



Universiteit  
Leiden  
The Netherlands

## Gender roles in traditional healing practices in Busoga

Isiko, A.P.

### Citation

Isiko, A. P. (2018, June 20). *Gender roles in traditional healing practices in Busoga*. Retrieved from <https://hdl.handle.net/1887/63215>

Version: Not Applicable (or Unknown)

License: [Licence agreement concerning inclusion of doctoral thesis in the Institutional Repository of the University of Leiden](#)

Downloaded from: <https://hdl.handle.net/1887/63215>

**Note:** To cite this publication please use the final published version (if applicable).

Cover Page



Universiteit Leiden



The handle <http://hdl.handle.net/1887/63215> holds various files of this Leiden University dissertation

**Author:** Isiko, Alexander Paul

**Title:** Gender roles in traditional healing practices in Busoga

**Date:** 2018-06-20

## CHAPTER ONE

### BACKGROUND, LITERATURE REVIEW AND METHODOLOGICAL ISSUES

#### 1.1 Introduction

Much has been written about traditional medicine in Africa and in Uganda in particular (Abbo, 2003; Abbo, et al., 2008; Abdullahi, 2011; Aligawesa, 2008; Cultural Research Center, 2013; Wreford, 2005; Rogerson, 2001; Feierman, 1985; Flint, 2008; Romane, 2000). However, these studies have focused primarily on how traditional medicine and healers can be integrated within modern medicine. Scholarship on traditional medicine in Busoga (Cultural Research Center, 2003, 2013; Tabuti, 2003, 2006; Abbo, C. et al, 2003, 2008) has been mostly preoccupied with herbalism and with people's cultural interpretation of specific diseases like psychosis (*eiralu*). These authors' major interest has been in establishing the medicinal values of herbs and their viability in treatment of specific diseases. In this study I take a broader perspective, taking all aspects of Basoga traditional medicine into account.

Studies by the World Health Organisation (WHO) on traditional medicine have been concerned with the development of traditional medicine as an alternative approach to health in the developing world (WHO, 1978, 2002, 2001, 2006). Whereas the World Health Organisation's definition of 'traditional medicine' is comprehensive enough, as shall be adduced in the next section, its practicability has been limited to herbalism. Little attention has been devoted to the cultural perceptions and beliefs upon which the preference for this medical practice thrives. Other writers (for example, Mbiti, 1965, 1967, 1969; Parrinder, 1974; Odiko, 1999; Bukyanagandi, 1993) have approached traditional healing practices from a purely religious perspective, interpreting it solely as an act of worship of the gods and other such supernatural beings. In this case, healers are discussed as religious authorities with an intercessory role in society. Disease is analysed as profaning gods as healing is a product of appeasement of the gods. This study presents traditional healing as a product of and an influencing factor in not only the religious, but also the cultural, socio-economic and political processes of society.

Other writers, like Masebo (2013), Flint (2008), Schumaker et al (2007), Pels (1997, 1998 & 2003), Ashforth (2005), and Feierman (1985), have discussed the historical challenge of the western world's engagement with traditional medicine in African societies, and the impact this has had on traditional medicine in Africa. Most of these scholars call for the integration of traditional medicine with modern western medicine, but without addressing how this might

affect women and men differently. In analyses of traditional medicine, gender has largely remained invisible. Popper & Ventura (2009:7) acknowledge that the available literature on traditional healing signals a re-examination of different dimensions of traditional healing. But Popper & Ventura also restrict themselves to only fortune telling (divination) among women and no attention is drawn to other aspects of traditional healing, which this study comprehensively discusses. Moreover, these authors discuss women's role in fortune telling in the context of traditional Arab women healers in Israel, a society with a different socio-cultural and religious setting than Busoga.

However, there is a remarkable body of scholarship on gender and health in developing countries. More specifically, there exists plenty of literature on the role of African women in traditional healing, both as healers and as clients. On the level of client relationship, the authors have been preoccupied with African women's preference for traditional medicine over biomedicine, and its importance in the promotion of women's reproductive health (Alexander, 2012; Nelms, 2006; Titaley, Hunter, Dibley, Heywood, 2010). The values and beliefs that cause women to prefer traditional medicine often remain unaddressed; precisely this will be central in this study. There has been a renewed interest in African female healers, by scholars like Popper & Ventura (2009), Luizza et al. (2013), Ofisi (2010), Ehrenreich & Deirdre (1973), Anyinam (1996), Soman (2011), Struthers (2000), Voeks (2007) and Igreja et al., (2008). However, these studies too reduce female healers either to 'spiritualists' or to 'herbalists'. Anyinam (1996), Popper & Ventura (2009), Igreja et al. (2008), and Struthers (2000, 2003) present female healers as exclusively engaged in fortune telling and divination, whereas Luizza et al. (2013), Voeks (2007), Ofisi (2010) and Barpujari (2005) reduce women's role in healing to 'herbalism'. Women are presented as lay herbalists; whose knowledge and practice of herbalism is not a conscious occurrence. Yet, traditional healing in African societies embodies a wide range of aspects, with divination and fortune telling being frowned upon by society, and women participating in them taking secondary roles as assistants to the male healers. In this study I demonstrate the central role of female healers in all the healing traditions of the Basoga.

Studies on female healers often focus on their everyday experiences and family backgrounds (Struthers, 2000, 2003; Ehrenreich & Deirdre, 1973), but fail to address the gendered nature of healing itself. This thesis strives to examine the distinct roles of men and women in traditional healing, departing from the following questions raised by Professor Charles Anyinam, an African medical geographer based in Canada: Do indigenous healing practices

operate within a framework of a division of labour? Do female healers occupy a subordinate position within the African traditional medical system? What is the role of African women in traditional healing practices? (Anyinam, 1996:103). Whereas Anyinam raises these legitimate questions, he declares his inability to provide answers, preferring to explore women's role in the provision of general healthcare in Africa. Using Busoga as a case study, I attempt to provide answers to these questions, analysing how the interplay of gender roles determine traditional healing in Busoga society.

## **1.2 Contextual Definition and Background to Traditional Healing**

Traditional healing practices are as old as humanity itself. The World Health Organisation notes that traditional medicine is not a new phenomenon, since it has always been an integral part of all human cultures (WHO, 1978:9). In Uganda's context, traditional medicine has been meeting people's local health needs since centuries (NACOTHA, 2009:1). Traditional healing practices, also termed 'traditional medicine', are defined as 'the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness' (WHO, 2001:2; 1978:8). Traditional medicine includes diverse health practices, incorporating plant, animal and/or mineral-based medicines, spiritual therapies, manual techniques and exercises applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness (WHO, 2001:1; Kebede et al., 2006:127). 'Traditional medicine' is a comprehensive term used to refer both to traditional medicinal systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various other forms of indigenous medicine (WHO, 2002:1). African traditional healing is just one of them.

African Traditional Medicine can be categorized as mind-body medicine (Millar & Bertus, 2006:17). Traditional African medicine is a holistic discipline involving indigenous herbalism and African spirituality. African traditional health practitioners include herbalists, spiritual healers, bone setters, traditional midwives, and hydrotherapists (Sekagya et. al., 2006:221). The traditional health practitioner is recognised by the community in which he or she lives as being competent in providing health care. The practitioners are members of those communities where they operate (Somma & Bodiang, 2003:6; NACOTHA, 2009:6). The traditional health practitioner uses animal, vegetable and mineral substances and 'certain other

methods' that may be based on social, cultural, and religious sources, as well as knowledge, attitudes, and beliefs that are prevalent in the community regarding physical, mental, and social well-being, and the understood causes of disease and disability (WHO, 1978:9; Abbo, 2003; Sekagya et al., 2006:221). These Practitioners claim to be able to cure various conditions, such as cancers, psychiatric disorders, high blood pressure, cholera, most venereal diseases, epilepsy, asthma, eczema, fever, anxiety, depression, benign prostatic hyperplasia, urinary tract infections, gout, setting bones and healing of wounds and burns (Helwig,2010).

However, diagnosis is reached through spiritual means and the treatment prescribed usually consists of an herbal remedy that not only has healing abilities, but also symbolic and spiritual significance. Traditional African medicine carries the belief that illness is not derived from chance occurrences, but through spiritual or social imbalance. Due to this, Onwuanibe (1979:25) argues that the philosophy of African medical practice is rooted in the African world-view. He stresses that those identifying the cause and cure of sickness ask about the ultimate "who rather than what". Mbiti, analysing the significance of medicine men and women in African societies states:

On the whole, the medicine man gives much time and personal attention to the patient, which enables him to penetrate deep into the psychological state of the patient. Even if it is explained to a patient that he has malaria because a mosquito carrying malaria parasites has stung him he will still want to know why the mosquito stung him. The only satisfactory answer to that question is that someone has caused (or sent) the mosquito to sting a particular individual, by means of magical manipulations. (1969:169)

In Mbiti's assertions, healing is a reaction to witchcraft. I will however, come to the notion of witchcraft later in this thesis, where I show the conceptual relationship between healing and witchcraft. Traditional healers and their clients are therefore more concerned with the cause of the illness than the illness itself. They therefore become preoccupied with establishing the origin and cause of the illness, which in most cases is attributed to either the intervention of God, evil spirits or other people, who do not wish the victim well. For many local people in sub-Saharan Africa, for every illness there must be someone responsible. Establishing the identity of the suspect is an important step in the practice of traditional medicine. Knowledge of the 'causer' of the illness determines greatly the kind of healing processes that will be undertaken. For example, if the identified 'causer' is God or the gods, then healing processes will involve appeasement of their temper. In case of witchcraft, the healing processes may involve retaliation, application of protective medicine or otherwise. The answers therefore given for the diagnosis and prescription

of traditional medicine are framed in terms of the cosmological beliefs of the specific local people among whom sickness has manifested.

Traditional medicine is attracting more and more attention within the context of health care provision and health sector reform. Furthermore, in many parts of the world, such as Sub-Saharan Africa, traditional medicine is becoming the preferred form of health care (WHO, 2002:1; Mubiru, 2004; Getachew et.al., 2002:23; WHO, 1978:17). However, Dawn (2003:20) notes that women have been both formally and informally marginalized in many aspects of life, including healthcare provision and utilisation. Formal marginalisation is confirmed by society's failure to address women's health needs, as well as by the provision of fewer resources devoted to the health needs of women. Informal methods of women's marginalisation are realised through the subtle discriminatory activities in society that disadvantage women in terms of living a fuller and healthier lifestyle, including their inability to seek healthcare services due to a heavy work burden which society imposes upon them.

More so, the healthcare systems in Uganda have over the years been created and recreated by foreign forces especially British colonial policies, which may have affected people's perceptions towards health and illness. It is also true that such inventions and reinventions, as I will discuss later in this chapter, may not have left social relations between men and women the same in relation to healthcare systems. These notwithstanding, colonialism's influences on indigenous women's roles in traditional medicine have not been addressed specifically in any of the literature. This implies a gap in the literature on traditional medicine, which has historically been primarily written by Eurocentric writers, usually male, who dismiss women's work altogether. Oyeronke (2002:1) argues that this has been so because gender focused research on African realities has been distilled from European and American experiences. When African realities are interpreted based on these Western claims, what we find are distortions, obfuscations in language and often a total lack of comprehension due to the incommensurability of social categories and institutions (ibid,4). She therefore suggests African research to be better informed by local concerns and interpretations and, concurrently, for African experiences to be considered in general theory-building, notwithstanding the structural racism of the global system (ibid, 1). Therefore, in my attempt to analyse gender roles in traditional medicine using the perspectives of the Basoga, I am mindful of such Euro-American influences and control in the production of knowledge concerning societies and culture. For this reason, I attempt to present the Basoga's perceptions from their own point of view, based on their local realities and thinking as

indigenous people. The challenge remains whether there can be knowledge which is purely 'Kisoga' and unadulterated, since no society may be immune to inventions and re-inventions. I will, however, come back to these arguments at a later stage in this chapter.

It is important to understand Busoga ideology on traditional healing practices because, as Millar and Bertus (2006:11) argue, in contemporary Africa, traditional knowledge and values are an important driving force in the decision-making and development activities of people. Understanding this knowledge and the way it is organized, is a major step toward building the concept of 'African science'.<sup>1</sup>In general, healing traditions of African societies are part of this 'African science', yet there is no homogeneity of these societies. This 'African science' has sometimes involved the manipulation of traditional epistemologies to cause pain other than well-being to society. No doubt healing and witchcraft are part and parcel of this African science. Ashforth (2005:216) argues that witchcraft and healing are an embodiment of true 'African science' as they serve as basic references for reckonings of the potentials of secret African knowledge and skills.

In some societies the ideology of healing is intertwined with perceptions of witchcraft, for they both harness supernatural forces to fulfil their intentions. This way of thinking, still a reality in some societies can be traced back to Europe's interaction with African societies. European colonial rulers could often not tell the difference between the activities and resources used in healing and in witchcraft. As I argue in chapter four, the British colonialists, for example, misconceived Kisoga healing with witchcraft, and suppressed it. It is therefore, important that a conceptual relationship between healing and witchcraft is drawn, so that when we look at gender roles, we can be specific about which practice is analysed: healing, witchcraft or a fusion of the two.

### **1.3 Conceptual Relationship between Healing, Sorcery and Witchcraft**

There is scholarly agreement about European invention of the term 'Witchcraft' in Africa (Pels, 2014:3; Geschiere, 1998:821; Ciekawy, 1998:120). There are, however, arguments and counter

---

<sup>1</sup>Akpan Chris, in his masterpiece titled, "The Method of African Science: A Philosophical Evaluation", defines 'African science' as 'traditional African science' which include activities of understanding, explaining, and exploiting nature (for man's use), which proceeded from African beginnings on African soil by African people. It is traditional because it proceeded from the African environment and has been passed down from generation to generation, and has not been adulterated by Western science. This presupposes that we are not limiting the word 'traditional' to our fore fathers who were the creators of such science and had since passed away. 'Traditional' also refers to the 'pure African scientists' who have refused to be adulterated by the method of modern (Western) science, and these are still many in several African communities. Indeed, it is about the traditional African man's way of observing, systematizing, testing, confirming facts of his environment, with the aim of achieving a high level of understanding of his environment to aid him in controlling or manipulating the forces of nature to his advantage or at least to escape the heavy consequences of uncertainties which characterise natural phenomena (2011:13).



arguments among scholars from both Africa and western social science over the reality of witchcraft. Peter Pels, in his recollection of western thought about witchcraft, states how colonial European rulers, ruled out the reality of witchcraft in Africa, but moved on to enact witchcraft ordinances to regulate it (Pels, 1998:200). In his analysis of Evans Pritchard's work, Pels recognises the western considerations of the unreality of witchcraft, describing it as simply an imaginary offence that cannot be proved (Pels, 1998:199). Peter Geschiere also discusses how the French, British and Belgians challenged the reality of witchcraft, accusing healers of defamation and disturbance of the peace (Geschiere, 2010:251).

On the other hand, African scholars, religious leaders and healers, as well as politicians maintain a common ground that witchcraft is a reality that ought to be considered as an integral part of African culture (Kohnert, 2003:220; Cohan, 2011:804; Sanders, 2003:339). Geschiere (2010:246-247) suggests that denial of the reality of witchcraft is not helpful if one is interested in understanding why witchcraft has a strong grip upon people. The belief in witchcraft is strong and the fear of it is real in many African societies. Witchcraft is part of modern society and influences how people think and act, also politically (Geschiere, 2010:235; Cohan, 2011:807; Diwan, 2004:352).

Forsyth and Eves (2015:1) argue for the unlimited fusion of healing with witchcraft practices and beliefs, because of the strong belief that illness, death and misfortunes are frequently caused by the deliberate interventions of individuals with special powers or magical knowledge. Restoration to life is the central theme in all African healing traditions. Ashforth (2005:211) argues that the distinction between witchcraft and healing is essentially amoral one, as healers and witches use supernatural forces supposedly for different ends, while both activities fall under the rubric of 'African science'. In this thesis, I do not intend to uncover the reality or unreality of witchcraft but seek to bring to the fore people's beliefs about witchcraft and how it intersects with healing traditions. I am inclined to making a taxonomic analysis of witchcraft, using what Turner (1970:366) calls a 'traditional-functional' approach. The detailed practice of witchcraft among the Basoga is therefore beyond the scope of this study. Firstly, I present what constitutes witchcraft and then analyse how different or similar is it to healing.

Petrus and Bogopa (2007:3-4) as well as Diwan (2004:355) argue that due to different interpretations and manifestations of witchcraft in various societies, witchcraft may have many different meanings depending on the cultural context within which it is believed to exist, and therefore formulating a single definition of witchcraft is very difficult. Kapferer (2002:10) and

Forsyth and Eves (2015:4) argue that determining actions of witchcraft can vary at different moments in the social processes depending on one's standpoint. But it is possible to make a distinction between the two concepts. African witchcraft is a broad concept that can refer to interrelated activities. It involves the use of supernatural forces for evil or harmful intent, and is thus distinguished from the use of supernatural powers for benevolent purposes, for example in divining or traditional healing. The two are, however, not mutually exclusive (Kapferer, 2002:12). English anthropologists, who have had an interest in Witchcraft Studies in Africa over the years, argue that witchcraft uses non-physical means to cause misfortune or injury to other humans and therefore can clearly be mystical and operating in the supernatural realm (Hutton, 2004:422; Cohan, 2011:809; Diwan, 2004:355).

Some scholars in anthropology, religion and cultural studies make a distinction between witchcraft and sorcery, though they often use these words interchangeably (Kapferer 2002:10; Cohan, 2011:810; Forsyth & Eves, 2015:4). To Evans Pritchard, the difference between a witch and sorcerer is that witchcraft is a purely psychic act, without any rite performed and there are no spells uttered neither does the witch possess any medicines to do his or her job. On the other hand, Evans Pritchard believed that that sorcerers cause harm to their victims by performing magic rites with bad medicines (1937:21). Cohan (2011:810) and Diwan (2004:355) have made this clearer when they describe witches to possess supernatural powers, whereas sorcerers are simply ordinary beings who have acquired techniques to harm others. About healing, Evans Pritchard (1937:1) states that against both witchcraft and sorcery, healers and diviners are the ring fence to protect the people.

Witchcraft is frequently conceived as emerging from within the community (Kapferer, 2002:12; Ciekawy & Geschiere, 1998:4). Efficacy of witchcraft is believed to increase in direct proportion to the intimacy between witch and the victim. Witchcraft is more pronounced among kinsmen and they are the first suspects when misfortunes or illness arise (Hutton, 2004:422; Ciekawy & Geschiere, 1998:4). Studies undertaken by Ciekawy and Geschiere (1998:4) and Geschiere (2010:251) in sub-Saharan Africa indicate that in many parts of Africa, witchcraft is explicitly linked to "home" and the family. They cite examples from Kenya, Ghana, Cameroon, who hold strong beliefs of witchcraft emanating from 'within'.

One consequence is that witchcraft accusations primarily target persons from within the family. Because of the kinship character of witchcraft, dealing with it requires the healing process to take place amid assembled family members. None the less witchcraft accusations

indicate the growing jealousy and aggression that exist among close relatives, who ought to live in harmony and be protective of each other in face of external aggression. In Busoga, it may involve assembling members of the whole clan, in a healing activity called *okusamira*, which is accompanied with playing of drums (also called *okukuba ensweezi*). An interview<sup>2</sup> with a woman in Nakyerere, who asked for anonymity, indicates how the medium required them to gather all the close relatives and held a long week session of *okusamira* in her home, trying to cure the husband of impotence. This gives a glimpse of the kinship nature of witchcraft in Busoga society, as in other societies in Sub-Saharan Africa. Witches are usually known and reside among their victims. Close relatives or neighbours are the likely perpetrators of witchcraft, whereas sorcerers usually come from outside the community.

Although sorcery and witchcraft both receive social disapproval, witchcraft operates in secrecy, normally giving the intended victim no consciousness and it is done out of malice (Cohan, 2011:809). Acts of witchcraft are never treated as legitimate retribution for wrongdoing or bad character on the side of the victim (Hutton, 2004:422). Since witches are regarded as opponents to the natural order of harmonious community life, any inexplicable or unnatural misfortunes that befall a community raise suspicions of witchcraft (Cohan, 2011:805).

Cohan (2011:810) argues that traditional healers are oriented towards healing and are often employed for identifying suspected cases of witchcraft. There are, however, suspicions held by the people about traditional healers' involvement in causing witchcraft. Conan highlights the conflict of interest that traditional healers have as their status and income depends on witchcraft as the bewitched will seek them out to treat symptoms of witchcraft as well as to identify the perpetrator of the harm. People thus suspect that traditional healers work in association with the witches to raise their revenues. Some of them thrive on their clients' special problems, ignorance and naive attitude to life. And such healers are often instrumental in generating witchcraft accusations, motivated by personal grudges or rivalries that prompt them to point the finger (2011:823). Whatever the case, witchcraft and sorcery is dreaded in society and there are always serious attempts to counteract them.

Witchcraft and their activities can be resisted by fellow humans through several actions. Hutton (2004:423) mentions three major ways through which witches are dealt with in societies, namely, persuading them either to abandon the practice by divesting themselves from those special powers that empower them to practice witchcraft or reversing the victim's situation by

---

<sup>2</sup>Female client in Nakyerere-Kibaale. Interviewed on 20/04/2015

undoing the witchcraft; secondly, neutralizing the power and work of the witch through detection by diviners and healers endowed with such special supernatural knowledge. But this involves sending back the witchcraft to the witch, so that he/she suffers the same way the victim suffered. The last but most common has been physical means like witch killing, banishment from the community, imprisonment (Cohan, 2011:804).

Sorcery and witchcraft carry gendered connotations. Women have been associated to be the major links and victims of sorcery and witchcraft. But what is real is that both men and women are identified as perpetrators and victims of witchcraft violence (Forsyth & Eves, 2015:7). Forsyth and Eves have described the categories of persons who could be victims of witchcraft violence as strangers on the inside such as women who have married in, or else 'insiders who have become strangers' such as community members who predominantly live away from their communities in urban settings, returning home seldom. In some societies, there are specific genders associated with witchcraft and sorcery. For example, in Papua New Guinea women are never associated with the vice and men share the monopoly of being categorized as sorcerers.

As victims of sorcery accusations, women are more vulnerable than men, due to unequal power relations and a lack of support structures and income. This has not only been the case in Africa, but in European societies too (Forsyth & Eves, 2015:7; Kivelson, 2001:67). The stereotyped image of witches as female, stemming from ancient beliefs in female susceptibility to evil, promotes the identification of women as witches (Kivelson, 2001:67). I have in various sections of the thesis shown how some actions and practices of traditional healing can be seen to have characteristics of witchcraft as discussed in this section. For example, the British colonialists' omnibus reference to all Kisoga healing practices as witchcraft may have been influenced by their failure to see any defining difference between healing and witchcraft.

However, Busoga society distinguishes healing from witchcraft, and manifestations of these in Busoga are discussed variously in the next chapters. In chapter four, I show how the colonial interventions dealt with healing and witchcraft and the inherent contradictions that arose from this. Yet still there exist unanswered questions as to whether perceptions about these healing traditions are universal. Can we talk of unified perceptions of healing across the continent? Even when the answer is rightly 'no', why then do scholars always make references to tendencies of 'African thinking' as though there exists homogeneity? In the next section I analyse the notion of 'African homogeneity', showing how and to what extent African ideologies

can be said to be 'African' yet there exist various categories of people on the African continent. The precise question under interrogation is 'Does Africanness exist? Does it exist as a geographical or identity concept? Answering these questions helps in analysing whether the healing ideologies can be generalized to the whole of Africa.

#### **1.4 Notions of 'African(s) and African Perception(s)' in Traditional Healing**

To analyse the meaning of 'Africa, African' and 'African perceptions' I have found the works of Mbiti (1969), Parrinder (1974), Mudimbe (1988), Edward Said (1993), Ranger (1997), Mazrui (2005) and Ikpe (2010) very useful. 'Africa' is both a geographical and an identity concept. But in the recent past, scholars in the cultural, sociological and anthropological studies as well as history and political science, the concept of 'Africa' has been more associated with 'identity' rather than geographical location. I will first deal with 'Africa' as a geographical concept. Africa as a geographical concept is easy to define and there are no contestations over it, but the term 'Africa', or 'African(s)' as an identity concept raises much debate among scholars (Ikpe 2010:3). In his masterly 'The Re-invention of Africa: Edward Said, VY Mudimbe, and beyond' (2005:74), Ali Mazrui argues that 'Africa', both as a geographical term and an identity concept, has been a creation and recreation by several players who have enjoyed interaction with peoples on the 'African' continent over the years. He states that initially, Africa was a geographical fiction, which was thought of as a separate entity and regarded as a unit to the degree that the map is invested with an authority imposed on it by the mapmakers (Mazrui, 2005:68).

The name 'Africa' is itself an invention with no trace to naturalistic existence. There are claims that the name was an import from the Romans, Greeks, Semites or the European neighbours. The claim that the name came from a Berber language within Africa, has received little attention and acceptability (Mazrui, 2005:69). Africa has therefore been externally conceptualized to be what she is now, both as a geographical mass and as an identity concept. The creation of Africa as a continent was further a creation of the Europeans, who through their geographical societies, turned Africa into a continent by drawing up its geographical boundaries through cartography, the way it was done with other continents (Mazrui, 2005:75). The indigenous peoples of Africa did not have any hand in determining that, for example, North Africa should not be part of Asia, when that part shared a lot in common with the Arab world (Mazrui, 2005:70). The word 'African' was applied to those who lived on the marked continental land mass, to distinguish them from non-natives. It was thought to be non-offensive. The

labelhelped in creating a sense of identity among ‘Africans’, as they were being defined as such in relation to Europeans and Indians (Mazrui, 1963:91).

Dismissing the geographical conception of ‘Africa’, Oliver (1997:114) and Said (1993:106-108, 317) agree to the fact that boundaries that define continents, nations and other places bring some form of identity, but this cannot be the envisaged unchanging identity, defining people who live in those places. This is because of the constant movements of people from one place to another, most of which, of recent, involves crossing of national and continental borders. This undermines the homogeneity of peoples thought to have been defined by the geographical boundaries. Therefore, it is more convincing to talk of ‘Africa’ as an ‘identity’ rather than a ‘geographical’ concept.

Mazrui (2005:70) consistently argues that the reference to an ‘African identity’ as being synonymous with the peoples on the African continent was a creation by her neighbours, but not a result of identical cultures on the African continent. This was birthed by many factors, including, the rise of black consciousness as opposed to people of other colour; racism and slavery imposed upon the black Africans by the Europeans; as well as Islamic religion, Arabic language and Kiswahilli, which have in combination generated a common sense of ‘Africanness’. Yet also, through colonialism, accompanied with western civilisation and Christianity, Europeans shaped and reshaped African identity the way they wanted it to be. For good or bad, they determined African identity and made Africans to realize their Africanicity, which was missing before Africa’s interaction with her neighbours.

However, beginning with the 1980s, a new paradigm developed contesting the notion of foreigners’ invention of Africa. The claim has been that Europeans distorted rather than invented what was authentically African, while replacing them with their own foreign imported traditions. This Afrocentricity School, contests alien forces such as Islam, Christianity, westernization and globalization, as having redefined African identity positively. These argue against colonialism as a blessing to defining African identity and traditions (Mazrui, 2005:77). These foreign forces led to destruction of African order while deliberately reinstating them with false memories (Ranger, 1997:212).

Throughout his book, John Mbiti (1969) argues that it is a fallacy to talk of ‘an African people’ but that it is better to talk of ‘African peoples’, because of the diversity among people living on the African continent and those of African descent (Mbiti, 1969: xi). In this thesis, whereas I agree that there is no uniformity among people on the African continent, I use the

words African(s), and African perception(s) in a restricted sense. The diversity of African peoples makes it quite difficult to talk of a 'unified African people' as well as 'an African perception'. Ikpe Ibanga argues that it is very important to understand who is being referred to when the term 'African' is used, since Modern Africa has a variety of differentiated people including; black Africans, Arab Africans, and African-Americans; all of whom are spread across the African continent and beyond. Even within these categories of African peoples, there are diverse perceptions concerning realities based on clans, gender, age, rural-urban divide, education, economic status and general manner of living.

It is however true, that Africans in the sub-Saharan part of the African continent have some elevated level of unified perceptions regarding many forms of life, though their interpretations may differ depending on their geographical location and way of living. This relative homogeneity in sub-Saharan Africa was also a creation of the Colonialists. Ali Mazrui, writing in the mid 20<sup>th</sup> century argues that the continental feeling built by colonialism was more felt in Sub Saharan Africa than in other parts of Africa (1963:90). Authors writing a decade later like Parrinder (1974:11), wholesomely, had come to believe in the homogenous nature of sub Saharan Africa. Parrinder specifically argues that African peoples are more closely related than people in industrialised societies. To him, the notion that every African tribe/society is very unique is not only untrue but also a conception held by anthropologists outside Africa. Mazrui (1963) further explains how the Europeans through colonialism created sub Saharan Africa to be more undifferentiated than other indigenous societies. Therefore, in this thesis, my application of African people(s) is restricted to those who are descended from sub-Saharan black Africa in general and Busoga in particular. My restrictive usage of 'African(s)' and African perception is in conformity with the ethno-philosophical ideologies that define African and African perception as black and a native of one of the ethnic nationalities of sub-Saharan Africa (ibid; Mwandayi, 2011:58). This 'African' is also traditional, not in the sense that they have not been 'influenced by the inevitable moral and technological culture from the West but because their own outlook and cultural wellbeing remains that of traditional Africa' (Ikpe, 2010:5).

In my usage of 'African holistic perceptions' throughout the thesis, I am mindful of the fact that such perceptions are not universal among Africans living both geographically on the African continent and outside of it. These perceptions are instead collective, spontaneous, unreflective and implicit worldviews, usually accepted, consciously or unconsciously by all

Africans in general or, more especially, by all the members of an ethnic group or an African society (Ikpe, 2010:4-5).

As Flint (2008:18) argues, to employ the word 'African(s)' does not mean that the practices of 'Africans' described can be attributed to all groups within Africa. Rather it is a way of acknowledging a more heterogeneous group of Africans. Consequently, reference to 'African perceptions' simply portrays the corporate nature of beliefs, ideas and practices but does not in any way imply that everybody in such African societies subscribe to these beliefs and practices (Mbiti, 1969:3). Healing practices are part of these traditions. I recognise that the use of the terms 'traditional' and 'tradition' further complicates the study of African ideologies on healing. In the next section, I will analyse the meaning of these words and how they shed light on healing in African societies today.

### **1.5 Ideologies of 'Tradition' and 'Traditional' in Healing**

I present an academic discourse of the notions of 'Tradition' and 'traditional' from some of the earlier propagators, especially of the 1980s through the present times. I will later show the application of these concepts to 'healing and medicine'. 'Tradition' includes the passage of items, images, symbols, events, beliefs, behaviours, customs or practices from one generation to another over the years. For the indigenous societies, 'traditional' relates to the pre-contact era, that is the period before the coming of foreign people into their land. Sometimes, it may in a common-sense way refer to period long past or what one's ancestors used to do (Linnekin, 1983:242). This is the earlier and common sense western world understanding of the concept of 'tradition'. This definition suggests that traditions are inherited by the next generation without change and distortion (Ben-Amos, 1984:99; Flint, 2008:12). This, too, brings to light an understanding that 'tradition' exists in contrast and at the same time with what is new and modern (Handler & Linnekin, 1984:273).

Further, the common-sense perception of 'tradition' refers to the study of cultural and social backwardness of the uncivilised, non-literate, savage peoples such as the black fellows of Africa. And that the study of 'tradition' ought to be concerned with discovering the laws and customs, stories and superstitions of those peoples that have been passed on from generation to generation (Ben-Amos, 1984:100). There is strong criticism by several authors, including Handler and Linnekin (1984) against this earlier perception of tradition (Hobsbawm & Ranger, 1983; Linnekin, 1983; Ben-Amos, 1984; Mudimbe, 1988; Mazrui, 2005; Thomas, 1992; Said,



1993; Ranger, 1997; Oliver, 1997; Pels, 1997). These authors have contributed to the postulation of what is now popularly called the 'invented tradition', as a reaction towards the proposed unchanging traditions. There is agreement among theorists of the 'invented tradition' that 'traditions' are continually changing, which therefore calls for a reassessment over time (Ben-Amos, 1984:99; Hobsbawm & Ranger, 1983:2; Linnekin, 1983:241; Pels, 1997:177). The theorists of the 'invented tradition' argue against the ideology of traditions being associated with the past. Their arguments are premised on the fact that traditions are usually recent in origin and in most cases simply invented (Hobsbawm & Ranger, 1983:1; Turner, 1997:361). They look at tradition as a cultural construct, subject to change from within and without. While there may be certain values, practices and symbols that persist overtime, their meanings shift to reflect society's norms and values (Flint, 2008:12, 16). The invented tradition theorists attempt to make a link between social formations derived from the past with social actions of the present such that tradition is seen an active interpretive process in which representations of the past are forged through the present discourse (Turner, 1997:361).

For example, in reference to invention of modern governments in Africa, Karen Fields observes how the application of indirect rule by the British did not do away with the customary leadership but instead believed that sound administration would rest on the prevailing traditions of the colonised (Fields, 1982:95). Healing systems in Africa are part of the 'traditions', which indirect rule aimed to protect and change during the colonial administration (Gray, 2001:341). For Peter Pels, it is not only the traditions that are invented but also what may be called 'modernity' for a given society is invented too (1997:177). And this is what defines a society's identity at present. The very identity of society rests on this continuity of the past with the present. The legacy of the past is not immutable, but the essential identity persists over time with modifications (Handler & Linnekin, 1984:275).

Such traditions appear and disappear in new forms and overtime depending on the expectations of the current generation (Linnekin, 1983:241; Hobsbawm & Ranger, 1983:1). The present generation picks up certain aspects of cultural practices that are relevant to them and they redefine them with symbolic values to meet their current demands (Linnekin, 1983:242; Said, 1993:4). The invented tradition becomes a product of both traditions that have been invented, constructed and formally instituted. This does not however mean that there is whole adoption of the past, rather in constructing the present using the past, some unwanted elements and narratives may be left out in the now formed tradition (Said, 1993:15). These establish themselves in a very

quick way that it becomes difficult to trace when and where they originated, looking clearly as though they have existed ever since (Hobsbawm & Ranger, 1983:1; Ben-Amos, 1984:99; Said, 1993: xxv). The concepts 'traditional' as opposed to 'new' are used in an interpretive rather than descriptive way because as already stated 'traditions' change overtime and therefore what may be seen to be new, would have simply taken on a symbolic value as 'traditional' (Handler & Linnekin, 1984:273; Ben-Amos, 1984:101).

There have risen questions of authenticity of tradition in the face of ceaseless changes in society and continuous adaptation to cultural imports. The question remains, does 'tradition' remain genuine, authentic or the same when some aspects are dropped and the new and appealing ones are imposed adopted or adapted? Critics of the invented tradition like Thomas (1992) and then later writings of Linnekin (1991) shed light on the authenticity of tradition in the presence of a changing society and colonialism. Not all authors agree with the argument that authentic traditions arise with the submerging of 'old' traditions into new ones. For example, Hobsbawm and Ranger distinguish genuine from invented traditions, arguing that invented traditions emerge in situations of rapid social change or when the historical past cannot be traced (Linnekin, 1991:447; Hobsbawm & Ranger, 1983:4). Thomas (1992:213) accuses Hobsbawm and Ranger (1983) as well as earlier works of Linnekin (1983) of often equating invention with inauthenticity. He however, argues that created identities are not somehow contrived and insincere as culture is tailored and embellished in the process of transmission, yet this process is dynamic, creative and real (Thomas, 1992:213).

Authors who oppose the notion of the 'invention of tradition' argue that its proponents present the false impression that it is an obvious fact and belief that once 'new' traditions emerge; they are automatically taken on by the present generation as they willingly drop the 'old' ones. Another false impression created by the proponents of the invented tradition, and for which they vehemently support is that cultural invention is always good for the specific group and that it is deliberately introduced to make indigenous societies better. Spear (2003:4) harshly criticised the theory of 'invention' for construing Africans as gullible subjects. Jocelyn Linnekin argues against cultural invention as a politically revisionist and anti-native rubric, which aims at undercutting the cultural authority of indigenous peoples by calling into question their authenticity. She further contends that those who propose invention of traditional culture want to discredit the authenticity of legitimate concerns and interests of indigenous groups that would otherwise accrue to them because of their long-standing position. They further want to discredit

their identity as a homogenous group with defined beliefs and legitimate political, economic, cultural and religious as well as social interests that ought to be respected and protected (Linnekin, 1991:446; Goucher, et.al., 1998:7; Bal, 2002:218). But to the proponents of the invented tradition, the inventions are common components of the ongoing development of authentic culture. Neither do they attempt to suggest that native models of culture, custom or tradition are inferior and inauthentic (Linnekin, 1991:447).

I now turn to show why and how healing practices fit into the description of being 'traditional' and being part of the 'traditions' of Busoga society. I need also to show in what context Busoga can be a 'traditional' society. Robert Thornton insists that healing practices are rapidly changing as African societies are increasingly becoming westernized and global. This implies that the term 'traditional healers' is a misnomer if by 'tradition' we mean an unchanging conservation of past beliefs and practices (Thornton, 2009:17).

Richter (2003:6-7) argues that the use of the words 'tradition' and 'traditional' to describe African healing systems is not appropriate because they do not actually represent the principles and philosophy upon which healing is practiced. However, any healing system, whether African or non-African, must be based on a knowledge foundation, with its epistemology, philosophy, scientific and logical validity, which can only be understood by the very people who practice and utilise it (Dawn, 2003:3). The techniques, principles, theories, ideologies, beliefs, opinions and customs applied in 'traditional' health practice must be unique to the society in which they are practiced (Flint, 2008:6). Authors associated with the African religious experience argue that the word 'traditional' is used for the original experience of the sacred cultivated by the African man and the concrete expression of that experience within different ecological and socio-historical backgrounds. They maintain that the term 'traditional' does not imply that African religion is static or unchanging from age to age. It further implies that the living experience and expression are handed down from one successive generation to another (Mwandayi, 2011:61). Mwandayi, citing Kofi Asare Opoku, argues that using the term 'traditional' 'does not in any way mean something from the past but, rather, only indicates that it is founded on a fundamentally indigenous value system, which has its own pattern, with its own historical inheritance and tradition from the past (ibid). 'Tradition' therefore, is adaptable and durable, meaning that it can change to suit the present generation, and this is what makes it durable and relevant to all generations (Flint, 2008:10).

These notions, therefore, carry politically loaded meanings, which brings misrepresentation of the truth about healing systems in African societies. The reference to the healing systems of Africa as ‘traditional’ is in contrast to definitions of biomedicine or western medicine. Biomedicine is looked at as being concerned with biological diseases, using diagnostic methods and principles originating from the western world. Traditional medicine is associated with the treatment of sicknesses, with emphasis on the spiritual realm of causation, diagnosis and treatment (Truter, 2007:57). Due to competition that exists between the two medical systems operating in African societies, some people use the notions of ‘tradition’ and ‘traditional’ to portray healing as being associated with irrationality and the pre-scientific age (Feierman, 1985:110; Flint, 2008:7).

The above assumptions are however erroneous regarding realities in Busoga society. To suit the values of the current generation; healing traditions have changed in many respects. Defining African healing as belonging to the pre-scientific age is simply based on the tenets of western science; that tends to regard other societies’ innovations as unscientific as long as they deviate from the modes and principles of western science (Dawn, 2003:25). The processes involved in diagnosis, treatment and preparation of traditional medicines in Busoga disqualifies the judgmental assertion made of it as being ‘irrational’ and ‘pre-scientific’. Assertions by Sugishita (2009:450) and Schumaker et al. (2007:707) that traditional medicine is indeed scientific and rational, are based on the WHO’s efforts to promote it. They argue that the promotion of traditional medicine by the World Health Organisation propounds its cultural legitimacy, scientific rationality and economic potential. As I analyse in chapters three and five, Busoga society healers have had a well-defined way of establishing the cause of sickness. Furthermore, not all traditional healers base their diagnosis and treatment on spiritual causation and effect. There are pure herbalists among them, who have mastered the chemical composition of several herbs, capable of curing certain diseases.

Traditional healers in urban areas have been influenced by advances in the modern health sector. They process their herbs in the form of tablets and purified liquids, carefully packaged in modern containers with very clear labels. They have opened herbal shops in Jinja’s Napier public market. Corporate associations of healers are in existence, akin to the biomedical’s Uganda Medical and Dental Practitioners body. They carry out self-censorship and regulation to weed out quack healers. Such changes have enhanced the credibility of the healers and the efficacy of their medicines. Flint (2008:2) notes that away from their previously known roles, ‘traditional’

healers have transformed themselves into a powerful force that influences the politics and economics of their societies. In most of the successive presidential elections in Uganda, President Yoweri Kaguta Museveni has always held special meetings with traditional healers, whereupon they pledge to appeal to their ancestral spirits to ensure his victory.<sup>3</sup> The bigger picture of these encounters is that healers hold power over those they treat, and they are respected members of their communities, capable of influencing voting patterns.

‘Traditional’ healers no longer sit in their healing centres to wait for clients. The examples of Maama Fina,<sup>4</sup> a successful businesswoman dealing in fabric garments, and Kabaale Bitimbuto,<sup>5</sup> a diviner in Namutumba district, who is a celebrated farmer of groundnuts and maize, attests to the changes that have occurred in healing over the years. Such changes cannot by any standard belong to the irrational and pre-scientific era. Furthermore, the traditional birth attendants (*Balerwa*) use a massaging technique (*okutenga endha*) on the expectant mother to redirect the unborn baby’s head towards the birth canal. Bonesetters also use a massaging technique to mend dislocated bones. These techniques cannot be pre-scientific when biomedicine uses physiotherapy methods to achieve the same.

The erroneous characterisation of ‘traditional’ medicine tends to reduce the numerous and diverse healing practices of Africa to ‘spiritual healing and divination’, which are sub components of healing traditions in Africa (Feierman, 1985:111). It is ‘traditional’ because it is carried out by local people in their societies (Richter, 2003:7; Rekdal, 1999:459). Feierman is explicit, stating that this is a social contextual description of ‘tradition’ and ‘traditional’. This means that these healing practices are only carried out by ‘Africans’, who are special and unique, and what they do is not amenable to change. Traditional healers ought to be living among those they treat, sharing a common culture with the clients (Richter, 2003:7; Feierman, 1985:110). It was part of Busoga ‘tradition’ that a ‘traditional’ healer had to operate among their kin’s people, and he/she was consulted whenever crisis or illness arose. It was a vote of no confidence in a healer, if their kin’s people or fellow villagers consulted another healer in the neighbourhood.

In view of this description it would render today’s healers ‘non-traditional’ because Busoga has witnessed a great deal of cultural exchange. The Koranic healers (*Abasawo Abaghalimu*), known to espouse no cultural boundaries in the treatment of the sick, would be

---

<sup>3</sup>The Observer Newspaper, (2011). Museveni Courts Cult, witchdoctors and religious heads. Published February 17, 2011. [www.observer.ug](http://www.observer.ug). Retrieved on 31<sup>st</sup> August 2017.

<sup>4</sup>Business name for Sylvia Namutebi, a nationally famed traditional healer and National Chairperson of Traditional Healers in Uganda. Have several businesses around Kampala city? Her known healing place is at Bulenga, along Kampala-Mityana road, about 20 kilometers from the City centre

<sup>5</sup>Chairperson of Traditional Healers of Namutumba District in Busoga

rendered 'non-traditional'. This description again implies the idea of 'localisation or villagisation' of healing, which reduces healing practices to just divination; a practice more closely associated with mediums residing in the traditional hubs of the ancestral spirits. Healers now migrate to urban areas where they meet more clients, other than being confined to their fellow clan members or fellow villagers. The commercialisation of traditional healing in society means that services may not be accessible to even the healer's fellow clan members or fellow villagers because they may not be able to afford to pay. Previously, it was easy to acquire herbs but due to a rapidly growing population in Busoga, much of the forest has been depleted for human settlement. Healers have to traverse long distances in search of herbs. Moreover, commercialisation of 'herbal medicines', which is accompanied by aggressive marketing and increased popularity, is likely to disconnect these treatments, and the resulting profits from the original knowledge systems and skilled practitioners who developed them (Schumaker, et al., 2007:708). Rekdal (1999:459-460), studying traditional healers among the Iraqw of Northern Tanzania, has established that the 'healers' in this African society are neither frequently 'Iraqw' nor 'traditional' because their attributes contrasted with the way African traditional healers have frequently been portrayed.

Herbal clinics are common in the urban areas of Jinja. These healers treat all categories of clients not known to them. Feierman (1985:110) states that regardless of the differing principles and philosophy upon which African traditional medicine and biomedicine are practiced, both are forms of ethnomedicine because they represent diverse cultural influences. Both, in fact, are supposed to be 'traditional' to those cultural societies from which they have originated. Flint (2008:6) argues that the exclusive use of 'traditional' to 'African healing' communicates 'power relations' that exist between those who believe in biomedicine on one hand and those who believe in 'traditional medicine' on the other hand, with the implication that biomedical practices take precedence over traditional medicine.

In a restrictive sense, the notion of 'traditional' in healing relates to all kinds of therapy that existed before colonial rule in African societies. Some of these therapies have withstood colonial influences (Feierman, 1985:112). African healers associate themselves with being 'traditional' as a demonstration of the uniqueness with which indigenous medicine is practiced being freed from the multicultural environment that exists (Flint, 2008:8, 12). Traditional healers have been influenced by socio-economic and political changes in Uganda so much so that there now exists a hybrid of traditional healing systems not commensurate with the practices of the

forefathers. There have been profound changes to healing practices in Uganda such that the notions of 'tradition' and 'traditional' are simply legendary. Other authors argue that the binary usage of 'traditional' and 'modern' is no longer valid either as observable phenomena or analytical categories (Weiss, 2001:368). Healers use the title of 'Doctor(s)' and have established and furnished their healing centres just like western trained medical doctors. They wear white overcoats, especially the herbalists. Many are becoming highly sophisticated by employing skilled laboratory technicians to investigate diseases not amenable to spiritual interpretation.

There is unprecedented collaboration between biomedical doctors and healers, though at individual levels. An interview with Kawuma Safina Nabirye revealed how she receives many referrals from biomedical doctors within Jinja especially on chronic diseases. She also refers several of her clients to biomedical health facilities, on the realisation that such a case can competently be handled by biomedical experts. The neatness associated with traditional herbalists is only comparable to the neatly arranged biomedical drugs in pharmacies. This, however, varies between rural and urban healers. Healers with a western education have resorted to high-level research using the internet and other literature to better understand the human anatomy. There exists a mixture of observance of traditions related to healing and modern systems of diagnosis and treatment.

Gender restrictive ideologies in traditional healing have not been left unaffected. There are powerful female healers, especially in herbalism, competing favourably with male healers. Female healers can afford to move from place to place looking for herbal medicines with the help of modern transportation in the form of motor vehicles rather than walking long distances on foot, which was risky. Female healers, though few, have emerged to provide leadership to traditional healers' associations being dominated by male healers in terms of membership. A case in point is the celebrated herbalist, diviner, businesswoman and philanthropist, popularly known as Maama Fina.

Age and manner of dress have shed more light on the 'level of what is traditional' in healing today. Several young men and women practising as traditional healers have refused to continue with the traditional characteristics of a traditional healer. Young female healers wear makeup, with plaited hair and fashionable clothing, and not the conventional bark cloth of yesteryears. They put on priestly garments only during the time of divination. I have discussed the dress code and general characteristics of traditional healers in both chapters three and five. This makes it difficult to determine how much of traditional healing today is indeed

traditional. It is true that whereas ‘traditional’ medicine is practiced based on certain core beliefs, it has been open to non-African beliefs, practices and substances (Flint, 2008:6). Since traditions reflect the present as much as they offer a window into the past (ibid. 9), I have most often used the past tense when discussing healing traditions in Busoga because ‘tradition’ represents both ‘what it was and how it was used’. Where I have established that a certain tradition continues to exist, I have used the present tense in reference to it.

Due to the changes that have occurred in Busoga traditional healing systems, a lot of unethical behaviours have surfaced among healers. Commercialisation of healing has come along with imposters, selling fictitious medicines. Child sacrifice has sprung up too. Rape of female clients seeking treatment from traditional healers is common. The negative connotations associated with healing make traditional healers to use the notion of ‘tradition’ to distance themselves from the quack healers, arguing that ‘traditional’ healing has nothing to do with such imposters. Traditional healers in Busoga are aware of this challenge, which is why in their classification there is emphasis on those who heal according to ‘tradition’, that is, following the core principles, philosophy, customs and values of Kisoga culture (*obusawo obwanakaidhongo*). Consequently, the use of the words ‘tradition’ and ‘traditional’ in healing is aimed at emphasising the authenticity and legitimacy of healing in a cultural landscape that has been adulterated (ibid. pp.12). Having demonstrated the application of the notions of African(s), ‘tradition’ and ‘traditional’ in healing, I now intend to demonstrate how gender roles differentiation is part and parcel of these notions.

## **1.6 Conceptualising Gender and Gender Roles**

Before a scholarly relationship between gender roles and traditional healing can be made, it is important that I present a conceptual understanding of ‘gender’ and ‘gender roles’. Several authors like Oakley (1972), West and Zimmerman (1987), Delphy (1993), and Blackstone (2003:335) have made effort to differentiate gender from sex, because many people tend to confuse the two concepts, while others use them interchangeably. Sex and gender are different terms though they serve interrelated functions. Oakley Ann, states that sex is a word that refers to the biological differences between male and female; the visible difference in genitalia, the related difference in procreative function. On the other hand, she defined gender as the social classification into masculine and feminine as determined by culture (1972:16). Blackstone Amy has expanded on Oakley’s definition when she states that sex as a biological concept, is



determined based on individual's primary sex characteristics, whereas gender refers to the meanings, values and characteristics that people ascribe to different sexes (Blackstone, 2003:337). Therefore, Gender is the social construction of male and female whereas sex relates to the biological construction of male and female (Delphy, 1993:6; West & Zimmerman, 1987:127). Gender is socially constructed, not determined by biology but it is a social elaboration in specific contexts of the obvious facts of biological difference. Being female and male is natural, but it is society that constructs who or what a 'man' or 'woman' should be. Gender is a concept that humans create socially through their interactions with one another and their environments, yet it relies heavily upon biological differences between females and males (Blackstone, 2003:335; West & Zimmerman, 1987:127).

Gender is constructed from cultural and subjective meanings that constantly shift and vary, depending on time and place (Courtenay, 2000:1387). Gender is an institutionalized system of social practices for constituting people as two significantly distinct categories, men and women, and organizing social relations of inequality based on that difference (Ridgeway & Correll, 2004:510). These gender descriptions may include one's character, behaviours, status, traits as well as roles. These gender differences determine men's and women's social roles and role-related activities, making it clearly distinctive in almost all spheres of life what is done by women and men (Bird & Rieker, 1999:748). It is therefore relevant to interrogate gender role differentiation in healing because for a very long time, cultural studies have been engrossed with the relative position of the sexes in various societies. There has been an emphasis on the roles of men and women as explanatory variables in the analysis of cultural behaviour (LeVine, 1966:183).

According to 'role theory', gender roles are simply learned (West & Zimmerman, 1987:128). Gender roles are usually hierarchical and operate to the advantage of men and to the disadvantage of women, with activities and roles performed by men being more valued than those performed by women. Gender roles are not necessarily rigidly defined in terms of men's and women's roles, as it is sometimes assumed. They are characterised by cooperation in joint activities as well as by separation. In this thesis, I have explored both healing roles that are exclusively performed by either women or men and those undertaken jointly by women and men.

Some authors have demonstrated women's presence in healing practices within specific societies. However, women's presence as healers varies from society to another and from one country to another. For example, in Zambia, 60% of traditional healers are female. This is

attributed to the HIV/AIDS epidemic in Africa, which has increased the demand for healthcare needs, some of which are gender specific (ibid.). Often, female traditional healers in this country speak of spirits guiding them to the bush to find medicinal plants. Differently, in Ghana, if a woman practices traditional healing it is only because she is considered a powerful witch who is not to be challenged. Gathering of plants in Ghana is a task for the male rather than the female traditional healer. Fathers will not send their daughters to the bush in search of plants in fear of others thinking she is a witch, and husbands will not allow their wives to help prepare medicine, stating that the concoction will consequently not work (Nelms & Gorski, 2006:186).

Popper and Ventura (2009) have studied women's involvement in healing in the Arab society, and have established that some traditional healing practices are a monopoly of the women in terms of service delivery and usage. In this society, divination is a feminine occupation. It relies upon those skills identified as feminine and takes place in the domestic space considered to be feminine, along with feminine materials, artefacts and acts. Traditional healing practices that employ daily, inexpensive and accessible artefacts and that are part of the house chores portray feminine leisure patterns and the reverse is also true (2009:16). It may be that some traditional healing practices are perceived as distinctively feminine occupations because they are the few options available to uneducated women in traditional societies to support themselves without violating basic social norms. Some researchers regard the feminine occupations of traditional healing as a choice made by women, not always consciously, to gain fulfilment, to attain status and autonomy but primarily to generate income (Scully, 1995:864). The women healers are mostly divorced, widowed, separated or unmarried. This is probably because such women desire to exercise their healing powers unhindered by limitations that men and society impose on married women. Some of the women healers are unmarried because men are uncomfortable with their powers or because their powers demand that they remain unattached (Popper & Ventura, 2009:17).

Some other female healers are mothers of many children who can, only find a source of income through healing. This source of income is both profitable and socially acceptable. Most female healers have reported that they either inherited their occupation, especially from their mothers, or received it as a gift from supernatural entities. These claims legitimize their activity and allow them to work freely in a society that, traditionally, opposes women's work (Popper & Ventura, 2009:17). Traditional healing practices perceived as distinctive to women are usually avoided by male healers. This is because of the inferior status accorded to women's healing

practices, in comparison to the more prestigious and superior status accorded to male dominated healing practices (Scully, 1995:867). On the other hand, traditional healing practices that are masculine in nature occur in the public sphere and are accompanied by ‘masculine’ materials and artefacts like papers, pens, calculators and books. Some of these artefacts have undergone consecration and hence differ from women’s common domestic artefacts. Consequently, masculine artefacts are part of the textual, orthodox or high culture traditional healing practices. Literature demonstrates that masculine traditional healing practices are performed via horoscope charts and numeric calculations, Holy Scriptures and fate books (Popper & Ventura, 2009:17).

For some societies in South Africa, Rogerson (2001) establishes that women are more likely to take on the divination form of healing than men, while men take on herbalism. She attributes this to the thinking in South African traditional communities that holds women to have an intuitive ability to heal. Rogerson further argues that herbalism, a domain for men, tends to involve the process of gathering, often digging for *muties*-medicinal substances, which is laborious and time-consuming. Most female healers have other reproductive roles that do not allow them to spend days if not weeks in the forests collecting medicines, hence the tendency to have more female diviners and male herbalists.

Globally, Heather (2007:7) illustrates that in many cultures, women and men have different knowledge of medicinal plants, which is linked to the division of labour, role expectations and responsibilities. In many rural-based and indigenous communities, women play key roles in the delivery of informal healthcare alternatives based on medicinal plants. This is because of women’s ascribed responsibilities of domestic healthcare, reproductive roles and general care work which have been designed to be a preserve of women. As a result, policies and initiatives that ignore gender dimensions of traditional knowledge in medicine can have serious implications. Based on a World Bank report, Heather notes the following:

As a result of this gender differentiation and specialization, the traditional medicinal knowledge and skills held by women often differ from those held by men, affecting patterns of access, use and control, while resulting in different perceptions and priorities for the innovation and use of Indigenous Knowledge. It also impacts the way in which it is disseminated, documented and passed on to future generations. (2007:7).

This World Bank report reveals discursive practices around traditional healing, in which medicinal knowledge is gendered. It further reveals an established boundary between women and men regarding knowledge of traditional medicine. It therefore becomes hard for one gender to

cross to a healing practice as it becomes controlled knowledge, operating in a controlled space that is protected. Such protective mechanisms become barriers for especially women against access and control of healing practices. This produces and nurtures structures that control healing practices, in which either men or women must be groomed into. Therefore, gender differentiation becomes a tool of influence determining what women and men can do or not do in the healing practices. Heather further documents women's roles in local knowledge systems. However, the literature on specific case studies setting out women's roles in traditional medicine knowledge and gender analyses of traditional medicine is limited, or virtually non-existent. This 'invisibility' persists in technical and scientific research, where women's knowledge and roles, responsibilities and management practices for the conservation and improvement of animal and plant genetic resources tend to be missed out altogether (Heather, 2007:8). This opens research questions focusing on the gendered nature of traditional healing practices, not only about access and participation but also in terms of the changing gender roles before and after western colonial influences upon Africa.

### **1.7 Statement of the Problem**

Though many scholars have emphasised the crucial role of traditional medicine in societies (and there has been great concern by the WHO to have integrated traditional medicine in the World's health systems since 1990), no special attention has been given to the question regarding how this integration may work for and affect men and women in particular countries. This is supported by Millar et al. (2006:8) who significantly note that whereas much has been done in the field of health sciences and particularly for herbal medicine, very little has been done by science-based scholars on the knowledge of other African traditional healing practices. Tabuti (2006:104) similarly argues that many aspects of traditional knowledge of the Basoga have not been documented, for instance the spiritual healing aspects. Researchers have been reluctant to examine the significance that people who have used traditional medicine for generations attach to traditional healing systems. Moreover, there is insufficient research about the role of women in terms of knowledge, custody and provision of traditional healing. Additionally, most research concerning traditional healing does not disaggregate information based on gender (NWAC, 2007:3). Furthermore, feminine traditional healing practices have rarely been the focus of research (Popper & Ventura, 2009:7). Therefore, the role of gender in traditional healing practices including provision, access and utilization patterns to ascertain gender equity in

traditional healing practices has not been explored. In addition, the ideologies of provision, utilization and maintenance of traditional medicine have been ignored completely. Annandale and Hunt (2000: viii) argue that research needs to be clearer than it has been to date about the nature of the social relations of gender as they impact upon the health of men and women.

### **1.8 General Objective**

Based on the preceding introductory reflections I can now formulate the general objective of this study. The general objective is to analyse gender roles in traditional healing practices in Busoga. More specific objectives are:

1. To analyse the ideology of traditional healing practices in Busoga society;
2. To examine the impact of colonialism on gender roles in traditional healing practices in Busoga;
3. To analyse the gendered patterns of access to and utilization of traditional healing practices in Busoga;
4. To analyse the responsibilities and influence of men and women in traditional healing practices in Busoga.

### **1.9 Research Questions**

The general objective of this study will be concretely realized by attempting to answer the following research questions:

1. How do the people in Busoga think about traditional healing practices?
2. How did colonial activities influence traditional health practices in Busoga, and how did this affect men and women differently?
3. What are the gendered patterns of access to and utilisation of traditional healing practices in Busoga?
4. What are the roles of men and women in traditional healing practices in Busoga?

### **1.10 Significance of the Study**

This thesis has significance both at an academic level and at a policy level, as it will advance knowledge that may help in designing strategies for effective utilization of traditional medicines, and for improving the promotional efforts of the WHO in integrating traditional medicine with Western medical regimes. The thesis contributes to an on-going discussion regarding the influence of gender relations embedded in access, utilization and practice of traditional medicine. Knowledge generated about Busoga society ideology on health and traditional healing generates further debate on the health status of individuals beyond those health indicators that are provided by Ministries of Health and other such organisations with concerns in the health sector, such as

the World Health Organisation. The ideologies held by indigenous people about health and illness is a challenge to conventional health care practitioners and policy makers, who have been preoccupied with the biological aspects of patients, neglecting their minds and souls. My argument in this thesis is that traditional healing traditions espoused by indigenous peoples provide us with a comprehensive view of health and illness, as opposed to the narrow view put forward by western biomedical practices. I also argue for the recognition and appreciation of using qualitative approaches and methods for the understanding of contemporary public health issues. This thesis highlights the significance of qualitative methodologies, filling a gap in the public health toolbox by studying cultural behaviours, attitudes and perceptions in a way that quantitative methods alone cannot. Since public health problems are complex, not only because of their multi-causality but also as a result of new and emerging domestic and international health problems, this thesis promotes appreciation of qualitative research approaches to public health issues.

This thesis outlines a conceptual understanding of how socially constructed gender beliefs determine the efficiency and effectiveness of the traditional health system as an integral part of the regular health system. It attempts to illustrate how gender-focused research complements health systems research. Health systems research is ultimately concerned with improving the health of a community by enhancing the efficiency and effectiveness of the health system. As an integral part of the overall process of health systems, the research may be described as: a set of cultural beliefs about health and illness that forms the basis for health-seeking and health-promoting behaviour, the institutional arrangements within which that behaviour occurs, and the socio-economic (political) physical context for those beliefs and the institution's socio-economic development. Indeed, as Miller (2009:186) ably put it in her study on the interpretivist approach to health, illness and healing, knowledge of socio-cultural conceptions of illness and healing play several roles in improving health systems: they inform healthcare providers, both traditional and western, about more appropriate forms of treatment; they guide local people in their increasingly complex medical choices; they help prevent health problems through changing detrimental practices; and they improve public health communication by making it more culturally informed and effective. This thesis attempts to illustrate how these gendered cultural beliefs and behaviours, as well as the gendered institutional arrangements, intersect to produce an efficient and effective health system.

### **1.11 Theoretical Framework: Ethnomedicine**

This thesis is influenced by ethnomedicine. Ethnomedical analysis focuses on cultural systems of healing and the cognitive parameters of illness (McElroy, 1996:1). The ethnomedical perspective focuses on health beliefs and practices, cultural values, and social roles. Originally limited to the study of primitive or folk medicine, ethnomedicine has come to mean the health maintenance system of any society (McElroy, 1996:4). This thesis borrows aspects of the explanatory model of traditional medicine.

This model proposed by Arthur Kleinman (1980) attempts to explain illness and health within socio-cultural contexts. In the cultural domain, the explanatory model brings to light notions about the causes of illness, diagnostic criteria, and treatment options that people in specific cultural contexts resort to (McElroy, 1996:4). The explanatory model advances a conceptual system centred on the social and experiential peculiarities of sickness and healing, with the aim of understanding the efficacy and meaning of healing (Pilch, 1995:318). Consequently, following this model has been helpful in understanding and analysing how the Basoga construct the meaning and nature of disease and illness as well as their management interventions in case an illness arises in society. Applying this framework to the study of Busoga has helped in delineating clearly the unique ideologies of the Basoga regarding healing.

According to Wikispaces (2016) ([www.medanth.wikispaces.com](http://www.medanth.wikispaces.com)), the explanatory model reveals how people make sense of their illness and provides a framework whereby social science researchers and healthcare providers may engage with clients to understand their experience of illness. Such a model investigates explanations of illness and social realities that are culturally shaped, and it investigates how individuals experience disease. Explanatory models are often used to explain how people view their illness in terms of how it happens, what causes it, how it affects them and what will make them feel better. The explanatory model guides perceptions of researchers by emphasizing the importance of examining health, health seeking behaviours and medicinal decision-making within a cultural context. This model, according to Kleinman (1980) is best suited to qualitative research, using ethnography, interviews, focus groups and participant observations. In this study I use interviews. Applying the explanatory model to ethnomedicine helps to provide researchers with lived experiences of illnesses that would otherwise be overshadowed by numbers and statistics.

Miller (2009) has expanded on this explanatory model and called it the ‘interpretivist approach to healing’. She states that researchers ought to examine health systems, including

traditional healing ones, as systems of meaning (Miller, 2009:177; Pilch, 1995:324). The interpretivist approach focuses on studying illness and healing as a set of symbols and meanings. Cross-culturally, definitions of health problems and healing systems for these problems are embedded in meanings (Miller, 2009:186). Miller (2009:165) explains that the first step to be undertaken by researchers in ethnomedicine is to learn how people label, categorize, and classify health problems. This involves the study and examination of various aspects of healing, such as ritual trance and symbolic performances (Miller, 2009:177). In summary, this theoretical framework is very important in this thesis especially in ensuring the understanding of the ideology of Busoga society and the construction of illness and well-being, causes and treatment of disease and sickness among the people.

### **1.11.1 Social theoretical Framework on Health**

My argument is also influenced by the framework of social theory on health that is postulated by Loforte (2004) and Annandale and Hunt (2000). Recent developments in social theory raise new questions about gender inequalities. The social theoretical framework on health also argues for the restructuring of gender-related experiences likely to have widespread implications for the mental and physical health of men and women in many years to come. This theoretical model considers the social construction of inequality. Special attention is thus given to socially constructed differences between men and women in terms of access to, participation and control of health resources, and with regard to inequalities among women and among men (Loforte, 2004:27). For this reason, this study seeks to analyse how socially constructed differences between men and women influence provision, access and utilization of traditional healing practices in the Busoga region.

The social theoretical framework for health puts strong emphasis on the concept of “social position”, which plays a significant role in the social determinants of health inequities (Loforte, 2004:28; Annandale & Hunt, 2000:22). The framework showcases two issues: social contexts and social stratification. Social contexts, which include the structure of society or the social relations in society, create social stratification and assigns individuals to different social positions. Social stratification, in turn, engenders differential exposure to health-damaging conditions and differential vulnerability in terms of health conditions and material resource availability. In following these elements of the social theoretical framework to health, the study



concerns the analysis of the social position of men and women in Busoga and how this affects their access to traditional healing practices as providers and users.

According to Annandale and Hunt (2000), using the social theoretical framework when addressing gender equality in health requires the exploration of how gender roles and the division of labour, as well as access to information, control of resources and mobility, influences the ability of men and women to participate in activities that promote health. It also requires the identification of constraints of a cultural or material nature that constitute barriers to health service access (Loforte, 2004:28). Deploying the concept of gender roles will help in understanding the cultural setting that determines the entitlements, responsibilities and benefits of men and women in traditional medical practices in Busoga.

### **1.12 Colonial Influence on Gender Roles in Traditional Healing Practices in Africa**

Dekker and Van Dijk (2010:1) illustrate that Africa has a long history of confrontation and contestation between different models of health and healing. The introduction of bio-medical care through the establishment of missionary health facilities, which later became incorporated in colonial and post-colonial governmental public health services, had set in motion a contestation of existing cultural-historical practices of health and healing that were increasingly placed under scrutiny and control. Postcolonial governments fostered the emergence of traditional healers' associations to formalize traditional healing, regularize membership and governing bodies, and standardize practices and amounts to be paid for treatments. At the same time, health features prominently in the UN Millennium Development Declaration, with a strong focus on bio-medical care that almost bypasses traditional healing practices (Dekker & Van Dijk, 2010:1).

Sekagya et al. (2001:2) affirms that in pre-colonial Uganda, traditional medicine was the only health system. Under colonial control, traditional medicine practice was equated with witchcraft and seen as contrary to the ideals of the pre-eminent colonial religion and western medicine. Until now, in Uganda traditional medicine was legislated under the still-functioning Witchcraft Act of 1957. This made the practice of witchcraft an offence per se, regardless of the purpose for which the act may be committed. Kazembe (2008:38) notes that African traditional medicine was suppressed and then ignored. Women's stories among the Aborigines in Deiter and Ottway (2001) show that women were deeply involved and knew a great deal about traditional medicine before the advance of European colonialism. This is illustrated by the testimony of one woman who explained that she and her grandmother knew all the traditional medicines before

the coming of the Europeans. Dorothy Rosenberg argues that the significant visibility of women in healing has been the case in many cultures from America to the Greeks, Hebrews, Asians and Africans alike. Women have since time immemorial been associated with healing. The word 'nurse', in fact, carries a synonymous explanation of women's life-giving powers (2000:140). According to Rosenberg (2000:140), in traditional matriarchal cultures healing was associated with the life-giving capacities of women. For many women, knowledge of herbal preparations was as common as knowledge of cooking is today. In addition, indigenous healing practices maintained by laywomen for thousands of years remain among the most important healing practices in most rural parts of the world (ibid).

Indeed, as Chisala (2005:2) observes, part of the misunderstanding regarding the role of African traditional health practitioners emanates from the negative colonial approach to African traditional medicine. In the pre-colonial era, the traditional medicine system was the only health system in many African communities. As already seen, at the onset of colonial rule, African traditional medicine was actively suppressed. Traditional healing practices were equated with witchcraft and seen as contrary to the cause and ideals of the pre-eminent colonial religion and 'Western' medicine. A lingering impression of that colonial illegality still shrouds traditional medicine and Traditional Healing Practice in Africa. This is contrary to the fact that the state of the African medical practice before colonialists put foot on the African soil was very good. She adds that the quality of medicine was almost as developed and advanced as that of so-called 'modern Western medicine' (Rogerson, 2001).

The impact of missionaries, boarding schools, legislations, and internalized colonialism upon several generations of men and women has been severe (Kazembe, 2008:38). This has been experienced with varying degrees among those societies that have witnessed colonialism. Kazembe, for example, explains the plight of traditional women in Zimbabwe, whose social, political, economic and spiritual well-being has been negatively affected. The National Women's Association of Canada explains also that there has been severe erosion of authority and the esteemed positions previously held by aboriginal women in Canada due to colonial influences (NWAC, 2007:2). In such societies, however, traditional women have continued to seek several ways to reassert themselves with a goal of regaining their traditional positions, especially in the traditional medicinal practice (Shoemaker, 2004:1157). In this respect Busoga society has not been an exception. Conscious or subconscious adoption of Western patriarchal ideologies by indigenous peoples cannot be measured, but is worth acknowledging. The best indicators of how

such ideologies have transformed traditional indigenous systems are the economic status and social standing of indigenous women. Dawn (2003:20) observes that colonialism's impact on indigenous women's role in traditional medicine and ceremonies worsened women's position in society. Dawn suggests that gender issues should be explored when researching and writing about traditional medicine (2003:21). Annandale and Hunt (2000) agree with Dawn on account that up to now, gender relations embedded in traditional healing practices before and after colonialism have not been analysed to ascertain how these were and have been structured.

### **1.13 Gender and Access to Traditional Healing Practices**

The WHO (2002:1) estimates that up to 80% of the population in Africa makes use of traditional medicine. In Sub-Saharan Africa, the ratio of traditional healers to the population is approximately 1:500, while medical doctors have a ratio of 1:40000 to the rest of the population (Richter, 2003:10). The South Africa's Department of Health estimates that there are 200, 000 traditional healers active in South Africa and that 97% of people living with HIV/AIDS (PWAs) first use traditional or complementary medicine and only then seek the help of a biomedical doctor if the ailment persists. Increasing efforts have been made in many African countries and beyond to include traditional healers in primary health care activities, as well as in HIV/AIDS care and prevention (ibid.).

Traditional healers and traditional medicine play an influential role in the lives of African people and have the potential to serve as crucial components of a comprehensive health-care strategy (Davids, et al., 2014:14). Traditional healing strategies produce a sense of satisfaction between the patient and practitioner; as it generates closeness between the two due to the caring attitude that is shown by the healer and the reciprocal responses of appreciation shown by the patient and -their entire family (Marianna, 1998:1032). However, at times women are further victimized in their inability to access traditional medicine as a healing tool. Citing the example of the indigenous women of Canada, Dawn (2003:18) observes that women have continuously been discriminated against from access to traditional medicine due to their financial incapacities. He further argues that this discrimination is also influenced by identity, and gender considerations in the society in which they live. There are however changing gender relations where poor women continue to have no access to traditional medicine, yet at the same time a few rich women gain unlimited access to traditional healers because of their financial ability to meet the cost. This creates unfair relations among women regarding meeting healthcare needs. Traditional healers are

often the first interface between patients and the health system; they have the potential to influence health-seeking behaviours including access to and utilization of health services in a culturally acceptable manner. This is because traditional healers belong to the same sociocultural 'universe' as the 'community' (Somma & Bodiang, 2003:14).

Access to sacred knowledge is ordinarily restricted to particular individuals and organizations within local communities, such as initiated men or women, or to members of special religious societies (Battiste & Henderson, 2000). However, male dominance in the access and practice of traditional healing is cited by Tibuti (2003), who established traditional medicine in Bulamogi to be dominated by mature men representing 85% of the traditional healers interviewed. Tibuti states that there were few women and no young people (below the age of 40) in the practice, which may be attributed to vested power relations in that society. Today, the revitalization of traditional medicinal healing practices is becoming public or mainstream, which introduces new challenges for traditional knowledge keepers and traditional healing practitioners (Dawn, 2003:17).

#### **1.14 Factors that Influence Preference for the Utilization of Traditional Healing Practices**

According to Popper and Ventura (2009:18) some traditional healing practices are an attractive field for female patients. Literature shows that women represent the majority of those utilizing traditional healing practices as patients. In their analysis of traditional healing practices among Moslem Arabs, Popper and Ventura (2009:18) note that in many cases, a Muslim woman prefers to turn to a female healer. Indeed, Yocom (1985:49), who in her fieldwork interviewed women as well as men, identifies that the practice of traditional healing by men and women takes place in different spaces and that female healers and patients often choose to meet somewhere private and intimate. According to her, the meeting space expresses not only a 'feminine touch', but also feminine influence and control; hence the kitchen or the dining room is often chosen as a feminine meeting space. On the other hand, male healers' meeting places are dark and scary, and they often wear animal skins and use intimidating voices reflecting their patriarchal outlook.

Referring to Kenyon's work titled, 'Five Women of Sennar: Culture and Change in Central Sudan' (1991), Popper and Ventura (2009:16) note that female healers operate in the domestic or private sphere and male healers in the public sphere. This is because women's work is held in the domestic sphere as part of the 'shadow economy' that provides women, even in a traditional society, with some economic and personal independence. In her opinion, women deal

with opposition to their 'invasion' in the public sphere by working from home. They do not enter the public sphere, but rather bring it inside through the many patients who come to their homes. By doing so, they neither compete with men nor threaten them, but simply work in an independent manner. This private space allows women to open to each other as companions and enables them to mingle and receive their counterparts' support. This is the basic reason why more women than men turn to female healers. This scenario breaks the social hindrances that prevent women from integrating the many little fragments of their lives even though the patriarchal culture continues to question the value of such integration (Yocom, 1985:50).

The services offered by women healers are cheaper than the male healers. The small fee may explain why women pursue certain traditional healing practices. That male healers' services are often very expensive further portrays the gendered dimensions in a society connected with money and assets' acquisition. Most women must raise the necessary funds for treatment themselves, using allowances or other monetary resources they succeeded in hiding from their husbands, and thus, often choose divination as a response to their misery - a one-time inexpensive solution (Anubha, 2008:3). According to Popper and Ventura (2009:18), women's access to traditional healing practices depends mainly on relational aspects. In Arab society in Israel, for example, the social and economic status of women and their personal welfare depends upon their relationships with men. This is especially so where women have no traditional supportive networks.

In Uganda, Mubiru (2004) observes, women are the largest group visiting traditional healers precisely because of the reproductive roles that society has conferred upon them. She argues that women have the responsibility in the home for the provision of health care. They therefore often go to seek antenatal and postnatal care and seek treatment for their children, which may sometimes be such a major burden that they cannot afford to travel to health centres or even pay the bills. She also states that women are never comfortable in such patriarchal societies and therefore some visit traditional healers to seek favour over their co-wives, to have children of a particular sex, mostly boys, as well as to find love.

Additional tensions underlying the decision to turn to traditional healing are also drawn from the transition to a modern lifestyle. In contrast to the past, where decisions about relational, economic and professional issues were decided upon by the extended family, today's women are required to confront such issues themselves. These tensions, enveloped by feelings of uncertainty, frustration and helplessness, are 'modern' by nature, and the prevailing institutions

cannot offer solutions for them. Therefore, more and more women turn to women healers for answers (Popper & Ventura, 2009:19).

Women consider female healers to understand them and they also position themselves within their surroundings. Female healers have similar experiences with their female clients. These include marriage and relationship challenges as well as social exclusion in society based on their gender. Consequently, the ability of a female healer to not only understand but also heal these challenges from the angle of experience endears many female clients to them. This also makes both the female healer and her female clients to rediscover their identity as the excluded, which is the first step towards their own liberation. With adequate knowledge of the challenges that women face leading them to healers, female healers' service, through their traditional counselling techniques and from their own individual experiences, become a foundation upon which female clients' conditions will improve as better wives and mothers, in both their homes and the wider community (ibid.).

Furthermore, traditional healers are in places to which the community has easy access. This makes them popular and readily relied upon (Abdool, et al., 1994:9). Similarly, traditional birth attendants (TBAs) are popular with women for whom access to health care facilities is beyond their financial capacity (Hausmann, et al., 2003:26). A female healer acts not only as a link between the patient, her family and community, but also as a socializing agent. For example, Kissman (1990:138) regards fortune-telling as one of the ways through which older women connect younger women to their roles as wives, mothers and housewives, and through which they initiate them into the world of romantic relationships, child rearing and economic survival. Similarly, the female healer, usually much older than her patient and proficient in cultural values and community customs, serves as a mentor. The socializing role of the female healer, therefore, replaces traditional institutions such as the extended family. Some traditional healing practices serve as tools that help women's socialization and fortify their status in the domestic sphere. As a result, they relieve the anxiety arising from changes in life style, family structure and gender roles (Heather, 2007:26).

Some traditional healing practices therefore respond to feminine challenges and opportunities. Some are occupations distinctive mainly to female healers, and primarily attract female patients and in many cases, focus on issues commonly identified as feminine. One lure of female healers for female patients revolves around the fact that the healer herself is a woman who relies upon the recommendations of other women: mothers, sisters or friends. Women often

accompany each other when turning to a female healer, and the healing takes place as part of women's activity in the domestic, feminine sphere (Popper & Ventura, 2009:19). Tabuti (2003) complements this view, asserting that traditional healing practitioners are consulted not only because they are closer and more affordable than their Western-trained counterparts, but also because they are embedded, extensively and firmly, within Ugandan culture.

### **1.15 Data Collection and the Research Process**

My study is limited to Busoga society in Uganda, though reference to and comparison with some other Bantu societies across the African continent is made. However, the findings of this thesis are specific to Busoga society.

#### **1.15.1 Cultural Analysis**

I used the approach of cultural analysis, with interviews, observations and archival research as the primary methods of empirical data collection. Just like in Linnekin's analysis variations on Hawaiian identity (1983:242), empirical evidence presented in this thesis is based on reflections of the interviewees' own interpretation past lifeways about healing in Busoga. Cultural analysis has much in common with ethnographic, anthropological approach but there is one significant difference; a difference that concerns a different emphasis on the role of cultural practice in relation to the culture in which those practices are being performed. An ethnographic approach aims to understand a culture based on cultural practices and objects. Cultural analysis aims to understand cultural practices and objects against the background of a general understanding of the culture in which those practices are being performed (Bal, 2002:4, 9). Cultural analysis does not aim to study 'culture' as it is with anthropology, but rather involves the study of objects and practices of a cultural society; these objects and practices are analysed systematically in relation to the culture in which they exist. This approach therefore analyses the cultural relevance of objects and practices, investigating them within their contemporary cultural context. (ibid. p 9).

Since cultural analysis puts emphasis on the study of artefacts, spaces and visible patterns of behaviour by which a specific society operate (Bill, 2000), I make cultural analytical descriptions of social scenes where traditional healing takes place (*amasabo*, the healing shrines), herbal substances, objects and symbols used in healing like stools, sitting arrangements in the healing shrines, garments worn during healing like bark cloths, sticks (*olugha*), cowrieshells, as well as symbols like language and preferred colours in healing traditions.

Through observations and interviews, I establish patterns of conduct of male and female traditional healers and clients, as well as the Basoga as a cultural group of people whose shared feelings, beliefs, practices, artefacts, folk knowledge, and actions influence their healing traditions. The use of cultural analysis is significant, because this study is a process and product of establishing, describing and interpreting cultural behaviour of the Basoga in relation to their traditional healing systems. This approach assumes that those studying cultural phenomena of specific groups ought to know that ‘traditions’ adapt to changing circumstances. Establishing what and how the Basoga perceived healing before colonialism and the way it is being understood now to produce cultural differences in health seeking behaviour, has been possible through personal interviews I had with providers and users of traditional medicine.

The use of cultural analysis has enabled me to understand the changes that have occurred over time in the healing traditions of the Basoga, and how these traditions have been able to adapt to global changes. At times I stayed at the healers’ places of work for many hours of the day, witnessing some healing processes taking place. I visited them several times to observe how roles are shared between men and women. I became a critical observer of the details that took place before, during and after healing processes.

Cultural analysis is useful in the study of gendered social systems, relations or social events, and enables to provide background information on how gender roles are manifested in traditional healing. Establishing Basoga society’s key assumptions, values, artefacts and symbols, has made me gain an understanding as to how and why certain elements of traditional healing practices are done the way they are (Sarantakos 1992; Bryman 2004). It has enabled me to investigate ruling ideas about the dynamic between individual and community and how this influence health seeking behaviours of the Basoga, who thereby maintain social relationships in their day to day life, including marriage. Through interviews and observations, I have been able to establish the distinct roles of women and men in traditional healing and to deduct the underlying values, customs and taboos held by the Basoga in relation to healing.

### **1.15.2 Sources, Methods and Tools of collecting Information**

I consulted both primary and secondary sources of information. My primary sources of information included archives, observations, and one-on-one interviews with practitioners and users of healing practices in Busoga. I used the National Archives at Entebbe with regard to analysing the colonial influence on traditional healing practices in Busoga. Work presented in Chapter Four is a combination of archival information and personal interviews with individuals I



found to be knowledgeable on the subject. Secondary sources of information included scholarly journal articles, full-length books, dissertations, newspaper articles and other such web information. A systematic review of the literature on traditional medicine and healing was done. My primary interest in the literature reviewed was to have a comprehensive background for understanding the theoretical debates and ideologies held by academicians and various societies respectively on traditional medicine and healing (Cronin et.al, 2008:38).

I specifically used qualitative in-depth interviews and observations as my data collection methods. Over the years, interviewing and limited participant observation have been regarded the most appropriate methods in cultural analysis, especially when interested in seeking to discover the practices, social discourses and interactions of people involved in producing culture, such as the healing traditions covered in this thesis (Davis, 2008:58). Traditional healing ideologies of indigenous societies are largely transmitted through the oral tradition. As Robbins and Dewar (2011:1) suggest, having a direct experience with healers can be the most important factor in being able to grasp the nature of traditional healing of any society. Therefore, interviewing was relevant since my sole interest was about understanding, describing and analysing the Busoga society discourses on traditional healing, a cultural phenomenon that has existed in the past but continues to exist with visible modern influences.

I personally conducted the interviews with informants. This was suitable for studying traditional healers and for revealing gendered assumptions that underlie traditional systems of healing. A semi-structured interview guide was used for this purpose. An audio recorder was used to record the interviews and conversations. A digital camera was used to take photographs of traditional healers and their physical sites. These enabled me to establish Busoga's assumptions and values attached to their healing activities, patterns of behaviour of healers and their clients, as well as analyse the artefacts and symbols in the healing traditions; all of which are the key tenets of an ideal cultural analysis model. I interviewed the traditional healers about the meaning and value of the artefacts I found in their shrines. I also inquired of any restrictions that may prevail on these artefacts regarding the gender of healers and clients. In many instances, I was restricted from touching these artefacts, as they required me to undertake certain rituals for me to do so. In other cases, only the healer or those who have been consecrated to the service of the spirits have an absolute right to touch them. I was keen on observing the details on occasions when I visited the homes of the healers for interviews. I was interested in looking at the available traditional medicines as well as the articles and objects used in traditional healing. I also

witnessed a few healing rituals taking place. An observation guide was used as a tool for this purpose. Verbal consent was sought from the traditional healers to record the interviews and take the necessary photographs, especially of the healers and their artefacts. I have included some of these photographs in this thesis with verbal permission from the traditional healers who appear in them. Traditional healers wish to provide the correct record about their profession as a way of authenticating Busoga society healing ideology. They also hoped that through publishing their photographs and names, their reputation would be improved.

On the other hand, clients were not comfortable to have their photographs taken and none of their photographs have been shown. The colonial prejudices attached to traditional medicine as being inferior, backward, and ineffective has impacted negatively on its users. Many use traditional medicine but would not want to be identified in the public. The clients were however willing to share their narratives of experience with traditional healing.

During interviews, I realised that the respondents did not have detailed information concerning the interaction and influence of British colonial administration on healing traditions in Busoga. Whereas the traditional healers and other key informants would be conversant with the traditions of healing, it was not the case when it came to the changes that may have occurred due to colonial legacy in Busoga. Some insisted that they were following what their forefathers had practiced. Largely, they held generalised prejudices about the colonial rulers that have continually been transmitted to each generation over the years. Therefore, contrary to the common practice where researchers visit and use archives to set in motion the kind of questions and interviews they will ask and hold, I went to the archives after doing most of the interviews. I wanted to get finer details about how the colonial administration reacted to traditional healing practices that were clearly not in line with their known western world scientific inquiry and approach to disease and health. I wanted to establish reality or unreality of the accusations and prejudices I had received from the interviewees. This helped in recollecting the biases I had heard from the interviews and would have been imported into the thesis findings.

The National Archives at Entebbe is a state department and therefore a public institution, open to whoever wants to use its archival resources. It provides free access to archival materials kept there. I was only required to provide a self-identification document and filling a simple form at the counter. The only setback though was that I was denied access to files dated 1960 onwards because they were still considered classified and confidential, and I could only access them through a lengthy process of seeking clearance from the office of the President of

Uganda. This denied me the opportunity to get data on how the immediate independence government of Uganda reacted to the colonial policies and legislations relating to traditional medicine.

I was provided with an archival records reference coded book, indicating a multiplicity of documents in the archives. I first identified selected documents and files about Busoga, regarding political, religion, medical, civil, administration and legislation. I studied annual, quarterly and monthly reports made by Busoga district Commissioner(s), Eastern Provincial Commissioner's reports on Busoga and eastern province in general, reports made by Uganda's Chief Secretary, correspondences between several administrative officers within Busoga and between Busoga chiefs and higher colonial administrative offices. I studied the written legislations and policies enacted or employed by the colonial administration in Busoga in relation to health and disease (medical), labour, and taxation. Documents with demographics of Busoga population in relation to disease during the colonial period were also studied. I further studied and analysed technical reports made by technical officers during colonial period, for example, medical officer(s)' reports, tax officers' reports and other such colonial government officers.

I was faced with many archival documents concerning the issues I have already identified above. Some of the documents were worn out and not legible enough to be read, some of the documents had missing pages. I could not trace some of the documents which were listed in the reference coded book, yet titles were suggestive of very critical correspondences, directives and decisions taken by colonial administrators about the health and wellbeing of the people of Busoga at the time. This could have robbed me of the opportunity to provide evidence based balanced argument in some cases. Reading all the materials was such a daunting task, but I used content analysis to sieve out information I was looking for. I read each of the documents carefully while taking notes. I photocopied and took photographs of some of the correspondences for further scrutiny. The issues of investigation from these materials were to establish the colonial government's actions and omissions towards traditional healing systems they found in Busoga. Interest was also drawn towards establishing the health situation of the people in Busoga at the time and the interventions put in place by the colonial administration to promote the health alongside traditional forms of healing that were already established.

I categorised my notes from the archival materials under the following themes; colonial legislations on Traditional healing, colonial policies and interventions on disease control and

health promotion, colonial administrators' attitude towards the health and health systems of the Basoga, and status role of women and men in health activities during colonial period. For each specific document I earnestly read and made descriptive notes from it, placed appropriately under one of the themes listed above and the descriptive notes were numerically numbered under the specific theme. I also indicated the actual source in terms of author, recipient or audience and date. I made further effort to read over and over the descriptive notes to establish whether they provided information to the questions that I could not get answers from the interviews as earlier stated in this thesis. By doing so I would determine the relevance of the specific numbered descriptive notes to my study. Because I had in some instances photocopied or photographed the archival material, I sometimes made further reference to the archival material when my descriptive notes sounded unclear at a later stage. Whenever, I wanted to emphasise a specific point with an example, I turned to the photocopied or photographed archival document.

### **1.15.3 Sample Size and Selection**

It was difficult to systematically pre-determine a sample size for this study, segmented according to the category of traditional healing. This was because I was not sure of the specific categories and numbers of traditional healers and clients that existed in Busoga to ensure proportional representation. But I was consoled by the fact that the kind of information I needed to draw conclusions about assumptions, values, artefacts and symbols in relation to Busoga society healing traditions was not largely dependent on numbers of people but rather specific categories of people with specified knowledge about experiences of the Basoga regarding healing. I therefore, reached the conclusion that qualitative research on traditional healing needs plenty of diversified information, which cannot be ascertained by mere numbers - because ideology and cultural values are like fish in the sea. A fisherman cannot predetermine how many fish there are in the sea; the best alternative is for the fisherman to go to the sea and fish as much as he can, until such a point as he has caught enough of the type he wishes.

I therefore used a theoretical sample strategy for the study (Davis, 2008:59). This was applied by simply enlisting specific categories of people linked directly to traditional healing, and these were the providers and consumers of traditional medicine. For providers of traditional medicine, it was simple for me to generate a sample of categories of traditional healers as my interviewees but was a challenge for consumers of traditional medicine as it was difficult for me to predetermine them since clients do not easily want to be identified. This may have led to some bias and omissions of potential participants on my part. This also explains why I was not able to

have an equal representation of categories of traditional healers and consumers of specific traditional medicine, with diviners being dominant in the study. My initial target was to have a total of sixty respondents for the study. This was premised on the thinking that traditional healers' associations kept records of their membership, which would help me to choose from, stratified by type of healing, gender, age, location etc. Therefore, having a predefined systematic sample of traditional healers was not done as it was just impossible to know how many and of what categories existed out there, which would be a starting point of planning for a systematic sample.

Relatedly, unlike in biomedical institutions that keep records and track of their clients, such that even follow up can be done, and with such information available to stakeholders, it is not the case with consumers of traditional medicine. I depended on the good will of the traditional healers, who referred me to some of their clients and those who were currently being attended to at the healing shrines. Upon explaining the kind of information, I wanted to get from the client; it was up to the healer to direct me to the one they thought would be useful. I took it for granted that the client I was directed to have a healer-patient relationship only, which I could not verify for authenticity. I discontinued the interviews by the 39th respondent. Below is a summary of the characteristics of interviewees for this study.

#### **1.15.4 Characteristics of Respondents and Implications on the Study**

A total of thirty-nine people were interviewed (see appendix iii). These were 24 males and 15 females. The higher number of males than females is because male healers occupy more leadership positions as owners of healing shrines or in membership of the healers' associations. This however does not mean that women are not well represented in the healing traditions of the Basoga. They are many at the healing centres but continue to work under the leadership of the male healers. They therefore remain invisible to the public, yet they perform several roles to accomplish the healing tasks of the male healer. Women mostly work as their assistants, and are not mandated to talk to strangers on happenings at the healing shrines.

The overrepresentation of the males in interviews is also attributed to the fact that my first contact was with male healers, upon whom I relied to identify more healers for the interviews. They identified and referred me to male healers with whom they had good working relationship and those they had worked with for long. Male healers tend to assume some superior status over female healers. Also, male healers tend to trust each other more than they trust their female counterparts. For divination, where there is rigorous induction of new healers, senior

male healers are responsible for inducting them due to their seniority. Women are believed to be timid at engaging in such a rigorous induction exercise, which implies that there is a more likelihood to find more male diviners than females. Reliability of information about the definite roles of women in traditional healing and avoidance of bias about their roles was achieved by triangulating interviews with observations at the healing centres. This helped in ascertaining the roles and activities that were performed by women and men in healing practices.

The average age of those interviewed was 60 years, with only 12 interviewees below the age of 50 years. I however found healers who were as young as 20 years old and below. These were working as assistants to the healer. I did not interview them though I was able to observe the kind of work they did at the healing centres. Those regarded as healers in Busoga are usually older in age, which attract respect to the healers and credibility of the healing service being offered. Old people are also believed to keep secrets of their clients. The snowball technique of identifying respondents led me to interview persons in that advanced age bracket, as healers directed me to mostly their peers in the healing practice. The much older healers I contacted first like Nabamba Budhagali and Kabaale Bitimbito could not have known young healers who had just come into the healing practice. But also, older healers have mistrust for young healers, usually referring to them as quacks. Yet again the young assistants, those technically called the 'healer', are not allowed to talk to strangers. During my first interview with Nabamba Budhagali, he rudely shut up an assistant who attempted to contribute to the interview. It was therefore not possible to get views of many of the young healers. The youngest healer I interviewed, at the age of 20 years, happened because I was not able to meet the senior healer-diviner, at Masese healing shrine, but she volunteered to provide me information. Except for the analysis of the observations I made with such young healer assistants in relation to their roles and relationship with the seniors-the healers, I missed the opportunity to have their views, which possibly could have influenced a better opinion of the changing ideology of the Basoga towards traditional healing practices. Overall, the clients were usually younger in age compared to the healers, with just four isolated cases above the age of 50 years.

Out of the 39 interviewees, 22 were healers, 14 were clients/users of traditional medicine and 03 were resourceful persons with knowledge on African traditional healing. The last category was selected because of their specialised knowledge and research experience in the fields of traditional healing. The clients were fewer because again, identification and selection of clients was through the snowball technique whereupon I depended on the traditional healers.

Many healers declined to direct me to their clients' locations for interview because they needed to protect the identity of their clients due to confidentiality relationship. But the fourteen were representative enough given the fact that they were more than half the number of the healers. The number was representative because I was able to interview at least one client who had been treated by each category of traditional healer. The views of the clients have therefore been adequately represented.

The 22 healers, who were interviewed, were segmented under the following categories. There were 11 diviners, 05 herbalists, 02 bone setters, 01 Koranic healer and 03 traditional birth attendants. The diviners were the majority because of two reasons. Firstly, this was due to the nature and system of sampling whereupon I was dependent on healers to provide contacts of other healers for interview. My very first contact was with the Chief diviner of Busoga that is Nabamba Budhagali and then Kabaale Bitimbuto, another diviner but also the chairperson of traditional healers in Namutumba district. These interact more with healers who do the same kind of healing and it was likely that they were to provide me with more contacts for diviners than any other category of healers. Secondly, diviners are more popular than any other category of healers in Busoga because they tend to combine all the roles that are performed by other specialised healers. For example, some diviners undertake bone setting and provide herbs. Female diviners and herbalists have traditionally been known for performing roles of traditional birth attendants. Therefore, no bias or omission can be realized in the findings because of having more diviners than any other category of healers as respondents.

The interviewees have further been divided and analysed along the rural-urban settings. 24 of the 39 interviewees were from the rural areas and the remaining 15 interviewees were from the urbanized settings. Interviewees from Jinja district and elsewhere were categorised as being urban whereas those from Namutumba district were categorised as being rural. Indeed, much of Jinja district is urban whereas Namutumba is typically a rural district. The three resourceful persons interviewed were also categorised as urban. The discrepancy in numbers interviewed with more rural based interviewees and less urban based interviewees is due to the unsettled circumstances of the urban people compared to the rural people who are more settled in one place than the urban people. Several appointments were made with prospective interviewees in the urban areas, but they could not honour the appointments due to constant travels both within and outside their urban zones to attend to clients for the healers and to look for survival for the clients.

The eventual total number of interviewees that have been used for this study is within the confines of realistic sample sizes that many qualitative research authors have found to be useful. For example, Morse (1994:225) and Bernard (2000:178) argue that samples of between thirty and sixty are ideal for any qualitative research involving study of cultural phenomena. Furthermore, the study has taken place among the Basoga, a relatively homogenous group. Guest et al. (2006:78) argue that for studies with a high level of homogeneity among the population, a sample not exceeding sixty interviews is sufficient to enable development of meaningful themes and useful interpretation. Further, in his study '*Sample Size and Saturation in PhD Studies Using Qualitative Interviews*', Mason (2010:12) notes that among the 560 PhD studies that were analysed for having used interviews, their sample size was between thirty and fifty, beyond which there was saturation.

#### **1.15.5 Sampling Methods and Procedure**

The interviewees were identified using the snowball technique and purposive sampling concurrently. Because identifying and penetrating the network of traditional healing practitioners and the users of traditional medicine needed cooperation, the snowball method proved very effective in identifying them. Whereas associations of traditional healers exist in Busoga, they do not keep records of membership. Again, not all traditional healers subscribe to these associations since it is voluntary and not regulated by any national law. In all matters of sample selection, an effort was made to sample according to the type of healing practice, male and female traditional healers, or male and female patients of traditional healers. This intended to exhibit a proportional representation of the different traditional healing practices in Uganda. Some practitioners and users of traditional healing, however, were more common than others. Sarantakos (1992) and Bryman (2004) agree to the fact that these two methods provide the target population with an equal chance of being selected for the study.

On the other hand, key informants of the study were sampled purposively, based on their experience, expertise and strategic position in the field of traditional healing in society. Purposive selection of respondents, was based on the fact that qualitative research approaches are not interested in an 'on average' view of a patient population. It rather aims at gaining an in-depth understanding of the experience of individuals or groups and there is therefore need to deliberately seek out individuals or groups who have the information that we need (Greenhalgh, 1997:171). Yet still, it was not a straightforward issue to get to the healers and their clients. In all circumstances, when considered a visitor, both healers and their clients are apprehensive about



divulging information about their work and their clientele. This is a challenge that preoccupies many other researchers on cultural studies, as Davis (2008: 60) notes that respondents are always fearful of interviews and the researcher must ensure that such fears are allayed, cooperation enlisted, and good relations established between the respondent and the researcher. He further notes that this challenge needs to be overcome because initial interviewees are likely to be simply gatekeepers to further interview contacts. I was able to penetrate this tight guarded information zone of the traditional healers and their clients at three levels. These were contacts with the most prominent healers, leaders of the traditional healers, personal contacts and relationships with the traditional healers in Busoga.

In specific places and circumstances, I used one of the three to have the traditional healer or the clients accept to be interviewed. Contact with the most prominent healers was established through Nabamba Budhagali. I first visited him at his shrine without any prior appointment. He is regarded as the most revered yet feared among healers, clients and the entire Busoga society. He is revered by those who know the status he holds in the Busoga cultural traditions as the chief custodian of all Busoga spirits and the most important healing shrine. He is feared by those who have heard of his stereotypically unrivalled spiritual prowess and healing powers. For the latter, I established that there are some of his most immediate neighbours who have never paid a visit to his home as a neighbour.

Upon my arrival, he thought I was a client who had gone for healing but was able to explain the purpose of my visit in such coherent Lusogalanguage to his delight. He was delighted by the fact that as a student I was interested in learning about Busoga cultural traditions and share them with the wider academic world. He was also delighted by the fact that I had gone to his place first, because he is regarded as the pinnacle of healing traditions and spirits in Busoga, and therefore any study of these traditions has to begin at his place. At this place I met clients and several other healers who had come for counsel and consultation. He introduced me to these healers. Wherever I went to seek for interviews with other healers and clients, Nabamba Budhagali, became my '*password*', telling them how I had been welcomed at Budhagali's place and that he had recommended that my current interviewee would be of help to my study. A mention of my previous interaction with Budhagali to other healers enlisted their confidence that I was a credible and trustworthy person. My initial contact with Nabamba Budhagali, the chief diviner meant that as a gatekeeper (Davis, 2008:59) to healers in Busoga, he was more aware and conversant with diviners and herbalists. The Busoga society ideology on traditional healing

presented in this thesis may therefore be more skewed by more opinions of diviners and herbalists and their clients than the other categories of healers.

In many cases, my first contact with healers whether by phone call or physical visits at their shrines, they thought I was seeking for treatment. This perception by the healers provided both opportunities and challenges. The opportunity was the kind reception I would receive upon arrival as they held expectations of a business opportunity. By the time my intention was made known, I had established a good relationship with both healers and their assistants in such a short time. Secondly, to showcase their abilities to their supposed client, some of the healers spoke uncoordinated things about their healing prowess. This provided me with preliminary information before the interview. It further helped me to gauge whether the healer was quack or real depending on the level of exaggerations.

Some traditional healers asked for money before interviews. These were, however, avoided for fear of compromising their opinions about the topic of discussion. But in many circumstances, to win their confidence, I paid '*ebigali*'-money put in *fetish* baskets strategically positioned in the middle of the shrine or in front of the diviner. *Ebigali* is the equivalent of consultations fees paid by patients in biomedical practice. This usually pleased the healers most of whom then opened up about their work. Meeting leaders of the healers' association before I could identify possible respondents was useful because these leaders helped in identifying and recommending members of their associations who became my informants. Kabaale Bitimbito, a diviner and chairperson of the traditional healers in Namutumba district was very pivotal in this regard, due to his position.

The high level of secrecy with which some people practice traditional healing limited the chances to acquire some vital information. There is a growing trend showing that traditional healing practitioners and users of traditional healing do not want to be identified because of the seemingly negative connotation that is associated with traditional healing practitioners. The negative criminal practices - especially child and human sacrifice, as well as cannibalism that have caused several arrests - deprived the researcher of the opportunity to meet and interact with such respondents with potentially unique and vital information. Because of the issues mentioned above, some clients of traditional healing practitioners only visit them at night, which made it very difficult to interview them due to logistical limitations. Many healing rituals are performed at night and diviners would not let the researcher into those secluded healing sessions with their clients, whose identity they so jealously guarded. In stark contrast, traditional healing has

become a very lucrative business despite the scorn it receives. This has led the 'business' to attract 'quack traditional healers', whose interest is the exploitation of unsuspecting clients. Distinguishing a true traditional healer from a quack may therefore prove a challenge. However, use of the snowball method of identifying traditional healers, provided assurance that only those who were well-known as being genuine by colleagues in the business and the wider community were interviewed.

The thematic framework was used to classify and organize information according to key themes, concepts and emerging categories. Audio interviews were transcribed and analysed for commonly occurring concepts, ideas, and themes that provided insight into traditional health practices in Busoga. Recorded interviews in Lusoga were later translated into the English language, instead of transcribing the Lusoga verbatim. According to Ritchie et al. (2003:220); the thematic framework facilitates rigorous and transparent analysis. Transcripts from interviews were read several times to identify emerging themes. Information from the different transcripts that corresponded to particular themes was grouped together. Each audio interview was listened to several times while reading the transcripts, to ensure that all relevant information is properly captured. Subsequently, each participant's audio and transcript was reflected on, separately to grasp the phenomenon. Thematic descriptions were significantly highlighted during the reading of the transcripts. Using Struthers' methodology, redundancies were eliminated through identification of supporting essential themes with thematic descriptions and significant statement (Struthers, 2000: 265). In the subsequent interviews that were held with the key informants, these themes and other significant statements were again asked to attempt to grasp the essential meanings and how they could be contextualized with the topic. This was to ensure that information under the established themes was valid, authentic and particular to Busoga society. Struthers (2000: 265), basing on earlier studies, argues that reliability in qualitative research studies is often unwarranted and may serve to weaken claims to validity. He states that qualitative researchers should be more concerned with the validity of information than its reliability and stresses that validity of information is assured when those who provide it recognize the findings to be true according to those who live the experience. I was therefore able to always test validity of information given by asking other interviewees their opinions about issues already asked to other respondents. Provision of same or similar answers provided me the comfort that information given was valid and authentic.

## **1.16 Organisation and Overview of the Thesis**

The thesis is logically arranged based on specific objectives as well as the themes that have emerged from information that has been collected from the respondents. The thesis is made up of six chapters. In chapter one, I show the development of traditional healing practices from the global level to Busoga society. I analyse conceptual and theoretical explanations of traditional healing and traditional healers. Chapter Two of the thesis traces the historical, socio-economic, political and religious setting of the area of study, that being Busoga society. Traditional healing practices of any society are a product of the cultural norms and values of that society that have been fused in the society's socio-economic, political and religious realms. Chapter Three describes the concepts of health, wellness, illness and ill-being among the Basoga. An attempt is made to describe and analyse the categories of traditional healing practices and healers in Busoga society, clearly showing how they execute their functions among peoples of this society. Chapter Four analyses the colonial impact on gender roles in traditional healing practices among the Basoga. This is done by showing how men and women benefited from or, alternatively, lost their once cherished social positions in traditional healing systems in Busoga as an effect of colonialism. Chapter Five discusses how the social positioning of men and women determine the roles and responsibilities performed by women and men in traditional healing practices. This chapter further discusses the gendered knowledge of traditional medicine, as well as the articles and images of male and female traditional healers in society.