16

Should We 'Modernise' Traditional Medicine?

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Introduction

Traditional medicine plays a big role in the Ugandan health system, and the fact that government is committed to working with this sub sector to ensure good health for the population is a clear reflection of the good leadership the country has had for the last nineteen years. Efforts to bring the 'modern'[1] sector closer to the 'traditional'[2] health sub-sector began as far back as 1993, when reforms in the health sector were introduced. Available evidence suggests that important milestones in the search for a partnership between these two sectors have been reached (Birungi et al. 2001, Ministry of Health 2003, National Health Policy 1999, GoU 1995). Thus, the platform for partnership has been set. However, the form the partnership should take remains a bone of contention. While the government is of the view that this partnership should culminate in the integration of traditional medicine into the overall national health services, a close look at the dynamics in this sub-sector suggest otherwise. Moreover, there is clear evidence that unlike other actors in the private sector whose integration does not present immense bottlenecks, the traditional medicine sub-sector has unique circumstances and qualities that do not easily render it amenable to integration with modern health services, especially in the case of Uganda (Mugisha et al. 2004).

Nationally, the regime's aim at integrating these two sectors has for long been involved in a war of semantics as to what form this partnership should take. While some would prefer 'formalisation', others, want 'collaboration'. In fact, some have even talked of 'co-habitation' and 'co-existence' as if the two sectors have not always co-habited and/or co-existed. Hand in hand with other problems that afflict the country's health sector, the war of semantics on the form of partnership to be pursued has continued and the implications this issue may have on the entire health system are very obvious. In view of the above, this paper presents an alternative approach, which posits granting traditional medicine

practitioners autonomous status, so as to drive the sub-sector towards 'modernisation'. The paper is divided into seven major sections: the introduction and background; the problem; the context of the public-private mix reform process, a critique of the existing model of integration; a review of empirical literature on challenges of integration; the model for the 'modernisation' of traditional medicine and practice, and lastly, conclusions and recommendations for the way forward are suggested. Where possible, the author has tried to capture local political issues pertaining to the sub-sector and how they fit in with the current debate on integration.

Background to the Problem

One third of the world's population still lacks regular access to affordable, modern, essential drugs. Traditional medicine is often the widely available and used alternative (Amai 2002). According to the World Health Organisation (WHO), 'traditional medicine' generally refers to ways of protecting and restoring health that existed before the arrival of modern medicine. 'African traditional medicine' has been conceptualised by the WHO Centre for Health Development as:

> The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing.[3]

Traditional medicine and traditional healers form part of a broader field of study classified by medical anthropologists as ethno-medicine. Ethno-medicine entails a study of the full range and distribution of health-related experience, discourse, knowledge and practice among different strata of the population; the situated meaning the aforementioned have for people at a given historical juncture; transformations in popular health culture and medical systems concordant with social change; and the social relations of health related ideas, behaviours and practices (Nichter 1992).

Traditional medicine therapy includes medication therapies, which involve the use of herbal medicines, animal fats and/or minerals, while non-medication therapies include acupuncture, manual therapy and spiritual therapy (Amai 2002). The Ministry of Health of the Uganda government has categorised traditional medicine practitioners into herbalists, spiritual healers, bone-setters, traditional birth attendants, hydro-therapists, traditional dentists and others. Of late, a number of non-Ugandan traditional medicine systems have been introduced such as Ayurvedic, Reiki, Chiropractic, Homeopathy and Reflexology and those who are involved in these practices are also recognised. However, traditional medicine practitioners do not include people who engage in harmful practices, such as casting of spells and child sacrifice (MoH 2004).

In Africa, up to eighty percent of the population use traditional medicine to meet their health care needs. In sub-Saharan Africa, the ratio of traditional healers

to the population is approximately 1:500, while it is 1:40,000 for medical doctors (Abdol, K. et al. 1994). On the other hand, the ratio of traditional medicine practitioners to the population in Uganda is between 1:200 and 1:400, which significantly contrasts with available trained medical personnel for whom the ratio is 1:20,000 or slightly less (WHO 2001). These ratios underscore the importance of traditional medicine in the overall health care delivery system. However, compared to other parts of the world such as China where up to forty percent of both modern and traditional health care has been integrated, (Hesketh and Zhu 1997), traditional medicine in Uganda is still largely operating independently of the modern health services.

The government of Uganda formally recognised the importance of traditional medicine way back in 1997 when it initiated a project to integrate[4] it in national health services as part of the public-private partnership in health approach (PPPH)[5] (MoH 2004, MoH 1999, HSSP 2000). Through the public-private partnership, government aims at providing an enabling environment that allows for effective coordination of efforts among all partners, increase efficiency in resource allocation, achieve equity in the distribution of available resources for health, improve quality, ensure sustainability of health services and increases effective access by all Ugandans to essential health care. For this, a sector-wide approach (SWAP) has been adopted in which a common framework for health sector planning, budgeting, disbursement, programme management, support supervision, accounting, reporting, monitoring and evaluation is used according to agreed national development objectives and the main strategies for attaining them (MoH 2004). Strengthening the collaboration and partnership between the public and private sector in health is an important guiding principle of the National Health Policy of 1999.

Traditional medicine is gaining popularity in the country because it is easily accessible, affordable, sometimes free and there is a strong belief in its curative effect (Amai 2002).[6] Elsewhere, efforts to enhance collaboration between modern health services and traditional medicine are based on the fact that traditional medicine provides client-centred, personalised health care that is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient. Traditional healers are culturally close to clients, which facilitates communication about disease and related social issues (UNAIDS 2000).

Despite all these efforts and recognition of its importance, traditional medicine has not fully been integrated into national health services and for some, it is even doubtful that the model of integration being pursued will yield the anticipated results.

The Context of the Public–Private Reform Process in Uganda

Before tackling the challenges of integrating traditional medicine into modern health services, it is warranted to comment on the context of the public-private partnership. Several factors have interacted in Uganda to present a complex context

for a public-private partnership policy to evolve in. These factors include the dynamic changes that are ongoing in the health care system such as decentralisation, the weak revenue generating capacity of the public sector, and the breakdown of public health services. These factors were in turn a result of the following landmarks in the history of the country in general and the sector in particular: (i) political upheavals the country experienced in the years after independence up to the 1980s, which had profound implications for the health sector such as declining government expenditure on health care delivery, poor management, planning, control and massive brain drain from the health sector. These effects ultimately led to the proliferation of private profit-oriented health care providers who lacked regulation. Lack of proper management in the sector also culminated in the informalisation of public health care services and loss of public confidence in the system (Obbo 1991, Munene 1992, Birungi 1994, as reported in Birungi 2001), (ii) the establishment of a referral health institutional framework predominantly based on provision of curative health care, without corresponding capacity building measures for its management and staffing, also after independence; and (iii) the debilitating effects of the structural adjustment programmes of the international finance institutions, which further reduced government spending on health.

These problems led to the decline in public health care delivery in the country and encouraged the emergence of a weak but increasingly important private sector. The private sector that emerged was weak because it lacked any standards, had no policy to regulate its practice and was poorly funded. On the other hand, the sector was becoming increasingly important because it was providing a large percentage of curative health services compared to the public sector (Hutchison 1998). The private sector is composed, as already seen, by many actors, some of who were licensed and recognised by the government, while others were not licensed, but appreciated and legitimised by the communities. Despite the significant role played by the private sector, it remained isolated from district/national planning and information until recently - there were no programmes, official subsidies or incentives to influence the direction of private practice, and the relationship between government and the private sector was one of isolation interspersed with attempts at regulation and control (Birungi et al. 2001).

The Problem

Although the policy on public-private partnership is still in draft form, the public-private partnership approach to governance of the health sector in Uganda has been ongoing for some years. A partnership between the public and private sectors, which is deeply entrenched in the National Health Policy and the Health Sector Strategic Plan, is manifested in financial assistance, technical support, supervision and regulatory mechanisms, among others. While some actors in the private sector, notably the Private Not For Profit and Private Health Providers, have to a large extent been integrated (the above mentioned areas of collaboration affect these

actors); traditional health practitioners are largely operating independently of the other actors in health delivery. Efforts to bring them on board have at best been implemented half-heartedly; they are still ridiculed, despised and treated with much cynicism.[7] Coupled with political interference and lack of support from outside the sub-sector, infighting, and the absence of meaningful involvement of traditional medicine practitioners in policy formulation has taken place, nursing some doubt as to how integration will be possible (Birungi et al. 2001).

The existing policy framework does not adequately acknowledge the diversity of traditional medicine, which, in fact is both heterogeneous and monolithic, that is, while there are different cultural groups and different cultural notions of healing, traditional medicine is a unique system of health care.[8] Traditional medicine has, as a result, remained fragmented, polarized and 'under developed', with serious negative implications for its future. This situation raises a number of fundamental questions, which this paper endeavours to address: (i) Is the existing model of integration relevant and applicable to traditional medicine and practice in Uganda? (ii) What are the challenges of trying to bring together modern and traditional medicine systems using the existing model of integration? (iii) Should we 'modernise' traditional medicine so as to make it more acceptable and competitive vis-à-vis modern medicine? (iv) What model of 'modernisation' is relevant in the prevailing context? Based on this analysis, solutions, which explore how traditional medicine and practice can be 'modernised' so as to make them acceptable to those who ridicule and undermine them on the one hand, and those who wrest life and a living from them on the other, are considered.

A Critique of the Existing Model of Integration

The current model of integration purportedly aims at bringing all stakeholders into national health services by providing an enabling environment that allows for effective coordination of efforts among all partners, increases efficiency in resource allocation, achieves equity in the distribution of available resources for health, improves quality, ensures sustainability of health services and increases effective access by all Ugandans to essential health care. However for this to succeed, an effective regulatory and institutional framework through which the various actors can collaborate is necessary.

Over the years, such a regulatory and institutional framework has evolved, although its content does not favour participation by all stakeholders in health and goes against the grain of some, particularly those in the traditional medicine sub-sector. The current regulatory framework does not consider the unique nature and diversity of traditional medicine. For instance almost every ethnic group in Uganda practices a particular form of traditional medicine, deeply entrenched in its cultural past and indigenous knowledge systems, but the current model of integration ignores this fact. Therefore the issue of standardisation becomes a daunting task, if not impossible, within the framework of integration and partnership being pursued in the country.

The question of who controls or regulates whom remains a big challenge to integration, given the fact that the values, philosophies and practices of modern and traditional medicine are in direct contrast with each other. Trying to regulate traditional medicine using the standards and principles of western medicine is a fundamental flaw in the existing framework and will not achieve its intended goals. According to the Secretary General of the National Council of Traditional Healers and Herbalists Associations (NACOTHA), in a workshop held in Kampala, the issue at hand is that those that are pursuing the current model of integration have:

> ... mixed cultural issues with religion. Cultural issues should not be mixed with religion or modern science. People should leave traditional medicine practitioners to explain these issues. For example, not everyone can explain things like 'ejjembe'[9] or 'emizimu'.[10] While these things are considered horrible, they are not necessarily bad as they are portrayed.

It seems from the above that efforts to incorporate traditional medicine into the cultural hegemony of western medicine will not be the best way forward for developing the sub-sector. Already, there is vehement opposition from practitioners to any attempts to streamline their practices into the fold of western medicine. Practitioners who attended a workshop held in Masindi town highlighted the extent of disagreement thus:

> This belief has taken long. It stems from colonialism. It was brought by the whites. They are the ones who branded everything African satanic. That is why our medicine is not developed, that is why we do not cooperate with modern practitioners. They emphasise tablets, but we insist on herbs and spiritual healing.

Although still in the doldrums, the public-private partnership has evolved in a reformed regulatory environment, which began in 1993, with the updating of the Uganda Pharmacy and Drug Act of 1970. These regulations have been reviewed relative to the private sector, and in a bid to increase its participation in health care delivery. In 1993, the National Drug Policy and Statute was passed, followed by the adoption of three professional bills in 1996 (now acts): the Uganda Dental Practitioners Bill, the Uganda Nurses and Midwives Bill, and the Allied Health Workers Professional Bill. The bills established for each category of health workers, a council - a public body to regulate and exercise general supervision and control over professionals and other provisions (Birungi, et al. 2001). However, this regulatory framework affects only health professionals in the public and 'formal' private sectors, but not traditional medicine practitioners. Failure to have an institutional and legal framework for traditional medicine means that it is difficult to regulate traditional medicine from the point of view of modern medicine, since the actors in this sector do not appreciate the dynamics of traditional medicine.

Other weaknesses in this regulatory framework have been raised by Birungi et al. (2001) and seem to emphasise the fact that the laws relating to traditional medicine and practice are old, archaic and have been overtaken by "events on the ground". Existing regulations treat traditional medicine practitioners as actors who are supposedly involved in wrong practices and must be controlled in the public interest. In an earlier study conducted in Kasese and Masindi districts (Mugisha et al. 2004), the views of the District Community Development Officer revealed the stark reality and extent to which traditional medicine practice is held in contempt. He noted thus:

> They have an association, which is not run well because these are illiterates. They are also recognised nationally. Given the support they have nationally, they would be strong, but sometimes, their activities undermine their strength, because some mix traditional healing with witchcraft. They would influence events because people believe in them, but poor management undermines them.

Thus, traditional medicine practitioners are very suspicious and sceptical of the intentions of public officials who have often victimised them. With this scenario, it is difficult to see how the much hyped partnership can work.

While collaboration between the public and private sectors has been ongoing, there is a lack of a comprehensive institutional framework enshrining this partnership in all matters of health service delivery such as planning, decision-making and resource mobilisation. In the present situation, the Ministry of Health is responsible for formulation, coordination and implementation of the national health policy, while districts, through the district health teams, implement policy and plan district health services. There is only a limited role played by 'formal' private sector actors through the expanded district health management teams, but not traditional practitioners.

Failure to not only consult but also provide for traditional medicine practitioners in these institutions at the district level means that big gaps exist, which could have strategic implications for the implementation of the partnership. Traditional medicine practitioners may oppose such structures, not because they do not want them but simply because they were not privy to their establishment and the fact that they do not cater for their interests. No wonder during workshops in Kampala and Masindi, practitioners expressed total disagreement with the proposed structures in the envisaged dispensation that will govern the sector. For example, members and the leadership of NACOTHA were of the view that instead of establishing a new council to oversee progress towards integration, their council should be formally empowered to take leadership through an act of parliament or be institutionalised in the policy being formulated.

Although traditional medicine practitioners have been encouraged to form associations and institutions through which they can articulate their interests, it appears these associations were not organised with regard to their terms and conditions. As has been the case in the past, government in collaboration with key

individuals in this sector set the agenda on which these associations and institutions were hastily organised, 'supposedly to start benefiting from the new partnership that was going to evolve'. The associations did not evolve as indigenous people's organisations/associations with a local agenda aimed at improving the lives of members. There is no doubt that the majority of the traditional practitioners have shunned them, and those who operate within their framework do so out of necessity but not choice. Commenting on the need for locally initiated people's organisations, one of the participants in the workshop held in Masindi had this to say:

> When I was a teacher, we had a teachers' association. We would ask for salary increment and get it, but if we are not united as traditional medicine practitioners through an association, be it Kamengo, Uganda herbalists association or... we need to make an association whether we like it or not. We must unite and have objectives. How can we be assisted unless we are one?

Despite calls for unity made by some practitioners, it seemed as though others were sceptical about the intentions of the leaders of local associations. Local associations were said to have evolved into money-making ventures and extortion machines and their original aim of forging unity seemed to have been eroded. According to practitioners who took part in the workshop that was held in Masindi, 'There is a power struggle in the association (Uganda n'edagala lyayo). So this results in exploitation, whereby leaders connive with local defence force personnel to extort money from practitioners. A person may be asked to pay license fees for all the years he has operated as a TM practitioner at once'.

An important challenge posed by all these developments is the question of intellectual property rights that has taken centre-stage in the new development paradigm of promoting indigenous people's knowledge. In its document on the 'Protection of the Heritage of Indigenous Peoples', the United Nations Commission for Human Rights notes that industrial property laws only protect 'new' knowledge and that 'old' knowledge like herbal remedies that have been used for ages, may not be regarded as patentable. In yet another twist to the problem, delegates at the Nairobi conference argued that the following problems may impede the patenting of some traditional medicines: regional specificity and short duration of the patent rights, the issue of bio-piracy, the lack of official recognition of community rights (as distinct from those of an individual applicant), and the lack of emphasis on availability and access of local communities to medicinal plant resources (Richter 2003).

Based on historical precedents, and mistrust and suspicion of governments' intentions, traditional medicine practitioners are very sceptical of divulging their sources of knowledge, documenting it and sharing it. They fear (and with reason too) that once they divulge their knowledge and practices, the government would turn it into a gold mine for the modern physicians who consider them conservative, subjective, backward and unscientific. Practitioners, in the workshops held in

Kampala and Masindi, succinctly and emphatically argued for protection and granting of property rights to them for their products.

> If I take my herbal drug for testing, my name should be inscribed on it. If it is approved, I should be able to benefit from it. People have drugs, even those that can cure cancer. But they need to be given property rights or at least benefit twenty per cent from them.

Traditional healers also thought that their knowledge is worth being protected since it has withstood the test of time, having been passed on from generation to generation. In addition, it has allegedly been used to cure different ailments, even some that have proved a menace for western medicine such as cancer. The challenge then is to find ways through which indigenous people's intellectual property rights can be safeguarded, since in the absence of economic capital, their knowledge is the only pillar of refuge to lean on.

From the foregoing observations, it is evident that the model of integration being pursued by the Ministry of Health is not relevant and applicable to the development of traditional medicine and practice in Uganda. In the circumstances, it is not rash to propose that the Ministry consider another way of bringing traditional practitioners into the main fold of health service delivery in Uganda.

Some Empirical Evidence on the Challenges of Integrating Modern and Traditional Medicine

The experiences of integrating the public and private sectors in national health service delivery are many, and they manifest great differences in different parts of the world. However, they are even more problematic when we consider the traditional medicine sub-sector. For instance Birungi et al. (2001), from whom this paper has borrowed considerably, conclude thus: "[T]here has been no policy dialogue between policy makers, consumers and informal providers. Yet the latter constitute a significant source of care for both rural and urban poor.... while communities recognise and appreciate such providers, authorities continue to blame and ridicule them. By failing to recognise and consult with this category of provider, the integration policy seems not to be interacting, or catching up, with some of the realities of the Ugandan health care system'.

Boerma and Baya (1990) in *World Health Organisation Centre for Health Development* (2002) have noted that before commencing collaborative effort in health care between modern and traditional sectors, a careful assessment of potential benefits and obstacles should be made. The medical services utilisation patterns of the communities need to be ascertained and the specific role of the traditional health practitioners considered. In such efforts, the ideas of healers themselves about possible collaboration are crucial. Chi (1994) in WHO (2002) outlined six recommendations for effective integration. They are: promotion of communication and mutual understanding among different medical systems that exist in a society; evaluation of traditional medicine in its totality; integration at the theoretical

and practical levels; equitable distribution of resources between traditional and modern western medicine; an integrated training and educational programme for both traditional and modern western medicine; and a national drug policy that includes traditional drugs.

Planning for the formalisation of traditional health services has many dimensions that need to be addressed, depending on the state of current sectoral development, level of political will, budget resources available, training infrastructure, the model of formalisation suitable to and preferred by the country, and the traditional health care community. It has been argued that underlying the general proposition for a mix of traditional and modern medicine is an agenda of incorporating the former into the political economic arena and cultural hegemony of bio-medicine (Morsy 1990, cited in Kagwanja 1997, also cited in WHO 2002). Clearly, if traditional medicine is to be given a formal place in national health care, this process needs to be done not only in close consultation with the traditional health sector, but taking direction from it as to appropriate models of partnership, formalisation and training.

A challenge to integrated health care is the need to conduct research to determine which illnesses are best treated through one approach rather than the other. In a study conducted in Zheijang, China, it was reported that simultaneous use of modern and traditional treatment is so commonplace that their individual contributions are hard to assess. Research to disaggregate the contributions of each medical system, in traditional medicine itself, and its integration is therefore, crucial (WHO 2002).

According to Chaudhury (1997), it is generally recognised that the regulation of traditional systems of medicine, the products used in these systems, and the practitioners of these systems, are weak in most countries. This leads to the misuse of the medicines by unqualified practitioners and loss in the credibility of the system. In traditional medicine, practitioners and manufacturers (particularly small ones) usually oppose any steps to strengthen regulation by health administration. Their fears are that regulation as applied to allopathic medicine is not suitable for traditional medicine and may stifle the ancient systems of medicine. Thus, they need to step up the systems themselves.

Important challenges to the integration of the two systems of medicine are the power differentials that occur after integration. Van Kirk, (1993) and Moffat and Herring (1999) as cited in Letendre (2002) have alluded to issues of a racial paradigm in relation to the health needs of the Aborigines of Canada and the fact that traditional medicine remains subject to the policies and regulations of Health and Welfare Canada. Western medicine has continuously demanded legitimisation from any other system of medicine and to see the scientific basis of medical care of the aborigines. The method of systematic recording of knowledge is in direct opposition to the philosophies of traditional medicine (Morse et al. 1991, Reynolds 1997, Shestowiski 1993 as cited in Letendre 2002). Furthermore, the complex structure of today's economic and political climate emphasises that

accountability be outlined in measurable terms in line with the philosophies of western medicine, which conflict with traditional medicine.

A fundamental problem to integration is the way the two systems conceptualise illness prevention. While western medicine develops large programmes for illness prevention based on its medical models, and participates in activities directed toward this goal, this system is incompatible with that of traditional medicine. Traditional medicine emphasises the prevention of illness, but it is not known how traditional healers engage in this activity. For instance, among the Aborigines, illness prevention is not a meaningful concept; on the other hand, western medicine encourages patients to come for regular checkups to ensure normality (Morse et al. 1991 as cited in Letendre 2002).

Others (Myat 2004) have pointed to the disruption of traditional medicine systems by the colonialists and differences ingrained in the values and philosophies of the two models of health care. While traditional medicine approaches disease from a holistic point of view, taking into consideration multiple causal factors for a particular disease, modern medicine is disease oriented. In addition, traditional medicine practice encourages a close relationship between physicians and patient, which may not always be the case with modern medicine.

Should We 'Modernise' Traditional Medicine?

The response to the question posed by this paper is as daunting as understanding the dynamics and processes of traditional medicine and practice. However, to break the ice, this paper will take a firm but cautious path to discussing the issues at hand. The concept of 'modernisation' is not to be understood in its literal sense; instead, it is to be given a contextual meaning that implies a desire to reinforce the position of traditional medicine practitioners by granting them autonomy to develop their own knowledge systems, practices, capacities and capabilities through training, documentation, regulation, peer evaluation and monitoring systems, in the light of the diversity and unique circumstances that most practitioners find themselves in.

Conceptual Framework

This paper posits two sub-sectors within national health services - the modern (sector) and traditional medicine (sub-sector). Traditional health practices are grounded in the social and cultural milieu of the societies in which they are uniquely practised; in the beliefs, norms, values and healing philosophies of particular societies. On the other hand, the link between modern health services and socio-cultural context, especially in Africa and other continents where traditional medicine is very central to health care, is weak. In addition, the link between the two sectors, although vital, is also weak. Yet, for meaningful integration to take place, the relationship between government and the traditional sector, through the modern health sector, must be strengthened. Practitioners who took part in the study

conducted in Masindi and Kampala argued that failure by government to popularise traditional medicine before crafting the National Health Policy was a glitch in the policy making process. Increasing knowledge and pledging support for the sector, they argued, could have increased its legitimacy as a knowledge system and healing practice. Besides, there are several outstanding challenges that stand in the way of meaningful integration (as reviewed in the previous two sections of this paper). For this reason, the paper proposes a new model, a new way of looking at the issue of cooperation between the traditional and modern health sectors - that of granting autonomy to traditional medicine practitioners to develop a future for the sector.

The new model - the model of 'modernisation' - is based partly on the challenges to integration referred to above, and on the desire to allow traditional medicine to grow as an independent system of healing with a unique and culturally relevant knowledge base and practice. However, it presupposes an active traditional medicine sector interested in cooperation with other actors not only in the health sector, but also other sectors of the economy (since health cuts across all sectors). This means that any efforts to improve it must take cognizance of this fact. 'Modernisation' of the traditional medicine sub-sector also implies that there will be an improvement in other sectors of the economy, in view of the linkages between health and other sectors. However, to 'modernise' the traditional medicine sub-sector requires that the actors (practitioners) in it take centre-stage, design the agenda and execute it themselves.

A model that seeks to 'modernise' traditional medicine within its context forsakes negative stereotypes that portray traditional medicine practitioners as backward, conservative and unscientific. It conceives healers as masters in their own field, and as individuals, groups and actors who have something to contribute to the development agenda. Therefore, to 'modernise' traditional medicine and practice requires efforts that increase practitioners' sensitivity to their place in the development agenda and health care, given the specific milieu of their communities.

This paper argues that to grant autonomy to traditional medicine practitioners, the village should be taken as a microcosm on which higher societal level organisation of the sub-sector should be based. This is because most of the key social processes on which traditional medicine practice are based stem from the way of life in the village. What may be observed at higher levels of social organisation may significantly differ from what takes place at the village level. Therefore if autonomy were to be granted, then the most appropriate starting level would be the village. In terms of operationalising the model, the following is proposed:

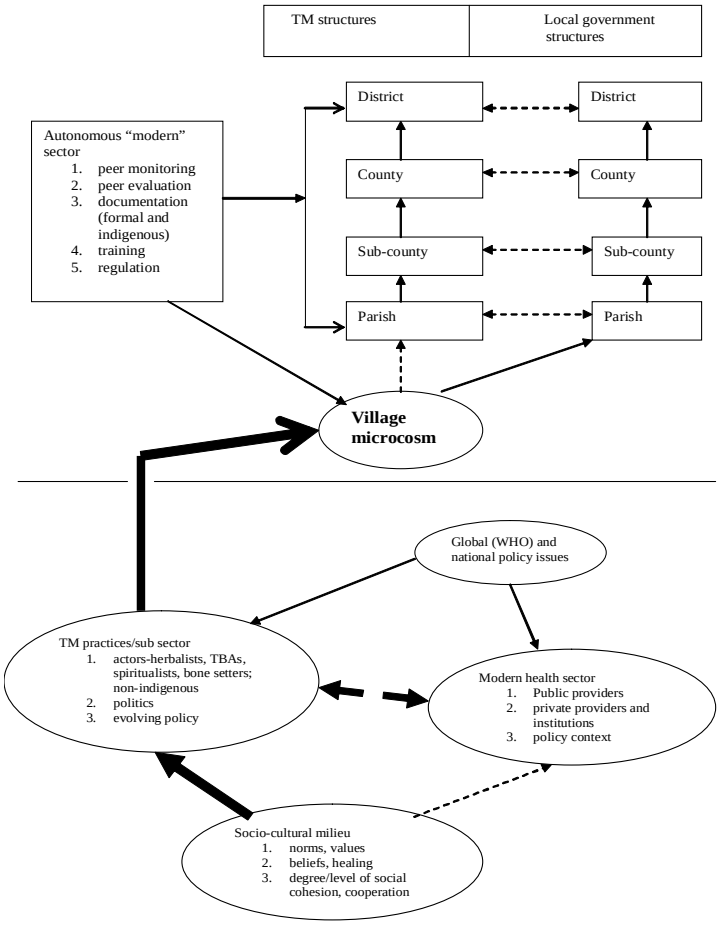
- A village in any district of the country could be selected as a pilot, and a specific area or 'speciality' of traditional medicine such as bone-setting selected. This would enable testing of the idea of autonomy for the 'modernisation' of traditional medicine. Although the idea of autonomy is emphasised, according to practitioners with whom the author had long

discussions, it would work well within the general framework of the National Health Policy, a policy on traditional medicine and under stewardship of the Ministry of Health.[11] Autonomy is simply to evolve local solutions for local problems without much outside interference and programming - to give the practitioners a voice.

- An independent civil society organisation, preferably a local community-based organisation rather than government, could take on the onus of mobilising the bone-setters and initiate an association/network of bone-setters in that village. However, once the association takes off, this organisation could leave it to take its course and only make available its human resources for consultation.
- Through the network or association, the bone-setters could discuss issues pertaining to their practice so as to gain common ground of the similarities and peculiarities in their practice. The network would also act as a forum for setting an agenda for training, reporting, information dissemination, documentation of practices, evaluation, monitoring, research and development and regulation, which are the major components of this model. However, efforts must be expended to ensure that all these aspects of the 'modernisation' project of traditional medicine practice are as indigenous as possible, springing from the cultural milieu of the society, such as the sanctions, normative regulations and belief systems.
- A system of financing the activities of this association could be designed in such a way that the members of the association through their earnings finance the core activities of the network/association so created. Moreover, once the itinerary of the so-called modern world such as fancy cars and complicated gadgets are not built into the system from the beginning, the desire for resources to acquire such things does not arise and cannot be used as a basis for frustrating activities of the practitioners. The resources collected from the members can jointly be managed for the common good, like many local associations are doing.

In terms of political organisation, once this initial experimental group succeeds, there would be an opportunity for other groups to succeed too. It is therefore argued that for full scale 'modernisation' to take place, there would be need to horizontally and vertically scale up the model by encouraging similar associations to blossom at parish, sub-county, county and district levels and in other forms of traditional practice. It is envisaged that this model would, in terms of such organisation, replicate so fast since the country is already politically organised at the said levels. Therefore, traditional medicine structures would simply run parallel to formal local government structures as shown in the conceptual diagram.

Conceptual Diagram



The proposed system of political organisation of the traditional medicine sector already exists within NACOTHA - one of the national umbrella organisations of traditional medicine (although yet to be formally recognised in the new dispensation). Therefore, these could be adopted in whole or with modification to please those who feel that NACOTHA is not legitimate.[12] From the structure of NACOTHA, it is evident that practitioners are capable of organising themselves

and that they have already made important strides in the direction of autonomy. Probably what is needed (and as they rightly argue) is a policy within whose context autonomy could be operationalised. Thus the words of the Secretary General, NACOTHA become instructive in concretising our idea of autonomy. He said: 'We did all this without any support in terms of funding, we were self sustaining... we need support through a law and funding'. Therefore, autonomy is possible, since with minimal resources, practitioners were able to achieve a high level of organisation (in terms of establishing necessary governance structures).

Although the model may appear utopian at first sight, there is need to pay very close attention to its underlying arguments which include views on the role traditional practitioners play in health care delivery, cultural sensitivity, contextual relevance, emphasis on diversity and the centrality owed to traditional practitioners in solving their own problems. In the final analysis, the idea is to have a national movement of traditional medicine practitioners' associations/networks whose bargaining powers are greatly enhanced, whose practices and processes of health care delivery are improved through systematisation, and whose initiative to participate in development is bolstered, not by anybody but by and for the practitioners themselves.

The Main Tenets of the 'Modernisation' Model

(a) Autonomy

As mentioned above, it is envisaged that granting autonomy to traditional medicine practitioners would increase their self-awareness, highlight their central role in society, and enable them to exercise their rights as traditional practitioners and citizens. Autonomy would enable them to develop structures and institutions through which they could govern themselves and chart a path for their future. Through these structures, practitioners could confront issues of regulation and enforcement of the regulations that have proved to be a nightmare for the public health officials.

The model of 'modernisation' that this paper posits and whose central concept is autonomy is grounded (through this concept) in the contribution of Foucault to our understanding of government. To him, government is 'conduct of conduct'. However, the idea of autonomy encapsulates related ideas of self-policing, self-management and self-governance. However, government or 'conduct of conduct' can be seen in different perspectives. Borrowing from Foucault, this author takes the perspective of government as an ethical and moral enterprise. Thus autonomy, or self-government, becomes an ethical and moral endeavour on the part of traditional medicine practitioners concerned with the form of direction appropriate to their trade. Morality is understood as the attempt to make oneself accountable for one's own actions, or as a practice in which human beings take their own conduct to be subject to self-regulation.

To grant autonomy to traditional practitioners is to accept that there is a peculiar rationality surrounding the domain of traditional medicine, which only the

traditional practitioners can exercise in their 'conduct of conduct'. Granting them autonomy is like giving them a stick to police and discipline themselves, which is opposed to the existing model of partnership where the public officials, through their own lens, are trying to govern traditional medicine and practice.

Governance of traditional medicine practice needs to go beyond individual conceptualisation of self-governance, to the governance of a society[13] - that is, there is movement from the governance of a multitude to the governance of a society and community - a society of traditional medicine practitioners. The idea is to have traditional medicine governed, but governed outside the public realm. This is because in the past the public officials have always emasculated the sector and demeaned it, regardless of the fact that it plays a crucial role in health care delivery.[14]

Granting autonomy to traditional medicine practitioners would have a number of advantages including the following: (i) it would not only enable them to govern themselves and channel their energies to improving their lot, but would also reduce their fear of being swallowed up, fear that has characterised interaction amongst themselves and between them and modern health services in the country to date. Commenting on the above, in the study conducted in Masindi and Kampala, practitioners cited power struggles, the politicisation of local associations, exploitation and connivance with local political leaders to extort money from them as key problems facing the sub-sector:

> The reason why TM is not developed stems from our associations. For example 'Uganda n'edagala lyayo' is like a political party. For one to stand for the post of chairperson, he has to use a lot of money. You must therefore recoup your expenses once you are voted into power. So you go to a computer person and make forms, which you sell expensively and arrest those who do not buy.

Self governance and autonomy through structures created by the practitioners themselves will help increase the bargaining power of the practitioners and predispose them well to constructively engage with government which has further advantages such as gaining a political niche, representation in national decision-making (parliament and executive), and lobbying, so as to increase resources going to the sector.

However, since autonomy cannot be secured while the sector is still fragmented, the starting point is mobilisation and organisation within the sector via the creation of local structures and institutions. Practitioners who took part in the studies conducted in Masindi and Kasese and Masindi and Kampala in 2004 and 2005 respectively strongly supported the formation of local associations of practitioners. For example in the first study, it was noted thus:

> If we can have a recognised association through which we can pass on our proposals, then the better, but today you find the assistance got is given to individuals... and if funding is given, it should not pass through our district because the officials there are corrupt, we can't get the assistance.

During the second study practitioners called for the formation of both local and umbrella organisations bringing together traditional medicine practitioners. The contributions of one participant are noted:

> We need to be one, just like a finger. You cannot split it. We were behind some years back, but when Museveni came - who depended on herbs during the war - he remembered us. I am asking that we get one way, one umbrella, one association of Masindi.

Therefore autonomy as envisaged in this model requires a number of pre-conditions and cannot be obtained cheaply. Rather, together with government, actors in both traditional and modern health sectors need to abandon hitherto cherished philosophical, colonial and practice oriented notions that provide the platform for the marginalisation of traditional medicine. But above all, lack of unity and infighting amongst practitioners, which strongly undermine them, need to be addressed urgently.

(b) Training

The 'modernisation' of traditional medicine will remain a wish unless training to improve traditional knowledge systems, practices, capacities and capabilities is carried out. While there is wide diversity in traditional medicine and practices in different parts of the country, it is still possible to undertake training in the different communities where traditional medicine is practiced. The need for training becomes more crucial given the fact that due to changes occurring in different countries, the young have increasingly migrated to the cities, leaving the old and infirm in the rural areas. The majority of the existing traditional medicine practitioners are aging and are likely to go to their graves with their knowledge. Capturing this knowledge before it is lost is very important and can be done only by those who own it. The million-dollar question is how this is to be done. How incentives are to be created to convince the old generation that their knowledge will not be 'stolen' and how to interest the young generation in a form of medicine that many consider archaic? Training is important also because of the need to create a critical mass of traditional medicine practitioners that can meaningfully engage with government and other actors in the health sector.

Training of traditional medicine practitioners could involve identifying diseases that can be effectively cured by traditional medicine, so as to avoid making traditional medicine appear to be a panacea for all illnesses. This would not only help to focus the activities of traditional medicine practitioners, but would also help in the development of knowledge systems and practices around these illnesses and develop comparative advantages in their management. Where there are national chemotherapeutic laboratories as in the case of Uganda, creating strong linkages between these laboratories and various institutions of traditional medicine practitioners would enhance training, research and development of appropriate cures for illnesses. Through such linkages, a national healing system based on traditional medicine is likely to evolve making actors in the traditional sector even

more crucial and central in national health systems. However, for collaborative efforts between practitioners and national laboratories to succeed, practitioners should be assured of direct benefit from their products.

(c) Documentation

Probably one of the major weaknesses of traditional medicine in Africa and other parts of the developing world is that it is not documented. Evidence from countries such as China and India points to the fact that for traditional medicine to gain status in national health services, it must be documented. Documentation has a number of advantages, including making practices of traditional healers available for future generations, dispelling the false and imperialistic notions that traditional medicine is not scientific, showing evidence of the efficacy of traditional medicines and systematising the discourse. To date most of the traditional medicine practices in Africa in general and Uganda in particular are not documented. Accordingly, the Uganda National Council of Science and Technology (UNCST) in its draft Indigenous Knowledge Bill noted thus:

> ... whereas a traditional birth attendant may keep her record by tying knots around her waist, other people may not easily understand this form of record keeping. As a result of this, many IK bearers are dying with vital IK that could be useful in national development. Inadequate documentation of IK is attributed to secretive practice and low levels of education (illiteracy) of the practitioners (UNCST 2004:7).

However, it should be noted that some physicians such as Dr Jjukko trained in modern medicine in Uganda have crossed over to traditional medicine, and together with other colleagues have started documenting traditional medicine and its practice.[15]

It is important to note though, that for training and documentation to be possible, there is a need to offer basic education skills of writing and numeracy to practitioners for developing and systematising indigenous knowledge systems. In the case of Uganda, adult literacy education is a well developed and well supported aspect of the education sector from which traditional medicine practitioners can benefit.

(d) Peer Evaluation, Monitoring and Regulation

Pertinent in the agenda to 'modernise' traditional medicine are issues of monitoring, evaluation and regulation, which are very important to maintain standards and gauge whether practitioners are doing what they ought to be doing and how well they are doing it. The questions that arise from pondering these issues are: what is to be monitored, evaluated and regulated, who is to monitor, evaluate and regulate whom? How are evaluation, monitoring and regulation to be accomplished? Where are the evaluated, monitored and regulated to be found? These questions are both difficult and easy to answer; difficult because the traditional medicine project is very amorphous, but easy to answer because the project has its own experts.

Peer evaluation, monitoring and regulation may involve a one-on-one stewardship by actors in the traditional medicine sub-sector. The concept of stewardship is taken as an extension of the way that not only governments must be responsible for the welfare of the population, but also how individuals become responsible for the guidance, leadership, and direction of their peers. While this may not have direct welfare implications as in the case of government responsibility for its citizens, it may have serious consequences for the conduct of daily business, enhancing legitimacy, transparency and reinforcing the social contract. Through stewardship, traditional medicine practitioners may have the capacity to exert influence on each other, shape individual behaviour and restrain insatiable private desires that may threaten the practice of traditional medicine.

Unfortunately, stewardship in Africa is biased towards bio-medical systems as if these are the be-all and end-all of health care on the continent. Stewardship as deployed here gains its basis from the deeply entrenched though fast eroding African traditions. Such traditions could bolster a regulatory framework that would evolve into a situation where traditional medicine practitioners are granted autonomy. For example, in a locality such as a village, all practitioners involved in a certain specialty like traditional birthing could organise themselves into a network, choose their leaders, set standards of practice and regulations, and put in place a reporting system (for example, of the condition of their clients, births undertaken, problems encountered, colleagues defaulting etc.). Then a high premium for defaulting, bad practice, incompetence and reneging on the network springing from the cultural milieu of the society could be set. Compliance with such regulations could be secured through the deployment of the time-tested and strict negative social sanctions that are still relevant in many societies such as blacklisting, ostracism, and ridicule through songs. These social control mechanisms may not only make one an enemy of the people, but they could also threaten his or her citizenship and in all likelihood would be respected.

However, evaluation and monitoring as understood conventionally are difficult, if not impossible to achieve with traditional medicine and practice, because of the diversity of traditional medicine and the lack of initially set programme goals and objectives as may be the case with, for example, Early Childhood and Nutrition Programmes that are implemented in the modern health sector. Probably one way would be to have practitioners identify common practices related to certain illnesses in a particular cultural setting and evolve standards for these practices based on their values and philosophy. An objective way of assessing compliance to these standards could then be easily designed from which socially institutionalised monitoring and evaluation could be undertaken. Whatever the line of argument one may take, the most important aspects to keep in mind are the values of traditional medicine and practice, its philosophy, the cultural values, attitudes of social responsibility, and peer influence that traditional practitioners hold and how these can be translated into meaningful efforts on the ground.

Shortcomings of this Model

The question posed at the beginning of whether to 'modernise' traditional medicine, seems to linger on even after espousing a model that aims at empowering traditional medicine practitioners. The main challenge this 'modernisation' model faces, which raises new research questions, is how to control an informal sector that might develop in a 'modernised' traditional sector. The fear is that some actors who may not wish to be bound by a moral responsibility to fellow practitioners and their clientele might withdraw to the underworld where they will continue practising or even engage in harmful practices that may threaten the lives of their clients.

Another challenge relates to how the sector can be linked with other actors in health without necessarily jeopardising the autonomy and eroding the gains that would have been made. This is a particularly thorny issue that may need protracted negotiation; otherwise, the government may find it difficult to relinquish all manner of regulation of the activities of the sector to actors in that very sector. Sensing this, some traditional practitioners with whom the researcher interacted in Kampala suggested that the question of regulation was one to be handled by both government and the leadership of the practitioners. They argued for example that in the proposed bill, which provides for a practitioners board, bye-laws crafted by practitioners would be enforced by government in collaboration with the board, so as to avoid a role conflict that would threaten internal democracy if the council were to be both the lawmaker and enforcer. Contention may also arise on other issues such as human rights, property rights and funding that may complicate the operationalisation of the model.

Conclusions

The integration of traditional medicine as seen in the context of the discourse on public-private mix bespeaks of the paranoia that comes in the wake of the western donors' developmentalist notions, which not only assume that what can work in the West can work in the developing world, but also that what can work in one developing country can work in another. Within this skewed thinking, traditional medicine has been lumped under the same category with private modern medicine practitioners as part of the 'private sector' as if it shared any similarities with these actors other than healthcare provision. For those in the developing world, the struggle to de-colonise the mind and shrug off the huge blanket of ignorance and lack of depth of analysis that is a hangover from colonisation is called for here. Only then will we start making sense of our reality and adopt relevant, context specific solutions that can re-direct our societies on the road to development. While there is a need for the resources which the donors dispose of, we must not close our eyes to the realities that surround us.

It is difficult to integrate traditional medicine into national health services in societies where it has not developed into a unified system, that is, in societies where traditional medicine is practised disparately according to ethnic group and

specific cultural settings. In such societies, trying to integrate traditional medicine and practices into national health services will only result in increasing the hegemony of the modern medical sector and seriously eroding the time-tested cultural medicinal practices. This is because traditional medicine is judged on the values, philosophies, accountability standards and efficiency measures of the Western model, which is just incompatible with local realities. In fact, trying out this model of integration, as is already the case in most developing countries, is as difficult to achieve as biting a bullet.

Therefore, it is imperative to consider the unique historical circumstances within which traditional medicine has evolved in Africa generally and in countries like Uganda, where it was outlawed, made inferior to modern medicine, and its practice shunned, ridiculed and castigated as backward. It is important to consider its diversity and context specificity in order to come up with policy options that give it the crucial 'space' and cutting edge it deserves in the national health systems of the country. In this breath, a model of 'modernising' traditional medicine through granting autonomy to the sector is suggested as discussed in the paper. Hopefully, through this, traditional medicine and its practice can find their place in the national health system.

Recommendations

A critical recommendation made by practitioners is that for any meaningful action to be taken in the sector (integration, autonomy or a public-private partnership), there is an urgent need to formulate and enact law and policy on traditional medicine and practice. According to practitioners, the policy would among others formally recognise traditional medicine, streamline leadership issues in the sector, provide for funding of the sector (under decentralised health service delivery funding for health comes from consolidated funding through the Primary Health Care grant), ensure representation of practitioners at all levels, attract necessary incentives for 'take-off' of the sector, and create appreciation for the environmental and socio-contextual circumstances in which traditional medicine practitioners operate.

To popularise traditional medicine and practice, it is important for government to undertake massive sensitisation of the public, including actors in the modern health sector who hold and cherish a negative and harmful colonial mentality about the activities of their counterparts. Short of this, the sector will remain operating in a context where actors are shunned by some during the day, but appreciated by the same people at night. There is a need to remove all negative attitudes of witchcraft that have been associated with the practice of traditional medicine, which in one way or the other encourages impostors to flourish.

Notes

1. The modern sector in Uganda is not based on purely bio-medical models and principles. Sometimes modern medicine has been practised in an informal/traditional manner, access is sometimes based on social networks and corruption, among others. These issues have been highlighted by Asiimwe et al., 1997 and Birungi et al., 2001.
2. Some practices in this sub-sector are at times similar to those of the modern sector. It is therefore difficult to talk about a purely modern sector or traditional sector.
3. 'Planning for Cost-Effective Traditional Medicine in the New Century. A Discussion Paper', WHO Centre for Health Development. Accessible at: http://www.who.or.jp/tm/research/bkg/3_definitions.html
4. The term 'integration' has come to be widely used to express the formalisation and official incorporation of traditional medicine into national health services.
5. The idea behind this partnership is to increase public participation in health care delivery. The PPP project implementing the partnership has categorised the different actors in the private sector into three categories: Private not for profit (PNFP) which comprises agencies that provide health services from an established/static health unit/facility and those that work in the community and other counterparts to provide non/facility based health services; Private health practitioners (PHP) who comprise all cadres in the clinical, dental, diagnostics, medical, midwifery, nursing, pharmacy, and public health categories which provide private health services outside the public and traditional and complementary medicine practitioners.
6. Traditional medicine may not necessarily be easily accessible and affordable. In fact, it may be socially very expensive and may not be accessible for social, geographical and economic reasons. A case in point is those people who are socially stigmatised for practising sorcery simply because they have visited a traditional healer.
7. Reporting the frustration some companies involved in the production of traditional medicine therapies for HIV/AIDS in South Africa are facing, Richter (2003) confirms the argument that mainstream medical organisations regard traditional medicine with much apathy or antipathy.
8. Richter also emphasises that it is important to take note of the fact that traditional healers, traditional medicine and beliefs of sickness and health, can vary from region to region and from clan to clan (p. 13).
9. Although the author cannot claim to give a thorough explanation of this form of healing, according to interaction he has had with various healers, this is a telepathic form of healing where a spirit medium intervenes between the afflicted party and the causes of his/her affliction. The healer simply aids the interaction between the patient and this supernatural power/medium since he is the only one endowed with the power to communicate with it.
10. While they may have another more structural meaning, especially from the point of view of traditional practices, these are generally considered to be spirits of departed members of the community which occasionally pay visits to the living. That is, they are the living-dead.
11. According to the practitioners, the Ministry of Health would not only attract experts from other countries to bolster efforts of local practitioners, especially in training, but it was in a better position to ensure government responsibility over the sector and continued support.

12. The organisational structure of NACOTHA starts at village to national level. From village to district level, the following offices exist: chairperson, vice chairperson, information secretary, youth secretary, treasurer, defence secretary, research officer, botanical section head, pharmacist section head, women representative, project manager and mobiliser. NACOTHA's structure, however, goes up to regional and national levels. At regional level, the following offices are provided for in the structure: regional chairperson, vice regional chairperson, inspector, treasurer, information secretary, women representative and secretary. At national level, the structure includes: Chairperson, vice chairperson, secretary women representative and secretary. At national level, the structure includes: Chairperson, vice chairperson, secretary general, treasurer, women representative, chief drug inspector, project manager, information officer, defence secretary, sanitation officer, secretary for youth, botanical section head, pharmacists section head, research officer, medical officer (western medicine), legal advisor and four committee members.
13. To take this notion of government/self-regulation is to accept Max Weber's thinking that 'there is no single Reason or universal standard by which to judge all forms of thought and that what we call Reason, is only the specific and peculiar rationalism of the west' (Dean 1999, p. 11). After Foucault, we know that even within western rationalism, 'there is a multiplicity of rationalities, of different ways of thinking in a fairly systematic manner, of making calculations, of defining purposes and employing knowledge' (ibid, p. 11).
14. The stifling of traditional medicine is not restricted to Uganda. In a review of the regulatory framework for traditional medicine in South Africa, Richter (2003) notes that the 'Traditional Health Practitioners Bill 2003' states that a person who 'diagnoses, treats, or offers to treat, or prescribes treatment or any cure for cancer, HIV/AIDS or such other terminal diseases as may be described, shall be guilty of an offence'. The question is; does modern medicine hold a sole preserve for curing these diseases? If so, why has it failed to end human suffering emanating from the same terminal diseases?
15. Jjuko and his colleagues have established a research centre at Kireka in Wakiso district near Kampala for conducting research in traditional medicine, and developing drugs and supplements from herbs. This group has also established a clinic for treating patients using drugs developed by the same group and a large botanical garden where they obtain the herbs necessary for the research. This garden also acts as a trial plot for herbs obtained from as far as India and China.

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