Engaging Rural Community Members as Problem Solvers: Application of Health Communication to Improve the Quality of Health Care in Southwest Uganda

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ENGAGING RURAL COMMUNITY MEMBERS AS PROBLEM SOLVERS:
APPLICATION OF HEALTH COMMUNICATION TO IMPROVE THE
QUALITY OF HEALTH CARE IN SOUTHWEST UGANDA

by

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ABSTRACT


Using communication theories and anthropological models, I analyze the narratives of community members who are caretakers of children ages 5 and under in Southwest Uganda to situate rural community members as problem solvers whose insights can be used to inform sustainable and effective public health strategies that can lead to improved health outcomes. Throughout my analysis, I uncover themes and concepts from community members’ narratives that demonstrate that health-seeking behaviors of rural community members are largely shaped by perceptions of interpersonal and social trust in local health care practitioners. Additionally, an analysis of discourse from patient-provider interactions in biomedical and indigenous settings demonstrates that community members bring a high level of certainty (that they will receive medicine from biomedical health practitioners and that indigenous health practitioners will share the same spiritual beliefs) in each setting that sets the tone of dialogue between patient and provider. These and other research findings that help us understand rural community members’ experiences seeking health care, understand the value they place on indigenous and biomedical health care systems, and understand their health care needs, are used to advocate for a community-based health initiative that meets the community’s self-identified need for increased preventive and self-treatment health knowledge.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Figures</td>
<td>vi</td>
</tr>
<tr>
<td>List of Images</td>
<td>vii</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 1. Dissertation Purpose and Theoretical Foundations</td>
<td></td>
</tr>
<tr>
<td>Dissertation Purpose</td>
<td>4</td>
</tr>
<tr>
<td>Chapter 2. Uganda: Country Background Information and Health Care System</td>
<td></td>
</tr>
<tr>
<td>Country Background Information</td>
<td>18</td>
</tr>
<tr>
<td>Health Care System &amp; Population Health</td>
<td>21</td>
</tr>
<tr>
<td>Chapter 3. Methodology</td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>39</td>
</tr>
<tr>
<td>Phase I (2008)</td>
<td>41</td>
</tr>
<tr>
<td>Phase II (2009)</td>
<td>46</td>
</tr>
<tr>
<td>Chapter 4. Questionnaire Findings: Community Perceptions and Health-Seeking Behaviors</td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>66</td>
</tr>
<tr>
<td>Perceptions of BHPs: Competence and Goodwill</td>
<td>69</td>
</tr>
<tr>
<td>Perceptions of IHPs: Competence and Goodwill</td>
<td>75</td>
</tr>
<tr>
<td>Health Seeking Behaviors in Social and Environmental Context</td>
<td>81</td>
</tr>
<tr>
<td>Chapter 5. Patient-Provider Interactions: Community Members’ Experiences in Biomedical and Indigenous Settings</td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>88</td>
</tr>
<tr>
<td>Seeking Biomedical Care</td>
<td>92</td>
</tr>
<tr>
<td>Seeking Indigenous Care</td>
<td>105</td>
</tr>
<tr>
<td>Patient-Provider Interactions in Social and Environmental Context</td>
<td>117</td>
</tr>
<tr>
<td>Chapter 6. Implementation of Research Findings: Informing a Model for Information Sharing</td>
<td></td>
</tr>
<tr>
<td>Overview</td>
<td>119</td>
</tr>
<tr>
<td>First Step: Moving Away From Collaboration</td>
<td>121</td>
</tr>
<tr>
<td>Next Step: Moving into Information Sharing</td>
<td>124</td>
</tr>
<tr>
<td>Conclusion</td>
<td>129</td>
</tr>
<tr>
<td>Study Limitations</td>
<td>133</td>
</tr>
<tr>
<td>References</td>
<td>137</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>A. Questionnaire</td>
<td>150</td>
</tr>
<tr>
<td>B. Intake Survey</td>
<td>156</td>
</tr>
<tr>
<td>C. Coding Scheme</td>
<td>158</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inequities in Mortality Rates – Ugandans Living in Rural vs. Urban Areas</td>
<td>27</td>
</tr>
<tr>
<td>2. Inequities in Health Service Utilization – Ugandans Living in Rural vs. Urban Areas</td>
<td>27</td>
</tr>
<tr>
<td>3. Mortality Distribution for Ugandan Children Ages 5 and Under</td>
<td>28</td>
</tr>
<tr>
<td>4. Community Members’ Levels of Interpersonal and Social Trust By Provider</td>
<td>68</td>
</tr>
<tr>
<td>5. Preferred Methods of Treatment for Physical, Social, and Mental Ailments</td>
<td>83</td>
</tr>
<tr>
<td>6. Seeking Health Care in Rural Southwest Uganda: Factors in Patient Decision Making</td>
<td>86</td>
</tr>
<tr>
<td>7. Patient-BHP Interaction: One-Dimensional Roles</td>
<td>93</td>
</tr>
<tr>
<td>8. Biopsychosocial Explanatory Model</td>
<td>108</td>
</tr>
</tbody>
</table>
# LIST OF IMAGES

<table>
<thead>
<tr>
<th>Image</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Health Center II Patient Exam/Consultation Room</td>
<td>24</td>
</tr>
<tr>
<td>B. Health Center IV Patient Consultation Room</td>
<td>25</td>
</tr>
<tr>
<td>C. Health Center IV Patient Consultation Room</td>
<td>25</td>
</tr>
<tr>
<td>D. Example of Translator/Interpreter Assisted Interviews in the Field</td>
<td>55</td>
</tr>
<tr>
<td>E. Example of Translator/Interpreter Assisted Interviews in the Field</td>
<td>55</td>
</tr>
<tr>
<td>F. Example of Translator/Interpreter Assisted Interviews in the Field</td>
<td>56</td>
</tr>
<tr>
<td>G. Biomedical Patient Consultation Setting</td>
<td>91</td>
</tr>
<tr>
<td>H. Indigenous Patient Consultation Setting</td>
<td>92</td>
</tr>
</tbody>
</table>
INTRODUCTION

In the summers of 2008 and 2009, I worked with other members of the Minority Health International Research Training Program to conduct critical ethnographic research in Southwest Uganda. While in Uganda, we explored the feasibility of forming a cooperation between indigenous and biomedical health practitioners to increase health care access for rural community members and reduce childhood illnesses. In 2008, I was part of a research team of three that included program coordinator Julia Hanebrink and Victoria Kronenwetter. As a graduate student, I assisted in the study design and implementation. In 2009, I co-led a research team with program coordinator Julia Hanebrink, which included graduate students Kara Miller and Joy Nolte.

Over two years after my initial visit to “Ug,” as the locals call it, I still find myself searching for a concise answer to a simple question posed by my peers: “How was your trip?” While this may appear to be a straightforward question, it is one of the most difficult inquiries I’ve ever faced. Succinct answers such as “good” and “enlightening,” are, by and large, scanty responses.

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1 This research was carried out by students and faculty associated with the Minority Health International Research Training (MHIRT) grant through Christian Brothers University (CBU), Memphis, TN USA. The MHIRT grant is funded by the National Institutes of Health, Bethesda, MD USA.

2 Critical ethnography is a type of ethnographic research in which the authors advocate for the emancipation of groups marginalized in society (Creswell, 2007).

3 Christian Brothers University Instructor; Louisiana State University: MA, Forensic Anthropology

4 Christian Brothers University: BA, Psychology

5 Louisiana State University: MA Candidate, Cultural Anthropology

6 Boston University: MPH Candidate, International Development
“Good” cannot capture my first moment of ‘This is Africa,’ which came a week into my trip. My moment, or better yet, moments came over the course of a five-hour drive from Uganda’s capital city of Kampala to a rural town known as Mbarara. I cannot share everything that I saw, all that I thought, or all that I felt. However, it was a drive that I remember as being filled with stimulating visuals and equally laden with emotion – all occurring in sheer silence and reflection.

From the capital city of Kampala we drove south… town after town, through fields of papyrus, and through herds of cows. It wasn't the serenity of the various landscapes that left an impression on me, nor was it being forced off of the road by President Museveni and his entourage of what had to be at least 200 soldiers in full combat gear wielding M-60 machine guns. It was the people. It was seeing the people of Uganda in what you and I may deem as going through every day life. Yet upon a closer look, it was surviving everyday life. Until that day, I had never witnessed the challenge, reality and will to prevail in what can be best described as organized survival.

As someone literally and figuratively passing through, I came to realize that I had no remote idea of what survival was, and I questioned whether my quest to change the world was unattainable. Nothing could have prepared me for the images I saw one after another – a ten year old boy wearing one oversized sandal on his left foot and the right bare, walking along the side of the road carrying a pile of logs, which I would be challenged to carry for more than the distance of a New York City block. An extremely worn man at least 65 years young or 40 years old pushing a bike loaded with endless bunches of matoke⁷ up a two-mile hill in slow, calculated strides. A four year old girl

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⁷ Steamed green plantains that resemble bananas
dressed in what appeared to be days of mud, playing in her front yard with her mother in the distance breastfeeding in one hand and bent over sweeping with a bundle of straw in the other. These are only a few of the snippets of “life” that I was able to witness and process on that five-hour drive. Yet, with every one of those images there were ones of smiles, hearty laughs, glee and above all, pride.

Ugandans have a transcendent level of pride that stems, in part, from their exceptional ability to persevere through extreme adversity. I was motivated daily by the inspirational perseverance of Ugandans that I encountered. One incident that stands out to me in particular came during an interview with a mother of two who was holding her youngest daughter at the time. Her daughter’s eyes were filled with mucous as her pupils methodically darted from side to side. As she slowly moved her jaw up and down in an attempt to chew the small pieces of bread her mother fed her, it hit me – this child is not going to make it. This woman is holding a dying child as she patiently answers my questions with genuine enthusiasm. Tough, but all I could do was keep my composure. She was my inspiration. Her dying child was my inspiration. I realized that we will always be faced with adversity in our quest to fight for social change – and it is through this adversity that we must always maintain two things: perseverance and pride.

My dissertation is dedicated to the people of “Ug” who taught me this valuable lesson. I will focus on sharing their stories and their experiences in the hope that our research eventually leads to improved health outcomes and in turn, contributes to the pursuit of social justice through the elimination of health disparities worldwide.
CHAPTER 1

DISSEBTATION PURPOSE AND THEORETICAL FOUNDATIONS

Dissertation Purpose

The research we carried out in Southwest Uganda was a unique opportunity for me to combine my personal interest in international cultures, passion for improving child welfare, and academic background in health communication. Working with our in-country partners, Mbarara University of Science and Technology\(^8\) and Healthy Child Uganda\(^9\), we focused on conducting research that would lead to improved health outcomes for children ages 5 and under in the area. We concentrated our efforts on improving the quality of life of this population because the highest mortality rates in Uganda exist among children ages 5 and under (Ross, 2004; WHO, 2006). We were also tasked with the challenge of identifying ways to improve access to quality healthcare in rural communities in the area. Thus, we explored the feasibility of increasing cooperation between indigenous health practitioners (IHPs) and biomedical health practitioners (BHPs) in an effort to increase health care access in rural communities and in turn, reduce pervasive childhood illnesses.

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\(^8\) Mbarara University of Science and Technology (MUST) is the second largest university in Uganda, and is home to the largest hospital in the southern region. The university was founded in 1989 to address the shortage of scientist in the country. We specifically worked with professors Dr. Edgar Mulogo and Dr. Fred Bagenda within the Department of Community Health to design our study and ensure the proper IRB procedures. Additional information on MUST and Drs. Mulog and Bagenda is available at [www.must.ac.ug](http://www.must.ac.ug).

\(^9\) Healthy Child Uganda is a non-profit community-based health organization that focuses on working with poor, rural communities in Southwest Uganda to identify and solve problems that most impact children ages 5 and under. I give special thanks to Moses Ntaro (Project Coordinator), Teddy Kyomuhangi (Project Manager), Angella Tumuhimbise (Community Health Facilitator), and the numerous community health workers and health center staff for their help and support. Additional information on Health Child Uganda is available at [http://www.healthychilduganda.org/](http://www.healthychilduganda.org/).
My dissertation focuses on select data collected during our study to a) explore shared experiences of rural community members who are caretakers of children ages 5 and under in Southwest Uganda; b) identify cultural values and themes that shape their health-seeking behaviors; c) demonstrate that caretakers of children ages 5 and under can be valuable problem-solvers in improving patient care and health care access in the area; and d) construct a testable model for improving patient care and health care access in the area.

As a health communication researcher, I am interested in evaluating the role of communication in health care settings throughout Southwest Uganda. More specifically, I am interested in the application of communication theory and practice to the local health care context. This ranges from provider-patient interactions to cultural influences on health. Accordingly, my dissertation research questions are:

1. What have been the health care experiences of rural community members who are caretakers of children ages 5 and under in Southwest Uganda and have sought care from IHPs and/or BHPs?

2. How are the health-seeking behaviors of rural community members who are caretakers of children ages 5 and under in Southwest Uganda shaped by their social priorities and cultural perceptions of local health practitioners (both indigenous and biomedical health practitioners)?

3. What are the perspectives of community members who are caretakers of children ages 5 and under on 1) community health needs, 2) the value of IHPs and BHPs, and 3) the feasibility of cooperation between indigenous and biomedical practices?
4. What recommendations do community members who are caretakers of children ages 5 and under have for improving health care access in rural areas of Southwest Uganda?

5. How can health communication researchers assist in constructing a culturally appropriate testable model for improving indigenous and biomedical patient care and health care access in Southwest Uganda?

Value of Patient Voice: Application of Communication and Anthropological Theoretical Foundations

A primary objective of my research is to highlight that community members have ideas that can be cultivated into effective and sustainable solutions that improve the health care system in rural areas of Uganda. By collecting and analyzing the narratives of community members, we can attempt to understand their lived experiences, and in turn, ensure that their perspectives are used to inform the design of future public health initiatives.

In addition to simply valuing narratives, rhetorical and communication theories such as standpoint theory, Kenneth Burke’s concept of identification, and muted group theory are critical to comprehensively understanding the health care needs of rural community members in Southwest Uganda, and developing a culturally appropriate, testable model for improving indigenous and biomedical patient care and health care access in the area. If we believe that rhetoric influences behavior, then we must also agree that rhetoric helps us to understand the motives behind health behaviors. Rhetoric is an art that does not stand on its own, but can help us understand health care challenges that revolve around communication.
Rhetoricians have long explored the role of discourse in decision-making, its relationship with logic and emotion, and its relationship with needs and expectations. Concepts that emerge from the analysis of these relationships can be used to find solutions that improve provider-patient relationships, and, in turn, lead to improved health behaviors. Therefore, it is through rhetorical and communication foundations that I have been able to 1) make at least some sense of the lived experiences of community members, 2) account for social challenges that influence their health behaviors, and 3) construct ideas to advocate against social injustices that impede on delivering sustainable quality health care in rural areas of Southwest Uganda.

Accordingly, I will expand on the aforementioned theoretical foundations and discuss:

- The value of patient narratives in increasing the validity of future recommendations to improve health care access in Southwest Uganda
- The value of patient narratives in recognizing health as a biomedical and social issue
- How standpoint theory can be used to understand the experiences of rural community members as a marginalized group, and how one’s social standpoint is related to their cultural identity
- How Kenneth Burke’s concept of identification helps us discover various ways cultural identity can affect provider-patient interactions when seeking care from IHPs and BHPs
- How adopting the premise of muted group theory can be used to acknowledge the immense potential value of giving rural community members a voice in
improving the quality of health care and advocate for social justice in Southwest Uganda

Uncovering the Truth: Narratives

A paucity of literature focuses on the perspectives of community members and their views on collaborative care. Van der Geest (1997) argues that rural community members may, in fact, disagree with Western points of view and may be not as enthusiastic about cooperation between IHPs and BHPs, despite contrary belief. A number of rural community members do not expect that basic health care will improve if IHPs and BHPs integrate their practices. This claim is supported by a question asked during a key-informant interview by a community member in Southwest Uganda during the summer of 2009: “If the dirty water system is the source of many diseases [in this village] and you are successful in forming a partnership between the health center and traditional healers how will that help?”

The narratives of rural community members can reveal social complexities that shape their illness experiences and give researchers insight as to why collaboration between IHPs and BHPs may or may not be the best solution to improving the quality of health care in rural Ugandan communities. Research from anthropologists (Brody, 2003; Kleinman, 1988; Mattingly & Garro, 2001), physicians (Groopman, 2007), and rhetoricians (Segal, 2005) demonstrate that narratives give meaning to a patient’s experience and shape health care outcomes.

Narratives help social researchers and health practitioners understand and address life. Stories help health practitioners and researchers gain a better understanding of a patient, their experience, and their perspective (Mattingly & Garro, 2001). The
perspectives of rural community members may be the most important point of view because 1) they are the ones most affected by changes in indigenous and biomedical care, and 2) their points of view are the most accurate based on the premises of standpoint theory.

Understanding Collective Experiences and Perspectives: Standpoint Theory

Standpoint theory suggests that the social groups we belong to powerfully shape what we experience, how we communicate, and what we know as true (Griffin, 2006). Original theorists of standpoint theory, Patricia Hill Collins, Donna Haraway, and Sandra Harding, argued that it is easier for women and other marginalized groups to look up than it is for men and other groups at the top of the social ladder to look down (Wood, 2005). In other words, groups lowest on the rung of social hierarchy and power (e.g. women, ethnic minorities and the poor) have more accurate views of social life than groups in higher positions. Views of social life are subjective and are situated based on social circumstance. Harding and other scholars refer to this claim as situated knowledge. Because knowledge is biased and a given situation can involve multiple interlocutors, there are multiple “knowledges.” In other words, knowledge is plural and refers to the overall ways of perceiving, experiencing, and knowing that are shaped by our social situations (Griffin, 2006). Increased accuracy in social knowledge is directly correlated with decreased position in social hierarchy because a) dominant groups benefit from being blind to the oppression and inequality that sustains their privilege, b) marginalized groups are forced to learn and conform to the ways of dominant groups to survive in a
society where dominant groups are in power\textsuperscript{10}, c) marginalized groups are more motivated to identify systems of oppression to advocate for social justice, and d) marginalized groups may find themselves in provisional positions of power or situations, allowing them access to the dominant world – leading to the formation of double-consciousness (Griffin, 2006; Wood, 2005).

Furthermore, our standpoint directly influences our outlook on the status of our individual health and their surrounding community’s collective health. Health communication scholar Mohan Dutta (2008) asserts that the nature of how and what we communicate about health is embedded in our views of what it means to be healthy, what it means to be ill, and how we approach illness (Dutta, 2008). Dutta’s assertion complements Kleinman’s claim (1988) that illness is a subjective experience of symptoms and suffering that can be influenced by and understood through one’s standpoint and culture. Therefore, to effectively address community wellness it is vital to account for the perspectives, knowledgebase, and shared culture of community members. Acknowledging that community members in Southwest Uganda have valuable insight into social and structural issues as they relate to health can help gain an in-depth understanding of patients’ health seeking behavior, perceptions of the effectiveness of health care within their community, and willingness to seek care from a cooperation between IHPs and BHPs.

Feminist philosopher Nancy Hartstock (1997) emphasizes, “a standpoint carries with it contention that there are some perspectives on society from which, however well intentioned one may be, the real relations of humans with each other and with the natural

\textsuperscript{10} There are individuals within marginalized groups who choose not to conform. However, this claim applies to marginalized groups as a whole (the majority).
world are not visible” (p. 218). Hartstock’s assertion may become evident when contrasting the views of community members, IHPs and BHPs. Ugandan professors Justus Mugaju (1999) and Fred Nuwaha (2002) note that three main points of divergence in the standpoints of all three groups include a) existence of illnesses, b) effectiveness of non-biomedical methods, and c) the intentions of non-biomedical practitioners.

Points of divergence between the standpoints of community members and BHPs are much greater than points of divergence between the standpoints of community members and IHPs (Kaboru, Falkenberg, Ndulo, Muchimba, & Faxelid, 2006; Mugaju, 1999; Nuwaha, 2002). This is because community members and IHPs often share the same cultural identity and have similar outlooks on health. Therefore, an advantage that IHPs have over BHPs is not just accessibility but their ability to account for social factors and cultural forces when treating marginalized patients in rural areas of Southwest Uganda (Mugaju, 1999; Halvorson, 2007). Truly understanding the shared meaning, values, and behaviors of this population requires awareness of their experiences and situated knowledge, as well as understanding of the systems of power, social hierarchy and social inequity that lead to disparate illness experiences. Cultural identity directly correlates to our concept of health and being healthy, receptiveness to health messages, willingness to adopt preventive behaviors, explanation of health-seeking behaviors, and explanation of illness experiences (Dutta, 2008).
Evaluating Patient-Provider Relationships: Burke’s Identification

Rhetorician Kenneth Burke (1969) argues that persuasion's very condition of possibility is identification, and identification is a humanistic process that is fundamental to communication. He asserts that the need to identify arises initially out of biological division, and then social divisions. Humans are “both joined and separate, at once a distinct substance and consubstantial with another” (p. 1325). Through verbal and non-verbal communication we continually seek ways in which our interests, values, beliefs, perceptions and experiences are similar. Burke asserts that identification is the key to persuasion. An effective speaker persuades by encouraging the audience to identify with her interests, and concurrently the speaker identifies with the interest of her audience to establish rapport between the two interlocutors. Burke refers to this process as “con-substantiation.” Points of identification include shared language, image, ideas, perspectives, and understanding – all of which are shaped by culture.

Aristotle’s three proofs – ethos, pathos, and logos – can be used to support the value of identification. Burke’s identification is largely related to ethos, although the involvement of pathos and logos is significant. According to Aristotle (2001), ethos (Greek for ‘character’) is based on the premise that during a rhetorical act an audience responds to personal qualities of the speaker – “We believe good men more fully and more readily than others: this is true generally whatever the question is, and absolutely true where exact certainty is impossible and opinions are divided” (p.182). Aristotle explains, “it is not true, as some writers assume in their treatises on rhetoric, that the personal goodness revealed by the speaker contributes nothing to his power of persuasion; on the contrary, his character may almost be called the most effective means
of persuasion he possess” (p. 182). For an audience to identify with a speaker, they must first view the speaker herself as credible (not just her argument or claim).

Results from a study conducted in Zambia by researchers from the Royal London Hospital Medical College (Burnett, 1999) complement findings by Van der Geest (1997) and Green (1994), which demonstrate that while BHPs gain their credibility from their access to biomedical tools and medicine, IHPs gain their credibility from their ability to identify with patients (particularly those in rural communities), not because of the proven efficacy of their treatments. Whether indigenous or biomedical, health practitioners who recognize the importance of demonstrating how their interests, values, beliefs, perceptions and experiences are similar to those of their patients will ultimately be more influential and effective than those who do not (Corburn, 2002; Ford et al., 2003; du Pre; 2004; O’Hair, et al., 2007).

Moreover, research from communication scholar William Gudykunst (2005) reminds us that health practitioners have to bear in mind that a patient’s identity is comprised of a number of sub-identities and affiliations with group acceptance. The identities that play out during interpersonal, intercultural and intracultural interactions are determined by who that person feels they want to and should be at that moment. This assumed identity can be regarded as ‘face,’ in which interactions involve continual maintenance of ‘face.’ Identity management is heavily influenced by culture. IHPs in rural areas of Southwest Uganda are able to more effectively manage a patient’s identity when providing care because they tend to be more aware of customs and traditions than BHPs. As health communication scholar Mohan Dutta (2008) asserts:
It is in the realm of culturally situated meanings and actions that individuals enact their agency…. The interactions that individuals have with social structures are made meaningful through the lens of culture; therefore it is through the symbols that circulate in the culture that individuals enact their agency. Similarly, the ways in which individuals go about their daily practices of health are rendered meaningful through the symbols that circulate in the culture. (p. 8)

IHPs’ value to the health care system in Uganda and other African countries is evident from a humanistic approach (Burnett, 1999; Green, 1994; Van der Geest, 1997; World Bank, 1993). Despite this, the insights of IHPs continue to be ignored when developing health initiatives, as are the insights of the patients they serve. Dutta (2008) notes that muting marginalized groups when developing public health initiatives is very common, and unfortunately has consequential effects. Several case studies have proven that a top-down approach is often ineffective, especially when attempting to address the health of marginalized groups (Berry, 2009; Feldman-Savelsberg, Ndonko, & Schmidt-Ehry, 2000; Hultberg, 1999; Last, 2005; Warren & Tregoning, 1979).

Marginalized Perspectives to Inform Health care Policy and Programming: Muted Group Theory

Muted group theory helps us to understand why top-down health initiatives are so common and advocates for the involvement of marginalized groups in the planning stages of public health initiatives (Dutta, 2008; Kramarae, 1981). Muted group theory explains that the universal lack of voice among marginalized groups is customary because dominant discourse renders their perspectives insignificant (Kramarae, 1981). Being
muted does not mean the group is silent but that their voices have been overlooked, muffled, or altered. Muted group theory argues that groups who are essentially made voiceless by cultural hierarchy (e.g. women, ethnic minorities, the poor) not only have different worldviews, but also experience the world differently than dominant groups, and are forced to conform by changing their behavior and language to that of dominant groups in an effort to fit in and get ahead. Muted group theory has some overlap with standpoint theory. However, muted group theory focuses on language while standpoint theory focuses on knowledge. Both muted group theory and standpoint theory a) acknowledge that societies are constructed with culturally imbedded power relations, b) recognize that the voices and perspectives of subordinate/oppressed groups have immeasurable value, and c) advocate for more equitable power distribution (Griffin, 2006).

Muted group theory began with a gender focused anthropologic study conducted by Edwin and Shirley Ardener. The Ardeners discovered that a large number of ethnic studies claimed to address collective societal issues without seeking and accounting for the voice of women within those societies. Researchers who led these studies were often trained in the masculine method of inquiry and grew up in societies where muting women was the norm. In defense of their skewed data, these researchers would, at times, claim that women were difficult to communicate with (Ardener, 2006; Griffin, 2006). Edwin Ardener (2006) asserted that:
We are, for practical purposes, in a male world. The study of women is on a level little higher than the study of the ducks and fowls they commonly own – a mere bird watching indeed. It is equally revealing and ironical that Levi-Strauss should write: ‘For words do not speak, while women do.’ For the truth is that women rarely speak in social anthropology in any but the male sense so well exemplified by Levi-Strauss’s own remark: in the sense of merely uttering or giving tongue. (p. 48)

Cheris Kramarae, Virginia Wolf and other scholars further explored the Ardeners’ research and asserted that the words of women were, and still are devalued by men. Scholars explored the way women were portrayed in cartoons and literature, and contended that female characters are objectified and portrayed as vague (Griffin, 2006). Furthermore, Mark Orbe (1994) expanded on the work of Kramarae to address the muting of African American males in America. Orbe (2005) highlighted that muted groups exist on a number of fronts within every society. More importantly, through his research on the communication of African American males, Orbe provided insight that has led to the development of strategies that have helped an array of muted groups combat their lack of voice in their respective societies.

Mugaju (1999) commented on the muting of IHPs and community members in rural areas of Uganda. He argued that Ugandan health service managers have been insensitive to the health needs of rural populations because there are no consequences for not making their health needs a priority: “the voiceless and powerless rural people were not in position to insist on the delivery of health services” (p. 8). The key to overcoming this barrier is to make certain that research targeting marginalized groups is truly
community based (Hultberg, 1999). Conducting community-based research in Southwest Uganda that unmutes community members and IHPs can help challenge systems of power and hegemony that hinder positive health outcomes in the area. Unmuting these groups can also lead to improvements in the quality of health care in the community (Gramsci, 1971).
CHAPTER 2

UGANDA: COUNTRY BACKGROUND INFORMATION AND HEALTH CARE SYSTEM

Country Background Information

The Republic of Uganda is a landlocked, developing country in eastern Africa. Uganda has an estimated population of 34 million people, with an annual growth rate of 3.3% (U.S. Department of State, 2010). Uganda’s free-market economy is heavily dependent on external aid (Okuonzi, 2004), and 38% of the population lives below the national poverty line – $1.25 a day (World Bank, 2009). The country’s last census estimated that approximately 12% of the population lives in urban areas (Uganda Bureau of Statistics, 2010), with the majority of Ugandans being either subsistence farmers or working in agriculture-related fields (Briggs, 2007).

The following is a snapshot of additional country background information, including geography, people, infrastructure, economy, and educational system:

Geography (See Map A)

- **Area**: 241,040 sq. km. (93,070 sq. mi.); approximately the size of Oregon (U.S. Department of State, 2010)
- **Major Cities**: Kampala is the capital of Uganda and has an estimated population of 1.4 million
  - Mbarara\(^{11}\) is the largest city in the southern region of Uganda and has an estimated population of 97,500.

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\(^{11}\) The research team resided in the city of Mbarara while conducting the study.
Mbarara district has an estimated population of 457,000 (Uganda Bureau of Statistics, 2010)

- **Terrain**: 18% inland water and swamp; 12% national parks, forest, and game reserves; 70% forest, woodland, grassland (U.S. Department of State, 2010)

- **Climate**: Two dry seasons: Dec.-Feb. and June-July (U.S. Department of State, 2010)

Map A. Uganda and Mbarara

### People

- **Religions**: Practiced religions include 85% Christian, 12% Muslim, 2% other (i.e. Jewish, Hindu, etc.)

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12 All study participants resided within the district of Mbarara.

13 Uganda has several levels of administration – district, county, sub-county, parish and village (in descending order).
- **Ethnicities**: There are approximately 30 tribal groups, including Baganda, Banyankole, Bahima, Bakiga, Banyarwanda, Bunyoro, Batoro, Langi, Acholi, Lugbara, Karamojong, Basoga, Bagisu, and others (Teuton, et al., 2007). The Baganda are the largest ethnic group in Uganda and comprise approximately 18% of the population (U.S. Department of State, 2010).

- **Languages**: English is the official language and is spoken mostly by reasonably educated Ugandans. Lugandan and Runyankore are among the two most widely spoken of the 33 indigenous languages. Lugandan is generally spoken in the north, and Runyankore is generally spoken in the south (Briggs, 2007). The majority of data collection for this study was conducted in Runyankore.

**Infrastructure**

- **Roads**: Uganda has approximately 28,000 miles of roads, of which 6,213 miles are main roads and 21,747 miles are feeder roads (U.S. Department of State, 2010)
  - Only 1,864 miles are paved, and most roads radiate from Kampala.

- **Rail**: The country has approximately 800 miles of rail lines, but most of them are not currently in use (U.S. Department of State, 2010)

**Economy**

- **Gross Domestic Product**: $14.5 billion (U.S. Department of State, 2010)
  - Foreign donor aid accounts for approximately 4.6% of gross domestic product, according to World Bank data. (Ojambo, 2010)
  - Agriculture accounts for approximately 60% of gross domestic product (Briggs, 2007)
- Uganda’s major exports include coffee, tea, cotton, tobacco, and sugar cane.

**Education**

- *Literacy Rate:* 74% (UNICEF, 2006)

- *School System:* The Ugandan school begins with children in primary school for seven years (Primary 1 - Primary 7), and then continues through secondary school for the next six years (Senior 1 - Senior 6).
  - Primary school enrollment is estimated at 83%; Secondary school enrollment is estimated at 16% (UNICEF, 2006)

**Health Care System & Population Health**

**Overview.** Uganda was considered to have one of the best health care systems in Africa prior to the rule of former president Idi Amin during the 1970s (Dodge, 1986). The quality of the country’s health care system began to decline during Amin’s presidency as a result of a mass exodus of doctors, nurses and other health professionals, some of whom fled the country while others were expelled. After Amin’s rule ended in 1979, health care was put on the backburner in the 1980s by the new administration to focus on rebuilding Uganda’s overall economy. The health care budget was decreased to 3.5% from 7.5% (Dodge, 1986).

Between 1993 and 1994, Uganda introduced health sector reforms, following the promotion of market-based reform by the World Bank’s *World Development Report 1993: Investing in Health* (Bossert & Beauvais, 2002; Okuonzi, 2004). With the reform came the decentralization of healthcare and the belief that Ugandans would take
responsibility for their own health through economic growth. Four principles guided the introduction of the reform (Okuonzi, 2004):

1. Individuals, charities, and private organizations should be held responsible for health care
2. Public funding of health care should be restricted to health promotion and prevention
3. Central government’s role should be restricted to policy formulation and technical guidance
   a. Delivery of service should be the responsibility of local authorities and private organizations
4. Private organizations and non-governmental organizations (NGOs) should be encouraged and supported to become the primary providers of health and social services

User fees were introduced as a key tactic to finance the health care reform and obtain a national World Bank loan (Bossert & Beauvais, 2002; Okuonzi, 2004). Although the fees were expected to improve the quality and equity of the health care system, they only accounted for 5% of total expenditures (Okuonzi, 2004). In 2001, the government removed user fees at all government health facilities and made a substantial investment in the health care system (Meessen, Vand Damme, Tashobya, & Tibouti, 2006). Removal of user fees by the Ugandan government has received mixed reviews. Some public health researchers argue that the removal of user fees has been beneficial to impoverished Ugandans because it grants them access (Meessen et al., 2006; Nabyonga et al., 2005; Xu et al., 2006), while others, such as Ugandan public health researcher Sam Agatre Okuonzi (2006), highlight that the poor cannot be better off because they have
access to care that is of extremely low quality and is essentially non-existent. Since the removal of user fees, Uganda’s public health facilities have been burdened with overcrowded wards, severe drug shortages, and overburdened staff (Meessen et al., 2006). Okuonzi supports his claim with results from participatory poverty assessments commissioned by the World Bank among impoverished Ugandans in 1999, 2002, and 2004, which show that the majority of poor Ugandans expressed dissatisfaction with the health care system and believed conditions were worsening (Okuonzi & Birungi, 2000). Furthermore, World Health Organization health economist Ke Xu and colleagues (2006) assert that although use of health care services among the poor rapidly increased after the removal of user fees, incidence of overall expenditure did not decrease. Expenditure among the poor remained relatively the same because patients were 1) forced to buy medicine from private clinics due to the frequent unavailability of medicine at government health facilities, and 2) because informal payments to health workers may have increased to offset lost revenue from the removal of user fees (i.e., bribes).

Today, Ugandans still do not pay user fees when seeking care from public health facilities, and although they technically have ‘access’ to health care, significant improvements in the country’s health care system are needed. Uganda’s health care system is presently ranked as one of the worst in the world (Kelly, 2009; WHO, 2000). With over 50% of Uganda’s health care spending coming from external aid (Okuonzi, 2006), the country’s health care system is currently overburdened and lacks the resources needed to significantly improve child and adult mortality rates throughout the country. Health care facilities throughout the country are often understaffed and lack basic resources (e.g., cleaning supplies, medication, gloves, etc.). The poor conditions of
Uganda’s health care facilities are captured in *Images A, B, C*, and Canadian nursing professor Jean Harrowing’s (2009) observations while conducting an ethnographic study in a Ugandan hospital:

Supplies and equipment such as gloves were rationed despite the increased risk of disease transmission [working with HIV positive patients] and injuries to staff members and patients. Some managers found themselves using storage closets as offices, where a broken gurney might serve as a desk; boxes of syringes and medications were stacked against walls and under furniture; and the nurse occasionally would be greeted in the morning by a flood because of damaged water pipes in the ceiling. Units with 18 beds often admitted 80 or more patients by making use of mats on the floor and with 2 nurses on duty to provide care. (p. E97 – E98)

Image A. Health Center II\(^{14}\) Patient Exam/Consultation Room. 1 of 3 rooms (exam/consultation room, waiting room, storage room)\(^{15}\)

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\(^{14}\) See Table 1 on p. 29 for a description.

\(^{15}\) Written consent has been obtained for all photos used in this dissertation.
Images B & C. Health Center IV\textsuperscript{16} Patient Consultation Room

\textsuperscript{16} See Table 1 on p. 29 for a description.
Lack of staff and poor conditions are worse in rural areas of Uganda where there are higher populations of people. In addition, Ugandans in rural areas face a number of inequities, including higher rates of mortality and lack of health care access (see Figures 1 and 2). Approximately 70% of Ugandan doctors and 40% of nurses/midwives are based in urban areas, serving only 12% of Uganda’s population (Kelly, 2009). With only 38% (Kelly, 2009) of health care posts filled throughout the country, health workers have little incentive to work in poor rural areas. Health workers face additional challenges, such as lack of accessibility and transportation, increased numbers of patients, and no additional compensation.

The poor condition of Uganda’s health care system is reflected in the health status of its people. While there have been minor improvements in child and adult disease rates over the past decade, the health status of Ugandans is relatively poor. (UNICEF, 2006). Life Expectancy at Birth is 49 years old for males, and 51 years old for females (WHO, 2010). The country’s under 5 mortality rate is 134 per 1,000 live births – one of the world’s highest (WHO, 2010). Children under 5 suffer from preventable and pervasive illnesses such as, phenomena, diarrhea, and malaria (WHO, 2009) (see Figure 3). Communicable diseases (e.g., neglected tropical diseases and HIV/AIDS) account for the majority of the overall disease burden, although there is a growing burden of non-communicable diseases. Extremely poor maternal and perinatal conditions also contribute to the country’s high mortality rate (WHO, 2009)
Figure 1. Inequities in Mortality Rates – Ugandans Living in Rural vs. Urban Areas (World Health Organization, 2009)

Figure 2. Inequities in Health Service Utilization – Ugandans Living in Rural vs. Urban Areas (World Health Organization, 2009)
Figure 3. Mortality Distribution for Ugandan Children Ages 5 and Under (World Health Organization, 2004)

**Two Practices: Indigenous and Biomedical Care.** Both IHPs and BHPs support Uganda’s health care system. The two traditionally share more responsibility in rural communities throughout Uganda and many other African countries, such as Zimbabwe, South Africa and Ghana (Brehony, 2000; Ingstad, 1990; Makundi, 2006; Nakaibwe & Christensen, 2007; Ngubane, 1992; Rekdal, 1999; Tumwesigye, 1996; Van der Geest, 1997; WHO, 2002). Stark differences exist between IHPs and BHPs in terms of their approaches to health care and methods of treatment (see Table 1). IHPs include spiritualists, herbalists, bonesetters and traditional birth attendants who use healing
knowledge that has been passed down through generations and local resources to create medicinal treatments and carry out medical procedures (WHO, 2002, p. 7). Conversely, BHPs include physicians, nurses, birth attendants and health care workers who are trained, funded, regulated and promoted by the government. Often referred to as Western medicine, biomedical health care is rooted in scientific knowledge.

Table 1. IHP/BHP Variables

<table>
<thead>
<tr>
<th></th>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approach</strong></td>
<td>- Holistic</td>
<td>- Allopathic</td>
</tr>
<tr>
<td><strong>Primary</strong></td>
<td><strong>Strengths</strong></td>
<td></td>
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<tr>
<td><strong>Primary</strong></td>
<td><strong>Weaknesses</strong></td>
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<td><strong>Source of</strong></td>
<td>Credibility</td>
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<tr>
<td><strong>Explanatory</strong></td>
<td>Models**</td>
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<td><strong>Accessibility</strong></td>
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<tr>
<td><strong>Cost</strong></td>
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<tr>
<td><strong>Stereotypes</strong></td>
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<tr>
<td><strong>Record</strong></td>
<td>Keeping**</td>
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<table>
<thead>
<tr>
<th><strong>Primary Strengths</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Holistic</td>
<td>- High level of cultural competence</td>
<td>- Allopathic</td>
</tr>
<tr>
<td>- Accounts for social and cultural illnesses</td>
<td></td>
<td>- Diagnostic tools</td>
</tr>
<tr>
<td>- Accessibility</td>
<td>- Lack formal training/certification</td>
<td>- Proper hygiene maintenance</td>
</tr>
<tr>
<td></td>
<td>- Lack diagnostic tools</td>
<td>- Scientific validity</td>
</tr>
<tr>
<td></td>
<td>- Lack basic medical supplies</td>
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<table>
<thead>
<tr>
<th><strong>Primary Weaknesses</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Low literacy</td>
<td>- Lack formal training/certification</td>
<td>- Lack variety in medical treatments</td>
</tr>
<tr>
<td>- Lack diagnostic tools</td>
<td>- Lack diagnostic tools</td>
<td>- Drugs are often in low supply</td>
</tr>
<tr>
<td>- Lack basic medical supplies</td>
<td>- Lack basic medical supplies</td>
<td>- Do not recognize cultural illnesses</td>
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<tr>
<td></td>
<td></td>
<td>- Often understaffed</td>
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<thead>
<tr>
<th><strong>Source of Credibility</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Role as community leaders</td>
<td>- Cultural beliefs held by community members</td>
<td>- Government accreditation</td>
</tr>
<tr>
<td>- Cultural beliefs held by community members</td>
<td></td>
<td>- Formal education/training</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Explanatory Models</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Illness as the experience of disease and the societal reaction to disease</td>
<td>- Disease as a biological malfunction</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Accessibility</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Often live within the community</td>
<td>- Reluctance to settle in rural areas</td>
<td></td>
</tr>
<tr>
<td>- Make home visits</td>
<td>- Emergency care at night usually unavailable</td>
<td></td>
</tr>
<tr>
<td>- May be unavailable as a result of being occupied with another income generating activity</td>
<td>- No standard hours</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cost</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cost of treatment varies</td>
<td>- Free care</td>
<td></td>
</tr>
<tr>
<td>- Criticized for overcharging patients</td>
<td>- Financial burden for transportation, over night hospital stay, income lost from work absence while seeking medical care, etc.</td>
<td></td>
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<tr>
<td>- Accepts non-monetary forms of payment</td>
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<tr>
<th><strong>Stereotypes</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Witchdoctors, non-Christians</td>
<td>- Uncaring, condescending</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Record Keeping</strong></th>
<th><strong>Indigenous Health Practitioners</strong></th>
<th><strong>Biomedical Health Practitioners</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Written documentation non-existent among most</td>
<td>- Written log of visit date, patient name, residence, age, sex, drug prescribed, kept by the patient: blue book</td>
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</table>

(table continues)
Table 1. IHP/BHP Variables (continued)

<table>
<thead>
<tr>
<th>Provider-patient Interaction</th>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
</tr>
</thead>
</table>
| Provider-patient Interaction | - Often able to communicate easily and readily to establish mutual confidence with patients  
- Consultations generally last an hour or more  
- Frequently touches patient and often discusses social issues during consultations | - Often uses a paternalistic approach to communicate with patients  
- Consultations generally last fifteen minutes or less |

<table>
<thead>
<tr>
<th>Willingness to Refer</th>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
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</thead>
</table>
| Willingness to Refer | - More likely refer patients to BHPs, and seek care from BHPs themselves  
- Criticized for referring patients to BHPs when illness is terminal and irreversible | - Less likely to refer patients to IHPs |

<table>
<thead>
<tr>
<th>Structure</th>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
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</thead>
</table>
| Structure | - No formal structure | - Uganda’s modern health care system is made up of both public and private health care facilities. The structure of the health care system consists of:  
- Village Health Teams: Village health teams consist of community volunteers who are provided with basic health training by the government.  
- Health Center II: A health center II should exist in every parish, according to Uganda’s federal health policy – although this is not always the case. These facilities are established as out-patient clinics. Health center II facilities are supposed to be staffed by an enrolled nurse, midwife, two nursing assistants and a health assistant. |
Table 1. IHP/BHP Variables (continued)

<table>
<thead>
<tr>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
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<tr>
<td></td>
<td>• Health Center III: A health center III should be found in every sub-county, according to Uganda’s federal health policy. These centers are established to provide outpatient services and include a maternity ward, and a laboratory. Health center III facilities are supposed to be led by a senior clinical officer and staffed by approximately 18 medical workers.</td>
</tr>
<tr>
<td></td>
<td>• Health Center IV: A health center IV operates as a small-scale hospital and serves a county or parliamentary constituency. In addition to all of the services provided at a health center III, a health center IV admits patients and should have a theatre(^{17}) for emergency operations. A senior medical officer and another doctor should be on staff at every health center IV. Patients are often referred to health center IV facilities for chronic or severe ailments.</td>
</tr>
<tr>
<td></td>
<td>• Hospital: A hospital should be found within every district throughout the country. Hospitals are expected to provide all the</td>
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\(^{17}\) Room in a hospital equipped for the performance of surgical operations.
In many African countries, including Uganda, the use of biomedical health systems is widespread. However, common acceptance and extensive use of biomedical health services does not mean that community members abandon indigenous beliefs and practices (Rekdal, 1999). Although BHPs are government certified, indigenous methods of healing are highly respected and sought out by rural community members. Over 80% of the rural population in Uganda seeks primary medical care from IHPs (WHO, 2002; World Bank, 2003). The high rate of rural community members who seek care from IHPs is due, in part, to the fact that gaining access to modern health care is difficult in rural areas of Uganda and other African countries (Burnett, 1999; Green, 1994; Tumwesigye, 1996). In Uganda, approximately one BHP exists for every 50,000 individuals, while approximately one IHP exists for every 300 individuals (WHO, 2002). Medical anthropologist Edward C. Green adds that high concentrations of IHPs in peri-

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<tr>
<th>Indigenous Health Practitioners</th>
<th>Biomedical Health Practitioners</th>
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<td></td>
<td>services found at a health center IV, as well as, specialized services (e.g. oncology, mental health, dentistry, etc.). Yet, all hospitals cannot handle all ailments. A number of referrals are made throughout the country to the national hospital located near the capital.</td>
</tr>
</tbody>
</table>

Sources: (Kleinman, 1978; Ngubane, 1992; Tumwesigye, 1996; Van der Geest, 1997)
urban areas suggest they are still frequently consulted, even when biomedical care is available (1994).

The indigenous approach to holistic care is a significant factor that attracts patients even when biomedicine is available, accessible, inexpensive or free (Waldram, 2000). By way of convention, IHPs tend to treat patients not only as individuals, but also as integral parts of a social and cultural whole. Despite the high community value of IHPs, many BHPs, government officials, and Western non-profit organizations view indigenous health care as unscientific and secondary to biomedicine. Members of these groups also question the efficacy of IHPs’ treatment methods (Anokbonggo et al., 1990; Van der Geest, 1997). Perceptions of IHPs being professionally inept are linked to historical stereotypes that degrade their character.

African indigenous health practitioners have long been depicted as primitive, irrational and evil witch doctors. Dated European travel documents and missionary reports showed that “witchdoctor frequently appeared as a metonym for Africa, a figure portrayed as incarnating a number of negative attributes that Europeans had ascribed to Africa” (Rekdal, 1999, p. 477). According to these documents and popular beliefs among Western voyagers, indigenous health practitioners had “no rational place in the modern technological world, and as the educational level of African natives improves and as time affords them cultural wisdom, it is expected that the people themselves will drift away from the primitive attractions of magic and seek help in science” (Margetts, 1954, p. 41).

On the contrary, several studies and initiatives from leading global health organizations have shown that through the 20th and into the 21st century indigenous care
continues to be highly respected, valued and needed in many African communities
(Burnett, 1999; Makundi & Malebo, 2006; Nakaibwe & Christensen, 2007; Tumwesigye,
1996; WHO, 2002.). Moreover, both medical and social scientists are slowly reshaping
widely held stereotypes of African IHPs. A primary reason for this is because the World
Health Organization (WHO) has recognized the central role of indigenous health systems
in efforts to provide primary healthcare (especially in rural areas) and has advocated for
collaborative health programs involving IHPs since 1977 (Akerele 1987; Green, Zokwe,
& Dupree, 1995; WHO, 1978). Advocacy for collaboration by WHO was initially based
on the fact that indigenous medicine is the main, and often the only, source of medical
care for a significant number of populations in the developing world (Romero-Daza,
2002). In addition, WHO acknowledged the value of indigenous medicine’s community-
centered nature and holistic approach to health (Chan, 2008; Romero-Daza, 2002; Van
der Geest, 1997).

In 1984 the WHO Global Medium-Term Program on indigenous medicine
provided further direction for incorporating IHPs into community-based health programs,
suggesting that enhancing the skills of IHPs would be more efficient than training new
biomedical health workers. WHO also recommended that governments not get bogged
down in the bureaucracy of establishing official policies regarding IHPs, and instead
involve IHPs in the planning of future initiatives and allow their roles to be organically
defined (Green, 1994). Medical anthropologist Sjaak Van der Geest claims that in the
years following, WHO quietly shifted its priorities and traditional medicine has become a
function of the Division of Drug Management and Policies “where it is dying a slow
death” (Van der Geest, 1997, p. 904). However, in a relatively recent address to the
WHO Congress on Traditional Medicine, Director-General Dr. Margaret Chan (2008) asserted that “research and development in traditional medicine is part of the WHO global strategy and plan of action on public health.”

Over the past three decades WHO and others have claimed that enlisting the help of IHPs can help to improve the quality of health care coverage in rural communities (Brehony, 2000; WHO 1978). Despite an ongoing debate on the efficacy of IHPs’ treatment methods and whether the practices of IHPs and BHPs are contradictory or complementary, IHPs can play an important role in disease prevention and advocating for positive health behavior changes within rural communities of African countries (Anokbonggo & Oluju, 1990; Van der Geest, 1997). The value of IHPs in public health initiatives is demonstrated by several cooperative initiatives involving African indigenous and biomedical health practitioners that have led to successful outcomes (Brehony, 2000; Ingstad, 1990; Makundi, et al., 2006; Nakaibwe & Christensen, 2007). Moreover, physician and medical anthropologist Marc Micozzi (2001) asserts that because biomedicine has limitations, indigenous medical systems can be used to contribute to a more comprehensive approach to health and healing. IHPs’ position in society, their medical practices and their beliefs are pertinent for predicting the success of any health campaign that targets rural communities in African countries, such as Uganda (Ingstad, 1990).

The Ugandan government and other African health ministries have recognized the importance of using IHPs in health campaigns that target rural community members (UNAIDS, 2000; WHO, 2002). The most notable collaborative initiative between IHPs and BHPs in Uganda was an early 1990’s effort to combat HIV/AIDS (UNAIDS, 2000).
The Ministry of Health and the National AIDS Commission launched an initiative called Traditional and Modern Health Practitioners Together Against AIDS (THETA). The aim of the project was to promote collaboration between IHPs and BHPs in the areas of treatment, care, support and prevention of HIV/AIDS and other STDs. The program still exists today and is said to have made a significant contribution to the reduction of HIV/AIDS in Uganda over the last decade (Green, 2000). Despite these past successes, today there are conflicts between the IHPS and BHPS that stem from misconceptions about one another’s practices, lack of trust in each other’s motives and lack of respect for the value that each contributes to the community (Burnett, 1999; Green, 1994; Tumwesigye, 1996). The discord between the two practices has caused efforts of collaboration to be difficult and essentially unsustainable.

The lack of sustainability and feasibility of collaborative initiatives has prompted Green (1994) and Van der Geest (1997) to question whether collaboration is the answer to improving the quality of health care in rural African communities. Additionally, Green (1994) draws attention to the use of collaboration versus cooperation when referring to improving the relationship between indigenous and biomedical health care providers. He cautions practitioners and researchers to be aware of the distinction between cooperation and collaboration because while the two terms are often used interchangeably, they have varied implications. Cooperation implies a better working relationship between IHPs and BHPs. An improved working relationship includes cultural sensitivity, understanding, and respect of each other’s practices as they are. On the contrary, collaboration involves some level of integration. Integration requires fundamental changes in both practices and in the roles of respective practitioners. In
most cases of collaboration between IHPs and BHPs, IHPs are often expected to change their practices and abide by biomedical rules and regulations (Green, 1994, 2000; UNAIDS, 2000; Van der Geest, 1997). Health practitioners and researchers must consider that IHPs and BHPs are not equal partners prior to collaboration, and that the disparity would be accentuated when bringing both practices together. Green (1994) argues that during collaboration the danger “is that the traditional healer may become a second-rate paramedical worker and thereby cease to carry out his or her important function in the local community” (p. 20).

Observations and claims made by Green, Van der Geest, Micozzi and others raise the question – Does collaboration seem feasible only when viewed through the lens of our Western logic? Perceived logical reasons for collaboration include (Green, 1994; Tumweisgye, 1996; Van der Geest, 1997):

- Biomedical health facilities are often understaffed and developing a referral system that allows IHPs to treat less serious illnesses would relieve the burden on hospitals
- IHPs are often the frontline of treatment in rural communities, but they lack basic resources that can be provided by BHPs (e.g., gloves, sanitary supplies, etc.)
- IHPs do not compete with BHPs at the local level
- BHPs at the local level tend to respect and believe in some indigenous practices
- Survey results demonstrate that IHPs are highly motivated to learn about biomedicine, to attend training workshops, and to cooperate with BHPs

While these points of view may make sense from an etic perspective (e.g., policy makers, idealists, and social scientist), they may not be as clear-cut from an emic perspective.
Rural community members may experience contextually complex social and, in turn, health issues that may motivate them to point to other solutions other than collaboration that improve the quality of their health care systems.

Over a decade ago, Van der Geest (1997) drew attention to the fact that hardly any community-based research had been conducted on how “ordinary people” perceive indigenous health care and whether they would favor collaboration between indigenous and biomedical health practices. Today, a lack of literature that accounts for rural community members’ perspectives on collaborative health care still exists (Kaboru, et al., 2006). Through an analysis of the research we conducted in Southwest Uganda, I will contribute to filling that gap and demonstrate that it is critical that the perspectives of community members be used to inform health initiatives in rural areas of Uganda and other developing countries.
CHAPTER 3

METHODOLOGY

Overview

Our research team collected a plethora of data over the summers of 2008 (Phase I) and 2009 (Phase II) to explore the feasibility of improving cooperation between indigenous health practitioners (IHPs) and biomedical health practitioners (BHPs) in an effort to increase health care access in rural communities and in turn, improve health outcomes for children ages 5 and under. Our research agenda was driven by alarming statistics of child mortality rates in Uganda (Ross, 2004; WHO, 2006), as well as, statistics that demonstrate gaining quality health care access is difficult in rural areas of the country (Kelly, 2009).

My dissertation focuses on data collected during Phase II of our study (summer, 2009), which explores the healthcare needs and experiences of community members who are caretakers of children ages 5 and under. As a health communication researcher, I am interested in evaluating the role of communication in health care settings throughout Southwest Uganda. More specifically, I am interested in the application of communication theories and practices to the local health care context – ranging from provider-patient interactions to cultural influences on health behaviors. Accordingly, my dissertation research questions are:

1. What have been the health care experiences of rural community members who are caretakers of children ages 5 and under in Southwest Uganda and have sought care from IHPs and/or BHPs?
2. How are the health-seeking behaviors of rural community members who are caretakers of children ages 5 and under in Southwest Uganda shaped by their social priorities and cultural perceptions of local health practitioners (both indigenous and biomedical health practitioners)?

3. What are the perspectives of community members who are caretakers of children ages 5 and under on 1) community health needs, 2) the value of IHPs and BHPs, and 3) the feasibility of cooperation between indigenous and biomedical practices?

4. What recommendations do community members who are caretakers of children ages 5 and under have for improving health care access in rural areas of Southwest Uganda?

5. How can health communication researchers assist in constructing a culturally appropriate, testable model for improving indigenous and biomedical patient care and health care access in Southwest Uganda?

Although my dissertation focuses on data collected during Phase II of our study, to describe the full scope of the project I have outlined the specific aims, timeline, population sample, and methods of data collection for Phase I. This description is followed by a more in-depth explanation of the research methodology for Phase II, which includes specific aims, timeline, population sample, methods of data collection, methods of analysis, ethical issues, and funding source.

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18 I conducted an analysis of Phase II data and the strategy for validation of research findings included in this dissertation as a health communication researcher. Other team members have conducted other analysis of the data with approaches/perspectives from their respective disciplines (e.g. anthropology and public health).
Phase I (2008)

Aims & Timeline

We arrived in Uganda in 2008 without a specific research agenda. Our goal was to engage in applied research that our in-country partners, Mbarara University of Science and Technology and Healthy Child Uganda, would deem as meaningful, beneficial, and appropriate. Because the highest mortality rates in Uganda exist among children ages 5 and under (Ross, 2004; WHO, 2006), with one of the leading causes of child mortality being malnutrition, we were also tasked with designing a study that would lead to the improvement of child health.

After a series of meetings where we discussed our in-country partners’ experiences and challenges as community health researchers and workers, we identified three primary questions that could inform public health initiatives to improve child health in the area: 1) What existing resources can be used to decrease the high rates of childhood malnutrition in the area? 2) Why do community members still seek care from IHPs when BHPs are accessible? 3) And simply, what can we do to improve the quality of health care in the area?

We conducted an in-depth literature review as our first step in engaging in research that may answer these questions. Results of our literature review suggested that cooperation between IHPs and BHPs might be an effective method of increasing the availability and quality of health care coverage in rural communities and reducing pervasive childhood illnesses beyond malnutrition. Therefore, we constructed the first phase of our 10-week in-country research to achieve the following aims:

- Evaluate the existing level of cooperation between IHPs and BHPs

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• Assess intergroup perceptions and interactions among IHPs and BHPs
• Identify obstacles to patient care for IHPs and BHPs
• Identify health seeking behaviors of community members
• Determine willingness of community members to participate in a cooperation between IHPs and BHPs
• Ascertain familiarity with symptoms, diagnoses, and treatments of malnutrition

We used the initial three weeks to set up study logistics (gain access to our sample population, arrange meeting times, arrange transportation, etc.). Data collection took place in the fourth through eighth weeks. Within this time, we spent approximately 150 hours in the field building rapport among study participants, conducting observations and collecting data. We reserved the final two weeks to conduct data analysis and provide a safeguard against any unforeseen events.

Population Sample

Our sample included:

- IHPs (N = 71); 75% female; mean age = 51 yrs
- BHPs (N = 24); 87.5% female; mean age = 40 yrs
- Community members (N = 39); 67% female; mean age = 37 yrs

Specific methods of data collection were as follows:
Data Collection Procedures

Focus Group Discussions: Indigenous Health Practitioners

IHPs in the Bushwere, Ryamiyonga, Kongoro and Kibare parishes were informed of our study and mobilized by parish leaders and community health workers associated with Healthy Child Uganda. We constructed and administered a survey to participating IHPs, which focused on obtaining knowledge of:

- Existing collaborations\textsuperscript{20} among IHPs
- Willingness to collaborate with one another
- Existing collaborations between IHPs and BHPs
- Willingness of IHPs to collaborate with BHPs
- Use of modern health treatments among IHPs
- Awareness of modern health practices among IHPs
- Perceptions of community need for BHPs among IHPs

Following administration of the surveys, we facilitated in-depth focus group discussions (FGD) and key-informant interviews with selected IHPs in the aforementioned parishes to explore:

- Factors that may encourage or discourage partnerships with BHPs
- Perceptions of best practices within indigenous and biomedical health systems
- Interest in receiving biomedical training
- Factors that may encourage or discourage willingness to join an organized association of indigenous healers

\textsuperscript{20} Collaboration accurately describes the language that was used during our study. The distinction between the erroneous and interchangeable use of collaboration vs. cooperation was identified after the study was completed.
• Awareness of malnutrition, related symptoms, diagnosis and recommended
treatment guidelines

Participating IHPs received reimbursement for their travel costs and a small snack.

Focus Group Discussions: Biomedical Health Practitioners

We facilitated in-depth focus group discussions with BHPs from Mbarara University Hospital to explore:

• Factors that may encourage or discourage partnerships with IHPs
• Perceptions of best practices within the indigenous and biomedical health systems
• Interest in cooperating with IHPs
• Awareness of malnutrition, related symptoms, diagnosis and recommended
treatment guidelines

Participating BHPs received lunch but were not reimbursed for their travel costs due to the extremely short distance traveled (approximately .10 mile) to participate in our study.

Surveys: Biomedical Health Practitioners

BHPs employed at Health Centers (HC) II\(^{21}\) and III\(^{22}\) in the Bushwere, Ryamiyonga, Kongoro and Kibare parishes were informed of our study and mobilized by

\(^{21}\) HC II stands for Health Center Grade II and serves a parish. It provides outpatient care, ante-natal care, immunization and outreach. A HC II is structured to be staffed by one enrolled nurse, one enrolled midwife and two nursing assistants. There are however typically only one to two staff members on hand.

\(^{22}\) HC III stands for Health Center Grade III and it serves a sub-county. It provides all the services of a HC II, in addition to inpatient care and environmental health. It is structured to be staffed by one clinical officer, one enrolled nurse, two enrolled midwives and one nursing assistant, one health assistant, one laboratory assistant and a records officer.
professors in the Department of Community Health at Mbarara University of Science and Technology. Participating BHPs completed a survey to help us obtain knowledge of:

- Current collaborations with IHPs
- Willingness to collaborate with IHPs
- Willingness to train IHPs in biomedical methods
- Perceptions on the effectiveness of indigenous treatments
- Perceptions of community need for IHPs among BHPs
- Factors that may encourage or discourage a partnership with IHPs
- Perceptions of best practices within the indigenous and biomedical health systems
- Awareness of malnutrition, related symptoms, diagnosis and recommended treatment guidelines
- Willingness to support government regulation and financing of IHPs

**Questionnaires: Community Members**

Members of the research team asked community members who were seeking care from or lived near one of the HC II and III in the Bushwere, Ryamiyonga, Kongoro or Kibare parishes, or the HC IV\(^{23}\) in Kinoni to voluntarily complete a questionnaire. The questionnaire was structured to help us obtain knowledge of:

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\(^{23}\) HC IV stands for Health Center Grade IV and it serves a health sub-district. It is the headquarters of the health sub-district. It provides all the services of Health Centre III, in addition to surgery, supervises the lower level units HC IIs and IIIs, collects and analyses data on health, and plans for the health sub-district. It is structured to have at least one medical officer, two clinical officers, one registered midwife, one enrolled nurse, one enrolled midwife, one comprehensive nurse, two nursing assistants, one laboratory technician, one laboratory assistant, one health inspector, one dispenser, one public health dental assistant, one Anaesthetic Officer, one Assistant Health Educator, one Records Assistant, one Accounts Assistant and two support staff. *While all HC II, III, and IVs are structured to be staffed by the healthcare providers noted, they are often understaffed.*
• Community members’ perceptions of best practices within the indigenous and biomedical health care systems
• Willingness to seek treatment at a health center that employed both a BHP and an IHP
• Willingness to seek treatment from an IHP who has an established referral system with a health center
• Awareness of malnutrition, related symptoms, diagnosis and recommended treatment guidelines

Community members received a small snack in exchange for their participation.

Phase II (2009): Focus of Dissertation

Aims & Timeline

Because participant responses from Phase I revealed a number of urgent community health issues in addition to malnutrition (e.g., malaria, STIs, severe rashes, and complicated pregnancies), we24 expanded our study focus to include overall child health and not just malnutrition. We also recognized the need to collect more in-depth information from community members because their health care experience would be most affected by an IHP/BHP partnership.

Building on these implications, the purpose of the second phase of the study was to conduct a needs assessment among community members who are caretakers of children age 5 and under. The needs assessment was guided by the central research question—“What has been the experience of caretakers of children age 5 and under in rural areas of Southwest Uganda who have sought health care from IHPs and/or BHPs?” To address

24 2009 Research Team: Tesfa Alexander, Julia Hanebrink, Kara Miller, and Joy Nolte.
this question we constructed the second phase of our research to achieve the following aims:

- Evaluate whether community members in remote rural areas see value in a partnership between IHPs and BHPs
- Evaluate community members’ cultural perceptions of illness
- Gain insights on how to increase community receptivity and awareness about severe and pervasive childhood illnesses that statistically contribute to the high rates of child mortality within the community (e.g., malnutrition, malaria)
- Identify effective methods to encourage community members to seek early care for severe and pervasive childhood illnesses

As in the first phase of our study, we conducted our field research over the course of 10 weeks during the summer of 2009, using the initial 2 weeks to set up study logistics. We spent the following 3 weeks collecting questionnaire data. We spent weeks 6 – 9 conducting observations of patient-provider interactions and key informant interviews. Lastly, we reserved the last week to conduct preliminary-data analysis and provide a safeguard against any unforeseen events.

Throughout our data collection we focused on participant narratives to gain cultural knowledge and themes surrounding:

- Perceptions of best practices within the indigenous and biomedical health care systems (for self and children)
- Perceptions of community need for BHPs and IHPs
• Awareness of common illnesses that statistically plague children within the community, related symptoms, diagnosis, and recommended treatment guidelines

• Perceptions of health priorities (self and children)

Sample Population

Our sample included:

- Total community members (N = 106); 91% female; mean age = 33.5 yrs

  - Questionnaire participants (N = 58); 97% female; mean age = 29 yrs

  - Key informant participants (N = 4); 2 males & 2 females; mean age = 28 yrs – all key informants were identified from the sample population of community members who participated in the questionnaire

  - Patient-provider observation participants (N = 48); 85% female; mean age = 38 yrs

Data Collection Procedures

Questionnaire

We asked a convenience sample of community members in attendance at Healthy Child Uganda’s Child Immunization Days (held on the country’s National Child Health Days) in the Bushwere (N = 9), Kongoro (N = 15), Kitiunguru (N = 10), Nyarubungo (N = 15), and Ryamiyonga (N = 9) parishes to complete our study questionnaire (see Appendix A for sample questionnaire). We purposefully visited the six sites on Healthy Child Uganda’s Child Immunization Days because, historically, considerably large
crowds in rural areas of Southwest Uganda turned out for those events. Therefore, we
knew that we would secure a large convenience sample of care takers of children ages 5
and under as they were seeking free immunizations for their children. Surprisingly,
children in rural areas are just as likely to be immunized in comparison to children in
urban areas (Hutchinson et al., 1999).

We randomly asked community members seeking vaccinations for their children
to complete our questionnaire. Those who consented completed the questionnaire in a
private location to ensure confidentiality. Questionnaire participants received a small
snack and were guaranteed that they would not lose their spot in the cue – coordinated
with administrators from Healthy Child Uganda. Completion of each questionnaire took
approximately one hour. The questionnaire was completed verbally and led by a member
of the research team, with the assistance of an interpreter who verbally translated
researcher questions (English to Runyankore) and participant responses (Runyankore to
English). We designed the questionnaire to help the research team obtain more in-depth
knowledge (in comparison to Phase I) of:

- Perceptions of the efficiency and effectiveness of indigenous and biomedical
  systems
- Patterns in health-seeking behavior
  - Level of self-treatment for various diseases
  - Length of time illness is endured before seeking assistance
  - Frequency of visits to practitioners
  - Preferred method of treatment for “folk,” physical and mental illnesses
• Ability of indigenous and biomedical practitioners to cure “folk” (traditional), physical and mental illnesses

• Awareness of general knowledge about healing
  o Association of certain diseases with certain cures

• Recommendations for improvement of the overall health system

Key-Informant Interviews

Following administration of the questionnaires, we asked select community members to participate in key-informant interviews (N = 4). Based on their questionnaire responses, we asked community members who had unique experiences to participate in interviews so that we could further explore:

• Unique experiences seeking care from indigenous and/or biomedical health practitioners

• Innovative recommendations for improvement of the overall health system

• Social and cultural values and themes that shape their health-seeking behaviors

• Perceptions regarding the feasibility of cooperation between indigenous and biomedical practices

Key-informant interviews took place approximately 2-3 weeks after initial questionnaire participation. We attempted to travel to the homes of our key informants to conduct the interviews so that they would not be burdened with any travel costs. However, finding their homes was extremely difficult and we thus asked them to meet us at the closest health center. All key-informants received reimbursement for their travel costs and compensation for their time.
Each key-informant interview was semi-structured and lasted approximately 75 minutes. Similar to the process for conducting the questionnaire, the key-informant interviews were led by members of the research team with the assistance of an interpreter who verbally translated interview questions (English to Runyankore) and participant responses (Runyankore to English).

Observations of Patient-Provider Interactions

We also observed patient-provider interactions in biomedical and indigenous health care settings. Observations were conducted at the Bushwere HC II (N = 14), Kinoni HC IV (N = 27), and at the home of a spiritual healer/omufumu25 (N = 7) approximately 3 km from the Kinoni HC IV. We selected the Kinoni HC IV to begin our observations of patient-provider interactions because it was the largest health center in the area. Bushwere HC II was chosen, in contrast to the Kinoni HC IV, so that we could observe patient-provider interactions at a much smaller health center in an isolated rural area. The observations of patient-provider interactions that were conducted at the home of an indigenous health practitioner within close proximity of a health center (Kinoni HC IV) were an attempt to observe patient-provider interactions in an indigenous health care setting with community members who have access to both biomedical and indigenous care.

Informed consent was obtained from all health care providers and patients observed. Patients seeking care at the Kinoni and Bushwere health centers were randomly selected to be observed and participate in a brief intake survey (see Appendix B for sample) prior to their consultation with the health care practitioner. The intake survey

25 Omufumu is frequently used to refer to spiritual healers in Southwest Uganda who stereotypically resemble the Western idea of a witchdoctor.
took approximately ten minutes to complete and was completed verbally. With the assistance of an interpreter, members of the research team collected demographic data (e.g., age, sex, level of education, etc.), and information on the patients’:

- Perceived illness suffered
- Perceived best method for treating current illness
- Motivation for seeking care that day
- Expectations of care that day
- Experience treating/seeking care for current illness prior to visit

Intake data was not obtained from patients seeking care at the IHP because confidentiality in information shared could not be ensured due to space limitations (lack of private location at the IHP’s home).

Each patient-provider interaction was observed by one member of the research team and one interpreter. We observed patient-provider interactions to:

- Understand the nature of indigenous and biomedical healthcare settings
- Explore the value community members in the area see in biomedical and/or indigenous care
- Identify patterns of communication and levels of patient agency

The interpreter translated and transcribed all of the interactions as they were happening through written documentation. All of the patient-provider interactions were also recorded and later translated by another interpreter to verify accuracy. The research team member observing the interactions took notes to document non-verbal communication, the setting, and personal impressions.
Lastly of note, operational supplies (e.g., buckets, mops, cleaning solution, etc.) were donated to the Bushwere HC II, Kinoni HC IV, and the spiritual healer who allowed us to observe patient-provider interactions.

Translation & Interpreters

As westerners conducting research in an area where English is rarely spoken, the use of formally trained and highly skilled interpreters was critical. We employed three native Southwest Ugandan interpreters (1 male, 2 females) to assist in field research during Phase II of our study. All three interpreters were recommended by and received formal training from professors at Mbarara University.

Prior to going into the field, all informed consent documents, the questionnaires and intake survey were translated from English to Runyankore by one interpreter, and then back translated by another interpreter from Runyankore to English to verify accuracy. During this process, interpreters clarified terms used within the data collection instruments and provided recommendations on culturally appropriate protocol.

All interpreters participated in a formal briefing with the research team prior to going into the field. Interpreters were briefed on the purpose of the study, data collection protocol, ethical issues, and our concerns around conducting qualitative research in a foreign culture. Interpreters were also briefed on roles; interpreters were reminded that the core research team members would be taking the lead in all data collection procedures (e.g., initiating and controlling all dialogue). Roles were explicitly communicated to emphasize that all questions and probing were to be initiated only by a member of the core research team.
While conducting research in the field, interpreters directly translated dialogue between members of the research team and study participants in real time. Interpreters were asked to translate everything that was said (e.g., not read questionnaires/surveys and not paraphrase) by both members of the research team and study participants during data collection.

Although some study participants had some competency in speaking English, we conducted all data collection procedures in Runyankore. Our decision was driven by research that shows that while participants may be able to communicate adequately in a second language, the extra effort required (especially when discussing emotional or sensitive topics) could hinder the accuracy of the information shared (Marshall & While, 1994; Nicassio et al., 1986; Westermeyer, 1990). Use of an interpreter to manage the communicative exchanges between the research team and study participants was intended to encourage study participants to fully express themselves and obtain a first hand account of rural community members’ perspectives.

Taking several steps pre, during, and post data collection to encourage interpreter accuracy and decrease interpreter variance was critical because my research focuses on the exact narratives (i.e., language and descriptions) used by all study participants. While I acknowledge that some language may have inevitably been lost in cultural translation (i.e., language ambiguity and idiomatic expressions), I directly use the translated

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26 Language ambiguity includes lexical ambiguity, case ambiguity and referential ambiguity. For example: The translation of “Please let him know when his book can be published,” can be interpreted as: “Please let him know at what time his book can be published” or At the time that his book can be published please let him know” (Jin, 1991).

27 Slang or dialect that are commonly known among native speakers.
narratives of community members in the subsequent chapters to share their views and experiences as accurately as possible.

Images D, E, F. Examples of Translator/Interpreter Assisted Interviews in the Field
Data Analysis Procedures
Methodology: Constructivist Grounded Theory

I have used constructivist grounded theory methodology (Charmaz, 2000; Mills & Bonner, 2006) to analyze community members’ responses to our questionnaires, conversations during community member key-informant interviews, and observations of patient-provider relationships. My decision to focus on the responses of community members is driven by the premises of standpoint theory (Collins 1990; Harding, 1991; Wood, 2005) and muted group theory (Griffin, 2006; Kramarae, 1981). Standpoint theory states that those on the lowest rung of the social ladder have a more realistic view of the world, and correspondingly, muted group theory states that there is a need to
proactively account for the voices and experiences of marginalized groups (Collins, 1990; Griffin, 2006; Harding, 1991; Kramarae, 1981; Wood, 2005). Our study participants are considered marginalized because of their low economic status (global and in country comparison) and gender, with the overwhelming majority of study participants being female.

Constructivist grounded theory methodology is a contemporary revision of Glaser and Strauss’s (1967) original grounded theory. Kathy Charmaz (2000), a student of Strauss and Corbin, revised the methodology to 1) account for a relativist approach, 2) acknowledge multiple standpoints and realities of both the grounded theorist and the research participants, and 3) take a reflexive stance toward researcher actions, situations, and participation in the field, and constructions of participants in researcher analyses. Constructivism emphasizes the subjective interrelationship between the researcher and participant, and the co-construction of meaning – ontologically relativist and epistemologically subjectivist. Thus, constructivist grounded theory reshapes the interaction between researcher and participants in the research process and in turn, positions the researcher as author (Mills & Bonner, 2006).

Constructivist grounded theory is the best methodology, given my focus on a culture-centered approach to the health experiences of rural community members. Describing the methodology, Charmaz (2000) states, “the viewer creates the data and ensuing analysis through interaction with the viewed” (p. 523). Dutta (2004) adds to Charmaz’s statement and notes that through dialogue researchers invest in learning about the culture of their study population and immerse themselves within that culture to construct effective applications and build sustainable partnerships. Moreover, Charmaz
(2000) argues that a constructivist approach to grounded theory is necessary because “data do not provide a window on reality. Rather, the ‘discovered’ reality arises from the interactive process and its temporal, cultural, and structural contexts” (p. 524).

Key to constructivist grounded theory is the constant-comparison technique (Boeije, 2002; Mills & Bonner, 2006). The constant-comparison technique involves comparing and contrasting coded themes that emerge from a data set to develop a theory. Researchers start by comparison of data with data, and then move to comparisons between their interpretations translated into codes and categories and more data. This technique “grounds the researcher’s final theorizing in the participants’ experiences” (Mills & Bonner, 2006, p. 3).

Using the constant-comparison technique, I used a 3-step procedure to analyze responses to our questionnaires, conversations during key-informant interviews, and observations of patient-provider relationships (see Appendix C for Coding Scheme):

1. Comparison of coded themes within each artifact: questionnaire; interview; patient-provider interaction

2. Comparison of coded themes between artifacts in the same location or village: questionnaires; interviews; patient-provider interactions

3. Comparison of coded themes between artifacts from different locations or villages: questionnaires; interviews; patient-provider interactions

I analyzed each collection of artifacts separately (e.g., all questionnaires, all interviews, etc.) using this three-step procedure. Each step within the comparison procedure involved a specific type of analysis activity, had a primary aim, included targeted questions, and led to distinct results (see Table 2).
Table 2. Detail of Three-Step Constant Comparative Analysis Procedure (Boeije, 2002)

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Analysis Activities</th>
<th>Aim</th>
<th>Questions</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison within a single questionnaire, interview, or patient-provider interaction</td>
<td>Open coding: Summarizing core of the data and finding consensus on interpretation of fragments</td>
<td>Develop categories of understanding</td>
<td>a) What is the core message of the questionnaire, interview, or patient-provider interaction? b) How are different fragments related? c) Are the data consistent? d) Are there contradictions? e) What do fragments with the same code have in common?</td>
<td>Summary of the data; Provisional codes; Conceptual profile</td>
</tr>
<tr>
<td>Comparison between questionnaire s, interviews, patient-provider interactions in the same location/village</td>
<td>Axial coding: Formulating criteria for comparing different sets of data; hypothesizing about patterns and types</td>
<td>Conceptualization of the subject and production of a typology</td>
<td>a) Is A talking about the same thing as B? b) What do both sets of data reveal about the category? c) What combinations of concepts occur? d) What interpretations exist for this? e) What are the similarities and differences between data sets, A, B, C…? f) What criteria underlie this comparison?</td>
<td>Expansion of code words until all relevant themes are covered; Description of concepts; Criteria for comparing data sets; Clusters of data sets (typology)</td>
</tr>
<tr>
<td>Comparison between questionnaire s, interviews, patient-provider interactions from different locations/villages</td>
<td>Triangulating data sources</td>
<td>Complete the picture and enrich the information</td>
<td>a) What is group 1’s perspective about certain themes and what is group 2’s perspective about the same themes? b) What themes appear in group 1 but not in group 2 and vice versa? c) Why do they see things similarly or differently? d) What nuances, details or new information does group 2 supply about group 1 and vice versa?</td>
<td>Verification of provisional knowledge of study participants and additional insight</td>
</tr>
</tbody>
</table>
Table 3. Examples of Emergent Themes

<table>
<thead>
<tr>
<th>Emergent Theme</th>
<th>Artifact</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Lack of Trust as a Barrier to Care”</td>
<td><strong>Sample from Questionnaire</strong></td>
</tr>
<tr>
<td></td>
<td>Interviewer: Have you ever received treatment from a traditional health practitioner?</td>
</tr>
<tr>
<td></td>
<td>Respondent: I don’t like omufumu because they cheat you. I don’t go to omufumu.</td>
</tr>
<tr>
<td></td>
<td><strong>Sample from Key-Informant Interview</strong></td>
</tr>
<tr>
<td></td>
<td>Interviewer: Ok. You went to the traditional health practitioner to treat your child for oburo and they did not get cured. When you went to the health center did they ask you what your child was suffering from?</td>
</tr>
<tr>
<td></td>
<td>Respondent: I cannot tell them the truth that I first took the child for cutting with oburo, because if I could tell them they do abuse us and chase us to go back where we first went. So what I do is I simply tell them the symptoms the child is having now.</td>
</tr>
<tr>
<td></td>
<td>Interviewer: Ok.</td>
</tr>
<tr>
<td></td>
<td>Respondent: …like the high temperatures.</td>
</tr>
</tbody>
</table>

| “Identification as a Rhetorical Act” | **Sample from Questionnaire**                                           |
|                                      | Interviewer: Where did you deliver your last child?                      |
|                                      | Respondent: At a traditional birth attendant                              |
|                                      | Interviewer: Why did you decide to deliver your last child at the traditional birth attendant? |
|                                      | Respondent: The woman who delivered my child was Catholic and I am a Catholic |
|                                      | **Sample from Patient-Provider Interaction**                             |
|                                      | Patient: You said I have to pay 750,000 shillings, yet you yourself recognized it that my financial status is not good. Is it possible for you to give me a discount? I lost my job and I no longer work. |

(table continued)
<table>
<thead>
<tr>
<th>Emergent Theme</th>
<th>Artifact</th>
</tr>
</thead>
<tbody>
<tr>
<td>THP: You will see the changes, you go and work. That is why I told you to pay in installments. When you start on the herbs, follow the right dosage. The herbs have a dose, a teaspoon in the morning, again at noon and at six. Three times a day. The bathing one, you also get one teaspoon and put it in your bathing water. Do not use soap. You bathe it for 3 days and that is enough. You will be back on your feet.</td>
<td></td>
</tr>
<tr>
<td>THP: Have you ever been to the health centre?</td>
<td>Patient: Yes</td>
</tr>
<tr>
<td>THP: How much is panadol?</td>
<td>Patient: 100 shillings.</td>
</tr>
<tr>
<td>THP: And in the pharmacy?</td>
<td>Patient: 150 shillings</td>
</tr>
<tr>
<td>THP: How often do you go back? Did you recover completely when they treated you?</td>
<td>Patient: No, it goes and comes back.</td>
</tr>
<tr>
<td>THP: Any other problem?</td>
<td>Patient: My main issue was the financial one. After giving me the herbs, will I have to come back?</td>
</tr>
<tr>
<td>THP: I will rid you of all evil spirits and you will be back on your feet in no time. You should have faith. How come when you go to the health centre and they tell you that the medicine is 100,000 shillings, you pay with no doubt? Why do you trust these white people, yet when a black one tells you something you doubt?</td>
<td>Patient: [No response]</td>
</tr>
</tbody>
</table>
Inter-rater Reliability

To obtain inter-rater reliability for each type of data, two graduate students assisted in the coding process. All members of the coding team initially read one transcript. While reading the transcript, I took the lead in developing an initial coding scheme, which I shared with the other two coders. Following collective agreement on the coding scheme, the entire team independently coded the same sample transcript. The coding scheme was refined and finalized after group discussion and agreement. The coding team members then each coded the same 20% of the transcript data. We shared our coding results with one another and when agreement was reached on 80% of the data subset, the coding scheme was considered reliable. I coded the remaining data. The coding process involved dividing the data into conversational turns, assigning codes to each, and then comparing the codes to develop top-level categories and sub-categories. I compared the top-level categories and sub-categories to categories used for the summative qualitative content analysis to identify inconsistencies and shared themes. I carried out this entire process individually for anecdotal responses to our questionnaire, transcripts from patient-provider interactions and community member key-informant interviews.

Verification Procedures

I employed the method of triangulation, as discussed by Creswell (2007) and Mathison (1988), to verify all data collected. Triangulation is defined by Creswell as a format for increasing the validity of evaluation and research findings by analyzing various data sources and methods “to lead to a singular proposition about the phenomenon being studied” (p. 13). I used a number of methodological approaches
during the course of this study – questionnaires, key-informant interviews, observations and an extensive literature review. While analyzing all the data, I considered the following criteria to ensure validity, as recommended by Creswell: possible interviewer influence of participant responses; accuracy of the transcriptions; accuracy of reflective documentation of participant’s experiences; other conclusions that could have been derived from others, aside from the researcher; clear articulation of the phenomenon being studied; and overall reflexivity.

Lastly, to ensure personal verification procedures, I adopted three approaches to conducting qualitative research that were coined by Hendrix (2001): 1) “don’t let other people think for you, use your own head” – while I was completely open to suggestions from others, it was critical that I follow my own intuition as one of the principal study investigators when faced with circumstances and decisions that could have changed the course of the study. Allowing “other people to think for me,” would have increased the likelihood that I might have lost control of the study direction, purpose, and focus on social justice. 2) “Watch how you carry yourself” – I (and my research team members) were, at times, identified as an outsiders when going into rural communities that were ‘off the beaten path’ in Southwest Uganda. In many instances, our presence caused a spectacle and all eyes were on us. It was important that we were mindful of our actions and of local customs so that we did not unintentionally damage the credibility and trust that we had built within the community. 3) Lastly, it was essential that I “keep good records” – at the core of ensuring that the data collected were valid was being confident that it was rich and above all, accurate. Ensuring the data were rich and accurate involved them being thorough and organized.
IRB Approval/Ethical Issues

IRB Procedures

Institutional Review Board (IRB) approval was obtained from both the University of Memphis and Mbarara University of Science and Technology in Southwest Uganda. IRB approval was required from Mbarara University because members of the institution oversee all academic research activities in the area and work in partnership with Healthy Child Uganda.

Ethical Issues

In addition to obtaining IRB approval from the University of Memphis and Mbarara University of Science and Technology, further steps were taken to ensure that no serious ethical issues arose during the course of this research. Additional steps to ensure that a high standard of ethics was maintained throughout the duration of the research include:

- The lead researcher ensured that all study activities were structured around the ultimate goal of improving quality healthcare access for the study population
- No health interventions were or will be recommended/implemented that cannot be sustained by the community
- Informed consent was obtained from all study participants
  - All study participants were informed of the study purpose and assured that participation was completely voluntary
- Numbers and letters for data filing were assigned to all study participants to protect anonymity
o No names will be used in published documents

• No medical records were used during the course of the study

• All precautions were taken to ensure that all participants were not at risk for any physical or emotional harm

• A copy of all published study documents will be provided to community leaders for review and distribution to the community
CHAPTER 4

QUESTIONNAIRE FINDINGS: COMMUNITY PERCEPTIONS AND HEALTH-SEEKING BEHAVIORS

Overview

Rural community members who are caretakers of children ages 5 and under responded to questions regarding: 1) the efficiency and effectiveness of indigenous and biomedical systems and 2) their individual health-seeking behaviors. Responses from questionnaire and key-informant participants reveal that the concept of trust fundamentally shapes their views of local health practitioners (both IHPs and BHPs) and experiences in seeking care. Respondents often conveyed their views not only in multidimensional constructs of trust, but more often, mistrust (moderate suspicion and lack of confidence) and distrust (high doubt in honesty and reliability). Furthermore, in their responses, community members defined provider trust within categories of interpersonal trust (confidence built through repeated interactions through which expectations about a person’s credibility and intentions can be tested over time) and social trust (confidence in collective institutions that is influenced by general social confidence and beliefs). Emerging themes within both categories were dominated by their perceptions of provider ethos. Provider ethos is shaped by views of a provider’s technical competence (level of training/education, access to resources, demonstrated skills), interpersonal competence (compassion, sensitivity, and communication skills), reliability, and dependability. Health provider ethos is often conceptualized as credibility, and is, by and large, based on perceived technical competence and interpersonal competence, otherwise known as goodwill (Pearson & Raeke, 2000; Rowe
& Calnan, 2006; Thom, et al., 2004). I define goodwill as how a patient perceives a health care provider’s genuine concern for their well-being, which is predominately affected by a provider’s level of compassion and sensitivity.

Perceived provider competence and goodwill play a significant role in patient trust (Fiscella et al., 2004). Health provider competence and goodwill are often based on cultural knowledge and impressions made during prior patient-provider interactions, or through group affiliation. Questionnaire responses demonstrated that while high levels of interpersonal mistrust and distrust shape community members’ perceptions of government supported BHPs, high levels of social trust in their competence, along with limited health care options supersede negative perceptions of goodwill associated with interpersonal mistrust and distrust. My research findings specifically focus on perceptions of government supported BHPs; however, of note, community members expressed moderate to high levels of interpersonal trust with BHPs working in private institutions. Responses from community members also demonstrated that levels of interpersonal and social trust, mistrust, and distrust associated with IHPs varied by specialty (e.g., herbalist, bonesetter, TBA, omufumu). The varied levels of interpersonal and social trusts were directly influenced by varied perceptions of indigenous provider competence and goodwill. A snapshot of the various levels of social and interpersonal trust of both BHPs and IHPs as expressed by community members can be seen in Figure 4 (Note: this figure is based on the author’s interpretation of dialogue from study participants on not based on any quantitative measurement).
Lastly, questionnaire responses demonstrated that multidimensional perceptions of provider competence influence the health-seeking behaviors of rural community members much more than perceptions of goodwill. Conclusions drawn about the health-seeking behaviors of rural community members were put within the contexts of cultural beliefs and social/environmental limitations.
Perceptions of BHPs: Competence and Goodwill

It is widely believed in rural areas of Southwest Uganda that BHPs are credible because as one community member stated “they have smartness.” My initial assumption at the beginning of our study was that biomedical providers are viewed in high esteem because of their level of training and education. However, my analysis of the data revealed that the competence and credibility of BHPs are largely attributed to their resources, rather than their personal skills and knowledge. BHPs who do not have drugs or diagnostic tools often lose credibility, and are viewed with mistrust by community members:

- “How do they know what drugs we need if they don’t have machines to test us?”
- “We come here to test our blood for HIV, but here they have no machines. I wonder how they get those results. Even people who are told they are positive, they don’t believe because they have no machines here.”

As demonstrated by these inquiries, community members often express trust in the effectiveness of biomedical tools to detect and assess illnesses, and to successfully treat illnesses. When asked questions regarding the efficacy of government supported BHPs and the value of biomedical care, the majority of questionnaire respondents attributed the effectiveness of biomedical care to tablets, injections, or scientific testing:

- “[My child] got better from tablets and rest”
- “Cortium for the child worked”
- “The child got better with tablets from the government hospital”
- “My child was better after injections and tablets”
• “They gave [my child] red tablets, she got some relief, but the sickness came back after a month”

• “What I like about modern\textsuperscript{28} is there treatment”

• “I just like their treatment... like treating children and myself, but I don’t like any other thing”

• “I like that they have tools to realize condition and identify disease”

In rural areas of Southwest Uganda, the value of biomedical medicine, and in turn government supported BHPs, is heightened because biomedical medical supplies are extremely limited. The only alternatives community members have to obtaining biomedical medicine from government supported BHPs are to purchase it from a pharmacy or pay for biomedical treatment at a private clinic. Both of those alternatives are often impossible for community members because of their inability to pay for transportation costs to access those services, let alone the actual medication or treatment. Therefore, in rural communities, government supported BHPs are gatekeepers who gain credibility because of their access to and control of dire medicine and diagnostic instruments.

The communal understanding that BHPs are gatekeepers to vital resources mitigates any negative perceptions of BHPs’ goodwill that community members may develop as a result of their personal experiences. Twenty-four percent of community members who responded to our questionnaire reported being mistreated by a BHP working in a government institution. However, the majority of community members responded “no” to the direct question – “Have [you] ever experienced mistreatment by a BHP?” Their responses to other questions indicated otherwise and revealed

\textsuperscript{28} Modern is the term used in Uganda to describe biomedical health care.
mistreatment. For example, a twenty-year-old mother of two from Kinoni stated, "The care within modern is not good... when pregnant mothers reach there, sometimes the health facilitator asks 'Am I the one who impregnated you?' It's a reason why I can decide not to go back." Yet, she claimed that she had never been mistreated by a BHP and was actually seeking biomedical care for her child on the day that she participated in our study. The mother of two from Kinoni and a number of other community members often spoke about “abuse” and “mistreatment” when seeking biomedical care, yet many shared the belief that “[BHPs] are the ones giving medicine so there is nothing I should hate about them.” Experiences of mistreatment expressed by community members fell within themes of verbal abuse, prolong waiting time, lack of practitioner concern, and gatekeeper enforcement (denial of medical resources). Narratives that fell within the theme of gatekeeper enforcement (alone and in combination with other themes) were most frequent:

- “They quarrel with you and talk badly to you and fail to give you treatment”
- “They delay, takes a long time then they tell you there are no drugs”
- “Sometimes I come here and drugs are there but they are not given out”
- “They normally come here and they refuse to give them medicine even if it’s there”
- “Sometimes see patients at their convenience and refuse care without explanation”
- “Sometimes you go to the health center and those medical workers look at you badly, talk to you badly, and don’t even care about why you are there. They
don't mind about your illness. Can you go home really happy when they have not helped you?”

The community value of BHPs is influenced by their roles as gatekeepers of biomedical medicine and tools, as well as, their roles as gatekeepers to specialists and more equipped health units (e.g., HC IVs and Hospitals). Although managed care policies in industrialized societies that emphasize primary care physicians as gatekeepers have been shown to impede access to specialists and undermine patient trust (Groopman, 2007; Grumbach et al., 1999), our research shows the opposite in rural areas of Southwest Uganda. Secondary to granting access to biomedical medicine, BHPs’ ability to refer patients increases community members’ perceptions of their level of competence. Moreover, a number of community members trust and value BHPs’ not just because of their practical ability to refer, but because of their willingness to refer:

- “They test and treat what they know. If they don’t know, they refer.”
- “They can refer. If they test you and find the task is difficult, they refer you to where you can get treatment.”

These two examples show that community members view BHPs’ willingness to refer as a demonstration of honesty and humility, which in turn increases perceptions of goodwill. Many healthcare providers in industrialized societies do not admit defeat, and often attribute failure to the illness or blame the patient (Groopman, 2007; Segal, 2005). The same scenario exists in Southwest Uganda, especially among IHPs (discussed in the following section - Perceptions of IHPs). Community members who are caretakers of children ages 5 and under in rural areas of Southwest Uganda highly value healthcare
providers who recognize when they cannot treat an illnesses and recommend another provider who can, working in the best interest of the patient.

Apart from trust related to access to biomedical tools and networks, an analysis of community member responses indicate that interpersonal trust in the intentions of BHPs is very low. There are several cases when community members indicated that interpersonal trust in a particular BHP was high, but it was on a case-by-case basis. A father of three in Ryamiyonga told us:

- “Some other people when they come here, especially pregnant mothers, the health workers mistreat them and they end up now not liking the health center. It is not with every health center. It is not with all nurses in the health center…. [There is frequent turnover]. Sometimes it is a benefit and other times it’s a challenge. Because they might bring a good person replacing the bad one who is transferred, and it might be the other way around.”

A reoccurring theme in the narratives of community members who experienced distrust among BHPs, unrelated to access to biomedical tools and networks, was “guilty by association.” Community members recurrently noted that they would be verbally abused by BHPs if they disclosed that care was sought from an IHP prior to seeking biomedical care:

- “What I have seen... the modern they do despise the traditional\(^{29}\). And if only you come from the traditional and you tell the modern, they mistreat you. They cannot talk very well on you.”

- “Like if I go to the hospital and bring herbal treatment, they would refuse.”

\(^{29}\) Traditional is the term used in Uganda to describe indigenous health care.
- “The modern, they abuse you if they have found out you have consulted traditional.”
- “I cannot tell [BHP] the truth that I first took the child for cutting with oburo, because if I could tell them they do abuse us and chase us to go back where we first went. So what I do is I simply tell them the symptoms the child is having now.”

Fear of being scolded by BHPs for seeking indigenous care not only increases levels of distrust, but also inhibits patient-provider communication.

The experiences of community members who have disclosed to BHPs that they sought indigenous care initially led me to assume that BHPs were acting out of malice because of possible resentment towards IHPs, fear of competition, or ignorance toward indigenous care – all of which may be true. However, the narrative of a rural community member offers another perspective:

- “It happens with the modern, some of them do despise the traditional birth attendants because of an example of some mothers who first go to the traditional birth attendants and when the traditional birth attendants first refers that person to the modern you find the nurse is now mistreating the pregnant mothers of delaying in the community.”

This and other community member narratives imply that the primary motivator for BHPs scolding community members for seeking care from IHPs is their belief that it delays patients from obtaining ‘proper care’ and puts patients’ health at risk. Results from previous research recorded evidence of this specific notion, noting BHPs’ concern over the potential harm of IHPs’ use of unsterilized instruments. While “mistreating” patients
creates high levels of distrust, from this perspective BHPs’ motives appear to be based on good intentions.

**Perceptions of IHPs: Competence and Goodwill**

IHPs earn their credibility within the community through their association with a specific type of practice (e.g., herbalist, bonesetter, TBA, omufumu), individual performance, and personal reputation. Where the overall level of social trust in the competence of BHPs is fairly uniform, the social trust in the competence of IHPs is extremely mixed. The only group of IHPs with consistent levels of social and interpersonal trust is the bonesetters.

Rural community members who are caretakers of children ages 5 and under view bonesetters as extremely competent because of their proven skill over decades to cure broken bones. The high level of communal credibility of bonesetters exists throughout Africa, and is not specific to Uganda (Onuminya, 2006). As noted by a key informant, it is widely known that bonesetters are the primary providers for skeletal fracture care:

- “Where I am basing my reason of not taking the broken person to modern is because I have never visited any. And if at all a person breaks and gets a broken bone, they rush that person to a traditional for bone setting. Maybe I hear of Mbarara hospital, the incidences that happen at Mbarara hospital. That is where I heard that people are taken to Mbarara hospital for bonesetting. But for me I have never experienced that condition of taking a person to the health unit or to the hospital, but instead we take the person to the bonesetter.”
This is supported by the beliefs of other community members that “bonesetters should be put in modern hospitals,” and evidence that demonstrates that social trust in the competence and effectiveness of bonesetters at times overrides negative personal views about indigenous care as a practice:

- “For me, I don’t believe in traditional. My religion doesn’t believe in traditional. But there are ones that can cure broken bones.”

Other than bonesetters, there is a general sense of ambiguity around the competence of IHPs. Community members’ narratives regarding the skills of IHPs often centered on themes of “needed validation”:

- “Those people use eyes to see and cure the disease. He looks at you and says ‘you are suffering from this disease.’ So I wonder, how does that person see the blood to determine disease?”

- “I wish to know how traditional do their things. Like the traditional birth attendant when they produce.”

- “What I know is that the modern first test and gets to know what type of illness you are suffering from and what type of drugs you need. But with the traditional he just guesses and gives you the medicine and incidentally but you get cured. There is a way how God gave them that knowledge. Because some of them they just see you or just touches you and he quickly tells you what you are suffering from. So it is the knowledge from God.”

- “I can ask the traditional healer… ‘you are treating people, where did you study those things from?’”
Despite the general sense of ambiguity around the competence of IHPs as a whole, individual IHPs earn their credibility through evidence-based results. This is evident by 1) statistics that show that over 80% of the rural population in Uganda seeks primary medical care from IHPs (WHO, 2002; World Bank, 2003); and 2) narratives from community members who describe experiences with specific IHPs as “working well,” “providing relief,” and “helpful.” Questionnaire responses indicate that from the experiences of community members, levels of individual trust with known herbalists and TBAs are moderate and levels of individual trust with omufumus30 are extremely low. This overall observation is supported by the views of a key-informant:

Me: “Would you like to see anything in the community changed in regards to traditional health?”

Community member (CM): “Needs to ban them all”

Me: “Ban them all?”

CM: “No, it depends.”

Me: “What would you like to see banned?”

CM: “Omufumu, but for traditional birth attendants they should remain… because there are a lot of people down the hill and it difficult to move up the hill to the health center. Sometimes they do things I am not happy with. Still, it is good for them to remain so they can help those people away from the health center.”

Me: “What about herbalists?”

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30 Omufumu is frequently used to refer to spiritual healers in Southwest Uganda who stereotypically resemble the Western idea of a witchdoctor.
CM: “Herbalists are not the same. There are some who give you herbs and you get cured of the illness. There are others who are about money. They just get a certain herb, they might, and give you without knowing it cures. They are just looking for money.”

Me: “Is there a way to know?”

CM: “We get to know them. “Say if you go to a certain herbalist, they get the herbs, and after taking them, you don’t get cured. There are some if you go to the herbalist and he gives you herbs and you get cured. Then you know this person has herbs that don’t cure.”

Omufumu distrust as explained by community members primarily centered on themes of “conflicts of interest” and “damaged relationships.” Conflicts of interest result from omufumus creating business for themselves; and damaged relationships between patients and their families were a result of omufumu prescribed cures and diagnosis.

Conflicts of interest occur when health care providers have motives or are in situations in which patients and others could conclude that the moral requirements of the provider’s roles are or will be compromised (Brennan, et al., 2006). Community members’ views of conflicts of interest among omufumus result from the communal belief that these IHPs are the only individuals who can cure spiritual illnesses and are also the ones who create them:

- “They work on two sides. They charm and cure the charm.”
- “They make you sick from obusiko31 then the same person you have to pay to cure”

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31 Folk illness
“The problem with them is that they are the ones who give charms, but the are also the ones who treat. It’s like a strategy”

Financial gain is at the root of conflicts of interests associated with omufumus. Rural community members express distrust in omufumus because they not only create business for themselves, but overcharge for it as well. Prices for the services of omufumus vary, but are the most costly of all health care services in Southwest Uganda. Prices for one consultation and dose of treatment can range from 10,000 – 500,000 shillings. To put that in perspective, a bottle of Quinine (malaria treatment) costs 1,300 Ugandan shillings, and approximately 50% of the population earns less than 2,500 shillings per day (UNICEF, 2006).

Rural community members also have high levels of social and interpersonal distrust in omufumus because as common practice, many omufumus indicate patients’ family members as the cause of spiritual illnesses:

- “When you give children herbs and they do not recover, first thing they tell you when you go there is that child is suffering from family problem, like grandma is affecting the child. So they end up breaking up a family.”
- “Some destabilize the home or family by bewitching”
- “Omufumu tells you a certain person is the one who bewitched you. They kill relationships between people. That’s why I hate them sometimes.”

Accusing a patient’s family member leads to high levels of patient distrust because it is an indirect form of patient blaming. Patient blaming is a rhetorical tactic that shifts the patient from being an innocent victim to guilty culprit. Omufumus oftentimes assign moral blame for illness and describe illness as the wages of sin, a behavior that has been
practiced by caregivers in many cultures for centuries (Gunderman, 2000). As a collectivist\textsuperscript{32} culture, assigning moral blame to a patient’s family member can be viewed as an indirect attack on the patient herself. This is because from a collectivistic perspective, close interpersonal relationships are the central, defining feature of self-concept (Oyserman, Coon, & Kemmelmeier, 2002). Collectivism is centrally defined by a connection between – rather than a separation from – the self and relevant others. Therefore, diagnoses that encourage patients to sever strong interpersonal bonds go against cultural norms, and lead to extremely high degrees of social and interpersonal distrust. This research finding was surprising in light of evidence that demonstrates IHPs are valued because of their understanding of cultural norms.

Another source of community members’ distrust across most indigenous practices is the notion of IHPs’ unwillingness to admit their inability to treat and cure certain illnesses. Community members gave accounts of experiences where omufumus, along with herbalist and TBAs allowed a patient’s condition to get worse – sometimes fatal – without taking ownership or acknowledging that their prescribed treatment was ineffective:

- “They can’t admit defeat. Even if you’re dying. Even if they can’t handle they will say they can handle. That is why sometimes I hate them.”
- “Cannot admit they cannot handle a case”
- “They just look for money. Even cases they don’t know, they say they can handle. People end up dying when they should’ve been cured.”
- “I don’t like the omufumu. They treat and fail and can’t admit their defeat.”

\textsuperscript{32} Collectivist societies value strong social bonds. A primary goal in a collectivist society is to maintain important group memberships and interpersonal relationships (Oyserman, et al., 2002).
The lack of honesty and humility led to high levels of interpersonal distrusts in particular providers. Experiences where IHPs failed to take ownership and work in the best interest of the patient were on a case by case basis, and thus were not generalized as high social distrust for the practice as a whole, nor specialties within the practice.

**Health Seeking Behaviors in Social and Environmental Context**

As demonstrated, rural community members who are caretakers of children ages 5 and under have varied levels of trust in the competence and goodwill of health care providers across both biomedical and indigenous health practices. Direct and indirect responses to questions regarding the health seeking behaviors of rural community members reveal that perceived levels of provider competence are much more influential than perceptions of goodwill.

Additionally, further analysis of responses shows that community members customarily categorize illnesses as either “traditional” or “modern”. Traditional illnesses are perceived to be best treated by IHPs and primarily include social problems (e.g. marital counseling, family disputes, etc.), bewitching/satanic diseases, and folk illnesses with physical symptoms, such as oburo\(^{33}\) and ebino\(^{34}\). Modern illnesses are perceived to be best treated by BHPs and primarily include physical ailments that require testing for formal diagnosis, such as malaria, cancer, sexually transmitted diseases, and tuberculosis. In spite of this generalization, a significant number of community members acknowledged IHPs’ (herbalist in particular) effective treatment of worms and stomach

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\(^{33}\) Oburo is believed to affect both children and adults, with symptoms that are closely related to pneumonia. IHPs treat this illness by slicing the chest of the infected host to remove millet-like nodules.

\(^{34}\) Ebiino is widely believed to affect every child at an early age, with symptoms that are closely related to diarrhea. IHPs can treat ebiino by extracting the child’s tooth to remove what is believed to be a maggot-like insect from the gums, or keeping the tooth intact and treating the gums with herbs.
aches as the one exception to their perceived inferior ability to treat physical ailments.

Some community members simply preferred indigenous care for worms and stomach aches, while others believed that BHPs were not capable of effectively treating these two maladies:

CM: “To me it is also preferable to take the child to the traditional before bringing that child to the health center, because sometimes the child is suffering from worms and even if you bring that child to the health center the child might not get better and you might have to take that child to the traditional again.

Me: “Ah, why do you think it is that the child does not get better when they go to the health center but they get better when they got to the traditional?”

CM: “Ok, to me the traditional, their herbs they work better than when I bring my children to the health center, especially when they are suffering from worms.”

Me: “Especially when they are suffering from worms.”

CM: “Yes”

Me: “Is there anything you would bring the children to the modern practitioner for first than the traditional practitioner? Any illnesses?”

Me: “Yes. Like malaria, headache, nasal bleeding... that is what I commonly bring the child here for first.”

Me: “Anything else?”

CM: “Even if there are other illnesses now I cannot remember them. But mostly I have remembered these ones in which I commonly bring the child to the health center.”
Me: “Ok. And are there other reasons, benefits to going to traditional besides their medicines or herbs?”

CM: “The grumbling stomach, that’s what I mostly take the child for to the traditional”

An examination of illness categories organized by physical, social, and mental ailments showed that among rural community members who are caretakers of children 5 and under in Southwest Uganda, BHPs were the preferred method of treatment for physical ailments, IHPs were the preferred method of treatment for social ailments, and there were mixed preferences between BHPs and IHPs for mental ailments (see Figure 5).
Figure 5. Preferred methods of treatment for physical, social, and mental ailments
Research conducted in industrialized societies shows that health-seeking behaviors are directly influenced by social, and most often, interpersonal trust in health care providers because increased trust often leads to increased satisfaction, adherence to treatment, continuity of care, disclosure of potentially important medical information, and improved health outcomes (Hall, Zheng & Dugan, 2002; Safran et al., 1998; Thom, Ribisl, Stewart & Luke, 1999). While this is common knowledge in health communication literature, these studies do not account for uncontrollable social and environmental circumstances that mitigate many of these factors in developing areas. Patients whose health-seeking behaviors are directly influenced by interpersonal trust often have one thing that rural community members in rural areas of Southwest Uganda do not: options. Interpersonal trust is often the last variable to be accounted for in the decision-making process of rural community members seeking care. Limited health care options make issues such as accessibility and cost more influential in shaping the health-seeking behaviors of rural Southwest Ugandans (see Figure 6).
Figure 6. Seeking Health Care in Rural Southwest Uganda: Factors in Patient Decision Making
Patients who have feasible options (accessibly and financially) of health care providers tend to be more trusting of the health care provider that is chosen (Rowe & Calnan, 2006; Tarn et al., 2005). This referent may explain why community members in rural areas of Southwest Uganda who have extremely limited health care options, experience wide ranging levels of social and interpersonal distrust and mistrust with both indigenous and biomedical health practitioners.
CHAPTER 5

PATIENT-PROVIDER INTERACTIONS: COMMUNITY MEMBERS’ EXPERIENCES IN BIOMEDICAL AND INDIGENOUS SETTINGS

Overview

We observed patient-provider interactions in biomedical (Kinoni HC IV and Bushwere HC II) and indigenous (home of a spiritual healer) settings to 1) understand the nature of both health care environments, 2) explore the value community members place on biomedical and indigenous care, and 3) identify patterns of communication and levels of patient agency. An analysis of patient-provider discourse in both settings demonstrates that patients bring a level of certainty to each setting – high expectation that they will receive biomedicine from their consultation with BHPs, and that IHPs (specifically spiritual healers) will share the same spiritual beliefs and explanatory models of health and illness. This level of certainty, along with the type of treatment sought, sets the tone of discourse in both settings. The overwhelming majority of patients observed in the biomedical settings sought care for physical ailments, and patient-provider dialogues demonstrate that the presence (or lack) of health information exchange did not affect whether patients received biomedicine. Alternatively, the overwhelming majority of patients observed in the indigenous setting sought care for social ailments. In such cases, patient-provider dialogues demonstrate that the exchange of health information is critical to diagnosis and treatment.

Despite the variance in the level of health information exchanged in both settings, patient agency was restricted by socially constructed roles and beliefs about BHPs and IHPs. As the gatekeepers of biomedicine, BHPs maintained control of the treatment
decision-making process, while the IHP did the same, in part because of patient fear of the practitioner’s “spiritual powers.” Moreover, although levels of patient voice varied by provider, patient-provider observations reveal that overall patient empowerment is extremely limited. Some patients had the opportunity to express themselves, yet the presence of patient voice led to little influence over the health care environment. The mere presence of patient voice in patient-provider dialogues did not guarantee that rural community members in Southwest Uganda were successful in their attempts to exert control and influence over their health care seeking experience, let alone the health care system.

Biomedical and Indigenous Settings

Kinoni HC IV

Observations of patient-provider interactions began at the Kinoni HC IV. One BHP who self identified as a “doctor” was observed over the course of three days. The BHP was a male who wore a white lab coat during all patient-provider consultations and was fluent in both English and Runyankore. The BHP usually arrived between 10 and 11 a.m. each day to meet a full waiting room of approximately 40-50 patients. The BHP would begin seeing patients immediately, with the average patient consultation lasting 77 seconds. The BHP saw patients one after another without taking a break until he had to attend to other obligations (e.g., on-site trainings, off-site meetings, and shifts at other health centers). Most patients had been seen by the BHP before he attended to other obligations, but there were times when some patients were not attended to and were instructed to come back the following day. During patient consultations, other staff members frequently came in and out of the room to speak with the BHP, pick up
documents, or gather medical supplies. This was, in part, due to the fact that the consultation room was the only way staff members could access the drug dispensary (see Image G). After consultation with the BHP, the majority of patients were instructed to wait outside in a grassy area until their names were called to receive prescribed tablets. The average wait time to receive drugs was 2-3 hours.

Bushwere HC II

We conducted patient-provider observations at the Bushwere HC II over the course of two days, following observations at the Kinoni HC IV. We intended to conduct observations over the course of three days, but the Bushwere HC II was unexpectedly closed on the first day (a day/time it is normally open). According to community members, the HC II was closed on the first day because it was staffed by only one BHP who was attending a funeral. We observed the primary BHP over the course of the remaining two days. The BHP observed was a male who wore dark blue scrubs on both days and self identifies as a “health worker.” The BHP arrived between 9 and 10 a.m. each day. He arrived to four patients waiting for him the first day and none the second day. The BHP consulted an average of 12 patients on each day, with the average patient consultation lasting 11 minutes. The BHP saw patients one after another without taking a break until all of the patients had been attended to. Patient consultations took place in a small room that the no one was allowed to enter once each consultation began (see Image G). The majority of patients received tablets from the BHP before they left the consultation room.
Lastly, we conducted observations of patient-provider interactions over the course of four days at the home of a spiritual healer who self identified as a “doctor.” The spiritual healer was a male who was often shirtless and smoked a tobacco pipe during patient consultations. Patients sought care at various times throughout the day. The IHP consulted an average of three patients during the time of observations from 9 a.m. – 4 p.m. each day. Patient consultations lasted approximately 26 minutes and took place in a small “hut.” There were various tools (e.g., cup of water for foretelling, fire pit, pipe, etc.) that were used during patient consultations (see Image H).
Seeking Biomedical Care

“The physician-patient interview is a rhetorical encounter in which the behavior of one interlocutor is determined to a great extent by his or her view of the other” (Segal, 2005, p. 40). As demonstrated in the previous chapter and discussed further in this chapter, both the patient and the provider himself narrowly perceive the role of BHPs as gatekeepers to biomedical resources. Additionally, both parties believe that the patient’s primary motive for seeking biomedical care should be to obtain biomedicine in the shape of tablets and injections. Thus, patient-provider interactions are primarily shaped by those preconceived one-dimensional roles: BHPs’ willingness to grant patients access to those sought biomedical resources. As a result, the full scope of a patients’ illness and provider resources are left unmatched at the point of care (see Figure 7).
Considering this point of view, it may be over-simplistically inferred that the majority of patients who sought biomedical care had favorable experiences. This inference is supported by research results, which show that over 95% of patients indicated that they expected to receive tablets or an injection on the day of their visit to the BHP, and over 90% of patient consultations ended with patients being given one of the two treatments. Furthermore, an analysis of patient-provider observations show that in particular, the narrowly shared objective among both patients and BHPs of
gaining/providing biomedicine renders the exchange between both interlocutors static. While there were significant differences in the approach to patient-interviewing and interactive settings (e.g., length of consultations, level of privacy, and level of provider communication competence) at the Kinoni HC IV and Bushwere HC II, there were numerous instances at both health centers where patients exhibited a lack of agency and BHPs failed to understand the full scope of a patient’s illness history and how it affected their life. Limitations in patient agency and provider understanding are a result of the one-dimensional communicative exchange. The dialogue essentially boils down to – Patient: “I am sick” Provider: “I am going to give you tablets.”

Observations at Kinoni HC IV

Patient consultations at the Kinoni HC IV were extremely static, brief, and monotonous. Communication between patient and provider was minimal (i.e., exchange of patient name, age, residence, and one to two sentence explanation of perceived illness). The following is an example of a typical dialogue between patient and BHP:

BHP: “What is your name?”
Patient: [States name]
BHP: “How old are you?”
Patient: [States age]
BHP: “Where are you from?”
Patient: [States home village]
BHP: “What are you suffering from?”
Patient: “I have a stomachache and I also get headaches.”
BHP: “I am going to give you deworming tablets and some others.”
This dialogue shows:

1. Primary purpose of consultation is to receive/provide biomedicine
   a. e.g., Once finding out the patient’s perceived illness, the immediate call to action for the provider is to provide tablets, without further investigation into the patient’s health in the form of additional questions or formal biomedical diagnosis.

2. Absence of patient control, and in turn, lack of patient agency
   a. e.g., Prior to the patient-provider consultation, the patient disclosed to members of the research team that he “came [to the health center] to get examined.” The patient did not express this desire to the BHP.

3. Miscommunication/non-communication between patient and provider
   a. e.g., Prior to his consultation with the BHP, the patient also told members of the research team that he believes his stomachache might be related to worms or ulcers, that he suffered from symptoms related to the illness for over a year, and that he sought care from both an herbalist and another BHP before. This vital information about the patient’s illness history was not communicated to the BHP.

4. Limited understanding of patient distress as a result of viewing illness solely within a biomedical model
   a. e.g., The patient expressed frustration to members of the research team because his stomach ailment limited what foods he could eat within an already limited pool of options. The patient not only experienced pain from his illness, but was often weak and unable to work because of his restricted diet.

Not one patient who visited the Kinoni HC IV appeared to have any sense of
control\textsuperscript{35} in the level or type of care they received. Research shows that “a patient’s sense of control is compromised when patient and providers have different goals and expectations for a particular visit or for a regimen of care” (Young & Flower, 2001, p. 92). Considering the fact that both patient and provider had the same goal and expectation of receiving/distributing medicine, varying goals and expectations do not initially seem to be the issue. However, further analysis of patient narratives revealed that the ultimate goal of the patient was not simply to receive medication, but to take biomedicine in order to get “relief” (alleviate pain or discomfort from illness symptoms) or “recover” (become cured of illness). This observation is illustrated by the experience of a mother who was seeking care for her seven-month old son who had been experiencing severe diarrhea, nasal congestion, and vomiting episodes for over a week. The mother initially sought care for her son’s illness approximately a week before we observed what was her second consultation with the BHP. She was prescribed medication for her son during her first visit, but “the medicine didn’t work, there was no relief.” And she, “came back to tell the doctor it’s not working.” While she indicated that she expected to receive medicine from the BHP that day (her second visit), her ultimate reason for visiting the health center was to obtain “relief” for her son. Yet, her consultation with the BHP solely centered on the administration of tablets and her son’s ability to swallow them:

\begin{verbatim}
BHP: “What is the problem?”
Patient: “The child remains sick.”
BHP: “Didn’t I tell you to buy some medicine?”
Patient: “I did.”
\end{verbatim}

\textsuperscript{35} I define ‘control’ as the power to direct or influence.
BHP: “You bought the one for putting in the nose?”

Patient: “Yes I did”

BHP: “So, is there still congestion in the nose?”

Patient: “Yes, and it itches him and he gets headaches.”

BHP: “But he is able to swallow, like when you give him tablets, does he have difficult swallowing them?”

Patient: “No, he takes them.”

BHP: “How long has he had the fever? What came first, the fever or the nasal problem?”

Patient: “The nasal problem came first. But he is always been sickly.”

BHP: “How old is the kid?”

Patient: “Seven months old, sometimes he also throws up.”

BHP: “So will he be able to keep down the tablets.”

Patient: “He will take them.”

BHP: So you said he gets nasal blockage?

Patient: “Yes, and it itches him.”

BHP: “Am going to give him this medicine.”

Although it is implied, the mother did not communicate that the previously prescribed medication was ineffective. Nor does the BHP address that “the child remains sick,” that the child “gets headaches,” and that “he’s always been sickly.” The conversation is narrowly centered on the distribution and receipt of tablets, with the act of providing biomedicine distracting the BHP and limiting what he hears from the patient.

Correspondingly, the mere act of receiving biomedicine seems to pacify patients.
Patients who were observed seeking care from the health center appeared to accept whatever they were given, as long as it was in the form of biomedicine.

There were several instances when patients willingly accepted biomedical treatments that were previously provided to them, even if their personal experiences already proved them ineffective. A twenty-year old mother, visiting the health care center with her one-year old son but seeking care for herself, shared with a member of the research team that she visited the Kinoni HC IV two months prior and was diagnosed with vaginal candidiasis. She received treatment during her initial visit that helped her experience some “relief but the itching persisted.” During her conversation with a member of the research team, she indicated that the treatment she received was essentially ineffective. Yet, when asked what type of tablets she wanted and if she would consider taking the tablets she was given before, she stated, “I will tell them if they give me the same I will take. If they give different I will also take” – indicating a potentially consequential lack of patient agency. Although vaginal candidiasis can be easily cured with effective treatment, it can be lethal if left untreated (Nyiriesy, 2008).

The shared view between patients and providers is that a biomedical encounter is in essence a passive negotiation of goods (biomedicine), rather than a transmission (one-way monologue) or exchange (two-way dialogue) of health information to seek and obtain the most appropriate and effective method of treatment. The perception that the end goal is to obtain either tablets or an injection renders the exchange of pertinent health information between patient and provider stagnant, and therefore limits the BHPs’ understanding of patient suffering, and in part, restricts what patients share with providers. For instance, a pregnant patient seeking treatment for stomach pain expressed
to members of the research team that she suffered from other ailments that she had questions about: “I have a problem with my hearing. I had measles. It reached a certain time I can’t hear anything and other I can. Why is this?.... I normally come for treatment, but it comes back. Why at a certain point does it come back?” Members of the research team stressed that they were not trained to provide medical advice, and highly recommended that the patient ask the BHP during her consultation. Yet, a transcript of the patient provider interaction shows that during the very brief interaction the patient does not share her concerns or inquiries with the BHP:

BHP: “Hello. Why are you here? Should you be in the maternity ward?”

Patient: “They have told me to come here. I am having pain in the stomach.”

BHP: “We are going to give you the drugs we have and buy what we don’t have.”

Patient: “Ok.”

The BHP instinctively jumps to providing “drugs” as a solution, rather than exploring the full scope of the patient’s suffering in order to provide a potentially effective cure. Similarly, the patient accepts the receipt of “drugs” as the conclusion to the consultation. While we did not collect any post-consultation data to measure patient satisfaction in regards to the care they received, patient expectations were met considering she noted prior to her visit with the BHP: “Expect drugs but don’t know what they are going to give me.” This was one of many cases where patient expectations had seemingly been met, even though the patient told members of the research team that they suffered from an illness and/or had medical questions that were not shared with or addressed by the BHP.
Observations at Bushwere HC II

Patient consultations at the Bushwere HC II were also primarily centered on community members’ receipt and BHPs’ distribution of biomedicine. In spite of this, there were significant differences (compared to consultations at the Kinoni HC IV) in the level of communication competence among providers. The level of provider communication competence at the HC II was at times much higher than at the HC IV because of the centers’ contrasting approaches to patient-interviewing and the level of identification established between community member and provider. As a result, the dialogue between community members and the BHP at the HC II ranged from being reflective of the patient-provider interactions that took place at the HC IV to more dynamic interactions that included the actual exchange of health information and more prudent distribution of biomedicine.

The following is an example of a relatively dynamic patient-provider interaction that took place at the HC II, even though the patient/provider expectation/goal of receiving/providing biomedicine still existed:

BHP: “How are you?”

Patient: “Fine”

BHP: “Do you remember me?”

Patient: “Yes”

BHP: “What’s the problem with the child?”

Patient: “My child has diarrhea, breathes very fast and high temperature. She has cough.”

BHP: “Name?”
Patient: [Provides name]

BHP: “Did you take her for immunization?”

Patient: “Yes, except that one of a 9 months.”

BHP: “What is her age, and what village are you from?”

Patient: [Provides age and resident village]

[BHP takes child’s temperature with thermometer]

BHP: “You said she has diarrhea?”

Patient: “Yes, that’s what started first.”

[BHP takes child’s weight]

Patient: “She was almost making 10 kilograms.”

BHP: “She has 8 kilograms. How many times does she have diarrhea a day?”

Patient: “Four to five times”

BHP: “What have you given her to drink?”

Patient: “Porridge.”

BHP: “If like you give her any medicine, does she vomit it?”

Patient: “I only gave her herbal drugs and did not vomit it”

BHP: “Her kilograms are going behind so you need to feed her well like beans with gnuts, small fish, greens, fruits, porridge with milk”

Patient: “Is it ok to give her milk since it’s going to get the drugs?”

BHP: “It’s ok.”

Patient: “Is it ok to give her avocado?”

BHP: “Yes.”

Patient: “Will you get sugar and salt?”

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36 Ground nut similar in look and taste to a peanut.
Patient: “Yes.”

BHP: “Mix 2 full caps of boiled water with 8 teaspoons of sugar and 1 teaspoon of salt. Keep giving her this for 24 hours. Beyond this it will be expired. Give it to her every hour. For high temperature, make warm water and use a piece of cloth and cover it the child… but not just pouring water onto the child.

Patient: “Ok”

BHP: “You are going to buy Septrin\(^{37}\) and give a half two to three times a day...morning, afternoon and evening. I am going to give you malaria tablets, headache, Septrins and [inaudible] we don' have them in store so you are going to buy them.”

Patient: “Thank you.”

While this dialogue exemplifies that receipt/distribution of biomedicine was central to the patient consultation at the HC II, this dialogue also shows:

1. Exchange of health information and patient agency
   a. e.g., The patient takes the initiative to ask the BHP recommended care related questions, specifically her concern and need for education on what to feed her child.

2. Slight act of identification on behalf of the provider
   a. e.g., The provider starts the conversation with asking the patient if she “remembers him,” forming a subtle humanistic connection.

3. Patient-interviewing, yet missed opportunities for understanding the full scope of illness beliefs
   a. e.g., The BHP asks the mother a number of questions about her

\(^{37}\) Tablets used primarily to treat bacterial infections.
child’s illness history, yet key parts of the child’s illness history that were shared with members of the research team were not shared with the BHP. Prior to her consultation with the BHP, the patient told members of the research team that she believed her daughter’s symptoms were a result of a wound on her leg, and treatment she received for the wound at the same health center: “Baby has cough, diarrhea, and vomiting. [Symptoms are all] related because first the baby had wounds on leg. Then after she got cough. After the injection for the wounds, the heat was inside and caused cough.”

Similar to patients who visited the Kinoni HC IV, patients who sought care at the Bushwere HC II were not viewed as, nor did they take on the role of shared decision makers and thus did not have a significant amount of control in the level or type of care they received. However, patients seeking care at the Bushwere HC II were generally more active participants in the health care setting. While increased patient participation did not lead to increased control or variance in seeming goals, expectations, and outcomes of biomedical consolations (i.e. receipt/distribution of biomedicine), it did lead to increased levels in the exchange of health information.

Increased levels in the exchange of health information can, in part, be attributed to (as documented in my observations notes) a sense of “comfort” and “familiarity.” Patients who sought care at the Bushewere HC II appeared to “know” the BHP. This sense of “knowing” was confirmed and reinforced by the BHP at the onset of a number of patient consultations. The BHP often began consultations by asking patients: “Do you know me?” or “Do you remember me?” All patients who were asked either question
responded in the affirmative, and most followed up with the BHP’s name. The BHP was not interviewed; therefore, we did not obtain a reason as to why he began most consultations by posing those questions to patients during our observations. Nevertheless, his line of initial questioning can be seen as a slight act of identification that encouraged patient participation in the exchange of health information. Burke (1969) noted that within just about every social interaction we attempt to identify with one another by establishing a common bond, interest, or connection. The BHPs’ initial question of “Do you know me?” or “Do you remember me?” appeared to be an attempt to remind patients of an already existing connection, a strategy that contributed to the elevated degree of rapport between the patient-and provider, not seen at the Kinoni HC IV.

The degree of rapport established between patient and provider at the onset of many consultations was also sometimes visible toward the end of the dialogue when the BHP gave specific prescription, dosage and administration instructions to patients. As noted by one of the interpreters: “I like his rapport. He takes the time to explain the drugs. Most patients are confused. When he asks them to repeat, you can see they don’t understand. This one, his procedure is good. It builds a patient’s conscious. For us [Ugandans] it’s about psychology.”

Despite the notable level of communication competence among the BHP at the Bushwere HC II (e.g., patient-interviewing, exchange of health information, level of rapport), there were a number of instances where patients did not share their illness histories and beliefs in their entirety. While there were relatively far fewer instances of non-communication at the Bushwere HC II than we observed at the Kinoni HC IV, a
number of patients in Bushwere told members of the research team that they suffered from an illness and/or had medical questions that were not divulged to the BHP. My conclusion is that regardless of the level of communication competence among either patient or provider, it is outside of the cultural norm for patients to exhibit agency in the biomedical setting. This is supported by research findings in the previous chapter which indicate that 1) the community perception is that BHPs should not be challenged because they “hold the key” to vital medicine that can be denied to patients without consequence, and 2) patient choice is restricted to either access to the limited supply of medicine available or no medicine; and 3) exhibiting agency does not lead to a variation in the type of care received.

**Seeking Indigenous Care**

Previous research demonstrates that community members and IHPs often share the same cultural identity and thus have similar outlooks on health and illness (Burnett, 1999; Green, 1994; Kaboru et al., 2006; Mugaju, 1999; Nuwaha, 2002; Van der Geest, 1997). Shared cultural identity between IHPs and community members allows them to use an explanatory model of health and illness the two interlocutors understand, acknowledge, and respect. Within that explanatory model is the belief that social ailments are legitimate and often serious illnesses that are tied to physical and emotional distress. Moreover, social ailments are inherently spiritual by nature. Thus, as demonstrated in the previous chapter, omufumus (spiritual healers) are the preferred provider for the treatment of social ailments.

An analysis of patient-provider interactions observed at the home of a spiritual healer revealed that the dialogue between patient and provider is largely driven, if not
dependent, on the shared cultural identity that recognizes the vital role spirituality plays in health and illness in rural areas of Southwest Uganda. Additionally, an analysis of patient-provider interactions in the indigenous setting illustrates patient accounts of interpersonal distrust experienced when seeking care from spiritual healers, as discussed in the previous chapter.

Observations at the Home of an Omufumu

Patient consultations conducted at the home of an omufumu (spiritual healer) involved extremely high levels of information sharing between patient and provider that were facilitated by shared health beliefs and cultural identity. I use a key representative dialogue between patient and spiritual healer to highlight the primary findings from my analysis of all of the patient-IHP consultations. However, I will not present the dialogue in its entirety and then discuss the results of my analysis (as done with patient-BHP interactions), because the representative dialogue (and others) between patient and spiritual healer is quite lengthy. Rather, I will use excerpts of the interactions to expand on the following findings:

- Patient-IHP consultations followed a biopsychosocial model of health and illness, and therefore had a triadic purpose of receiving/providing physical (i.e., herbs), emotional (i.e., counsel), and social (i.e., advice) treatment
- The spiritual healer used patient patient-centered interviewing to understand the full scope of patients’ distress and illness history

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38 American Psychiatrist George Engel introduced the theory of a biopsychosocial model of health and illness in 1977. The model accounts for biological, psychological, and sociological systems as interconnected spectrums that all play a significant role in health or illness. Indeed, health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms (Santrock, 2007).
• Ongoing exchange of health information between spiritual healer and patient led to collaborative diagnosis of patients’ illness
  ○ However, patient agency was limited during the prescription of treatment options
• Shared spiritual beliefs shaped explanatory models of health and illness
• Patients and provider often used their social standing as a rhetorical tool during negotiations with one another about treatment costs

The primary representative patient-provider interaction that will be used to expand on my research findings involves a father of two who sought care from the spiritual healer for what would commonly be considered within the biomedical model an inability to conceive. However, the opening of the dialogue between patient and spiritual healer reveals that the patient’s illness beliefs went beyond physical suffering and also included emotional and social distress:

IHP: “How may I help you?”

Patient: “My home is bewitched. I married my first wife, we had two children and she left. I married my second wife. It has been 6 years since and yet we have no children. She has children too from another marriage. I do not know what is happening between me, my home and this woman. It has been 6 years since and yet we have no children. I do not know what is happening between me, my home and this woman.”

All of the patients observed seeking care from the spiritual healer received treatment for a combination of physical, emotional, and social ailments. Although constraints on patient privacy prohibited us from collecting information on patient expectations prior to the
consultation, patient-provider dialogues suggest that the provider’s approach to treatment matched patient expectations. The spiritual healer and community members seeking care both viewed and discussed illness within the biopsychosocial explanatory model (see Figure 8). Thus, expectations for care and expectations for treatment correlated with one another. The spiritual healer and patients appeared to intrinsically discuss health and illness as it related to the patient’s life outside of the immediate clinical encounter.

Adopting this holistic approach to health and illness required patients to become dialogical partners with the spiritual healer. Through patient-centered interviewing, the spiritual healer encouraged patients to share the impact of a physical ailment on their social or emotional well-being, or conversely, the impact of a social ailment on their

Figure 8. Biopsychosocial Explanatory Model
physical or emotional well-being. Physical and social ailments were either identified as the primary illness or described as a symptom. Emotional ailments were never described as a primary illness for which patients sought care, but as a secondary symptom that followed either physical or social symptoms. As an example, the patient who sought care for the bewitching of his home (social ailment) as the primary illness noted that, as a result, he and his wife have been unable to conceive (physical ailment) and thus expressed anxiety (emotional ailment) around not being able to have another child.

Patient information sharing was critical to not only the ongoing exchange of information, but to the spiritual healer’s prescribed treatment. The spiritual healer often expressed a need to understand the full scope of a patient’s illness history and scope of suffering before prescribing treatment. Case in point, the father of two who sought care for physical, emotional and social distress was encouraged to share how illness impacted his past and present life. Throughout the course of the consultation the patient not only shared that he and his wife had problems conceiving and that his home was bewitched, but he went into detail about his overall distress, which revealed that he suffered from headaches and heavy sweating, often felt weak, suffered financial losses because of his illnesses, believed that his father being married three times had something to do with the marital issues he was having, and was referred to the spiritual healer by a BHP, among other things. The following excerpt demonstrates that the patient’s detailed sharing of information helped the spiritual healer not only understand the full scope of the patient’s illness experience, but also helped both patient and spiritual healer rule out other potential causes of suffering prior to prescribing treatment options (e.g., physical symptoms being related to social and emotional distress, and not malaria):
IHP: “How come you get dizzy, hallucinate and lose focus?”

Patient: “It starts with the headaches, then when I sleep I dream about unrelated events. By the time I get up in the morning, am weak and dizzy.”

IHP: “Do you feel it when both your arm and leg get paralyzed and your heart starts racing?”

Patient: “I can never go to bed and put my arm under my head. If I do that, I will not be able to straighten it out afterwards.”

……..

IHP: “What happens is that you get attacked and you sweat a lot.”

Patient: “A lot, I do not even cover myself at night.”

IHP: “That is the attack am talking about. Have you ever had malaria? Have you ever been x-rayed?“

Patient: “I have been in an x-ray and I have had malaria but usually when I take the medicine, I recover and I go back to do doing my work.”

From the ongoing back and forth dialogue between the two interlocutors and sharing of personalized health information throughout the entire consultation, the spiritual healer narrowed down treatment options to specifically address, as stated by the patient, “all my problems… marital, financial and health wise.”

Moreover, a closer analysis of patient-provider interactions showed that while a high degree of patient health information shared encouraged a collaborative approach to identify illness causes, an approach to shared-decision making was not adopted when it came to identifying and prescribing treatment options. Toward the end of every
consultation, the spiritual healer adopted a paternalistic approach when prescribing patient treatment, telling the patient what he or she will or will not do:

- “You see these herbs, for bathing and drinking... you will get it and it will help you.”
- “You need to get the drug to bathe such that you get away with this bad luck.”
- “You will take this medication for three days.”
- “Take that drug and put it on your car and go drive your car. And I will give you another drug and put it in your house.”
- “No need of coming back [for treatment]. The remaining work... leave it with me. It’s me to inform you about everything.”

The one exception was a treatment prescribed to a male patient who was seeking care for strained relationships with his siblings. Part of the treatment prescribed and advice given by the spiritual healer is based on the expressed preference of the patient:

IHP: “Your sister does not want you to marry. Why?”

Patient: “Whenever I say that I am going to look after my child, my sister says I am going to eat the money. Just in case, I want to sell on the piece of my land. She even informs my other siblings of how disobedient I am and they also hate me.”

IHP: “So what you want is to sell your land?”

Patient: “Yes”

IHP: “You are going to sell your land and I am going to give drugs, such that people come and give you money. That whoever will see the land likes it and that
people come and buy this land. People gather and come to buy the land. Abachwezi\textsuperscript{39} will help.”

Patient-provider dialogues indicated that the provider was able to take an authoritative approach when prescribing treatment because he possessed a sacred skill that was needed for any treatment option (e.g., herbs or prayer) to be effective. The spiritual healer’s skill was often described during patient consultations as a “connection to the spirits” and an ability to “ward off evil spirits.” Accordingly, all prescribed treatments during the observed patient-provider interactions involved a spiritual element, in view of the fact that both spiritual healer and patients discussed all patient experienced maladies within a spiritual context.

All patient-provider interactions were inundated with spiritual references. Spirituality appeared to be the common interest that not only brought patients and the spiritual healer together, but also helped to facilitate a cooperative dialogue. Both interlocutors shared spiritual beliefs and ideas that enabled them to connect with one another and co-construct patients’ illness experiences. This is demonstrated by another excerpt from the dialogue between the spiritual healer and patient who sought care for bewitching and his inability to conceive. After receiving care for himself, he asked the spiritual healer for treatment for his sister who “should have even finished university, but when it would get to the end of year she would run mad.” The following excerpt shows that through shared beliefs, the patient is able to describe his sister’s problem by using an explanatory model that describes health, illness, and healing, in part, as spiritual constructs that the practitioner understands:

IHP: “... Do you live near your sister?”

\textsuperscript{39} Type of spirit
Patient: “No, now she is in Kampala. I sent her to a church so that they could pray for her.”

IHP: “Yes, prayer is better than nothing. Has there been any improvement since you took her there?”

Patient: “She is not yet back in school, that means she is not yet alright.”

IHP: “But has there been any noticeable improvement?”

Patient: “She is slightly better.”

IHP: “Why don’t you give the prayers an opportunity to work?”

Patient: “Am worried about her, she is aging. For someone who is supposed to have finished university she is far behind.”

IHP: “So what exactly do you want?”

Patient: “I want her to go back to school.”

IHP: “I will find out what is wrong but these are spirits disturbing her. Sometimes they even appear to her, has she ever told you that?”

Patient: “Yes, sometimes she will call me and say she had a dream about our mother almost dying. Then mother gets so sick and is admitted in the hospital.”

IHP: “Those are evil spirits.”

Patient: “In church when they are praying for her, she falls down…”

IHP: “And she starts to mumble unrelated words. Those are the evil spirits, you usually hear about. They are the ones attacking her.”

Patient: “You said that, they are family spirits, but by the time we started understanding, our father was already dead and we know nothing about all this.”

Furthermore, this excerpt and other patient-provider interactions in the indigenous
health care setting demonstrate that shared identification between patient and provider can be a relational activity that contributes to the creation of a partnership dimension of health care interactions (Beck, Daughtridge, & Sloane, 1997). As noted by Burke (1969), shared symbols enable individuals to identify with others and talk in terms of what both parties know and can understand. Spirituality was undoubtedly a significant part of the IHP’s identity as a spiritual healer, and was also described by patients as an essential part of their lives. This observation is illustrated by the closing of the consultation between IHP and the patient just noted:

Patient: “I have faith that this will work with God’s\textsuperscript{40} blessings.”

IHP: “Everything comes from God. There is nothing that does not go through him. Go in peace.”

While identification through shared spiritual beliefs shaped explanatory models of health and illness used by the IHP and patients, identification through spirituality was completely abandoned when the dialogue turned to the topic of treatment cost. All patient-provider consultations involved a negotiation of the IHP’s requested price for treatment, with both patient and provider attempting to get the other interlocutor to identify with his/her socioeconomic circumstance. Patients made their plea to the IHP by asking him to recognize their financial situation and lower the cost of treatment:

- “You said I have to pay 750,000 shillings\textsuperscript{41}, yet you yourself recognized it that my financial status is not good.”

- “You know things are hard for me. I can even spend ten years without getting this money.”

\textsuperscript{40} The God referred to by both patient and IHP are based on Christian beliefs.

\textsuperscript{41} 750,000 shillings was equivalent to $335 USD at the time of this study.
• “But the way you know me, I don’t have any money with me. So please reduce [the cost of treatment] for me.”

On the other hand, the IHP often countered pleas from patients by shaping his identity in comparison to BHPs:

• “How come when you go to the health center and they tell you that the medicine is 100,000 shillings, you pay with no doubt? Why do you trust these white people, yet when a black one tells you something you doubt?”

• “Do you think I would wish myself to be here smoking (referring to a smoke pipe used during patient consultations)? The ones I studied with are now nurses and doctors but you see me, I am here smoking… I sit here because it is by traditional things I am help you.”

Negotiations around treatment cost often ended with the IHP maintaining the initially quoted price and the patient and practitioner coming up with a payment plan:

IHP: “You think it is a lot. How much can you afford?”

Patient: “As you have heard my problems and seen how poor I am, if you could charge me 200,000, I would be grateful. But still I can only pay it in installments. You give me the herbs, I go look for the first installment and I bring it.”

IHP: “Today is twentieth, I want the first installment on the eleventh.”

Patient: “What about if I get the money before? May I have your number so that I call first.”

IHP: “It is ok, you can come.”

Patient: “So it is alright now. I am fearing that I might go and you send spirits after me.”
IHP: “Go with peace, consultation fee is 2,000, that you paid. The herbs will cost you 350,000. On the eleventh, you should bring 180,000 and then you can pay the rest in installments.”

This dialogue and others demonstrate that while patients were able to exhibit agency and express their concerns about the cost of the IHP’s services, control ultimately lay with the provider because of patient fear and recognition of the provider’s “power.” While, we were unable to obtain observed patients’ views on their experience negotiating treatment costs, my observational notes describe their body language as often being “deflated and defeated” at the conclusion of the negotiation. These observations are consistent with study findings discussed in the previous chapter that demonstrate how damaged relationships and interpersonal distrust between patients and spiritual healers stem from patient views that spiritual healers overcharge for their services and can use their spiritual power to create business for themselves.

**Patient-Provider Interactions in Social and Environmental Context**

My research findings include an analysis of patient-provider communication within the framework of overlapping models that include patient-centered interviewing\(^{42}\), collaborative interpretation\(^{43}\), and provider and patient communication competence\(^{44}\).

Health communication literature around these models often promotes their use to

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\(^{42}\) Exchange of relevant information about a patient in order to understand a patient’s illness experience and in turn, enhance effectiveness of care (Freeman, 1987; Henbest & Stewart, 1989).

\(^{43}\) Approach to the exchange of information that helps patients share their ailments in the context of their life experiences, helps patients share their logic behind their health care decisions, and help both patients and providers identify their goals and expectations for treatment (Young & Flower, 2001).

\(^{44}\) The degree to which a receiver of a message views the communicator as effective - levels of ethos, pathos, and logos (Brody, 1999; Levenstein, McCracken, McWhinney, Stewart & Brown, 1986; Stewart & Buck, 1977).
advocate for patient-centered approaches that 1) increase patient agency, and 2) view the patient as a rational decision maker and equal partner with the health care provider in the process of prescribing and adhering to treatment recommendations (Brody, 1999; Freeman & Heller, 1987; Henbest & Stewart, 1989; Levenstein et al., 1986; Stewart & Buck, 1977; Young & Flower, 2001). Moreover, as illustrated in the *British Medical Journal*, Western biomedical literature also advocates for patient-centered approaches that view the patient as an equal partner in the health care setting:

> Doctors and patients are equals. It is not for patients to submit to doctors. Rather doctors have their health beliefs, and patients have theirs. They are all equally valid. (Cuthbertson & Noble, 1997, p. 690)

While I agree that patients should be viewed as equal partners in health care settings worldwide, the social and cultural dynamics within and outside of the health care settings in rural areas of Southwest Uganda make adopting that approach nearly impossible. The enormous socioeconomic gap between patients and BHPs, scarce medical resources, and high illness burden completely counter a patient-centered approach in biomedical settings. Additionally, the enormous power differential that exist between patients and IHPs (specifically spiritual healers) limits a patient centered approach in indigenous settings when it matters most, during the process of prescribing treatment recommendations.

As discussed in the previous chapter, patients must often submit to both biomedical and indigenous health practitioners because they 1) do not have any other options for obtaining care:

> Research Team Member (RTM): “What do you expect from the health center
today?"

Patient: “Medicine”

RTM: “If you take some medicine and there is no relief, what is your next step?”

Patient: “There is no alternative. Just live with it.”

and 2) face health challenges due to marginalized conditions:

Patient: “The stomach pain started this month… depends on what I eat.”

RTM: “What types of food do you eat that causes your pain?”

Patient: “With avocado and tomato it comes. But I must take avocado everyday

because it is all we have.”

To become equal partners with health care providers in biomedical and indigenous health

care settings, rural community members need to be granted access to medical and healing

knowledge, and above all, be provided with choices for quality health care and

environmental conditions that affect their health.
Overview

I have explored the narratives of rural Southwest Ugandans who are caretakers of children ages 5 and under in order to understand their experiences seeking health care in their communities, identify their health care needs, understand the value they place on indigenous and biomedical health care systems and how that shapes their health-seeking behaviors, and identify their recommendations for improving the quality of health care in their community. Throughout my analysis of their narratives, I realized that community members’ recommendations went beyond improving the quality of health care system itself. Rather, community members focused on 1) improving socioeconomic and environmental factors that directly affected their health (e.g., eliminating government corruption, decreasing pollution of water sources, reducing widespread poverty); 2) taking preventive measures that could directly affect their health (e.g., boiling drinking water, improving household and community sanitation, eating a balanced diet); and 3) obtaining biomedical knowledge about other preventive health measures (e.g., family planning) and indigenous knowledge about self treatment (e.g., herbs that treat childhood diarrhea). Community members’ recommendations centered on taking ownership of their health. Environmental and social reforms as a method of improving the quality of health care were viewed by rural community members as unrealistic, while health care system reforms, such as increased collaboration between BHPs and IHPs, as a method of improving the quality of health care were unwanted.
I propose using my research findings to advocate for a shift in focus from a potential cooperation between indigenous and biomedical providers as a means for improving care to a focus on providing community members with what they want: health knowledge on prevention and self treatment options. Within that shift in focus, I also recommend that community members be included in the design and implementation of an in-depth needs assessment\(^4\) that takes a deeper look into community members’ request for preventive and self-treatment health knowledge. Correspondingly, community members should actively be involved in the design and implementation of any health initiative that is derived from the results of the in-depth needs assessment. Constructing, carrying out, and sustaining an effective health communication initiative that builds on a need identified by members of a marginalized community requires the active participation and additional insights of those same individuals who have been historically silenced by traditional and hegemonic methods of health communication. Moreover, I strongly believe that community participation in outlining health priorities and issues is a critical step toward developing health initiatives that lead to successful outcomes (Dutta, 2008). Thus, I consider this shift in focus and proposal for increased community involvement in future research as a critical step in developing health initiatives in Southwest Uganda that lead to outcomes that are not only successful by public health measures, but are viewed by the community as meaningful, impactful, sustainable and pragmatic.

\(^4\) A health needs assessment is a systematic method of identifying unmet health and health care needs of a population and making changes to meet those unmet needs. The assessment provides information to improve health, for service planning, priority setting and policy development. (National Institute for Health and Clinical Excellence, 2005)
First Step: Moving Away From Collaboration

Throughout the analysis of our study data it became increasingly apparent that collaboration between biomedical and indigenous practices is not an effective method of increasing the availability and quality of healthcare coverage in rural communities in Southwest Uganda. Collaboration between the two practices goes completely against cultural and historical norms and would not be accepted by rural community members. Community members’ narratives reveal that any form of integration of the two practices would lead to a major volition of expectancies and, in turn, discourage them from seeking care. When asked how they would feel if treated with herbs at a health center, community members responded:

- “I would feel bad... I would expect tablets.”
- “I would not receive that medicine because I would have come to get treatment from a modern, not a traditional.”
- “I would not feel ok. I went for medical treatment”
- “They are not supposed to be giving herbs. Herbs are supposed to be coming from omufumu and herbalists.”

Similarly, when asked how they would feel if treated with tablets or injections when seeking care from an IHP, community members responded:

- “I would not feel comfortable. I expected herbs.”
- “I don’t feel ok because I had gone for herbal treatment and they have given me tablets.”
- “I would refuse, I went for herbs.”
• “It cannot happen”

Furthermore, responses to both questions revealed that a violation of expectations could lead to feelings of distrust:

• “I can think that maybe the omufumu are uniting against the community.”

• “It becomes hard for me. The herbs would make me fear because I had gone to the hospital looking for tablets and then the nurse brings the herbs.”

• “I would know they are collaborating with the traditional and cannot take such drug.”

• “I would think it was a lie... I would be confused.”

I embarked on this research over two years ago with a biased belief that collaboration was “the answer” to improving access to quality health care in Southwest Uganda. Admittedly, although I had well-meaning intentions, my early adoption of this belief and premature vision for implementing collaborative care as a means of improving quality health care access fell within the scope of the top-down approach that I currently advocate against. When we began our research in the summer of 2008 we collected data on practitioners’ perspectives on the feasibility of a cooperation between indigenous and biomedical practices. Our main goal was to assess “whether our idea would work.” I over simplistically and hastily thought that our idea would be effective because two (types of practices) is better than one. One of my initial beliefs was that rural community members would most likely seek care from practitioners in the community who had access to both biomedical and indigenous resources, rather from a practitioner who solely practiced biomedical or indigenous health care. As a part of my bias, I viewed health and illness through my own perspective as a member of an individualistic culture where
health behaviors are largely individual choices that result from an active process of information evaluation, attitude formation, and rational choice based on this process. Since that first summer in Uganda, I have gradually come to realize that experiences of health and illness in rural areas of Southwest Uganda are the exact opposite. Rural community members experience health and illness as a community, which is contrary to an unconnected series of individuals behaving. Rural community members’ health behaviors are, in fact, largely shaped by their innate sense of collectivism, a lack of individual choice, and their spiritual beliefs.

As my understating of health and illness as experienced by community members in rural areas of Southwest Uganda has evolved, so has my approach to research and consequently my role as a researcher. My current approach to research was enacted during my second summer in Uganda (2009), and involves the realization that effective and sustainable change requires an account of what the community wants, not what outside researchers think is best. This view required me to adjust my role as a researcher from that of an interventionist who plans and executes health programs and campaigns, to a listener and participant who engages in dialogue with and within the community to facilitate the development of desired health initiatives (Dutta, 2008). By adopting this approach when developing health initiatives, health communication researchers can assist in the creation of programs that are consistent with a community’s cultural framework, and are therefore more likely to be embraced and sustained.
Next Step: Moving into Information Sharing

Switching my approach to a listener rather than an interventionist allowed me to “hear” a number of socioeconomic and environmental issues (e.g., poverty and pollution) that negatively affected the health of rural community members in rural areas of Southwest Uganda. I was also able to identify issues within the health system (e.g., lack of resources, mistrust and distrust of providers, overpricing of services, etc.) that tainted their care seeking experiences. While I strongly believe that these issues need to be addressed, an attempt on my behalf to address them would be overly optimistic and unrealistic. I do not have the resources to influence the complex social, environmental, and cultural structures that have been in place for decades, nor is it my place to. Rather, I plan to apply my research findings to assist in developing and implementing a culturally appropriate model that addresses another, more tangible issue identified by rural community members: the need for health information on preventive measures and self-treatment.

Information provided in response to our questionnaire, patient intake surveys, and key-informant interviews demonstrates community members’ strong desire to receive advice on preventive measures from BHPs and knowledge on self-treatment (specifically for minor childhood ailments such as diarrhea, worms, and upset stomach) from IHPs. When asked hypothetical questions about enacting agency during all methods of data collection (e.g., “If given the opportunity, what question would you ask a IHP/BHP?”), the overwhelming majority of rural community members noted a need to obtain knowledge from IHPs and BHPs around:
This expressed need for health information proposes what could be a potentially innovative solution to the challenges of health care accessibility (geographically and financially) and limited agency faced by rural community members in the area. By receiving and successfully utilizing information on preventive measures and self-treatment, community members could significantly decrease the number of times they need to access biomedical and indigenous care and lessen the burden they face when attempting to obtain care from either practice. Moreover, providing rural community members with effective and practical self-treatment knowledge in particular could decrease their dependence on local practitioners and empower them with an alternative to seeking biomedical or indigenous care.

Although I have a number of ideas around developing a culturally appropriate model that addresses community members’ need for health information on preventive measures and self-treatment, attempting to put those ideas into action without in-depth community participation would be an injustice to rural Southwest Ugandans. An initiative that is designed and implemented solely based on my own ideas would fall into the traditional top-down approach of “doing for” or “doing to” that often mutes marginalized groups (Camacho, Yep, Gomez & Velez, 2008; Dutta, 2008). An approach of “doing with” must be adopted in order to develop an initiative that is not only tailored,
practical, and well received, but also potentially helpful to rural community members as they challenge systems of power and hegemony that hinder positive health outcomes in the area.

Thus, I recommend the development of a health initiative that addresses the community need for preventive and self-treatment knowledge and adopts a community-based participatory\textsuperscript{46} approach to staff at Mbarara University and Healthy Child Uganda. I will recommend that my primary study findings be considered, but not solely relied on to 1) serve as a basis and justification for conducting a more in-depth needs assessment that is strictly focused on community members’ requests for biomedical and indigenous preventive care and self-treatment knowledge; and 2) advocate for the importance of interpersonal communication in the implementation of any future initiatives that stem from the results of the in-depth needs assessment.

It is my hope that my research findings, which support the design and implementation of initiatives that increase preventive and self-treatment knowledge, enable local researchers and rural community members to recognize and consider the inherent value and cultural dynamics of interpersonal communication in the delivery of health messages. My analysis of our research findings demonstrates that levels of provider trust, perceptions of provider credibility, patient-provider explanatory models, perceptions of provider roles, patient expectations, and patient illness beliefs all play significant roles in patient adoption and patient-provider exchange of health information.

\textsuperscript{46} Community-based participatory research is a collaborative process of research involving researchers and community representatives. This approach engages community members, employs local knowledge in the understanding of health problems and the design of interventions, and invests community members in the processes and products of research.
in rural health care settings in Southwest Uganda. All of these variables need to be taken into account when considering:

- Who would likely be the most effective messengers of preventive and self-treatment knowledge (based on perceived provider credibility and trust in correlation to illness topic)
- Which health care settings, if any, would be the most appropriate environments to provide preventive and self-treatment knowledge (based on expectations of health and illness information shared in varied health care)
- The structure and content of preventive and self-treatment knowledge (based on patient-provider explanatory models and health beliefs in correlation to illness topic)

Furthermore, the narratives of community members suggest that as a collectivist society, the use of social networks to provide needed health information may be extremely beneficial. Community members frequently described their perceptions of local health practitioners and health beliefs as being shaped by the experience of others within their community (i.e., social network). Correspondingly, health communication research demonstrates that social networks can have a far-reaching impact on the health outcomes of a community because they are often critical to the delivery, reception, and retention of health messages that may positively influence health behaviors (Ackerson & Viswanath, 2009; Arora, 2008).

It is interpersonal communication that drives and shapes social networks (Ackerson & Viswanath, 2009). As demonstrated in my research findings, it is through
interpersonal communication that community members, within and outside of their roles as patients, engage in social participation, create normative behaviors, and develop perceptions of group trust. Therefore, it is critical to recognize the value of interpersonal communication as a primary medium that facilitates the flow of vital health information and health beliefs in rural areas of Southwest Uganda.
CONCLUSION

“It is clear, further, that [rhetoric’s] function is not simply to succeed in persuading, but rather to discover the means of coming as near such success as the circumstances of each particular case allows... For example, it is not the function of medicine simply to make a man quite healthy, but to put him as far as may be on the road to health; it is possible to give excellent treatment even to those who can never enjoy sound health.” Aristotle, (2001, p. 181)

It is evident that rural community members in Southwest Uganda who are caretakers of children ages 5 and under face enormous environmental and social challenges that negatively affect their health and the quality of the health care services they receive. No single initiative will lead to a significant improvement in the health outcomes of this marginalized group. Rather, it will take a collaborative effort on the behalf of national stakeholders (with the help of international stakeholders) in the areas of public health policy, epidemiology, social science, health education, and health services management to significantly curb the current morbidity and child mortality rates in the area. Although that is a daunting task, rural community members in Southwest Uganda deserve to receive the same quality of health care as those who are socioeconomically more fortunate than they are.

As implied by the quote from Aristotle, it is our ethical duty as researchers and practitioners who are committed to public health to do everything in our power to assist in improving health outcomes for those who are marginalized, restricted and muted through social systems. During the process of exploring the health of marginalized communities and developing strategies to improve their health outcomes, public health
researchers and practitioners (specifically in the field of health communication) must not narrowly look at health behaviors as indications of individual choice, but rather “locate poverty and the lack of basic resources at the center of human behavior and communicative choice” (Dutta, 2008, p. 114)

Along those lines, it is unfair and prejudicial to adopt a research approach that places blame for a marginalized group’s health outcomes (in both international and domestic communities) on cultural behaviors and norms, especially when the researchers themselves are not members of the studied group. This unfortunate approach is suggested by public health scholars Leland K. Ackerson and K. “Vish” Viswanath (2009) who state “communication can be used to draw attention to cultural norms that are detrimental to health so that these harmful norms can be addressed and changed” (p. 12). I argue that seeing cultural norms as harmful and needing to be changed is a hegemonic and etic point of view that fails to account for the true experiences and viewpoints of the study population by ignoring the unequivocal impact of the larger social environment on their circumstances and behaviors. Health communication research is more effective when used to draw attention to the influence of culture on health, and the importance of developing health initiatives that are culturally appropriate and feasible.

Insights from my research can be used to understand what community members in rural areas of Southwest Uganda value in patient-provider interactions and assist in developing a health communication model that is consistent with those values, based on their recommendations, and constructed within their cultural framework. For example, health communication researchers often criticize practitioners in biomedical settings for being concerned with disease in its physiological manifestation rather than the lived
experience of a person who is ill (Hunter, 1991; Segal, 2005). However, in rural areas of Southwest Uganda, BHPs’ egalitarian separation of person and illness is seen to work in the favor of community members who do not look to the BHP for an emotional connection, but rather to simply provide access to a tangible resource, medicine. As long as they do not disclose that they’ve sought care from an IHP, patients are “guaranteed acceptance and care no matter who they are or what their lives have been, no matter how tired the physician may be or how horrible the malady” (Hunter, 1991, p. 133) (noting that the implied definition of “acceptance and care” is granting access to free biomedicine that is in extremely limited supply). Therefore, miscommunication or non-communication during biomedical encounters (that is not perceived as such by the patient) is neither a failure of the patient nor the provider; it is a result of the culturally understood static nature of the biomedical health care setting.

Furthermore, viewing rural community members’ perspectives on health and health care within cultural context encourages me, a health communication researcher, to move away from an analysis of message transmission to analysis of the social and structural constructs of health. Adopting a culture-centered approach to health communication allows me to challenge traditional methods within the field that typically adopt hegemonic viewpoints and silence marginalized communities both structurally and communicatively (Dutta & Basu, 2008). The act of being silenced is often directly correlated with being marginalized. Marginalized communities are usually not involved in the development and implementation of health care initiatives and policies that affect them; they are essentially told what to do rather than consulted as active participants in healthcare decisions. “The experience of not having anything goes hand in hand with the
experience of not getting to say anything” (Dutta, 2008, p. 152).

In sum, I truly hope that this research leads to an increase in positive health outcomes for rural community members in Southwest Uganda and that it serves as a tool for demonstrating that those typically viewed as being on the bottom-rung of the social ladder have extremely valuable insights that should be incorporated in any initiative that aims to serve them. Using culturally-centered communication and a community-based participatory research approach to give voice and power to marginalized communities with limited healthcare access will undoubtedly increase such communities’ ability to actively participate in the reform process, as well as, influence the agenda and priorities of the global health care sector.
STUDY LIMITATIONS

Sampling

The level of external validity of our research findings is low as a result of our convenience sample of community members. It can be contended that our study sample is not an accurate representation of the larger Southwest Ugandan population because:

- Community members who participated in the study were already seeking care from a health care practitioner. Therefore those who are less likely or unable to seek care for an illness were not included in the study
- The majority of community members who participated in the study lived near to or had access to a biomedical health center
  - These community members may have had biases toward indigenous health practices because of their long-term exposure and convenience of location to biomedical health practices

Because of time, resources and community accessibility constraints, we relied on Healthy Child Uganda to assist us with obtaining access to a considerable sample of community members. Moreover, as foreigners we also relied on Healthy Child Uganda to ensure that we were welcomed and trusted by both health center staff and patients through our association with the organization.

Study Location

As a result of our reliance on Healthy Child Uganda, the majority of data collection took place near a health center affiliated with the organization. Thus, community members may have been reluctant to disclose information about their experiences seeking care from indigenous health practitioners because of perceived
researcher affiliation with both biomedical care and Healthy Child Uganda. All research team members ensured patient confidentially and informed community members that we were not employees of Healthy Child Uganda, affiliated with any neighbor health center, or affiliated with any biomedical or indigenous practitioners.

**Comparison of Sample Sizes**

The amount of data including patient-IHP interactions is disproportionately small in comparison to the amount of data including patient-BHP interactions. This is due to the high concentration of patients who visited the biomedical health centers during our study (41 over the course of 4 days), in comparison to the extremely low number of patients that visited the indigenous health practitioner (7 over the course of 4 days). Moreover, we were only able to observe patient interactions with one type of indigenous health practitioner (spiritual healer) because of time constraints. Correspondingly, it is important to highlight that study participant responses demonstrate that the type of indigenous specialty (e.g., herbalist, bone setter, traditional birth attendant, etc.) are extremely influential in the perceptions community members have of IHPs.

**Variance in Behavior**

As behavioral theorist Icek Ajzen (1985) and others have shown, there is often variance between intended behavior and actual behavior when conducting both qualitative and quantitative research. In my study results, I have considered that human behaviors are governed not only by personal attitudes and intentions, but also by social pressures and other factors that may be out of one’s control. In addition, the influence of researcher presence (especially during observations of patient-provider interactions) on
both patient and provider behavior must be accounted for. A number of precautions were
taken to limit researcher influence and participants’ awareness of researcher presence
(e.g. sitting in a discrete locations, conducting observations for extended periods of time
to increase BHP/IHP comfort, ensuring participant confidentiality, etc.). However, it is
likely that our presence influenced the behaviors of some study participants.

Lost in Translation

Potential interpreter error, variance in interpreter accuracy, and variance in
cultural connotations of words and descriptions may have affected the precision of
participant narratives. As noted in Chapter 3, several steps were taken (e.g. comparing
interpreter notes of patient-provider interactions to translated transcripts of the same
interactions by another interpreter, use of back translation to verify original translation of
data collection tools, comparison of researcher observational notes with interpreter notes,
etc.) to ensure translator/interpreter accuracy.

Study Significance

In spite of these study limitations, I strongly believe the data collected represents
the shared health-seeking experiences and health beliefs of rural community members
who are care takers of children ages 5 and under in Southwest Uganda. Our efforts to
obtain and authentically present the unrefined insights of rural community members
demonstrate that rural community members can be valuable problem-solvers, and that
their insights have the potential to inform the development of future health initiatives that
are meaningful, practical, embraced by the community, and thus lead to improved health
outcomes.
Moreover, insights gained from this research may not only positively serve the citizens of Uganda, but also demonstrate that members of marginalized communities can be engaged in improving the quality of health care in impoverished areas worldwide. Accordingly, my experience carrying out effective qualitative research methods abroad will directly help me incorporate comprehensive cultural understandings to assist in the elimination of health disparities among minority adolescents in the U.S. I share a dual focus in both national and international health issues because I strongly believe that the edification acquired through the development of an analytical process and the discovery of effective solutions can be used to improve health outcomes abroad and domestically. Thus, it is my sincere hope that my passion for the overall physical and psychological betterment of all children will lead to successful cross-cultural interventions that improve health outcomes for disadvantaged children worldwide.
REFERENCES


APPENDICES

Appendix A – Questionnaire

2009 MHIRT Questionnaire: Healthcare in SW Uganda: Community Perceptions, Experiences and Needs

Date:
Location:
Interviewer:
Interpreter:

DEMOGRAPHICS:

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<td>DO YOU HAVE A SOURCE OF INCOME? IF YES, WHAT?</td>
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<td>TOTAL # OF PPL IN HOUSEHOLD</td>
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<td>TOTAL # OF CHILDREN UNDER 5 YEARS OLD LIVING IN HOUSE</td>
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<td>DO CHILDREN GO TO SCHOOL?</td>
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<td>HOW DID YOU KNOW TO COME TODAY? HOW FAR DID YOU TRAVEL TO GET HERE?</td>
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<td>WHO IS PRIMARY DECISION MAKER IN HOUSE REGARDING HEALTHCARE? (Self, shared, other)</td>
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1) Where did you deliver your youngest child?
   a) Was that your ideal place to give birth?

2) Did you receive antenatal care? If so, from who?

3) Did you receive postnatal care? If so, from who?

4) When was the last time any of your children were sick? (*identify which child if possible*)
   a) Type of illness suffered?
   b) How did he/she get better?

5) In the past year, how many times did you:
   a) Go to a HC or Hospital for treatment for your children? For yourself?
b) Go to a private clinic for treatment for your children? For yourself?

c) Go to a THP for treatment for your children? Type? For yourself?

6) When was the last time you went to a MHP?

   a) Type of illness suffered?
   b) Where was treatment sought?
   c) How effective was the treatment?
   d) Do you know what village the provider is from?
   e) Does this provider practice a religion? If so, do you know which one?

7) When was the last time you went to a THP?

   a) Type of illness suffered?
   b) Type of provider? Where was treatment sought?
   c) How effective was the treatment?
   d) Do you know what village the provider is from?
   e) Does this provider practice a religion? If so, do you know which one?

(***NOTE to interviewer: If subject denies going to a THP, ask about experience as a child. If subject is against THPs, ask about spiritual healers***)

8) Where, if anywhere, do you prefer to go for physical remedies? (HC, Private Clinic, Self-treat, THP)

9) Where, if anywhere, do you prefer to go for mental remedies? (HC, Private Clinic, Self-treat, THP)

10) Where, if anywhere, do you prefer to go for social remedies? (HC, Private Clinic, Self-treat, THP)
11) If you went to a HC or hospital and you or your children were treated with herbs, how would you feel? Have you ever experienced this? (*NOTE: Observe body language here!*)

12) If you went to a THP and were treated with injections or tablets, how would you feel? Have you ever experienced this? (*NOTE: Observe body language here!*)

13) Are there any ailments or situations a MHP cannot treat? Please describe.

14) Are there any ailments or situations a THP cannot treat? Please describe.

15) Aside from medical services, is there anything you like/dislike about MHP?

16) Aside from medical services, is there anything you like/dislike about THP?

17) Can you treat diarrhea yourself?
   a) Where do you get that treatment?
   b) Do children and adults get the same treatment?
   c) At what point might you seek treatment elsewhere?
   d) What causes diarrhea?

18) If you could ask a THP any question, what would you ask? (*NOTE: If they respond with a question about their own illness, clarify ‘what would you like to know in general about THP’?)

19) If you could ask a MHP any question, what would you ask (NOTE: If they respond with a question about their own illness, clarify ‘what would you like to know in general about MHP’?)?

20) In your opinion, what is the perfect healthcare system? (*prompt for who and where*)
   a) How can this system be created?

21) Are there any reasons for THPs and MHPs to work together?
a) Any reasons not to work together?

b) Any illnesses that would be better treated by a cooperation between MHPs and THPs? Why?

22) Can you identify a THP you would want to form a partnership with a MHP?

23) Who should regulate biomedical healthcare in Uganda?

   a) Who should regulate traditional healthcare?

24) How can community members, like yourself, help improve the healthcare system?

Finally, I am going to ask you some true or false questions about what you believe. Please respond with one word – true if you agree and false if you disagree. There are no right or wrong answers.

Possible T/F Questions:

- A MHP has told me that I did not have an illness that I knew I had.
- A THP has told me that I did not have an illness that I knew I had.
- A MHP has told me that my child did not have an illness that I knew he/she had.
- A THP has told me that my child did not have an illness that I knew he/she had.
- All of my children were born at home.
- At least one of my children was delivered by a TBA.
- I received an antenatal card or documentation of antenatal care for my most recent birth (Q4)
- I prefer to give birth in a hospital.
- I have sought care from more than one type of practitioner at the same time. (Q15)
- I have been referred to a MHP by a THP. (Q16)
• I have been referred to a THP by a MHP. (Q17)
• I have been misdiagnosed by a MHP (Q18)
• I have been misdiagnosed by a THP (Q19)
• MHPs can treat ebiino (23a)
• MHPs can treat oburo (23b)
• MHPs will treat ebiino
• MHPs will treat oburo
• There are things THP can learn from MHPs (34)
• There are things MHPs can learn from THPs (34)
• Only an herbalist can make herbal treatments. (efficacy)
• I can make the same herbal treatments as an herbalist.
• I think MHPs should train THPs in biomedical treatment.
• I think herbalists should train MHPs in herbal therapies.
• I think herbalists and MHPs should co-treat patients.
• I think spiritual healers and MHPs should co-treat patients.
• Omufumus (black spirits) can affect health.
• Many children in my village suffer from malnutrition.
• Malnutrition can be cured by a THP
Appendix B – Intake Survey

Date:
Health Center:
Survey Investigator:
Interpreter:
Observer of Consultation:
Patient Number:

Age:
Sex:
Religion:
Education Level:
Healthcare Recipient: Child-
Distance Traveled to HC:

1. What's wrong with your child?
   a. What illness do you think you have?

2. Are you experiencing any other symptoms?

3. How long have you been experiencing these symptoms?

4. Have you sought care for this illness before today?
   a. From who?
   b. Were you diagnosed?
   c. Were you given any medications, herbs, or remedies?

5. Have you visited this HC or another biomedical provider for treatment of this illness before today?
   a. Were you diagnosed?
   b. Did you receive treatment?
   c. What treatment?

6. Have you visited a THP for treatment of this illness?
   a. Were you diagnosed?
   b. Did you receive treatment?
   c. What treatment?

7. Have you tried to treat the illness yourself?
   a. Have you taken any herbs or medications for this illness?

8. What made you decide that you needed to receive care from this health center today [if not stated above]?
9. Have you ever suffered from this illness before?
   a. If so, when? How did you get better? How long did you have the illness last time?

10. How do you think you got this illness?

11. What do you think is the best method to treat [insert illness]?

12. What do you expect from the health center today?
### Appendix C – Coding Scheme

#### Questionnaire and Key Informant Interview Coding Scheme

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3. Acknowledgment of shared beliefs, interests, or values | discussion  
2. Non-medical discussion | 2. No effect on care  
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2. Expressed to research team and not enacted with practitioner  
3. Enacted with practitioner and expressed to research team | 1. Worry  
2. Fear  
3. Anger  
4. Frustration  
5. Anxiety | 1. Addressed by practitioner  
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