



Published in final edited form as:

Soc Sci Med. 2022 March ; 296: 114756. doi:10.1016/j.socscimed.2022.114756.

“Sex is supposed to be naturally more pleasurable”: Healers as providers of holistic sexual and reproductive healthcare in Uganda

Erin V. Moore^{a,*}, William Ddaaki^b, Jennifer S. Hirsch^c, Larry Chang^d, Fred Nalugoda^b, John S. Santelli^c

^aThe Ohio State University, Columbus, OH, USA

^bRakai Health Sciences Program, Kalisizo, Uganda

^cColumbia University Mailman School of Public Health, New York, NY, USA

^dJohns Hopkins University School of Medicine, Baltimore, MD, USA

Abstract

Global health researchers often approach Traditional, Complementary, and Alternative Medicine (TCAM) from a health efficacy perspective, asking whether the presence of plural medical systems helps or hinders the uptake of biomedicine. Medical anthropologists, by contrast, typically emphasize how plural medical systems encourage us to rethink health ontologies—that is, who and what comes to constitute the experience of health and illness, and through which practices. Building on both approaches, we explore the role of “healers,” a term we use to encompass several different kinds of TCAM providers, in the sexual and reproductive healthcare (SRH) of young people from southcentral Uganda, a region well known as an HIV/AIDS epicenter. Drawing from ethnographic data, we describe three reasons that young people seek SRH from healers. First, they associate stigma, scarcity, and high costs with biomedical SRH. Second, healers work across biomedical and non-biomedical therapeutic divides, prescribing herbs for sexually transmitted infections while simultaneously referring clients to biomedical HIV clinics. Third, healers provide counseling focused on pleasurable and economically-motivated sex. Because these therapies diverge from international and national HIV prevention messaging that frames non-marital and transactional sex in terms of danger and disease, healers’ holistic approach to SRH may help to reconstitute the meaning, practice, and experience of “sexual health” in contemporary Uganda. This has important implications for improving global SRH programs and for understanding the continued appeal of TCAM more generally.

This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

*Corresponding author. Dr. Carl F. Asseff Assistant Professor in Anthropology and the History of Medicine, Department of Anthropology, The Ohio State University, 4034 Smith Laboratory, 174 W 18th Avenue, Columbus, OH, 43210, USA. moore.4540@osu.edu (E.V. Moore).

Credit author statement

Erin V. Moore: Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing – original draft; **William Ddaaki:** Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing—reviewing and editing; **Jennifer S. Hirsch:** Supervision, Conceptualization, Methodology, Writing—reviewing and editing; **Dr. Larry Chang:** Writing—reviewing and editing; **Fred Nalugoda:** Conceptualization, Supervision, Project administration, Writing—reviewing and editing; **John S. Santelli:** Funding acquisition, Supervision, Project administration, Writing—reviewing and editing.

Keywords

Traditional, complementary, and alternative medicine (TCAM); Sexual and reproductive health; HIV/AIDS; Global health; Africa

1. Introduction

Traditional, complementary, and alternative medicine (TCAM) has long captured global public health's imagination. Researchers and practitioners alike often approach TCAM from a health efficacy perspective, examining whether plural medical systems help or hinder the uptake of biomedical treatment. For example, some HIV/AIDS researchers argue that competition between biomedical, faith-based, and other healing systems creates confusion and “bottlenecks” in the cascade of HIV/AIDS treatment (Moshabela et al., 2017; Pantelic et al., 2015). Other research has shown, however, that healers are compelling AIDS educators and in some cases are even more effective at encouraging family planning and condom use among clients (Leclerc-Madlala et al., 2016; Ssali et al., 2005).

Most global health scholars agree that in contexts such as sub-Saharan Africa, with under-resourced and overburdened health systems, facilitating collaborations between TCAM and biomedicine is crucial, and moreover that these seemingly incommensurate health systems can complement and improve one another (De Coninck, 2016; Deml et al., 2019; Langlois-Klassen et al., 2008; Wanyama et al., 2017). The World Health Organization, for its part, embraced TCAM in the early 2000s and has adopted several resolutions for incorporating and regulating healers as part of its broader mission to achieve universal health coverage (WHO, 2014). Similarly, the United States' National Institutes of Health founded its National Center for Complementary and Integrative Health (NCCIH) in 1998 with a mission to determine the “fundamental science, usefulness, and safety of complementary and integrative health approaches and their roles in improving health and health care;” in 2020 the NCCIH received \$151.9 million in funding (NIH, 2021). Such investments signal growing interest in the institutionalization of TCAM systems widely used around the world (Pescosolido et al., 2020).

In its attempts to engage with the vernacular therapies associated with TCAM, however, global health work has tended to enfold them within broader biomedical systems, envisioning them as lower cost alternatives or as a “first step” on the way to appropriate treatment (e.g. Sundararajan et al., 2020; UNAIDS, 2002). As Stacey Langwick (2008) has argued, TCAM becomes visible to biomedicine only as it is rendered useful, assessable, and deployable as a resource—engulfed by the health efficacy model. Social scientists, especially medical anthropologists, have increasingly challenged the portrayal of TCAM providers as “well-meaning consultants, as a cheap way to augment failing or weak health systems” (Thornton, 2015, p.367) and likewise their “co-optation” by biomedical systems (Patel et al., 2021). Influenced by critical studies of science, these scholars emphasize how plural medical systems help us to rethink health ontologies—understood as *who* and *what* constitute the experience of malady and medicine, and *through which* practices (Langwick,

2011; Livingston, 2005; Pigg, 1996; on health ontologies, see Ahlin, 2014; Farquhar et al., 2014).

Yet the questions raised by a health ontologies perspective are not necessarily in conflict with concerns for health efficacy, so this article draws from both approaches to explore healers' role providing sexual and reproductive healthcare (SRH) to adolescents and young adults in the rural Rakai district of southcentral Uganda, a region well known as an HIV/AIDS epicenter. Analyzing data from ethnographic research, we present three key findings: First, young people seek healers for SRH because they associate stigma, higher costs, and scarcity with biomedical services and technologies. Second, *abasawo bekinansi* (literally, doctors of traditional things) traverse imagined and actual therapeutic divides between biomedicine and TCAM as part of their routine practice. For example, healers treat gonorrhea with herbs, refer patients to hospitals for STI testing, and support anti-retroviral therapy (ART) adherence by prescribing hunger-stimulating medicines from their gardens to make the drugs stomachable. Finally, key to healers' SRH practice is counseling related to sexual pleasures and desires, a therapeutic approach that acknowledges young people's sexual citizenship by encouraging them to consider how they experience and whether they enjoy sex, and to consider their partner's pleasure as well (Hirsch and Khan, 2020). We discuss healers' attention to the erotic and relational dimensions of healthy sex, contrasting it with national and international HIV prevention messaging that frames sex—especially non-marital and transactional sex—as morally and medically dangerous. We argue that healers' holistic approach to SRH draws young people to their services, providing a bridge to biomedical healthcare while simultaneously reshaping the meaning and experience of sexual health in contemporary Uganda.

2. Background

2.1. Sex, health, and healing after Uganda's "HIV miracle"

Uganda's 35-year experience with HIV/AIDS has shaped the therapeutic landscape in which young people seek and receive sexual healthcare by influencing both public discourse and public health funding priorities. As the first country in sub-Saharan Africa to have reversed trends in HIV incidence, Uganda is said to have achieved a "HIV miracle." Between the mid-1980s and early 2000s, Uganda's HIV prevalence rates fell by reportedly 70 percent (see Parikh, 2015). While reasons for the decline are complex, and were largely driven by HIV-related mortality (Wawer et al., 1997), the Museveni government received widespread international praise for curbing the epidemic with its robust public response, particularly at a time when other African leaders were denying the effects of AIDS. Museveni's HIV prevention campaigns initially promoted testing and treatment, and advocated for the ABCs—abstain, be faithful, use condoms. By the mid-1990s, the World Health Organization deemed the ABC approach so successful it exported it around the globe (*New Vision*, 1994).

Once internationally acclaimed for their direct approach to HIV prevention, in the early 2000s Uganda's HIV campaigns abandoned discussions of safer sex and condom use and began emphasizing the dangers of non-marital, non-monogamous, and transactional sex (Kuhanen, 2008). This shift followed changes to international donor priorities, namely under the United States President's Emergency Plan for AIDS Relief (PEPFAR), which mandated

33% of HIV prevention funds be directed toward promoting abstinence (Parkhurst, 2011; Santelli et al., 2013). The dominance of abstinence-only approaches to sexual health in Ugandan public health messaging was compounded by two factors. First, Ugandan feminist advocacy for the criminalization of “sugar daddies,” older men who gift for sex, led to an amendment to Uganda’s Defilement Law raising the age of sexual consent from fourteen to eighteen, and efforts to publicize and enforce the law that followed strongly condemned intergenerational and transactional sex (Parikh, 2012). Second, Evangelical Christianity spread rapidly throughout the country in the early 2000s and was embraced by political leaders, eventually becoming embedded within government-sponsored HIV prevention campaigns. For example, in 2004, Uganda’s first lady led a virginity march through the capital city and the president declared a “war on condoms” (Epstein, 2007). In addition to circumscribing discussions of safer sex within national HIV prevention messaging, PEPFAR also rerouted HIV/AIDS prevention funds to faith-based NGOs, which have received the majority of HIV prevention funding in Uganda to date (Boyd, 2015; Nakkazi, 2020).

National campaigns maligning pre-marital and transactional sex have conditioned how and where young people learn about sex, seek contraceptives, and experience sexual and reproductive healthcare. As Shanti Parikh (2015) has argued, the sheer ubiquity of HIV campaigns thrust “medically constructed talk” about sex into the public sphere while relegating conversations about sexual pleasure to other, more surreptitious venues, such as pornographic movie halls and tabloid newspapers. This “bifurcation” of risk and pleasure in public discourse about sex continues to shape how most young people learn about sex and romance. For instance, one recent study of young Rakai residents’ responses to HIV prevention messaging found that they overwhelmingly perceive sex to be dangerous because of its association with HIV (Mathur et al., 2016). Earmarking funds for abstinence programming also affects the availability of condoms, anti-retroviral therapy, and other SRH technologies, the wholesale costs of which are offset by government subsidies, as well as the willingness of providers to distribute them to young, unmarried men and women, as we discuss below. This national policy context shapes the therapeutic landscape in which young Ugandan people pursue SRH from healers, who provide alternative therapies for those who may feel stigmatized by the sex education they have grown up with and the attitudes they encounter in biomedical settings.

2.2. Institutionalizing TCAM in Uganda

TCAM is and has long been institutionally recognized in Uganda. Well before the signing of the Buganda Agreement in 1900, which made Uganda a British Protectorate, healing was deeply entangled with political power, and royal leaders often acted as healers themselves (Kodesh, 2007). Healing was codified under colonial rule in 1935 by the Public Health Act, which made it illegal to practice “witchcraft,” construed broadly to include healers, spirit mediums, and traditional birth attendants. These regulations were intensified by the Witchcraft Act of 1957, which outlawed the manufacturing and prescription of herbal medicine and forced healers to practice in secret (Uganda Legal Information Institute, 1957). At the same time, British colonial medical officers and researchers also sought to understand and appropriate African therapeutic traditions as part of their broader efforts to eradicate infectious diseases such as trypanosomiasis, or sleeping sickness, just as African healers

gradually made use of the biomedical tools and ideas of colonizers (Livingston, 2005; Tilley, 2011).

Soon after Uganda gained independence from Britain in 1962, state efforts to criminalize traditional medicine shifted to initiatives for institutionalization. For example, in 1964 Uganda's Ministry of Health established the Natural Chemotherapeutics Research Laboratory, which had a mandate to conduct research on herbal medicines and popular therapies in order to bolster healers' legitimacy (WHO, 2019). While the 1960s and 70s were a heyday for Ugandan biomedicine, in ensuing decades the national healthcare system was drastically weakened by war and political turmoil as well as state retrenchment under the IMF and World Bank's structural adjustment programs (Crane, 2013; Dodge and Wiebe, 1985; Whyte, 1992). Subsequently, incorporating healers into Uganda's national health infrastructure has been envisioned as filling gaps in an otherwise crumbling healthcare system.

Since the late 1990s, Ugandan laws and policies have continued both to legitimate and differentiate healers as part of Ugandan national healthcare (Ampurire, 2019). For example, the 1998 Medical Practitioners and Dental Surgeons Act prohibited unlicensed persons from practicing medicine, dentistry, or surgery, but allowed for the practice of any system of therapeutics by persons recognized to be duly trained in such practice by the community to which they belong (Tibugwisa, 2020). In 2000, the Uganda National Health Policy publicly recognized the role of TCAM as part of its national healthcare system (Uganda Ministry of Health, 2000), and in subsequent decades numerous public and private organizations have emerged to promote, regulate, and certify healers, all overseen by the National Council for Traditional Healers and Herbalists Association (Fissel and McKay, 2006).

3. Methodology

This article is based on collaborative, team-based ethnographic fieldwork conducted between June–August 2018 as part of an interdisciplinary study investigating how the social transition to adulthood shapes HIV vulnerabilities among adolescents and young adults in Rakai. The article also draws from long-term ethnographic fieldwork conducted by Dr. Erin V. Moore among adolescent girls and young women in Kampala, Uganda's capital and largest city, between 2009 and 2018, including doctoral fieldwork during the years 2012–2013 and several shorter periods in 2009, 2010, 2014, 2017, 2018, 2019 and in Rakai in 2018 and 2019. Our analyses were further informed by the long-term qualitative research experience of William Ddaaki, and seven other members of the Social and Behavioral Sciences team at the Rakai Health Sciences Program (RHSP), who brought decades of methodological, sociological, and theoretical insight to the study. All research activities were approved by the Institutional Review Boards at Columbia University, the Uganda Virus Research Institute and Ethics Committee, and the Uganda National Council of Science and Technology.

Data were collected in 6 different communities in the Rakai district of southcentral Uganda, which borders Tanzania and Lake Victoria, Africa's largest lake. Using already existing longitudinal demographic data collected by RHSP, study sites were selected based on

population size as well as their social, economic, and geographic characteristics to represent three different types of communities in the area: fishing communities, agrarian communities, and trading centers. The most significant demographic difference between community types is HIV prevalence: in some of Rakai's fishing communities, HIV prevalence rates near 50%, compared with less than 10% in nearby agrarian communities and trading hubs (Chang et al., 2016). RHSP maintains community contacts in each study site who connected us with additional research participants.

Following Urie Bronfenbrenner's (1979) ecological systems theory, the broader study sought to identify the micro-, meso-, and macro-level systems shaping individual transitions to adulthood in each community type and to determine whether and how these nested systems influence HIV vulnerability. We also sought to identify locally salient meanings of adolescence, youth, and adulthood as well as community perceptions of young people's health vulnerabilities. Ethnographic methods included participant observations (N = 60) in domestic spaces, NGO meetings, vocational schools, workplaces (factories, motorcycle hubs, salons, fishing boats, restaurants), religious services (Catholic, Muslim, Evangelical, Anglican), and spaces of leisure (bars, betting halls); interviews (N = 43) with key community members (industry heads; NGO officers; healthcare providers; religious, cultural, and political leaders); focus group discussions (N = 24) with younger and older men and younger and older women; and in-depth interviews (N = 26) with young people and their partners. Triangulating these data revealed how crucial economic independence is to other institutions of social adulthood, including marriage and childbearing, and moreover that economic independence is increasingly elusive for young people in Rakai, especially for young men. These findings informed our baseline understanding of the issues relevant to the everyday lives of young Ugandans, including to their romantic relationships, family lives, and sexuality, and therefore to their sexual and reproductive health.

3.1. Mapping SRH access

Because SRH is a proximal determinant of adolescents' and young people's HIV vulnerability (Sommer and Mmari, 2015), and learning to seek healthcare providers on one's own is integral to achieving social adulthood, we conducted a sub-study mapping young people's access to and utilization of SRH to investigate where and how young people sought and attained contraceptives, HIV testing and treatment, and sex education. SRH mapping exercises (N = 6) included counting the number of pharmacies, hospitals, and non-biomedical clinics such as shrines and storefronts in each study site as well as participant observations in each SRH site. During observational visits (N = 24), our research team documented patient-provider interactions, the availability of contraceptives and family planning methods, and the presence of information and advertisements regarding available SRH services and technologies (condoms, biomedical family planning methods, herbs). SRH mappings also included semi-structured interviews with pharmacists (N = 10), biomedical clinicians (N = 6), and healers (N = 7).

3.2. Defining "healers"

There is no ideal term by which to refer to the group of different healthcare providers that we discuss in this article as "healers." To refer to this group as "traditional" risks

signaling that their practices are not “modern,” and thus an assessment of value (Scherz, 2018). Referring to this group as “local” or “vernacular” practitioners also obscures the extent to which many healers adopt and enfold practices from all over the world—from Chinese medicine to modes of healing associated with Christianity and Islam—into their therapeutic repertoire, particularly as the twenty-first century has enabled mass access to foreign media. Moreover, the empirical line between biomedical and non-biomedical healing practices has long been blurry. Patients pursue different therapies both simultaneously and sequentially from a continuum of possibilities, just as practitioners move across medical modalities themselves, as we describe below (Olsen and Sargent, 2017). We use the term “healers” to avoid unnecessarily associating therapies taking place in the present with the past while drawing attention to the long history of African healing practices that root “health” in the social body and likewise view “healing” as a public project and therefore as a source of political power and social criticism (Comaroff, 1985; Feierman, 1985; Hunt, 2013; Langwick, 2011; Livingston, 2005).

The healers described below represent several different types of practitioners who are socially and legally recognized in Uganda: *abasawo bekinansi*, “doctors of traditional things,” whose practice often involves divination and tending a shrine; *balerwa*, or “Traditional Birth Attendants;” and *ssengas* and *koojas*, “aunties” and “uncles” classically responsible for the sexual education of younger kin who now obtain official certification to market their services as commercialized “sexperts” (see Parikh, 2015; Tamale, 2016). Healers interviewed for the study included four women and three men between the ages of 30–69, all of whom were certified as either practitioners of traditional medicine or traditional birth attendants (TBAs) by local and national councils. Some healers reported being called to their craft by ancestral spirits and having apprenticed with family members or neighbors, while others’ pathways to the practice were through training courses provided by a growing number of private agencies. For example, the TBA we spoke with began her practice at the age of eighteen when she helped a neighbor give birth, and she continued working as a midwife before receiving training in community-based reproductive health by private organizations and being certified by the local government. Six of the healers operated clinics from home or from shrines near to their places of residence, while one healer we interviewed ran a mobile clinic between the capital city and a fishing community.

3.3. Analysis

As is typical in ethnographic research, we analyzed the data inductively and according to grounded theory, which allowed patterns to emerge from the data as they were collected and for the revision of research instruments as the study progressed. Our research team worked in groups of two data collectors per study site and met once each week during the twelve-week data collection period to report and review findings. These collaborative analysis meetings allowed our team to discuss emerging themes by comparing findings between study sites. As we analyzed interviews and focus group discussions with young people and began to identify both a general sense of distrust of biomedical providers and the widespread use of herbs for matters related to sex and sexual health, we turned attention to the availability and utilization of plural medical systems for SRH. After initial themes were identified during the collaborative analysis process, two researchers systematically coded the

SRH access mapping data using NVivo software. Data included fieldnotes, analysis meeting notes, photographs, interview transcripts, and an archive of television and newspaper media, all of which were triangulated with findings from our broader ethnographic study in a second stage of analysis.

3.4. Positionality

It is important to note that our research team's affiliation with recognizable institutions of global public health undoubtedly conditioned the way healers and young people spoke about TCAM, perhaps overemphasizing the extent to which they deferred to biomedical clinics for HIV/AIDS diagnoses, for example (Pigg, 1996). Founded in 1987 and renowned by epidemiologists all over the world, RHSP conducts research and provides prevention and treatment services to people living with HIV/AIDS in Rakai, where the program maintains a significant biomedical-infrastructure presence: "Are you here to take my blood, *musawo* (health worker)?" is a refrain with which RHSP researchers are well familiar. At the same time, researchers' affiliation with a well-known, well-resourced biomedical institution also provided unique opportunities to understand healers' willingness to work across both imagined and actual therapeutic divides; healers likely understood relationships with RHSP researchers as access points to HIV/AIDS treatment programs. It is also conceivable that healers took the opportunity to offer our research team what they understood was an ontologically different framing of sexual health, one that emphasized the importance of both pleasure and financial wellness.

4. Healing as holistic SRH

Young people come to my shrine with various cases, but they are all related to sexual matters.

(Male healer, 30 years old)

The data presented below show that young people seeking SRH services visit healers in addition to, and sometimes in lieu of, biomedical clinics and pharmacies for many reasons, some of which are already well documented by other studies of Ugandan young people. These include religious and family influences, cost, distance, and the scarcity of available biomedicines (Lawrence et al., 2014). In addition to the reasons listed above, our data highlight the widely held perception that, in contrast to biomedical clinics and pharmacies, healers provide more compassionate and realistic care for young people seeking SRH. In particular, by offering SRH counseling that centers sexual pleasure and financial well-being, healers offer a holistic approach to sexual health and citizenship that both departs from the moralizing, medicalized frameworks that dominate biomedical SRH in Uganda and is grounded in local social norms.

4.1. Barriers to accessing biomedical SRH

Young people reported that the high costs, inconsistency of supply, and experience of stigma in biomedical clinics and pharmacies influenced their preferences to visit healers in lieu of biomedical SRH providers. For example, young women in Lake Victoria's fishing communities stopped buying Depo-Provera from local drug shops because the cost

was prohibitive at 5000 Ugandan Shillings (UGX) per course (\approx \$1.36). Pharmacists and drug shopkeepers from urban areas also told us that while they never heard young men complaining about using condoms (even as diminished sexual pleasure is often cited as the reason for their lack of use), they did regularly complain of the costs. These costs change depending on the brand of condoms available wholesale to pharmacists, which in turn are differentially subsidized by the government. One shopkeeper reported that young men often stop in to purchase condoms, expecting to pay 500 UGX (\approx \$0.14) only to leave empty handed after discovering the brand in stock costs three times as much. Young men from Rakai's poorer, rural communities also reported being unable to afford STI treatment at government health clinics. These findings are consistent with research showing that the high cost of many essential drugs, including transportation costs to clinics for routine ART, leaves many people living with HIV/AIDS reliant on herbal medicines, particularly to treat opportunistic infections (Bodeker et al., 2000; Tuller et al., 2010).

Those that can afford contraceptives cannot always find a place to buy them because pharmacists and drug shopkeepers face regular scarcities from distributors. Sex workers who meet with clients in a large town that serves as a main truck-stop along the Trans-African Highway described frequent government condom shortages, redressed only when their organizer, or madame, traveled to Kampala to acquire condoms at full price. In rural locations, pharmacists who provide family planning pills and injectables also reported frequent stock-outs. For example, a clinician working in the single health center serving nearly 8000 people in a geographically isolated fishing community told us, of IUDs and birth control pills, "We need them, but we haven't seen them." Moreover, pharmacists and shopkeepers also reported that despite high demand, national law prevented them from providing mifepristone for medical abortions, while licensing fees required by the Ministry of Health and local town councils further hindered their ability to purchase and provide contraceptives.

Young people also described fears of being subject to stigma or receiving poor-quality care in biomedical settings. For example, women in an agrarian community told us they prefer working with traditional birth attendants because hospital nurses are "rude, just out of school," meaning too pedantic, particularly as they do not yet understand the pains of childbirth themselves. Young people also described traveling to SRH clinics in nearby towns to ensure anonymity, which adds travel costs to the expense of treatment. Our interviews with providers indicate that young people's fear of stigma was well-founded. One pharmacist in a small, rural trading post told us that he refused to distribute family planning methods, even condoms, to young people he knew were not legally married. In a fishing village, a pharmacist who had once provided emergency contraception, by far the most preferred family planning method for young women, stopped selling it because he realized that he was the only provider in the area, and he feared retribution for bringing shame upon his clients.

Young people also expressed skepticism about contraceptive effectiveness, the accuracy of HIV testing, and worries about the side effects of other biomedical SRH technologies including Norplant and IUDs. For example, young women told us they knew of women who became pregnant even after receiving contraceptive implants. Others reported discontinuing

the use of certain forms of contraception, especially implants, because they experienced negative side effects such as irregular bleeding. Many young women reported rotating prophylactic methods between birth control pills and herbs to reduce the discomfort associated with the former. Others told us that they distrusted HIV testing at their nearest clinic because they believed their partners might bribe medical staff to produce negative results. Coupled with the difficulty and discomfort accessing biomedical SRH, concerns about side effects and effectiveness indicate some of the key reasons why young people pursue SRH from healers.

4.2. Traversing therapeutic divides

While different healers combine therapies in different ways, and some eschew biomedicine all together, the healers we spoke with reported traversing a spectrum of therapies—counseling, herbal medicine, suggestions for herbal and other pharmaceutical treatment, and referrals to biomedical providers. As they traverse this spectrum, healers diagnose and treat both the social-emotional components of sexual health as well as sexually transmitted infections, including syphilis, gonorrhea, oral and vaginal candida, and herpes, as well as complications from AIDS. As is well documented in the literature on HIV/AIDS, healers frequently refer clients to biomedical care and report taking precautions to avoid drug interactions between herbal medicines and ARVs (Audet et al., 2017). In fact, most Ugandans living with HIV report using herbal medicines to treat HIV-related symptoms alongside ART (Endale Gurmu, 2017; Halpin et al., 2018; Lubinga et al., 2012).

Before medicines are prescribed or referrals made, the most consistent form of therapy provided by the healers we spoke with was counseling, particularly regarding love and romance. As one healer described,

I do provide time to advise my client before he or she receives the herbal medicine. Sometimes a client can get recovery only through psychosocial support by advising him or her on what to do. Most young people may also need guidance on what he or she is supposed to do. For instance, I can advise a young man on how to behave while together with the girlfriend. In this context, I can only advise to a young man and finally the girl accepts for a relationship with him. Also, I have herbal medicine that can help in such cases because traditional healers are all aware that someone can be jinxed. For instance, a young man may say, 'I am always unlucky. Every girl I speak with, she refuses to have a relationship with me.' Therefore, we have herbal medicine purposely for bathing to solve this challenge. After use of this herbal medicine, the client may finally testify to say, 'Our relationship started and thus the herbs worked out well.'

In this instance, with a patient seeking romantic advice, the healer combined what he described as “psychosocial support” with herbal remedies to treat the “jinx” that has made the patient unlucky in love. Because this example is about securing a love affair rather than protecting or treating someone already in one, it may seem to feature a malady located outside the classic domain of biomedical SRH. However, that the successful pursuit of a girlfriend is central to health and healing practices in Uganda demonstrates the expansive notion of sexual health healers and their patients engage. Relationship advice

that encourages a young man to pursue a young woman successfully, and respectfully, is in the service of cultivating healthy sexual citizenship.

Beyond counseling, occasions that called for pharmaceutical recommendations or biomedical referrals were generally related to the diagnosis and treatment of physical ailments, such as a patient presenting with a sexually transmitted infection or a request for an HIV test. As one healer explained,

There are some diseases that may require medical tests which we cannot do as traditional healers. For instance, it is difficult to determine the CD4 count for someone who is HIV positive. However, if you are medically examined that probably you have STDs like syphilis, the traditional healer may find it easier to provide herbs for treatment as opposed to making tests.

Other healers sought to convince clients who visited them seeking HIV tests to visit biomedical providers, while the TBA we spoke with told us she refused to take patients with visible physical abnormalities or who had had operations of any kind, referring them to nearby hospitals instead. She also described rushing women to the hospital if complications arose during delivery, where she would use her status as a certified TBA to ensure expedited treatment. Another healer drew from her own experience living with HIV to diagnose patients “by the eyes” before she advised them to seek ART from nearby hospitals, deferring to biomedicine for treatment but not for its diagnostic technologies.

It would be a mistake, however, to suggest that all healers are eager to work across therapeutic divides, which raises some concerns for treating HIV/AIDS and attending to complicated pregnancies or failed abortions. Some healers are willing to work across medical systems to help patients locate optimal care while others are not, which is equally true for biomedical providers. Some literature suggests healers rarely receive official referrals (Mendu and Ross, 2019), while other studies have shown patients and providers engaging in “traditional” therapies within hospitals themselves, sometimes calling into question the authority of biomedicine and its providers (Langwick, 2008; Sargent and Olsen, 2017).

4.3. Medicine, money, and pleasure

Whichever therapeutic traditions healers draw together in their routine practice with young people, they are offered in service of helping patients to manage “sexual matters” and their attendant economic, affective, and physical components. The ways the healers we spoke with described their practices indicates that they and their patients understand these elements, especially desire, arousal, and pleasure, as key indicators of healthy sexual life interrupted by the physical discomforts of sexually transmitted infections. As one explained,

At least we are all aware that sex is supposed to be naturally more pleasurable. However, this may be compromised due to some diseases people get including syphilis, or effects in fallopian tubes among others as opposed to problems that require attention from traditional healers or herbalists. Such diseases may cause someone to have issues about sexual strength and lack of sexual desire. In this case, we do provide special herbs to treat the problem.

As opposed to a biomedical SRH approach focused wholly on the physical symptoms of health and illness, healers frame diagnosis and treatment not in terms of ill effects for the individual body but rather as diminishing sexual pleasure for the person and stymieing desire within a relationship.

Furthermore, in Rakai, where exchanging gifts and money to signal romantic interest is both socially normative and difficult to afford, healers provided advice for navigating financial stresses, including those required to court a love interest. Unemployment is rampant in Rakai as it is throughout Uganda, and people told us repeatedly that the number one health problem young people face was lack of income. One healer put it this way, “The most problems people face are related to finance. For instance, someone would be working, but he or she is not earning well. This is common in young people. A young man may come to my place specifically to get blessings to make money after realizing another person was blessed. This explains why young people always visit traditional healers to get blessings to live better.”

It almost goes without saying that while economic distress, romantic turmoil, and sexually transmitted infections are suffered by both young men and women, the SRH therapies sought and offered in Rakai are gendered, corresponding both with sexed bodies and with the social and cultural norms that govern respectable forms of love and the pursuit of relationships. For example, one herbalist, a young man in his early 30s who practiced medicine from a shrine up a grass road from his home, told us that he prescribes the same herbs to both men and women to treat candida and gonorrhea (herbs which have the benefit of enhancing sexual pleasure, he explained), but his therapies are otherwise typically gendered, as are the ailments patients present. While preventing pregnancies was not part of his practice, he told us that he prescribes herbs to help with conception and offers divination services for women who have trouble conceiving. He also provides young men who seek his services with herbs to make it easier to court women, while young women leave his clinic with different herbs to enhance their sexual pleasure. For all the healers we spoke with, gendered ailments related to relationship building, desire, and pleasure constituted the main focus of their practice.

Moreover, while it has been typical in Rakai for men to seduce women with money and gifts, young men have also started seeking relationships with older women for financial support. As one healer, a woman in her mid-40s who treated both men and women and had inherited her practice from her father, explained, “Young men admire older women for money, girls admire married men because they give them money to fulfill their needs, and girls love money more than boys. The girls do not like young boys because the boys do not give them money.” Because coming by the money required to seduce women and establish relationships is so difficult, many young men are further concerned that their financial investments in romance will go unreturned. For instance, when asked about the problems young men present with at his clinic, one healer answered, “Like being rejected by a partner, girls eating men’s money and they do not give them sex. Those ones.” The interviewer further questioned, “So, you give them herbs and partners stop rejecting them?” to which the healer responded, “Yes, even that medicine is here. And I get customers both men and women.” In counseling and prescribing herbs against money lost on romance, healers help

young people to avoid the widely reviled practice of “detoothing,” or taking someone’s money without following through with the sexual interaction the money should facilitate. Young men and women alike perceive detoothing not only as a hit to one’s wallet but a single to one’s masculinity (Moore, 2020). At the same time, healers enable detoothing by providing therapies for young women to enhance their seductive power.

Healers also treat the more physical symptoms of financial distress, including erectile dysfunction. As one healer described of his young male patients, “Some of them can come with bodily or mental stress. They lack jobs thus no money, yet they want to have sex. So, when he gets a person to have sex with, the man prowess disappears, and he runs to this place for medicine. So, I have medicine to increase man prowess, and I also have medicine that treats prostate.” “Man prowess,” or *amaanyi g’ekisajja*, entails a man’s ability to both physically and financially support one or more partners (Wyrod, 2016). Fliers lacquered to the sides of buildings advertise herbs to bolster *amaanyi g’ekisajja*, as well as penis enlargement, and nearly every young man we spoke with described various herbs they used for sexual enhancement, or “prowess.” Yet some of the healers we spoke with see these herbs as dangerous, so they counsel men on sexual technique instead. For instance, one healer regularly cautioned young men against herbal enlargement, advising instead they “learn how to use their small penis to satisfy their ladies,” as he put it. Another healer who also advised against herbal penis enlargement, a sheikh with a degree in ethnopharmacology, shared with young men the Luganda phrase *teri nkasi ettagusa lyato mitala*, meaning “there is no oar that doesn’t take the boat to the shores.”

Whereas young men primarily seek healers’ services to attract and please partners, young women tend to visit healers to increase their sexual desire or arousal, for which healers offer herbs and counsel on techniques for giving and receiving pleasure—both to one’s partner and oneself. Healers report that young women present with reduced sexual drive especially after using family planning methods such as IUDs and the pill. As one healer explained, “For young women, besides looking for herbal medicine to get attracted to a man, they usually present cases of lack sexual desire. For instance, a young woman may start staying with her boyfriend, but she does not get any sexual feelings. Or a young woman says, ‘I find trouble to get sexual fluids while having sex with my boyfriend.’” The healer continued, offering both etiology and remedy for vaginal dryness:

As traditional healers, we always know that in most cases if a young woman finds trouble with getting sexual desire, it means that her body is not healthy. Therefore, the first herbal medicine I provide is purposely to cleanse her body. This may include cleaning *enseke* and entire body (meaning to flush the reproductive system of hormones left over from biomedical contraceptive methods). This medicine is taken orally. After some given period, she will give us feedback and says, ‘I am now feeling fine, I can now feel the sexual desire once I get a man and have enough sexual fluids while having sex with a man.’

In addition to prescribing herbs, some healers counsel young women to suck on sweets before sex to increase salivation throughout the body, or they advise women to learn to pleasure themselves. “Like I told you,” a 60-year old man who practiced from a sizeable store in a large town, packed with herbal pharmaceuticals, explained, “someone can come

here and I advise them: some ladies use cucumber, mingling stick for sexual satisfaction. I am going to show you after the interview!” That healers, even older male healers, emphasize sexual pleasure and arousal for young women is notable. Women’s eroticism has long been celebrated, and cultivated, by healers (*ssengas* and *koojas*) in central Uganda, if in private (Tamale, 2016), yet national, religiously inflected HIV prevention campaigns have censured women’s sexuality as dangerous by promoting the idea that the key purpose of sex is the reproduction of national citizens (Moore et al., 2021). By contrast, as healers advise their patients on techniques and technologies for enhancing sexual pleasure, whether mingling sticks or salivation inducing sweets or herbs, they acknowledge young people’s sexual citizenship by encouraging them to take into account how they and their partners feel, operating with the notion that “sex is supposed to be naturally more pleasurable” whether one is married or not.

5. Discussion

Healers have long demonstrated willingness to collaborate with the biomedical community for HIV/AIDS care (Baguma, 1996; Kayombo et al., 2007; UNAIDS, 2006), and our findings indicate that healers are and should be engaged as allies in HIV prevention and other biomedical SRH efforts. From a health efficacy perspective, many healers act as connection points to biomedical systems, where they frequently refer clients for testing and treatment. Even more important for bolstering the effectiveness of SRH for young people, healers provide a destigmatized, holistic SRH experience by embracing the fact that young people are sexual citizens who engage in premarital and transactional sex, particularly in a national public health climate and therapeutic landscape that otherwise censors it. In Uganda, where decades of HIV prevention campaigns focused on the medical and moral dangers of non-marital sex have left young people fearing rebuke from community providers, as exemplified by the pharmacist who refused to sell condoms to unmarried young people, healers close gaps in care by providing a sex-positive approach to SRH.

From a health ontologies perspective, as healers coach young people on sexual technique, giving and receiving pleasure, and the financial commitments required to court and sustain a love interest, they broaden the meaning of SRH beyond the individual body to the web of intimate and social-economic relations in which individuals are embedded. In fact, the World Health Organization proposed just such a holistic approach to SRH more than a decade ago, defining sexual health as “...a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences...” (see <https://www.who.int/health-topics/sexual-health>). Yet the concept of pleasure seems to have remained outside the domain of global SRH research and interventions, especially in legally restrictive contexts (see Epstein, 2022; Logie et al., 2021). Subsequently, scholars and practitioners of global public health stand to benefit from taking healers’ conceptualization of sexual health—as including physical, emotional, social, and especially economic well-being—seriously. This does not mean simply reevaluating healers’ usefulness to biomedical SRH efforts, nor does it mean employing a generic TCAM component as part of global public health strategy. Rather, scholars and practitioners can

learn from the holistic vision of sexual health and healing we have documented among healers and their patients in Rakai, which includes acknowledging that money and pleasure are integral elements of young Ugandans' sexual and reproductive health.

From both perspectives, by locating health providers "outside" the biomedical clinic (Scherz, 2018), we have shown how healers' SRH therapies offer a systems-level way to acknowledge young people's sexual lives and citizenship, which have been so frequently denied by biomedicine and public health. Historically, African healing practices have always been entangled with politics (Feierman, 1985), and, as Langwick notes, "the political promise of traditional medicine rests in African efforts to reclaim some sort of inclusiveness for the public" (Langwick, 2015, p. 506). Healers in Rakai make SRH more inclusive by centering the socially normative yet institutionally taboo subjects of money and pleasure. That young people seek healers for SRH conveys a powerful critique of the decades of widely circulating, internationally-funded and government-supported HIV/AIDS campaigns that condemn non-marital and transactional sex among young people. From Uganda to the United States and beyond, our case shows that effective SRH for young people is more than a choice of therapeutic method: quality care must respect young people's sexual citizenship.

Acknowledgments

This research was supported by the US National Institutes of Health as part of an interdisciplinary study led by Dr. John S. Santelli, titled "Structural and Social Transitions among Adolescents and young adults in Rakai" (SSTAR 5R01HD091003). Dr. Jennifer S. Hirsch's contributions to this work were supported in part by the Eunice Kennedy Shriver National Institute of Child Health and Human Development under grant number P2CHD058486, awarded to the Columbia Population Research Center. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

We are very grateful to the many people in Rakai, Uganda, who spoke with us about young people's sexual health, and to Neema Nakyanjo, the Director of the Social and Behavioral Sciences team at the Rakai Health Sciences Program, as well as Rosette Nakubulwa, Dauda Isabirye, Rodah Nambi, Lydia Namirembe, Charles Ssekyewa, and Frank Lukabwe, for their assistance collecting analyzing the data that informed this article. We are also grateful to three anonymous reviewers for *Social Science & Medicine*, who provided especially helpful feedback. Bridget Morse-Karzen provided invaluable research and editorial assistance, as did Lee Daniel.

References

- Ahlin T, 2014. Ontology as an analytical approach to concerns of medical anthropology. *Somatosphere*. Jul-Aug-Sep 2014. <http://somatosphere.net/2014/ontology-asa-panel.html/>.
- Ampurire P, 2019. Government Prohibits Advertisement of Unlicensed Herbalists in New Law, Wants Herbs Tested., February 14. *Softpower News*. <https://www.softpower.org/govt-prohibits-advertisement-of-unlicensed-herbalists-in-new-law-wants-herbs-tested/>.
- Audet CM, Ngobeni S, Wagner RG, 2017. Traditional healer treatment of HIV persists in the era of ART: a mixed methods study from rural South Africa. *BMC Compl. Alternative Med* 17 (1), 1–6.
- Baguma P, 1996. The traditional treatment of AIDS in Uganda: benefits and problems. Key issues and debates: traditional healers. *Societes d'Afrique & SIDA: Newsletter of the Societes d'Afrique & SIDA Network* (13), 4–6.
- Bodeker G, Kabatesi D, King R, Homsy J, 2000. A regional task force on traditional medicine and AIDS. *Lancet* 355 (9211), 1284. [PubMed: 10770339]
- Boyd L, 2015. *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda*. Ohio University Press.
- Bronfenbrenner U, 1979. *The Ecology of Human Development: Experiments by Nature and Design*. Harvard University Press, Cambridge.

- Chang L, et al. , 2016. Heterogeneity of the HIV epidemic in agrarian, trading, and fishing communities in Rakai, Uganda: an observational epidemiological study. *Lancet HIV* 2, 388–396.
- Comaroff J, 1985. *Body of Power, Spirit of Resistance: the Culture and History of a South African People*. University of Chicago Press, Chicago.
- Crane JT, 2013. *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*. Cornell University Press.
- De Coninck J, 2016. Promoting Herbal Medicine in Uganda. ICHNGO Forum, The Cross-Cultural Foundation of Uganda. <http://www.ichngoforum.org/promoting-herbal-medicine-uganda/>.
- Deml MJ, Notter J, Kliem P, Buhl A, Huber BM, Pfeiffer C, Burton-Jeangros C, Tarr PE, 2019. “We treat humans, not herds!”: a qualitative study of complementary and alternative medicine (CAM) providers’ individualized approaches to vaccination in Switzerland. *Soc. Sci. Med* 240 (2019), 112556. [PubMed: 31563005]
- Dodge CP, Wiebe PD, 1985. *Crisis in Uganda: the Breakdown of Health Services*. Pergamon Press.
- Endale Gurmu A, Teni FS, Tadesse WT, 2017. Pattern of traditional medicine utilization among HIV/AIDS patients on antiretroviral therapy at a university hospital in northwestern Ethiopia: a cross-sectional study. *Evid. base Compl. Alternative Med* 2017.
- Epstein H, 2007. *The Invisible Cure: Africa, the West, and the Fight against AIDS*. Macmillan.
- Epstein S, 2022. *The Quest for Sexual Health: How an Elusive Ideal Has Transformed Science, Politics, and Everyday Life*. University of Chicago Press.
- Farquhar J, Lezaun J, Pedersen MA, Mol A, 2014. A Reader’s Guide to the “Ontological turn.”. *Somatosphere*. Jan-Feb-Mar 2014.
- Feierman S, 1985. Struggles for control: the social roots of health and healing in modern Africa. *Afr. Stud. Rev* 28 (2/3), 73–147. [PubMed: 11616461]
- Fissel A, McKay K, 2006. Action! Why people engaged in the fight against HIV/AIDS should take note of traditional healer organizations in Uganda. *Pract. Anthropol* 28 (4), 22–25.
- Halpin SN, Carruth EC, Rai RP, Edelman EJ, Fiellin DA, Gibert C, Gordon KS, Huang W, Justice A, Marconi VC, Rimland D, Perkins MM, 2018. Complementary and alternative medicine among persons living with HIV in the era of combined antiretroviral treatment. *AIDS Behav.* 22 (3), 848–852. [PubMed: 28733920]
- Hirsch JS, Khan S, 2020. *Sexual Citizens: A Landmark Study of Sex, Power, and Assault on Campus*. WW Norton & Company.
- Hunt NR, 2013. Health and healing. In: Parker J, Reid R (Eds.), *The Oxford Handbook of Modern African History*. Oxford University Press.
- Kayombo EJ, Uiso FC, Mbwambo ZH, Mahunnah RL, Moshi MJ, Mgonda YH, 2007. Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania. *J. Ethnobiol. Ethnomed* 3 (1), 6. [PubMed: 17257409]
- Kodesh N, 2007. History from the healer’s shrine: genre, historical imagination, and early Ganda history. *Comp. Stud. Soc. Hist* 49 (3), 527–552.
- Kuhanen J, 2008. The historiography of HIV and AIDS in Uganda. *Hist. Afr* 35, 301–325.
- Langlois-Klassen D, Kipp W, Rubaale T, 2008. Who’s talking? Communication between health providers and HIV-infected adults related to herbal medicine for AIDS treatment in western Uganda. *Soc. Sci. Med* 67 (1), 165–176. [PubMed: 18406030]
- Langwick SA, 2008. Articulate (d) bodies: traditional medicine in a Tanzanian hospital. *Am. Ethnol* 35 (3), 428–439.
- Langwick SA, 2011. *Bodies, Politics, and African Healing: the Matter of Maladies in Tanzania*. Indiana University Press, Bloomington.
- Langwick SA, 2015. Partial publics: the political promise of traditional medicine in Africa. *Curr. Anthropol* 56 (4), 493–506.
- Lawrence D, Smith H, Magala E, Cooper M, 2014. Young people’s opinions about herbal medicines in a suburban district of Central Uganda. *Int. Health* 6 (4), 337–338. [PubMed: 24969647]
- Leclerc-Madlala S, Green E, Hallin M, 2016. Traditional healers and the “Fast-Track” HIV response: is success possible without them? *Afr. J. AIDS Res* 15 (2), 185–193. [PubMed: 27399048]

- Livingston J, 2005. *Debility and the Moral Imagination in Botswana*. Indiana University Press, Bloomington.
- Logie CH, Perez-Brumer A, Parker R, 2021. The contested global politics of pleasure and danger: sexuality, gender, health and human rights. *Global Publ. Health* 16 (5), 651–663.
- Lubinga SJ, Kintu A, Atuhaire J, Asiimwe S, 2012. Concomitant herbal medicine and Antiretroviral Therapy (ART) use among HIV patients in Western Uganda: a cross-sectional analysis of magnitude and patterns of use, associated factors and impact on ART adherence. *AIDS Care* 24 (11), 1375–1383. [PubMed: 22292937]
- Mathur S, Romo D, Rasmussen M, Nakyanjo N, Nalugoda F, Santelli JS, 2016. Refocusing HIV prevention messages: a qualitative study in rural Uganda. *AIDS Res. Ther* 13 (1), 1–9. [PubMed: 26734067]
- Mendu E, Ross E, 2019. Biomedical healthcare and African traditional healing in the management of HIV and AIDS: complimentary or competing cosmologies? *Afr. J. AIDS Res* 18 (2), 104–114. [PubMed: 31282302]
- Moore EV, 2020. What the Miniskirt Reveals: sex panics, women’s rights, and pulling teeth in urban Uganda. *Anthropol. Q* 93 (3), 321–350.
- Moore EV, Hirsch JS, Spindler E, Nalugoda F, Santelli JS, 2021. Debating sex and sovereignty: Uganda’s new national sexuality education policy. *Sex. Res. Soc. Pol* 10.1007/s13178-021-00584-9.
- Moshabela M, Bukenya D, Darong G, Wamoyi J, McLean E, Skovdal M, Wringe A, 2017. Traditional healers, faith healers and medical practitioners: the contribution of medical pluralism to bottlenecks along the cascade of care for HIV/AIDS in Eastern and Southern Africa. *Sex. Transm. Infect* 93 (Suppl. 3).
- Nakkazi E, 2020. As Uganda takes control of the HIV epidemic, U.S. shifts funding. *UNDARK*, 10 June. <https://undark.org/2020/06/10/uganda-takes-control-of-hiv-epidemic/>.
- National Institutes of Health, 2021. NCCIH funding: appropriations history. <https://www.nccih.nih.gov/about/budget/nccih-funding-appropriations-history>.
- Olsen WC, Sargent C, 2017. In: Sargent C, Olsen WC (Eds.), “Introduction” in *African Medical Pluralism*. University of Indiana Press, Bloomington, pp. 1–28.
- Pantelic M, Cluver L, Boyes M, Toska E, Kuo C, Moshabela M, 2015. Medical pluralism predicts non-ART use among parents in need of ART: a community survey in KwaZulu-Natal, South Africa. *AIDS Behav* 19 (1), 137–144. [PubMed: 25034940]
- Parikh S, 2012. “They arrested me for loving a schoolgirl”: ethnography, HIV, and a feminist assessment of the age of consent law as a gender-based structural intervention in Uganda. *Soc. Sci. Med* 74 (11), 1774–1782. [PubMed: 21824700]
- Parikh S, 2015. *Regulating Romance: Youth Love Letters, Moral Anxiety, and Intervention in Uganda’s Time of AIDS*. Vanderbilt University Press.
- Parkhurst JO, 2011. Evidence, politics and Uganda’s HIV success: moving forward with ABC and HIV prevention. *J. Int. Dev* 23 (2), 240–252.
- Patel G, Brosnan C, Taylor A, Garimella S, 2021. The dynamics of TCAM integration in the Indian public health system: medical dominance, countervailing power and co- optation. *Soc. Sci. Med* (2021), 114152 [PubMed: 34465489]
- Pescosolido BA, Manago B, Olafsdottir S, 2020. The global use of diverse medical systems. *Soc. Sci. Med* 267 (2020), 112721. [PubMed: 31870508]
- Pigg SL, 1996. The credible and the credulous: the question of “villagers’ beliefs” in Nepal. *Cult. Anthropol* 11 (2), 160–201.
- Santelli JS, Speizer IS, Edelstein ZR, 2013. Abstinence promotion under PEPFAR: the shifting focus of HIV prevention for youth. *Global Publ. Health* 8 (1), 1–12.
- Sargent C, Olsen WC, et al., 2017. *African Medical Pluralism*. Indiana University Press, Bloomington.
- Scherz C, 2018. Stuck in the clinic: vernacular healing and medical anthropology in contemporary sub-Saharan Africa. *Med. Anthropol. Q* 32 (4), 539–555. [PubMed: 30015362]
- Sommer M, Mmari K, 2015. Addressing structural and environmental factors for adolescent sexual and reproductive health in low- and middle-income countries. *Am. J. Publ. Health* 105 (10), 1973–1981.

- Ssali A, Butler LM, Kabatesi D, King R, Namugenyi A, Kanya MR, McFarland W, 2005. Traditional healers for HIV/AIDS prevention and family planning, Kiboga District, Uganda: evaluation of a program to improve practices. *AIDS Behav.* 9 (4), 485–493. [PubMed: 16249945]
- Sundararajan R, Mwanga-Amumpaire J, King R, Ware NC, 2020. Conceptual model for pluralistic healthcare behaviour: results from a qualitative study in southwestern Uganda. *BMJ Open* 10 (4), e033410.
- Tamale S, 2016. Eroticism, sensuality and ‘women’s secrets’ among the Baganda. *IDS Bull.* 37 (5), 89–97.
- Thornton R, 2015. Magical empiricism and ‘exposed being’ in medicine and traditional healing. *Med. Anthropol* 34 (4), 353–370. [PubMed: 25806659]
- Tibugwisa D, 2020. A Call for Regulation of the Herbal Medicines Industry in Uganda., February 6. *The Legal Reports.* <https://thelegalreports.com/2020/02/06/a-call-for-regulation-of-the-herbal-medicines-industry-in-uganda/>.
- Tilley H, 2011. *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge.* University of Chicago Press, Chicago, pp. 1870–1950.
- Tuller DM, Bangsberg DR, Senkungu J, Ware NC, Emenyou N, Weiser SD, 2010. Transportation costs impede sustained adherence and access to HAART in a clinic population in southwestern Uganda: a qualitative study. *AIDS Behav.* 14 (4), 778–784. [PubMed: 19283464]
- Uganda Legal Information Institute, 1957. Witchcraft act of 1957. <https://ulii.org/ug/legislation/consolidatedact/124#:~:text=Any%20person%20who%20hires%20or,period%20not%20exceeding%20five%20years.>
- Uganda Ministry of Health, 2000. Ministry of health national health policy. <https://extranet.who.int/nutrition/gina/sites/default/files/UGA%202000%20National%20Health%20Policy.pdf>.
- UNAIDS, 2002. Ancient remedies, new disease: involving traditional healers in increasing access to AIDS care and prevention in east Africa. https://data.unaids.org/publications/irc-pub02/jc761-ancientremedies_en.pdf.
- UNAIDS, 2006. Collaborating with traditional healers for HIV prevention and care in sub-Saharan Africa: suggestions for programme managers and field workers. https://data.unaids.org/pub/report/2006/jc0967-tradhealers_en.pdf.
- Wanyama JN, Tsui S, Kwok C, Wanyenze RK, Denison JA, Koole O, Colebunders R, 2017. Persons living with HIV infection on antiretroviral therapy also consulting traditional healers: a study in three African countries. *Int. J. STD AIDS* 28 (10), 1018–1027. [PubMed: 28162034]
- Wawer MJ, Serwadda D, Gray RH, Sewankambo NK, Li C, Nalugoda F, Lutalo T, Konde-Lule JK Trends in HIV-1 prevalence may not reflect trends in incidence in mature epidemics: data from the Rakai population-based cohort, Uganda. *AIDS* 11 (8), 1023–1030.
- Whyte SR, 1992. Pharmaceuticals as folk medicine: transformations in the social relations of health care in Uganda. *Cult. Med. Psychiatr* 16 (2), 163–186.
- World Health Organization, 2014. WHO traditional medicine strategy 2014–2023. <https://www.who.int/publications/i/item/9789241506096>.
- World Health Organization, 2019. WHO global report on traditional and complementary medicine 2019. [https://www.who.int/traditional-complementary-integrativemedicine/WhoGlobalReportOnTraditionalAndComplementaryMedicine2019.pdf?ua=.](https://www.who.int/traditional-complementary-integrativemedicine/WhoGlobalReportOnTraditionalAndComplementaryMedicine2019.pdf?ua=)
- Wyrod R, 2016. *AIDS and Masculinity in the African City: Privilege, Inequality, and Modern Manhood.* University of California Press.