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TRADITIONAL HEALERS  
BASELINE SURVEY IN  
GOMBA COUNTY  
(UGANDA)

A Report Prepared by PRITECH Subcontractor:  
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TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT

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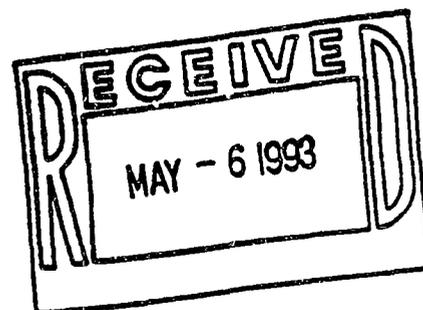
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IN GOMBA COUNTY.**

LPC - 079 - UG

**(16TH - 30TH OCTOBER 1992)**



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**LIST OF ABBREVIATIONS**

|                |   |   |
|----------------|---|---|
| <b>AIDS</b>    | - | <b>Acquired Immune Deficiency Syndrome</b>                    |
| <b>CDD</b>     | - | <b>Control of Diarrhoeal Diseases</b>                         |
| <b>CFT</b>     | - | <b>Central Facilitating Team</b>                              |
| <b>DFT</b>     | - | <b>District Facilitating Team</b>                             |
| <b>HWs</b>     | - | <b>Health Workers</b>   |
| <b>MOH</b>     | - | <b>Ministry of Health</b>                                     |
| <b>PRITECH</b> | - | <b>Technologies for Primary Health Care</b>                   |
| <b>RC</b>      | - | <b>Resistance Council</b>                                     |
| <b>TBA</b>     | - | <b>Traditional Birth Attendant</b>                            |
| <b>THs</b>     | - | <b>Traditional Healers</b>                                    |
| <b>TOP</b>     | - | <b>Training of Participants</b>                               |
| <b>TOT</b>     | - | <b>Training of Trainers</b>                                   |
| <b>UCMB</b>    | - | <b>Uganda Catholic Medical Bureau</b>                         |
| <b>UTHI</b>    | - | <b>Uganda Traditional Healers Initiative</b>                  |
| <b>UTHIVP</b>  | - | <b>Uganda Traditional Healers Initiative Vanguard Project</b> |

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## EXECUTIVE SUMMARY

### OBJECTIVES

The objectives of this baseline survey were to find out the number of Traditional Healers and their characteristics in relation to diarrhoea treatment in the project area. And to sensitize THs and the communities at large about the Uganda Traditional Healers Initiative Vanguard Project.

### GEOGRAPHICAL AREA

The survey covered the whole of Gomba County in Mpigi District. This county was identified as the project area. It is alleged to be the least developed county in Mpigi district. It covers an area of about 160,000 people the majority of whom are Baganda. The county has an estimated 518 THs of different specialities. There is no hospital in Gomba. However, there are eight health units the largest of which is a health centre belonging to a Catholic Mission. The health units render both curative and preventive services. Diarrhoea ranks fourth among the common diseases and as a major cause of morbidity in the underfives.

### METHODOLOGY

A team of 12 interviewers, 4 supervisors and 6 mobilizers were trained to carry out this survey which lasted two weeks. Through mobilization exercise, all THs were invited through their parish and village chairmen (RC II and RC I) to attend sensitization meetings at specific places in their respective parishes. After each sensitization meeting all the THs present were individually interviewed. The sensitization meetings were also attended by religious leaders, RC officials, chiefs, elders and mothers/caretakers of children under five years. Data was recorded by the interviewers and later processed and analyzed by Computer. Apart from a few THs who did not turn up for the meetings and those who were reluctant to give information, there were no major problems in the field.

## FINDINGS

A total of 437 THs were interviewed during the survey. The main findings of this survey indicate that the majority of THs treat a variety of childhood diseases including diarrhoeal diseases. In their treatment THs emphasize stopping diarrhoea and not dehydration. The latter is not taken as a serious consequence of diarrhoea. In fact most of the Traditional Healers are not aware of the danger signs of diarrhoea. Counselling of caretakers is not part of THs management of diarrhoea; and less than 25% know how to prevent diarrhoea. The findings also show that most of the THs are willing to collaborate with Health Workers and participate in joint workshops on health matters. However, some HWs do not see the reasons why they should refer patients to THs. The findings form the basis by which the UTHIVP will be evaluated, mainly through assessing the knowledge and practices of THs and mothers/caretakers about the prevention and management of diarrhoea at home. Referring of patients by THs and HWs to each other as well as the changed attitudes of religious leaders will also be used as indicators to measure the possible impact made by the project.

## CONCLUSIONS AND RECOMMENDATIONS

Gomba county is an appropriate place for the implementation of the UTHIVP. Many THs are trainable and can impart messages to mothers whose children suffer from diarrhoea. By setting the following criteria: THs less than 60 years old; have been in practice for five or more years; are able to read and write in Luganda, treat per day at least two children suffering from diarrhoea, and recommended by interviewers, the survey has identified (44) possible candidates for training under the UTHIVP.

1.

## INTRODUCTION

In Nov. 1990 a study (Hogle et al 1990) was carried out in three districts (including Mpigi district) of Uganda to find out Traditional Healers (THs) knowledge and management of childhood diarrhoeal diseases. During this study many THs mentioned topics for joint discussions with Health Workers (HWs). Topics included, among others, false teeth, midwifery, processing and preservation of herbal medicine and AIDS.

It was also found that THs were interested in workshops not only for purposes of interacting among themselves and improve their knowledge, but also to gain new skills related to Primary Health Care.

2

In May 1991 a need assessment was carried out to find in greater details the topics mentioned by the THs in the Nov. 1990 study. It was also the purpose of this needs assessment to find out what form the collaboration between health workers and traditional healers would take. This needs assessment study was intended to concentrate on THs within a radius of five kilometres around the two health units of Kanoni and Mpenja in Gomba County, Mpigi District. This was the area earmarked for a Pilot Project on the collaboration between THs and HWs in the management of childhood diarrhoeal diseases.

However, in analyzing the data for the May 1991 needs assessment, it was found that many of the THs had come from outside the catchment area. Furthermore, at the end of the analysis, it was found that the study was not as detailed as had been planned.

The planning committee of the Uganda Traditional Initiative (UTHI) decided to carry out another needs assessment in Nov. 1991

The Nov. 1991 needs assessment was planned to concentrate only on those THs within the catchment areas of Mpenja and Kanoni. It was also decided that it should include community leaders, religious leaders, drug shop owners, mothers/caretakers of children under five years, and other residents within the catchment areas. The main objectives of the needs assessment were to find out about the content and format of the training workshop; promotion and problems of collaboration between THs and HWs; and, identification and selection of THs for training workshops.

During a planning workshop in March 1992 it was decided to embark on a Vanguard Project (VP) instead of a pilot project. In principle the former was preferred because of being more flexible than the latter and would suit the objectives of the UTHI. However, the previously selected catchment areas of Mpenja and Kanoni were considered too small for the needs of Vanguard Project. It was therefore decided that the Vanguard Project should cover the whole of Gomba County.

According to the 1990 Study (Hogle et al. 1990) there are about 14 THs in each parish in Mpigi District. Hence, in Gomba county (37 parishes) one would estimate 518 THs. Ten per cent of these would give a "reasonable" sample for the Vanguard Project training purposes. The main purpose of this baseline survey, therefore was to get some details about THs in Gomba county and to sensitize the communities in the area about the UTHIVP.

### **1.1 Objectives of the Baseline Survey**

The main objectives of the Survey were:

- a) To enumerate all Traditional Healers in Gomba County before sampling for training takes place;
- b) To collect baseline data on diarrhoeal diseases and treatment for measuring post-training changes in caseload and specific practices;
- c) To increase Traditional Healers' awareness and correct misinformation about the Vanguard Project and provide a channel for the Traditional Healers to raise issues and express concerns; and
- d) To sensitize the communities in Gomba County about the Uganda Traditional Healers Vanguard Project so that they can support and sustain the Project.

**MPIGI DISTRICT PROFILE**

Mpigi District is located in the Central Region of Uganda. It is bordered by the Districts of Luwero in the North, Mukono in the East, Masaka in the South and Mubende in the West. Mpigi District completely surrounds Kampala District which is in the Central Region. It has five counties namely, Gomba, Busiro, Kyadondo, Mawokota and Butambaia.

The District Headquarters is about 35Kms South West of Kampala City and about 64Kms from the Ministry of Health Headquarters at Entebbe.

The District Executive Secretary is the head of the Civil Service at the District level. Below him are a hierarchy of chiefs up to parish level. The Administrative structure is at two levels; the Civil Service and the Political level.

The District Administrator (D.A) is the political head of the district. He reports directly to the President (Head of State). Below him are Resistance Council (RC) executives at different levels. At the lowest level (village) there is a resistance (RCI). It is a village committee of 9 members including a chairman (RC.I) They are all democratically elected.

Several village councils together form a parish resistance council (RC.II). Parish councils form Sub-County resistance councils (RC.III). Sub-County councils finally form the District resistance council (RC.V). The District Executive Secretary links the resistance councils to the Civil Service.

**2.1****Climate and Vegetation**

Before the Survey, a severe drought hit the district like some other parts of Uganda. The drought started in December 1991 up to August 1992. This disrupted the usual rainfall bimodal peaks in February to April and September to November. The climate patterns are changing and it is difficult to predict the climate. On average the temperature ranges between 22 - 25°C.

**2.2****Physical Features**

Mpigi district lies in the Lake Victoria basin. It is 1200 - 1400 metres above sea level. It is characterised by flat topped hills with shallow valleys and swamps in between.

About 90% of the district is Savannah land and 5% is tropical forest. The rest are hills plus swamps which had temporarily dried up during the drought.

## **2.3 Social-Economic Cultural Aspects**

### **2.3.1 Family Structure**

The family structure in the District is patrilineal with both monogamous and polygamous families in existence. However, the monogamous structure is predominant. On average a mono-nuclear family has 8 -10 persons. More than 50% of these are children below 14 years of age.

### **2.3.2 Ethnicity**

The indigenous Baganda are the dominant group. The migrant Banyarwanda, Banyankole, Barundi and other ethnic groups from other districts form a minor group.

Luganda is the most commonly used language except in some parts of Maddu sub-county where Lunyankole seems to be commonly spoken. English is the official language of communication.

### **2.3.3 Religion**

About 40% of the total population is catholic, 30% protestants and 25% moslems. The remaining 5% include Seventh Day Adventists, Orthodox, and other religions. (Mpigi District Health Plan 1992)

### **2.3.4 Education**

There are 86 Secondary Schools, 512 Primary Schools and 200 Preparatory Schools in the district. Most of the Schools are mixed and day. The average standard of education is P.7. The Literacy rate is 35% for male and 15% for female. (Mpigi District Health Plan 1992).

### **2.3.5 Transport and Communication**

There is a good network of roads and most Health Units can be reached by feeder roads. Foot and bicycles are mainly used as means of transport. Buses and taxis serve a substantial portion of the population. One railway line (non-functional) runs through the district. Postal and telephone services are available, but not equally distributed. Gomba county has no telephone services.

### 2.3.6

#### Health

There are a total of 225 Health Units. Eighteen (18) are Non-government owned and 48 are government owned. These include Hospitals, Health Centres, Dispensaries with Maternity and government aided units as table 1 shows. The remaining 159 are registered private Health Units. Of these 133 are private clinics, and 24 are maternity homes and domiciliary units.

TABLE 1

#### CATEGORIES OF GOVERNMENT AND NGO HEALTH UNITS IN THE DISTRICT

| HEALTH FACILITY                 | GOVERNMENT | NON-GOV'T | TOTAL     |
|---------------------------------|------------|-----------|-----------|
| Hospitals                       | 3          | 1         | 4         |
| Health Centres                  | 5          | 1         | 6         |
| Dispensary with Maternity units | 7          | 3         | 10        |
| Dispensary/Sub-dispensary       | 27         | 13        | 40        |
| Aided Government Units          | 6          | 0         | 6         |
| <b>TOTAL</b>                    | <b>48</b>  | <b>18</b> | <b>66</b> |

### 2.3.7

#### On-going Health Projects and Programmes in the District

There are 9 PHC Projects in the district run by various organisations. Some TBAs and about 40 Community Based Health Care (CBHC) workers have been trained. These together with the THs constitute the force that provides treatment for various illness at village level.

Some of the on-going Health Programmes in the District include:

- Expanded Programme on Immunization (UNEPI);
- Control of Diarrhoea Diseases (CDD);
- AIDS Control Programme (ACP);
- Maternal Child Health and Family Planning (MCH/FP); and
- Rural and Urban Sanitation.

Inspite of the Health Units and on going health programmes in the district there is a shortage of qualified government Health Workers Table 2 below shows the various existing Health Workers in the district.

**TABLE 2****CATEGORIES OF HEALTH WORKERS IN MPIGI DISTRICT**

|                           |    |
|---------------------------|----|
| Doctors                   | 7  |
| Health Visitors           | 1  |
| Health inspectors         | 10 |
| Assistant Health Visitors | 5  |
| Health Assistants         | 20 |
| Medical Assistants        | 26 |
| Nursing Officers          | 13 |
| Enrolled Nurses           | 30 |
| Dental Assistants         | 4  |
| Laboratory Assistants     | 3  |
| Health Educators          | 4  |

**2.3.8 Health Problems in the District**

The following are some of the Health Problems that exist in Mpigi District:

- Pit latrines coverage in the district is low - 40%. About 60% of the entire population dispose excreta indiscriminately;
- Lack of safe water especially in Gomba County. Most water sources are unprotected and dry up during the dry seasons.
- Nutrition - 10% of the children attending young child clinic are either under weight or have nutritional deficiencies. This is probably due to ignorance and various cultural practises;
- Culture: About 15% of the population depend completely on Traditional medicine and witch craft even when a health facility is in easy reach. The patients in very poor condition are always brought to Health Units after failing at a Traditional Healers;
- Staff mal-distribution: Most qualified staff resist deployment in rural or remote Health Units.

### **2.3.9 Health Service delivery problems**

- There is general low morale among the Health Workers due to:-
  - Lack of accommodation at their Units;
  - Lack of Transport;
  - Delayed promotion and confirmation of the staff;
  - Shortage of trained staff like Doctors, Medical Assistants, Nurses and Midwives. Even those who are qualified resist deployment to rural areas or remote health units.
  - Poor distribution of Health Units especially in rural areas.

### **2.3.10 Top ten leading diseases in District in order of their magnitude (Source 1<sup>st</sup> half yearly District Report 1992)**

1. Malaria
2. Upper Respiratory Tract Infection (URTI)
3. Lower Respiratory Tract Infection
4. Intestinal Worms
5. Diarrhoeal Diseases
6. Trauma
7. Skin Diseases
8. Eye Infection
9. Anaemia
10. Malnutrition

### **3.0 GOMBA COUNTY PROFILE**

Gomba is one of the counties in Mpigi District. It is the target area for the UJHI - Vanguard Project. It borders Mubende and Masaka districts. It has four sub-counties namely, Mpenja, Maddu, Kabulasoke and Kyegonza.

Gomba is free of major urban influences and is reputed to have many Traditional Healers. It covers an area of 1,606sq.Kms.

#### **3.1 Population**

Gomba County has an estimated population of 162,073 (Uganda Population Census 1991). It has 37 parishes and 247 villages.

#### **3.2 Family Structure**

Both monogamous and polygamous families exist with many being extended families. The head of the family is usually the male unless he has died in which case the woman remains head of the family or the family is absorbed into another.

#### **3.3 Ethnicity**

Baganda are the dominant group in three sub-counties. In Maddu Sub-County, there are more Banyankole, Banyarwanda and Barundi. Luganda is the language of communication in the 3 sub-counties while Lunyankole appears to be common in Maddu.

#### **3.4 Religion**

All the three main religions, that is, Catholics, Protestants and Moslems exist in the area. There are also Seventh Day Adventists and some sects of Balokole (saved group).

#### **3.5 Agriculture and Income Generating Activities**

Most people practise subsistence farming with Matooke, Beans, Cassava and Groundnuts. However, because of the drought, most crops dried up.

Cash crops are mainly Coffee, Beans, Maize and Groundnuts. Maddu Sub-County has a number of cattle keepers but some of them migrated due to drought.

Money is generated through cattle and goat keeping plus sale of cash crops. There is also petty trading through shop keeping, market vendors and hawkers. There is some fishing on Lake Wamala.

### **3.6 Social Cultural Beliefs**

Some cattle keepers in Maddu Sub- County do not believe in using pit-latrines. This is believed to bring bad cmen to their animals. Extraction of false teeth and Oburo (millet) in the under fives are common practices.

"Oburo" disease is literary translated as Millet Disease. It is believed that one of the causes of diarrhoea is the presence of millet in a child's chest. Treatment is administered by making incision on the chest with a hope of removing the millet and consequently stop diarrhoea.

### **3.7 Communication and Transport**

There is a fairly good network of murram and earth roads. There are few privately owned buses and taxis but the commonest means of transport is bicycles and moving on foot. Although there are postal services in some trading centres, there are no telephone contacts.

### **3.8. Health**

#### **3.8.1 Health Service Delivery**

There are 8 Health Units in Gomba County. Seven belong to the government and one to non-governmental organisation. All these serve a population of 162,073 people (projected 1991 census). The distribution of Health Facilities in Gomba is shown in table 3 below:-

**TABLE 3****DISTRIBUTION OF HEALTH FACILITIES IN GOMBA COUNTY**

| HEALTH UNIT                       | SUB-COUNTY | CONDITION   |
|-----------------------------------|------------|---|
| Kanoni Health Centre              | Kyegonza   | Has just been renovated by World Bank 1992  |
| Bukalagi Health Centre under UCMB | Kyegonza   | The structures are in good condition.   |
| Mpenja D.M.U                      | Mpenja     | Has just been renovated by World Bank 1992  |
| Maddu Dispensary                  | Maddu      | Needs major repairs on windows, doors, painting and roof repair.                                |
| Kitwe Prison                      | Maddu      | Operating from unipots  |
| Kyayi Sub-Dispensary              | Maddu      | Under construction on self help basis. Also gets assistance from Mpigi District Administration. |
| Kifampa Dispensaries              | Kabulasoke | Still under construction on self help basis.  |
| Kisozi Dispensary                 | Kabulasoke | The structures are well maintained.   |

All the above Health Units are rendering both curative and preventive services. They receive their drugs from the Uganda Essential Drugs Management Programme) and they had just received the 3rd quarter at the time of this survey.

Health unit management committees have been formed and user's charge fee has been instituted in most units. However, there is a general outcry from the community that the fee is rather high. There is an indication that the community will continue seeking some curative services from the Traditional Healers since they can offer credit facilities, accept payment in kind and are in easy reach.

There is no other organisation that is carrying out health related activities in Gomba except Safe Motherhood whose objective is to reduce maternal morbidity and mortality rates by promoting safe motherhood within the local community and provide basic information and counselling to women of child-bearing age in the communities.

So far, this organisation has trained 36 TBAs and many of them are herbalists and treat childhood diseases including diarrhoea.

### **3.8.2 Top ten diseases in Gomba County**

According to the available data collected from the Health Units in Gomba from January - July 1992 the following are the common diseases in order of their magnitude.

1. Malaria
2. URTI
3. Intestinal Worms
4. Diarrhoeal Diseases
5. Skin Diseases
6. Anaemia
7. Malnutrition
8. Lower Respiratory Tract Infection
9. Eye diseases
10. Trauma

The major causes of morbidity in the under fives are:-

1. Malaria
2. URTI
3. Lower Respiratory Tract Infection
4. Diarrhoea Diseases
5. Nutritional Deficiency
6. Anaemia
7. Trauma
8. Others.

### **3.8.3 Health related Problems in Gomba**

According to the Information from the RCs, Chiefs, Religious Leaders and the Community at large, the major health problems are:

1. Chronic Shortage of drugs in the Health Units;
2. Long Distances to travel to health facilities. Some people travel about 10 miles (16Kms) on foot to the nearest health facility;
3. Shortage of Domestic water;
4. Some dangerous practices such as extraction of false teeth and "Oburo" (millet) disease.
5. Failure to use pit latrines.

- 6. A chronic shortage of food particularly in Maddu Sub-County partly because the cattle keepers do not grow food and intermittent spells of drought; and**
- 7. Poor Sanitation - especially of pit latrines in the homes, poor housing structures, lack of proper refuse disposal, bushy compounds, etc.**

**3**

## **4.0 METHODOLOGY**

### **4.1 Introduction**

In order to carry out this Baseline Survey a total of 22 people were divided into four sensitization teams and one mobilisation team as follows:-

**a) Interviewers (12):**

There were three interviewers in each of the four sensitization teams. Interviewers came from different backgrounds; there were nurses, Makerere University students, teachers and Community Development workers. Their role was to carry out personal interviews with Traditional Healers at the sensitization meetings.

**b) Mobilizers (6):**

Each sensitization team had one mobilizer. All were members of the District Facilitating Team (DFT) and very familiar with Mpigi District and particularly Gomba County. The main role of the mobilizers was to assist in answering some of the technical questions related to the UTHIVP area and to carry out on-spot mobilization. They would also assist in interviewing when a need would arise. Two mobilizers belonged to the mobilization team whose main task was to sensitize the RC.II Chairmen in all parishes who would then mobilise all those required for the sensitization meetings in each parish.

**c) Supervisors (4):**

There was one Supervisor in each sensitization team. They included three members of the Central Facilitating Team (CFT) and the District Medical Officer for Mpigi District. They were the leaders of the sensitization teams and responsible to give key messages about UTHIVP in the sensitization meetings. They would also co-ordinate the activities and attend to all problems of their teams in the field.

In addition to the above participants, the following people also participated in the Survey.

a) **Technical Co-ordinator:**

He was responsible for co-ordinating all the Baseline Survey activities. He also headed the mobilization team. He was also responsible for writing this report.

b) **CDD Manager:** On two occasions he joined one of the teams and assisted in sensitization.

c) **PRITECH Country Representative:**

Participated throughout the study and was responsible for all logistical issues and overall organisation of data as it came in from the field.

#### **4.2 Baseline Survey Training Workshop**

All the participants in the survey attended a one-day training workshop at Mpigi district headquarters. At this workshop participants were sensitized about UTHIVP (Its goals, objectives, strategies and activities).

They were also trained in data collection methods relevant to UTHIVP and fully explained the objectives and importance of the Baseline Survey.

#### **4.3 Field Work**

The Survey covered the whole of Gomba County and lasted for two weeks (18th October - 31st October). Field teams stayed at a lodge (Buwama International Lodge) some 20Kms away from Gomba County: hence each day the teams had to drive to and from the Survey area. Each team had a vehicle provided by the CDD Programme (MOH). The Lodge was the nearest accommodation available.

Field Work included:-

- a) Mobilization
- b) Sensitization meetings
- c) Personal interviews with Traditional Healers.

#### **4.4 Mobilization**

This was done by a team of three people: namely, the Technical Co-ordinator, Assistant Health Educator in Charge of Gomba county, and the Mpigi District Cultural Officer. In principle, the team visited the RC.II Chairmen in each parish at least two days before the sensitization meeting. The visit to each chairman was specifically to:

- a) Sensitize him about the Uganda Traditional Healers Initiative Vanguard Project (UTHIVP) (Its goals, objectives, strategies, and activities); and
- b) Officially request him to mobilize his parish for the sensitization meeting on a set date. Each chairman was given a letter to all his RC.I Chairmen indicating who to mobilize for the sensitisation meeting. The people to invite in each parish included the following: RC1 and RCII executives, Traditional Healers, Religious leaders, Village Health Committee executives, teachers in schools, leaders of different organisations operating in the parish, elders, and mothers/caretakers of children under five years of age around the meeting place. (See invitation letter for more details Appendix 1)

The mobilization team visited some of the RC.I Chairmen and THs and invited to attend the sensitization meeting.

#### **4.4.1.1 Problems encountered during mobilization**

Although mobilization was the "heart" of the whole survey, it proved to be the hardest exercise. The problem encountered during mobilization included:

- i) Some of the RCII Chairmen:
  - Had a negative attitude toward Traditional Healers and were reluctant to mobilize their RC.I Chairmen and other concerned people;
  - Said that the meetings were not income generating. They probably expected payment for mobilization. Hence, they did not put in much effort to mobilize the people.
  - Complained of short notices for the meetings, yet experience had shown that when given ample time people do not turn up for the meetings; and
  - Had no means of transport and yet they had to cover long distance to reach RC.I Chairmen.
- ii) The Survey was carried out at a time when there was a problem of kidnapping people especially children in the Country. People in the rural areas were very sensitive about this problem and would run away whenever a vehicle approached them.

- iii) The Survey was carried out during a rainy season after a very long severe drought; hence many people including RC chairmen were busy in their gardens/plantations and it was difficult to mobilize them.

#### **4.4.2 Sensitization**

In principle, sensitization in each parish was scheduled to begin at 10.00a.m but it did not do so due to various reasons.

On average sensitization began after mid-day. In some parishes it began as late as 3.00p.m. In most cases sensitization opened with prayers, National Anthem, introduction of sensitisation team and opening remarks by the RC.II Chairman.

Sensitization mainly focused on creating community awareness on UTHI-VP specifically explaining the background, goals, objectives, strategies and activities.

It also focused on providing channels for the participants to raise issues and concerns related to the Project.

Registration of those who attended went on concurrently with the sensitization (a piece of paper was passed around and participants wrote on their names, occupation and place of abode). Those in attendance included RC.I and II executives, Religious leaders of various denominations, Traditional Healers, Chiefs, Elders, Teachers and Mothers.

In many meetings and at the beginning of the sensitization most Traditional Healers feared to identify themselves, but after the sensitization more Traditional Healers present in the meeting came forward. After sensitization, personal interviews with Traditional Healers followed.

Some Traditional Healers did not turn up for the meetings due to various reasons. Some of those who did not attend the meetings were visited at their homes. However this was disadvantageous in that those interviewed in their homes missed a lot of ideas that came up during the general sensitization meetings. Many Traditional Healers who were visited at their homes were not so welcoming. In one parish, for example, five Traditional Healers refused to talk to the interviewers.

#### **4.4.3**

#### **Some of the issues raised in sensitization meetings**

Although there were lively discussions and exchange of ideas during sensitization, a number of health issues and related cultural beliefs were raised. Below are some of the issues:-

- Traditional Healers wondered whether it will be possible for Health Workers to refer patients to them and whether Health Workers will accept patients from Traditional Healers.
- THs also wondered whether there will be any form of payment after the training.
- Some THs asked whether they would be provided with facilities to preserve their herbs.
- TBAs asked for gloves to use when attending to pregnant mothers
- Some illiterate but interested Traditional Healers wondered whether they would also be allowed to participate in the project.
- Religious leaders and other community leaders requested the Ministry of Health to address the issue of witch craft during the training.
- In some parishes participants requested the Ministry of Health to assist them set up nearby health centres.
- Participants also noted that some dangerous cultural beliefs are still practised in some parishes for example extraction of false teeth (ebinyo) and millet (oburo) and some cattle keepers do not use pit latrines.
- Other issues focused on AIDS, Immunisation and Family Planning.

#### **4.4.4**

#### **Problems encountered during sensitization**

- The majority of participants came late for the sensitization meetings. As a result, sensitization in many parishes started at or after 12.00. This was because it was planting season and people came for the meeting after working in their gardens.
- The survey was carried out during a rainy season. Some meetings were held in the open. In some cases rain disrupted the sensitization because the meetings would only continue after the rain had stopped.

- In some parishes, Traditional Healers were accused of being witches. This made them feel stigmatised and feared to come for the meetings.
- There were a lot of unconstructive criticisms between Religious Leaders and Traditional Healers.

#### 4.4.5

#### Reasons why some Traditional Healers did not turn for sensitization

- Some THs did not turn up for the sensitization meetings because of suspicion towards the sensitization team.

A week before the Survey there was a team of researchers from the Chemotherapeutic Department, Ministry of Health which was asking THs about herbs they use for different diseases. Sometime in 1980 a similar team from the same department had done the same thing without feeding back to the THs. This created a negative attitude in some THs: they felt they had been exploited and hence they would not release any information related to their work. Somehow some had a feeling that this survey was another exploitive venture.

- Mobilization in some parishes was not effectively done. Some RC.II chairmen did not send the message downwards to the villages in the parish. Some of them expected to be paid. Some parishes are big and have many villages and the message could not be sent to all these villages.
- It is possible that some THs had other programmes and could not attend the meetings on short notice.
- Some THs could not attend the meetings because of long distances to the meeting places. Moreover some of THs were very old.
- It was planting season after a severe drought in the area. Some of the THs didn't turn up for the meetings because they were busy in their gardens.

#### 4.4.6

#### Personal Interviews

During sensitization meetings, all Traditional Healers were identified and at the end of the meeting they were requested to remain behind. Personal interviews were used to collect data from Traditional Healers. All data was recorded on an interview schedule designed for that purpose. Each interview lasted for 15 minutes on average.

#### 4.4.6.1

##### Problems encountered during personal interviews

- Some THs were very old and interviewers had problems getting the required information.
- Some THs were reluctant to give the information and some of them were expecting rewards.
- Some of the THs who did not turn up for the meetings were visited at their homes. Many of them were not so welcoming, and some refused to be interviewed.

#### 4.4.7

##### General problems encountered during field work

- Time for mobilization was probably too short and could have led to a poor turn up in some parishes.
- The meeting places were not convenient for some participants, some parishes have many villages and some of them were very far from the meeting places.
- It was planting season and this contributed to the poor turn up in some cases. Rain also disrupted some sensitization meetings which took place in open places. Again, because of rain, some roads were so slippery that some of the vehicles of sensitization teams got stuck and had to be pushed. This wasted a lot of time.
- Some vehicles were not in good mechanical conditions. Those which didn't have 4 wheel drive facility got problems on the slippery roads. One vehicle had no glass in one of its doors and thus created problems for the team that travelled in it on rainy days.
- There were a number of deaths during this period. Some people were attending funeral services and could therefore not attend the sensitization meetings. In one parish, sensitization started after burial service at 4.30pm.

## 5.0

## FINDINGS

### 5.1

#### Introduction:

The findings presented here are the result of aggregated data analysis from the personal interviews with 437 THs who were covered by this baseline survey. Included in the findings are some of the views expressed and recorded during sensitization meetings in various parishes in Gomba county. Other observations by both the sensitization and mobilisation teams are also presented.

The main findings focus on the socio-demographic data of THs, their treatment of childhood diseases including diarrhoea and its prevention and the THs interest in collaboration with HWs and participating in joint training workshops.

### 5.2

#### Age

The Healers age ranged from 10 years to 100 years with a mean age of 52 years see table 4 below:-

TABLE 4:

#### AGE OF TRADITIONAL HEALERS

| AGE GROUP     | FREQUENCY  | PERCENT     |
|---------------|------------|-------------|
| 10 - 19       | 1          | 0.2%        |
| 20 - 29       | 29         | 6.6%        |
| 30 - 39       | 63         | 14.4%       |
| 40 - 49       | 79         | 18.1%       |
| 50 - 59       | 99         | 22.7%       |
| 60 - 69       | 80         | 13.7%       |
| 70 - 79       | 44         | 10.1%       |
| 80 - 89       | 15         | 3.4%        |
| 90 + +        | 8          | 1.8%        |
| Does not know | 39         | 8.9%        |
| <b>TOTAL</b>  | <b>437</b> | <b>100%</b> |

## 5.3

Ethnicity

Most Healers are Baganda (71%) followed by Banyarwanda (9%), Banyankole (7%) Barundi (6%) and the rest (5%) are Bakiga, Banyoro, Batoro, Basoga, Bamba and other tribes from Tanzania see table 5 below:-

TABLE 5

ETHNICITY OF TRADITIONAL HEALERS

| ETHNIC GROUP | FREQUENCY  | PERCENT    |
|--------------|------------|------------|
| Baganda      | 310        | 71%        |
| Banyarwanda  | 39         | 9%         |
| Banyankole   | 32         | 7%         |
| Barundi      | 27         | 6%         |
| Bakiga       | 8          | 2%         |
| Others       | 21         | 5%         |
| <b>TOTAL</b> | <b>437</b> | <b>100</b> |

## 5.4

Religion

The Majority of the Healers are Roman Catholic as seen in the table 6 below and other religion Seventh Day Adventists, Saved and Malachi.

TABLE 6

RELIGION OF TRADITIONAL HEALERS

| RELIGION         | FREQUENCY  | PERCENT     |
|------------------|------------|-------------|
| Roman Catholic   | 205        | 47%         |
| Church of Uganda | 123        | 28.2%       |
| Moslim           | 96         | 22%         |
| None             | 2          | 0.5%        |
| Others           | 10         | 2%          |
| <b>TOTAL</b>     | <b>436</b> | <b>100%</b> |

## 5.5

Marital Status

The majority of the Healers are married and it was difficult to distinguish the divorced from the separated; See table 7 below:-

TABLE 7

MARITAL STATUS OF TRADITIONAL HEALERS

| MARITAL STATUS | FREQUENCY  | PERCENT     |
|----------------|------------|-------------|
| Married        | 280        | 64.2%       |
| Single         | 102        | 23.4%       |
| Widowed        | 44         | 10.1%       |
| Divorced       | 10         | 2.3%        |
| <b>TOTAL</b>   | <b>436</b> | <b>100%</b> |

## 5.6

Education

According to the findings of this study, about one third of the THs in Gomba have no formal education. Those who can read and probably comprehend Luganda are about 47.8% as table 8 below shows:-

TABLE 8

EDUCATION OF TRADITIONAL HEALERS

| EDUCATIONAL LEVEL | FREQUENCY  | PERCENT     |
|-------------------|------------|-------------|
| None              | 144        | 33%         |
| P.1 - P.3         | 85         | 19.5%       |
| P.4 - P.7         | 163        | 37.4%       |
| S.1 - S.4         | 36         | 8.3%        |
| S.5 - S.6         | 2          | 0.5%        |
| Others            | 6          | 1.4%        |
| <b>TOTAL</b>      | <b>436</b> | <b>100%</b> |

## 5.7

Years in Practice

The average years of practice are 21 years though there are some healers who cannot tell the number of years they have been in practice.

About 74% of the healers were treating childhood diarrhoea and only 26% were not handling diarrhoea cases. About 95% of the healers were interested in participating in a workshop indicating that the majority of the healers are interested in workshop. Of all the healers 65% were considered by the interviewers to be suitable for training.

## 5.9

Childhood illnesses treated by the Traditional Healers in Gomba County

Traditional Healers that do treat children in Gomba County do treat a number of childhood illnesses including behavioral illnesses such as Busobe. The major illnesses mentioned by THs are listed in table 9.

TABLE 9

CHILDHOOD DISEASES TREATED BY TRADITIONAL HEALERS IN GOMBA COUNTY

| CHILDHOOD DISEASES TREATED BY THs    | NO OF RESPONSES | PERCENT |
|--------------------------------------|-----------------|---------|
| Simple Diarrhoea                     | 233             | 16%     |
| Eyabwe (Cerebral Malaria)            | 203             | 14%     |
| Obusobe                              | 130             | 9%      |
| Ekikubuko (enlarged spleen)/ Malaria | 99              | 7%      |
| Measles                              | 71              | 5%      |
| Kigalanga                            | 70              | 5%      |
| Enjoka (worms)                       | 64              | 4%      |
| Omusujja (fever)                     | 58              | 4%      |
| Obwosi (Kwashiorkor)                 | 58              | 4%      |
| Vomiting                             | 55              | 4%      |

N.B. One Healer treats more than one disease.

Other illnesses mentioned were bloody diarrhoea, whooping cough, "ekibengo" (marasmus), common cold, prolapsed rectum, jaundice and "emizimu" (spirits).

5.10: Diarrhoeal Diseases treated by THs in Gomba:

It was in the interests of this survey to find out the different types of diarrhoea diseases treated by THs in Gomba. The findings show that there are 27 different types of diarrhoeal diseases treated by the THs. However, the top ten diarrhoeal diseases treated are shown in table ten below.

**TABLE 10**

**TOP TEN DIARRHOEAL DISEASES TREATED BY TRADITIONAL HEALERS IN GOMBA COUNTY.**

| TYPE OF DIARRHOEA   | NO. OF RESPONSES | PERCENT    |
|---------------------|------------------|------------|
| 1. Simple Diarrhoea | 180              | 27         |
| 2. Bloody Diarrhoea | 180              | 27         |
| 3. Obusobe          | 128              | 19         |
| 4. Enjoka (worms)   | 47               | 7          |
| 5. Measles          | 33               | 5          |
| 6. Enlarged Spleen  | 29               | 4          |
| 7. Kwashiorkor      | 27               | 4          |
| 8. Eyabwe           | 27               | 4          |
| 9. Ekigalanga       | 14               | 2          |
| 10. Fever           | 10               | 1          |
| <b>TOTAL</b>        | <b>678</b>       | <b>100</b> |

**N.B** One TH treats more than one type of diarrhoea.

There are 27 different types of diarrhoea treated by Traditional Healers in Gomba County (see appendix for full list)

5.11 **Danger Signs of Diarrhoea**

Awareness of danger signs of diarrhoea is crucial in the management of diarrhoea. In this study, therefore, THs were asked to mention the danger signs of diarrhoea they knew. Their responses are shown in Table 11 below:-

**TABLE 11****DANGER SIGNS OF DIARRHOEA MENTIONED BY THS**

| <b>SIGN</b>        | <b>FREQUENCY</b> |
|--------------------|------------------|
| Sunken eyes        | 165              |
| Loose skin         | 115              |
| Irritability       | 66               |
| Blood in stool     | 59               |
| Dry mouth          | 38               |
| Thirst             | 30               |
| little or no urine | 11               |
| Others             | 95               |

Note: Traditional Healers could mention more than one danger sign of diarrhoea.

**5.11****Prevention of Diarrhoea**

The baseline survey was interested in finding out whether Traditional Healers knew how to prevent diarrhoea. They were therefore asked how one prevents diarrhoea. The responses are recorded in table 12 below:-

**TABLE 12****HOW TRADITIONAL HEALERS PREVENT DIARRHOEA**

| <b>PREVENTIVE MEASURES</b> | <b>FREQUENCY</b> |
|----------------------------|------------------|
| Boil water                 | 107              |
| Cover food                 | 93               |
| Clean surroundings         | 91               |
| Use latrine                | 71               |
| Wash hands                 | 65               |
| Clean utensils             | 58               |
| Keep flies away            | 40               |
| Cover latrine              | 21               |
| Wash fruits                | 19               |
| Immunise                   | 8                |

Note: Traditional Healers could mention more than one preventive measure.

## **6.0**        **DISCUSSION**

### **6.1**        **Socio-demographic Data**

The majority (95%) of THs in Gomba are of Bantu origin. Their characteristics such as average age, specialties and average number of years in practices are similar to those found in the previous studies (Hogle et al 1990; and Lwanga et al 1991) Most of them (75%) are christians, (Roman Catholics and Protestants) married, and can read and write at least in Luganda, the dominant language in the county. Again most of them (?%) treat childhood diseases including diarrhoea.

### **6.2**        **THs and Management of Diarrhoea**

Many THs in Gomba County treat a variety of diarrhoea including behavioural (obusobe) and developmental (teething, crawling, etc) diarrhoea. However, in their treatments they do not give oral fluids per se to stop dehydration. Fluids are given because they have to be mixed with the herbs which are intended to stop diarrhoea. In fact, there is no indication that THs in this survey are concerned about dehydration as a serious consequence of diarrhoea.

Although THs mentioned sunken eyes, loose skin, irritability, etc. as danger signs of diarrhoea there was no indication that treatment is geared to counteract them.

Furthermore, no TH mentioned continued breastfeeding during diarrhoea or the use of extra/additional feeding after diarrhoea has stopped.

Comparing the number of THs in this study with their responses about prevention of diarrhoea, it is evident that most THs are not aware of how diarrhoea can be prevented in a home. Many THs are concerned with stopping diarrhoea once it has started. Even in case of "obusobe" (behavioural diarrhoea) the preventive part of it mentioned by some THs is not necessarily concerned with diarrhoea but probably some of the other consequences of the condition. These would include the revelation that one has had extramarital sexual intercourse which could easily weaken the marriage; and the anxiety that might accompany confession of the guilty person.

It is also interesting to note that there was no correlation between THs level of education and management of diarrhoea especially the recognition of danger signs, giving oral fluids, and prevention of diarrhoea. For instance those with no formal education at all knew similar numbers of danger signs as those who had been to school

(Primary four onwards). This is probably because those THs who had formal education did so before Health Education was introduced in the school curriculum. It is also possible that THs have learnt about danger signs of diarrhoea through their practices or some other sources.

THs did not mention counselling in their management of diarrhoea. It is possible that the designing of the tool for data collection in the survey did not specifically address this objective of the UTHIVP. Nevertheless, THs in Gomba County treat both adults and children. This combination of knowledge and skills (dealing with adults and children) will be advantageous when addressing counselling mothers about home treatment and prevention of diarrhoeal illnesses.

### **6.3 Collaboration Between THs and HWs**

The majority of THs are willing to collaborate with HWs on health matters. However, THs expressed skepticism about Health Workers referring patients to Traditional Healers. This fear is probably rooted in the colonial legacy that the use of tradition medicine is a sign of being a pagan and that THs are at the same time "Witchdoctors."

On the other hand some HWs had also wondered about the reasons for referring patients to THs. In principle, after treatment at H/units and as judged by HWs some diarrhoea cases could be referred to trained THs for follow up. In this way THs could help to monitor the progress of the child. This could save the time of the mothers/caretakers since they may go to the nearest TH instead of covering long distances to the Health Units. Again THs would offer counselling services on prevention of diarrhoea to mother/caretakers whose children have had diarrhoea. THs would therefore act as agents of change in the prevention and management of diarrhoea at home. Collaboration would work better and probably be more effective if it is seen by THs as a two-way process.

### **6.4 Participation in Training Workshop**

As indicated in this and other studies (Hogle et al 1990 and Lwanga et al 1991), THs are interested in participating in training workshops involving HWs on topics of common interests about childhood diseases and other health issues.

Although this survey did not focus on specific topics of interest by THs, the findings of previous studies (Hogie et al 1990; 1991, and Lwanga et al 1991) would be useful when selecting topics for the training workshops.

Since the UTHIVP wishes to include 10% of THs on Gomba in the training workshops, suitable criteria would have to be decided upon. The criteria would probably include the following:-

- Age of THs - preferably < 60 years. (beyond this age retention of learned material could pose problems and there is no correlation between age and number of patients seen).
- Number of years in practice - THs should have been in practice preferably for five or more years.
- Treatment of childhood diseases including diarrhoea.
- Treatment of at least 2 children a day (as stated in personal interviews).
- Ability to read and write in Luganda (Luganda is the commonly spoken language in Gomba).
- Recommendation/assessment by interviewer during personal interview with THs.

## **6.5 Evaluation of UTHIVP**

This being a baseline survey, its findings will certainly be useful in the evaluation of the UTHIVP.

The main elements/aspects that would be useful in evaluation include:

1. THs knowledge about the relationship between dehydration and diarrhoea
2. THs knowledge about danger signs of diarrhoea
3. Changed emphasis from stopping diarrhoea to stopping dehydration.
4. THs emphasis on the use of Home Available Fluids in the management of Diarrhoea
5. THs counselling mothers/caretakers of children with diarrhoea

6. THs knowledge on prevention of diarrhoea
7. Knowledge of mothers and caretakers (counselled by THs) on prevention and home case management of diarrhoea
8. Changed attitudes on Religious Leaders towards THs
9. Collaboration between THs and HWs.
10. Multiplier effect of the UTHIVP - especially for those other THs who will not be trained.
11. The incidence/morbidity of diarrhoea in Gomba county (although no data was available at the time of the survey, the incidence of diarrhoea in Gomba was assumed not very different from that of Mpigi District).

#### **6.6 Estimated number of Traditional Healers**

Using the predictions (14 THs per parish) of the 1990 Traditional Healers Study (Jane Jogle et al), it had been estimated to obtain 518 healers in Gomba County. However, 437 healers were interviewed and there were slightly more women (52%) than men (48%).

## **7.0 CONCLUSIONS**

- 1. On the basis of the findings of this Baseline Survey, 84.4% (N=518) of the expected Traditional Healers in Gomba county were enumerated. Hence one of the objectives of the survey was achieved.**
- 2. Traditional Healers in Gomba County treat different types of Diarrhoea and other childhood illnesses. Some of the Traditional Healers that were interviewed in this Survey are trainable and capable of passing on messages to target groups of caretakers of children below five years of age.**
- 3. THs know how to prevent diarrhoea; however, the majority of them are not aware of the danger signs of diarrhoea.**
- 4. In the management of diarrhoea, THs in Gomba county are not aware of the bad consequences of diarrhoea. They put more emphasis on using herbal medicine to stop diarrhoea rather than giving home available fluids once diarrhoea sets in. No traditional healer talked of extra feeds or even breast feeding during or after diarrhoea.**
- 5. According to the findings the majority of THs are willing and interested in participating in the Training Workshops to share ideas about managing Diarrhoea in children at home.**
- 6. THs raised issues regarding the problems that may be encountered in carrying out the proposed Vanguard Project. They were mainly concerned with the HWs and Religious leader's attitude to traditional medicine. They also wondered whether HWs would ever refer patients to them (THs)**
- 7. The Communities in Gomba County are positive about UTHIVP and willing to support and sustain it. However, they were negative about some practices of some THs like witch craft.**

## **8.0 RECOMMENDATIONS**

- 1. Those Healers who are to be trained should be below the age of 60 years, have been in practice for five or more than 6 years, able to read and write Luganda and treat per day at least 2 children suffering from childhood diseases including diarrhoea. They should also be THs who were recommended by the interviewers. (see Appendix II for list of THs for training)**
- 2. In view of the activities the healers are engaged in their respective areas, it is recommended that training of participants (TOP) take place in the afternoon and preferably in dry seasons.**
- 3. The District Facilitating Team should continue with the sensitization exercise.**
- 4. Since THs are not managing Diarrhoea properly the training of trainers (TOT) should start as soon as possible preferably January 1993.**
- 5. Since THs are not aware of the bad consequences of diarrhoea, they should be introduced to:**
  - a) The use of Home Available Fluids in the management of diarrhoea.**
  - b) The value of a balanced diet during and after diarrhoea has stopped.**
- 6. It is strongly recommended to include components of attitude formation and change in the training of trainers and participants (TOT and TOP). This will help to overcome some of the negative attitudes held by different factions in the community.**
- 7. The training of participants (TOP) should include some of the topics on which they wish to learn.**

## REFERENCES

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3. Mpigi District Administration Health Plan for 1992
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MPIGI DISTRICT MEDICAL OFFICE  
P.O. BOX 161  
MPIGI  
16TH OCTOBER 1992

TO:-  
THE SUB-COUNTY CHIEF.....  
THE PARISH CHIEF.....  
CHAIRMAN RC.III.....  
CHAIRMAN RC.II.....  
CHAIRMAN RC.I.....

RE:- OKUNONYEREZA KWEKITONGOLE KY'EBYOBULAMU MU SSAZA LYE  
GOMBA KUGIKWATAGANA NE NDWADDE Y'E KIDDUKANO MU BAANA  
OKUVA NGA 19TH-30TH OCTOBER 1992

Okusinzira ku songa eyo waggulu, nina esanyu okutegeza nti ekitongole ky'ebbyobulamu nga kiri wamu n'e bitongole ebilala bajja kukyala mu Ssaza lye Gomba, basisinkane abantu hanno wamanga kumbuga zemiluka gyabwe:-

1. Chairman RC.II ne RC.I mubuli kyalo ekiri mu muluka;
2. Secretaries RC.II ne RC.I mubuli kyalo ekiri mu muluka;
3. Secretaries for Women RC.II ne RC.I mubuli kyalo ekiri mu muluka;
4. Secretaries for Mass Mobilization RC.II ne RC.I mubuli kyalo ekiri mu muluka;
5. Abassawo Bonna Abekinansi abali mu muluka;
6. Abami ab'emiluka nabatongole ababuli kyalo ekiri mu muluka;
8. Abakulumbeze b'eddini zonna eziri mu muluka;
9. Chairman wakiiko n'o Muwandiisi we abakola kubyobulamu;
10. Abakulumbeze bebibina ebitali bimu mu buli Muluka;
11. Abasomesa mubuli masomero agali mu muluka;
12. Obukiiko Bweby'obulamu obwabuli ngeri yonna mu buli Muluka.
13. Abakyala ababaana abatanawqeza myaka etaano abaliranye ekifo omuluka wegukunganira.

Okusisinkana abantu abo abogedwako waggulu kwakutandikanga essawa 4.00 (nnya) ezenkya mubuli Muluka kulunaku olunaba lulonedwa.

Nze Omuweerezawo,

Dr. R. Nasanga  
DISTRICT MEDICAL OFFICER/MPIGI

16TH OCTOBER 1992

TO:-

THE SUB-COUNTY CHIEF.....

THE PARISH CHIEF.....

CHAIRMAN RC.III.....

CHAIRMAN RC.II.....

CHAIRMAN RC.I.....

RE:- RESEARCH BY THE MINISTRY OF HEALTH ON CHILDHOOD DIARRHOEA  
IN GOMBA COUNTY FROM 19TH - 30TH OCTOBER 1992.

Regarding the above mentioned research, I am pleased to inform you that the Ministry of Health together with Department of Culture and Makerere University will visit Gomba county to meet the following people at their respective Parish Headquarters:-

1. Chairmen RC.II and RC.I of all villages in the Parish;
2. Secretaries RC.II and RC.II of all the villages in the Parish;
3. Secretaries for Women RC.II and RC.I of all the villages in the Parish;
4. Secretaries for mass Mobilization RC.II and RC.I of all the villages in the Parish;
5. Secretary for information RC.II and RC.I of all the villages in the Parish;
6. All Traditional Healers in the Parish;
7. Parish Chiefs and Villages Chiefs of all villages in the Parish;
8. All religious leaders in the Parish;
9. Chairman and Secretary of each Health Village Committee;
10. Heads of various groups in the Parish;
11. Teachers in Schools in the Parish;
12. Organizations related to health operating in the Parish; and
13. Mothers of children under five years of age around the parish headquarters.

The meeting with the above mentioned people will begin at 10.00am at every Parish Headquarters on the agreed date.

Yours faithfully

Dr. R. Nasanga

DISTRICT MEDICAL OFFICER/MPIGI

## APPENDIX II

### LIST OF THS SELECTED FOR TRAINING (TOP)

#### MPENJA SUB-COUNTY

|     | <u>NAME OF TH</u>       | <u>PARISH</u>       | <u>VILLAGE</u> |
|-----|-------------------------|---------------------|----------------|
| 1.  | Makumbi Michael         | Kiriri              | Kiriri         |
| 2.  | Nantege Vellia          | Ngomanene           | Ngomanene      |
| 3.  | Majambere               | Ngomanene           | Nakasozi       |
| 4.  | Stephen Kibubbu         | Golola              | Kitojjo        |
| 5.  | Deborah Nantayi Ndongo  | Golola              | Kitojjo        |
| 6.  | Kasagara Fred           | Kanzira             | Nkole          |
| 7.  | Kisenyi Ruth Musika     | Mpogo               | Kikoko         |
| 8.  | Yafesi Kyewalyanga      | Mpogo               | Busolo         |
| 9.  | Keefa Nsibambi Ssalongo | Luzira (Sabagabo B) | Kyegaliro      |
| 10. | Mwalimu Kaggwa          | Luzira (Sabagabo B) | Luzira         |
| 11. | Mohamed Kaweesi         | Luzira (Sabagabo B) | Ngeye          |
| 12. | Sematengo               | Sabagobo B (Luzira) | Ngeye          |

#### MADDU SUB-COUNTY

|    |                           |                 |            |
|----|---------------------------|-----------------|------------|
| 1. | Nabyoga Restetuta         | Degeya          | Kigulubya  |
| 2. | Namukasa (Christine Yiga) | Degeya          | Kamengo    |
| 3. | Francis Namwandu Nakavuma | Mumyuka (Maddu) | Mugya      |
| 4. | Nalongo Ssembatya         | Mumyuka         | Sakabusolo |
| 5. | Ssenkubuge Mohamud        | Degeya          | Degeya     |
| 6. | Hussein Mayanja           | Degeya          | Degeya     |

#### KABULASOKE SUB-COUNTY

|     |                          |           |             |
|-----|--------------------------|-----------|-------------|
| 1.  | Nabakobwa Annet          | Lugaaga   | Wabibo      |
| 2.  | Nalubega Jane            | Mawuki    | Buhinda     |
| 3.  | Hajati Masitula Nakyajja | Mawuki    | Nakulamudde |
| 4.  | George Sseyonga          | Mawuki    | Mawuki      |
| 5.  | Teddy Nsubuga            | Mawuki    | Nakulamudde |
| 6.  | Kagombe Marn             | Kifampa   | Lwabayaga   |
| 7.  | Adam Kyakuwadde          | Kifampa   | Miti-egonda |
| 8.  | Paschal B. Musoke        | Butiti    | Butiti      |
| 9.  | Scholastica Kigozi       | Butiti    | Lubaale     |
| 10. | Namutebi Fatima          | Mawuki    | Nakulamudde |
| 11. | George Kiyingi           | Rukandula | Rigo A.     |

#### KYEGONZA SUB-COUNTY

|     |                         |             |              |
|-----|-------------------------|-------------|--------------|
| 1.  | Flasica Nampijja        | Mamba       | Mamba        |
| 2.  | Hajji Badru Serugunda   | Mamba       | Nabuyindo    |
| 3.  | Kasujja George William  | Saali       | Mabuye       |
| 4.  | Elmah Kasirye Ssalongo  | Saali       | Ssali        |
| 5.  | Teopista Matovu         | Saali       | Bukalagi     |
| 6.  | Yowasi Kazooba          | Koome       | Koome        |
| 7.  | Hamadi Ssali            | Kanoni      | Kanoni       |
| 8.  | Mbuule Lawrence         | Kanoni      | Kiwanda      |
| 9.  | Nakirya Maria           | Wanjeyo     | Kirumba      |
| 10. | Sselestino Ssentongo    | Wanjeyo     | Mayangayanga |
| 11. | Edward Minge            | Wanjeyo     | Mayangayanga |
| 12. | Ssetumba Sanyu Margaret | Bukundugulu | Nsanvu       |
| 13. | Busulwa Laurensio       | Bukundugulu | Bukundugulu  |
| 14. | Kasalina Nanfuka        | Kisoga      | Kisoga       |
| 15. | Getrude Naziwa Kivumbi  | Kisoga      | Namuyoba     |

APPENDIX III

LIST OF DIARRHOEA RELATED DISEASES.

LUGANDA

Embiro, Ekidukano  
Okutuula  
Okwavula  
Okutambula  
Okuntandika, Okuwa Omwana, Emeere  
Endala  
Ebinnyo  
Enyumba Empya  
Emmere Embi  
Ebiwuka, Enjoka  
Obusobe  
Obwosi, Omusana  
Okuyonsa nga omukyala ali lubuto  
Olukusense, Omulangira  
silumu  
Oburo  
Muwogo  
Okukwata ensenene  
Omukweno  
Akabengo, Ekikubuuko  
Emizimu

ENGLISH

Simple diarrhoea or water stools  
Sitting  
Crawling  
Walking  
  
Weaning  
False teeth  
New House  
Unsuitable food  
Worms  
Sexual misbehaviour  
Kwashirkor  
Breastfeeding while pregnant  
Measles  
AIDS  
Millet disease  
Cassava disease  
Catching grasshoppers  
Main House Pole  
Enlarged spleen  
Spirits

APPENDIX IV LIST OF MOBILIZERS, INTERVIEWERS AND SUPERVISORS

MOBILIZERS:

|                        |  |
|------------------------|--|
| Mr. J.S. Lwanga        | Team Leader - Project Technical Co-ordinator |
| Mr. Jjuko              | Health Assistant - Mpigi                     |
| Mrs. Buwembo Nansubuga | Assistant Health Educator i/c Gomba county   |
| Ms. Sarah Kabuye       | DHV Mpigi                                    |
| Ms. Tabisa Mawano      | District Cultural Officer                    |

INTERVIEWERS

|                       |  |
|-----------------------|--|
| Ms. Tabaaro Winfred   | CDD - Ministry of Health                 |
| Ms. Mbonye Betty      | HE - Ministry of Health                  |
| Mr. Kasozi Edward     | DHE Mpigi                                |
| Mr. Sebugwawo A       | DHI Mpigi                                |
| Ms. Kiggundu Molly    | Grade 'B' Hospital Entebbe               |
| Ms. Namangi F         | P.O.Box 1 Entebbe                        |
| Ms. Nakiggudde Grace  | Mass Communication - Makerere University |
| Ms. Nabbanja SC       | Makerere University                      |
| Ms. Ntegamahe         | Teacher - Kololo SSS                     |
| Ms. Rita Kyalikampa   | Community development office             |
| Ms. Mpairwe Christine | Makerere University                      |
| Ms. Kaggwa Florence   | Social Scientist Makerere University     |

SUPERVISORS

|                      |  |
|----------------------|--|
| Dr. Nansanga Ruth    | DMO Mpigi                                    |
| Mr. W.W. Lwanga      | DHI Masaka                                   |
| Mr. Kasozi Bulezi    | Cultural Officer                             |
| Mrs. Kisamba Mugerwa | Department of Sociology Makerere University. |