). Their other main occupation being crop agriculture.

3.2. Becoming a TMP

Traditional medicine practitioners learn the craft of healing by apprenticing under senior TMPs who are usually relatives. All TMPs interviewed (n = 47) except two had apprenticed under expert TMPs. The TMPs in turn train other interested people for a fee. Family members are not charged for such training.

The decision to become a TMP is varied; for some it is a deliberate choice, while for others spirits choose them (Fig. 1). The spirits may be ancestral ‘muswezi/mandwa’ or nature spirits. The chosen person is identified in various ways: a home may experience some difficulties, or specifically a key person in a family may die and following his/her death a ritual is performed. During the ritual, ancestral spirits may descend on a person and request him/her to become a healer. When the patient agrees the necessary rituals are performed and he/she is requested by spirits to become a healer. When the patient agrees the necessary rituals are performed and he/she is requested by spirits to become a healer.

Table 1

Disease system: common/local name, local name

- Cardiovascular system: Ill-defined heart disease, Mwoyo
- The digestive system: Abdominal pain, Ania
- The nervous system and mental disorders: Epilepsy, Bizimba
- Ear nose and throat: Bad breath, Kantoloze
- Musculo-skeletal system: Arthritis, Bizimba
- Specific diseases and conditions, Miscellaneous: Antidote (insect bites), Musuja
- Parasitic diseases, not of the digestive system: Malaria, Musuja
- Infectious diseases: Bubo or LGV, Nalwekika
- Skin diseases and subcutaneous tissues: Boils, Musuja
- Eye diseases: Bacterial sepsis, Maiso go munyu
- Childhood diseases and conditions: Amoebiasis, kuilya Musahi
- Muscular spasms, Kinsimbye

The decision to become a TMP is varied; for some it is a deliberate choice, while for others spirits choose them (Fig. 1). The chosen person then apprentices under an experienced ‘muswezi.’ Sometimes selection of someone to become a TMP manifests itself after one suffers from a chronic or difficult to understand illness. After trying various treatments without success, the afflicted person seeks out traditional medicine, and while undergoing treatment, it is divined that the person is requested by spirits to become a healer. When the patient agrees the necessary rituals are performed and he/she improves, he/she then undergoes a period of apprenticeship.
under the TMP for a period of 6–12 months to learn the art of traditional healing. The apprenticeship is oral, and during the whole period of training, the patient/prospective healer lives with the trainer. Some people do not undergo any form of training prior to becoming TMPs but get their powers and healing concoctions from dreams. Traditional medicine practitioners adapt and draw on the experience of others. They readily share knowledge about phytomedicines amongst themselves and either exchange this knowledge freely or pay for it. Knowledge of concoctions may be purchased, or a healer if he/she is treating a patient with a condition he/she does not know the cure for, may refer and accompany his/her patient to another healer who knows the cure and learns from there. Payment to other healers may be cash or livestock, or other material items such as clothes. When two healers use different concoctions to treat a certain ailment or condition they commonly exchange trade secrets on it. Because healing is a source of income to practising TMPs, not many are willing to divulge knowledge freely or pay for it. Knowledge of concoctions amongst themselves and either exchange trade secrets on it. Because healing is a source of income to practising TMPs, not many are willing to divulge knowledge freely or pay for it. Knowledge of concoctions amongst themselves and either exchange trade secrets on it. Because healing is a source of income to practising TMPs, not many are willing to divulge knowledge freely or pay for it. Knowledge of concoctions amongst themselves and either exchange trade secrets on it. Because healing is a source of income to practising TMPs, not many are willing to divulge knowledge freely or pay for it.

### Table 3

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sex (n = 47)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>40</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>2. Education (n = 46)</td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>10</td>
</tr>
<tr>
<td>Islamic basic education</td>
<td>3</td>
</tr>
<tr>
<td>Primary education</td>
<td>25</td>
</tr>
<tr>
<td>Secondary education</td>
<td>8</td>
</tr>
<tr>
<td>3. Religion (n = 46)</td>
<td></td>
</tr>
<tr>
<td>Protestants</td>
<td>23</td>
</tr>
<tr>
<td>Catholics</td>
<td>3</td>
</tr>
<tr>
<td>Muslims</td>
<td>7</td>
</tr>
<tr>
<td>Traditional ‘n’cyr’</td>
<td>13</td>
</tr>
<tr>
<td>4. Other work (n = 45)*</td>
<td></td>
</tr>
<tr>
<td>Crop agriculture</td>
<td>17</td>
</tr>
<tr>
<td>None</td>
<td>12</td>
</tr>
<tr>
<td>5. Experience in years (n = 44)</td>
<td></td>
</tr>
<tr>
<td>Between 1 and 10</td>
<td>12</td>
</tr>
<tr>
<td>Between 11 and 20</td>
<td>12</td>
</tr>
<tr>
<td>Between 21 and 30</td>
<td>6</td>
</tr>
<tr>
<td>Between 31 and 40</td>
<td>9</td>
</tr>
<tr>
<td>Between 41 and 50</td>
<td>3</td>
</tr>
<tr>
<td>Between 51 and 60</td>
<td>2</td>
</tr>
<tr>
<td>6. Affiliation to traditional healers association (n = 48)</td>
<td></td>
</tr>
<tr>
<td>Uganda ne Daqala ne Kumuwe (UDK)</td>
<td>23</td>
</tr>
<tr>
<td>Uganda ne Daqala Liy mosquito (UDL)</td>
<td>7</td>
</tr>
<tr>
<td>Bulamogi Traditional Healers Association (BUTHA)</td>
<td>2</td>
</tr>
<tr>
<td>UDK and BUTHA</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>13</td>
</tr>
</tbody>
</table>

*Individual frequencies for all other activities/professions: butcher, herding, politics, local defence, mechanic, and petty trade are one.

Shown frequencies are of valid responses only.
3.4. Health care seeking behaviour of the people

When asked which of the two medical systems, TM or OM they prefer when they are unwell, the majority of people (65%, \( n = 124 \), Fig. 2) declared that they would use both systems depending on the sickness they were suffering at the time. It was explained that diseases such as epilepsy or madness, could only be treated under TM system, while for others like malaria, modern medicine offered the best treatment (Table 4).

When the same question was asked in a different way as "which treatment did you employ the last time you were sick?" the outcome was different. It turned out that 88% (\( n = 116 \)) sought western medicine, and only 10% had used TM (Fig. 2). On probing further why they chose the western treatment system over the traditional one, the main reasons that the people gave were that: they found OM to be more effective in healing than TM (Fig. 3); western-trained physicians were better at diagnosing illnesses; and that the people were more familiar with OM than TM. Other reasons given for why OM was more popular than TM were: OM is cheaper than TM both for the diagnosis and the treatment; some TMPs are dishonest ‘quacks;’ fear of TMPs especially diviners ‘aba mahembe;’ and western drugs are easier to administer, while traditional drugs are given in large doses. Born-again Christians or fundamentalists did not use TM because of their religious beliefs.

Otherwise, the health care seeking behaviour of the Balamogi follows definite patterns. Once a person is unwell an evaluation of the malady is done by the patient or by members of his/her family to determine which course of action to take. For easy to diagnose common ailments such as malaria or diarrhoea, people buy western drugs from the many drug shops, small kiosks and from itinerant traders in the weekly markets. Drug outlets are allowed to sell class “C” or non-prescription drugs, however, in practice they sell all classes of drug. If the condition does not improve, another assessment of the illness is made and a decision taken to seek profession help from orthodox medicine practitioners (OMPs). If the patient’s condition still does not improve, then a TMP is consulted. There are many maladies however, including spiritual conditions such as witchcraft and spirits, epilepsy, uterine fibroids (Table 4) for which services of TMPs are sought outright over those of OMPs.

Traditional medicine is also often employed in the form of self-medication using folk remedies. In Table 5 are listed the conditions for which the community often uses folk remedies.

![Fig. 2. Preferred (\( n = 124 \)) and most patronised (\( n = 116 \)) medicine system in Balamogi.](image1)

![Fig. 3. Reasons orthodox medicine is preferred over traditional medicine (\( n = 75 \), the respondents that prefer orthodox medicine). A: OM is more effective than TM, B: OM doctors make better diagnosis, C: familiar to OM, D: OM cheaper than TM, E: OM easier to administer than TM, F: TMPs are dishonest, G: TM given in large doses, H: fear TMPs (especially 'mahembe' doctors), I: OM easily accessible, J: does not use TM due to religious beliefs, K: have forgotten TM.](image2)
4. Discussion

4.1. The role of traditional medicine

TM in Bulamogi is holistic and its practitioners endeavor to cure both physical and psycho-spiritual conditions of the people. Traditional medicine serves a different role from that of OM, and people trust it especially for the treatment of psycho-spiritual conditions (e.g. to eliminate effects of witchcraft, treat mental illnesses) and chronic ailments. The chief value of TM to its clients lies in its methods and the concepts underlying its use; its main characteristic is that it is able to supply meaningful explanations for most maladies. People understand, for example, that malaria is caused by mosquito bites, but why only the head of the household suffers with the malaria and not anyone else, can be better explained by TM than OM (World Health Organization, 1978; Anokbonggo et al., 1990; Madge, 1998; Teh, 1998). Traditional medicine is also used in the form of self-administered folk remedies, which are free and therefore help save the people's meagre incomes.

4.2. Traditional medicine practitioners and traditional knowledge

The TMPs recruitment patterns observed among the community of Bulamogi appear common to Africa. Such patterns have also been documented in other parts of Uganda (Obbo, 1996), and elsewhere in Africa such as in...
During the TMPs apprenticeship indigenous knowledge (IK) of local healing from earlier generations is passed down to them. Formerly IK has been maintained orally and in many cases was not written down, but this is changing now that many TMPs are able to read and write. The state of TM knowledge is not static in Bulamogi but is embellished by knowledge from neighbouring cultures through the traditional healer associations and other informal exchanges. Through these interactions TMPs constantly share information about healing. These information exchanges probably help to conserve the traditional knowledge of healing, because when one holder of such information dies other TMPs can retain this knowledge.

The conservation of traditional knowledge is acknowledged as important to modern society (Moran et al., 2001). This is because knowledge, such as that related to traditional medicine under discussion here, can provide important new leads for drug discovery (World Health Organization, 1978; Moran et al., 2001). Traditional knowledge related to TM may be protected and conserved through the development of intellectual property rights (IPRs) and/or through benefit sharing (Zhang, 2000; Moran et al., 2001). Intellectual property rights are rights over intangible information that provide incentives for future innovations (Moran et al., 2001). Intellectual property rights are often protected by patents. The IPR system can also, besides protecting cultural knowledge, protect biodiversity. The compensation of indigenous people can validate their knowledge of the biodiversity they manage and also provide them with an equitable reward for sharing it, thereby compensating biological stewardship and encouraging conservation (see Svarstad, 2000; Moran et al., 2001). At present there are no clear legal mechanisms to protect IK in Uganda.

Under different contexts benefit sharing between the users of and stewards of TK, may be more suitable than developing IPRs agreements. Benefit sharing may take the form of the bio-prospector providing upfront monetary benefits, through trusts and other financial rewards, to the indigenous owners of TK, with promises of future royalties from any commercial benefits that may accrue from any drug developed. It may also include non-monetary benefits such as the acknowledgement of the indigenous peoples contributions in publications or joint authorship and co-ownerships of IPRs among other benefits (Moran et al., 2001). Shaman Pharmaceutical, Inc. an American based company has used the benefit sharing approach in several countries around the world. In Uganda Shaman Pharmaceutical, Inc. collaborated with certain traditional healers and provided them immediate monetary compensation, and set up medium and long-term benefit sharing programmes (Nelson-Harrison et al., 2002). However, the process of benefit sharing is complex and deserves constant review (Lard, 2000, p. 97).

4.3. Orthodox medicine and self-medication

The TMPs are well distributed in the county at a ratio of 1:400 TMPs to inhabitants. On the other hand, orthodox medicine (OM) in the county as elsewhere in Uganda is very poorly developed. There are few orthodox medicine practitioners (OMPs) and there is a general lack of medical infrastructure. The whole county has one physician for the estimated 150,000 people and there are only a few health units (see Section 1.1). Despite the poor status of OM in the county, people seem to trust it more than TM and TM suffers from a poor reputation. This finding agrees with results from another study carried out in Uganda, that TM does not carry a high social status, and that there are strong prejudices against it (Obbo, 1996). The image of TM was hurt further, at the time we conducted this study, by a spate of ritual murders in the country. These rituals murders served to alienate TM from the community further. This not withstanding TM has a special function in the community as it serves a different role from that of OM. Therefore, people must be persuaded to drop their prejudices against TM and to view traditional remedies as second rate (World Health Organization, 1978). The mass media in Uganda is doing much to promote TM.

Since there are few health personnel and the health infrastructure is weak, people frequently use self-medication to treat themselves. Self-medication using western type medicines is common in Uganda (Obbo, 1996). Results from research carried out in western Uganda showed that over 70% of the people practise self-medication for common diseases (Mwoga, 2001). In third world countries, drugs, including classified ones, are freely available across the counter without doctors' prescriptions (Tsey, 1997; Cocks and Dold, 2000) and self-medication is widespread in, for example, Kenya (Geissler et al., 2000; Nyamongo, 2002) and Tanzania (Juntunen, 2001). Self-medication takes the form of treating oneself with over the counter medications and home remedies (Tsey, 1997; Cocks and Dold, 2000), and references therein; Geissler et al., 2000). It is a convenient way of health care, which can save time and money by not involving long and costly consultations with professional health care givers (Cocks and Dold, 2000). Self-medication is adaptive to environments where people are frequently sick and where the cost of consulting professional caregivers would be too high to sustain. It is also indicative of a poor public health system (Geissler et al., 2000).

4.4. Development of traditional medicine and potential role of traditional medicine practitioners

The World Health Organisation (WHO) has called for the promotion and development of TM for wider use after...
recognising that TM is an acceptable, safe and economically feasible way to achieve health coverage for all (World Health Organization, 1978, 2002). Traditional medicine is the people’s own health care system and is generally well accepted by them. As an integral part of the people’s culture, it is particularly effective in solving certain cultural health problems (World Health Organization, 1978; Obbo, 1996). The WHO has laid down guidelines for the development of TM and its integration with OM in order to provide more realistic, efficient, cheaper health care and a culturally acceptable health system (World Health Organization, 1978, 1995).

The development of TM may take advantage of the many existing TMPs. These TMPs, as apprentices under TM, receive informal training from more experienced TMPs, and this training added to their subsequent experience in the curative practices of TM means that they become competent to deliver health services to the community. As such TMPs can play a significant role in health care delivery to the community by complementing OM. The success of integration or co-recognition depends on the prevailing socio-economic circumstances, cultural patterns, and the wishes of the people. Integration also requires the co-operation of stakeholders at the international, national, professional and community levels (World Health Organization, 1978). Countries interested in integrating the two systems of medicine would have to formulate national policies, provide legal recognition and social equality for TMPs, and organise employment opportunities and mobility. Sofowora (1993) explains that for integration or co-recognition to succeed, any nation would need to set up a separate division in the existing ministry of health, and enact a law to set up a Council for Traditional Medicine. In addition, the country would need to register all TMPs and their premises or clinics, standardise the training of TMPs, and enact laws and regulations for TMPs codes of conduct (World Health Organization, 1978; Sofowora, 1993). The Health Sector Strategic Plan of Uganda has called for the recognition and mobilisation of TMPs in the country and a draft bill for a law to recognise, co-ordinate and regulate the practise of TMPs is in the advanced stages of development (Ministry of Health, 2000). The Public-Private Partnership and the Planning Unit of the Ministry of Health (MOH) are at the forefront of this initiative. A comprehensive policy to promote and develop TM, and to protect related intellectual property rights is, however, lacking in Uganda (Nelson-Harrison et al., 2002).

Among the WHO guidelines for developing and integrating TM is a requirement for retraining practising TMPs in basic hygiene and health care. Since 1996, the THETA organisation, has encouraged collaboration in Kamuli district, where we find Bulamogi. It has also trained TMPs in record keeping and at the same time encouraged them to refer cases that they cannot handle to OMPs. THETA is another initiative of the MOH that was initially set up as a study to evaluate the potential effectiveness of herbal treatment for HIV/AIDS-related illnesses and to foster collaboration between TMPs and OMPs.

Another requirement for successful integration is the setting up of a dialogue between TMPs and OMPs (World Health Organization, 1978; Sofowora, 1993). THETA has played an essential role in promoting collaboration between TMPs and OMPs. Prior to these initiatives, collaboration existed between the Ugandan ministry of health and TMPs in the areas of reproductive health and diarrhoea control among others. The cooperation consisted mainly of provision of equipment and essential drugs such as reproductive health delivery kits and oral rehydration salts for delivery and diarrhoea control to the TMPs. Although TMPs of Bulamogi are willing to collaborate and are already referring patients to health units, biomedical workers on their part still look down on TMPs expertise and are not ready to collaborate.

As pointed out earlier, for integration to be successful, TMPs need to be registered. TMPs in Bulamogi are registered to national and local healers associations. This means, they can be easy to identify by policy makers for inclusion in the public health care system, and for regulation and monitoring. Regulation of TMPs activities is important for checking harmful practices as well as eliminating dishonest practitioners and ensuring a high level of professional ethics and practice (World Health Organization, 1978; Sofowora, 1993). Traditional medicine practitioners when organised have a powerful voice to lobby for their rights and benefit from their IK (Moran et al., 2001). The Malian experience illustrates very well the benefits of healers’ associations to TMPs (Diallo and Paulsen, 2000). In Mali, the traditional healer associations have promoted a better knowledge and respect for TM, while facilitating dialogue between TMPs and OMPs through seminars and workshops. The associations have also helped formulate policies to defend the interests of TMPs and to conserve important biodiversity. The Malian TMPs have control over herbal medicine collection areas. Healer associations in Mali have also facilitated sharing of benefits from bioprospecting between healers and the department of traditional medicine, by for example: improving infrastructure on healers’ premises; increasing profits from TM through the commercialisation of and acquiring patents for improved traditional medicines; and helping train TMPs (Diallo and Paulsen, 2000). Traditional medicine practitioners when organised in healers’ associations may also play a role in plant conservation, for they are usually aware of the importance of plant diversity and can be influential in changing local opinion to limit over-exploitation (Cunningham, 1993; Dhillion et al., 2002) as in the Malian example. In Thailand efforts are being made to integrate TM knowledge and biodiversity regulations and several new bills are in place, although detailed regulations will take time to develop (Dhillion and Ampornpan, 2000).
5. Conclusions

In this study we set out to consider the relevance of TM to the health needs of Bulamogi as well as different aspects of TMPs we thought were relevant to the development of TM. The functional values of both OM and TM are different in that they serve varied health needs in the society, but are nevertheless compatible and complementary as a clear reliance on both systems is observed. We found that TM use is on the decline, people trust OM much more than TM, and TM is mostly consulted for psycho-spiritual and chronic diseases. Reasons for this distrust are many, but the main one may be the poor promotion or lack of promotion of TM in Uganda. In order not to lose this important heritage, different interventions by international and regional organisations such as the World Health Organization, the International Development Research Centre (IDRC) and the Organization of the African Unity (OAU) among others, have been made to foster the development and the promotion of TM. It is not very clear how much has been achieved in this respect, but the traditional use of medicinal plants has been documented in Uganda by the Scientific, Technical and Research Commission of the OAU (Adjanohoun et al., 1993) and the National Chemotherapeutics Laboratory, IDRC supported project (see Hamill et al., 2000; Nelson-Harrison et al., 2002). Traditional medicine practitioners in the area are well versed with their craft and are a ready source of manpower to provide health care, following prerequisite promotion and their retraining. The Ministry of Health of Uganda is actively promoting TM, but a lot remains to be done to develop TM and TMPs, such as improving the image of TM and TMPs among its clients and among orthodoxy health professionals. There is also a strong requirement for a solid regulatory system to monitor and regulate the practice of TMPs to ensure a high level of service delivery.

Acknowledgements

The people of Bulamogi who generously shared their knowledge are deeply thanked and acknowledged. This project was supported by project funds from NORAD and NUFU. The research is linked to that of the Management of Biodiversity Group, TEGO and NTFP research at SUM-University of Oslo and IBN, Agricultural University of Norway led by S.S. Dhillon. The Botany Department of Makerere University Uganda provided for the local logistics. We thank Prof. R. Bukunya-Zriba for his encouragement and advice. We thank also Ms. J.E. Baturinga in the council and Ms. J. Bradley Norman, for useful comments to this paper.

References


Traditional and Modern Health Practitioners Together Against AIDS (THETA), 2000. THETA Outreach STD/AIDS Counselling Training Programme in Kamuli District.


Traditional and Modern Health Practitioners Together Against AIDS (THETA), 2000. THETA Outreach STD/AIDS Counselling Training Programme in Kamuli District.


