



Traditional knowledge in HIV/AIDS treatment and prevention program in northern Uganda

Francis Adyanga Akena

Abstract

Uganda's health care sector is choking with various challenges, such as poor physical infrastructure, inadequate professionals to run the few existing health centers, poor culture of adherence to professional ethical standards by some health care practitioners, shortages of medicines in most government hospitals/health centers, and corruption. Most of the challenges are more endemic in rural areas. It is on the above premise that this article discusses some of the challenges that health centers face in provision of care to the increasing number of HIV/AIDS patients in hard-to-reach rural communities in northern Uganda and the implications of such challenges on the economy. Uganda's success in the fight against HIV/AIDS in the early 1990s was globally applauded because of its aggressive grassroots behavioral change crusades aimed at reducing the number of sexual partners. The success inspired a wave of financial aid programs from the US government to fight the disease across the developing world. However, the success was short-lived as the rate of HIV/AIDS infection in Uganda is currently rising, with the health care system struggling to provide care for the ballooning number of patients. To contribute to the curtailing cases of new infections, this article discusses the integration of the traditional authority and knowledge system in the national HIV/AIDS care and prevention program along with the biomedical approach currently being used.

Keywords: Traditional knowledge; HIV/AIDS interventions; professional ethics; voluntary medical male circumcision

Introduction

Traditional knowledge has a vast stock of resources that guide the lives of communities by offering lessons in moral, social, and political behaviors. Community elders are the repositories of traditional knowledge, which imbues them with authority on how to organize, mediate, and influence cultural mores and behaviors. Members of the community still value the role of community elders in vital issues, including marriage, divorce, and family relations, and concertedly seek resolution in the customary courts, where the power and authority of elders

are exercised [1–4]. In the epoch of the HIV/AIDS epidemic, many national health officials have rightly emphasized biomedical and behavioral interventions, including antiretroviral (ARV) therapy, use of condoms, HIV counseling and testing, orphans and vulnerable children programs, and universal primary and secondary education. However, what has consistently been overlooked is the role of community elders as repositories of traditional knowledge and their place in organizing society, mediating social behaviors, and setting norms that have strong binding

CORRESPONDING AUTHOR:

Francis Adyanga Akena, PhD
College of Education, University of South Africa (UNISA),
P.O. Box 392, 0003, Pretoria
E-mail: adyanga1@gmail.com

Received 16 December 2015;
Accepted 15 January 2016



Traditional knowledge in HIV/AIDS treatment and prevention program in northern Uganda

powers on community members. In the rural contexts of most African nations, access to radios and public health professionals is sparse, with the implication that public health education is limited and often nonexistent. A new innovative and robust way of transmitting public health information could be achieved through the traditional source of authority already existing in the community and wielding significant influence on social behavior.

This article examines how traditional authority could be integrated in the national HIV/AIDS treatment and prevention programs particularly in inaccessible rural settings of northern Uganda. The study will contribute to the sociocultural aspects of prevention and treatment and is more innovative by its focus on the utilization of the already existing sources of authority and power in HIV/AIDS treatment and prevention. It will also promote the appreciation of the context of third world poverty, illiteracy, and disease through the engagement of the entire community in the advancement of communal values and aspirations. The intervention strategy will benefit the community by promoting health standards, education, and collective awareness related to HIV/AIDS prevention and treatment in the community.

HIV/AIDS prevalence in rural northern Uganda

During a 2-month visit to northern Uganda in May and June 2015, I observed that HIV/AIDS still remains a serious threat to humanity and socioeconomic development in most hard-to-reach rural communities in this region. The affected people are unable to engage in agriculture and income-generating activities as the major source of their livelihoods. The communities that I observed are at the border of Uganda with South Sudan. These communities are ‘inaccessible’ and are located in remote areas: the roads leading there are not tarmacked and are ‘impassable’ for most part of the rainy seasons. Although the Government of Uganda and other development partners have conducted HIV/AIDS prevention, care, and treatment programs, the virus occurrence has remained stagnant over the decade, with the national HIV/AIDS prevalence rate being 7.3% [5] and the rate of new HIV infections remaining high. There are multiple reasons for this. First, most interventions are still on a scale that is insufficient to make substantial impact. Second, most HIV prevention interventions are not

aligned with the sources of new infections. Third, as a result of destitution resulting from extreme poverty, risky sexual behaviors have increased among young people. This is coupled with poor knowledge of the virus among residents in hard-to-reach communities. Finally, failure by health care providers to adhere to professional ethics in many hard-to-reach communities has been a major factor in the rise in cases of new infection and fatality.

Narratives of the problem

In Kitgum District, northern Uganda, the HIV/AIDS prevalence rate is 8.3%, as compared with the national rate of 7.3%. The district has a population of about 205,000 [6], and it is documented that about 26,600 persons (13.1%) have HIV/AIDS and are in immediate need of care, treatment, and support. Out of that number, about 5300 (20%) are in need of ARVs. Also close to 95,000 adolescents in the district need behavior change communication services, including education on proper condom use [7], and more than 16,000 men have an unmet need of voluntary medical male circumcision (VMMC) [8]. VMMC is the surgical removal of the retractable skin that covers the head of the penis. According to WHO, medical male circumcision reduces the risk of female-to-male sexual transmission of HIV by approximately 60% [9]. Access to condoms is still a major challenge among the youth because of cost. Much as condom cost is a challenge for most people in hard-to-reach communities, condoms are also hardly available in shops. In terms of knowledge, risk perception, and behavioral change among youths of 15–24 years, only 55.8% have ever used condoms, first time use of condom in sex is reported to be at 40.5%, 20.0% use a condom consistently, last time use is at 27.4%, and 33.0% know how to use a condom correctly [8]. Youths reported using a white plastic bag on some occasions as a substitute for a condom.

The civil war lasting more than 2 decades has left a negative footprint on the lives of many youths in hard-to-reach communities. For example, in early 2015 it was reported that a group of HIV-positive youths in one of the subcounties of Kitgum District came together to mercilessly infect others with the virus. They used the slogan *Min anga ma okok kene*, literally translated as “whose mother should mourn alone.” The youths, after discovering that they had acquired HIV, decided to take



matters into their own hands by doing the unbelievable. They engaged in rampant courting, luring, and having unprotected sexual intercourse with young girls and women to intentionally spread the virus.

I also noted that there are ethical issues at the Health Center III located in the subcounties where health workers are faced with various degrees of challenges in getting people with HIV/AIDS to adhere to treatment. HIV-positive subsistence farmers skip hospital to attend to their gardens/small-scale farming in remote villages, only to return to health centers with extremely high viral loads as a result of missing their ARV dose for weeks or even months.¹ In such a context, monitoring patients to determine the trends of new and old viral infections is a serious challenge. There are also other challenges that people with HIV/AIDS face. These include lack of public awareness about HIV/AIDS, the distance to counseling and testing centers, extreme poverty, mythical beliefs that HIV infection can be cured by traditional healers/herbalists, and unethical conduct of health workers. This has resulted in an increase in the rate of new infections and deaths resulting from opportunistic infections. All Uganda is still registering increased numbers of new infections because current intervention programs have not adequately addressed key structural drivers of the upsurge in the number of people with HIV/AIDS. This accounts for the high rate of fatality from HIV infection. In 2010 and 2013, for example, the national statistics indicated that 67,000 and 63,000 persons, respectively, died because they were infected with HIV [6].

There have been cases of poor adherence to professional standards by health care workers in providing care to HIV patients. Patients complained that they are humiliated and stereotyped by health workers in the distribution of ARV drugs and other medications. As an example, patients complained that some health workers shout out their names in the presence of other patients in the native Acholi language, such as *John Paul, bin igam yat cilimi en*, literally translated as “John Paul, come and get your ARV medications.” This lack of professionalism grossly violates patients’ privacy and confidentiality and exposes them to public stereotype and indignity. It partly

contributes to patients abandoning the treatment, hence their descending into a state of hopelessness.

There are also complaints that health workers openly blame patients for acquiring HIV. For instance, when patients ask health workers ‘stressful’ questions, one response is *anga ma ocwali ka nongo cilim, pe iroba ba*. This is loosely translated as “don’t bother me, for it’s not my fault that you acquired the virus.” Blaming patients for acquiring HIV and stereotypical attitudes have led to increased withdrawal from ARV treatment, resulting in increased viral loads and premature death. Because of humiliation of HIV patients by health workers, husbands shun accompanying their expectant wives to antenatal clinics, where voluntary counseling and testing is done [10]. The policy at the antenatal clinics requires expectant mothers to attend the clinics with their husbands to receive services. However, because husbands do not want their HIV status made public, they shun antenatal clinics, and consequently their wives get denied services. The wives then have to trek a long distance to the main government hospital in Kitgum town (several miles away). At the main hospital, the wives receive antenatal care services regardless of whether or not they are accompanied by their husbands.

Men who shun counseling and testing in most cases end up using their wife’s status to determine their own. In hard-to-reach communities, this has led to widespread domestic violence and divorce because men blame their HIV-positive wives for bringing the virus into the marriage. Some men on knowing their wife’s HIV-positive status start stealing the wife’s ARV drugs, hence increasing viral loads and the chance of new infection because the medication would not cover the stipulated period. For example, in one community, I came across an incident in which the health workers at the Health Center III were concerned about one HIV-positive pregnant woman whose ARV drugs always ran out before the next refill cycle. After further scrutiny and involvement of the local community leaders, it was discovered that the husband, who had shunned counseling and testing, was stealing his wife’s ARV drugs. The husband, who was not aware of his HIV status, assumed that he too was HIV positive after his wife had tested positive and hence decided to embark on unprescribed treatment. The habit to shun testing is mostly perpetuated by stigma and the stereotyping

¹ Read a related story at <http://ugandaradionetwork.com/a/story.php?s=58718>.



Traditional knowledge in HIV/AIDS treatment and prevention program in northern Uganda

that HIV-positive people go through in these communities. This is exacerbated by poor client–patient relationships, as described earlier.

Literature reviews

There are lots of uncertainties and conflicting data clouding the trajectory of HIV/AIDS occurrence in most rural communities in Africa and the extent to which interventions can produce expectant results even with increased commitment of financial resources. This calls for reassessment of the effectiveness of research methods that culminate in interventions. The existing literature indicates that different interventions in the form of aid, grants, and loans for projects aimed at addressing diverse adversities in Africa have often failed. Since the inception of the Millennium Development Goals in September 2000, numerous studies have examined the total cost of comprehensive packages for interventions against HIV/AIDS [11]. For instance, efforts to reduce HIV/AIDS transmission in most African societies have taken the form of mass media campaigns, interventions for commercial sex workers, and treatment of sexually transmitted infections where resources are available. Also, prevention of mother-to-child transmission, voluntary counseling and testing, and school-based education have been beefed up as cost-effective on the basis of standard international benchmarks. Recently, ARV therapy has been the latest intervention road-mapped and adopted by governments across sub-Saharan Africa [12–15]. The voluntary counseling and testing and referrals approach has yielded insignificant outcomes in these communities. It is hence consistent to argue that the current intervention by Uganda's government in selected 'inaccessible' communities has taken a linear and homogenous approach designed by the World Health Organization and imposed on local communities. Yet in Australia with the context of education, experience has shown that, the linear model had to be realigned to include indigenous world views. Yunkaporta and McGinty [16] described a case of a school serving an indigenous community and how some of the techniques used to bring local indigenous knowledge into the classroom failed. For it to work, the pedagogical approach of teaching had to be revised around the indigenous cosmology of local patterns recurring at general levels, rather than the Western view of universal laws applying

in local contexts. The top-down methods of instruction were found to be less effective than "focusing on the local, real-life Indigenous link to the content" (p. 67) of lessons. In South Africa Coombes [17] noted that none of the different HIV/AIDS intervention programs implemented were based on any research, but were rather based on a top-down approach.

Knowledge, scientific research, and any form of intervention cannot be divorced from a people's world views because these form the theoretical basis upon which the success of such intervention resides [18]. Because all knowledge has cultural and contextual relevancy, it is profoundly toxic and flawed to assume universal imposition of one knowledge over other knowledge [19]. The African indigenous scientific knowledge system had many positive contributions to African societies before colonization and may even have had many positive contributions since colonization but such positive effects have in many cases been watered down by governments and nongovernmental agencies in service delivery in Africa [20]. There is no doubt that validation of indigenous scientific knowledge as legitimate knowledge in the global education system has been a perpetual source of contestation among scholars [3, 21–25]. This is despite the fact that most scholarly research recognizes its usefulness in different indigenous societies. Many African and non-African scholars [4, 22, 24, 26, 27] have confirmed the existing tension resulting from knowledge hierarchization, which as a result, marginalizes the indigenous African health knowledge and practices from most countries' education systems and service delivery. As seen in the foregoing discussions, most of the existing literature focuses on the absence of indigenous knowledge in education, the resultant effects of its marginalization, or reasons why it should be included in the mainstream education system.

Bridging the gap

However, lacking from the literature are strategies for inclusion of such a knowledge system in social service delivery such as health care delivery in Africa and the implications of such inclusion. Because African indigenous philosophies are often not taken seriously in the principally Western ideologically dominated African societies when it comes to social service delivery, many interventions in health care provision have either failed or partially succeeded. The case of men shunning



voluntary counseling and testing services articulated earlier speaks to the much rooted systemic challenges that interventions in the health sector face in rural African societies and the need to review the current strategies.

To bridge this gap and ensure effective HIV/AIDS intervention, it is crucial that we tap into the knowledge, expertise, and authority of clan heads, elders, and community leaders in HIV/AIDS intervention. There is a need to conduct detailed research to aid in the design of new intervention modules that utilize the knowledge and authority of local leaders to reduce the rate of new HIV infections and provide care where it is most required. When empowered and involved in HIV interventions, elders would ensure that expectant women are accompanied by their husbands to antenatal clinics for counseling, testing, and referral for care where appropriate and that behavioral change among the youth is enforced. The argument in this article seeks to heighten awareness of the need to include indigenous knowledge in the design and implementation of HIV/AIDS intervention in these communities. It affirms the aptness of the Afrocentric model in African interventions and engages a participatory type of research which values and includes indigenous people, knowledge, and cultural norms.

The goal is to ensure that elders maximize their common resources, including their indigenous language and ancestral knowledge, to contribute assertively to the campaigns against HIV/AIDS. This strategy will be based purely on a cultural framework where elders and clan leaders are highly regarded; they pass by laws that govern their clans, communities, and the greater society. The involvement of elders in HIV/AIDS treatment and prevention would ensure that expectant couples start taking ARV drugs at the same time when the test results are positive. It is also crucial for discordant² and concordant³ couples to make informed sexual decisions and life choices.

² Discordant couples are those where one partner is infected with HIV and the other is not, where a couple is defined as two persons in an ongoing sexual relationship and each of these persons is referred to as a 'partner' in the relationship.

³ Concordant couples refer to a situation in which both partners in a sexual relationship or marriage are infected with the same sexually transmitted disease, such as HIV.

The proposed integration of traditional knowledge into HIV/AIDS treatment and prevention programs aligns with Afrocentric research methods/interventions championed extensively by Asante [19, 28]. It involves the examination of African reality from the lens and perspectives of African people. This research method places the experiences (past and present) of African people at the center of any intervention involving African people. It is a method that recognizes African voices and reaffirms their cultural experience as the place to begin and create a dynamic multicultural approach [29] to research and intervention. In essence, the Afrocentric approach advocate not only cultural inclusion and indigenizing methods of research that Africans and non-Africans can use to make sense of their own realities but also the identification of local challenges and solutions from African points of view.

It is a participatory approach that allows health care providers and researchers to learn with, by, and from indigenous African communities, thereby creating a reliable working climate in which people's priorities are fully considered in research and interventions. This allows dignified treatment of indigenous communities in which research/intervention is piloted. Specifically, it allows local African people to be treated as equals in the research and decision making process that brings about policy change regarding their communities [29]. Being participatory, the approach allows grooming of young African students by elders and empower them to become development experts that have deep roots in sustainable utilization of their biodiverse resources, while standing a better chance of becoming leaders in scientific innovation and resolution of intractable challenges of health, resource utilization, sustainability, and human security.

Conclusion

The main argument in this article is that for any social service intervention to be culturally relevant and empowering in most rural African societies, custodians of traditional African knowledge – the elders, clan heads, and community leaders – must be consulted and included from the inception. This effort should be maintained throughout different stages of implementation of projects/program. Affirmed and utilized in intervention programs/project, indigenous knowledge is a powerful



Traditional knowledge in HIV/AIDS treatment and prevention program in northern Uganda

tool to assert the intellectual agency of African people and validate their experiences. The pretext of financial constraints by many implementing agencies in HIV/AIDS intervention should not be regarded as the principal barrier and focus must shift to a change of strategy. The key policy question therefore is: to what extent can we infuse indigenous knowledge and people with dominant interventions as culturally relevant strategies in combating HIV/AIDS in hard-to-reach communities of northern Uganda. The response to this question can be obtained from an Acholi proverb: *kulu pong ki jange*, literally translated as “a river is flooded by its multiple tributaries.” This implies that to engage a realistic, measurable, and achievable HIV/AIDS intervention in hard-to-reach rural African communities, we cannot negate the dominant stream of local knowledge/interventions but rather must engage both knowledge systems to arrive at action-oriented and sustained intervention strategies.

Conflict of interest

The author declares no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

- Ocitti JP. African indigenous education: as practised by the Acholi of Uganda. Nairobi: East African Literature Bureau; 1973.
- Mosha RS. The heartbeat of indigenous Africa. A case study of Chagga Educational System. New York: Garland Publishing; 2000.
- Odora HCA. Indigenous knowledge and the integration of knowledge systems. Towards a philosophy of articulation. Cape Town, South Africa: New Africa Books Ltd.; 2002.
- Dei GJS. Indigenous philosophies and critical education. A reader. New York: Peter Lang, Publishing Inc.; 2011.
- Uganda AIDS Indicator Survey. 2011. Downloaded on August 26 2015. www.usaid.gov/sites/default/files/documents/1860/Uganda_AIDS_Indicator_Survey_2011.pdf.
- The HIV/AIDS Uganda Country Progress Report (2014). Republic of Uganda. www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries.
- UAC. 2007. National HIV&AIDS Strategic Plan 2007/8–2011/12, Moving Towards Universal Access. www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_125553.pdf.
- Kitgum District Local Government Statistical Abstract. 2013. Report prepared with support from UNFPA and Uganda Bureau of Statistics. www.ubos.org/onlinefiles/uploads/ubos/2009_HLG_%20Abstract_printed/CIS+UPLOADS/Higher%20Local%20Government%20Statistical%20Abstracts_2014/Kitgum.pdf.
- WHO. 2012. Voluntary medical male circumcision for HIV prevention. www.who.int/hiv/topics/malecircumcision/factsheet/en.
- Matovu JK, Wanyenze RK, Wabwire-Mangen F, Nakubulwa R, Sekamwa R, Masika A, et al. “Men are always scared to test with their partners...it is like taking them to the Police”: motivation for and barriers to couples’ HIV counseling and testing in Rakai, Uganda: a qualitative study.” *J Int AIDS Soc* 2014;17:19160.
- Stover J, Walker N, Garnett GP, Salomon JA, Stanecki KA, Ghys PD, et al. Can we reverse the HIV/AIDS pandemic with an expanded response? *Lancet* 2002;360:73–7.
- UNAIDS, WHO. AIDS epidemic update: Geneva; 2004.
- Hogan DR, Baltussen R, Hayashi C, Lauer JA, Salomon JA. Achieving the millennium development goals for health: Cost effectiveness analysis of strategies to combat HIV/AIDS in developing countries. *Br Med J* 2005;331:1431–5.
- Walker D. Cost and cost-effectiveness of HIV/AIDS prevention strategies in developing countries: is there an evidence base? *Health Pol Plan* 2003;18:4–17.
- Marseille E, Hofmann PB, Kahn JG. HIV prevention before HAART in sub-Saharan Africa. *Lancet* 2002;359:1851–6.
- Yunkaporta T, McGinty S. Reclaiming aboriginal knowledge at the cultural interface. *Aust Educ Res* 2009;36(2):55–72.
- Coombes Y. Evaluating according to purpose and resources: strengthening the evidence base incrementally. In: Thorogood M, Coombes Y, editors. *Evaluating health promotion: practice and methods*. 2nd ed. Oxford: Oxford University Press; 2004.
- Owusu-Ansah FE, Mji G. African indigenous knowledge and research. *Afr J Disabil* 2013;2(1):1–5.
- Asante MK. *The Afrocentric idea*. Philadelphia: Temple University Press; 1987.
- Nsamenang AB. Factors influencing the development of psychology in Sub-Saharan Africa. *Int J Psychol* 1995;30(6):729–39.



21. Gupta DD. Indigenous knowledge systems and common people's rights. Jodhpur, India: Agrobios; 2009.
22. Kincheloe JL, Steinberg RS. Indigenous knowledges in education. Complexities, dangers, and profound benefits. In: Denzin NK, Lincoln YS, Smith LT, editors. Handbook of critical and indigenous methodologies. Thousand Oaks, CA: Sage; 2008. pp. 135–80.
23. Sillitoe P. Local science vs. global science: An overview. In: Sillitoe P, editor. Local science vs. global science approaches to indigenous knowledge in international development. New York: Berghahn Books; 2007. pp. 1–22.
24. Smith LT. Decolonizing methodologies. Research and indigenous people. New Zealand: University of Otago Press; 1999.
25. Wane N. Indigenous education and cultural resistance: a decolonizing project. *Curriculum Inq* 2009;39(1):159–77.
26. Dei GJS, Marlon S. The Indigenous as a site of decolonizing knowledge for conventional development and the link with education: the African case. In Langdon J, editor. Indigenous knowledges, development and education. Rotterdam, The Netherlands: Sense Publishers; 2009. pp. 15–36.
27. Wane N. Mapping the field of indigenous knowledge in anticolonial discourse: a transformative journey in education. *Race Ethnic Educ* 2008;11(2):183–97.
28. Asante MK. Afrocentricity. Trenton, NJ: Africa World Press; 1988.
29. Mkabela O. Using the Afrocentric method in researching indigenous African culture. *Qualitative Report* 2005;10(1):178–89.