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Gender roles in traditional healing practices in Busoga

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CHAPTER FOUR

THE COLONIAL IMPACT ON TRADITIONAL HEALING AMONG THE BASOGA

4.1 Introduction

The Basoga's ideas about traditional healing have adapted to the changing circumstances of society. One major factor of influence has been colonialism. In this chapter I discuss what happened to the traditional healing systems of Busoga because of colonialism. Colonial legacies led to the diffusion of African medical knowledge, as well as the alteration of traditional conceptions of health and healing. African perspectives of health and healing were challenged, which resulted in an increased invisibility of women in Busoga's institution of traditional healing.

Before colonization of the African continent, Africans used their indigenous medical remedies as the only form of health care (NACOTHA, 2009:1; Struthers, 200:263; Schoenbrun, 2006:1403-1406). However, this changed with the arrival of colonialists on the continent (Eyong, 2007:131; Abdullahi, 2011:115; Waldron, 2010:55; Romane, 2000:144-145; Noel, 2012:1; Feierman, 1985:85-86). There is substantial evidence to show that colonialism and its associated activities like capitalism and neoliberalism brought misfortune to African traditional medical systems (Abdullahi, 2011:115-116; Millar et. al, eds. 2006:8). Mudimbe (1988:1-4) categorically states how colonialism changed the constructs of Africa from Afrocentric to Eurocentric. He argues how this involved the European domination of the mind and body of Africans as well as the infusion of western ideas into a civilization that was already established. Indeed, colonialism in Africa and elsewhere was not just about a scramble for markets and other opportunities but involved colonies being re-inscribed in European discourse (Nkomo, 2011:7).

However, other scholars believe that colonialism helped to transform traditional medicine from the primitive and less regulated ways to better practices that would eventually enhance its efficacy and credibility (Schoenbrun, 2006:1403). Many colonial policies and organisations aimed at supporting and promoting the development of traditional medicine to improve the welfare of the people of Africa (Sugishita, 2009:435). Though widely criticized by the colonized, colonial policies transformed traditional medicine into a socio-cultural heritage, for which the Africans would be proud (Elujoba et al., 2005:46; Onwuanibe, 1979:27). White (2000:235) notes that in some cases, like in Zimbabwe, there were colonial attempts to reshape traditional medicine into a health service parallel to western medicine. Abdullahi (2011:116) and

Onwuanibe (1979:27) also argue that institutionalization of modern healthcare on the African continent brought along significant innovation that helped to minimize the scourge of malaria, for which traditional medicine had failed. Feierman (1985:86) argues that despite increased recourse to witchcraft by African populations, in the wake of increased epidemics like malaria, sleeping sickness, smallpox and other diseases, there was no change in the health of the people, especially of the East African region, until the intervention of colonial rulers, who drastically minimized these epidemics.

Though traditional medicine still carries on up to date, there have been attempts to reduce it to the state of heretical medicine (Lantum, 2007:7). As discussed in chapter two and three, traditional medicine is sustained in society by the authority of traditional rulers in the context of diverse customary institutions of power sharing and governance. It exists under some, usually unwritten, local policy frameworks, which determine its internal regulations and ethics concerning the informal training of its manpower, their initiation formalities, their practices, their taboos and even their status in society. As such, the over-riding policies of the conquering authorities marginalized these traditional systems. They would even have succeeded in destroying traditional medicine, if the allopathic system had been hundred percent efficient (Lantum, 2007:8).

Discussion in this chapter is based on various sources of information: documents from the Uganda National Archives, Entebbe; resources from the Busoga Cultural Research Center in Jinja; work by African and non-African authors about the influences of western colonialism; and interviews with respondents from the Busoga sub-region. The analysis shows how the colonial legacy has impacted traditional healing in Busoga, and how women and men have benefited from or lost their once cherished social positions. Colonial impact on traditional healing systems in Busoga can be generalized to the whole of Uganda.

4.2 The Diffusion of African Medicinal Knowledge

During the colonial era of the late nineteenth and first half of the twentieth centuries, foreign powers encountered diverse cultures, superstitions and diseases. They labelled the entire continent dangerous and primitive. For early explorers and colonialists, diseases and the threat of ill health were what defined Africa. For Uganda, when the British introduced biomedicine, it existed alongside traditional healing systems. However; in 1912 a Witchcraft Ordinance was

passed by the colonial government, and was revised in 1957 as the Witchcraft Law.¹⁸⁰ It transferred the power to control traditional healing systems in the whole of Uganda into the hands of the colonial governors. All traditional healers were classed as witches. Stringent punishments were spelt out for those guilty of practicing witchcraft. Fields Karen illustrates how Ugandan administrators charged ordinary persons under the witchcraft ordinance, when found in possession of charms, even when intended for personal means. And they had responsibility to prove that they were not intended for destruction of others (Fields, 1982b:576).

By 1946, Europeans were still grappling with the untamed confidence¹⁸¹ that locals had in their traditional healers, whom the latter insisted on calling witchdoctors.¹⁸² Peter Pels (1998:200) discusses the challenges that came with implementation of these witchcraft ordinances. Among these was the cultural transgressions that "indirect" colonial rule brought along. Busoga was chiefly governed under this same system of indirect rule, with native local chiefs acting as colonial agents in their localities. Peter Pels argues that British administrators who had to apply a Witchcraft Ordinance that said that witchcraft was, indeed, an "imaginary offence," and who had to punish those who engaged in witchcraft accusations, found that they easily lost their credibility as moral authorities when punishing those who were regarded as criminals by the people concerned. Indirect rule's conservative side-the requirement to build rule on indigenous routines-actively produced a sub-version of the Witchcraft Ordinance, allowing "witchcraft" evidence to fulfil certain functions in colonial legal practice. Karen Fields provides similar arguments for the colonial dilemma in implementing witchcraft ordinances in Zambia (1982a:98). The local chiefs were in a dilemma of allegiance, whether to report acts of witchcraft to British officials yet customary law required them to be the guardians of society customs and tradition (Fields, 1982a:105).

The colonial law in Uganda prohibited possession of any articles used in healing. Section 6 of the 1957 Witchcraft Act provided for the confiscation and destruction of herbs and any other resources used in traditional healing.¹⁸³ This marked the beginning of the marginalization of not only the healers but also the entire system of traditional healing in Busoga (World Bank, 2004; Aligawesa, 2008:2; Abbo et.al, 2008:2). Though under suppressed, traditional healing continued

¹⁸⁰ Uganda Protectorate (1957), Ordinances and Subsidiary Legislations Containing Orders in Council, Rules, Regulations, Proclamations, Orders, Notices, Native Laws Etc. Printed and Published by The Government Printer, Entebbe. This Document Was Accessed Through the Uganda National Archives at Entebbe.

¹⁸¹ Uganda National Archives, (1946), Medical fees charged to Africans. C.570.

¹⁸² Uganda National Archives, (1946), Medical fees charged to Africans. C.570.

¹⁸³ Uganda Protectorate (1957), Ordinances and Subsidiary Legislations Containing Orders in Council, Rules, Regulations, Proclamations, Orders, Notices, Native Laws Etc. Printed and Published by The Government Printer, Entebbe. This Document Was Accessed Through the Uganda National Archives at Entebbe.

to be practiced in a less explicit manner. In any case as suggested by Peter Pels (2014:2), Africans adopted coping mechanisms like enhancing the rationality of ‘witchcraft’ by calling it ‘African science’, which is based on traditional ritual knowledge.

The colonial administrators did not consider the good work done by traditional healers, who had for centuries been glorified. It was therefore very difficult to prove cases brought under this law and this resulted into mob justice upon those suspected to be practicing witchcraft. Therefore, the witchcraft ordinance in Uganda seemed to protect witches to the detriment of the locals. Indeed, witchcraft ordinances aimed to stop both the accusation of witches and their trial, possibly to demystify the reality of witchcraft and its allied healing practices (Fields, 1982b:576). But to Richard Waller, beneath the witchcraft ordinances was an issue of ‘power’. Witchcraft was punishable because the British saw it as a powerful force among the native customary hands, that might in the future challenge colonial rule. On the other hand, their preoccupation with witch hunters rather than witches themselves indicated the fear that British had for witch murderers because they posed a greater threat to colonial government. Allowing witch murders would cast doubt on the power and authority of colonial rule, as to whether they possessed monopoly of force in society (Waller, 2003:244).

For example, in 1931, the High Court in Mbale and subsequently the Court of Appeal upheld a death sentence upon two men who were convicted of murdering a suspected witch.¹⁸⁴ Geschiere (2010:251) and Waller (2003:244) take note of similar occurrences in Cameroon and Kenya respectively, where the locals accused the whites of enacting laws that protected witches. It was such misconceived ordinances and legislations passed by the British government in Uganda that led to subsequent mistreatment of traditional healers.

The establishment of such laws and courts to try suspected offenders of the witchcraft law robbed the Basoga and other Ugandans of the opportunity to continue using their traditional systems of resolving conflicts as they arose. The Basoga had processes through which they could adequately diagnose the cause and causer of illness and death through divination. Unfortunately, this counter action was defined as witchcraft. In instances where traditional forms of diagnosis were used, the spirits and mediums could always be depended on to tell the truth.¹⁸⁵ In these circumstances, the Basoga avoided unwarranted deaths. In case a member was identified by the

¹⁸⁴ Uganda National Archives, (1931), Native Affairs-Witchcraft, C.1770

¹⁸⁵ Wairagala Patrick Mandwa

spirits and diviners to be guilty of the death or illness of another, mechanisms were available to make redresses.¹⁸⁶

The frustration by the legal processes, which the locals could not understand, led to the killing of traditional healers in society. The worst hit were the female traditional healers. Anecdotal evidence among the Basoga indicates that elderly women were always suspected of being witches. Though it was not possible to obtain information about specific individual women who suffered because of this severe code, it was evident that in a situation regarding a complaint of suspected witchcraft in a community, aging women were the first suspects.¹⁸⁷ Perusal of judicial reports submitted to the Eastern Provincial Commissioner at Jinja by the District Commissioner of Busoga during the Protectorate Government did not yield any cases of witches who were summarily prosecuted and convicted under this legislation.¹⁸⁸

However, the allegation that women in Busoga suffer more than any other category of individuals regarding accusations of witchcraft continues to date. Kyalya (2014) articulates, for example, how women in the community have been accused of witchcraft, leading to their mistreatment and their sexual identity being attributed to witchcraft. Kyalya states the following:

Most women become murderers when they lose their husbands or step children, a one-way passport to being thrown out of their deceased husband's home. (2014:4)

Kyalya's statement reveals the blame game in Busoga society whenever misfortunes arise. Secondly, it reveals how society identifies women as benefiting from the loss of the husbands and or stepchildren as this gives them an advantage over family resources along with their biological children as sole benefactors. Thirdly, the blame against women reinforces a gendered identity of women (widows) as sources of society suffering, implying that women have to bear the burden for any misfortunes that befall their communities. The phenomenon of witchcraft was not entirely unique to Busoga; this was the belief across most parts in sub-Saharan Africa, where it was believed that every evil and misfortune, including mysterious illnesses and deaths were attributed to witchcraft as Quarmyne (2011:478) also asserts that older women and widows were the ultimate carriers of witchcraft.

¹⁸⁶ Ibid.

¹⁸⁷ These assertions were echoed by many interviewees, yet they could not provide significant examples of known individuals/women who were killed for practising witchcraft. But the thinking among many Basoga I interviewed is that most of the old women, especially those who live alone, and those widowed are believed to be witches.

¹⁸⁸ Uganda National Archives, Monthly Reports-Busoga 1918-1919, z.0612; Miscellaneous Reports. Quarterly-Busoga 1926-1929, z.0016/11; Busoga District Annual Report for 1918-1919, N.0146 etc.

The law then cemented people's beliefs about witches. Female traditional healers operated in fear lest they would be the first suspects should death occur in their communities. The witchcraft law was therefore, one way of passing a death sentence on women who fit into this category. They were ostracized in their own communities under the guise of the law. In effect and practice, this law was discriminative against women and led to the disenfranchising of only female traditional healers in Busoga and Uganda at large. The law would lead women to be unfairly accused and victimized of witchcraft, let alone being treated as second hand citizens in their own society. Apart from facing the punishments as stipulated by law, they faced the risk of banishment from their own communities.¹⁸⁹Quarmyne (2011:483) also argues that women accused of witchcraft were likely to lose honour and respect. They would face stigmatization, leading to emotional distress and mental anguish.

Witchcraft accusations levelled against old women would also have severe social and economic impact on the crucial role of grandmothers in such communities. Elderly women were the custodians of the knowledge of social order and custom. Consequently, if these women were marginalized within their communities, younger women lost role models that would inspire them. One would be right to argue that gender inequality in healthcare provision was occasioned by such colonial policies. Women began to suffer oppression never seen before in Busoga. The fact that women were associated with witchcraft rather than the restoration of wellness meant that the power to control the life of the living was stripped away from them (Ofisi, 2010:324). Burke (1988) shows how women had, through history, been key resources as midwives and herbalists in African traditional society. Their knowledge of medicine was unquestionable compared to men in the same communities. With the introduction of western medicine related to pregnancy and child birth, Basoga midwives popularly known as '*Balerwa*', lost all the power accorded to them. A case in point is found in a letter to the Saza chiefs of Kamuli, when A.R Cook wrote:

We have written this letter asking you to tell your people in the Lukiiko (local parliament) as we have sent to you a qualified midwife, that is to say a midwife, who has got a certificate of that work.¹⁹⁰

A.R Cook's thoughts reveal the colonialists' ideology of healing as based on western epistemology, which is perceived to be based on rationality and institutions, which ultimately

¹⁸⁹ Nabogho Daniel (46 years), School Headteacher, Bukonte Village-Namutumba district. Interviewed on 26th June 2015

¹⁹⁰ Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

disregards the thinking of the local Basoga. It also shows the British's attempt to institutionalize values of healing through the Lukiiko. Institutionalization of such health values is a move towards modernisation of health values, an indication of serious attempts by the British to reinvent the health traditions of the Basoga, with incorporation of formal training and certification. The traditional birth attendants were relegated to the background, yet they had done this work since time immemorial. No training opportunity was available to them to upgrade their midwifery skills. This would have been ideal since they adequately knew the cultural situation of the people they were serving. The idea that a qualified healer was one who had undergone college training downplayed the knowledge, experience and wisdom of the *Balerwa*.¹⁹¹ The notion that a good midwife was one with paper qualifications was counterproductive to the considerable work that had for long been done by the *Balerwa*. The demands of biomedical practices created a tier among women doing the same work, leading to suffocation of the traditional midwife.

Then arose the 'certificate syndrome', a requirement for each traditional healer to have a certificate in post-colonial Busoga and Uganda at large. This was largely an extension of European hegemony over the healing systems of the colonized. In another separate set of minutes written by A.R Cook to the District Commissioner of Busoga, he curiously pointed out that the Saza chiefs should be made to understand that the midwife being sent to them had scored a distinction in her examinations and was therefore the best to treat expectant Basoga women.¹⁹² This was in disregard of the cultural norms of the Basoga, who felt comfortable being treated by the *Balerwas*. The unavailability of paper qualifications had not proved the *Balerwas* inefficient. Whatever the case, availing of midwives with paper qualifications or requiring one to have them was in effect driving *Balerwas* out of this profession.

Henceforth, the *Balerwa* were looked at as agents of a healthcare regime that endangered the lives of fellow women. Indeed, discrediting and blaming traditional healers under colonial era became the norm. In a letter to the Saza (County) chiefs of Kamuli in Busoga, A.R Cook, who was then in charge of Mengo Hospital, was very apprehensive of the use of traditional medicine by traditional birth attendants. He stated the following:

And your Lukiiko ought to tell all the people as to how the native medicine such as *Nsamba* and some other kinds of that sort are hit poison. It is very bad to drink or a

¹⁹¹ *Balerwa* is a Kisoga name for 'traditional birth attendant/traditional midwife

¹⁹² Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

woman to make another woman who is travelling to drink it. Because many women are dead from drinking that medicine.¹⁹³

The instructions that were given to the local leaders show the British's conscious attempt to impose or reinvent Kisoga health values. It also meant disregard of traditional medicine in favour of western medicine. This is indicated by the labelling Kisoga traditional herbs as 'poisonous', the *Balerwa* of Busoga were blamed for the deaths of expectant mothers. Traditional birth attendants were under attack here because only they had the power to administer traditional medicine to expectant mothers whether before or during the delivery of a baby. The western governors were engineering negative relations between *Balerwa* and women in Busoga.

The trust and confidence that expectant mothers had in the *Balerwa* was being contested by the colonialists within Busoga. This sort of antagonism challenged the principle of sisterhood that binds women who face similar circumstances. The colonialists' perception that *Balerwa* would attempt to kill fellow women using their power as healers was in contradiction with the Kisoga ideology where women prefer to be treated by fellow women. Traditional birth attendants had for long been regarded as life giving mediums and not murderers. The traditional healers' status and position in society had always been exceptional. It is not clear if maternal mortality rates declined in Busoga after western midwives were introduced. Two elderly traditional birth attendants named Kirangi Monica¹⁹⁴ and Kakose Seforoza¹⁹⁵ were interviewed at Bulagala village in Namutumba district. Their story is testimony that Busoga had women who were accomplished gynaecologists and obstetricians. The two recounted how effective they were in helping fellow women to deliver babies with minimal fuss. They also highlighted their knowledge of and effectiveness of herbal remedies in quickening labour pains. However, having been labelled unclean and unhygienic, these two women were denied space to continue their work. People told me how the 'Balerwa' in Busoga were often blamed for maternal and infant mortality rates due to the perceived poor hygiene during their management of child deliveries.¹⁹⁶ Albert Cook's letter mentioned earlier attests to these assertions made against the *Balerwa* in Busoga. In the letter, it was cited that many women were dying because of drinking native medicine given to them by fellow women.¹⁹⁷

¹⁹³ Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

¹⁹⁴ Kirangi Monica

¹⁹⁵ Kakose Seforoza

¹⁹⁶ Edisa Namwase

¹⁹⁷ Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

Unfortunately, by the time post-colonial governments in Uganda had the idea to give such women a basic training to integrate them in the mainstream reproductive health care system; they had become too old to engage in such training. Women's disenfranchisement led men to gain monopoly of gynaecology and obstetrics, which was not possible to accommodate in Busoga tradition. It was unacceptable for a man, including one's husband, to participate in helping any woman to deliver a baby. This had been entirely the work of women. The opening of nursing and medical training schools to men gave men an opportunity to enter what had been a predominantly women's field in Busoga.

The introduction of western midwifery medical practice had effects on social relations within Busoga and other such British colonies. Soman (2011:26) writes about the Indian experience where the promotion of new practices in health knowledge and care not only replaced the 'dias' (traditional birth attendants) and created a category of 'lady' doctors. In Busoga, it created a further stratification of roles and responsibilities. The traditional birth attendants – *Balerwa* - were the most affected. The new medical practice created a class among women in Busoga. There was now the elite class of midwives who had been to school and who had been trained. The *Balerwa* were isolated and replaced. They lost income, power and prestige in their communities. Another social class did, however, emerge. The women, who sought the services of the trained, registered midwives, began to enjoy a higher social status than those women who continued to use the *Balerwa*. This gender stratification of the consumption of the services of midwifery continues to be reflected not only in Busoga but throughout Uganda. Having been forbidden from practising medicine, the *balerwa* practiced secretly. Many Basoga women preferred them to the western trained midwives and their male counterparts.

Colonial officials changed the perception of the Basoga towards their own system of healing. Due to stigma and labelling, providers and users of traditional medicine were left with no other option but to participate in secrecy. Many Basoga began to seek services of traditional healers only at night. The performance of divination ceremonies and rituals at night can be understood as a coping mechanism, which healers devised to escape the wrath of British punitive structures.¹⁹⁸ Women's access to traditional healing was made more complicated. Society had stringent restrictions against women's movements. It was not acceptable for women to move alone at night, because the night was considered to come along with insecurity. Yet, night-time was the most conducive for healing practices, as it was difficult for the law enforcement to

¹⁹⁸ Isabirye Balige ya

apprehend the healers. Women found themselves excluded from access to traditional healing. Therefore, when women needed to consult a traditional healer, they had to be accompanied by their husbands or brothers, yet these escorts were the subjects of their consultations. In addition to restrictions on movement, women experienced feminine challenges like warding off co-wives, barrenness, wishing to be the most loved and favoured, for which they sought services of healers without the knowledge of their husbands. This made it difficult for women users to express their diseases and illnesses to the healers in the presence of their husbands or brothers.

The changed perception was that traditional medicine was in contradiction with the good forces that sustained life. Safina Nabirye, aka, Songa Wa Busoga as well as Dhadha Budhagali,¹⁹⁹ along with many other healers who were interviewed, testified how they had helped many politicians to win elections, but that they had come to the traditional healing centres at night for fear of being noticed by their electorates. This hampers the capacity of traditional healers to develop their coveted traditional medicine. For example, herbalists were successful in treating mental illnesses (*eiraru*) using local herbs through fumigation (*okunioteza*). They too had anti-psychotic herbs in form of a stick that they could use to tap on the mad person's body and she or he calms down for further diagnosis and treatment.²⁰⁰ This was not only cheap but effective. Herbal plants thought to have high medicinal values were taken by European pharmacology industries and redeveloped into high efficacy medicines. They were later brought back to Busoga and Africa as a whole, to be sold at exorbitant prices. A case in point is the Aloe Vera plant (*ekikaka*) and 'Mululuza' that had for long been used by traditional healers to fight against different ailments like malaria.²⁰¹ The high medicinal value attached to products made from *ekikaka* and *mululuza* plants is now well beyond the income of an ordinary Musoga (Millar & Havercort, 2006:17). Hassim et.al, (2007) argues that traditional healing systems were stigmatized and marginalised, which reduced the possibility of Africans to legitimatising and developing their traditional medical system.

Colonialism largely inhibited the development of indigenous technology in Africa and the indigenous manufacturing capability was deliberately undermined to facilitate European medical exports (Waldron, 2010:66; Eyong, 2007:131). This has made Busoga dependent on the western world for medicinal solutions for many otherwise uncomplicated diseases. Had this not been the case, herbalists would have continued with their work. There is no doubt that

¹⁹⁹ Kawuma Safina Nabirye also known as 'Senga Wa Busoga' & Nabamba Budhagali

²⁰⁰ Banuri Wairagala

²⁰¹ Kakaire Balimwikungu

colonialism with its attendant effects worked to undermine the advancement of traditional medicine knowledge and its role as the major answer to African health problems (Eyong, 2007:131).

However, the modern hospitals established by the colonial administrators and the Christian missionaries enhanced the health of the people. In Busoga, there were medical clinics at each Catholic parish. The medical facility at the now renowned CMS trading centre in Iganga, for example, provided medical care to all, irrespective of their religious affiliation. Another health clinic was functional at Nawaikona, established by the Anglican Church in Busiki County.²⁰² I have already stated that by 1920, the colonial administrators had brought in a qualified midwife from Europe to treat and care for expectant mothers in Kamuli.²⁰³ The hospitals established by the colonial administrators and missionaries have continued to be some of the best medical facilities. Among these is Rubaga hospital, Nsambya hospital, Mengo Hospital, Lacor Hospital, Kisubi Hospital. These hospitals have reduced the incidence and prevalence of disease among Ugandans. Despite the establishment of hospitals and dispensaries, the colonial governments initially registered low patient enrolments. This was because of the revolutionary style used to undo traditional healing mechanisms. Europeans described African healing systems as heathen, primitive, barbaric, uncivilized and ignorant. It was also associated with illiteracy, irrationality and lack of science (Shizha & Charema, 2011:171). This was true when Europeans described African peoples on traditional treatment as being archaic.²⁰⁴

Measures adopted by the colonial powers to control diseases were discriminatory and imposed by force. No time was devoted to educating them about the benefits of their medical system (Dube, 2009:7). The forceful eviction of people from the shores of Lake Victoria and the islands of Sumba and Sigulu, for example, attests to this fact.²⁰⁵ Patrol police were put in place to arrest those who still lived in their huts, which were then forcefully burnt down and the inhabitants forced to relocate to faraway places.²⁰⁶ Many people were beaten up and their property destroyed.²⁰⁷ Ordinances like the contagious disease ordinance and the sleeping sickness ordinance were enacted, and heavy penalties were set for those who did not observe the laws. The Contagious Diseases Act of 1912 compelled chiefs, none of whom had undergone a similar medical examination, to report to the authorities anyone they suspected of having a

²⁰² Nabogho Daniel

²⁰³ Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

²⁰⁴ Uganda National Archives (1946) Medical Fees charged to Africans. C.570.

²⁰⁵ Uganda National Archives (1927), Sleeping sickness in Busoga. Z.1268. File No.194

²⁰⁶ Ibid.

²⁰⁷ Uganda National Archives, (1946), Sleeping Sickness-Busoga, C.1192.

venereal disease.²⁰⁸ Yet illnesses that had a connection with a person's genitalia were a secret between the patient and the healer. It was customary for women to be treated by women healers. Appointing male chiefs to detect and arrest women suspected of having venereal diseases was in total disregard of the African cultural health values and norms. In traditional health values in Busoga, it was improper for any woman to let any other person - including her husband - know about her genital-related disease. Such diseases were only disclosed to healers and, in this case female ones, who provided the treatment. This was the basis of women's trust and confidence in other women as healers. Such observance of confidentiality in Kisoga traditional health system was largely for gendered reasons. Women were expected to keep high levels of hygiene in order not to disorient their husbands from making love to them.

Little or nothing at all had been done to understand the Basoga cultural health traditions upon which an acceptable health regime would be implemented. The traditional healers were neglected and not consulted albeit having experience. Onwuanibe (1979:27) argues that there was no serious attempt to investigate the scientific merit of some of the traditional medical practices, especially diagnosis of diseases and the curative power of the traditional medicine. The prevalent attitude on the part of the foreigner was that what was native was pagan and superstitious, and therefore, bad. In one of the minutes of the Lady Coryndon Maternity Training School Committee, it was decided that the Principal Medical Officer at Entebbe should request the Provincial Commissioners to use their good offices to convince the chiefs to educate their people about the advantages of the Zaliros,²⁰⁹ especially at Kikoma (Mubende district) and Kamuli (Busoga district) and Nabumali in the Eastern Province, where expensive centres manned by experienced midwives had been put up but very few women were going to them for treatment.²¹⁰ It should, however, be pointed out that non-enrolment in the biomedical facilities by the locals was misconceived by the British as not only laziness and primitivity but also a lack of concern for one's own health.²¹¹

The British erroneously thought that shunning the biomedical facilities was a deliberate attempt to embrace bad health. Colonial health interventions painted a picture of local populations as inherently incapable of caring for their own health needs and a reservoir of

²⁰⁸ Uganda National Archives, (1923), Medical: Anti-Venereal Work –Uganda: Official report about contagious diseases acts-Uganda, dated 22nd March 1922. C.0637.

²⁰⁹ Also called 'Mazaliros' local word for 'maternity centres', literally 'places where mothers deliver from'

²¹⁰ Uganda National Archives, (1925), Native Affairs: Qualified Native Midwives: Letter written by Principal Medical Officer. N.180.

²¹¹ Uganda National Archives (1946) Medical Fees charged to Africans. C.570.

venereal diseases.²¹² Consequently faith was placed in western biomedicine (Dube, 2009:6), even when it could not cure some illnesses in Busoga, especially those related to spirituality. Biomedicine could not be used to treat incest, neither was it capable of appeasing angered spirits that would cause misfortunes.²¹³ The British were blind to the fact that healing and treatment in African societies was not exclusively at the healing centre. Very often healers went to the sick, and the performing of ceremonial rites to appease the spirits would sometimes take days for holistic healing. Such practices were castigated by the British as lack of concern and laziness on the part of the Africans.²¹⁴

Whereas there are those convincing arguments against colonial policies on traditional healing, I have also established that in many ways colonial policy though detested by the healers and contested by majority of African scholars, has proved effective in ‘modernising’ traditional medicine. The criticisms labelled against traditional medicine forced its practitioners to move a step further to make their occupation professional and respectable.²¹⁵ Colonial regulations controlled charlatans, who invaded the healing systems for selfish motives. This opened the eyes of African healers to critically think of regulating themselves to weed out quacks. Busoga alone is a host to several self-regulated associations of traditional healers that coordinate their recognition and registration with local government offices. Herbalists insist on displaying their certificates of registration and recognition in their healing centres as it is with the western biomedical doctors.²¹⁶ The most pronounced traditional healers’ association in Busoga is ‘Uganda Nedagala Iyayo’. Other healers’ associations operate at district levels. Namutumba and Jinja districts, the two sampled districts of Busoga, have strong associations with an elective leadership. Each of the associations awards certificates to her members upon verification. I can therefore conclude that colonial regulation on traditional healing was well intentioned but detested by those who were charlatans. These local self-regulatory associations have their unwritten codes of practice that prohibit child and human sacrifice and hoodwinking vulnerable clients. Leadership of these associations work with district security organs to destroy quack healing centres and arrest those involved in charlatanism. The enmity heaped upon the colonial rulers for constraining traditional medicine has been transferred upon the self-regulatory associations of healers that look out for quacks.

²¹² Uganda National Archives, (1923), Medical: Anti-Venereal Work –Uganda: Official report about contagious diseases acts-Uganda, dated 22nd March 1922. C.0637.

²¹³ Kabaale Bitimbuto

²¹⁴ Uganda National Archives, (1946), Medical Fees charged to Africans. C.570.

²¹⁵ Kawanguzi Dan

²¹⁶ Isabirye Baligeeya

Photograph 2



Ssenga wa Busoga alias Safina Nabirye Kawuma, a female herbalist at Bugembe-Jinja, in her herbal clinic with several processed herbal medicines. Source: Photograph taken by the researcher- Isiko Alexander Paul, with permission from the herbalist who appears in it

Schumaker et.al, (2007:708) argues that the modernisation of traditional medicine is to healers' aspirations and to pressures from western medicine as well as global economic forces. For the case of Busoga, photograph 2 above provides a glimpse of the modernising aspect that traditional medicine in that society is undergoing. There are now educated herbal practitioners with well labelled and packaged herbs. Those in the urban settings no longer use the herbal concoctions of *ekyogero* but rather an herbal cream that healers process from the same herbal substances that composed *ekyogero*. The physical setting of traditional herbal clinics in the urban setting of Jinja would be confused with a modern health care clinic. In the left-hand side of photograph 2, there are books and files for registering clients and issuance of cash receipts to clients for payment for services. I cannot agree any more with Schumaker's arguments that the modernising comes from the need to compete favourably with colonial western medicine. Female herbalists in the urban areas have been receptive to these modernising changes of traditional medicine compared to men. They are more law abiding.

4.3 Altered Traditional Conceptions of Health and Healing

The new healthcare model introduced by the British carried along Europeans' understanding of health and disease, neglecting and negating Basoga's perception of health and healing. No doubt that whereas traditional conceptions may have been greatly affected by the new healthcare regime, there were great strides recorded in management of diseases that had for long been a challenge to the people of Busoga and Uganda at large. I discuss this point later in this section but firstly I need to discuss the ways in which the British changed Busoga society's ideology of health and ill being. One of the areas that were changed was related to procedures involved in delivery and post-natal management of babies. Basoga women had for long delivered their babies in a squatting or kneeling position, while holding onto a banana plant.²¹⁷ This was to ensure safe delivery and safeguarding against suffocating the baby to death. When this common practice was replaced with the westernized maternity beds, some women refused to give birth there.²¹⁸

Masebo (2013:78) also contends that colonial agents used western medicine as a cultural tool to construct African health and illness. He identifies it when colonialists began to construct and control African conceptions of health and healing by redefining African conditions of health, illness and healing using their own experiences. A.R Cook's letter to the Saza chiefs of Kamuli²¹⁹ signified not only an alteration but a comprehensively drafted plan by the colonial governments to sway the Basoga from using their long-known traditional medicine. A part of this letter states:

...and it is better for you to make this known everywhere in the Gombololas, that all women who are pregnant can always go to her (midwife) to be treated, or those who always have miscarriages, and also those who may be suffering from syphilis. They will also be taught some wisdom as how they ought to look after their children when they are born.²²⁰

Such directives were aimed at institutionalizing foreign health values. At the same time, it represents an agenda to erode traditional values. Indigenous knowledge was disrespected, against the western taught knowledge which was seen, as desirable and necessary for one to live a health life. Busoga had for long taught her women many things about child bearing, health and upbringing. Actually, many women in traditional Busoga society were accomplished 'paediatricians'. Eyong (2007:128) emphasized how African women had held close their

²¹⁷ Interview with Kakose Seforoza & Kirangi Monica

²¹⁸ Uganda National Archives, (1925), Native Affairs: Qualified Native Midwives: Letter written by Principal Medical Officer. N.180.

²¹⁹ At the time Kamuli composed of the current districts of Buyende, Kaliro and Kamuli

²²⁰ Uganda National Archives, (1920), Letter to the Saza Chiefs of Kamuli, written by A.R Cook. N.180.

indigenous knowledge concerning care for their children and husbands. Mothers never went to school to study how to prepare a balanced diet. Colonial policy for African mothers to be taught how to feed and care for their children was a mark of disrespect of and lack of confidence in African indigenous knowledge on health. The notion that once women became sick they should go along with their children to visit a biomedical practitioner, was one way of taking away knowledge from the people to colonial institutions. It was contrary to the ideals of Kisoga tradition that all lives, and health belong to institutions rather than to individuals.

But it is also true that preventable diseases that the western world had decisively dealt with were continuing to endanger the lives of the African people. Such diseases were Polio, and tetanus. Polio also locally called '*Isejja*' which leads to paralysis of both upper and lower limbs had always been attributed to witchcraft. Many children died from it. There is evidence that introduction of polio vaccination led to reduction of numbers of children dying. Small pox was also contained by the colonial officials. In the previous chapter, I discussed how women were instrumental in diagnosis of disease amongst children, especially when they were breastfeeding them. However, a well spelt-out curriculum was designed by the British to teach African mothers about childcare, including what was termed as better ways of feeding and clothing of children.²²¹ The notion that African women were to be taught and given wisdom by a western-trained nurse undermined the knowledge that African women held about their own health and diffused the healing tradition of Africans.

European emphasis that knowledge on child health was the monopoly of the biomedical expert was wrong, because such expert knowledge was colonizing knowledge, in a system which did not recognise the power of the individual over his or her own health, but that of the expert. It is also clear that traditional healing was not trusted as sufficient to meet the health needs. There were however strong efforts to contain diseases in Busoga by the colonial officials that were depopulating the natives. Colonial administrators made track of statistics of people who were affected by most of the sicknesses, ranging from jiggers, malaria, smallpox, plague, venereal diseases, and sleeping sickness to famine. I found most of these statistics in monthly and annual reports of colonial administrators kept at the Uganda National Archives. Keeping of statistics is a clear indication of the amount of interest that the colonial administrators had in the health and well-being of the Basoga. Schneider (2009:193) discusses European colonial efforts to eradicate small pox and he argues strongly that it was due to the efforts of colonial rule that this disease is

²²¹ Uganda National Archives, (1956), Publications: Health in the Home. SD.400.

no longer a danger to the people in tropical Africa. Vaccination campaigns against small pox are one of the major success stories of colonial rule that cannot be disputed to date. Whereas there has been a lot of criticism against colonial rule over its draconian public health programmes, the Europeans eliminated small pox by the 1970s. In the 1916-1917-year report, the Busoga District Commissioner states:

“In September, the senior medical officer detailed a smallpox Inspector to accompany me upon a visit to Bugwe, to assist in the furtherance of measures for the isolation of cases. And subsequently an inspector was appointed to work exclusively in this county”²²²

Besides smallpox there were rigorous attempts by the British to eliminate several other diseases. Plague also called *Kawumpuli* in the Lusoga language had claimed many lives, with the Busoga district annual reports of 1915-1916 and 1916-1917 indicating 327 and 538 deaths due to plague respectively.²²³ This was widespread in the areas of Jinja and Iganga townships, commonly spread by rats. The European officials took drastic steps to promote cleanliness in both townships and ensured that there were no substances capable of harbouring rats. They ordered the destruction of produce, stored in unauthorized places. They also ordered the destruction of massive quantities of cotton seed and the burning of several grass roofed huts. They encouraged the local people to concrete the floor of their houses.²²⁴ Generally, the colonial officials were much aware of the high cost of medical services that the local peoples were bound to meet. The sick were therefore exempted from paying taxes to re-channel the money to health service.²²⁵ Other recent diseases especially HIV/Aids have received great attention from Europeans. New discoveries in biomedicine have led to the Aids scourge to reach now controllable state in Sub Saharan Africa. It is now possible to have an HIV free baby even when the mother is infected. Women who more than men are vulnerable to HIV infection due to susceptibility to sexual violence can be provided with emergency medication if they have been forced into sex with someone whose HIV status is positive. Through the provision of the Anti-retroviral therapy, many HIV/Aids patients can enjoy a much higher lifespan in the recent years in comparison to the 1980s and 1990s when Basoga attributed it to witchcraft and other such supernatural forces.

²²² Uganda National Archives, Busoga District Annual Report for 1916-1917. N.0146

²²³ Uganda National Archives, Busoga District Annual Reports for 1915-1916 and 1916-1917. N.0146, Z.0571

²²⁴ Ibid.

²²⁵ Ibid.

4.4 The Influence of Christian Missionaries on Traditional Healing in Busoga

Romane (2000:144) states that traditional healing in Africa was affected by the coming of Christianity and western scientific development. Christian missionaries championed the fight against African cultural systems. Traditional medicine and healing was no exception. Onwuanibe (1979:27) states that despite the many ways through which African healing was undermined by Christian centred medical services, the contribution of Christian missionaries is immense. Christ's healing power through biomedical services helped to fulfil a need for health services which were obviously inadequate in developing African societies. This was heightened by the establishment of modern health facilities based on western medical models, which were to provide free medical services to the people. Traditional healers found themselves in a fix - with no major demands expected of the sick in the modern health facilities, yet traditional healing and medicine demanded a lot of ritualistic expectations. Only those with proximity to traditional healers continued to shun the biomedical facilities. The Principal Medical Officer had already raised the challenge of distant locations of established expensive hospitals and dispensaries as responsible for the continued usage of the village medicine man.²²⁶ In areas where there was easy access to biomedical facilities, there was reduced power and influence of traditional healers.

The new Christian religion unapologetically labelled African traditional healing systems as devilish and the traditional healers devil incarnates. One is right to argue that along with the gospel, Christianity came to Africa with a set of complex combination of western culture, politics, science, technology, medicine, schools and methods of conquering nature. Tabuti (2006:102) citing specific references to Busoga observed how colonialism, with its accompanying upsurge of Christian fundamental religious beliefs and values, dominated the traditional belief system including healing. Followers of these Christian religious movements became intolerant of most traditional practices, including Kisoga traditional medicines.

The new form of medical care and knowledge brought by the Europeans began to reduce infant mortality rate and put under control certain diseases like small pox, malaria and stomach ailments, which were often the main killers in Africa. This led people to begin querying the authenticity and efficacy of traditional medicine (Mbiti, 1969). The claim that Jesus was the sole healer according to the Christians led the new African converts to doubt the roles that had been performed by African traditional healers. Christianity was imposed on the Africans with disregard of their culture.

²²⁶ Uganda National Archives, (1946), Medical Fees charged to Africans. C.570.

Christian principles and teachings alienated African converts from their culture. To win the hearts of African converts to Christianity, various churches developed a strategy of setting up modern health care facilities based on western scientific models of healing. Traditional healers therefore lost the confidence that many members of their communities had had in them. Because of the labelling that was orchestrated by the imperialists, traditional healers went into hiding and some took on new identities. They abandoned their real names and took on aliases. Healers were associated with superstitions and beliefs that missionaries sought to replace with Christianity. Missionaries used medicine to aid spiritual conversion, and “the asserted superior power of European medicine over African treatment of disease was used to demonstrate the validity of Western rational explanation over African superstition” (Ranger, 1992:258). This linkage between health and religion provided a rare common ground for Africans and missionaries, even though specific perceptions remained diverse. For many Africans, there was typically no delineation between society, health, and religion; rather all three made up the composition of daily life. It can be argued that missionaries took advantage of this perceived similarity of community to create converts. However, “mission medical provision with its scientific rationality was not experienced by Africans as a continuing part of Christ’s ministry” (Ranger, 1992:259). Early biomedical incursions into African ideology were therefore rejected on the grounds of singularity, depicting widespread African beliefs of universal interconnectedness. Missionaries were often viewed as extensions of the government of the day, and colonial machinery in general.

4.5 Undermined Traditional Societal Mechanisms of Disease Control

The role of traditional healers was undermined by the emergence of complex social relations that resulted from mixture of local and European ideologies. Colonisation through urbanisation disrupted the otherwise close-knit family structures, leading to family fragmentation and increased social networks that were well beyond the control of the village healer, who had been pivotal in times of sickness and misfortunes (Farah et.al, 2011:4). Relatives were no longer the only determinants in choice of healing services but friends and workmates with whom they worked in the urban based factories and construction sites of Jinja. Educational institutions widened interactions between people, but also made people to acquire more knowledge to question the authenticity and efficacy of traditional healing. The school and the workplace were brought in the arena of determining health seeking choices, which obviously disadvantaged traditional healing in favour of biomedical services. Yet the traditional healer, who ordinarily

healed people using traditional means, was to compete with the modern medical practitioner, and another hybrid of modern healers, who mixed traditional and modern methods of healing. The latter, who was accommodated under the law, continue to use traditional herbal remedies but with modern technologies like microscopes to diagnose diseases. (Romane, 2000:145).

British rulers overlooked the existing strategies and practices that Africans had adapted to guard against certain diseases. For example, the practice of home treatment was viewed as lack of concern rather than moving it into the healing centre or hospital.²²⁷ Equally overlooked was the importance of communal organization among kin groups in the realms of health and economy. The history of health and healing in Africa is one of the major meeting points of family socialites and economics; it also serves to emphasize the importance of kinship and community cooperation (Noel, 2012:1). British rulers ought to have known this but simply acted in disregard of cultural norms of Africans. The Director of Medical Services, writing in 1946, acknowledged that traditional societies in Uganda consider a sick man to be a poor man, since wealth depends almost entirely on his ability to earn a living with his hands. It was therefore construed to be true that in these communities, the healthy relatives as a rule support the weaker members in times of sickness.²²⁸ During and after the colonial period, many of the important values and safety nets that had previously upheld the health and curative processes of Africans were renegotiated, and in some cases abandoned, leaving behind the continued yet misperceived notion of Africa as a continent continuously riddled with disease.

It should, however, not be assumed that the pre-colonial practices and safety nets of Africans were perfect or an appropriate model for the future (Noel, 2012:2). In the following paragraphs, I discuss the colonial impact on these safety nets but also show the ineffectiveness that came along with their application in African communities. I also analyse how the newly established colonial strategies have been transformed into lasting mechanisms that have contained diseases that would have swept away villages of people had they not been in existence. Colonialism came with social dislocations that made it impossible for the Basoga to continue with an extended family system as a safety net for ensuring communal health. Colonialism disabled the social mobilisation that for years had kept the Basoga confident of checking against socio-economic upheavals. Due to movement of people in form of labour to the hydroelectric and railway construction projects, sugar cane plantations, communal

²²⁷ Ibid.

²²⁸ Ibid.

cooperation against sicknesses and diseases was curtailed.²²⁹ The men who used to unite against societal ills like famine through cooperative farming turned into migrant labourers in the factories that produced goods for export. Famine became rampant in some parts of Busoga with resultant malnutrition among children.²³⁰ The sickness of 'eryuuse', the equivalent of kwashiorkor which was known to affect small children during their mothers' pregnancy was witnessed among the Basoga due to insufficient food production in the homes.²³¹ Women, left alone in the villages, could not sustain feeding their children.

I need to state here that there is no convincing evidence that extended family system and communal way of living among the Basoga had made the society disease free and that these provided the most important pillars upon which the well-being of the Basoga was based. Neither was there any assurance that these practices would stand the test of time as new diseases and sicknesses emerged and Busoga opened herself to interaction with the outside world. For example, a man having more than one wife would ordinarily expose community to widespread of sexually transmitted diseases and this could partly explain the tough measures that the colonial administrators put in place to control venereal diseases including restricting British workers from having sexual relationships with African women, which was heavily punishable.²³² It is as well a challenge in modern Busoga to maintain extended family as the cost of healthcare service would ordinarily rest on one man. Contagious diseases are likely to spread faster among people who are living communally in extended family settings than those in nuclear settings. For example, in the late 1980s a polygamous man with four wives died of a terrible skin rash also called *Wailindi* along with the wives, one dying after the other.²³³ Extended family system was convenient in such a non-monetary society where all that was needed could be produced at home including medicine for maintenance of members' health. In a more monetized Busoga society of this century, extended family rather than being a safety net against communal health shocks is one of those burdens that can greatly increase healthcare costs upon family heads.

The clamping down on some of the cultural practices of the Basoga by the colonialists led to the decline of their well-being. Some of these cultural practices were efficient safety nets

²²⁹ Uganda National Archives, Monthly Reports-Busoga 1918-1919, z.0612; Miscellaneous Reports. Quarterly-Busoga 1926-1929, z.0016/11; Busoga District Annual Report for 1918-1919, N.0146 etc.

²³⁰ Uganda National Archives, (1908), Uganda: Correspondence Relating to famine in the Busoga district of Uganda. C 003

²³¹ Nabamba Budhagali.

²³² Uganda National Archives, (1908), Polygamous Marriages: Questions arising from in connection with British Nationality law. C.00192

²³³ Nabogho Daniel. Telephone interview on 2nd August 2016

that ensured both the physical health and societal well-being of the Basoga. For example, undermining the practice of widow inheritance,²³⁴ led to widespread malnutrition in many parts of Africa including Busoga (Feierman, 1985:83). In this case, women and children who would have found refuge in a family member's home were suddenly left to fend for themselves (Noel, 2012:4). Criticism against widow inheritance by the Europeans was not in any way ill-intentioned to stifle Busoga's cultural pride. It was intended to defend and promote the rights of women in a patriarchal society. Apart from being a degrading practice to womanhood, where a woman who has lost her husband is transferred to one of her late husband's brothers as her new husband, widow inheritance was one of the major avenues through which the HIV/Aids spread in Busoga during its early years. By 1997 nearly 50% of deaths that led to widowhood were Aids related (Ntozi, 1997:132). Ntozi (1997) discusses the dilemma that faces widows and the spread of Aids in Ugandan societies, Busoga inclusive. In his own words, he writes;

Despite the knowledge that a man has died of AIDS, his widows are being inherited and sexual intercourse happening between the widows and the inheritor. Secondly, the widows of dead men have frequently been harassed and dispossessed. Thirdly, those non-AIDS widows who refuse to be inherited by men they suspect to be HIV-infected are left to fend for themselves and their children. The situation is worse with AIDS widows who are shunned by in-laws because they cannot inherit them. Widowhood in Uganda brings poverty which is worsened by the requirement for the widow to pay off the debts incurred while caring for her sick husband. (1997:128)

The practice of widow inheritance was used to subordinate desperate women and their orphaned children. Those who resisted inheritance struggled for basic needs. The practice therefore wasn't well intentioned to benefit the widow and her children but rather it was an avenue through which powerful men in society continued to exercise their power over the powerless through tokenism. The rarity of widow inheritance in Busoga today proves that it was a practice that was more of liability than one that would sustain and transform society. The Europeans' ideology that promoted the individual rather than groups of people disorganized the communal traditions of the Basoga in fighting ill health and other public sicknesses. The people had for ages operated and lived in extended lineages and clans that were interrelated in a complex social web for the well-being of their members (Fallers, 1965:64-96; Cohen, 1972:6-12; Nayenga, 1976:14-32). Using the European model of health, sick people were isolated from the community and taken to hospitals and rehabilitation centres. Buluba Hospital in present-day

²³⁴ The practice of widow inheritance was widespread in Busoga, for the major purpose of ensuring survival and continuation of well-being of family members who would have lost a bread winner. This is emphasised by Nayenga (2002:44), Fallers (1965:64-96) as well as Cohen (1972:9-12).

Mayuge district of Busoga was established as a national hospital to treat tuberculosis and leprosy. Buluba Hospital ended up being cordoned off for normal people. This deprived the Basoga of their tradition of nursing the sick.

Whereas traditional healing is aimed at treating both the physical and psychological states, there are situations where the sick is deprived of this advantage for the good of the community. Such situations are not available in Busoga traditional health system. The sick are not isolated but made to be fully part of the community or family. Isolation strategies used by the colonial medical officials were in situations of contagious diseases to deter further spread of the diseases to those who were still unaffected. Tuberculosis for example which is airborne, isolation of patients at Buluba was one way of safeguarding the rest of the community from contracting the disease. There are also situations when traditional healers may demand the sick to stay at his/her home until he/she has recovered fully. The advantage though with the latter is that at the healer's place, the sick is not confined as it usually happens in major hospitals. The practice of isolation is very effective as has been adopted by the medical personnel in Uganda from time to time whenever a given community has had a contagious disease. During the Ebola outbreak in the Uganda, an isolation ward was opened at the main National Referral hospital- Mulago in Kampala.

In examining the role of the individual in African health and healing, Landau (1996:269) and Noel (2012:6) mention the European evasion of collective causes of disease, and how colonial medicine overlooked wider community dynamics in favour of focusing on individual bodies. The colonial focus on the individual also had roots in biomedicine, which was problematic because "Africans did not share with medical missionaries clear-cut distinctions between cause, diagnosis, disease, and cure" (White, 1995:1389). The attempt of colonialists to divide communities that valued communal cooperation was therefore a perpetuation of the practice of ignoring existing safety nets. In addition to influencing health practices and its dominance in dictating social relationships, this lack of individualism also directly influenced local African economies and labour supply. Value was placed not on accumulating personal wealth and success, but on contributing to and increasing the success of your kin and community (Cohen, 1972:6-19). The clan and community were of central importance in the broader picture of African communalism in resource production and control (Fallers, 1965:64-96).

In the face of the often-harsh realities of African life, conditions such as famine, epidemics, and warfare required communities to unite and collaborate to ensure collective well-being. Young men were often viewed as community labour resources, able to assist not only in agriculture and cattle rearing but in ensuring safety in times of conflict. This was the very reason why men abandoned labour sites and went back to assist their families in times of famine and illnesses.²³⁵ Communities also relied on new and diverse knowledge bases to ensure their success (Kodesh, 2008:197), which is evidence against the colonial perception of African societies as immobile and static. The African emphasis on economic cooperation and resource-sharing not only contributed to stronger communities and therefore stronger communal well-being, but acted as a safety net against crises. The labour policies that supplanted men from their communities were a precursor to famine that hit Busoga, negatively affecting the well-being of natives.²³⁶

Globalization and capitalism have effectively eroded much of the value placed on communal wealth, yet social relationships remain an important facet of everyday African life. As technology improves and mortality declines, people living with chronic diseases and other forms of debility face healing in an entirely new way. Biomedical practitioners need to learn from the experience of traditional healers who see the need to treat social disease as well as individual ill-health, and understand that resolving social tensions is part of the healing process (Marks, 1997:219). While a physical cure may continue to be elusive, the relationships surrounding a debilitated person became more important.

Pre-colonialist African societies incorporated these ideas of communal well-being and cooperation into daily life, erasing the traces of separation between individual and community. They extended ideas of communal cooperation to economics and safety, issues now relegated to individual responsibility. However, “even the lives of the ‘modern’ could never be fully detached from older hierarchies rooted in local notions” (Thomas, 2003:186). While communal cooperation in the realm of wealth and resources is not a viable contemporary practice to fall back on, ideologies regarding strong personal relationships that provide social support are still important in many facets of modern African activity.

Post-colonial governments fostered the emergence of traditional healers’ associations to formalize traditional healing, regularize membership and governing bodies, and standardize

²³⁵ Uganda National Archives, Monthly Reports-Busoga 1918-1919, z.0612; Miscellaneous Reports. Quarterly-Busoga 1926-1929, z.0016/11; Busoga District Annual Report for 1918-1919, N.0146 etc.

²³⁶ Ibid.

practices and amounts to be paid for treatment. This led to the unfortunate occurrence of monetization and commoditization of traditional medicine, which were never in the ideological making and dispensation of traditional healing systems in Busoga. Yet also in the cultural/historical forms of healing, the shift from kind to cash in the payment for treatment, as it occurred on a large scale in Africa, meant that healing became a 'commodity'. The market of healing is conjoined in this sense by other new markets such as that of religion, where new forms of entrepreneurialism have emerged, precisely in their use of healing-practices, for example by powerful charismatic groups providing spirit-healing to the public on a massive scale (Dekker & Dijk, 2010:1).

4.6 The Invisibility of Women Healers in Busoga

Due to outright banning of traditional healing through legislation, practising women healers lost income, status and the power they had. Herbalists were forced to modernize but women did not have the land onto which to put their shrines.

Whereas Busoga society had for a long time treated women and men healers with almost equal respect, western-European medical systems heightened the inequities. The power differences between western medicine and Kisoga traditional healing were consequently transmitted to the traditional healing systems. As Waldron (2010:51) rightly observed, the inherent power inequities between indigenous and Euro-Western knowledge are illustrated in the production, reproduction and dissemination of health discourse, and in the institutional structures that support professional practices that reflected the dominant health discourses. Traditional healers also followed suit. These relational differences were occasioned by the cultural-ideological clash that practically undermined and stigmatized the traditional health care system in Africa because of the over-riding power of Western medicine (Abdullahi, 2011:116).

All the above eventually led to the invisibility of women healers. During the pre-colonial era, women healers had been visible in society. They were accorded as much power and status as their counterparts. Apart from the wives and daughters of chiefs and rulers in Busoga, female traditional healers were high up the social ladder. Through healing they had demonstrated to society that women could have unique and specialized knowledge and wisdom that no other would possess. People would walk long distances just to go and see a specialized female traditional doctor. With the relegation of traditional healing to the periphery of society, traditional healers, especially women, became more and more invisible. Their clientele greatly reduced and so was their relevance in society. This was worsened by the fact that women healers

failed to carry on with their trade stealthily as was the case with their male counterparts. This was not only for fear of victimization but also influenced by the patriarchal social system run by the Basoga. Women were left to wallow in self-pity as they watched near syndicate play between the men and the colonialists. Slowly and steadily, women became submissive to male healers. Hence the Kisoga saying, “*omwami kyakoba zeena kyenkoba*” literally translated as “what a husband says is what I also say”. This kind of subordination of the women went beyond being subjective to the men. It became the women’s mindset. As a result, when the colonialists outlawed traditional healing, female healers, unlike the male healers never resisted.

The male healers’ attitude could have been a sign or demonstration to show that men were not easily cowed into submission - as expected by society. What began as a mere male superiority complex resulted in a series of events that led to the waning of women’s role in traditional healing in Busoga. Some of the women healers indeed continued with traditional healing but hid behind unscrupulous male healers, who then took them on as subservient workers. This further explains why mostly men own traditional healing centres, while women healers only work under them.

Tabuti (2006:102) who has undertaken considerable research on traditional knowledge in Busoga, underscores the fact that other reasons leading to loss of traditional medicine in Busoga are related to scarcity of plant species that has come because of depletion of forests. When an exploited species becomes scarce, the users are deprived and over time the medicinal herb is lost. Herbs are now being sourced from northern Busoga in Buyende and Bunya (southern Busoga), where there is still considerable forest.²³⁷ This leaves women healers at the periphery of traditional healing as it is very difficult for them to move such great distances in search of herbs. There exist middle men in the procuring of herbal remedies, where some women healers are now forced to buy herbs at expensive prices. Restrictions on women’s movement in society, especially the married ones, are also responsible for women healers’ decreased participation in herbal medical practice.

Looking at the broader spectrum of the suppression of women healers in those societies where western medical practices were introduced, Ehrenreich and Deirdre (1973:2) acknowledge that the rise to dominance of male healers was not a “natural” process, resulting automatically from changes in medical science, nor was it the result of women’s failure to take on healing work. It was an active takeover by male professionals. And it was not science that enabled men

²³⁷ Ali Wairagala

to win out. The critical battles took place long before the development of modern scientific technology. Ehrenreich and Deirdre further maintain that colonial policies brought about political and economic monopolization of medicine by men, which translated into absolute control over healing systems including their institutional organizations, their theory and practice, their profits and prestige.

The suppression of female healers by the medical establishment was a political struggle, first because it was part of the history of sex struggle in general. When women healers were attacked, they were attacked as women; when they fought back, they fought back in solidarity with all women. Secondly it was part of a *class* struggle. Women healers were people's doctors, and their medicine was part of a people's subculture. To this very day, women's medical practice has thrived in the midst of rebellious lower-class movements which have struggled to be free from the established authorities (Ehrenreich and Deirdre, 1973:10).

4.7 From Endemic to Epidemic Health Conditions

Whereas it was true that the people in Busoga suffered from many diseases long before the coming of the colonialists and Christian missionaries, they had developed mechanisms of containing such diseases. The most common diseases were sleeping sickness (*mongoota*), malaria (*Omusuudha*), syphilis (*kabotongo*) and leprosy (*ebigenge*). Dube (2009:6) authoritatively puts it that these epidemics were part of Europe's own recent experience.

By 1918, influenza and leprosy had prevailed throughout the eastern province with several clerks having succumbed to the illness.²³⁸ Small pox had become prevalent around the areas of Iganga.²³⁹ The health conditions of the locals deteriorated because legal sanctions had been put in place to deter anybody from using traditional medicine, which was said to be witchcraft.²⁴⁰ Forceful interventions through legislations to deter the spread of these diseases proved a major failure.²⁴¹

Sleeping sickness was particularly common in southern Busoga (formerly Bunya County and present-day Mayuge district). The southern part of Busoga was covered by a forest towards Lake Victoria. These were not settlement areas for the Basoga. The few Basoga who were in these places were fishermen and hunters who, after work, went back to freer homesteads far from

²³⁸ Uganda National Archives, (1919). Provincial Commissioner's Report on Busoga for the month of January 1919. Z.612.

²³⁹ Uganda National Archives, (1910), Busoga District Reports for the period 1909-1910. Archival No-026

²⁴⁰ Uganda Protectorate (1957), Ordinances and Subsidiary Legislations Containing Orders in Council, Rules, Regulations, Proclamations, Orders, Notices, Native Laws Etc. Printed and Published by The Government Printer, Entebbe. This Document Was Accessed Through The Uganda National Archives at Entebbe.

²⁴¹ Uganda National Archives, (1913), Contagious Diseases Acts for Britain; Medical: Anti Venereal work-Uganda C.0637.

the forest zones. In this way, there was minimal contact with the mosquitoes and tsetse flies that spread malaria (*Omusuudha*) and sleeping sickness (*mongoota*) respectively. Moreover, the environment, until then had been kept intact because herbal medicine for the treatment of those affected would easily be acquired.

Scholars like Berrang-Ford et.al (2006:224) and Masebo (2013:75-76) argue that the diseases mentioned above reached epidemic levels due to a wide range of causal factors, including eco-social imbalance caused by colonial disruption, a hut-tax system resulting in widespread movements of labourers, and changes in livestock populations following an 1889-1892 rinderpest outbreak. Masebo argued that pre-colonial Africans managed the environment by balancing population, wildlife, tsetse fly and livestock in ways that limited the possibility of sleeping sickness to transform from endemic to epidemic proportions. He further argues that environmental management involved limiting contact with causative agents of sleeping sickness, let alone mentioning that people were developing natural immunity.

Colonialism destroyed this environmental management system, loosened indigenous disease control systems and consequently transformed sleeping sickness into epidemic proportions in East Africa. They both reached the conclusion that due to colonial conquest and the subsequent activities that followed, there appeared an ecological imbalance that affected food production, social relations and individual existence which eventually led to the outbreak of sleeping sickness to such proportions that Busoga had never witnessed before in history. Due to the hut tax, men who used to be confined at home had to find alternative means of earning to fulfil colonial administrative taxes. Many men in Busoga, especially in the settlement areas of Busiki (now Namutumba district), Kigulu, Bulamogi (currently Kaliro district) as well as those in northern Busoga (currently Kamuli and Buyende districts) moved to such places in search of better income to meet the colonial tax obligations. They found themselves in the practice of agriculture on a large scale in the forest areas of Bunya. These became transmitting agents of diseases to the rest of the people once they went back to their original areas of settlement.

Men in other parts of Busoga had to move to the once fertile parts of southern Busoga, to begin extensive agriculture, and around the Lake Victoria area to do fishing. These did not settle there permanently, but used to return home, whereupon they exposed their family members to risks of infection like that of sleeping sickness. Some respondents argued that syphilis, commonly known as '*kabotongo*' had been a common disease in the area, and there were readily available herbal remedies for it, but this also grew to an epidemic situation with the introduction

of labour movements permits.²⁴² The few educated Basoga and those who worked in the factories did not move with their wives. This was because the colonial rulers and European employers only catered for the employee and not the whole of his family as had been the case in African traditional settings. Once in town they hooked up with other women for casual sex. The Contagious Diseases' Act that would compel the sick to report to health centres did not help to reduce the scourge.²⁴³

Meanwhile, the women who were left in the villages also indulged in sexual relationships with other men there. Notwithstanding the presence of local medicine, how then would sexually transmitted diseases like *Kabotongo* be controlled with such widening sexual networks?²⁴⁴ Because *Kabotongo* was common among men who went in the newly established factories to work, it came to be referred to as a disease for those on the move, thus '*endwayire y'abatabazi*'.²⁴⁵ This is the reason why Masebo (2013:75) asserts that the imposition of colonialism created a conducive environment for the transmission of diseases which had hitherto been under check in pre-colonial African societies.

Unbalanced power relations in favour of men facilitated further spread of the disease. *Kabotongo* was also called '*endwayire y'abazira*', literary meaning a 'disease for the heroes or veterans'. This meant that men who contracted *Kabotongo* were believed to espouse a lot of sexual prowess as it was associated with having multiple sexual partners. And this was celebrated in Busoga society. For the men to do this there were herbs that they ate or drunk to improve on sexual functioning and delayed orgasm. The herbs included '*omulondo*', which is a root for chewing by the men. Where *kabotongo* was essentially known to spread through sex, and more so because of sexual promiscuity, men who contracted the disease were not judged but celebrated.

On the other hand, earlier detection of the disease in a woman than the man brought harsh judgment. She was seen as promiscuous and adulterous regardless whether the husband was the one who infected her. Therefore, women, who suffered from *kabotongo*, were stigmatized, which made it difficult for them to seek treatment from traditional healers for fear of isolation and rejection. Whereas society demanded wives to be unconditionally supportive of their husbands with any sickness including *kabotongo*, it enlisted tensions and conflicts if the wife was found to be the first victim to the disease. And since there were common herbs for the treatment of

²⁴² Ali Wairagala

²⁴³ Uganda National Archives (1923), Medical: Anti Venereal work-Uganda, C.0637.

²⁴⁴ Ibid

²⁴⁵ Katende Kibenge

kabotongo, it was the responsibility of women to collect and process these herbs for the treatment of their husbands. Women often suffered from *kabotongo* silently to maintain harmony in the home.

The death rate drastically shot up. Diseases like malaria that had for long been contained by use of ‘*mululuza*’ and ‘*ekikaka*’ began killing Basoga in scores. The District Commissioner’s reports for Busoga over the years under colonial rule were punctuated with unprecedented numbers of deaths never heard of before in Busoga’s history. For example, quarterly reports between 1926 and 1929 indicated frequent outbreaks of malaria, plague (*Kawumpuli*) caused by rats.²⁴⁶ At one time a whole municipal office at Jinja had to be closed due to malaria outbreak. In 1928, the Busoga district commissioner expressed worry of the rampant mosquitoes in Jinja that had made malaria an epidemic in Busoga.²⁴⁷ Yet, in 1927, there had been an outbreak of plague in the areas of Busembatia and Iganga townships.²⁴⁸ The Busoga district annual report for 1918-1919 showed how the natives in the district had contracted influenza and the death rate was very high, though accurate statistics were not available.²⁴⁹ Dr. Major Wiggins’, report to the provincial commissioner over his findings about leprosy in Busoga indicated how the disease’s prevalence had reached uncontrollable levels. He stated:

...I am convinced that it (i.e. the prevalence) is not less than 3%. At present I, have seen over 35000 lepers and the population is approximately 260000 and I do not think I have seen half of them. If as authorities agree, there are two unknown to every known case, then the matter is still more serious.²⁵⁰

In all these, the local women and children were the worst hit. Women, being responsible for the caring of the sick, meant that much more time was needed from them to do this work, yet they still had to undertake subsistence care for the rest of the family members. The cause of the escalation of diseases to epidemic levels was largely due to colonial policies. Many Basoga were recruited to work at government establishments especially in plantations, factories and construction works. This increased mobility in once upon a time stable stationed communities. Railway construction as well as the hydroelectric project demanded many numbers of labourers each month.²⁵¹ In other places of tropical Africa, the story was not any different as the labour movements did not only quicken the spread of diseases but led to disruption of disease ecologies,

²⁴⁶ Uganda National Archives, (1928, 1926, 1927, 1929), Quarterly Reports-Busoga, Z.16 (2).

²⁴⁷ Uganda National Archives, (1928), Quarterly Report-Busoga, Z.16 (2).

²⁴⁸ Uganda National Archives, (1927), September Quarterly Report-Busoga, Z.16 (2).

²⁴⁹ Uganda National Archives, (1919), Busoga District Annual Report-1918-1919. N.146

²⁵⁰ Uganda National Archives, (1929), Medical: leprosy policy and principles: c.1384B

²⁵¹ Uganda National Archives, (1929), Quarterly Reports for the months of June, April, September-Busoga, Z.16 (2).

which eventually turned into epidemics (Dube, 2009:43). The colonial masters were themselves aware of how their labour policies had done much in worsening the prevalence of certain diseases. In a letter written by Uganda's Chief Secretary to his counterpart of Kenya to cooperate towards fighting the epidemic of sleeping sickness, he notes:

...cases of sleeping sickness have recently been diagnosed close to Jinja and flies capable of transmitting the disease are known to exist within a few miles of the site of the Jinja dam, so that it is feared that the influx of labour in the near future for the construction of the hydro-electric project may result in a major outbreak of the disease.²⁵²

The colonial government's policy to encourage cash crop growing at the expense of food crops led to famine around 1918-1919 to levels never witnessed before in Busoga. Famine affected mainly women and children. This was due to colonial policy on cotton growing at the expense of food crops, taking away the men, as they supplied labour in the towns and left grounds untilled for food crop growing. In one of the Provincial Commissioner's report about Busoga in March 1919, he notes:

...a considerable number of deaths have occurred due to famine and people eating wild animals and injurious roots. Deaths have been mostly amongst old people, women and children. In northern Busoga deaths number over 700.²⁵³

This, of course, was disastrous for Busoga. One of the safety nets against disease and illnesses that had traditionally been observed by Basoga was to ensure that their granaries referred to as '*ebyajji*', were full of excess food throughout the year. There were never cases of malnutrition in traditional Busoga. Though women did much of subsistence farming, the men were charged with the duty of breaking the ground where the women would later go to prepare for gardening and subsequent tending of the crops. With the incursion of the whites, men were no more because they had presumably gone to seek greener pastures. They had been supplanted from their homes to go and work in the railway construction and the hydroelectric power projects in Jinja and other industries.

In addition, the emphasis on cotton growing which would bring in money to the families meant that even the few men who remained home concentrated on the growing of cotton to earn an income, while food crop growing was entirely relegated to the women. With reduced labour for food production, famine was eminent and indeed it occurred. The health and well-being of

²⁵² Uganda National Archives, (1950), Letter by Uganda's Chief Secretary; concerning sleeping sickness in Busoga. C.1192

²⁵³ Uganda National Archives, (1918-1919) Monthly reports on Busoga. Z.612.

the Basoga was affected negatively. By 1908, about 4000 locals had died of famine.²⁵⁴ There was change in the ideology of wellness and well-being. With cash crop farming, a man's wellbeing was no longer defined in terms of the amount of food that his family produced, but the amount of the money he minted out of the cotton sale. Only those men who remained cautious about the health and well-being of their families, deserted from the labour conscriptions they were in at the railway construction sites and went back to cultivate during the rainy seasons, but these were few and far in between.²⁵⁵

There was a clear indication that the colonial governments minded little about the well-being and health of the locals. Much interest was in the health of the Europeans in Africa.²⁵⁶ However, I need to mention that the British colonialists should have performed their best for all people during the time they were in charge of administration. The higher numbers of diseased persons and increasing mortality recorded was due to effectiveness of the British in tracing and recording cases of sickness and mortality which was not the case before their arrival. On the contrary, there was no documentation on deaths before the British's arrival in traditional Busoga society since it was illiterate. It may not therefore be sustainable to argue for increasing mortality since we do not have actual statistics for deaths before colonial rule.

None the less, the British are believed to have misinterpreted the role of the men in the overall management of the home. In pursuing their industrialization agenda, the imperialists thought less, if at all, of the families of their labourers. In the monthly report for January 1919 about Busoga, the Provincial Commissioner of the Eastern Province noted that labour in Busoga was very unsatisfactory due to food shortage and the natural desire by natives to cultivate during the rains.²⁵⁷ Indeed there was an increase of illnesses among the children and the women due to the hiring of the men in the government establishments away from their homes.²⁵⁸ Decreased labour supply for the month of January 1919 was attributed to desertion by men returning to their homes to hunt and looking for food for their families because there was much famine and illnesses.²⁵⁹

With most of the men taken to work on colonial projects, it was an impossible task to control the tsetse flies. It was common practice for men to clear the bushes in preparation for

²⁵⁴ Uganda National Archives, (1908), Uganda: Correspondence Relating to famine in the Busoga district of Uganda.C 003

²⁵⁵ Ibid

²⁵⁶ Uganda National Archives, Monthly reports-Busoga 1915-1916. The district Commissioner for Busoga was only interested in reporting about the health of Europeans and Asians, yet the reports were about the whole district of Busoga. This was so for the months of April 1916, March 1916, February 1916, January 1916, December 1915.

²⁵⁷ Ibid

²⁵⁸ Ibid

²⁵⁹ Uganda National Archives, (1919) Provincial Commissioner's Report on Busoga for the month of January 1919. Z.612.

farming. This was exclusively men's work since it required a lot of energy. Without the men, it was difficult for women to keep the vegetation under control. This was the case in most parts of sub-Saharan Africa. For example, in Zimbabwe and Mozambique, Dube (2009:65) noted that when men were taken to work on the colonialists' plantations and in the mines, the women could not readily take over their duties. This led to the reduction in the size of cultivated land as the women concentrated on lands already cleared, rather than clear new lands. The absence of men also meant less labour on the fields, leading to further reduction in cultivated lands. As a result, as the cultivated land shrunk, bush encroached, extending the habitat of the tsetse fly.

The British policies to control the epidemic diseases further undermined traditional healing ideologies. The colonial policy to quarantine the sick was not only alien but also against the Kisoga healing tradition, which obliged community members to visit the sick. Yet illness of one member of the community would imply ill health for the whole community. The establishment of in-patient hospitals robbed the sick free traditional psycho-social support that was mainly the domain of the women. Basoga women were therefore being kicked out of their traditionally socialized role of caring and pampering the sick. The community social support in time of illness was being sidelined, being replaced with the western trained counsellors stationed at the hospitals. The introduction of the biomedical system, which centred on the sick's physical state, neglected the social aspect of the disease as defined in the African setting.

The British rulers' policy of quarantining the sick and the affected, though intended for the common good of the society, worked to undermine traditional methods of psycho-social support.²⁶⁰ Moreover, the colonial policy dealing with disease control only picked on men and neglected women.²⁶¹ The British administrators called on men to be health inspectors in the tsetse fly infested areas and curtail the cutting down of trees in the areas of Bunya County.²⁶² But it ought to be restated that women in most of the African societies, Busoga inclusive, had extensive knowledge of the natural environment. They were gatherers, which meant that their communities depended on them to provide nourishment or they risked starvation. Indigenous African women were custodians of vital knowledge on herbs and medicines that also ensured the survival of their communities (Ofisi, 2010:231).

This eventually led to a changing ideology towards health, with the men rather than the women as the decision makers concerning the health of family members. The policy of burning

²⁶⁰ Uganda National Archives, (1913-1918) Provincial Commissioner's Report on Busoga. Z.612.

²⁶¹ Uganda National Archive, (1927), Busoga District Commissioner's letter dated 4th January 1927. M.12

²⁶² Bunya county currently covers the present district of Mayuge in Busoga

down huts and depopulating areas that had mosquitoes, tsetse flies as well as rats was in effect depriving the Basoga of their Butaka, which was directly linked with their culture and traditions.²⁶³ Much of the traditional medicines were destroyed and burnt as locals were forced to move to camps and other non-infested areas. Cherished articles that were used in the healing processes were lost. The indiscriminate clearing of vegetation led to the diminishing or complete extinction of medicinal plants that were key in checking on female reproductive health diseases and maternity complications. No wonder there was widespread fear among the British colonists that infant and maternal mortality rates were on the increase during their rule.²⁶⁴ Traditional dwelling places (the shrines or amasabo) of divination spirits were destroyed and this impacted on the efficacy of the spirits in divination. Some of the traditional medicine would not easily be acquired as it could only be procured by killing wild animals, rare birds and reptiles. This left the divination work originally dominated by women in ruins, and those women who sanctioned it stripped of powers.

With the traditional health safety nets destroyed, the colonial administration employed selfishly engineered disease control measures. The zeal to control the diseases by the colonial rulers was driven by their desire to have a healthy labour force rather than a healthy population. Indeed, as Dube (2009:1) has highlighted, whereas colonial policies disturbed disease ecologies due to frequent movement of labour, the Europeans were reluctant to curtail these epidemics because health service provision for the natives was driven by economic reasons rather than genuine concerns for Africans' health. A letter written by the Director of Medical Services castigating the introduction of medical charges upon natives justifies this conclusion. He stated the following:

...this is evident to all those who have seen Africans in their homes living unconcerned, in a state of health that cannot be allowed to continue *if we hope for progress to higher production and more wealth.....*²⁶⁵ (emphasis mine)

With this kind of attitude of the Europeans towards the health of Africans, the women were destined for worst times. The fact that European-initiated projects required male labourers, women who did not offer this labour had no opportunity to enjoy the medical treatment that would be offered by the Europeans. Nobody was interested in their health since it would have no bearing on the labour productivity that the colonialists were dearly wishing to maintain. Contrary

²⁶³ Uganda National Archives (1927), Sleeping sickness in Busoga. Z.1268

²⁶⁴ Uganda National Archives, (1925) Native Affairs: Qualified Native Midwives, N.180

²⁶⁵ Uganda National Archives, (1946), Medical Fees charged to Africans. C.570.

to the ideals of western introduced health service delivery, the traditional health care system was aimed at ensuring that the whole community with was devoid of any disease. The approach to control the epidemics by the colonial governments was that control, treatment and prevention should be aimed at curtailing the risk of economic loss that would accrue to the government because of having an unhealthy labour force, rather than significantly aiming to suffocate epidemic resurgence. This is the reason why more women and their children became victim to these epidemics than men. With traditional healing virtually banned, and the men taken away from the villages, coupled with inexperienced methods of managing tropical diseases by Europeans, together with the inequities in the methodologies used to curtail these diseases, it was apparent that epidemics would surge at any time.

4.8 Conclusion

Part of the misunderstanding of the role of African traditional health practitioners (THP) 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 countries. Colonization of African people produced an encounter between traditional medicine and modern medicine which was strongly hinged in Western epistemology and epistemic tendencies. Modern medicine and its knowledge systems was dominating knowledge that under looked traditional medicine. Traditional medicine and its practices were viewed as witchcraft, sign of backwardness and not resonate with rationality. Since that time, all endeavours have been made to denounce traditional healing practices and medicine; and modern medicine became a tool of diagnostic analysis and standard for treating disease and illness. A lingering impression of that colonial illegality still shrouds traditional medicine and THP. In Africa, however, a century of colonialism and cultural imperialism have held back the development of African traditional health care in general and regarding medicines in particular. During several centuries of conquest and invasion, European systems of medicine were introduced by colonizers. Existing African systems were stigmatized and marginalised. Indigenous knowledge systems were denied the chance to systematize and develop. There is no doubt that African traditional health care is a legitimate branch of medicine that has been historically suppressed.

Although colonial powers and structures criticized traditional health care because of its strong spiritual component, they overlooked the fact that for many centuries European and other health care systems also had strong spiritual and religious components. One of the consequences of many years of discrimination and unregulated traditional health care practice has been the

widening of the gap between traditional healers and the practitioners of biomedicine. It should be known that the pre-colonial era witnessed African traditional medicine in its full bloom, as it was part of a people's culture without any alternative or competing medicinal system. Colonial rule, which was indeed a cultural invasion, brought along new 'western culture' of which allopathic or conventional medicine, developed on scientific basis, was an essential component to protect and heal its progenitors primarily and then the colonized people subsequently. As a matter of policy in all colonies, the imported medicinal system was instituted as part and parcel of the government administration with a budget, excluding indigenous medicine completely.